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COMMENTARY

Aboriginal and/or Torres Strait Islander Allied Health Co-Workers: A Possible Role in Advancing Aboriginal and Torres Strait Islander Health and Well-Being

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ABSTRACT

Aim: To propose the novel role of Aboriginal and/or Torres Strait Islander Allied Health Co-Worker to address an urgent unmet need in rural and remote Australia that focuses on disability, rehabilitation and preventative health needs in a unique cultural context.

Context: Allied health and therapy assistants represent a rapidly expanding workforce with considerable potential to relieve workforce shortages and address urgent and unmet healthcare needs in rural and remote Australia. However, the current recognised roles of "Allied Health Assistant" or "Therapy Assistant" are incompatible with the needs of the Aboriginal and Torres Strait Islander communities.

Approach: This commentary prosecutes the case that for Aboriginal and Torres Strait Islander families and communities, the allied health assistant role should be adapted to an Aboriginal and/or Torres Strait Islander Allied Health Co-Worker (AHCW). The AHCW would provide allied health clinical care within the scope of an allied health assistant, as well as cultural brokerage and leadership to support the cultural needs of the people and communities with which the services are interacting. Recommendations are proposed for sustainable implementation of this role.

Conclusion: It is proposed that Aboriginal and/or Torres Strait Islander Allied Health Co-Workers' roles and appropriate recognition of their cultural leadership roles be introduced and embedded in health and disability employment policies.

1 | Background

The allied health workforce is experiencing a severe workforce shortage and maldistribution [1]. To combat this in rural and remote communities, bold thinking is needed to consider alternative models of allied health service delivery. Considering the distinctive needs of Aboriginal and Torres Strait Islander communities in remote Northern Australia, we propose extending the Allied Health Assistant role to one of *Aboriginal and/or Torres Strait Islander Allied Health Co-Worker* (AHCW). This proposed adaptation has been successfully trialled, demonstrating its impact in making an essential contribution to health

service leadership and culturally responsive care [2, 3]. In this commentary, we argue the case for increased investment in and uptake of AHCW roles as part of the solution to the broader allied health crisis in Australia's north. Table 1 details the currently recognised roles that this paper will refer to.

2 | Distinctive Skills Mix for a Particular Setting

In remote Australia, the allied health workforce is essential to providing primary health care, [9] but the availability of clinical allied health services in remote and very remote communities is 50% or less than that of their metropolitan counterparts [10]. More practitioners are needed, but the demographic and cultural context in which they must practice is also distinctive. Australia's northern population comprises 16% of Aboriginal and Torres Strait Islander peoples and notably includes many discrete Aboriginal and Torres Strait Islander communities [11].

The authors of this piece, comprising Aboriginal and/or Torres Strait Islander and non-Indigenous allied health workforce leaders, researchers, and public health experts, argue that the reach and quality of allied health service delivery in northern Australia could be substantially improved with scaled-up use of AHCW roles. The proposed role comprises a distinctive mix of skills that includes the standard clinical skills and roles completed by allied health assistants, and the cultural skills embedded in the long-established Aboriginal and Torres Strait Islander Health Worker roles. For example, while delivering clinical care delegated by an allied health professional, similar to non-identified allied health assistants, AHCW can also provide cultural brokerage that has been shown to improve client engagement, in the same way intended that Aboriginal and Torres Strait Islander Health Practitioners have dual clinical and cultural skills in primary care [3].

In 2023, only 0.6% of the allied health professionals registered with Ahpra (Australian Health Practitioner Regulation Agency) identify as Aboriginal and/or Torres Strait Islander [12]. A cultural gap in clinical practice exists due to the discrepancy between the proportion of Aboriginal and Torres Strait Islander allied health practitioners relative to the Aboriginal and Torres Strait Islander population, which is magnified in certain regions such as northern Australia. Cultural safety requirements have recently been embedded within the Ahpra registered professions via amendments to the National Law, [13] and whilst this represents progress, the cultural gap will persist until our Aboriginal and Torres Strait Islander allied health workforce numbers grow sufficiently to meet the needs of Aboriginal and Torres Strait Islander communities. In the meantime, inconsistent education and training on cultural safety and Aboriginal and Torres Strait Islander health and well-being have resulted in persistent gaps in terms of culturally safe practice within professions [14]. The cultural knowledge, cultural safety, and community trust that AHCW would bring to their practice as well as the professional knowledge provide a holistic solution to improving access and quality of services for Aboriginal and Torres Strait Islander communities. The uniqueness of the role of 'identified' positions to adapt western or biomedical health care practices is well established for Aboriginal and Torres Strait Islander Health Worker and Aboriginal and Torres Strait Islander Practitioner roles [6]. While the cultural knowledge and community understanding of AHCW do align with those of long-established Aboriginal and/or Torres Strait Islander Health Workers, the scope of practice and clinical competencies of that particular role are not recognised to extend to allied health care. The piloting of the AHCW role extends into therapy practice areas such as ageing and disability settings where the primary care-focused Aboriginal and Torres Strait Islander Health Worker and Aboriginal and Torres Strait Islander Practitioner roles are not usually located. The vast unmet need for allied health support among Aboriginal and Torres Strait Islander people in Australia's north demands improved access to such services [15]. With knowledge and skills to deliver services at the critical intersection of cultural and clinical allied health needs, the AHCW role represents a transformative addition to the northern Australian, rural and remote health workforce.

