Defining the public health workforce

Submission to the
Department of Health
and Aged Care

January 2023

ABOUT NACCHO

NACCHO is the national peak body representing 145 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 144 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Recommendations

NACCHO recommends:

1. integrating the Priority Reforms of the National Agreement on Closing the Gap in design considerations
2. equity be positioned as a key public health objective
3. the objectives specifically identify safe, environmentally fit for purpose and adequate housing as a key primordial prevention measure
4. the paper include a discussion of the positive and negative impact of determinants of health, including social, economic, commercial and cultural determinants
5. the primary healthcare workforce be explicitly included in the list of Workforce Occupations, including Aboriginal Health Practitioners, Aboriginal Health Workers, General Practitioners, Registered Nurses and Nurse Practitioners
6. the need to increase the number of Aboriginal and Torres Strait Islander public health workers is identified and discussion of training and development needs included
7. the discussion of public health leadership be expanded to include community leaders and organisations
8. the competency around cultural safety be significantly strengthened and include reference to the National Agreement on Closing the Gap.

Introduction

NACCHO welcomes the opportunity to provide a submission to the Department's consultation on Defining the Public Health Workforce.

The Aboriginal Community Controlled Health (ACCHO) sector is a critically important part of the Australian health system architecture and is best placed to deliver programs and services to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. Critically, they provide genuine employment opportunities for community members who wish to work and live on Country.

However, the sector is facing major workforce challenges, existing services are experiencing severe staff shortages and demand will soon outstrip supply of suitably skilled and job ready Aboriginal and Torres Strait Islander health workers.

ACCHO's primary health and care integrated workforce is multidisciplinary. Central to this model is the inclusion of social and emotional wellbeing (SEWB), family, community and culture to ensure person-centred, culturally safe care. ACCHOs have the potential to overcome many of the barriers to access experienced by Aboriginal and Torres Strait Islander people. Integral to the success is a sustainable and strong multidisciplinary workforce embedded within ACCHOs. To achieve this, workforce expansion and sustainable development is required.

On 30 November 2022, NACCHO met with representatives from EY to discuss the questions outlined in the consultation paper. This response provides additional information to that feedback.

National Agreement on Closing the Gap

In July 2020, the Australian Government, all state and territory governments, the Australian Local Government Association and the Coalition of Peaks signed the *National Agreement on Closing the Gap* (National Agreement). The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians. All governments have committed to the implementation of the National Agreement's four Priority Reform Areas, which seek to bring about structural change to affect ways in which governments work with Aboriginal and Torres Strait Islander organisations, communities and individuals. The four Priority Reforms are:

Priority Reform Area 1 – Formal partnerships and shared decision-making
This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector
This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions
This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth

telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform 4 – Sharing data and information to support decision making
This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

It is regrettable that the consultation paper does not include mention of the National Agreement on Closing the Gap. **NACCHO recommends** integrating the Priority Reforms of the National Agreement in design considerations (pg 17) to inform the work at large. Specifically, the Priority Reforms should be integrated at the level of objectives of public health (further comments below). This will be critical if the Department hopes to make meaningful progress toward closing the gap and fulfilling their obligation to adhere to the National Agreement.

Challenges and opportunities

As noted above, our ACCHOs are currently facing critical workforce shortages. We know that the growth needs of the health and care sector are significant and demand for services is growing rapidly. There is a need to build a workforce of suitably skilled and job ready Aboriginal and Torres Strait Islander employees to help improve access to culturally safe, effective and efficient support and assistance.

Workforce shortages are further exacerbated in remote areas, and in some regional and urban settings, where the extent of Aboriginal and Torres Strait Islander persons' disadvantage and dislocation from traditional Country sees them disproportionately overrepresented in unemployment, incarceration, poverty and disconnected from support and services.

The priority for ACCHOs is addressing the existing high burden of chronic disease with the additional staffing challenges faced since 2020. Workforce data reported to the AIHW shows a decrease of FTE clinical staff per 1,000 population of around 20 – 30% in ACCHOs and a 50% increase in the number of unfilled positions since the start of the pandemic.[1]

The current approach to training and skills development is not working and a different approach to workforce training, support and pathways is required.

