To Associate, Deputy President Gostencnik
Cc AMOD Team

Kennedys

Submissions

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Modern Award Review

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Outline of submissions concerning the *Aboriginal Controlled Community Health Services Award 2010* (Award)

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NATSIHWA
National Aboriginal and Torres Strait Islander Health Worker Association

Contents

A. INTRODUCTION

Role of NATSIHWA and overview

1 This submission is made by the National Aboriginal and Torres Strait Islander Health Worker Association Limited (ACN 138 748 697) (**NATSIHWA**), an interested party in the 4 yearly review of the Award.

2 The changes sought by NATSIHWA are articulated in the Final Draft Determination dated 18 June 2019 (**Final Draft Determination**) that is filed with these submissions. The Final Draft Determination includes updated wage rates to reflect the Annual Wage Review 2018-19 Decision.[1] NATSIHWA relies on 34 lay statements and the expert reports of Alyson Wright and Associate Professor Ray Lovett.

3 NATSIHWA is the national health professional association for Aboriginal and/or Torres Strait Islander health workers and health practitioners (**A&TSIHWs and A&TSIHPs**) and has been funded by the Australian Government Department of Health since its establishment in 2009. As at 31 May 2019, NATSHIWA had approximately 1902 members[2].

4 In Australia, there is a glaring disparity between the health outcomes of non-Aboriginal and/or Torres Strait Islander (**non-A&TSI**) Australians and Aboriginal and/or Torres Strait Islander (**A&TSI**) Australians. The health gap between non-A&TSI and A&TSI Australians has been recognised in the Council of Australian Governments' (**COAG**) overarching social policy of "Closing the Gap" designed to address health and social outcomes including:

4.1 the *decade* gap in the life expectancy between non-A&TSI and A&TSI Australians; and

4.2 to reduce *child mortality* for children under age five years.

[1] [2019] FWCFB 3500.
[2] Statement of Karl John Briscoe, paragraph 93.

5 Critically, A&TSIHWs and A&TSIHPs support the delivery of culturally appropriate health care in their community[3]. Research evidence and clinical experience continues to demonstrate that the involvement of A&TSIHWs and A&TSIHPs in the provision of health care leads to improved care and health outcomes of the A&TSI people[4].

6 The purpose of NATSIHWA is to promote, support and increase recognition for the vital roles that A&TSIHWs and A&TSIHPs play in providing professional, effective and culturally respectful health services to A&TSI individuals, families and communities across Australia[5]. Most importantly, NATSIHWA's primary role is to achieve health outcomes for the A&TSI community, by:

6.1 promoting the prevention and control of diseases within the community;

6.2 improving health outcomes in the pursuit of the objectives to 'Close the Gap' in life expectancy;

6.3 addressing the impacts of disadvantage on the health of A&TSI people; and

6.4 assisting in the delivery of holistic primary health care within A&TSI communities[6].

7 The A&TSIHW and A&TSIHP workforce evolved from the need to provide culturally safe clinical and primary health services to A&TSI people whose health needs were not being met by mainstream services[7]. The roles that A&TSIHWs and A&TSIHPs undertake are critical to the efforts to close the gap in health outcomes so that health equity is achieved for A&TSI Australians[8]. A&TSIHWs and A&TSIHPs play a critical cultural brokerage

[3] Expert Report of Alyson Wright, paragraph 9.
[4] Expert Report of Alyson Wright, paragraph 11.
[5] NATSIHWA Annual Report 2018, Tab 5 of Exhibit KB-1.
[6] Statement of Karl John Briscoe, paragraph 10.
[7] Expert Report of Alyson Wright, paragraph 12.
[8] Expert Report of Alyson Wright, paragraph 13.

role in the delivery of healthcare to ATSI people which cannot be replaced by mainstream positions[9].

8 In this introductory section A, NATSIHWA:

8.1 explains the difference between A&TSIHWs and A&TSIHPs and summarises why their role in providing health services to A&TSI people is vital; and

8.2 provides an overview of the substantive changes sought by NATSIHWA in the Final Draft Determination in this 4 yearly review.

9 Detailed submissions on each substantive change sought by NATSIHWA and the reasons why the changes are necessary to meet the modern awards objective (section 134(1) and (2) of the *Fair Work Act 2009* (Cth) (the **Act**)) and the minimum wages objective (section 284 of the Act) then follow.

Definitions of A&TSIHWs and A&TSIHPs

10 An A&TSIHW is an A&TSI person who has gained (or is working towards obtaining) a Certificate II or higher qualification in A&TSI Primary Health Care from one of the health training packages.

11 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**).

12 NATSIHWA supports A&TSIHWs and A&TSIHPs and their communities through its programs, by:

12.1 providing continuing development tools and resources for A&TSIHWs and A&TSIHPs;

[9] Expert Report of Alyson Wright, paragraph 13.

12.2 providing opportunities for career development and professional networking to facilitate them in their roles;

12.3 raising awareness within the broader Australian public (particularly the health sector), and building networks to address A&TSI health priorities and concerns;

12.4 raising awareness within the health sector of the most effective models of heath care for A&TSI Australians; and

12.5 building networks between A&TSIHWs and A&TSIHPs, other health professionals and the health sector generally[10].

13 Most A&TSHIWs and A&TSIHPs work within the primary health care setting and predominantly in Aboriginal Controlled Community Health Services (**ACCHS**)[11]. An ACCHS is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management[12]. In 2016, it is estimated that Commonwealth funded A&TSI health organisations including 204 primary health care services employed 941 A&TSHIWs and A&TSIHPs[13]. Some A&TSHIWs and A&TSIHPs also work in private practice[14].

14 A&TSHIWs and A&TSIHPs have a vital role to play because they provide culturally safe preventative health care and treatment services to A&TSI people so as to enable them to experience health equity[15]. There is increasing evidence that the inclusion of A&TSHIWs and A&TSIHPs in models of care facilitates culturally appropriate care, reduces communication gaps, reduces discharge against medical advice, provides

[10] Statement of Karl John Briscoe, paragraph 12.
[11] NATSIHWA Policy Statement, Tab 8 of Exhibit KB-1.
[12] https://www.naccho.org.au/about/
[13] NATSIHWA Policy Statement, Tab 36 of Exhibit KB-1.
[14] Statement of Dr Stephanie Trust, paragraphs 12, 13 and 25; statement of Haysie Penola.
[15] NATSIHWA, "Who we are and what we do", Tab 6Exhibit KB-1, Expert Report of Ray Lovett, Question 1 page 1

cultural education, increases inpatient contact time, improves follow up practices and enhances patient referral lineages[16].

15 Based on census data, whilst there has been a 33% rise in the 10 year period from 2006 to 2016 in the amount of ATSIHWs (from 1009 to 1347 health workers), this increase *has not been enough* to keep up with A&TSI population growth[17]. This small increase masks substantial issues in workforce growth, retention and recruitment[18]. There is thus a national imperative for A&TSIHWs and A&TSIHPs to be afforded a minimum safety net of terms and conditions which recognise and provide a career structure for this uniquely important profession.

Overview of substantive changes sought by NATSIHWA in review of the Award

16 In this section, NATSHIWA briefly sets out the history of the Award and then provides an overview of the substantive claims it seeks[19] as part of the 4 yearly review of the Award. The changes sought are necessary to meet the modern awards objective by reference to the considerations in section 134 of the Act.

17 The proposed changes to the Award are supported by:

17.1 National Aboriginal Community Controlled Health Organisation (**NACCHO**)[20];

17.2 Australian Indigenous Doctors' Association (**AIDA**)[21];

17.3 Health Services Union (**HSU**);

[16] A National Profile of Aboriginal and Torres Strait Islander Health Workers, 2006-2016, Alyson Wright, Karl Briscoe and Ray Lovett, Australian and New Zealand Journal of Public Health, 2019, Volume 43, No. 1 (Tab 75 of Exhibit KB-1).
[17]NATSIHWA Annual Report 2018, Tab 5 of Exhibit KB-1.
[18] NATSIHWA Annual Report 2018, Tab 5 of Exhibit KB-1.
[19] These issues were notified to the Commission by NATSIHWA in its submissions dated 26 April 2018, save for some variations in relation to the isolation allowance which are discussed further at paragraphs 182 to 186 below.
[20] Letter from Patricia Turner, Chief Executive Officer of NACCHO dated 18 June 2019, Tab 87 of Exhibit KB-1.
[21] Letter from Anita Mills, Chief Executive Officer of AIDA dated 7 June 2019, Tab 86 of Exhibit KB-1.

17.4 United Voice (**UV**).

History of the Award

18 By way of order dated 4 December 2009, the Fair Work Commission (**Commission**) created the Award.

19 The key proponent of the Award in 2009 was NACCHO. NACCHO is the national peak body representing 143 ACCHSs across Australia on Aboriginal health and well-being issues[22]. NACCHO sought the creation of a separate and distinct industry award on a number of bases[23], including:

19.1 that ACCHSs constituted a separate industry, with its own unique characteristics;

19.2 the perilous state of Aboriginal health; and

19.3 a mainstream award would take little to no account of the special needs, experience, qualifications and other issues such as the self-determination of aboriginal people, their communities and organisations.

20 In creating the exposure draft for the Award in 2009, the Commission largely adopted the draft provided by NACCHO[24]. The Commission also decided some matters relating to allowances at the hearing in October 2009. Those allowances included the bilingual qualification allowance, a meal allowance and an allowance for relocation and removal.

21 NATSIHWA was formed in 2009. It therefore was not in a position to make submissions in relation to the formation of the Award, and in particular the classification structure, coverage or allowances. NATSIHWA is the only organisation directly representative of A&TSHIWs and A&TSIHPs. Thus, at the time of the formation of the Award, A&TSHIWs and A&TSIHPs did not have a voice to express the realities of the job they undertake, nor to

[22] https://www.naccho.org.au/about/
[23] NACCHO Submission to AWARDMOD Full Bench- 16 and 26 February, 24 July 2009.
[24] Award Modernisation- Statement- Full Bench [2009] AIRCFB 865 at [126].

make submissions on what constituted a fair and relevant minimum safety net of terms and conditions from their perspective.

22 NATSIHWA next sets out the changes to the award that it seeks.

Occupational coverage and new title for the Award[25]

23 NATSIHWA seeks to extend the coverage clauses[26] to include A&TSHIWs and A&TSIHPs *as an occupation*, so as to provide award coverage for A&TSHIWs and A&TSIHP in private practice. As a consequence, NATSIHWA also seeks to change the Award title to read: "*Aboriginal and/or Torres Strait Islander Health Workers and Practitioners and Community Controlled Health Services Award*", so as to reflect its *occupational and industry coverage*.

