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Does policy support Aboriginal and Torres Strait Islander people to enter and remain in nursing: A discourse analysis

A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy

Charles Sturt University
(Oct 2019)
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Certificate of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

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Date: [Signature Date]
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Professional editorial assistance was provided in relation to the following: standard copyediting to improve grammar, syntax, word usage, spelling, punctuation and consistency in style. This document has been edited in compliance with D and E of the Australian Standards for Editing Practice.

The principal supervisor approved the use of a professional editorial service.
Acknowledgements

I would like to acknowledge the traditional owners of the lands of the Wiradjuri Nation on which I live and work, and pay my respects to elders past and present. I would like to express my thanks to all of the Aboriginal people I have known throughout my life, who have always encouraged and supported me.

To my supervisors, your support and encouragement has kept me going through the times of hardship, personal grief and loss that have made this journey at times unbearable. Your words of wisdom and strength and your understanding have kept me going.

To my immediate family, there are not many of us left now. I encourage you to follow your own dreams and know that anything is possible if you put your mind to it.

This thesis is dedicated to my mother, who was a writer who gained the courage to go back to university after I completed my first degree. She was a skilled storyteller and she would have gone on to achieve many great things if life had not put so many barriers in her way. She left this world too early.

Thank you to Charles Sturt University for providing me with the support to complete my PhD and helping me to develop as a researcher and an academic. I will use the knowledge I have gained to make small differences to the world in which I live.
Statement of Contribution to Publications

The following publications are included in this thesis:


All papers listed above were written by Linda Deravin as first author. Contributions by co-authors during the writing process were made on the understanding that these papers would contribute to this thesis and should therefore represent the work of Linda Deravin. As such the papers represent the first author's development of concepts and ideas, data analysis, recommendations and conclusions. All co-authors support the use of the papers as integrated within the thesis.

Professor Karen Francis  Date   _29/04/2019_

Dr Judith Anderson   Date   29/4/19
Glossary and Abbreviations

**Aboriginal and Torres Strait Islander**: For the purposes of this study, the term ‘Aboriginal and Torres Strait Islander people’ is used in preference to Indigenous Australians. However, the term Indigenous appears where it is sourced from a direct quote or policy document. Aboriginal and Torres Strait Islander people is a term that represents the wide and varied population groups who were the first inhabitants of Australia and were living in Australia prior to European settlement.

**Country**: for Aboriginal and Torres Strait Islander people the reference to country holds a particular meaning. For Aboriginal people it includes all living things as well as a connection to culture including stories and creation spirits. It is not only a place of belonging but incorporates a way of being.

**Cultural awareness**: is having an understanding of the difference between one group of people from another. This may include difference in country of origin or attitudes, values and beliefs.

**Cultural capability**: through the use of knowledge, skills and displayed behaviours an individual will be able to plan implement and improve services to a specific group in a culturally respectful way.

**Cultural competence**: to gain an understanding of another person’s culture through the development of an individual’s knowledge and skill which allows that individual to ethically work in a range of personal and professional intercultural settings.

**Cultural humility**: This process supports professionals to learn about other cultures and recognise cultural differences between other cultures and their own. The goal is to provide care in an unbiased and non-discriminatory way.

**Cultural mentors**: This term is used to describe mentors that are of Aboriginal and/or Torres Strait Islander origin who have an inherent understanding of the challenges, barriers and attitudes experienced by this population group.

**Cultural safety**: is the practice of providing care or an interaction with another person or persons from a range of cultural background in a respectful and ethically appropriate manner. The goal being to eliminate racism and to establish trust between individuals and groups.
**Indigenous:** This term is used in policy documents to indicate the original inhabitants of Australia who are of Aboriginal and Torres Strait Islander origin. It is an acceptable and ‘politically correct’ term used in government documents.

**Nursing:** This term refers to the group of nurses, midwives, enrolled nurses (ENs) and assistants in nursing (AINs), both regulated and unregulated positions, that collectively make up the nursing profession.

**Sovereignty:** The ability of a group to self-govern or have the power and authority to make decisions for themselves.

**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AIN</td>
<td>Assistant in Nursing</td>
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<tr>
<td>ANMAC</td>
<td>Australian Nursing and Midwifery Accreditation Council</td>
</tr>
<tr>
<td>CATSINaM</td>
<td>Congress of Aboriginal and Torres Strait Islander Nurses and Midwives</td>
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<tr>
<td>CDEP</td>
<td>Community Development Employment Project</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>HWA</td>
<td>Health Workforce Australia</td>
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<tr>
<td>IEP</td>
<td>Indigenous Employment Program</td>
</tr>
<tr>
<td>KATCH</td>
<td>Koori Action Towards Careers in Health</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<td>USQ</td>
<td>University of Southern Queensland</td>
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Abstract

Background

Following the release of the Social Justice report in 2005, the federal government of Australia, along with other states and territories, signed an agreement (commonly known as the ‘Closing the Gap’ policy) as an overarching document to support strategies designed to reduce the health inequity between Aboriginal and Torres Strait Islander and non-Indigenous Australians. Although the Closing the Gap policy has been in place since 2008, progress has been limited. The policy agreement noted that investment was required to increase the Aboriginal and Torres Strait Islander health workforce, including nursing, as a way to reduce this health inequity.

Aims of this study

The aim of this study was to illuminate the rationale for, and implications of, the Australian Government’s affirmative-action strategy, Closing the Gap, which aimed to increase the proportion of Aboriginal and Torres Strait Islander people in the health workforce. Specifically, the implications for the profession of nursing are examined.

Method

To understand the way government policy affects Aboriginal and Torres Strait Islander people’s decisions to enter and remain in nursing, the research adopted a critical discourse analysis methodology, as informed by Fairclough. This methodology used a four-phase approach that included linguistic and sociolinguistic analysis, consideration of historical events that influenced policy development and evidence of dialectical argumentation.

Two primary texts were examined: the ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ and the ‘National Indigenous Reform Agreement (Closing the Gap)’. In addition, secondary- and tertiary-level texts, including subsequent government annual reports, were reviewed to provide correlations (triangulation) to the overt and covert discourses found within the primary texts. These discourses revealed that there is an imbalance of power when the knowledge of one group is not shared with the other.
Results

The textual analysis showed that the Closing the Gap policy carries an overt message that the balance of power favours the government over the Aboriginal and Torres Strait Islander people for whom the policy was developed. This has a significant influence on the level of representation of Aboriginal and Torres Strait Islander people in the nursing workforce. Other significant factors that also have an impact include; cultural considerations, obligations to family and community; the embedding of cultural competence and humility within the health and education sectors; and the lack of access to education, limiting employment choices in areas such as nursing. In addition, pathways into nursing are affected by government policy, which prioritises (through funding initiatives) a pathway for Aboriginal and Torres Strait Islander people into an unregulated and unskilled health workforce, rather than professions such as nursing.

Conclusion

This study identifies barriers that are not likely to support the implementation of the Closing the Gap policy, that may influence Aboriginal and Torres Strait Islander people from choosing nursing as a career option. Recommendations that would support an increase in Aboriginal and Torres Strait Islander people in nursing are cultural competency programs for academic and health staff and the embedding of cultural content including Indigenous pedagogies into health curricula; increased representation of Aboriginal and Torres Strait Islander people on ANMAC course accreditation reviews for nursing and midwifery; ongoing support, both financial and cultural, to Aboriginal and Torres Strait Islander students, regardless of study modalities; the promotion of successful role models in nursing, to attract Aboriginal and Torres Strait Islander people into the nursing profession particularly in leadership roles within clinical settings and academia; the expansion of Indigenous only nursing cohorts within the tertiary education sector; reverse articulation pathways where a student can graduate with a lower award, i.e. Diploma (as an enrolled nurse) and thereby sustain nursing workforce at various levels within the industry; the modification of funding models provided to universities that support student progression through significant milestones in a study program and the mapping to nursing qualifications and skills, giving recognition and credit for prior learning from other health professions.
Chapter 1: INTRODUCTION

1.1 The River Walk: A Journey Begins

‘Let’s take a walk along the river and let me tell you a story. It’s a special story, one that we must hold in our hearts and minds and remember,’ said my mother.

Storytelling and narratives are an important part of Aboriginal and Torres Strait Islander culture. Therefore, at the beginning of my PhD journey, I felt that it was important to explain why I chose this topic for my thesis. My great-grandmother was a Wiradjuri woman, yet we know very little about her. Only through the memory of my grandmother was there any recollection of her existence. My grandmother lived with an inherent fear that her children would be taken from her. However, she did pass on the dreamtime stories to my mother, with strict instructions that these were not to be shared with those who were not of our family. My mother remembered being told never to let anyone know that she held the stories, ‘because they will know you are “not a whitey” and the police will take you away’.

Unfortunately, much has been lost through the generations owing to the fear of being identified as an Aboriginal and Torres Strait Islander person. It was better to be seen as ‘white’, or being of dark Welsh or Mediterranean descent, rather than as an Aboriginal Australian. This bias and discrimination was something that my mother endured and shunned and not until the later years of her very short life did she have the courage to tell both my sister and me about our lineage.

I had already entered my nursing career when I discovered my links to Aboriginal and Torres Strait Islander people. At the time, I reacted with anger and denial and took the attitude that I would achieve what I could achieve without using my newfound heritage to help me. I never disclosed my Aboriginal background for fear of being treated differently or discriminated against, based on my cultural heritage. I have progressed through the ranks of nursing, attaining numerous executive nursing management positions before moving to academia.

Over the last 20 years, I have changed my views regarding disclosure. Although mine has not always been an open disclosure and I am disconnected from my community, I have
done my best to educate others about cultural attitudes. Through a range of health restructures, I was moved into a senior nurse management position that focused on the recruitment of Aboriginal and Torres Strait Islander nurses. I saw this as my opportunity to make some small difference.

I was surprised to learn that significant numbers of Aboriginal and Torres Strait Islander people were residing within the geographical boundaries of the Local Health District in which I worked. Of the 852 Aboriginal and Torres Strait Islander nurses employed in New South Wales (NSW) in 2011, only seven were employed within my region (Workforce Planning and Development, 2012). This was significantly disproportionate to the Aboriginal and Torres Strait Islander population in NSW at the time, which represented 2.4% of the state’s population (Australian Bureau of Statistics, 2012). I wanted to understand this disparity.

When I questioned my health colleagues about the reasons for incentive initiatives such as Aboriginal nurse cadetships attracting such low numbers (only two or three applicants per year), I was confronted with racism. I recall being told, ‘They only do the bare minimum so that the bean counters are at least happy; employing Aboriginal people in nursing is too much like hard work and they are not worth the trouble’. Some senior staff insisted that I should not bother doing anything to change the representation of Aboriginal and Torres Strait Islander people within the nursing workforce, as it was more trouble than it was worth. I reflected on these conversations. My musings led me to consider my ability, as a senior nursing manager, to influence recruitment practices within my jurisdiction to address what I considered a social wrong.

My deliberations raised several questions for me:

- Why were Aboriginal and Torres Strait Islander nurses perceived to be such ‘hard work’?
- What stopped Aboriginal and Torres Strait Islander people from completing their nursing degrees?
- What were the major drivers for offering Aboriginal and Torres Strait Islander people additional support to enter a health career and in particular nursing?

In the period before the ‘Closing the Gap’ policy was published, there was a growing awareness of the significant disadvantage experienced by Aboriginal and Torres Strait
Islander people in relation to employment, health and education opportunities. To address this inequity, it was felt that a multi-layered approach was warranted. I witnessed targeted health promotion programs, an increase in Aboriginal Health Workers, scholarships for people wanting to join a health profession and dedicated positions for Aboriginal and Torres Strait Islander people to work in health. I felt still more could be done. I appreciated that implementing any change is always met with suspicion and distrust. I understood that major change takes time and that working to improve cultural safety within the workplace can take years. So with which part of the ‘elephant’ should we start?

Within my role, I had an opportunity to increase the numbers of Aboriginal and Torres Strait Islander people entering nursing with support. I was successful in increasing the number of sponsored scholarships for Aboriginal nurse cadets in my area, from three to 17 within 12 months. This was achieved by working alongside dedicated people within the health and education sectors who were committed to supporting change. While those who monitored increases in workforce numbers praised my success, I felt that if other people were not of the same mind-set as me, then perhaps this change would stop eventually. I heard other senior managers articulating a focus on increasing percentages and celebrating the escalating numbers, such as the one I had championed, to meet targets and key performance indicators (KPIs); as I continued to read a variety of documents related to workforce targets, I wondered why this whole process was about numbers and benchmarks (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). What had happened to thinking about people and communities?

In health, the focus was shifted to the Closing the Gap policy as an overarching document that would lead states and territories to think about ways to reduce the health inequity between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. However, although this policy had been in place for several years, I wondered how much difference it was really making. Was this policy important and if so, why? Was this policy just another government directive and would it truly help to improve the health disparity? What would this mean for nursing? Could this policy help to bridge the gap and break down the barriers to Aboriginal and Torres Strait Islander people entering the profession of nursing? Would this policy really have an effect or was it simply chasing numbers and ticking the boxes? I needed to know more; I wanted to understand.

So, walk along the river with me as I seek to find the answers to my questions …
1.2 Background

Following the release of the Social Justice report in 2005 by the Australia and Torres Strait Islander Social Justice Commissioner, Tom Calma (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005), and the United Nations Declaration on the Rights of Indigenous People (United Nations General Assembly, 2007), Australian governments were challenged to make a serious commitment to improving the health and life expectancy of Aboriginal and Torres Strait Islander people and to do so within one generation (Australian Indigenous HealthInfoNet, 2015). Human rights organisations supported a public awareness campaign called ‘Close the Gap’. It should be noted that the ‘Close the Gap’ campaign is separate from the well-known Closing the Gap government-driven policy and strategy which can potentially create confusion for the non-discerning reader. The Close the Gap campaign attracted the attention of both the Australian public and government. Subsequently, in 2008, concordance was reached between federal and state governments, as informed by the Human Rights Campaign, as a way forward to improve the health and well-being of Aboriginal and Torres Strait Islander people and communities (Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering Committee for Indigenous Health Equality, 2008). The ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’, commonly referred to as the Closing the Gap policy, was signed and implemented by government entities within Australia (Council of Australian Governments, 2008). At the time of this agreement, Aboriginal and Torres Strait Islander people represented 2.5% of the Australian population and had a lower life expectancy than non-Indigenous people (Council of Australian Governments, 2008, 2012b). In 2008, life expectancy for Aboriginal and Torres Strait Islander women was 17 years lower and in men 18 years lower than the non-Indigenous population highlighting the importance of this disparity in health outcomes (Australian Government, 2009).

Within this agreement, the COAG (2008) outlined the following six targets to address the disadvantage faced by Aboriginal and Torres Strait Islander Australians in life expectancy, child mortality, education and employment. These were:

- (a) to close the gap in life expectancy within one generation;
- (b) to halve the gap in mortality rates for Indigenous children under five years within a decade;
(c) to ensure all Indigenous four years olds in remote communities had access to early childhood education within five years;
(d) to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
(e) to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
(f) to halve the gap between Indigenous and non-Indigenous Australians in employment outcomes within a decade.

(Council of Australian Governments, 2008, p.3)
The first report that described progress on these targets was titled ‘Closing the Gap on Indigenous Disadvantage: The Challenge for Australia – February 2009’ (Australian Government, 2009). This document contained a strong message that to improve the health of Aboriginal and Torres Strait Islander people, a focus on education and employment outcomes would be required. It indicated that commitment by all levels of government would be essential to increase employment opportunities in the Aboriginal and Torres Strait Islander working-age population. Employment areas such as health, including professions such as nursing, were targeted as being areas that would have the greatest influence and would, in turn, improve the health of the Aboriginal and Torres Strait Islander population (Australian Government, 2009). Health Workforce Australia (HWA), a now-defunct Commonwealth statutory authority, was established to co-ordinate workforce reform across Australia. The HWA strategic plan (2011b) outlined a commitment to reduce the gap between the Aboriginal and Torres Strait Islander and non-Indigenous workforce by 20% over the next 10 years in priority areas, including the nursing profession, as a way to address this health inequity.

In consideration of the significant government investment required to develop career pathways to encourage Aboriginal and Torres Strait Islander people to join the health workforce throughout the nation, the aim of this study is to examine the level to which the Closing the Gap policy supports or discourages Aboriginal and Torres Strait Islander people in choosing a career in nursing. Current entry requirements, associated remuneration packages and career pathways for Aboriginal and Torres Strait Islander people who may consider entering nursing are presented. These data are interrogated, together with the Closing the Gap policy, using a critical discourse methodology informed by Fairclough (2003), to provide critical commentary on government policy and the implications for Aboriginal and Torres Strait Islander representation in nursing. The study
provides commentary on national initiatives that have influenced the outcomes within NSW and draws on this state’s experience.

