NHLF
National Health Leadership Forum

Leading Aboriginal and Torres Strait Islander healthcare

Submission

House of Representatives Standing Committee on Indigenous Affairs - Pathways and Participation Opportunities for Indigenous Australians in Employment and Business

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About the NHLF

The National Health Leadership Forum (NHLF) was established in 2011. The NHLF is a collective partnership of 12 national organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing and mental health and social and emotional wellbeing.

The NHLF was instrumental in the formation of the Close the Gap Campaign and continues to lead the Campaign as the senior collective of Aboriginal and Torres Strait Islander health leadership. Committed to achieving health equality, we draw strength from cultural integrity, the evidence base and community.

The NHLF provides advice and direction to the Australian Government on the development and implementation of informed policy and program objectives that contribute to improved and equitable health and life outcomes, and the cultural wellbeing of Aboriginal and Torres Strait Islander peoples. Health is a noted human right, it is an underpinning to everyday life, and key factor in economic (and environmental) sustainability. Our vision is for the Australian health system to be free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable.

The NHLF Membership

- Australian Indigenous Doctors' Association
- Australian Indigenous Psychologists' Association
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- The Healing Foundation
- Indigenous Allied Health Australia
- Indigenous Dentists' Association of Australia
- The Lowitja Institute
- National Aboriginal and Torres Strait Islander Health Workers' Association
- National Aboriginal and Torres Strait Islander Leadership in Mental Health
- National Aboriginal Community Controlled Health Organisation
- National Association of Aboriginal and Torres Strait Islander Physiotherapists
- Torres Strait Regional Authority

Introduction

1. The NHLF welcomes the opportunity to respond to the request for submission by the House of Representatives Standing Committee on Indigenous Affairs, Inquiry into Pathways and Participation Opportunities for Indigenous Australians in Employment and Business. This inquiry will be critical in framing what the government leadership and public policy should look like to provide true employment opportunities and programs for Aboriginal and Torre Strait Islander Australians.

2. The NHLF believes that the lack of recognition in the Australian Constitution for Aboriginal and Torres Strait Islander people as the First Peoples of this country, has shaped our national identity which has contributed to the exclusion of Aboriginal and Torres Strait Islander people from full participation in Australian society.

3. Much of the psychological distress, associated mental health conditions, harmful behaviours experienced by Aboriginal and Torres Strait Islander peoples are associated with the prolonged adversity (intergenerational trauma) and exacerbated by the negative impacts of the social determinants. The social determinants such as income, access to health services, access to education, employment, transport, and housing can impact negatively on anyone, which influences health outcomes. However, the negative impacts are experienced by greater numbers of Aboriginal and Torres Strait Islander people, and more intensely. [1]

4. Aboriginal and Torres Strait Islander people have expressed repeatedly the need to eliminate the interpersonal and institutional racism that obstructs their equal access to, and outcomes from, health, economic opportunities, education and all other resources associated with self-determination and healthy sustainable living. Racism and the multi-generational experiences of trauma and dislocation continue to have real impacts on the lives of many Aboriginal and Torres Strait Islander people.[2]

5. This submission is shaped by Australia's public policy framework, culture of exclusion and privileging that has denied many Aboriginal and Torres Strait Islander people the opportunity from gaining employment and participating in social and economic activities to their full potential, whilst maintaining their identity and culture.

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[1] National Aboriginal and Torres Strait Islander Leadership in Mental Health: Dudgeon, P. Calma, T and Holland C. (2015) Future Directions in Aboriginal and Torres Strait Islander Social and Emotional Wellbeing, Mental Health and Related Areas Policy. Retrieved fromhttps://natsilmh.org.au/resources

[2] NHLF, 2017, Position Paper on Racism: https://www.catsinam.org.au/policy/position-statements; and Joint Statement (NMBA, CATSINaM, ACM, CAN and ANMF), 2018, Cultural safety: Nurses and midwives leading the way for safe heath care: https://www.catsinam.org.au/communications/press-releases-and-joint-statements.