24 An occupationally based award meets the modern awards objective under section 134(1) and (2) of the Act and provides a "*fair and minimum safety net of terms and conditions*" as there is no other modern award which accurately or adequately captures the work performed by A&TSHIWs and A&TSIHPs in private practice. Expanding coverage will also promote social inclusion through increased workforce participation, which is critical to "close the gap". The Commission is not limited to consideration of the section 134 factors[27]. In the circumstances pertaining to this particular modern award, the national objective and imperative to improve A&TSI health and to "close the gap", and the critical role played by the A&TSIHWs and A&TSIHPs in performing this role, are further factors in favour of extending coverage.

25 The change to coverage was agreed to by all interested parties except for AFEI, who asserted that A&TSHIWs and A&TSIHPs *might* be covered by

[25] Clauses 2 and 3 of the Final Draft Determination, Item S3 of the FWC Substantive Issues Table up to 18 July 2017 (**Substantive Issues Summary Table**); see also paragraphs 18 to 20 of the Full Bench decision *4 yearly review of modern awards – Award stage – Group 4 awards* [2018] FWCFB 1548 (**Decision**).
[26] Clauses 4.1 and 4.2 of the Award.
[27] 4 yearly review of modern awards – Pharmacy Industry Award 2010 [2018] FWCFB 7621 at [126].

another modern award[28]. This is incorrect for the reasons NATSIHWA sets out in its detailed coverage submissions (refer to Section B below, commencing at paragraph 38).

Progression[29], recognition of previous service[30] & evidence of qualifications clauses[31]

26 NATSIHWA's proposed clauses dealing with progression[32], recognition of previous service[33] and evidence of qualifications[34] were agreed to all by interested parties. The incorporation of these clauses is necessary to achieve the modern award objective. It brings the Award in line with other modern awards and provides an elementary career structure for A&TSIHWs and A&TSIHPs, who hitherto have never had the opportunity to make submissions on what is a fair and reasonable safety net of terms and conditions. Please see NATSIHWA's detailed submission in Section C, commencing at paragraph 67 below.

Revised classification structure with two new grades[35]

27 NATSIHWA's proposed classification structure effectively provides for an increase in the number of grades, from the current number of four grades, to six grades. In broad terms, the new classification structure is sought to incentivise education, training and development and to accurately capture the work performed by A&TSIHWs and A&TSIHPs. The additional two grades are created by dividing the current grade 1 into two grades, grade

[28] Australian Federation of Employers and Industries, Amended Submission – Aboriginal Community Controlled Health Services Award – AM2014/250 dated 24 April 2017, paragraph 7.
[29] Clause 5 of the Final Draft Determination; see also paragraphs [13] to [16] of the Decision.
[30] Clause 6 of the Final Draft Determination; see also paragraphs [13] to [16] of the Decision.
[31] Clause 7 of the Final Draft Determination; see also paragraphs [13] to [16] of the Decision.
[32] NATSIHWA's proposed clause is in terms similar to that currently included in clause 13.3 of the *Social, Community, Home Care & Disability Services Industry Award 2010* (**SCHCDSI Award**).
[33] NATSIHWA's proposed clause is in terms similar to that included in the *Educational Services (Teachers) Award 2010* to clarify that service in the industry is recognised irrespective of an employee's movement between employers.
[34] NATSIHWA's proposed clause is in terms similar to that included in the *Educational Services (Teachers) Award 2010* to clarify that service in the industry is recognised irrespective of an employee's movement between employers.
[35] Clause 8 of the Final Draft Determination.

1 and grade 2; and by creating a new classification, grade 6, to provide for A&TSIHWs and A&TSIHPs in senior management roles, roles that have been omitted in the Award despite the important role that the A&TSIHWs and A&TSIHPs perform in A&TSI health. NATSIHWA's proposed new classification structure also provides for A&TSIHWs who have attained a Certificate II in A&TSI Primary Health Care, a qualification that is currently not provided for in the Award, despite it being a key entry level qualification.

28 In Section D, commencing at paragraph 78, NATSIHWA sets out in detail its proposed classification structure and the rationale for its suggested changes. Please also see Annexure A to these submissions which compares the current classification structure in the Award to NATSIHWA's proposed classifications.

Work value case

29 A work value case is sought to be made in respect of two proposed classifications.

30 First, NATSIHWA seeks an uplift in wages and changed classification structure for those health workers who are "Advanced Health Workers – Practice" and "Health Practitioners" (Grade 5). Following the introduction of the Award in 2009, since 1 July 2012 there has been a requirement for these A&TISHPs to be registered, which has resulted in changes to the nature of the work performed by A&TSIHPs, an increase in the level or skill or responsibility involved in doing the work, and changes to the conditions under which the work is performed.

31 Second, NATSIHWA seeks to introduce a senior management grade, being Grade 6, for A&TSIHWs and A&TSIHPs who are "Senior Health Practitioners" or "Coordinator Care". This is an "aspirational" classification, because when the Award was formulated A&TSIHWs and A&TSIHPs did not have any opportunity to provide input into the Award, including the classification structure. Providing A&TSIHWs and A&TSIHPs with a career structure which envisages senior level management roles, will allow A&TSIHWs and A&TSIHPs to bring their own set of expertise and

skills to a multidisciplinary health care team at a senior level. It will also strengthen the profession and prevent the perception that this unique professional identity is a bridge to other professions[36]. The wages proposed for the new senior grade are the same as those currently provided for in the case of a Level 8 Social and Community Services Employee under the SCHCDSI Award. These wages have been proposed as the new Grade 6 roles of Senior Health Practitioners and Coordinator Care have equivalent characteristics, responsibilities and requirements.

32 NATSIHWA's submissions as to why these classification satisfy the work value test are set out in detail below, in Section E, commencing at paragraph 90.

Agreed Allowances

33 NATSIHWA seeks to introduce the following Agreed Allowances to which there is no opposition[37]:

33.1 An expense related telephone allowance for persons required to be on call (see clause 18.11 of the *Health Professional Support Services Award 2010* (**HPSS Award**));

33.2 A disability related Nauseous Work allowance;

33.3 A disability related Blood Check allowance; and

33.4 An expense related Damaged Clothing allowance,

(together, the **Agreed Allowances**).

34 These allowances constitute a fair and relevant minimum safety net and are necessary to achieve the modern awards objective for the reasons set out in Section F below, commencing at paragraph 132.

[36] Expert Report of Alyson Wright at paragraph 38.
[37] As indicated by NATSIHWA in its submissions dated 26 April 2018 and notwithstanding [27] of [2018] FWFCAB 1548.

Contended allowances

35 NATSIHWA also seeks to introduce the following allowances:

35.1 A disability based heat allowance for working in high temperature areas (see clause 18.6 of the HPSS Award);

35.2 A disability based isolation allowance to accommodate A&TSIHWs and A&TSIHPs performing services in isolated and/or comparatively dangerous areas;

35.3 A skill-based occasional interpreting allowance (see clause 18.9 of the HPSS Award); and

35.4 A skill-based medication administration allowance for persons required to administer medications as part of their duties,

(together, the **Contended Allowances**).

36 The introduction of these allowances is necessary to achieve the modern awards objective: *Communications, Electrical, Electronic,* Information, *Postal, Plumbing and Allied Services Union of Australia* (AM2015/09) at [39].

Ceremonial leave

37 Finally, NATSIHWA seeks to clarify the current ceremonial leave clause, being clause 26 of the Award, so as to allow a covered employee to take ceremonial leave for bereavement related ceremonies and obligations. This amendment is sought to take account of the broader concepts of family and kinship amongst A&TSI people. See NATSIHWA's submissions in Section G below.

B. OCCUPATIONAL COVERAGE AND NEW AWARD TITLE

Meets the Modern Awards Objective

38 In reviewing the Award, it is necessary for the Commission to come to an evaluative judgment about what terms ought be included by reference to the considerations in section 134 of the Act, and any other consideration

consistent with the purpose of the modern awards objective. Section 138 of the Act is also relevant because it provides that terms may only be included in a modern award to the extent that they are necessary to meet the modern awards objective[38].

39 NATSIHWA submits that it is necessary to amend clause 4.1 of the Award to extend coverage of the Award to A&TSIHWs and A&TSIHPs as an occupation, in order to meet the modern awards objective. NATSIHWA also seeks a consequential change to the title of the Award.

40 Extending coverage to this unique and culturally distinct occupation meets the modern awards objective, as required by section 134(1) of the Act, providing a "*fair and relevant minimum safety net of terms and conditions*". A&TSIHWs and A&TSIHPs who are employed in private practice are currently *not covered* by any modern award. The change will promote social inclusion through encouraging increased workforce participation and recognition. These are relevant considerations pursuant to sub-sections 134(1)(c), 134(1)(e) and 134(1)(g) of the Act.

41 Further, the historical context to the Award also supports extended coverage as the Commission had no evidence, and no cause to consider, the coverage of A&TSIHWs and A&TSIHPs in private practice in 2009.

No modern award coverage for A&TSIHWs and A&TSIHPs in private practice

42 All interested parties supported coverage extension, apart from AFEI who objected on the basis that the A&TSIHWs and A&TSIHPs who are employed in private practice *may* already be covered by another modern award, in particular, the HPSS Award. AFEI were prepared to consent to extended coverage on the basis that clause 4.2(b) be amended so that it excluded employees covered by the HPPS Award.

43 However, in our submission, the HPPS Award does not cover A&TSIHWs and A&TSIHPs, and there is no overlap between the HPSS Award and the Award, for two principal reasons.

[38] [2018] FWCFB 6019 at [17].

44 First, there is no overlap because the cultural skill levels of the A&TSIHWs and A&TSIHPs are intrinsic and fundamental to the work performed by them.

45 Clause 4.1 of the HPSS Award covers employers throughout Australia in the health industry and their employees in their specified classifications, to the exclusion of any other modern award. However, none of the specified classifications of Health Profession Employees in Schedule B2 of the HPSS Award specify any inherent requirement that the health professionals "*have a culturally safe and holistic approach to health care*". The A&TSIHWs and A&TSIHPs working in private practice thus do not have coverage under the HPSS award.

46 Secondly, this reasoning accords with the Full Bench's decision when the Award was conceived as a separate industry based award in 2009, during the then award modernisation process. The HSU sought to advance in 2009 that A&TSIHWs and A&TSIHPs were covered by the HPSS Award[39] and that there was therefore no need for the Award. The Full Bench said in response to this argument in 2009 that they were "*satisfied that the nature of health services that are delivered in a culturally sensitive way is sufficiently different to justify a separate award. The difference is not only about the way the services are established and controlled* ***but is critically seen in the way that employees of the services operate***"[40] (our emphasis).

47 The Full Bench was not asked in 2009 to make a modern award specifically applicable to A&TSIHWs and A&TSIHPs, presumably because there was no evidence at that stage of A&TSIHWs and A&TSIHPs being engaged in private practice. NATSIHWA submits that now is the time to ensure that the modern award objective is met by recognising A&TSIHWs and A&TSIHPs as a unique, culturally distinct occupation with modern award recognition.