1.3 Government Policy and Reports

The ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008) and the subsequent support government policy document, ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b), are analysed in this thesis. These policy documents direct all levels of government (Australian and State/Territory) to implement affirmative actions to improve the health and well-being, and reduce the gap in health inequity of, Aboriginal and Torres Strait Islander people and non- Aboriginal and Torres Strait Islander Australians (COAG, 2008, 2012b). These documents require the state and territory governments to develop workforce strategies to meet the Australian governments’ edict. To address this requirement, state- and territory-level governments have developed a variety of documents including policy frameworks, annual performance reports, workforce profile documents and strategic plans in the field of nursing and midwifery, specifically designed to report on, and to support, progress towards an increase in the Aboriginal and Torres Strait Islander workforce in the nursing profession (Government of South Australia, 2008; Government of Western Australia Department of Health Nursing and Midwifery Office, 2012; Nursing and Midwifery Office, 2016; Queensland Health, 2009; Victorian Department of Health and Human Services, 2017; Workforce Planning and Development, 2012).

The underlying assumption of this action is that by increasing the numbers of Aboriginal and Torres Strait Islander Australians employed in the health workforce, the gap in health inequity between Aboriginal and Torres Strait Islander and non- Indigenous populations will reduce. It has been argued and accepted by the Australian Government that Aboriginal and Torres Strait Islander people are less likely to seek health advice and/or intervention from non- Indigenous health providers (Australian Government, 2011). The literature suggests that such policies, although still in their infancy of implementation, are not having the desired effect (McMurray, 2010; Usher, Lindsay, Miller, & Miller, 2005; Workforce Planning and Development, 2012).
In this research, a number of documents are analysed to gauge progress on the implementation of the Closing the Gap policy and its effectiveness. These documents include policy documents, performance reports, workforce profile reports and strategic frameworks and plans that are readily accessible through the Internet. These documents were found by searching Google Scholar or through public information sites such as government webpages. The documents that were studied covered the period from 2008 to 2017. The landmark document, ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’, more commonly referred to as the Closing the Gap policy, was published in 2008. All other relevant documents with regard to progress, including the ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b), have been published since then. A summary of the 23 documents that were studied is provided in Chapter 4.

1.4 Aims of the Study

The period covered by this study of the progress of the Closing the Gap policy and its impact on increasing the representation of Aboriginal and Torres Strait Islander people within nursing is from its inception in 2008 to the end of 2017. The data used to demonstrate progress are drawn from publicly available Closing the Gap performance reports, which are published annually by the federal government. The aim of this study is to illuminate the rationale for, and implications of, the Australian Government’s affirmative-action strategy to increase the proportion of Aboriginal and Torres Strait Islander people in the health workforce. Specifically, the implications of this for the profession of nursing are examined.

The research questions, therefore, are as follows:

- Has government policy (Closing the Gap) had an effect on whether Aboriginal and Torres Strait Islander people choose nursing as a health career?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to consider joining the nursing profession in preference to other regulated and unregulated health careers?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to remain in nursing?
1.5 Aboriginal and Torres Strait Islander People of Australia: Health and Well-being

In June 2016, Aboriginal and Torres Strait Islander people represented 3.3% of the overall Australian population of approximately 24.8 million (Australian Bureau of Statistics, 2018). This population group is not homogeneous and is comprised of both Aboriginal and/or Torres Strait Islander people. Statistically, the data indicate that Aboriginal and Torres Strait Islander people’s overall health is poorer than that of the general population of Australia; in addition, mortality rates are significantly higher, there is a higher level of unemployment and literacy and numeracy rates are lower than the national average (Commonwealth of Australia, 2016b; National Preventative Health Taskforce, 2008). It is suggested in the literature that a multifocal approach, supporting improvements in housing, education and employment opportunities, is linked to improvements of the overall health and well-being of a community (Commonwealth of Australia, 2016b; Department of Health, 2015; National Preventative Health Taskforce, 2008). By improving the level of education in a community, the literature asserts that the potential to gain employment, earn an income and purchase a home is optimised, leading to improvements in health and well-being (Commonwealth Government of Australia, 2007).

1.6 Overview of the Aboriginal and Torres Strait Islander Nursing Workforce

Current Commonwealth Government policy supports an increase in Aboriginal and Torres Strait Islander people representation in the health workforce (Australian Government, 2010). At the same time, Australia, like other nations such as Canada and New Zealand, is experiencing significant health workforce shortages (Ministry of Health New Zealand, 2011; Vukic, Jesty, Mathews, & Etowa, 2012). The Australian Government has made available untargeted funding to support an increase in the Aboriginal and Torres Strait Islander health workforce, as a way to address the skills shortages experienced in areas where Aboriginal and Torres Strait Islander people have the greatest inequity of access to health care (McMurray, 2010). HWA (2012) asserts that while there are sufficient doctors and allied health professionals within the workforce, they are not well distributed across all geographical regions; the majority are located in the major capital cities in each state and territory. However, the nursing workforce is
better distributed across the country and ideally placed to have a significant influence on improving health outcomes particularly for socially disadvantaged groups (Health Workforce Australia, 2012).

In NSW, the aim was to increase the Aboriginal and Torres Strait Islander health workforce from 1.33% (with 74.2% being female) in 2011 to 2.6% by 2015. Of the 2011 figure, only 0.8% of the Aboriginal and Torres Strait Islander health workforce were nurses (please see Chapter 8 Table 8.1 for more detail on reported figures) (NSW Government Public Service Commission, 2012). This report confirmed that the majority of the Aboriginal and Torres Strait Islander workforce are employed in non-clinical type roles. The number of Aboriginal and Torres Strait Islander people working in Aboriginal specific health-related programs varied across the state, with some local health districts identifying that less than 1.33% of the workforce were of Aboriginal and Torres Strait Islander origin. This verifies that in 2011, Aboriginal and Torres Strait Islander people were significantly underrepresented in professional health care groups such as doctors, allied health staff and nurses highlighting the need for strategies to increase numbers working in these professions (Workforce Planning and Development, 2012).

Nurses are at the forefront of delivering health care and can potentially effect change that can positively influence health outcomes. Even though there has been commitment to increasing the Aboriginal and Torres Strait Islander nursing workforce through government policy and funding initiatives, it is questionable whether these actions are having any real effect. Significant work was undertaken by the now-defunct HWA (its work has been subsumed by the federal government Department of Health and Ageing) to provide an overall strategy that supported an increase in Aboriginal and Torres Strait Islander numbers in the health workforce (Health Workforce Australia, 2011b). This, in real terms, included both clinical and non-clinical positions.

Strategies identified in the second annual Closing the Gap report (Australian Government, 2010) note that improving employment and education prospects for Aboriginal and Torres Strait Islander people are social contributing factors that can improve health outcomes for this population group, which will in turn, reduce the gap in health inequity. This study seeks to understand the effect of federal and state policy and strategic direction setting and its effect on the nursing workforce within NSW.
The following peer-reviewed journal article, titled ‘Choosing a Nursing Career: Building an Indigenous Nursing Workforce’ (Deravin, Anderson, & Francis, 2017), describes the status of the Aboriginal and Torres Strait Islander nursing workforce in Australia and considers some of the contemporary issues faced by the nursing profession in enticing more Aboriginal and Torres Strait Islander people to enter nursing (see Figure 1.1).

Figure 1.1: ‘Choosing a Nursing Career: Building an Indigenous Nursing Workforce’ (Deravin, et al., 2017)
partnership agreement on closing the gap in Indigenous health outcomes\textsuperscript{,12} as a way to address this inequity by working in partnership with all states and territories to improve the health of Indigenous people. One of the components within this agreement indicated that to improve Indigenous health outcomes, significant investment was required with particular reference to building an Indigenous workforce. The “National health workforce innovation and reform strategic framework for action 2011–2015” developed by Health Workforce Australia\textsuperscript{3} a now defunct entity, was established to co-ordinate the reform. Within this plan a commitment to reducing the gap between the Indigenous and non-Indigenous workforce within the next 10 years is articulated.\textsuperscript{3} The nursing profession make up the majority of the health workforce, therefore the need to increase Indigenous nursing workforce numbers is paramount in order to support health programs and policy to address this health inequity.

2. METHOD

In order to gain an understanding of the current Indigenous nursing workforce, publically available performance report documents were sourced from various government websites. As a way to expand beyond just an interpretation of the data, current literature was also examined (within the last 6 years) using key search terms such as nursing, Indigenous, workforce, and education which reported on progress or provided commentary on this issue. Only 7 articles met the inclusion criteria within the literature demonstrating that little is known about this issue.

3. RESULTS AND DISCUSSION

3.1 Indigenous nursing workforce – current status

Nurses are at the forefront of health care to deliver and effect change that makes an impact on patient outcomes. Components that must be considered to build an Indigenous nursing workforce include education and employment strategies to fill this void.\textsuperscript{4} As demonstrated in Table 1, nurses that identify as being of Indigenous descent across the entire nation rose from 0.6% in 2008 to 1.1% in 2015, indicating a 99% increase. However in real terms the actual numbers only increased by 1,589 (1,598 to 3,187). In a nation where there are over 307,000 nurses employed within the health system this increase was minor. The most significant increase occurred in NSW where the Indigenous nursing workforce grew by 590 from 2008 to 2015 (see Table 1). Even though there has been commitment through government policy and funding initiatives at both the federal and state level it is questionable that these initiatives are having any real impact on growing an Indigenous nursing workforce. If the Indigenous population are 2.5% of the national population, it is reasonable to assume that numbers within the existing nursing workforce should be similar. In 2015 it was reported that there were 307,104 nurses in Australia. To reach 2.5% there would need to be 7,677 Indigenous nurses.\textsuperscript{5} The current growth rate of 14.12% per year indicates that it will possibly be another 26 years before the percentage of Indigenous nurses mirrors the percentage of the general population that are Indigenous. The evidence demonstrates that growth has been slow.

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of RN and EN's who identify as Indigenous in NSW</td>
<td>598</td>
<td>650</td>
<td>862</td>
<td>865</td>
<td>994</td>
<td>1,184</td>
<td>1,188</td>
</tr>
<tr>
<td>% of nursing workforce NSW</td>
<td>0.8</td>
<td>0.8</td>
<td>1.1</td>
<td>1.1</td>
<td>1.2</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>Number of RN and EN's who identify as Indigenous in Australia</td>
<td>1,598</td>
<td>1,605</td>
<td>2,246</td>
<td>2,301</td>
<td>2,601</td>
<td>3,036</td>
<td>3,187</td>
</tr>
<tr>
<td>% of nursing workforce Australia</td>
<td>0.6</td>
<td>0.6</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>1.0</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note: Data not available for 2010.\textsuperscript{5,12} RN denotes registered nurse and EN denotes enrolled nurse, these designations are those nurses who are credentialed within Australia.

Government policy documents celebrate that their efforts to increase Indigenous nurses within the health workforce are successful with numbers almost doubling at both the state and federal level from 2008 to 2015.\textsuperscript{5,12} However, actual numbers remain low and with the percentage of Indigenous nurses being reported at 1.1% of the entire nursing workforce nationally, there has been minimal impact to the numbers of Indigenous nurses. West et al.\textsuperscript{14} agreed that although many strategies to address the Indigenous representation in nursing have been instigated these in fact have shown little improvement overall. With a 75% increase in Indigenous nursing numbers in NSW from 2008 to 2015 and an increase nationally of 83%, statistically this would seem that progress is going well however in real terms with actual numbers increasing slowly as indicated previously it is obvious that more needs to be done to support Indigenous people to choose nursing as a career within the health workforce. Stuart and Nielsen\textsuperscript{13} affirmed the need for increasing Ind-
3.2 Pathways into nursing

In order to support the growth in numbers of Indigenous nurses, consideration should be given to available pathways to enter the nursing profession.\textsuperscript{[4,14]} There are a number of pathways available to enter nursing at either the vocational education and training, or university level as places of tertiary education. Options for study currently include: assistant in nursing, enrolled nurse and registered nurse. Depending on the qualification, time spent undertaking study in order to be qualified for one of these positions ranges from 12 months to obtain a certificate level 3 to a minimum of 3 years full time study to become a registered nurse. Competition by education providers to entice Indigenous people to join the nursing workforce is fierce, particularly in light of other health roles that are available.

An alternate health professional role for those who may potentially consider nursing is the Indigenous health worker role. This role differs from state to state, but was commonly designed to provide culturally safe care to Indigenous peoples, supporting their visits to health professionals and providing primary health care. These workers are employed by a variety of organisations and are regulated by the Aboriginal and Torres Strait Islander Health Practice Board of Australia.\textsuperscript{[15]} Qualifying as an Indigenous Health Worker for example has an entry level qualification of a certificate level 3 which can be completed in 6 weeks depending on where there initial qualification is obtained.

These and many other health professional roles have a place in the delivery of health care to bridge the gap in health inequity for Indigenous people yet how do we continue to grow and expand the nursing workforce when such competition exists?

3.3 Supporting success

Many students when entering tertiary education, regardless of cultural background, find the financial impact a major barrier to the successful completion of their studies.\textsuperscript{[16]} There are a number of financial scholarships available for Indigenous people to access as a way to manage the financial hardship of attending university. These scholarships are provided from a range of sources including government departments such as health, university scholarships and private organisations. Additional support is also provided in mentoring programs and cultural support groups based within the tertiary education sector. Even with these programs in place, successful completion rates of Indigenous people undertaking tertiary education remain low.\textsuperscript{[16]}

West et al.\textsuperscript{[13]} recommended ways to move forward in addressing these issues require a combined approach. Some of the suggested strategies include incorporating an Indigenous pedagogy within undergraduate nursing programs to educate non Indigenous people about traditional culture and attitudes toward health systems which are not culturally sensitive.\textsuperscript{[17]} Another strategy suggests that more Indigenous nurses should be employed within universities so that they may act as supports to Indigenous nursing students and provide good role models. Ideally developing a critical mass of Indigenous students so that cultural support may be provided by peers is another important aspect to consider\textsuperscript{[14]} yet obtaining this critical mass is the challenge currently faced.

4. CONCLUSIONS

Despite efforts to increase nursing workforce numbers, there has been limited impact to any real successful gains in the nursing workforce since 2008. In considering recruitment strategies that will build and increase the number of nurses within the Indigenous health workforce, a multilevel approach involving government, the tertiary education sector and employers is required.\textsuperscript{[8,18]} One of the considerations to encourage more people to enter the nursing profession is mapping of existing pathways of other health worker roles such as the Aboriginal and Torres Strait Islander worker to nursing programs that recognises the skills and qualifications attained. Even with the available supports for Indigenous people entering tertiary study, retention and completion rates remain low.\textsuperscript{[17]} It is essential that culturally appropriate support strategies are provided within all education sectors to address this disparities anomaly.

Indigenous people through the support of their communities, should be encouraged to enter into the nursing profession. Even though in some cultures entering the nursing profession may not be seen as an attractive career, within Australia the profession is highly valued. There are limited studies that have investigated Indigenous representation in the Australian nursing workforce despite the profession recognising that this group are necessary if the needs of Indigenous Australians are to be met.\textsuperscript{[16,17,18]} Indigenous people who have successfully achieved a higher level of education by becoming a nurse should be celebrated and promoted as role models for Indigenous people.\textsuperscript{[16]} Opportunities to promote nursing as a career option and participate in decision making processes that affect Indigenous people regarding health policy should be created and encouraged.\textsuperscript{[19]} Building and growing an Indigenous nursing workforce will support the “Closing the Gap” initiative yet without significant efforts to achieve this, the initiative will continue to struggle in achieving its outcomes.
CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

REFERENCES


1.7 Mind Map

As a process for organising my thoughts for this research, I constructed a mind map (see Figure 1.2) to capture the key issues that I believe affect Aboriginal and Torres Strait Islander representation within the Australian nursing workforce. I acknowledge that these are my assumptions, based on my initial readings and the experiences that I had prior to commencing this study. To reduce the effect of bias within this study, these issues are explored and verified or rejected; others that arose in the process are interrogated, using the techniques inherent in the research approach that I selected to help me to answer the research questions that were the impetus for undertaking this study.

**Figure 1.2: Mind Map**

Presentation of these ideas in the mind map were provided at the International Rural Nursing and Research Conference in Bozeman, Montana, United States of America (USA), in 2014. Feedback from participants challenged me to consider further classifications of health professionals, such as the Aboriginal Health Worker roles, and their influence on attracting Aboriginal and Torres Strait Islander people into nursing. At the beginning of this study, I realised that in addition, I needed to consider the implications for tertiary education organisations in addressing the gap between different health professional qualifications and
nursing. A copy of my poster presentation ‘Are we closing the gap or widening it?’ is provided in Figure 1.3.

