[2020] FWCFB 3827

DECISION

Fair Work Act 2009
s.156 - 4 yearly review of modern awards

4 yearly review of modern award—*Aboriginal Community Controlled Health Services Award 2010*

(AM2018/12)

Indigenous organisations and services

DEPUTY PRESIDENT GOSTENCNIK
DEPUTY PRESIDENT MASSON
COMMISSIONER BISSETT

MELBOURNE, 22 JULY 2020

4 yearly review of modern awards – Aboriginal Community Controlled Health Services Award 2010 – substantive claims.

Introduction and Background

[1] This decision deals with substantive claims made by the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) and the Health Services Union of Australia (HSU) for variations to the *Aboriginal Community Controlled Health Services Award 2010* (Award) that are being dealt with as part of the 4 yearly review of modern awards (the Review).

[2] The Review has been conducted by the Fair Work Commission (the Commission) in three stages —an initial stage, a common issues stage and an award stage. The award stage and the common issues stage have run in parallel and the award stage has included dealing with claims to make substantive changes to award provisions. For the purposes of scheduling, the award stage divided the 122 modern awards into four groups for determination. The Award is being reviewed in Group 4 of the award stage.

[3] As part of the Review, a core Full Bench was established to hear and determine technical and drafting matters arising from each group during the award stage. The core Full Bench has heard and determined a number of technical and drafting matters in respect of the Award,[1] culminating in the finalisation of an exposure draft and determination of the consequent

[1] See for example [2018] FWCFB 1548, [2018] FWCFB 4175, [2018] FWCFB 6852.

variations.[2] In determining the variations the title of the Award has been changed to the *Aboriginal Community Controlled Health Services Award 2020* (the 2020 Award). The core Full Bench noted that there were a number of substantive variations sought to be made to the Award which required determination and it was proposed that a separate Full Bench be constituted to hear and determine those matters.[3]

Nature of the application

[4] The NATSIHWA and the HSU seek substantive variations to the Award. On 1 October 2018, Justice Ross issued a Statement[4] constituting this Full Bench to consider the variations sought. To facilitate the determination of these matters, directions for interested parties to file materials were issued. Pursuant to the directions, submissions and witness statements were filed by NATSIHWA, HSU, United Voice (now United Workers' Union), Australian Federation of Employers and Industries (AFEI) and Australian Business Industrial and the New South Wales Business Chamber (ABI). The matter was listed for hearing before us on 25 and 26 July 2019.

[5] For the reasons recorded in the transcript,[5] following the hearing some further directions were issued for the filing of further material. Submissions were received from NATSIHWA, the HSU and the Australian Medical Association (AMA).

Background to the making of the Award

[6] On 28 March 2008, the Minister for Employment and Workplace Relations (the Minister) made an award modernisation request under section 576C of Part 10A of the *Workplace Relations Act 1996*. The award modernisation process was carried out by the Commission pursuant to Part 10A of the *Workplace Relations Act 1996* (WR Act), Schedule 5 to the *Fair Work (Transitional Provisions and Consequential Amendments) Act 2009* (Transitional Act) and the request by the Minister, (as amended and referred to as the consolidated request).[6]

[7] In a statement issued on 25 September 2009[7], the Commission noted that it had received a range of submissions from indigenous organisations seeking to have awards made that were to apply only to those indigenous organisations and their employees.

[8] Having considered the submissions, the Commission determined that the operation of aboriginal community controlled health organisations should be regulated by a separate modern award. The Full Bench said:

> "We are satisfied that the nature of health services that are delivered in a culturally appropriate way is sufficiently different to justify a separate award. The difference is not

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[2] [2020] FWCFB 1541, PR716550.

[3] [2018] FWCFB 4175 at [16].

[4] [2018] FWC 6107.

[5] Transcript dated 26 July 2019 at PN1312 - PN1314 and PN1550 - PN1554.

[6] The request was varied on 7 occasions: 16 June and 18 December 2008, 2 May, 28 May, 1 July, 17 August and 26 August 2009.

[7] [2009] AIRCFB 865.

only about the way the services are established and controlled but is critically seen in the way that employees of the services operate. We accept that the aboriginal health worker within aboriginal community controlled health services is critical. No equivalent health care worker operates in what we might describe as mainstream services."[8]

[9] The Award was made on 4 December 2009.[9]

Background to NATSIHWA

[10] NATSIHWA is the national health professional organisation for Aboriginal and Torres Strait Islander (A&TSI) health workers and practitioners (A&TSIHWs and A&TSIHPs). These health workers and practitioners work in the Aboriginal and Torres Strait Islander communities.[10] NATSIHWA contends that prior to its establishment on 7 August 2009,[11] neither A&TSIHWs nor A&TSIHPs had an opportunity to provide input as to the provisions of the Award which affected them.[12] NATSIHWA liaises between Aboriginal community controlled and non-Indigenous community controlled services. In particular, NATSIHWA provides culturally appropriate[13] healthcare programs and resources to support A&TSIHWs and A&TSIHPs whether they are employed in an Aboriginal Community Controlled Health Organisation, in a mainstream health service or in private practice.[14] To assist with 'closing the gap', A&TSIHWs and A&TSIHPs adopt a holistic approach to health care which is aligned with traditional Aboriginal and Torres Strait Islander culture and philosophy.[15]

Background to closing the gap

[11] NATSIHWA relies on the Council of Australian Governments' (COAG) social policy – "Closing the Gap" – to illustrate the disparity between the health and social outcomes of non-Aboriginal and or Torres Strait Islanders and Aboriginal and/or Torres Strait Islanders.[16] Despite national initiatives such as "Closing the Gap", NATSIHWA contends there remains a health disparity amongst Indigenous Australians and this places additional pressure on Indigenous health professionals. NATSIHWA suggests that this profession is not covered by any modern award.[17]

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[8] Ibid at [125].

[9] PR991082.

[10] Transcript dated 25 July 2019 at PN14.

[11] NATSIHWA Submission dated 18 June 2019 at [3]. See also Transcript dated 25 July 2019 at PN74.

[12] Transcript dated 25 July 2019 at PN15.

[13] Ibid at PN86.

[14] Transcript dated 25 July 2019 at PN77 to PN81. See also Witness Statement of Karl John Briscoe dated 18 June 2019 at [12].

[15] Transcript dated 25 July 2019 at PN384.

[16] NATSIHWA Submission dated 18 June 2019 at [4].

[17] Transcript dated 25 July 2019 at PN306 - PN316.

Summary of variations sought

NATSIHWA claims

Expanding coverage of the Award

[12] NATSIHWA seeks to vary the coverage of the Award to include Aboriginal and/or Torres Strait Islander health workers and practitioners as an occupation, so as to extend award coverage to A&TSIHWs and A&TSIHPs in private practice. It also seeks a consequential amendment to the title of the Award.

Introducing a 6 "Grade" classification structure to incentivise education, training and development

[13] NATSIHWA contends there is a lack of opportunity for career progression in the existing 4 Grade classification structure in the Award. The additional two grades proposed are created in part by separation of the current grade 1 into two grades – grade 1 and grade 2. It says that such an amendment will assist grade 1 employees to obtain a Certificate II in A&TSI Primary Health Care (grade 1); and recognise those employees who have already obtained the Certificate II. Currently, the Award does not recognise the Certificate II.

[14] NATSIHWA also seeks to include several new definitions which are proposed for the classification structure it seeks.

Work value case

[15] The 6 Grade structure would also include a new Grade 6 for Senior Health Practitioners and Coordinator Care for which NATSIHWA seeks to make a work value case in support of.

Introducing clauses for "progression", "recognition of previous service" and "evidence of qualifications"

[16] NATSIHWA proposes new "progression", "previous service" and "evidence of qualifications" provisions. Taken together, NATSIHWA contends that the proposed provisions clarify the existing operation of the Award with respect to progression within a grade and provide a balanced and fair mechanism for classification/minimum wage determination on commencement for employees and employers.

Introducing allowances

[17] NATSIHWA seeks to insert several new allowances – a telephone allowance, a nauseous work allowance, a blood check allowance, a damaged clothing allowance, a heat allowance, a sole practitioner allowance, an occasional interpreting allowance and a medication administration allowance.

Expanding the ceremonial leave clause

[18] NATSIHWA also seeks to expand the ceremonial leave clause to allow unpaid leave for bereavement related ceremonies and obligations.

Summary of positions of other interested parties

National Aboriginal Community Controlled Health Organisation

[19] The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak body representing 143 Aboriginal Community Health Services on Aboriginal health and well-being issues[18]. NACCHO supports the expansion of Award coverage to A&TSIHWs and A&TSIHPs employed in private practice settings[19]. NACCHO also supports the insertion into the Award of the Level 6 management grade classification proposed by NATSIHWA.[20] NACCHO did not appear in the proceedings.

Australian Federation of Employers and Industries

[20] AFEI opposes some of the allowance claims but notes that a number of the allowance claims are agreed.[21] Otherwise it opposes or does not support aspects of the classification structure and the expanded coverage proposals.[22] AFEI wrote to the Commission on 19 July 2019 advising it would not attend the oral hearings.

HSU

[21] The HSU supports the claims of NATSIHWA. In addition, it seeks to vary the Award to introduce provisions for tea-breaks and a removal expenses allowance, provisions for casual loading to be paid in addition to public holiday rates and amending the on-call and recall allowance provision to allow a 10 hour break between work recalls, instead of the current six hour break entitlement.[23]

Australian Business Industrial & NSW Business Chamber

[22] ABI filed written submissions in the proceedings. On 24 July 2019 ABI wrote to the Commission stating it relied on its written submissions.

Australian Medical Association

[23] The AMA agrees that the Award should provide fair conditions for the essential role that A&TSI Health Workers and Health Practitioners have in community-controlled health services and supports proposed variations that improve their working conditions. The AMA notes that private medical practitioners are covered by the *Health Professionals and Support Services Award 2010* (HPSS Award) and submits that the coverage issue which is currently the subject of proceedings in AM2016/31 (substantive issues in the HPSS Award) should be resolved before the coverage claim before us. The AMA submits that NATSIHWA should intervene or make an application to vary in those proceedings.

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[18] *About NACCHO* (Web Page) https://www.naccho.org.au/about/

[19] Witness statement of Karl John Briscoe dated 18 June 2019, Exhibit KB-1, Tab 87 –Correspondence from NACCHO to Mr Karl Briscoe dated 18 June 2019.

[20] Exhibit 3, Correspondence with amended draft determination to Mr Briscoe from Ms Turner dated 25 July 2019.'

[21] AFEI Submission dated 19 July 2019 at [1.23]-[1.24].

[22] AFEI Submission dated (in AM2014/250) dated 24 April 2017 at [5]-[6].

[23] HSU Submission dated 18 June 2019 at [2].

Legislative context

[24] The legislative context for the Review was canvassed in detail in the *4 yearly Review of Modern Awards: Preliminary Jurisdictional Issues* decision (the Preliminary Jurisdictional Issues Decision).[24]

[25] Subsection 156(2) of the *Fair Work Act 2009* (Act) provides that the Commission must review all modern awards and may, amongst other things, make one or more determinations varying modern awards. The 'scope' of the Review was considered in the Preliminary Jurisdictional Issues Decision. In that decision, the Full Bench said that during the Review, the Commission will proceed on the basis that *prima facie*, the modern award being reviewed achieved the modern award objective at the time it was made.[25] Variations to modern awards should be founded on merit based arguments that address the relevant legislative provisions, accompanied by probative evidence directed to what are said to be the facts in support of a particular claim. The extent of the argument and material required will depend on the circumstances.[26] Several provisions in the Act relevant to the Review constrain the breadth of the discretion in s.156(2). The modern awards objective (in s.134) applies to the performance or exercise of the Commission's 'modern awards powers', including under Part 2-3. The modern awards objective therefore applies to the Review. The modern awards objective is set out in s.134(1):

> **"134 The modern awards objective**
>
> *What is the modern awards objective?*
>
> (1) The FWC must ensure that modern awards, together with the National Employment Standards, provide a fair and relevant minimum safety net of terms and conditions, taking into account:
>
> (a) relative living standards and the needs of the low paid; and
>
> (b) the need to encourage collective bargaining; and
>
> (c) the need to promote social inclusion through increased workforce participation; and
>
> (d) the need to promote flexible modern work practices and the efficient and productive performance of work; and
>
> (e) the principle of equal remuneration for work of equal or comparable value; and
>
> (f) the likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and
>
> (g) the need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and

[24] [2014] FWCFB 1788.

[25] Ibid at [24].

[26] Ibid at [23].

(h) the likely impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.

This is the ***modern awards objective***."

[26] Section 138 of the Act is also relevant to the Review:

"A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective."

[27] Terms that are included in modern awards must be 'necessary to achieve the modern awards objective'. That which is 'necessary' in a particular case involves a value judgment taking into account the matters in s.134 of the Act, to the extent that these are relevant, having regard to the submissions and evidence directed to those considerations. Before varying a modern award in the Review, the Commission must be satisfied that the variation is necessary to achieve the modern awards objective.

[28] Section 136 deals with the content of modern awards:

"**136 What can be included in modern awards**

Terms that may or must be included

(1) A modern award must only include terms that are permitted or required by:

(a) Subdivision B (which deals with terms that may be included in modern awards); or

(b) Subdivision C (which deals with terms that must be included in modern awards); or

(c) section 55 (which deals with interaction between the National Employment Standards and a modern award or enterprise agreement); or

(d) Part 2-2 (which deals with the National Employment Standards).

Note 1: Subsection 55(4) permits inclusion of terms that are ancillary or incidental to, or that supplement, the National Employment Standards.

Note 2: Part 2-2 includes a number of provisions permitting inclusion of terms about particular matters.

Terms that must not be included

(2) A modern award must not include terms that contravene:

(a) Subdivision D (which deals with terms that must not be included in modern awards); or

(b) section 55 (which deals with the interaction between the National Employment Standards and a modern award or enterprise agreement).

Note: The provisions referred to in subsection (2) limit the terms that can be included in modern awards under the provisions referred to in subsection (1)."

[29] No particular primacy is attached to any of the above considerations and not all will necessarily be relevant in the context of a particular proposal to vary a modern award.[27]

[30] Section 138 of the Act provides that terms included in modern awards must be "necessary to achieve the modern awards objective". That which is 'necessary' will involve a value judgment based on the assessment of the considerations stated in s.134(1)(a) to (h), having regard to the submissions and evidence.[28]

[31] The Commission's power to vary minimum wages in modern awards is constrained by s.135 of the Act, which provides the following:

> "**135 Special provisions relating to modern award minimum wages**
>
> (1) Modern award minimum wages cannot be varied under this Part except as follows:
>
> (a) modern award minimum wages can be varied if the FWC is satisfied that the variation is justified by work value reasons (see subsections 156(3) and 157(2));
>
> (b) modern award minimum wages can be varied under section 160 (which deals with variation to remove ambiguities or correct errors) or section 161 (which deals with variation on referral by the Australian Human Rights Commission).
>
> Note 1: The main power to vary modern award minimum wages is in annual wage reviews under Part 2-6. Modern award minimum wages can also be set or revoked in annual wage reviews.
>
> Note 2: For the meanings of modern award minimum wages, and setting and varying such wages, see section 284.
>
> (2) In exercising its powers under this Part to set, vary or revoke modern award minimum wages, the FWC must take into account the rate of the national minimum wage as currently set in a national minimum wage order."

[32] Subsection 156(3) of the Act provides that the Commission may only make a determination varying modern award minimum wages if it is satisfied the variation is justified by "work value reasons", which carries the meaning ascribed by s.156(4) as follows:

> "***Work value reasons*** are reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to any of the following:
>
> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work;
>
> (c) the conditions under which the work is done."

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[27] [2017] FWCFB 1001 at [115].

[28] [2014] FWCFB 1788 at [36].

Background and context to claims

[33] Before turning to consider the substantive issues, it is necessary to traverse the material advanced by NATSIHWA that underpins the claims. That material highlights, *inter alia*, the disparity in health outcomes between A&TSI and non-A&TSI Australians; the need for and importance of delivering culturally safe health care and treatment to improve health outcomes for A&TSI people; the critical role that A&TSIHWs and A&TSIHPs can play in improving health outcomes for A&TSI people; and the need to increase the number of A&TSIHWs and A&TSIHPs as well as enhancing skills development and career opportunities for A&TSIHWs and A&TSIHPs.

Need for workers

[34] A reason for the substantive changes sought by NATSIHWA is its concern for improving the health outcomes for A&TSI people. In its written submissions, NATSIHWA contends there is a glaring disparity, in Australia, between the health outcomes of non-A&TSI people and A&TSI people.[29] It contends the health gap between non A&TSIs and A&TSIs has been recognised in COAG's overarching social policy "Closing the Gap" which is designed to address the health and social outcomes including the decade gap in the life expectancy between non-A&TSIs and A&TSIs and reducing child mortality for children under five years of age.[30]

[35] NATSIHWA submits that its focus in improving health outcomes for the A&TSI community is to promote the prevention and control of diseases within the community; improve health outcomes in the pursuit of the objectives to 'Close the Gap' relating to life expectancy; address the disadvantage on the health of A&TSI people; and assist in the delivery of holistic health care within the A&TSI communities.[31] In order to achieve the health outcomes for A&TSI people, NATSIHWA says it is critical to support and increase the recognition of the roles in which A&TSIHWs and A&TSIHPs play, particularly in providing professional and culturally respectful health services to the individuals, families and communities of A&TSI people across Australia.[32]

[36] NATSIHWA submits that A&TSIHWs and A&TSIHPs deliver culturally appropriate health care in the A&TSI community.[33] NATSIHWA relies on the expert report provided by Alyson Wright which details how research evidence and clinical experience demonstrates that A&TSIHWs and A&TSIHPs involvement in the provision of health care leads to improved care and health outcomes of A&TSI people.[34]

[37] NATSIHWA also relies on Ms Wright's expert report which contends there is a need for health practitioners and health workers to provide culturally safe clinical and primary health services to A&TSI people;[35] that the health needs of the A&TSI people were not being met by mainstream services; and that the scope of work that A&TSIHWs and A&TSIHPs performed

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[29] Submission of NATSIHWA dated 18 June 2019 at [4].

[30] Ibid at [4].

[31] Ibid at [4] – [6].

[32] NATSIHWA Submission dated 18 June 2019 at [6]; NATSIHWA *Annual Report 2018* Exhibit KB-1 (tab 5).

[33] NATSIHWA Submission dated 18 June 2019 at [5]; Expert report of Alyson Wright dated 11 June 2019 at [9].

[34] NATSIHWA Submission dated 18 June 2019 at [5]; Expert report of Alyson Wright dated 11 June 2019 at [11].

[35] NATSIHWA Submission dated 18 June 2019 at [7]; Expert report of Alyson Wright dated 11 June 2019 at [12] – [13].

had evolved.[36] NATSIHWA submits that the roles of A&TSIHWs and A&TSIHPs are critical to improving health outcomes for A&TSI people and cannot be replaced by mainstream positions.[37]

[38] NATSIHWA submits that A&TSIHWs and A&TSIHPs provide culturally safe preventative health care and treatment services to A&TSI people, which is significant in providing an equitable experience for A&TSI people in terms of health care.[38] NATSIHWA points to evidence suggesting the inclusion of A&TSIHWs and A&TSIHPs in providing care for A&TSI people *facilitates culturally appropriate care, reduces communication gaps, reduces discharges against medical advice, provides cultural education, increases inpatient contact time, improves follow up practices and enhances patient referral lineages*.[39]

[39] NATSIHWA relies on the evidence of Associate Professor Lovett setting out the importance of the health professionals in closing the gap to improving the health outcomes of A&TSI people and achieving health equity. It also submits that A&TSIHWs and A&TSIHPs play the role of a cultural broker and assist A&TSI people through the health care journey and non-Indigenous health care providers to better communicate with A&TSI clients. NATSIHWA also points to Associate Professor Lovett's opinion based on his work and personal experience as a Aboriginal health worker, that extending the coverage of the Award to cover A&TSIHWs and A&TSIHPs in private practice could enable the cultural brokerage model to be expended into a sector that may provide service to approximately 53% of the A&TSI population.[40]

[40] Associate Professor Lovett also opined that discriminatory practices in non-Indigenous primary health care settings contributes to poor health outcomes and a decline in the number of A&TSI people utilising the services because of the treatment endured. According to Associate Professor Lovett, a step in redressing this issue is to have A&TSI people involved and working at numerous levels within the health care system.[41]

[41] NATSIHWA relies on the Health Workforce Australia report from 20 January 2011 (January 2011 Report). The study was undertaken to inform development policies which aim is to strengthen and sustain the Aboriginal and Torres Strait Islander Health Worker workforce into the future and to inform the requirements of the national registration of health

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[36] NATSIHWA Submission dated 18 June 2019 at [7]; Expert report of Alyson Wright dated 11 June 2019 at [12].

[37] NATSIHWA Submission dated 18 June 2019 at [7]; Expert report of Alyson Wright dated 11 June 2019 at [13].

[38] NATSIHWA Submission dated 18 June 2019 at [14]; Expert report of Associate Professor Raymond William Lovett dated 18 June 2019 at p.1.

[39] NATSIHWA Submission dated 18 June 2019 at [14]; Alyson Wright et al, 'A National Profile of Aboriginal and Torres Strait Islander Health Workers, 2006-2016' (2019) 43.1 *Australian and New Zealand Journal of Public Health* 24 (Tab 75 of Exhibit KB-1).

[40] Transcript dated 25 July 2019 at PN292; Expert report of Associate Professor Raymond William Lovett dated 18 June 2019 at p. 394-396.