[39] Transcript of proceedings dated 10 August 2009 at PN378.
[40] [2009] AIRCFB 865, 125.

Section 134 considerations

48 The absence of any modern award covering A&TSIHWs and A&TSIHPs employed in private practice raises the following section 134 considerations.

49 First, there is no overlap of modern awards and the modern award system remains simple, sustainable and easy to understand in accordance with the considerations in section 134(1)(g) of the Act. There is a clear occupational dividing line[41].

50 As a result of the "Closing the Gap" initiative, the social and political environment surrounding the employment of A&TSIHWs and A&TSIHPs has undergone a substantial shift by reaffirming this occupation as integral to broader health objectives. However, despite this change in social and political climate, at present A&TSIHWs and A&TSIHPs who work in private practice or in a private hospital are not recognised by any modern award. As a result, there is no minimum safety net of wages or conditions for the A&TSIHWs and A&TSIHPs that work outside of ACCHSs.[42]

51 Second, providing a modern award for those A&TSIHWs and A&TSIHPs in private practice will ensure equal remuneration for work of equal or comparable value to that performed by A&TSIHWs and A&TSIHPs inside ACCHSs, a relevant consideration pursuant to section 134(1)(e) of the Act.

52 While those A&TSIHWs or A&TSIHPs working in private practice may be limited in number,[43] those numbers have increased since 2010[44].

53 The lack of modern award coverage and recognition for A&TSIHWs and A&TSIHPs working in private practice has resulted in uncertainty and, at

[41] Compare for example and by way of contrast, *4 yearly review of the Vehicle Manufacturing, Repair Services and Retail Award 2010* (AM2014/93) [2016] FWCFB 4418 at [46].
[42] Expert Report of Alyson Wright, paragraph 25.
[43] Statement of Karl John Briscoe, paragraph 96.
[44] Statement of Karl John Briscoe, paragraph 100.

times, confusion regarding the applicable pay rate for A&TSIHWs and A&TSIHPs[45].

54 The lack of minimum safety net also renders A&TSIHWs and A&TSIHPs in private practice unable to access Indigenous-specific benefits that are available to A&TSIHWs and A&TSIHPs working in ACCHSs, such as ceremonial leave (clause 30 of the Award) and bilingual qualification allowance (clause 15.1 of the Award).

55 Given that by definition all A&TSIHWs and A&TSIHPs are of A&TSI background, there is no reason why A&TSIHWs and A&TSIHPs in private practice should be denied access to these Indigenous-specific conditions. A&TSIHWs and A&TSIHPs cannot make the health system more culturally appropriate for A&TSI people if their workplaces are not made more culturally appropriate for the A&TSIHWs and A&TSIHPs themselves.[46]

56 As a result of two Medicare Benefits Scheme Reviews (one in 2017, and a second in 2018), there are currently 7 Medicare items relevant to A&TSI primary health care. Of those 7 items, A&TSIHPs can claim all 7 items, while A&TSIHWs are only able to claim 3 items.[47]

57 However, as a result of a further review of the Medicare Benefits Scheme currently underway, and a subsequent report issued by the A&TSI Health Reference Group of the Medicare Benefits Schedule Review Taskforce, it may be the case that A&TSIHWs will soon be able to claim all 7 items. This will encourage private practices to employ more A&TSIHWs[48].

58 The lack of award coverage for all A&TSIHWs and A&TSIHPs has resulted in a large number of different, inconsistent, definitions for the A&TSIHW and A&TSIHP. As noted by Mr Briscoe, COAG is in the process of implementing a national scope of practice for all A&TSIHWs and A&TSIHPs across

[45] Statement of Karl John Briscoe, paragraphs 99 and 133, Statement of Dr Stephanie Trust paragraphs 19-20.
[46] Statement of Daniel Niddrie, paragraphs 20-21.
[47] Statement of Karl John Briscoe, paragraph 102.
[48] Statement of Karl John Briscoe, paragraphs 101-105.

Australia[49], but until that national scope of practice is implemented, the uncertainty will remain.

59 If the Award is expanded to cover all A&TSIHWs and A&TSIHPs in the federal jurisdiction, rather than only those employed in ACCHSs, this will bring greater certainty and consistency within the occupation because employers will be able to have reference to the classifications and descriptions outlined in the Award.

60 Critically too, the change will promote social inclusion through increased workforce participation.[50]

61 Aboriginal Communities operate 143 ACCHSs in urban, rural and remote Australia[51]. These ACCHSs are not accessible to all A&TSI Australians.[52]

62 Growing the A&TSIHW and A&TSIHP workforce is integral in achieving the "Closing the Gap" initiative[53].

63 There is evidence to suggest that A&TSI people often drove past multiple mainstream medical providers in order to attend an Aboriginal Medical Service, due to the lack of A&TSIHW or A&TSIHP at the mainstream medical providers. Evidently there is a need for A&TSI people to access health in a culturally safe environment.[54] For those mainstream general practices that do provide health services to A&TSI people, there is a need to place A&TSI people in those practices, to provide healthcare in a culturally safe manner[55].

64 There is express and anecdotal evidence that there is an interest from private practice to employ A&TSIHWs and A&TSIHPs.[56]

[49] Statement of Karl John Briscoe, paragraph 137.
[50] Expert Report of Ray Lovett, Question 3 (page 3).
[51] https://www.naccho.org.au/about/
[52] Statement of Karl John Briscoe, paragraphs 141-146.
[53] Statement of Karl John Briscoe, paragraphs 123-125, 139.
[54] Statement of Karl John Briscoe, paragraph 144.
[55] Statement of Karl John Briscoe, paragraph 146.
[56] Statement of Dr Stephanie Trust, paragraphs 17-18 and Expert Report of Alyson Wright, paragraph 28.

65 Expanding coverage of the Award to include A&TSIHWs and A&TSIHPs in private practice will formally recognise this occupation within the modern award system and in turn, will encourage more people to enter the role, as it will provide those prospective A&TSIHWs and A&TSIHPs with:

65.1 a minimum safety net of culturally appropriate terms and conditions;

65.2 greater certainty about their role (including the complexity of the work undertaken at each Grade), including rates of pay and career progression; and

65.3 more job opportunities, as it will create transferability between roles in ACCHSs and private practice[57].

66 The recognition and promotion of this unique occupation will, in turn, increase access to A&TSIHWs and A&TSIHPs for A&TSI clients who rely on this occupation to have their health needs addressed at a primary stage (such as by early prevention or intervention) rather than at a tertiary or acute stage[58]. This will contribute to reducing health costs to the national economy, a relevant factor under section 134(1)(h) of the Act.

C. PROGRESSION, PREVIOUS SERVICE AND EVIDENCE OF QUALIFICATIONS CLAUSES

67 NATSIHWA's proposed new progression, previous service and evidence of qualifications clauses were not opposed by interested parties. The changes sought are supported by NACCHO[59]. Given the history of this Award, this is the first opportunity that A&TSIHWs and A&TSIHPs have had to make submissions on any issues. The absence of a clear career structure and pay/rewards system has been a disincentive for A&TSIHWs and A&TSIHPs to undertake training of further study[60].

[57] Statement of Karl John Briscoe, paragraph 148.
[58] Statement of Karl John Briscoe, paragraph 49. Expert Report of Ray Lovett, Question 3 (page 3).
[59] Tab 87 of Exhibit KB-1.
[60] Expert report of Alyson Wright at paragraph 36.

68 The provisions, taken together are intended to:

68.1 clarify the existing operation of the award with respect to progression within a grade; and

68.2 provide a balanced and fair mechanism for classification/minimum wage determination on commencement for employees and employers.

Progression

69 In its application for substantive variations to the Award, most recently articulated in the Final Draft Determination, NATSIHWA seeks the insertion of a clause providing a mechanism for employees to progress through the different classifications (**Progression Clause**). In our submission, the Progression Clause does not more than clarify (by articulating) the existing rules for progression between levels within a grade.

70 If the Award is amended to provide a defined mechanism for career progression (by means of the Progression Clause and the Recognition of Previous Service Clause), this will:

70.1 clarify the operation of the Award;

70.2 encourage A&TSIHWs and A&TSIHPs to pursue a higher level of skills and/or qualifications in order to progress through the classification levels, with a view to retaining the existing workforce; and

70.3 increase the attractiveness of the profession to potential or prospective A&TSIHWs and A&TSIHPs by providing prospects for promotion and associated wage increases for workers employed by ACCHSs or in private practice, thereby creating an incentive for A&TSI persons to enter the A&TSIHW and A&TSIHP workforce[61].

[61] Statement of Karl John Briscoe, paragraph 178, Statement of Robert John Dann, paragraphs 14-15, Expert Report of Alyson Wright, paragraphs 23 and 31.

71 Associate Professor Lovett gives evidence that amending the Award to set a career structure and provide a means for career progression will lead to an increase in the A&TSIHW and A&TSIHP workforce.[62]

Recognition of Previous Service

72 In its application for substantive variations to the Award, most recently articulated in the Final Draft Determination, NATSIHWA seeks the insertion of a clause recognising employees' service with previous employers, for the purposes of career progression (**Recognition of Previous Service Clause**).

73 The current Award does not provide any formal mechanism for employers to recognise an employee's experience obtained with a previous employer. This is like to have the unintended consequences that employees are appointed, on commencement with a new employer, to grades that are not commensurate with their skills. In turn this is likely to disincentive transfers to existing or new employers and hence limit the expansion of the occupation (which is recognised as integral to meeting broader health objectives).

74 If A&TSIHWs and A&TSIHPs hold the necessary qualifications, and can have their previous experience taken into account when transferring to another role (as occurs in other modern awards)[63], this has the ability to increase the prospect that the profession will retain current A&TSIHWs and A&TSIHPs, and attract new staff to these roles[64].

Evidence of Qualifications

75 In its application for substantive variations to the Award, most recently articulated in the Final Draft Determination, NATSIHWA seeks the insertion of a clause permitting employers to require an employee to provide documentary evidence of qualifications and experience (**Evidence of Qualifications Clause**).

[62] Expert Report of Ray Lovett, Question 5 (page 5).
[63] See clause 13 of the Educational Services (Teachers) Award 2010.
[64] Statement of Karl John Briscoe, paragraph 178, and Expert Report of Alyson Wright, paragraph 31.

76 As a practical matter, the Evidence of Qualifications Clause is necessary to enable employers to verify a prospective employee's previous qualifications and experience for the purposes of the Recognition of Previous Service Clause.[65]

77 There is evidence that managers recruiting new A&TSIHWs and A&TSIHPs base their wages on their qualifications and their previous experience.[66] Further, there is evidence that A&TSIHWs and A&TSIHPs currently receive pay rises on the basis of attainment of new skills or qualifications, improvement of existing skills, and their experience.[67]

D. NEW CLASSIFICATION STRUCTURE

Overview of New Classification structure

78 Annexure A to these submissions is a two page summary of the differences between the current classification structure in the Award and NATSIHWA's proposed changes.

