IN THE FAIR WORK COMMISSION **AM2018/12**

4 YEARLY MODERN AWARD REVIEW

ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES AWARD 2010

Witness Statement – Karl John Briscoe

I, **KARL JOHN BRISCOE**, of C/- [redacted] in the Australian Capital Territory, **CHIEF EXECUTIVE OFFICER**, affirm and declare:

1. I am the Chief Executive Officer of the National Aboriginal and Torres Strait Islander Health Worker Association Limited (ACN 138 748 697) (**NATSIHWA**).

2. I am authorised to make this statement on behalf of NATSIHWA.

3. I make this statement in support of NATSIHWA's application for substantive variations to the *Aboriginal Community Controlled Health Services Award 2010* (**Award**).

4. Exhibited to me at the time of affirming this witness statement is a bundle of documents marked with **"KB-1"** (**Exhibit KB-1**). Where I refer to *"Tab"* numbers throughout this witness statement, I am referring to the document behind that Tab in Exhibit KB-1.

Background, qualifications and experience

5. I belong to the Kuku Yalanji people, from the Mossman – Daintree area of Far North Queensland. I identify as Aboriginal.

6. I hold the following qualifications:

   (a) in around 2004 – Certificate III in Indigenous Community Services and Primary Health Care;

   (b) in around 2005 – Certificate IV in Indigenous Primary Health Care (Generalist);

   (c) in around 2006 – Diploma in Indigenous Primary Health Care;

(d) in around 2007 – Advanced Diploma of Indigenous Primary Health Care;

(e) in around 2009 – Masters of Public Health;

(f) in around 2014 – Graduate Certificate in Public Sector Management;

(g) in around 2016 – Diploma in Practice Management; and

(h) in around 2017 – MURRA Indigenous Business Master Class Program.

7. My employment history is as follows:

(a) from around 2002 to 2004 – Trainee Aboriginal Health Worker with Queensland Health in Mossman Community Health;

(b) from around 2004 to 2005 – Generalist Aboriginal Health Worker with Queensland Health in Mossman Community Health;

(c) from around 2005 to 2006 – Advanced Aboriginal Health Worker with Queensland Health in Mossman Community Health;

(d) from around 2006 to 2008 – Acting Senior Health Worker with Queensland Health in Mossman Community Health;

(e) from around 2008 to 2008 – Senior Policy Officer in Northern Area Health Service;

(f) from around 2008 to 2010 – Senior Policy Officer in Office of Rural and Remote Health;

(g) from around 2010 to 2010 – Principal Policy Officer in Office of Rural and Remote Health;

(h) from around 2010 to 2011 – Acting Manager Partnerships in Office of Rural and Remote Health;

(i) from around 2011 to 2012 – Principal Indigenous Health Coordinator in Cape York Local Health District;

(j) from around 2012 to 2013 – Acting Director of Primary Health Care in Cape York and Torres Strait Hospital and Health Service;

(k) from around 2013 to 2016 – Executive Director of Indigenous Health and Outreach Services in Cape York and Torres Strait Hospital and Health Service;

(l) from around 2015 to 2016 – Clinical Services Manager at the Galambila Aboriginal Health Services in Coffs Harbour; and

(m) from around 2016 – Chief Executive Officer of NATSIHWA.

NATSIHWA

8. NATSIHWA is a national organisation that was incorporated pursuant to the *Corporations Act 2001* (Cth) on 7 August 2009. NATSIHWA's constitution appears at **Tab 1** of Exhibit KB-1.

9. NATSIHWA was established following the Australian Government's announcement of increased funding as part of its *'Closing the Gap'* initiative. A letter from Mr Graeme Rossiter, Director, Aboriginal and Torres Strait Islander Health Workforce Solution, dated 27 July 2012, which outlines the background and establishment of NATSIHWA, appears at **Tab 2** of Exhibit KB-1.

10. NATSIHWA's role in the Aboriginal and/or Torres Strait Islander (**A&TSI**) community is focused on achieving health outcomes. NATSIHWA's *'Objects'* pursuant to its constitution, which appears at Tab 1 of Exhibit KB-1, are to:

    (a) promote the prevention and control of diseases in Aboriginal and/or Torres Strait Islander communities;

    (b) improve health outcomes for A&TS people in pursuit of the objectives to 'Close the Gap' in life expectancy;

    (c) address the impacts of disadvantage on the health of A&TSI people;

    (d) assist Aboriginal and/or Torres Strait Islander Health Workers (**A&TSIHW**) and Aboriginal and/or Torres Strait Islander Health Practitioners (**A&TSIHP**) in delivering holistic primary health care within A&TSI communities in order to improve health outcomes for A&TSI people; and

    (e) do all such lawful things as may be incidental or conducive to the attainment of the above objectives.

11. NATSIHWA's vision, which is set out under the *'Our Vision'* tab of its website, which appears at **Tab 3** of Exhibit KB-1, provides that NATSIHWA is:

> *An association, founded on the cultural and spiritual teachings of our past and present leaders, which best serves our members in their important role in achieving physical, social, cultural and emotional wellbeing for all Aboriginal and Torres Strait Islander peoples.*

<u>What does NATISHWA do?</u>

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

(a) providing continuing development tools and resources for A&TSIHWs and A&TSIHPs;

(b) providing opportunities for career development and professional networking to facilitate them in in their roles;

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

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

(e) building networks between A&TSIHWs and A&TSIHPs, other health professionals and the health sector generally.

13. NATSIHWA supports all A&TSIHWs and A&TSIHPs, regardless of whether they are employed in an Aboriginal Community Controlled Health Organisation (**ACCHO**) (sometimes referred to as an Aboriginal Medical Service, or **AMS**), a mainstream health service or private practice.

14. The '*What we do*' page on NATSIHWA's website, which appears at **Tab 4** of Exhibit KB-1 outlines that:

Our organisation, through our members' work, contributes significantly to closing the gap in health outcomes between Indigenous and non-Indigenous Australians, which is of direct and immediate benefit to Aboriginal communities across Australia and also a significant national priority for Australia. NATSIHWA supports A&TSI Health Workers and A&TSI Health Practitioners and their communities through our programs, by:

- *providing tools and resources for A&TSI Health Workers and A&TSI Health Practitioners and their services;*
- *facilitating and delivering professional development opportunities to contribute to their effectiveness in their roles;*
- *raising awareness in broader Australian public (particularly health sector) and building alliances to address Aboriginal and Torres Strait Islander health priorities;*
- *communicating and networking across the Health Sector to bring greater awareness of the effective models of care for Aboriginal and Torres Strait Islander peoples;*

- *building networks among A&TSI Health Workers and A&TSI Health Practitioners, and other health professions and the broader health sector; and*

- *Offering mentoring to develop leadership and capabilities in our members*

15. A copy of NATSIHWA's 2018 Annual Report appears behind **Tab 5** of Exhibit KB-1.

Membership to NATSIHWA

16. NATSIHWA has three levels of membership: full membership, associate membership, and "friend" of NATSIHWA.

17. In order to become a full member, a person must identify as A&TSI, be qualified as an A&TSIHW or an A&TSIHP, and have completed a minimum qualification of Certificate II in A&TSI Primary Health Care.

18. In order to become an associate member, a person must identify as A&TSI, and:

    (a) work and/or study in the health field, but not be an A&TSIHW or A&TSIHP; or

    (b) be studying to become an A&TSIHW or A&TSIHP.

19. A "friend" of NATSIHWA is any person or organisation that wishes to support the work of NATSIHWA.

20. At present, NATSIHWA's membership database does not automatically divide our members by where they work (such as private practice, ACCHO, public sector and so on).

The role of A&TSIHWs

21. A&TSIHWs are persons who:

    (a) are of A&TSI heritage; and

    (b) hold any of the following qualifications:

        i. a Certificate II in A&TSI Primary Health Care, or are training to hold a Certificate II if they are a trainee A&TSIHW;

        ii. a Certificate III in A&TSI Primary Health Care (Care);

        iii. a Certificate IV in A&TSI Primary Health Care (Care)

iv. a Diploma in A&TSI Primary Health Care (Care); or

v. an Advanced Diploma in A&TSI Primary Health Care (Care).

