A HIDDEN HISTORY OF ABORIGINAL WOMEN'S WORK IN THE COMMUNITY CONTROLLED HEALTH SECTOR.

A literature review considering the intersection of cultural skills and gender-based skills: gender undervaluation in priority occupations under the Aboriginal And Torres Strait Islander Health Workers and practitioners and Aboriginal Community Controlled Health Services Award 2020 (Aboriginal And Torres Strait Islander Health Award)

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The contents of this paper are the responsibility of the authors and the research has been conducted without the involvement of members of the Fair Work Commission.

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Acknowledgement of Country

The authors and partners of this report wish to acknowledge the Traditional Owners of the nations across Australia and pay our respect to Elders past and present.

A note on terminology

In this report, we use the terms ‘Aboriginal and Torres Strait Islander peoples’ and ‘Aboriginal and/or Torres Strait Islander people’ (where the ‘and/or’ recognises that some individuals belong to both groups) interchangeably with ‘Indigenous’ to refer to Aboriginal and Torres Strait Islander peoples of Australia. However, we recognise that this approach is not without contention. First, these terms do not reflect the diversity of Indigenous Australians, and it is important to remember that many Aboriginal and/or Torres Strait Islander people prefer to be known by their specific group or clan names, and some by ‘First Nations’. Second, we acknowledge that some Aboriginal and/or Torres Strait Islander people do not like being referred to as Indigenous, as this is deemed a catchall term often used by government to include all Aboriginal and Torres Strait Islander peoples of Australia. We have therefore, wherever possible, referred to both Aboriginal and Torres Strait Islander peoples or Aboriginal and/or Torres Strait Islander people but, where appropriate and sometimes for brevity, we have used ‘Indigenous’. We apologise if this causes any offense – this is not our intention.

Definitions

Community: Where the report refers to ‘community’ it is referring to Aboriginal and/or Torres Strait Islander communities.

Country: “Country defined by an Aboriginal person is multifaceted, it includes the physical, non-physical, linguistic, spiritual and emotional. It includes self and feels emotion as we do... Country is family, incorporating its animals, plants, landforms and features right down to the smallest of things like a grain of sand” (Nicholson & Jones, 2018, p. 20).

Racism: This report recognises that for many Aboriginal and/ or Torres Strait Islander people, racism at work is endemic. It manifests in structural and interpersonal ways and has a real and dramatic impact on Indigenous employees. For Indigenous people reading this report, the experiences relayed in the literature may be distressing. However, we felt that this behaviour needed to be named and so we made a conscious choice to call out racism.

Stolen Generations: The Stolen Generations is the collective term used to describe Aboriginal and Torres Strait Islander children who were forcibly removed from their families and communities under Australian federal and State and Territory government policies and legislation between the mid-1800s until the 1970s. Over one third of all Aboriginal and Torres Strait Islander peoples are their descendants. No family or community was left untouched by this shameful period, and we acknowledge their suffering and the ongoing trauma that has resulted from this shameful period of our collective Australia history (Healing Foundation, 2024).

Stolen Wages: This term is used to refer to the unpaid wages withheld from Aboriginal and Torres Strait Islander workers between the 1880s and 1960s in Australia. These wages were, in some instances, put into government run trust funds, which Aboriginal and Torres Strait Islander people were unable to access. In other cases they were paid in non-monetary forms including rations (food and clothing). In recent decades, State government schemes to repay stolen wages have been enacted where small ex-gratia amounts have been offered. In some jurisdictions, litigation has been launched to varying levels of success (Anthony, 2013).

Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisations
ACCHS	Aboriginal Community Controlled Health Service
ACMS	Aboriginal Corporation Medical Service
AH&MRC	Aboriginal Health and Medical Research Council
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ATO	Australian Taxation Office
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSICHS	Aboriginal and Torres Strait Islander Community Health Service
CDEP	Community Development Employment Projects
CHW	Community Health Workers
DCA	Diversity Council of Australia
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIHO	National Aboriginal and Islander Health Organisation
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NAWU	North Australian Workers Union
OAA	Office of Aboriginal Affairs
QAIHC	Queensland Aboriginal and Islander Health Council
QNU	Queensland Nurses Union
UTS	University of Technology Sydney
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service
WGEA	Workplace Gender Equality Agency
WHO	World Health Organisation
WYUT	Wiyi Yani U Thangani

Executive Summary

Following a decision of an Expert Panel of the Fair Work Commission (the Commission), the Commission initiated proceedings to consider variations to certain award classifications and minimum wage rates in five priority Awards, with a focus on remedying potential gender undervaluation. This includes Dental Assistants and Dental Therapists covered by the *Aboriginal and Torres Strait Islander Health Workers and Health Practitioners and Aboriginal Community Controlled Health Services Award 2020* (the Award).

This literature review was conducted to support the proceedings by examining the intersection of 'invisible' cultural skills and gender-based skills as well as the histories of the Aboriginal Community Controlled Health sector and domestic and caring work performed by Aboriginal and Torres Strait Islander women. It also explores the forced indentured labour of Indigenous women in such roles and how these may have impacted wage fixation under the Award or any related predecessor awards.

There is a dearth of published scholarly and grey literature on dental assistants and dental therapists in the context of the Award, and on wage fixation and how it relates to Aboriginal and Torres Strait Islander women covered by the Award generally. As a result, the scope of this literature review has been broadened to Aboriginal and/or Torres Strait Islander health workers and practitioners, to enable findings to be extrapolated and applied to the subset occupations.

To understand how we have arrived at the current wage situation, we have examined how Aboriginal and Torres Strait Islander women and girls were stereotyped from the point of invasion, and how those stereotypes influenced government policies on their engagement in the labour market. Australia, as a nation, is not yet comfortable with the idea of slavery in our past. However, a simple understanding of the term, and recorded historical facts, shows that Aboriginal and Torres Strait Islander peoples, and specifically women, were forced into unpaid or underpaid and enforced work without the freedom to make personal choices about their labour and lives.

What we see with this review is a thread connecting the past with the wages of Aboriginal female health workers today. Under consideration are early negative sexual stereotyping of Aboriginal and Torres Strait Islander women and girls that persisted for more than 180 years, and which ultimately influenced policy and the direction of their labour force engagement. This was combined with explicit and systemic state policy to forcibly remove pubescent girls from their families and communities to attempt to assimilate them and their children and permanently break their cultural ties and traditions.

Racism, power and patriarchy have combined to build the industrial structures that remain the foundation on which the system operates today. While there has been development and modernisation, no seismic shifts have addressed the deeply entrenched systemic racism and gender bias. This lack of change must be acknowledged and taken into account in assessing how our contemporary industrial relations system continues to value the work of Aboriginal and Torres Strait Islander women in the community controlled health sector.

This literature review focuses on scholarly and grey literature, data and insights about:

- The history of the Aboriginal Community Controlled Health Organisations sector, and whether the history of its formation impacted wage fixation in the Award or any predecessor Award;
- The history of domestic and caring work and the forced indentured labour of Indigenous women in caring and domestic work and its impact on wage fixation under the *Aboriginal and Torres Strait Islander health workers and practitioners and Aboriginal Community Controlled Health Award 2020* or any predecessor Award;
- The cultural skills needed by Aboriginal and Torres Strait Islander health workers and practitioners for the delivery of health services under the *Aboriginal and Torres Strait Islander health workers and practitioners and Aboriginal Community Controlled Health Award 2020*; and
- The gender-based skills utilised by health workers and practitioners and the intersection between gender-based skills and Aboriginal and Torres Strait Islander cultural skills.

This literature review provides a high-level summation of the industrial context of Aboriginal and Torres Strait Islander workers in terms of early colonial history, the shameful era of stolen wages, and industrial action and advocacy. It should not be considered comprehensive. Much has been written about the topics that surround the intersectionality in wage fixation for Aboriginal and Torres Strait Islander female health workers. However, most writing has adopted a lens that precludes consideration of Award payments, or explores the Stolen Generations and stolen wages, and has not necessarily been written by Indigenous people from an Indigenous standpoint.

Comprehensive histories are yet to be written on the undervaluation of Aboriginal and Torres Strait Islander work as a whole, the value of this work to the economic well-being of the nation more generally, of Aboriginal and Torres Strait Islander women in the workforce, and of workers in the health sector. This review should only be considered as a starting point for our deeper understanding.

The Aboriginal Community Controlled Health Sector and the current state of employment for dental assistants and dental therapists under the Award have been examined, and found that the value of the roles have been identified as being influenced by:

- The voluntary basis on which work was provided by community members and health professionals in the very early days of sector development;
- The link between the fight for appropriate levels of funding for the Aboriginal Community Controlled organisations to provide safe, adequate and accessible health services to their communities; and
- The positioning of Aboriginal health workers – a feminised industry from the start – as low-paid, with tenuous job security and limited opportunities for progression.

Scholarship focussing on the history of domestic work and forced indentured labour is analysed due to the lack of historical information available related to those covered by the Award. This group of women, impacted over a prolonged period by the intersection of gender and race, are largely invisible from industrial relations scholarship. This supports the need for further research to be done. This is an uncomfortable history and one of sexual, physical and economic exploitation and abuse, cultural disassociation and attempted forced assimilation in patterns not unique to Australia but repeated across other settler nations. The history of domestic and care work sheds light on the role of Aboriginal and Torres Strait Islander women in early healthcare as trained providers enhancing the health of families other than their own.

Cultural skills requirements and the gender-based nature of health work expected of Aboriginal and Torres Strait Islander women health workers are analysed and considered as valuable assets in both prevention and treatment work. These complex and multifaceted roles are unique, client-centred and shaped by a strengths-based model of Indigenous knowing, being and doing that can only be provided by Aboriginal and Torres Strait Islander workers. This necessarily includes skills that were developed and utilised prior to colonisation.

Combined with the gendered nature of care work, these are both ‘crucial enablers’ in attempts to ‘close the gap’ on health outcomes and life expectancy of Indigenous peoples and communities.

Systemic challenges highlighted here point to the need to improve the work and employment conditions of Aboriginal and Torres Strait Islander workers in both the health and care sectors. This literature review found no evidence of the consideration of the cultural and localised skills of Aboriginal and Torres Strait Islander workers in the fixing of wages in the Award. There was some evidence of differences in rates of pay between Indigenous and non-Indigenous workers. It is important to remember that pay rates are not the sole lens through which the workplace is measured.

Structure of the literature review

The literature review has been structured into three sections. The first considers published work on the characteristics and developments of the Aboriginal community controlled health sector, addressing the need to understand its history and whether its formation influenced wage fixation in the Award or any previous Award. It also examines the history of the sector, and the current state of dental practitioner employment is considered.

Published works on the history of domestic and caring work, and the forced indentured labour of Indigenous women in caring and domestic work, are analysed to examine how this history may have impacted contemporary wage fixation under the Award.

The third section of this literature review contemplates the cultural skills specifically required of Aboriginal and Torres Strait Islander workers for the delivery of health services under the Award, the broader gender-based skills utilised by health workers and practitioners, and the intersection between these.

Findings

A set of key findings have been identified from the literature review. These are as follows:

1. Paradox of undervaluation

A range of historic, social and political factors resulting from the ongoing impacts of colonisation contribute to the undervaluation of both ACCHOs and Aboriginal health workers. This undervaluation can be seen as a paradox given the importance placed on both the community controlled organisation and Aboriginal health workers in the provision of safe, culturally appropriate and accessible health care for meeting the ‘Closing the Gap’ objectives on health related outcomes.

2. Data gaps

2.1 The literature review has highlighted the limited data available and the importance of building the evidence base further. Specifically, the findings show the need to ensure consistent data in relation to the number of workers employed as Dental Assistants and Dental Therapists, and the respective Award in which these workers are employed under. Ideally, data would be available to understand the current level and grade of employees to understand previous and current differences in the rates of comparable occupations between the two Awards.

2.2 Current ABS data is also inconsistent with the AIHW and the National Health Workforce Database. It is recommended that new data is collected to also review the Award that health services are currently using.

3. Research gap

3.1 It is clear that a research gap exists, and that further research is required on the undervaluation of the work of Aboriginal and Torres Strait Islander women and gender-diverse people to fully comprehend how historic and systemic racism has impacted contemporary experiences in the workforce. In particular, a comprehensive published history of the Aboriginal community controlled health sector is a current knowledge gap. Additionally, the overwhelming majority of scholarship on women and work in Australia does not include Aboriginal and Torres Strait Islander women. Identifying intersections in identity lays open the problem with treating women as a homogenous group and does not recognise that characteristics beyond gender may exacerbate or compound experiences of inequality.

3.2 For the purpose of wage fixation under the Award or any predecessor Award, consideration of the historical unpaid and underpaid work demonstrated in this review, and its links to lower rates and undervaluation of Aboriginal and Torres Strait Islander women workers, is required.

4. Lack of appropriate valuation of cultural and gender skills in the Award

4.1 The review shows that while there is an expectation that Aboriginal and Torres Strait Islander health and care workers will draw on both cultural and gender-based skill sets, there is great ambivalence around the value of these skills. It also found no literary evidence to suggest that there has been any assessment of the valuation of these skills undertaken for this Award.

4.2 The review shows that the history of care and domestic work of Aboriginal women and the evolution of Aboriginal Community Controlled Health has likely contributed to an undervaluation of both cultural skills and gender-based skills, as similarly referenced in Finding 1.

5. Broader review of potential undervaluation of cultural and gender-based skills in other sectors

5.1 Beyond the work currently being undertaken on undervaluation under the Award, a broader consideration should be undertaken of where this may be the case in other sectors. In particular, other caring industries – the aged care and disability care sectors specifically should be of interest. A broader examination of other sectors where Aboriginal and Torres Strait Islander women are present (for example the media and childcare) should be considered to assess undervaluation at the intersection of gender and race and how this may impact wages.

5.2 It is also important to broaden knowledge from the focus on simply getting Indigenous people *into* employment. Understanding the experiences of Aboriginal and Torres Strait Islander women in the labour market is critical. This includes recognising and valuing the skills they utilise in the performance of work, such as cultural skills, which are arguably invisible. Jumbunna's Gari Yala 'Speak the Truth' work in conjunction with Diversity Council Australia is a starting point for understanding their experiences and perspectives *in* the workforce firsthand.