Objectives

Equity

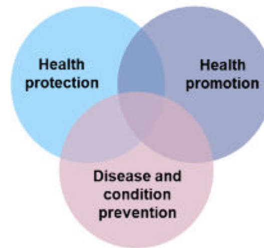
The public health objectives identified in the consultation paper provide a limited understanding of the goals of public health and do not adequately capture the need to ensure equity across the

[1] Australian Institute of Health and Welfare (2022) Aboriginal and Torres Strait Islander specific primary health care: results from the nKPI and OSR collections viewed 16.11.2022 https://www.aihw.gov.au/reports/indigenous-australians/indigenous-primary-health-care-results-osrnkpi/contents/osr-introduction

population. In this regard, the objectives need strengthening or at minimum to be informed by a set of guiding principles.

NACCHO proposes that equity and the Priority Reforms of the National Agreement sit at the centre of the diagram on p10.

Figure 3: Objectives[4]



As illustrated in Figure 3, the Objectives are highly overlapping, representing the multidisciplinary and cross sectoral nature of public health.

While we note equity is included at the competency level, we suggest this diminishes notions of equity, community and rights-based approaches to public health, placing them at the individual level of responsibility rather than at the structural level where their inclusion is most effective.

Primordial prevention

NACCHO recommends the discussion in section three specifically identify safe, environmentally fit for purpose and adequate housing as a key primordial prevention measure, particularly for Aboriginal and Torres Strait Islander communities.[2] Improved hygiene facilities, water infrastructure and living conditions support prevention of communicable diseases including scabies, trachoma and otitis media.

Overcrowding and poor sanitary conditions are also the primary reason for significantly higher rates of acute rheumatic fever and rheumatic heart disease among Aboriginal and Torres Strait Islander people. The burden of these diseases can last a lifetime and include complications such as atrial fibrillation, endocarditis, heart failure and stroke.

Living in overcrowded housing with poor sanitary conditions increases the likelihood of several chronic health conditions. For example, Australia remains the only developed country in the world where trachoma still exists in endemic proportions, primarily in Aboriginal and Torres Strait Islander populations. Overcrowding also makes Aboriginal and Torres Strait Islander children more susceptible to acute or chronic ear infections such as otitis media. Often the result of a virus, it is particularly difficult to prevent the progression of middle-ear infections without proper washing facilities. Children with ear infections can sustain hearing loss that has a negative impact on their ability to learn at school. Similarly, skin infections such as scabies can quickly spread through crowded households, particularly when washing facilities are limited or non-existent. Scabies may be complicated by bacterial infection, leading to the development of skin sores that, in turn, lead to the development of septicaemia, heart, liver or chronic kidney disease. Eye, ear and skin infections effect a child's long-term behaviour, development, education, employment and income prospects.

Overcrowding also makes it extremely difficult to isolate or quarantine during COVID-19 outbreaks. In 2020, there were reports of Aboriginal and Torres Strait Islander people isolating in tents to avoid

[2] https://csof.naccho.org.au/, p3

spreading COVID to family members. Moreover, recent natural disasters of fires and flooding has resulted in displaced and homeless families and communities.

Determinants of health

A discussion of the determinants of health is required. As it stands, the discussion demonstrates a narrow, and limited understanding of these influences. These are complex, interwoven factors that can both positively and negatively influence health outcomes. There are several instances where determinants of health are citied as only negative, without any acknowledgement that public health can also focus on increasing factors that are positive predictors of health (not just removing risk factors).

Use of the word 'lifestyle' should be removed in this context as it suggests that determinants are simply behavioural factors within the control of the individual to change. Whereas behaviours are influenced by myriad factors outside the control of the individual such as experiences of trauma, systemic racism, environmental factors, and the activities of companies (commercial determinants) amongst others.

Discussion should include social, economic, environmental and commercial determinants, both their positive and negative influences. In the case of commercial determinants, the practices and activities of companies can have far-reaching impacts on public health outcomes – the tobacco industry being a well-known example. The influence of commercial activities is pervasive – the World Health Organisation have recently undertaken a study of the impacts of commercial activities on cancer diagnosis, treatment and care.[3]

A discussion of cultural determinants must also be included, noting these have a largely positive influence on health outcomes, particularly for Aboriginal and Torres Strait Islander communities. For example, increased connection to culture, language and Country has been shown to have a protective influence on social and emotional wellbeing (SEWB) and other health outcomes.[4] However the intersections between culture and health are complex and this should also be acknowledged.[5]

Page 11 Table 2 The definition of health promotion needs to be reworked as it currently implies that these factors, and in particular culture, have only negative impacts on health.

