2018

Aboriginal and Torres Strait Islander Health Worker

INDUSTRY REFERENCE COMMITTEE
INDUSTRY SKILLS FORECAST

SKILLSIQ

CAPABLE PEOPLE MAKE CLEVER BUSINESS

Contents

Skills Forecast

Name of IRC:
Aboriginal and Torres Strait Islander Health Worker

Name of SSO:
SkillsIQ Limited

About SkillsIQ:

SkillsIQ supports 18 Industry Reference Committees (IRCs) representing diverse 'people-facing' sectors. These sectors provide services to people in a variety of contexts such as customer, patient or client. The IRCs are collectively responsible for overseeing the development and review of training package products, including qualifications, serving the skills needs of sectors comprising almost 50% of the Australian workforce.

Our qualifications deliver skilled people that are valued and make a difference to others.

- Cross Sector Skills Committee, February 2018

WARNING: Aboriginal and Torres Strait Islander readers are warned that this document may contain images of deceased persons and we respectfully acknowledge the consent of the person and family for the use of their image.

SkillsIQ would like to respectfully acknowledge the Traditional Owners of the land and sea throughout Australia and extend that respect to Elders past and present. SkillsIQ also recognises those whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future Elders and leaders.

We recognise that information contained in this document was provided by individuals and the community. We honour and respect this input and will use it advance Aboriginal and Torres Strait Islander peoples.

We gratefully acknowledge images in this document supplied by Qld Health.

Executive Summary

Culture and identity are central to Aboriginal and Torres Strait Islanders' perceptions of health. This has seen the Aboriginal and Torres Strait Islander Health Worker workforce evolve into a more culturally comprehensive service provider that meets the needs for the provision of culturally safe clinical and primary health care services to Aboriginal and Torres Strait Islander people whose health needs cannot be met by mainstream services. Aboriginal and Torres Strait Islander Health Workers today are able to respond to local health needs and contexts and perform different tasks depending on the services needed. This is reflected in the wide degree of variation that exists in Aboriginal and Torres Strait Islander Health Worker roles, definitions, scopes of practice, education standards and career pathways.[1]

Generally, Aboriginal and Torres Strait Islander Health Workers provide culturally safe health care to Aboriginal and Torres Strait Islander people, such as advocating for Aboriginal and Torres Strait Islander clients in order to explain their cultural needs to other health professionals, and educating or advising other health professionals on the delivery of culturally safe health care; performing a comprehensive primary health care role (which includes, for example, clinical assessment, monitoring and intervention activities, and health promotion); and adapting the roles they perform in response to local health needs and contexts.[2]

The Aboriginal and Torres Strait Islander Health Worker Industry Reference Committee (IRC) has responsibility for seven qualifications, packaged in the HLT Health Training Package.

The National Schedule details the training package review and development work commissioned by the Australian Industry and Skills Committee (AISC). The National Schedule is informed by this Industry Skills Forecast, which outlines the proposed timing for the update of existing training package products. This Forecast has been compiled using a number of information sources, including academic literature, statistical data, IRC member input and expertise, feedback received via public consultation, and an industry analysis of both new and emerging workforce skills needs within the Aboriginal and Torres Strait Islander Health Worker sector.

The sector is currently experiencing several challenges and opportunities which are impacting workforce skill requirements. These include:

- Aboriginal and Torres Strait Islander people's health challenges, including but not limited to cardiovascular disease, cancer, diabetes, kidney disease, sexually transmitted infections (STIs) and blood-borne viruses (BBVs), mental health and substance abuse issues, regional and remote Aboriginal and Torres Strait Islander health issues, and the challenge of health care visitation among the Aboriginal and Torres Strait Islander community
- An ageing workforce
- Racism as a major detriment facing Aboriginal and Torres Strait Islanders within the health system
- Family violence as a leading contributor to Aboriginal child removal, homelessness, poverty, poor physical and mental health, drug and alcohol misuse and incarceration
- State and territory jurisdictional legislation.

All seven qualifications under the remit of the IRC are currently the subject of a Case for Change, due to be provided to the AISC in June 2018. Until such time as this Case for Change has been considered, no further work is proposed by this IRC.

Sector Overview

The 2016 Census reported that there were 649,200 Aboriginal and Torres Strait Islander people in Australia. This represents 2.8% of the total population.[3] The health and wellbeing of Aboriginal and Torres Strait Islander Australians is a significant concern for all Australian governments (Council of Australian Governments (COAG) 2008). It is well documented that Aboriginal people experience a range of disparities in health outcomes and do not benefit equitably from health services. As with other colonised populations worldwide, Aboriginal and Torres Strait Islander Australians experience poorer health outcomes and shorter life expectancy compared with non-Indigenous Australians.[4] Providing equitable access to primary health care (PHC) is a continuing challenge, despite a universal health insurance scheme (Medicare) and the funding of community-controlled and government-managed health services specifically designed to meet the health needs of Aboriginal and Torres Strait Islander peoples. Potentially preventable chronic diseases are the greatest contributor to the difference in health status between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.[5]

The health needs of Aboriginal and Torres Strait Islander people are primarily met by Aboriginal and Torres Strait Islander Health Workers and Practitioners. The roles that they perform vary and are dependent on the needs of the community they serve. The types of roles can include clinical functions; liaison and cultural brokerage; health promotion; environmental health; community care; administration; management and control; and policy development and program planning.[6]

The current minimum qualification for entry to employment in Aboriginal and Torres Strait Islander primary health care is a Certificate II in Aboriginal and Torres Strait Islander Primary Health Care as a Trainee Aboriginal and Torres Strait Islander Health Worker or a Certificate III in Aboriginal and Torres Strait Islander Primary Health Care as an Aboriginal and Torres Strait Islander Health Worker. To be eligible to register as an Aboriginal and Torres Strait Islander Health Practitioner, a person must hold a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice, or the equivalent (as determined by the Aboriginal and Torres Strait Islander Health Practice Board of Australia).

Nationally Recognised Aboriginal and Torres Strait Islander Health Worker Qualifications – Current as at June 2018

The VET qualifications that cater to this sector are:

- HLT20113 Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care
- HLT30113 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care
- HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care
- HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice*
- HLT50113 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care
- HLT50213 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice
- HLT60113 Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care

Note: *Qualification required for registration with the Aboriginal and Torres Strait Islander Health Practice Board of Australia as an Aboriginal and/or Torres Strait Islander Health Practitioner.

Registered Training Organisation Scope of Registration

Table 1 indicates the number of Registered Training Organisations (RTOs) with Aboriginal and Torres Strait Islander Health Worker qualifications on scope. This data is current as at June 2018, per the listing on the National Register of VET (www.training.gov.au).