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Response to the Inquiry's Terms of Reference

Systemic Racism and Employment

6. Systemic racism is a dominant barrier to employment for Aboriginal and Torres Strait Islander peoples. Without addressing the systemic issue of racism within our society we will not improve the employment rate for Aboriginal and Torres Strait Islander people within public and private enterprises.[3]

7. The projected population growth rate for Aboriginal and Torres Strait islander Australians is greater than the rate for non-Indigenous Australians, and this requires more effort to increase employment than just investment in education, training and skill development. Without a more national strategic investment and effort, education and training alone will not be enough to close the gap in employment.[4] Current data suggests that improvement in education and training will increase Indigenous Australians employment, yet whilst education and training is improving the employment gap is not closing to any significant level.[5] Accordingly, this inquiry needs to look at 'mainstream' Australian employers' and their recruitment and retention policies and practices, government policies and practices, as well as the macroeconomic environment, rather than focusing on the cause and placing the responsibility for the employment gap on Aboriginal and Torres Strait islander Australians.

8. Additionally, it is not possible to look at employment and business enterprises without looking at education from early childhood, primary through to secondary and onto postsecondary education. For employment to improve it is essential to look at full participation in learning and education, which contributes to economic wellbeing as well more broadly health, safety and security. Furthermore, economic participation cannot be looked at without examining the complex interplay between individual and family factors and broader community and societal factors, which all impact on employment. Solutions will be compromised if they just centre on higher education and/or the VET sector to the exclusion of other socioeconomic factors.

9. During the strong macroeconomic conditions between 1994 to 2008 there was strong employment rates including for Aboriginal and Torres Strait Islander Australians. Likewise, when the macroeconomic conditions fell so did employment and in particular male Indigenous

[3] NHLF, 2017, Position Paper on Racism: https://www.catsinam.org.au/policy/position-statements; Joint Statement (NMBA, CATSINaM, ACM, CAN and ANMF), 2018, Cultural safety: Nurses and midwives leading the way for safe heath care: https://www.catsinam.org.au/communications/press-releases-and-joint-statements; and Lai. G.C., Taylor, E.V. Haigh, M.M. and Thompson, S.C. 2018. Factors Affecting the Retention of Indigenous Australians in the Health Workforce: A system Review. International Journal of Environmental Research and Public Health. (more

[4] Gray, M., Hunter B. and Biddle, N. 2014. The economic and social benefits of increasing Indigenous employment. Centre for Aboriginal Economic Policy Research (CAEPR) Topical Issue no.1. ANU. Canberra

[5] Ibid

employment.[6] There is a pattern of strong Indigenous employment coinciding with strong economic conditions and low unemployment rates, however when conditions decline or even moderate, employments rates for Aboriginal and Torres Strait Islander Australians declines at a greater rate than for non-Indigenous Australians.[7]

10. The current health workforce distribution and shortage combined with the high demand for the Aboriginal and Torres Strait Islander health workforce where there is a proportionately higher Aboriginal and Torres Strait Islander population, is a great employment opportunity. Particularly as there is a projected growth in health, and social assistance services, of 250,000 new/ extra jobs over next 5 years (health, disability services and aged care etc), with nearly 70,000 of these in rural and remote.[8] However, creating sustainable pathways for Aboriginal and Torres Strait Islander workers in the health sector requires more than the provision and opportunity for skill development.[9]

11. From an NHLF perspective, the barriers to recruitment and retention (i.e. employment) can be summed up as a lack of valuing of Aboriginal and Torres Strait Islander people within the health services systems, because a qualification from higher education does not automatically lead to a job. Many health graduates have advised that once they leave a well-supported educational institution, they encounter hostile unsupported employment environments which leads them to walk away from a job.

Social Determinants of Health opportunities for employment

12. Health is a holistic concept that incorporates the physical, social, emotional and cultural wellbeing of individuals and their communities. Culture is a key enabler of good health - acknowledging that stronger connections to culture and country, build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety. For there to be real and sustained change, health and wellbeing must be self-determined and relative to place-based need.[10]

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[6] Gray, M., Hunter, B. and Lohoar, S. and Closing the Gap Clearinghouse and Australian Institute of Health and Welfare. 2012, *Increasing Indigenous employment rates*. Canberra; and Venn D. and Biddle, N. 2016 Census Papers. Centre for Aboriginal Economic Policy Research (CAEPR) Census Paper No. 5. ANU. Canberra.
[7] Ibid
[8] Australian Government. Department of Employment, Skills, family and Small Business. Industry Employment Projections 2019 Report. Retrieved from: http://lmip.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections.
[9] Lowitja Institute. 2014. Policy Brief: Shifting Gears in Career: Identifying Drivers of Career Development for Aboriginal and Torres Strait Islander Workers in the Health Sector. Melbourne.
[10] Prof. Ngiare Brown. 2013. *Culture is an important determinant of health*. NACCHO Summit August 2013Retrieved from: https://blogs.crikey.com.au/croakey/2013/08/20/culture-is-an-important-determinant-of-health-professor-ngiare-brown-at-naccho-summit/

13. Community building and community development align with the social determinants of health and tackling unemployment. This type of approach would provide a more robust framework than the narrower focus on service delivery and would align with and contribute to economic development.[11]

14. Whilst the focus on the social determinants of health (SDoH) is on the impact on health and well-being outcomes, they also demonstrate the intersecting issues of employment across the social and economic breadth of our society. From an NHLF perspective policy makers treat health and employment as two separate government agendas yet if these policies were designed within a complementarity framework, they would address both concerns.