P 21, 6.3 Wider workforce text suggests that wider determinants are purely social – this is not the case. This must include commercial determinants of health.

Defining the workforce

The breadth of the public health workforce is not well established in the consultation paper. While there are specific public health roles outlined, for the ACCHO sector in particular, it is important to recognise the role of the entire workforce and community in delivering comprehensive primary health care. In this regard, non-clinical staff (eg CEOs, Board members, community members,

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[3] 2022 Eurohealth (28.2), https://eurohealthobservatory.who.int/publications/i/commercial-determinants-of-cancer-control-policy-(eurohealth)

[4] Verbunt, E., Luke, J., Paradies, Y. et al. Cultural determinants of health for Aboriginal and Torres Strait Islander people – a narrative overview of reviews. Int J Equity Health 20, 181 (2021). https://doi.org/10.1186/s12939-021-01514-2

[5] Waterworth P, Pescud M, Braham R, Dimmock J, Rosenberg M (2015) Factors Influencing the Health Behaviour of Indigenous Australians: Perspectives from Support People. PLoS ONE 10(11): e0142323. https://doi.org/10.1371/journal.pone.0142323

receptionists, practice managers, program managers etc) all play a key role in achieving public health objectives.

NACCHO's Core Services and Outcomes Framework[6] quotes a participant at a CSOF Expert Advisory Group meeting in Sydney, December 2019:

> *To call yourself a comprehensive primary health care service, you need to be more than a 'sick care service'. You also need to be public health advocates to garner action on poverty and overcrowding. You must invest in communities, develop leaders and reclaim community empowerment. You must look to act on social determinants of health as well.*

While the roles of Aboriginal and Torres Strait Islander Health Program Officers and sexual health nurses are explicitly highlighted, it is worth noting that the primary healthcare workforce also does significant work in delivering population level interventions. Yet, there appears to be little or no mention or inclusion of the primary healthcare workforce in the list of Workforce Occupations (p10). This list should include Aboriginal Health Practitioners, Aboriginal Health Workers, General Practitioners, Registered Nurses and Nurse Practitioners.

The omission of these roles may be because interventions such as screening have been rolled into individual level interventions, however the Cervical Screening Test (CST) for example, could be considered a population level intervention as it screens for Human Papilloma Virus (HPV), a communicable disease.

As currently written (p22), it implies that only trained community members are carrying out public health roles, however some public health workforce are untrained volunteers.

Aboriginal and Torres Strait Islander workforce

Although the categorisation of 'core, wider and surge' workforce may be similarly applied to the ACCHO sector public health workforce, there are significant points of difference and nuance which have not been captured and which could support a more sustainable and future-proofed workforce.

The role and contribution of the ACCHO sector to public health in Australia is significant - the example set by the sector at the start of the COVID-19 pandemic cannot be overlooked. The ACCHO sector is a critically important part of the Australian health system and is best placed to deliver programs and services to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. The ACCHO model of care, outlined in NACCHO's Core Services and Outcomes Framework[7], demonstrates the breadth of public health activity an ACCHO undertakes.

Further, there is a need for greater clarity around the roles of Aboriginal Health Workers (AHW) and Health Practitioners (AHP) whose roles are somewhat misrepresented in the discussion paper. These are distinct roles, with AHPs paying a key clinical role, particularly in the ACCHO context. Our AHWs and AHPs are the heart of our ACCHO workforce. They are skilled, valued and trusted members of ACCHO teams and local communities. This is especially true for remote settings where it is already difficult to find and retain specialised workers.

In line with the recommendations of the *Aboriginal and Torres Strait Islander Health Plan 2021-2031* and the *National Aboriginal and Torres Strait Islander Health Workforce Framework and*

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[6] https://csof.naccho.org.au/
[7] https://csof.naccho.org.au/

Implementation Plan 2021-2031, the need to increase the proportion of Aboriginal and Torres Strait Islander people in the public health workforce should be identified. Without an overall increase in the number of Aboriginal and Torres Strait Islander people participating in the health sector, employers and subsectors will be competing with each other for ever diminishing and stretched resources.