Following these conversations, I began to think critically about what was required to encourage more Aboriginal and Torres Strait Islander people to enter nursing and the strategies that might support this. I then wrote an article titled ‘Creating Pathways in Nursing Education to Increase Indigenous Nursing Numbers’ (see Figure 1.4), which appeared in the Australian Nursing and Midwifery Journal (Special Edition: Indigenous Health). This short article highlighted the Aboriginal and Torres Strait Islander nursing shortage and offered some thoughts about encouraging other health professionals to consider nursing as a career option. As this journal has a wide audience among nursing professionals, the article stimulated significant interest. An education provider then approached me to be a special guest speaker at a National Aborigines and Islanders Day Observance Committee week event in 2016, to discuss the thoughts contained within my article. Representatives from the media, the Department of Premier and Cabinet, tertiary education (both management and educators) and future nursing and Aboriginal Health Workers were present. The report about this guest presentation, titled ‘Strategic Push to Boost Indigenous Nursing Numbers’, is provided in Appendix A. Interest in my study continued, with further media exposure in May 2017, when I was interviewed by the Australian Nursing and Midwifery Journal about education pathways for Aboriginal and Torres Strait Islander nurses (Fedele, 2017). An extract from the article is included for interest in Appendix B. For me, these experiences confirmed that this journey had significant value to both nurses and the public and this continues to encourage me on this journey.
Figure 1.3: Are We Closing the Gap or Widening It?

Are we Closing the Gap or Widening it?

Does policy support Indigenous people to enter, remain and advance in Nursing?

A PhD study in progress

Cultural and Community Expectations
- ATSIs are reluctant to engage culturally insensitive health care providers
- Non-Indigenous lack of understanding of cultural traditions, beliefs and values
- One health care system fits all
- Low numbers of ATSIs presents difficulties in voice/representation
- Health care expectations and limits compared to metropolitan or city based health care provision is a
  major disparity

Methodology - Discourse Analysis informed by Norman Fairclough
[Who is speaking, who is the audience, power/knowledge imbalance between cultural groups]

Health Workforce Australia Strategic Framework 2012-15
Key Performance Indicator Reports 2011-2013 - National Benchmarks

Preliminary PhD Findings - Recruitment and Retention
- Funding mechanisms- supports available and financial incentives
- Value of nursing profession
- Career progression and advancement
- Remuneration according to qualification

Preliminary PhD Findings - Policy/Strategy
- Nursing Workforce Incentives for health care organisations
- Change in workforce mix including registration requirements
  - Unregulated staff

Literature Review Revealed
- Insularity between the health of Indigenous Australians (Aboriginal, Torres Strait Islander) compared to
  Non Indigenous Australians
- 2.5% of the Australian Population Identity as ATSIs
- In New South Wales 1.3% of the workforce are ATSIs
- Only 0.9% of NSW nurses are ATSIs
- Government articulates strategy to improve the overall health of ATSIs Australians by
  increasing the number of ATSIs in the workforce
Figure 1.4: Creating Pathways in Nursing Education to Increase Indigenous Nursing Numbers (Deravin-Malone, 2016)
1.8 Selection of Research Methodology

For this research methodology critical discourse analysis, informed by Fairclough (2003), was adopted to gain an understanding of the sociocultural practices described by the texts that were under study. In using this methodology, it was envisaged that both the covert and the overt messages would be illuminated, revealing the existing power imbalance between the two groups (Aboriginal and Torres Strait Islander people and government). The aim was to raise awareness and provide an understanding of the impetus that underpins social change.

1.9 Format of Thesis

This thesis is structured as follows:

Chapter 1, Introduction, provides an overview of the importance of this research in relation to nursing, as well as my reasons for undertaking this research and the current situation regarding the Aboriginal and Torres Strait Islander nursing workforce. Two publications and items from a conference presentation related to this study are included; these indicate the importance of this work at both the national and international level. The aims of the study are identified and an explanation of the selected research methodology is provided.

Chapter 2, Synopsis of the Literature, is an integrative review of the literature. The way the literature was sourced is described and key themes for investigation in this study are identified.

Chapter 3, Methodological Framework, outlines the way the research methodology was selected. The use of critical discourse analysis and particularly, Fairclough’s approach, is justified, along with an explanation of my preference to use this research methodology rather than an Indigenous research framework.

Chapter 4, Method of Critical Discourse Analysis, describes this approach in detail, covering corpus linguistic analysis, ethnographic sociolinguistic analysis, the historical approach and dialectical argumentation.

Chapter 5, Language in Policy, contains the analysis using the methodological framework and process described in Chapters 3 and 4. Included in this analysis is the scrutiny of the
two seminal government policy documents that were intended to drive social change. The focus of this chapter is a linguistic analysis, looking for collocations and concordance of words and phrases. Within the linguistic analysis, assumptions and contradictions are examined. Finally, an ethnographic sociolinguistic analysis provides evidence of the use of jargon and ‘political speak’. An interpretation of the use of language within the policy documents and the way this can influence the reader’s interpretation or viewpoint is presented.

Chapter 6, Policy and Power, provides a commentary on the way government policy has influenced the communities over which it has authority. In particular, it examines the way government policy has affected Aboriginal and Torres Strait Islander people throughout history, describing the influence of past policy and the effects of colonisation. A short publication highlighting the importance of this policy in meeting health targets is included. Within this chapter, the implementation of government policy is considered, along with its ability to affect long-term change within a social context.

Chapter 7, Social Action/Inaction, employs Fairclough’s action/inaction approach to critical discourse analysis to interrogate policy documents and to look for evidence of dialectical argumentation. Building on the analysis from the two previous chapters, the effect of government policy on Aboriginal and Torres Strait Islander people and the reasons that some decisions are made is presented. In this chapter, the three axes of discourse (knowledge, power and ethics) are applied to the two seminal policy documents and an interpretation of its influence is offered. A further publication is included to provide a critical review of progress in the Closing the Gap policy and its importance to nursing.

Chapter 8, Increasing the Representation of Aboriginal and Torres Strait Islander People within Nursing, discusses factors that have had an influence on the recruitment and retention of Aboriginal and Torres Strait Islander people within nursing. These include cultural considerations such as obligations to family and community; the embedding of cultural competence and humility within the health and education sectors; and the lack of access to education, limiting employment choices in areas such as nursing. Pathways into nursing are considered. The effect of government policy on funding initiatives that lead to Aboriginal and Torres Strait Islander people becoming part of an unregulated and
relatively unskilled health workforce, rather than in professions such as nursing, is explored.

Chapter 9, Recommendations and Conclusion, offers recommendations that would support an increase of Aboriginal and Torres Strait Islander people in the nursing workforce. These include cultural competency programs for academic and health staff and the embedding of cultural content into health curricula; ongoing support, both financial and cultural, to Aboriginal and Torres Strait Islander students regardless of study modalities; promotion of successful role models in nursing, to attract Aboriginal and Torres Strait Islander people into the nursing profession; and the mapping in nursing courses of existing qualifications and skills, with recognition of prior learning. The effect of the Closing the Gap policy on the balance of power between the government and the Aboriginal and Torres Strait Islander people for whom the policy was developed is described, as well as the strengths and limitations of this study. My personal reasons and motivation for undertaking this study are reviewed.

1.10 Chapter Summary

The Closing the Gap government policy arose from a public awareness campaign called Close the Gap, conducted in 2005, that highlighted the poor health status of the Australian Aboriginal and Torres Strait Islander people. This critical discourse analysis study provides insight into the effect of the Closing the Gap policy in order to gain an understanding if this government policy either supports or discourages Aboriginal and Torres Strait Islander people’s representation in nursing.

The next chapter presents an integrative review of the literature, aiming to gain an understanding of the factors that were influencing Aboriginal and Torres Strait Islander people to consider entering the nursing profession at the time when the Closing the Gap policy was being implemented and post its implementation.
Chapter 2: SYNOPSIS OF THE LITERATURE

‘We today take the first step by acknowledging the past and laying claim to a future that embraces all Australians.’

Kevin Rudd, Prime Minister of Australia 2008

2.1 Integrative Review of the Literature

This literature review provides the background to the implementation of the Closing the Gap policy (Council of Australian Governments, 2008) and facilitates an understanding of the effects of this policy on the health workforce with a particular focus on the nursing profession, after its implementation. This sets the scene for the use of Fairclough’s approach to critical discourse analysis (2003, 2010, 2015), as this study’s methodology.

Using the parameters from the PRISMA framework (Moher et al., 2015), the literature search focused on scholarly works. Internet databases that were utilised in this search were EBSCOHost, Google Scholar, ProQuest and Primo Search. The integrative literature review involved scholarly articles (drawn from peer-reviewed journals), including research, discussion and personal reflections, as well as PhD dissertations. The key search terms used were ‘Indigenous and/or Aboriginal and Torres Strait Islander nurses’ and ‘Australia’. The period for eligible articles and documents was 2005 to 2015, so that trends both before and after the implementation of the Closing the Gap policy could be identified. Only articles that were relevant to Australia were included at this point, as this research was specifically about the Australian experience. Short commentaries and opinion pieces from non-peer-reviewed journals and grey literature including government policy and strategy documents (which are reported on in Chapter 4) were excluded from the integrative literature review, as they were not considered scholarly works.

The first search yielded 20 articles. A further 30 articles were identified from reference lists, resulting in 50 articles for possible inclusion. The titles of articles were read to ensure their relevance to the study and that they met the inclusion criteria mentioned above. After duplicates were removed, 39 articles remained. Abstracts of each article were then scrutinised against the inclusion criteria to ensure relevance, resulting in 12
articles being eliminated from the literature review. This left 27 articles for inclusion in this systematic literature review (see Diagram 2.1).

**Diagram 2.1 PRISMA Flow Diagram: Aboriginal and Torres Strait Islander Nurses in Australia - based on Moher et al. (2015)**

All remaining articles were read in their entirety. The contents of these articles are provided in Table 2.1, which summarises each article’s aims, findings/recommendations, relevance to this study and theme(s). Each of these is explored in more detail in the following discussion.
2.2 Recruitment and Retention

Compounding the health status inequity for Aboriginal and Torres Strait Islander people is the maldistribution of the health workforce in areas considered rural and remote (Bolton, 2008; Lenthall et al., 2011; Workforce Planning and Development, 2012). One of the major targets within the Closing the Gap policy was to ‘halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade’ (COAG, 2008, p.3). This target was amended in 2014 to become ‘halve the gap in employment outcomes between Indigenous and other Australians by 2018’ (Australian Government, 2014, p.12). As a two-pronged approach to improve both health and employment rates of Aboriginal and Torres Strait Islander people, increasing the numbers of employed persons within the health care field, and then subsequently within nursing, would support the achievement of the government’s target. This is particularly important in rural and remote areas, where specialisation in rural qualifications would address the needs of the population within this demographic. Ongoing education and support has been shown to improve job satisfaction, which, in turn, will influence both Aboriginal and Torres Strait Islander and non-Indigenous people with regard to remaining in nursing (Molinari & Monserud, 2008).

Encouraging Aboriginal and Torres Strait Islander people to enter nursing has been recommended in past government reports prior to the development of the Closing the Gap policy (House of Representatives. Standing Committee on Aboriginal Affairs, 1979; National Aboriginal Health Strategy Working Party, 1989). Continually within the literature it has been recommended that increasing the representation of Aboriginal and Torres Strait Islander people in nursing is a step towards achieving the goal of increasing employment opportunities that may contribute to improving the gap in health outcomes. As discussed later in this chapter, there are a number of education incentives to support Aboriginal and Torres Strait Islander people to complete further education and gain the skills and qualifications to work as a nurse (Mills, Birks, & Hegney, 2010). However, once they have completed their qualification, the experience of working within the nursing field can be challenging for some.

A number of strategies are recommended in the literature to support Aboriginal and Torres Strait Islander people to remain within nursing. Francis and Mills (2011) offer suggestions such as adequate child support for working nurses, incentive payments for
length of time in the industry and ongoing support for continuing education to support all nurses to stay in the profession. The provision of clinical workplace mentors to support the transition from student to registered nurse (RN) is highly valued (Mills, Francis, & Bonner, 2007a; Usher, Lindsay, Miller, et al., 2005). In environments where cultural bias has existed for some time, the development and fostering of supportive workplace relationships (Mills, Francis, & Bonner, 2007b), particularly for Aboriginal and Torres Strait Islander nurses, influence Aboriginal and Torres Strait Islander people to stay within nursing. The literature notes that while nurses are at the forefront in influencing cultural change within both the health and education sectors, more needs to be done to make the workplace an environment in which individuals feel comfortable and accepted (Best & Nielsen, 2005; Usher, Lindsay, Miller, et al., 2005).

Other strategies that would support the recruitment and retention of nurses who identify as Aboriginal and Torres Strait Islander include promulgating ‘good stories’, such as those of successful Aboriginal and Torres Strait Islander nurses (Usher, 2011). Eley, Eley and Rogers-Clark (2010) suggest that promotion of the caring nature of nursing, which aligns with the inherent nature of Aboriginal and Torres Strait Islander people, may be more successful than focusing solely on the financial benefits of a nursing career.

Strategies such as those listed above require government policy and financial support (Lenthall et al., 2011). However, changes in government can affect political favour and influence, particularly when cuts to government spending are required. This can have a significant effect on the implementation and sustainability of any strategies for the recruitment and retention of a growing Aboriginal and Torres Strait Islander nursing workforce. For this reason, it is important to keep Indigenous health issues on political agendas, to ensure sufficient political and financial support to increase the number of Aboriginal and Torres Strait Islander nurses.

### 2.3 Career Pathways

Recruitment and retention studies have revealed that there are a number of factors that influence people with regard to joining, remaining in, or leaving the health workforce (Eley et al., 2010; NSW Health, 2008; Stuart & Gorman, 2015; West, Usher, Buettner, Foster, & Stewart, 2013). There are a number of professions, including nursing, in which people interested in a career in health may seek to undertake. These include both clinical
and non-clinical roles. As this study relates to the nursing profession, this is the focus of the examination of career entry requirements in this research. As there are varying levels of nursing qualifications, both regulated and unregulated, there is flexibility and choice when considering a nursing career. It is possible to enter directly into an undergraduate degree program to become an RN. Other pathways may involve stepping from a certificate Level 2, 3 or 4 to become an Assistant in Nursing (AIN), then on to a Diploma (Level 5), to become an enrolled nurse (EN). These qualifications can then be used via recognition of prior learning to enter a degree program to become an RN (Level 7) (Australian Qualifications Framework Council, 2013b).

The flexibility of choosing a stepped pathway may be a consideration for individuals who are unsure about undertaking tertiary study, helping them to gain confidence in undertaking a university degree. It is important that such success stories are celebrated and for Aboriginal and Torres Strait Islander people, even more so (Best & Stuart, 2014; Usher, 2011). Having inspirational Aboriginal and Torres Strait Islander nurse leaders and role models clearly demonstrates that a career in nursing is possible (Clark, 2013). In addition, highlighting the opportunities for career diversity and promotion is one way to make nursing an attractive career (Eley et al., 2010; Francis & Mills, 2011).

A number of alternative options are available for a career in health (Council of Australian Governments, 2010). To cope with the anticipated demand for services in health care, HWA Australia (a now-defunct entity) encouraged the development of other health worker classifications to deliver health care (COAG, 2010, 2012a) in both regulated and unregulated categories. Within NSW, government policy encourages Aboriginal and Torres Strait Islander people to join the health workforce and supports a variety of career pathways to facilitate this (COAG, 2010; Health Workforce Australia, 2011b; NSW Health, 2016b; Workforce Planning and Development, 2016). However, this does not necessarily mean that Aboriginal and Torres Strait Islander people will choose nursing, when other health careers require lower levels of education and academic qualifications and are remunerated equal to, or higher than, nursing (Industrial Relations Commission of New South Wales, 2018a, 2018c). It is clear that there has been significant effort in developing ways to expand the health workforce. However, the effect this policy direction is having on established professions such as nursing, when other career opportunities that
potentially create wider choice of career options, has not been explored (Lockyer, 2013; West, Usher, & Foster, 2010).