To realise this impact, there must be a commitment to investing in, and careful consideration of the models of care that will

TABLE 1 | Currently recognised roles and definitions.

Role	Definition
Allied Health Assistant	An Allied Health Assistant is a healthcare worker who has demonstrated competencies to provide person-centred, evidence-informed therapy and support to individuals and groups to help protect, restore and maintain optimal function and promote independence and well-being. An Allied Health Assistant works within a defined scope of practice in various settings; and under the delegation and supervision of an Allied Health Professional [4, 5].
Aboriginal and/or Torres Strait Islander Health Worker	A professional role held by Aboriginal and/or Torres Strait Islander individuals located mainly in primary care settings and working in a multi-faceted capacity across three core functions: health promotion, clinical service and cultural brokerage [6]. An Aboriginal and/or Torres Strait Islander Health Worker holds a Certificate II or higher qualification in Aboriginal and Torres Strait Islander Primary Health Care [7].
Aboriginal and Torres Strait Islander Health Practitioner	An Aboriginal and/or Torres Strait Islander Health Practitioner provides clinical services and patient care. They have a focus on providing culturally safe care [8]. Practitioners have gained a qualification in Aboriginal and/or Torres Strait Islander Primary Health Care Practice, and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia through the Australian Health Practitioner Regulation Agency (Ahpra) [7].

ensure the longevity of the role. Drawing on our collective experience and expertise, we outline some requirements and considerations with regard to opportunities for expansion along with the support, supervision, and governance of the role to reach its potential.

3 | Career Structure and Employment

The role of AHCW is unique and critical to delivering clinically effective and culturally responsive allied health care and should be recognised as such. While embedding cultural safety within the mainstream workforce and systems is important, growing the Aboriginal and Torres Strait Islander workforce, including via emerging roles, is foundational to achieving meaningful change, recognising and valuing cultural knowledge and optimising models of care. Developing the training and employment pathway for AHCW roles would require careful consideration, specifically how it would integrate with existing training and qualifications for allied health assistants, Aboriginal and Torres Strait Islander health workers and health practitioners. It is imperative to develop a policy and strategy that considers the role, terminology, and career opportunities as well as committing to a broader transformation of a health system work culture to eliminate racism. Collectively, these activities will support and retain this workforce, and in doing so, enhance health outcomes for Aboriginal and Torres Strait Islander peoples [16].

Building and retaining an AHCW workforce may provide an attractive and viable training pipeline into health careers for remote community members alongside more established pathways in nursing and Aboriginal and Torres Strait Islander Primary Care. Vocational education and training can provide essential pathways for Indigenous Australians to enter tertiary education and the health professions [17]. As an example, the Indigenous Allied Health Australia National Aboriginal and Torres Strait Islander Health Academy [18] is demonstrating the viability of allied health assistance as an employment and education pathway; graduates are enjoying success in both obtaining employment in allied health and other roles, including within remote communities, and also directly entering and succeeding in further studies [19]. Underpinning the Indigenous Allied Health Australia (IAHA) Academy model is community awareness of allied health roles and functions, promotion of pathways and profile of role models, all of which increase interest in career pathways.

To achieve health equity in Australia, Aboriginal and Torres Strait Islander leadership within clinical teams and services must be appropriately increased, recognised, and renumerated [20]. Learnings applicable from other professions highlight some of the potential challenges for building and retaining an AHCW workforce. Similar to the case for Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander Health Practitioners, AHCWs are at risk of limited opportunities for financial and professional reward even though their role cannot be readily performed by any other group within the health system [20]. For instance, in Queensland public health services, identified Aboriginal and/or Torres Strait Islander allied health assistants (as these roles are currently called) are employed under the clinical assistant pay structure at a CA3 level (Queensland) [21]. At present, there is no loading or recognition within this pay structure for the cultural leadership role that identified allied health positions are required and expected to play. AHCWs have been employed in remote community services [2, 3] because of their unique skills, and the current structure does not recognise that effective clinical treatments and therapy require equal cultural and community knowledge to know and support HOW services are delivered.