[41] Transcript dated 25 July 2019 at PN293; Expert report of Associate Professor Raymond William Lovett dated 18 June 2019 at p. 396.

practitioners.[42] NATSIHWA points to parts of the report detailing cultural accessibility, particularly the following passage:

> "Health services need to be both available and culturally accessible and that separate and distinct concepts, certain barriers can render available health services inaccessible to Aboriginal and Torres Strait Islander Peoples.
>
> An individual's fear of racial discrimination might be overcome through a health worker's first approach whereby the Aboriginal and Torres Strait Islander health worker if the first point of contact in a health service for an Aboriginal and Torres Strait Islander client this can assist in establishing trusting, respectful, and understanding relationships between the client and other non-Aboriginal or Non-Torres Strait Islander health professionals.
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> Therefore, it cannot be assumed that health service availability equates to accessibility. Data has shown that some Aboriginal and Torres Strait Islanders in non-remote areas actually have a higher level of unmet need than those living in remote areas. That is despite the fact that health services are more densely concentrated and therefore more available than non-remote areas. One hypothesis explaining this phenomenon is that the increased concentration of health workers in remote areas has a positive effect on health service accessibility for Aboriginal and Torres Strait Islander people. Regardless it is clear that health services must be culturally safe to be accessible for Aboriginal and Torres Strait Islander communities."[43]

[42] NATSIHWA contends cultural context and the role it plays in accessibility to the health care system by A&TSIs is significant. Differences in culture impacts accessibility of and to healthcare services.[44] As the report noted:

> "…cultural and linguistic differences may affect the understanding of Western medical practices and the success rates of Western medical treatments and care plans for Aboriginal and Torres Strait Islander peoples. Failure to understand and accommodate the diverse cultural beliefs of Aboriginal and Torres Strait Islander communities is likely to result in inappropriate responses to their health care needs."[45]

[43] NATSIHWA submits that recognising the cultural differences between A&TSI health workers and mainstream Australian health workers, in the health and care of A&TSI people, will lead to improved health outcomes and enhance the accessibility of the health care systems for the A&TSI people.

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[42] Transcript dated 25 July 2019 at PN325.

[43] Transcript dated 25 July 2019 at PN331; Health Workforce Australia, *Aboriginal & Torres Straight Island Health Worker Project Environmental Scan: Version 7.0 Final* (Report, January 2011) at p. 3 (See exhibit KB-1 (tab 71)).

[44] Transcript dated 25 July 2019 at PN339.

[45] Transcript dated 25 July 2019 at PN340; Health Workforce Australia, *Aboriginal & Torres Straight Island Health Worker Project Environmental Scan: Version 7.0 Final* (Report, January 2011) at p.18 (See exhibit KB-1 (tab 71)).

Aboriginal & Torres Strait Islander Health Worker Project Environmental Scan: Version 7.0 Final Report

[44] NATSIHWA draws upon the January 2011 Report which considers the important role the historical and cultural context play in relation to Aboriginal and Torres Strait Islander people and the Health Worker and contends that the historical and cultural experiences have impacted the mental and physical health of Aboriginal and Torres Strait Islander peoples, and indeed the way in which they interact with health services and institutions.[46]

[45] The January 2011 Report considers the broader concept of 'health', which has been described by NATSIHWA as incorporating total physical, emotional and mental wellbeing. The January 2011 Report suggests that improving wellbeing necessarily involves a consideration of the physical environment, of dignity, of community, of self-esteem and of justice.[47] The publication further contends that 'community health' is therefore not only about Health Workers, but is very much centred around the Aboriginal & Torres Strait Islander people's experience of daily life.

[46] NATSIHWA draws upon the January 2011 Report to consider the burden of disease amongst Aboriginal and Torres Strait Islander people:

> "The top five contributors to the burden of disease of Aboriginal and Torres Strait Islander peoples include cardiovascular disease, mental disorders, chronic respiratory disease, diabetes and injury. The risk of developing the majority of these diseases is exacerbated by lifestyle choices including smoking, drinking, substance abuse, physical inactivity, poor diet and domestic violence. Therefore, a key strategy to reducing the disease burden is through a preventative, holistic approach to health care. Health education and promotion activities provide an opportunity to affect behavioural choices that contribute to the incidence of disease." [48]

[47] In support of its claims, NATSIHWA directed the Full Bench to the following passages from the January 2011 Report which pertains to the accessibility and availability of health services: [49]

> "Health services need to be both available and culturally accessible. These are separate and distinct concepts. Certain barriers can render available health services inaccessible to Aboriginal and Torres Strait Islander peoples.
>
> An individual's fear of racial discrimination might be overcome through a Health Worker-first approach, whereby the Aboriginal or Torres Strait Islander Health Worker is the first point of contact in a health service for Aboriginal and Torres Strait Islander clients. This can assist in establishing trusting, respectful and understanding

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[46] Health Workforce Australia, *Aboriginal & Torres Straight Island Health Worker Project Environmental Scan: Version 7.0 Final* (Report, January 2011) at p. 3.

[47] Transcript, 25 July 2019 at PN327.

[48] Health Workforce Australia, *Aboriginal & Torres Straight Island Health Worker Project Environmental Scan: Version 7.0 Final* (Report, January 2011) at p. 3.

[49] Ibid.

relationships between the client and other non-Aboriginal or non-Torres Strait Islander health professionals.

Therefore, it cannot be assumed that health service availability equates to accessibility. Data has shown that some Aboriginal and Torres Strait Islanders in non-remote areas actually have a higher level of unmet need than those living in remote areas. This is despite the fact that health services are more densely concentrated, and therefore more available, in non-remote areas. One hypothesis explaining this phenomenon is that the increased concentration of Health Workers in remote areas has a positive effect on health service accessibility for Aboriginal and Torres Strait Islander peoples. Regardless, it is clear that health services must be "culturally safe" to be accessible for Aboriginal and Torres Strait Islander communities." [50]

[48] NATSIHWA further considered the scope of practice and the role of the Aboriginal and Torres Strait Islander Health Worker workforce when it referenced the following passage from the January 2011 Report:

> "Unique to the Health Worker scope of practice is the provision of comprehensive primary health care within a culturally appropriate and culturally safe environment."[51]

[49] Relevant to the context of coverage in private practice, NATSIHWA referred to the January 2011 Report's findings, which stated:

> "… using the best available data, certain key points are clear… The distribution of the total Health Worker workforce does not align to the distribution of the Aboriginal and Torres Strait Islander population – 48% of the Health Worker workforce is located in remote or very remote areas of Australia (Australian Bureau of Statistics, 2006), whilst only 24% of the Aboriginal and Torres Strait Islander population is located in these areas (Australian Bureau of Statistics, 2006)".[52]

[50] NATSIHWA cited the January 2011 Report which noted that 70 per cent of Aboriginal and Torres Strait Islander Health Workers are female.[53] According to NATSIHWA this is of particular importance given the clear divisions between men's business and women's business in the traditional cultural beliefs of Aboriginal and Torres Strait Islander peoples. Indeed, any breach of gender divisions in the provision of health care may cause great distress or shame for Aboriginal or Torres Strait Islander individuals. This is relevant when considering the needs of Aboriginal or Torres Strait Islander patients, in addition to the needs of Aboriginal or Torres Strait Islander Health Workers from their place of employment.

[51] Further, NATSIHWA notes relevant passages of the January 2011 Report which draws a distinction between the culture of Aboriginal and Torres Strait Islander peoples and

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[50] Ibid at pp.3 – 4.

[51] Ibid at p.4.

[52] Ibid at p.4.

[53] Ibid at p.4.

mainstream Australian culture and how that incongruity can influence the accessibility of health care services. At page 18 of the January 2011 Report, it states:

> "…cultural and linguistic differences may affect the understanding of Western medical practices and the success rates of Western medical treatments and care plans for Aboriginal and Torres Strait Islander peoples. Failure to understand and accommodate the diverse cultural beliefs of Aboriginal and Torres Strait Islander communities is likely to result in inappropriate responses to their health care needs."[54]

[52] NATSIHWA also highlights the danger in making generalisations about the cultural beliefs of Aboriginal and Torres Strait Islander peoples, as such generalisations do not acknowledge the cultural differences between many Aboriginal and Torres Strait Islander communities and families. Further, NATSIHWA raised concern that there are fundamental differences between certain core beliefs relating to 'health' that are common to many Aboriginal and Torres Strait Islander peoples and Western medicine beliefs. NATSIHWA cites the January 2011 Report which quotes an excerpt from the National Aboriginal Health Strategy published in 1989:

> "Aboriginal culture is the very antithesis of Western ideology. The accent on individual commitment, the concept of linear time, the switch in focus from spiritual to worldly, the emphasis on possession and the pricing of goods and services, the rape of the environment and, above all, the devaluing of relationships between people, both within families and within the whole community, as the determinant of social behaviour, are totally at variance with the fundamental belief system of Aboriginal people.
>
> "Health" to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.
>
> … In contemporary terms Aboriginal people are more concerned about the "quality of life". Traditional Aboriginal social systems include a three-dimensional model that provides a blue print for living. Such a social system is based on inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between a set of relationships."[55]

[53] NATSIHWA cites the following excerpt from the January 2011 Report, which concerns the traditional Aboriginal and Torres Strait Islander beliefs regarding the interconnected causal factors of ill health:[56]

> "For some Aboriginal and Torres Strait Islander peoples, 'individual wellbeing is always contingent upon the effective discharge of obligations to society and the land itself' (Maher, 1999, Morgan et al., 1997). For this reason, an Aboriginal or Torres Strait Islander individual may prioritise their social responsibilities and obligations instead of their own health (Maher, 1999, Devensian and Maher, 2003). According to the beliefs of some Aboriginal and Torres Strait Islander peoples, the causes of illness may also be

[54] Ibid at p.18.

[55] Ibid at p.19.

[56] Ibid.

attributed to supernatural intervention or sorcery (Maher, 1999, Devanesen and Maher, 2003). In other words, scientific explanations of the causes of disease may not carry as much weight for clients who have a different belief system than the one underpinning Western medical science. This may contribute to a lack of "compliance" with medical treatment plans developed by medical practitioners (McConnel, 2003, Humphrey and Weeramanthri, 2001)."

[54] NATSIHWA highlights the gap in adult mortality rates in the Aboriginal and Torres Strait Islander population. The January 2011 Report noted: [57]

> "The Aboriginal and Torres Strait Islander population has a much higher rate of mortality and a much lower life expectancy than the total Australian population. In 2003, the probability of dying between the ages of 15 and 60 was 33% and 23% for Aboriginal and Torres Strait Islander males and females, respectively. In comparison, the rates for the total Australian population were 10% and 6% (Vos et al., 2003)."

[55] The January 2011 Report provides more recent estimates of mortality rates of A&TSI people from the Australian Bureau of Statistics, being approximately 12 years less than other male Australians, and 10 years less than other female Australians. [58]

[56] NATSIHWA relies on the finding of the January 2011 Report that "despite a large number of reforms and initiatives since 1997 few Indigenous Australians obtain the full appropriate benefits of the schemes".[59] Indeed, the differences in accessibility between Aboriginal and Torres Strait Islander peoples living in remote and non-remote areas are explored in the Report:

> "When considering this information from the perspective of Australian Standard Geographical Classification locations, it is clear that there is a significant difference in accessibility between Aboriginal and Torres Strait Islander peoples based in remote and non-remote areas (see Figure 17). Aboriginal and Torres Strait Islanders in non-remote areas actually have a higher level of unmet need than those living in remote areas (Council of Australian Governments Reform Council, 2010). This challenges the assumption that a greater availability of health services equates to a greater level of accessibility. Although there may be fewer health services located in remote areas, it appears that they might be better able to meet the needs of Aboriginal and Torres Strait Islander peoples than those in non-remote parts of Australia." [60]

[57] NATSIHWA flags a theory provided in the January 2011 Report to justify these accessibility differences for across remote and non-remote areas: [61]

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

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[57] Ibid at p.42.

[58] Ibid.

[59] Ibid at p.59.

[60] Ibid at p.63.

[61] Ibid at p.64.

consideration of the distribution of Aboriginal and Torres Strait Islander Community Controlled Health services and Aboriginal and Torres Strait Islander Health Workers"

[58] NATSIHWA draws on the January 2011 Report in order to identify a range of barriers to health care access, which include:

- cultural safety;
- language barriers;
- experiences of discrimination or racism;
- access to transport; and
- cost of health care. [62]

[59] NATSIHWA highlights the valuable role Health Workers are able to perform by brokering culturally safe and appropriate health care and thereby improving health service accessibility.

'Growing our future: the Aboriginal and Torres Strait Islander health worker project final report'

[60] NATSIHWA also relies on the Health Workforce Australia's report of 2011, 'Growing our future: the Aboriginal and Torres Strait Islander health worker project final report' (December 2011 Report).[63]

[61] Amongst a range of findings, the December 2011 Report found:

- "The poor health outcomes of Aboriginal and Torres Strait Islander people are well recognised. A contributing factor is the lack of access to culturally safe primary health services. The contribution that Aboriginal and Torres Strait Islander Health Workers make in improving access by delivering culturally safe comprehensive primary health care is not well understood by or recognised across a range of key stakeholders, including policy makers, employers and other health professionals." [64]

- "The Aboriginal and Torres Strait Islander Health Worker workforce is a major health workforce delivering culturally safe, comprehensive primary health care to Aboriginal and Torres Strait Islander Australians." [65]

- "A growing body of evidence links the Aboriginal and Torres Strait Islander Health Worker workforce to improved health outcomes in diabetes care, mental health care, maternal and infant care, and palliative care."[66]

- "The history of the Aboriginal and Torres Strait Islander Health Worker workforce began over five decades ago. The workforce grew from the need to provide health

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[62] Ibid at p.70.

[63] Health Workforce Australia, *Growing Our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker Project* (December 2011).

[64] Ibid at p.IX.

[65] Ibid at p.XII.

[66] Ibid at p.XII.

services to Aboriginal and Torres Strait Islander people whose health needs were not being met by mainstream services. Aboriginal and Torres Strait Islander Health Workers first emerged as leprosarium workers and hospital assistants in the 1960s. These roles soon took on added significance as Aboriginal and Torres Strait Islander Health Workers combined Western and traditional Aboriginal health practices to provide accessible, culturally safe health care for Aboriginal and Torres Strait Islander people. Western health professionals soon recognised Aboriginal and Torres Strait Islander Health Workers for the 'vitally important roles' they played in responding to the health needs of their communities."[67]

- "The information collected shows Aboriginal and Torres Strait Islander Health Workers are a unique profession in the way they:

    - Perform a comprehensive primary health care role (for example: clinical assessment; monitoring and intervention activities; and through health promotion and illness prevention programs and chronic disease management services);

    - Provide culturally safe health care to Aboriginal and Torres Strait Islander people (such as advocating for Aboriginal and Torres Strait Islander clients."[68]

- "The project findings demonstrate that no other health profession provides this combination of services for Aboriginal and Torres Strait Islander people. For example, although Aboriginal and Torres Strait Islander nurses may provide culturally safe health care, the focus of their training and approach to care delivery is generally based on an acute care service model."[69]

- "There is increasing recognition of the importance of Aboriginal and Torres Strait Islander leadership and empowerment in tackling disadvantage. Solutions that are not developed in this way have limited capacity to create lasting change." [70]

- "COAG has committed $1.57 billion between 2008–2012 to improve Aboriginal and Torres Strait Islander health and wellbeing."

- "A large portion of these funds has been invested in funding new workforce positions, such as Outreach Workers, Healthy Lifestyle Workers and Tobacco Workers, designed to target chronic disease. These new workers perform similar roles to Aboriginal and Torres Strait Islander Health Workers." [71]

- "The health care reforms outlined above will only be sustainable with the right health workforce. Health Workforce Australia (HWA) was established to facilitate health workforce reform in Australia. HWA developed the National Health Workforce

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[67] Ibid at p.1.

[68] Ibid.

[69] Ibid at p.3.

[70] Ibid.

[71] Ibid at p.4.

Innovation and Reform (WIR) Strategic Framework for Action (2011–2015). The Strategic Framework is a national call for action to reform the workforce across the health and education sectors. It acknowledges the need to increase the number of Aboriginal and Torres Strait Islander people working in the health sector to improve health care for Aboriginal and Torres Strait Islander Australians." [72]

- "Another relevant workforce framework is the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2010–2015). The framework was developed by the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) on behalf of the Australian Health Ministers' Advisory Council (AHMAC). It aims to achieve equitable health outcomes for Aboriginal and Torres Strait Islander people through a competent health workforce. Aboriginal and Torres Strait Islander Health Workers represent 17% of the total number of Aboriginal and Torres Strait Islander people who work in health professions. Both of these frameworks emphasise the importance of breaking down barriers to Aboriginal and Torres Strait Islander education and building the Aboriginal and Torres Strait Islander health workforce."[73]

- "[National Registration and Accreditation Scheme (NRAS)] protects the public by ensuring that only people who are suitably trained and qualified to practise in a competent and ethical manner are registered as Aboriginal and Torres Strait Islander Health Practitioners. It facilitates workforce mobility across Australia and the provision of high-quality educational training of Aboriginal and Torres Strait Islander Health Practitioners." [74]

- "Aboriginal and Torres Strait Islander Health Workers are a unique profession in the way they combine comprehensive primary health care roles with cultural safety roles. No other health profession provides this distinct form of health care to Aboriginal and Torres Strait Islander people. Broader awareness of the importance of these roles will support the ongoing development of the Aboriginal and Torres Strait Islander Health Worker workforce." [75]

- "Strong education and career pathways provide the foundation of any workforce. As the Aboriginal and Torres Strait Islander Health Worker workforce has evolved, more structure has gradually been introduced to shape Aboriginal and Torres Strait Islander Health Worker training and career development." [76]

- "It is broadly accepted that there is a need to create clearly structured and accessible education and career pathways for the future." [77]

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[72] Ibid at p.4.

[73] Ibid at p.5.

[74] Ibid at p.5.

[75] Ibid at p.12.

[76] Ibid at p.13.

[77] Ibid.

- "There are not enough male Aboriginal and Torres Strait Islander Health Workers - only 30% of the Aboriginal and Torres Strait Islander Health Worker workforce is male; 50% of the target population is male." [78]

- "The Aboriginal and Torres Strait Islander Health Worker population is ageing - which contrasts with the younger age profile of the Aboriginal and Torres Strait Islander population."[79]

- "There is a much lower Aboriginal and Torres Strait Islander Health Worker/population ratio in urban areas than in remote areas. Despite high levels of unmet health needs in cities, 48% of the Aboriginal and Torres Strait Islander Health Worker workforce is located in remote or very remote areas, where only 24% of the population usually lives." [80]

- "A number of health services have long-standing position vacancies for Aboriginal and Torres Strait Islander Health Workers - with many vacancies lasting several years." [81]

- "Many health services report retention challenges - with reports of Aboriginal and Torres Strait Islander Health Workers leaving the workforce to pursue opportunities promising better recognition, respect and employment conditions (in other health professions and non-health related fields)."[82]

- "Aboriginal and Torres Strait Islander Health Workers are currently looking for new career opportunities within the Aboriginal and Torres Strait Islander Health Worker profession - but do not know where to find them." [83]

- "A number of systemic issues affect recruitment and retention. Inequity in pay and conditions is identified as an underlying cause of Aboriginal and Torres Strait Islander Health Worker retention problems. There are widespread perceptions of pay inequities between Aboriginal and Torres Strait Islander Health Workers employed in the government health sector and the Aboriginal Community Controlled Health Sector (ACCHS)." [84]

- "Improving health outcomes for Aboriginal and Torres Strait Islander Australians is currently one of Australia's most pressing priorities. Building a strong pipeline of Aboriginal and Torres Strait Islander Health Workers with the right skills will better equip the Australian health system to meet these needs in future. A more collaborative and strategic approach to planning the Aboriginal and Torres Strait Islander Health Worker workforce is essential." [85]

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[78] Ibid at p.14.

[79] Ibid.

[80] Ibid.

[81] Ibid.

[82] Ibid at p.15.

[83] Ibid.

[84] Ibid.

[85] Ibid.

- "These types of workplaces were characterised by:
    - cultural awareness and respect;
    - recognition and trust in Aboriginal and Torres Strait Islander Health Workers;
    - long-term commitment to the professional development of individual Aboriginal and Torres Strait Islander Health Workers;
    - positive inter-professional relationships, in other words positive relationships between those in different professions in health and social care;
    - strong leadership and management; and
    - Aboriginal and Torres Strait Islander Health Workers in management roles."[86]
- "The workplace environment is clearly an important area of focus for Aboriginal and Torres Strait Islander Health Worker workforce development efforts. Aboriginal and Torres Strait Islander Health Workers are expected to play a key role in supporting the health of their communities. For Aboriginal and Torres Strait Islander Health Workers to do this well, they first need to be enabled and supported in the workplace."[87]

Australia's Health Workforce Series: 'Aboriginal and Torres Strait Islander Health Workers/Practitioners in focus' Report

[62] NATSIHWA also relies on the Health Workforce Australia's report of 2014, 'Australia's Health Workforce Series: Aboriginal and Torres Strait Islander Health Workers/Practitioners in focus' (2014 Report).[88]

[63] Amongst a range of findings, the 2014 Report found:

- "Commonly, Aboriginal and Torres Strait Islander Health Workers:
    - provide culturally safe health care to Aboriginal and Torres Strait Islander people, such as advocating for Aboriginal and Torres Strait Islander clients to explain their cultural needs to other health professionals, and educating or advising other health professionals on the delivery of culturally safe health care;

[86] Ibid at p.17.

[87] Ibid at p.18.

[88] Health Workforce Australia, *Australia's Health Workforce Series: Aboriginal and Torres Strait Islander Health Workers/Practitioners in focus* (Report, July 2014).

- perform a comprehensive primary health care role, for example, clinical assessment, monitoring and intervention activities, and health promotion; and

- adapt the roles they perform in response to local health needs and contexts." [89]

- "Aboriginal and Torres Strait Islander Health Workers are employed by a number of different service providers, including Aboriginal Community Controlled Health Organisations, Aboriginal Medical Services, hospitals, state and territory governments, and GP clinics."[90]

- "Aboriginal and Torres Strait Islander Health Practitioners are the registered component of the Aboriginal and Torres Strait Islander Health Worker workforce. From 2012, under the NRAS, practitioners who use the title 'Aboriginal and Torres Strait Islander Health Practitioner', 'Aboriginal Health Practitioner', or 'Torres Strait Islander Health Practitioner' are required to be registered." [91]

- "In terms of workforce characteristics, information from the Census shows the Aboriginal and Torres Strait Islander Health Worker workforce:

    - has experienced substantial growth over the last fifteen years; and

    - is predominately female.