22. A copy of NATSIWHA's *'Who we are and what we do'* brochure dated 2018 appears behind **Tab 6** of Exhibit KB-1.

23. An A&TSIHW's role is to provide holistic healthcare to A&TSI persons, consistent with the broader A&TSI notion of 'health' which extends beyond physical health.

24. In order to perform their role, A&TSIHWs need the appropriate clinical skills and training, community connections and cultural knowledge to provide a bridge between the mainstream health services and A&TSI people.

25. Generally speaking, an A&TSIHW's role is to provide primary health care to A&TSI people. A&TSIHWs may perform a broad range of tasks including:

(a) 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. A flow chart showing the best practice model for conducting health assessments, care planning and care coordination appears behind **Tab 7** of Exhibit KB-1;

(b) treating diseases or injuries, and maintaining health records;

(c) 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;

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

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

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

(g) providing education to the A&TSI communities regarding health conditions and health services available to them;

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

(i) informing non-Indigenous health care workers to provide health services in a culturally sensitive manner.

26. In around 2018, NATSIHWA released a Policy Position Statement regarding the importance of primary health care to improve the health and wellbeing for A&TSI people. A copy of this Policy Position Statement appears behind **Tab 8** of Exhibit KB-1.

27. The exact nature of an A&TSIHW's role will vary depending on:

(a) the context within which they work, such as a hospital, an ACCHO or private practice; and

(b) the location that they practice in.

28. If an A&TSIHW works in a remote rural area, they may operate as a sole practitioner, rather than as part of a team. If an A&TSIHW is working remotely as a sole practitioner, they will need to have more extensive knowledge and skills, such as the ability to conduct an ECG or perform suturing, because there may not be any other medical professionals nearby to assist.

29. On around 15 January 2014, the Rural Health Channel published a video on YouTube titled *"A Unique Profession: Aboriginal & Torres Strait Islander Health Workers"*, which is available at https://www.youtube.com/watch?v=XX5nQhkYd8I (**Unique Profession Video**). In this video, the Rural Health Channel explains the role that ATSIHWs play, and the wide range of duties that are performed by ATSIHWs in a number of different contexts.

The role of A&TSIHPs

30. A&TSIHPs are persons who:

(a) are of A&TSI heritage;

(b) hold a Certificate IV in A&TSI Primary Health Care (Practice);

(c) comply with the reporting and registration requirements under the National Registration and Accreditation Scheme, administered by the A&TSI Health Practice Board of Australia (**A&TSIHPBA**) (discussed further below); and

(d) if relevant depending on the location where the A&TSIHP works, comply with the requirements under the relevant state legislation in relation to the A&TSIHP's handling, possession and administration of medications.

31. An A&TSIHP may also hold a Diploma of A&TSI Primary Health Care (Practice), however the Australian Health Practitioner Regulation Agency

(**AHPRA**) will not permit an A&TSIHP to be registered if they do not hold a Certificate IV in A&TSI Primary Health Care (Practice).

32. A&TSIHPs tend to work as independent practitioners alongside other medical professionals such as doctors, nurses, and mainstream health professionals.

33. Subject to the requirements of their relevant state or territory, A&TSIHPs can undertake a broad range of duties, including (but not limited to):

(a) assessing, diagnosing and treating clients;

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

(c) supplying and administering medication, subject to the applicable state legislation.

(d) 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;

(e) treating diseases or injuries, and maintaining health records;

(f) 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;

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

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

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

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

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

(l) informing non-Indigenous health care workers to provide health services in a culturally sensitive manner.

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

Registration requirements

35. 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.

36. 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&TSIHPB and meet the A&TSIHPBA's Registration Standards in order to practice as an A&TSIHP in Australia. A copy of the A&TSIHPBA website outlining the requirements for registration, printed on 2 April 2019, appears behind **Tab 9** of Exhibit KB-1.

37. A copy of the A&TSIHPBA:

    (a) A&TSI Registration Standard effective from 1 July 2012 appears behind **Tab 10** of Exhibit KB-1;

    (b) Continuing Professional Development Registration Standard effective from 1 July 2012 appears behind **Tab 11** of Exhibit KB-1;

    (c) Criminal History Registration Standard effective from 1 July 2015 appears behind **Tab 12** of Exhibit KB-1;

    (d) English Language Skills Registration Standard effective from 1 July 2012 appears behind **Tab 13** of Exhibit KB-1;

    (e) Professional Indemnity Insurance Arrangements Registration Standard effective from 1 July 2012 appears behind **Tab 14** of Exhibit KB-1; and

    (f) Recency of Practice Registration Standard effective from 1 July 2012 appears behind **Tab 15** of Exhibit KB-1.

Each of the documents referred to in paragraph **37** above form part of the A&TSIHPBA's Registration Standards.

38. A&TSIHPs are required to renew their registration with A&TSIHPBA annually.

39. A&TSIHPs must pay a fee in order to register or renew their registration with A&TSIHPBA. A&TSIHPBA's schedule of fees that applied to the 2018 renewal period, printed on 2 April 2019, appears behind **Tab 16** of Exhibit KB-1.

40. A&TSIHPs are expected to comply with A&TSIHPBA's Code of Conduct for registered health practitioners. The Code of Conduct, effective from March 2014, appears behind **Tab 17** of Exhibit KB-1. The Code of Conduct places obligations on A&TSIHPs in relation to matters including providing good care,

working with clients, working with other practitioners, minimising risk and behaving in a professional manner.

41. In addition, A&TSIHPs are expected to comply with a number of guidelines published by A&TSIHPBA, such as the Guidelines for Mandatory Notifications and Guidelines for Advertising Regulated Health Services.

42. Before 2012, there was limited accountability and responsibility for A&TSIHPs practising outside of the Northern Territory in relation to their supply and administration of medication, and no protection for the public to ensure their work practises were up to standard.

43. As a result of the requirement for registration with AHPRA, A&TSIHPs experience more responsibility and accountability for the work that they do. This is because they could receive a notification against them to AHPRA if they fail to perform their role to a suitable standard, such as if a patient's blood pressure is outside the acceptable range and the A&TSIHP fails to take further action to address this.

44. In addition, the annual renewal and continuing professional development requirements provide protection for the public to ensure that A&TSIHPs practice to a suitable standard and remain up to date. In contrast, there is no requirement for A&TSIHWs to be registered or accredited in order to practice.

Additional legislative requirements

45. In addition to the registration requirements, A&TSIHPs must comply with the relevant state legislation in relation to the supply and administration of medication.

46. 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. An extract of this Act appears behind **Tab 18** of Exhibit KB-1. In addition, the Northern Territory Government Department of Health has issued a Guideline titled *"Section 250 NT Medicines, Poisons and Therapeutic Goods Act PHC Remote Guideline"*. This guideline appears behind **Tab 19** of Exhibit KB-1.

47. From 1 November 2018, A&TSIHPs working in isolated practice areas in Queensland are authorised to use scheduled medicines under the *Health (Drugs and Poisons) Regulation 1996* (Qld) in certain circumstances 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'*. This protocol appears behind **Tab 20** of Exhibit KB-1. The Queensland Health Department has also issued guidance regarding using medicines as an A&TSIHP, which appears behind **Tab 21** of Exhibit KB-1.

48. 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. The current applicable regulations are contained in rule 41 of the *Medicines and Poisons Regulations 2016* (WA). An extract of these regulations appears behind **Tab 22** of Exhibit KB-1. In addition, in around 2017, the Government of Western Australia Department of Health has issued Guidelines for A&TSIHWs and A&TSIHPs working with medicine. These guidelines appears behind **Tab 23** of Exhibit KB-1.

