

Charlatan Training: How Aboriginal Health Workers Are Being Short-changed

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- Helen Hughes, *Lands of Shame: Aboriginal and Torres Strait Islander 'Homelands' in Transition* (June 2007).

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHOS	Aboriginal Community Controlled Health Organisations
AHPRA	Australian Health Practitioner Regulation Agency
AHW	Aboriginal Health Workers
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Service Alliance Northern Territory
ATSIHRTONN	Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network
CS&HISC	Community Services and Health Industry Skill Council
IISC	Industry and Indigenous Skills Centre
IAD	Institute for Aboriginal Development
NCVER	National Centre for Vocational Education Research
RTO	Registered Training Organisation
VET	Vocational Education and Training

Executive Summary

Aboriginal Health Workers (AHWs) have been short-changed. They have not only been provided with charlatan training but also sold a charlatan role. The amount of training they receive does not match the level of responsibility expected of them, and there are few opportunities for promotion within the profession. Overall, AHWs receive the lowest pay among community service and health workers, but are assumed to be able to deal with some of the country's most intractable health problems.

The AHW role was created in the 1970s in the Northern Territory to enable the mostly illiterate Indigenous population to provide health services to their communities. The role was designed as a 'bridge' between traditional medicine and Western medicine, and the primary responsibility of the AHWs was to act as cultural brokers. However, ongoing ambivalence about the need for English literacy and Western education, in favour of community control and culturally appropriate approaches, has led to AHWs having the least educational preparation of any group of primary health care workers in the world.

At the same time, the tasks and responsibilities expected of AHWs have increased since the role was created. A clear definition of the AHW role and functions is an essential prerequisite for the effective delivery of training. But government and interest groups are no closer to defining the AHW role than they were 30 to 40 years ago. As a result the numerous attempts to improve training for AHWs have failed.

In addition to the conflicting role descriptions of AHWs across Australia, the number of different Registered Training Organisations (RTOs) delivering health worker training also makes achieving consistency next to impossible. Thirty-six RTOs offer AHW training for approximately 1,000 workers.

RTOs are given financial incentives such as the Supplementary Recurrent Assistance* to get 'bums on seats,' but are not held accountable for inadequate course delivery and poor outcomes. As long as these disparities and lack of accountability continue, it is unlikely that the national registration of AHWs on 1 July 2012 will make a substantive difference to the AHW role or enhance its 'professional' status.

Currently, many AHWs are overburdened with performing the role of 'Jack of all trades' but being 'master of none.' Instead of continuing with a role that from its very beginning had problematic and contradictory objectives, government should consider splitting the AHW role into three different positions.

1. **The clinical aspect of the AHW role**, defined as the Aboriginal and/or Torres Strait Islander Primary Health Practice in the Health Qualifications Framework, correlates with competencies described in enrolled nursing training. The clinical part of the AHW role should be opened up to provide a broader and more widely recognised qualification (such as assistant nursing), which could provide a clear pathway to further studies, such as a degree in nursing. One of the problems with AHW courses is that they only prepare and 'qualify' Aboriginal people to work with and treat Aboriginal people. No doubt some AHWs would like to be involved more broadly in providing health care to the wider community.
2. **The community care aspect of the AHW role**, currently defined as Aboriginal and/or Torres Strait Islander Primary Health Community Care in the Health Qualifications Framework, could be changed to that of a community worker role; training for this position could be covered by the existing Certificate IV in Community Services Work.

* This is a supplementary per capita assistance to eligible non-government Vocational Education and Training (VET) institutions with a minimum of 20 full-time equivalent students.

3. **The cultural brokerage aspect of the AHW role** cannot be transferred to a mainstream position. In communities where English language and literacy remain an issue, it may be necessary to continue to have an Aboriginal person act as a translator for visiting health care providers. This position could be called Aboriginal Liaison Officer and the role extended to cover interpreting for all non-Indigenous visitors to the community. The prerequisites for this position would be fluency in English and the Aboriginal languages spoken by members of the community. However, just speaking the language may not be enough, as being a reliable translator requires particular knowledge and skills, specifically the ability to understand the questions being asked and communicate them to the patient or client.

Rather than pouring more money into a seemingly unfixable problem—AWH qualifications and training—government should invest money in quality literacy and numeracy education for remote Indigenous residents.

The emphasis on greater clinical skills for AHWs has made it virtually impossible for remote Indigenous residents to become health workers. At the same time, the cultural brokerage aspect of the AHW role is not necessarily relevant for urban-based AHWs. Many AHWs living in cities and rural towns lack knowledge and understanding of Indigenous culture but hesitate to admit this because the assumption is, ‘if you are Indigenous you hold Indigenous knowledge.’¹ Aboriginal people living in the southern states have more educational opportunities than their counterparts in remote northern communities, and should be encouraged to take up other health-related occupations that offer better career opportunities and rewards than Aboriginal health work.

The belief that the AHW role is the only health occupation that provides Aboriginal people the opportunity to deliver ‘culturally appropriate’ health care is false. Aboriginal people employed as nurses or doctors do not cease identifying as Aboriginal, evident in the existence of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) and the Australian Indigenous Doctors’ Association (AIDA).²

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) claims there is a crisis in Aboriginal health work because the number of Aboriginal people electing to become AHWs is falling.³ But the future and the opportunity for real self-determination does not lie with the creation of yet more ‘culturally appropriate’ courses and career paths specifically for Aboriginal people but with decent schooling and education that will enable Aboriginal people to become whatever they want to be.

AHWs are expected to take the most responsibility with the least educational preparation of any group of primary health care workers in the world.

Introduction

The 2011–12 federal budget included unprecedented investment in training. Along with investment into a National Workforce Development Fund and mentoring programs for apprentices, the Gillard government is providing an extra \$1.75 billion on top of an existing \$7 billion for reforms to the vocational education and training system.⁴ However, will the government get ‘more bang for its buck,’ or will the extra funding be mismanaged by incompetent Registered Training Organisations (RTOs) on useless courses?

The quality and consistency of training across the various states and territories has been a matter of concern for some time. Legislative changes to establish a national system of regulation for Australia’s Vocational Education and Training (VET) sector were introduced in March 2011 to try and address these inconsistencies.⁵ Problems with the quality of vocational education are even more apparent within Aboriginal-specific courses. Although this policy monograph examines training for Aboriginal Health Workers (AHWs), the problems identified are common to nearly all training specifically for Aboriginal people.⁶

Training for AHWs has been the subject of numerous reviews over the years. A major national review in 2000 identified a number of problems with the role and training of AHWs.⁷ Two recent reports on AHW training—*The Aboriginal and Torres Strait Islander Health Worker Project* and *The Aboriginal Health Worker Profession Review* (Northern Territory)—suggest that many of these longstanding issues remain unresolved.⁸ Despite this, the federal government has committed to ‘national registration and accreditation’ of AHW practitioners on 1 July 2012 under the Australian Health Practitioner Regulation Agency (AHPRA).⁹

This monograph first examines the rationale for having AHWs and questions whether the need for AHWs has changed since the role was established in the 1970s. It investigates some of the current problems in defining the role and the disjuncture between theory (intended aims of AHW courses) and practice (actual outcomes of AHW training).

Next it examines some of the problems in recruiting AHWs. Tightening up the qualification requirements for AHWs has been problematic because many remote Aboriginal people do not have the literacy and numeracy to undertake training. Others are finding that their role as AHWs is not valued and that they are overqualified for the work they are given. A 30% drop in the number of AHWs in the Northern Territory over the last decade has led Aboriginal Medical Services Alliance Northern Territory (AMSANT) to announce the profession is facing a major threat and declare 2011–12 the year of the AHW in an attempt to promote the role’s importance.¹⁰ Like previous research undertaken by the Indigenous Affairs program at The Centre for Independent Studies,¹¹ this monograph examines the unintended consequences of having race-based policies and whether the problems faced by AHWs are symptomatic of this separatism.

Historical background

To understand the various problems in defining the role and the type of training needed for AWHs, it is useful to examine how the role arose and the various agendas that have influenced its development over time.

The role of AHWs goes back to the employment of Aboriginal women as leprosarium workers in the 1950s and medical assistants in NT hospitals in the 1960s.¹² However, the AHW program was not established until 1973 in the Northern Territory.¹³ The role spread to other Australian states in the late 1970s and 1980s.¹⁴

In developing the AHW program, the federal and NT governments drew on overseas examples of medical auxiliaries or primary health workers (also known

as ‘barefoot doctors’) in Africa, Asia and South America. Medical auxiliaries tend to be people who have completed a minimum level of secondary education. Their training is usually based in hospitals or medical schools, and a number of countries have career structures that enable auxiliaries to become health professionals. Primary health workers (also known as village health workers) tend to be selected by their own villages to provide basic primary health care. Many village primary health care workers are unpaid and continue other work such as subsistence farming. Health workers can be further categorised into single- or multipurpose workers—the former are generally non-literate and tend to perform one task such as leprosy control while the latter are generally literate and perform a wider range of duties.¹⁵ The federal and NT governments adopted the multipurpose primary health care model but favoured community selection over English literacy. As a result, AHWs are expected to take the most responsibility with the least educational preparation of any group of primary health care workers in the world.¹⁶

When the AHW program was established in the 1970s, the dominant paradigm for Indigenous policy was ‘self-determination.’[†] Under the Whitlam government, funds were provided for Aboriginal people to establish their own organisations, which included Aboriginal Housing Companies and Aboriginal Medical Services (now known as Aboriginal Community Controlled Health Organisations (ACCHOS)). The government’s hope in developing the AHW program was that Aboriginal people would take responsibility for all primary (or first contact) health care in their communities. To facilitate this, the NT government began a program of withdrawing nursing sisters from the smaller settlements (communities) and encouraging Aboriginal people to consult AHWs before seeing a nurse in the larger settlements.¹⁷

The policy of allowing AHWs to be selected by their own communities aligned with the principle of self-determination but was inconsistent with the notion of self-management. The primary concern in selecting health workers was their maturity and standing in the community, not their education level. As a result, a number of non-literate health workers were employed, particularly in the southern region of the Northern Territory where (at one time) one out of every three health workers was illiterate.¹⁸

This ambivalence about literacy and numeracy was reflected in the training provided to AHWs. Initially, health worker training was given at Darwin Hospital, and there was a career structure that enabled health workers to progress to full professional status as nurses. However, by 1976, the philosophy had shifted to view AHWs as a ‘profession’ in its own right. Aboriginal health work ceased to be a medical auxiliary position and became a primary health worker role. Instead of receiving training in hospitals, AHWs were trained on-site by resident nurses in the various settlements and communities.¹⁹

On-site training proved difficult to coordinate and deliver consistently as it was virtually impossible to ensure that all AHWs received the same (or even adequate) instruction. Generally, nurses did not have the time or resources to deliver functional literacy to AHWs. The NT Department of Health’s belief that literacy was not a prerequisite for employment or for effective performance as a health worker was reflected in the lack of funding and infrastructure provided for educational and literacy programs.²⁰

As literacy programs were not considered mandatory, there was a shortage of resources for adult education. In 1976, a detailed proposal by the Institute for Aboriginal Development (IAD) for an on-site English language and literacy program in selected communities was accepted in principle, but the health department could not fund the \$250,000 per annum the program was expected

The NT government chose to promote AHWs as multipurpose health workers without providing them with the literacy and numeracy training necessary to perform the job.

† There are two views of self-determination. The dominant view in Australia (and articulated in government policy) is one of Aboriginal people providing services for Aboriginal people. The other view is where individuals take responsibility for their own lives.

to cost. Instead, training was delivered at Regional Training Centres three times a year through block courses of one week's duration. Not surprisingly, there is no record of AHWs learning to read and write with this approach. Efforts by the NT health department to engage part-time adult educators through the NT Department of Education repeatedly failed. The education department did not provide adequate training to part-time instructors working in remote communities and turnover rates were notoriously high. Between 1980 and 1982, 16 instructors were employed in six different communities; none stayed longer than six months.²¹

When the NT government established the AHW program, it could have chosen to develop the role as medical auxiliaries (where health workers trained in hospitals and had a clear career structure), or it could have chosen to reduce the role to that of a single-purpose health worker to take into account literacy problems. Instead, the NT government chose to promote AHWs as multipurpose health workers without providing them with the literacy and numeracy training necessary to perform the job. The decision to take this path was heavily influenced by the dominant ideologies at the time—that Aboriginal people should take full responsibility for their own health services. Reducing the role to a single-purpose health worker would have led to non-Aboriginal health professionals taking primary responsibility for the health needs of communities. Prescribing a mandatory level of education for prospective health workers was inconsistent with the view that Aboriginal communities should be responsible for nominating health workers.