- Information from the NHWDS shows the Aboriginal and Torres Strait Islander Health Practitioner workforce:

    - is slightly older than the Aboriginal and Torres Strait Islander Health Worker workforce (an average age of 44 years, compared with 41 years);

    - has one of the longest average weekly working hours among both registered and non-registered health workforces;

    - is predominately female; and

    - is mostly employed in clinical roles." [92]

- "Information from NCVER shows the number of students completing Certificate III and IV level courses in Aboriginal and Torres Strait Islander health increased steadily between 2008 and 2011, with a particularly sharp increase between 2010 and 2011. The increasing number of course completions is reflected in Census data, which showed an increase in the proportion of Aboriginal and Torres Strait Islander Health Workers qualified to certificate and diploma level between 2006 and 2011 (increasing

[89] Ibid at p.2.

[90] Ibid.

[91] Ibid at p.3.

[92] Ibid at p.43.

to over half of the workforce – from 45.3 per cent in 2006 to 55.6 per cent in 2011). However, jurisdictions and stakeholders both noted issues with training and education, specifically the accessibility and affordability of courses and the availability of workplace training and opportunities for professional development, as affecting both the current workforce and future workforce supply.

- Census information showed workforce growth for Aboriginal and Torres Strait Islander Health Workers tended to be in the older age groups, suggesting people choose to enter the profession later in life. Measures to encourage younger Aboriginal and Torres Strait Islander people to this career may be beneficial for future workforce supply.

- Despite information showing people enter this profession later in life, the WDI for average age and percentage aged 55 and over do not show particular cause for concern for Aboriginal and Torres Strait Islander Health Workers and Practitioners. However stakeholders highlighted their view that this assessment should be interpreted in the context of the lower life expectancy of Aboriginal and Torres Strait Islander peoples (which is approximately 10 years less than that of non-Aboriginal and Torres Strait Islanders in Australia). Stakeholders also noted that, in addition to differences in life expectancy, there are health disparities between Aboriginal and Torres Strait Islander people and Australians of other descent which may affect retention of skilled workers. For example, an Aboriginal and/or Torres Strait Islander person in their mid-40's may have chronic health conditions more common in older people among Australians of other descent, which may result in early retirement or a need to reduce work hours at a relatively young age.

- Another area of concern, not highlighted by the WDI, is the gender imbalance of the current workforce. The Aboriginal and Torres Strait Islander Health Worker and Practitioner workforce is predominately female, and the underrepresentation of males may impact the delivery of culturally appropriate health care. Given cultural protocol and gender restrictions, it is important that all Aboriginal and Torres Strait Islander men have adequate access to male health professionals. Resources and initiatives dedicated to recruiting, retaining, and training a higher number of male Aboriginal and Torres Strait Islander Health Workers and Practitioners would help to meet this need.

- Feedback received from jurisdictions and stakeholders noted a key issue impacting demand for Aboriginal and Torres Strait Islander Health Workers workforce is short-term contracts and changes to budgets, programs, and funding arrangements. Both jurisdictions and stakeholders also noted variability between states and territories, in terms of pay scales, job descriptions, and scopes of practice. This variability between jurisdictions may be reflected by Census data on the distribution of the Aboriginal and Torres Strait Islander Workforce. In 2011, South Australia had the highest number of Aboriginal and Torres Strait Islander Health Workers per 100,000 Aboriginal and Torres Strait Islander population, however in the Census only 5.6 per cent of Aboriginal and Torres Strait Islander people reported their usual place of residence was in South Australia. Conversely, while 31 per cent of Aboriginal and Torres Strait Islander people reported their usual place of residence was in New South Wales in the

2011 Census, this state had one of the lowest rates of Health Workers per 100,000 population."[93]

Aboriginal and Torres Strait Islander health organisations Online Services Report – key results 2016-17

[64] NATSIHWA directed the Full Bench to the following passages from a report by the Australian Institute of Health and Welfare:

> "Primary health-care services play a critical role in helping to improve health outcomes for Indigenous Australians. Indigenous Australians may access either mainstream or Indigenous primary health-care services, which offer prevention, diagnosis and treatment in a range of settings."[94]

> "Aboriginal and Torres Strait Islander health workers have an important role in improving the health of Aboriginal and Torres Strait Islander people. In 2013, the Community Services and Health Industry Skills Council (CSHISC) released new health training packages that contained a suite of updated qualifications, skill sets and units of competency in first aid, workplace health and safety and telehealth (CSHISC 2014). At 30 June 2017, 357 Aboriginal and Torres Strait Islander health workers held a Certificate IV practice stream qualification, 141 held a Certificate IV community stream qualification and 273 a Certificate III qualification (see Table S3.42)."[95]

A national profile of Aboriginal and Torres Strait Islander health Workers 2006-2016

[65] NATSIHWA drew the Full Bench's attention to the first paragraph of an article by Alyson Wright et al which notes the importance of A&TSI health workers and the increasing evidence that their inclusion in models of care "facilitates culturally appropriate care, reduces communication gaps, reduces discharges against medical advice, provides cultural education, increases inpatient contact time, improves follow-up practices and enhances patient referral linkages".[96]

[66] NATSIHWA also directed the Full Bench to the following passages:

> "Over the past 10 years, several government policy documents have called for action to build a competent workforce to deliver equitable health outcomes for Aboriginal and Torres Strait Islander people and to increase the number of Aboriginal and Torres Strait Islander people in the health sector."[97]

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[93] Ibid at p.43-44.

[94] Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2016-17* 9 (2018) at p.4.

[95] Ibid at p.42.

[96] Transcript, 25 July 2019 at PN441; Alyson Wright et al, 'A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-1016' (2019) 43.1 *Australian and New Zealand Journal of Public Health* 24, at p.24.

[97] Alyson Wright et al, 'A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-1016' (2019) 43.1 *Australian and New Zealand Journal of Public Health* 24, at p.24.

"In 2012, the Australian Government introduced national registration for Aboriginal and Torres Strait Islander Health Practitioners, which created the Health Practitioner in National Health Workforce dataset. However, as this only captures Aboriginal and Torres Strait Islander Health Practitioners, the Health Workforce dataset does not provide sufficient coverage of the entire Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce." [98]

"There was an overall increase of 338 people who reported their occupation as an Indigenous Health Worker… The total number of Indigenous Health Workers was not commensurate with population growth; there were 221 Indigenous Health Workers per 100,000 Indigenous people in 2006 and 207 Indigenous Health Workers per 100,000 Indigenous people in 2016. There was a greater proportion of female Indigenous Health Workers in the workforce (71.0% in 2006 to 73.3% in 2016) and declines in the proportion of male Indigenous Health Workers (29.5% in 2006 to 26.8% in 2016).

There were declines in the proportion of Indigenous Health Worker aged 15–24, 25–34 and 35–44 (decline of 12.5% across these age groups) (Figure 1B). In comparison, for all the older age groups (45-54, 55-64, 65+) there were substantial increases in the proportion of Indigenous Health Workers. In particular, there was an increase of 7.5% in Indigenous Health Workers aged 55-64 (9.2% in 2006 to 16.7% in 2016) and a 3.6% increase in Indigenous Health Workers aged 45-54 (25.7% in 2006 to 29.3% in 2016)."[99]

[67] NATSIHWA states that the article also outlines the proportions of increases and decreases in each state, noting there has been a marked decline in the proportion of indigenous health workers in Northern Territory, South Australia, Victoria and Western Australia and slight increases in the other states.[100] NATSIHWA then highlights the following passages:

"Despite policy rhetoric about the importance of growing the Indigenous Health workforce, we remain concerned that there has been inadequate growth in Aboriginal and Torres Strait Islander Health Workers since 2006. Our results demonstrate the slight increase in workforce numbers is not commensurate with the Aboriginal and Torres Strait Islander population growth. The most notable declines in this workforce are in the proportion of younger adults, males and workers in the NT entering the workforce. There were notable increases in Health Workers in only two states – Queensland and NSW.

The ageing Health Worker population presents both concerns and strengths. We suspect that the decline in younger Indigenous Health Workers (aged ≤44 years) is due to lack of people obtaining qualifications, traineeships and skills to enter the profession, although it is also likely that that some younger Indigenous Health Workers are moving into other professions. However, the retention of older Indigenous Health Workers (aged 45+) builds expertise and experience in long-term employees who can act as mentors for the younger workforce. Felton Busch et al. in their exploratory study of Aboriginal Health Workers, found many participants wanted career advancement in management

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[98] Ibid.

[99] Ibid at p.25.

[100] Transcript dated 25 July 2019 at PN446; Alyson Wright et al, 'A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-1016' (2019) 43.1 *Australian and New Zealand Journal of Public Health* 24, at p. 24.

or specialist Health Worker areas (for example, specialisation in Alcohol and Other Drugs), with fewer participants expressing interest in medicine and nursing.

The increase in Aboriginal and Torres Strait Islander Health Workers in Queensland may also highlight this jurisdiction's employment policy strengths. Queensland Health has defined a career structure for Health Workers and Practitioners in the state health care system which provides pathways to advance in the profession."[101]

"The workforce retention and recruitment issues are complex and compromised by data limitations." [102]

"Overall, the small increase in the number of Aboriginal Health Workers nationally from 2006 to 2016 masks the issues in the workforce growth, retention and recruitment. Using simple descriptive analysis, we have highlighted immediate concerns, including growth that is incommensurate with population increases, a stagnant proportion of male Indigenous Health Workers and an ageing workforce. This analysis adds weight to the call for a National Indigenous Health Workforce Strategy and the need to address critical recommendations in the Growing our Future report." [103]

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016 to 2023

[68] NATSIHWA highlighted the following introductory passages from the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016 to 2023*:[104]

"This National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023) (the Framework) is a mechanism to guide national Aboriginal and Torres Strait Islander health workforce policy and planning. The Framework focuses on prioritisation, target setting and monitoring of progress against growing and developing the capacity of the Aboriginal and Torres Strait Islander health workforce.

It will assist in contributing to the needs of the Aboriginal and Torres Strait Islander health workforce across all service delivery areas (both public and private), including: social and emotional wellbeing; drug and alcohol; and the mental health workforce.

The Framework has been developed by the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG), a working group of the Health Workforce Principal Committee of the Australian Health Ministers' Advisory Council, with input from key Aboriginal and Torres Strait Islander health stakeholders."[105]

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[101] Alyson Wright et al, 'A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006-1016' (2019) 43.1 *Australian and New Zealand Journal of Public Health* 24 at p.26.

[102] Ibid.

[103] Ibid.

[104] Transcript, dated 25 July 2019 at PN453.

[105] Aboriginal and Torres Strait Islander Health Workforce Working Group, 'National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023' (Framework, Australian Health Ministers' Advisory Council, undated) at p.1.

[69] NATSIHWA highlighted the stated aim of the framework:

"The Framework aims to contribute to the achievement of equitable health outcomes for Aboriginal and Torres Strait Islander people through building a strong and supported health workforce that has appropriate clinical and non-clinical skills to provide culturally-safe and responsive health care.

Implementation of the Framework is expected to contribute to the delivery of the following outcomes:

- Aboriginal and Torres Strait Islander people being strongly represented across all health disciplines;
- The representation of Aboriginal and Torres Strait Islander people in the health workforce being proportional to the composition of the total population;
- A health workforce that is able to adapt to changing health needs and service delivery environments;
- Health workforce planning that optimises access to health care for Aboriginal and Torres Strait Islander people;
- Workplaces that attract, encourage and develop the talents of Aboriginal and Torres Strait Islander health professionals;
- A collaborative approach to health workforce development that involves all relevant stakeholders;
- Aboriginal and Torres Strait Islander health professionals are supported to lead the development of social, human, economic and cultural capital within the health workforce;
- Aboriginal and Torres Strait Islander health professionals playing a vital role in enhancing the Aboriginal health workforce capability through a range of career pathways;
- Non-Aboriginal and Torres Strait Islander health professionals recognise the trained skill sets and cultural knowledge of the Aboriginal and Torres Strait Islander workforce; and
- Best-practice training to build a culturally-safe and responsive health workforce."[106]

[70] NATSIHWA highlighted the following passages in relation to key policy linkages:

"The Framework has been developed within the overall policy context of the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (the Health Plan), and its specific goal to ensure that Australia has a health system that delivers clinically

[106] Ibid at p.2.

appropriate care that is culturally-safe, non-discriminatory and free from racism, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander people.

The Health Plan provides a long-term, evidence-based strategic policy framework as part of the overarching COAG's approach to closing the gap in Indigenous disadvantage, which was set out in the National Indigenous Reform Agreement (NIRA) signed in 2008."[107]

[71] NATSIHWA highlighted the following passages in relation to cultural respect:

"This Framework is consistent with the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, which commits the Commonwealth government and all states and territories to embedding cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services."[108]

"This Framework shares the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 vision of an Australian health system that is free of racism and inequality, and where all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable; and that the health system is comprised of an increasing Aboriginal and Torres Strait Islander health workforce delivering culturally-safe and responsive health care."[109]

[72] NATSIHWA directed the Full Bench to a number of passages relating to the Framework's commitment to various principles. In relation to the 'Centrality of Culture', NATSIHWA highlighted the following:

"• Cultural knowledge, expertise and skills of Aboriginal and Torres Strait Islander health professionals are reflected in health services models and practice."[110]

[73] In relation to the principle of 'Health Systems Effectiveness', NATSIHWA highlighted the following:

"• Developing a health workforce with appropriate clinical and cultural capabilities to address the health needs and improve the health outcomes of Aboriginal and Torres Strait Islander people is central to increasing access to health services that are effective, high quality, appropriate and affordable. Appropriate ongoing professional development and training that is recognised, supported and resourced is essential to achieving this.

• Workplaces must be free of racism, culturally-safe, supportive and attractive to the Aboriginal and Torres Strait Islander health workforce."[111]

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[107] Ibid at p.2.

[108] Ibid at p.4.

[109] Ibid at p.6.

[110] Ibid.

[111] Ibid.

[74] In relation to the principle of 'Partnership and Collaboration', that is, partnership between A&TSI people and government and non-government sectors, NATSIHWA highlighted the following:

> "• All stakeholders, including the Aboriginal and Torres Strait Islander health workforce and communities, must be actively included in decision making."[112]

[75] In relation to the principle of 'Leadership and Accountability', NATSIHWA highlighted the following dot points:

> "• Strong quality Aboriginal and Torres Strait Islander leadership at the senior manager and executive levels is essential to planning and designing culturally-respectful health care services for Aboriginal and Torres Strait Islander people.
>
> • Intentional leadership and talent development initiatives are required to advance Aboriginal and Torres Strait Islander people in both targeted and mainstream positions.
>
> • Creation of structured career pathways is a vital element in leadership development and retention of Aboriginal and Torres Strait Islander employees.
>
> • Commitment to achieving a culturally proficient and safe health workforce must come from the top and then filter down through the different levels of each organisation. This is key to growing the Aboriginal and Torres Strait Islander workforce, and will require sound policy, budgetary directions and strong leadership across governments.
>
> • Strong leadership from both Aboriginal and Torres Strait Islander and non-Indigenous health professionals is essential in building social participation and eliminating racism from the health system. Commitment and accountability across and between all levels of government and non-government sectors are critical requirements to support health workforce strategies.
>
> • Workplaces must be encouraged to attract and develop Aboriginal and Torres Strait Islander people across all levels of the organisation, including management and representation in governance arrangements."[113]

[76] NATSIHWA highlighted the following suggested mechanism to achieve the Framework's key strategy "to improve the skills and capacity of the Aboriginal and Torres Strait Islander health workforce in clinical and non-clinical roles across all health disciplines":

> "• Provide opportunities for the development of leadership capability, at all levels; from entry to leadership positions, which includes access to ongoing training and work-based experience."[114]

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[112] Ibid.

[113] Ibid at p.7.

[114] Ibid at p.8.

[77] NATSIHWA highlighted the Framework's key strategy, that is, for health and related sectors to "be supported to provide culturally-safe and responsive workplace environments for the Aboriginal and Torres Strait Islander workforce."[115]

Our Choices Our Voices – A report prepared by the Lowitja Institute for the Close the Gap Steering Committee

[78] NATSIHWA drew the Full Bench's attention to the following passage from the foreword of this report in support of their claims:

> "The stories profiled in this report demonstrate that when Aboriginal and Torres Strait Islander people are involved in the design of the services they need, we are far more likely to achieve success. These stories illustrate that 'our choice and our voice' are vital if we are to make gains and start to close the gap."[116]

[79] NATSIHWA highlighted the following passages from the report:

> "The overriding principle throughout the stories is that the success of these initiatives is based on community governance and leadership, which is imperative to the success and longevity of the programs. The stories also highlight the importance of cultural determinants of health such as strength, resilience, identity and importantly self-determination.
>
> Aboriginal Community Controlled Organisations (ACCOs) are an essential success component of the provision of holistic, affordable and appropriate primary health care for Aboriginal and Torres Strait Islander people."[117]

[80] NATSIHWA highlighted a passage in relation to the report's priority theme of targeted, needs-based primary healthcare:

> "Aboriginal and Torres Strait Islander people have a right to access the health care we need, in the location we choose."[118]

Cultural respect and general practice: a cluster of randomised controlled trial

[81] NATSIHWA directed the bench to the following passages from an article from *The Medical Journal of Australia* by various authors on cultural respect in general practice to support their claims:[119]

> "The known: The gap in life expectancy between Indigenous and non-Indigenous Australians remains large. Urban Indigenous Australian-controlled health services are under-resourced, and mainstream primary care services are often not culturally sensitive.

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[115] Ibid at p.9.

[116] The Lowitja Institute, *Our Choices Our Voices* (Report, Close the Gap Steering Committee, 2019) at p.1.

[117] Ibid at pp.1-2.

[118] Ibid at p.6.

[119] Transcript dated 25 July 2019 at PN486-PN495.

> The new: A practice-based cultural respect program — including a workshop and toolkit of scenarios, with advice from a cultural mentor, and guided by a care partnership of Indigenous and general practice organisations — did not significantly influence Indigenous health check rates or cultural respect levels.
>
> The implications: Cultural respect programs may require more than 12 months to increase Indigenous health check rates and the cultural quotient scores of general practice clinic staff."[120]

> "Aboriginal Community Controlled Health Services (ACCHSs) are important providers of primary health care to Indigenous communities. However, most Indigenous Australians living in urban areas also use standard primary care and GP services."[121]

> "About one-third of Indigenous Australians live in major cities, but only 16 of 138 ACCHSs are in major cities; urban ACCHSs have lower staff/client ratios than regional and remote ACCHSs.
>
> Indigenous Australians frequently encounter cultural disrespect in mainstream primary care services. The 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey reported that 16% of Indigenous Australians had experienced racism in health settings; 20% of these respondents reported that doctors, nurses and other hospital or clinic staff were discriminatory, and 7% avoided seeking health care because of unfair treatment. Of 755 adult Indigenous Victorians surveyed in 2011, 29% had experienced racism in health settings."[122]

Substantive issues

[82] Having summarised the extensive material on which NATSIHWA relies as providing the context for the claims advanced, we turn to the substantive issues.

Expanding coverage of the Award

[83] In respect to the Award's coverage clause[123], NATSIHWA submits that the coverage clause should be expanded to include A&TSIHWs and A&TSIHPs as an occupation.[124] It posits an amendment to the coverage clause is necessary in order for the Award to meet the modern awards objective under s.134(1) of the Act.[125]

[84] It states that A&TSIHWs and A&TSIHPs in private practice are not currently covered by any modern award.[126] In written and oral submissions, it states its proposed amendment would promote social inclusion through encouraging increased workforce participation and

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[120] Siaw-Teng Liaw et al, 'Cultural respect in general practice: a cluster randomised controlled trial' (2019) 210 *The Medical Journal of Australia* 263 at p.263.

[121] Ibid.

[122] Ibid.

[123] Clause 4.1 of the *Aboriginal Community, Controlled Health Services Award 2010.*

[124] NATSIHWA Submission dated 18 June 2019 at [39]; Transcript dated 25 July 2019 at PN117.

[125] NATSIHWA Submission dated 18 June 2019 at [39].

[126] NATSIHWA Submission dated 18 June 2019 at [40]; Transcript dated 25 July 2019 at PN121.

recognition.[127] NATSIHWA notes that when the Aboriginal Community Health Award was made there was no evidence of A&TSIHWS and A&TSIHPS engaged in private practice.[128]

[85] Currently, clause 4.1 of the Award is as follows:

> "**4.1** This industry award covers employers throughout Australia in the Aboriginal community controlled health services industry and their employees in the classifications listed in clause 16 – Minimum wages to the exclusion of any other modern award."

[86] NATSIHWA proposes clause 4.1 be amended to the following:

> "This industry and occupation award covers:
>
> (a) employers throughout Australia in the Aboriginal community controlled health services industry and their employees in the classifications listed in clause 14[129] – Minimum wages to the exclusion of any other modern award; and
>
> (b) employers throughout Australia with respect to their employees engaged as an Aboriginal and/or Torres Strait Islander Health Worker."[130]

[87] It further proposes clause 4.5 be amended as:

> "This award does not cover:
>
> (a) an employee excluded from award coverage by the Act;
>
> (b) employers covered by the following awards with respect to employees covered by the awards:
>
> (i) *Nurses Award 2010*; or
>
> (ii) *Medical Practitioners Award 2010*."[131]

[88] NATSIHWA also seek a consequential change to the title of the Award flowing from proposed expansion of the coverage clause of the Award NATSIHWA to include A&TSIHWs and A&TSIHPs engaged in private practice. The proposed title for the Award is as follows;

> "Aboriginal and/or Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award"

[89] In response to our concerns about the potential productivity, cost and regulatory burden,[132] NATSIHWA submits some employers in private practice would be covered by a

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[127] Transcript dated 25 July 2019 at PN572 - PN573; NATSIHWA Submission dated 18 June 2019 at [40].