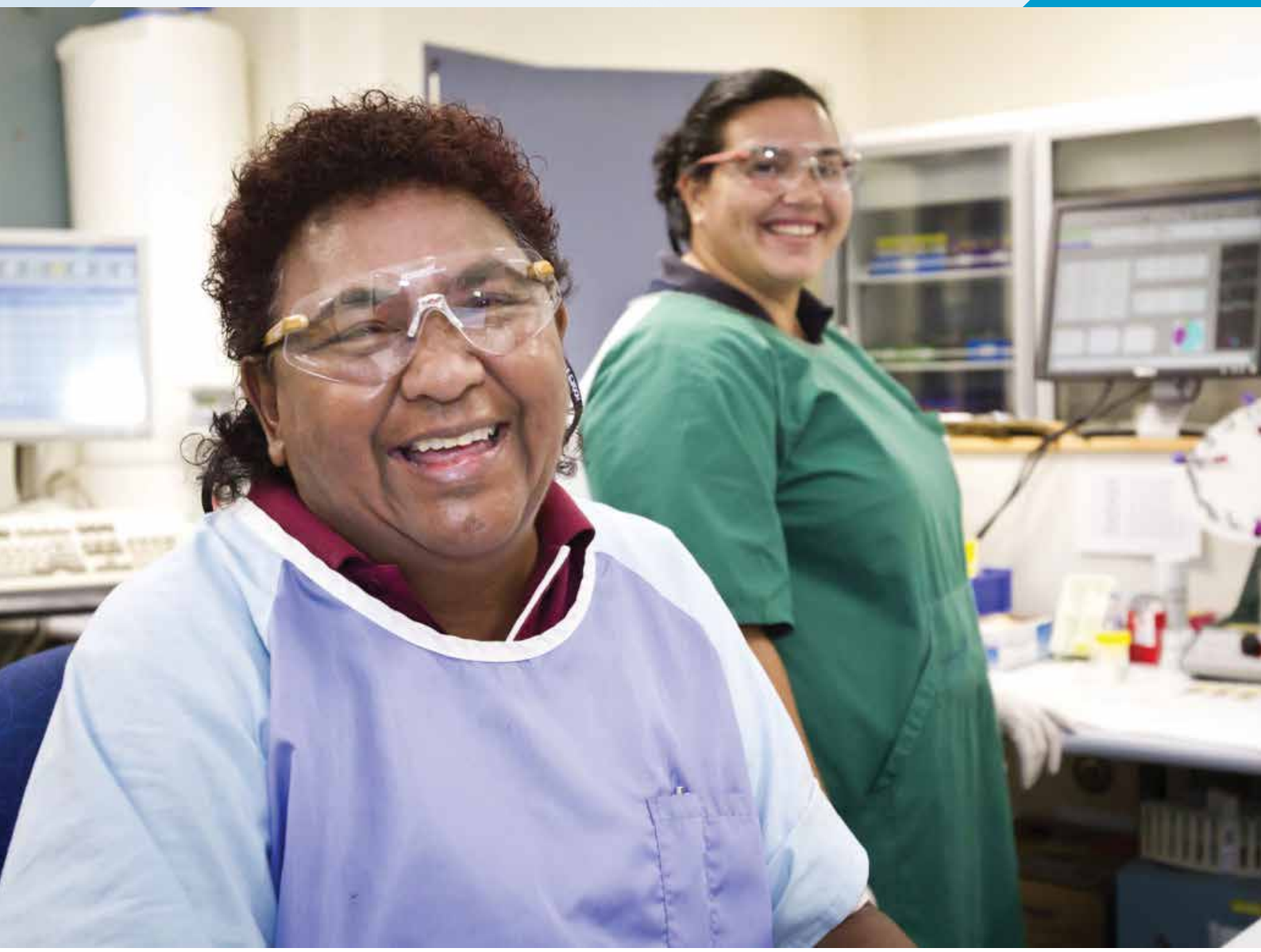


Table 1 Number of RTOs by nationally recognised qualifications on scope – Aboriginal and Torres Strait Islander Health Worker Training Package Products

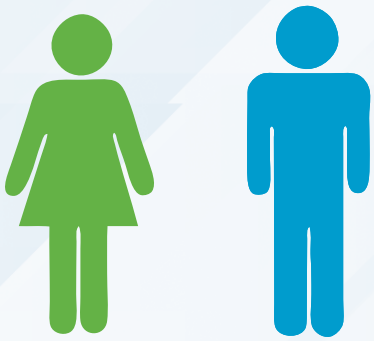
Qualification Code	Qualification Title	No. of RTOs with Qualification on Scope
HLT20113	Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care	11
HLT30113	Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care	19
HLT40113	Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care	16
HLT40213	Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice	19
HLT50113	Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care	6
HLT50213	Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice	7
HLT60113	Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care	1

Source: Training.gov.au. RTOs approved to deliver this qualification. Accessed 21 June 2018.

2016 ENROLMENT SNAPSHOT

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER TRAINING PACKAGE PRODUCTS

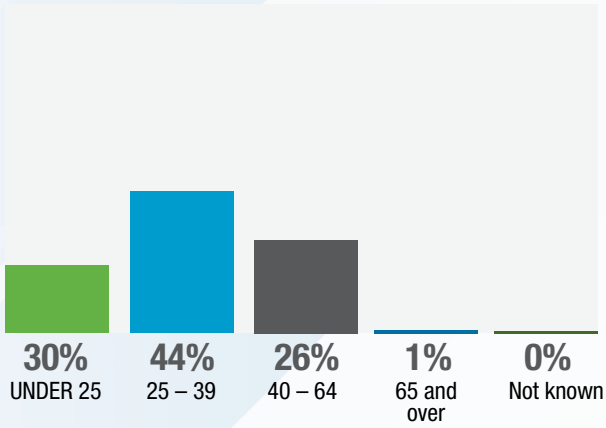
GENDER



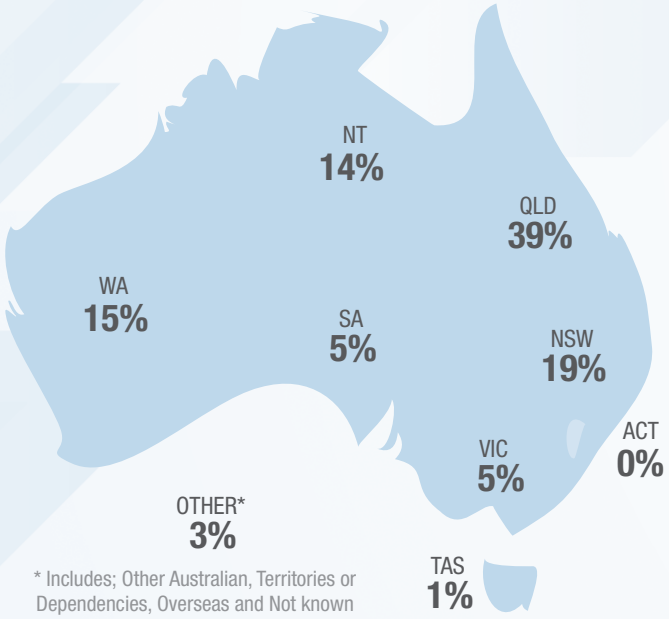
70% 30%

AGE

Percentage Years of age



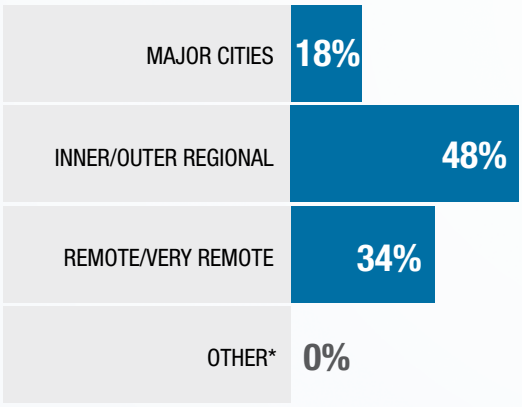
STATE/TERRITORY OF RESIDENCE



* Includes; Other Australian, Territories or Dependencies, Overseas and Not known

STUDENT REMOTENESS REGION

2011 Accessibility and Remoteness Index of Australia (ARIA+)



* Includes; Outside Australia and Not known

Source: NCVER VOCSTATS (Program enrolments 2016 by various breakdowns) Base count n = 4,597

General notes on statistics

1. Enrolment data is sourced from NCVER VOCSTATS (program enrolments, 2014–2016), accessed November 2017.
2. It is important to note that not all training providers are currently required to submit enrolment data, and some figures presented may therefore under-represent the true count of enrolments and completions for a qualification. From 2018, all training providers will be required to submit data, and current discrepancies noted in the national NCVER figures versus actual attendance should therefore be minimal in future releases. The data presented in this report is shown for indicative purposes.
3. Figures reflect public and private RTO data.
4. Superseded qualifications and their respective enrolment data are not tabled, unless otherwise indicated.

The following section (Table 2) details enrolment figures for the years 2014–2016. This data has been sourced from the National Centre for Vocational Education Research (NCVER). Please note that due to the limitations on reporting, which has not been compulsory across all RTOs, the data below is not a true reflection of enrolment but, rather, an indicative number. The latest figures released by the NCVER also pertain to 2016.

The specialised nature of the Aboriginal and Torres Strait Islander Health Worker sector means that numbers of enrolments can be limited in some qualifications. However, the importance of these roles to Aboriginal and Torres Strait Islander communities is paramount in terms of addressing health needs for Aboriginal and Torres Strait Islander peoples in a culturally sensitive and appropriate manner.