15. The social determinant of health: - education/training, housing, transportation, law and justice, environment (land and water) and infrastructure are all opportunities for employment within the public and private systems. For example, housing provides shelter, safety and improved health outcomes but it also provides employment. The investment in this sector has been poor due to a focus on quick fixes delivered by external private companies resulting in substandard outcomes. Yet, investing in local communities to provide housing and maintenance services would create long term sustainable training and employment opportunities. Similarly, investments in infrastructure (water, roads, transport, communication, waste management), environmental management and education (early childhood, primary, secondary and tertiary) would create a unified strategic employment framework.

Health Sector

16. The health sector is the biggest industry for Aboriginal and Torres Strait Islander peoples' employment. It is a sector that needs more support to continue to grow and retain the Aboriginal and Torres Strait Islander health workforce.

17. There are commonalities between all the health professions in terms of: pathways into universities and the VET sector; retention and poor completion rates in higher education, and difficulties accessing employment upon graduation. For education retention[12] there are several factors that affect outcomes, including financial support, academic and literacy support, racism, cultural bias and whether learning environments are culturally safe places. The NHLF nominates the following priorities and challenges that, with support, will create more employment opportunities and retain those currently with jobs:

[11] Markham, F., Jordan K. and Howard-Wagner D. 2018. Closing the Gap Refresh: papering over the gaps or structural reform? Centre for Aboriginal Economic Policy Research (CAEPR) Topical Issue no.2. ANU. Canberra

[12] Taylor, E. V. Lalovic, A. Thompson, S.C. 2019. Beyond Enrolments: a systematic review exploring the factors affecting the retention of Aboriginal and Torres Strait Islander health students in the tertiary education system. International Journal for Equity in Health. 18:136. https://doi.org/10.1186/s12939-019-1038-7

17.1. Secondary school advice for students about gaining a job in health; university and VET pathways; support for completion and retention of Indigenous students in secondary school; support to transition from secondary school to higher education.

17.2. Increase and expand financial support to students through the Puggy Hunter Memorial Scholarship Scheme (PHMSS). The number of applications for this scholarship is greater than the available funding, which is a good example for the need for financial assistance. The funding level for this program has been steady for some time yet demand increases with an average between 15% and 28% of applicants receiving assistance (see Appendix 1). It is also timely to review the administration of the PHMSS and its outcomes for students. Other support services and financial support services include academic skill building, literacy support, cadetships and pathways into employment.

17.3. Retention: including addressing racism; lack of cultural safety in workplaces; requirement for training in cultural safety for supervisors and those undertaking recruitment roles to address the barriers to career advancement and development.

17.4. Challenges with the Aboriginal Community Controlled Health Sector (ACCHOs) include a lack of employment of Aboriginal and Torres Strait Islander nurses and midwives and an inability to provide wage parity compared to mainstream health services. The lack of employment opportunities with the ACCHO sector is often due to limited funding resources therefore many ACCHOs are compelled to employ experienced, often non-Indigenous nurses, as they don't have the resources to provide the necessary supports for newly graduated Aboriginal nurses and midwives.

17.5. Burnout: health professionals who are expected to be 'everything for everyone' including supporting Aboriginal and Torres Strait Islander patients and families, attending committees and managing their own cultural and family obligations.

17.6. Adequately funded and culturally supportive cadetships have been proven to support the retention and completion rates for Indigenous students completing university studies.

17.7. Measures and outcomes need to be set to make the health services more accountable including rates of retention of Aboriginal and Torres Strait Islander health professionals in hospitals and primary care programs.

17.8. Cultural Safety needs to be embedded into the health services and non-Indigenous health professionals need to be held to account for racist and inappropriate behaviour/attitudes towards Aboriginal and Torres Strait Islander patients and health professionals.