Despite AHWs themselves requesting that the AHW program contain a literacy and numeracy component so they could read medicine labels, count pulses, and write medical records, there was a general belief among policymakers that too much Western education risked alienating AHWs from their communities.²²

The poor health of Aboriginal people was considered a political problem, not a technical one; the solution was to provide Aboriginal people with more authority and responsibility, not more training. According to Susan Rifkin, author of *Politics of Barefoot Medicine*, all that was needed for health workers to undertake a wider variety of medical tasks than previously was more responsibility and respect from supervisors and nurses:

Better health is not a question to [sic] training. It is a question of authority and responsibility ... The answer is health care workers who can mobilise their own communities to improve their own health.²³

In 1980, many people in the health field believed the AHW training program stood out as a beacon of hope amid the disease and despair of Aboriginal communities.²⁴ That the program has failed to deliver on its promise stems largely from the lack of attention to literacy and numeracy. Sadly, if the NT government had provided the estimated \$250,000 per annum (\$1,095,873 in 2010²⁵) needed for literacy and numeracy training in the 1970s, maybe AHWs could have been more successful in mobilising their communities towards better health outcomes. The ambivalence towards Western education and literacy—in favour of community control and culturally appropriate approaches—has continued to influence the AHW profession and contribute to its problems.

AHWs and recent government policies

Characteristics

Problems with statistics

The following statistics provide a picture of the characteristics of the AHW workforce; however, there are a number of problems with the data sources. As there is no nationally consistent definition of an AHW, each jurisdiction may include or

The ambivalence towards Western education and literacy—in favour of community control and culturally appropriate approaches—has continued to influence the AHW profession and contribute to its problems.

exclude different types of roles in its health workforce data. The only source of national health worker data is the Australian Bureau of Statistics (ABS), and this data source is incomplete as it relies on self-reporting.

The Northern Territory is the only jurisdiction where a secondary data set is publicly available for the Aboriginal health workforce. A comparison of the NT data with the ABS data reveals significant disparities. The ABS reported 223 AHWs employed in the Northern Territory in 2001 and 224 in 2006,²⁶ while the NT Department of Health and Families identified 367 in 2001 and 340 in 2006.²⁷ So either ABS data under-represent the actual numbers of AHWs employed across Australia or the NT data overstate the numbers.

Number of AHWs

According to the 2006 Census (the most recent statistics available), there were 966 AHWs across Australia. However, this figure does not take into account related occupations with similar responsibilities such as Environmental Health Officers and Health Promotion Officers (of which there were 98 and 438 respectively).²⁸

Most of the AHWs (70%) were female, and 81% were aged between 25 and 54 years. Approximately two-thirds (67%) worked full time (35 hours or more per week).²⁹

Table 1: Number of Aboriginal people in health-related occupations³⁰

Occupation	1996	2001	2006	Percentage change
AHW	667	853	966	44.8%
Nurse	1,258	1,123	1,449	15.2%
Nurse Manager	20	38	56	180%
Doctor	61	90	101	65.6%
Allied Health Professional [‡]	179	274	441	146.4%
Health Promotion Officer	n/a	n/a	438	n/a
Environmental Health Officer	122	114	98	-19.7%

Source: Australian Bureau of Statistics (ABS), 2006 Census of Population and Housing.

* The table lists only a selection of the different health occupations in which Aboriginal people were employed.

Information from the 2006 Census suggests 5,336 Indigenous people aged 15–64 years were working in the health sector in 2006.³¹ NSW had the highest number of workers (1,743), followed by Queensland (1,343), Western Australia (486), and the Northern Territory (390). Overall, AHWs made up 20% of the Indigenous health workforce in 2006. Almost 40% of health personnel in 2006 worked in nursing, including more than 1,160 registered nurses and midwives, compared to the 100 medical practitioners (2%).³²

Where do AHWs work?

Just under half (48%) of AHWs are working in either remote or very remote regions of Australia (see Table 2).

‡ Allied Health Professional includes such occupations as dietician, social worker, and speech therapist.

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Table 2: Geographic spread of AHWs

Location Australian standard geographic classification	Number of AHWs	
	2001	2006
Major cities	122	177
Inner-regional	113	146
Outer-regional	179	200
Remote Australia	103	155
Very remote Australia	358	329
Total[§]	875	1,007

Source: Australian Bureau of Statistics (ABS), 2006 Census of Population and Housing, Customised Data Report requested by Health Workforce Australia, Canberra.

Queensland has the most AHWs, followed by the Northern Territory, NSW and Western Australia.

Table 3: Number of AHWs employed by state/territory

Year	NSW	QLD	NT	SA	VIC	TAS	WA	ACT	Total
1996**	90	500 ^{††}	149	48	10	5	74	3	879
2000 ^{‡‡}	225	356	255	137	96	–	200	22	1,291

AHWs are mainly employed by ACCHOS and by state and territory government health departments. In most states and territories, government health services employ more AHWs than ACCHOS.

Qualifications

Qualifications held by AHWs vary greatly, from none to very rare master's degrees. In each state and territory, a large proportion of AHWs lack any formal qualifications, although recent ABS data show that the level of education and qualification of AHWs is slowly improving. In 2001, just under half of the AHWs surveyed indicated they either did not have any qualifications or had qualifications outside the scope of their work; this figure dropped to 36% in 2006.³³ In addition, the proportion of AHWs reporting Certificate-level qualifications rose from 16% to 30% in the same period.³⁴

What do they earn?

Data obtained from state and territory websites indicate that the average wages for AHWs is between \$28,288 and \$52,364 per annum.³⁵ A comparison of 12 selected community service occupations by the Australian Services Union in 2007 found that AHWs received the lowest average weekly pay (\$547.76), lower than children's

§ Note: Statistics/data on AHW workforce are notoriously unreliable and the number of AHWs differs to official ABS statistics.

** Personnel data from Commonwealth Department of Health and Family Services (DHFS), 'A National Training and Employment Strategy,' National Health and Medical Council [rescinded].

†† Queensland figure includes nursing assistants.

‡‡ *Training Re-Visions*—'National Review of Aboriginal and Torres Strait Islander Health Worker Training' includes previously unreported information.

A comparison of 12 selected community service occupations found that AHWs received the lowest average weekly pay (\$547.76).

care workers (\$570.09), welfare and community workers (\$877.54), counsellors (\$905.95), and social workers (\$909.89).³⁶

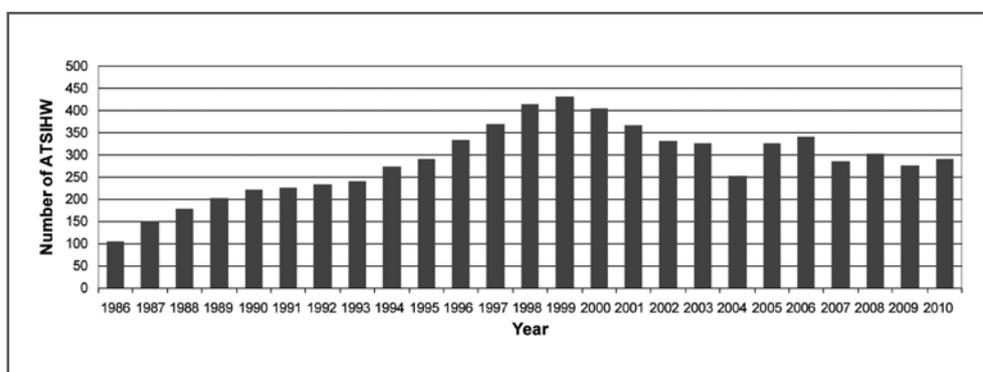
However, wages and conditions vary widely, both within and between states and territories. AHWs working in major cities or inner-regional areas record a higher median income compared to those working in remote and/or very remote areas. Generally, higher wages are paid by government health services than by ACCHOS. Exceptions are the ACCHOS in Western Australia, where health workers are paid more than those in similar levels/positions in the WA Department of Health.³⁷

Trends in the AHW workforce

According to AMSANT, the AHW profession in the Northern Territory is under threat due to a 30% drop in the number of AHWs over the last 10 years and an ageing and feminised workforce.³⁸ However, AMSANT does not provide numbers to back up its claim. Nor is an ageing and highly feminised workforce unique to AHWs; it is a characteristic of the health workforce in Australia generally.³⁹

A recent report suggests that the number of AHWs in the Northern Territory has remained relatively steady over the last four years.⁴⁰ Before that, the number of AHWs had been steadily increasing from 105 in 1986 to 431 in 1999 (see Figure 1). Since then, AHW numbers have fluctuated. However, data may reflect an increase in the number of AHWs becoming registered but not an increase or decrease in the number of people employed as AHWs. A 2000 review of AHWs noted that of the approximately 450 registered AHWs in the Northern Territory, only 195 were employed.⁴¹ In addition, although the Northern Territory requires AHWs to be registered to practice, health workers employed in non-clinical positions are exempt from this requirement.

Figure 1: Number of registered AHWs in the Northern Territory (1986–2010)



Source: Aboriginal Health Workers Board of the Northern Territory (2008); NT Health Professions Licensing Authority (2009, 2010).

The number of AHWs registered in the Northern Territory has remained relatively steady over the last few years, but the number of AHWs as a percentage of the overall health workforce in the territory is dropping because of an increase in the number of nurses and other health professionals. Since 2005, there has been a 38% growth in the number of nurses employed by the NT Department of Health and Families.⁴² Another reason for the decline in the number of AHWs in relative terms is that the NT Department of Health and Families is finding it hard to fill ‘vacancies.’ The department’s 2008–09 budget allowed for a progressive increase in the number of AHWs to create an additional 25 positions by the end of the year. However, not all the positions were filled and the funds were transferred elsewhere.⁴³ AMSANT argues this has eroded the number of AHW positions in government health services, but the question remains: Why are these positions not being filled?

Of the approximately 450 registered AHWs in the Northern Territory in 2000, only 195 were employed.

Although the Northern Territory requires AHWs to be registered to practice, health workers employed in non-clinical positions are exempt from this requirement.

Moreover, as Table 1 shows, the number of Aboriginal people becoming nurses and allied health professionals is increasing, and new roles such as Health Promotion Officers have been established. If the number of AHWs in the Northern Territory is decreasing, as AMSANT claims, this could be because Aboriginal people are electing to work in other health-related fields that pay better. For example, Indigenous ‘Tobacco Workers’ employed under COAG’s Tackling Smoking measure launched in July 2009 are paid around \$74,000.⁴⁴

Recent government policies

Since the mid- to late 1980s, numerous policies have been introduced (by governments and other interested parties) to improve the training, status and conditions of employment of AHWs and the Aboriginal health workforce in general (Table 4 and Appendix 1).⁴⁵

Table 4: Key government policies, reviews and reports (1985–2011)

Date	Policy/government review/publication
1985	The Northern Territory Health Practitioners and Allied Professional Registration Act recognised AHWs as a professional group and established the Aboriginal Health Worker Registration Board. ⁴⁶
1989	The National Aboriginal Health Strategy (NAHS) emphasised the importance of Aboriginal Community Controlled Health Organisations (ACCHOS), which at the time was collectively the largest employer of AHWs.
1996	National Competency Standards were developed for AHWs throughout Australia by the National Community Services and Health Industry Training Advisory Board (ITAB). It does not appear that these standards were compulsory: ACCHOS such as Marr Mooditj Training Inc. ran their own programs until 2007 when the Community Services & Health Industry Skills Council introduced a qualifications framework.
1999–2000	The Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned A National Review of Aboriginal and Torres Strait Islander Health Worker Training . The findings were published in the report <i>Training Re-Visions: A National Review of Aboriginal and Torres Strait Islander Health Worker Training</i> in 2000.
2002	The Aboriginal and Torres Strait Islander Health Workforce National Framework was developed by the Standing Committee on Aboriginal and Torres Strait Islander Health on behalf of the Australian Health Ministers’ Advisory Council (AHMAC). The framework was informed by the recommendations of the National Aboriginal and Torres Strait Islander Health Worker Training Review and reflected the principles set out in the 1989 National Aboriginal Health Strategy. Objective 2 of the framework was to improve: <ul style="list-style-type: none"> • the clarity of roles, regulation and recognition of AHWs as a key component of the health workforce, and • VET support for training AHWs.
2007	A nationally consistent health worker qualification framework (HLT07: Health Training Package) was introduced by the Community Services & Health Industry Skills Council (CS&HISC). <ul style="list-style-type: none"> • It established opportunities for health workers to choose between clinical practice and community care streams of education. • It identified training parameters for each level of qualification.⁴⁷

2008	<p>On 29 November, COAG signed the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and committed \$1.57 billion over four years to improve Aboriginal health and wellbeing.</p> <p>Part of the package under the National Partnership Agreement was funding for the National Indigenous Health Workforce Training Package, under which the Commonwealth committed \$19 million over three years (2008–09 to 2011–12) to support an Indigenous health workforce and encourage more Indigenous Australians to take up health careers. It included funding for AHWs to transition to national qualifications.</p>
2009	The Health Practitioner Regulation National Law Bill was passed—the bill outlines plans for incorporating four partially regulated professions, including Aboriginal and Torres Strait Islander health practice, in the National Regulation and Accreditation Scheme (NRAS, which was introduced on 1 July 2010) by 1 July 2012.
2010	The National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) was formally launched by the Minister for Indigenous Health, Warren Snowdon, on 29 January.
2010	In April, the final report of the Aboriginal Health Worker Profession Review was released by the NT Department of Health.
2011	On 20 January, the Aboriginal and Torres Strait Islander Health Worker Project Environmental Scan was released by Health Workforce Australia. The aim of the project was to inform the development of policies that will strengthen and sustain the AHW workforce. The outcomes of the project are hoped to inform the requirements for national registration and accreditation of AHWs due on 1 July 2012.