Table 2: Total number of enrolments (Total VET Activity, [TVA]) by nationally recognised qualifications on scope - Aboriginal and Torres Strait Islander Health Worker Training Package Products, 2014–2016

QUALIFICATION	2014	2015	2016	TOTAL
HLT20113 Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care	479	435	254	1,168
HLT30113 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care	236	318	275	829
HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care	72	161	220	453
HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice	307	543	762	1,612
HLT50113 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care	38	56	44	138
HLT50213 Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care Practice	26	54	60	140
HLT60113 Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care	0	0	0	0

Source: NCVER VOCSTATS, accessed November 2017.

Stakeholders

National Peak Bodies and Key Industry Players

The following list represents a range of organisations that perform a variety of key roles in this sector. These organisations and their networks are well placed to offer industry insights at the time of training package review. Engagement and consultation activities will include a broad range of industry stakeholders beyond those included in this list.

- Government departments and agencies
  - State and territory health departments
- Peak and industry associations
  - National Aboriginal Community Controlled Health Organisation
  - Aboriginal Health & Medical Research Council of NSW
  - Victorian Aboriginal Community Controlled Health Organisation
  - Queensland Aboriginal and Islander Health Council
  - Aboriginal Health Council of Western Australia
  - Aboriginal Health Council of South Australia
  - Aboriginal Medical Services Alliance Northern Territory
  - Tasmanian Aboriginal Centre
  - Royal Australian College of General Practitioners
- Health Professionals' organisations
  - National Aboriginal and Torres Strait Islander Health Worker Association
- Employee associations
  - Health Services Union
  - Australian Nursing and Midwifery Federation
  - United Voice
- Regulators
  - Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Large and small private employers across metropolitan, regional, rural and remote areas
- Registered training providers, both public and private.

Challenges and Opportunities

Health Sector Overview

The health services sector in Australia includes a range of health services and facilities. Australia's age profile and private health insurance coverage are expected to continue rising over the next five years, which should strengthen demand for most health services.

Health expenditure statistics show:

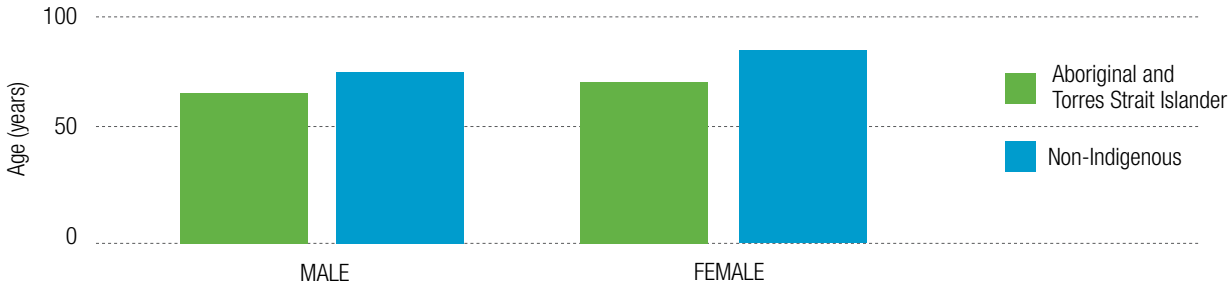
- Total government health expenditure ($114.6 billion), about two-thirds (67.3%) of all health expenditure, grew by 4.1% in real terms in 2015–16.[7]
- In 2015–16, total direct government expenditure on Aboriginal and Torres Strait Islander Australians was estimated to be $33.4 billion, a real increase from $27.0 billion in 2008–09.
- Of this approximately $6.3 billion was spent on health-related services for Aboriginal and Torres Strait Islander people.[8]

The key driver of the demand for health services is demographic change. Australia, like most developed nations, is experiencing a long-term ageing of its population. The Intergenerational Report (IGR) shows that both the number and proportion of Australians aged 65–84 and 85 years and over are projected to grow substantially. In 2015, approximately three million people, or 13% of the population, were aged 65–84. With these changing demographics comes an increasing demand for, and use of, health services, particularly for the Aboriginal and Torres Strait Islander community. With this will come a need to increase the Aboriginal and Torres Strait Islander workforce and ensure it has the necessary skills to cope with future demand for services. The high influx of migrants coming to Australia each year, of whom 80% are of working age, will help to counteract Australia's ageing workforce and contribute to cultural diversity.

Aboriginal and Torres Strait Islanders' Health Overview

Aboriginal and Torres Strait Islanders experienced a burden of disease that was 2.3 times the rate of non-Indigenous Australians in 2011. The life expectancy of Aboriginal and Torres Strait Islanders has improved slightly in recent years but progress will need to accelerate if the 2020 Council of Australian Governments' (COAG) target to close the gap in life expectancy by 2031 is to be met.[9] At present, mortality rates for Aboriginal and Torres Strait Islander people are much worse than for non-Indigenous people. Figure 1 highlights the disparity between Aboriginal and Torres Strait Islander and non-Indigenous Australians in terms of life expectancy at birth.

Figure 1 Life expectancy at birth for Aboriginal/Torres Strait Islander and non Indigenious males and females, born in 2010–2012



Source: Australian Indigenous HealthInfoNet (2017) Summary of Aboriginal and Torres Strait Islander health, 2016. Perth, WA: Australian Indigenous HealthInfoNet

Many Aboriginal and Torres Strait Islander people are affected by cardiovascular disease (CVD). Around one in eight (13%) Aboriginal and Torres Strait Islander people reported in the *2012–2013 Australian Aboriginal and Torres Strait Islander Health Survey* (AATSIHS) that they had some form of CVD. One in twenty-five (4%) Aboriginal and Torres Strait Islander people reported having some form of heart, stroke and/or vascular disease. Around one in twenty (6%) Aboriginal and Torres Strait Islander people reported having high blood pressure. CVD was 1.2 times more common for Aboriginal and Torres Strait Islander people than for non-Indigenous people.[10]

Aboriginal and Torres Strait Islander people are also more susceptible to dying from cancer than non-Indigenous people. This could be due to the types of cancers they develop (such as cancers of the lung and liver) which are more likely to be fatal. Their cancer may also be more advanced by the time it is diagnosed (which is partly because Aboriginal and Torres Strait Islander people may visit their doctor later and/or may not participate in screening programs), and as such are less likely to receive adequate treatment.[11]

Diabetes and kidney disease are also serious health problems for the Aboriginal and Torres Strait Islander community. The death rate among Aboriginal and Torres Strait Islander peoples for diabetes was five times higher and for kidney disease was three times higher than for the non-Indigenous community.[12]

For Aboriginal and Torres Strait Islander people, 'health' is a holistic term as defined within the *National Aboriginal Health Strategy* (1989), meaning 'not just the physical wellbeing of an individual, but (also) the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life'.[13] Self-determination is also central to the provision of Aboriginal and Torres Strait Islander health services.[14]

In 2012–13, 30% of Aboriginal and Torres Strait Islander peoples reported that they **needed to, but didn't**, go to a health care provider in the previous 12 months. This varied by type of service, with 21% **not** going to a dentist, 14% not going to a doctor, 9% **not** going to a counsellor, 9% **not** going to other health professionals and 6% **not** going to hospital **when they needed to**. Aboriginal and Torres Strait Islanders living in non-remote areas (32%) were more likely to report not seeking care when needed than those living in remote areas (22%). Selected potentially preventable hospitalisation rates for Aboriginal and Torres Strait Islander peoples were three times the non-Indigenous rate during the period July 2013 to June 2015. Aboriginal and Torres Strait Islander peoples had lower rates of hospitalisations with a procedure recorded (62%) compared to non-Indigenous Australians (81%). Aboriginal and Torres Strait Islander peoples also had lower rates of elective surgery and longer wait times. Aboriginal and Torres Strait Islander peoples' discharge from hospital against medical advice was seven times the rate of non-Indigenous Australians.[15] The challenge of health care visitation among the Aboriginal and Torres Strait Islander community is something that Aboriginal and Torres Strait Islander Health Workers will need to overcome to enable better health outcomes.