79 There is a current lack of opportunities for career progression for A&TSIHWs and A&TSIHPs reflected in the existing, short 4 Grade classification structure. This is despite:

79.1 evidence that A&TSIHWs and A&TSIHPs want to stay in the profession and want career progression in this profession, rather than moving into nursing or medical careers[68];

79.2 the growing evidence of the importance of A&TSIHWs and A&TSIHPs in the provision of health care leading to improved care and health outcomes of their people because they are

[65] Statement of Karl John Briscoe, paragraph 180.
[66] Statement of Charlene Badham, paragraph 15, Statement of Karen West, paragraph 17.
[67] Statement of Aaron Everett, paragraph 15, Statement of Naomi Zaro, paragraphs 14-15, Statement of Debbie Gertz, paragraph 15, Statement of Lorraine Gilbert, paragraphs 11, 12 and 14, Statement of Roslyn Hart, paragraph 14, Statement of Antoinette Liddell, paragraph 11.
[68] Expert Report of Alyson Wright, paragraph 31.

uniquely positioned to support the delivery of culturally appropriate health care in their community[69]; and

79.3 the various national and state policy documents that support the role of A&TSHIWs and A&TSIHPs in closing the gap. At a federal level, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023* is acknowledged as the principal reference that supports growing the capability of the A&TSIHWs and A&TSIHPs[70]. It aims to promote a system that is free of racism and inequality, and where all A&TSI people have access to health services that are effective, high quality and affordable and a health system that is comprised of "*an **increasing** Aboriginal and Torres Strait Islander health workforce delivering culturally safe and responsive health care*" (our emphasis).

80 The current structure:

80.1 is internally flawed. For example "*Aboriginal Health Worker Grade 1 / Aboriginal Community Health Worker Grade 1 means an employee in their first year of service who will generally have no direct experience in the provision of Aboriginal health services.*" (our emphasis) This is despite there being 3 '*levels*' for progression within Grade 1 (see current clause 14.1);

80.2 contains minimal description of the work *actually* performed by A&TSIHWs and A&TSIHPs;

80.3 contains minimal *incentives*/guidance on how movement between Grade should occur; and

80.4 contains minimal description of the expectations concerning community involvement, supervision and management (despite this occurring in practice).

[69] Expert Report of Alyson Wright, paragraph 9.
[70] Expert Report of Alyson Wright, paragraph 9.

81 NATISHWA's changes are intended to articulate and recognise the important work that is actually performed by A&TSIHWs and A&TSIHPs. In formally recognising this work, it is hoped that an important educational objective is also met.

82 NATSIHWA proposes to split the current Grade 1 in the Award into two grades, Grades 1 and 2, both for Health Worker trainees, with no change in remuneration. The reason for this splitting Grade 1 into Grades 1 and 2 is:

82.1 for employers to assist Grade 1 A&TSIHWs in obtaining a Certificate II in A&TSI Primary Health Care or equivalent (Grade 1); and

82.2 to provide recognition for employees that have already obtained a Certificate II in A&TSI Primary Health Care or equivalent (Grade 2). The existing Award does not recognise the Certificate II qualification.

83 Although it is not mandatory for an A&TSIHW to hold a Certificate II in A&TSI Primary Health Care, the Certificate II provides a strong foundation and entry pathway into the profession for persons seeking to work as an A&TSIHW.[71]

84 The current Grade 2 in the Award thus becomes Grade 3 in the new classification structure.

85 With respect to the current Grade 3 in the Award, it is proposed that:

85.1 the Advanced Health Worker - Care classification automatically moves to Grade 4; and

85.2 the Advanced Health Worker - Practice and Health Practitioner classifications move to Grade 5 with an uplift in wages. Submissions on the work value reasons for the uplift in wages commence at paragraph 138 below.

[71] Statement of Karl John Briscoe, paragraph 63.

86 The health workers in Grade 4 who are Senior Health Workers – Care move to Grade 5 with no uplift in wages.

87 There is a new Grade 6 for Senior Health Practitioners and Coordinator Care. This is a new classification and NATSIHWA's submissions on the work value reasons for the insertion of a new grade and new wages commence at paragraph 138.

New Definitions[72]

88 Clause 2 of the Exposure Draft published on 15 March 2019 (**Exposure Draft**) was amended in accordance with the Full Bench's determination at [2018] FWCFB 1548 at [11] to include the following definitions proposed by NATSIHWA:

88.1 Aboriginal and/or Torres Strait Islander Health Worker;

88.2 Advanced Health Worker – Care;

88.3 Advanced Health Worker – Practice;

88.4 Community Controlled Health Services Employees;

88.5 Coordinator Care;

88.6 Generalist Health Worker;

88.7 Health Practitioner;

88.8 Senior Health Care Worker – Care; and

88.9 Senior Health Practitioner,

(collectively, **New Definitions**).

89 NATSIHWA sought the inclusion of the New Definitions because they are utilised in the re-drafted classification structure sought by NATSIHWA. Whilst the insertion of the definitions was not opposed by any other

[72] Item S2 of the Substantive Issues Summary Table.

interested parties, unless the Commission amends the Award to include NATSIHWA's proposed classification structure, the New Definitions serve no function.

E. WORK VALUE CASE

Principals relating to work value

90 The capacity of the Commission to vary minimum wages in a modern award in the course of the conduct of the 4 yearly review is constrained by sections 135 and 156(3) of the Act, which provide, relevantly, that modern award minimum wages can only be varied where the Commission is satisfied that the variation is justified by "*work value reasons*". The expression "*work value reasons*" is defined under s 156(4) of the Act to be 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*; *and*

(c) *the conditions under which the work is done*".

91 There are two recent leading decisions involving 4 yearly review of modern awards which establish the method to be used by the Commission to determine work value. The most recent of these is *Education Group* (AM2015/6)[73] (***Education Group***). At paragraph [53] of *Education Group*, the Commission referred to a second leading decision, *Pharmacy Industry Award* (AM2016/28) (***Pharmacy Industry***)[74], and in particular:

91.1 the discussion in that case of the historical background relating to the statutory framework and assessment of work value; and

[73] [2019] FWCFB 488.
[74] [2018] FWCFB 7621.

91.2 a number of propositions explained by the Commission relating to the proper application of sections 156(3) and (4) of the Act.

92 Those propositions contained in *Pharmacy Industry* can be summarised as follows[75]:

92.1 section 156(3) requires that the Commission may only make a determination varying modern award minimum wages if it is justified by work value reasons;

92.2 section 156(4) provides that work value reasons are reasons justifying the amount that employees ought be paid for doing a particular kind of work, being reasons related to the nature of the work, the level of skill or responsibility in doing the work or the conditions under which the work is done;

92.3 the "*significant net addition to work requirements*" is no longer the applicable test. Sections 156(3) and (4) leave it to the Commission to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay;

92.4 it is no longer incumbent upon the Commission to establish a "*datum point*"; and

92.5 it is open to the Commission, in the exercise of its discretion, to take into account previous work value cases and previous statutory regimes.

93 In the exercise of the Commission's discretion to take into account previous work value cases, at [159] – [161] *Pharmacy Industry* makes reference to a series of considerations relevant to the previous requirement to satisfy the "*significant net addition to work requirements*" test referred to within 2005 *A.C.T. Child Care Case* PR954938 (***Child Care***). These identical factors were set out again by the Full Bench in the Draft Background Document for *United Voice and Australian*

[75] *Pharmacy Industry* [163] – [169].

Paramedics Association Victoria v Ambulance Australia (C2015/3378 and C2015/7416) dated 8 March 2016 (***United Voice***) at [17]. It is noted that this matter never proceeded to hearing before the Full Bench, with the parties attending conciliation before the Commission issued a private recommendation to resolve the matter[76].

94 In the context of section 156(4) and those discretionary considerations above, NATSIHWA relies upon the following work value changes to justify the increase in pay in relation to some classifications in Grade 5, and the creation of the new Grade 6.

Work value case for Grade 5 A&TSIHPs

Nature of the work

95 The current role of an A&TSIHW is to perform a broad range of tasks including (but not limited to):

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;

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;

[76] Transcript of Proceedings dated 23 March 2016, C2015/3378 & C2015/7416

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[77].

96 The exact nature of the role will vary depending on the context within which they work, and the location in which they practice.

97 A&TSIHPs, on the other hand, tend to work as independent practitioners alongside doctors and nurses, and can undertake a broad range of duties, including:

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;

[77] Statement of Karl John Briscoe, paragraph 25.

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

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[78].

98 A&TSIHPs may be generalist practitioners, or they may specialise in areas such as mental health, sexual health or drug and alcohol health.

99 Evidence suggests that the ongoing involvement of A&TSIHWs and A&TSIHPs in models of care increases patient contact and often ensures that the patient's family is included in ongoing plans of care and management. It can reduce discharges against medical advice and supports ongoing referrals[79].

100 A&TSIHPs are key advocates for their communities and clients. They have local knowledge able to support a person's health care arrangements based not only on their health needs, but the circumstances of the family, their environment and the community which they are situated in. Their advocacy role can assist to redress the power imbalances that exist

[78] Statement of Karl John Briscoe, paragraph 33.
[79] Expert Report of Alyson Wright, paragraph 15.

between Aboriginal people, and healthcare providers (doctors and nurses)[80].

101 In 2012, it was noted A&TSIHW remuneration in the community sector was not progressing in line with government employed health workers. This is despite the fact that some commentators have suggested that A&TSIHWs in ACCHSs have higher levels of clinical skills and responsibilities than colleagues in state health[81].

Level of skill or responsibility involved in doing the work

102 At the time that the Award was created in 2009, the Award recognised that at the Certificate IV level, the qualifications split into the streams of Care (formerly Community) and Practice.

103 However, in 2012, a significant change took place which made a clear distinction between A&TSIHWs and A&TSIHPs. Since 1 July 2012, all A&TSIHPs have been required to be registered with the A&TSIHPBA and meet the A&TSIHPBA's Registration Standards in order to practice as an A&TSIHP in Australia[82].

104 A&TSIHPs are now required to renew their registration with A&TSIHPBA annually. In doing so, they must:

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;

[80] Expert Report of Alyson Wright, paragraph 18.
[81] Expert Report of Alyson Wright, paragraph 22.
[82] Statement of Karl John Briscoe, paragraphs 35 and 36, Statement of Daniel Niddrie, paragraph 23.

104.5 meet requirements about their practice;

104.6 comply with A&TSIHPBA's Code of Conduct; and

104.7 pay a fee[83].

105 A&TSIHPs now have more responsibility and accountability for the work they do as a result of the above. Any failure to perform in their role, and they face a notification against them to the overseeing body[84].