As illustrated above in Table 4, a large range of partnerships and agreements underpin AHW policy. Other specific Indigenous forums and committees include the **Working Group on Indigenous Reform** to progress the agenda outlined in the **National Indigenous Reform Agreement**; the **Ministerial Council for Aboriginal and Torres Strait Islander Affairs** (comprising relevant state and territory ministers); and the **Standing Committee for Aboriginal and Torres Strait Islander Affairs** (comprising senior officials from relevant government departments). Other relevant health committees and organisations include the **Australian Health Ministers' Conference** (AHMC), which provides a national forum for discussing health policy, services and programs. AHMC's membership comprises the federal, state and territory governments in Australia and ministers in New Zealand with direct responsibility for health matters. The **Australian Health Ministers' Advisory Council** (AHMAC) supports AHMC. Its membership includes all heads of the respective health authorities. The **Health Workforce Principal Committee** and its standing committees, including the **Aboriginal and Torres Strait Islander Health Workforce Working Group**, support AHMC and AHMAC on AHW issues. The Aboriginal and Torres Strait Islander Health Workforce Working Group is developing the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework.⁴⁸

It remains to be seen whether these committees and partnership agreements will make any substantial difference to the AHW workforce. Many of the concerns raised in *The National Review of Training for Aboriginal and Torres Strait Islander Health Workers* ('Training Re-visions') in 2000 have not been addressed, in particular, clarifying a national definition of the AHW role. Until this can be resolved, it will not be possible to have the nationally consistent standards needed for national registration and accreditation of AHWs.

Many health workers in communities in remote regions are likely to have limited English literacy and numeracy and may never meet registration requirements.

It took two years for the National Competency Standards for AHW training to be endorsed by all state and territory governments as some jurisdictions felt that the level of competencies was too low.⁴⁹ The difficulty in setting national standards or competencies for AHWs was because the role and education level of AHWs differed so much from jurisdiction to jurisdiction. For example, the type of work that AHWs do in remote parts of the Northern Territory, Western Australia, Queensland, and South Australia is not comparable with the work in urban Australian jurisdictions.⁵⁰ Many health workers in communities in remote regions are likely to have limited English literacy and numeracy and may never meet registration requirements. Under the new national registration and accreditation scheme, only appropriately qualified and skilled AHWs will be registered. In fact, it is not expected that all people currently employed as AHWs will meet registration requirements. Instead, government advises that they remain unregistered health workers.⁵¹ Having two tiers—registered and unregistered AHWs—risks confusing the AHW role further, not to mention the potential health and safety issues involved in continuing to have non-registered and untrained AHWs working in what is arguably one of the most challenging health arenas.

The problems

The National Review of Training for Aboriginal and Torres Strait Islander Health Workers (2000) identified three main issues hindering AHWs. The first was the unclear definition of the AHW role, which often resulted in the work of AHWs not being fully appreciated or valued. The second issue was that although AHWs were often described as unique and essential to health care in Australia, they frequently lacked the education to confidently and effectively perform their job requirements. This situation created a paradox where the least educated and most poorly paid health care workers in Australia were assumed to be capable of tackling some of the country's most intractable health problems. The third issue was related to AHW training. Due to the lack of clarity of the role of AHWs, the training delivered was ad hoc, poorly coordinated, and inconsistent. Different industrial awards and career structures inhibited the portability of AHW qualifications. The report's overall finding was that AHW training programs were not producing the essential educational outcomes that would enable trainees to perform their roles effectively.⁵²

The following section looks at these three issues—role definition, contradictions of the role, and quality of training—to see whether there has been an improvement in the 12 years since the national review in 2000.

Defining the AHW role

Part of the reason for the difficulty in defining the AHW role are the increasing and variable demands placed on health workers since the role was created in the 1970s. Originally, AHWs primarily acted as cultural liaisons between their communities and health professionals. Over the years, the role expanded in response to self-determination policies and other demands, depending on the geographic location, workplace, and communities of AHWs. Consequently, there are now significant differences between the roles performed by AHWs across Australia. AHWs are also employed by a number of different service providers, including ACCHOS, Aboriginal Medical Services, hospitals, and GP clinics. All these workplaces require different levels of involvement by AHWs.⁵³

Reflecting the different roles performed by AHWs are the different role definitions used by state and territory government departments, agencies, peak bodies, organisations, and health worker boards and associations. Even within each jurisdiction, the definition of a health worker varies significantly depending on the workplace and the services provided. Often, different terminology is used to describe people performing the same role. Aboriginal and Torres Strait Islanders perform

Due to the lack of clarity of the role of AHWs, the training delivered was ad hoc, poorly coordinated, and inconsistent.

a large range of other roles—Mental Health Workers, Hospital (or Aboriginal) Liaison Officers, and Indigenous Outreach Workers—that come under the purview of AHW tasks. There are also often significant discrepancies between the ‘scope of practice’ that AHWs perform: For various reasons, some AHWs are allowed to perform only a portion of their role.⁵⁴

To demonstrate these variations, several examples of the different definitions of AHWs used across Australia are outlined below. The list is by no means exhaustive.

The National Aboriginal and Community Controlled Health Organisation (NACCHO) defines AHWs as an Aboriginal and/or Torres Strait Islander person who:

- works within an Aboriginal Primary Health Care Framework to achieve better health outcomes and better access to health services for Aboriginal and/or Torres Strait Islander individuals, families and communities
- holds a minimum qualification of Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care, and
- advocates for the delivery of services in accordance with the Cultural Respect Framework.⁵⁵

The NSW Department of Health defines an AHW as someone who is:

- an Aboriginal or Torres Strait Islander person, and
- employed in an identified position in the NSW Public Health System and provides health services and programs directly to Aboriginal people regardless of whether the person is employed in a general or specialist position. It encompasses all/any areas, irrespective of the award that covers the employment of the worker.⁵⁶

This definition explicitly includes those who specialise in mental health, family health, sexual health, and drug and alcohol issues, and Health Education Officers and Hospital Liaison Officers.

In the Northern Territory, the term ‘Aboriginal Health Workers’ applies to only health workers with clinical responsibilities, excluding those defined as AHWs in other jurisdictions who do not perform clinical roles. This is partly attributable to the Northern Territory being the only Australian jurisdiction that registers and regulates the health worker scope of work practices, particularly clinical work, to minimise risks to public safety.⁵⁸

In the Northern Territory, the qualifications required for an AHW are legislated, as are the scope of practice, code of ethics, and clinical competency framework. The Aboriginal Health Workers Board of the Northern Territory regulates health worker practice and defines the AHW role as follows:

AHWs predominately work in Primary Health Care (PHC) in remote Aboriginal communities. They are often recruited from their remote communities enabling local participation in the direction and delivery of health services. AHWs also work in urban community health, in public health and in hospitals. AHWs are involved in specialist areas of health care such as, but not limited to, renal dialysis, women’s and men’s health screening, early childhood screening and

In the Northern Territory, the term ‘Aboriginal Health Workers’ applies to only health workers with clinical responsibilities.

§§ The Northern Territory is the only jurisdiction in Australia with a formal registration process for AHWs, although Queensland has regulations that provide some health workers with Isolated Practice Authorisation (from Aboriginal and Torres Strait Islander Health Worker Project, *Environmental Scan*, see endnote 8).

Sometimes AHWs are the only staff available to deal with medical emergencies in remote Aboriginal communities. This can require them to deliver treatment outside their training or that is illegal for them to perform.

development, nutrition, mental health, alcohol and other drugs, health service management and design. AHWs often use complex medical equipment, take and test samples of biological material, sometimes requiring invasive procedures such as venipuncture. They are also authorised to administer a limited range of medications in accordance with the Northern Territory Poisons and Dangerous Drugs Act and have significant cultural brokerage role in the provision of health care, enabling them not only to be health care providers but also to facilitate care provided by other health professionals ... While the Territory has a range of other roles such as Aboriginal mental health worker, Aboriginal nutrition worker and Aboriginal community worker, these do not have the same clinical focus as AHWs and are not registered.⁵⁷

The Queensland Department of Health's definition of an AHW is an Aboriginal and/or Torres Strait Islander person who

- works within a Primary Health Care (PHC) framework to achieve better health outcomes and better access to health services for Aboriginal and/or Torres Strait Islander individuals, families and communities
- holds an Aboriginal and Torres Strait Islander Primary Health Care qualification
- advocates for the delivery of services in accordance with the Cultural Respect Framework, and
- is appointed under the Aboriginal and Torres Strait Islander Career Structure.⁵⁸

The WA Department of Health defines an AHW as someone who:

- is an Aboriginal and/or Torres Strait Islander person or descendent and is recognised as such by their community, and
- holds a recognised qualification such as Certificate III in Aboriginal Health Work from an accredited RTO.⁵⁹

The range of definitions demonstrates the major discrepancies in definitions of AHWs across Australia. In particular, there is no common view on whether the term should only refer to those who perform clinical tasks or a wider group of health personnel.⁶⁰

While it is often stated that the AHW role is a primary health care role, more often than not it is a clinical role in treating those who come to the clinic rather than working on prevention and education in communities.⁶¹ The Menzies School of Health Research claims that while AHWs are trained to act as cultural brokers, provide first aid, and recognise many life-threatening health problems, they do not have the skills of more highly trained professionals who can deal with chronic conditions that have serious, long-term health implications or implement preventative programs.⁶²

The AHW role incorporates a variety of different models: the 'health worker-first' model, where AHWs are the first point of contact (this has encouraged some AHWs to act as gatekeepers to other health personnel); integration of AHWs within multidisciplinary teams; and health workers as a separate team within a health service.⁶³ In the Northern Territory, Western Australia, Northern Queensland, and other remote locations, AHWs tend to have a higher level of clinical responsibility than in other jurisdictions because of the shortage or high turnover of other health professionals.⁶⁴ This has a number of health and safety implications. Sometimes AHWs are the only staff available to deal with medical emergencies in remote Aboriginal communities. This can require them to deliver treatment outside their training or that is illegal for them to perform, for example,

dispensing drugs they do not have the authority or education prerequisites to administer. If something goes wrong, AHWs can face retribution from their communities.⁶⁵

The one area of universal agreement is of the AHW providing culturally ‘relevant’ and ‘appropriate’ health care. According to many commentators, AHWs ‘bridge the cultural chasm’ separating traditional and Western world views, and the real value of AHWs lies in ensuring the acceptability of the service to Indigenous Australians and providing a link between Indigenous patients and non-Indigenous health professionals.⁶⁶ The cultural brokerage role is probably more important and relevant in remote areas where many residents do not speak English fluently, and where kinship systems and traditional laws are still practised. In areas such as urban and regional NSW, many AHWs lack knowledge and understanding of Indigenous culture but hesitate to admit it because it is assumed that ‘if you are Indigenous you hold Indigenous knowledge.’⁶⁷