Introduction

In the Annual Wage Review 2024 Decision, an Expert Panel of the Fair Work Commission (the Commission) determined that the Commission would initiate proceedings on its own initiative pursuant to s 157 of the *Fair Work Act 2009* (Cth) to consider variations to certain health roles and their classifications. It would also consider the long standing issues of minimum wage rates on work value grounds to remedy potential gender undervaluation in five priority Awards. These include Dental Assistants and Dental Therapists in the *Aboriginal and Torres Strait Islander Health workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* (the Award). This was confirmed in a Statement issued by the Expert Panel in June of 2024.

After the Commission initiated these proceedings, Jumbunna Institute for Indigenous Education and Research (Jumbunna) and the Business School at the University of Technology Sydney (UTS) were engaged to undertake this literature review. The review would explore:

- the intersection of cultural skills and gender-based skills,
- background information on the history of ACCHOs,
- the history of domestic and caring work and the forced indentured labour of Indigenous women in caring and domestic work, and
- how these may have impacted wage fixation under the Award or any predecessor awards.

While we understand that the scope of the review of gender undervaluation under the Award is confined to dental assistants and dental therapists, for the purposes of the literature review, we have had to go beyond those occupations to consider health workers and practitioners more broadly. However, the broad findings can be extrapolated and applied to dental assistants and dental therapists under the Award.

About Jumbunna

Jumbunna Research is the research arm of the Jumbunna Institute for Indigenous Education and Research at UTS. Their Indigenous-led work is guided by one central principle: that it should be driven by Aboriginal and Torres Strait Islander people, and contribute to their strength, sustainability, and wellbeing. Jumbunna Research works within a framework of self-determination. They believe that Aboriginal and Torres Strait Islander nations and peoples can use research as a tool to drive change and build capacity. Jumbunna Research focuses on work that combines their strengths to make a genuine impact and change for First Nations communities in Australia and internationally guided by the following principles:

- Impact – focussing on research that has real world impact that changes people's lives.
- Transformation – focusing on work that aims to address historic structural problems and barriers.
- Self-Determination – using research frameworks that promote self-determination, with Indigenous voices and perspectives always central to the work.
- Indigenous-Led – crafting a research agenda in response to requests from First Nations communities and government and others on issues that impact First Nations communities and responding to those issues with research projects that have Indigenous leadership.
- Capacity Building – working with First Nations people and their communities to ensure that our research builds lasting capacity.
- Cultural Strength – using research methodologies designed to incorporate cultural values and protocols and prioritising community voices of First Nations sovereignty, strength, and vitality.

About UTS Business School

The UTS Business School works closely and collaboratively with businesses, policymakers and public institutions, and the community to produce socially responsible and economically fair outcomes and use education and research as a pathway to individual mobility, social diversity and economic equality.

They are internationally recognised for innovative and high impact research that makes a meaningful contribution to the public good. UTS Business School is committed to developing capability for both First Nations and other Australians and building workplaces and businesses where First Nations people can thrive.

This is supported through a diverse range of research and industry collaborations, specialist Indigenous leadership programs such as the Bachelor of Business Administration and the Indigenous Nation Building stream of the Executive MBA, as well as embedding Indigenous knowledge as an essential part of core curriculum to ensure all graduates have the skills to work with and for Indigenous Australians.

Recent research undertaken by Jumbunna and UTS Business School includes:

- Gari Yala (Speak the Truth): Gendered Insights (UTS, WGEA, DCA, 2021) and
- Gari Yala (Speak the Truth): Centreing the work experiences of Aboriginal and/or Torres Strait Islander Australians (UTS, DCA, 2020)

- Mapping Government anti-racism programs and policies (AHRC, 2024)
- Do Better Report (2020) and Do Better – Collingwood Football Club 2021 Progress Review (2021) (Collingwood Football Club).

Understanding the context

Australia's history of stolen wages of Aboriginal and Torres Strait Islander workers is marked by its colonial antecedents. As Kidd (2007, p. 8) wrote:

> *We struggle to comprehend that slavery is also part of our own nation's history. Many of us are unaware that the practice here took place in far more recent times.*
>
> *Governments around Australia controlled wages, savings and benefits belonging to Aboriginal and Torres Strait Islander people for most of the 20th century. Payments withheld included child endowment, pensions and even soldiers' pay. Much of the money held in trust was never paid to its owners. Trust account funds were transferred to public revenue or disappeared through fraud or negligence along with many of the records.*

There is an early Australian colonial history of using Aboriginal and Torres Strait Islander workers in multiple roles to address workforce shortages across the Continent, with the intention to access cheap labour and influence downwards the wages of the 'White' workers (Pope, 1988).

Before the 1967 Referendum that changed the Australian Constitution to include Aboriginal and Torres Strait Islander peoples as counted members of the population and for the Commonwealth to draft laws that pertained to their affairs, Aboriginal and Torres Strait Islander people's wages and employment were directly controlled by the government (Anthony, 2013; Kidd, 2007). More often than not, Aboriginal and Torres Strait Islander people were given modest rations (composed of flour, sugar and tea, a key recipe for chronic health issues that would plague the next generations with diabetes, cardiovascular disease, and renal disease) for their work instead of wages or paid a small proportion of their wages. The bulk was placed in a trust and access to it was permitted at the discretion of a Government Protector — who tended to reject such requests (Anthony, 2007). The withholding or stealing of wages was most notably occurring for pastoral work post-World War Two, where landowners practised 'booking down'. Booking down was a practice whereby they avoided paying Aboriginal workers by recording Aboriginal workers' wages in the station's store accounts and selling them store goods at inflated prices (Anthony, 2007).

The placing of wages in trust was based on a perception that Aboriginal and Torres Strait Islanders people were incapable of managing their finances (Austin, 1992). However, these wages were stolen and used to fund public works that were built for other Australians to enjoy (Kidd, 2007). These practices were finally contested by the Stolen Wages campaigns in recent decades. The campaigns sought compensation for workers and their descendants in all the states and territories of Australia (Anthony, 2013; Kidd, 2007; Ludiski, 2016) and had varying levels of success.

Queensland was the first State to establish a scheme in 2002, followed by NSW in 2005 and WA in 2012 (from March to November 2012 only), and more recently, this year in the Northern Territory (Anthony, 2013; Harkin, 2020; Houlbrook-Walk, 2024). In April 2024, the Western Australian Government announced it had reached a settlement on stolen wages in a class action brought on behalf of all Aboriginal and Torres Strait Islander peoples who were not paid their wages between 1936 and 1972 (Shine Lawyers, 2024; WA DPC, 2024).

In addition to seeking reparation for stolen wages, Aboriginal and Torres Strait Islander workers have a strong history of campaigning for equal pay. In 1965, following the Northern Territory Aboriginal stations' workers' agitation for change, and made practical by an application by the North Australian Workers Union (NAWU), the Commonwealth Conciliation and Arbitration Commission handed down a decision to include Indigenous workers in the *Cattle Industry (Northern Territory) Award 1951* (Anthony, 2007).

The outcome of the inclusion of Indigenous workers in the *Cattle Industry (Northern Territory) Award 1951* equal pay matter (7 March 1966) provided an opportunity for Indigenous workers to receive equal wages for the same work. This was a landmark decision in equal pay to advance wages and conditions provisions and inclusion in Awards for Indigenous workers across the country. This decision brought Aboriginal workers, unless they were working pursuant to mainstream employment coverage and provisions, into the regulated wages system. The variation to the Award, in its most simplistic sense, removed both the definition of the word 'Aboriginal' as follows:

> *Order and prescribe:—*
>
> *That the said award be and the same is hereby varied in manner following that is to say:—*
>
> *I By deleting from clause 3 the definition of " Aboriginal ".*
>
> *II By deleting from clause 6 the word " aboriginals ".*
>
> *III The foregoing variations shall operate on and from the 1st day of December, 1968, and shall remain in force for twelve months thereafter.*

However, we now understand that the decision was underpinned and overlaid with the prevalent views of Australia towards Aboriginal people of the time and that the decision was nuanced. For example, Anthony (2007*, p. 15*) contends that contrary to the outcome presented in the *Cattle Industry (Northern Territory) Award (1966) 113 Commonwealth Arbitration Reports 651*, the decision of the Commonwealth Conciliation and Arbitration Commission did not constitute a decision for equal wages because:

> *First, the Commission relied on arguments regarding the lower work value of Indigenous workers to allow individuals to be categorised as 'slow workers' on below-Award wages. Second, the Commission referred to evidence on the Commonwealth's assimilation policy to advocate the removal of workers from 'tribal' camps on stations. The transcripts reveal racial biases of the Commission.*

The decision excluded domestic service workers employed on the stations given the definitions contained in the award, although they were impacted by the practices of 'booking down' as much as stockworkers and station hands and approaches to employment conditions in the pastoral industry more generally.

Pastoralists had met the equal pay application and subsequent decision with firm opposition. In August 1966, around 200 Gurindji stockmen, domestic workers and their families commenced strike action, leading to a nine-year dispute. This followed decades of attempts to end exploitation and improve conditions for Aboriginal pastoral workers at Wave Hill Station, and unsuccessful negotiations between the parties on payment and timing of the implementation of the new levels of wages. Not only was this an industrial fight, but the walk off was also one of the key events sparking the move to Aboriginal land rights. In 1973 the Wave Hill licence was surrendered and two new leases issued – one to the Traditional Owners (Ward, 2016). In 2020, the Gurindji native title claim to Wave Hill Station was granted (National Museum of Australia, 2024).

In later decades in the health industry, some allied health workers with their trade unions were successful in their case for equal wages. For example, in 1984, the Queensland Nurses Union (QNU) campaigned to achieve wage equality for Aboriginal and Torres Strait Islander nurses. The lobbying resulted in Aboriginal and Torres Strait Islander nurses in seven Health Department hospitals being awarded equal wages, but not the nurses in the twenty Aboriginal and/or Torres Strait Islander hospitals in North Queensland and the Torres Strait (Ludiski, 2016).

The Commonwealth in 1968, a year after the referendum, established the Office of Aboriginal Affairs (Murray, et. al, 2005). It was from this office that small grants were being formulated to support Aboriginal health projects across the nation. The aim of this work was to enhance State-run Aboriginal health units (Murray et al., 2005, p. 6). The establishment of the Aboriginal community controlled health care sector required a workforce, and reliance on funds from the Commonwealth under different funding mechanisms remained chronically less than State and Territory governments. ACCHOs' governance models situate the authority of running their organisations to provide primary health care and health promotion services. Federal funding in these earliest stages did not encompass the extent and vision that was held by the services set up to respond to their people's needs.

> *Health professionals and others who dared to criticise this poor state of affairs commonly found themselves the victim of government smear campaigns or had project funding withdrawn.* (Murray et al., 2005, p. 4)

This became a common practise, and ACCHOs were often fearful that their funds would be ceased if they questioned or complained about anything (NACCHO, 2024a).

In 1972, Prime Minister Gough Whitlam's call for change was heard, and his office transformed the Aboriginal Affairs Office into a federal Department. This Department was given an enormous mandate aimed at relieving 200 years of colonial policy. The Department and its bureaucrats' focus was on support for the development of new programs targeting education, employment, health, housing and justice (Murray, et al; 2005:6). Access to healthcare shifted dramatically for most, with the establishment of the national public health scheme, Medicare, in 1975. Medicare's aim was universal healthcare access for the first time in Australia's history.

Redfern Aboriginal Medical Service (AMS) was established in 1971 and by 1978 there were 12 AMSs across the country. They provided primary health care, and also offered employment and education opportunities for Aboriginal and Torres Strait Islander peoples. Redfern AMS ran its own education and training centre for Aboriginal health workers, a role that today has been taken up by Accredited Training Organisations (ATOs). Funding for ACCHOs has not been reflective of need, and the self-determination in Aboriginal and Torres Strait Islander health is limited by government control of priorities and funding (Mazel, 2016).

Since the 1970s, workers have also been advocating for the 'Aboriginalisation' of work, explained as a process where "communities are able to define the work context […]. There is a high degree of local control over setting employment outcomes and work schedules" (Altman & Smith, 1993, p. 7). An example of this is provided by the Fraser Government's 1977 establishment of the pilot Community Development Employment Projects (CDEP) scheme (Altman & Smith, 1993).

In this context, the Fair Work Commission (2024a) has identified that the Award wages of Dental Assistants and Dental Therapists under the Award are occupations where the indicia of possible gender undervaluation is strongest and therefore a priority for review. One of the issues being considered in the Review, when determining if there has been a gender undervaluation is:

> Does the work of employees under any of the classifications involve the exercise of 'invisible' skills (**including gender-related Indigenous cultural skills**) and/or caring work of the nature described in paragraphs [156(1)] and [172]–[173] and elsewhere in the Stage 3 Aged Care decision? (Fair Work Commission, 2024a).

The approach

This literature review provides a summative analysis of intersectionality in wage fixation in Australia for Aboriginal and Torres Strait Islander female health workers based on a review of the scholarly and grey literature. The analysis focuses on research data and insights about:

- The history of the Aboriginal Community Controlled Health Organisations sector, and whether the history of its formation impacted wage fixation in the Award or any predecessor Award;
- The history of domestic and caring work and the forced indentured labour of Indigenous women in caring and domestic work and its impact on wage fixation under the *Aboriginal and Torres Strait Islander health workers and practitioners and Aboriginal Community Controlled Health Award 2020* or any predecessor Award;
- The cultural skills needed by Aboriginal and Torres Strait Islander health workers and practitioners for the delivery of health services under the *Aboriginal and Torres Strait Islander health workers and practitioners and Aboriginal Community Controlled Health Award 2020*; and
- The gender-based skills utilised by health workers and practitioners and the intersection between gender-based skills and Aboriginal and Torres Strait Islander cultural skills.