18. For Aboriginal and Torres Strait Islander peoples the educational and training pathways into health careers is inefficient. The gaps are found in employment opportunities / financing settings, rather than with community need and demand, which is proven and extremely high

but not met. The NHLF's view is that jobs need to be created locally and this will improve less effective service delivery and save expenditure on practices such as Fly-in and Fly-out (FIFO) employees. The ACCHO Sector has proven the value and impact on communities and is a model of employment as well as service delivery that could and should be expanded and into other areas.

19. Jurisdictional variances in legislated workforce practices such as drugs and poisons acts, impact on employment because where individuals choose to work is, for many, based on how they will be received and respected as professionals. Variances between jurisdictions towards an individual's ability to work to their full scope of practice, as provided by their education and training, will influence where that health professional chooses to work. This artificial barrier creates disparities within health profession and between professions, and as importantly for communities. For example

    19.1. The drug and poison acts in the various jurisdictions differentiate between health professionals in their ability to administer medications contrary to their scope of practice. For example, the Health (Drugs and Poisons Regulation 1996 – Qld) differentiate between Cairns and the Yarrabah Community and Aboriginal Health Practitioners' ability to administer medications.

    19.2. Similarly, the differences between Queensland and the Northern Territory means that some Aboriginal health practitioners who have wanted to work in Queensland have moved to the Northern Territory in order to work to their full scope of practice.

    19.3. CATISNAM nurses and nurse practitioners have had their employment options limited, because of the variances in the ability to work to full scope of practices a result of legislative restrictions rather than qualification and capability.

20. Similarly, the lack of a national minimal scope of practice for Aboriginal Health Workers impacts mobility and choices as to where they can work. As importantly, the lack of a consistent approach nationally to this unregulated health profession impacts on service delivery and planning to meet the needs of communities.

21. Equally, Aboriginal and Torres Strait Islander nurses and midwives have expressed frustration with a lack of employment opportunities in primary health care and community-based programs. They are often competing with non-Indigenous health professionals who despite racist and inappropriate behaviour are promoted and given senior roles. There is also a lack of leadership and senior nursing and midwifery positions given to Indigenous nurses and midwives. This is evident in Aboriginal Maternity Group Practices (AMGPs) who don't employ Aboriginal midwives. CATSINaM has been informed that a few of the AMGPs continue to employ non-indigenous midwives despite these programs targeting Aboriginal and Torres Strait

Islander women. They offer a range of reasons for the lack of Indigenous midwives including being unable to attract and retain the Indigenous midwives yet CATSINaM members want to work in this space.

22. The health sector comprises many health professions, of which only a few (15) are nationally regulated resulting in many professions not as well understood regarding their numbers, distribution and effectiveness. This lack of data of the unregulated professions is a serious gap in the information required to undertake proper health workforce planning to meet community health needs and providing employment opportunities because we don't know who is out there and who is doing what. Whilst government agencies at local levels may collect data on their health workforce it is not necessarily aggregated or shared. Workforce planning, for any industry, is an important element in increasing employment. This requires good data collection and in the case of the health system, data needs to be collected for all health professionals from training to becoming a regulated or unregulated health practitioner.

23. Currently, workforce planning is framed around defined budgets rather than on population need. This reflects the direction of workforce investment based around the quantum of funding available and not what is needed in actual staffing requirements to meet patient/client needs. There is a lack of investment in growing the workforce to meet Aboriginal and Torres Strait Islander peoples' needs. For example, Aboriginal Health Practitioners are not utilised throughout our services system, rather they are limited to the Aboriginal community-controlled health sector and some public hospitals.[13] Likewise, Aboriginal and Torres Strait Islander midwives, maternal and child nurses are not necessarily employed by services located within areas that have a high Aboriginal and Torres Strait islander population, yet we know that the Aboriginal and Torres Strait Islander population is younger, and the fertility rate is higher.

24. Allied health professionals (AHPs) provide a wide range of services and supports across the lifecycle and across our service system – health, disability, aged care and schools. But there is an acute shortage of AHPs in rural and remote Australia. These shortages are due to "failure of the market" which is a flawed concept because the service system and funding models reflect urban centre constructs. Reshaping the funding and/or market supports in rural and remote Australia provides an opportunity to increase employment.[14] Reframing market supports would also enable health service delivery to become more patient or community centric in its delivery, rather than program or funding centric which does not necessarily reflect the needs of the population/community.

[13] Bond. C 2018, Indigenous Health Program at the University of Queensland. https://www.lowitja

[14] SARRAH, Services for Australian Rural and Remote Allied Health. 2019. Submission to the Senate Selection Committee Inquiry into Jobs for the Future in Regional Areas.