[128] NATSIHWA Submission dated 18 June 2019 at [41] – [47].

[129] Now clause 16 of the *Aboriginal Community, Controlled Health Services Award 2010.*

[130] NATSIHWA Further Amended Draft Determination dated 9 August 2019 at p.2.

[131] NATSIHWA Further Amended Draft Determination dated 9 August 2019 at p.3.

[132] Transcript dated 26 July 2019 at PN1509 - PN1518.

combination of the Award, the *Nurses Award 2010* and the *Medical Practitioners Award 2010*.[133] It relies on the EY Sweeney's May 2016 report titled 'Fair Work Commission – Multiple modern award coverage and the utility of majority clauses' to address our concerns of the burden on private practices that would be required to apply more than one modern award.[134] It contends the report suggests that private practice medical clinics are often small to medium sized businesses; small to medium sized business are prepared for multiple award coverage and there are effective strategies such as HR software to mitigate the regulatory burden of multiple award coverage.[135] NATSIHWA submits an expanded coverage clause would not have an adverse impact on private practices.[136]

[90] In its submissions of 24 April 2017, AFEI opposes NATSIHWA's proposal to expand the coverage clause 'to include A&TSIHWs and A&TSIHPs as an occupation, so as to provide award coverage for [them] in private practice.'[137] AFEI notes the observation made by the Full Bench of the AIRC in the creation of the modern award, in which they said:

> "the services provided by aboriginal community controlled health organisations are notably different from what might be called mainstream health services, including as to the work that is performed by its employees."[138]

[91] AFEI also raises concerns about issues that may arise due to overlapping coverage and "the possible consequences of expanding occupational coverage to employees who may already be covered by another award."[139]

[92] In further submissions filed on 19 July 2019, AFEI again refers to the Award's historical context where the Full Bench of the AIRC were satisfied that Aboriginal community controlled health services are a distinct sector of the health industry.[140]

[93] AFEI raises questions regarding the evidence relied on by NATSIHWA. AFEI submits that NATSIHWA have not provided specific details on how many A&TSIHWs and A&TSIHPs work in private practice and also, NATSIHWA have provided evidence indicating that it is currently "unclear how to pay A&TSIHW within private practice."[141] Based on this, AFEI claims that it raises questions as to whether NATSIHWA have "put forward an argument of merit and adduced probative evidence demonstrating facts supporting the proposed variation."[142]

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[133] NATSIHWA Submission dated 9 August 2019 at [4] and [5].

[134] Ibid at [4] - [15].

[135] Ibid at [14].

[136] Ibid at [15].

[137] NATSIHWA Submission dated 18 June 2019 at [23].

[138] *Award Modernisation*, [2009] AIRCFB 945 at [98].

[139] AFEI Submission (in AM2014/250) dated 24 April 2017 at [5]-[6], 24 April 2017 at [6].

[140] [2009] AIRCFB 865, [124]-[125]; AFEI Submission dated 19 July 2019 at [1.14].

[141] AFEI Submission dated 19 July 2019 at [1.14(b)].

[142] Ibid.

[94] AFEI submits that, should the Award be varied, "the rates of pay applicable to A&TSIHWs and A&TSIHPs working in private practice ought to be in sync with the rates of pay with other award covered health professionals."[143]

[95] AFEI did not attend the hearing to provide oral submissions.

Numbers in practice

[96] NATSIHWA contends that while the exact number of health professionals is not known, there are Aboriginal and Torres Strait Islander health workers in private practice and the numbers are likely to increase. If the class of worker is expanded to the private sector, it would facilitate growth.

[97] A&TSI health workers and health practitioners can loosely be distinguished by qualification, namely those who NATSIHWA refers to as A&TSIHWs and A&TSIHPs.[144]

[98] An A&TSIHW is an A&TSI person who has gained, or is working toward, a Certificate II or higher qualification in A&TSI Primary Health Care from one of the health training packages.[145] An A&TSIHP is an A&TSI person who has gained a Certificate IV in A&TSI Primary Health Care (Practice) and who is registered with the A&TSI Health Practice Board of Australia (A&TSIHPBA) through the Australian Health Practitioner Regulation Agency (AHPRA).[146]

[99] NATSIHWA submits that by extending the coverage clauses to include A&TSIHWs and A&TSIHPs as an occupation, it would provide coverage for A&TSIHWs and A&TSIHPs in private practice,[147] as currently NATSIHWA submits that A&TSIHWs and A&TSIHPs who are employed in private practice are currently not covered by any modern award.[148] Extending the coverage clause, to incorporate the coverage of those working in private practice, is likely to promote social inclusion through encouraging increased workforce participation and recognition.[149]

[100] In respect of the numbers in practice, NATSIHWA relies on evidence given by Mr Briscoe who stated that the number of A&TSIHWs and A&TSIHPs working in private practice are limited in number.[150] Further, that prior to 2010, it was highly unusual for A&TSIHWs and A&TSIHPs to be working in private practice,[151] and since then, there has been an increase in numbers. Mr Briscoe claims that there have been A&TSIHWs working in private practice and employers wanting to employ A&TSIHWs to work in their firm, however both employee and

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[143] Ibid

[144] NATSIHWA submission dated 18 June 2019 at [3]

[145] Ibid at [10].

[146] Ibid at [11].

[147] Ibid at [23].

[148] Ibid at [40].

[149] Ibid at [40].

[150] Ibid at [96]

[151] Ibid at [100].

employer are uncertain of the pay rates because of the absence of coverage in the Award.[152] NATSIHWA submits, while relying on the evidence of Mr Briscoe[153] and Dr Stephanie Trust,[154] that A&TSIHWs and A&TSIHPs working in private practice has resulted in uncertainty and, at times, confusion regarding the applicable pay rate.[155]

[101] NATSIHWA relies on the evidence given by Dr Trust[156] and the expert report of Alyson Wright[157] that there is interest from private practice to employ A&TSIHWs and A&TSIHPs.

[102] NATSIHWA contends that this is a unique workforce that isn't covered by any other award and the numbers of A&TSIHWs and A&TSIHPs in practice are likely to grow.[158] Mr Briscoe claims that although it is difficult to accurately assess the number of A&TSIHWs and A&TSIHPs practicing in Australia, because there is no single body that governs or regulates them and because they work across a number of different contexts and locations around Australia, there is a need to fill the constant vacancies and more young people preparing to join the health workers and health practitioners workforce for an expanding population.[159] Mr Briscoe, in his witness statement, refers to a policy statement in his annexure KB-1, which outlines the nature of the A&TSIs workforce.[160]

[103] With respect to the numbers, NATSIHWA relies on the evidence referred to by Mr Briscoe that there are constant vacancies and more young people preparing to join the Aboriginal and/or Torres Strait Islander health workers and health practitioners' workforce. According to the 2011 data, the health practitioners' framework stated that 99 per cent of workers in these professions are Aboriginal and/or Torres Strait Islanders.[161] It has been suggested that there are 941 employed in the primary health care services, and as at August 2017, there were 608 health practitioners, mostly in the Northern Territory, 35 per cent in NSW, Western Australia and Queensland, and ACT with less than 1 per cent.[162]

[104] Mr Briscoe, in his statement, said that around May 2010, following a review of Medicare primary care items, Medicare introduced the Medicare Benefits Scheme (MBS) health assessment item 715, which applies to health checks for A&TSI people. Mr Briscoe points out that there are 7 Medicare items relevant to the primary health care of A&TSIs, however there is a difference in the number which health workers and health practitioners can claim. A&TSIHPs can claim all 7 items, while A&TSIHWs are only able to claim 3 items.[163] However

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[152] Witness statement of Mr Karl John Briscoe, dated 18 June 2019 at [96]-[99]; See witness statement of Ms Haysie Penola dated 28 June 2019; Transcript dated 25 July 2019 at PN244.

[153] Witness statement of Mr Karl John Briscoe, dated 18 June 2019 at [99] and [133].

[154] Witness statement of Dr Stephanie Trust dated 18 June 2019 at [19]-[20].

[155] Submission of NATSIHWA dated 18 June 2019 at [53].

[156] Witness statement of Dr Stephanie Trust dated 18 June 2019 at [17]-[18].

[157] Expert report of Alyson Wright at [28].

[158] Transcript dated 25 July 2019 at PN241.

[159] Transcript dated 25 July 2019 at PN242; Witness statement Mr Karl John Briscoe dated 18 June 2019 at [94].

[160] Transcript dated 25 July 2019 at PN241.

[161] Ibid at PN242.

[162] Ibid at PN243.

[163] Witness statement Mr Karl John Briscoe dated 18 June 2019 at [101]-[102].

in around 2018, the MBS commenced a further review into the MBS primary health care items.[164]

[105] NATSIHWA refers to a report from the Aboriginal and Torres Strait Islander Reference Group as part of the Medicare Benefits Review Taskforce which outlines recommendations in response to this matter. One of the recommendations is to enable qualified A&TSIHWs to claim for certain items provided on behalf of a medical practitioner that can be claimed by A&TSIHPs. The longer-term recommendations are to invest in the growth and sustainability of the A&TSIHWs and A&TSIHPs and to invest in a campaign explaining the role of the practitioners.[165]

[106] NATSIHWA again relies on Mr Briscoe's evidence and annexure[166] that one of the main problems facing the workforce is that whilst the workforce is growing, it is not growing at the same rate as the A&TSI people, and makes the point that therefore the number of health workers per population is decreasing.[167] NATSIHWA agrees with the taskforce recommendations, particularly,

> "…by adding health workers that have the skills, knowledge and ability to provide services for and on behalf of GPs would triple the number of available Aboriginal and Torres Strait Islander health professionals and bring Australia closer to closing the gap. There are only 641 registered Aboriginal and Torres Strait Islander health practitioners and 1256 health workers in Australia..."[168]

[107] In addition, the taskforce added,

> "…by increasing patients' ability to claim rebates for basic medical services will support the growth of the Aboriginal and Torres Strait Islander health workforce, which has been limited over the previous two decades. In 1996, there were 19 Aboriginal and Torres Strait Islander health workers per 10,000. By 2011, this had only increased to 23 per 10,000 Australians…"[169]

[108] NATSIHWA points out the recommendation to invest in the growth and sustainability of the A&TSI health worker and agrees with the recommendation to strengthen the career path for A&TSIHWs and A&TSIHPs, and refers directly to what the taskforce said, being, "There is a shortage of qualified health professionals who can provide culturally and clinically appropriate care to Aboriginal and Torres Strait Islander people, and this is partly because Aboriginal and Torres Strait Islander are significantly under-represented in the Australian health workforce."[170]

[109] NATSIHWA also relies on the expert report of Associate Professor Raymond Lovett. Mr Lovett in his report sets out whether there has been an increase in the number of health

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[164] Ibid, Exhibit KB-1.

[165] Transcript dated 25 July 2019 at PN248.

[166] Witness statement Mr Karl John Briscoe dated 18 June 2019, Exhibit KB-1.

[167] Transcript dated 25 July 2019 at PN251.

[168] Ibid at PN252.

[169] Transcript dated 25 July 2019 at PN254.

[170] Ibid at PN258.

workers working in the private sector and states that there are two national datasets. Firstly, Associate Professor Lovett claims that an A&TSIHW is an unregulated category of worker not requiring professional registration and the numbers are difficult to determine. Associate Professor Lovett states that the total number of Indigenous health workers was not commensurate with population growth. There were 221 Indigenous health workers per 100,000 Indigenous people in 2006 and 207 Indigenous health workers per 100,000 Indigenous people in 2016.[171]

[110] Associate Professor Lovett provides a calculation of an estimate of the number of A&TSIHPs since professional registration commenced in 2012. NATSIHWA relies on the expert report, particularly in that the evidence has shown that whilst there has been an increase with respect to health practitioners and that there has been a near doubling of registration on a population basis since 2012, overall the growth in this sector has not kept up with population growth of the Aboriginal and Torres Strait Islander people.[172]

[111] Associate Professor Lovett notes that there is a lack of knowledge or understanding that the workforce existed in the private sector as well as the public sector.[173] Associate Professor Lovett noted that employing [the private sector] category of workers would actually improve access to healthcare to a private general practice, however, the health workforce generally must understand that the private sector professionals exist and delineating their role compared to other health professionals will improve the workforce going forward.[174]

[112] As to the numbers of A&TSIs in private practice, Associate Professor Lovett said that across Australia, particularly in at least three communities where he has worked, where there are no Aboriginal community controlled health organisations, the services provided are either provided by the state or by private general practice, and in the particular communities referred to, there are no Aboriginal health workers employed, although they are majority Aboriginal communities.[175] Associate Professor Lovett also claims that adopting a change in the coverage of the Award, particularly instating further classifications within the Award, particularly for senior level health workers, would provide validation within the A&TSI communities for future progression.[176]

Consideration

[113] The evidence adduced by NATSIHWA in support of its claim to extend the coverage of the Award, which we have earlier summarised was uncontested and we accept the evidence. The claim, if granted, would result in a hybrid award coverage. The proposition advanced would alter coverage currently limited to a distinct group of employers – Aboriginal Community Controlled Health Services – and their employees to one where in addition to these employers and all their employees coverage would extend to the distinct occupations of A&TSIHWs and A&TSIHPs in private practice. In this sense the Award would become an occupational and

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[171] Expert report of Associate Professor Raymond William Lovett dated 18 June 2019, p.3-4; Transcript dated 25 July 2019 at PN305.

[172] Ibid.

[173] Transcript dated 25 July 2019 at PN511.

[174] Ibid at PN511 - PN512.

[175] Transcript dated 25 July 2019 at PN514.

[176] Transcript dated 25 July 2019 at PN526-528.

industry award. The proposed title of the Award - *Aboriginal and/or Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award* - reflects this hybrid coverage.

[114] As earlier noted, the only opposition to the proposal was that advanced by AFEI, which did not appear at the hearing, nor did it adduce any evidence in support of its position on coverage or in opposition to that led by NATSIHWA. The first point of opposition, that of the potential for overlapping or multiple award coverage of medical practices and other health services, is readily answered. These practices and services already face dealing with multiple awards depending on the type and breadth of service offered and the health occupations which they chose to employ in delivering the services offered. By itself this is not an impediment to acceding to the coverage claim. More relevant however, is the fact that there is no other modern award which currently covers the employment of A&TSIHWs and A&TSIHPs in private practice. The most relevant award, the HPSS Award, does not contain any classification which contains the requirement that the relevantly classified health professional practice "a culturally safe and holistic approach to health care". Nor are we able to identify any other award which contains a comparable requirement. This is an inherent requirement of the occupations the subject of NATSIHWA's claim.

[115] There is no evidence that expanding coverage will have a negative or adverse impact on private practices or other health services. AFEI's contention to the contrary is not supported by evidence. We invited the AMA to participate in the proceedings, *inter alia*, to hear from representatives of medical practitioners operating private medical practices about the potential for any adverse impact of NATSIHWA's claims. As we have already noted the AMA elected not to participate and simply observed that it supported NATSIHWA's attempts to provide for fair conditions of employment for A&TSIHWs and A&TSIHPs, but the coverage issue should be resolved through proceedings dealing with the HPSS Award. The AMA does not say that it opposes award coverage of the occupations of A&TSIHW and A&TSIHP in private practices or that extending coverage of the Award will have any adverse impact on private medical practices.

[116] We are satisfied that the expanded coverage will not have any material immediate negative impact on private practices and health services, when account is take of the modern awards objective and the fact that these workers employed outside of the health services currently covered by the Award, are not covered by any award providing them with fair and relevant minimum safety net terms and conditions of employment.

[117] The second basis for opposition advanced by AFEI relates to the historical basis for making the Award, namely that the services provided by the employer's covered by the Award are notably different from that which might be described as mainstream health services. Whilst it must be accepted that the historical context for making the Award and setting its coverage is the distinct nature of the work carried out by Aboriginal Community Controlled Health Services and their recognition as a distinct sector of the health industry, that reason alone is not a barrier to extending the Award's coverage. It must be remembered that a central proposition advanced by NATSIHWA in support of expanding coverage is that A&TSIHWs and A&TSIHPs in private practice are currently not award covered but should be. The work A&TSIHWs and A&TSIHPs carry out in private practice is, by reason of their cultural background, cultural understanding and training, the same work that is carried out by these occupations when delivering health services through an Aboriginal Community Controlled Health Service. Relevantly, A&TSIHWs and A&TSIHPs are trained and endeavour to deliver health care to

Aboriginal and Torres Strait Islander communities in a culturally safe and holistic way. In this way in private practice A&TSIHWs and A&TSIHPs bring forth and apply the unique character of healthcare delivery that is inherent in the model of healthcare delivery adopted by Aboriginal Community Controlled Health Services and carried out, *inter alia*, by A&TSIHWs and A&TSIHPs in their employ. In the result the distinct nature of service delivery recognised in the current Award coverage is thereby preserved and maintained in the proposed expanded coverage.

[118] Moreover we accept that expanding the coverage to cover A&TSIHWs and A&TSIHPs in private practice will, in addition to establishing fair and relevant minimum safety net terms and conditions of employment for these workers, likely lead to a greater recognition of the roles performed by them and also lead to an increase in workforce participation which, as the evidence earlier recounted shows, will contribute to better health outcomes and access to culturally appropriate health resources for the Aboriginal and Torres Strait Islander communities in which these workers deliver health services.

[119] We are also satisfied on the evidence that there is a shortage of personnel delivering culturally appropriate primary health resources to Aboriginal and Torres Strait Islander communities and that the growth in the workforce has failed to keep pace with the population growth in these communities. We are persuaded on the evidence that expanding coverage and the real prospect of increasing workforce participation in these occupations in the result will help to alleviate this shortage. In addition, it seems to us that clear award coverage by expanding the coverage provisions of the Award will likely lead to greater employment opportunities for these workers in private practices that provide services to Aboriginal and Torres Strait Islander communities.

[120] Without repetition, we accept NATSIHWA's submission that expanding the Award's coverage is consistent with the modern awards objective and that the several other discretionary considerations identified at [48] – [66] of its submissions favour an extended award coverage.

[121] We will therefore vary the Award to expand the coverage of the Award in the manner sought. Consistent with the changing coverage we consider that it is appropriate to change the title of the Award. As earlier noted, NATSIHWA contends that the title of the Award should be the *Aboriginal and/or Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award*. The proposed titled more accurately reflects the mix of industry and occupational coverage for which the varied Award will provide. For reasons which will later become clear, the precise title of the award will be settled during consultation on the draft variation determination which we publish with this decision.

Introducing a 6 "Grade" classification structure to incentivise education, training and development

[122] Schedule A of the Award contains classification definitions which NATSIHWA seeks to vary. NATSIHWA suggests under the current classification structure[177] there is a lack of career progression for A&TSIHWs and A&TSIHPs.[178] It says for example, despite the existing three 'levels' for progression within Aboriginal Community Health Worker Grade 1, there is

[177] NATSIHWA Submission dated 18 June 2019 at [79] – [80].

[178] Ibid at [79].

minimal description of actual performed work, minimal guidance on movement between Grades and minimal description on the community involvement, supervision and management.[179] NATSIHWA relies on the expert report of Alyson Wright which suggests A&TSIHWs and A&TSIHPs want career progression in this profession rather than moving into alternative careers.[180]

[123] As reflected in its draft determination[181] and submissions,[182] NATSIHWA proposes to insert a new classification structure (the proposed structure) to reflect the work that is actually performed by the A&TSIHWs and A&TSIHPs and to provide a career path to incentivise this profession.[183] NATSIHWA contends that the HPSS Award is unable to provide adequate coverage to the health worker classifications being sought.[184]

[124] NATSIHWA submits the proposed structure provides for an increase in the number of grades.[185] The proposed structure separates the current Grade 1 into two grades - Grades 1 and 2 for health worker trainees with corresponding wage rates to remain as currently set.[186] NATSIHWA submits the amendment would assist individuals to obtain a Certificate II in A&TSI Primary Health Care and provides recognition to individuals who already hold a Certificate II.[187] The current Grade 2 would be renumbered to Grade 3.[188] NATSIHWA contends that the optional Certificate II qualification provides individuals seeking to work as an A&TSIHW with an entry pathway.[189]

[125] NATSIHWA notes the duties for both the health worker trainee and for the Grade 2 are similar.[190] The duties primarily involve providing primary health services, education and liaison as well as performing a range of routine tasks and operate office and other equipment. Workers in these grades exercise minimal judgement because the levels require entry-level qualification and workers undertake orientation and training programs as available.[191] NATSIHWA submits that a new classification structure would ensure that there is always a position to which health workers or health practitioners can be appointed should they achieve particular qualifications, experience or service.[192]

[126] Under NATSIHWA's proposed classification structure, Advanced Health Worker – Care classification would be Grade 4.[193] Current grade 4 health workers (who are Senior Health

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[179] Ibid at [80.1] to [80.4].

[180] Expert Report of Alyson Wright dated 11 June 2019 at [31].

[181] NATSIHWA Draft Determination dated 9 August 2019.

[182] NATSIHWA Submission dated 18 June 2019.

[183] Transcript dated 25 July 2019 at PN20.

[184] Ibid at PN17 to PN18.

[185] NATSIHWA Submission dated 18 June 2019 at [27].

[186] NATSIHWA Submission dated 18 June 2019 at [82] – [84]; Transcript dated 26 July 2019 at PN711.

[187] Transcript dated 26 July 2019 at PN711.

[188] NATSIHWA Submission dated 18 June 2019 at [84].

[189] Ibid at [83].

[190] Transcript dated 26 July 2019 at PN713.

[191] Ibid at PN714 to PN715.

[192] Ibid at PN756.

[193] NATSIHWA Submission dated 18 June 2019 at [85.1].