Additional discussion around training and development is required, including the need to include Vocational, Education and Training (VET) courses in skills considerations. VET training provides important entry-level pathways and skill-set development for local people, particularly in Aboriginal and Torres Strait Islander communities, including AHWs and AHPs who play an important public health role. Moreover, VET qualifications offer excellent work ready pathways and provide opportunities to build multidisciplinary teams via upskilling. A stronger emphasis on VET as a pathway into health and public health careers is likely to deliver more Aboriginal health professionals which will support better health outcomes for Aboriginal communities.

To effectively support growing demand, there is a need to leverage the current ACCHO workforce and draw from local communities to build a strong workforce that includes both cultural and clinical experts. Up-skilling, re-training and utilising the existing workforce and creating pathways to build capacity is the key to success.

An additional element in training and development considerations is the need for strong wrap-around supports for Aboriginal and Torres Strait Islander students. There is strong evidence[8] that the provision of such support results in better completion rates for these students.

Additionally, while the discussion paper notes an iterative co-design process, it is not clear whether the Aboriginal community controlled sector will be part of this process. NACCHO strongly recommends our sector be included in any co-design process.

Surge workforce

The role and contribution of the ACCHO sector to public health in Australia is significant. The COVID-19 pandemic has continued to highlight the responsive and resilient nature of the ACCHO sector. ACCHOs have played a significant role in raising awareness of COVID-19, promoting and delivering vaccines, and supporting those contracting COVID-19. They are the only services in Australia that have led both public health and primary health responses.

Despite the challenges associated with COVID-19 outbreaks across the country, up until November 2022 there were fewer than 300 COVID-19 deaths among Aboriginal and Torres Strait Islander people. This was largely due to the proactive and collaborative efforts of the Aboriginal community-controlled primary health care sector.

The success of ACCHO responses to the epidemic and the quality of services provided to Aboriginal and Torres Strait Islander people highlight and underscore the importance of the National Agreement.

During the COVID-19 pandemic, NACCHO supported its members to access the Vaccine Administration Partnership Program (VAPP) which was rolled out from September 2021.[9] Under the

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[8] Gwynne et al, Customised approaches to vocational education can dramatically improve completion rates of Australian Aboriginal students, Australian Health Review, 2020, 44 , 7–14, https://doi.org/10.1071/AH18 51

[9] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/application-process-open-for-additional-covid-19-vaccination-providers?language=en

program, the Department of Health engaged vaccine administrators and send them into communities where requested. Information provided by the Department shows that between February and November 2022, most ACCHOs requested a minimum 4 vaccinators for 5 weeks on average, and that about 60% of ACCHOs who received VAPP support also sought support a second time (particularly in QLD, WA and NSW).

Feedback from ACCHOs was largely positive - VAPP staff were viewed as a helpful surge resource where services may not have had enough staff to offer COVID-19 vaccinations every day or week. Particularly for ACCHOs in rural and remote settings, VAPP alleviated the stresses associated with locating and employing clinical staff. It also meant ACCHOs had the option to redirect their full-time staff to other activities and to complete their regular roles and responsibilities.

However, some ACCHOs have reported that VAPP staff were not culturally sensitive. Although the Department reported sending VAPP staff to cultural training prior to entering community, this was not always effective. Consequently, some ACCHOs sought additional funding from NACCHO to employ local staff instead. Some ACCHOs reported the lack of cultural knowledge by some VAPP staff was particularly damaging as ACCHO staff then had to work hard to encourage community to feel safe enough to attend their health service again and to receive a COVID-19 vaccination.

Public health leadership

It is important to emphasise that leadership in public health exists beyond traditional roles such as primary health practitioners such as clinicians. For example, the leadership of NACCHO's CEO Pat Turner and Deputy CEO Dr Dawn Casey was instrumental in shaping Australia's response to the COVID-19 pandemic. Both are formidable public health leaders who continue to inform and influence Australia's approach to public health in relation to Aboriginal and Torres Strait Islander communities.