This literature review should not be considered comprehensive. Much has been written about many of the topics that surround the intersectionality in wage fixation for Aboriginal and Torres Strait Islander female health workers. However, most writing has adopted a lens of history that precludes consideration of Award payments, or explores the lens of the Stolen Generations and stolen wages, and has not necessarily been written by Indigenous people from an Indigenous standpoint. Comprehensive histories are yet to be written on the undervaluation of Aboriginal and Torres Strait Islander work as a whole, the value of this work to the economic wellbeing of the nation more generally, of Aboriginal and Torres Strait Islander women in the workforce, and of workers in the health sector This report should only be considered as a starting point to our deeper understanding.

Health Sectors' characteristics and developments

A logical starting point for consideration of intersectionality in wage fixation in Australia for Aboriginal and Torres Strait Islander female health workers broadly is understanding the sector in which they operate and how it developed.

In both historic and contemporary terms, Aboriginal and Torres Strait Islander people are under-represented in the broader health sector, compared with the overall Aboriginal and Torres Strait Islander population and share of patient demographics (Lai et al., 2018). Aboriginal and Torres Strait Islander people experience poorer health outcomes than the overall population and the reasons for this are complex and based in a range of historic, political and social factors resulting from colonisation and its ongoing impacts (AIHW, 2015; Sherwood, 2013).

The following is an examination of scholarship and data about the history of the Aboriginal Community Controlled Health Services sector and the current state of employment for dental assistants and dental therapists.

Aboriginal Community Controlled Health Services

In undertaking this literature review, it became apparent that a comprehensive history of the Aboriginal Community Controlled health sector is yet to be published. This chapter relies on published articles, reports, submissions and websites that include reference to the development of the sector.

The emergence of the Aboriginal community controlled health sector can be based on two factors. In the first instance, it was a direct response to the historically segregated colonial health system and the ongoing exclusionary and racist systemic practices within the health care system in Australia (Mazel, 2016).

Secondly, it resulted from a long history of political and social advocacy for Aboriginal and Torres Strait Islander rights which culminated in the 1970s and 1980s. The 1960s and 1970s saw a distinct growth in demands for land rights, anti-discrimination legislation, compensation for alienation practices and a focus on poverty and ill health (Stanner, 1979, as cited in Rowse, 2013). Increasing political activity included, but was not limited to, events such as the 1958 formation of the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI) (Fredericks et al., 2021), the 1963 Yirrkala Bark Petitions, the 1965 Freedom Rides in NSW, the 1967 Gurindji walk-off at Wave Hill and the equal pay case, and the 1972 establishment of the Aboriginal Tent Embassy.

The Aboriginal and Torres Strait Islander Community Controlled health sector began establishing from the early 1970s to meet the demand for community control of the design and provision of appropriate and accessible health care services to Aboriginal and Torres Strait Islander communities (Mazel, 2016). Unlike mainstream primary health services, Aboriginal community controlled services were built on Indigenous approaches to health and health care (Mazel, 2016; Sherwood & Edwards 2006) and also focussed on prevention, advocacy and a holistic approach which continues today. Juanita Sherwood and Tahnia Edwards (2006, p186) explain:

> *Indigenous peoples are the experts in relation to their own health and health needs. Indigenous knowledge, local, traditional and ecological, provides essential ways of knowing related to Indigenous worldviews that are important for formulating health policy and praxis.*

Self-determination

> *But underneath them was frequently the unstated opposition to Aboriginal self-determination, to Aboriginal people claiming and exercising their rights. It was about the exercise of power.* (Ah Chee, 2024)

The right to self-determination holds universal appeal to Indigenous peoples globally as a way of "anchoring their internal struggles within the state" (Davis, 2012, p. 12) and came to represent the fundamental principle underpinning Aboriginal and Torres Strait Islander peoples' aspirations (Davis, 2012; Mazel, 2016). Although predating the 1978 World Health Organisation's (WHO) *Declaration of Alma Mater* and the much later 2007 *United Nations Declaration on the Rights of Indigenous Peoples*, Aboriginal and Torres Strait Islander community control and health services were both early experiments in organisational means of self-determination (Rowse, 2013) and today remain seen as a best practice model for the implementation of the right to self-determination (Mazel, 2016).

By 1967, federal Labor and non-Labor parties had concluded that Aboriginal and Torres Strait people rejected assimilation. Labor defined a new policy shift as 'self-determination' while non-Labor parties considered it 'self-management' (Rowse, 2013). Following their election, the Whitlam Labor Government adopted self-determination as the national Aboriginal Affairs policy (Mazel, 2016) and it has continued to ride the wave of political favour ever since.

Aboriginal Community Controlled Health Organisations

The first ACCHO was Redfern AMS, established by activists in Redfern in NSW in 1971 as a response to the need to provide appropriate and accessible health services for the local Aboriginal and Torres Strait Islander population (Foley, 1991). Thirteen years before the introduction of Medicare, the majority of the local community was without medical insurance and discrimination at the hands of the mainstream medical health services led to increasing ill health and premature deaths provoking the need for a different approach. Redfern AMS pioneered health care services designed and controlled by Aboriginal and Torres Strait Islander people and delivered their own model of health care. Within a year the service was unable to meet the ever increasing demand (Marles et al., 2012).

Initially, the work undertaken was voluntary, with initial services provided from the boot of the car of a doctor and the services were staffed by voluntary doctors, nurses and community members (Foley, 1991).

The health conditions of the Aboriginal and Torres Strait Islander community in the inner city and growing political agitation were mirrored in other centres and the sector grew rapidly across Australia (Fredericks et al., 2021). By 1977 approximately ten ACCHOs were operating nationally. In South Australia, Pika Wiya Health Services (now Pika Wiya Health Service Aboriginal Corporation) was established in Port Augusta in the early 1970s. Predating Redfern AMS as an Aboriginal community controlled organisation but not offering health care, Nunkuwarrin Yunti of South Australia began operating in the 1960s as one of the first Aboriginal organisations in the state (AHCSA, 2024) if not the nation. After incorporation in 1971, one of their early programs was to engage the services of doctors (AHCSA, 2024).

By 1980, almost 50 Aboriginal health services were operating nationally (Foley, 1991, p 12), including:

- The Victorian Aboriginal Health Service (VAHS) which started operating in 1973 servicing the health needs of the community in Melbourne (Fredericks et al., 2021).
- In the same year, the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) began operating in Brisbane (Fredericks et al., 2021).
- The Perth Aboriginal Medical Service (now Derbarl Yerrigan) opened in 1974 – the second AMS in Australia (DYHS, 2024).
- In the Northern Territory, the Central Australian Aboriginal Congress (Congress) established a medical service in 1975, two years after its own formation (Ah Chee, 2024).
- In NSW, Durri Aboriginal Corporation Medical Service (Durri ACMS) opened in Kempsey in 1976 (Durri ACMS, 2024) and Awabakal Newcastle Aboriginal Co-operative (now Awabakal Ltd) commenced in 1977 with the establishment of a health centre as one of four aims (Awakabal, 2024).

The common primary health care philosophy implemented across the ACCHOs grounded in Aboriginal and Torres Strait Islander approaches, culture and needs was innovative and supported community aspirations for accessible, effective and comprehensive health care that focussed on prevention and social justice (NACCHO, 2019).

The first thirty years of the Aboriginal health sector's formation saw the greatest opposition to their existence. Arguments against community control included unnecessary duplication of mainstream services, that Aboriginal people did not want to use Aboriginal services, and that Aboriginal people were not capable of running health services (Ah Chee, 2024).

Events external to the health system supported the provision of government funding. The 1975 Commonwealth Race Discrimination Act had *legally* stopped consideration of Aboriginal and Torres Strait Islander peoples as second-class citizens (Rowse, 2013) and the enactment of land rights legislation had led to the development of the legal and administrative base of what Rowse (1992) describes as the 'Aboriginal domain'. In the health arena, two public funding streams were made available for Aboriginal and Torres Strait Islander health provision - federal funding allocation to State and Territory health departments and the making of direct grants to ACCHOs (Hill et al., 2021).

The 1982 NSW Task Force on Aboriginal Health Report recognised the importance of Aboriginal-controlled health services in the provision of relevant, accessible health care that would be utilised by the communities they served and made specific note of the evidence of the local impact of the AMS's in Redfern and Kempsey (*Aboriginal and Islander Health Worker Journal, 2001*). It was noted that the ACCHOs were integral to improving health standards but were a generally underfunded component of the Aboriginal health care system (*Aboriginal and Islander Health Worker Journal, 2001*). The Taskforce considered that until such time as Aboriginal health was of the same standard as the general population and it could be proved that Aboriginal communities were willing to utilise mainstream health services, that 'a substantial segment of the Aboriginal population of NSW will require access to community controlled health services' (*Aboriginal and Islander Health Worker Journal, 2001*).

A 1995 Commonwealth reform moved responsibility for Aboriginal and Torres Strait Islander health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the much larger budget of the Commonwealth Department of Health (Ah Chee, 2024). From that point, this meant that substantial increases in national funding for primary health care were directed through Aboriginal community controlled health services. This led to, for example, funding in Central Australia increasing from $700 per person in 2000 to more than $4000 per person in 2024 (Ah Chee, 2024).

ACCHOs continue to be of fundamental importance to redressing the gap in health outcomes for Aboriginal and Torres Strait Islander peoples. Over their more than 50-year history government support has varied and financial support has not met the growing demand for services (Mazel, 2016). From the very start, ACCHOs struggled to convince government of the need for appropriate levels of funding. Foley (1991, p. 6) in his twentieth anniversary history of Redfern AMS explained:

> *Indeed, the first submission to the government by the AMS was in August 1971 when we sought a total of $29,700 from the Office of Aboriginal Affairs…We received a mere $13,000. In February 1972 a second submission for $69,000 was made to the OAA [Office of Aboriginal Affairs]. The AMS received $14,000. The minimal financial support initially offered by the Government was to set a pattern for at least the next fifteen years.*

State and territory based peak bodies began to form from 1981 with the establishment of the Aboriginal Health Council of South Australia (AHCSA, 2024, p3) followed by the Aboriginal Health and Medical Research Council (AH&MRC) in NSW in 1985 (following a recommendation of the Brereton Report by the NSW Aboriginal Taskforce on Aboriginal Health in 1982) (AH&MRC, 2024), and Winnunga Nimmityjah Aboriginal Health & Community Services in the ACT in 1988 (Winnunga, 2024). The Queensland Aboriginal and Islander Health Council (QAIHC) was founded in 1990 (QAIHC, 2024), and Aboriginal Medical Services Alliance Northern Territory (AMSANT) and Victorian Aboriginal Community Controlled Health Organisation (VACCHO) in 1994 and 1996. The final State body formed was the Aboriginal Health Council of West Australia in 2005 (NACCHO, 2024c).

These State and Territory bodies act as representative and advocacy bodies for the Aboriginal and Torres Strait Islander health sector. All are members of the National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak body. Originally formed as the National Aboriginal Health Organisation (NAIHO) in 1975, NACCHO replaced NAIHO in 1992 (NACCHO, 2024d).

NACCHO is one of Australia's largest national peak bodies, focussing on advocating for the Aboriginal community controlled health sector, providing advice and direction to government, and contributing to the strengthening of the sector (Nous Group, 2016).

It is important to distinguish between organisations operating in the Aboriginal health sector. An ACCHO (also known as an Aboriginal Community Controlled Health Service or ACCHS) is initiated and operated by the local Aboriginal and Torres Strait Islander community to design and deliver primary health care services that are holistic, comprehensive and culturally appropriate. An AMS is a health service primarily funded to provide health services to the local community but are not necessarily community controlled. They may be a State or Territory government health service (Australian Indigenous Health InfoNet, 2024). Identified Aboriginal Health Worker positions are also found in State and Territory government health services.

Today, the Commonwealth Indigenous Australians' Health Program funds ACCHOs and other health initiatives delivered through mainstream organisations (DHAC, 2024). In 2022-23, 213 organisations were funded to provide Aboriginal and Torres Strait Islander specific primary health care compared with 210 in 2018-19 (AIHW, 2024). In the same period, 69% were ACCHOs compared with 65% in 2018-19 (AIHW, 2024).

Aboriginal Health Workers

Aboriginal and Torres Strait Islander Community Health Workers (CHWs) are defined as "cultural brokers that help Indigenous patients feel more comfortable and safe throughout the delivery of care" (Lai et al., 2018, p. 2). They are "individuals who may or may not be paid, who work towards improving health in their assigned communities" (Conte et al., 2020, p. 563). The predecessor award to the *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020*, the Aboriginal Community Controlled Health Services Award 2010 (p.4), defined an Aboriginal Health Worker as follows:

> *Aboriginal health worker includes a person who is registered with a national, State or Territory registration body, where registration is required in the State or Territory where the person is employed.*

According to Abbot and Elliott's (2013) research, the professional organisation and registration of Aboriginal health workers has its roots in the Northern Territory following the example of the ngangkaris (traditional healers) and midwives. By 1984 Redfern AMS in NSW was offering its own Aboriginal Health Worker Program (Foley, 1991; Mazel, 2016).

Most CHWs are employed and/or trained by an ACCHO, which is "a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management" (NACCHO, 2024a, p. 10). Since the first ACCHO was created on Gadigal land (Redfern, NSW) in 1971, there are now around 145 ACCHOs in Australia, members of both NACCHO and their state and territory affiliate members (the peak bodies above). In 2006, the Australian Government introduced accreditation requirements for ACCHOs (CREATE, 2020).

There are another 25 Aboriginal community controlled organisations that either operate a primary health care service in addition to non-health care functions, or are community controlled organisations providing health related services in Queensland and the Northern Territory (QAIHC, AMSANT, 2024),

Most of the healthcare work is conducted in clinical settings and framed by a Western biomedical model (Bailey, et al., 2021; Conte et al., 2020).

There are significant differences in employment conditions and rates between Indigenous and non-Indigenous health workers and professionals (Lai et al., 2018). The majority of the Aboriginal and Torres Strait Islander CHWs are employed in positions with low-pay and tenuous job security, requiring low or no qualifications, and with limited opportunities for promotion and adequate work/life balance (Bailey et al., 2021; Lai et al., 2018).

Because of the rewards that do not adequately compensate for the high levels of responsibility and heavy workloads, these positions are stressful, often lead to burnout and reduced job satisfaction (Lai et al., 2018).