Workers) become Grade 5. However corresponding wage rates would remain the same.[194] The Advanced Health Worker – Practice and Health Practitioner classifications would become Grade 5 with a corresponding wage rate increase.[195] As part of NATSIHWA's work value case later discussed, it proposes a management classification at Grade 6 with Senior Health Practitioners and Coordinator Care be included.[196] NATSIHWA contends the new senior role would be responsible for implementation, coordination, management and evaluation of health programs and service delivery.[197]

[127] A summary of the current and proposed new structure and accompanying weekly rates of pay is provided immediately below in Table 1:

Table 1

Current			Proposed		
A&TSI Health Worker Grade 1	Level 1	$837.10	**A&TSI Health Worker Trainee (Entry) Grade 1 (Health Worker Trainee)**	Level 1	$837.10
	Level 2	$897.00	**A&TSI Health Worker Trainee (Entry) Grade 2 (Health Worker Trainee)**	Level 1	$897.00
	Level 3	$927.70		Level 2	$927.70
A&TSI Health Worker Grade 2	Level 1	$976.10	**A&TSI Health Worker (Generalist) Grade 3**	Level 1	$976.10
	Level 2	$1027.20		Level 2	$1027.20
	Level 3	$1077.10		Level 3	$1077.10
A&TSI Health Worker Grade 3; • Senior A&TSI Health Worker • A&TSI Health Worker Team Leader • A&TSI Health Worker (Cert IV)	Level 1	$1107.10	**A&TSI Health Worker (Care) – Grade 4 (Advanced Health Care Worker)**	Level 1	$1107.10
	Level 2	$1137.00		Level 2	$1137.00
	Level 3	$1163.10		Level 3	$1163.10
A&TSI Health Worker Grade 4	Level 1	$1190.90	**A&TSI Health Worker Grade 5;** • A&TSI Health Worker Advanced (Practice)	Level 1	$1190.90

[194] Ibid at [86].

[195] Ibid at [85.2].

[196] NATSIHWA Submission dated 18 June 2019 at [87]; Transcript dated 26 July 2019 at PN785.

[197] Transcript dated 26 July 2019 at PN777.

Current			Proposed		
			(Advanced Health Worker Practice) • A&TSI Health Practitioner (Health Practitioner) • A&TSI Health Worker – Senior (Community) (Senior Health Worker – Care)		
	Level 2	$1218.90		Level 2	$1218.90
	Level 3	$1248.40		Level 3	$1248.40
			A&TSI Health Worker Grade 6; • Senior A&TSI Health Practitioner (Practice) (Senior Health Practitioner) • Senior Health Practitioner (Diploma of A&TSI Health Care (Practice)) • A&TSI Health Worker Coordinator (Care) (Coordinator Care)	Level 1	$1407.50
				Level 2	1435.10
				Level 3	$1462.90

Consideration

Work value case

Grade 5 work value claim

[128] NATSIHWA advances a work value case in respect of two classifications. First, NATSIHWA seeks an uplift in rates of pay and a change to the classification structure for workers who are "Advanced Health Workers – Practice" and "Health Practitioners" (*Grade 5 work value claim*).[198] In support of its claim, NATSIHWA sets out the nature of the work, the level of skill or responsibility involved and the changing nature of the work.

Nature of the work

[129] In its submissions NATSIHWA notes that while the exact nature of A&TSIHWs' work will vary depending on context and location, they perform a broad range of tasks including the following:

> "95.1 being the first point of contact for clients, gathering medical data and information from the client which may have been otherwise obscured by cultural factors. For example, A&TSIHWs often perform a yearly health check for their clients, checking up on the client's care and then formulating a care plan;
>
> 95.2 treating diseases or injuries, and maintaining health records;

[198] NATSIHWA, submission dated 18 June 2019 at [30].

95.3 attending medical appointments with A&TSI people, to act as communicator, advocate, and/or translator between the mainstream health professional and the A&TSI person;

95.4 providing clarification to A&TSI clients and ensuring that they have understood the medical advice they have received;

95.5 taking part in case management and follow up of A&TSI clients, either independently or with other health care providers;

95.6 advocating for A&TSI clients with mainstream health workers, to overcome the historical distrust of mainstream workforces;

95.7 providing education to the A&TSI community regarding health conditions and health services available to them;

95.8 providing input into the planning, development, implementation, monitoring and evaluation of all health programs in the community; and

95.9 informing non-Indigenous health care workers to provide health services in a culturally sensitive manner."[199]

[130] NATSIHWA observes that, in contrast, A&TSIHPs tend to work as independent practitioners alongside doctors and nurses and undertake a broad range of tasks including the following:

"97.1 assessing, diagnosing and treating clients;

97.2 undertaking clinical care duties such as taking blood, dressing wounds, suturing, and taking client observations; and

97.3 supplying and administering medication, subject to the applicable state and territory legislation;

97.4 being the first point of contact for clients, gathering medical data and information from the client which may have been otherwise obscured by cultural factors;

97.5 treating diseases or injuries, and maintaining health records;

97.6 attending medical appointments with A&TSI people, to act as communicator, advocate, and/or translator between the mainstream health professional and the A&TSI person;

97.7 providing clarification to A&TSI clients and ensuring that they have understood the medical advice they have received;

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[199] Ibid at [95].

97.8 taking part in case management and follow up of A&TSI clients, either independently or with other health care providers;

97.9 advocating for A&TSI clients with mainstream health workers, to overcome the historical distrust of mainstream workforces;

97.10 providing education to the A&TSI community regarding health conditions and health services available to them;

97.11 providing input into the planning, development, implementation, monitoring and evaluation of all health programs in the community; and

97.12 informing non-Indigenous health care workers to provide health services in a culturally sensitive manner."[200]

Level of skill or responsibility involved

[131] NATSIHWA submits that since the creation of the Award in 2009 the nature of work performed by A&TSIHPs has changed and the level of skill and responsibility has increased.

[132] NATSIHWA states that when the Award was created in 2009, it recognised that the Certificate IV level qualifications split into streams of Care (formerly Community) and Practice. In July 2012, however, a requirement was introduced for A&TSIHPs to be registered with the A&TSIHPBA and to meet the A&TSIHPBA's Associations Registration Standards in order to practice as an A&TSIHP in Australia. NATSIHWA submits this change created a clear distinction between A&TSIHWs and A&TSIHPs.[201]

[133] NATSIHWA notes that A&TSIHPs now need to register and renew their registration annually, requiring them to:

"104.1 comply with Continuing Professional Development standards, being 60 hours over a three year cycle, with a minimum of 10 hours in any one year;

104.2 pass a criminal history test;

104.3 pass an English proficiency requirement (usually demonstrated by passing Certificate IV in Aboriginal and Torres Strait Islander Health Care (Practice)).

104.4 be covered by professional indemnity insurance;

104.5 meet requirements about their practice;

104.6 comply with A&TSIHPBA Association Code of Conduct; and

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[200] Ibid at [97].

[201] NATSIHWA submission dated 18 June 2019 at [30].

104.7 pay a fee."[202]

[134] NATSIHWA submits that these requirements have increased responsibility and accountability for A&TSIHPs. In support of this submission, NATSIHWA draws on the evidence of Mr Briscoe who made the following statements:

> "Before 2012, there was limited accountability and responsibility for A&TSIHPs practising outside of the Northern Territory in relation to their supply and administration of medication, and no protection for the public to ensure their work practises were up to standard.
>
> As a result of the requirement for registration with AHPRA, A&TSIHPs experience more responsibility and accountability for the work that they do. This is because they could receive a notification against them to AHPRA if they failed to perform their role to a suitable standard, such as if a patient's blood pressure is outside the acceptable range and if the A&TSIHPs fails to take further action to address this.
>
> In addition, the annual renewal and continuing professional development requirements provide protection for the public to ensure that A&TSIHPs practice to a suitable standard and remain up to date. In contrast, there is no requirement for A&TSIHWs to be registered or accredited in order to practice."[203]

[135] In support of its claim for increased remuneration, NATSIHWA refers to the following statement made by Ms Wright in relation to the registration requirement:

> "This change has supported the professionalism of the career and encourages and supports continual professional development, but the changes also mean extra workloads and responsibilities for those registered, including extra administration to maintain registration, ensuring the minimum CPD requirements are met and practice standards maintained. These additional responsibilities should be supported through appropriate and fair increases in remuneration."[204]

[136] NATSIHWA submits that an increase in remuneration for A&TSIHPs to account for the additional requirements of the role is likely to increase the number of A&TSIHPs that enter the workforce. This, it submits, will reduce the number of acute A&TSI medical incidents through more primary intervention, reducing the personal cost on A&TSI community members and the financial cost to the economy of providing acute healthcare.[205]

[137] In addition, NATSIHWA notes that A&TSIHPs in remote and isolated areas can now supply and administer medication. This, it contends, allows A&TSI clients to access medication they might not otherwise be able to access and reduces the need to travel into the city for treatment, diminishing the strain placed on community when clients are away from their family.[206]

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[202] Ibid at [104].

[203] Witness statement of Mr Karl John Briscoe dated 18 June 2019 at [42] – [44].

[204] Transcript dated 26 July 2019 at PN1080 and Wright, Expert Report at [24].

[205] NATSIHWA submission dated 18 June 2019 at [106].

[206] Ibid at [107].

Changing conditions

[138] NATSIHWA submits that the growth of the general A&TSI population has led to a greater volume of work for existing A&TSIHWs and A&TSIHPs increasing stress for these workers. It notes that a national review of A&TSIHW training conducted in 2000 [207] found that most A&TSIHWs regularly worked hours exceeding their requirements and, in many instances, worked more than 10 overtime hours each week.[208]

[139] NATSIHWA states that, since around 2015, A&TSIHPs increasingly perform clinical duties:

> "Where doctors might have previously sought a nurse's assistance, they now go to the A&TSIHP as their first port of call. This has increased the workload for A&TSIHPs and given them far greater responsibilities on the ground than they had previously. In addition, the scope of practice for many A&TSIHPs has expanded so that they are now required to perform a broader range of clinical duties, such as doing drug screening, sexually transmitted infection screening and pap smears."[209]

[140] NATSIHWA notes that, over the past 10 years, there has been ongoing changes in the units being delivered for A&TSIHP and A&TSIHW qualifications, requiring constant upskilling which can involve costs for retraining or completing further qualifications.

[141] NATSIHWA provides lay evidence that the work of A&STIHWs and A&TSIHPs is performed in:

> "113.1 hot conditions;
>
> 113.2 isolated locations so that there may not be any other A&TSIHWs or A&TSIHPs working there, or the A&TSIHW or A&TSIHP has to perform duties they do not feel experienced in, or they may be working in makeshift camps;
>
> 113.3 potentially dangerous situations while working out in the community, such as entering the house of angry or violent community members;
>
> 113.4 nauseous conditions, such as dealing with maggot infested wounds or discharging foot ulcers;
>
> 113.5 areas that are away from their family and their people, in circumstances where connection to people and country is fundamental to A&TSI people; and

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[207] Curtin Indigenous Research Centre, *Training Re-visions: A national review of Aboriginal and Torres Strait Islander Health Worker Training*, (Curtin University of Technology, Canberra 2000).

[208] NATSIHWA submission dated 18 June 2019 at [109].

[209] Ibid at [111].

113.5 conditions that can be confronting, dealing with so many people who are in need or increasing numbers of people being diagnosed with chronic conditions."[210]

[142] NATSIHWA states that, by uplifting the classification for Advance Health Worker – Practice and Health Practitioners to Grade 5:

"115.1 the Varied Classification structure recognises the higher level of qualifications and registration requirements for an A&TSIHP, and the higher duties required of A&TSIHPs;

115.2 this recognition will increase the likelihood that A&TSIHWs seek to become A&TSIHPs, and/or other A&TSI people become A&TSIHPs;

115.3 the increased workforce participation will promote social inclusion for more A&TSI people (sections 134(1)(c) and 284(1)(b) of the act), thereby increasing the ability for A&TSI people to access health care;

115.4 increased workforce participation is likely to lead to improvements in A&TSI people's health; and

115.5 the reduction in health issues (and especially acute health issues) will also benefit the national economy by reducing the costs incurred (sections 134(1)(h) and 284(1)(a) of the act)."[211]

[143] NATSIHWA submits there will need to be a significant increase in A&TSIHPs and A&TSIHWs to achieve significant improvements in A&TSI health. In support of this submission, NATSIHWA draws from the evidence of Mr Briscoe:

"The A&TSIHW and A&TSIHP workforce has also been experiencing difficulties in recruiting and retaining workers. While there has been an increase in the numbers of A&TSIHWs and A&TSIHPs, this is an aging workforce (refer to the report that I co-authored with Alyson Wright and Dr Ray Lovett, behind Tab 75). A younger generation of new A&TSIHWs and A&TSIHPs needs to come through so that the elders can pass down their knowledge. If the profession does not successfully recruit additional workers, the ongoing viability of the profession will be endangered due to loss of the elders' knowledge once they are gone.

…

I cannot say what the current ratio of A&TSIHW and A&TSIHP to the A&TSI population is without current research; however, in my experience, even if the profession achieves numbers equivalent to its former peak ratio, this will not be enough to resolve the endemic health issues experienced by A&TSI people. Australia needs to significantly increase the proportionate numbers of health workers and health

[210] Ibid at [113].

[211] NATSIHWA submission dated 18 June 2019 at [115].

practitioners if there is ever going to be a chance to achieve significant improvements in A&TSI health outcomes."[212]

[144] NATSIHWA also refers to the evidence of Ms Wright provided in her expert report in support of their claim, citing the National Aboriginal and Torres Strait Islander Health Plan 2013-2023:

> "Aboriginal and Torres Strait Islander health professionals are essential to the delivery of culturally safe care, in primary health care settings with a focus on health promotion, health education, in specialist and other health services, and the engagement of Aboriginal and Torres Strait Islander people in their own health. The employment of Aboriginal and Torres Strait Islander health professionals also contributes to the development and maintenance of culturally safe workplaces and assists in addressing institutionalised racism."[213]

[145] NATSIHWA notes that Ms Wright opined that the uplift proposed, and in particular the associated remuneration, "is likely to have flow on benefits in encouraging further training, taking on higher duties in the workplace and maintaining registration – all these areas are a win for developing and enhancing Aboriginal and/or Torres Strait Islanders' capacity to improve the health of their people".[214]

Grade 6 work value claim

[146] NATSIHWA also seeks the introduction of a Grade 6 (*Grade 6 work value claim*)[215] which is a new grade that contemplates the creation of senior roles for A&TSIHWs and A&TSIHPs operating at a senior level with responsibility in the implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs. The proposed new roles are:

> "117.1 Senior Health Practitioner, who holds a Diploma of A&TSI Primary Health Care (Practice), or other qualifications or experience deemed equivalent; and
>
> 117.2 Coordinator Care, which is an A&TSIHW who holds either a Diploma or Advanced Diploma of A&TSI Primary Health Care (Care) or other qualifications or experience deemed equivalent."[216]

[147] NATSIHWA states the proposed Grade 6 is a new grade which anticipates A&TSIHWs and A&TSIHPs undertaking senior roles in which they may report to the Board of Directors or be responsible for the administration of the health service.

[148] NATSIHWA notes that this level of responsibility for A&TSIHWs and A&TSIHPs is not currently recognised by the Award. NATSIHWA further comment that when the Award

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[212] Witness statement of Mr Karl John Briscoe dated 18 June 2019 at [168] – [170].

[213] Transcript dated 26 July 2019 at PN1071 and Wright, Expert Report, at [19].

[214] NATSIHWA submission dated 18 June 2019 at [116] and Wright, Expert Report at [37].

[215] NATSIHWA, submission dated 18 June 2019 at [31].

[216] Ibid at [117].

was formulated, A&TSIHWs and A&TSIHPs did not have an opportunity for input into the Award, including the classification structure.

[149] NATSIHWA submits that the proposed grade would provide a career structure for A&TSIHWs and A&TSIHPs who have completed a Diploma or Advanced Diploma of A&TSI Primary Health Care and are required to utilise their qualifications in managerial positions.

[150] NATSIHWA submits that providing A&TSIHWs and A&TSIHPs with a career structure which envisages senior level management roles allows A&TSIHWs and A&TSIHPs to bring their own set of expertise and skills to a multidisciplinary health care team at a senior level.[217] Further, it contends that a career structure will strengthen the profession and prevent the perception that the unique professional identity is a bridge to other professions.[218]

[151] NATSIHWA submits that creating this role would provide A&TSIHWs and A&TSIHPs with a greater level of recognition when required to provide support and manage other workers, particularly in the delivery of specialised programs. Further, it may lead to more A&TSIHWs and A&TSIHPs being considered in management roles of small remote community clinics, creating more sustainable employment options than short-term or temporary nurses.

[152] NATSIHWA refers to Associate Professor Lovett's evidence, contending that:

> "Associate Professor Lovett is also of the view that professionalism of a career with the requisite grading and salary will contribute in large part to increased recruitment and retention, and that creating a grade 6 classification is likely to result in development of senior management roles for A&TSIHWs and A&TSIHPs, incentivising those professionals to make a long-term career out of their occupation. This will create greater opportunity for A&TSI people to manage the health outcomes for their communities."[219]

[153] NATSIHWA submits that the addition of Grade 6 provides a fair and relevant minimum safety net of terms and conditions for A&TSIHWs and A&TSIHPs who deserve the opportunity for a career structure that recognises their contribution (and potential contribution) to manage and promote health outcomes for their communities.

[154] In relation to remuneration, NATSIHWA submits that A&TSIHWs and A&TSIHPs deserve to be compensated for Grade 6 work at a rate equivalent to non-A&TSI employees who perform work of equal or comparable value.

[155] NATSIHWA proposes remuneration that is equivalent to workers classified under Grade 8 of the *Social, Community, Home Case and Disability Services Industry Award 2010* (SCHCDSI Award), submitting that the proposed Grade 6 workers:

> "124.1 have equivalent characteristics;
>
> 124.2 have equivalent responsibilities; and

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[217] Ibid at [31].

[218] Ibid.

[219] NATSIHWA submission dated 18 June 2019 at [121].

124.3 have equivalent prerequisites."[220]

[156] NATSIHWA submits that, like a Grade 8 SCHCDSI employee, the Senior Health Practitioner will work at a senior level. A Senior Health Practitioner will be responsible for implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs or sub-programs.

[157] NATSIHWA submits that, like a Grade 8 SCHCDSI employee, the Coordinator Care will work at an advanced level in a specialised program with broad discretion, minimal supervision and exercising accountability and responsibility for the programs they oversee.

[158] NATSIHWA submits the proposed Grade 6 categories share the following characteristics and responsibilities with Grade 8 SCHCDSI employees:

- exercising managerial responsibility;
- providing advice to the Board and on policy matters;
- working with a high level of proficiency in problem solving;
- working autonomously;
- undertaking work of significant scope and complexity;
- undertaking work of a critical nature with little direction;
- undertaking functions across a range of specialist areas;
- administering complex program matters; and
- initiating and formulating organisational programs.[221]

[159] NATSIHWA submits that, in addition, the Senior Health Practitioner and the Coordinator Care must have level 3 A&TSI cultural skills and the ability to liaise with external stakeholders and advocate for the rights and needs of community members.

[160] NATSIHWA also submits the requirements of Grade 8 SCHCDSI employees are equivalent to that of a Senior Health Practitioner or Coordinator Care worker as the skills, knowledge, qualification and training of these proposed categories include detailed knowledge of policy, programs, guidelines, procedures and practices and a diploma plus the acquisition of considerable skills and extensive and diverse experience.[222]

Submissions in reply

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[220] Ibid at [124].

[221] Ibid at [126].

[222] Ibid at [127] and [130].

[161] In its written submissions in reply, AFEI raises concerns with the quantum of the proposed wage increases and their relativity with other award rates of pay.

[162] In relation to the new Grade 6 management classification, AFEI observes the proposed rates of pay are based on the highest classification rates in the SCHCDSI Award, which usually apply to Chief Executive Officers of SCHCDSI organisations, including those providing first nation people's services.

[163] In addition, AFEI states they are equivalent to the rates of pay for the Chief Executive of an ACCHS who is typically responsible for all health professionals and other employees within such an organisation. The ACCHS Award specifies that the Administration Grade 8 classification will be the Chief Executive Officer of an Aboriginal community controlled health services.

[164] AFEI notes the proposed Grade 6 rates of pay are substantially higher, by $99.20 to $202 per week than a Dental Therapist Grade 2 position, which it submits appears similar to the Grade 6 classification proposed by NATSIHWA in that they are both senior roles.

[165] AFEI submits that the duties of the Grade 6 classification seem similar to existing roles, noting that the role of an Aboriginal Health Worker in Grade 4 of the current Award overlaps with the proposed grade in the following ways:

- the qualification required for the Grade 6 role is the same – Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care or equivalent; and

- both are senior roles involving coordination management.

[166] AFEI states there is uncertainty as to the intended operation of the proposed Grade 6 classification, noting that while the proposal states that workers at this level may report to the Board of Directors or Board of Management it is unclear as to what matters this may include and whether the Grade 8 CEO would continue to be responsible for A&TSIHWs. Here, AFEI submits that if the new Grade 6 role is intended to operate parallel to and independent of the CEO it is unlikely the work value would be comparable with the CEO.

[167] AFEI submits the proposal to move the role of "Advanced Health Worker – Practice and Health Practitioner", currently classified as Grade 3 termed Senior Aboriginal Health Worker to Grade 5 would result in a significant increase of $80.50 to $83.80 per week.

[168] AFEI states the proposed Grade 5 rates are similar to the rates of pay for a Dental Therapist Grade 2 despite the Dental Therapist Grade 2 role involving significantly more complex duties and responsibilities than that of a Senior Aboriginal Health Worker. AFEI illustrates this as follows:

Senior Aboriginal Health Worker (grade 3) is required to:

- Perform their duties with little supervision and may be required to work as a sole practitioner remote from the health service.

Dental therapist (grade 2) is required to:

- Work as a professional practitioner
- Perform normal professional work under general professional guidance
- Perform novel, complex or critical professional work under professional Supervision
- Perform normal professional work of an organisational unit or of a specialised professional field encompassed by the work of the unit and accept technical responsibility for those tasks
- Work in isolation at times
- Exercise of independent professional judgement
- Carry out research
- Professional supervision of dental therapists
- Advisory role
- Advise on interpretation of regulations or standards

[169] AFEI notes the wage rates for Dental Assistants and Dental Therapist within the ACCHS Award are comparable to the rates provided in the HPSS Award.