25. The need for more Aboriginal and Torres Strait Islander health professionals is especially acute across northern Australia. The proportion of the population who are Aboriginal and/or Torres Strait Islander at around 10 per cent in northern Queensland; 25 per cent in the Northern Territory and close to 40 per cent in northern Western Australia. There are too few health professionals in northern Australia to provide a comparable service coverage to that enjoyed by most Australians. This makes the development of local workforce capacity and pathways even more critical, which can only be achieved through investment in health infrastructure and the workforce. [15]

26. There are opportunities to build the Aboriginal and Torres Strait Islander health workforce in remote communities with intensive Primary Health Care coaches. Training local Aboriginal or Torres Strait Islander people using a micro-credentialing (Certificate II or III) approach within the Aboriginal Health Worker or Practitioner pathway enables future extension to additional diseases with additional training if desired by the remote community. Training could be delivered on-site within the participating community leveraging VET capabilities. Micro credentialing offers participants the opportunity to use the credits gained to advance within the Aboriginal Health Worker or Practitioner pathways or move into other health care qualification pathways. Using locally recruited, trained and managed Aboriginal or Torres Strait Islander people as health coaches to intensify self-management support for chronic conditions has been successfully trialled in remote communities.[16] A co-design and governance partnership model with participating Aboriginal and Torres Strait Islander primary health care service providers, ACCHOs, government departments, health researchers, VET providers, remote communities and Primary Health Networks would be required.

27. The National Aboriginal and Torres Strait Islander Health Workforce Plan that is currently being developed, is essential to closing the gap in Indigenous disadvantage and should contribute to improving Aboriginal and Torres Strait Islander health and wellbeing by growing the Aboriginal and Torres Strait Islander health workforce across all professions and levels. The NHLF recommends that to improved health outcomes and employment all governments through the COAG Health Council must agree on sustained investment to complement the implementation of this Health Workforce Plan including:
    27.1. investment in Indigenous-led models of pathway programs from VET in schools, greater support for VET programs with the articulation onto tertiary studies,

[15] IAHA. 2019. Submission to the Senate Select Committee Inquiry on the effectiveness of the Australian Government's Northern Australia Agenda.
[16] Burgess CP, Bailie RS, Connors CM, Chenhall RD, McDermott RA, O'Dea K, et al. Early identification and preventive care for elevated cardiovascular disease risk within a remote Australian Aboriginal primary health care service. BMC Health Services Research. 2011;11(1):24.

27.2. increase and expand support for cadetships and traineeships supported by an Indigenous-led pathways program,

27.3. increase the funding level for the Puggy Hunter Memorial Scholarship Scheme and evaluate the effectiveness for student outcomes,

27.4. create consistency across jurisdictions in their drugs and poisons Act for all health professionals, and

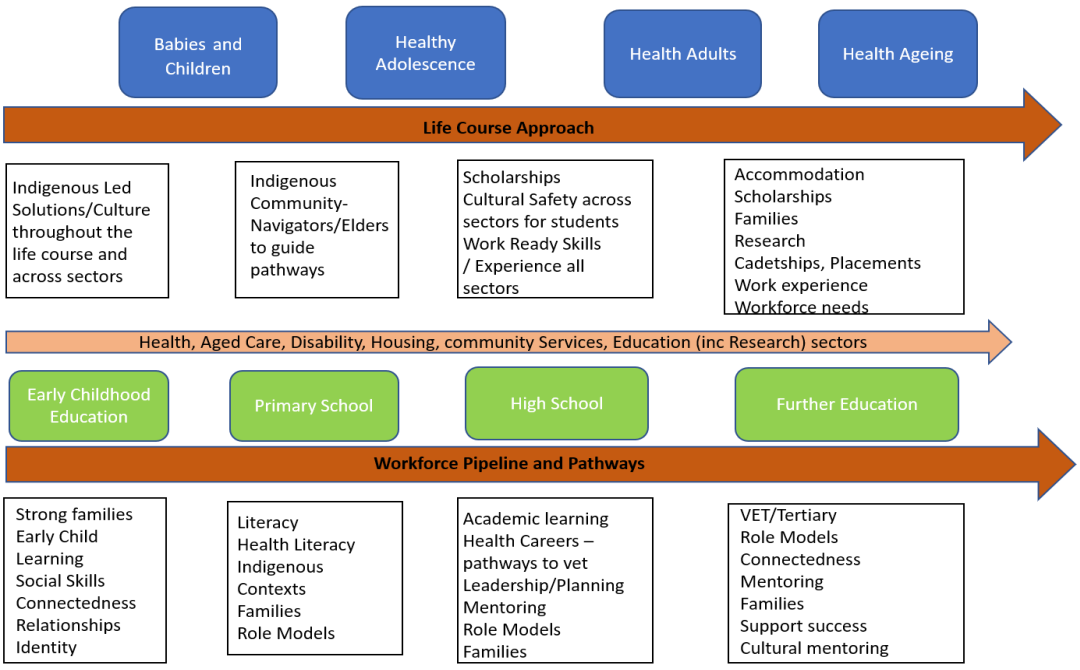
27.5. invest in data and research capacity building to grow the Aboriginal and Torres Strait Islander health research workforce