Besides a strong motivation to care for community and make a difference for Indigenous health, the enablers that make it possible for Aboriginal and Torres Strait Islander people to enter the healthcare workforce include; community, peers and colleagues' support and encouragement, having role models, flexible and local work arrangements, job security, appropriate rewards and recognition, culturally safe workplaces, access to professional supervision and development, perceiving health as a career option, and a strong cultural identity (Bailey et al., 2021; Lai et al., 2018).

Aboriginal and Torres Strait Islander people also experience a range of barriers to becoming and being CHWs. The barriers exist before entering the profession and once in employment and are linked to structural, relational and individual factors at the community and organisational levels (Bailey et al., 2021; Lai et al., 2018). They include the lack of access to education and training, professional development and mentoring, career progression, financial capacity to pay for work-related expenses (e.g., uniform), flexible work arrangements as well as low wages, a dominant biomedical model of health, racism, inadequate organisational funding, stressful work conditions and expectations (Bailey et al., 2021; Lai et al., 2018; Topp et al., 2022).

Topp et al. (2022) found an example from Queensland of the underpayment of Aboriginal and Torres Strait Islander health workers under certified agreements compared with their professional counterparts. The underpayments were linked to a lack of appropriate classification in the *Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement (No.1) 2019*, the *Nurses and Midwives (Queensland Health) and Department of Education) Certified Agreement (EB10) 2018*, and the *Medical Officers' (Queensland Health) Certified Agreement (No.5) 2018*. These state industrial instruments are "still classified as part of a general 'Operational' professional stream alongside clerical and non-health professionals including cleaners" (Topp et al., 2022, p. 2955).

The underpayment and inadequate classification made the workers feel "'overlooked,' 'sidelined,' and 'undervalued'" (Topp et al. 2022, p. 2955). Additionally, increasing the wages of CHWs employed by ACCHOs is problematic because of the lack of commensurate increase in government funding (CREATE, 2020).

The undervaluation of Aboriginal and Torres Strait Islander health workers can be seen as a paradox given the importance placed on them in meeting the 'Closing the Gap' objectives and their roles in the leprosaria and as medical assistants in the Northern Territory in 1950-60s (Topp et al., 2018). That later role was acknowledged in the Northern Territory through the *Northern Territory Health Practitioners and Allied Health Professional Registration Act 1985 (NT)* and the establishment of the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) as the national peak body in 2009 (Topp et al., 2018).

Improved primary health care has resulted from the establishment of Aboriginal community controlled health services and increases in funding from the 1990s and early 2000s (Ah Chee, 2024). They continue to play a vital role in the provision of safe, culturally appropriate and accessible health care for Aboriginal and Torres Strait Islander communities across Australia.

> *But what I know for certain is that the defeat of the national Voice makes the voice of self-determinant Aboriginal organisations – such as Congress and all the other Aboriginal community-controlled health services – more important, not less important. (Ah Chee, 2024)*

Finding

1. Paradox of undervaluation

A range of historic, social and political factors resulting from the ongoing impacts of colonisation contribute to the undervaluation of both ACCHOs and Aboriginal health workers. This undervaluation can be seen as a paradox given the importance placed on both the community controlled organisation and Aboriginal health workers in the provision of safe, culturally appropriate and accessible health care for meeting the 'Closing the Gap' objectives on health related outcomes.

Current state of employment of dental practitioners

The Statement on the Gender Undervaluation – Priority Awards Review (the Statement) (Fair Work Commission, 2024b) outlines the scope of proceedings as health professionals covered by the *Health Professionals and Support Services Award 2020* and *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* to include both Dental Assistants and Dental Therapists. The Statement excludes the Health Worker classifications under the Award from this review.

This section provides an analysis of Dental Assistant and Dental Therapist employment, exploring Australian Bureau of Statistics (ABS) Census (the Census) findings in relation to each occupation. Lastly, an analysis is provided on the impact of Award variations.

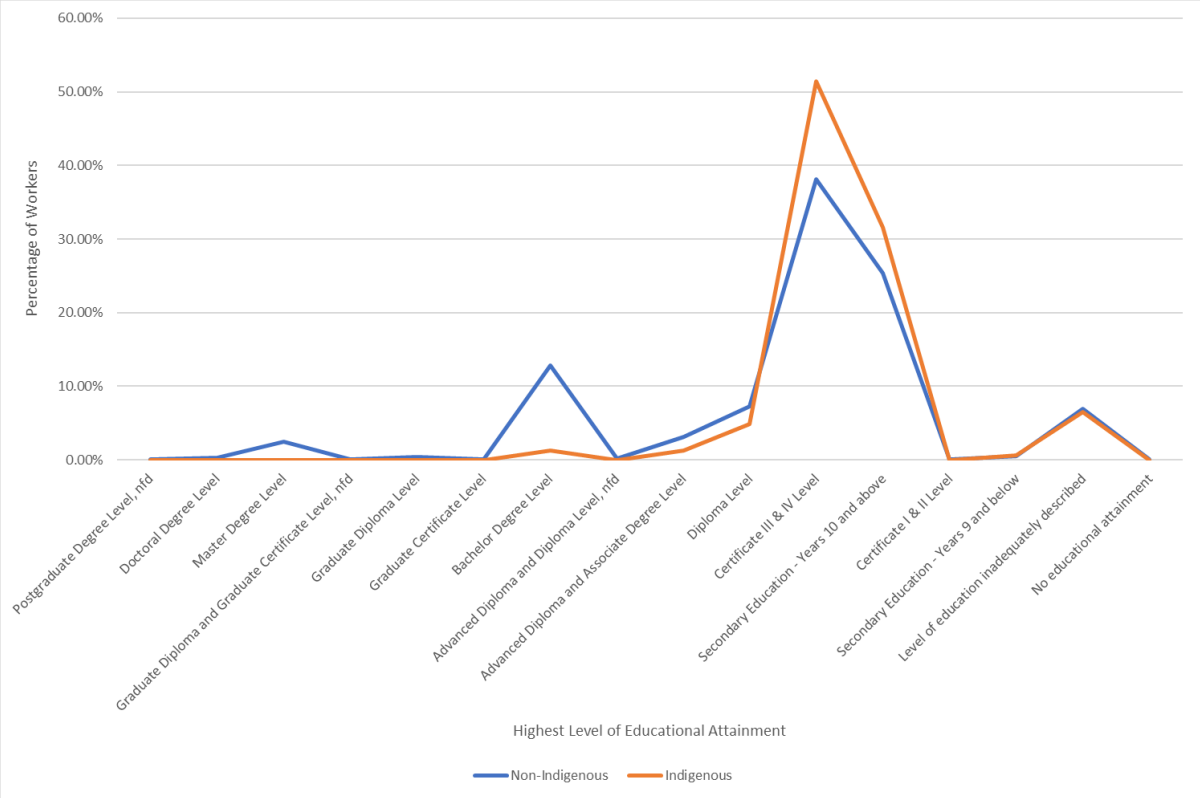
Dental Assistants

In the 2021 ABS Census, 26,438 people noted that they worked as a Dental Assistant (ANZSCO Code 4232). Of this group, 97.5 per cent are female and 2.33 per cent identify as Aboriginal and/or Torres Strait Islander. The age profile of Dental Assistants is young, with 27.4 per cent (n=7,056) of non-Indigenous Assistants and 49.1 per cent (n=284) of Aboriginal and Torres Strait Islander Assistants aged 24 years old or younger. Just 31.7 per cent of Dental Assistants were employed in full-time work, with 35.9 per cent of Dental Assistants employed in casual employment (Cortis et al., 2023).

The Census data also provides insights into the highest education attainment level of those employed in dental services, with approximately 94.97 per cent (n=586) of Aboriginal and Torres Strait Islander respondents having a Diploma qualification or lower, compared to 78.25 per cent (n=20,150) for non-Indigenous workers. Those with Year 12 qualifications or lower were also disproportionate, with 38.73 per cent (n=239) of the Aboriginal and Torres Strait Islander workforce compared to 32.85 per cent (n=8,459) of the non-Indigenous workforce.

Figure 3.1 below demonstrates the highest level of education attainment of Indigenous and non-Indigenous cohorts as a percentage of the relevant workforce. Evident from the figure is the significant difference between educational attainment levels, with non-Indigenous workers more likely to hold a bachelor's degree and Aboriginal and Torres Strait Islander workers more likely to have completed either Secondary Education or a Certificate III or IV.

Figure 3.1- Indigenous and non-Indigenous Highest Education Attainment Level

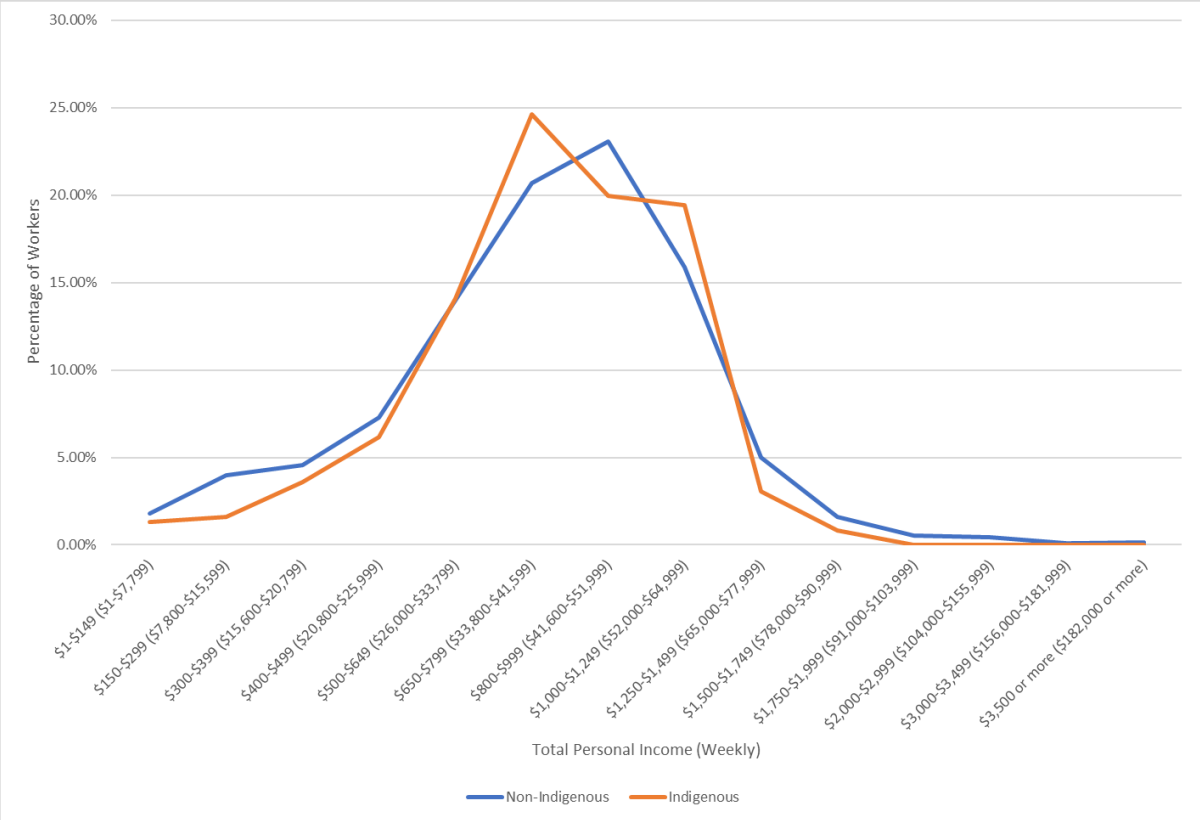


Source: Census of Population and Housing, 2021, TableBuilder

The median pay rate for Dental Assistants was also significantly low at $28 per hour, with half of Dental Assistants receiving below this amount (Cortis et al., 2023). Over 75 per cent (n=19,965) of Dental Assistants receive less than $1,000 per week. Figure 3.2 demonstrates the difference in pay rates between Aboriginal and Torres Strait

Islander and non-Indigenous Dental Assistants, with almost a quarter (24.6 per cent) of Indigenous Dental Assistants receiving between $650 and $799 per week.

Figure 3.2- Indigenous and non-Indigenous Total Personal Income (Weekly)



Source: Census of Population and Housing, 2021, TableBuilder

Larger versions of both these figures are found below at Appendix B and C.

Dental Therapists

In the 2021 ABS Census, 2,552 people noted that they worked as a Dental Therapist (ANZSCO Code 411214). Of this group, 91.0 per cent are female and 1.10 per cent identify as Aboriginal and/or Torres Strait Islander. In contrast to Dental Assistants, just 11 per cent of Dental Therapists are aged 24 years old or younger.

This lower proportion of Dental Therapists aged 24 years or younger is likely due to the requirement that a Dental Therapist hold a minimum of a Bachelor of Dental Therapy or Bachelor of Oral Health.

Award review

It is important to note that the *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* places an additional cultural load on Dental Assistants and Dental Therapists, noting the desirability of Aboriginal knowledge and cultural skills— Level 1 for employees at Grade 2 onwards for Dental Assistants and Grade 1 and 2 for Dental Therapists. This means that in addition to the skills required for the relevant employee classifications under the *Health Professionals and Support Services Award 2020*, Dental Assistants and Dental Therapists employed under the *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* have an additional load because it is desirable that they have Aboriginal and Torres Strait Islander cultural skills which is defined at Schedule A.1.1 of the Award to mean:

> (a) an understanding, awareness and sensitivity to Aboriginal and/or Torres Strait Islander culture and lore, kinship and skin relationships, local cultural values, the ability to conduct oneself in a culturally appropriate manner and an understanding that Aboriginal and/or Torres Strait Islander culture is not homogenous throughout Australia;
>
> (b) where relevant, a knowledge of one or more relevant Australian Aboriginal and/or Torres Strait Islander language groups;

(c) an ability to deliver or assist in the delivery of effective and appropriate services to an Aboriginal and/or Torres Strait Islander clientele through knowledge of the relevant Australian Aboriginal and/or Torres Strait Islander community, the ability to effectively communicate with Aboriginal and/or Torres Strait Islander people, and a knowledge of cultural conventions and appropriate behaviour;

(d) an awareness of the history and role of Aboriginal and/or Torres Strait Islander organisations in the relevant region, an understanding of the organisations and their goals and the environment in which the organisations operate;

(e) the ability to function effectively at work in an Aboriginal and/or Torres Strait Islander organisation; and

(f) an understanding and/or awareness of the concepts of Aboriginal and/or Torres Strait Islander self-determination and Aboriginal and/or Torres Strait Islander identity.