[170] AFEI submits that, if the Commission is persuaded the Award should be varied as proposed, it is likely that the wages for health workers would significantly misalign with health workers in other awards.

Consideration

[171] In order for us to properly deal with the classification structure claim it is necessary to firstly consider the Grade 5 & 6 work value claims because our conclusions about these claims have a direct bearing on the classification structure. The relevant statutory provisions setting out the work value requirements and the matters about which the Commission must be satisfied have been set out earlier.

[172] We first turn to the Grade 5 work value claim which proposes that under the revised 6 grade structure, an uplift in the rates of pay is sought for "Advanced Health Workers – Practice" and "Health Practitioners". Persons so classified would be required to hold a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or equivalent. Under the existing classification structure persons holding such qualifications would be classified at Grade 3. The effect of the uplift, if accepted, would be to be increase the weekly rate of pay from $1088.10 at Grade 3 Level 1 to $1170.40 at Grade 5 Level 1 with similar uplifts in the respective Level 2 & 3 rates of pay.

[173] We have sought to summarise above at [133]-[150] the evidence and the basis of the work value claim. That evidence goes to the nature of the work undertaken by A&TSIHPs, the

level of skill and responsibility and the conditions under which work is done, from which we draw the following key points made by NATSIHWA:

- While the requirement to obtain a Certificate IV (Practice) qualification remains unchanged, the units delivered for both A&TSIHP and A&TSIHW qualifications have changed and increased over time;

- The work of A&TSIHPs can be distinguished from that of A&TSIHWs in that A&TSIHPs tend to work as independent practitioners alongside doctors and nurses;

- The nature of work performed by A&TSIHPs has changed and the level of skill and responsibility has increased;

- Since 2012 A&TSIHPs have been required to be registered with the A&TSIHPBA, the elements and requirements of which registration are detailed at [130] above;

- The registration requirements have increased the responsibility and accountability of A&TSIHPs;

- The work of A&TSIHPs and A&TSIHWs occurs in hot, isolated and sometimes challenging community conditions;

- The growth of the general A&TSI population has increased the workload on A&TSIHPs and A&TSIHWs; and

- A&TSIHPs may also be required to administer medication in remote communities in some states and territories.

[174] A proposition advanced by NATSIHWA in support of the Grade 5 work value claim is that of the registration requirements to which we have referred above. While we readily accept that the A&TSIHPBA registration requirement imposes a level of accountability on A&TSIHPs that distinguishes them from A&TSIHWs, it is not apparent to us that such registration requirements in themselves result in an increased level of skill or responsibility. We would also observe that the requirement of A&TSIHPs to maintain registration as a condition of employment is not new. Such a requirement was envisaged and provided for in the Award when made in 2009[223] and remains in the Award in similar terms in respect of the existing Aboriginal and/or Torres Strait Islander Health Worker Grade 3 classification:

> "NOTE: An Aboriginal and/or Torres Strait Islander Health Worker required by State or Territory legislation to maintain registration as a condition of their employment and who holds a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) or Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Community) or equivalent must be classified as no less than a Grade 3 Level 2 Aboriginal and/or Torres Strait Islander Health Worker."[224]

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[223] PR991082 at Schedule B, Clause B.1.3.

[224] MA000115 at Schedule A, Clause A.2.3.

[175] Recognition of the requirement for A&TSIHPs to maintain registration as a condition of employment is already evident in that where A&TSIHPs hold a Certificate IV and are required to maintain registration as a condition of employment they must be paid no less than Grade 3 Level 2. This in our view appears to acknowledge the additional accountability required of A&TSIHPs in obtaining and maintaining registration.

[176] Turning to the administering of medication. The evidence reveals that the administering of medication by A&TSIHPs is not regulated consistently across all states and territories. According to NATSIHWA, A&TSIHPs are currently only permitted to administer medication in certain states, those being in remote areas of the Northern Territory and Western Australia and isolated areas of Queensland. Thus, while A&TSIHPs may undertake training as part of their study towards a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) not all A&TSIHPs are then required to apply that knowledge and skill.

[177] We are satisfied that the administering of medication carries greater responsibility. We note however that NATSIHWA have made a separate claim for payment of a "Medical Administration Allowance" in recognition of the additional responsibility some A&TSIHPs are required to exercise in administering medication. The pressing of the claim by NATSIHWA for the "Medical Administration Allowance", with which we deal further on in our decision, while also seeking to rely on the exercise of that same responsibility in support of the Grade 5 work value claim appears to us to be an exercise in double dipping.

[178] We consider the better course in circumstances where administering of medication is not required to be performed by all A&TSIHPs is for the merit of the claim of additional responsibility to be considered in determining the "Medical Administration Allowance" claim. To that end we decline to consider the medication administration requirement as part of the Grade 5 work value clam.

[179] As to the conditions in which the work is performed, we readily accept that the work is required to be performed at times in hot, geographically isolated, personally confronting and challenging family and community circumstances. We also accept the evidence that there is an increasing demand for the services provided by A&TSIHPs and A&TSIHWs. These features appear to characterise the work of A&TSIHPs and A&TSIHWs at all levels more generally and is, on the evidence, not unique to A&TSIHPs the subject of the Grade 5 work value claim. It would also appear that the particular conditions to which we have referred are not recent and were features of Aboriginal community controlled health services at the time of the making of the Award and are presumed to have been taken into account in the making of the Award. We are not persuaded that the conditions in which the work is performed justify varying the rates of pay.

[180] It follows from the above that we are not persuaded that a *work value* case has been made out by NATSIHWA that the nature of the work, the skills or responsibility exercised and the conditions under which the work is performed is such as to justify the increase in rates sought. The Grade 5 work value claim is declined.

[181] We now turn to consider the Grade 6 work value claim in which NATSIHWA seek the introduction of new roles for A&TSIHWs and A&TSIHPs operating at a senior level with responsibility in the implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs.

[182] If NATSIHWA's claim were accepted, the proposed new roles of Senior A&TSI Health Practitioner (Care) and A&TSI Health Worker Coordinator (Care) would receive a weekly rate of pay of $1383.30 at Grade 6 Level 1 which compares with the current highest rate of pay for an A&TSI Health Worker classification of Grade 4 Level 3 of $1226.90 per week.

[183] The claim is advanced by NATSIHWA on a number of grounds including that:

- The new grade anticipates A&TSIHWs and A&TSIHPs undertaking senior roles in terms of reporting to a Board or being responsible for administration of a health service;
- The level of responsibility envisaged is not currently recognised by the Award;
- The new role would provide a career path to encourage and recognise completion of a Diploma or Advanced Diploma in A&TSI Primary Health Care; and
- It will strengthen the profession and prevent the perception that the 'unique professional identity is a bridge to other professions'.

[184] In proposing the new roles and rates of pay, NATSIHWA has sought to align the rates of pay with that of Grade 8 in the SCHCDSI Award contending that the prerequisites, skills and responsibilities are comparable.

[185] On the material before us we consider that the creation of the more senior roles is not without some merit in respect of the implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs. However, we have significant concerns about the current proposal which we detail below.

[186] It is not clear to us how the proposed new roles which, on NATSIHWA's submission, may report to the Board or be responsible for administration of a health service, interact with the existing CEO classification. The CEO classification is found in the Administrative stream of the current Award classification structure and is defined as follows:

> "**A.3.8 Grade 8**
>
> Positions at this grade will be the Chief Executive Officer of an Aboriginal and/or Torres Strait Islander community controlled health service other than those classified at Grade 7 who reports to and is responsible for the administration of the health service to the Board of Management and to whom heads of programs or activities within the health service report and are responsible.
>
> It is desirable that staff at this grade have Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 3."

[187] There appears to us to be a tension in the creation of the new roles that may report to the Board and/or be responsible for administration of a health service when there is already a classification within the Award that applies. We agree with AFEI's submission that the rates of pay proposed are essentially equivalent to the rates of pay for the CEO of an ACCHS who is typically responsible for all health professionals and other employees within such an

organisation. This tension was not addressed in the case put to us. The rates of pay for the Grade 8 CEO role in the Award are as follows:

- Level 1 $1407.20
- Level 2 $1443.30
- Level 3 $1491.80
- Level 4 $1527.10

[188] Furthermore, we are not persuaded on the material before us that the proposed new roles are comparable to the Grade 8 role in the SCHCDSI Award. To illustrate, the minimum qualification requirement for the proposed new Grade 6 roles in the Award are that of a Diploma (or equivalent) in the case of a Senior Health Practitioner and an Advanced Diploma (or equivalent) in the case of a Coordinator Care. By comparison, the pre-requisite requirements in respect of a Grade 8 in the SCHCDSI Award is stated as follows:

> "**(b) Prerequisites**
>
> **(i)** qualifications are generally beyond those normally acquired through a degree course and experience in the field of specialist expertise;
>
> **(ii)** substantial post graduate experience;
>
> **(iii)** lesser formal qualifications and the acquisition of considerable skills and extensive and diverse experience relative to an equivalent standard; or
>
> **(iv)** attained through previous appointments, service and/or study with a combination of experience, expertise and competence sufficient to perform the duties of the position."[225] [Emphasis added]

[189] Finally, we also consider there is some force to AFEI's submission that, if the work value claims were accepted, there is likely to be a misalignment of pay rates between the proposed new roles and those of health workers covered by other awards and also specifically in respect of Dental Therapists covered by the Award. Grade 2 Dental Therapists under the Award receive $1181.42 al Level 1 and up to $1284.02 per week at Level 4 of the Award. The pay rate misalignment point of AFEI is further illustrated by reference to that of an entry level 4-year degree qualified persons under the SCHCDSI Award who would be entitled to a weekly rate of pay of Level 3 Pay Point 1 of $1009.00 per week.

[190] Our reservations about the proposed new Grade 6 detailed above are such that we are not persuaded to grant the work value claim sought by NATSIHWA.

[191] Returning now to the proposed new 6 level classification structure, it will be apparent that our decision to decline the Grade 5 & 6 work value claims has implications for the proposed classification structure. The most obvious is that of both the Grades into which particular proposed classifications fit and also the number of grades.

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[225] MA000100 at Schedule B, Clause B.8.3

[192] Notwithstanding our conclusions on the Grade 5 & 6 work value claims detailed above, we are persuaded of the merit of some changes being made to the existing classification structure. Specifically, separating the existing Grade 1 entry level classification into two grades - Grades 1 and 2 for Health Worker trainees with corresponding wage rates to remain as currently set is supported. We agree that such a change would assist individuals to obtain a Certificate II in A&TSI Primary Health Care and provide recognition to individuals who already hold a Certificate II. The proposed change would ensure that the optional Certificate II qualification would provide individuals seeking to work as an A&TSIHW with an entry pathway. We are satisfied that the proposed change meets the modern award objective at s.134(c) of the Act.

[193] The change to the classification structure would result in a consequent change from the existing 4 grade to 5 grade structure. NATSIHWA will be invited to provide a revised draft classification structure reflecting our decision.

Introducing clauses for "progression", "recognition of previous service" and "evidence of qualifications"

[194] In order to traverse the proposed classification levels, NATSIHWA seeks to include three additional provisions. The first proposed is a progression clause as a mechanism for employees to progress through the Award.[226] NATSIHWA contends this would provide clarification about how workers are to move between levels (or experience in a particular grade).[227]

[195] The clause proposed is as follows:

> "**13.3 Progression**
>
> (a) At the end of each 12 months' continuous employment, an employee will be eligible for progression from one level to the next within a grade if the employee has demonstrated competency and satisfactory performance over a minimum period of 12 months at each level within the level and;
>
> (i) the employee has acquired and satisfactorily used new or enhanced skills within the ambit of the classification, if required by the employer; or
>
> (ii) where an employer has adopted a staff development and performance appraisal scheme and has determined that the employee has demonstrated satisfactory performance for the prior 12 months' employment.
>
> (b) Movement to higher classification will occur by way of promotion or re-classification." [228]

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[226] NATSIHWA Submission dated 18 June 2019 at [69].

[227] Transcript dated 26 July 2019 at PN787 - PN788; NATSIHWA Submission dated 18 June 2019 at [69] - [70].

[228] NATSIHWA's Further Amended Draft Determination dated 9 August 2019 at p.3.

[196] The second provision deals with recognition of prior service (proposed recognition clause).[229] The clause proposed is as follows:

> "**13.4 Recognition of prior service**
>
> (a) On appointment, an employee will be classified and placed on the appropriate level on the salary scale in clause 14 – Minimum Salary, according to their qualifications and experience as an Aboriginal and/or Torres Strait Islander Health worker.
>
> (b) Service as a part-time Aboriginal and/or Torres Strait Islander Health Worker will normally accrue on a pro-rata basis according to the percentage of a full-time Aboriginal and/or Torres Strait Islander Health Worker load undertaken in any year; provided that where the hours are more than 90% of a full-time load, service will count as a full-time year.
>
> (c) In the case of a casual employee, the equivalent of a full-time year of service is 200 casual days."

[197] The third provision deals with evidence of qualifications (proposed evidence of qualifications clause).[230] The clause proposed is as follows:

> "**13.5 Evidence of qualifications**
>
> (a) On engagement, the employer may require that the employee provide documentary evidence of qualifications and experience. If an employer considers that the employee has not provided satisfactory evidence, and advises the employee in writing to this effect, then the employer may decline to recognise the relevant qualification or experience until such evidence is provided. Provided that the employer will not unreasonable refuse to recognise the qualifications of an employee."

[198] NATSIHWA contends that the proposed recognition clause will enable employers to recognise an employee's prior experience and ensures that an employee's classification is commensurate with the employee's skills and experience.[231]

[199] NATSIHWA contends that amending the Award by including a new classification structure, a proposed progression clause and proposed recognition clause would effectively provide a method for A&TSIHWs and A&TSIHPs to progress in their careers and attract workers leading to a desirable and necessary increase in the size of the available workforce.[232]

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[229] NATSIHWA Submission dated 18 June 2019 at [72] – [74].

[230] Ibid at [75] – [77].

[231] NATSIHWA Submission dated 18 June 2019 at [73].

[232] Transcript dated 25 July 2019 at PN502 to PN548.

Consideration

[200] We have considered the proposed clauses dealing with progression within the classification structure, recognition of prior service and evidence of qualifications. If accepted, the clauses would support the more effective operation of the classification structure. Further, they would in our view encourage and recognise qualifications and skills acquisition and thereby support career development of A&TSIHWs and A&TSIHPs.

[201] We note the extensive evidence advanced by NATSIHWA about shortages of A&TSIHWs and A&TSIHPs. We accept that including the proposed clauses will provide for more transparent and effective qualification and prior experience recognition processes and classification progression mechanisms, which will support efforts to increase the number of A&TSIHWs and A&TSIHPs both within the Aboriginal Community Controlled Health Services and in private practice. To that end we are satisfied that varying the Award to include the proposed clauses is consistent with the modern award objectives found at ss.134(1)(c) and (g) of the Act.

[202] We propose to include these provisions in the Award but there will be some renumbering to reflect the 2020 Award clause numbering.

Allowances

[203] NATSIHWA submits that the parties have reached a consent position on four new allowances they propose be inserted in the Award. In a decision concerning the Group 4 Awards issued on 7 August 2018,[233] the Full Bench noted that while these allowances are agreed between the parties, they are substantive amendments and require further consideration, particularly in relation to the modern awards objective.

[204] In a submission in reply dated 19 July 2019,[234] AFEI states that NATSIHWA submits the four allowances below are "agreed" and refers to its submissions dated 24 April 2017. In those submissions AFEI raises its concerns about the appropriateness of transposing allowances directly from one award to another.[235] It is unclear if AFEI is opposed to the four "agreed" allowances being inserted and as already noted it did not appear at the hearings to provide clarification.

Telephone allowance

[205] NATSIHWA seeks to vary the Award to include a telephone allowance clause, in the following terms:

> "**15.8 Telephone allowance**
>
> Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts. This clause will not

[233] [2018] FWCFB 4175.

[234] AFEI submission in reply dated 19 July 2019 at [1.23].

[235] AFEI submission dated 24 April 2017 at [9].

apply where the employer provides the employee with a mobile telephone for the purpose of being on call."

[206] Mr Briscoe gave evidence that in his experience A&TSIHWs and A&TSIHPs working in more remote communities are more likely to be required to be on call. Further, he cited the example of Aurukun where A&TSIHWs and A&TSIHPs are required to keep a telephone for the purpose of being on call.[236] Mr Briscoe's evidence as to the requirement for some A&TSIHWs and A&TSIHPs to be on call was supported by the evidence of Mr Aaron Everett,[237] Ms Charlene Badham[238] and Mr Zibeon Fielding.[239]

Nauseous work allowance

[207] NATSIHWA seeks to vary the Award to include a nauseous work allowance clause, in the following terms:

"**15.9 Nauseous Work Allowance**

An allowance of 0.05% of the standard rate per hour or part thereof will be paid to an employee in any classification if they are engaged in handling linen of a nauseous nature other than linen sealed in airtight containers and/or for work which is of an unusually dirty or offensive nature having regard to the duty normally performed by such employee in such classification. Any employee who is entitled to be paid for this allowance will be paid a minimum amount of 0.27% of the standard rate for work performed in any week."

[208] Extensive evidence was given as to the nature of the nauseous work that A&TSIHWs and A&TSIHPs are required to perform in the course of their duties including; the handling of dirty or soiled linen,[240] cleaning and dressing soiled and maggot infested wounds,[241] working with clients that have soiled themselves,[242] cleaning up after clients that have vomited and cleaning faeces from the public toilet at the clinic,[243] being vomited and urinated on by infants[244] and collection of stool samples.[245]

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[236] Witness Statement of Mr Karl John Briscoe dated 18 June 2019 at [209].

[237] Witness Statement of Mr Aaron Everett dated 19 June 2019 at [20].

[238] Witness Statement of Ms Charlene Badham dated 18 June 2019 at [24].

[239] Witness Statement of Mr Zibeon Fielding dated 19 July 2020 at [24].

[240] Witness Statement of Ms Charlene Badham dated 18 June 2019 at [25].

[241] Witness Statement of Ms Lorraine Gilbert dated 26 June 2019 at [21].

[242] Witness Statement of Mr Derek Donahue dated 18 June 2019 at [13].

[243] Witness Statement of Ms Naomi Zaro dated 18 June 2019 at [25].

[244] Witness Statement of Ms Sharon Wallace dated 28 June 2019 at [20].

[245] Witness Statement of Ms Haysie Penola dated 28 June 2019 at [22].

Blood check allowance

[209] NATSIHWA seeks to vary the Award to include a blood check allowance clause, in the following terms:

> "**15.6 Blood check allowance**
>
> Any employee exposed to radiation hazards in the course of their work will be entitled to a blood count as often as is considered necessary and will be reimbursed for any out of pocket expenses arising from such a test."

[210] Mr Briscoe gave evidence that in his experience A&TSIHWs and A&TSIHPs are "exposed to the risk of radiation hazards when assisting clients who have undertaken chemotherapy or radiation therapy". Further if an employee is exposed to this risk, they may have to incur the expense of obtaining a blood check.[246]

Damaged clothing allowance

[211] NATSIHWA seeks to vary the Award to include a damaged clothing allowance clause, in the following terms:

> "**15.5 Damaged Clothing Allowance**
>
> Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects, the employer will be liable for the replacement, repair or cleaning of such clothing or personal effects provided, where practicable, immediate notification is given to the employer of such soiling as soon as possible."

[212] Evidence was provided by a number of witnesses that damage to clothing arises from routine performance of duties by A&TSIHWs and A&TSIHPs including through: coming into contact with various bodily fluids during medical procedures;[247] being urinated on by infants;[248] and exposure to excessive bleeding from a client.[249] According to Mr Richard Assan the damage to clothing can occur despite the wearing of protective gowns and depending on the damage the clothing may need to be thrown out after it has been damaged.[250]

Submissions

[213] NATSIHWA submits all the agreed allowances fall within s.139(g), which provides that a modern award may, *inter alia*, include terms about:

> "(g) allowances, including for any of the following:
>
> (i) expenses incurred in the course of employment;

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[246] Witness Statement of Mr Karl John Briscoe dated 18 June 2019 at [208].

[247] Witness Statement of Ms Charlene Badham dated 18 June 2019 at [23], Witness Statement of Mr Peter Yarran at [14].

[248] Witness Statement of Ms Haysie Penola dated 28 June 2019 at [20].

[249] Witness Statement of Ms Naomi Zaro dated 18 June 2019 at [24].

[250] Witness Statement of Mr Richard Assan dated 18 June 2019 at [16].

(ii) responsibilities or skills that are not taken into account in rates of pay;

(iii) disabilities associated with the performance of particular tasks or work in particular conditions or locations."

[214] Further, NATSIHWA compares the agreed allowances to similar allowances in other awards:

- Telephone allowance: thirteen other modern awards,[251] with the HPSS Award, the Animal Care and Veterinary Service Award 2010, the Medical Practitioners Award 2010 and the Social, Community, Home Care and Disability Services Industry Award 2010 being examples of health-based awards.

- Nauseous work allowance: the Aged Care Award 2010 at clause 15.5, the Australia Post Enterprise Award at clause 26.14 and the HPSS Award at clause 18.8.

- Blood check allowance: HPSS Award at clause 18.2.

- Damaged clothing allowance: twelve other modern awards, with the HPSS Award at clause 18.4 being an example of a health-based award.[252]

[215] NATSIHWA contends that when the Award was made, it appears there was minimal consideration given to including these allowances. Other employees in the health industry who perform work of comparable value receive these allowances and NATSIHWA submits that making the proposed variation would ensure equal remuneration for work of equal or comparable value, as required by s.134(1)(e) of the Act.