Recent health data indicates that Aboriginal and Torres Strait Islander people have a higher rate of infection when it comes to sexually transmitted infections (STIs) and blood-borne viruses (BBVs). The recently released *Blood-borne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander People Annual Surveillance Report 2017* shows that the rate of diagnosis of HIV for Aboriginal and Torres Strait Islander people is now more than double that for non-Indigenous Australian-born people. The high prevalence of other STIs among Aboriginal and Torres Strait Islander people, particularly in remote communities, heightens the risk of HIV taking hold in communities. Men and women with STIs are at significantly higher risk of acquiring HIV sexually and face a range of serious long-term health problems.[16]

STIs are endemic in some remote communities, with many people having more than one STI. Limited sexual networks in remote communities with endemic STI rates mean that if a person in a sexual network acquires HIV, either sexually or through injecting-drug use, there is potential for an outbreak of HIV in the community.[17] Aboriginal and Torres Strait Islander HIV Awareness Week

(ATSIHAW) is an initiative designed to start the conversation in Aboriginal and Torres Strait Islander communities about HIV prevention and the need for regular testing for HIV. ATSIHAW has proven to be an effective means of mobilising communities to address rising rates of diagnosis, as well as engaging HIV researchers, doctors, health workers and policy makers. ATSIHAW has been funded by the Commonwealth since its inception in 2014. This commitment has been crucial to ATSIHAW's success.[18]

Poor nutrition is a major contributing factor involved in many of the prevalent diseases among Aboriginal and Torres Strait Islander groups that have been outlined above (i.e. cardiovascular disease, diabetes and cancers). Diet is arguably the single most important behavioural risk factor that can be improved to have a significant impact on health. As the quality and quantity of foods and drinks consumed has a significant impact on the health and wellbeing of individuals, society and the environment, better nutrition has huge potential to improve individual and public health and decrease health care costs.[19] Poor diet can be attributed to approximately 19% of the national Aboriginal burden of disease.[20] All pregnant and lactating women, infants and young children have proportionally higher nutritional needs for healthy growth and development. The Australian Aboriginal population is recognised as having more young mothers, infants and young children compared to the non-Aboriginal population. Offering sound nutritional advice at every opportunity is therefore critical.[21]

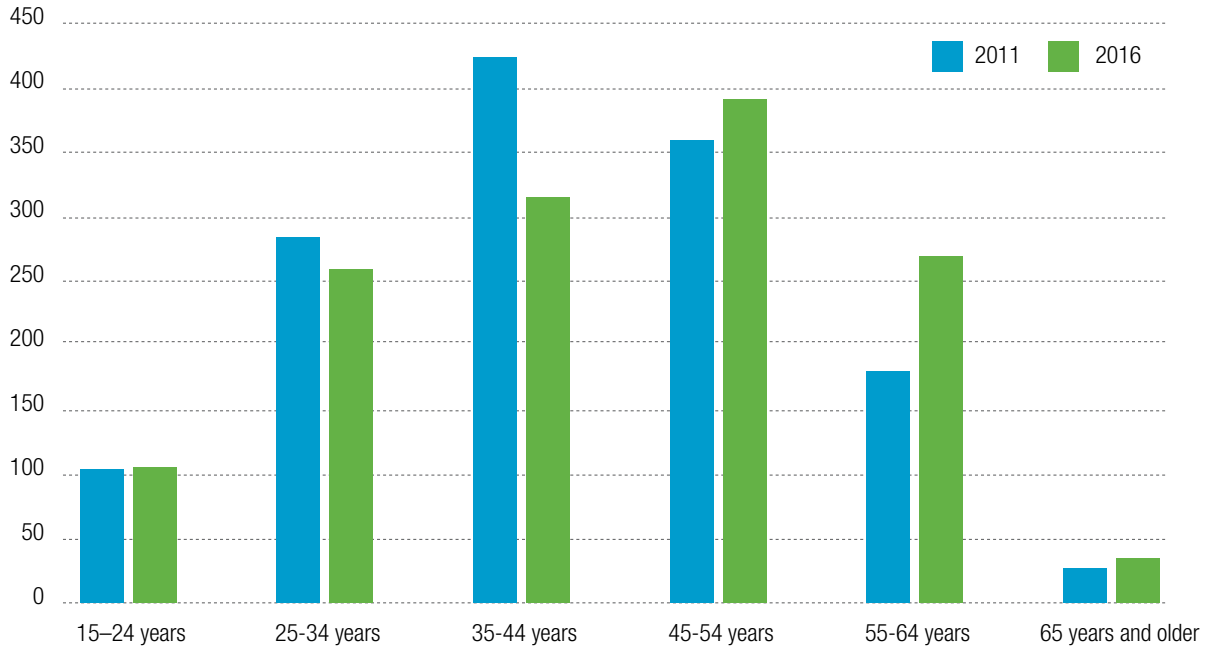
A potential barrier to Aboriginal and Torres Strait Islanders participating in a healthier nutrition plan is the cost of healthy foods which can be more expensive.[23] However, while it may be more expensive in rural and remote communities, it can still be cheaper to cook a family meal than purchase a heat-and-eat meal such as pizza. This is something Aboriginal and Torres Strait Islander Health Workers working within the community, especially in rural and remote areas, must be mindful of, rather than just telling people to 'eat healthily'. It is also important that Aboriginal and Torres Strait Islander Health Workers have a robust understanding of what healthy nutrition entails. Being able to avoid diseases that have plagued the Aboriginal and Torres Strait Islander community through the adoption of healthier diets is an achievable goal, and workers in the Aboriginal and Torres Strait Islander health sector will need the right skills and knowledge in order to promote and enable this.

The Aboriginal and Torres Strait Islander Health Worker

Australia's health system is facing significant challenges, including an ageing population and an ageing health workforce (see Figure 2); the changing burden of disease, and in particular a growing level of chronic disease; and increased demand for health services with higher numbers of people requiring complex and long-term care. To face these challenges the health workforce needs planning for now and the future. This is especially critical in the Aboriginal and Torres Strait Islander health care sector. The latest NCVER data has shown that completions of these qualifications are not especially high and that much needs to be done to improve this situation. A Case for Change is currently being prepared to update the training package products for the Aboriginal and Torres Strait Islander Health Worker sector, which will also examine avenues to increase completion of training and encourage more new entrants to the sector.

Culture and identity are central to Aboriginal and Torres Strait Islanders' perceptions of health. This has seen the Aboriginal and Torres Strait Islander Health Worker workforce evolve into a more culturally comprehensive service provider that meets the need to provide culturally safe clinical and primary health care services to Aboriginal and Torres Strait Islander people whose health needs have not been met by mainstream services. Aboriginal and Torres Strait Islander Health Workers today are able to respond to local health needs and contexts and perform different tasks depending on the services needed. This is reflected in the wide degree of variation that exists in Aboriginal and Torres Strait Islander Health Worker roles, definitions, scopes of practice, education standards and career pathways.[24] According to the 2016 Census, Health Care and Social Assistance was the primary employment industry of Aboriginal and Torres Strait Islander people aged 15 to 64 years in Australia (15%). This includes doctors, nurses, dentists, physiotherapists, child care workers and aged care providers.[25]

Figure 2 Number of Indigenous Health Workers by age group, 2011 and 2016



Source: ABS Census 2011, 2016. Analysis conducted by Alyson Wright (2018), National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)
Note: ABS uses the term Indigenous Health Workers, although the IRC preference is Aboriginal and Torres Strait Islander Health Workers

Generally, Aboriginal and Torres Strait Islander Health Workers provide culturally safe health care to Aboriginal and Torres Strait Islander people, such as advocating for them in order to explain their cultural needs to other health professionals, and educating or advising other health professionals on the delivery of culturally safe health care; performing a comprehensive primary health care role, which includes, for example, clinical assessment, monitoring and intervention activities, and health promotion; and adapting the roles they perform in response to local health needs and contexts.[26]