National scope of practice

49. On 1 August 2018, I attended the A&TSI Health Leaders Roundtable with the Council of Australian Governments (**COAG**) Health Council. The COAG Health Council's Indigenous Roundtable Communique arising from this meeting appears behind **Tab 24** of Exhibit KB-1. In this communique, the COAG Health Council identified the following discussion point:

> *"Develop a National Indigenous Health and Medical Workforce Plan that provides a career path, national scope of practice and builds more balance of Indigenous and non-Indigenous people across all health professions, make health an aspirational career for Aboriginal people. This should include a specific focus on a national scope of practice for Aboriginal Health Workers and Practitioners."*

50. Once established, the national scope of practice will specify the minimum scope of practice required for any state or territory across the public sector, private sector and ACCHOs.

51. I understand that a draft plan will be submitted to the COAG Health Council for pursuing a national scope of practice in around July 2019, with this topic being listed as a discussion point for the COAG meeting in July 2019.

Cultural factors for A&TSIHWs and A&TSIHPs

52. For persons of A&TSI heritage, the notion of 'health' is broader than physical health, encompassing the physical, spiritual, emotional and cultural wellbeing of the individual. Therefore, health care for an A&TSI person requires care for more than just the person's physical health.

53. In around 2019, HealthInfoNet published a report titled *"Summary of Aboriginal and Torres Strait Islander health status 2018"* (**Health Status Report**), which appears behind **Tab 25** of Exhibit KB-1. In that report, HealthInfoNet identified a number of cultural, historical, social and political factors influencing the health of A&TSI people. These factors are all at play when an A&TSIHW or A&TSIHP performs their duties.

54. In addition, certain A&TSI cultural beliefs can alter the manner in which health care needs to be provided to people of A&TSI heritage. A key example is the A&TSI beliefs around death and dying, which can have significant ramifications for the way in which healthcare providers treat dying A&TSI clients, and how they communicate with family members of an A&TSI client who has died. On 20 November 2015, the New South Wales Health Northern Sydney Local Health District published a framework titled *"Death and Dying in Aboriginal and Torres Strait Islander Culture (Sorry Business)"* which illustrates a number of these issues. This framework appears behind **Tab 26** of Exhibit KB-1.

55. The A&TSI concept of 'family' and 'kinship' is much broader than for non-Indigenous people. I discuss this further in paragraphs **219** to **221** below.

56. Fear and shame can provide practical barriers to A&TSI people accessing healthcare from mainstream services.

57. Further, a lack of understanding can prevent A&TSI people from accessing health care or from doing so safely and effectively. For example:

    (a) an A&TSI person may not understand the medical terminology or services that are available to them, and therefore not seek the help that they need; or

    (b) an A&TSI person may seek health support, but not understand the medical advice that they receive. As a result, this can prevent the client from:

        i. benefiting from that advice, because they cannot implement it in their lives, such as if certain lifestyle changes are required. In some circumstances this lack of understanding can also be dangerous for the A&TSI client, such as if the A&TSI client does not understand that certain medications conflict with other medications and are not to be taken at the same time; and

        ii. advocating for their own needs and the medical support that they require to promote improved health outcomes in their circumstances.

58. Another key cultural barrier to A&TSI people accessing mainstream health services is the need for trust and a strong relationship between the A&TSI client and the A&TSIHW or A&TSIHP. Therefore, an essential component of the A&TSIHW or A&TSIHP's role is to build trust and a respectful relationship with the A&TSI community, so that A&TSI clients will seek their support and assistance, and believe their advice.

59. This need for deep trust and a respectful relationship can have practical ramifications for how an A&TSIHW or A&TSIHP performs their role. For example, if an A&TSI member of the community seeks help from an A&TSIHW late at night or on the weekend, and the A&TSIHW refuses to help the client

because of the late hour, that A&TSI client will lose trust in the A&TSIHW and likely refuse to seek or accept their help again. In some cases, A&TSI communities will ostracise an A&TSIHW or A&TSIHP if the community believes that the A&TSIHW or A&TSIHP is only doing their role for the money and is not truly interested in helping their community.

60. For this reason, A&TSIHWs and A&TSIHPs are trained to engage with their A&TSI clients regardless of when. However, this comes with a cost for A&TSIHWs and A&TSIHPs, who have to be trained in self-care and limiting burn out to ensure that they balance the community needs and their own personal needs. For instance, when I need to recharge, I will take my family camping for a weekend to get away and reconnect with country.

61. To help bridge this cultural divide, NATSIHWA has made a number of publications around the importance of culture in providing health care to A&TSI people. A copy of NATSIHWA's:

    (a) Cultural Safety Framework, published in around 2013 to assist healthcare systems to deliver culturally safe medical services to A&TSI people, appears behind **Tab 27** of Exhibit KB-1; and

    (b) Policy Position Statement regarding the centrality of culture to health care for A&TSI people, published in around 2018, appears behind **Tab 28** of Exhibit KB-1.

Qualifications for A&TSIHWs

62. The training packages for A&TSIHWs and A&TSIHPs have been designed by A&TSI people for A&TSI people.

Certificate II in A&TSI Primary Health Care

63. The Certificate II in A&TSI Primary Health Care is an introductory course which introduces A&TSIHWs to the basic foundations of primary health care. This course is designed to provide a good entry pathway into the profession, and is aimed at workers with lower levels of English. This is because many A&TSI people may have English as their second, third, fourth or even fifth language, particularly in remote and very remote areas.

64. A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT20113 Certificate II in A&TSI Primary Health Care dated 8 December 2015 appears behind **Tab 29** of Exhibit KB-1.

65. This Certificate covers material such as how to:

    (a) work with A&TSI clients and communities (core unit HLTAHW001);

(b) support clients to obtain access to health services (core unit HLTAHW002);

(c) provide basic health information to a client (core unit HLTAHW003);

(d) provide first aid (core unit HLTAID003); and

(e) perform work in the A&TSI primary health care context (core unit HLTAHW004).

66. A&TSIHWs operating with a Certificate II in A&TSI Primary Health Care operate under direct supervision.

67. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Certificate III in A&TSI Primary Health Care

68. The Certificate III in A&TSI Primary Health Care is the minimum qualification requirement for a person to work as an A&TSIHW under supervision, but without direct supervision. A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT30113 Certificate III in A&TSI Primary Health Care dated 8 December 2015 appears behind **Tab 30** of Exhibit KB-1.

69. This Certificate covers material such as:

(a) work in A&TSI primary health care context (core unit HLTAHW005);

(b) how to undertake basic health assessments (core unit HLTAHW007);

(c) assisting in the planning and implementation of basic health care (core unit HLTAHW008);

(d) providing information about social and/or emotional support (core unit HLTAHW009);

(e) assisting with basic health screening, promotion and education services (core unit HLTAHW011); and

(f) identifying community health issues, needs and strategies (core unit HLTAHW010).

70. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Certificate IV in A&TSI Primary Health Care (Care)

71. The Certificate IV in A&TSI Primary Health Care (Care) is a more advanced qualification for A&TSIHWs than the Certificate III in A&TSI Primary Health Care. A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT40113 Certificate IV in A&TSI Primary Health Care dated 8 December 2015 appears behind **Tab 31** of Exhibit KB-1.

72. This Certificate covers material such as:

    (a) working in an A&TSI primary health care context (core unit HLTAHW005);

    (b) facilitating and advocating for the rights and needs of clients (core unit HLTAHW006);

    (c) assessing and supporting clients' social and emotional wellbeing (core unit HLTAHW017);

    (d) supporting the safe use of medications (core unit HLTAHW037);

    (e) planning, implementing and monitoring health care in a primary health care context (core unit HLTAHW018);

    (f) providing nutrition guidance (core unit HLTAHW021); and

    (g) delivering primary health care programs for A&TSI communities (core unit HLTAHW019).

73. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Diploma of A&TSI Primary Health Care

74. The Diploma of A&TSI Primary Health Care is a more advanced qualification for A&TSIHWs that enables A&TSIHWs to operate at a management or program coordinator level. The Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT50113 Diploma of A&TSI Primary Health Care dated 8 December 2015 appears behind **Tab 32** of Exhibit KB-1.