Indigenous Led Pathways

28. A nationally supported employment strategy is required and must be framed around workforce planning across sectors and take a long-term perspective such as 10 years, instead of short-term financial year framing. The Department of Health's primary health care reform process demonstrates the shared common workforce and community objectives between health and employment.

29. Developing an employment strategy from this inquiry framed around the SDoH sectors as well as taking a life course approach would provide the guidance for forward planning. The life course approach illustrates the pipeline and pathways required to improve Indigenous employment and creating Indigenous business enterprises, see figure 1 below.

Fig. 1 Holistic Approach to Employment and Workforce Planning



30. Implementing Indigenous-led pathway programs would recognise and enhance existing Indigenous capabilities, leadership and enable transformative aspirations.[17] It would enable families and communities to be engaged from early childhood through to high school and beyond to showcase career choices. It would enable employment and education to intersect more deeply, it would assist in countering racism within schools as demonstrated by low expectations of teachers and therefore lack of support to students which is an inherent barrier to school retention good educational outcomes. This approach aligns with the approach previously mentioned in point 18.

31. The ACCHO sector and the Aboriginal community-controlled training organisations are great examples of Indigenous led models of service delivery, education, training and employment. However, their funding has primarily been framed around health service delivery and health outcomes rather than as an employer and providing employment opportunities. Studies have shown that ACCHOs deliver more cost-effective, equitable and effective primary health care services to Aboriginal and Torres Strait Islander peoples.[18]

32. A key problem within current educational pathways into health careers is a lack of consistency in information and processes between VET and higher education regarding credit and recognition for prior learning (RPL). For example, NATSIHWA[19] is working with individual universities regarding recognition for RPL for Aboriginal Health Workers or Aboriginal Health Practitioners who wish to go to university and advance their health career. There is no national consistency regarding credit or RPL across health curriculums for those wanting to move from VET sector training and work experience and enter high education.

33. Pathways from education and unemployment into careers need to be better supported. The current pathways are too ad hoc – investment in workforce planning needs to include better coordinated and tracked across all sectors (portfolios) and across jurisdictions. Pathways include school-based traineeships that lead to health qualifications but could lead to other sectoral qualifications. Cadetships linking education either tertiary or vet with employers enables an individual to earn and learn at the same time and gain the valuable employment experience often required by recruiters. These pathways allow for health career planning at high school to provide aspirational thinking lead by Indigenous professionals and sectors to demonstrate to young people that their options can be broad if they choose the right subjects and complete school.

[17] Op Cit. Bond. 2018.
[18] Ong, K S, R Carter, M Kelaher, and I Anderson. 2012. Differences in Primary Health Care Delivery to Australia's Indigenous Population: A Template for Use in Economic Evaluations, BMC Health Services Research 12:307
[19] The National Aboriginal and Torres Strait Islander Health Worker Association

34. Indigenous-led pathway models help with career development, which is lacking in the mainstream health system, and arguably across many sectors, this needs to be consciously supported through investment of funding, resources, and time to enable health professionals to advance their careers in order to retain them. The type of support required is cultural support (personal and professional) and mentoring. Having access to supportive professional associations and implementing anti-racism strategies is requirement to improve employment rates. But this approach would also go beyond the narrow focus of workforce numbers and professional skill development or occupational aspirations it's a model that could be part of transformative change to communities, services and systems.[20]

35. Health and the National Disability Insurance Scheme are growth areas for employment. With more articulated pathways into health and the disability sectors and with appropriate conditions for trainees, including remuneration, minimum length of funding for positions, appropriate training, gaining a qualification through a traineeship, support/mentoring etc these sectors can increase the number of Aboriginal and Torres Strait Islander people employed. The NHLF encourages this inquiry to examine government policy in order to recognise and incorporate the commonalities between health/employment/community in long-term planning around employment.