Mental Health and Substance Abuse Issues within the Aboriginal and Torres Strait Islander Community

Aboriginal and Torres Strait Islander people have suffered profound negative impacts as a result of colonisation with the loss of traditional ways and culture, people and communities. These include disconnection from the land, from traditional food, and from native law, cultural practices and language. The dramatic impact of colonisation on family life for Aboriginal and Torres Strait Islander Australians has resulted in 'traumatic distress, chronic anxiety, physical ill-health, mental distress including fear and depression, high levels of substance use problems and high rates of imprisonment'.[27] Aboriginal and Torres Strait Islander people experience higher rates of mental health issues than other Australians, with deaths from suicide twice as high; hospitalisation rates for intentional self-harm 2.7 times as high; and rates of high/very high psychological distress 2.6 times higher than other Australians. Social, historical and economic disadvantage (including institutionalised racism) have contributed to high rates of physical and mental health problems, high adult mortality, high suicide rates, child removals and incarceration rates, which in turn have led to higher rates of grief, loss and trauma.[28] Barriers to accessing mental health services include the perceived potential for unwarranted intervention by government organisations, long wait times (more than one year), lack of inter-sectoral collaboration and the need for culturally competent approaches, including in diagnosis.[29]

In terms of alcohol consumption Aboriginal and Torres Strait Islander people are less likely to drink alcohol than non-Indigenous people, but those who do drink are more likely to drink at harmful levels. Drinking too much alcohol is associated with health conditions like liver disease, diabetes, cardiovascular disease and some cancers; accidents and injury; and harm to families and communities.[30] These are health and safety issues of which to be mindful within the Aboriginal and Torres Strait Islander community.

Cigarette smoking is a leading contributor to the burden of morbidity and mortality among Aboriginal and Torres Strait Islander people. The health impacts of smoking vary by smoking duration and intensity, but it is well established that smoking causes a range of adverse health conditions. Although there have been marked smoking reductions in Australia, the prevalence of smoking among Aboriginal and Torres Strait Islander adults remains high, estimated at 41.4%, compared with 14.5% in the total Australian adult population.[31] Evidence indicates that there is widespread awareness of tobacco-related health consequences among Aboriginal and Torres Strait Islander peoples, with variation by region and between specific health conditions.[32] However, this widespread awareness is not necessarily positively associated with an intention to quit or reduce smoking. As smoking is the leading contributor to the burden of disease among Aboriginal and Torres Strait Islander peoples, it is essential that strategies emerge to reduce the prevalence of smoking, as this will generate substantial health gains.[33]

According to Aboriginal leaders, if better health outcomes are to be realised at a national level there must be an integrated, cross-discipline, cross-portfolio, Aboriginally-led initiative. This is the only way in which underlying issues can be identified and tackled. It is time to be innovative, considering options that fall outside 'Western' health and medical models. This approach must take account of social, cultural, spiritual, economic and environmental determinants such as education, employment, safe housing, and culturally appropriate health practices and health promotion.[34]

Some reforms to ensure higher participation in health services for Aboriginal and Torres Strait Islander people include:

- having Aboriginal and Torres Strait Islander Health Workers on staff
- increasing the number of Aboriginal and Torres Strait Islander people working in the health sector (doctors, dentists, nurses, etc.)
- designing health promotion campaigns especially targeted towards Aboriginal and Torres Strait Islander people
- having culturally competent non-Indigenous staff
- making important health services available in rural and remote locations (so Aboriginal and Torres Strait Islander people living in rural and remote areas do not have to travel to cities, away from the support of their friends and families)
- funding health services so they are affordable for Aboriginal and Torres Strait Islander people who might otherwise not be able to afford them.[35]

Racism

Racism is a major detriment to Aboriginal and Torres Strait Islander people within the health system. It can prevent Aboriginal and Torres Strait Islander people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low levels of access to health services by Aboriginal and Torres Strait Islander people.[36] The lack of confidence in the health system on the part of Aboriginal and Torres Strait Islander consumers will remain until action is taken against institutional racism. This has also led to many Aboriginal and Torres Islander health consumers not identifying as Indigenous for fear of discrimination.[37] Racism also has a detrimental effect on the wellbeing of Aboriginal and Torres Strait Islander people. Racism can cause depression, anxiety and loss of self-esteem and lead to mental health issues for Aboriginal and Torres Strait Islander peoples.[38] To be effective for the Aboriginal and Torres Strait Islander community, the health system needs to deliver clinically appropriate care that is culturally safe, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander people.[39] A zero-tolerance approach towards racism should be adopted across the health sector. In addition to this there needs to be increased cultural competency among workers who interact with Aboriginal and Torres Strait Islander people.

Royal Commission into Family Violence (Victoria)

In 2015 the Victorian Government established a Royal Commission into Family Violence. The establishment of the Royal Commission was an acknowledgement of the seriousness of the issue. The Commission was tasked with identifying more effective ways to prevent family violence; improving early intervention so as to identify those at risk; supporting victim-survivors; making perpetrators accountable; developing and refining systemic responses to family violence; better coordinating community and government responses to family violence; and, finally, evaluating and measuring the success of strategies, frameworks, policies, programs and services introduced to prevent family violence.

Aboriginal and Torres Strait Islander peoples, especially women and children, are disproportionately affected by family violence. Not only are they more likely to be affected by family violence, but they also face unique barriers to obtaining assistance, whether from a mainstream or culturally appropriate service. It is clear that the injustices experienced by Aboriginal and Torres Strait Islander peoples, including the dispossession of their land and traditional culture, and the grief and trauma associated with policies leading to the wrongful removal of children from their families, have had a profound intergenerational impact on these communities. Family violence is a leading contributor to Aboriginal and Torres Strait Islander child removal, homelessness, poverty, poor physical and mental health, drug and alcohol misuse and incarceration.[40]

Aboriginal and Torres Strait Islander Health Workers are in a unique position to identify and respond to family violence. Some victim-survivors of family violence will not contemplate engaging with a specialist family

violence service but will interact with health professionals at times of heightened risk for family violence—for example, during pregnancy or following childbirth—or seek treatment for injuries or medical conditions arising from violence they have experienced. Failing to identify signs of family violence or minimising the importance of disclosures by patients can have a profound impact on victim-survivors and deter them from seeking help in the future.

A range of health services interact with people experiencing family violence, and these include hospitals, general practitioners, maternal and child health services, mental health and drug and alcohol services, pharmacists and ambulance officers. There are many reasons for health professionals failing to inquire about family violence or lacking the confidence to respond to disclosures, including a lack of family violence training and awareness, inadequate referral options, and time pressures, which can all contribute to missing opportunities to intervene and offer support to victim-survivors.[41]

Most people place considerable trust in health professionals' advice. Such advice can help victim-survivors come to recognise family violence, make safety plans and gain access to the services they need. The Commission makes a range of recommendations to improve health sector responses, through strengthened screening and risk assessment procedures, greater workforce training and development, and better coordination and information sharing between different parts of the health care system. This should be underpinned by clear political and professional leadership to ensure that awareness of, and the ability to respond to, family violence are central components of comprehensive patient care.

