REPORT OF THE

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

IN RELATION TO

ABORIGINAL HEALTH WORKERS IN THE KIMBERLEY REGION

Presented by Hon Mark Nevill MLC (Chairman)

Report 34

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

Date first appointed:

December 21 1989

Terms of Reference:

1. There is hereby appointed a Standing Committee to be known as the *Estimates and Financial Operations Committee.*
2. The committee consists of 5 members.
3. The functions of the Committee are to consider and report on:
   (a) the estimates of expenditure laid before the Council each year; and
   (b) any matter relating to the financial administration of the State.
4. The Committee shall report on the estimates referred under clause 3 by or within one sitting day of the day on which the second reading of the *Appropriation (Consolidated Revenue Fund) Bill* is moved.
5. For the purposes of clause 3(a), the House may appoint not more than 6 members at any stage of its examination.
6. A reference in clause 3 to "estimates of expenditure" includes continuing appropriations, however expressed, that do not require annual appropriations.
7. The Committee may initiate investigations under clause 3(b) without prejudice to the right of the Council to refer any such matter.

Members as at the time of this inquiry:

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Hon Muriel Patterson MLC
Hon Ed Dermer MLC
Hon Simon O'Brien MLC
Hon Ljiljanna Ravlich MLC

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Government Response

This Report is subject to Standing Order 337:

> *After tabling, the Clerk shall send a copy of a report recommending action by, or seeking a response from, the Government to the responsible Minister. The Leader of the Government or the Minister (if a Member of the Council) shall report the Government's response within 4 months.*

The four-month period commences on the date of tabling.

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IN RELATION TO

ABORIGINAL HEALTH WORKERS IN THE KIMBERLEY REGION

1 EXECUTIVE SUMMARY AND RECOMMENDATIONS

Executive Summary

1.1 The continuing poor health status of Aboriginal people throughout Australia is a cause for great concern. In the Kimberley region of Western Australia, Aboriginal people face the additional health burdens of a particularly harsh physical environment combined with remoteness from quality health services.

1.2 During the course of the Standing Committee on Estimates and Financial Operations ("the Committee") inquiry into the provision of health services in the Kimberley region, the Committee was struck by the fact that many of the submissions received by the Committee expressed the view that the standard of Aboriginal health in the region was worse now than it had been 30 years ago.

1.3 One of the areas in which the Committee believes that the State Government could make a significant contribution to improving the access of Aboriginal communities in the Kimberley region to effective health services is by making better use of Aboriginal Health Workers ("AHWs"). As one witness told the Committee:

> *"Health work is the area in which I could see a good investment but making sure it is coupled with good placements, supervision and an ongoing position, so that they are not there for 12 months and cut out. That would be a medium-term investment in Aboriginal health that would make quite a difference, but it has got to be done with good supervision so there is support for them, they get some training, use it, get more training and get more skilled. That certainly needs to be coupled with some sort of registration or accreditation system, otherwise they are left in limbo next time someone else comes in."*[1]

[1] Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, p. 10.

1.4 In the 32nd Report of the Committee, *Environmental Health in Aboriginal Communities in the Kimberley Region*, the Committee recommended that the primary focus of State Government spending in the area of Aboriginal health be on the provision of basic community-based health programs, public health education, and environmental health programs.[2] The Committee envisages that AHWs would play a key role in such a redirection in the focus of programs providing health services to Aboriginal people in the Kimberley region.

1.5 The Committee notes, however, that before AHWs can assume a more prominent and effective role in the provision of health services to Aboriginal people, that the State Government must take action to resolve the following important issues:

1.5.1 the provision of standardised training for AHWs throughout the State;

1.5.2 the introduction of a basic qualification and reasonable minimum competencies for all AHWs;

1.5.3 the amendment of the *Poisons Regulations 1965* so as to enable senior AHWs in remote area nursing posts to administer Schedule 4 medications to patients in emergency situations;

1.5.4 the introduction of statutory regulation of AHWs, so as to define the position of "AHW", and to maintain the basic qualifications, competencies and professional conduct standards of all AHWs;

1.5.5 the introduction of clear Job Description Forms and Duty Statements for the position of AHW within the Health Department of Western Australia ("HDWA");

1.5.6 consistency between the job entitlements available to AHWs employed by the HDWA and those provided to other professional health staff within the HDWA; and

1.5.7 the introduction of a career structure within the HDWA to enable appropriately qualified AHWs to advance to management positions, or alternatively to become enrolled nurses and registered nurses.

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[2] Standing Committee on Estimates and Financial Operations, *Environmental Health in Aboriginal Communities in the Kimberley Region*, Report 32, dated November 14 2000, tabled in the Legislative Council on November 16 2000, Recommendation 1, p. 83.

Recommendations

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RECOMMENDATION 1

The Committee recommends that the number of State Government employed or funded Aboriginal Health Workers in the Kimberley region be increased as part of a shift in the focus of the provision of State Government Aboriginal Health services in the Kimberley region to more community-based, preventative, health services.

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RECOMMENDATION 2

The Committee recommends that State Government employed or funded Aboriginal Health Workers take a much greater role in preventative health education in all Aboriginal communities throughout the Kimberley region. The role should include education regarding environmental health. Aboriginal Health Workers should practice in association with the local governments' Environmental Health Officers and Aboriginal Environmental Health Workers.

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RECOMMENDATION 3

The Committee recommends that an accredited standard training program and qualification be developed for all Aboriginal Health Workers in Western Australia.

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RECOMMENDATION 4

The Committee recommends that TAFE take responsibility for providing an accredited standard training program for Aboriginal Health Workers in Western Australia.

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RECOMMENDATION 5

The Committee recommends that State Government employed or funded Aboriginal Health Workers working in remote Kimberley communities be given access to the benefits and inducements provided to other Kimberley-based health professionals who work in these communities.

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RECOMMENDATION 6

The Committee recommends that the State Government adopt a career structure for Aboriginal Health Workers within the Health Department of Western Australia similar to those currently in place within Queensland Health and the Territory Health Services.

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RECOMMENDATION 7

The Committee recommends that the *Poisons Regulations 1965* be amended so as to permit senior Aboriginal Health Workers working at remote area nursing posts to administer according to protocol to patients in emergencies those medications that are listed in Schedule 4 of the *Poisons Act 1964.*

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RECOMMENDATION 8

The Committee recommends that the qualifications and standards of conduct of Aboriginal Health Workers in Western Australia be regulated by way of a statutory registration and disciplinary scheme along the lines of that which is presently operating in the Northern Territory under the *Health Practitioners and Allied Professionals Registration Act* (NT) and the *Dental Act* (NT).

2 INTRODUCTION

2.1 The Standing Committee on Estimates and Financial Operations ("the Committee") was first appointed on 21 December 1989. Under its terms of reference, the Committee is required, *inter alia*, to consider and report on any matter relating to the financial administration of the State.

2.2 In June 2000, the Committee resolved to inquire into the expenditure of public funds on the provision of health services in the Kimberley region of Western Australia. The following terms of reference were adopted for the inquiry:

> *"The Standing Committee on Estimates and Financial Operations shall conduct an inquiry and report to the Legislative Council on the allocation and expenditure of public financial resources on the provision of health services in the Kimberley region of Western Australia having regard to:*
>
> *1. The facilities and resources available to, and working conditions of, the State Government health service providers in the Kimberley region.*
>
> *2. The provision and effectiveness of public funding for health services in remote areas of the Kimberley region.*
>
> *3. The provision and effectiveness of public funding for community education and preventative health programs in the Kimberley region.*
>
> *4. The provision and effectiveness of public funding for specialist medical services in the Kimberley region.*
>
> 5. *The provision and effectiveness of public funding for health services to Aboriginal communities in the Kimberley region.*
>
> 6. *Any other matters in relation to the provision of public funds for health services in the Kimberley region."*

2.3 The Committee advertised the above terms of reference in relevant newspapers, and called for public submissions. Public hearings were conducted in the major towns of

the Kimberley region during the week of August 21-25 2000. Further public hearings were conducted in Perth.

2.4 Due to the volume of evidence gathered, and the wide variety of issues raised during the inquiry, the Committee has chosen to prepare a number of separate reports, each based upon a specific issue that the Committee has identified as significant in relation to the provision of health services in the Kimberley region. This report is the third of these separate reports arising from the inquiry, and shall deal with the issue of AHWs in the Kimberley region of Western Australia.

2.5 The Committee would like to thank all those persons and organisations that made submissions to the Committee and/or appeared as witnesses in hearings before the Committee (for a list of witnesses and submissions received during the inquiry, see Appendix B of the 32nd Report of the Committee, *Environmental Health in Aboriginal Communities in the Kimberley Region*). In particular, the Committee expresses its gratitude for the assistance given to the Committee by the staff of the HDWA.