75. This Diploma covers material such as how to:

    (a) work in an A&TSI primary health care context (core unit HLTAHW005);

    (b) plan, implement and monitor primary health care (core unit HLTAHW018);

(c) plan, develop, evaluate and deliver primary health care programs for A&TSI communities (core unit HLTAHW023);

(d) supervise a health care team (core unit HLTAHW062);

(e) apply a strategic approach to A&TSI health (core unit HLTAHW048); and

(f) apply reflective practice in an A&TSI primary health care setting.

76. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Advanced Diploma of A&TSI Primary Health Care

77. The Advanced Diploma of A&TSI Primary Health Care provides for a higher level of management training.

78. A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT60113 Advanced Diploma of A&TSI Primary Health Care dated 8 December 2015 appears behind **Tab 33** of Exhibit KB-1.

79. This Advanced Diploma covers material such as how to:

(a) manage the delivery of A&TSI primary health care (core unit HLTAHW066);

(b) manage health education and promotion (core unit HLTAHW067);

(c) develop work plans and health care policy (core units HLTAHW068 and HLTAHW069);

(d) manage human resources (core unit HLTAHW070); and

(e) provide leadership across the organisation (core unit BSBMGT605).

80. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Qualifications for A&TSIHPs

Certificate IV in A&TSI Primary Health Care (Practice)

81. The Certificate IV in A&TSI Primary Health Care (Practice) is the minimum qualification requirement for a person to be able to work as an A&TSIHP (provided that they have met the other registration and accreditation requirements). A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT40213 Certificate IV in

A&TSI Primary Health Care Practice dated 8 December 2015 appears behind **Tab 34** of Exhibit KB-1.

82. This Certificate covers material such as:

(a) working in an A&TSI primary health care context (core unit HLTAHW005);

(b) delivering primary health care programs for A&TSI communities (core unit HLTAHW019);

(c) facilitating and advocating for the rights and needs of clients and community members (core unit HLTAH006);

(d) administering and supporting the safe use of medications (core units HLTAHW020 and HLTAHW037);

(e) planning, implementing and monitoring health care in a primary health context (core unit HLTAHW018); and

(f) addressing social determinants of A&TSI health (core unit HLTAHW022).

83. This Certificate generally takes approximately 18 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Diploma of A&TSI Primary Health Care (Practice)

84. The Diploma of A&TSI Primary Health Care (Practice) provides training on management for A&TSIHPs. A copy of the Industry Skills Councils' release outlining the units of competency and electives for the qualification HLT50213 Diploma of A&TSI Primary Health Care Practice dated 8 December 2015 appears behind **Tab 35** of Exhibit KB-1.

85. This Diploma covers material such as:

(a) planning, developing, evaluating and delivering primary health care programs for A&TSI communities (core unit HLTAHW045);

(b) administering and supporting the safe use of medications (core units HLTAHW020 and HLTAHW037);

(c) applying advanced skills in primary health care (core unit HLTAHW046);

(d) supervising the health care team (core unit HLTAHW062); and

(e) managing medicines in A&TSI health care (core unit HLTAHW065).

86. This Certificate generally takes approximately 12 months to complete, subject to how the specific Registered Training Organisation delivers the course.

Training for A&TSIHWs and A&TSIHPs

87. In addition to the formal qualifications outlined above, A&TSIHWs and A&TSIHPs may receive practical on the job training through an apprenticeship or informal learnings, including from elders and more experienced A&TSIHWs or A&TSIHPs

88. For example, when I was working as a trainee A&TSIHW in Mossman, Aunty Judy Leftwich took me under her wing and showed me how to actually perform my duties in a culturally respectful manner and how to engage with the community. Aunty Judy is not my relative, however I call her "Aunty" because she is a respected elder.

89. When I was a qualified A&TSIHW, I remember teaching other A&TSIHWs never to take a nurse into a community member's home without first going to the community member and asking whether it was okay to bring the nurse in to assist with the person's care. If the client said no, I would go back to the nurse who was waiting in my car, get advice about what I needed to do, and then go into the client's house alone to deliver their primary health care.

90. I remember teaching other trainee A&TSIHWs and trainee nurses that they would see things in the community that would not accord with their values and beliefs, but they could not judge the community, or else they would lose the engagement and respect of the community and would not be welcomed back into the community.

91. A&TSIHWs and A&TSIHPs may also undertake training in phlebotomy (blood collection), complex wound management, foot assessment, diabetes management, brief interventions such as suicide, smoking, drug and alcohol, social and emotional wellbeing and intergenerational trauma.

The A&TSIHW and A&TSIHP workforce

92. In around 2018, NATSIHWA released a Policy Position Statement regarding the importance of A&TSIHWs and A&TSIHPs in Australia's health system. On page 2 of this Policy Position Statement, which appears behind **Tab 36** of Exhibit KB-1, there are a number of statistics regarding the size and location of the A&TSIHW and A&TSIHP workforce.

93. As at 31 May 2019, NATSIHWA had 875 full members, 69 student members (who fall within the associate member category), 623 associate members and 335 friends.

94. It is extremely difficult to accurately assess the number of A&TSIHWs and A&TSIHPs practicing in Australia, because:

(a) in relation to A&TSIHWs, there is no single body that governs or regulates them; and

(b) A&TSIHWs and A&TSIHPs work across a number of different contexts (such as ACCHOs, private practice and hospitals) and locations around Australia including remote regional locations.

95. NATSIHWA has undertaken a number of searches and enquiries in an attempt to ascertain the current scope of the A&TSIHW and A&TSIHP workforce. I set out the information that NATSIHWA has located below.

A&TSIHWs and A&TSIHPs in private practice

96. Based on my experience, I am aware that there are some A&TSIHWs or A&TSIHPs working in private practice, however they are limited in numbers.

97. I am aware that NATSIHWA has received contact from a couple of A&TSIHWs in around 2018 or 2019 who were working in private practice in Cairns.

98. In addition, I have had a discussion with an A&TSIHW called Heyse who had been working in private practice on the Gold Coast for approximately 2 years. However, she told me that because there was no award, there was no career pathway or ability for her to progress to another level.

99. In around March 2019, NATSIHWA was contacted by Dr Stephanie Trust, an Aboriginal General Practitioner working in Kununurra in Western Australia, who wanted to employ an A&TSIHW to work in her practice, however she did not know what rates to pay the A&TSIHW.

100. Based on my experience and observations, it was highly unusual for an A&TSIHW or A&TSIHP to be employed in private practice prior to 2010.

101. In around May 2010, following a Medicare Benefits Scheme (**MBS**) review of Medicare primary care items, Medicare introduced the MBS health assessment item 715. This item applies to adult health checks for A&TSI people. The Medicare Health Assessment for A&TSI People (MBS Item 715) fact sheet dated October 2013 appears behind **Tab 37** of Exhibit KB-1.

102. There are currently 7 Medicare items relevant to A&TSI primary health care. Of the 7 items, A&TSIHPs can claim all 7 items, while A&TSIHWs are only able to claim 3 items.

103. In around 2018, the MBS commenced another review into the MBS primary health care items. Subsequently in 2018, the A&TSI Health Reference Group of the Medicare Benefits Schedule Review Taskforce issued their report in relation to this review. This report appears behind **Tab 38** of Exhibit KB-1.

104. Behind **Tab 39** of Exhibit KB-1 is a summary of the A&TSI Health Reference Group's recommendations that I prepared for a presentation that I gave on 29 May 2019.

105. A key recommendation of the A&TSI Health Reference Group was to allow A&TSIHWs to claim all 7 MBS items. If this recommendation is approved following the closure of public consultations on 7 June 2019, this will create more revenue for practices employing A&TSIHWs. On this basis, I anticipate that this will encourage private practices to employ more A&TSIHWs, which will result in more favourable health outcomes for A&TSI people.