Aboriginal and Torres Strait Islander Health in Regional and Remote Areas

In both 2006 and 2011 the highest number of Aboriginal and Torres Strait Islander Health Workers were located in very remote areas – a total of 319 (33%) in 2006 and 316 (25%) in 2011. The highest concentration of Aboriginal and Torres Strait Islander Health Workers per 100,000 Aboriginal and Torres Strait Islander population was also in very remote areas in 2006 and 2011.[42]

There is a discrepancy between the distribution of the Aboriginal and Torres Strait Islander Health Worker workforce and the distribution of the Aboriginal and Torres Strait Islander population. The 2016 Census showed approximately 35% of Aboriginal and Torres Strait Islander people lived in major cities, with 20% in remote or very remote areas.[43] However, the majority of Aboriginal and Torres Strait Islander Health Workers are located in remote and very remote areas, and the fewest in major cities. This likely reflects health service delivery models, such as remote health clinics, and accessibility to a wider range of health services in major cities.[44] The most significant issue for the rural and remote health workforce is not one of overall supply but, rather, workforce distribution associated with the availability and sustainability of local health services.[45] It has been reported through industry that there are significant challenges associated with the provision of training in remote areas. Community-based training is essential in terms of providing opportunities for Aboriginal and Torres Strait Islander people to develop the skills and knowledge required to work in this sector. However, there are ongoing difficulties in building adequate numbers of Aboriginal and Torres Strait Islander trainers and assessors, and this is especially difficult in remote areas. The government has implemented the *Indigenous Employment Initiatives* program which provides funding to Indigenous-specific aged care services to employ Aboriginal and Torres Strait Islander aged care workers in rural and remote areas. Over 100 participating aged care services receive funding specifically for employee wages and are able to allocate this funding to full-time or part-time personal aged care workers according to the workforce needs of individual health services.[46]

State and Territory Jurisdictional Legislation

Each state and territory in Australia has its own jurisdictional legislation around working with medications, including administration and management. Workers are bound by these restrictions when practising in that state/territory. There are significant variations between these legislative instruments, and some states restrict Aboriginal and Torres Strait Islander Health Practitioners registered under the Australian Health Practitioner Regulation Agency (AHPRA) in the ability to apply their skills and knowledge to parts of the job role. Some jurisdictions (Queensland, for example) are currently developing a *Health Drugs and Poisons Regulation* (HDPR) to enable the workforce to fully practise in the scope of their role and support a workforce that is mobile and able to provide more effective, efficient and accessible/available service delivery.

Aboriginal and Torres Strait Islander Health Practitioners, where the Northern Territory is their principal place of practice, are identified in, and permitted to administer medication under, the Poisons and Dangerous Drugs Act.[47]

Aboriginal and Torres Strait Islander Health Workers and Practitioners are in many cases unable to fully develop their scope of practice and, as a result, are faced with barriers to employment, service delivery and the ability to register with AHPRA. To qualify for registration with AHPRA, a worker must complete the qualification *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice* which includes the unit *HLTAHW020 Administer medications* as a core unit. However, due to state and territory legislation, students are restricted in their ability to fully apply the knowledge and skills learned via this unit and put them into practice. This is acknowledged in the unit of competency itself, which states that assessment should take place *'in the workplace, unless state or territory legislation prevents practice in the workplace'*. Where state or territory legislation prevents practice in the workplace, simulated assessment environments may be used in place of workplace assessment. All learners completing the qualification are required to be trained and assessed per the specifications of the training package.

Employment and Skills Outlook

Labour Force Data

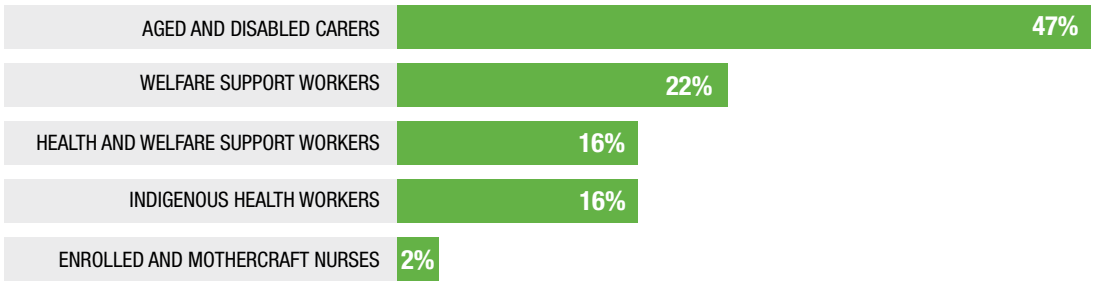
Figure 3 shows that, as in most health-related services, Aboriginal and Torres Strait Islander Health Workers are expected to grow in number over the next five years. The sector is therefore primed for growth as Aboriginal and Torres Strait Islander people will continue to need access to health-related services.

Aboriginal and Torres Strait Islander peoples are significantly under-represented in the health workforce. This potentially contributes to reduced access to health services for the broader Aboriginal and Torres Strait Islander Australian population. The Aboriginal and Torres Strait Islander workforce is integral to ensuring that the health system has the capacity to address the needs of Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander health professionals can align their unique technical and sociocultural skills to improve patient care, improve access to services and ensure culturally appropriate care in the services that they and their non-Indigenous colleagues deliver.[48]

The number of registered Aboriginal and Torres Strait Islander Health Workers at September 2017 was 623 nationwide.[49] Figure 4 shows a breakdown of Registered Health Workers by State/Territory.

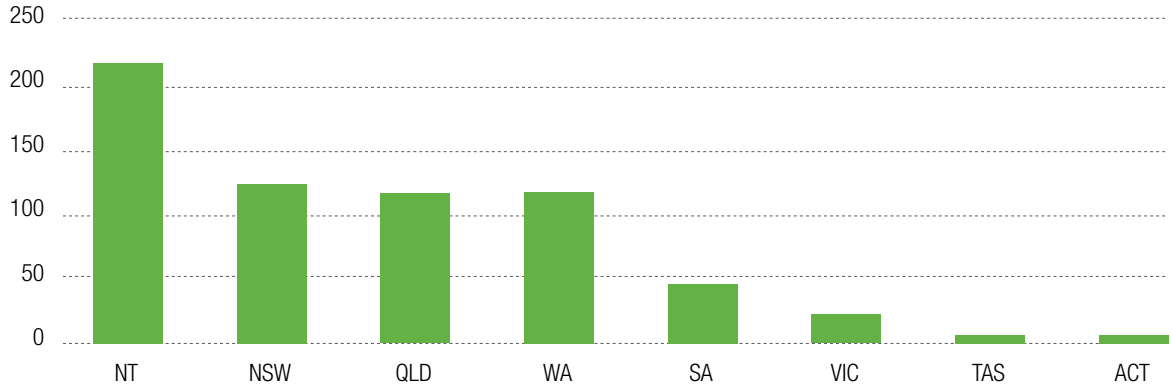
The Aboriginal and Torres Strait Islander Health workforce is ageing. Most (52%) of the workers are over the age of 45. The biggest group of workers is aged 45–54 (30%). See Figure 5 for a breakdown by age of Registered Aboriginal and Torres Strait Islander Health Workers.

Figure 3 Projected growth (%) in selected health and community services specific occupational groups 2017–2022



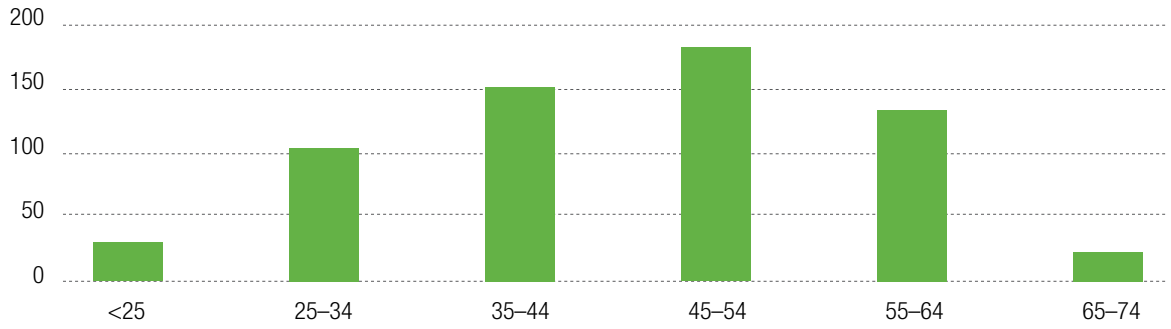
Source: Australian Department of Jobs and Small Business, 2017 Occupational Projections – five years to May 2022

Figure 4 Number of Aboriginal and Torres Strait Islander Health Practitioners by Gender and State/Territory - September 2017



Source: Aboriginal and Torres Strait Islander Health Practice Board of Australia Registrant Data, Reporting period: 1 July 2017 – 30 September 2017.