The Award also includes Aboriginal and/or Torres Strait Islander knowledge and cultural skills levels 2 and 3 and the full definitions are set out at Appendix D. These skills are listed as either required or desirable in many of the roles in the Award, they are not limited to Dental Therapists and Dental Assistants.

The setting of classifications and wages under the two awards are set out in the Commission's Stage 2 report which includes an award history of both the *Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020* and the *Health Professionals and Support Services Award 2020*.

ACCHO Dental Support

The Australian Institute of Health and Welfare (AIHW) show that less than a third (32.43 per cent, n=48) of ACCHOs employ a dental support worker. Of 129 FTE dental support workers, 53 FTE are Aboriginal and/or Torres Strait Islander. The majority of these, (approximately 34) are employed in major cities or inner regional areas.

Table 3.6- FTEs of employed dental support workers and distribution of ACCHOs by remoteness.

Remoteness area	FTEs of employed dental support workers			Distribution of ACCHOs		
	First Nations	Other Australians	Total FTEs	Has employed dental support	No employed dental support	Total ACCHOs
Major cities	17.10	43.53	60.63	13	9	22
Inner regional	16.71	19.60	35.31	13	25	38
Outer regional	11.03	10.88	21.91	12	27	39
Remote	8.60	1.05	9.65	7	11	18
Very remote	n.p.	n.p.	1.54	3	28	31
Total	**53.48**	**75.54**	**129.04**	**48**	**100**	**148**

Note: Distribution by Indigenous status in Very Remote areas are suppressed according to AIHW data confidentiality policy.
Source: AIHW analysis of OSR data collection- as provided in the NACCHO Submission.

Findings

2. Data gaps

2.1 The literature review has highlighted the limited data available and the importance of building the evidence base further. Specifically, the findings show the need to ensure consistent data in relation to the number of workers employed as Dental Assistants and Dental Therapists, and the respective Award in which these workers are employed under. Ideally, data would be available to understand the current level and grade of employees to understand previous and current differences in the rates of comparable occupations between the two Awards.

2.2 Current ABS data is also inconsistent with the AIHW and the National Health Workforce Database. It is recommended that new data is collected to also review the Award in that health services are currently using.

Domestic work and forced indentured labour

Due to the lack of scholarship that specifically examines dental assistants and dental therapists, and other health professionals more generally, an examination of the history of domestic and care work mostly experienced as enforced indentured labour is necessary to consider the historic development of undervaluation of the work of Aboriginal women.

Despite the particular disadvantage of Aboriginal and Torres Strait Islander women in the labour market, there is little research that considers their experiences which were shaped further by their cultural identity and physical locations. This group of women, impacted over a prolonged period of time by the intersection of gender and race, are largely invisible from industrial relations scholarship. This lack of detail itself is worthy of attention from both policy makers and researchers (Kaine, 2017).

Intersectionality

Identifying intersections in identity exposes the difficulty of presenting women as homogenous and fails to recognise that other characteristics beyond gender might exacerbate the experience of inequality (King, 1988, as cited in Kaine, 2017). Through this very lens, we see that the intersection of gender and race has shaped the experiences of Aboriginal and Torres Strait Islander women in every aspect of their lives, and influenced, perhaps unconsciously, how the contemporary industrial system continues to undervalue their contributions in the labour market. As Choo and Ferree (2010, as cited in Kaine, 2017, p. 272) state in Sarah Kaine's examination of Australian women and industrial relations:

> *The purpose of intersectional analysis is to recognise, contest and debate such differences, informed by an understanding that doing so give voice to those who are in positions of oppression.*

Kaine (2017) herself writes that the purpose of using intersectionality is to offer an insight into those groups of women whose disadvantage may be compounded by other circumstances.

Winter (2016) provides a chronological order to coerced labour in Australia: indentured servitude (the first twenty years of the colony); convictism (from invasion until 1850); and Aboriginal workers (initially on small scale from the 1830s but from 1860s on). He makes the point that the widespread exploitation of Aboriginal labour coincided with the colonial expansion into north-west Australia *that did not include convict labour*.

While the term 'slavery' is not part of common discourse in Australia, when the history of enforced Aboriginal and Torres Strait Islander labour is considered, we are forced to ask ourselves - what then is slavery if not, by definition, unfree labour? Victoria Haskins (2021, p. 5) uses the 1947 definition of US judge, Jacob Weinberger:

> *A slave [we should say 'enslaved person'] is a person who is wholly subject to the will of another, one who has no freedom of action and whose person and services are wholly under the control of another, and who is in a state of enforced compulsory service to another.*

While there are examples of Aboriginal male domestic servants in Australia, the majority of domestic servants have been women, highlighting the gendered nature of the work (Haskins & Lowrie, 2015).

Starting in 1866, girls and young women from the Stolen Generations, as young as 12 years old, were sent away from their land to work as domestic servants in European settler homes by the heads of missions and reserves (Austin, 1992; Kidd, 2007). These young girls were generally allowed to leave their positions between the ages of 18 and 21 upon approval of a formal request to permission to be released from their duties (Austin, 1992).

Sexual stereotyping

European theories about Aboriginal women and their social and sexual relations were in place prior to the invasion of Australia, and these ideas of sexually available, wanton and shameless coquettes persisted strongly during the whole colonial period. Initially adopted and adapted purposefully by a multitude of administrations over time (Bradley, 1987; Goodall, 1990; 1995; McGrath, 1990), these theories established a recurrent theme that created a tainted platform on which to build upon the undervaluation – and indeed the devaluation - of Aboriginal and Torres Strait Islander women to this day.

These older views about sexuality and poor mothering formed the background for Aboriginal policy development and, as pointed out by Goodall (1995, p. 76) "questions of sexual stereotyping and regulation of sexual activity, of policy in relation to Aboriginal mothers and children, and the nature of Aboriginal women's engagement in the labour force as domestic servants, are all inextricably entwined". Although now regarded as uncomfortable policy shaped by specific perceptions of Aboriginal people, the overarching approach - rooted in the broader social and political goals of the state (Goodall, 1995) - was to sever all cultural ties of Aboriginal women to influence future

generations. It was a purposeful attempt at cultural genocide and forced assimilation (Goodall, 1995; Haskins, 2007; 2019).

There is a substantial body of work on the systemic removal of Aboriginal children. While the policy of child removal was applied to both sexes, the state apparatus for removal – the 'apprenticeship' policy – was from its inception explicitly directed at removing girls reaching puberty from their communities (Goodall, 1995). Victorian attitudes to women and sexuality strongly influenced the various schemes across colonial states and in the area that became the Northern Territory. It was intended as a direct intervention in rising Aboriginal birth rates and aimed to restrict and control young women's sexual activity.

The NSW Protection Board and Charles McKellar who conducted the Royal Commission into Neglected and Delinquent Children agreed on the same 'solution' in terms of what they saw as a source of 'menacing vice' - Aboriginal pubertal girls – that their removal and detention during child-bearing age was a necessity (Goodall, 1995). The apprenticeship model was not new. It was an established mechanism already used in British child welfare structures across their colonial empire. Protection Boards in Australia made minor adjustments to the model and continued the practice long after the policy had been abandoned by general child welfare departments.

In the first ten years of the NSW scheme, from 1912 to 1921, 81 per cent of the children removed were girls (Goodall, 1995, p. 81). Overall, girls made up 72 per cent of all children aged 12 years and over (Goodall, 1995, p. 81-82) - "between school and marriageable age" (Kidd, 2007, p. 21) - who were forcibly removed from their families. In NSW, age, sex and proximity to the Protection Board Inspectors' travel routes were the only reliable predictors of removal (Goodall, 1995; 1990). The Boards argued that Aboriginal girls and women required strictly controlled training to fulfil domestic labour requirements, but also that this was the best work to which they could aspire (Goodall, 1995).

In concert with assumptions around sexuality, labour market conditions were the other factor directing the focus toward Aboriginal girls. White working-class women were taking advantage of growing industrialisation in urban locations and were shifting from cheap rates of pay and highly controlled domestic service and into factory work. This created a thirty-year period in which the domestic labour force was greatly diminished, prior to the expansion of domestic appliances that could take the place of staff in the home. The labour market demand for domestic servants created an opportunity for the state (Goodall, 1995; Goodall, 1990).

Abuse and exploitation

Heather Goodall (1990) wrote of widespread reports of sexual exploitation and rape of the 'apprentices', describing the NSW Protection Board's recording of minimal rates of pregnancies as at least 7 per cent. Goodall (1990, para. 19) quotes Henry Hardy, a Yualiay man interviewed in Brewarrina in 1978, explaining what he had witnessed in the 1920s and 1930s:

> *They'd come and get `em and take 'em away. They'd have `em down there for twelve months and they'd get 'em into trouble and they'd be comin' back with white babies. That's what we were up against. That's true that is. And it was better if they'd left `em with their own lot, let 'em link up that way, that's my opinion of it.*

Jackie Huggins (1991, p. 1) wrote the first-person experiences recounted by Agnes Williams in 1991 of her time as a domestic worker in rural Queensland:

> *When they [her employers] went away at weekends…to see their son in Toowoomba, they used to lock me in a cell. What could I do? I couldn't run away as I had no money and nowhere to go…From my experience all masters wanted to do was to jump into bed with you. I told one wife after being propositioned and she didn't believe me.*

Haskins (2021, p. 16) cites historian Inara Walden's research findings that on Aboriginal apprentices' death rates:

> *…they suffered a very high death rate, seven times that for young white women of the period. The leading recorded cause of death was tuberculosis; the second, horribly, was childbirth.*

In the 1920s, the Australian Aboriginal Progressive Association considered the sexual exploitation of Aboriginal wards as an attempt 'to exterminate the noble and ancient race of Australia' (Goodall, 1990).

Cultural disassociation and assimilation by systemic policy

Aboriginal girls and women were not only targeted to fill the need for domestic workers. The state came to see them as "future bearers of white culture and lifestyle straight into the heart of the Aboriginal family and community life to change cultural practices" (Goodall, 1995, p. 83). Here was the fundamental difference between the variations in the models used by the child welfare system of the time; its application to white working-class girls and women did not include the attempt to sever the cultural practices and ties of the group (Goodall, 1995, p. 84).

As cited in Goodall (1995, p. 84), a 1926 NSW Aborigines Protection Board report stated that:

> *…having been removed from the environment of camp life at a fairly early age, trained and placed in first class private homes, the result must be that the standards of life of this younger generation*

> *will be superior to those of their parents, thus paving the way for the general absorption of these people into the general population.*

The apprenticeship scheme for Aboriginal women was designed to regulate their sexuality, reduce the opportunities to bear children to Aboriginal men and to change their future approach as homemakers and mothers. Assumptions were used to justify colonial government power over Aboriginal women and girls, a power which was used as a weapon in the hands of colonial government and used frequently to control the labour and residence of whole communities (Goodall, 1995).

Other settler colonies shared experiences of forced domestic work for Indigenous women. In the USA for example, the domestic sphere was a key site of strategic manipulation and abuse of power by government, "as a transitional point for Indigenous girls, the urban household a liminal space into which these girls were inserted by the state and from which they were, it was hoped, to step into oblivion" (Haskins, 2007, p. 125).

Aboriginal and Torres Strait Islander people protested the discriminatory labour exploitation practice. In the 1930s, activists including Pearl Gibbs and Bill Ferguson denounced the scheme, considering it colonial and repressive (Goodall, 1990).

In Australia, Aboriginal domestic workers were mythologised as "passive and grateful subjects for domestication by their white mistress" (Haskins, 2019). Obligations for responsibilities for moral protection were passed on by government to the white female employers, resulting in the close monitoring of social activities and movements outside the home (Haskins, 2019). The home, as the place of so-called 'employment', became a space of containment and surveillance. However, the state's interest lay only as far as the appearance of its authority and not in actually protecting the woman and girls from abuse.

Pocket money and stolen wages

Aboriginal domestic servants were often 'paid' in the form of clothes, but when paid in cash, their low wages were placed in trust funds (Austin, 1992; Martínez, 2007). 'Booking down' was also common practice for domestic service and care work performed by Aboriginal and Torres Strait Islander people (Anthony, 2007), and Aboriginal women in rural Australia received very low wages in comparison with whites, or no wages at all, even when pay not withheld - in the form of 'pocket money' - was not forthcoming (Frances et al., 1996; Kinane et al., 2015).

The control over their placements and wages is characteristic of indentured labour. While this practice was presented as a benevolent approach underpinned by a humanitarian protectionist ethos of providing young Aboriginal people with an apprenticeship and work opportunities, it was in fact a core aspect of the government assimilation programs and used as a source of cheap labour (Austin, 1992; Martínez, 2007). It was also an example of 'extreme bureaucratic paternalism' and negative stereotyping of Aboriginal women and their sexuality and as 'morally vulnerable' (Austin, 1992; Goodall, 1995; Martínez, 2007). In Australia, this was endemic well into the twentieth century (Kidd, 2007).

Again, Auntie Agnes Williams recounting to Huggins (1991, p. 2):

> *I received two shillings per week 'pocket money'. I know the balance of our money (eight shillings) went to the Department of Native Affairs. In 1947 I received a cheque with my exemption for nine pounds and five pence after ten years of service.*

The practices used in relation to Aboriginal domestic workers in Australia were part of a colonial pattern. Frances et al. (1996, p. 55) in their comparative piece on women and work in Australia and Canada wrote:

> *…wage inequality based on gender, the undervaluing of women's work, the double oppression of Indigenous women…and neglect of women's occupational hazards at work are all depressing similarities between the two countries.*

It was not only paternalism from white men that Aboriginal women domestic workers had to suffer. In the second half of the nineteenth century, European women settlers sought to claim control over Aboriginal domestic servants—and their sexuality—from their husbands and from the state. This led to campaigns to create positions of Women Protectors or Visitors of Aboriginal domestic servants to supervise their treatment and employment conditions, including the receipt of wages. These campaigns did not, however, lead to reforms and improved conditions for the Aboriginal domestic servants, but to the establishment of an additional layer of control of workers' work and lives (Haskins, 2007).