In remote communities, AHWs have to work within cultural protocols, talk in ‘the proper way’ with people, and consider gender and relationship issues. Since they live within the community, and are members of that community, AHWs can be on call 24 hours a day and feel pressure to fulfil kinship obligations.⁶⁸ A survey of AHWs in *The National Review* (2000) found that most AHWs regularly worked hours in excess of the time they were employed. In several instances, AHWs worked 10 or more overtime hours each week.⁶⁹ Communities often expect AHWs to act as a taxi driver, help with Medicare forms, social security problems, and housing issues. The breadth of current definitions of AHW responsibilities contributes to a lack of boundaries and AHWs performing the role of ‘Jack of all trades.’ Not surprisingly, many AHWs ‘burn out and drop out.’⁷⁰ In particular, in the Northern Territory and Western Australia, large numbers of trained AHWs are not working as health workers.⁷¹

The AHW paradox

Many AHWs may feel like they are the ‘Jack of all trades’—that they are ‘master of none’ is unfortunately also true. There is a definite paradox with the AHW role. On the one hand, AHWs are increasingly expected to deal with complex and difficult health problems, including alcohol-related health problems, but the rate at which they are acquiring professional knowledge and skills and levels of remuneration have not kept pace with rising expectations. As one health researcher commented: ‘The least educated and most poorly paid of all health care workers are being asked to tackle what is, arguably, Australia’s most difficult health problems.’⁷²

AHWs are often described in health literature and government reports as unique and essential to health care in Aboriginal communities. At the same time, they are undervalued and often lack the educational preparation needed to confidently and effectively perform their role.⁷³

AHWs are given mixed messages. ACCHOS and other vested interests constantly promote the importance of the AHW role, but there is a large gap between the ideal of what an AHW should do and the reality of the role. A major discrepancy arises from the disparity between the basic training provided and the skills and knowledge needed for the complex health problems AHWs encounter.⁷⁴ This is particularly apparent for AHWs working in remote locations where AHWs have lower levels of English literacy and numeracy but greater responsibility as there may be no permanent supervisory staff.

The ambiguity of the AHWs’ role can undermine their relationships with other health professionals.⁷⁵ A report on AHWs in NSW found that AHWs are often viewed by their colleagues as ‘inexperienced, inefficient and incapable.’⁷⁶ A particular problem arising from the uncertainty of the functions of AHWs is the delegation of responsibilities between AHW and registered nurses.⁷⁷ Jennifer Cramer, author

Many AHWs may feel like they are the ‘Jack of all trades’—that they are ‘master of none’ is unfortunately also true.

of *Sounding the Alarm: Remote Area Nurses and Aboriginals at Risk*, highlights how conflicting expectations of the AHW role can create a 'no win' situation:

When I first came here I got told by management that we were to hover in the background. I was told to let the AHWs do all the basic care and they would see me and consult with me if they feel they need to ... Then at the last meeting the health workers said, 'Oh, we want the Sister right next to us all the time.'⁷⁸

Colleagues either expect too much or too little of AHWs because they do not have clear benchmarks to form reasonable expectations of AHWs.⁷⁹ This contributes to AHWs feeling that other health professionals do not respect and value their work. In many cases, AHWs are not consulted on organisational policy and planning issues even though these could have a direct impact on their work. Nursing managers, among others, tend to make decisions for them.⁸⁰ AHWs also feel undervalued because AHW qualifications are not universally recognised. In Queensland, AHWs trained by ACCHOS to take pap smears and give vaccinations can only use these skills in Aboriginal Community Controlled Medical Services because their training is not recognised in other health sectors.⁸¹

The 2010 review of AHW training in the Northern Territory found regular monitoring of AHWs' performance in the workplace was limited. There were few structured approaches to performance appraisal and management so that good performance was not recognised and poor performance was not held to account. The exaggerations contained in the role description of AHWs (for instance, the Aboriginal Health Workers Board of the Northern Territory) compound any realistic assessment of AHW abilities. The unrealistic and fanciful notions of AHW abilities feeds down to managers who pretend it is true and thus perpetuate the myths of what AHWs are able to do.⁸² Some managers avoid confronting AHWs about their performance; in some health services, there are high levels of absenteeism and 'presenteeism' (being at work without working).⁸³ But for AHWs working responsibly, there are few opportunities for promotion or professional development through further education.⁸⁴

The absence of a clear career structure and pay/reward system is also a disincentive for AHWs to undertake training or further study. Allocation of pay levels is often arbitrary. For instance, Aboriginal Liaison Officers employed on the Hospital Services Officers Award in urban hospitals are paid more than AHWs although they may not be trained for the job they are doing. In other cases, pay levels seem to have no bearing on the level of qualifications or position held. In many cases, unqualified AHWs perform work at a similar level to those who are qualified and receive the same level of pay. A number of AHWs have no qualifications.⁸⁵

Quality of AHW training

AHW training in 2000

The National Review of Aboriginal Health Worker Training identified a number of concerns with the quality of AHW training. In particular, as no clear definition of the AHW role existed, training was 'all over the place' with little consistency and quality control. The history of AHW education and training in Australia was ad hoc and uncoordinated, with each state and territory developing its own training, resulting in differences in course development and delivery even within regions, states and territories. Some people even argued that it was not necessary for all AHWs to have literacy and numeracy skills to perform their duties, and that too much emphasis on literacy and numeracy issues acted as a barrier for Aboriginal people to become AHWs.⁸⁶

In some health services, there are high levels of absenteeism and 'presenteeism' (being at work without working).

Due to the ambivalence towards English literacy and ‘Western education,’ substantial numbers of AHWs had no qualifications or had not completed training. Each training provider had its own program, and method of assessment and delivery. Nationally, around 61 training providers were delivering around 230 courses.⁸⁷

Many short courses for health workers were not accredited and appeared to have little merit, with the subject matter reported to be superficial and repetitive. AHWs, health service managers, and workplace supervisors expressed concerns about a lack of skilled educators, poorly organised courses, and lack of rigour in the content and implementation of training programs. There also appeared to be incentives for training providers to have ‘bums on seats’ rather than providing quality training as funding was based on enrolment numbers.⁸⁸

In *The National Review*, several states, notably Western Australia, South Australia, and Queensland, reported a lack of adequate assessment for competency attainment, which usually takes place in the work setting. A major problem noted by all state and territory reviews was the lack of qualified workplace assessors. For example, none of the health services in Queensland employed staff qualified to do workplace assessments.

A lack of audit or evaluation of the course content and delivery lowered the credibility and appropriateness of courses to the learning needs of AHWs. At the time of the review, training providers said the certificate course in the Northern Territory, South Australia, or Western Australia had not been formally evaluated. Many AHWs questioned the relevance of the training program to their role and responsibilities in the workplace. AHWs also had few opportunities to upgrade and/or update their skills.⁸⁹

The National Review’s analysis of the Certificate II and Certificate III AHW training revealed anomalies between the accredited curriculum document and the content of the learning materials. Specific anomalies included inconsistencies between the material in some modules and the stated purpose; materials and assessments were incongruent with learning outcomes and there was repetition or duplication of content across modules. In some modules, material additional to the stated content was included by excluding some required content. Also, content materials were inappropriate for the level stated and/or had no assessment criteria. In several cases, curriculum material was omitted, or there was excess material for the curriculum requirements or for the hours allocated to students. Another problem was variability in the rigour of module presentations. For example, the language, terminology and concepts in some modules were beyond the level of the AHW training program.⁹⁰

While criteria in the assessment methodology of the curriculum document appeared comprehensive and demanding, they were not compatible with the course knowledge required and modes of assessment. When compared with the content of learning materials, the level of assessment was minimal, lacked rigour, and required few writing skills. For example, an objective of Certificate III is to ‘use research skills to investigate and explore issues and information regarding Aboriginal primary health care.’ A criterion for assessment of this objective is that students are able to ‘read ... easily ... without ... additional workplace literacy and numeracy supports.’ The review concluded that the AHW certificate course lacked the development of reading and writing skills usually required for comparable certificates at the same level, preventing students from undertaking further education in more academic courses.⁹¹

In a survey of AHWs undertaken as part of *The National Review*, one AHW said:

How do some Health Workers pass their training courses when they cannot do the work that is required after they finish their courses?
Some of these courses were established to ‘set people up to fail.’⁹²

‘A great number of poorly trained Aboriginal Health Workers have been churned out of the system with no career structure and very little support and prestige and they have given up the work very quickly.’

The National Review heard from a number of respondents about the unrealistic expectations of what AHWs were able to do with just 12 months of training. A spokesperson from a state health department commented:

The bottom line needs to be that basic health skills and competencies are gained ... [T]he problem nowadays is that a great number of poorly trained Aboriginal Health Workers have been churned out of the system with no career structure and very little support and prestige and they have given up the work very quickly. A terrible waste of the resources at all levels. I think there needs to be more rigour at the earlier stage and the retention would improve.⁹³

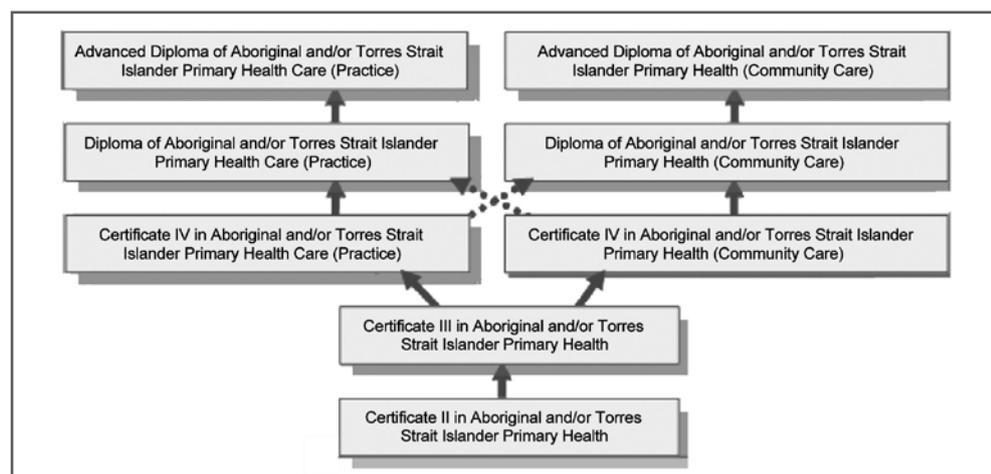
A submission from the Northern Territory described the current one-year structure for a certificate that qualifies AHWs for clinical practice as ‘ridiculous’:

I am very much aware through delivering specialty modules into Aboriginal Health Worker training of the difficulties of trying to fit the likes of a forty hour module into a week block that in reality only comprises of twenty hours training time availability. At the same time it is expected that students will be competent at the end of the module. The result is half trained students and RTOs that compromise the training agenda and the qualifications of other students who actually do complete the prescribed training.⁹⁴

The training landscape today

A number of policy changes to the education and training environment have been made in the 12 years since the 2000 *National Review* to improve AHW standards. In particular, a national health worker training package by the Community Services & Health Industry Skills Council (CS&HISC) was developed in 2007 (see Figure 2).

Figure 2: Aboriginal and Torres Strait Islander Health Qualifications Framework***



Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care is a one-year course (256–383 hours) designed as an entry-level qualification for workers with limited English literacy and numeracy.⁹⁵ According to CS&HISC, English literacy/numeracy requirements are minimal if there are workplace communication systems/tools that allow AHWs to communicate effectively with mainstream workers and the communities they serve. This suggests that although

*** Note these qualifications are part of the ‘Health Training Package’ (2007).

‘The result is half trained students and RTOs that compromise the training agenda and the qualifications of other students who actually do complete the prescribed training.’