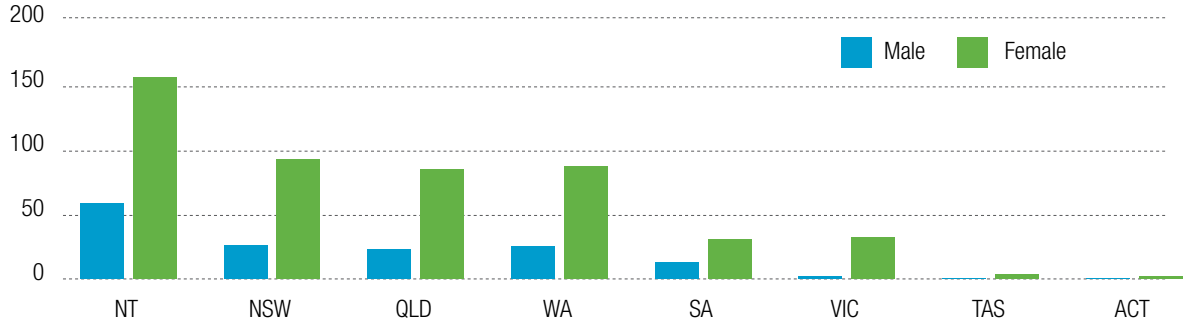
Figure 5 Number of Aboriginal and Torres Strait Islander Health Practitioners by by Age Group - September 2017



Source: Aboriginal and Torres Strait Islander Health Practice Board of Australia Registrant Data, Reporting period: 1 July 2017 – 30 September 2017

Females make up the majority of the Aboriginal and Torres Strait Islander health workforce (76%). Figure 6 shows a breakdown of the gender split of the registered Aboriginal and Torres Strait Islander health workforce by state.

Figure 6 Number of Aboriginal and Torres Strait Islander Health Practitioners by Gender and State/Territory - September 2017



Source: Aboriginal and Torres Strait Islander Health Board of Australia Registrant Data, Reporting period: 1 July 2017 – 30 September 2017

The lower number of males represented in the Aboriginal and Torres Strait Islander health workforce has a detrimental effect on the number of Aboriginal and Torres Strait Islanders who seek health services.[50] It is essential that Aboriginal males be recruited and retained in order to fill the gaps in the sector to ensure that male Aboriginal and Torres Strait Islanders can seek and receive health care. The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016–2023)* provides a guide to assist in the planning, prioritising, target setting, monitoring and reporting of progress in building capacity within the Aboriginal and Torres Strait Islander health workforce. A key aim of the Framework is to improve the recruitment and retention of Aboriginal and Torres Strait Islander health professionals in clinical and non-clinical roles across all health disciplines, including by ensuring that workplace environments are culturally safe for Aboriginal and Torres Strait Islander Health Workers. The Framework also suggests strategies for increasing the number of Aboriginal and Torres Strait Islander people studying and completing qualifications in health. These include:

- Developing and implementing communication strategies and awareness campaigns and delivering them at primary and secondary school health careers initiatives.
- Offering extended learning opportunities to improve the preparedness of students entering higher education (both at the tertiary and Vocational Education and Training levels).
- Providing work experience and work readiness skills programs both in the health and other sector settings where opportunities for health professionals exist, promoting a holistic approach to health and wellbeing.
- Offering and resourcing scholarships and expanding cadetship and graduate programs, traineeships and internships.
- Developing partnerships with Aboriginal and Torres Strait Islander organisations at local, regional and national levels in order to plan and implement activities to increase the number of Aboriginal and Torres Strait Islander students studying for qualifications in health.[51]

It has also been suggested that strengthening personal supports for students through employers and other key industry stakeholders, especially when those students are new to study and/or are away from their own communities (be they urban, rural or remote), will enable them to complete courses of study successfully.

The Commonwealth funds four Aboriginal and Torres Strait Islander health professional organisations to support the Aboriginal and Torres Strait Islander workforce and culturally appropriate health care services. This funding aims to improve retention rates of Aboriginal and Torres Strait Islander health professionals; increase the number of health care providers delivering culturally appropriate care; increase the number of Aboriginal and Torres Strait Islander students studying for qualifications in health; and improve completion rates for Aboriginal and Torres Strait Islander health students; and provide advice to government and other stakeholders on issues affecting the Aboriginal and Torres Strait Islander health workforce.[52]

In 2011, approximately two-thirds of all employed Aboriginal and Torres Strait Islander Health Workers (800, or 64%) worked in the private sector, which includes non-profit organisations and non-governmental organisations such as Aboriginal Community Controlled Health Services. In terms of industry, most (1,111 or 88%) Aboriginal and Torres Strait Islander Health Workers were employed in the Health Care and Social Assistance industry. Within this, approximately one-third (337 or 30%) worked in hospitals. As Census data is self-reported, this may include people employed in hospital settings as Aboriginal Liaison Officers who identified their occupation in the Census as being an Aboriginal and Torres Strait Islander Health Worker.[53] Historically, Aboriginal and Torres Strait Islander Health Workers have not had a huge presence in the public health system in southern jurisdictions, with the exception of Aboriginal Liaison Officers. However, in the current climate, there is acknowledgement of the need for broader Aboriginal and Torres Strait Islander Health Worker roles in hospitals, particularly in mental health, drug and alcohol, maternal and infant care, and cancer care services.

Source: Australian Government Department of Jobs and Small Business, Job Outlook, Australian and New Zealand Standard Classification of Occupations (ANZSCO) ID: 4115.
Note: The Australian Government Department of Jobs and Small Business uses the term Indigenous Health Worker, although the IRC's preference is Aboriginal and Torres Strait Islander Health Worker.

The Aboriginal and Torres Strait Islander Health Workforce – Challenges and Issues

The current minimum qualification for entry to employment in Aboriginal and Torres Strait Islander primary health care is a *Certificate II in Aboriginal and Torres Strait Islander Primary Health Care* as a Trainee Aboriginal and Torres Strait Islander Health Worker or a *Certificate III in Aboriginal and Torres Strait Islander Primary Health Care* as an Aboriginal and Torres Strait Islander Health Worker. To be eligible to register as an Aboriginal and Torres Strait Islander Health Practitioner, a person must hold a *Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice*, or the equivalent (as determined by the Aboriginal and Torres Strait Islander Health Practice Board of Australia). However, there are several gaps in the education of Aboriginal and Torres Strait Islander children which impact on areas such as language, literacy and numeracy (LLN). It is critical that there be a tangible commitment to working with Aboriginal and Torres Strait Islander communities to improve access to education services for Aboriginal and Torres Strait Islander children and to lift school attendance, which is a vital step on the road to improving educational outcomes for Aboriginal and Torres Strait Islander students

and closing the gap between them and their non-Indigenous peers.[54] There remain literacy and numeracy gaps for Aboriginal and Torres Strait Islander Health Workers. There are LLN requirements within the *Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice* which are challenging for some learners whose capabilities in this area do not meet those requirements. It's therefore important to ensure that there are opportunities to address these challenges in order to provide equity in terms of access to training and jobs in the sector. Furthermore, to train in standard LLN skills there's a need for 'technical literacy' in order to provide the necessary skills to meet requirements that are specific to these qualifications and job roles. There is also limited evidence from NCVER that the rate of completions for qualifications that sit within this IRC is not sufficient to replace the ageing workforce. Increasing the importance of, and access to, education and training for Aboriginal and Torres Strait Islander people is essential to developing this workforce.[55]

Closing the gap in education is intrinsically linked to multiple aspects of socioeconomic disadvantage, including access to quality health; employment opportunities; incarceration rates; and housing. These combine to form the social determinants of educational success.[56] This is especially true in the Aboriginal and Torres Strait Islander communities where there is severe socioeconomic disadvantage which includes a lack of access to education. To increase the Aboriginal and Torres Strait Islander workforce there needs to be a transformation in access to education for this community. The Council of Australian Governments (COAG) has implemented many strategies in order to close the gap in education and employment for Aboriginal and Torres Strait Islander people by 2018–2020.[57]

Digital Health

Digital health looks to integrate technology into health care. Digital health technologies have the potential for improving health and medical care. These technologies can effectively provide information, support and social networks for health consumers and improve health care access and delivery. Some technologies include 'apps' and self-monitoring wearable devices such as Fitbits and Smartwatches; Telehealth technologies and electronic health records; and patient portals.