106 By increasing the remuneration for A&TSIHPs to account for these additional more stringent requirements on their role, it is likely that there will be an increase in the number of A&TSIHPs entering the workforce, either at an A&TSIHP level or by A&TSIHWs obtaining additional training to achieve the higher classification. In the long run, this 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[85].

107 In addition, A&TSIHPs in certain locations (remote areas in Northern Territory and Western Australia, and isolated areas in Queensland) now have the ability to supply and administer medication. This means that A&TSI clients in those areas are able to access medications that they otherwise might not be able to access. This reduces the number of A&TSI clients in those areas experiencing acute health issues, reducing health costs for the economy. In addition, for A&TSI clients living in remote or isolated areas, they will generally have to travel into the city to receive treatment for acute health issues, which places strain on the community while the client is away from their family[86].

[83] Statement of Karl John Briscoe, paragraphs 36-41.
[84] Statement of Karl John Briscoe, paragraph 43.
[85] Statement of Karl John Briscoe, paragraph 164. See also Expert Report of Alyson Wright, paragraph 24.
[86] Statement of Karl John Briscoe, paragraph 165.

Conditions under which the work is done

108 While the size of the A&TSIHW and A&TSIHP workforce has grown, that growth is not proportionate with the growth of the general A&TSI population.[87] As a result, there is a greater volume of work for existing A&TSIHWs and A&TSIHPs, causing increased stress on these workers.[88]

109 The National Review (2000) found that most A&TSIHWs regularly worked hours that exceeded their requirements and, in several instances, A&TSIHWs worked 10 or more overtime hours each week. Communities members can often place additional expectations on A&TSIHWs and A&TSIHP that can involve driving them to appointments or following up with referrals, help with Medicare forms, dealing with other agencies, social security and welfare payments, and housing issues. They are often the first point of call for community members who need medical advice/assistance, whether they are on duty or not[89].

110 The A&TSIHW and A&TSIHP workforce has also been experiencing difficulties in recruiting and retaining workers.[90] While there has been an increase in the numbers of A&TSIHWs and A&TSIHPs, this workforce is an aging one[91]. This places additional pressure on the demands of A&TSIHWs and A&TSIHPs.

111 Since around 2015, A&TSIHPs have become much more involved in performing clinical duties in the treatment room with doctors. 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

[87] Statement of Karl John Briscoe, paragraph 167. Expert Report of Ray Lovett, Question 4 (page 4).
[88] Statement of Karen West, paragraphs 13-15, Statement of Roslyn Hart, paragraphs 16-17, Statement of Devetta Mundraby, paragraph 10.
[89] Expert Report of Alyson Wright, paragraph 17, Statement of Karl John Briscoe, paragraphs 59-60, Statement of Karen West, paragraph 15, Statement of Naomi Zaro, paragraph 11, Statement of Aaron Everett, paragraph 20, Statement of Antoinette Liddell, paragraph 19.
[90] Statement of Karl John Briscoe, paragraph 168, Statement of Antoinette Liddell, paragraph 15, Statement of Karen West, paragraph 19, Statement of Kristy Pursch, paragraph 13.
[91] Expert Report of Alyson Wright, paragraph 31.

ground than they had previously.[92] 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.[93]

112 Over the past 10 years, there has been an ongoing change in the units that are being delivered for the A&TSIHP and A&TSIHW qualifications. This has been difficult for the A&TSIHW and A&TSIHP workforce, because they have had to constantly upskill, including incurring costs for retraining or completing further qualifications.[94]

113 From the lay evidence provided by NATSIHWA, this work is performed in:

113.1 hot conditions;[95]

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;[96]

113.3 potentially dangerous situations while working out in the community, such as entering the house of angry or violent community members;[97]

113.4 nauseous conditions, such as dealing with maggot-infested wounds or discharging foot ulcers;[98]

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;[99] and

[92] Statement of Georgina Taylor, paragraph 18.
[93] Statement of Cynthia Sambo, paragraphs 15-16, Statement of Rebecca Tracey, paragraph 16.
[94] Statement of Robert John Dann, paragraph 13.
[95] Statement of Naomi Zaro, paragraph 26, Statement of Evelyn Wilson, paragraphs 12 and 22, Statement of Haysie Penola, paragraph 23.
[96] Statement of Daphne de Jersey, paragraphs 8, 19-23, Statement of Evelyn Wilson, paragraph 12.
[97] Statement of Daphne de Jersey, paragraph 14.
[98] Statement of Lorraine Gilbert, paragraph 21, Statement of Daniel Niddrie, paragraph 28.

113.6 conditions that can be confronting, dealing with so many people who are in need or increasing numbers of people being diagnosed with chronic conditions.[100]

114 It is uncertain what the current ratio of A&TSIHW/A&TSIHPs to the A&TSI population is. However, 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.[101] There will need to be a significant increase in the proportionate numbers of A&TSIHWs and A&TSIHPs if there is going to be a chance to achieve significant improvements in A&TSI health.

115 By uplifting the classification for Advanced 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

[99] Statement of David Hart, paragraph 13, Statement of Daniel Niddrie, paragraph 12.
[100] Statement of Karen West, paragraph 14, Statement of Tanya King, paragraph 13.
[101] Statement of Karl John Briscoe, paragraph 170.

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).[102]

116 Ms Wright's opinion is that the uplift of Advanced Health Workers – Practice and Health Practitioners to Grade 5, and in particular, the associated increased 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."*[103]

Work value case for Grade 6 worker

Overview

117 Grade 6 in the Varied Classification Structure is a new grade which contemplates the creation of senior roles for A&TSIHWs and A&TSIHPs operating at a senior level and having responsibility in the implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs or sub-programs. These two 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.

118 The Award does not presently provide any classification for A&TSIHWs who have achieved an Advanced Diploma of A&TSI Primary Health Care (Care).

[102] Statement of Karl John Briscoe, paragraph 171.
[103] Expert Report of Alyson Wright, paragraph 37.

Analysis of work value reasons

119 Grade 6 is a new grade which anticipates A&TSIHWs and A&TSIHPs undertaking a senior role at a management function, a role in which they may report to the Board of Directors or be responsible for the administration of the health service.

120 This type of senior function and level of responsibility for A&TSIHWs and A&TSIHPs is not currently recognised by the Award. Adding Grade 6 is consistent with providing a career structure for A&TSIHPs who have completed a Diploma of A&TSI Primary Health Care (Practice) or A&TSIHWs who have completed a Diploma or Advanced Diploma of A&TSI Primary Health Care (Care), and who are required to utilise their qualifications and skills in managerial positions (as described in the new Grade 6).

121 Creating this role would allow these professionals to have greater opportunity for recognition where they are required to support and manage A&TSIHWs and A&TSIHPs, and particular, in relation to the delivery of specialised programs or sub-programs. Further, it may also lead to more A&TSIHWs and A&TSIHPs being considered in the management roles of small remote community clinics, creating more sustainable employment options than short-term and/or temporary nurses[104]. 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 managerial 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[105].

[104] Expert Report of Alyson Wright, paragraphs 23 and 39.
[105] Expert Report of Ray Lovett, Question 8.

122 Significantly, the principal employer of A&TSIHWs and A&TSIHPs, NACCHO, supports this additional senior management grade.[106]

123 Creation of this additional senior grade provides a fair and relevant minimum safety net of terms and conditions for A&TSIHWs and A&TSIHPs who, as a matter of fairness and equity, deserve the opportunity to have a career structure which recognises their contribution (including potential contribution) where they are appointed to roles which require them to utilise their qualifications and experience to manage and promote the health outcomes for their communities. A&TSIHWs and A&TSIHPs also deserve to be remunerated for doing so at a rate equivalent to that paid for work of equal or comparable value to non-ATSI employees in other careers. Further, the new classification has the benefit of promoting social inclusion through increased workforce participation, it has no negative impact on business, and it is simple and easy to understand.

Remuneration

124 The remuneration sought for this grade is equivalent to the Grade 8 SCHCDSI Award employee because it is contemplated that these Grade 6 workers:

124.1 have equivalent characteristics;

124.2 have equivalent responsibilities; and

124.3 have equivalent prerequisites.

Analysis of Senior Health Practitioner's Work

125 Like the Grade 8 SCHCDSI employee, the Senior Health Practitioner will work at a senior level, being responsible for the implementation, coordination, management and evaluation of health programs and service delivery in one or more specialised programs or sub-programs. The characteristics of the Grade 8 SCHCDSI employee are of the same nature and level as the Senior Health Practitioner. Both are required to

[106] Letter from Patricia Turner, Chief Executive Officer of NACCHO dated 18 June 2019, Tab 87 of Exhibit KB-1.

exercise managerial responsibility, both may provide advice to the Board, both may provide advice on policy matters, both must have a high level of proficiency in problem solving skills and to work autonomously.

126 Likewise, the responsibilities of the Grade 8 SCHCDSI employee and the Senior Health Practitioner are equivalent. Both are required to undertake work of significant scope and complexity, both are required to undertake work of a critical nature with little direction, both are required to undertake functions across a range of specialist areas, to administer complex program matters and to initiate and formulate organisational programs. Additionally, the Senior Health Practitioner must have level 3 A&TSI cultural skills, and the ability to advocate for the rights and needs of community members and liaise with external stakeholders.

127 Finally, the requirements of the two positions are equivalent. The skills, knowledge, qualification and training of a Senior Health Practitioner include detailed knowledge of policy, programs, guidelines, procedures and practices and a diploma plus the acquisition of considerable skills and extensive and diverse experience.

Analysis of Coordinator Care's Work

128 Like the Grade 8 SCHCDSI employee, the Coordinator Care will work at an advanced level in a specialised program with broad direction and minimal supervision and will exercise accountability and responsibility for the programs under their control and the quality standards of work produced. The characteristics of the Grade 8 SCHCDSI employee are of the same nature and standard as the Coordinator Care. Both are required to exercise managerial responsibility, both may provide advice to the Board, both provide advice on policy matters, both must have a high level of proficiency in problem solving skills and to work autonomously.

129 Likewise, the responsibilities of the Grade 8 SCHCDSI employee and the Coordinator Care are of an equivalent level. Both are required to undertake work of significant scope and complexity, both are required to undertake work of a critical nature with little direction, both are required to undertake functions across a range of specialist areas, to administer

complex program matters and to initiate and formulate organisational programs. Additionally, the Coordinator Care must have level 3 A&TSI cultural skills, the ability to advocate for the rights and needs of community members and liaise with external stakeholders and ability to represent their health service on national, state and regional level activities.

130 Finally, the requirements of the two positions are equivalent. The skills, knowledge, qualification and training of a Coordinator Care include detailed knowledge of policy, programs, guidelines, procedures and practices and a diploma plus the acquisition of considerable skills and extensive and diverse experience.