6.3 Wider workforce should be broadened to include community leaders and organisations.

Functions

While there are eleven functions listed in total, there is no clear overall framework or structure for the functions which risks ambiguity, complexity and duplication. It is also unclear why an apparently new set of functions has been developed for this paper, when those developed by the National Public Health Partnership in 2004 remain relevant, and would require only limited revision. That list also includes critical social functions that are missing from this list, in particular:

- Strengthen communities and build social capital through consultation, participation, and empowerment, and
- Promote, develop and support actions to improve the health status of Aboriginal and Torres Strait Islander people and other vulnerable groups

It's not clear why this latter function has been removed from the proposed list, particularly given the renewed focus on closing the gap since the execution of the National Agreement and the recent change of government.

F6 Lead public health policy and strategies - Should include equity – eg "supporting ***equitable*** and greater cost-effective decisions…"

F7 Public health communication - Should include culturally appropriate – eg "Supporting the population through accessible, ***culturally appropriate*** and effective communication…"

F9 Funding for public health initiatives - Should include equity – eg "providing adequate ***and equitable*** funding for …"

Core Competencies

A significant consequence of a lack of focus on equity at the objectives level, is that equity is not adequately cascaded throughout the functions or competencies. It is not clear whether the numbering of competencies reflects their relative importance and therefore why cultural competence, and diversity, equity and inclusiveness are so low on the list. Likewise, it is not clear from either the functions or competencies how the workforce interacts with the community.

C1 Professionalism – This definition should be expanded as follows: *working in an ethically sound,* ***culturally safe*** *and professional manner.*

C7 Cultural competence – This competency needs to be significantly strengthened and must reference the National Agreement on Closing the Gap. NACCHO proposes amending to align with the definition of cultural safety as contained in the National Agreement:

> *Cultural safety is about overcoming the power imbalances of places, people and policies that occur between the majority non-Indigenous position and the minority Aboriginal and Torres Strait Islander person so that there is no assault, challenge or denial of the Aboriginal and Torres Strait Islander person's identity, of who they are and what they need. Cultural safety is met through actions from the majority position which recognise, respect, and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people. Only the Aboriginal and Torres Strait Islander person who is recipient of a service or interaction can determine whether it is culturally safe.*[10]

The definition should further make it clear that cultural competence for Aboriginal and Torres Strait Islander people looks different in different communities, and that cultural competence for clients from CALD communities will look different again depending on the cultural background of the person. Critical to the definition is the understanding that *only the person who is recipient of a service or interaction can determine whether it is culturally safe*.[11]

C10 – Diversity, equity and inclusiveness – The inclusion of this competency is welcome, however stronger language is required around the role and function of the public health workforce in terms of cultural safety, equity and anti-racism (see also comments above). The definition should be expanded to better articulate what this competency looks like in practice. For example, *awareness, application* ***and championing*** *of the principles of diversity, equity*.

An additional competency should be added around maintaining the wellbeing of the workforce itself. An emphasis on mental health and social-emotional wellbeing would be well-placed here. There are currently no examples provided relating to the need to better support mental health outcomes, which is a key area of both need and demand that is not currently being met.

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[10] National Agreement on Closing the Gap, Definitions, https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap/12-definitions

[11] Refer to the Aboriginal and Torres Strait Islander Health Performance Framework - summary report 2020. https://www.indigenoushpf.gov.au/

General comments

The definitions around primarily population and individual interventions are noted, but in reality over-simplify things. For instance, in the ACCHO sector, the same workforce (eg: AHWs and AHPs) can be achieving both simultaneously. A community event to raise awareness about a health issue also provides an opportunity to yarn with individuals about their overall health and perform opportunistic screening tests. The one event is designed to achieve multiple goals.

It is unclear whether adaptions to the UK model will be sufficient to make it fit for the Australian context, noting that the UK national public health bodies have recently undergone significant governmental restructuring resulting in the creation of Office of Health Improvement and Disparities as a separate entity to UK Health Security Agency (UKHSA) which has taken on the role of Public Health England (PHE), NHS Test and Trace, and the Joint Biosecurity Centre (JBC).[12]

The discussion paper would benefit from a holistic definition of health. Aboriginal and Torres Strait Islander concepts of health include a deep understanding of the need for social and emotional wellbeing and person centred model of care. A glossary of terms would be a useful addition and might include definitions of: comprehensive primary health care; equity; cultural safety; community control and ACCHOs.

[12] https://researchbriefings.files.parliament.uk/documents/CDP-2022-0015/CDP-2022-0015.pdf, 24 Jan 2022