2.6 The Committee would like to note, however, that a significant number of individuals approached by the Committee expressed reluctance to make any submission to the Committee due to a fear of intimidation and prejudice in their employment position.

2.7 Whether these fears are real or imagined, the Committee found during the course of the inquiry that there is an inordinately high degree of fear and mistrust both between and within the various government agencies, private organisations, and individuals working in the area of Aboriginal health in the Kimberley region. Whilst the Committee makes no specific recommendation regarding this situation, readers of this report should note this very important aspect of the difficult environment in which health service providers operate on a day-to-day basis in the Kimberley region of Western Australia.

3 THE ROLE OF AHWS

3.1 AHWs are employed within most of the Australian states and territories, although the majority of AHWs work in the Northern Territory and Western Australia. AHWs, in the main, work for either state or territory government health departments or within the Aboriginal community-controlled (and essentially Commonwealth funded) health services, which are generally known as Aboriginal Medical Services ("AMSs"). Some Aboriginal communities employ their own AHWs.

3.2 The Kimberley based AMSs are members of the Kimberley Aboriginal Medical Services Council Inc., ("KAMSC"). Most of the full-time employed AHWs in the Kimberley region work for the members of KAMSC:

> *"The Kimberley is unique in relation to the cooperative relationship between independent Aboriginal community controlled health services. Member services comprise the East Kimberley Aboriginal Medical Service (Kununurra), Yura Yungi Aboriginal Medical Service (Halls Creek), Nindilingarri Cultural Health Service (Fitzroy Crossing), the Derby Aboriginal Health Service, Jurrugk Aboriginal Health Service (Gibb River Road), the Broome Regional Aboriginal Medical Service and Beagle Bay and Bidyadanga community health services. There are also individual community clinics jointly managed under formal agreements between ACCHSs and communities (at Ringers Soak, Doon Doon and Glen Hill communities)."*[3]

3.3 KAMSC advised the Committee of the following distribution of AHWs employed by AMSs in the Kimberley:

> *"There are 32 AHWs currently employed in the 5 centres* [that is, all of the Kimberley towns, except Wyndham] *and 3 homelands communities with established or developing Aboriginal community controlled health services. These cover a range of career options including public health program management, clinic supervisors, educators, health promotion, clinic and health program work and remote community practice."*[4]

3.4 Within the Kimberley Health Service of the HDWA, there are 838 permanent and casual "active" employees.[5] Of these 838 employees, 226 are Registered Nurses, 50 are Enrolled Nurses, 38 are Nursing Assistants, 34 are General Medical Practitioners, and only 33 are AHWs.[6] In 1999, the population of the Kimberley region was 29,527, which is approximately 1.6 percent of the Western Australian population.[7] The Kimberley Aboriginal population, estimated by the Australian Bureau of Statistics in its 1996 Census at 11,467 but most recently estimated at up to 15,500 people, comprises between 40 percent and 50 percent of the regional population.[8] Over a

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3 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 11.

4 Ibid, p. 10.

5 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 1, p. 5.

6 Ibid.

7 Submission by Hon John Day MLA, Minister for Health, August 30 2000, pp. 8-9.

8 Submission of Kimberley Aboriginal Medical Services Council Inc., July 31 2000, p. 2.

quarter of the total Western Australian Aboriginal population reside in the Kimberley region.[9]

3.5 The Kimberley Health Service of the HDWA employs AHWs within Community Health services in each of the six Kimberley towns, that is: Broome (one Level 3 and one Level 2 position); Derby (four Level 2 positions); Fitzroy Crossing (two Level 2 positions); Halls Creek (three Level 2 positions); Kununurra (one Level 3 and 1.5 Level 2 positions); and Wyndham (one Level 3 and two Level 2 positions). Further AHWs are employed at the Community Health Remote Area Clinics in Kalumburu (two Level 2 positions), Warmun (two Level 1 positions), One Arm Point (one position), Looma (one position), Noonkanbah (one Level 2 position), and Wangkatjungka (one Level 2 position).[10] HDWA employed AHWs also take part in a visiting service to the Aboriginal communities of Bayulu, Bidyadanga, and Mowanjum.[11] AHW positions are also provided within Public Health services to work in the areas of health promotion (one position in Broome), nutrition (one position in Wyndham), and road safety (one position in Broome).[12]

3.6 None of the HDWA employed AHWs work in acute care in any of the six public hospitals in the Kimberley.[13]

3.7 Under the State Government's Norhealth 2020 Plan, it is anticipated that the number of AHWs trained and employed in the North West of the State will increase, with the exact number of additional AHWs to be determined in conjunction with Aboriginal Regional Planning processes to address service gaps across Aboriginal communities.[14]

3.8 The *Kimberley Regional Aboriginal Health Plan* recently identified a serious shortage in the number of AHWs employed by the State Government.[15] The Plan noted a deficiency of about 100 AHWs across the Kimberley.[16] Of particular concern to the

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9 Ibid.

10 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 3, Attachment A, p. 25.

11 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 4, Attachment B.

12 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 3, Attachment A, p. 26.

13 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

14 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 6, p. 39.

15 David Atkinson, Catherine Bridge, and Dennis Gray, *Kimberley Regional Aboriginal Health Plan: Executive Summary and Recommendations*, December 1999, p. 4.

16 Ibid.

Committee, is the fact that the Plan suggests that the number of AHWs employed by the HDWA in some areas has declined in recent years.[17] The Plan noted that:

> *"While the Aboriginal Community Controlled Health Services encourage and foster Aboriginal employment, the State run health care services employ relatively few local Aboriginal people. The Aboriginal employment that does exist within these services consists of a small number in positions such as cooking, cleaning and general maintenance, a small number of AHWs and very few indeed in other professional positions."*[18]

3.9 The *Kimberley Regional Aboriginal Health Plan* identified the employment and improvement of conditions of AHWs as one of the highest priorities for increases in recurrent funding in the provision of health services in the Kimberley.[19] The Plan specifically recommended that a goal be set for the Kimberley of an AHW to population ratio of one AHW per 100 Aboriginal population, which would effectively involve a trebling of existing AHW numbers.[20]

3.10 The Committee also notes that there is an urgent need for more male AHWs to be trained and employed throughout the Kimberley. A recent review of Aboriginal communities south of Halls Creek noted anecdotal evidence that there is an increase in the numbers of men attending health clinics when male medical staff are in attendance.[21]

3.11 The role of AHWs in the Northern Territory was recently defined by the Territory Health Services in the following role statement:

> *"The role of the Aboriginal Health Worker in the Health Delivery Service is to act as a broker in the health delivery of the service to enable their communities to take responsibility for the management of the standard of health in their community.*
>
> *AHWs do this by taking the principle role in the delivery of a Primary Health Care system to work with community management, families and individuals, using the empowerment bestowed in them by*

17 Ibid.

18 Ibid, p. 11.

19 Ibid, p. 6.

20 Ibid, recommendation 30, p. 22.

21 John Wakerman, John Tregenza, and Ilan Warchivker, *Review of Health Services in the Kutjungka Region of Western Australia*, Final Report, October 1999, p. 21.

> *communities in which they work and their training and experience in both the Medical Health and Traditional Health models.*
>
> *The aim is a general improvement of the health of the community through a health delivery system that meets the needs and priorities of the community with a delivery that is socially and culturally acceptable to its clients."*[22]

3.12 The most important role played by AHWs is in instilling within Aboriginal communities a degree of trust and confidence in the medical services provided by the HDWA and the AMSs. Aboriginal people naturally feel more comfortable dealing in the first instance with a health service provider who understands their culture and beliefs. As KAMSC noted in its submission:

> *"There is anecdotal evidence and some qualitative research indicating significant problems with the cultural safety of many mainstream health services for Aboriginal people. At worst this can result in personal discomfort and late presentation of sick Aboriginal clients; at worst, overtly discriminatory treatment and unnecessary morbidity and mortality."*[23]

3.13 The Committee was told that there is often a breakdown in communication between young, university-educated, nurses and Aboriginal people in remote communities. Aboriginal people are more likely to be open and communicate their health problems to another Aboriginal person.[24]

> *"You have to understand that Aboriginal people will listen to their own. They have got confidence in their own persons, in their own ranks, and they will not tell another white nurse their problems to the fullest. They will tell them the good things but they will not tell them really what is wrong with them and this is where the decline in health has deteriorated within the last 10 years because most of our health workers have gone and been replaced with more nurses."*[25]

3.14 AHWs also provide a degree of continuity of medical service. There is an extremely high turnover of doctors and nursing staff in the Kimberley region, both within the

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22 Tracy Worrall and John Clarke, *Status Report on Aboriginal Health Worker Training in the Northern Territory*, Office of Aboriginal and Torres Strait Islander Health, June 2000, pp. 2-3.

23 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 5.