<u>A&TSIHPBA Reporting for A&TSIHPs</u>

106. Since around September 2012, A&TSIHPBA has published quarterly data profiling the A&TSIHP workforce. The:

(a) A&TSIHPBA reports for September 2012 and December 2012 appears behind **Tab 40** of Exhibit KB-1;

(b) A&TSIHPBA reports for 2013 appears behind **Tab 41** of Exhibit KB-1;

(c) A&TSIHPBA reports for 2014 appears behind **Tab 42** of Exhibit KB-1;

(d) A&TSIHPBA reports for 2015 appears behind **Tab 43** of Exhibit KB-1;

(e) A&TSIHPBA reports for 2016 appears behind **Tab 44** of Exhibit KB-1;

(f) A&TSIHPBA reports for 2017 appears behind **Tab 45** of Exhibit KB-1;

(g) A&TSIHPBA reports for 2018 appears behind **Tab 46** of Exhibit KB-1; and

(h) A&TSIHPBA report for January-March 2019 appears behind **Tab 47** of Exhibit KB-1.

<u>Freedom of information requests</u>

107. On 20 July 2018, on my instruction, Kennedys (Australasia), solicitors for NATSIHWA (**Kennedys**) issued a Freedom of Information request to the Department for Health and Wellbeing in South Australia. The:

(a) Freedom of Information request from Kennedys to the Department for Health and Wellbeing dated 20 July 2018 appears behind **Tab 48** of Exhibit KB-1; and

(b) response from the Department of Health and Wellbeing dated 5 September 2018 appears behind **Tab 49** of Exhibit KB-1.

108. On 20 July 2018, on my instruction, Kennedys issued a Freedom of Information request to the Department of Health and Human Services in Tasmania. The:

(a) Freedom of Information request from Kennedys to the Department of Health and Human Services in Tasmania dated 20 July 2018 appears behind **Tab 50** of Exhibit KB-1; and

(b) Right to Information Decision from the Department of Health in Tasmania dated 24 September 2018 appears behind **Tab 51** of Exhibit KB-1.

109. On 24 July 2018, on my instruction, Kennedys issued a Freedom of Information request to the Australian Bureau of Statistics. The:

(a) Freedom of Information request from Kennedys to the Australian Bureau of Statistics dated 24 July 2018 appears behind **Tab 52** of Exhibit KB-1;

(b) email from Jarred Synnott, FOI Contact Officer of the Australian Bureau of Statistics, dated 2 August 2018 appears behind **Tab 53** of Exhibit KB-1; and

(c) letter from the Australian Bureau of Statistics dated 24 August 2018 appears behind **Tab 54** of Exhibit KB-1.

110. On 25 July 2018, on my instruction, Kennedys issued a Freedom of Information request to the Australian Government Department of Health. The:

(a) Freedom of Information request from Kennedys to the Australian Government Department of Health dated 25 July 2018 appears behind **Tab 55** of Exhibit KB-1; and

(b) email from Casey Parsons, Legal Advice & Legislation Branch of the Australian Government Department of Health dated 17 August 2018 appears behind **Tab 56** of Exhibit KB-1.

111. On 8 August 2018, on my instruction, Kennedys issued a Freedom of Information request to the Department of Health, Strategy & Governance Division, in Western Australia. The:

(a) Freedom of Information request from Kennedys to the Department of Health, Strategy & Governance Division, dated 8 August 2018 appears behind **Tab 57** of Exhibit KB-1; and

(b) response from the Department of Health, Strategy & Governance Division dated 3 September 2018 appears behind **Tab 58** of Exhibit KB-1.

112. On 26 August 2018, on my instruction, Kennedys issued a Freedom of Information request to AHPRA. The:

(a) Freedom of Information request from Kennedys to AHPRA dated 26 August 2018 appears behind **Tab 59** of Exhibit KB-1; and

(b) response from AHPRA dated 31 August 2018 appears behind **Tab 60** of Exhibit KB-1.

113. On 6 September 2018, on my instruction, Kennedys issued a Freedom of Information request to the Northern Territory Department of Health. The:

(a) Freedom of Information request from Kennedys to the Northern Territory Department of Health dated 6 September 2018 appears behind **Tab 61** of Exhibit KB-1; and

(b) email response from Tracey Rubery, Information and Privacy Manager, Legal Services for the Northern Territory Department of Health dated 8 February 2019 appears behind **Tab 62** of Exhibit KB-1.

114. On 6 September 2018, on my instruction, Kennedys issued a Freedom of Information request to ACT Health. The:

(a) Freedom of Information request from Kennedys to ACT Health dated 6 September 2018 appears behind **Tab 63** of Exhibit KB-1; and

(b) response from ACT Health dated 28 September 2018 appears behind **Tab 64** of Exhibit KB-1.

115. On 17 September 2018, on my instruction, Kennedys issued a Freedom of Information request to the Department of Health and Human Services in Victoria. The:

(a) Freedom of Information request from Kennedys to the Department of Health and Human Services dated 17 September 2018 appears behind **Tab 65** of Exhibit KB-1; and

(b) response from the Department of Health and Human Services dated 16 November 2018 appears behind **Tab 66** of Exhibit KB-1.

116. On 17 September 2018, on my instruction, Kennedys issued a Freedom of Information request to the Queensland Department of Health. The:

(a) Freedom of Information request from Kennedys to the Queensland Department of Health dated 17 September 2018 appears behind **Tab 67** of Exhibit KB-1; and

(b) response from the Queensland Department of Health dated 9 November 2018 appears behind **Tab 68** of Exhibit KB-1.

117. On 26 September 2018, on my instruction, Kennedys issued a Freedom of Information request to the New South Wales Ministry of Health. The:

(a) Freedom of Information request from Kennedys to the New South Wales Ministry of Health dated 26 September 2018 appears behind **Tab 69** of Exhibit KB-1; and

(b) response from the New South Wales Ministry of Health dated 3 December 2018 appears behind **Tab 70** of Exhibit KB-1.

Secondary sources

118. On 20 January 2011, Health Workforce Australia released a report titled *"Aboriginal & Torres Strait Islander Health Worker Project Environmental Scan: Version 7.0 - FINAL"* (**Environmental Scan Report**). Among other things, the Environmental Scan Report conducted an analysis of the distribution and demographics of the A&TSIHW workforce as at around January 2011. The Environmental Scan Report appears behind **Tab 71** of Exhibit KB-1.

119. In December 2011, Health Workforce Australia released a report titled *"Growing our Future: Final Report of the Aboriginal and Torres Strait Islander Health Worker Project"*. The report appears behind **Tab 72** of Exhibit KB-1.

120. In around July 2014, Health Workforce Australia released a further report titled *"Australia's Health Workforce Series: Aboriginal and Torres Strait Islander Health Workers/ Practitioners in focus"*. The report appears behind **Tab 73** of Exhibit KB-1.

121. On 10 July 2018, the Australian Government Australian Institute of Health and Welfare released a report titled *"Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results 2016-17"* (**2016-17 Online Services Report**). The report appears behind **Tab 74** of Exhibit KB-1.

122. On 28 January 2019, the Australian and New Zealand Journal of Public Health published an article titled *"A national profile of Aboriginal and Torres Strait*

Islander Health Workers, 2006-2016" that I co-authored with Alyson Wright and Dr Ray Lovett. The article appears behind **Tab 75** of Exhibit KB-1.

Closing the Gap and A&TSIHWs and A&TSIHPs

123. In 2008, the Australian Government committed to six *Closing the Gap* targets, which included a target to close the gap between Indigenous and non-Indigenous life expectancy within a generation (by 2031) (**Closing the Gap Initiative**).

124. There are a number of cultural factors (outlined in paragraphs **52** to **60** above) which can prevent A&TSI persons from accessing and/or participating effectively in Australia's health care system. By helping to bridge the cultural divide between A&TSI clients and health care providers, A&TSIHWs and A&TSIHPs help overcome the difficulties caused by these cultural differences.

125. In the National A&TSI Health Workforce Strategic Framework 2016-2023, the A&TSI Health Workforce Working Group acknowledged that the A&TSIHWs and A&TSIHPs play a key role towards closing the gap between Indigenous and non-Indigenous health outcomes in a number of respects. The National A&TSI Health Workforce Strategic Framework 2016-2023 appears behind **Tab 76** of Exhibit KB-1.