4 | Model of Care

Any change in practice, such as the workforce innovation proposed here, must be centred in a shift of health and disability systems to be designed around people and the community needs [22]. Consumers of health and disability services want to have access to quality (including culturally safe) services close to home, [22] and we are proposing the inclusion of community-based AHCW in service models such as hub and spoke. In defining an AHCW role, we see it as critical that the relationship between the allied health professional and AHCW is one of equality; the allied health professional—whether Aboriginal and/or Torres Strait Islander or non-Indigenous—has clinical knowledge and skills that can be shared and delegated with the AHCW, and the co-worker will be equally sharing abilities that relate to community and cultural knowledge. Language that supports recognition of shared knowledge and power within clinical teams has been applied within contexts including the Aboriginal Community Controlled Health Sector. For Central Australian Aboriginal Congress, their Family Support Service describes a bi-cultural model of practice where a case worker (often a non-Indigenous practitioner) is working with an Aboriginal Family Support Worker to deliver a service. Case management is shared and input is equal [23].

Whilst this role is emergent, it is not without precedent or evidence of success. Examples from remote Queensland [2, 24], Western Australia [3], and the Northern Territory [25] show that community, health, and education co-design processes can design and strategically position AHCW roles central to service delivery. Service models in which allied health co-workers can lead on decisions about how, where, and when client engagement and therapy happens help to embed cultural responsiveness, improve client engagement, and have the potential to improve health outcomes.

5 | Leadership

Strong collective leadership, at all service levels (e.g., clinic/hospital/health service) is necessary to guide the shift in interprofessional relationships to a model that encourages and incentivises shared responsibility between allied health clinicians and AHCW. Given that traditional hierarchical Western service practices tend to discourage power-sharing, it is necessary to redesign context-appropriate service delivery models, where equal value is given to the relative expertise of the allied health clinician and the AHCW. This model represents an evolution that must be led by the community-based AHCW and respect Aboriginal and Torres Strait Islander ways of doing and being as genuine methods of clinical service delivery where relationship building is central and prioritised as essential to the quality of care. Service planning must have community and cultural

knowledge as its foundation; this will ensure clinical services are evolving to and reflective of community needs. If enacted sincerely, this model represents an evolution from current models such as fly-in fly-out allied health services. The absence of community-led approaches in health planning perpetuates ineffective service models and workforce configuration [26]. As well as service-level leadership to address models of care, a shift in the power-sharing of service development and delivery will require meso (local health district or similar) and macro (system) level leadership to create, embed and appropriately empower the positions. In addition to clinical benefits, cultural and financial benefits are also probable, with knowledge, skills and resources remaining in the community, building more resilient communities. Developing 'fit for purpose' remote health workforce requires the prioritisation of Aboriginal and Torres Strait Islander employment where services are delivered in communities with high Aboriginal and Torres Strait Islander populations [27].

The Aboriginal and Torres Strait Islander allied health co-worker workforce has a clear opportunity and need for growth. Service models are evolving rapidly (e.g., NDIS), and health services are responding to the importance of ensuring cultural safety. Culturally responsive services are services that, among other things, involve community leadership and ongoing cultural mentoring and brokerage for non-community staff. The allied health workforce is experiencing a critical shortage; we must bravely embrace different ways to conceptualise allied health workforce development and service delivery in rural and remote communities. Alternatives to the traditional allied health service and workforce models will be the only way to provide culturally responsive, equitable, sustainable and multidisciplinary services. The Unleashing the Potential of our Health Workforce—Scope of Practice Review [28] recognises many of these issues, and we look forward to recommendations as a result of this review.

6 | Recommendations

To progress the Aboriginal and Torres Strait Islander Allied Health Co-worker (AHCW) role, we recommend the development of a comprehensive strategic action plan with the objective of the role being accepted in the Australian healthcare system. Such a plan should include key stakeholders and peak bodies and begin with the development of a consensus statement describing the AHCW role and key functions within effective, multidisciplinary allied health services. Furthermore, the project should create a workforce plan to consider how this combined clinical and cultural role can sustainably be implemented into the allied health workforce in the various sectors in which they operate, including the education and training pathways and funding models that underpin it. Particular attention must be paid to creating effective support for AHCWs applying cultural knowledge to clinical service delivery. This support must include recommendations for appropriate qualifications, financial remuneration for recognition of the specialist cultural skills, knowledge, and leadership required, embedded cultural mentorship to complement clinical supervision, and ongoing evaluation of the impact of this role.

Author Contributions

This article arose from discussions at the Northern Australian Research Network (NARN) leadership group on lessons learnt from piloting Aboriginal and/or Torres Strait Islander Allied Health Assistant roles as part of innovative models of care across Northern Australia. Authors comprise Aboriginal (K.S.), Torres Strait Islander (J.S.) and non-Indigenous (A.C., P.G., JD, S.T., N.C., L.T., and H.M.) allied health professionals, academics and workforce leaders representing northern Australia. Author P.G. is the Director of Research for Indigenous Allied Health Australia, the national peak body representing Indigenous allied health professionals, including Indigenous allied health assistants. Author Topp is a Professor of Public Health and global workforce equity leader. All authors contributed to the ideas presented. Author A.C. wrote the initial draft. All authors reviewed, edited and approved the final manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

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