24 Ms Elsta Foy, Shire Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 20.

25 Evidence given in private session.

HDWA health services[26] and the AMSs. For instance, the Committee understands that the Broome Regional Aboriginal Medical Service has had a turnover of 22 locum doctors in the last twelve months.

3.15 The Committee is of the view that the number of AHWs employed by the HDWA should be increased in all areas of health service provision across the Kimberley.

RECOMMENDATION 1

The Committee recommends that the number of State Government employed or funded Aboriginal Health Workers in the Kimberley region be increased as part of a shift in the focus of the provision of State Government Aboriginal Health services in the Kimberley region to more community-based, preventative, health services.

3.16 The Committee notes that there is presently some uncertainty within both the government and community-controlled health sectors as to the precise role of AHWs, and the actual duties performed by AHWs can vary considerably depending upon their immediate supervisors. Some AHWs are given significant responsibilities and independence in decision-making, whilst others are simply used as errand runners and drivers:

> *"In the Health Department they like to employ us just as their little taxi drivers or their little jacky jackys."*[27]

3.17 Dr David Atkinson, of the University of Western Australia, is presently conducting a review, on behalf of the Office of Aboriginal Health of the HDWA, of AHW training in Western Australia. The review is part of a national, Commonwealth funded, review of AHW training.[28] Dr Atkinson advised the Committee that many problems identified by AHWs as arising from inadequate training, were, in fact, related to inadequate supervision and support for AHWs on the job.[29] Dr Atkinson noted:

> *"The continual on-the-job training must go together with being allowed to do things. Many of the government health service workers complain about not being allowed to do this, that and the other. They*

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26 See Standing Committee on Estimates and Financial Operations, *Environmental Health in Aboriginal Communities in the Kimberley Region*, Report 32, dated November 14 2000, tabled in the Legislative Council on November 16 2000, pp. 26-27.

27 Evidence given in private session.

28 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, p. 4.

29 Ibid, p. 4.

> *must have good supervisory staff who can support them so that they can develop good work practices and become more effective members of the team. Some of the Aboriginal Medical Service health workers are performing quite high level jobs but it is a small number of people and it would be nice if there were a whole pile more."*[30]

3.18 A recent review of health services in the Kutjungka region of the Kimberley, which covers an area south of Halls Creek and which includes the Aboriginal communities of Wirrimanu (Balgo), Kurrurungku (Billiluna), Mulan and Yagga Yagga, noted the following:

> *"Despite many years of experience, there are no fully qualified AHWs employed in the [Kutjungka] region. AHWs appear to be utilised differently in the different clinics. Generally they seem to play a variable but minor role in clinic activities. This is dependent on individual skill levels and relationships with other health staff, especially nurses. More often they drive patients to and from the clinic. With the current funding for and emphasis on AHW training, there has been a greater engagement of AHWs in clinical work."*[31]

3.19 The use of qualified AHWs to undertake tasks such as picking up patients and driving them to clinics for scheduled appointments not only diminishes the professional standing of the AHWs in the eyes of their own community, but also encourages an unhealthy degree of dependency amongst the Aboriginal people of the Kimberley:

> *"[A]t one stage we were going ahead and now, in the last few years, I have noticed that we have gone backwards. I have got to say this because it has been on my mind for a long time: we have taken a lot of things away from our people. Independence is one of them I can remember when I was a kid and had to go and see the doctor we used to walk up to the hospital. Now they will not even walk; you have to go and pick them up in a car if you are going to the AMS, and that sort of thing. You know, they are just little things but it is taking their independence away from them."*[32]

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30 Ibid, p. 5.

31 John Wakerman, John Tregenza, and Ilan Warchivker, *Review of Health Services in the Kutjungka Region of Western Australia*, Final Report, October 1999, p. 20.

32 Evidence given in private session.

3.20 The Kutjungka region health services review team were of the view that the lack of appropriate training, lack of support and high turnover of nursing staff contributed to the under use of AHWs.[33]

3.21 The Committee notes that in the AMSs, AHWs *"for reasons of efficiency"* undertake administrative duties which would normally be performed by accountants and book-keepers.[34]

3.22 The Committee recognises that one of the problems in establishing standard training, qualifications, job descriptions, and career structure, is that a variety of health staff of Aboriginal origin are employed under the title of "Aboriginal Health Worker":

> *'All Health Workers provide direct services to individuals, families and communities, plan to meet future health needs, promote wellbeing and prevent ill health. Not all Health Workers undertake clinical practice, as the term "health" is used holisticaly and includes environmental, spiritual, psychological and social wellbeing.'*[35]

3.23 The Committee notes that some AHWs work in hospitals, others work in general practice clinics, some work in community health clinics, some work in remote area nursing clinics, some specialise in alcohol and substance abuse counselling, some specialise in mental health care, whilst others specialise in environmental health:

> *"The problem with the work of Aboriginal health workers is that it is so diverse across Australia. In some areas you have an Aboriginal health worker who is just dealing with men's health in a public health area. In other areas you have an Aboriginal health worker who is dealing with social and emotional wellbeing issues and counselling, and in another area you have someone who is taking Pap smears, taking blood, resuscitating people, making decisions about their medications, ordering, prescribing and dispensing medications, maintaining a pharmacy. So you have a basic level of training which covers environmental health, antenatal care, and other areas under public health, and then that is appropriate for the people doing that particular job, and you have people who are doing social and emotional wellbeing work, where they may have a degree in Aboriginal mental health from Curtin University, so they would be*

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33 John Wakerman, John Tregenza, and Ilan Warchivker, *Review of Health Services in the Kutjungka Region of Western Australia*, Final Report, October 1999, p. 32.

34 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 11.

35 Letter from Dr R L Stable, Director-General, Queensland Health, October 16 2000, Attachment 1, p. 3.

> *able to work in that particular area. So having a basic course really only is a starting point."*[36]

3.24 In this report, the Committee is concerned with that type of AHW which undertakes basic first aid, public health education, and assists nursing and medical staff in clinical and remote area nursing post settings. It is this type of AHW which the Committee believes has an essential role to play in improving Aboriginal health outcomes in the Kimberley.

3.25 The Committee is of the view that the profession of "AHW" should be defined, preferably by legislation. The Committee believes that an AHW should be qualified and competent to undertake the following duties and protocols, as a basic minimum, without the need for constant supervision by a medical practitioner or registered nurse:

3.25.1 take blood pressure readings;

3.25.2 take temperature readings;

3.25.3 take blood and urine samples;

3.25.4 perform cardio-pulmonary resuscitation (CPR);

3.25.5 take pap smears;

3.25.6 suture and apply dressings and bandages to minor wounds;

3.25.7 conduct antenatal education;

3.25.8 administer immunisations to school aged children and adults;

3.25.9 perform emergency dental care;

3.25.10 conduct public and environmental health and nutrition education programs;

3.25.11 provide counselling (domestic violence, post trauma, post'natal depression);

3.25.12 provide routine care for men's health; and

3.25.13 provide sexually transmitted disease ("STD") screening services.

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[36] Ms Isabelle Ellis, Lecturer in Nursing, University of Notre Dame Australia, Transcript of Evidence, August 21 2000, p. 6.

3.26 The Committee notes the following observation and recommendation arising from the *Review of Health Services in the Kutjungka Region of Western Australia* in relation to the services provided by the Mercy Community Health Service to Aboriginal communities south of Halls Creek, and believes that the recommendation should equally apply to the services provided by the HDWA throughout the Kimberley region:

> *"The current mix of services is skewed towards clinical and curative health care. Currently health education is carried out sporadically, often at the initiative of individual nurses. The involvement of Aboriginal people in health promotion is limited. We recommend a greater involvement of Aboriginal people in this important area of service delivery. … There is a need to coordinate health and education activities to develop local health promotion material and programs, supported by visiting specialist staff. With appropriate resources and training, community-based prevention and health promotion activities controlled and delivered by local AHWs should be a priority of the health service."*[37]

3.27 The Committee is of the view that more AHWs are urgently required to provide public health education in Aboriginal communities, as well as to take on roles within the acute care sections of all six Kimberley hospitals.

RECOMMENDATION 2

The Committee recommends that State Government employed or funded Aboriginal Health Workers take a much greater role in preventative health education in all Aboriginal communities throughout the Kimberley region. The role should include education regarding environmental health. Aboriginal Health Workers should practice in association with the local governments' Environmental Health Officers and Aboriginal Environmental Health Workers.

4 TRAINING OF AHWS

4.1 There is currently no standard qualification or training program for AHWs that is recognised in all of the Australian jurisdictions where AHWs operate.

[37] John Wakerman, John Tregenza, and Ilan Warchivker, *Review of Health Services in the Kutjungka Region of Western Australia*, Final Report, October 1999, p. 36.