126. On 21 March 2019, the Lowitja Institute for the Close the Gap Steering Committee released the *"Our Choices Our Voices: Close the Gap"* report. In that report, the Lowitja Institute for the Close the Gap Steering Committee identified the growth of the A&TSIHW and A&TSIHP workforce as an essential step to enable Australia to close the gap between Indigenous and non-Indigenous health outcomes (page 13). The report appears behind **Tab 77** of Exhibit KB-1.

127. In "The Northern Territory Intervention – An Evaluation, Health and Life Expectancy", the Castan Centre for Human Rights at Monash University found that it would take 495 years to close the current life expectancy gap, or 27 generations (based on 18 years per generation).

NATSIHWA's proposed changes to the Award

(1) Coverage

128. In its application for substantive variations to the Award, most recently articulated in the Amended Draft Determination dated 1 June 2017 (**Amended Draft Determination**), NATSIHWA seeks to vary the coverage of the Award from an industry award (covering employers and employees in the Aboriginal community controlled health services industry) to an industry and occupation award (covering employers and employees in the

Aboriginal community controlled health services industry, and employees engaged as an A&TSIHW or A&TSIHP).

Necessity for expansion to coverage

(i) *Minimum safety net of conditions for A&TSIHWs and A&TSIHPs in private practice*

129. It is an essential characteristic of the A&TSIHW and A&TSIHP's role that they identify as A&TSI. Further, the role performed by an A&TSIHW and A&TSIHP is directly aimed at providing primary health care in the A&TSI context (see, for example, paragraphs **65, 69, 72, 75, 79, 82** and **85** above). The Indigenous characteristics of the A&TSIHW and A&TSIHP roles are unique to these roles, and are not found in the roles of any other health professionals (such as those that fall under the *Health Professional Support Services Award 2010*).

130. Since the commencement of the Closing the Gap Initiative in 2008, in the decade since the creation of the Award, a large body of research and publications has been developed about the role of the A&TSIHWs and A&TSIHPs and their importance for closing the gap in relation to Indigenous health outcomes.
For example, please refer to **Tabs 71-77 and 78.**

131. As a result of this increased awareness and understanding, the social and political environment surrounding the employment of A&TSIHWs and A&TSIHPs has undergone a substantial shift.

132. 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 covered 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 ACCHOs.

133. The lack of applicable award for A&TSIHWs and A&TSIHPs working in private practice has resulted in uncertainty and, at times, confusion regarding the applicable pay rate for A&TSIHWs and A&TSIHPs. For example, I refer to paragraph **99** above in relation to Dr Stephanie Trust.

134. 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 ACCHOs, such as ceremonial leave (clause 30 of the Award) and bilingual qualification allowance (clause 15.1 of the Award).

135. 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 that are available to A&TSIHWs and A&TSIHPs working in ACCHOs.

136. By reason of paragraphs **129** to **134** above, it is necessary to expand coverage of the Award to ensure that A&TSIHWs and A&TSIHPs in private practice are subject to a minimum safety net of terms and conditions, and to Indigenous-specific conditions that are highly relevant to their workforce.

(ii) Certainty about the role of A&TSIHWs and A&TSIHPs

137. In addition, 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 outlined in paragraphs **49** to **51**, COAG is in the process of implementing a national scope of practice for all A&TSIHWs and A&TSIHPs across Australia. However, until this national scope of practice is implemented, there will remain uncertainty for some A&TSIHWs, A&TSIHPs and their employers regarding the scope of the role and the work that they should be able to perform in that role. For example, please refer to pages 75 to 85 of the Environmental Scan Report (**Tab 71**).

138. If the Award is expanded to cover all A&TSIHWs and A&TSIHPs in the federal jurisdiction, rather than only those employed in ACCHOs, 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.

(iii) Need to grow the A&TSIHW and A&TSIHP workforce

139. By reason of the matters outlined in paragraphs **123** to **126** above, it is necessary to grow the A&TSIHW and A&TSIHP workforce in order to close the gap for Indigenous health outcomes.

140. In addition, for the reasons which follow, there is a need to grow the A&TSIHW and A&TSIHP workforce in non-remote areas and in private practice, to ensure that A&TSI people can access culturally safe health care in those areas.

141. On 25 March 2019, the Medical Journal of Australia published an article titled *"Cultural respect in general practice: a cluster randomised controlled trial"*, which appears behind **Tab 78** of Exhibit KB-1. In this article the authors stated, amongst other things, that:

(a) there are only 16 out of 138 ACCHOs located in major cities;

(b) urban ACCHOs have lower staff/client rations than regional and remote ACCHOs; and

(c) most Indigenous Australians living in urban areas also use standard primary care and GP services, in addition to ACCHOs.

142. In 2011, Health Workforce Australia found that availability of health services did not equate to increased access to health services, because A&TSI clients

had lower access to health services in non-remote areas (see Environmental Scan Report pages 3-4, **Tab 71**).

143. On one occasion when I was working as an A&TSIHW, an A&TSI client walked 2 kilometres past a hospital to see me in order to see whether he needed stitches for a cut on his arm. When he came to me and lifted his hand to show me the wound, blood started spurting from the wound. This client's trust in me as his A&TSIHW (and conversely, the lack of A&TSIHW at the local hospital) meant that he sought me out in preference to the hospital, despite his clear need for urgent medical attention.

144. In around April 2019, I attended a conference where Neil Willmett, CEO of Queensland Aboriginal and Islander Health Council, showed a map showing that A&TSI people often drove past multiple mainstream medical providers in order to attend an AMS, due to the lack of A&TSIHW or A&TSIHP at the mainstream medical providers. This accords with my own experience and my understanding of the need for A&TSI people to access health in a culturally safe environment.

145. We have been unable to ascertain clearly how many A&TSIHWs and A&TSIHPs are currently employed in private practice, however as outlined at paragraphs **96** to **99** above, based on my experience I am aware that there are some A&TSIHWs and A&TSIHPs working in private practice.

146. In addition, on around 3 September 2017, the Hunter New England and Central Coast Primary Health Network (HNECC PHN) published a video on YouTube titled *"PHN Aboriginal Health Workers course"*. A copy of this video can be accessed at https://www.youtube.com/watch?v=RUSXK-ZeMZ0. In this video, Toni Manton of the Primary Health Network stated *"our data has indicated that there are a lot of people that access community controlled sector, but there is also the majority of Aboriginal people that access mainstream general practice. So the way to combat that to ensure cultural safety within those practices is to place Aboriginal people in those practices"*.

147. Regardless of the specific number of A&TSIHWs and A&TSIHPs currently employed in private practice, by reason of paragraphs **139** to **146** above, it is necessary to increase the number of A&TSIHWs and A&TSIHPs working in private practice to ensure that A&TSI persons have access to culturally safe medical services, even in the absence of a nearby ACCHO.

148. Increasing coverage of the Award to include A&TSIHWs and A&TSIHPs in private practice will provide A&TSIHWs and A&TSIHPs in private practice with:

(a) a minimum safety net of terms and conditions;

(b) greater certainty about their role; and

(c) more job opportunities, as it will create transferability between roles in ACCHOs and private practice.

Given these factors, increasing coverage of the Award to include A&TSIHWs and A&TSIHPs in private practice is likely to increase the number of people in the A&TSIHW and A&TSIHP workforce, particularly in private practice. This increased workforce participation will promote social inclusion.

(iv) Other matters

149. Based on my experience, increased access to A&TSIHWs and A&TSIHPs will mean that A&TSI clients can have their health needs addressed at a primary level (such as by early prevention or intervention) rather than at a tertiary or acute level. As a result, if the number of A&TSIHWs and A&TSIHPs grows, then it is likely that the number of A&TSI people getting acutely sick will diminish. This will cause a substantial personal benefit to A&TSI families and communities, and will also benefit the national economy by reducing the cost of acute health intervention for A&TSI people.

(2) Classification structure

150. In its application for substantive variations to the Award, most recently articulated in the Amended Draft Determination, NATSIHWA seeks certain variations to the classification structure (**Varied Classification Structure**).

Necessity for changes to the classification structure

(i) Grade 1 and 2

151. The Varied Classification Structure splits the existing Grade 1 classification into two trainee grades, being Grade 1 and Grade 2.