AHWs should be able to communicate in English, they do not need to know how to read and write. Assessment tasks involving literacy and numeracy are only to be used in so far as the same level of literacy/numeracy is required to perform the function being assessed. At this level, Workers may be trainee AHWs working as assistants in rural or urban areas, or they may deliver limited health care services in communities isolated from mainstream services—although the CS&HISC noted that in some jurisdictions Certificate II may have no work outcomes.⁹⁶

Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care is a 12 to 18-month course (880–940 hours), and is regarded in many jurisdictions as the minimum qualification for AHWs.⁹⁷

Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) is a two-year course for health workers with some prior knowledge and skills; this qualification is required for AHWs in the Northern Territory to be registered with the Aboriginal Health Workers Registration Board.⁹⁸ In other jurisdictions, people with this qualification may become senior AHWs. Workers are expected to undertake a broad range of tasks and know how to assess and treat a wide range of health problems. Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health (Community Care) is more concerned with community care (including alcohol and drug work) and preventive health—people with this qualification may work as Aboriginal Health Education Officers, Stolen Generation Advisors, or Aboriginal Hospital Liaison Officers. Diplomas in Aboriginal and Torres Strait Islander Primary Health Care (Practice) and (Community Care) provide qualifications for people to work as specialists, clinic coordinators, program managers, and managers.⁹⁹

The introduction of clearly defined national training requirements for AHWs has supposedly paved the way for greater consistency of curricula and training standards across jurisdictions, but it has not changed the reality on the ground.

Registered Training Providers (RTOs)

Thirty-six RTOs offer a range of programs for AHWs (see Appendix 1). This is just over half the number of RTOs since the 2000 *National Review*. Of these 36 RTOs, 18 are ACCHOS and form part of the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN). The majority of RTOs only provide training for Certificate III and Certificate IV. Just one-third (11) offer higher qualifications for AHWs up to the Advanced Diploma level. NSW has the highest number of RTOs in the country, while the Northern Territory has only two. Outside of the VET sector, there are two undergraduate-level university courses that specifically target AHWs—one at the University of Wollongong in NSW and the other at Curtin University in Queensland. The University of Queensland also offers a major in Aboriginal health. However, AHW courses at universities are unlikely to have a clinical component due to complications in authority for teaching clinical practice and accreditation requirements.

In addition to the RTOs providing courses specific to AHWs, other RTOs provide training in health-related accredited courses^{†††} to Aboriginal and Torres Strait Islanders. These include the Seventh-Day Adventist Church, which delivers Certificate III, Certificate IV, and Diploma in Indigenous Lifestyle Health Promotion (see Appendix 1). Another 95 RTOs deliver training in Certificate II in Health Support Services. Although some Aboriginal and Torres Strait Islanders could receive this training and work as AHWs, these are not Indigenous-specific courses. Only one RTO (Pilbara TAFE) provides an AHW Certificate I course.¹⁰⁰

Although the number of RTOs has declined since the 2000 *National Review*, the number still seems unnecessarily high given that there are only approximately 1,000 AHWs across Australia.

††† Accredited courses meet training needs that are not addressed by existing training packages.

At an ACCHO in Western Australia in 2011, of the 60 students enrolled in Certificate III (Practice), 36 withdrew before completing the course.

Although the number of RTOs has declined since the 2000 *National Review*, the number still seems unnecessarily high given that there are only approximately 1,000 AHWs across Australia. Do we need so many RTOs for a workforce that is only (at the most) around 200–300 in each state/territory? In Western Australia (where there is a proliferation of RTOs delivering health-related qualifications/courses to Aboriginal people, including private training providers), there are 5,000 doctors employed, but until recently, only one medical school.

Part of the reason for the high number of RTOs could be because ACCHOS feel it is their responsibility to provide AHW training to ‘keep the profession alive’ and ensure Aboriginal people have Aboriginal health professionals to treat them. Among the Aboriginal health industry, there is the widespread belief that Aboriginal people feel more comfortable dealing with a health service provider who understands their culture and beliefs.¹⁰¹ Yet it is equally true that Aboriginal people (like everyone else) expect and deserve to be treated by qualified and competent health professionals.

The government provides a number of financial incentives for AHW training. The **National Indigenous Health Workforce Training Package** (\$19 million from 2008–09 to 2011–12) includes funding for ACCHOS to encourage more Indigenous Australians to take up health careers and for AHWs to transition to national qualifications (see Table 1 and Table 7 in Appendix 1 for more details). There are also four funding packages specifically for Indigenous students in the VET sector:¹⁰²

1. The **Supplementary Recurrent Assistance** (2009–11) provides supplementary per capita assistance to eligible non-government VET institutions with a minimum Indigenous enrolment of 20 full-time equivalent students to assist institutions to accelerate educational outcomes for their Indigenous students.
2. The Australian government jointly administers **Industry and Indigenous Skill Centre (IISC)** funding with state and territory training authorities. These funds provide capital assistance to industry training organisations, Indigenous communities, and VET providers to facilitate an increase in the numbers of Indigenous and non-Indigenous Australians undertaking VET by providing a range of accredited and non-accredited VET courses.
3. The **Training Initiatives for Indigenous Adults in Regional and Remote Communities Program** (2007–11) provided funding to attract, engage and support Indigenous adults in regional and remote communities to access vocational education and training opportunities, including additional training places under the Australian government’s Skilling Australia for the Future policy.
4. The **Indigenous Regional Projects**, part of the Industry Training Strategies Program, supports a range of innovative projects and initiatives that assist key stakeholders to improve the participation of Indigenous Australians in nationally recognised training and skills development programs, specifically Australian apprenticeships and training packages that lead to sustainable employment.

Assessing the extent to which the supply of RTOs outstrips demand for training and employment opportunities is difficult due to the lack of data. In 2006, 220 VET sector students had completed a course aimed at AHWs (Table 5). Table 5 only provides the number of completions for one year (2006—before the additional funding incentives began), not a comprehensive picture of the number of Aboriginal and Torres Strait Islanders enrolled in training who dropped out or did not complete that year. It is likely that there are high dropout rates from courses. At an ACCHO in Western Australia in 2011, of the 60 students enrolled in Certificate III (Practice), 36 withdrew before completing the course.¹⁰³ Data on employment outcomes

for AHWs who have completed their training are also difficult to find, but overall, the proportion of Indigenous students who were employed after completing VET courses is low (63.7% for Indigenous graduates and 50.7% for Indigenous Module Completers in 2009).¹⁰⁴

Table 5: Number of VET students completing a program aimed at AHWs (2006)

Qualifications	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Australia
Certificate I	–	–	–	–	–	–	–	–	–
Certificate II	–	–	–	–	–	–	–	–	–
Certificate III	–	–	61	31	–	–	–	6	98
Certificate IV	–	–	12	23	31	–	–	2	68
Diploma or higher	7	–	4	7	18	–	–	–	36
Total	7	–	77	61	49	–	–	8	202

Source: National Centre for Vocational Education Research (NCVER), in ABS (Australian Bureau of Statistics), Aboriginal and Torres Strait Islander peoples training for health-related disciplines, Cat. No. 3.18 (Canberra: ABS, 2006).

More information on the number of AHWs completing courses is available from the Northern Territory. According to the Batchelor Institute of Indigenous Tertiary Education, 142 students completed AHW courses between 2001 and 2008. Although data on the outcomes for all those students are not available, there is information on the employment outcomes of 66 graduates from 2006–10. Twenty-six are employed with the NT Department of Health and Families, and the remaining 40 are either working in ACCHOS or unemployed. Central Australian Aboriginal Congress claims it has trained 23 AHWs since 2006; 17 of those are employed as AHWs, one is in other employment, two are unemployed, and the outcome of three is unknown.¹⁰⁵ Since 2010, the two RTOs in the Northern Territory have trained 89 AHWs (no data are available on the numbers of AHWs who enrolled but did not complete training). The figure of 89 AHWs equates to an average of 22 students a year over a four-year period, which is higher than the figure of eight provided by the National Centre for Vocational Education Research (NCVER).

To increase the number of qualified AHWs, the NT Department of Health and Families initiated an apprenticeship scheme in July 2007. Health services employed trainees and provided on-the-job training. Initially, there were some problems with clinical support, but they were overcome by an injection of funds for an educator to travel to health services and provide greater on-site support to apprentices. This AHW Apprenticeship Program, a pilot program with no recurrent funding, was successful in retaining and qualifying 17 apprentices (out of the initial 27 men and women). Although no formal evaluation was conducted, the program highlighted the real level of support apprentices need to complete the course and the impossibility of relying on local health service staff (nurses and other AHWs) alone to provide this.¹⁰⁶ A recent report commissioned by GenerationOne found that on-the-job training and mentoring is crucial to employing and retaining disadvantaged Indigenous staff.¹⁰⁷

Course delivery

The CS&HISC describes the AHW sector as an emerging area of work (even though the role has been around for more than 30 years) to explain the different occupational titles and roles across jurisdictions and workplaces. Due to the different roles performed by AHWs, the CS&HISC allows industry stakeholders (health

The AHW Apprenticeship Program highlighted the real level of support apprentices need to complete the course and the impossibility of relying on local health service staff (nurses and other AHWs) alone to provide this.

Culturally appropriate practices appear to take precedence over performance criteria.

departments and ACCHOS) to determine qualifications and packages of electives and compulsory units of competence. This has enabled RTOs to tailor AHW training to suit their students' needs while still supposedly meeting the requirements of the Aboriginal and/or Torres Strait Islander Health Worker Qualifications. One of the compulsory units for Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care is HLTAHW304A: Undertake basic health assessments. The 16-page health training package for this competency provides detailed examples of the performance criteria and required skills and knowledge needed. However, some of these requirements appear to be diluted in the section titled 'Range statement and evidence guide.' For example, the range statement allows for different work environments and situations that may affect performance, while the evidence guide, under context of assessment, states: 'Assessment should replicate workplace conditions as far as possible.' Culturally appropriate practices appear to take precedence over performance criteria.

This competency standard supports the recognition, protection and continued advancement of the inherent rights, cultures, and traditions of Aboriginal and Torres Strait Islander peoples.¹⁰⁸

An example of the training schedule provided by an RTO for Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care is shown in Table 6.

Table 6: Block delivery of Certificate III

Block	Date	Units
One	15 Feb–26 Feb (10 days)	2 days orientation <ul style="list-style-type: none"> • HLFA301B—Apply first aid • HLFA402B—Apply advanced first aid (ELECTIVE) • HLTAHW301A—Work in Aboriginal and/or Torres Strait Islander primary health care context • BSBCM206A—Process and maintain workplace information • BSBCM205A—Use business technology
Two	27 April–7 May (10 days)	<ul style="list-style-type: none"> • HLTOHS300A—Contribute to OHS processes • HLTOP307B—Provide information and support on environmental health issues • HLTAHW302A—Facilitate communication between clients and service providers • HLTIN301A—Comply with infection control policies and procedures in health work
Three	24 May–4 June (10 days)	<ul style="list-style-type: none"> • HLTAHW305A—Plan and implement basic health care • HLTAHW304A—Undertake basic health assessments (this competency includes the 16 pages of requirements mentioned above)
Practicum Placement 2–14 weeks^{†††}		
Four	30 Aug–10 Sept (10 days)	<ul style="list-style-type: none"> • HLTAHW306A—Provide information about social and emotional support • HLTAHW303A—Advocate for the rights and needs of community members

††† Note these qualifications are part of the Health Training Package (2007).

Practicum Placement 2–11 weeks		
Five	29 Nov–10 Dec (10 days)	<ul style="list-style-type: none"> HLTAHW307A—Identify community health issues, needs and strategies HLTAHW308A—Assist with basic health screening, promotion and education services

It is evident that concerns with the delivery of training in 2000 still apply, specifically the unrealistic assumptions and scope of what an AHW might need or be able to learn. The performance criteria, required skills, and knowledge for units of competence do not match the hours recommended by the National Training Authority. Ten weeks is too short to adequately cover all the units of competency outlined above. The Northern Territory Review of AHW training found the method of delivery of course material was often too difficult for students to absorb; students also questioned the relevance of some of the content. Also of concern is the inconsistent range of Practicum Placements from two to 14 weeks. Surely all students should be required to undertake Practicum Placements for the same length of time, but only those students who are already employed in a health service get a longer placement; most students only get two weeks.