4.2 The following comment was indicative of many of the submissions received by the Committee on the training of AHWs and the relevance of current training courses to the actual work of AHWs in the Kimberley:

> *"[T]here is inappropriate use of appropriately trained health workers, so we have either got health workers who are not trained and skilled enough in particular areas or we have got them skilled and trained and then we cannot use them, so they have no registration to practise, really using them in a fairly rudimentary way, and so health workers consequently do not stay in the profession of health work. It is not really a recognised profession and there are a lot of people who are very keen to be health workers. They get into a job and they are meant to be a taxi driver on one day there, the brain surgeon the next day."*[38]

4.3 The Minister for Health advised the Committee that Western Australia has endorsed national competencies for AHWs and is currently engaged in further work to provide nation wide consistency in AHW training.[39]

4.4 Dr David Atkinson noted the following:

> *"Health worker training is accredited in Western Australia, the Northern Territory and Queensland at the same level as enrolled nurse training. However, the expectations placed on health workers is dramatically more than is usually placed on enrolled nurses, who must work under the supervision of nurses, generally in an institution where sets of rules and guidelines apply. Health workers generally work in the middle of nowhere. If they are lucky they can seek information by telephone, but they have much individual responsibility. I am a bit concerned about the balance between the level of expectation and the training and support and post basic training.*
>
> *One of the recommendations of the review is that the basic training be at certificate level 4, the same level, although different training, as enrolled nurses, and then have a diploma qualification so that health workers who work on their own have a bit more training and a higher qualification.*

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38 Ms Isabelle Ellis, Lecturer in Nursing, University of Notre Dame Australia, Transcript of Evidence, August 21 2000, p. 2.

39 Letter from Hon John Day MLA, Minister for Health, August 30 2000, p. 16.

> *Health workers have been put in an invidious position; for example, not necessarily having even completed the basic training, a health worker can be the only person available in the community. If a health worker lives in a community and the nurse goes home, the health worker is called on. As a medical practitioner, that has always worried me."*[40]

4.5 AHW training in the Kimberley region has traditionally been conducted by KAMSC at its School of Health Studies:

> *"The value of local Aboriginal people working with their own communities in health care has been reflected in the roles of so-called 'camp-nurses' from the early colonial days. Formal training of AHWs was jointly pioneered in WA by the then Perth Aboriginal Medical Service and the Broome Regional Aboriginal Medical Service in the late 1970's/early 1980s. The curriculum developed became the basis of the current industry standard in Aboriginal Health Worker training - the Certificate 4 in Aboriginal Health Work (Aboriginal Communities), registered to the Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO). WAACCHO training providers (the Kimberley Aboriginal Medical Services Council, Marr Mooditj Aboriginal College, Bega Garnbirringu Health Services and Ngaanyanyatjarra Health Service) are the major industry training providers with Curtin University and James Cook University providing mostly specialised and continuing Aboriginal Health Worker education."*[41]

4.6 The KAMSC School of Health Studies has "Registered Training Organisation" status for AHW training.[42] KAMSC operates the AHW training course out of the AMS buildings in Broome and Kununurra, and also out of the HDWA "Family Futures" program buildings in Fitzroy Crossing.[43] KAMSC trains 70 AHWs a year.[44] The recent *Kimberley Regional Aboriginal Health Plan* recommended that substantial

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40 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, p. 6.

41 Kimberley Aboriginal Medical Services Council Inc., *Aboriginal Health Worker Issues in WA*, undated, p. 2, at Internet site: http://www.hcn.net.au/kamsc/WA_AHWs.htm

42 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 11.

43 Mr Arnold Hunter, Chair, Kimberley Aboriginal Medical Services Inc., Transcript of Evidence, August 21 2000, p. 16.

44 Ibid.

funds for capital be provided in the short term for increased training facilities for AHWs through the KAMSC School of Health Studies.[45]

4.7 The basic AHW course offered by KAMSC is a 12 month course. KAMSC also offers a course in Medication for senior AHWs who may be called upon to administer medication to patients.

4.8 The Committee was advised that there is an existing coordinating structure for Aboriginal health worker training and industrial issues through a WAACCHO Certification Panel (comprising Aboriginal Community Controlled Health Services representatives, AHWs, AHW education providers, union representatives, the HDWA and independent professionals).[46] KAMSC have described the WAACCHO Certification Panel as the principal forum for progressing and coordinating training and industrial issues in Aboriginal health work for more than a decade.[47]

4.9 There are three Aboriginal colleges for AHW training operating in Western Australia. There are plans, however, on the part of the State Government for AHW training to also be carried out by TAFE colleges.

4.10 Some of the witnesses who appeared before the Committee supported the move towards standardised AHW training through TAFE:

> *"As far as Aboriginal health work, my personal opinion is that it should be a standardised course. It should be offered through the TAFE because the TAFE has the infrastructure. They also have the South Australian TAFE course which is run at Danila Dilba in the Northern Territory. It is accredited with the board and it is covered under the Act in the Northern Territory. It trains people. That particular course is a standard course. It is written to the national competency standards, and it means that whoever employs a health worker knows that they have met a set number of objectives and that that person will be able to do a certain role. KAMSC has a place, and I think KAMSC is a very good organisation, in that it can meet a niche market for postgraduate or specialist areas. However, KAMSC running the whole course, with no collaboration with other*

45 David Atkinson, Catherine Bridge, and Dennis Gray, *Kimberley Regional Aboriginal Health Plan: Executive Summary and Recommendations*, December 1999, recommendation 28, p. 22.

46 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

47 Kimberley Aboriginal Medical Services Council Inc., *Aboriginal Health Issues*, at Internet site: http://www.hcn.net.au/kamsc/WA_AHWs.htm, p. 1.

organisations means that you would get a lot of confusion about the role of the health worker and what it is that they do."[48]

4.11 Other witnesses who appeared before the Committee expressed concern at the proposal to offer AHW training through TAFE colleges:

"I am cautious about TAFE because it tends to at least potentially downgrade the skills level of Aboriginal health workers. Certainly, if TAFE provides some of the training, there needs to be some other mechanism of supervision because I know that TAFE training can be even more variable than any existing training we have had. There have been some problems with existing training but at least it is fairly uniform. It does not make a lot of sense to take a system that is doing some good things and introduce something else which might make things worse without looking at it as a whole. We are talking about a work force of 200 or 300 people: How many different training organisations are sensible? There are 5 000 doctors in Western Australia and we have only one medical school. Should we be having five or six different providers of health worker training for a work force that in the foreseeable future will be under a few hundred?"[49]

4.12 KAMSC has expressed its dissatisfaction with current proposals of the HDWA to introduce changes to the way AHWs are trained, including the proposal to establish AHW training within the TAFE sector:

"Aboriginal Health Worker roles in the region are well developed in the Aboriginal community sector but remain limited in state-run services. There is an urgent need to expand Aboriginal Health Worker employment and AHW roles in mainstream services in the region. Of particular concern, the HDWA has unilaterally embarked on significant reforms of Aboriginal Health Worker training which has the potential to reduce portability, damage development of the Aboriginal Health Worker profession and impact on safety to practice."[50]

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48 Ms Isabelle Ellis, Lecturer in Nursing, University of Notre Dame Australia, Transcript of Evidence, August 21 2000, p. 7.

49 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, p. 11.

50 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 1.

> *"More recently, the Office of Aboriginal Health and the Health Workforce Division of the HDWA have unilaterally embarked on major reforms of Aboriginal Health Worker training. This involved identifying and purchasing a basic-level Queensland training program and determining that this was to be delivered through TAFE. The course bears little relationship to the current AHW course content, is thin on clinical practice material and has the potential to split the WA Aboriginal Health Worker profession into AHW practitioners in the community sector (the major employers) and AHW 'nurse assistants' in the government sector. These reforms have been undertaken while the Department has been simultaneously brokering the WA component of the National Aboriginal and Torres Strait Islander Health Worker Training Review and has been strongly criticised by AHWs and Aboriginal Community Controlled Health Services."*[51]

4.13 It is interesting to note, by way of comparison, that there has been a proliferation of training courses for AHWs in Queensland in recent years, with 10 Training Providers (including a TAFE institute and universities) currently in existence offering a variety of accredited and non-accredited training courses (51 courses in total, 36 of which are accredited).[52] Eight of these Training Providers offer courses at the Vocation, Education and Training ("VET") level, that is Certificate, Diploma and Advanced Diploma courses. The other two Training Providers deliver courses at the tertiary level.[53]

4.14 KAMSC has claimed that recent Abstudy cuts to 'away-from-base' (block-mode) financial support will greatly restrict access to AHW training in the future for people in remote areas.[54]

4.15 The Committee notes that the Commonwealth Government has initiated a review of Aboriginal and Torres Strait Islander Health Worker training *"as a basis for the development of a strategic approach to Health Worker Training at both the National and State and Territory levels."*[55]

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51 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

52 Letter from Dr R L Stable, Director-General, Queensland Health, October 16 2000, Attachment 1, p. 4.

53 Letter from Dr R L Stable, Director-General, Queensland Health, October 16 2000, Attachment 1, p. 4.

54 Kimberley Aboriginal Medical Services Council Inc., *Aboriginal Health Issues*, at Internet site: http://www.hcn.net.au/kamsc/WA_AHWs.htm, p. 1.