131 The Commission can be satisfied by proposing the same remuneration for the two proposed roles in the new Grade 6 as for the Grade 8 SCHCDSI employee, NATSIHWA has carefully considered the principle that there ought be equal remuneration for work of equal or comparable value (sections 134(1)(e) and 284(1)(d) of the Act).

F. ALLOWANCES

132 Each of the allowances NATSIHWA seeks to insert into the Award must meet the modern award objective, as set out in section 134 of the Act.

133 Section 139 of the Act defines the terms that may be included in modern awards. In respect of allowances, it provides:

> (g) allowances, including for any of the following:
>
> (i) expenses incurred in the course of employment;
>
> (ii) responsibilities or skills that are not taken into account in rates of pay; and
>
> (iii) disabilities associated with the performance of particular tasks or work in particular conditions or locations.

134 In relation to the allowances sought below, NATSIHWA submits that they form part of a fair and relevant minimum safety net and achieve the

modern awards objective, having regard to the following specific factors of section 134 of the Act:

134.1 the need to promote social inclusion through increased workforce participation (section 134(1)(c) of the Act);

134.2 the need to promote modern flexible work practices (section 134(1)(d) of the Act);

134.3 the likely impact of the exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden (section 134(1)(f)); and

134.4 the need to ensure a simple, easy to understand, stable and sustainable modern award system (section 134(1)(g)).

135 Each of the agreed and contended allowances have the support of NACCHO, the principal employer of the vast majority of A&TSIHWs and A&TSIHPs.[107] This is the first opportunity afforded to A&TSIHWs and A&TSIHPs to make submissions on allowances that will provide them with a minimum safety net of terms and conditions.

AGREED ALLOWANCES

Telephone allowance

136 The allowance sought is in these 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 apply where the employer provides the employee with a mobile telephone for the purpose of being on call.[108]

[107] Letter from Patricia Turner, Chief Executive Officer of NACCHO dated 18 June 2019, Tab 87 of Exhibit KB-1.
[108] Clause 13 of the Final Draft Determination.

137 The Telephone allowance falls within section 139(g)(i) of the Act, in that it relates to expenses incurred in the course of employment.

138 Parties have agreed to this amendment, however, it has been referred to the Full Bench for determination in accordance with [2018] FWCFB 4175 at [11] – [12], on the basis that consideration must be given to the modern awards objective before the variation be made.

139 Some A&TSIHWs and A&TSIHPs are required to be 'on call' during certain portions of their working roster. It is for this reason that both A&TSIHWs and A&TSIHPs should be entitled to a telephone allowance.

140 For example, A&TSIHWs and A&TSIHPs have been required to be on call in the following circumstances:

140.1 some remote clinics in Aurukun require A&TSIHWs and A&TSIHPs to be on call to perform their duties and have a telephone for that purpose;[109]

140.2 an A&TSIHP in the Anangu Pitjantjatjara Yankunytjatjara Lands is frequently required to be on call, including in relation to fatal and serious emergencies in the night;[110]

140.3 an A&TSIHW working in the drug and alcohol service in Hobart, Tasmania has had to be on call, to assist if there is an issue with one of the clients in that service;[111] and

140.4 a Clinic Coordinator working in Innisfail, Queensland, has to have her own telephone for being on call, such as if the immunisation fridge goes down in order to monitor that the vaccines are kept at a constant temperature.[112]

141 Both A&TSIHWs and A&TSIHPs can be required to be 'on call'.

[109] Statement of Karl John Briscoe, paragraph 209.
[110] Statement of Zibeon Fielding, paragraph 24.
[111] Statement of Aaron Everett, paragraph 20.
[112] Statement of Charlene Badham, paragraph 24.

142 Of the 137 modern awards, 13 of those contain a telephone allowance[113]. In relation to those specific awards that concern health, the following contain a telephone allowance:

142.1 Animal Care and Veterinary Service Award 2010 (cl. 16.1);

142.2 HPSS Award (cl 18.11);

142.3 Medical Practitioners Award 2010 (cl 16.5); and

142.4 SCHCDSI Award (cl 20.6).

143 Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as the Telephone allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award), performing work of comparable value to the A&TSIHWs and A&TSIHPs are entitled to receive the Telephone allowance. Amending the Award to include the Telephone allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

Damaged Clothing Allowance

144 The allowance sought is in these 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.*

[113] 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), HPSS Award (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), SCHCDSI Award (cl 20.6), Stevedoring Industry Award 2010 (cl 14.5), Telecommunications Services Award 2010 (cl 17.1(c)).

This clause will not apply where the damage or soiling is caused by the negligence of the employee.[114]

145 The Damaged Clothing allowance falls within section 139(g)(i) of the Act, in that it relates to expenses incurred in the course employment.

146 Parties have agreed to this amendment, however, it has been referred to the Full Bench for determination in accordance with [2018] FWCFB 4175 at [11] – [12], on the basis that consideration must be given to the modern awards objective before the variation be made.

147 Sometimes in the course of performing their duties, A&TSIHWs and A&TSIHPs may suffer damage or dirtying of their clothing. For example:

147.1 an Alcohol, Tobacco and Other Drugs worker in the community may dirty or damage their clothing while assisting an intoxicated client who has defecated him or herself, or has vomited over him or herself;[115]

147.2 other A&TSIHWs and A&TSIHPs more generally also suffer damage to their clothing when assisting clients who have vomited, urinated or defecated on themselves, or who are bleeding. For example, a patient who was having a seizure vomited on Mr Daniel Niddrie while he was assisting the patient, and babies have vomited on Mr Niddrie while he has been weighing their mothers;[116]

147.3 A&TSIHWs and A&TSIHPs suffer damage to their clothes when they come into contact with bodily or other fluids (e.g. iodine) during medical procedures, which can happen suddenly and unexpectedly. For example, Ms Haysie Penola estimates she

[114] Clause 11 of the Final Draft Determination.
[115] Statement of Karl John Briscoe, paragraph 206.
[116] Statement of Charlene Badham, paragraph 23, Statement of Daniel Niddrie, paragraph 27.

experiences spillage of ear discharge on her clothing while performing an ear syringe on about a bi-daily basis;[117]

147.4 Ms Penola has been urinated on while trying to assist in collection of a child's urine specimen;[118]

147.5 A&TSIHWs and A&TSIHPs suffer damage to their clothes while helping clients to shower who have soiled themselves;[119] and

147.6 A&TSIHWs and A&TSIHPs may occasionally suffer damage to their clothes while working out in country.[120]

148 Of the 137 modern awards, 12 of those contain an allowance similar to NATSIHWA's proposed clothing allowance[121]. In relation to those specific awards that concern health, please see clause 18.4 of the HPPS Award.

149 Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as the damaged clothing allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award), performing work of comparable value to the A&TSIHWs and A&TSIHPs are entitled to receive the damaged clothing allowance. Amending the Award to include the damaged clothing allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

[117] Statement of Charlene Badham, paragraph 23, Statement of Haysie Penola, paragraph 20, Statement of Lorraine Gilbert, paragraph 21.
[118] Statement of Haysie Penola, paragraph 20.
[119] Statement of Naomi Zaro, paragraph 24, Statement of Peter Yarran, paragraph 14.
[120] Statement of Aaron Everett, paragraph 18.
[121] 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)), HPSS Award (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).

Nauseous Work Allowance

150 The allowance sought is 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 of 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.*[122]

151 The Nauseous Work allowance falls within section 139(g)(iii) of the Act, in that it relates to disabilities associated with the performance of particular tasks or work in particular conditions or locations.

152 Parties have agreed to this amendment, however, it has been referred to the Full Bench for determination in accordance with [2018] FWCFB 4175 at [11] – [12], on the basis that consideration must be given to the modern awards objective before the variation be made.

153 A&TSIHWs and A&TSIHPs may sometimes have to handle linen of a nauseous nature in the course of performing their duties, such as:

153.1 if a maternal and health child worker has a child who vomits or urinates, and the A&TSIHW or A&TSIHP has to clean up the vomit or urine;[123]

153.2 if an A&TSIHW or A&TSIHP has to assist a client with showering and handling their clothes for either washing or throwing out if they have soiled themselves;[124]

153.3 if an A&TSIHW or A&TSIHP has to clean faeces from the public toilet at the clinic;[125]

[122] Clause 14 of the Final Draft Determination.
[123] Statement of Karl John Briscoe, paragraph 210.
[124] Statement of Naomi Zaro, paragraph 25, Statement of Peter Yarran, paragraph 15.

153.4 if an A&TSIHW or A&TSIHP has to deal with soiled dressings, infected or festering wounds, ulcers, cleaning a patient's shoes of discharge from their diabetic foot ulcers. For example, Lorraine Gilbert took the dressing off a patient who had alcohol issues, and found that he had maggots in the wound;[126]

153.5 if a mental health patient soils their pants and the bed they are sitting on, the A&TSIHW or A&TSIHP has to clean up the patient's clothes and sheets[127]. Other A&TSIHWs and A&TISHPs outside of the mental health area also have to handle dirty or soiled linen;[128] and

153.6 if an A&TSIHW or A&TSIHP has to collect a stool sample for A&TSI children, to test for lactose intolerance. A number of A&TSI people are lactose intolerant.[129]

154 Of the 137 modern awards, three awards contain a nauseous work allowance similar to NATSIHWA's proposed allowance being the Aged Care Award 2010 (clause 15.5), the Australia Post Enterprise Award 2015 (clause 26.14) and HPSS Award (clause 18.8).

155 Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as the nauseous work allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award), performing work of comparable value to the A&TSIHWs and A&TSIHPs are entitled to receive the nauseous work allowance. Amending the Award to include the nauseous work allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

[125] Statement of Naomi Zaro, paragraph 25.
[126] Statement of Lorraine Gilbert, paragraph 21, Statement of Daniel Niddrie, paragraph 28.
[127] Statement of Daniel Niddrie, paragraph 28.
[128] Statement of Charlene Badham, paragraph 25, Statement of John Watson, paragraph 16.
[129] Statement of Haysie Penola, paragraph 22.

Blood Check Allowance

156 The Blood Check Allowance sought is 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.*[130]

157 The Blood Check allowance falls within section 139(g)(i) of the Act, in that it relates to disabilities associated with the performance of particular tasks or work in particular conditions or locations.

158 Parties have agreed to this amendment, however, it has been referred to the Full Bench for determination in accordance with [2018] FWCFB 4175 at [11] – [12], on the basis that consideration must be given to the modern awards objective before the variation be made.

159 A&TSIHWs or A&TSIHPs are exposed to the risk of radiation hazards when assisting clients who have undertaken chemotherapy or radiation therapy.[131] If an employee experiences this risk, they may have to incur the expense of obtaining a blood check.