36. The NHLF supports the First Peoples Disability Network and their work calling for whole-of-community approaches that incorporates peer to peer leadership that implements inclusive education and employment programs. This approach would recognise and value the existing skills, knowledges and experiences of people within the disability and enable people with disabilities to be self-determining but also inform this inquiry's interest in increasing employment for Aboriginal and Torres Strait Islander peoples and business enterprises.[21]

37. Health research is another example of where there are opportunities for employment. There is enough research that demonstrates that the role of Indigenous peoples conducting research provide vital work in improving infrastructure of the broader health workforce such as frontline service delivery requirements.[22] To grow the Australian Aboriginal and Torres Strait Islander health research workforce, more support is required to develop pathways to careers and provide stable employment.

[20] Op Cit. Bond. 2018.
[21] First People's Disability Network. (2018). *FPDNA.* Retrieved from Ten Priorities to Address Disability Inequity in Aboriginal and Torres Strait Islander Communities for the NDS and the NDIS: https://fpdn.org.au/wp-content/uploads/2018/10/FPDN-ten-priorities-2018.pdf
[22] Ewen, S.C. Ryan, T. and Platania-Phung, C. 2019. Capacity building of the Australian Aboriginal and Torres Strait Islander health researcher workforce: a narrative review. Human Resources for Health 17:10 https://doi.org/10.1186/s12960-019-0344-x

Government policy and accountability

38. The Indigenous Procurement Policy (IPP) and other policies designed to grow Aboriginal and Torres Strait Islander business enterprises must be properly implemented and accountable. The objectives of the IPP are to increase employment; stimulate private investment in Indigenous business; create Indigenous wealth and to enable economic development in remote and regional locations. There is a role for the Productivity Commission to evaluate if the IPPs measurable outcomes are being achieved.

39. Currently, IPP eligibility requires businesses to be 50 percent or more owned by Indigenous Australians. Many large and small non-Indigenous businesses have developed joint enterprises with Aboriginal or Torres Strait Islander people to exploit the IPP. The 50% rule raises questions about how much benefit from these enterprises goes to Aboriginal or Torres Strait Islander people, how much of the IPP process looks at program outcomes and ignores the inputs? It is not good enough for government to allow corporations to establish Aboriginal fronted entities to access procurement opportunities that are targeted to Aboriginal and Torres Strait Islander owned and identified businesses. The IPP should not enable 'black cladding' of non-Indigenous organisations that takes away from genuine Indigenous owned business or community led business development. To do so, undermines the intention of the IPP. Allowing resources and capacity of major corporations who have the capacity to establish a subsidiary that are not representative of community and provide no real benefit to improving employment outcomes for Aboriginal and Torres Strait Islander peoples.

40. Another example of where outcomes are not necessarily meeting the intent of government policy is the Primary Health Networks (PHNs). PHNs have a commissioning role to engage providers to fill service gaps in priority areas such as Aboriginal and Torres Strait Islander health. These gaps are often in areas where there are ACCHOs but due to their limited funding can't provide the necessary services. This raises questions of why the ACCHOs were not directly funded to fill the identified gaps when they are a provider on the ground and able to fill the gaps if funded to expand capacity and capability. This would have enabled this sector to increase their employment opportunities for Aboriginal and Torres Strait Islander people.

41. As PHNs have the role as commissioning agent they should be directly engaging with the ACCHO sector and/or other Aboriginal and Torres Strait Islander health organisations to address the gaps identified in Aboriginal and Torres Strait Islander Health. Whilst the PHN and ACCHO Guiding Principles (March 2016) state that 'commissioned service delivery will be a strengths-based approach reflecting the United Nations Declaration on the Rights of Indigenous Peoples'; it appears that commissioning processes vary greatly between PHNs and between jurisdictions

with evidence of fragmentation and lack of coordination. Hence not only are there inefficiencies in service delivery there are missed opportunities to increase employment in this sector. [23]

42. Additionally, where the PHNs commission non-Indigenous providers to fill the service gaps for Aboriginal and Torres Strait Islander peoples, the PHNs should ensure that these providers employ Aboriginal and Torres Strait Islander staff and their non-Indigenous staff are delivering culturally safe and responsive services. Furthermore, PHNs also have a role to play to support services, such as general practices, who have Aboriginal and Torres Strait Islander clients to ensure they are delivering culturally safe and responsive care. In turn PHNs also need to become culturally safe, address institutional racism and include Aboriginal and Torres Strait Islander people within their governance and executive as well as improving their accountability.