Workplace assessments for AHWs still appear to be a problem, with many students complaining of too much classroom-based teaching and limited on-the-job training. The Batchelor Institute admits that it relies on local health services to provide clinical job training support, and that unfortunately, some students end up working in health centres where there are no clinical educators, senior AHWs, or other medical staff to supervise and support their clinical practice. As a result, these students are not able to complete their training effectively. The Batchelor Institute also admitted that it has limited correspondence with supervisors to structure the learning outcomes of trainees.¹⁰⁹ There is also evidence that at least one RTO in Western Australia keeps no record of the hours worked by AHW trainees on Practicum Placements.¹¹⁰

Future options

In contrast to the AHW role, registered nurses have transferrable qualifications that are recognised all over the world. Some AHWs have left the workforce to study nursing because it offers better career opportunities and better pay. One AHW explained how she loved working as an AHW but felt limited by her qualifications; becoming a registered nurse provided her with more opportunities to help Aboriginal people.¹¹¹

However, some commentators view the AHW role as distinct from other health careers in its delivery of ‘culturally appropriate’ health care and do not want it to be seen as a stepping stone to nursing.

Aboriginal Health Workers form a distinct professional group that brings its own set of expertise and skills to a multidisciplinary health care team. It would be unfortunate if this unique professional identity were to be weakened by the notion that it is a bridge to other professions. It is important that strategies to increase the participation of Aboriginal people in the full range of health care professions avoid treating Aboriginal Health Work as a ‘feeder’ system.¹¹²

Another argument for the continuation of the AHW role is that people have to leave their community to train as nurses, which could potentially result in them losing contact with their people (obviously this argument would not apply to AHWs in urban areas). One AHW said she was afraid to become a nurse as she felt people in her community would shun her.¹¹³

There is evidence that at least one RTO in Western Australia keeps no record of the hours worked by AHW trainees on Practicum Placements.

In contrast, a state health department official argues:

Aboriginal Health Workers should be encouraged to enter other health professions, not because the Aboriginal doctors and nurses will treat their own people better, but because the message will be clear to all Aboriginal children; they can do anything they want and they don't have to remain in any profession because that's all there is on offer.¹¹⁴

While many Aboriginal people in remote communities do not receive the primary and high school education that would enable them to train as nurses and doctors, poor schooling should not continue to be hidden behind 'culturally appropriate' careers, which are really code for token employment—career paths with lower standards of entry, pass rates, inferior pay, and limited career options.

When the AHW role was first developed in the 1970s, there was a need for a 'cultural brokerage' role—many residents of remote communities did not speak English and had limited means of communicating with other health professionals. Yet, arguably, if remote residents had received decent schooling then, there would be no need for cultural brokers now.

The relevance of the AHW role has to be questioned, particularly in urban and regional areas where the 'cultural brokerage' role is in decline. The general factotum role of AHWs is inconsistent with the increasing complexity and specialisation of medical practices today.¹¹⁵ The NSW government appears to have recognised this, and in September 2011, launched a training initiative for Aboriginal assistants-in-nursing at the Centre for Education and Workforce Development in Sydney.¹¹⁶ Assistant nurses will be placed in Sydney hospitals and medical services after completing their training.

The drop in the number of registered AHWs in the Northern Territory and the low numbers of AHWs completing their training are not the result of a lack of RTOs or government funding but the lack of education and interest among remote Indigenous people to become AHWs.¹¹⁷ Thirty years of welfare dependency has sapped the motivation to seek employment among many remote Indigenous residents. For example, one young woman had to be literally dragged off the Community Development Employment Project (CDEP) to undertake a traineeship in AHW:

I remember when I was just turned 18, I was always very negative about things and wasn't interested in nothing ... There was this lady there who helped workers get full-time jobs. She came to me one morning saying she had a traineeship for Aboriginal health workers that I could apply for, but I said no. She still dragged me along and helped me fill out the forms and got me clothes for the interview. When she dropped me off I remember giggling the whole way. Two weeks later a man from Wuri called me and said I got the job. I remember my whole family coming and congratulating me on my job. I could see they were proud so I thought I would give it a shot.¹¹⁸

Many Aboriginal people have made the rational decision not to become AHWs because the incentives do not match the responsibilities expected of them. While the recruitment to Aboriginal health work has traditionally been by community selection, many AHWs are now saying they do not want to work in their own communities because of family and cultural obligations. The community selection process, once viewed as so important to the AHW role, is losing its importance as higher qualifications are now needed to work as an AHW in the Northern Territory. Due to the poor literacy and numeracy skills of many remote residents, there is a limited pool from which to select community-based people.

Many Aboriginal people have made the rational decision not to become AHWs because the incentives do not match the responsibilities expected of them.

In towns and cities, AHW recruitment faces stiffer competition—not just from other health professions such as nursing but also from higher paying occupations like mining. Aboriginal people who have the skills to qualify for Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) could potentially also meet the prerequisites for nursing.

Conclusion

AHWs have been short changed. They have not only been provided with charlatan training but also sold a charlatan role. The amount of training they receive does not match the level of responsibility expected of them, and there are few opportunities for promotion within the profession. AHWs receive the lowest level of pay among community service and health occupations but are assumed to be able to deal with some of the most intractable health problems in the country. Not surprisingly, the number of people becoming AHWs today is reducing dramatically.

The numerous attempts by government to improve training for AHWs has failed because government and interest groups are no closer to defining the AHW role than they were 30 to 40 years ago. A clear definition of the AHW role and functions is an essential prerequisite for the effective delivery of training. The large number of different RTOs delivering AHW training also makes achieving consistency next to impossible. Training continues to be provided by RTOs who receive financial incentives from government to get ‘bums on seats’ but are not accountable for inadequate course delivery and poor outcomes. It is unlikely that the national registration on 1 July 2012 will make a substantive difference to the AHW role and increase its ‘professional’ status as long as these disparities and lack of accountability continue.

Currently, many AHWs are overburdened because they are performing the role of ‘Jack of all trades’ but are ‘master of none.’ Instead of continuing with a role that has had problematic and contradictory objectives from its very beginning, government should consider splitting the AHW role into three:

1. **The clinical aspect of the AHW role**, defined as the Aboriginal and/or Torres Strait Islander Primary Health Practice in the Health Qualifications Framework, correlates with competencies described in enrolled nursing training. The clinical part of the AHW role should be opened up to provide a broader and more widely recognised qualification (such as assistant nursing), which could provide a clear pathway to further studies, such as a degree in nursing. One of the problems with AHW courses is that they only prepare and ‘qualify’ Aboriginal people to work with and treat Aboriginal people. No doubt some AHWs would like to be involved more broadly in providing health care to the wider community.
2. **The community care aspect of the AHW role**, currently defined as Aboriginal and/or Torres Strait Islander Primary Health Community Care in the Health Qualifications Framework, could be changed to that of a community worker role; training for this position could be covered by the existing Certificate IV in Community Services Work.
3. **The cultural brokerage aspect of the AHW role** cannot be transferred to a mainstream position. In communities where English language and literacy remain an issue, it may be necessary to continue to have an Aboriginal person act as a translator for visiting health care providers. This position could be called Aboriginal Liaison Officer and the role extended to cover interpreting for all non-Indigenous visitors to the community. The prerequisites for this position would be fluency in English and the Aboriginal languages spoken by members of the community. However, just speaking the language may

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The future and real self-determination lies with decent schooling and education that will enable Aboriginal people to become whatever they want to be.

not be enough, as being a reliable translator requires particular knowledge and skills, specifically the ability to understand the questions being asked and communicate them to the patient or client.

The role of the AHW was an attempt to bridge two worlds, but we are preventing progress if we continue to promote AHW as the only culturally appropriate educational pathway in health care for Aboriginal people. This form of cultural relativism has promulgated many myths, namely, that Aboriginal people are unable to cope in mainstream health positions, and that they are turning their back on Aboriginal people and traditional medicine if they become nurses and doctors. However, Aboriginal people employed as nurses or doctors do not cease identifying as Aboriginal, evident in the existence of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) and the Australian Indigenous Doctors' Association (AIDA).¹¹⁹

Instead of pouring more money into an unfixable problem—AHW qualifications and training—government should invest money in quality literacy and numeracy education for remote Indigenous residents.

Those who claim there is a crisis in AHW are clinging to the past; they cannot see that change is inevitable. The future and real self-determination does not lie with the creation of yet more 'culturally appropriate' courses and career paths specifically for Aboriginal people but with decent schooling and education that will enable Aboriginal people to become whatever they want to be.

Appendix 1: Government programs and publications (1985–2011)

Table 7: Key developments (1985–2011)

Date	Policies/ reviews/publications
1985	A comprehensive review of AHWs was undertaken by the Department of Aboriginal Affairs in 1985, but a report was apparently never published. ¹²⁰
1985	The NT Health Practitioners and Allied Professional Registration Act recognised AHWs as a professional group and established an AHW Registration Board. ¹²¹
1989	The National Aboriginal Health Strategy (NAHS) emphasised the importance of Aboriginal Community Controlled Health Organisations (ACCHOS), which at the time were collectively the largest employer of AHWs.
1993–1995	<ul style="list-style-type: none"> The national consensus on improving education and training led to the federal government establishing a national reform agenda, outlined in the strategic plan of the Australian Committee on Training Curriculum (ACTRAC). In 1993, ACTRAC commissioned a project to 'identify Aboriginal and Torres Strait Islander priorities for national vocational training curriculum development.' The Community Services, Health & Education Industry Training Council (CSH&EITC) commissioned a study through the Centre for Aboriginal Studies, Curtin University of Technology, that aimed 'to identify how Aboriginal Terms of Reference (ATR) could be applied to the development of competency standards in relevant occupations, and to trial the identified process in the development of ATR competency standards for two specific relevant occupations in Western Australia.' The Australian Health Ministers' Advisory Council (AHMAC) identified the need to develop national competency standards for AHWs. The National Health and Medical Research Council (NHMRC) supported the need for competency standards for AHWs: 'Core curriculum and competency standards should be developed and recognised by the relevant accreditation agency and as required by the agreement titled "National Framework for Recognition of Training".'

1996	National competency standards were developed for AHWs throughout Australia by the National Community Services and Health Industry Training Advisory Board (ITAB). It does not appear that these standards were compulsory: ACCHOS such as Marr Mooditj Training Inc. ran their own programs until 2007.
1997	The National Aboriginal and Torres Strait Islander Health Workers Conference recommended a national curriculum for AHWs to ensure universal recognition of qualifications; a related suggestion was to adapt and modify the curriculum for local application and meet community and student requirements.
1999–2000	The Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) commissioned a National Review of Training for Aboriginal and Torres Strait Islander Health Workers . The findings were published in the report Training Re-Visions: A National Review of Aboriginal and Torres Strait Islander Health Worker Training in 2000.
2000	The Health is Life report recommended that the Commonwealth, in conjunction with the states, territories and the community-controlled sector, develop within two years a national system of training for AHWs based on agreed national standards and competencies and the varied nature of their roles. The 26 recommendations suggested the national system had to incorporate a combination of: <ul style="list-style-type: none"> • basic local training based in community-controlled organisations and involving practical work in the community • block release type training, leading to more advanced qualifications through accredited training organisations, including Aboriginal Medical Services • more formal undergraduate and post-graduate training through TAFE and university, and • supporting the development of a national training system by introducing common classifications for AHW and an agreed career structure.
2002	The Aboriginal and/or Torres Strait Islander Health Workforce National Framework was developed by the Standing Committee on Aboriginal and Torres Strait Islander Health on behalf of AHMAC. The framework was informed by the recommendations of the National Aboriginal and Torres Strait Islander Health Worker Training Review and reflected the principles in the 1989 National Aboriginal Health Strategy. Also referred to as The Yellow Book , this document outlined strategies to achieve five objectives: <ul style="list-style-type: none"> • increase the number of Aboriginal and Torres Strait Islander people working across all the health professions • improve the clarity of roles, regulation and recognition of AHWs as a key component of the health workforce, and improve vocational education and training sector support for training for AHWs • address the role and development needs of other health workforce groups contributing to Aboriginal and Torres Strait Islander health • improve the effectiveness of training, recruitment and retention measures targeting both non-Indigenous and Indigenous Australian health staff working in Aboriginal primary health services, and • include clear accountability for government programs to quantify and achieve these objectives and support for Aboriginal and Torres Strait Islander organisations and people to drive the process.
2006–07	OATSIH developed the Improving Indigenous Health Worker Employment Program to provide real jobs and real wages for 130 positions in community-based Aboriginal and Torres Strait Islander health care and substance use services. Positions paid under the Community Development Employment Project (CDEP) program were translated to 130 permanent positions providing real employment prospects and increased financial benefits for the workers and their communities.
2007	A nationally consistent health worker qualification framework (HLT07: Health Training Package) was introduced by the Community Services & Health Industry Skills Council (CS&HISC). This established opportunities for health workers to choose between clinical practice and community care streams of education, and identified training parameters for each level of qualification. ¹²²