160 The HPSS Award contains a blood check allowance, see clause 18.2. Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as the blood check allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award), performing work of comparable value to A&TSIHWs and A&TSIHPs are entitled to receive the blood check allowance. Amending the Award to include the blood check allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

[130] Clause 12 of the Final Draft Determination.
[131] Statement of Karl John Briscoe, paragraph 208.

CONTENDED ALLOWANCES

Medication Administration Allowance

161 The allowance contended for is 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.*[132]

162 The Medication Administration allowance falls within section 139(g)(ii) of the Act, in that it relates to responsibilities or skills that are not taken into account in rates of pay.

163 This allowance has not been agreed by the parties.

164 A&TSIHPs are only permitted to administer medication in certain states (currently in remote areas of the Northern Territory and Western Australia, and isolated areas of Queensland), and subject to regulation by the relevant state legislation.

165 Given that not all A&TSIHPs perform the administration of medication, these responsibilities are not taken into account in the wages paid to A&TSIHPs under the Award.

166 In the Northern Territory, section 250 of the *Medicines, Poisons and Therapeutic Goods Act 2012* (NT) permits an A&TSIHP to supply or administer specified medications in remote locations[133]. The evidence demonstrates that there are A&TSIHPs that administer medication in the Northern Territory.[134]

167 From 1 November 2018, A&TSIHPs working in isolated practice areas in Queensland were authorised to use scheduled medicines under the *Health (Drugs and Poisons) Regulation 1996* (QLD) in certain circumstances

[132] Clause 17 of the Final Draft Determination.
[133] Statement of Karl John Briscoe, paragraph 46.
[134] Statement of Daniel Niddrie, paragraph 25, Statement of Lorraine Gilbert, paragraph 19.

and conditions, and in accordance with a drug therapy protocol, primarily the protocol titled *'Drug Therapy Protocol – Aboriginal and Torres Strait Islander Health Practitioners Isolated Practice Area'*[135].

168 Since at least around 2017, A&TSIHPs in remote Aboriginal health services have been permitted to supply patients with prescription medicines for the treatment of chronic health conditions, where those medicines have already been prescribed, pursuant to rule 41 of the *Medicines and Poisons Regulations 2016* (WA)[136]. The evidence demonstrates that there are A&TSIHPs that administer medication in Western Australia.[137]

169 The ability to supply medication means that A&TSI clients in these areas are able to access medications that they otherwise might not be able to access. This reduces the number of A&TSI clients in those areas experiencing acute health issues, reducing health costs for the economy (section 134(1)(h) of the Act). In addition, for A&TSI clients living in remote or isolated areas, they will generally have to travel into the city to receive treatment for acute health issues, which places strain on the community while the client is away from their family[138].

Heat Allowance

170 The allowance contended for is as follows:

> ***15.10 Heat Allowance***
>
> *An employee who works in a place where the temperature raises to between 46º and 54º Celsius must be paid an additional 3.2% of the hourly standard rate per hour or part thereof for work performed in the hot period; with an additional 4% of the hourly standard rate per hour or part thereof, where the temperature exceed 54º Celsius.*[139]

[135] Statement of Karl John Briscoe, paragraph 47.
[136] Statement of Karl John Briscoe, paragraph 48.
[137] Statement of Daniel Niddrie, paragraph 25, Statement of Haysie Penola, paragraph 21, Statement of Cynthia Sambo, paragraph 25, Statement of Naomi Zaro, paragraph 22.
[138] Statement of Karl John Briscoe, paragraph 165.
[139] Clause 15 of the Final Draft Determination.

171 The Heat Allowance falls within section 139(g)(iii) of the Act, in that it relates to disabilities associated with the performance of particular tasks or work in particular conditions or locations.

172 This allowance has not been agreed by the parties.

173 A large number of the Department of Health-funded primary healthcare providers are located in very remote areas of central, northern and western Australia[140].

174 In paragraphs 189 to 196 of his Statement, Mr Briscoe gives evidence to the effect that there are some A&TSIHWs and A&TSIHPs who will experience temperatures of 45ºC and above.

175 Evelyn Wilson gives evidence that, when she worked as a Remote Area Coordinator, she would travel to remote towns and communities between the Northern Territory and Western Australian border, and put up a table and chair to perform her duties out in the heat. Ms Wilson states that she occasionally performs work in temperatures between 46ºC and 54ºC, and sometimes the temperature would go above 54ºC, particularly when she would do remote area trips in the Kimberley.[141]

176 Naomi Zaro gives evidence that she performs work in temperatures between 46ºC and 54ºC, particularly if she needs to go outside and assist a client who is dehydrated or suffering from the heat in the Goldfields.[142]

177 Cynthia Sambo gives evidence that the temperature often rises above 46ºC in Kalgoorlie where she works, and she has sometimes had to be out and about in the heat as part of her work as an A&TSIHP.[143]

178 Ms Penola gives evidence that she has occasionally performed work in temperatures between 46ºC and 54ºC, mainly while performing school health checks in Kalgoorlie in the summer. Occasionally, the temperature has exceeded 54ºC (which she knows because her car thermometer cannot

[140] Statement of Karl John Briscoe, paragraph 189.
[141] Statement of Evelyn Wilson, paragraphs 12 and 22.
[142] Statement of Naomi Zaro, paragraph 26.
[143] Statement of Cynthia Sambo, paragraph 24.

register over 55°C, so it reads zero). The mobile clinic had an annex that could pull out, so Ms Penola always had access to shade, but it was very hot.[144]

179 Derek Donohue gives evidence that the temperature reaches 46°C regularly in Kununurra, and that working out in the remote clinic in these temperatures can be very difficult.[145]

180 Of the 137 modern awards, NATSIHWA has identified eight which contain a heat allowance similar to NATSIHWA's proposed allowance[146].

181 Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as the nauseous work allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award), performing work of comparable value to the A&TSIHWs and A&TSIHPs are entitled to receive a heat allowance. Amending the Award to include the heat allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

Isolation Allowance

182 The Isolation allowance falls within section 139(g)(iii) of the Act, in that it relates to disabilities associated with the performance of particular tasks or work in particular conditions or locations.

183 The isolation allowance previously sought by NATSIHWA (as articulated in the Amended Draft Determination dated 1 June 2017) was drawn from what is known as the 'Broken Hill' allowance.

[144] Statement of Haysie Penola, paragraph 23.
[145] Statement of Derek Donohue, paragraph 14.
[146] Airline Operations – Ground Staff Award 2010 (cl 21.19(d)), Food, Beverage and Tobacco Manufacturing Award 2010 (cl 26.3(c)), HPSS Award (cl 18.6), Joinery and Building Trades Award 2010 (cl 24.3(k)), Manufacturing and Associated Industries and Occupations Award 2010 (cl 32.3(d)), SCHCDSI Award (cl 20.7), Sugar Industry Award 2010 (cl 22.20), Timber Industry Award 2010 (cl 21.16).

184 However, NATSIHWA recognises that the isolation allowance in the form previously sought would have been unclear and uncertain for employers seeking to apply that allowance, in the absence of a clear definition for the terms "*rural*" and "*remote*". For that reason, NATSIHWA has altered the form of the isolation allowance that it seeks (contained in clause 16 of the Final Draft Determination), as follows:

> ***15.11 Isolation Allowance***
>
> *Employees engaged to work in a Small Town will in addition to all other payments be paid an allowance for the exigencies of working in such areas of 4.28% of the standard rate.*[147]
>
> Where **'Small Town'** is defined to mean *a town with fewer than 10,000 people that is not within 50 (driving) kilometres of a town with a population in excess of 50,000 people (according to Australian Bureau of Statistics Census data).*[148]

185 For the purposes of this clause, NATSIHWA has adopted the Australian Bureau of Statistics' definition of "*Small Town*" (being a town with fewer than 10,000 people)[149], and has qualified this definition with a requirement that the Small Town be not within 50 (driving) kilometres of a town with a population in excess of 50,000 people (which the Australian Bureau of Statistics defines as a medium town).

186 All of the elements of this definition for Small Town are able to be objectively ascertained, based on Australian Bureau of Statistics Census data and geographical data. As a result, this definition is sufficiently certain and clear to be able to be applied.

187 For the reasons which follow, where an A&TSIHW or A&TSIHP works in a Small Town, this can result in the A&TSIHW or A&TSIHP experiencing additional difficulties in performing their duties.

188 Due to the small population, there may be fewer other health professionals in the area to provide support and assistance to the A&TSIHW

[147] Clause 16 of the Final Draft Determination.
[148] Clause 1 of the Final Draft Determination.
[149] Tab 85 of Exhibit KB-1.

or A&TSIHP, resulting in them taking on more responsibility or higher duties than otherwise might have been the case.[150]

189 For example, Helena Badham is located in Nhulunbuy in the Northern Territory, which had a population of 3,240 people at the time of the 2016 Census.[151] Ms Badham gives evidence that her duties are so broad that she is performing virtually the same work as a nurse, however, she is paid less than a nurse.[152]

190 Another example is Daphne de Jersey, who is located in Mapoon, Far North Queensland. Mapoon had a population of 317 at the time of the 2016 Census.[153] Ms de Jersey gives evidence that she feels very inexperienced in doing phlebotomy, dealing with chronic disease health care (such as foot ulcers) and drawing blood, and does not feel that she has enough training in these duties. However, as she is the only A&TSIHP working at her organisation, there is no one else who can perform these duties, she just has to do them.[154]

191 Zibeon Fielding, who is located in Mimili in the Anangu Pitjantjatjara Yankunytjatjara Lands in South Australia, has observed that A&TSIHWs and A&TSIHPs face serious difficulties in remote areas because there are fewer services available. For example, one A&TSIHW has to drive 100 kilometres to pick up a patient for an appointment, and then 100 kilometres to drop them back. Further, due to their isolation, A&TSIHWs and A&TSIHPs are less able to access other sources of medical assistance which could otherwise provide support to them in the performance of their duties. There are only two nurses and a doctor that come to the Nganampa Health Council twice a week, every two to three weeks. For the remainder of the time, the A&TSIHWs and A&TSIHPs are the people on the ground responsible for their A&TSI patients.[155]

[150] Statement of Karl John Briscoe, paragraph 200-201.
[151] Statement of Helena Badham, paragraph 8.
[152] Statement of Helena Badham, paragraphs 15-16.
[153] Statement of Daphne de Jersey, paragraph 8.
[154] Statement of Daphne de Jersey, paragraphs 19-23.
[155] Statement of Zibeon Fielding, paragraphs 27-29.