2.4 Education Pathways

To address inequities in the distribution of the health workforce, the Australian Government has implemented a number of affirmative actions, including funding through cadetships and scholarships to encourage Aboriginal and Torres Strait Islander people to join the health workforce. As indicated in government policy documents and reports (NSW Health, 2008, 2012), having Aboriginal and Torres Strait Islander people join the health workforce (including as nurses) is critical to making a difference in the health and well-being of Aboriginal and Torres Strait Islander people, particularly in regional and remote areas (Bolton, 2008; Stuart & Gorman, 2015). Additional supported places in recognised tertiary education programs specifically for Aboriginal and Torres Strait Islander people are available (Department of Education and Training, 2018). Tertiary education institutions are encouraged to develop specific qualifications for Aboriginal and Torres Strait Islander people as a pathway to enter the health workforce (Health Workforce Australia, 2011a).

Substantial research has been undertaken to examine supportive strategies that may encourage Aboriginal and Torres Strait Islander people to complete education (Best & Stuart, 2014; Francis & Mills, 2011). As mentioned previously, such supportive measures include financial assistance through scholarships. However, this should not be the sole type of support. Best and Stuart (2014) note the success of an Indigenous-led model in Queensland supporting Aboriginal and Torres Strait Islander nursing students through their study. In this model, successful and positive role models from the Aboriginal and Torres Strait Islander education community including Aboriginal and Torres Strait Islander nursing academics, provided academic support. Another critical factor in the success of the Queensland program is providing this cultural support in partnership with both local Indigenous communities and Indigenous academics. It would seem prudent that programs such as the Queensland model should be replicated throughout the tertiary education sector across Australia (Best & Stuart, 2014). The priority to employ more Aboriginal and Torres Strait Islander nursing academics in targeted recruitment campaigns for the tertiary sector, particularly where attrition rates are a major concern needs to be emphasised and acted upon. To address undergraduate attrition rates, the
tertiary sector and the Aboriginal and Torres Strait Islander community need to work together to support Aboriginal and Torres Strait Islander nursing students to achieve successful completion of their studies (West et al., 2010).

Building on success with study is another possible pathway that may encourage Aboriginal and Torres Strait Islander people to enter an undergraduate degree to become an RN (Best & Stuart, 2014; Stuart & Gorman, 2015). As mentioned previously, stepping through from AIN to EN to RN, with recognition of prior learning occurring at all levels of the education sector, should be considered. Expanding on this strategy, Stuart and Gorman (2015) assert that tertiary education providers could map other health professional qualifications (e.g., the Aboriginal Health Worker position) to nursing curricula. In addition, providing recognition of prior learning and acknowledging transferable skills from one profession to another (Stuart & Gorman, 2015) may increase enrolment in nursing education programs. This option requires further exploration.

### 2.5 Cultural Considerations

It is acknowledged that government policy has failed to make allowances for the effect of cultural influences on Aboriginal and Torres Strait Islander people (Hinton & Chirgwin, 2010; West et al., 2013). Family and community obligations prevent many Aboriginal and Torres Strait Islander people from leaving home to undertake education or for some, remaining employed in the health system. Studying at the tertiary education level can be difficult for any individual who may need to relocate away from family and support networks to gain further qualifications (Clark, 2013). The financial burden of studying away from home, including accommodation and day-to-day living expenses, can be high. Some students need to find work to sustain themselves while attaining higher education qualifications, thus placing themselves under additional hardship and pressure (Hinton & Chirgwin, 2010; Stone, O’Shea, May, Delahunty, & Partington, 2016).

For Aboriginal and Torres Strait Islander students, this burden is compounded by the cultural obligation to share what they have among their family, including income earned, to support family members (Hinton & Chirgwin, 2010). When Aboriginal and Torres Strait Islander students successfully complete nursing studies and gain a place in a transition to a practice program that lasts for 12 months, some may have to relocate even further away from home, family and community support structures (NSW Health, 2016a).
The geographical distance between family members contributes to a level of additional stress for Aboriginal and Torres Strait Islander students, who often have feelings of isolation (Usher, Lindsay, Miller, et al., 2005).

Another factor that contributes to this isolation and feeling of being disconnected is the lack of understanding by some family and community members regarding the responsibilities of either the student nurse or the new graduate nurse. This could occur initially as they undertake their education and then, to gain the skills and experience in their new role away from family and community networks (West et al., 2013). This pressure can be twofold. First, the community may expect the Aboriginal and Torres Strait Islander nurse to return to their community to help improve and look after the community, regardless of the individual’s preferred specialty or work area. Second, after the Aboriginal and Torres Strait Islander nurse who may now have gone away from their community and support networks to gain an education, the community or family may then express either jealousy or a level of discomfort that the person is now ‘too good for them’. This lack of support from the community and/or family can have a negative effect on a student’s willingness to complete their education or stay within the health system to work in their chosen profession (Stuart & Gorman, 2015; Stuart & Nielsen, 2011).

One way to bridge this understanding and provide additional support to the Aboriginal and Torres Strait Islander nurse who is either completing study or working in the health system is through creating a greater awareness of cultural differences through cultural safety training programs (Goold, 2011; NSW Health, 2008). Even though there are policies and legislation in Australia against discrimination based on race, previous studies have highlighted that hidden racism remains within the health system (Best, 2011; Keast & Dragon, 2015; Stuart & Gorman, 2015). Incorporating Aboriginal and Torres Strait Islander culture content within tertiary education curricula, which includes an undertaking to improve cultural safety, is an approach to raising awareness of the cultural issues faced by Aboriginal and Torres Strait Islander people within the Australian health care system (Goold & Usher, 2006; Universities Australia & Charles Sturt University, 2011). Professional standards for nurses and midwives both with standards of practice (Nursing and Midwifery Board of Australia, 2016a, 2016b, 2018) and for tertiary institutions that are responsible for the education of the future workforce, incorporating cultural safety is mandated (Australian Nursing and Midwifery Accreditation Council,
Simultaneously, the introduction of cultural awareness, safety training for non-Indigenous health professionals within the health sector in Australia has been a way forward in developing an understanding of cultural issues (Blackman, 2009, 2011; Downing, Kowal, & Paradies, 2011). Not all health facilities are Aboriginal and Torres Strait Islander friendly or culturally appropriate which may influence their willingness to seek medical assistance (Nielsen, Stuart, & Gorman, 2015). Although breaking down the barriers of racism will require a significant shift in people’s attitudes and challenging their long-held beliefs (Stuart & Gorman, 2015), this can be achieved over time. The medical model of health care and, as suggested by Nielsen et al. (2015), the concept of ‘whiteness within nursing’, contributes to the power imbalance between Aboriginal and Torres Strait Islander and non-Indigenous nurses (Stuart & Gorman, 2015). This remains an area of concern. Nurses and midwives of both Aboriginal and Torres Strait Islander and non-Indigenous descent, through participating in cultural safety programs that may lead to improved capability, are ideally placed to lead reform and to change cultural attitudes (Goold, 2011).
Table 2.1 Themes – Recruitment and Retention, Educations Pathways, Career Pathways, Cultural Considerations

<table>
<thead>
<tr>
<th>No.</th>
<th>Author</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Best (2011)</td>
<td>Yatdjuligin: The stories of Queensland Aboriginal registered nurses 1950–2005</td>
<td>Using an Indigenous methodology, this article aims to describe the experience of Aboriginal and Torres Strait Islander nurses through history</td>
<td>Discusses individual experiences, national and international trends in the workforce and education for Aboriginal and Torres Strait Islander nurses.</td>
<td>Acknowledges racism as a lived experience and describes the disadvantage of Aboriginal and Torres Strait Islander people in accessing training.</td>
<td>Cultural considerations</td>
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<tr>
<td>2</td>
<td>Best and Stuart (2014)</td>
<td>An Aboriginal nurse-led working model for success in graduating Indigenous Australian nurses</td>
<td>This article aims to outline a successful Indigenous nursing support model (Helping Hands), conducted at University of Southern Queensland, from which 80 Aboriginal and Torres Strait Islander nurses and midwives graduated</td>
<td>Identified four key elements that contributed to the success of the program: supporting Aboriginal and Torres Strait Islander students through individual mentoring; inclusion of Indigenous health content within the nursing curriculum; availability and access to Aboriginal and Torres Strait Islander academics to support Aboriginal and Torres Strait Islander nurses’ progress; and</td>
<td>Provides recommendations for nursing education and the recruitment of nurses into approved nursing programs, as well as describing the current situation with regard to recruitment and retention.</td>
<td>Education pathways</td>
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<td>2</td>
<td>Blackman (2009)</td>
<td>Knowledge for practice: Challenges in culturally safe nursing practice.</td>
<td>This article provides an exemplar for clinician as a way to illustrate the importance of Aboriginal nurses available nursing care to Aboriginal people with particular reference to cultural considerations</td>
<td>Nurses should consider how well they understand local Aboriginal health support systems and how these interact and can support the delivery of health care to local Aboriginal communities</td>
<td>Simple misunderstandings or lack of knowledge of cultural factors when caring for Aboriginal and Torres Strait Islander people can be overcome with improved partnerships and gaining cultural awareness, safety and competence for health professionals</td>
<td>Cultural considerations</td>
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<td>3</td>
<td>Blackman (2011)</td>
<td>Understanding culture in practice: Reflections of an Australian Indigenous nurse</td>
<td>This article aims to provide a personal reflection of an Aboriginal and Torres Strait Islander nurse with a view to developing cultural competence</td>
<td>Identifies a starting point of using self-reflection and broadening an individual’s awareness of cultural factors, so nurses can begin their journey to cultural competence.</td>
<td>Discusses the concept that although cultural competence is supported by organisations, it requires an</td>
<td>Cultural considerations</td>
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<td>4</td>
<td>Bolton (2008)</td>
<td>Viewpoint: Indigenous demography and the regional and remote nursing workforce</td>
<td>To discuss the differences between rural and remote areas when developing a future recruitment and retention plan for nursing (in rural areas, the Aboriginal and Torres Strait Islander demography has a higher percentage than in city areas)</td>
<td>As there is a higher incidence of chronic health issues in the Aboriginal and Torres Strait Islander population, recruitment and retention policies need to take this factor into account, rather than basing their approach on the workforce in metropolitan hospitals.</td>
<td>Policies regarding rural recruitment and retention need to take into account the demography of the population.</td>
<td>Recruitment and retention</td>
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<td>5</td>
<td>Clark (2013)</td>
<td>Leadership issues in the workplace for Aboriginal and Torres Strait Islander nurses in Australia</td>
<td>To explore the way Aboriginal and Torres Strait Islander nurse leaders can make a difference in shaping the future in health care</td>
<td>Aboriginal and Torres Strait Islander nursing students have dual obligations towards their family and the community. The complexity of their role means they need inspirational leaders.</td>
<td>This paper acknowledges the Aboriginal and Torres Strait Islander nursing role and that Aboriginal and Torres Strait</td>
<td>Recruitment and retention Cultural considerations</td>
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<td>6</td>
<td>Downing et al. (2011)</td>
<td>Indigenous cultural training for health workers in Australia</td>
<td>To review six models of cultural training for health workers, including nursing, and their effects on developing cultural competence.</td>
<td>There is little evidence that cultural safety training makes any difference at the individual level. There needs to be a change in thinking to move away from solely teaching about cultural issues and towards understanding the power imbalance, which has a greater effect on health staff.</td>
<td>Islander nurses need inspirational leaders who can speak on behalf of many Aboriginal and Torres Strait Islander nations, to improve health care.</td>
<td>Cultural considerations</td>
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<td>7</td>
<td>Eley et al. (2010)</td>
<td>Reasons for entering and leaving nursing: An Australian regional study</td>
<td>To examine the reasons for nurses and nursing students entering and leaving nursing through a comparative study conducted in Queensland.</td>
<td>Retention strategies need to consider the age of the nurse. It is important to understand that nurses remain in nursing for a variety of factors, such as access to professional development; personal fulfilment and satisfaction; being in a stable and merit-based environment that recognises achievement; attainment of seniority; adequate staffing; and level of autonomy. Remuneration or pay rates did not have an influence on departure. The belief that the Gen Y cohort wants more lifestyle choice did not hold true. In this study, nurses said they left nursing because they were disillusioned; there was limited career progression outside of nursing; and personal health concerns. The paper recommended that recruitment campaigns should</td>
<td>Consideration of future workforce planning needs in relation to recruitment and retention strategies.</td>
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<td>8</td>
<td>Francis and Mills (2011)</td>
<td>Sustaining and growing the rural nursing and midwifery workforce: Understanding the issues and isolating directions for the future</td>
<td>To recommend future strategies that would sustain and grow the nursing and midwifery rural workforce, with a particular emphasis on government policy development.</td>
<td>Supporting the nursing and midwifery workforce is a growing priority for Australian governments. Other factors such as education programs, locum relief, incentive payments, spouse/partner support and child care support should be offered. Career advancement opportunities should be considered.</td>
<td>Identifies ways to encourage more nurses to join the workforce. Recruitment and retention is a priority for governments but strategies are insufficient to achieve their goals.</td>
<td>Recruitment and retention</td>
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<td>9</td>
<td>Goold (2011)</td>
<td>Nurses and midwives closing the gap in</td>
<td>To suggest ways that nurses and midwives can help to ‘close the gap’ on</td>
<td>Although much of what is known about Indigenous health is represented by</td>
<td>Education is required to help more nurses and</td>
<td>Education pathways and</td>
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<td>10</td>
<td>Goold and Usher (2006)</td>
<td>Meeting the health needs of Indigenous people: How is nursing education meeting the challenge?</td>
<td>To highlight the issues in preparing nurses to work with Aboriginal and Torres Strait Islander people and to gain an understanding of some of the challenges that Aboriginal and Torres Strait Islander nursing students may face when undertaking higher education.</td>
<td>Stereotyping and bias need to be overcome, which can be achieved by including Aboriginal and Torres Strait Islander content in the nursing curriculum.</td>
<td>midwives to understand cultural safety and that as a profession, nursing has a responsibility to lead the way in this area.</td>
<td>cultural considerations</td>
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<td>11</td>
<td>Hinton and Chirgwin (2010)</td>
<td>Nursing Education: Reducing reality shock for graduate Indigenous nurses: It’s all about time</td>
<td>To review strategies that were implemented during the delivery of a Bachelor of Nursing Program, as a way to improve the retention of Aboriginal and Torres Strait Islander nurses.</td>
<td>Retention could be improved by increasing clinical placement hours to support theory-based learning. Having mentors to assist undergraduate students is essential. The study found that even with additional support, traditional family</td>
<td>Community and family obligations have a greater significance for Aboriginal and Torres Strait Islander nurses as</td>
<td>Cultural considerations</td>
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<td>12</td>
<td>Keast and Dragon (2015)</td>
<td>Stepping into the gap</td>
<td>To critique the current situation regarding Aboriginal and Torres Strait Islander health inequity despite the significant government investment in multiple programs</td>
<td>Programs have not been sufficient to reduce the gap to a satisfactory level. Future cuts in government expenditure may affect many funded programs, which places the Closing the Gap initiative at risk. Nurses and midwives must become actively involved in initiatives that support Closing the Gap.</td>
<td>Mentions existing racial discrimination. Identifies the significant lack of Aboriginal and Torres Strait Islander nurses to meet the demands of this specific vulnerable population.</td>
<td>Education pathways</td>
</tr>
<tr>
<td>13</td>
<td>Lenthall et al. (2011)</td>
<td>Recruitment and retention in very remote Australia, characteristics and key issues</td>
<td>To describe the situation regarding recruitment and retention of the health workforce in remote Australia and discuss some of the key characteristics and issues of this area.</td>
<td>The health workforce in remote Australia is ageing. Despite the introduction of rural qualifications that would prepare people to work in remote communities, few nurses have these qualifications. This alarming trend may have a negative</td>
<td>The issue of recruitment in the areas of most need remains consistent.</td>
<td>Recruitment and retention</td>
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<td>14</td>
<td>Lockyer (2013)</td>
<td>Dig deep and reach for the stars, the moon and the sun: My health research journey</td>
<td>To convey one Aboriginal and Torres Strait Islander nurse’s experience of working with Aboriginal and Torres Strait Islander people and her inspiration to undertake further education.</td>
<td>More Aboriginal and Torres Strait Islander people should be encouraged to pursue health careers and engage in Indigenous research as a way of advancing the voices of Indigenous people.</td>
<td>Recognises the need for increased representation of Aboriginal and Torres Strait Islander people in the field of health.</td>
<td>Career pathway</td>
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<tr>
<td>15</td>
<td>Mills et al. (2010)</td>
<td>The status of rural nursing in Australia: 12 years on</td>
<td>To define what a rural nurse is and provide an overview of their role and function, as well as describe some of the challenges that rural nurses face in relation to recruitment and retention.</td>
<td>The culture of living in a rural community is described. An undergraduate education program and ongoing learning and development programs for the qualified nurse are recommended. Some states are more advanced in developing an advanced practice role for nurses in rural areas, which may encourages nurses to stay in rural areas.</td>
<td>Outlines some of the general challenges for nurses in being rural and recognises that education is key to recruitment and retention for all people.</td>
<td>Recruitment and retention</td>
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<td>16</td>
<td>Mills et al. (2007a)</td>
<td>The accidental mentor: Australian rural nurses developing supportive</td>
<td>To examine the experiences of Australian rural nurses with regard to mentoring.</td>
<td>The concept ‘accidental mentoring’ is a short-term relationship between an</td>
<td>Discussion of the role of the mentor and mentee in</td>
<td>Recruitment and retention</td>
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<td>17</td>
<td>Mills et al. (2007b)</td>
<td>Live my work: Rural nurses and their multiple perspectives of self</td>
<td>To explore rural nurses’ experiences of mentoring.</td>
<td>Living in a rural community involves challenges for the novice nurse. Experienced nurses who engaged in supportive mentoring relationships with novices were well received, especially when the mentor and mentee lived and worked in the same community.</td>
<td>Supporting relationships for nurses in the workplace will assist them to stay relevant to cultural influences and persuade them to join and stay in nursing.</td>
<td>Recruitment and retention Education pathways</td>
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<tr>
<td>18</td>
<td>Molinari and Monserud (2008)</td>
<td>Rural nurse job satisfaction</td>
<td>To examine whether individual or organisational characteristics affect job satisfaction for rural nurses.</td>
<td>Lifestyle and personal life issues were important factors when choosing a job. Nurses who had 1–3 years of nursing experience were the most dissatisfied with their jobs.</td>
<td>Considers the effect of recruitment and retention strategies for rural areas.</td>
<td>Recruitment and retention</td>
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<td>19</td>
<td>Nielsen et al. (2015)</td>
<td>Confronting the cultural challenge of the whiteness of nursing: Aboriginal registered nurses’ perspectives</td>
<td>To describe the experiences and perceptions of Aboriginal and Torres Strait Islander nurses working within the Australian health care system, which is predominantly ‘white’.</td>
<td>For RNs who are Aboriginal and Torres Strait Islander, the concept of ‘whiteness’ remains a deterrent to working within the health care system. Nurses and midwives need to challenge practices within their profession and engage in discourse around culturally competent and safe patient care practices for both Aboriginal and Torres Strait Islander nurses and patients.</td>
<td>Openly speaks about the power imbalance between Aboriginal and Torres Strait Islander nurses and non-Indigenous nurses and the effects of hidden bias and discrimination on future recruitment of Aboriginal and Torres Strait Islander people, as well as the way health care is administered to Aboriginal and Torres Strait Islander people.</td>
<td>Cultural considerations and career pathways</td>
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<tr>
<td>20</td>
<td>NSW Health (2008)</td>
<td>Report on the Aboriginal Students’ residential workshop KATCH (Koori Action Towards Careers in Health)</td>
<td>To examine the effects of the pilot project KATCH, which was a designed to engage, motivate and challenge Aboriginal</td>
<td>At the conclusion of the KATCH study, 60% of the students requested ongoing support and guidance from local health service staff. This interesting pilot study to encourage Aboriginal and Torres Strait Islander people.</td>
<td>Interesting pilot study to encourage Aboriginal and Torres Strait Islander people.</td>
<td>Cultural considerations and education pathways</td>
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<td>21</td>
<td>Stuart and Gorman (2015)</td>
<td>The experiences of Indigenous health workers enrolled in a Bachelor of Nursing at a regional Australian university</td>
<td>To describe the experience of five Indigenous Health workers enrolled in a Bachelor of Nursing program and identify the barriers that hindered their progression.</td>
<td>The prior qualifications of Aboriginal and Torres Strait Islander people could be mapped generically into the Bachelor of Nursing course, as the need to gain an exemption on an individual basis created an undue level of stress. Discrimination from non-Indigenous students remains an issue. Aboriginal and Torres Strait Islander nurse academics were great role models. Successfully completing their studies encouraged other Aboriginal and Torres Strait Islander people to enter into a higher education pathways, career pathways and cultural considerations</td>
<td>Provides an insight into the hidden discrimination and power imbalance that exists between Aboriginal and Torres Strait Islander nursing students and non-Indigenous nursing students. Mapping of existing qualifications to a Bachelor of Nursing program may encourage more Aboriginal and Torres Strait nursing students to pursue careers in the health sector.</td>
<td>Provides an insight into the hidden discrimination and power imbalance that exists between Aboriginal and Torres Strait Islander nursing students and non-Indigenous nursing students. Mapping of existing qualifications to a Bachelor of Nursing program may encourage more Aboriginal and Torres Strait nursing students to pursue careers in the health sector.</td>
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<td>22</td>
<td>Stuart and Nielsen (2011)</td>
<td>Two Aboriginal registered nurses show us why black nurses caring for black patients is good medicine</td>
<td>To provide an historical overview of the current situation for Aboriginal and Torres Strait Islander people through a thematic analysis of research papers to validate the argument that having more Aboriginal and Torres Strait Islander nurses would have a positive effect on the health of Aboriginal and Torres Strait Islander people.</td>
<td>Increasing the number of Aboriginal and Torres Strait Islander nurses working with Aboriginal and Torres Strait Islander communities is the best possible way to improve Indigenous health outcomes. This article identified three main themes: barriers to healing for Aboriginal patients; the importance of communication in a culturally appropriate way and that cultural knowledge and understanding assists with communication; and caring being inherent to Aboriginal nurses. Western health care systems do not accommodate the cultural and spiritual considerations of Aboriginal and Torres Strait Islander people.</td>
<td>Islander people to enter nursing.</td>
<td>Cultural considerations</td>
</tr>
<tr>
<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
<td>Aim of the Text</td>
<td>Findings/Recommendations</td>
<td>Relevance to Study</td>
<td>Theme</td>
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</tr>
<tr>
<td>23</td>
<td>Usher (2011)</td>
<td>Indigenous higher degree research students making a difference to the Indigenous health agenda</td>
<td>To highlight the views of four Aboriginal and Torres Strait Islander health and nursing research students, which provides a perspective on closing the gap, cultural cares and their experience of accessing health services in Australia.</td>
<td>Education and research can be empowering for Aboriginal and Torres Strait Islander people who are engaging in a health system that contains existing bias. Through positive support models and demonstrating success, more Aboriginal and Torres Strait Islander people could be encouraged to engage in further education.</td>
<td>Success stories and promoting cultural competency in nursing may help to engage more Aboriginal and Torres Strait Islander people to enter nursing.</td>
<td>Education pathways, recruitment and retention</td>
</tr>
<tr>
<td>24</td>
<td>Usher, Lindsay, Miller, et al. (2005)</td>
<td>Challenges faced by Indigenous nursing students and strategies that aided their progress in the course: A descriptive study</td>
<td>To explore the challenges faced by undergraduate nursing students undertaking a nursing degree.</td>
<td>The students faced a range of hardships, including financial difficulties/lack of resources, lack of Aboriginal and Torres Strait Islander mentors, poor study skills, lack of educational preparation prior to commencing tertiary study, staff insensitivity to cultural issues, discrimination and bias, as well as ongoing family commitments.</td>
<td>Cultural barriers mean that the reality of what happens in practice is opposite to the intent of the government policy.</td>
<td>Cultural considerations</td>
</tr>
<tr>
<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
<td>Aim of the Text</td>
<td>Findings/Recommendations</td>
<td>Relevance to Study</td>
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<tr>
<td>25</td>
<td>West et al. (2013)</td>
<td>Indigenous Australians’ participation in pre-registration tertiary nursing courses: A mixed methods study</td>
<td>To explore, through a mixed methods study, the success factors that may shape the future of nursing and the Aboriginal and Torres Strait Islander health workforce policy at the local, state and national level.</td>
<td>Although there is a shortage of Aboriginal and Torres Strait Islander nurses, there is no nationally agreed set target. Enabling factors of success include individual student characteristics; academics’ knowledge, understanding and awareness of Aboriginal and Torres Strait Islander cultural safety; institutional structure systems and processes that support Aboriginal and Torres Strait Islander undergraduate nursing students; community and family knowledge and understanding; relationships, partnerships and connections among students and academics.</td>
<td>Supports the idea that undergraduate nursing student success is contingent on a variety of factors. This situation is complex. That government initiatives have had no significant effect in increasing Aboriginal and Torres Strait Islander nursing numbers and more is needed to achieve this goal.</td>
<td>Education pathways</td>
</tr>
<tr>
<td>26</td>
<td>West et al. (2010)</td>
<td>Increased numbers of Australian Indigenous nurses would make a significant contribution to ‘closing the gap’ in</td>
<td>To provide an overview of current Aboriginal and Torres Strait Islander nursing student numbers, focusing on the Queensland experience.</td>
<td>It is essential to incorporate an Indigenous pedagogy into the nursing curriculum. Failure rates within undergraduate nursing</td>
<td>A multilayered approach would support the growth of Aboriginal and Torres Strait Islander nursing</td>
<td>Education pathways, recruitment and retention</td>
</tr>
<tr>
<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
<td>Aim of the Text</td>
<td>Findings/Recommendations</td>
<td>Relevance to Study</td>
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<tr>
<td></td>
<td></td>
<td>Indigenous health: What is getting in the way?</td>
<td></td>
<td>programs need further investigation.</td>
<td>numbers and tertiary education sectors are well placed to support this change.</td>
<td></td>
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</tbody>
</table>
2.6 Chapter Summary