152. There is no change to the wages for Grade 1 and Grade 2 under the Varied Classification Structure from the existing Grade 1 wages.

153. The Varied Classification Structure provides for employers to assist Grade 1 A&TSIHWs in obtaining a Certificate II in A&TSI Primary Health Care.

154. Further, the Varied Classification Structure provides recognition for employees that have already obtained a Certificate II in A&TSI Primary Health Care (Grade 2). The existing Award does not recognise the Certificate II qualification.

155. As outlined above, although it is not mandatory in most organisations 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.

(ii) *Grade 3*

156. Grade 3 in the Varied Classification Structure is equivalent to Grade 2 under the current Award. Accordingly, there is no change to the wages for this classification.

(iii) *Grade 4*

157. An Advanced Health Worker – Care (Grade 4) in the Varied Classification Structure is equivalent to an existing Grade 3 classification under the current Award. Therefore, there is no change to the wages for this classification.

(iv) *Grade 5*

158. Senior Health Workers – Care (Grade 5 in the Varied Classification Structure) are equivalent to a Grade 4 classification under the current Award. Therefore, there is no change to the wages for this classification.

159. However, under the Varied Classification Structure, the classifications of Advanced Health Worker – Practice and Health Practitioners have been uplifted from Grade 3 to Grade 5, and their wages have been increased accordingly.

160. Under the Varied Classification Structure proposed by NATSIHWA, Advanced Health Worker – Practice and Health Practitioners are required to hold a Certificate IV in A&TSI Primary Health Care (Practice). Employees working in these classifications are required to be registered with the A&TSIHPBA in order to practice.

161. As outlined in paragraphs **35** to **44** above, the requirement for A&TSIHPs to be registered and accredited commenced on 1 July 2012, after the creation of the Award. This was a significant development because it dramatically altered the way that A&TSIHPs practice, and it clearly delineated the distinction between A&TSIHPs and A&TSIHWs.

162. Since 1 July 2012, A&TSIHPs have been subjected to increased oversight and accountability by reason of the need for A&TSIHPs to demonstrate on an annual basis that they meet the requirements for registration, in order to renew their registration with A&TSIHPBA.

163. In addition, A&TSIHPBA has powers in relation to the investigation and handling of any notifications made against A&TSIHPs. There is no equivalent regime for the oversight and monitoring of A&TSIHWs.

164. 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.

165. As a result of the increased accountability and scrutiny on A&TSIHPs, protections have been put in place to prevent A&TSI communities from receiving substandard health advice or advice provided by persons who are not suitably qualified to practice as an A&TSIHP.

166. In addition, the ability for A&TSIHPs to supply and administer medication in remote areas (Northern Territory and Western Australia) and isolated areas (Queensland) (see paragraphs **45** to **48** above) 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 (see, for example, the Unique Profession Video linked in paragraph **29** above).

167. 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 (refer to the report that I co-authored with Alyson Wright and Dr Ray Lovett, behind **Tab 75**). As a result, there is a greater volume of work for existing A&TSIHWs and A&TSIHPs, causing increased stress on these workers.

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

169. On around 4 May 2018, the International Journal of Environmental Research and Public Health published an article by Genevieve Lai, Emma Taylor, Margaret Haigh and Sandra Thompson titled *"Factors affecting the retention of Indigenous Australians in the health workforce: a systematic review"*. The article appears behind **Tab 79** of Exhibit KB-1.

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

A&TSIHWs and A&TSIHPs if there is going to be a chance to achieve significant improvements in A&TSI health outcomes.

171. By uplifting the classification for Advanced Health Worker – Practice and Health Practitioners to Grade 5:

   (a) 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;

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

   (c) this increased workforce participation will promote social inclusion for more A&TSI people, thereby increasing the ability for A&TSI people to access health care; and

   (d) this will benefit the national economy by reducing the costs incurred as a result of A&TSI people suffering acute medical issues.

(v) Grade 6

172. Grade 6 in the Varied Classification Structure is a new classification.

173. This classification is necessary to recognise the Advanced Diploma of A&TSI Primary Health Care (Care), which is not currently recognised under the Award, as well as the Diploma of A&TSI Primary Health Care (Care) which is currently recognised under Grade 4 of the Award.

(3) Progression

174. In its application for substantive variations to the Award, most recently articulated in the Amended Draft Determination, NATSIHWA seeks the insertion of a clause:

   (a) providing a mechanism for employees to progress through the different classifications (**Progression Clause**);

   (b) recognising employees' service with previous employers, for the purpose of career progression (**Recognition of Previous Service Clause**); and

   (c) permitting employers to require an employee to provide documentary evidence of qualifications and experience (**Evidence of Qualifications Clause**).

<u>Necessity for changes</u>

175. A&TSIHWs and A&TSIHPs that currently fall outside the coverage of the Award and are in private practice do not have any clear career structure or means for career progression.

176. Even if the Award is amended to provide coverage for A&TSIHWs and A&TSIHPs working outside ACCHOs, the current Award fails to provide any mechanism for A&TSIHWs and A&TSIHPs to progress through different classifications based on the attainment of years' experience and/or appropriate skills.

177. Further, the current Award does not provide any mechanism for employers to recognise an employee's experience obtained with a previous employer.

178. 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:

(a) encourage A&TSIHWs and A&TSIHPs to pursue a higher level of skills and/or qualifications in order to progress through the classification levels, thereby strengthening the profession;

(b) if A&TSIHWs and A&TSIHPs hold the necessary qualifications, ensuring that their previous experience is taken into account when transferring to another role, thereby increasing the prospect that the profession will retain current A&TSIHWs and A&TSIHPs; and

(c) increasing 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 ACCHOs or in private practice, thereby creating an incentive for A&TSI persons to enter the A&TSIHW and A&TSIHP workforce.

179. For the reasons referred to in paragraph **178**, inserting the Progression Clause and the Recognition of Prior Service will increase participation in the A&TSIHW and A&TSIHP workforce. Therefore, these amendments will also help close the gap between Indigenous and non-Indigenous health outcomes (refer to paragraphs **123** to **126** above).

180. 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 purpose of the Recognition of Previous Service Clause.

(4) Allowances

181. In its application for substantive variations to the Award, most recently articulated in the Amended Draft Determination, NATSIHWA seeks the insertion of the following allowances:

(a) an occasional interpreting allowance;

(b) a heat allowance;

(c) an isolation allowance;

(d) a medication administration allowance;

(e) a damaged clothing allowance;

(f) a blood check allowance;

(g) a telephone allowance; and

(h) a nauseous work allowance.

(i) Occasional interpreting allowance

182. 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.

183. A large number of primary health care providers are located in regional, remote or very remote areas (see, for example, pages 22-23 of the 2016-17 Online Services Report **(Tab 74)** in relation to Department of Health-funded Indigenous primary healthcare services).

184. 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.

185. 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 purpose of obtaining medical treatment.

186. 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.

187. Not all A&TSIHWs and A&TSIHPs need to provide this occasional interpreting assistance as part of their role, as many A&TSI clients have sufficient familiarity with the English language to proceed without any interpretation. Therefore, these responsibilities or skills provided by some A&TSIHWs and A&TSIHPs are not accounted for in the minimum wages in the Award.

188. By removing communication barriers to A&TSI people accessing primary health care, A&TSIHWs and A&TSIHPs who undertake occasional interpreting duties increase the likelihood that an A&TSI client will receive treatment at a

primary preventative (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.

(ii) *Heat allowance*

189. Page 22 of the 2016-17 Online Services Report (**Tab 74**) provides a pictorial representation of the location of the Department of Health-funded primary healthcare providers in 2016-17. This map demonstrates that a large number of the Department of Health-funded primary healthcare providers were located in very remote areas of central, northern and western Australia.

190. NATSIHWA has been unable to locate a pictorial representation of the locations where all A&TSIHWs and A&TSIHPs work across Australia (as opposed to only Department of Health-funded organisations). As a result, the map referred to in paragraph **189** above is the best pictorial representation we have been able to locate showing where at least some A&TSIHWs and A&TSIHPs work.