43. As with the IPP, the PHNs and their commissioning role to engage providers to fill service gaps should also be evaluated under the umbrella of the Productivity Commission and the Indigenous Evaluation Strategy. Key questions of such an evaluation are:
    - How much?
    - Which PHNs?
    - Who gets what?
    - How are program outcomes measured and reported?
    - How do PHNs manage their accountability to Aboriginal and Torres Strait Islander communities?
    - How do PHNs manage their governance to include Aboriginal and Torres Strait Islander communities?

44. Much of Australia's health and support service system is predicated on models that are designed for high population, metropolitan settings that do not easily translate to rural, remote and especially Aboriginal and Torres Strait Islander community settings. Often policy and program adjustments designed to translate services to these settings are little more than:

    44.1. a scaling down of the service, which in practical terms often means a removal of allied health and other less "general", but effective care services; and/or

    44.2. purportedly delivered through inadequate, infrequent and ineffective visiting services and/or telehealth-type servicing.

45. To meet the needs of Aboriginal and Torres Strait Islander peoples and communities, governments and other stakeholders need to fundamentally look at ways to develop local services which in turn provide a local employment base. For example, part of the Indigenous led pathways model is the development of an assistant workforce, providing ongoing therapy

[23] Lesley Russell, Paresh Dawda (2019). The role of Primary Health Networks in the delivery of primary care reforms. Retrieved from Analysis and Policy Observatory Website: https://apo.org.au/node/220956

and assistance under direction of professionals who may be available less frequently in location. This requires supporting education and training models that NHLF member organisations have suggested in their own submissions to various inquires.

46. There also needs to be more accountability from mainstream services who receive funding to deliver services to Aboriginal and Torres Strait Islander communities yet do not employ Aboriginal and Torres Strait Islander people. Employment programs require investment with the intent of enabling people to obtain sustainable long-term jobs and this requires skill development for industries and prospective employers. Employment programs need to be framed around developing employment opportunities with business not as a means of justifying income assistance payments. Jobs are more than just welfare, they provide income independence and give people a purpose, which combined, assists with social and emotional wellbeing through enabling access to the other social determinants of health.

47. Government programs need to look at matching skill development and qualifications for the unemployed with local and regional employment opportunities[24] to allow people to remain with family and community and if they wish on country. Shifting Gears 2014 Policy Brief argues that current approaches to health policy are an impediment to careers for Aboriginal and Torres Strait Islander health workforce and puts forward a conceptual framework of five key drivers of change for career opportunities:
    i. Policy frameworks
    ii. Workplace processes
    iii. Individual characteristics
    iv. Intermediary behaviour
    v. Professional association interventions.

[24] Venn D. and Biddle, N. 2016 Census Papers. Centre for Aboriginal Economic Policy Research (CAEPR) Census Paper No. 5. ANU. Canberra.

Recommendations

48. The NHLF recommends the following action by the COAG Health Council to improve employment opportunities for Aboriginal and Torres Strait Islander peoples within the health sector:

    48.1. agree to endorse and implement the National Aboriginal and Torres Strait Islander Health Workforce Plan (once completed), and

    48.2. agree on sustained investment to complement the implementation of the National Aboriginal and Torres Strait Islander Health Workforce Plan including:

    - Indigenous-led pathway programs from VET in schools, greater support for VET programs with the articulation onto Tertiary studies,
    - increase and expand support for cadetships and traineeships,
    - increase the funding level for the Puggy Hunter Memorial Scholarship Scheme, and for the Scheme to be evaluated for its effectiveness for student outcomes,
    - create consistency across jurisdictions in their drugs and poisons Acts for all health professionals, and
    - invest in research capacity building to grow the Aboriginal and Torres Strait Islander health research workforce.

49. The NHLF also recommends that this Inquiry listen to the First Peoples Disability Network on how to improve support services, social inclusion and as importantly employment for Aboriginal and Torres Strait Islander peoples with a disability.

Appendix A

Puggy Hunter Memorial Scholarship Scheme

The table below show the cohort, total number of applications received, and the scholarships offered:

Cohort	Total applications	Scholarships awarded
2020	654	100
2019	360	100
2018	523	78
2017	470	100
2016	466	133
2015	422	109
2014	510	140
2013	460	155
2012	533	153
2011	413	112
2010	304	169
2009	242	136
2008	174	120
2007	219	76
2006	126	77
2005	84	37
2004	52	26
2003	?	15
2002	?	8