2007	In December, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and/or Torres Strait Islander communities to close the gap in Aboriginal and Torres Strait Islander disadvantage covering a range of health, education and employment outcomes (COAG, 2009). ¹²³
2008	On 20 March, a Statement of Intent was signed by the Commonwealth government, Congress of Aboriginal and Torres Strait Islander Nurses; Indigenous Dentists Association of Australia; National Aboriginal Community Controlled Health Organisation; Australian Indigenous Doctors' Association; Aboriginal and Torres Strait Islander Social Justice Commission, and Human Rights Equal Opportunity Commission. Parties to the Statement of Intent agreed to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islanders and other Australians by 2018 (this was later extended to 2030—COAG, 2009).
2008	On 29 November, COAG signed the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and committed \$1.57 billion over four years to improve Aboriginal health and wellbeing.
2008	<p>Part of the package of funding under the National Partnership Agreement was funding for the National Indigenous Health Workforce Training Package, under which the Commonwealth government committed \$19 million over three years (2008–09 to 2011–12) to support an Indigenous health workforce and encourage more Indigenous Australians to take up health careers. It included funding for:</p> <ul style="list-style-type: none"> • the Australian Indigenous Doctors' Association (AIDA) and the Congress of Aboriginal and Torres Strait Islander Indigenous Nurses (CATSIN) to support, encourage and mentor Indigenous students and health professionals • the Aboriginal community-controlled health sector to encourage young Indigenous people to study and take up careers in health • AHWs to transition to national qualifications • establishing a National Aboriginal Health Worker Association • embedding Indigenous health into the curriculum of medical, allied health, and nursing schools, and • testing health career pathway models aimed at supporting Indigenous children from school to vocational education and training and onto university.
2008	<p>In April, the former National Aboriginal and Torres Strait Islander Health Council endorsed Pathways into the health workforce for Aboriginal and Torres Strait Islander people: a blueprint for action, which includes key recommendations for the Indigenous health workforce focusing on:</p> <ul style="list-style-type: none"> • supporting retention and attainment of Indigenous students at school and through to post school qualifications • maximising Aboriginal and Torres Strait Islander participation in the health workforce, and • retaining and building capacity of the Aboriginal and Torres Strait Islander health workforce.
2008	<p>The National Indigenous Health Equality Council (NIHEC) was established in 2008 to bring together the Australian government; the Aboriginal and Torres Strait Islander community (including the Aboriginal community controlled health sector), and the broader health sector to work towards the attainment of equal health status between Aboriginal and Torres Strait Islander and non-Indigenous peoples.</p> <p>One of NIHEC's roles is to consider workforce development and make recommendations to the Australian government concerning workforce development and sustainability, including providing advice on pathways to increase Indigenous workforce representation. At the National Indigenous Health Equality Summit, the following targets relating to the health workforce were proposed:</p> <ul style="list-style-type: none"> • provide an adequate workforce to meet Aboriginal and Torres Strait Islander health needs by increasing the recruitment, retention, effectiveness and training of health practitioners working within Aboriginal and Torres Strait Islander health settings and build the capacity of the Indigenous health workforce • increase the quality of the health services and the workforce, and • build an effective mental health/social and emotional wellbeing workforce.

2009	The Health Practitioner Regulation National Law Bill was passed—the bill outlines plans for four partially regulated professions to be included in the National Regulation and Accreditation Scheme (NRAS was introduced on 1 July 2010) by 1 July 2012. These four partially regulated professions include Aboriginal and Torres Strait Islander health practice.
2010	The National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) was formally launched by the Minister for Indigenous Health, Warren Snowdon, on 29 January 2010. According to the press release: 'The NATSIHWA will work for the interests of its Aboriginal Health Worker members by supporting their careers, professional development, networking, accreditation of the profession and representing their interests at peak regional, State and national forums.' In Western Australia, the AHWA closed down due to small membership and disagreements within the committee. ¹²⁴
2010	On 20 April, the prime minister, premiers and chief ministers of states and territories (with the exception of Western Australia) agreed on National Health and Hospital Reform Agreement at COAG. This included investment in Australia's health workforce to train more doctors, provide clinical training pathways for nursing students, and support nurses and allied health professionals working in rural areas.
2010	In April, the final report of the Aboriginal Health Worker Profession Review was released by the NT Department of Health and Families.
2011	On 20 January, the Aboriginal and Torres Strait Islander Health Worker Project Environmental Scan was released by Health Workforce Australia. The object of the Aboriginal and Torres Strait Islander Health Worker project is to inform the development of policies that will strengthen and sustain the AHW workforce. It is also hoped that the outcomes of the project will inform the requirements for national registration and accreditation of Aboriginal health practitioners due to occur on 1 July 2012.

Appendix 2: RTOs AHW training

According to the Aboriginal and Torres Strait Islander Health Worker Project, which relied on CS&HISC figures, there are 33 RTOs offering a range of programs for AHWs.

Table 8: Distribution of AHW by state/territory and qualification

No	Registered Training Organisation	CERT II		CERT III		CERT IV		DIPLOMA		ADVANCED DIPLOMA	
		HLT 21307	HLT 33207	Practice HLT 43907	Community Care HLT 440007	Practice HLT 52107	Community Care HLT 52207	Practice HLT 61307	Community Care HLT 61207		
NEW SOUTH WALES											
1	Aboriginal Health College*		X	X	X	X	X	X	X	X	X
2	Booroongen Djugen College*		X	X	X						
3	deFaye College		X	X	X						
4	NSW Health		X		X			X			
5	TAFE NSW Illawarra		X	X							
6	TAFE NSW New England		X		X					X	

7	TAFE NSW North Coast		X	X	X			X	
8	TAFE NSW Riverina		X	X	X			X	
9	TAFE NSW South Western Sydney				X				
10	TAFE NSW Western		X	X	X			X	
NORTHERN TERRITORY									
11	Batchelor Institute of Indigenous Tertiary Education		X	X	X				
12	Central Australian Remote Health Development Services Ltd*		X	X		X			
QUEENSLAND									
13	Central Queensland Institute of TAFE		X	X	X				
14	Cunningham Centre				X				
15	First Aid Safety Training		X						
16	Health Industry Training Queensland		X		X		X		
17	Queensland Aboriginal and Torres Strait Islander College for Health Education and Training*		X	X	X	X	X	X	X
18	Queensland Aboriginal and Torres Strait Islander Health Worker Education Program Aboriginal Corporation*		X	X	X	X	X	X	X

19	Southern Queensland Institute of TAFE		X		X	X	X		
20	The Bremer Institute of TAFE		X						
21	Tropical North Queensland Institute of TAFE		X						
SOUTH AUSTRALIA									
22	Aboriginal Health Council of Australia*		X	X	X	X	X		
23	Nganampa Health Council Inc*		X	X	X			X	
TASMANIA									
24	Tasmanian Aboriginal Centre Inc*		X	X	X				
VICTORIA									
25	Bendigo Regional Institute of TAFE				X				
26	East Gippsland Institute of TAFE		X						
27	Victorian Aboriginal Community Controlled Health Organisation Inc*		X	X	X				
28	Sunraysia Institute of TAFE		X						
WESTERN AUSTRALIA									
29	Aboriginal Health Council of Western Australia*		X	X	X	X	X		
30	Bega Garnbirringu Aboriginal Corporation*		X	X					

31	Kimberley Aboriginal Medical Services Council Inc*		X	X	X	X	X	X	X
32	Marr Mooditj Training Inc		X	X		X		X	
33	Wirraka Maya Health Service Aboriginal Corporation		X	X	X				

Note: * denotes ACCHOS.

My additions after checking the training.com.au website are highlighted in bold.

My own analysis from www.training.gov.au¹²⁵ found three other RTOs not listed in Table 8 but which deliver AHW training; one appears to be a non-government (private training) provider.

Table 9: Additional information on distribution of AHW training

No	Registered Training Organisation	CERT II	CERT III	CERT IV		DIPLOMA		ADVANCED DIPLOMA	
		HLT 21307	HLT 33207	Practice HLT 43907	Community Care HLT 440007	Practice HLT 52107	Community Care HLT 52207	Practice HLT 61307	Community Care HLT 61207
NEW SOUTH WALES									
34	Moving Mountains Pty Ltd							X	
QUEENSLAND									
35	Indigenous Wellbeing Centre*		X		X				
SOUTH AUSTRALIA									
36	Nunkuwarrin Yunti of South Australia Inc*				X				

Table 10: Accredited qualifications related to Aboriginal health (not specifically AHW) training

Course provider	Accredited qualification/course
NEW SOUTH WALES	
Booroongen Djugen College	Certificate II and III in Indigenous Environmental Health
NORTHERN TERRITORY	
Batchelor Institute of Indigenous Tertiary Education	Certificate II and III in Indigenous Environmental Health
QUEENSLAND	
Queensland Aboriginal and Torres Strait Islander Health Worker Education Program Aboriginal Corporation	Certificate II and III in Indigenous Environmental Health

SOUTH AUSTRALIA	
TAFE SA Regional	Certificate II and III in Indigenous Environmental Health
Pilbara TAFE	Certificate II and III in Indigenous Environmental Health
WESTERN AUSTRALIA	
Auswest Specialist Education and Training Services (ASETS)	Certificate II in Indigenous Environmental Health
Djaringo Pty Ltd*	Certificate II and III in Indigenous Environmental Health
Empower Education	Certificate II in Indigenous Environmental Health
Karraylli Adult Education Centre Aboriginal Corporation*	Certificate II in Indigenous Environmental Health
Kimberley TAFE	Certificate II and III in Indigenous Environmental Health

Course Provider	Accredited Courses
NEW SOUTH WALES	
NSW Health	Certificate IV in Aboriginal Family Health
Seventh-Day Adventist Church	Certificate III, IV and Diploma in Indigenous Lifestyle Health Promotion
QUEENSLAND	
Cunningham Centre	Certificate IV in Child and Youth Health
VICTORIA	
Victorian Aboriginal Community Controlled Health Organisation Inc	Certificate IV in Indigenous Women's and Babies Health
Victorian Aboriginal Community Controlled Health Organisation Inc	Course in Aboriginal Hospital Liaison Officer (Acute Health)

Endnotes

- 1 Lorraine Holland and Louise Lawler, 'A Plague of Presumption,' paper presented at *The Australian Rural and Remote Workforce Agencies Group Conference* (Alice Springs: 2005), 6.
- 2 CATSIN (Congress of Aboriginal and Torres Strait Islander Nurses), www.indiginet.com.au/catsin; AIDA (Australian Indigenous Doctors' Association); www.aida.org.au.
- 3 AMSANT (Aboriginal Medical Services Alliance Northern Territory), 'Closing the gap through caring for our peoples: Year of the aboriginal health worker launched,' media release (1 September 2011).
- 4 Greg Jerrico, 'And then there it was: Pretty much budget as expected,' *The Drum* (11 May 2011).
- 5 Senator Christopher Evans, Minister for Tertiary Education, Skills, Jobs and Workplace Relations, 'Gillard Government delivers national reform to Australia's VET sector,' media release (24 March 2011).
- 6 Justine Ferrari, 'Millions spent, no evidence of benefit,' *The Australian* (7–8 January 2012), 1; Auspoll, *Walk in my Shoes: Employer experiences of barriers and drivers in the employment cycle for Indigenous Australians and Indigenous experiences of barriers and drivers in the employment cycle* (report prepared for GenerationOne, 23 December 2011).