191. The Australian Government Bureau of Meteorology (**BOM**) publishes maps of Australia showing the highest maximum temperature recorded in any given month, and the mean maximum temperature recorded in any given month.

192. A copy of the BOM maps showing the monthly highest maximum temperature for Australia for each of the Summer months since January 2010 (**Highest Maximum Maps**) appears behind **Tab 80** of Exhibit KB-1.

193. The BOM maps showing the monthly mean maximum temperature for Australia for each of the Summer months since January 2010 (**Mean Maximum Maps**) appears behind **Tab 81** of Exhibit KB-1.

194. Very few of the Mean Maximum Maps contain "dark brown" areas (representing 45°C and above), whereas far more of the Highest Maximum Maps contain areas designated "dark brown" (45°C and above).

195. This indicates that, although persons working in those designated areas do experience temperatures of 45°C and above, these temperatures are not experienced by all A&TSIHWs and A&TSIHPs working across the country.

196. In these circumstances, work conditions requiring A&TSIHWs and A&TSIHPs to work between 46°C and 54°C are currently not accounted for in the standard wages under the Award.

(iii) *Isolation allowance*

197. Pages 91 to 97 of the Environmental Scan Report (**Tab 71**) provides the number of A&TSIHWs that were working in regional, remote and very remote areas of each state in 2001 and 2006.

198. Page 42 of the 2016-17 Online Services Report (**Tab 74**) provides the proportion of A&TSI health workers that were working in Department of Health-funded primary health care providers located in regional, remote and very remote areas in 2016-17.

199. As demonstrated by these graphs, there are a number of A&TSIHWs and A&TSIHPs located in rural, remote or very remote areas, or who are required to travel to remote or very remote areas (such as remote A&TSI communities) in order to provide primary healthcare services to A&TSI people.

200. Based on my experience, the remoteness of their location has practical ramifications for the performance of an A&TSIHW or A&TSIHP's duties. For example, their remoteness (and the associated small population in their location) may mean that there are fewer other health professionals in the area to provide support and assistance to the A&TSIHW or A&TSIHP and, therefore, the A&TSIHW or A&TSIHP may need to take on more responsibility or higher duties than otherwise might have been the case.

201. For example, an A&TSI woman may be giving birth "out bush", or in a remote A&TSI community. Due to their location, there may only be one A&TSIHW or A&TSIHP in the area who can provide assistance to the woman as she gives birth. This can result in greater stress, responsibility and skill requirements being placed on the A&TSIHW or A&TSIHP while they assist the woman in labour, receiving instructions from a doctor over the telephone.

202. Another disadvantage for A&TSIHWs and A&TSIHPs working in isolation is that they have fewer access to training opportunities from elders, who provide invaluable training on the ground.

203. These difficulties and disadvantages are experienced because of the remoteness of the A&TSIHW's and A&TSIHP's location of work.

(iv) Medication administration allowance

204. As outlined in paragraphs **45** to **48** above, 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 state legislation.

205. 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.

(v) Damaged clothing allowance

206. In my experience, sometimes in the course of performing their duties, A&TSIHWs and A&TSIHPs may suffer damage or dirtying of their clothing. For example, 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.

207. Not all A&TSIHWs and A&TSIHPs experience damage or dirtying of their clothing in the course of performing their duties. For example, an A&TSIHW performing an educational function is less likely to suffer damage to their clothing than an A&TSIHW or A&TSIHP that is assisting an intoxicated client.

(vi) Blood check allowance

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

(vii) Telephone allowance

209. In my experience, A&TSIHWs or A&TSIHPs working in more remote communities are more likely to be required to be first on call. For example, I am aware that some remote clinics in Aurukun require A&TSIHWs and A&TSIHPs to be on call to perform their duties, and require those workers to keep a telephone for the purpose of being on call.

(viii) Nauseous work allowance

210. Based on my experience, A&TSIHWs and A&TSIHPs may sometimes have to handle linen of a nauseous nature in the course of performing their duties, such as if 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.

211. Given that these responsibilities are not a routine component of an A&TSIHW or A&TSIHP's role, these responsibilities are currently not taken into account in the rates of pay under the Award.

(5) Amended Ceremonial Leave clause

212. In its application for substantive variations to the Award, most recently articulated in the Amended Draft Determination, NATSIHWA seeks that the ceremonial leave clause be extended to expressly include bereavement related ceremonies and obligations.

(i) Cultural background to the amendment

213. I recall early in my career as an A&TSIHW a work colleague of mine had received some sad news from the Torres Strait where he had been named after someone who had just passed away. The manager at the time did not understand the significance of this, let alone the cultural obligations that the worker was required to undertake in attending the funeral. Ever since that

incident I have found myself advocating for bereavement leave that includes extended family members.

214. People of A&TSI heritage hold very strong cultural views about death and dying, and the necessary steps that need to be taken after a person has died to ensure peaceful rest for the deceased in the afterlife.

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

216. 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.

217. The specific beliefs and ceremonies associated with Sorry Business vary from language group to language group.

218. 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.

219. 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".

220. For me, my cousins are my brothers and sisters, and my aunties and uncles are my mothers and fathers. For this reason, my extended family is as important to me as my immediate family.

221. Therefore, A&TSIHWs and A&TSIHPs may be required to participate in bereavement ceremonies for a member of their community by reason of the broader notion of kinship, even though they may not strictly be classified as a family member of the deceased within the meaning of the *Fair Work Act 2009* (Cth).

(ii) Necessity of amendment to the Award

222. A&TSI people have a higher mortality rate than non-Indigenous persons (see, for example, the Health Status Report at **Tab 25**). Therefore, there are a higher number of A&TSI deaths, and associated funerals and bereavement ceremonies for A&TSI people to attend to.

223. In addition, given the extended notion of "kinship" (referred to above), 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.

224. The Fair Work Ombudsman has prepared a guide called *"Supporting workers during Sorry Business"*, which appears behind **Tab 82** of Exhibit KB-1. This is indicative of the importance of bereavement ceremonial obligations for A&TSI employees, and a need to provide clarity to employers around their employment obligations at these times.

225. Given that the A&TSIHW and A&TSIHP workforce is by definition of A&TSI ethnicity, and every worker is therefore likely to experience bereavement ceremony obligations at some time in their working career, it is particularly relevant to the A&TSIHW and A&TSIHP workforce to provide clarity about employers' obligations in relation to bereavement ceremonies.

226. By amending the existing ceremonial leave clause to expressly cover bereavement ceremonies, the Fair Work Commission will reduce an area of confusion and uncertainty under the current Award.

Additional materials

227. On 9 July 2018, the Australian Broadcasting Corporation published an article titled *"Health workers go to extreme lengths to track down Indigenous patients in outback Queensland"*. This article appears behind **Tab 83** of Exhibit KB-1.

228. On 10 June 2019, the Sydney Morning Herald published an article titled *"Ken Wyatt promises new approach to Indigenous health to close the gap"*. This article appears behind **Tab 84** of Exhibit KB-1.

229. On 12 July 2018, the Australian Bureau of Statistics published an edition of the *"2071.0 Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016"* titled *"Small Towns"*. This publication appears behind **Tab 85** of Exhibit KB-1.

Industry support

230. On 7 June 2019, I received a letter from Anita Mills, Chief Executive Officer of the Australian Indigenous Doctors' Association (ABN 84 131 668 936) (**AIDA**) confirming that AIDA supports the changes to the Award sought by NATSIHWA. The letter appears behind **Tab 86** of Exhibit KB-1.

231. On 18 June 2019, I received a letter from Patricia Turner, Chief Executive Officer of the National Aboriginal Community Controlled Health Organisation (**NACCHO**), confirming that NACCHO supports NATSIHWA's application to the Fair Work Commission. The letter appears behind **Tab 87** of Exhibit KB-1.

on (date) ...18/06/2019...

Signature of **KARL JOHN BRISCOE**

Before me:

18·6·19

Signature of witness

Full name of witness: ...Alicia Hatzismalis...

Qualification of witness: ...Justice of the Peace Northern Territory Ph: (08) 8999 6380...