Consideration

[216] There is general agreement (subject to the views expressed by AFEI above) amongst the parties who appeared before us as to the following allowances. We are satisfied that the allowances fall within s.139(1)(g) in that they are expenses incurred in the course of employment and/or recognise disabilities associated with the performance of particular tasks or work in particular conditions or locations. The telephone allowance, blood check allowance and damage or repair to clothing allowance recognise expenses incurred in the course of

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[251] *Air Pilots Award 2010* (cl 19.6), *Airservices Australia Enterprise Award 2016* (cl 12.17), *Commercial Sales Award 2010* (cl 16.1), *Contract Call Centres Award 2010* (cl 20.3), *Health Professionals and Support Services Award 2010* (cl 18.11), *Marine Towage Award 2010* (cl 14.2(c)), *Market and Social Research Award 2010* (cl 17.1(c)), *Medical Practitioners Award 2010* (cl 16.5), *Nurses and Midwives (Victoria) State Reference Public Sector Award 2015* (cl 14.5), *Real Estate Industry Award 2010* (cl 18.6), *Social, Community, Home Care and Disability Services Industry Award 2010* (cl 20.6), *Stevedoring Industry Award 2010* (cl 14.5), *Telecommunications Services Award 2010* (cl 17.1(c)).

[252] *Aboriginal Legal Rights Movement Award 2016* (cl 16.4), *Australian Broadcasting Corporation Enterprise Award 2016* (cl 36.3), *Food, Beverage and Tobacco Manufacturing Award 2010* (cl 26.2(d)), *Health Professionals and Support Services Award 2010* (cl 18.4), *Joinery and Building Trades Award 2010* (cl 24.2(d)(i)), *Journalists Published Media Award 2010* (cl 15.3), *Manufacturing and Associated Industries and Occupations Award 2010* (cl 32.2(d)), *Maritime Offshore Oil and Gas Award* (cl 14.5), *Mobile Crane Hiring Award 2010* (cl 14.3(b)), *Rail Industry Award 2010* (cl 15.3(a)(i)), *Seafood Processing Award 2010* (cl 19.1(c)), *Storage Services and Wholesale Award 2010* (cl 16.6).

employment. The nauseous work allowance relates to disabilities associated with the performance of particular work undertaken by A&TSIHWs and A&TSIHPs. It should be clear that we have not adopted these clauses because they are in other Awards but because we are satisfied that there are grounds for their inclusion.

[217] We will include the clauses set out below in the Award as proposed by the parties with some minor changes. Firstly, we have amended the title of the 'Damaged Clothing Allowance' clause proposed by NATSIHWA to that of 'Replacement, Cleaning or Repair to Damaged Clothing Allowance' as it would more effectively describe the intended purpose of the allowance. We have also slightly varied the 'Replacement, Cleaning or Repair to Damaged Clothing Allowance' clause from that proposed to remove the term 'immediate' as shown below as there is a tension in the use of the word 'immediate' when notification of the damage is also required to occur 'as soon as possible'.

[218] The clause numbering below is also consistent with the revised clause numbering in the 2020 Award:

19.2(c) Nauseous Work Allowance

An allowance of 0.05% of the standard rate per hour or part thereof will be paid to an employee in any classification if they are engaged in handling linen of a nauseous nature other than linen sealed in airtight containers and/or for work which is of an unusually dirty or offensive nature having regard to the duty normally performed by such employee in such classification. Any employee who is entitled to be paid for this allowance will be paid a minimum amount of 0.27% of the standard rate for work performed in any week.

19.3 (d) Telephone allowance

Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts. This clause will not apply where the employer provides the employee with a mobile telephone for the purpose of being on call.

19.3(e) Blood check allowance

Any employee exposed to radiation hazards in the course of their work will be entitled to a blood count as often as is considered necessary and will be reimbursed for any out of pocket expenses arising from such a test.

19.3(f) Replacement, Cleaning or Repair to Damaged Clothing Allowance

Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects, the employer will be liable for the replacement, repair or cleaning of such clothing or personal effects provided, where practicable, <u>provided</u> ~~immediate~~ notification is given to the employer of such soiling as soon as possible.

Contested allowance claims

[219] NATSIHWA submits that when the Award was first made, there appears to have been minimal consideration to including a number of the contested allowances and that other employees working in the health industry, performing work of a comparable value, are entitled to these allowances.

[220] The following allowance claims are not agreed between the parties. AFEI opposes NATSIHWA's claims, submitting it is concerned whether it is appropriate to transpose the allowances from one award to another.[253] AFEI relies on submissions by NACCHO during the award modernisation process, in which NACCHO submitted that care in the Aboriginal Health Sector is of a culturally appropriate nature and can involve duties such as interpreting and administering medication.[254]

Heat allowance

[221] NATSIHWA seeks to vary the Award to include a heat allowance clause, in the following terms:

> "15.10 Heat Allowance
>
> (a) Where work continues for more than two hours in temperatures exceeding 46º Celsius, employees will be entitled to 20 minutes rest after every two hours' work without deduction of pay.
>
> (b) It will be the responsibility of the employer to ascertain the temperature."

[222] According to NATSIHWA a large number of publicly funded primary healthcare providers are located in very remote areas of central, northern and western Australia and therefore, some A&TSIHWs and A&TSIHPs experience conditions at 45º Celsius and above.[255] Evelyn Wilson gave evidence that she occasionally undertakes her work in temperatures between 46º Celsius and 54º Celsius and sometimes, above 54º Celsius when working in the Kimberley.[256] Ms Naomi Zaro gave evidence that she regularly works in temperatures between 46º Celsius and 54º Celsius and Ms Cynthia Sambo and Ms Derek Donohue gave evidence that in Kalgoorlie and Kununurra, the temperature often rises above 46º Celsius.[257] Ms Haysie Penola gave evidence that she has occasionally undertaken work in temperatures between 46º Celsius and 54º Celsius in Kalgoorlie.[258]

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[253] AFEI submission dated 24 April 2017 at [9] and AFEI submission in reply dated 19 July 2019.

[254] Submissions on behalf of National Aboriginal Community Controlled Health Organisation before the Australian Industrial Relations Commission (Matter Number: AM2008/64) dated 24 July 2009.

[255] Witness Statement of Mr Karl John Briscoe dated 18 June 2019 at [189] – [196].

[256] Witness Statement of Ms Evelyn Wilson at [12] and [22].

[257] Witness Statement of Ms Naomi Zaro dated 18 June 2019 at [26]; Witness Statement of Ms Cynthia Sambo at [24]; Witness Statement of Mr Derek Donohue dated 18 June 2019 at [14].

[258] Witness Statement of Ms Haysie Penola dated 28 June 2019 at [23].

[223] In correspondence[259] to the Commission following the hearing NATSIHWA amended its initial claim for payment of an allowance to address the work health and safety hazards associated with employees working in temperatures at or exceeding 46º Celsius. The amended claim is for the provision of appropriate rest breaks and is intended to remediate the underlying health and safety hazards encountered by employees working in temperatures at or exceeding 46º Celsius.

Consideration

[224] We are grateful for the amendments made to the initial claim for a heat allowance to properly respond to the health and safety issues associated with working in extreme heat. Whilst there is merit in the inclusion of the provision in the Award, we consider that it is more properly characterised as a rest break provision, and hence should be renamed and placed in that section of the Award dealing with Hours of Work.

[225] We are satisfied that the clause we propose falls within s.139(1)(c) of the Act dealing with arrangements for when work is performed, including rest breaks. Consequently a new clause 15.3 will be added to the Breaks provisions of the Award as follows:

> **15.3 Rest Breaks – working in heat**
>
> (a) Where work continues for more than two hours in temperature exceeding 46C, employees will be entitled to a 20 minute rest break every two hours without deduction from pay.
>
> (b) The employer must take all reasonable steps to ensure that an employee takes the breaks/s to which he or she is entitled.
>
> (c) It will be the responsibility of the employer to ascertain the temperature.

Sole Practitioner allowance

[226] NATSIHWA seeks to vary the Award to include a sole practitioner allowance, in the following terms:

> "**15.11 Sole Practitioner Allowance**
>
> Employees who are:
>
> (a) engaged to work in a Small Town; and
>
> (b) are the only Aboriginal and/or Torres Strait Islander Health Worker employed by their employer in that location,
>
> will, in addition to all other payments, be paid a weekly allowance for the exigencies of working in such areas of 4.28% of the standard rate."

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[259] NATSIHWA submission dated 9 August 2019 at [20].

[227] NATSIHWA also seeks to vary the Award to include a new definition of 'Small Town' at clause 2:

> "**Small Town** means a town with fewer than 10,000 people that is not within 50 kilometres (driving distance) of a town with a population in excess of 50,000 people (according to Australian Bureau of Statistics Census data)."

[228] Where A&TSIHWs and A&TSIHPs work in a small town according to the proposed definition, NATSIHWA submits that they can experience additional difficulties. Mr Briscoe gave evidence that remoteness and small population can result in fewer other health professionals being available, resulting in A&TSIHWs and A&TSIHPs taking on greater responsibility.[260] For example, an A&TSIHW or A&TSIHP may be the only one assisting a woman giving birth while taking instructions from a doctor over the telephone, which results in increased stress, responsibility and higher skill requirements.[261] Further, isolation can mean reduced access to training opportunities from elders.[262]

[229] Helena Badham, an A&TSIHP located in Nhulunbuy, Northern Territory (population of 3,240 as at 2016), gave evidence that she performs such a broad range of duties that she does the same work as a nurse (but is not paid accordingly).[263] Daphne de Jersey, an Indigenous Health Practitioner based in Mapoon, Far North Queensland (population 317 as at 2016) gave evidence that because she is the only IHP working at her organisation, she undertakes duties that she feels she does not have enough training to perform.[264] Zibeon Fielding, an Aboriginal Health Practitioner based in Mimili South Australia, gave evidence that A&TSIHWs and A&TSIHPs in remote areas 'do it very tough' because there are fewer services available and they are less able to access sources of assistance that could support them.[265] An example of this is one Aboriginal Health Worker who has to drive 100km to pick up a patient for an appointment at a health clinic, and drive another 100km to drop them back.[266] The closest hospitals are 400km – 500km away.[267] NATSIHWA submits the evidence establishes there are a number of A&TSIHWs and A&TSIHPs working in small towns that fall under the proposed definition, in Far North Queensland, the Northern Territory, Queensland, Western Australia and South Australia.[268]

[230] NATSIHWA submits that inclusion of this allowance is consistent with the modern awards objective, particularly ss.134(1)(a) and (e).

Consideration

[231] We have decided not to grant the application in relation to this allowance. We are not persuaded that the Award, including its scope, and hence the classification structure does not

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[260] Witness Statement of Karl John Briscoe dated 18 June 2019, at [200].

[261] Ibid at [201].

[262] Ibid at [202].

[263] Witness Statement of Helena Badham at [15] – [16].

[264] Witness Statement of Daphne de Jersey at [19] – [24].

[265] Witness Statement of Zibeon Fielding at [27] – [30].

[266] Ibid at [27].

[267] Ibid at [28].

[268] NATSIHWA submissions 20 June 2019 at [193].

already compensate for a A&TSIHWs and A&TSIHPs working as a sole practitioner. It seems to us that the making of this Award was in part in recognition of the unique role of A&TSIHWs and A&TSIHPs and the working environment within the Aboriginal Community Controlled Health Services. That A&TSIHWs and A&TSIHPs may work as sole practitioners is not a recent development. It is therefore reasonable to conclude that the wages and classification structure already recognise that this may be a facet of the work performed.

Occasional interpreting allowance

[232] NATSIHWA seeks the insertion of an occasional interpreting allowance, in the following terms:

> **"15.2 Occasional interpreting allowance**
>
> (a) An employee not employed as a full-time interpreter and who:
>
> (i) performs interpreting duties in the course of their work duties; and
>
> (ii) is not entitled to receive the Bilingual qualification allowance under clause 15.1, will receive an additional payment of 1.27% of the standard rate per week.
>
> (b) For the purpose of clause 15.2(a) interpreting is not limited to interpreting one language from or to the English language."

[233] NATSIHWA submits that in respect of the bilingual allowance at clause 15.1 of the Award (clause 18.8(a) in the 2020 Award), bilingual means a recognised proficiency in English in addition to any one of the languages normally used by the employer's clients.[269] Subclause 15.1(e) in the Award may present difficulties for A&TSIHWs and A&TSIHPs because proof of proficiency and accreditation must be obtained before they can be entitled to the allowance:[270]

> **(e)** Proof of bilingual proficiency and accreditation will be obtained before an employee will be entitled to this allowance. Bilingual accreditation is obtained by the employee confirming their bilingual proficiency in writing from an interpreting and/or translating service agreed by the employer and the employee.

[234] A&TSIHWs and A&TSIHPs may be required to interpret one Aboriginal language into another and to provide proof of that may be difficult.[271] The variation proposed, derived from the HPSS Award, is to address those issues.[272]

[235] A number of witnesses gave evidence that from time to time, A&TSIHWs and A&TSIHPs need to interpret for a client or translate particular words into a certain dialect, to

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[269] Transcript dated 26 June 2019 at PN1475.

[270] Ibid at PN1475.

[271] Ibid at PN1475.

[272] Ibid at PN1476.

ensure the client understands and can engage with the services being provided.[273] They can also be required to interpret for non-Indigenous medical staff to enable understanding and communication.[274] Ms Chandel Compton gave evidence that while assisting a dentist treating an Aboriginal and Torres Strait Islander client, she was able to interpret when the client said 'stop', so the dentist knew when to stop.[275] Ms Karen West gave evidence that sometimes when Aboriginal and Torres Strait Islander clients are required to travel to access healthcare, they feel intimidated and revert to speaking language; therefore the A&TSIHWs and A&TSIHPs are required to interpret.[276] NATSIHWA submits that A&TSIHWs and A&TSIHPs undertaking interpreting duties help to remove communication barriers, therefore increasing the likelihood that a client receives early treatment which reduces health costs.[277]

Consideration

[236] We note that, since the time of making submissions in relation to this application, the Full Bench of the Commission dealing with the finalisation of the 4 yearly review of modern awards has issued a determination varying the 2010 Award. That determination has resulted in the deletion from the Award of what was clause 15.1(e), which deals with proof of proficiency, and is set out above.

[237] Given the revised provisions in the 2020 Award it is our provisional view that the basis for the variation for the inclusion of the Occasional Interpreting Allowance no longer exists. However, prior to making a final decision interested parties will be given the opportunity to make submissions in relation to the claim based on clause 18.2(a) of the 2020 Award.

[238] Parties who seek the inclusion of the Occasional Interpreting Allowance should file any submissions in support of the allowance by **Wednesday 5 August 2020**. Any party opposed to the inclusion should file submissions in rely by **Wednesday 19 August 2020**. Subject to any contrary views of those filing submission we will make a decision on the basis of the submissions filed.

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[273] Witness Statement of Karl John Briscoe dated 20 June 2019 at [186]; Witness Statement of Daniel Niddrie at [26]; Witness Statement of John Watson dated 18 June 2019 at [15]; Witness Statement of Ms Haysie Penola dated 28 June 2019 at [18]; Witness Statement of Aaron Everett dated 19 June 2019 at [16] - [17]; Witness Statement of Daphne de Jersey at [25] – [29].

[274] Witness Statement of Ms Charlene Badham dated 18 June 2019 at [22]; Witness Statement of Evelyn Wilson at [19].

[275] Witness Statement of Ms Chandel Compton dated 26 June 2019 at [19].

[276] Witness Statement of Ms Karen West dated 18 June 2019 at [20] – [21].

[277] NATSIHWA submission 18 June 2019 at [205].

Medication administering allowance

[239] NATSIHWA seeks the insertion of a medication administering allowance, in the following terms:

> **"15.12 Medication Administration Allowance**
>
> Aboriginal and/or Torres Strait Islander Health Workers who are qualified and permitted under law to administer medications in the performance of their duties are entitled to an allowance of 0.25% of the standard rate per week."

[240] A&TSIHPs can administer medication only in remote areas of the Northern Territory and Western Australia and isolated areas of Queensland and this is subject to state based regulation.[278] Daniel Niddrie, an Aboriginal Health Worker based in Queensland, gave evidence that he administered medication in the past while working as a Senior Health Practitioner in Darwin, Tennant Creek and Broome.[279] Naomi Zora gave evidence that in her current work as an A&TSIHP in Kalgoorlie, she administers medication. This allows clients to access medications they might not otherwise be able to, reduces acute health issues, reduces health costs and reduces time spent travelling to cities for treatment. Zibeon Fielding gave evidence that he frequently gives immunisations and muscular injections.[280]

[241] NATSIHWA contends that while A&TSIHPs undertake training and study, the practitioners in remote areas in the Northern Territory, Western Australia and Queensland are assuming the risk of administering medication to the appropriate skill levels in accordance with the requirements for registration.[281] NATSIHWA submits the proposed medication administering allowance falls within s.139(g)(ii) of the Act, because it relates to responsibilities or skills that are not taken into account in rates of pay.

Consideration

[242] We are satisfied that an allowance for this purpose should be included in the Award. It is apparent from the evidence and we accept that the administration of medication is a matter that is regulated differently in each State and Territory. In circumstances where there is no uniform practice, we also accept that it is highly unlikely that the skills and responsibility for administration of medication are taken into account in the rates of pay. We are therefore satisfied that the inclusion of the allowance falls within s.139(1)(g)(ii) of the Act.

[243] We will include the clause as set out above, albeit it will be renumbered to be clause 19.2(f) in the 2020 Award.

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[278] *Medicines, Poisons and Therapeutic Goods Act 2012* (NT); *Health (Drugs and Poisons) Regulation 1996* (QLD); *Medicines and Poisons Regulations 2016* (WA).

[279] Witness Statement of Daniel Niddrie at [25].

[280] Witness Statement of Zibeon Fielding at [31].

[281] Transcript dated 26 July 2019 at PN1381.

Ceremonial leave

[244] NATSIHWA seeks to clarify the current ceremonial leave clause, so that it allows an employee to take ceremonial leave for bereavement related ceremonies and obligations. Clause 26 currently provides the following:

> "**26. Ceremonial leave**
>
> An employee who is legitimately required by indigenous tradition to be absent from work for Aboriginal and/or Torres Strait Islander ceremonial purposes will be entitled to up to 10 working days unpaid leave in any one year, with the approval of the employer."

[245] NATSIHWA seeks clause 26 be amended to the following (changes highlighted):

> "**26. Ceremonial leave**
>
> An employee who is legitimately required by indigenous tradition to be absent from work for Aboriginal or Torres Strait Islander ceremonial purposes, <u>including for bereavement related ceremonies and obligations,</u> will be entitled to up to 10 working days unpaid leave in any one year, with the approval of the employer."

[246] According to NATSIHWA, which filed a number of witness statements in support of its claims, Aboriginal and Torres Strait Islander persons refer to the cultural and ceremonial practices following the death of a community member as 'Sorry Business'.[282] These practices vary between language groups.[283] Robert John Dann gave evidence that respect and acknowledgement of the loss of a loved one is a core value of Aboriginal and Torres Strait Islander persons.[284] Following a death, there is an extended period of ceremony which can last for days, weeks or months.[285] Some Torres Strait Islander groups will hold a tombstone opening ceremony approximately 12 months after a burial.[286] The concept of 'kinship' determines who is required to be involved in the ceremonies, and is broader than the non-Indigenous concept of 'family'.[287]

[247] Aboriginal and Torres Strait Islander people have a higher mortality rate,[288] therefore there are more bereavement ceremonies for them to attend, and given the extended notion of 'kinship' more Aboriginal and Torres Strait Islander people are likely to have obligations following a death.[289] Many A&TSIHWs and A&TSIHPs work far away from their family, and have further to travel to attend to Sorry Business – for example, from New South Wales to

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[282] NATSIHWA submission 18 June 2018 at [209].

[283] Witness Statement of Karl John Briscoe dated 20 June 2019 at [215] – [217].

[284] Witness Statement of Robert John Dann at [17].

[285] NATSIHWA submission 18 June 2018 at [212].

[286] Witness Statement of Karl John Briscoe dated 20 June 2019 at [218].

[287] Ibid at [219].

[288] Ibid at [222].

[289] NATSIHWA submission 18 June 2018 at [214].

Western Australia.[290] Being unable to take enough time to attend to cultural commitments can lead to burnout and employees leaving their employment.[291] Employees can also face negative consequences from their community if they do not pay their respects to the family of the deceased.[292]

[248] NATSIHWA submits that the proposed amendments to the ceremonial leave clause are for clarification only, are minor and are necessary to achieve the modern award objective by providing a framework of fair and minimum entitlements.[293] The evidence and research establishes the importance of respecting the cultural sensitivities and providing culturally respectful workplaces.[294]

Consideration

[249] We are satisfied that the Ceremonial Leave clause should be amended as proposed. The amendment is minor but clarifies the circumstances of application of the Award. In this respect the variation will make the Award easier to understand.[295] The clause as varied will be included and renumbered as clause 27 in the 2020 Award.

HSU claims

[250] In its submissions, the HSU proposes to vary the Award as follows:

- providing that employees are entitled to tea-breaks (2020 Award clause 15);
- providing that a removal expenses allowance is paid to an employee who transfers from one locality to another;
- ensuring that casual loading is paid in addition to public holiday rates (clause 11 and clause 28.2 of 2020 Award); and
- amending the on call and recall allowance clause by providing a 10 hour uninterrupted break after being recalled to work, instead of a six hour break (clause 20.6 of the 2020 Award)'.[296]

[251] The HSU rely on the evidence of two witnesses, Mr Damian Rigney and Jackson Shillingsworth, Aboriginal Health Workers, in support of their proposed variations to the award.

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[290] Witness Statement of David Hart dated 18 June 2019 at [20]; Witness Statement of Evelyn Wilson filed 19 June 2020 at [24].

[291] Witness Statement of John Watson dated 18 June 2019 at [21] – [22]; Witness Statement of Naomi Zaro at [29]; Witness Statement of Daniel Niddrie at [32].

[292] Witness Statement of Naomi Zaro at [28].

[293] Transcript dated 26 July 2019 at PN1505.

[294] Transcript dated 26 July 2019 at PN1505.

[295] *Fair Work Act 2009* s.134(1)(g).

[296] HSU Submission dated 18 June 2019.

[252] NATSIHWA support the HSU's proposed variations. It should be noted that the HSU also support the claims of NATSIHWA.[297]

Tea breaks

[253] The HSU submits that the Award "should be varied to include a paid tea break for every four hours worked."[298] It contends that this entitlement is standard across almost all the awards in the health sector.