This review of the literature indicates that further investigation is required into the way government policy has an influence on whether Aboriginal and Torres Strait Islander people enter, remain and advance in nursing. Maintaining political and financial support to increase the number of Aboriginal and Torres Strait Islander nurses is crucial to the implementation of any such strategy. While the intent of the Closing the Gap policy has merit, implementation strategies to support this policy in a range of areas, are having a limited effect. This has a significant influence on increasing the representation of Aboriginal and Torres Strait Islander people within nursing.

Combating cultural ignorance through education and cultural awareness programs, with supportive measures to encourage Aboriginal and Torres Strait Islander people to enter and then stay in nursing, is a logical step in addressing bias and discrimination. The tertiary education sector and the health care system are ideally placed to support the change that is required. I contend that without political support, through policy initiatives and adequate resources, any efforts to effect this change will remain futile.
Chapter 3: METHODOLOGICAL FRAMEWORK

‘Texts are elements of social events – they bring about change – in knowledge, value, belief, attitudes.’

Fairclough, 2008

As a way to gain a better understanding of the way the Closing the Gap policy influences Aboriginal and Torres Strait Islander people to enter and remain in nursing, examination of the principal policy documents is required. In this chapter, the reason for the selection of the research methodology, critical discourse analysis, is presented.

3.1 Paradigms of Qualitative Research

To understand the selection of the most appropriate methodology for this study, it is important to know where critical discourse analysis, as the preferred methodology, sits within the theory of knowledge surrounding the scientific discipline of qualitative research (Jirojwong, Johnson, & Welch, 2011). Ambert, Adler, Adler and Detzner (1995) identify four key goals when using qualitative research. First, it is important to utilise a qualitative framework, rather than a quantitative framework, to facilitate a deeper understanding of how we, as humans, make sense of the world in which we live (for this study, the way government policy relates to the world and the community for which it was created). A second goal is to learn how and why people think and make meaning of what they do and how this may be interpreted by others. A third goal is to undertake several levels of analysis of the text, in relation to those who wrote the policy, those who read and enacted the policy and those who are affected by the policy. Finally, qualitative research facilitates an opportunity for discovery, rather than simple verification, which is the goal of quantitative research (Ambert et al., 1995).

This study required a qualitative research framework to examine the underlying meaning of two primary texts: the ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008), commonly known as the Australian Government’s Closing the Gap policy, and the ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b). The aim was to consider the effect of these texts on the identified community. This study sought to understand what the authors of these
policies may have been thinking and to discover both covert and overt messages contained within these texts, as well as examine the way these may be interpreted.

The ‘paradigm’ (or framework) within which this methodology is placed can be explained further by providing a brief overview of the five qualitative research paradigms as outlined by Lincoln, Lynham and Guba (Denzin & Lincoln, 2013). Paradigms can be divided into four components: axiology (ethics) – how to be a moral person in the world; ontology – the nature of reality and the nature of the human being in the world; epistemology – ways of knowing the world; and methodology – the best way to gain knowledge about the world (Denzin & Lincoln, 2013). A more detailed explanation of these four components is provided next, in relation to critical discourse analysis and its position within the five research paradigms as detailed by Denzin and Lincoln (2013).

3.1.1 Five research paradigms: Delineating the best fit for this study

The five research paradigms identified by Denzin and Lincoln. (2013) are positivism, postpositivism, critical theory, constructivism and participatory action frameworks. A brief description of each paradigm is provided in the following text and they are illustrated further in Table 3.1.

Within the positivist paradigm, the researcher utilises methods to quantify observations and precipitate the accumulation of knowledge, using repeatable patterns to understand or provide rules or patterns regarding social life (Ambert et al., 1995; Collins, 1992). The researcher is able to generate predictions and control natural phenomena, as well as demonstrate laws that can be applied to the natural order (Denzin & Lincoln, 2013; Liamputtong, 2013). Some examples of methodologies that sit within this paradigm are cohort studies, longitudinal design studies, case control studies and comparative design studies, as illustrated in Table 3.1 (Jirojwong et al., 2011). This study does not sit within the positivist paradigm, as it seeks to understand the underlying meaning of the text in relation to social structures and it does not seek to predict any natural phenomena.

Postpositivism allows the researcher to put forward a non-falsified hypothesis. The postpositivist researcher believes in a singular truth that may have multiple hidden values and variables. The researcher illustrates their hypothesis using statistical analyses to interpret the findings visually and uses a hypothetical deductive method to make generalisations about the research (Denzin & Lincoln, 2013; Liamputtong, 2013).
Examples of postpositivist research design are descriptive research design, correlation studies and epidemiological studies, as illustrated in Table 3.1. This study does not sit within a postpositivist paradigm as the aim is to understand the many truths that underpin the primary text through use of linguistic interpretation of text (Fairclough, 2015; Jirojwong et al., 2011).

The constructivist paradigm, according to Denzin and Lincoln (2013), allows the researcher to gain knowledge that is constructed cognitively from the experience of the interaction between the researcher and the subject. The researcher attempts to gain increased knowledge regarding their study by interpreting the way its subjects perceive and interact within a social context (Jirojwong et al., 2011; Liamputtong, 2013). Examples of methodologies that sit within this paradigm are phenomenology and grounded theory, as illustrated in Table 3.1. This study does not sit within the constructivist paradigm, as there is no direct engagement with participants through interviews or conversations.

The participatory or postmodern paradigm allows the researcher to gain knowledge based on democratic participation between the researcher and the subject. It seeks to understand what the form of reality is and what can be known about it (Denzin & Lincoln, 2013). Examples of methodologies that sit within this paradigm are action research and ethnography, as illustrated in Table 3.1 (Jirojwong et al., 2011; Liamputtong, 2013). This study does not sit within the participatory or postmodern paradigm as similarly to the constructivist paradigm, there is no direct engagement with participants through interviews and conversations.

The critical theory paradigm seeks to understand the way human nature operates in a world that is based on a struggle for power. Researchers examine the study of social structures, freedom and oppression, as well as the struggle for power and control, to provide a voice for, and to empower, socially marginalised groups, with the intent of supporting social transformation (Denzin & Lincoln, 2013). Examples of research methodologies that sit within this paradigm are Marxist social theory, feminist theory, queer theory and critical discourse analysis, as illustrated in Table 3.1 (Denzin & Lincoln, 2013; Liamputtong, 2013). This study uses critical discourse analysis, which sits within this research paradigm. Further explanation demonstrating the way critical discourse analysis aligns with this paradigm is provided later in this chapter.
3.1.2 Critical Theory paradigm components: Axiology, ontology, epistemology and methodology

As noted above, the critical theory paradigm seeks to understand the way human nature operates in a world that is based on a struggle for power. The meaning to this study of the four components of this paradigm (axiology, ontology, epistemology and methodology) is outlined in the following.

3.1.2.1 Axiology (ethics)

The axiology or ethical perspective of the critical theory paradigm asks the researcher to consider the moral position of the study. The researcher acknowledges that there is specific interest in the development of a society and the power struggles within that society. The researcher must be mindful to undertake the research without prejudice to the development of that society (Denzin & Lincoln, 2013). For this reason, critical social theory is appropriate for this study, as it seeks to examine the power struggles between marginalised cultural groups (Aboriginal and Torres Strait Islander people) and the entity (government) that holds power over them. The study adopts an ethical approach that is guided by asking the research questions outlined in Chapter 1.