- 7 Curtin Indigenous Research Centre with Centre for Educational Research and Evaluation Consortium and Jojara & Associates, *Training Re-visions: A National Review of Aboriginal and Torres Strait Islander Health Worker Training*, report submitted to the Office for Aboriginal and Torres Strait Islander Health (Canberra: 2000).
- 8 HWA (Health Workforce Australia), *Environmental Scan: Aboriginal and Torres Strait Islander Health Worker Project, Version 7.0—Final* (20 January 2011); HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, report prepared for the NT Department of Health and Families (April 2010).
- 9 National Registration and Accreditation Scheme for the Health Profession, 'NRAS Project for the 2012 Health Professions.'
- 10 'Vital profession is facing major threat,' *Koori Mail* (7 September 2011), 29.
- 11 See previous work by the CIS on education, housing, health and alcohol: Sara Hudson, *Alcohol Restrictions in Indigenous Communities and Frontier Towns*, Policy Monograph 116 (Sydney: The Centre for Independent Studies, 2011); Helen Hughes, Mark Hughes and Sara Hudson, *Private Housing on Indigenous Lands*, Policy Monograph 113 (2010); Helen Hughes and Mark Hughes, *Indigenous Education 2010*, Policy Monograph 110 (2010); and Sara Hudson, *Closing the Accountability Gap: The First Step Towards Better Indigenous Health*, Policy Monograph 105 (2009).
- 12 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above.
- 13 Eileen Willis, 'Has the primary health worker program been successfully exported to the Northern Territory?' *Aboriginal Health Project Information Bulletin* 6 (August 1984), 13–18.
- 14 Australian Indigenous HealthInfoNet, 'Aboriginal Health Workers: Workforce Development.'
- 15 Eileen Willis, as above, 13–14.
- 16 As above, 13.
- 17 As above, 15.
- 18 As above, 15–16.
- 19 As above. It is unlikely that those trained in hospitals were from the same group who were trained on-site in remote communities. Until a formal program was devised, nurses in remote settlements gave informal instruction to AHWs from the 1960s onwards.
- 20 Eileen Willis, as above, 16.
- 21 As above, 17–18.
- 22 Dayalan Devansesen and Johnny Briscoe, 'The Health Worker Training Program in Central Australia,' *Lambie Dew Oration* (The Sydney University Medical Society, 1980), 9.
- 23 As above, 15.
- 24 As above.
- 25 Calculation from RBA website, www.rba.gov.au/calculator/annualDecimal.html.
- 26 ABS (Australian Bureau of Statistics), *Census of Population and Housing*, Customised Data Report requested by HWA (Health Workforce Australia), *Environmental Scan*, as above.
- 27 Data from the NT Health Professions Licensing Authority (2010) in HWA (Health Workforce Australia), *Environmental Scan*, as above.
- 28 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2008, Indigenous Compendium* (Canberra: Productivity Commission, 2008).
- 29 ABS (Australian Bureau of Statistics), *Census of Population and Housing*, as above.
- 30 AIHW (Australian Institute of Health and Welfare), 'Aboriginal and Torres Strait Islander People in the Health Workforce' in *Aboriginal and Torres Strait Islander Health Performance Framework 2008 Report: Detailed Analyses* (Canberra: 2008), 1856–1876. Note: An earlier publication states there were approximately 4,891 Indigenous Australians employed in health-related occupations in 2006; this figure was revised.
- 31 As above.
- 32 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2008*, as above.
- 33 ABS (Australian Bureau of Statistics), *Census of Population and Housing*, as above. Note: Exact numbers not provided in data report. HWA (Health Workforce Australia), *Environmental Scan*, as above, 88.
- 34 As above.

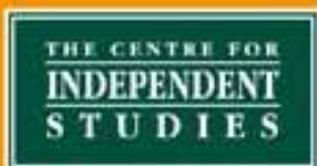
- 35 Information from various state and territory career websites: www.trainingwa.wa.gov.au (Western Australia); www.tafesa.edu.au (South Australia); www.careerthatmatter.com.au (Victoria); www.jobguide.thegoodguides.com.au (Queensland); and www.jobguide.thegoodguides.com.au (NSW/ACT).
- 36 NCETA (National Centre for Education and Training on Addiction), Submission 44 to the *Senate Select Committee on Regional and Remote Indigenous Communities* (2009).
- 37 HWA (Health Workforce Australia), *Environmental Scan*, as above, 88.
- 38 AMSANT (Aboriginal Medical Services Alliance Northern Territory), 'Closing the Gap through caring for our peoples,' as above.
- 39 Overall, three-quarters of the Indigenous health workforce were females, virtually the same proportion as for the total Australian health workforce; almost three-fifths of the Indigenous health workforce was aged between 35 and 54 years, again a similar proportion to the total Australian health workforce—see Australian Indigenous HealthInfoNet, 'Aboriginal Health Workers: Workforce Development.'
- 40 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above.
- 41 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above.
- 42 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above.
- 43 As above.
- 44 Personal correspondence.
- 45 Australian Indigenous HealthInfoNet, 'Aboriginal Health Workers: Workforce Development.'
- 46 Emma Collins, 'Aboriginal Provisions of Health Services Before and After Colonisation and Aboriginal Participation in and Control of Health,' *Aboriginal and Islander Health Worker Journal* 19:5 (September/October 1995), 26–31.
- 47 HWA (Health Workforce Australia), *Environmental Scan*, as above, 5.
- 48 NATSIHEC (National Aboriginal and Torres Strait Island Health Equality Council), 'Indigenous health workforce existing targets.'
- 49 The Parliament of the Commonwealth of Australia, *Health is Life: Report on the Inquiry into Indigenous Health* (Canberra: House of Representatives, Standing Committee on Family and Community Affairs, May 2000).
- 50 The Hon. Mark Nevill MLC (Chairman), *Report of the Standing Committee on Estimates and Financial Operations in Relation to Aboriginal Health Workers in the Kimberley Region*, Report 34 (Perth: WA Legislative Council, 12 December 2000), 21.
- 51 Australian Indigenous HealthInfoNet, 'Aboriginal Health Workers and national registration and accreditation,' *Australian Indigenous Health Bulletin* 11:1 (14 March 2011).
- 52 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above.
- 53 As above, 19.
- 54 HWA (Health Workforce Australia), *Environmental Scan*, as above.
- 55 NACCHO (National Aboriginal Community Controlled Health Organisation), 'Policy statement for the Scope of Practice of Aboriginal or Torres Strait Islander Health Workers' (Canberra: 2008).
- 56 NSW Department of Health, 'Information Bulletin: Definition of Aboriginal Health Worker' (Sydney: 2005).
- 57 Aboriginal Health Workers Board of the Northern Territory, submission to Support National Regulation of Aboriginal Health Workers in Australia (2008).
- 58 Queensland Department of Health, cited in HWA (Health Workforce Australia), *Environmental Scan*, as above, 77.
- 59 Poelina, J., et al., in Kulunga Research Network, *Start Stronger Live Longer: Resource Manual Guide for Aboriginal Health Workers* (Perth: Telethon Institute for Child Health Research, 2010), 17.
- 60 HWA (Health Workforce Australia), *Environmental Scan*, as above.
- 61 The Hon. Mark Nevill MLC, *Report of the Standing Committee on Estimates and Financial Operations*, as above.
- 62 The Menzies School of Health Research submission to Parliament of the Commonwealth of Australia, *Health is Life*, as above, 98.
- 63 Parliament of the Commonwealth of Australia, *Health is Life*, as above, 99.
- 64 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above; The Hon. Mark Nevill MLC, *Report of the Standing Committee on Estimates and Financial Operations*, as above.

- 65 The Office of Aboriginal Health, *Review of Primary Medical Care Services to Remote Area Aboriginal Communities* (WA Health Department, undated), 30.
- 66 Parliament of the Commonwealth of Australia, *Health is Life*, as above.
- 67 Lorraine Holland and Louise Lawler, 'A Plague of Presumption,' as above, 6.
- 68 Various sources, including Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above; Melvina Mitchell and Lynette M. Hussey, 'The Aboriginal Health Worker,' *Medical Journal of Australia* (MJA) 184:10 (15 May 2006), 529–530.
- 69 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above, 176.
- 70 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above; and Melvina Mitchell and Lynette M. Hussey, 'The Aboriginal Health Worker,' as above.
- 71 The Hon. Mark Nevill MLC, *Report of the Standing Committee on Estimates and Financial Operations*, as above, 32.
- 72 Komla Tsey, 'Aboriginal Health Workers: Agents for Change?' *Australian and New Zealand Journal of Public Health* 20:3 (1996), 228.
- 73 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above, 17.
- 74 As above, 23.
- 75 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above.
- 76 Lorraine Holland and Louise Lawler, 'A Plague of Presumption,' as above, 2.
- 77 Caroline Fallon, *Conflict in the Clinic: A critical analysis of impact of government policies on the roles of remote area nurses and Aboriginal health workers*, PhD thesis (Curtin University of Technology: 2008), 205, 218.
- 78 Jennifer Cramer, *Sounding the Alarm: Remote Area Health Nurses and Aboriginals at Risk* (Perth: University of Western Australia Press, 2005), 185.
- 79 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 28.
- 80 Lorraine Holland and Louise Lawler, 'A Plague of Presumption,' as above; Melvina Mitchell and Lynette M. Hussey, 'The Aboriginal Health Worker,' as above; Caroline Fallon, *Conflict in the Clinic*, as above.
- 81 Melvina Mitchell and Lynette M. Hussey, 'The Aboriginal Health Worker,' as above.
- 82 Caroline Fallon, *Conflict in the Clinic*, as above, 223.
- 83 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 36, 40; Jennifer Cramer, *Sounding the Alarm: Remote Area Health Nurses and Aboriginals at Risk*, as above.
- 84 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 36, 40.
- 85 Curtin Indigenous Research, et al., *Training Re-visions*, as above; Melvina Mitchell and Lynette M. Hussey, 'The Aboriginal Health Worker,' as above.
- 86 Schofield, et al., (1999), cited in Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above.
- 87 Curtin Indigenous Research, et al., *Training Re-visions*, as above.
- 88 As above, 137.
- 89 As above.
- 90 As above
- 91 As above.
- 92 As above, 131.
- 93 As above, 160.
- 94 As above.
- 95 CS&HISC (Community Services & Health Industry Skills Council), 'Aboriginal and Torres Strait Islander Health Worker Qualifications Framework,' Summary of qualifications part of the Health Training Package 2007 (updated March 2009).
- 96 As above.
- 97 As above.
- 98 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 31.
- 99 CS&HISC, 'Aboriginal and Torres Strait Islander Health Worker Qualifications Framework,' as above.
- 100 Information from www.training.gov.au.
- 101 Evidence given in private session to The Hon. Mark Nevill MLC, *Report of the Standing Committee on Estimates and Financial Operations*, as above, 10.

- 102 NATSIHEC (National Aboriginal and Torres Strait Island Health Equality Council), 'Education Training and Employment.'
- 103 Personal correspondence.
- 104 DEEWR (Department of Education, Employment and Workplace Relations), 'Vocational education and training outcomes for Indigenous Australians,' *Annual National Report of the Vocational Education and Training System* (Commonwealth of Australia, 2008), 272.
- 105 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 33–34.
- 106 As above, 35.
- 107 Auspoll, *Walk in my Shoes*, as above.
- 108 Health Training Package, HLTAHW304A: Undertake Basic Health Assessments (Commonwealth of Australia).
- 109 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 35.
- 110 Personal correspondence.
- 111 HCA (Human Capital Alliance), *Final Report Aboriginal Health Worker Profession Review*, as above, 36.
- 112 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above, 132.
- 113 As above.
- 114 As above.
- 115 Caroline Fallon, *Conflict in the Clinic*, 248.
- 116 Minister for Health Jillian Skinner, 'Training for Aboriginal assistants-in-nursing,' media release (2 September 2011).
- 117 Eleni Roussos (reporter) and Melinda James (presenter), 'Urgent need for more Indigenous health workers,' ABC Stateline NT (5 March 2010).
- 118 'Vital profession is facing major threat,' *Koori Mail* (7 September 2011), 29.
- 119 CATSIN (Congress of Aboriginal and Torres Strait Islander Nurses), www.indiginet.com.au/catsin; AIDA (Australian Indigenous Doctors' Association), www.aida.org.au.
- 120 Curtin Indigenous Research Centre, et al., *Training Re-visions*, as above, 159.
- 121 Emma Collins, 'Aboriginal Provision of Health Services Before and After Colonisation and Aboriginal Participation in and Control of Health Programs,' as above.
- 122 HWA (Health Workforce Australia), *Environmental Scan*, as above, 5.
- 123 As above.
- 124 Personal correspondence with a committee member.
- 125 The website www.training.gov.au encompasses the national register, which contains the authoritative information about Registered Training Organisations (RTOs), recognised training products, and the approved scope of each RTO to deliver nationally recognised training as required in national and jurisdictional legislation in Australia. Information on this site is maintained by the Registration and Course Accreditation Bodies (RCABs) and the Industry Skills Councils (ISCs).

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