The growing volume of feminist literature from the 1970s on argues that the uniqueness of the existence of compulsory arbitration in Australia, in contrast with other former British colonies "has had important consequences for women workers. On the negative side, it has acted to institute or solidify sexual divisions of labour which relegated women to lower paid, lower status work" (Frances et al., 1996, p. 55). While the arbitration system did eventually provide a level of protection for the wages and conditions of women workers, not all women were able to access the system to narrow wage differentials, and not substantially until the 1970s (Frances et al., 1996).

From the late nineteenth century, the strong union movement in Australia also impacted industrial changes, but during the period between the first and second world wars, some trade unions hardened their stance on Aboriginal membership and formally excluded them as part of an overall ethnic and racial exclusion across the Australian

labour movement (Frances et al., 1996). Early twentieth century campaigning by Labor women for childhood endowment and maternity allowances excluded Aboriginal and Pacifica women from the eligibility criteria.

The Second World War period led to changes for Aboriginal workers, many of whom received wages for the first time. The post-war period saw increasingly effective organised resistance to forced labour. While a rare occurrence, some Aboriginal women domestic workers mobilised for better conditions. For example, between 1946 and 1949, they joined the Aboriginal male pastoral workers in the 'Pilbara Walk-Off' that took place in Western Australia's Ngarla, Nyamal, and Kariyarra (Ngarluma) Country (Haskins & Scrimgeour, 2015). Aboriginal women workers also took part in the 1968 Wave Hill walk-off on Gurindji Country, and in 1973 took part in the Wee Waa Aboriginal cotton chippers' strike (Frances et al., 1996).

The outcomes of this movement are however mixed, as Haskins and Scrimgeour (2015, p. 89) wrote:

> *The participation of domestic workers in the Pilbara strikes would make their labour visible in a way that challenged entrenched assumptions about marginality and insignificance in the social and political economy of the Northwest. The domestic workers' strike highlighted the dependence of the pastoralists upon this Labor, customarily taken for granted. Such visibility, and the challenges that the domestic strikes posed in themselves, destabilised the precarious framework of race and class hierarchy upon which the pastoralists' dominance rested. The irony is that the invisibility of the Aboriginal women's household labour before the strikes has been perpetuated since in the histories of the Walk-Off that ignore the roles they played, both as workers and strikers. This continued invisibility is a direct product of the way in which their labor was obscured or denied recognition in the historical record.*

Huggins (1991) and Goodall (1995) both point out that Aboriginal women played an important role in the union movement by attempting to connect and support growing numbers of public servants. The second half of the twentieth century saw increasing unionisation of women and over the decade of the 1970s, Australia saw campaigns for equality, major structural changes in the labour force and the new family wage economy. However, these were movements led by white women for white women. Aboriginal women struggled against oppressive legislation and the associated controls over all aspects of their lives. They endured substandard housing on reserves and missions and the health outcomes of poor housing and diet. Perhaps most significantly, their children continued to be stolen by government officials.

While the training of Aboriginal and Torres Strait Islander women as nurses and midwives is traced to 1906, it took almost fifty years for their voices to be heard. Best and Gorman (2016) record that as early as 1955, the Aboriginal health activist voice was heard, first from Sister Muriel Stanley, Aboriginal matron at Yarrabah mission in far north Queensland in Dawn Magazine.

The first national gathering of Aboriginal and Torres Strait Islander nurses was in 1977 (Best & Gorman, 2016, p162) and in the following decades, particularly from the 1980s, prominent Aboriginal nurse advocates including Alison Bush, Joan Winch, Gracelyn Smallwood, Nancy De Vries, Laurel McCarthy, and later Odette Best and Juanita Sherwood voiced their experiences in the health system. They provided commentary on what was required to adequately address the struggles of the nursing profession and provide appropriate care for the Aboriginal and Torres Strait Islander communities (Best & Gorman, 2016).

Even as late as 1965, the Commonwealth viewed the vast majority of Aboriginal and Torres Strait Islander people in the labour market as "not yet worthy of Award wages" (Anthony, 2007, p. 20) and that it would only be "after 'the vestiges of aboriginal (sic) society' had diminished, could they seek Award wages" (Anthony, 2007, p. 20).

Traditional and patriarchal methods of defining and measuring work obscured Indigenous women's contributions to colonial economies. In Australia, unpaid labour was essential to the development of significant sectors such as pastoral, maritime, mining industries but seldom officially recognised. Aboriginal women (along with the rest of their communities) were not counted in the official census until 1971. (Frances et al., 1996).

Haskins (2019, p. 1291) summarises the experience of Indigenous women in both Australia and the US:

> *…scholars of the gendered policies of Indigenous assimilation have argued that the kind of disciplinary domesticity imposed on Indigenous women by the state in both Australia and the US was at best based on misguided and outdated Victorian ideals of womanhood, and at worst a cynical ruse to disguise what was nothing more than a brutal lesson in subordination and dispossession.*

Enforced domestic work continued well into the twentieth century as a technique of state discipline and governance until the demand for domestic servants began to decline by the 1960s, in part due to advances in technology. Even so, Aboriginal women who sought payment of wages owing to them and held in trust by the state were commonly denied their monies (Kidd, 2007).

Pre-health system homebased care work

In the absence of state-sanctioned health care, Aboriginal women highly likely used methods passed down to them by their Elders for healthcare. It is unclear in understanding the history of Aboriginal domestic servitude, where domestic work ended and healthcare labour commenced, due to an almost complete absence in scholarship on this area specifically. Haskins cites historical sociologist Carol Thomas in the argument that domestic labour is, in

essence, health work, drawing on the increasing labour of women in the home from the late 19th century and improving health outcomes in the twentieth century (Haskins, 2021). This draws a logical comparison to the role of Aboriginal domestic workers undertaking provision of home hygiene, nursing the ill and weak, childcare and provision of fresh, untainted food.

If we consider Haskins' (2021) argument of domestic work as a form of 'health work', and the role of Aboriginal women working to enhance the health of families other than their own and the assimilationist aim of training them in "the gendered mores of white domesticity" (Haskins, 2021, p. 9), we have the foundation of critical care givers, albeit "'forced to care' at an unbelievably low cost" (Haskins, 2021, p. 9).

Findings

3. Research gap

3.1 It is clear that a research gap exists, and that further research is required on the undervaluation of the work of Aboriginal and Torres Strait Islander women and gender-diverse people to fully comprehend how historic and systemic racism has impacted contemporary experiences in the workforce. In particular, a comprehensive published history of the Aboriginal community controlled health sector is a current knowledge gap. Additionally, the overwhelming majority of scholarship on women and work in Australia does not include Aboriginal and Torres Strait Islander women. Identifying intersections in identity lays open the problem with treating women as a homogenous group and does not recognise that characteristics beyond gender may exacerbate or compound experiences of inequality.

3.2 For the purpose of wage fixation under the Award or any predecessor Award, consideration of the historical unpaid and underpaid work demonstrated in this review and its links to lower rates and undervaluation of Aboriginal and Torres Strait Islander women workers is required.

Cultural and gender-based skills

Aboriginal and Torres Strait Islander female health workers and practitioners operate at the intersection between gender-based skills and Aboriginal and Torres Strait Islander cultural skills. Their roles demand both cultural skills for the delivery of safe and culturally appropriate health services to the communities they serve and the gender-based skills that have come to be expected in health and other caring work. This section considers literature on the requirement of cultural skills, the gender-based nature of the work and systemic challenges in the caring sector generally.

Cultural skills requirement

Providing culturally safe, person-centred and holistic care is central to improving the health outcomes of Aboriginal and Torres Strait Islander people. These skills are based on Indigenous ways of knowing, being and doing that focus on treating the person as opposed to just the illness or disease (Topp et al., 2021). They include an understanding and shared experience of historical trauma, kinship structures and cultural obligations (CREATE, 2020). While these skills are undervalued outside of communities, the cultural expertise, community connections and ways of conducting business make a significant difference to the care the workforce provides (Bailey et al., 2021; Conte et al., 2020; CREATE, 2020).

Cultural skills are a valuable asset that Aboriginal health workers bring to prevention and treatment work because they are the bridge between cultural protocols and clinical standards (CREATE, 2020). Further, they "provide links between communities and health services, and build trust, relationships and culturally appropriate education and care systems" (Conte et al., 2020, p. 563).

In the context of aged care, the Royal Commission's Inquiry into Aged Care Quality and Safety (RCACQS, 2021) recognised the importance of cultural knowledge when caring for Aboriginal and Torres Strait Islander people. They also emphasised the fact that this highly valuable skill requires training.

Health workers play a complex and multifaceted role that spans across health promotion, clinical service and cultural brokerage (Topp et al., 2021; 2022). Topp et al. (2021) noted the uniqueness of their role because it is client-centred and shaped by a strength-based model of Indigenous knowing, being and doing that can be brought to bear on specific situations in the healthcare context.

Topp et al. (2018) emphasises the spectrum of tangible and intangible cultural skills that Aboriginal and Torres Strait Islander health workers provide and emphasised that the former relates to the ability of workers to be part advocate and interpreter. Workers draw on their knowledge and understanding of community life to inform the decisions made by themselves and their non-Indigenous colleagues to ensure that patients receive culturally appropriate healthcare. This places health workers as 'critical enablers' of the practice of doctors and nurses and mitigates the impact of poor cultural and self-awareness from non-Indigenous health professionals. Their set of skills and knowledge requires experience, mentoring and dedication to develop, contrary to the assumption that underpin Award wage decisions of being an innate quality (Topp, 2022).

Conte et al., 2020, (p. 564) noted that "while most bring cultural and community knowledge to the role, many CHWs have little or no training in Western medicine or in navigating its health systems prior to becoming CHWs". The lack of higher education and/or training in Western health systems may negatively influence the perceived value of the cultural skills CHWs contribute to their work and the improved health outcomes of Aboriginal and Torres Strait Islander communities. Further, there is an expectation that workers will absorb the emotional and financial cost of delivering culturally appropriate healthcare, which can result in unmanageable workloads (Conte et al., 2020).

NACCHO has emphasised that the pressure placed on Aboriginal and Torres Strait Islander health workers due to these inflated role expectations is significant. As members of the community they work in, they are often on call 24 hours a day every day of the week and do not receive appropriate remuneration despite bridging an important gap between the Indigenous community and broader health sector (NACCHO, 2022).

Taking expertise and their role in improving health outcomes for communities (Lai et al., 2018; CREATE, 2020) as defined by NACCHO (2024, p. 10):

> *[The] means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.*

They also highlight the need to recognise the contributions of Aboriginal workers to the health industry and enabling a healthy life to encompass the work and skills of domestic and care workers (Haskins, 2021).

The gender-based nature of the work

As discussed above, until at least the 1950s, Aboriginal and Torres Strait Islander women were largely consigned to domestic servitude as a part of the segregationist and protectionist laws and policies of the day. This delayed their entry into the formal health workforce as Aboriginal and Torres Strait Islander nurses and midwives and in

other professions, as assimilationist policies began to lift, enabling them to begin to make decisions about their own futures (Best & Bunda, 2020).

Despite this historical record, numerous accounts place Aboriginal and Torres Strait Islander women as nurses and midwives before the 1950's which helps to paint a fuller picture of their participation in the health profession, and of the availability of career pathways even against an assimilationist backdrop (Best & Bunda, 2020). Part of this includes the role of Aboriginal and Torres Strait Islander women on missions and reserves, which were dependent on their skills and labour, as non-Indigenous nurses were unavailable to work at hospitals in regional and more remote locations (Best, 2015, as cited in Best & Bunda 2020).

Best and Bunda (2020, p. 620) acknowledge that, despite a dearth of Aboriginal and Torres Strait Islander literature on the topic, the "history of Indigenous nurses and midwives in Australia is yet to be fully examined". They argue that assembling an accurate account is challenging because Aboriginal and Torres Strait Islander nurses and midwives have been largely excluded from the historical record. This gap sits within a broader gap in the literature about the experiences of Aboriginal and Torres Strait Islander women, with Bargallie et al. (2023, p. 7) arguing that they represent "one of the most under-researched yet most disadvantaged cohorts in the workplace".

In addition to their cultural skills and knowledge, Aboriginal and Torres Strait Islander women have specific gender responsibilities and expertise to draw from. These have their basis in Aboriginal and Torres Strait Islander laws governing specific knowledge and rules around supporting families and communities, including 'many teachings about the extensive, challenging and life-affirming journey of maternal health and birthing and growing children on Country' (WYUT, 2020).

Aboriginal and Torres Strait Islander health workers report that aspects of their jobs are gender-specific and therefore must be informed by appropriate health responses to 'women's business' (Opie et al., 2019). The sensitive nature of reproductive and sexual health is something that was traditionally discussed with an Elder of the same gender and this is important in the context of the work that Aboriginal and Torres Strait Islander health workers provide (Opie et al., 2019).

The historical experiences of Aboriginal and Torres Strait Islander women being segregated in healthcare settings such as hospitals during labour has been identified as an important issue that warrants acknowledgement. Some women were left to labour on verandahs open to public view or placed in separate buildings altogether (Opie et al., 2019). Goodall (1995, p, 96) described conditions on the north coast of NSW in her 1995 article:

> *Aboriginal women during the 1950s in Bowraville were excluded altogether from the maternity hospital facilities there, so they walked for two days over the surrounding hills, camping out overnight, to give birth in the makeshift segregated 'Aboriginal' ward at Bellingen hospital.' In 1961 the labour wards at north coast hospitals in NSW including Kempsey and Bellingen were still segregated.*

The employment of Aboriginal and Torres Strait Islander staff, particularly women, improves the access of community members to such services (Opie et al., 2019). Non-Indigenous nurses and midwives cite the importance of ensuring that Aboriginal and Torres Strait Islander women are employed within hospital settings, noting improvements to maternal and infant outcomes, as well as the value of a 'two way' model of care (Stamp, et al., 2008). In doing so, they emphasise the importance of their cultural and gendered knowledge in being able to communicate to Aboriginal and Torres Strait Islander women in traditional languages and ways during the various stages of labour, as well as the incorporation of such knowledge through the involvement of Aboriginal and Torres Strait Islander grandmothers (Stamp, et al., 2008). Best (2011) stresses that these practices were widely used by non-Indigenous midwives as late as the 1940s (Best, 2011), and that Aboriginal and Torres Strait Islander women had a preferred skill-base to some staff including doctors in the early colony. The skills of senior Aboriginal and Torres Strait Islander women were regularly called upon to assist in labour and delivery, such as through using sterilised shells to cut through umbilical cords and ensure placentas were appropriately disposed of (Best, 2011). Such intervention aided in the delivery of more hygienic care and was thought to stave off diseases that ravaged other European societies.