3.1.2.2 Ontology

The ontology aspect of the critical theory paradigm asks the researcher to consider the nature of reality and the nature of the human being in the world (Denzin & Lincoln, 2013). It also expects the researcher to consider the way human beings operate within a world based on the struggle for power or dominance. Foundational critical theorists, such as Foucault and Habermas, encourage the researcher to consider the interactions by those who hold power and the potential or actual oppression of other social groups. In doing this, the researcher gains an understanding of political influence over marginalised or socially disadvantaged groups and the capacity of these groups to make decisions or choices affecting their own lives (Foucault, 1980; Habermas, 1971, 1991, 2010). This oppression can be based on race, ethnicity, socioeconomic class, gender, mental or physical competence and sexual preference (Clark, 2003; Denzin & Lincoln, 2013; Fairclough, 2015).
This study seeks to understand the existing power relationships through the analysis of text and the subsequent influence this text has had on Aboriginal and Torres Strait Islander people. Historically, Aboriginal and Torres Strait Islander people have been subjugated through colonisation and the continual influence of the governing policy that affects this population (Anderson & Whyte, 2006; Broome, 2010). Critical social theory allows the researcher to explore power relationships within the context of the real world, as well as the way such groups interact within the world (Brown, 2000; Fairclough, 2003, 2015; Young & McGrath, 2011).

3.1.2.3 Epistemology

The epistemology aspect of the critical theory paradigm aims to understand the relationship between what we know and what we see, by focusing on the social structures and the balance between power and oppression. Researchers aspire to bring about knowledge that may change oppressive structures through empowering the oppressed and increasing the social conscience and awareness of those who hold the power (Denzin & Lincoln, 2013).

This study analyses the text of the Closing the Gap policy with the aim of understanding the initial impetus for the strategy; the way this policy is implemented; the way it may have been interpreted; who is actually speaking within the document; and whether any power relationships exist. Critical social theory is an appropriate framework for examining this concept in greater depth (Fairclough, 2015).

3.1.2.4 Methodology

The critical theory paradigm asserts that knowledge about the world is emancipatory and can lead to social transformation and revolution. Examples of methodologies used within this paradigm are Marxist social theory, queer and race theory, and discourse analysis (Denzin & Lincoln, 2013; Jirojwong et al., 2011).

To understand the social context within which power struggles and relationships exist, using a critical theory framework allows the researcher to raise awareness of power imbalances. Raising awareness of power imbalances supports the impetus for social change (Fairclough, 2010; Foucault, 1977; Ruiz, 2009) and challenges previous
misconceptions, which can create a better understanding of the world in which social inequity exists.
### Table 3.1: Axiology, Ontology, Epistemology, Methodology and Types of Studies of the Five Research Paradigms -adapted from Denzin and Lincoln, (2013) and Jirojwong et al., (2011)

<table>
<thead>
<tr>
<th>Paradigm</th>
<th>Positivism</th>
<th>Postpositivism</th>
<th>Critical Theory</th>
<th>Constructivism</th>
<th>Participatory (Postmodern)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Axiology (ethics)</strong></td>
<td>Extrinsic – moral tilt towards deception</td>
<td>Intrinsic – moral tilt towards revelation</td>
<td>Intrinsic – process tilt towards revelation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ontology</strong></td>
<td>Naïve realism</td>
<td>Critical realism</td>
<td>Historical realism</td>
<td>Relativism</td>
<td>Participative reality</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
<td>Dualist/objectivist; findings are true</td>
<td>Modified dualist/objectivist; findings are probably true</td>
<td>Transactional/subjectivist; value-mediated findings</td>
<td>Transactional subjectivist/co-created findings</td>
<td>Critical subjectivity in participatory transaction with the world</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Experimental, manipulative, verification of hypotheses, chiefly quantitative methods</td>
<td>Modified experimental/manipulative, critical multiplism, falsification of hypotheses, may include qualitative methods</td>
<td>Dialogic/dialectical</td>
<td>Hermeneutical/dialectical</td>
<td>Political participation in collaborative action inquiry</td>
</tr>
<tr>
<td><strong>Types of studies</strong></td>
<td>Cohort studies, longitudinal design studies, case control studies, comparative design studies</td>
<td>Descriptive research design, correlation studies, epidemiological studies</td>
<td>Feminist theory, queer theory, critical discourse analysis</td>
<td>Phenomenology, hermeneutics, grounded theory, symbolic interactionism</td>
<td>Action research, ethnography, case studies</td>
</tr>
</tbody>
</table>
3.2 Selection of Qualitative Research Methodology

Several critical theory methodologies are available to the researcher. Table 3.1 provides an overview of the way the methodologies align with the five paradigms of research mentioned previously. This list is not exhaustive in relation to qualitative and quantitative research methods; however, it provides an overview to demonstrate the way each methodology aligns with each research paradigm. Further detail on the research methodologies that sit within the critical social theory paradigm (i.e., Marxist theory, queer theory, feminist theory and critical discourse analysis) is provided next, as well as the reasons for the selection of the chosen methodology, critical discourse analysis.

3.2.1 Marxist theory

Marxist theory seeks to produce social and political change through challenging existing social injustices, which would therefore lead to equal rights for all parties. Within Marxist theory, those who have economic dominance within a society, thus being those who have power and control, are able to oppress and manipulate the lives of those who do not have this economic power (Denzin & Lincoln, 2013; Jirojwong et al., 2011). Contemporary critical theorists have drawn from the primary works of Marx and Engels to establish the social inequity or unequal power relationships that may exist within a society (Marx & Engels, 2002; Skousen, 2014). Although Marxist theory examines unequal power relationships from an economic and historical viewpoint, I have not chosen this for my study as I seek to understand the power relationships by analysing the language of a government policy document and its subsequent influence on a specific cultural group. Contemporary theorists have developed subsequent critical theory approaches that fit better with the study purpose and resonate more with me as a researcher.

3.2.2 Queer theory

Queer theory focuses on sexual and gender studies. It has often been termed as the methodology for people who identify as gay, lesbian or homosexual, aiming to give voice to this marginalised social group and to politically challenge the normal social structures of current society (Denzin & Lincoln, 2013). As queer theory is specific to gender or sexuality, it has not been selected for this study, which seeks to understand the power and political motivations of a specific cultural group regardless of gender or sexual preference.
3.2.3 Feminist theory

Feminist theory is specific to women and seeks to capture women’s lived experiences (Ambert et al., 1995; Jirojwong et al., 2011; Liamputtong, 2013). It focuses on women’s unique experiences while adhering to principles of ensuring the research is done with women, not on women, and that all interactions should have an empowering and equal relationship (Richardson-Tench, Taylor, Kermode, & Roberts, 2014). Feminist theory is not relevant to this research, as it studies males and females equally.

3.2.4 Critical discourse analysis theory

Critical discourse analysis theory allows the researcher to discover social inequities and provide reasoning for social change. According to Jirojwong et al. (2011), critical discourse analysis attempts to critique political ideologies and conventional social structures, to increase awareness and facilitate social change. Fairclough describes critical discourse analysis as a combination of critique of discourse and an explanation of how it ‘contributes to the existing social reality, as a basis for action to change that existing reality’ (Fairclough, 2015, p.6). Discourse analysis sits within the paradigm of critical social theory and has been selected for use within this study, thus providing both a methodology and a theoretical basis to conduct an analysis of both the overt and covert messages contained within the text, to understand the way the language influences social change (Fairclough, 2010). Further justification for this selection is provided later in this chapter.

3.3 Trustworthiness of Selected Methodology: Critical Discourse Analysis

With critical theory established as the underpinning methodological approach for this study, further justification is provided regarding the trustworthiness of critical discourse analysis. As qualitative research seeks to understand the experiences and perspectives of participants or subjects, an evaluation of the trustworthiness of the selected methodology is achieved below in relation to five criteria: credibility, dependability, confirmability, transferability and authenticity (Cope, 2014; Liamputtong, 2013).

One significant criticism of qualitative research is the potential for bias. The researcher may potentially read and interpret from their own personal viewpoint and may not equally represent all of the stakeholders in the study (Francis, 2013; Smith, 2007). This criticism
is countered by qualitative researchers who maintain that bias is acknowledged as being inherent to any research; however, it can be minimised through the use of a consistent methodological approach (Smith, 2007). The literature now acknowledges that qualitative research can be judged on its own merits and it offers new knowledge and understanding in a way that factual quantitative research cannot (Cope, 2014; Francis, 2013; Liamputtong, 2013; Noble & Smith, 2015).

### 3.3.1 Credibility (truth value)

Credibility in qualitative research refers to the truth value or trustworthiness of the research, which can be achieved by the researcher acknowledging multiple realities and declaring personal experience and viewpoints that may result in methodological bias (Noble & Smith, 2015). The interpretation of the research needs to be accurate to either allow readers to validate the findings from their own experience or show them as clearly recognised phenomena that hold true within the context of the qualitative study. Credibility can be demonstrated by clearly outlining the methodology that is to be adopted in a research project and showing evidence of audit trails and personal reflections (Cope, 2014; Hammarberg, Kirkman, & De Lacey, 2016; Liamputtong, 2013). Within this study, credibility is shown through the declaration of personal experience and bias with regard to the interpretation of the phenomena. Any independent researcher would arrive at the same findings and the recommendations are based on the truth of the multiple realities within the social context of this study.

### 3.3.2 Dependability

Dependability in qualitative research is demonstrated through a logical and clearly articulated process by which the research was undertaken (Liamputtong, 2013). The researcher is able to show the reason for their choice of methodology, how they collected the data and that there are clearly defined links between the data and the findings (Liamputtong, 2013). In this study, the reason for the selection of the methodology critical discourse analysis has been clearly articulated. Justification for the selection of the reviewed texts under analysis is outlined and the findings from the analysis are clearly linked to the primary texts under review.

### 3.3.3 Confirmability

In qualitative research, the researcher demonstrates confirmability by clearly articulating the way the findings and conclusions were derived. It is important that the researcher does
not allow bias and personal interests to influence their conclusions. Conclusions must show clear linkages to the data and that they were derived from the data within the research (Cope, 2014; Liamputtong, 2013). In this study, bias and personal perspective are acknowledged and by following a logical process with regard to the way the findings were discovered, bias is minimised. Quotations from the reviewed texts support the researcher’s conclusions as well.

3.3.4 Transferability

In qualitative research, transferability (or applicability) means that the theoretical knowledge and findings derived from the research can be applied to other situations, contexts, groups or settings (Hammarberg et al., 2016; Liamputtong, 2013; Noble & Smith, 2015). According to Cope (2014), transferability is reliant upon the aim or objective of the qualitative research. Transferability may be applicable only if the intent of the study is to generalise about the phenomenon. Within this study, transferability is demonstrated when the generated findings are compared against the literature (Francis, 2013).

3.3.5 Authenticity

Authenticity can be demonstrated when the subject or participant experiences are clearly articulated by the researcher so that the reader can develop an understanding of the experience of the participant or subject (Cope, 2014). Although there are no participants in this study, authenticity can be demonstrated by showing that the results can be trusted, that the text under analysis is appropriate for the research question and that sufficient resources, such as historical, political and social contexts, have been described (Crowe, 2005). Multiple authentic realities can be revealed through data that are constructed linguistically (Denzin & Lincoln, 2011) and the reader would come to the same conclusions as the researcher if given the same data to review (Liamputtong, 2013). In this study, the primary texts are triangulated with supporting documents that show the validity of the findings put forward by the researcher (Ambert et al., 1995).

3.4 Defining Critical Discourse Analysis

This section provides an explanation of key terms that help to define critical discourse analysis. The term critical (meaning critique) has two components: normative and explanatory. According to Fairclough (2015), normative critique within discourse does
not go outside the social reality that it is critiquing. It identifies the internal contradictions in the values to which people and institutions are committed, as opposed to what is actually said and then done within the identified social reality. *Explanatory critique* involves explanation and it is described as being the whole critique, as opposed to being only a stage of critique. Explanatory critique provides a connection between explanation and action, where the untruths or injustices identified within the normative critique allow for the opportunity to call to action, which would result in a change to the existing reality (Fairclough, 2015). *Discourse* refers to a particular view of language or communication that is present in talk or text (Fairclough, 2003; Johnstone, 2008; Phillips, 2002). In the methodology of critical discourse analysis, *analysis* is the process of taking things apart or looking at them from a variety of perspectives to gain understanding (Johnstone, 2008).

Fairclough (2015) rationalises that even though interpretation, evaluation, explanation and critique are not unique to critical analysis, the difference in critical discourse analysis as a methodology for research is the way in which the discourse is interpreted, evaluated, explained and critiqued. Thus, it is important to understand how critical discourse analysis is conducted.

There are a variety of approaches for undertaking a critical discourse analysis (Glynos, Howarth, Norval, & Speed, 2009; Miller & Brewer, 2003). As this study is informed by Fairclough (2003, 2015), I have chosen to adopt the four major approaches to critical discourse analysis he advocates. (Fairclough, 2015). These approaches to critical discourse analysis are listed as corpus linguistic, ethnographic sociolinguistic, historical, and dialectical argumentation. Fairclough (2015) advocates that each approach is an important component of conducting a critical discourse analysis that leads to an analytical interpretation of any selected text. Fairclough’s recent works (2015) identify dialectical argumentation as a new approach to discourse analysis that builds on corpus linguistic, ethnographic sociolinguistic and historical interpretations to achieve a thorough interpretation of the texts within a social context. As this study examines the way a government policy may affect a particular population group, it is relevant to study the data from the viewpoint of each approach.

### 3.4.1 Corpus linguistics

Corpus linguistics allows the researcher to use a range of tools to analyse the text in a quantitative way. The researcher may seek to review the text to identify a statistically significant higher use of key phrases, terms or words. ‘Collocation’ is used by the
researcher to identify where the occurrence of words or phrases within a set number of words is higher than normal chance would predict (Fairclough, 2015; Gee, 2011). ‘Concordance’ identifies a specific word (or a collection of words) within a set span of language that is repeated or is significant in the description of the subject. Fairclough (2015) affirms that corpus linguistics is not a form of critical discourse analysis but is, in fact, a tool that can help to inform analysis when conducting critical discourse analysis. This study identifies key words and phrases (collocations and concordances) that occur significantly more often than normal chance would predict.

3.4.2 Ethnographic sociolinguistics

In this approach to critical discourse analysis, the researcher is aware that different cultures, communities and groups of individuals have their own forms of communication that are specific to them (Fairclough, 2015). For example, those who work in health and medicine have an understanding of language that is specific to their field of expertise, commonly known as jargon. Different sociocultural groups have their own language that can be based on geography or social class; for example, people who live in Australia predominantly communicate in English and those who live in France communicate in French. Within geographical regions, certain groups may develop their own dialect of language; for example, in the United Kingdom, which is predominantly English, there are sub-forms of language, such as cockney and brogue. Another example within Australia, is the use of Aboriginal English which been incorporated into the vernacular with words such as kangaroo, kookaburra and wombat. Specific regions may also develop colloquialisms that identify individuals as belonging to a specific group. Fairclough’s (2015) criticism of ethnographic linguistics implies that even though the critique identifies inequalities in the text (normative critique), it does not go to the next step to undertake an explanatory critique. For this reason, Fairclough presents his concept of ‘dialectical argumentation’, which is explained later in this chapter.

Within this study, an ethnographic sociolinguistic approach is conducted to identify whether there are any specific language occurrences that may affect the interpretation of the texts for different groups, such as political or media speak (Fairclough & Fairclough, 2012; McCallum, 2013; Sullivan, 2011).
3.4.3 Discourse: Historical approach

Researchers who adopt the historical approach seek to identify inequalities or inconsistencies based on the power relations within a social context. They may undertake a retrospective view of the development of social cultures and seek to illuminate injustices that may be inflicted from one group to another, based on knowledge or economic and political influence. The researcher may study a discursive event and seek to explore the relationships of groups within social contexts and structures (Fairclough, 2015; Glynos et al., 2009). An example of this approach would be to review the construction of language in propaganda, such as that which existed to encourage young men to join the military in World War 1 to defend their country against an enemy who were portrayed in a negative way. Other examples are the effects of industrialisation, with social class divisions becoming more pronounced (Fairclough, 2015).

This study considers the influence of colonisation (both political and economic influence); the effects of previous government policies; and the way these shape the language used in the documents that are the subject of this study. In this study, it is important to acknowledge the history that has shaped the social contexts of today.