55 Standing Committee on Family and Community Affairs, *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives, May 2000, p. 99.

4.16 The Aboriginal Health Worker & Torres Strait Islander Health Worker National Competency Standards were developed and endorsed by State and Territory governments in 1997/1998. The Committee was advised that one of the difficulties in setting national standards or competencies for AHWs was the fact that the type of AHW that exists in WA, and particularly in the Kimberley, that is, *"… a front line primary care practitioner with substantial medical skills in addition to the cultural brokering, liaison role …"*[56], is not comparable with AHWs in the other Australian jurisdictions, except for those working in parts of the Northern Territory and parts of North Queensland.[57]

4.17 As a result of these differences in the role of AHWs across the Australian jurisdictions, there was some difficulty in reaching agreement amongst the jurisdictions on national competencies for AHW training, with several jurisdictions viewing the competencies as being set too low.[58]

4.18 The Committee agrees that the work of AHWs in Western Australia can only be regarded as comparable to the work of AHWs in the Northern Territory, and in certain parts of North Queensland. As such, the Committee believes that the issue of standard AHW training and duties is a matter for the State Government, to be undertaken in consultation with the governments of the Northern Territory and Queensland.

4.19 The Committee is of the view that AHW training should be standardised in Western Australia, and placed under the umbrella of a single training body. The TAFE system has the infrastructure to best undertake this task across the State. The Committee also agrees that it would be appropriate for KAMSC to continue to have an important role in the training of Kimberley-based AHWs by providing postgraduate and specialist training.[59]

RECOMMENDATION 3

The Committee recommends that an accredited standard training program and qualification be developed for all Aboriginal Health Workers in Western Australia.

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56 Dr Richard Murray, Medical Director, Kimberley Medical Services Council Inc., Transcript of Evidence, August 21 2000, p. 22.

57 Ibid.

58 Standing Committee on Family and Community Affairs, *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives, May 2000, p. 99.

59 Ms Isabelle Ellis, Lecturer in Nursing, University of Notre Dame Australia, Transcript of Evidence, August 21 2000, p. 7.

RECOMMENDATION 4

The Committee recommends that TAFE take responsibility for providing an accredited standard training program for Aboriginal Health Workers in Western Australia.

5 CONDITIONS OF EMPLOYMENT OF AHWS

5.1 The submission of the Australian Nursing Federation stated that AHWs have no career structure, no staff development or support, and that the retention of AHWs is poor.[60]

5.2 As stated above, there are some 70 AHWs trained throughout the Kimberley by KAMSC each year. Only a relatively small number of these trained AHWs actually find employment as AHWs. The Committee was told that although there may be shortages of trained AHWs in certain parts of the State at certain times, there is generally no problem filling AHW vacancies – the problem is in the shortage of funded positions for AHWs.[61]

5.3 All HDWA employed AHWs in the Kimberley region are on a normal wage[62], as are the AHWs employed in the town-based AMSs. In fact, senior AHWs employed by the AMSs receive a wage which is almost equivalent to that of a Registered Nurse. However, a significant number of AHWs based in Aboriginal communities are funded through the Community Development Employment Program ("CDEP"), which is effectively a "work for the dole" scheme, and therefore receive a much lower wage than AHWs employed by either the HDWA or the AMSs.[63]

5.4 AHWs employed by the Mercy Community Health Service in the Kutjungka region are paid on an hourly basis through CDEP with an additional top-up payment of $6.09 per hour.[64] Other AHWs operating in the Kutjungka region who are not employed by the Mercy Community Health Service, such as those working in the Aboriginal community of Yagga Yagga, receive only the basic CDEP.[65]

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60 Submission of Mr Mark Olson, State Secretary, Australian Nursing Federation, July 28 2000, Attachment A, p. 7.

61 Dr Richard Murray, Medical Director of the Kimberley Aboriginal Medical Services Inc, Transcript of Evidence, August 21 2000, p. 19.

62 Mr Ian Smith, Manager, Kimberley Health Service, HDWA, Transcript of Evidence, August 25 2000, p. 5.

63 John Wakerman, John Tregenza, and Ilan Warchivker, *Review of Health Services in the Kutjungka Region of Western Australia*, Final Report, October 1999, p. 32.

64 Ibid, p. 38.

65 Ibid.

5.5 AHWs are generally not given access to benefits and incentives provided to other rural-based health professionals, for example, subsidised housing and a vehicle.[66]

5.6 KAMSC advised the Committee that the two most common complaints relating to the employment conditions of AHWs employed by the HDWA are:

a) lack of housing; and

b) lack of support for continuing education.[67]

5.7 AHWs employed by the Kimberley Health Service of the HDWA receive the standard award north west provisions, that is, a district allowance, extra leave for employees living north of the 26 degrees South Latitude, annual leave travel concession, Government Employees Housing Authority gas subsidy and the dependent school age child allowance.[68] The HDWA advised the Committee that, in addition to the above benefits, *"… access to air conditioning subsidies, housing and vehicles are available via government policy…"*.[69]

5.8 However, the Committee was advised that, in the main, AHWs employed by the HDWA in Aboriginal communities must either provide their own housing or rely upon housing provided by the individual community council.[70] The lack of housing for AHWs can cause problems in situations where it may be necessary to bring in to an Aboriginal community an AHW from another area for a few weeks, such as a visiting male AHW to treat male patients or in the event of a death in the community:

> *"[T]hat's where we disagree as health workers; like we should be able to go in to another community. Like sometimes we think in, like, the peninsular; if there is a death or something it is best to get a health worker from Broome or even Beagle Bay to come into work because of cultural reasons but we cannot do that because there is no accommodation for, like, an outside health worker to come in. We would like to rotate between ourselves in the remote areas. … [B]ecause a lot of times, for cultural reasons, it is the health worker who will get blamed first, not the nurse."*[71]

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66 Kimberley Aboriginal Medical Services Council Inc., *Aboriginal Health Worker Issues in WA*, undated, at Internet site: http://www.hcn.net.au/kamsc/WA_AHWs.htm, p. 1.

67 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

68 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 1, Attachment F, p. 5.

69 Ibid.

70 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

71 Evidence given in private session.

5.9 In contrast to the position of AHWs, registered nurses are provided with housing and also receive a financial incentive after 12 months' service.[72] The employment benefits provided to medical practitioners working within the Kimberley Health Service of the HDWA include being provided with a motor vehicle which is available for limited private use, being provided with housing, an on-call allowance comprising 25 percent of base salary, a gratuity payment comprising four weeks' salary for each completed year of service after completing three years' continuous service, and sabbatical leave of five weeks after each five years' service.[73]

5.10 AHWs employed by the HDWA also demand greater access to professional development opportunities, such as study leave, paid airfares to regional centres or the metropolitan area to pursue further learning, and access to Internet resources.

RECOMMENDATION 5

The Committee recommends that State Government employed or funded Aboriginal Health Workers working in remote Kimberley communities be given access to the benefits and inducements provided to other Kimberley-based health professionals who work in these communities.

5.11 In 1997 the Northern Territory Government established the Aboriginal Health Worker Career Structure for AHWs employed by the Territory Health Services.[74] The career structure has also been adopted by the Northern Territory AMSs. A Determination signed by the Commissioner of Public Employment in October 1997 established a structure of six levels for AHWs in the Territory Health Services, with qualification and experience standards relevant at each level,[75] and determined three important principles for community-based positions in the AHW Class 1 to AHW Class 3:

5.11.1 new entrants to the Territory Health Services will undergo a period as an intern, to confirm their competence in the initial skills required of an AHW;

5.11.2 progression from Class 2 to Class 3 is automatic after 5 years, or after 2 years and demonstration of a specified level of skill or experience; and

5.11.3 this skill can be defined in terms of time and/or competency.[76]

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72 Submission of the Health Department of Western Australia, July 28 2000, Term of Reference 1, Attachment F, p. 5.

73 Ibid, p. 6.

74 Tracy Worrall and John Clarke, *Status Report on Aboriginal Health Worker Training in the Northern Territory*, Office of Aboriginal and Torres Strait Islander Health, June 2000, p. 6.