[254] In its submissions, the HSU outline comparative tea or rest break provisions in health related awards, which are detailed below:

- *Aged Care Award 2010* – Clause 24.2 – Tea breaks;
- *Ambulance and Patient Transport Industry Award 2010* – Clause 23.3 – Rest breaks;
- *Health Professionals and Support Services Award 2010* – Clause 27.2 – Tea breaks;
- *Nurses Award 2010* – Clause 27.2 – Tea breaks;
- *Pharmacy Industry Award 2010* – Clause 28.1 – Breaks; and
- *Social, Community, Home Care and Disability Services Award 2010* – Clause 27.2 – Tea breaks.[299]

[255] The HSU submits that the only health related award that does not provide for paid tea breaks is the *Medical Practitioners Award 2010*.

[256] The HSU claims that the provision of such an entitlement is particularly relevant in the Aboriginal Community Controlled Health sector as there are high demands placed on Aboriginal Health Workers. It relies on the witness statement of Mr Jackson Shillingworth to illustrate the heavy workload an Aboriginal Health Worker can be expected to manage, and the negative impact it can have.[300]

[257] The HSU contends that the provision of tea breaks in the Award "would help prevent overwork and fatigue amongst employees, thereby enabling efficient and productive performance of work in the long term".[301] It submits that this is a relevant consideration to s.134(1)(d) of the Act.[302]

[258] The HSU submits that tea breaks should be extended to this Award as "they are provided for in almost all current modern awards in the health sector" and this is a relevant consideration to s.134(1)(g),[303] which refers to a "stable and sustainable modern award system".[304]

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[297] Ibid; Transcript dated 26 July 2019 at PN1535.

[298] Ibid at [6].

[299] Ibid at [8].

[300] Exhibit 4 at p.1.

[301] HSU Submission dated 18 June 2019 at [11].

[302] Ibid.

[303] Ibid.

[304] Ibid at [12]; *Fair Work Act 2009*, s.134(1)(g).

[259] During the hearing, the HSU agreed that the more appropriate term for the breaks is rest breaks and did not oppose such an amendment.[305]

Consideration

[260] We accept the submission of the HSU that the provision of a tea beak after four hours worked is standard in almost all awards which apply in the health sector. We also accept that, given the demands of the work undertaken, appropriate breaks are necessary to deal with fatigue issues. In this respect we accept that the inclusion of a clause which provides for such breaks comes within s.139(1)(c) of the Act.

[261] To give effect to the above we propose to amend the existing clause 15 'Unpaid Meal Breaks' by renaming the clause to that of 'Breaks' and incorporating a 'Paid rest breaks' provision in the following terms:

15. Breaks

15.1 Unpaid meal breaks

(a) An employee who works more than 5 hours will be entitled to an unpaid meal break of between 30 and 60 minutes.

(b) The time of taking the meal break may be varied by agreement between the employer and employee.

15.2 Paid rest breaks

(a) Two separate 10 minute rest breaks (in addition to meal breaks) will be allowed to each employee on duty during each ordinary shift of 7.6 hours or more.

(b) Where less than 7.6 ordinary hours are worked, employees will be allowed one 10 minute rest break in each four hour period.

(c) Subject to mutual agreement, such intervals may alternatively be taken as one 20 minute interval.

(d) Rest breaks will count as time worked.

[305] Transcript dated 26 July 2019 at PN1539-PN1542.

Removal expenses

[262] The HSU submits that the Award should be varied by inserting the following new clause:

> "**Transfer removal expenses**
>
> An employee who is required to transfer from one locality to another is entitled to be reimbursed by the employer:
>
> (a) the reasonable cost of conveyance of the employee and their dependants to the new locality; and
>
> (b) the cost reasonably incurred by the employee of removal of furniture and household effects of the employee and dependants."[306]

[263] The HSU contends that Aboriginal Community Controlled health services tend to be based in regional or remote areas and health workers who relocate for work "are often required to move significant distances".[307] The HSU rely on the witness statement of Mr Damian Rigney to support this claim.[308]

[264] The HSU submits that the amendment is necessary to satisfy ss.134(1) and 138 for employees working in Aboriginal Community Controlled health services who are required to move significant distances for their work.[309]

[265] The HSU claims that the amendment will promote flexible work practices by enabling employees to move to regional or remote areas for work and also assist in attracting employees to such work and locations.[310] The HSU submit that these are relevant considerations to ss.134(1)(d) and 134(1)(h) of the Act.

[266] During the hearing, a question about similar clauses in other awards was raised and taken on notice. Further submissions were filed by the HSU on 9 August 2019. The HSU submissions provide a table comparing similar provisions in other awards, which we outline below:

- *Air Pilots Award 2010* – Clause 17 – Transfers;
- *Aircraft Cabin Crew Award 2010* – Schedule B.1.1 – Relocation expenses;
- *Australian Government Industry Award 2016* – Schedule H.9 – Removal expenses;
- *Australian Public Service Enterprise Award 2015* – Clause 11.5 – Removal expenses;
- *Broadcasting, Recorded Entertainment and Cinemas Awards 2010* – Clause 32.10 – Change of residence;
- *Fire Fighting Industry Award 2010* – Clause 17.6 – Change of residence expenses;
- *Journalists Published Media Award 2010* – Clause 15.4 – Transfer;

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[306] HSU Submission dated 18 June 2019 at [13].

[307] HSU Submission dated 18 June 2019 at [14].

[308] Exhibit 5, 1-3.

[309] HSU Submission dated 18 June 2019 at [15].

[310] Ibid.

- *Rail Industry Award 2010* – Clause 15.1(c) – Relocation allowance; and
- *Crown Employees (Transferred Employees Compensation) Award* – Clause 10 – Removal and Storage Expenses (**New South Wales State Award**).[311]

Consideration

[267] We note the submissions of the HSU in relation to this matter. Whilst we agree that an employee required to move by their employer should be paid relocation expenses, there is no provision in this Award which would allow an employer to place such a requirement on an employee.

[268] The circumstances of this Award can be contrasted to several of the awards cited by the HSU where the removal expenses compensate for the costs associated with compulsory transfer arrangements.

[269] The Air Pilots Award 2020 for example, allows for the temporary or permanent transfer of location of pilots. Reasonable costs of such transfers are met. The Aircraft Cabin Crew Award 2010 provides for the payment of all reasonable expenses when an employee is required to relocate at the direction of the employer.

[270] The relocation costs in the Broadcasting, Recorded Entertainment and Cinemas Award 2010 are payable when an employee is "transferred" and is required to change residence suggesting a level of compulsion. The provision applies however in only one sector of the industry covered by that award.

[271] The Fire Fighting Award 2020 allows for the reimbursement of expenses where the relocation is as a result of promotion or transfer or when an employee is ordered to relocate and that requires a change of residence.

[272] The Journalists and Published Media Award 2010 provides for the payment of relevant expenses where the employer requires the employee to permanently relocate and the relocation provisions in the Rail Industry Award 2020 apply where the employer requires the employee to relocate.

[273] The exceptions where there is no compulsion associated with the allowance are the Australian Government Industry Award 2016 and Australian Public Service Enterprise Award 2016 which contain provisions for assistance for relocation in circumstances where the relocation is not at the direction of the employer.

[274] We are concerned that an unintended consequence of the inclusion in this Award of the clause proposed by the HSU is that the employer will implicitly be able to require an employee to relocate, even if it is against the wishes or interests of the employee.

[275] Without substantial further consideration of these consequences of inclusion of the provision we are not prepared to grant the application. That provisions exist in other awards is not, of itself and absent other compelling reasons, justification for inclusion of the provision or a like provision in this Award.

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[311] HSU further submissions – Relocation or removal expenses clauses in awards dated 9 August 2019.

Casual loading

[276] The HSU submits that clause 28.2(b) of the 2020 Award should be varied so that "casual employees are paid casual loading in addition to public holiday rates".[312] The HSU claims that "the approach is consistent with the function of casual loading",[313] and the "default" approach discussed by the Full Bench in the *Penalty Rates Decision*, which is to provide "a casual loading that is simple and easy to understand, consistent with s.134(1)(g)"[314] of the Act.

[277] The HSU refer to the *Penalty Rates Decision*,[315] in which the Full Bench said:

> "[891] Casual loadings and weekend penalty rates are separate and distinct forms of compensation for different disabilities. Penalty rates compensate for the disability (or disutility) associated with the time at which work is performed."

[278] The HSU claim that, under the current award provisions, it is evident "casual loading is paid in addition to overtime rates and shiftwork penalties."[316] The HSU contend that there is no basis for casual employees "to have to forgo the casual loading for public holiday penalty rates",[317] as they serve different functions.[318]

Consideration

[279] We decline to grant the claim because the HSU has failed to advance an evidentiary case in support of its application for the payment of the casual loading in addition to the public holiday rate.

Rest break after recall to work

[280] The HSU submits that "the Award should be varied to ensure that employees receive at least a ten hour break after being recalled to work."[319] It claims that this is necessary to allow an employee to have eight hours of sleep in addition to time for travelling to and from work.[320]

[281] The HSU submits that the amendment is necessary to satisfy s.134(1) as it will ensure that "employees receive adequate rest following being recalled to work."[321]

[282] The HSU contends that "an employee cannot be expected to perform work productively on less than six hours rest", and this is a relevant consideration to s.134(c) of the Act.

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[312] HSU Submission dated 18 June 2019 at [22].

[313] Ibid at [18].

[314] [2017] FWCFB 1001 at [338].

[315] [2017] FWCFB 1001.

[316] HSU Submission dated 18 June 2019 at [21].

[317] Ibid.

[318] Ibid.

[319] Ibid at [23].

[320] Ibid at [24].

[321] Ibid.

[283] Furthermore, the HSU claims that the amendment will bring the clause in line with clause 20.4(a) of the 2020 Award, which provides for a ten hour rest period after overtime, and this is a relevant consideration to s.134(1)(g) of the Act.[322]

[284] NATSIHWA support the HSU's proposed variations.[323]

Consideration

[285] We note that the Award contains two rest break provisions – one in relation to overtime (at clause 20.4(a) of the 2020 Award) and the other in relation to a recall to work (clause 20.6(c) of the 2020 Award). Each of the rests breaks is for a different minimum period and each operates with its own distinct characteristics. It appears (although this is not definitive) that recall to work is not treated as overtime with loadings separately specified for work conducted under recall provisions than that for overtime.

[286] It is not apparent to us why these differences exist. Nor is it apparent how these different clauses and provisions are intended to interact or why the rest period in relation to recall is different to that for overtime.

[287] We are not satisfied on the material before us that the HSU have advanced a merit argument supported by submissions addressing the relevant legislative provisions (s.134(1)). Nor was there sufficiently probative evidence adduced supporting the proposed variation. This is not to say that the claim is without some merit, but a more fulsome application would need to be made to enable it to be properly considered.

Next Steps

[288] The variations we propose to make are set out in the draft variation determination attached to this decision (see Attachment A). We propose to provide interested parties with an opportunity to comment on the draft variation determination by no later than **Wednesday 12 August 2020**.

[289] Interested parties are asked to address the following questions in submissions about the draft variation determination:

Question 1–Award title

[290] NATSIHWA proposed that the award title should be amended to '*Aboriginal and/or Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award*'. Aboriginal community controlled health services is a defined term in clause 4.2 of the Award. Interested parties are asked to comment on whether the title of the award should be '*Aboriginal and Torres Strait Islander Health Workers and Practitioners and <u>Aboriginal</u> Community Controlled Health Services Award*'.

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[322] Ibid at [26].

[323] Transcript dated 26 July 2019 at PN1549.

Question 2–Exclusions from award coverage

[291] The proposed exclusion clause has been amended in the draft variation determination to include clauses 4.5(c) and (d) which deal with modern enterprise awards, enterprise instruments, state reference public sector modern awards and state reference public sector transitional awards. Interested parties are asked to confirm whether these clauses should be retained.

Question 3–On-hire and group training provisions

[292] Interested parties are invited to comment on whether the change in coverage of the Award requires any consequential amendment to clauses 4.3 and 4.3 which deal with coverage of on-hire and group training services respectively. Each of these provisions refer to the 'Aboriginal and community controlled health services industry' and are set out in full below:

> 4.3 This award covers any employer which supplies labour on an on-hire basis in the Aboriginal community controlled health services industry in respect of on-hire employees in classifications covered by this award, and those on-hire employees, while engaged in the performance of work for a business in that industry. Clause 4.3 operates subject to the exclusions from coverage in this award.
>
> 4.4 This award covers employers which provide group training services for trainees engaged in the Aboriginal community controlled health services industry and/or parts of that industry and those trainees engaged by a group training service hosted by a company to perform work at a location where the activities described herein are being performed. Clause 4.4 operates subject to the exclusions from coverage in this award.

Question 4–Monetary allowances

[293] Since the applications were made, the Award has been varied and is now a 2020 Award. All allowances are now expressed as a dollar figure, not asa percentage of the standard rate. Schedule C now contains a summary of monetary allowances. The draft variation determination has been drafted for consistency with the new award. Parties are asked to comment on the calculation of the allowances.

Question 5–Blood check allowance

[294] We have granted NATSIHWA's claim to insert a 'blood check allowance' into the award. The title of the proposed clause is 'blood check allowance', however the clause refers to a 'blood count'. Parties are asked to confirm whether the clause should also refer to a 'blood check'.

[295] We also propose to provide NATSIHWA an opportunity to submit a revised classification structure reflecting our conclusions summarised at [193] above by no later than **Wednesday 12 August 2020**. Interested parties will have an opportunity to comment on that classification structure by **Wednesday 26 August 2020**.

[296] Further, interested parties seeking to press the claim for inclusion of an 'Occasional interpreting allowance' as referred to at [232] - [238] above, are invited to file submissions by

Wednesday 5 August 2020 following which any interested parties opposed to inclusion of such an allowance will be required to file submission in reply by **Wednesday 19 August 2020**.

[297] Any submissions or comments are to be made, in writing to amod@fwc.gov.au. Any outstanding issues will be determined based on the written material filed unless a request for an oral hearing is received by **Wednesday 26 August 2020**.

DEPUTY PRESIDENT

Appearances:

J Steele of Counsel and *N Avery-Williams* of Counsel for NATSIHWA
L Svendsen and *R Liebhaber* for the HSU

Hearing details:

2019
Melbourne
25 and 26 July

Further written submissions:

NATSIHWA, 9 August 2019 and 18 September 2019
HSU, 9 August 2019
AMA, 28 August 2019

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Attachment A

MA000115 PRXXXXXX

DRAFT DETERMINATION

Fair Work Act 2009
s.156—4 yearly review of modern awards

4 yearly review of modern awards
(AM2018/12)

ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES AWARD 2020
[MA000115]

Indigenous organisations and services

DEPUTY PRESIDENT GOSTENCNIK
DEPUTY PRESIDENT MASSON
COMMISSIONER BISSETT

MELBOURNE, XX JULY 2020

4 yearly review of modern awards – Aboriginal Community Controlled Health Services Award 2020 – substantive claims.

A. Further to the decision [[2020] FWCFB XXXX] issued by the Full Bench of the Fair Work Commission on XX July 2020, the above award is varied as follows:

1. By deleting clause 1.1 and inserting the following:

1.1 This award is the Aboriginal and Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award 2020.

2. By deleting clause 4.1 and inserting the following:

4.1 This industry and occupation award covers:

(a) employers throughout Australia in the Aboriginal community controlled health services industry and their employees in the classifications listed in clause 16—Minimum rates to the exclusion of any other modern award; and

(b) employers throughout Australia with respect to their employees engaged as an Aboriginal and/or Torres Strait Islander Health Worker.

3. By deleting clause 4.5 and inserting the following:

4.5 The award does not cover:

(a) an employee excluded from award coverage by the Act;

(b) employers covered by the following awards with respect to employees covered by the awards:

(i) Nurses Award 2010; or

(ii) Medical Practitioners Award 2020.

(c) employees who are covered by a modern enterprise award, or an enterprise instrument (within the meaning of the Fair Work (Transitional Provisions and Consequential Amendments) Act 2009 (Cth)), or employers in relation to those employees; or

(d) employees who are covered by a State reference public sector modern award, or a State reference public sector transitional award (within the meaning of the Fair Work (Transitional Provisions and Consequential Amendments) Act 2009 (Cth)), or employers in relation to those employees.

4. By inserting clause 12.3 as follows:

12.3 Progression

(a) At the end of each 12 months' continuous employment, an employee will be eligible for progression from one level to the next within a grade if the employee has demonstrated competency and satisfactory performance over a minimum period of 12 months at each level within the level and;

(i) the employee has acquired and satisfactorily used new or enhanced skills within the ambit of the classification, if required by the employer; or

(ii) where an employer has adopted a staff development and performance appraisal scheme and has determined that the employee has demonstrated satisfactory performance for the prior 12 months' employment.

(b) Movement to higher classification will occur by way of promotion or re-classification

5. By inserting clause 12.4 as follows:

12.4 Recognition of prior service

(a) On appointment, an employee will be classified and placed on the appropriate level on the salary scale in clause 16—Minimum rates, according to their qualifications and experience as an Aboriginal and/or Torres Strait Islander Health worker.

(b) Service as a part-time Aboriginal and/or Torres Strait Islander Health Worker will normally accrue on a pro-rata basis according to the percentage of a full-time Aboriginal and/or Torres Strait Islander Health Worker load undertaken in any year; provided that where the hours are more than 90% of a full-time load, service will count as a full-time year.

(c) In the case of a casual employee, the equivalent of a full-time year of service is 200 casual days.

6. By inserting clause 12.5 as follows:

12.5 Evidence of qualifications

On engagement, the employer may require that the employee provide documentary evidence of qualifications and experience. If an employer considers that the employee has not provided satisfactory evidence, and advises the employee in writing to this effect, then the employer may decline to recognise the relevant qualification or experience until such evidence is provided. Provided that the employer will not unreasonably refuse to recognise the qualifications of an employee.

7. By deleting clause "15—Unpaid meal breaks" and inserting the following:

15. Breaks

15.1 Unpaid meal breaks

(a) An employee who works more than 5 hours will be entitled to an unpaid meal break of between 30 and 60 minutes.

(b) The time of taking the meal break may be varied by agreement between the employer and employee.

15.2 Paid rest breaks

(a) Two separate 10 minute rest breaks (in addition to meal breaks) will be allowed to each employee on duty during each ordinary shift of 7.6 hours or more.

(b) Where less than 7.6 ordinary hours are worked, employees will be allowed one 10 minute rest break in each four hour period.

(c) Subject to mutual agreement, such intervals may alternatively be taken as one 20 minute interval.

(d) Rest breaks will count as time worked.

15.3 Rest Breaks – working in heat

(a) Where work continues for more than 2 hours in temperature exceeding 46oC, employees will be entitled to a 20 minute rest break every 2 hours without deduction from pay.

(b) The employer must take all reasonable steps to ensure that an employee takes the breaks/s to which he or she is entitled.

(c) It will be the responsibility of the employer to ascertain the temperature.

8. By inserting clause 18.2(b) as follows:

(b) Nauseous Work Allowance

An allowance of $0.49 per hour or part thereof will be paid to an employee in any classification if they are engaged in handling linen of a nauseous nature other than linen sealed in airtight containers and/or for work which is of an unusually dirty or offensive nature having regard to the duty normally performed by such employee in such classification. Any employee who is entitled to be paid for this allowance will be paid a minimum amount of $2.64 for work performed in any week.

9. By inserting clause 18.2(c) as follows:

(c) Medication Administration Allowance

Aboriginal and/or Torres Strait Islander Health Workers who are qualified and permitted under law to administer medications in the performance of their duties are entitled to an allowance of $2.44 per week.

10. By inserting clause 18.3(d) as follows:

(d) Telephone allowance

Where the employer requires an employee to install and/or maintain a telephone for the purpose of being on call, the employer will refund the installation costs and the subsequent rental charges on production of receipted accounts. This clause will not apply where the employer provides the employee with a mobile telephone for the purpose of being on call.

11. By inserting clause 18.3(e) as follows:

(e) Blood check allowance

Any employee exposed to radiation hazards in the course of their work will be entitled to a blood check as often as is considered necessary and will be reimbursed for any out of pocket expenses arising from such a test.

12. By inserting clause 18.3(f) as follows:

(f) Replacement, Cleaning or Repair to Damaged Clothing Allowance

Where an employee, in the course of their employment suffers any damage to or soiling of clothing or other personal effects, the employer will be liable for the replacement, repair or cleaning of such clothing or personal effects provided, where practicable, immediate notification is given to the employer of such soiling as soon as possible.

13. By deleting clause 26 and inserting the following:

26 Ceremonial leave

An employee who is legitimately required by indigenous tradition to be absent from work for Aboriginal or Torres Strait Islander ceremonial purposes, including for bereavement related ceremonies and obligations, will be entitled to up to 10 working days unpaid leave in any one year, with the approval of the employer."

14. By deleting the table appearing in clause C.1.1 and inserting the following:

Allowance	Clause	% of standard rate	$	Payable
Nauseous Work Allowance–per hour	18.2(b)	0.05	0.49	per hour
Nauseous Work Allowance–minimum per week	18.2(b)	0.27	2.64	minimum per week
Medication Administration Allowance	18.2(c)	0.25	2.44	per week
Bilingual qualification allowance—Level 1	18.2(a)(ii)	206.93	2019.84	per annum
Bilingual qualification allowance—Level 2	18.2(a)(ii)	414.18	4042.81	per annum
On-call and recall allowances—After ordinary working hours—other than public holiday	20.6(a)(i)	1.97	19.23	per any 24 hour period or part thereof
On-call and recall allowances—Public holiday	20.6(a)(ii)	3.94	38.46	per any 24 hour period or

				part thereof

15. By updating the table of contents and cross-references accordingly.

B. This determination comes into operation from XX Month 2020. In accordance with s.165(3) of the *Fair Work Act 2009* this determination does not take effect in relation to a particular employee until the start of the employee's first full pay period that starts on or after XX Month 2020.

DEPUTY PRESIDENT

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