3.4.4 Dialectical argumentation

Fairclough’s (2015) latest work describes dialectical argumentation as being the next evolution in critical discourse analysis. According to this approach, for transformative action towards social change to occur, a decision needs to be made. To make that decision, some form of deliberation is required. Fairclough (2015) purports that deliberation is a form of argumentation: a weighing up of alternatives. Critical analysis focuses on relations between social elements and discourse through explanatory critique. Fairclough (2015) explains that dialectical reasoning/argumentation (critical questioning and deliberation) and dialectical relations (social practices and processes) are connected. Dialectical arguments begin from the language, beliefs and opinions of those who are engaged in the social reality under review. From this, cognitive or causal relations are identified and transformative action (praxis) can proceed.

This study aims to understand the social processes and discourses espoused within the texts under review, which can be either dominant or silent. By using both normative and explanatory critique, the deliberations that support transformative action are presented.
3.5 The Evolution of Critical Discourse Analysis

There are multiple ways to undertake a critical discourse analysis and a number of theorists have contributed to the body of knowledge on how it can be conducted. As Norman Fairclough is the chosen theorist for this study, I focus here on the theorists who have had an influence on, and in some way have contributed to, the development of critical discourse analysis theory as described by Fairclough. Much of Fairclough’s work has been based on theorists such as Foucault, Bourdieu and Habermas (Fairclough & Fairclough, 2012; Fairclough, 2003, 2010, 2015), who were influenced by theorists such as Marx, Nietzsche and Wittgenstein. As I progressed through my learning journey to understand the purpose of critical discourse analysis, I felt that it was important to gain a sense of where and how the theorists mentioned above developed their theories and how they may have influenced contemporary theorists such Fairclough, Chouliaraki and Wodak. The following provides a brief overview of theorists who have engaged with critical discourse analysis since its inception, contributed to its evolution and influenced Fairclough’s theory.

3.5.1 Karl Marx

In the development of critical discourse analysis theory, Fairclough provided commentary within his own writings about classical critical social theorists such as Karl Marx (Fairclough, 2010). Marx’s theory examined unequal power relationships through the analysis of language used within different types of economic and political texts from an historical and economic viewpoint. Fairclough notes that Marx used elements of Aristotelian methods of analysis through the dominance of specific terminologies within a text and then drew upon this to make logical abstract relationships that examined the differences between social groups. Marx called upon the abstract to make specific assertions about the individual (Marx & Engels, 2002; Marx & Mandel, 1978).

Marx’s work and the examination of the linguistic component of texts formed the basis of the corpus linguistic approach that Fairclough identifies as a framework for the researcher to perform a critical discourse analysis (Fairclough, 2010). Marx was perhaps the first theorist of this type of critical discourse analysis. Other theorists, such as Foucault and Habermas, have had a greater influence on Fairclough in the development of modern critical discourse analysis theory.
3.5.2 Ludwig Wittgenstein

Wittgenstein’s focus was the linguistic interpretation of text and the hidden meaning of the text, how the structure of language shaped the reality of the world, thus aiming to gain an understanding of the world in which we live. Some of Wittgenstein’s most influential works on philosophy were published after his death in 1951. Although Fairclough does not refer to Wittgenstein in his works, other contemporary theorists such as Wodak (2006, 2011), with whom Fairclough worked to develop modern critical discourse analysis theory, recognise that Wittgenstein contributed to critical discourse analysis theory in the analysis of words within texts (Wittgenstein & Docherty, 1991). Thus, Wittgenstein had an influence on the evolution of modern critical discourse analysis.

3.5.3 Friedrich Nietzsche

The philosopher Friedrich Nietzsche had a profound influence on Foucault, who in turn, shaped Fairclough’s thinking. Nietzsche’s focus was on the philosophical underpinnings of power, as opposed to Marx, who described power relations as a product of economic dominance within society (Kaufmann, 1976; Nietzsche, 2003). The foundational work of Nietzsche encouraged Foucault to explore his own understandings of his writings, rather than conforming to the social norms of how things should be written and understood. Fairclough acknowledged Foucault’s argument that many different discourses exist and influence people’s experiences of their world. These discourses may overlap or be contradictory, yet can be valuable in gaining an understanding of various aspects that exist within a world, or a number of realities or truths (Fairclough, 2003).

3.5.4 Pierre Bourdieu

Pierre Bourdieu was another important social theorist who articulated the importance of understanding the environment in which people live and the way that may influence any textual analysis from a socialisation or experience perspective (Bourdieu, 1977; Fairclough, 2003). Fairclough acknowledges that Bourdieu’s work supports his concept of dialectical argumentation, in that the social context must be considered in relation to the way we interpret events or texts within a social context, the people involved, the relationship with others and the relationship to themselves as the object of the analysis (Fairclough, 2003).
3.5.5 Jürgen Habermas

Contemporary social critical theorists such as Fairclough are influenced by Jürgen Habermas, who contended that there is a relationship between language and power (Fairclough, 2015). In addition, Habermas highlighted the need to understand that human rights have a direct relationship with moral perspectives and that social status can affect ‘human dignity’. In turn, social status is influenced by the laws of society (both formal and informal) and thus, imbalances of social power between varying social groups can be revealed by studying the language used (Habermas, 1991, 2010). Fairclough extends these propositions in his recent theoretical framework of critical discourse analysis, highlighting the dichotomies between social or culturally different groups (Fairclough, 2015).

3.5.6 Michel Foucault

Michel Foucault, a critical social theorist who lived in the late 20th century, had a profound influence on the development of critical social theory and therefore, on critical discourse analysis. I initially considered this theorist as the possible philosopher upon which to base this study. Foucault’s work revealed the way that people who have social power, knowledge and political favour can dominate those who do not, such as those with mental illness or in socially disadvantaged or cultural minority groups (Foucault, 1977, 1980; Foucault & Bouchard, 1980; Foucault & Kritzman, 1988).

Fairclough expands on Foucault’s foundational work within his dialectical argumentation approach to critical discourse analysis by taking Foucault’s description of the three axes of discourse (power, knowledge and ethics) and demonstrating the relationships between these concepts and the ways they can influence or control action on or over ‘things’. By understanding the fundamental concept of the way these three axes intersect, we can then gain an understanding of the underlying meaning of events (Fairclough, 2003). This concept is described in further detail in the analysis Chapters 5, 6 and 7. The relationships between Foucault’s axes, as described by Fairclough, are illustrated in Figure 3.1.
Chapter 3 - Methodological Framework

Figure 3.1 Foucault’s Three Axes of Discourse - adapted from Fairclough (2003)

3.5.7 Ruth Wodak and Lillie Chouliaraki

Ruth Wodak and Lillie Chouliaraki are contemporary critical social theorists who worked alongside Norman Fairclough and contributed to the development of contemporary critical discourse analysis as a methodology. Chouliaraki’s work focuses on re-contextualising the understanding of discourse in particular fields (e.g., government and the media), seeking to understanding the meaning behind the specific language used by these social groups as a means of power, control and influence within society (Chouliaraki & Fairclough, 1999; Fairclough, 2010). The work of Chouliaraki and Fairclough acknowledges that language can be seen as belonging to a certain genre: for example, ‘political speak’.

Ruth Wodak, building on Bourdieu’s earlier works, explores discourse in relation to politics and the influence that political language can have in shaping the thinking of communities and thereby, facilitating the progression of thoughts into becoming actions (Fairclough & Fairclough, 2012; Wodak, 2011). Both of these critical theorists have published works with Fairclough and they have been cited as experts in their field.

3.5.8 Norman Fairclough

Norman Fairclough is the primary theorist whose work informed this study. His perspective on critical discourse analysis evolved in the late 20th century and continues today. In undertaking a critical discourse analysis, Fairclough articulates that language can be viewed schematically. His earlier works highlight the importance of social
structures that have a direct influence on social practices or events and note that these events must be viewed within their context and can be illuminated through a variety of text forms (Fairclough, 2003). For the purpose of this study, I chose to follow his latest thinking on critical discourse analysis and the application of this methodology. He acknowledges that while understanding the syntax of language is important, the interaction and the context within which the language is delivered is equally (if not more) important in understanding the covert and overt meanings of the text (Fairclough & Fairclough, 2012; Fairclough, 2010, 2015).

3.6 The Value of Critical Discourse Analysis in Indigenous Health Policy

This chapter has shown that as critical discourse analysis allows the researcher to examine the dynamics of language that may affect the balance of power between social groups, it is a suitable methodology for examining the effects of the Indigenous health policy on Aboriginal and Torres Strait Islander people with regard to entering and remaining in nursing. Yet why have I, as a Wiradjuri woman, chosen a Western research framework for my study? At this point in my thesis, I would like to provide an explanation.

Throughout my journey, I have been repeatedly challenged as to why I chose not to use an Indigenous research framework, as opposed to the ‘Westernised’ discourse analysis framework that has been selected for this study. Martin (2003) emphasises that an Indigenous framework (ways of knowing, being and doing) is an essential basis for conducting research on Aboriginal and Torres Strait Islander people. Today there is growing acceptance that research undertaken both on and with Aboriginal and Torres Strait Islander people needs to consider this rich cultural heritage, which includes historical and social experiences that are significantly different to those of non-Indigenous people. In the past, Western ways of doing research on Aboriginal and Torres Strait Islander people have had a negative effect and often, beneficence has not been observed (Martin, 2003). This is a compelling argument for the validity of using an Indigenous research paradigm.

However, in this research I am seeking to discover the existence (or nonexistence) of power balances/imbalances in the policy documents that directly affect Aboriginal and Torres Strait Islander people, as well as flow-on effects with regard to Aboriginal and Torres Strait Islander people entering the nursing profession. Utilising a critical discourse
analysis as informed by Fairclough, is the most appropriate methodology to answer the following research questions;

- Has government policy (Closing the Gap) had an effect on whether Aboriginal and Torres Strait Islander people choose nursing as a health career?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to consider joining the nursing profession in preference to other regulated and unregulated health careers?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to remain in nursing?

As policy makers and authors have historically been non-Indigenous, I believed that basing this research on a Western model, yet seen through an Indigenous lens, could provide an argument on equal terms. Using an Indigenous lens when conducting this critical discourse analysis brings a richness to the research and an understanding of the way policy has influenced the Aboriginal and Torres Strait Islander people of today. Using an Indigenous lens whilst acknowledging the existence of my own personal bias, I seek to gain an understanding of the power and social relationships, as well as the balances or imbalances, that may exist within a social context: specifically, to understand the power imbalance in Aboriginal and Torres Strait Islander health policy, as well as its effect on the nursing profession and the social group on which it has the greatest effect.

3.7 Chapter Summary

Understanding the power imbalances between marginalised groups, such as Aboriginal and Torres Strait Islander people, and entities, such as the government, can be illuminated through conducting a critical discourse analysis of publicly available texts. For the purpose of this study, utilising critical discourse analysis as described by Fairclough to explore the underlying meanings of the two primary texts (the ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’, (Council of Australian Governments, 2008) and the ‘National Indigenous Reform Agreement (Closing the Gap)’, (Council of Australian Governments, 2012b) allows me, as the researcher, to determine whether any social inequities exist (Fairclough, 2003, 2010, 2015). In addition, correlations are drawn from the secondary- and tertiary-level texts, as described in Chapter 4.
In conducting this research, I identify whether any power relationships are evident in the text and whether these have any influence on whether Aboriginal and Torres Strait Islander people seek to pursue a nursing career. The approach to undertaking this research study, informed by Fairclough (2015) includes a corpus linguistic, ethnographic sociolinguistic, historical and dialectical argumentation analysis, as described earlier in this chapter. Further explanation of the way this is achieved is provided in Chapter 4.
Chapter 4: METHOD OF CRITICAL DISCOURSE ANALYSIS

‘Traveler, there are no paths. Paths are made by walking.’

Antonio Machado, Spanish poet, 1898

As noted in Chapter 1, the research questions are as follows:

- Has government policy (Closing the Gap) had an effect on whether Aboriginal and Torres Strait Islander people choose nursing as a health career?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to consider joining the nursing profession in preference to other regulated and unregulated health careers?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to remain in nursing?

4.1 Discourse Analysis Process

As noted earlier, the aims of this study are to illuminate the rationale for, and implications of, the Australian Government’s Closing the Gap policy, particularly its implications for the profession of nursing. The method that I followed in preparation for the analysis of the two primary texts - ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008) and ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b) is described next. The secondary- and tertiary-level texts, including subsequent government annual reports, were reviewed as well, to demonstrate evidence of the underlying messages observed within the primary texts, thus supporting the analysis through correlations (triangulation) within the data (see Figure 4.1).
The analysis is enriched further by an examination of the four approaches to discourse analysis informed by Fairclough (2015): corpus linguistics, ethnographic sociolinguistics, an historical approach and dialectical argumentation (see Chapter 3). The stepped process described below uses these four approaches to critical discourse analysis and provides a guide for the methodological approach used in this study.

Stage 1: Focus on a social wrong in its semiotic aspect, as follows (see Chapters 1 and 3):

- Step 1 – Frame the *research* question/s.
- Step 2 – Identify the research methodology.

Stage 2: Identify obstacles to addressing the social wrong, as follows:

- Step 1 – Analyse dialectical relations between semiosis and other social elements by conducting a literature review (see Chapter 2).
- Step 2 – Select the texts and categories for analysis (see Chapter 2) by isolating the texts that constitute the data and determine how the text will be accessed.
- Step 3 – Analyse the texts (see Chapters 5, 6 and 7). (In this study, the software program NVivo Pro was used, which allowed interrogation of the data from the documents that were identified in Step 2.) Diagrammatical representation of the analysis and a mind map of NVivo nodes and trees are provided in Figure 4.2.
Analysis of the texts was completed using the following procedure for each of the four approaches identified by Fairclough (2015):

- A corpus linguistics (collocations and concordance) and an ethnographic sociolinguistics approach (within a social context) were used to answer the following questions:
  
  o Are rules and patterns present?

  o How have rules and patterns been constructed?

  o Are there any assumptions?

  o Are there any contradictions?

- An historical critical discourse analysis approach was taken to answer the following questions:

  o Who is speaking?

  o Why are they speaking?

  o Who has allowed them to speak?

  o What historical influences exist?

  o How does this have an influence on nursing today?

- A dialectical argumentation approach was taken to answer the following questions:

  o What discourses are dominant?

  o What discourses are silent?

  o What are the consequences of the dominant discourses?

  o What are the implications of this discourse?

  o Are there any inconsistencies in the discourse?

  o How does this have an influence on nursing?
Stage 3: Consider whether the social order ‘needs’ contribute to the existence of a social wrong. The following perspectives were used to examine the research questions proposed in this study (see Chapters 5–8):

- the way government policy relates to the world and the community for which it was created (Chapters 6 and 7)
- how and why people think and make meaning of what they do and how this may be interpreted by others (Chapters 5, 6 and 7)
- the overt and covert messages in relation to those who wrote the policy, those who read and enacted the policy and those who are affected by the policy (Chapters 6 and 7)
- the implications for the nursing profession as part of the health workforce, both now and in the future (Chapter 8).

Stage 4: Identify possible solutions and construct recommendations (see Chapter 9).

Throughout this study, my reflections appear in shaded boxes. Questions that challenged me to think laterally and consider my biases, as I deliberated on the analytical procedure I was performing and the assumptions I was making, are noted. These reflective questions reveal my thinking and they are offered as declarations of potential bias.
Figure 4.2: Nodes and Trees in NVivo
4.2 Sources of Text for Review

This study required the collection and critical review of the current literature available in relation to government policy and health workforce data. Data for this discourse analysis were drawn from a number of texts. As noted earlier, the primary documents involved in this analysis were ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008) and ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b). In addition, subsequent federal government annual performance reports from 2009 to 2017 were examined. Documents that supported these overarching policy documents were sourced and included, but were not limited to the Australian and State Government policy documents, strategic plans and key performance indicator (KPI) reports. All of the documents sourced were readily available to the public and therefore, ethics approval was not required.

The selected documents were examined to identify how and why the policy had been implemented, as well as the implications of each policy for the nursing profession. An overview of the relevant federal and state government policy and annual reporting documents that were integral to this study are listed in Table 4.1.