75 Ibid, p. 7.

76 Ibid.

5.12 The AHW classifications in the Northern Territory Aboriginal Health Worker Career Structure are as follows:[77]

Requirement	AHW Classification
Basic Skills Certificate (**NOTE**: for those AHWs who qualified prior to the introduction of the Certificate III requirement for registration)	Class 1
Certificate III	Class 2
	Class 3
Completed Stage 2 of Diploma	Class 4
Completed Diploma	Class 5
Advanced Diploma	Class 6

5.13 AHWs employed by the Queensland State Government are employed within a defined career structure that was established on August 1 1997 (with the endorsement of the Queensland Industrial Relations Commission) and which encourages the attainment of further qualifications by the possibility of advancement to AHW management positions:[78]

Queensland Health's Health Worker Positions, Award Levels and Salary Levels

Position	Level Operational Stream / Technical Stream	Salary
District Health Worker Co-ordinator	Level 007	$40, 420 - $46, 645
Program Co-ordinator or Senior Health Worker	Level 006	$40, 159 - $42, 343
Health Worker Advanced (Specific)	Level 004 / TO2	$30, 819 - $33 924
Health Worker Generalist	Level 003	$27, 209 - $29, 437
Health Worker Trainee	Level 002	$23, 739 - $26, 640

77 Ibid, p. 8.

78 Letter from Dr R L Stable, Director-General, Queensland Health, October 16 2000, Attachment 1, p. 2.

5.14 The Committee notes that in the Kimberley, the current highest level AHW employed by the HDWA is only a Level 3.

RECOMMENDATION 6

The Committee recommends that the State Government adopt a career structure for Aboriginal Health Workers within the Health Department of Western Australia similar to those currently in place within Queensland Health and the Territory Health Services.

5.15 The Kimberley Health Service organises an annual conference for AHWs employed by the HDWA throughout the Kimberley. This conference provides an opportunity for the AHWs in the public sector to meet and discuss issues relating to their work. However, the Committee understands that there is little or no interaction or sharing of information between AHWs employed by the HDWA and those AHWs employed either by the community controlled AMSs or directly by Aboriginal communities.

5.16 The Committee is of the view that AHWs require a State-wide representative body to promote their interests. The Committee notes that the Central & Barkly Region Aboriginal Health Workers Association ("the C&BRHWA") is the only AHW association in Australia at present.[79] The C&BRHWA is located in Alice Springs with coverage of the Central Australia and Barkly regions, although it has recently announced its intention to extend its coverage to all of the Northern Territory. [80]

5.17 Whilst the creation of a representative body for Western Australian AHWs is not a role for the State Government to undertake, the Committee believes that such a body would be more likely to develop in circumstances where all AHWs are subject to common requirements such as standard qualifications, training, regulatory and disciplinary controls. The Committee is of the view that the best way to introduce and to maintain common training, duties and standards for all AHWs across the State is by way of statutory regulation of the profession (a subject which will be discussed further in Section 7 of this report).

6 ADMINISTERING OF MEDICATION BY AHWS IN REMOTE AREAS

6.1 The Committee was advised that AHWs employed by the AMSs in the Kimberley work to the limits of their training and expertise, that is, while the junior AHWs undertake simple tasks such as changing dressings and taking blood pressure checks,

79 Tracy Worrall and John Clarke, *Status Report on Aboriginal Health Worker Training in the Northern Territory*, Office of Aboriginal and Torres Strait Islander Health, June 2000, p. 12.

80 Ibid.

the more senior AHWs work with a greater degree of independence, performing tasks such as the dispensing of medication to patients:[81]

> *"The system was not 100 per cent error free, but I cannot recall a serious medication incident during my time at Halls Creek. It is probably no more of a risk for health workers to dispense medication than it is for hospital nursing staff to dispense it. Medication errors occur everywhere. The health workers were comparable to hospital nursing staff."*[82]

6.2 A recent perceived threat to the existing clinical role of AHWs in the community controlled AMSs has been reforms to the *Poisons Act 1964* and *Poisons Regulations 1965* that extended statutory cover of medicating roles to registered nurses in remote communities but which continue to exclude AHWs.[83] KAMSC has stated that "… *[a]chieving statutory cover for safe medicating practice by AHWs is likely to be a watershed issue in the retention of clinical professional roles by AHWs …".*[84]

6.3 Pursuant to reg. 11 of the *Poisons Regulations 1965* the Commissioner of Health may designate a remote area site to be a remote area nursing post for the purposes of the regulations. Upon receipt of such a designation, a registered nurse at the remote area nursing post may administer certain drugs classified as poisons under Schedule 4 of the *Poisons Act 1964* to patients in certain defined situations, that is:

> *"[H]e or she is a registered nurse working at a remote area nursing post and he or she supplies a poison* [included in Schedule 4 of the Poisons Act 1964], *not being a psychoactive poison* --
>
> > (i) [if satisfied that the person to whom the poison is sold or supplied is under medical treatment with the poison and requires emergency treatment with the poison and does not sell or supply to that person more than three days medication of the poison];
> >
> > *(ii) for the treatment of an acute medical condition in compliance with the written standing orders of a medical*

81 Dr Matthew Ritson, Medical Practitioner, Transcript of Evidence, September 13 2000, p. 9.

82 Ibid, p. 9.

83 Submission of the Kimberley Aboriginal Medical Services Council Inc., July 29 2000, p. 10.

84 Kimberley Aboriginal Medical Services Council Inc., *Aboriginal Health Issues*, at Internet site: http://www.hcn.net.au/kamsc/WA_AHWs.htm, p. 1.

> *practitioner which have been approved in writing by the Commissioner of Health; or*
>
> *(iii) for the treatment of an acute medical condition in compliance with oral instructions of a medical practitioner for that particular patient."*[85]

6.4 The Committee is of the view that AHWs working at remote area nursing posts should also be entitled to the same statutory coverage as registered nurses in the administering of Schedule 4 drugs to patients in emergency situations. Often AHWs are the only available staff at remote Aboriginal communities when an emergency medical situation arises:

> *"Aboriginal Health Workers often provide the continuity for the health services especially when there is a high turnover of other health staff. Remote area nurses and the AHWs often are required to deliver treatment at the remote direction of a doctor. Particular problems are encountered when they are required to deliver a treatment that is outside their training or is illegal for them to perform. For example, nurses and AHWs without the qualifications are sometimes required to administer scheduled drugs that fall within the Poisons Act. They virtually have no choice as they are the only person in the community to give the drugs. This opens them to a risk of being sued or in the AHWs case being held responsible by the Aboriginal community for a death and then being punished traditionally."*[86]

6.5 The Committee, however, believes that only senior AHWs, say of five years' experience or more in a clinical setting, should be authorised to supply Schedule 4 medications, and then only according to established protocols.

RECOMMENDATION 7

The Committee recommends that the *Poisons Regulations 1965* be amended so as to permit senior Aboriginal Health Workers working at remote area nursing posts to administer according to protocol to patients in emergencies those medications that are listed in Schedule 4 of the *Poisons Act 1964*.

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85 Regulation 36(1)(d) *Poisons Regulations 1965.*

86 *Review of Primary Medical Care Services to Remote Area Aboriginal Communities*, The Office of Aboriginal Health, Health Department of Western Australia, undated, p. 30.

7 STATUTORY REGULATION OF AHWS: THE NORTHERN TERRITORY AS A CASE STUDY

7.1 The Northern Territory is the only jurisdiction that provides for the registration of AHWs and regulates their qualifications and standards of conduct by way of statute, that is, by the *Health Practitioners and Allied Professionals Registration Act* (NT), which has been in force since September 17 1996, and by the *Dental Act* (NT), which has been in force since July 1 1996.

7.2 The term AHW has a very specific and narrow definition in the Northern Territory, where AHWs are a defined occupation with clinical health training a pre-requisite for registration:

> *"In the Northern Territory Aboriginal Health Workers have a specific occupational role supported by registration. Primarily, Aboriginal Health Workers in the Northern Territory have a much greater clinical aspect to their work than those in other States/Territories. All Aboriginal Health Workers in the Northern Territory require professional registration prior to being able to practice. The legislation enabling this registration recognises a clinical role for Aboriginal Health Workers and requires demonstrated competence in this before registration is granted. This registration is protected by legislation and is currently based on the recognition of courses and course content."*[87]

7.3 The responsibilities and work undertaken by a typical registered Northern Territory AHW in a hospital or clinical setting on any given day is set out below:

> *"(a) knowledge of cultural and Aboriginal community issues;*
>
> *(b) prepare and maintain clinical work areas;*
>
> *(c) knowledge of importance of clean or sterile environment;*
>
> *(d) screen and assess patients, ie:*
>
> - *take history.*
> - *review previous notes.*

87 Tracy Worrall and John Clarke, *Status Report on Aboriginal Health Worker Training in the Northern Territory*, Office of Aboriginal and Torres Strait Islander Health, June 2000, p. 2.