192 In addition, due to the smaller population, there may be fewer (or no) elder A&TSIHWs or A&TSIHPs working there who can provide on the ground training and assistance to the A&TSIHW or A&TSIHP. This can make the role practically more challenging than performing the role in an environment where there is greater support.[156]

193 NATSIHWA has evidence of A&TSIHWs and/or A&TSIHPs working in ACCHSs in Small Towns including the following:

193.1 Mapoon, Far North Queensland;[157]

193.2 Nulhunbuy, Northern Territory;[158]

193.3 Yarrabah, Queensland;[159]

193.4 Napranum, Queensland;[160]

193.5 Kununurra, Western Australia;[161]

193.6 Innisfail, Queensland; and

193.7 Mimili in the Anangu Pitjantjatjara Yankunytjatjara Lands, South Australia.[162]

194 In NATSIWHA's submission, the inclusion of this allowance is consistent with the modern award objective, in particular 134(1)(a) and 134(1)(e).

[156] Statement of Karl John Briscoe, paragraph 202, Statement of Daphne de Jersey, paragraphs 19-23.
[157] Statement of Daphne de Jersey, paragraph 8.
[158] Statement of Helena Badham, paragraph 8.
[159] Statement of Devetta Mundraby, paragraph 8.
[160] Statement of Leeann Geas, paragraph 8.
[161] Statement of Evelyn Wilson, paragraph 8, Statement of Derek Donohue, paragraph 6.
[162] Statement of Charlene Badham, paragraphs 9 and 11.

Occasional Interpreting Allowance

195 The allowance sought is as follows:

> ***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 purposes of clause 15.2(a) interpreting is not limited to interpreting from one language from or to the English language.*[163]

196 The Occasional Interpreting allowance falls within section 139(g)(ii) of the Act, in that it relates to responsibilities or skills that are not taken into account in rates of pay.

197 This allowance has not been agreed by the parties.

198 The current Award does not provide any recognition for employees who do not qualify for the bilingual qualification allowance but who do interpret occasionally in the performance of their duties.

199 A large number of primary health care providers are located in regional, remote or very remote areas. It is common for A&TSI persons located in regional, remote or very remote areas to speak English as their second, third, fourth or even fifth language.[164]

200 Further, A&TSI people commonly use hand gestures rather than words to communicate, which need interpreting for the non-Indigenous staff.[165] For example, Ms Penola gives evidence that one time, an A&TSI patient was signalling that he wanted something, to which a non-Indigenous woman

[163] Clause 10 of Final Draft Determination.
[164] Statement of Karl John Briscoe, paragraph 184, Statement of Lorraine Gilbert, paragraph 17, Statement of Naomi Zaro, paragraph 23.
[165] Statement of Lorraine Gilbert, paragraph 18.

kept yelling *"use your words"*. Ms Penola stepped in to interpret his signal, saying *"no, he just wants a cup of tea"*.[166]

201 From time to time, A&TSI clients located in non-remote areas may also have less familiarity with the English language, for example if they have travelled from a remote location for the purposes of obtaining medical treatment.[167]

202 In these circumstances, A&TSIHWs and A&TSIHPs sometimes have to interpret for their A&TSI client, or translate certain words into the relevant Indigenous dialect, to ensure that the A&TSI client can understand and engage with the healthcare services being provided to them.[168]

203 Further, A&TSIHWs and A&TSIHPs sometimes have to interpret for the non-Indigenous medical staff, so that they can understand what the A&TSI patient is saying.[169] For example, Chandel Compton gives evidence that she was assisting a dentist who explained to the A&TSI client that she should put her hand up if she was in pain. The A&TSI client did not put up her hand, but started saying *"Wandi, wandi"*, which means *"stop"*. Ms Compton was able to interpret so that the dentist knew to stop.[170]

204 In addition, sometimes when A&TSI people travel from another location and feel intimidated when seeking healthcare assistance, they revert to speaking language even if they are able to speak English.[171] In these circumstances, the A&TSIHW or A&TSIHP is required to interpret for these patients so that they can obtain healthcare assistance.

205 By removing communication barriers to A&TSI people accessing primary health care, A&TSIHWs and A&TSIHPs who undertake occasional

[166] Statement of Haysie Penola, paragraph 19.
[167] Statement of Karl John Briscoe, paragraph 185.
[168] Statement of Karl John Briscoe, paragraph 186, Statement of Daniel Niddrie, paragraph 26, Statement of John Watson, paragraph 15, Statement of Haysie Penola, paragraph 18, Statement of Aaron Everett, paragraphs 16-17, Statement of Daphne de Jersey, paragraphs 25-29.
[169] Statement of Charlene Badham, paragraph 22, Statement of Evelyn Wilson, paragraph 19.
[170] Statement of Chandel Compton, paragraph 19.
[171] Statement of Karen West, paragraph 20-21.

interpreting duties increase the likelihood that an A&TSI client will receive treatment at a primary (intervention) stage, thereby reducing the likelihood of an acute health episode. This benefits the national economy by reducing national health costs incurred in providing acute treatment[172].

206 Of the 137 modern awards, NATSIHWA have identified six modern awards which contain an allowance similar to the proposed occasional interpreting allowance[173].

207 Due to the circumstances surrounding the creation of the Award, there appears to have been minimal consideration previously given to the incorporation of allowances such as occasional interpreting allowance into the Award. Other employees working in the health industry (such as those under the HPSS Award and the State Nurses Award), performing work of comparable value to the A&TSIHWs and A&TSIHPs are entitled to receive an occasional interpreting allowance. Amending the Award to include the occasional interpreting allowance will ensure equal remuneration for work of equal or comparable value, which is a requirement under section 134(1)(e) of the Act.

G. CEREMONIAL LEAVE

208 NATSIHWA seeks to clarify the ceremonial leave clause, currently clause 26 of the Award, as follows:

> *An employee who is legitimately required by indigenous tradition to be absent from work for Aboriginal and/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.*[174]

209 A&TSI persons refer to the cultural practices following the death of a community member, including the ceremonial rituals, as "Sorry Business".

[172] Statement of Karl John Briscoe, paragraph 188.
[173] Airline Operations – Ground Staff Award 2010 (cl 21.14), Australian Broadcasting Corporation Enterprise Award 2016 (cl 9.8), Australian Capital Territory Public Sector Enterprise Award 2016 (cl 12.18), Australian Public Service Enterprise Award 2015 (cl 11.15), HPSS Award 2010 (cl 18.9), Nurses and Midwives (Victoria) State Reference Public Sector Award 2015 (cl 14.8(b)).
[174] Clause 18 of the Final Draft Determination.

The specific beliefs and ceremonies associated with Sorry Business vary from language group to language group[175].

210 One of the core values that is part of the fabric of the A&TSI people is respect and acknowledgment of the loss of a loved one.[176]

211 In broad terms, A&TSI people believe that the spirit of an Aboriginal deceased returns to the Dreaming Ancestors provided that their community conduct the appropriate ceremonies and rituals.

212 Following the person's death, there will be an extended period of ceremony. This period can last for days, weeks or months, depending on the traditions of the relevant language group. In some Torres Strait Islander groups, a family will hold a tombstone opening approximately 12 months after the burial, which is a large ceremony that is even bigger than a wedding celebration.[177]

213 The persons required to be involved in the period of ceremony is determined by the A&TSI concept of "kinship". The kinship system determines how A&TSI people relate to each other, their responsibilities towards one another, and is the foundation for determining family obligations and ceremonial roles. Kinship is far broader than the non-Indigenous concept of "family"[178].

214 A&TSI people have a higher mortality rate than non-Indigenous persons[179]. There are hence a higher number of A&TSI deaths, and associated funerals and bereavement ceremonies for A&TSI people to attend to. Given the extended notion of "kinship" it is likely that a wider group of A&TSI people will have obligations in respect of each death than would otherwise be expected in a non-Indigenous context.[180]

[175] Statement of Karl John Briscoe, paragraphs 215 and 217.
[176] Statement of Robert John Dann, paragraph 17.
[177] Statement of Karl John Briscoe, paragraph 218.
[178] Statement of Karl John Briscoe, paragraph 219.
[179] Statement of Karl John Briscoe, paragraph 222.
[180] Statement of Tanya King, paragraph 15, Statement of Cynthia Sambo, paragraph 28, Statement of Daniel Niddrie, paragraphs 30-31, Statement of Peter Yarran, paragraph 17, Statement of Charlene Badham, paragraphs 27-28.

215 Many A&TSIHWs and A&TSIHPs are working in locations that are far away from their family. As a result, they need to travel further to attend to Sorry Business (for example, from New South Wales back to Western Australia).[181]

216 Failure to allow A&TSIHWs and A&TSIHPs to take enough time to attend to Sorry Business and their cultural commitments can result in the workers getting burnt out, and ultimately leaving their job.[182] It can also have significant cultural consequences for the worker, who may be in trouble with their community for failing to pay their respects to the family of the deceased.[183]

18 June 2019

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[181] Statement of David Hart, paragraph 20, Statement of Evelyn Wilson, paragraph 24.
[182] Statement of John Watson, paragraphs 21-22, Statement of Naomi Zaro, paragraph 29. See also Statement of Daniel Niddrie, paragraph 32.
[183] Statement of Naomi Zaro, paragraph 28.

ANNEXURE A

Classification Structure

CURRENT AWARD CLASSIFICATION STRUCTURE AND WAGES			PROPOSED CHANGES			Draft Final Determination page references
	Role Title/s	**Per week ($)**		**Role Title/s**	**Per week ($)**	
Grade 1			**Grade 1**	Health Worker Trainee		
Level 1		882.70	Level 1		822.70	4
			Grade 2			
Level 2		881.60	Level 1		881.60	4
Level 3		911.70	Level 2		911.70	4
Grade 2			**Grade 3**	Generalist Health Worker		
Level 1		959.30	Level 1		959.30	4
Level 2		1009.50	Level 2		1009.50	4
Level 3		1058.60	Level 3		1058.60	5
Grade 3*			**Grade 4***	Advanced Health Worker – Care		
Level 1		1088.10	Level 1		1088.10	5

CURRENT AWARD CLASSIFICATION STRUCTURE AND WAGES			PROPOSED CHANGES			Draft Final Determination page references
	Role Title/s	**Per week ($)**		**Role Title/s**	**Per week ($)**	
Level 2		1117.40	Level 2		1117.40	5
Level 3		1143.10	Level 3		1143.10	5
Grade 4			**Grade 5 ****	Advanced Health Worker – Practice; Health Practitioner; Senior Health Worker - Care		
Level 1		1170.40	Level 1		1170.40	5
Level 2		1197.90	Level 2		1197.90	5
Level 3		1226.90	Level 3		1226.90	5
			Grade 6***	Coordinator Care; Senior Health Practitioner		
			Level 1		1383.30	5
			Level 2		1410.40	5
			Level 3		1437.70	5

* Advanced Health Worker – Care (previously at grade 3 and therefore no change).

** Advanced Health Worker – Practice, Health Practitioners (previously at grade 3 and therefore uplift (and work value case to be made out to support uplift in wages)). This Grade also covers Senior Health Workers – Care (no uplift in wages)

***New classification – work value case to be made out concerning insertion of new grade. Wages 'taken' from Social and Community Services Employee level 8 (see here).