The gender-based skills required to perform the work are intimately linked to the fact that the care sector is highly feminised as noted by Cortis et al. (2023). However, as is the case within the broader Australian culture, the role of women in Aboriginal and Torres Strait Islander cultures was undervalued and given a marginal place in society. Indeed, drawing on Ramsamy (2014), Wall (2010; 2017) and Ward's (2018) work, Dugeon and Bray (2019, p. 5) noted:

> *Prior to colonisation, Aboriginal and Torres Strait Islander women had a strong and respected place within their cultures. The land was often recognised as mother, and women the custodians. Women's Law, or Grandmother Law, was pivotal to the harmonious governance of a land mass twice the size of Europe...*
>
> *... Women's Law has indeed been subjected to erasure and patriarchal appropriation... One of the more powerful Laws is Grandmothers' Law which is a holistic Law governing a whole way of living, an axiology of wellbeing, guiding kinship connections and the spiritual and cultural foundations of families, in particular the sacred women's business of pregnancy, birth, and child- care... In many ways, the Social Emotional Wellbeing of women, children, indeed the flourishing of communities and the future of those communities was an expression of these Grandmother Laws.*

Aboriginal and Torres Strait Islander women have occupied important roles in family and community life going back millennia and they undertook these roles alongside men prior to colonisation. There were clear divisions of labour and all were expected to contribute to the family unit (Leroy-Dyer, 2021).

Aboriginal and Torres Strait Islander women used their rich cultural knowledge in these roles, developing over countless generations, to act as caregivers and primary child rearers, as well as in their broader place in family and community providing for and looking after family. As matriarchs, Aboriginal and Torres Strait Islander women have straddled traditional ways of life alongside the changes wrought by colonisation, including the introduction of the labour force. These changes have brought with it a disruption to the cultural roles of women and introduced Western expectations around the role of women in the home and in broader economic life in a capitalist economy (WYUT, 2020). As a result, Aboriginal and Torres Strait Islander women have occupied unique roles at the intersection of gender and culture and of life since the early days of the Australian colonies. It is important to acknowledge that Aboriginal and Torres Strait Islander women have undertaken roles beyond caregiving, to less documented work as stockwomen, fencers and sealers, yet they have and continue to have a prominent role in the feminised workforce (Russell, 2012; Simone, 2017).

The entry of Aboriginal and Torres Strait Islander women and girls into the formal labour force was built on discrimination. Aboriginal girls were commonly 'apprenticed' into wealthy white families to provide free or cheap labour, where they received clothes or rations as wages (Leroy-Dyer, 2021), akin to descriptions of slavery in other colonies and nations. Not only has their labour largely been unpaid and unrecognised, but in addition to being removed from their culture, Country and families, they endured appalling and often dangerous work conditions characterised by long days, poor food and inhospitable living conditions (Leroy-Dyer, 2021). Exploitation and abuse in these environments was heavily gendered, with Aboriginal and Torres Strait Islander women and girls regularly sexually and physically abused and the resulting children they bore being removed under the protection regimes of the day (Walden, 1995; AHRC as cited in Bargallie et al., 2023).

These findings are consistent with research that has found that the gendered nature of care –including in allied and health work—has been offered as an explanation for the undervaluation and underpayment of that workforce (Das & Das, 2021; Fotaki et al., 2019; PM&C, 2023; Wichterich, 2021).

The findings also show the lack of intersectional analysis and consideration in the review of Awards. Intersectionality, along the lines of culture and gender differences, has been established as a key driver of unequal treatment of marginalised female workers (Adebayo et al., 2018; Coe, 2019; Glenn, 2010; Wichterich, 2021). We see this to also be the case for Aboriginal and Torres Strait Islander women through their racialisation and sexualisation as well as the gendered construction of the care work they perform (Austin, 1992; Goodall, 1995; Lai et al., 2018; Martínez, 2007; Topp, 2022). It is, therefore, crucial to better understand how racism and sexism interconnect in the undervaluation of Aboriginal and Torres Strait Islander health and care workers in order to adequately and equitably review the Award wages.

Systemic challenges

As we explored the Aboriginal and Torres Strait Islander health and care sectors and workforce, the complex ambiguity surrounding the recognition and valuation of the workers, their work and skills, has surfaced as deeply intertwined with historical developments and systemic factors. The literature review reveals that the drivers of historical undervaluation and underpayment of the Aboriginal and Torres Strait Islander care workforce are linked to social norms and structures shaped by colonialism, and the development of the Australian labour force, which combine extractivist ideologies with deep-seated prejudice.

Anthony (2007) discussed the construction of Aboriginal workers in the 1960s as having lower work value and being slow workers. This was underpinned by a perception of Aboriginal and Torres Strait Islander workers as "retarded by tribal and cultural reasons" (CCAC, 1965, p. 663) which made them unskilled and unreliable people or unable to perform according to the ideal white male worker stereotype. Their capacity to master skills was dismissed for several reasons. First, because skills were seen as natural or innate ability. Secondly because the hands-on learning process was not seen as training or requiring reading and writing skills. In the third instance, because Aboriginal and Torres Strait Islander workers were thought to require constant supervision to ensure tasks were performed in a timely and consistent manner and prioritised their work over their cultural responsibilities and ties (Anthony, 2007).

In the absence of requirements for formal qualifications for low-paid health and care work, low-qualified workers are often perceived as unskilled and lacking professionalism (Wichterich, 2019). The low wages were also justified on the premise that Aboriginal and Torres Strait Islander people did not have the same expectations and value ascribed to labour relations as Europeans (e.g., Morris, 1983).

The racialisation of care workers is a key driver of undervaluation and underpayment that has established a social stratification, and a hierarchy of skills based on skin tones and cultural background, which in a settler-colonial nation like Australia is built on the assumed superiority of British rule and civilisation (Coe, 2019; Cognet, 2010; Glenn, 2010; Pelzelmayer, 2016; Ranci et al., 2021). The stratification is maintained by 'regulatory capitalism' - government policies and regulations (Levi-Faur, 2017) - and ensures access to cheap labour through the coercion of the population located at the bottom of the hierarchy - including Aboriginal and Torres Strait Islander people - into unequal work conditions (Kalemba, 2023).

As Pope (1988, p. 14) wrote: “The endemic racism of the day prevented Europeans from acknowledging the contribution that Aborigines could make to colonial society”. The lack of acknowledgement applied to the skills Aboriginal workers had as well as their contribution to the economy.

In addition, as Kidd (2007, p. 9) explains: “Many of these workers across Australia faced a double injustice because they were also members of the Stolen Generations.”

The systemic challenges that are discussed in this literature review point to the need to improve the work and employment conditions of Aboriginal and Torres Strait Islander workers in the health and care sectors. Fixing the wage issue is an important step toward addressing broader challenges in recruitment and retention, and in recognising the significant contributions of the workforce. (CREATE, 2020; Jumbunna/DCA, 2020).

In addition, there is a need for Award wage increases and salary parity with non-Indigenous workers (Lai et al., 2018) but also the need for Award wages to take into consideration “local experience and qualifications rather than requiring institutionally recognised employment and education histories” (Conte et al., 2020, p. 569).

While the argument was made for the withholding wages for pastoral workers (Anthony, 2013; Kidd, 2007; Kinnane et al., 2018), the need to reconcile and compensate for the past actions through a federal statutory reparations scheme could also be applied to the underpaying of Aboriginal and Torres Strait Islander health and care workers.

Findings

4. Lack of appropriate valuation of cultural and gender skills in the Award

4.1 The review shows that while there is an expectation that Aboriginal and Torres Strait Islander health and care workers will draw on both cultural and gender-based skill sets, there is great ambivalence around the value of these skills. It also found no literary evidence to suggest that there has been any assessment of the valuation of these skills undertaken for this Award.

4.2 The review shows that the history of care and domestic work of Aboriginal women and the evolution of Aboriginal Community Controlled Health has likely contributed to an undervaluation of both cultural skills and gender-based skills, as similarly referenced in Finding 1.

5. Broader review of potential undervaluation of cultural and gender-based skills in other sectors

5.1 Beyond the work currently being undertaken on undervaluation in relation to the Award, a broader consideration should be undertaken of where this may be the case in other sectors. In particular, other caring industries – the aged care and disability care sectors specifically should be of interest. But a broader examination of other sectors where Aboriginal and Torres Strait Islander women are present (for example the media and childcare) should be considered to assess undervaluation at the intersection of gender and race and how this may impact wages.

5.2 It is also important to broaden knowledge from the focus on simply getting Indigenous people *into* employment. Understanding the experiences of Aboriginal and Torres Strait Islander women in the labour market is critical. This includes recognising and valuing the skills they utilise in the performance of work, such as cultural skills, which are arguably invisible. Jumbunna’s Gari Yala ‘Speak the Truth’ work in conjunction with Diversity Council Australia is a starting point for understanding their experiences and perspectives *in* the workforce firsthand.

Conclusion

This review draws together key themes from available literature on the historical experiences of Aboriginal and Torres Strait Islander women in the workforce with a particular focus on the history of participation in the health and domestic care sectors. Although literature directly relating to dental assistants and dental therapists is limited, this review seeks to understand their place in industrial relations today by examining the history of the treatment of Aboriginal and Torres Strait Islander workers and peoples more broadly.

The review highlights the need for a contemporary approach to the wages of Aboriginal health workers, ensuring they reflect the value of the skills required and account for the intersection of gender and race. This approach should prevent wages from embedding or mirroring the historical legacy of slavery and forced labour experienced by Aboriginal and Torres Strait Islander peoples, as outlined in this review. This foundation, along with historic and racist assumptions about Aboriginal Torres Strait Islander women and girls and their communities, is firmly entwined in the thread that links the past with today. As Frances et al. (1996, p. 69) stated in their research:

> *the dual process of racism and gender-segregation meant that native women and women of colour, who because of the marginal economic status of their families and communities had to engage in wage work, were banished to the lowest rungs of the occupational ladder.*

Racism, power and patriarchy are the commonalities in the treatment of Aboriginal and Torres Strait Islander women since invasion and occupation. The work of the researchers cited here – and many others not included – provides an understanding that those with power created the labour systems and structures that continue to regulate how we work, and are compensated for our work, in Australia. Although these systems and structures have developed and modernised over time, the deeply entrenched systemic racism that began with the arrival of the British in Australia must be acknowledged. This is particularly important in understanding how today's industrial relations system treats Aboriginal and Torres Strait Islander peoples, especially women in the health sector and other feminised industries. Additionally, it is necessary to consider whether the evolution of industrial instruments has perpetuated the historical underpayment and undervaluation of work performed by Aboriginal and Torres Strait Islander peoples.

It is important to remember that pay rates are not the sole lens through which the workplace is measured. The literature review found no evidence to suggest that any assessment of the valuation of cultural and gender-based skills has been undertaken in regard to this Award, or any other. This is despite the importance the Closing the Gap initiative places on the Aboriginal community controlled health sector and the key role of (predominantly female) health workers with cultural skills in the attempt to improve health outcomes for Aboriginal and Torres Strait Islander people.

Research on the experiences of Aboriginal and Torres Strait Islander women working in the care sectors more broadly could provide a better understanding and valuation of these invisible skills that are both desired and necessary for delivery of such work. Research that accurately captures the experiences of Aboriginal and Torres Strait Islander women in the labour market is scarce. In 2020, to address this gap, Jumbunna, in conjunction with Diversity Council Australia (DCA), released the *Gari Yala (Speak the Truth) Report*, examining the workforce experiences of Aboriginal and Torres Strait Islander peoples in the labour market. The report was the first opportunity for Aboriginal and Torres Strait Islander people to narrate their experiences of work, rather than being aggregated in mainstream reports or examined and interpreted by non-Indigenous people.

Some of the key findings of *Gari Yala* (Jumbunna/DCA, 2020) include:

- 28 per cent of survey participants reported that their workplace was culturally unsafe and 73 per cent in culturally unsafe workplaces had heard racial slurs or jokes in the past year, compared to 21 per cent of Aboriginal and Torres Strait Islander workers in culturally safe workplaces.
- Overall, 44 per cent reported hearing racial slurs sometimes, often or all of the time.
- 59 per cent of respondents reported receiving comments about the way they look or 'should' look as an Aboriginal and Torres Strait Islander person.
- 39 per cent experience a high cultural load in the workplace.
- 37 per cent never, rarely or only sometimes felt comfortable expressing their cultural and personal beliefs at work.
- 65 per cent of respondents felt they had to work harder to prove that an Aboriginal and Torres Strait Islander person could do the job.
- 33 per cent had been told to 'tone it down' or be less outspoken in the workplace about Aboriginal and Torres Strait Islander issues.

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Appendix A. - Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020

Schedule B- Classification Definitions

A.4 Dental

A.4.1 Dental Assistant Grade 1- Employees at this grade will have no prior experience as a Dental Assistant. Appointment to this level will be for a period of three months after which the employee will progress to the appropriate level. While employed at this grade employees will:

(a) work under direct supervision;

(b) gain familiarisation with a range of basic dental and/or clerical tasks; and

(c) gain familiarisation with the employer's policies including health and safety.

A.4.2 Dental Assistant Grade 2 means an employee who has obtained the skills required of a Dental Assistant Grade 1 who performs solely Dental Assistant duties and has no formal qualifications.

It is desirable that staff at this grade have Aboriginal knowledge and cultural skills– Level 1.