- *record observations - BP (Blood Pressure), pulse, temperature, respirations, BSL (Blood Sugar Levels).*
- *assess client.*
- *decide whether to perform extra tests - take blood for analysis, respiratory function, Electro Cardio Graphs, urine collection, STD swabs and smears.*
- *decide on form of treatment.*
- *decide whether to refer to medical officer to conclude treatment.*
- *perform treatments - suturing, dressings, plasters to fractures, treatment of skin infections, immunisations, STD swabs and smears, eye drops, asthma and chest infection treatment, ante-natal and post-natal care, oxygen treatment.*
- *child health assessment and care.*
- *referrals to other agencies.*
- *emergency care skills.*
- *sterilisation of instruments.*
- *ordering stores and linen.*
- *preventative care.*
- *management of long term and palliative care patients.*
- *mobile service to town camps.*
- *health education of clients on a one-to-one basis.*
- *health promotion talks to groups (schools, other organisations).*
- *counselling - domestic violence, post-trauma, post-natal depression, etc.*

- *men's and women's health issues.*
- *interpretation of language for medical officers.*
- *interpretation of tests and treatment for clients.*
- *communication with families and mediation between family members.*
- *liaison with other organisations and departments.*
- *resource person for clients dealing with government departments eg Medicare, Centrelink etc.*
- *knowledge of environmental health issues - water, sewerage, housing.*
- *development and implementation of health programs eg child health clinics.*
- *understanding of nutritional guidelines for children and adults.*
- *knowledge of drug and alcohol issues."*[88]

7.4 At Royal Darwin Hospital AHWs assist in educating indigenous patients about their treatment and procedures, gaining informed consent for surgery, tests and procedures, explaining the ramifications on non-compliance with treatments, and with communication problems which may exist between medical staff and patients. Their role helps ensure that treatment provided to Aboriginal and Torres Strait Islander patients is culturally appropriate.[89]

7.5 Northern Territory AHWs adopted the following Code of Ethics in 1981 which, although somewhat dated now, gives a good overview of the role and responsibilities of an AHW:

> *"1. The AHW is a healer.*

[88] *What Do Health Workers Do in an Average Day?*, Danila Dilba Medical Service, Northern Territory, undated, at Internet site: http://www.daniladilba.org.au/ahwdo.html

[89] http://www.nt.gov.au/nths/royaldarwinhospital/innovations/ab_health_workers.htm

2. The AHW has a special place in the community because of this, like a traditional healer.

3. The AHW has a duty to care for all who are sick, no matter what their race, or family group, or language group, or skin group.

4. The AHWs can use their special status to care for people even in an avoidance relationship, if needed, if nobody in a right relationship to the patient is present.

5. The AHW must always keep secret anything they learn about a patient while they are caring for him.

6. The AHW must not use his special status for personal gain, or to disadvantage anyone.

7. The AHW must never be intoxicated when caring for patients.

8. The AHW is a promoter of health, as well as a curer of sickness. This means that they should set an example in their life.

9. The AHW will never knowingly harm any person, born or unborn.

10. The AHW will refer any patient whose condition he has not been trained to recognise and treat, or who is not responding to standard treatment.

11. The AHW will always regard persons who have taught them their craft with respect, like their parents. (This is an idea from Hippocrates)."[90]

7.6 There are approximately 450 AHWs registered in the Northern Territory.[91] Of that 450, the Territory Health Services employs about 165 and the AMSs employ about 90.[92] As in Western Australia, at any time in the Northern Territory there are a large number of trained AHWs not working as AHWs.

7.7 The Bachelor Institute of Indigenous Tertiary Studies – School of Health presently has enrolled approximately 100 full-time and part-time participants in its Certificate III in

90 *Code of Ethics for Health Workers*, Northern Territory Aboriginal Health Worker Conference, August 1981, at Internet site: http://www.daniladilba.org.au/ahwethic.html

91 Tracy Worrall and John Clarke, *Status Report on Aboriginal Health Worker Training in the Northern Territory*, Office of Aboriginal and Torres Strait Islander Health, June 2000, p. 6.

92 Ibid.

Aboriginal Health Work (Clinical), the basic qualification for registration as an AHW in the Northern Territory.[93] The Bachelor Institute is an independent institute offering both VET qualifications and tertiary qualifications. The Certificate III course is also offered to a smaller number of students by the Danila Dilba Biluru Butj Binnilutlim Medical Service Aboriginal Corporation (approximately 17 full-time and part-time students), the Miwatj Health Aboriginal Corporation (approximately 15 full-time and part-time students), the Anyinginyi Congress Aboriginal Corporation (approximately 14 full-time and part-time students), and the Central Australian Aboriginal Congress Ltd (approximately 15 full-time and part-time students).[94]

7.8 The Committee is of the view that there are strong arguments for a Northern Territory style registration system to be put in place to regulate the qualifications and conduct of AHWs in Western Australia. Such a registration scheme already exists in this State with respect to nurses, medical practitioners, dentists, and a number of other health professionals:

> *"For any health professional who has the ability to cause harm, we have an Act of Parliament governing our practice. That also means that we have a board who can conduct disciplinary procedures if people are not meeting the competencies or the standards of that profession; that is, medicine, nursing, dentistry. Aboriginal health workers have an ability to cause harm. Anyone who gives someone an injection, a drug, is involved with their care, personal care, has an ability to cause harm. They currently are unregulated, unsupervised, and still have the ability to cause harm. We have a very concerning situation in the Kimberley in that we have remote area health workers expected to be on call for emergencies, who are dealing with the sickest population in Australia, with the least trained people to deal with the worst problems, and there is nothing regulating their ability to do the job appropriately. It would not be stood for by any other member of society in any other area. We would have the biggest legal battle ever. If you went to see somebody and you did not know anything about their training, or that they were even trained or regulated, and they were giving you medication, drugs, taking blood, doing a Pap smear, you would not stand for it. Aboriginal people are forced to stand for that situation because there is no other provider. They are not covered by an Act, we do not regulate their activities, and they are kidded to think that they are doing the right thing for their people. They are not doing the right thing for their people. If*

93 Ibid, p. 13.

94 Ibid, pp. 13-18.

> *they make a mistake, there is no-one to even check what it is that they have done."*[95]

7.9 The Minister for Health advised the Committee that the Government is of the view that the work practices of AHWs are not inappropriately restricted by the absence of specific enabling legislation, and as such the Government can see no advantage to be derived by such legislation.[96]

7.10 Dr Atkinson stated the following to the Committee:

> *"I have worked with health workers since the early 1980s and I have a strong view that one of the most important ways of developing their professional role is to have their own Act and registration. Standards can then be looked at as there is something against which to measure them. I have also spoken to most health workers around the State, particularly those in the Kimberley, on the health worker training project I have worked on this year. Their overwhelmingly clear message is their desire to be registered like nurses.*
>
> *In the review of Aboriginal health worker training in which I have been involved, the Health Department made it clear that it does not want to have registration under an Act and another board, such as the Nurses Board, but it is happy to have a system of accreditation. That would be a compromise based on trying out a system of accreditation, run by a board appointed by the minister to see whether that achieves the aim. That would be a long step away from where they are at present with no recognition and no standards. I believe it would be better if it were done through registration, but I can understand the Government's reluctance to become involved in passing legislation and the parliamentary schedule being full of other things to debate. Nevertheless, it is a good idea."*[97]

7.11 The AHWs themselves are pushing for greater recognition as health professionals, and they believe that registration and statutory regulation would assist in providing this professional recognition:

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95 Ms Isabelle Ellis, Lecturer in Nursing, University of Notre Dame Australia, Transcript of Evidence, August 21 2000, pp. 3-4.

96 Letter from Hon John Day MLA, Minister for Health, dated August 30 2000, p. 16.

97 Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, pp. 5-6.

> *"[A]t the end of the day, when the white nurses and the white doctors go home and knock off, it is not them that gets lots of bothers. It is the Aboriginal health worker that is living in the community who gets woken up and banged on the door and have to be answerable to their community and yet there is no reimbursement for their time or effort and their qualification at any level. So if you are thinking about how to go about that, we would fully support any process to actually recognise our Aboriginal health workers. They themselves I must say - we had a meeting in the Kimberley with our mob. They have drawn the line in the sand by saying that anybody who is not trained up to this level should not be a health worker. They are telling us. They are very clear on this. They are very clear. They have set some standards for us, that they do not want anybody - and because they are tired of the so-called bus drivers and people who just drop people off are being classified as health workers, and they do not like that."*[98]

7.12 The Committee is impressed by the statutory scheme set up to register Northern Territory AHWs and regulate their standards under the *Health Practitioners and Allied Professionals Registration Act* (NT) ("the HPAAPRA") and the *Dental Act* (NT).