Health technologies should lead to greater sharing of data and information. This is where real value is created for both consumers and health providers. Software that links health data across health care and social services, such as the National Disability Insurance Scheme and aged care, will provide greater information for the provision of appropriate health care to connect communities. It will improve care provision and data integration and decrease 'silos'.[58]

Telehealth is also growing in its use due to the advances in technology. Telehealth involves the distribution of health-related services and information via electronic telecommunication technologies. One outcome of Telehealth's growth is that geographical and physical location becomes less relevant in determining access to care, and the same level of care can be provided regardless of the patient's whereabouts.[59] This can be helpful in the Australian context in terms of providing health services to people in rural and remote areas. However, adoption of Telehealth by health service providers is a challenge, along with patient adoption. To be successful, Telehealth solutions must go beyond simply creating platforms that are technically compatible with existing infrastructure. They must also provide a better user experience for patients and service providers.[60]

With new technology comes the requirement that training and skills should be capable of implementing the technologies to their full capacity. A study of the effectiveness and efficiency of training in digital health care packages has revealed that staff do benefit from formal training on new software systems.[61]

Future Skills Needs

With the constant evolution of technology through automation, artificial intelligence (AI) and robots, the skills needed by the workforce in the coming years will be vastly different to those that are required today. It is imperative that this be factored in to training packages that are being developed, adapted and updated. Technological disruption (as it has done in the past) will replace some industries, companies and workers, especially those that lack the flexibility to adapt.

Australians are generally welcoming of technology and most believe that innovation and new technology development is vital for Australia's future prosperity.[62] There are some claims that, due to technology, approximately 40% of the workforce will be replaced by computers in the next 10 to 15 years.[63] This does not take into account the fact that new technology also creates new jobs and often replaces inefficient processes. Rather than replacing a worker's role, the rise of technology and automation won't necessarily change what jobs workers do; rather, it will change the way in which workers perform their roles. Technological advancement has the ability not to simply impact low-skilled workers' roles by replacing menial tasks through automation, but also has the potential to impact highly skilled workers' jobs as a result of supplementary AI or even the replacement of cognitive tasks.[64]

In order to succeed in the advent of automation and innovation many believe that STEM (Science, Technology, Engineering and Maths) skills are part of the solution when it comes to preparing workers for jobs of the future. The focus on STEM, while not new, is crucial to building a twenty-first century knowledge-based economy underpinned by data, digital technologies and innovation, which are essential for growth.[65] Digital literacy and being competent in the use of different technological platforms will also be essential skills in the future. Without basic digital competencies a person will not have the skills to negotiate the digitally connected world which has now become the norm.[66] Workers will need the ability to use digital technology in their jobs in order to access and use information and digital content; communicate and collaborate through digital technologies; manage their digital identities; develop digital content; and use and protect their digital devices, their personal and organisational data and their privacy.[67] This will be important for the Aboriginal and Torres Strait Islander workforce as, in the future, the delivery of health services and the collection of related data will involve technology and a sound knowledge of digital literacy.

While STEM skills are critical for future skill needs, other 'softer' skills are just as important. Soft skills include things like communication, teamwork, problem solving, emotional judgement, professional ethics and global citizenship. Deloitte Access Economics forecasts that two-thirds of jobs will be soft-skill intensive by 2030.[68] Businesses are aware of the importance of soft skills, and a survey conducted in 2015 of over 450 business managers and executives in Western Sydney cited teamwork, communication skills and time management as vital skills for job applicants (TAFE NSW, 2015). Megatrends like technology advancement and globalisation will contribute to more demand for people with soft skills as geographical barriers fall away due to technology's ability to enable connection between people and organisations across countries.[69] The need for soft skills is yet more prominent in leadership positions. A survey conducted by Deloitte found that soft skills were more important for determining the potential success of a leader than technical knowledge.[70] For decision-makers the ability to effectively communicate, problem solve and think critically is important for success. Credentials for soft skills are beginning to emerge. The benefits to businesses are twofold. Firstly, recruitment processes can be made more efficient as credentials allow recruiters to pre-screen potential candidates for the requisite soft skills. Secondly, more finely targeted recruitment of soft-skilled candidates allows businesses to make savings in training and developing their own workforce later on.[71] The development of soft skills in Aboriginal and Torres Strait Islander Health Workers is critical as Aboriginal and Torres Strait Islander populations have historically had problems accessing and seeking health services. It's important that Aboriginal and Torres Strait Islander Health Workers establish connection and trust through the employment of soft skills within the communities they serve.

Key Generic Skills – Ranked in Order of Importance

Note: The 12 generic skills listed below, including the descriptors, were provided by the Department of Education and Training for the purpose of being ranked by industry representatives. For the 2018 ranking exercise, an 'Other' generic skill option was included in the list to capture any additional key skills for an industry. Please note that, in this case, no other generic skills were identified. However, the IRC has identified that cultural safety, cultural competency and cultural diversity should essentially be embedded across all 12 generic skills.

1	LANGUAGE, LITERACY & NUMERACY (LLN)	Foundation skills of literacy and numeracy.
2	STEM (Science, Technology, Engineering and Maths)	Sciences, mathematics and scientific literacy.
3	COMMUNICATION / COLLABORATION / SOCIAL INTELLIGENCE	Ability to understand/apply principles of creating more value for customers and collaborative skills. Ability to critically assess and develop content with new media forms and persuasive communications. Ability to connect in a deep and direct way.
4	LEARNING AGILITY / INFORMATION LITERACY / INTELLECTUAL AUTONOMY / SELF-MANAGEMENT	Ability to identify a need for information. Ability to identify, locate, evaluate, and effectively use and cite the information. Ability to develop a working knowledge of new systems. Ability to work without direct leadership and independently.
5	MANAGERIAL / LEADERSHIP	Ability to effectively communicate with all functional areas in the organisation. Ability to represent and develop tasks and processes for desired outcomes. Ability to oversee processes, guide initiatives and steer employees toward achievement of goals.
6	TECHNOLOGY AND APPLICATION	Ability to create/use technologies, understand their interrelation with life, society, and the environment. Ability to understand/apply scientific or industrial processes, inventions, methods. Ability to deal with mechanisation/automation/computerisation.
7	ENVIRONMENTAL / SUSTAINABILITY	Ability to focus on problem solving and the development of applied solutions to environmental issues and resource pressures at local, national and international levels.
8	CUSTOMER SERVICE / MARKETING	Ability to interact with other people, whether helping them find, choose or buy something. Ability to supply customers' wants and needs. Ability to manage online sales and marketing. Ability to understand and manage digital products.
9	FINANCIAL	Ability to understand and apply core financial literacy concepts and metrics, streamlining processes such as budgeting, forecasting, and reporting, and stepping up compliance. Ability to manage costs and resources, and drive efficiency.
10	DATA ANALYSIS	Ability to translate vast amounts of data into abstract concepts and understand data-based reasoning. Ability to use data effectively to improve programs, processes and business outcomes. Ability to work with large amounts of data.
11	DESIGN MINDSET/ THINKING CRITICALLY / SYSTEM THINKING / PROBLEM SOLVING	Ability to adapt products to rapidly shifting consumer tastes and trends. Ability to determine the deeper meaning or significance of what is being expressed via technology. Ability to understand how things that are regarded as systems influence one another within a complete entity, or larger system. Ability to think holistically.
12	ENTREPRENEURIAL	Ability to take any idea and turn that concept into reality/make it a viable product and/or service. Ability to focus on the next step/move closer to the ultimate goal. Ability to sell ideas, products or services to customers, investors or employees etc.

Proposed Schedule of Work

All seven qualifications under the remit of the IRC are currently the subject of a Case for Change, due to be provided to the Australian Industry and Skills Committee (AISC) in June 2018. Until such time as this Case for Change has been considered, no further work is being proposed by this IRC.

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