A.4.3 Dental Assistant Grade 3 means:

(a) a person who has completed a Dental Assistant qualification performing solely Dental Assistant duties;

(b) an unqualified Dental Assistant performing a combination of duties including routine clerical, reception duties and Dental Assistant duties; or

(c) an unqualified Dental Assistant performing solely Dental Assistant duties who has 12 months' experience at Grade 2.

It is desirable that staff at this grade have Aboriginal knowledge and cultural skills– Level 1

A.4.4 Dental Assistant Grade 4 means:

(a) An unqualified Dental Assistant performing solely Dental Assistant duties who has 12 months' experience at Grade 3 and has demonstrated competence in the following areas:

(i) knowledge of dental equipment;

(ii) sterilisation techniques with attention to infection control;

(iii) basic understanding of techniques and procedures;

(iv) understanding of the set-up prior to procedures; or

(b) an unqualified Dental Assistant performing a combination of Dental Assistant, clerical and reception duties who has 12 months' experience at Grade 3;

(c) a qualified Dental Assistant performing solely Dental Assistant duties who has 12 months' experience at Grade 3; or

(d) a qualified Dental Assistant performing a combination of Dental Assistant, clerical and reception duties.

It is desirable that staff at this grade have Aboriginal knowledge and cultural skills– Level 1.

A.4.5 Dental Assistant Grade 5 means:

(a) an unqualified Dental Assistant performing a combination of Dental Assistant, clerical and reception duties who has 12 months' experience at Grade 4;

(b) a qualified Dental Assistant performing solely Dental Assistant duties who has 12 months' experience at Grade 4; or

(c) a qualified Dental Assistant performing a combination of Dental Assistant, clerical and reception duties who has 12 months' experience at Grade 4.

It is desirable that staff at this grade have Aboriginal knowledge and cultural skills– Level 1.

A.4.6 Dental Therapist Grade 1 works under the professional supervision of a higher grade professional officer as to method of approach and requirements and is a professional practitioner who performs normal professional work and exercises individual knowledge, skills, professional judgment and initiative in the application of professional principles, techniques and methods.

(a) This grade is the professional formation phase of a professional officer. It includes new graduates generally lacking practical experience in the application of their professional knowledge.

(b) The work requires initiative and professional judgment. Since experience is limited, this level is normally expected to apply only established principles, techniques and methods in early postgraduate years. With professional development, it is expected that new techniques and methods will be learnt and applied to progressively more difficult problems.

(c) Initially work is subject to professional supervision. As experience is gained, the contribution and the level of professional judgment increases and professional supervision decreases, until a wide range of professional tasks is capable of being performed with little technical direction.

(d) When experienced, advice and guidance may be provided to less experienced professional staff. They are not required to provide general professional guidance but may be required to provide general supervision of and/or train technical and other non-professional staff.

(e) Staff may be required to develop and apply advanced techniques learnt during the undergraduate course or later; however, decisions to incorporate such new techniques into normal procedures would be taken at a higher level.

It is desirable that staff at this grade have Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1.

A.4.7 Dental Therapist Grade 2 works as a professional practitioner, performs normal professional work under general professional guidance, and may perform novel, complex or critical professional work under professional supervision.

(a) Staff at this grade perform normal professional work of an organisational unit, or of a specialised professional field encompassed by the work of the unit, and accept technical responsibility for those tasks.

(b) Staff may also be expected to perform difficult or novel, complex or critical professional work where they are isolated from immediate professional supervision, for example, because of remoteness of the functional work area. Staff at this grade are expected to exercise independent professional judgment when required, particularly in recognising and solving problems and managing cases where principles, procedures, techniques and methods require expansion, adaption or modification.

(c) Staff may carry out research under professional supervision and may be expected to contribute to advances in the techniques used.

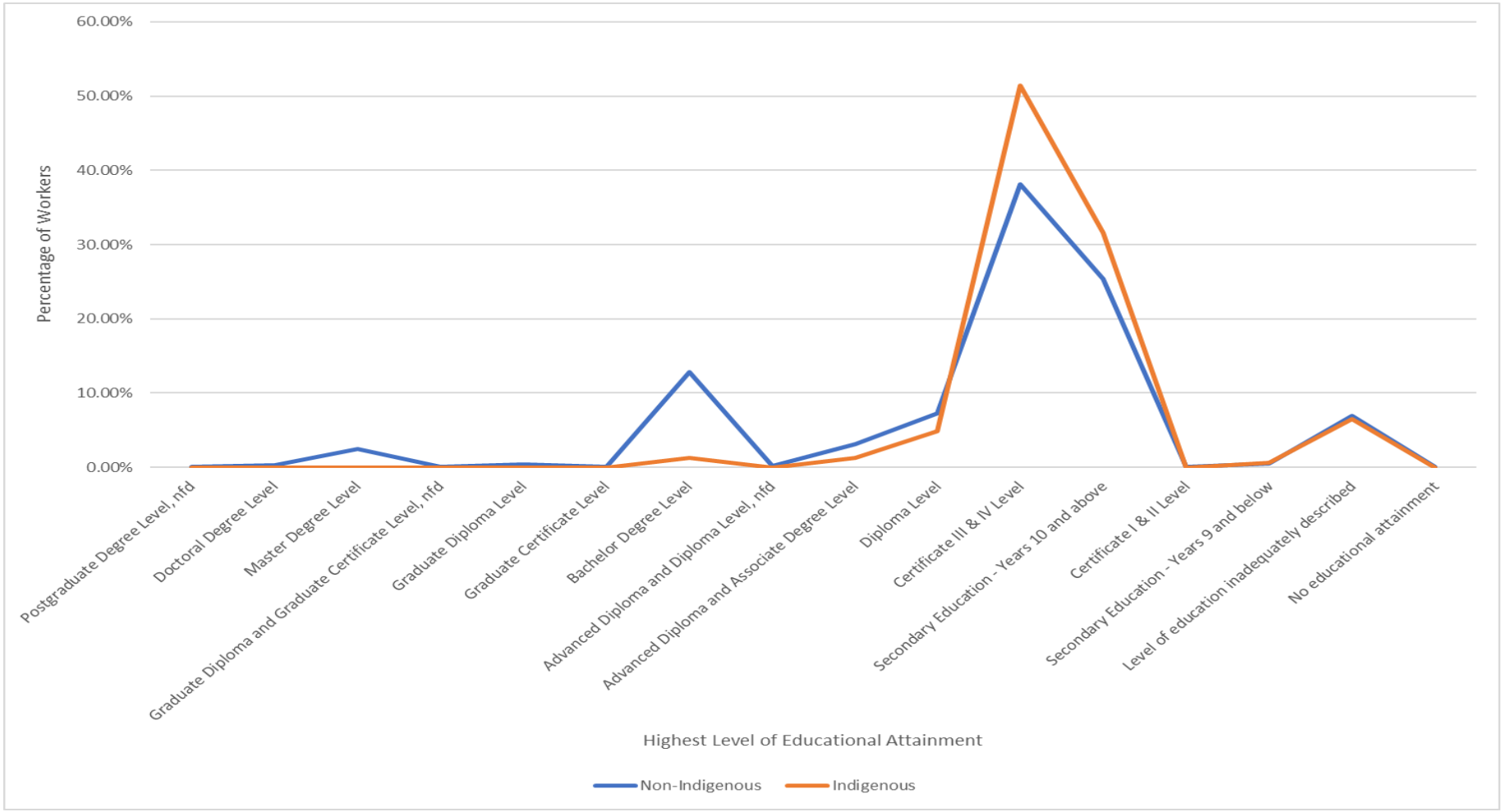
(d) Work at this grade may include professional supervision of Dental Therapists Grade 1 together with general supervision over technical and other personnel. Dental Therapists at this level may also be required to guide Dental Therapists Grade 1 in the methods to be used, policies to be followed and standards to be observed with respect to the professional work performed by the organisational unit.

(e) Staff may provide an advisory role up to the level of expertise.

(f) Staff are required to understand industry problems if advice on interpretation of regulations or standards is required and to undertake associated liaison tasks.

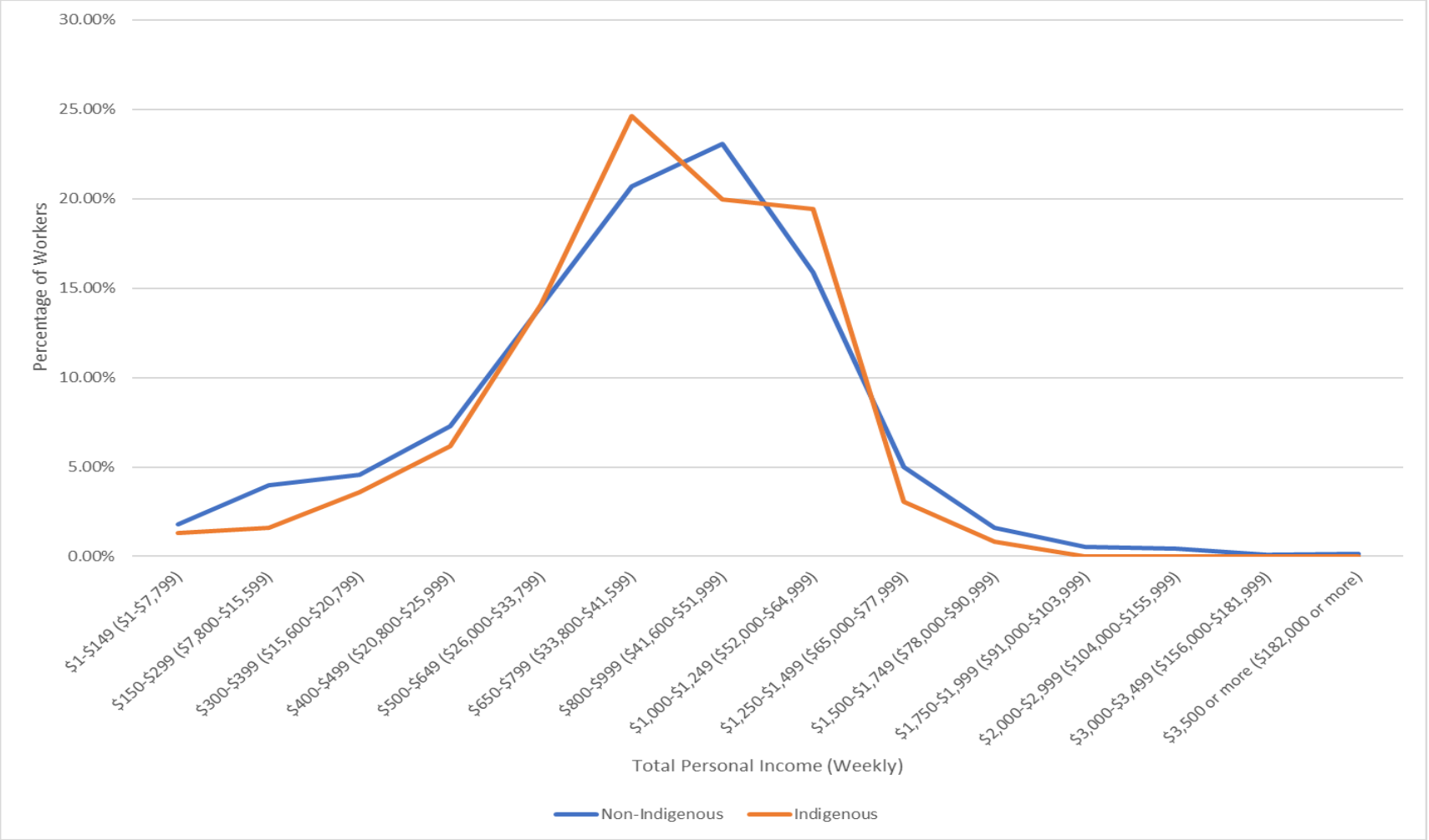
It is desirable that staff at this grade have Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1.

Appendix B: Figure 3.1 Indigenous and non-Indigenous Highest Education Attainment Level



Source: Census of Population and Housing, 2021, TableBuilder

Appendix C: Figure 3.2 Indigenous and non-Indigenous Total Personal Income (Weekly)



Source: Census of Population and Housing, 2021, TableBuilder

Appendix D – Schedule a definitions of Aboriginal and/or Torres Strait Islander knowledge and cultural skills

A.1.1 **Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1** means:

(a) an understanding, awareness and sensitivity to Aboriginal and/or Torres Strait Islander culture and lore, kinship and skin relationships, local cultural values, the ability to conduct oneself in a culturally appropriate manner and an understanding that Aboriginal and/or Torres Strait Islander culture is not homogenous throughout Australia;

(b) where relevant, a knowledge of one or more relevant Australian Aboriginal and/or Torres Strait Islander language groups;

(c) an ability to deliver or assist in the delivery of effective and appropriate services to an Aboriginal and/or Torres Strait Islander clientele through knowledge of the relevant Australian Aboriginal and/or Torres Strait Islander community, the ability to effectively communicate with Aboriginal and/or Torres Strait Islander people, and a knowledge of cultural conventions and appropriate b

(d) haviour;

(e) an awareness of the history and role of Aboriginal and/or Torres Strait Islander organisations in the relevant region, an understanding of the organisations and their goals and the environment in which the organisations operate;

(f) the ability to function effectively at work in an Aboriginal and/or Torres Strait Islander organisation; and

(g) an understanding and/or awareness of the concepts of Aboriginal and/or Torres Strait Islander self-determination and Aboriginal and/or Torres Strait Islander identity.

A.1.2 **Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 2** means Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 1 plus a thorough knowledge of the history and role of Aboriginal and/or Torres Strait Islander organisations in the region, including an understanding of the organisations and their goals and knowledge of the political and economic environment in which the organisations operate.

A.1.3 **Aboriginal and/or Torres Strait Islander knowledge and cultural skills—level 3** means Aboriginal and/or Torres Strait Islander knowledge and cultural skills levels 1 and 2, plus an understanding, awareness and/or sensitivity to local, national and international cultural values and a clear understanding of Aboriginal and/or Torres Strait Islander organisations, their establishment and goals, and the political and economic environment in which the organisations operate at a local, national and international level.