7.13 The HPAAPRA regulates the practice and standards not only of AHWs, but also chiropractors, occupational therapists, osteopaths, physiotherapists, and psychologists in the Northern Territory. The Committee notes with interest that of all the professions regulated by the HPAAPRA, AHWs are the only profession that Western Australia does not also regulate by way of statute.[99]

7.14 The HPAAPRA establishes the Aboriginal Health Workers' Registration Board[100], consisting of a Chairman, three AHWs and a member of the public.[101] The functions of the Aboriginal Health Workers' Registration Board are to determine, subject to the approval of the Minister responsible for administering the HPAAPRA, the qualifications (where they are not prescribed) for registration of persons as, and the appropriate standards of conduct by, AHWs.[102]

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98 Mr Arnold Hunter, Chair, Kimberley Aboriginal Medical Services Inc., Transcript of Evidence, August 21 2000, p. 20.

99 See the following Western Australian legislation: *Chiropractors Act 1964, Occupational Therapists Registration Act 1980, Osteopaths Act 1997, Physiotherapists Act 1950,* and the *Psychologists Registration Act 1976*.

100 Section 5, *Health Practitioners and Allied Professionals Registration Act* (NT).

101 Section 6, *Health Practitioners and Allied Professionals Registration Act* (NT).

102 Section 14, *Health Practitioners and Allied Professionals Registration Act* (NT).

7.15 The specific powers of the Aboriginal Health Workers' Registration Board are set out in s15 of the HPAAPRA:

> *"15. POWERS OF BOARD*
>
> *(1) Subject to this Act, the Board has power to do all things that are necessary or convenient to be done for or in connection with or incidental to the exercise of its powers and the performance of its functions.*
>
> *(2) Without limiting the generality of subsection (1), the Board, for the purpose of exercising its powers or performing its functions in relation to the category or categories of health practice for which it is established, including the powers conferred on it elsewhere in this Act -*
>
> *(a) may authorize or refuse to authorize the full or conditional registration of persons in accordance with this Act;*
> *(b) may issue registration and practising certificates;*
> *(c) may receive, hear and investigate complaints against practitioners;*
> *(d) shall cause to be maintained registers of practitioners;*
> *(e) may take proceedings against a person who contravenes or fails to comply with this Act;*
> *(f) may cancel or suspend a registration or practising certificate;*
> *(g) may punish by way of fine or reprimand a person who contravenes or fails to comply with this Act; and*
> *(h) shall investigate any matter referred to it by the Minister and report on it to him."*

7.16 Under s34 of the HPAAPRA, the prescribed qualification for full registration as an AHW is either the basic skills certificate for AHWs awarded by the Department responsible for administering the HPAAPRA, or a qualification that is, in the opinion of the Aboriginal Health Workers' Registration Board, equivalent to the basic skills certificate.

7.17 The HPAAPRA establishes formal procedures for dealing with complaints against AHWs, as well as for taking disciplinary action against AHWs.[103] Appeals against decisions of the Aboriginal Health Workers' Registration Board may be taken to the

[103] Part V, *Health Practitioners and Allied Professionals Registration Act* (NT).

Health Practitioners and Allied Professionals Tribunal, which is comprised of a legal practitioner and two senior AHWs.[104]

7.18 The *Dental Act* (NT), in force as of July 1 1996, also provides Northern Territory AHWs with the statutory authority to undertake certain dental procedures.[105] Under s18(1) and s44(1) of the *Dental Act* (NT), an AHW may, under the direct or indirect supervision of a dentist and in accordance with guidelines set by a dentist, provide the following services:

> "***Practice of dentistry by Aboriginal Health Worker***
>
> ***1. Relief of pain:***
>
> *(a) give analgesics, antibiotics for acute infection;*
>
> *(b) removal of soft debris and caries with hand instruments and placing of temporary sedative filling; and*
>
> *(c) simple extraction under local anaesthesia of periodontally involved teeth.*
>
> ***2. Prevention:***
>
> *(a) oral hygiene instruction and dental health education in school and community;*
>
> *(b) undertake plaque control using disclosing methods and dental prophylaxis paste on low speed rubber cups;*
>
> *(c) apply topical fluoride preparations;*
>
> *(d) promote fluoridation of community water supply; and*
>
> *(e) removal of dental calculus.*
>
> ***3. Assist visiting dental officer at chairside, particularly as an interpreter.***
>
> ***4. Placing of fissure sealants.***"[106]

104 Part VI, *Health Practitioners and Allied Professionals Registration Act* (NT).

105 Section 44(1)(c), *Dental Act* (NT).

106 Schedule 3, *Dental Act* (NT).

7.19 In 1987 the Minister for Health initiated a review of unregistered health occupation groups in Western Australia. The Committee Reviewing the Status of Unregistered Health Occupation Groups reported to the Minister for Health in September 1989.[107] The report recommended that a two tiered system of regulation be put in place, that is, regulation of certain health occupation groups (being those who have the potential to cause serious harm to the health of a person or a recipient of a service) by way of either certification or registration depending upon certain defined criteria.[108]

7.20 At the time of the review, AHWs, along with 16 other unregulated health practitioner groups, made submissions seeking statutory regulation.[109] The only health practitioner group that has achieved statutory regulation following the 1989 report has been osteopaths (in 1997).[110]

7.21 Western Australian health practitioners who seek statutory regulation are presently required to substantiate their application against both criteria set by the Australian Health Ministers' Advisory Council ("AHMAC") and National Competition Policy requirements:[111]

> *"The Australian Health Ministers Advisory Council (AHMAC) is made up of the heads of all State and Commonwealth health departments and meets regularly to make recommendations to State, Territory and Federal Health Ministers on matters of common concern. In 1993, AHMAC agreed that before any State proceeds with a proposal to register a previously unregistered health occupation, a majority of States should agree that such registration was required. AHMAC established a working group with representatives from a number of States, to examine applications from and make recommendations concerning the need for occupational registration of unregistered health practitioner groups. The working*

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107 *Review of the Status of Unregistered Health Occupation Groups: The Committee Report to the Minister for Health for Western Australia*, September 1989, Schedule 10, Part 1 of *Review of Western Australian Health Practitioner Legislation*, Discussion Paper, Health Department of Western Australia, October 1998, pp. 152-154.

108 Ibid, p. 153.

109 *Review of Western Australian Health Practitioner Legislation*, Discussion Paper, Health Department of Western Australia, October 1998, pp. 72-73.

110 Ibid, p. 73.

111 Ibid.

group formulated six criteria for assessing the regulatory requirements of unregulated health occupations."[112]

7.22 The AHMAC criteria used for assessing the need for statutory regulation of unregulated health occupations is as follows:

7.22.1 Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

7.22.2 Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

7.22.3 Do existing regulatory or other mechanisms fail to address health and safety issues?

7.22.4 Is regulation possible to implement for the occupation in question?

7.22.5 Is regulation practical to implement for the occupation in question?

7.22.6 Do the benefits to the public clearly outweigh the potential negative impact?[113]

7.23 The Committee is of the view that AHWs in Western Australia satisfy all of the above criteria for statutory registration. AHWs in the Kimberley, and in many other parts of Western Australia, are required to work in clinics in remote Aboriginal communities, without supervision by either a medical practitioner or a registered nurse, where they must deal with medical emergencies on a daily basis. The Committee believes that AHWs have the potential to cause significant harm to patients in the course of their work and, as such, there should be in place statutory protection for the benefit of both patients and AHWs.

7.24 As stated above, the Committee is of the view that the only other Australian jurisdictions which have AHWs who perform comparable duties to those performed by Western Australian AHWs, are the Northern Territory and, to a lesser extent,

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112 Victorian Ministerial Advisory Committee, *Traditional Chines Medicine: Report on Options for Regulation of Practitioners*, July 1998, at Internet site: http://hna.ffh.vic.gov.au/phb/hce/chinese/review/tcm.pdf, p. 3.

113 *AHMAC Criteria used for Assessing the Need for Statutory Regulation of Unregulated Health Occupations*, Schedule 10, Part 2 of *Review of Western Australian Health Practitioner Legislation*, Discussion Paper, Health Department of Western Australia, October 1998, pp. 155-156.

Queensland. The Committee believes that the Northern Territory's regulation of AHWs by way of registration is a model that should be adopted by Western Australia.

RECOMMENDATION 8

The Committee recommends that the qualifications and standards of conduct of Aboriginal Health Workers in Western Australia be regulated by way of a statutory registration and disciplinary scheme along the lines of that which is presently operating in the Northern Territory under the *Health Practitioners and Allied Professionals Registration Act* (NT) and the *Dental Act* (NT).

7.25 On a final note, the Committee would like the Government to consider a change of name for the profession of AHW, even if only for those AHWs employed by the HDWA. The Committee is of the view that the prefix "Aboriginal" in the title "Aboriginal Health Worker" is unnecessary and may also be considered demeaning by some people. The Committee believes that consideration should be given to using a race neutral title such as "Health Worker", "Health Aide", or "Health Worker (Aboriginal communities)" instead.

HON MARK NEVILL MLC
CHAIRMAN

DATE: DECEMBER 11 2000