4.3 Evaluation

Following the textual analysis of the primary documents, other supporting government documents were used to inform and contribute to the identification of discourses that have had an effect on Aboriginal and Torres Strait Islander entering and remaining in nursing. After the completion of the analysis, recommendations that were identified as potentially bolstering the numbers of Aboriginal and Torres Strait Islander people choosing nursing as a career, which are either supported or suggestions for future support, within government policy, are offered.
Table 4.1: Government Policy and Reports for Review

<table>
<thead>
<tr>
<th>No.</th>
<th>Author</th>
<th>Title of Text</th>
<th>Aim(s) of the Text</th>
<th>Relevance to Study</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Australian Government (2009)</td>
<td>Closing the gap on Indigenous disadvantage:</td>
<td>To provide information about the progress of government initiatives against the</td>
<td>As this is an early review of progress, the information acts as a baseline for</td>
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<td></td>
<td></td>
<td>The challenge for Australia</td>
<td>identified six COAG targets</td>
<td>future reports.</td>
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<td>2</td>
<td>Australian Government (2010)</td>
<td>Closing the gap: Prime Minister’s report 2010</td>
<td>To provide information about progress on the six specific targets to reduce the</td>
<td>Provides a snapshot view of the status of health inequity of Indigenous people of</td>
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<td></td>
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<td>gap in health inequity</td>
<td>Australia and the progress so far towards the six key targets. It notes that the</td>
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<td>majority of Aboriginal and Torres Strait Islander people live in Queensland and</td>
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<td>NSW however the focus of the report is centred on disadvantage in the Northern</td>
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<td></td>
<td>Territory and Western Australia. Similarly the focus is also around remote and</td>
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<td>regional areas as opposed to where the majority of Aboriginal and Torres Strait</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Islander people live.</td>
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<td>3</td>
<td>Australian Government (2011)</td>
<td>Closing the gap: Prime Minister's report 2011</td>
<td>To provide information about strategies that support progress in achieving the</td>
<td>This report provides an update on progress towards the COAG targets however there</td>
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<td></td>
<td></td>
<td></td>
<td>targets as set within the COAG document</td>
<td>in no new data. Data is repeated from the previous report.</td>
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<td>4</td>
<td>Australian Government (2012)</td>
<td>Closing the gap: Prime Minister’s report 2012</td>
<td>To provide information about strategies that support progress in achieving the</td>
<td>A progress report providing an outline of the strategies in place to aid with</td>
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<td></td>
<td></td>
<td></td>
<td>targets as set within the COAG document</td>
<td>achieving the targets set. There is little change in the evidence presented that</td>
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<td>demonstrates</td>
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<td>Relevance to Study</td>
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<tr>
<td>5</td>
<td>Australian Government (2013)</td>
<td>Closing the gap: Prime Minister’s report 2013</td>
<td>To provide information about strategies that support progress in achieving the targets as set within the COAG document</td>
<td>A progress report that indicates a significant decline in Aboriginal and Torres Strait Islander mortality rates (adult and children) however the gap remains constant. The report suggests that health for all Australians has improved leading to poor performance in this KPI. This document also indicates that completion rates in high schools (year 12) has improved. Employments rates had also improved, with the gap narrowing between the Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander working aged population.</td>
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<td>6</td>
<td>Australian Government (2014)</td>
<td>Closing the gap: Prime Minister’s report 2014</td>
<td>To provide information about strategies that support progress in achieving the targets as set within the COAG document</td>
<td>A progress report which states that the gap in life expectancy had reduced between the Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander people. Two KPI’s were amended with a change to the timeframe for education outcomes. It was noted in this report that</td>
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<tr>
<td>7</td>
<td>Australian Government (2015)</td>
<td>Closing the gap: Prime Minister’s report 2015</td>
<td>To provide information about strategies that support progress in achieving the targets as set within the COAG document</td>
<td>the gap in employment rates had now widened as a result of less Aboriginal and Torres Strait Islander people working within CDEP programs. This may be as a result of a change in government priorities and allocation of funding.</td>
</tr>
<tr>
<td>8</td>
<td>Commonwealth Government of Australia (2007)</td>
<td>National strategic framework for Aboriginal and Torres Strait Islander health 2003–2013</td>
<td>To recognise the significant health disadvantage of Indigenous people and outline a plan for a primary health care initiative to improve Indigenous peoples’ health.</td>
<td>Identifies key priority areas that require focus and outlines strategies within the implementation plan. These priority areas were seen as key indicators to improve the health of Aboriginal and Torres Strait Islander people. This included expanding the Indigenous health workforce in primary health care with a focus on chronic disease management. It also identifies that the general health workforce needs to have the cultural skills to assist Aboriginal and Torres Strait Islander people to improve health outcomes.</td>
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<td>No.</td>
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<td>9</td>
<td>Commonwealth of Australia (2016b)</td>
<td>Closing the gap: Prime Minister’s report 2016</td>
<td>To provide information about progress in achieving the targets as set within the COAG document</td>
<td>There is a change in the dialogue in this report. It indicates that efforts should be focused toward where the majority of Aboriginal and Torres Strait Islander people live rather than perpetuating the stereotype that Aboriginal and Torres Strait Islander people live in remote areas. It blames poor education results on poor quality teaching.</td>
</tr>
<tr>
<td>10</td>
<td>Commonwealth of Australia (2017)</td>
<td>Closing the gap: Prime Minister’s report 2017</td>
<td>To provide information about progress in achieving the targets as set within the COAG document</td>
<td>Many of the targets either are not on track to meet the end target or will remain unmet. This may have an impact on the recruitment of Aboriginal and Torres Strait Islander people into the health workforce and specifically nursing if the Closing the Gap policy is abandoned or significantly modified.</td>
</tr>
<tr>
<td>11</td>
<td>Council of Australian Governments (2008)</td>
<td>National partnership agreement on closing the gap in Indigenous health outcomes</td>
<td>To outline the agreement between the states of Australia and the Commonwealth Government to improve the health and well-being of Indigenous people of Australia</td>
<td>This is the primary document that identifies the six core targets for closing the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians</td>
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<td>12</td>
<td>COAG (2010)</td>
<td>National partnership agreement on hospital and health workforce reform</td>
<td>To outline improvements in the efficiency of the health system that will improve and develop capability and capacity in the health workforce</td>
<td>As a supporting agreement that will influence change in the nursing workforce, provides the KPIs required to demonstrate the efficiency of health services and</td>
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<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
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<td>13</td>
<td>COAG (2012a)</td>
<td>National agreement for skills and workforce development</td>
<td>To outline the need to improve the national training system, to enable it to provide working-age Australians with the skills and knowledge required to participate in the labour market and thus contribute to building Australia’s economic future</td>
<td>As a supporting agreement to the national agreement on improving Aboriginal and Torres Strait Islander health outcomes, outlines KPIs that will support progress in building a skilled workforce and improved economic participation for all working-age Australians.</td>
</tr>
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<td>14</td>
<td>COAG (2012b)</td>
<td>National Indigenous reform agreement (Closing the Gap)</td>
<td>A strategic government document that aims to support the 2008 COAG national partnership agreement, supporting and shaping the way forward to meet the identified COAG targets</td>
<td>Outlines ‘building blocks’ or key focus areas to enact social change and improvements in Aboriginal and Torres Strait Islander disadvantage within the Australian context. Provides information on subsequent national agreements that support the original COAG agreement.</td>
</tr>
<tr>
<td>15</td>
<td>Health Workforce Australia (2011a)</td>
<td>Growing our future: The Aboriginal and Torres Strait Islander health worker project final report</td>
<td>To inform policies and strategies designed to strengthen and sustain the Aboriginal and Torres Strait Islander Health</td>
<td>Identifies equity in pay and conditions as a key factor that influenced Aboriginal and Torres Strait Islander Health Worker recruitment and retention efforts. This may</td>
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<tr>
<td>16</td>
<td>Health Workforce Australia (2011b)</td>
<td>National health workforce innovation and reform strategic framework for action 2011–2015</td>
<td>To provide a guideline for workforce reform across the education and health sectors, to meet current workforce demands</td>
<td>Notes that without a national imperative for system reform, changes in the health workforce cannot be realised, inhibiting efforts to close the gap in health outcomes for Aboriginal and Torres Strait Islander people and reduce their disadvantage.</td>
</tr>
<tr>
<td>17</td>
<td>Health Workforce Australia (2012)</td>
<td>Health workforce 2025: Doctors, nurses and midwives (Vol. 1)</td>
<td>To encourage consideration of future health workforce reform to meet the needs of an ageing population, particularly in the education and training system’s capacity to produce more doctors and nurses and for equity in the workforce distribution (immigration being a temporary measure to address immediate shortfalls)</td>
<td>Notes that a coordinated approach among many sectors within government and private industry would be required to instigate the required health workforce reforms and achieve the projected outcomes. Mentions the need to increase the numbers of Aboriginal Health Workers but no reference made to the need for Indigenous doctors and nurses as part of the health workforce.</td>
</tr>
<tr>
<td>18</td>
<td>Health Workforce Australia (2014a)</td>
<td>Aboriginal and Torres Strait Islander health workers/practitioners in focus</td>
<td>To outline the role of the Aboriginal Health Worker and the need for this position</td>
<td>Provides a report on the educational qualifications and number of Aboriginal Health Workers within the Australian workforce and compares those numbers with other professional health fields. This will be useful as a comparison to nursing.</td>
</tr>
<tr>
<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
<td>Aim(s) of the Text</td>
<td>Relevance to Study</td>
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<tr>
<td>19</td>
<td>National Preventative Health Taskforce (2008)</td>
<td>Australia: The healthiest country by 2020: A discussion paper</td>
<td>To outline the Australian Government’s strategy to improve the health of the nation, with specific mention of the significant disadvantage and poorer life expectancy among Aboriginal and Torres Strait Islander people</td>
<td>Identifies the need for a skilled workforce to support health care strategies, but without specifically referring to the Aboriginal and Torres Strait Islander workforce.</td>
</tr>
<tr>
<td>20</td>
<td>Nursing and Midwifery Office (2016)</td>
<td>NSW Aboriginal nursing and midwifery strategy (webpage)</td>
<td>To indicate the intention to improve Aboriginal health by providing education and employment opportunities in the field of nursing and midwifery for Aboriginal and Torres Strait Islander people</td>
<td>Highlights a range of supportive measures such as nursing and midwifery scholarships and cadetship programs to support future and existing Aboriginal and Torres Strait Islander nurses to either enter or remain within the nursing and midwifery workforce.</td>
</tr>
<tr>
<td>21</td>
<td>Steering Committee for the Review of Government Service Provision (2011)</td>
<td>Overcoming Indigenous disadvantage: Key indicators 2011</td>
<td>To provide outcomes and examples of programs and policies that have been demonstrated to improve health outcomes for Aboriginal and Torres Strait Islander people</td>
<td>Discusses a variety of programs including those within the health sector that may have an effect on health outcomes. The suggestion is put forward that providing opportunities for Indigenous Health Workers to upgrade their qualifications to other clinical roles such as nursing should be implemented.</td>
</tr>
<tr>
<td>22</td>
<td>Workforce Planning and Development (2016)</td>
<td>Good health – great jobs: Aboriginal workforce strategic framework 2016–2020</td>
<td>To provide a framework for health services to build and develop their Indigenous health workforce in both clinical and other roles.</td>
<td>Identifies targets and provides overarching strategies to increase the numbers of Aboriginal and Torres Strait Islander people employed by NSW Health; also...</td>
</tr>
<tr>
<td>No.</td>
<td>Author</td>
<td>Title of Text</td>
<td>Aim(s) of the Text</td>
<td>Relevance to Study</td>
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</tr>
</tbody>
</table>
| 23  | Workforce Planning and Development (2012) | Good health – Great jobs, NSW Health Aboriginal workforce strategic framework 2011–2015: Key performance indicator report July–December 2011 | To provide key priorities in increasing the proportion of Aboriginal and Torres Strait Islander people within the health workforce in NSW to 2.6% by 2015  
To support employment and retention of Aboriginal and Torres Strait Islander people through specifically designed processes  
To conduct a mapping exercise to show the NSW Health Aboriginal workforce by occupation, location, classification and salary level, to ensure workforce distribution matches community needs | Notes that on 31 December 2011, Aboriginal and Torres Strait Islander staff comprised 1.8% of the health workforce in NSW and in nursing, the rate was 0.8%; i.e., significantly below population parity and the proportion of Aboriginal and Torres Strait Islander people who are employed in total within NSW. |
4.4 Chapter Summary

This chapter has outlined each stage in the process of the critical discourse analysis for this study and its various steps. Adhering to this structural framework helped to reduce unconscious bias in the study. Utilising this structured approach helped to reveal both overt and covert messages that contributed to power imbalances between those who wrote the texts and those who were affected by the implementation of these policies. This is of particular relevance when considering the effect of government policy and its influence on Aboriginal and Torres Strait Islander people who may consider the nursing profession as a future career choice. The next chapter examines the language of these documents.
Chapter 5: LANGUAGE IN POLICY

‘The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.’

President Franklin D Roosevelt, Second inaugural address, January 20, 1937

In this chapter, the use of language within the text of the two primary policy documents is presented, specifically focusing on the linguistic analysis. Examining the use of words at a micro level within the policy documents (Johnson, 2011) will help in understanding the covert meanings within the text and discern whether any silent discourses are contained within the text (Fairclough, 2003; Foucault & Bouchard, 1980).

It is important that I acknowledge my cultural heritage as a Wiradjuri woman and accept that some of this interpretive analysis may be influenced by my personal experiences (Francis, 2013; Smith, 2007, p.4). Utilising the structured approach outlined in Chapter 4 helps to minimise this potential bias (Cope, 2014; Francis, 2013). However, I contend that my cultural heritage and lived experience as a Wiradjuri woman provides a lens through which understanding of the selected texts can be enhanced. In addition, as this study focuses on the nursing profession, which is a predominantly female workforce, it is important to acknowledge that throughout history, nursing has been viewed as a profession that is subservient to medicine (Tosh, 2007) and that the balance of power between men and women in Westernised culture has typically favoured men. Therefore, I wish to acknowledge that I am female, a RN and a Wiradjuri woman.

In undertaking this analysis, I acknowledge that my preconceived ideas could influence my interpretation of the data as I attempt to provide an impartial analytical understanding of government policy that has affected Aboriginal and Torres Strait Islander people and the nursing profession.

5.1 Corpus Linguistics

Corpus linguistics is the first stage in the four-stage approach to critical discourse analysis (Fairclough, 2015). It involves the identification of key phrases, terms or words that may be used within a text more frequently than in the normal discourse of language (Ruiz,
2009). As a process method in critical discourse analysis, this allows for identification of patterns, assumptions or contradictions in the language used within a text. Fairclough (2003, 2015) asserts that even though it is not a true form of critical discourse analysis, it is a tool that can be used to interpret a text when conducting a critical discourse analysis.

Identifying patterns, as a component of corpus linguistics, can be described further as either collocations or concordances (Fairclough, 2015). Collocation is the repetition of words and phrases, within a set number of words that occur more frequently than would be expected in normal discourse. Concordance is the repetition of specific words, or collections of words, within a text. Adopting a quantitative approach, focusing on the statistical aspect of corpus linguistics by concentrating on the repetition of words and or phrases, grammar and semantics is useful as a form of content analysis. However, the view adopted for this study is that the linguistic analysis of the text could identify elements of social events or practices (Fairclough, 2010, 2015; Ruiz, 2009).

5.1.1 Strategy or policy?

The Australian Government action to improve the health of Aboriginal and Torres Strait Islander people is commonly referred to as the Closing the Gap policy or strategy; however, these words do not appear within the first seminal document, ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008). The word ‘strategy’ is used in the second seminal document, ‘National Indigenous Reform Agreement (Closing the Gap)’ (COAG, 2012b).

The first document is an agreement outlining the way the federal government proposed to work with state governments to improve the health of Aboriginal and Torres Strait Islander people. I find it interesting that the Aboriginal and Torres Strait Islander people of Australia, who were to be affected by this document, had no representation within the agreement, as only government representatives were signatories. There is no evidence of consultation with Aboriginal and Torres Strait Islander people within this document (COAG, 2008). As governments have the resources to make fundamental changes, I do not understand why governments believe they have the right to make decisions on behalf of Aboriginal and Torres Strait Islander people. However, I am mindful that the political Close the Gap Campaign was very active at the time that this document was created, with the summit between the campaign and government representatives occurring in 2008 (Aboriginal and Torres Strait Islander Social Justice Commissioner and the Steering
Committee for Indigenous Health Equality, 2008). While this was the likely source of information from which the targets were developed, I question why Aboriginal and Torres Strait Islander people were not party (as signatories) to the development of the Closing the Gap policy.

Under Australian law, agreements are considered legally binding contracts. They can be amended or varied if parties enter into dispute about the contents of the agreement (Arts Law Centre of Australia, 2012). To enforce or enact the Closing the Gap agreement, the document states that all signatory parties were to be held responsible or accountable for meeting the prescribed terms, with ‘reward payments’ withheld until they were met (COAG, 2008). This threat held in the structure of the language within these texts reinforces the power of one entity over another (Fairclough & Fairclough, 2012).

Reflection

*I wonder how, without any funding to achieve these goals, governments could resource any changes.*

It is noteworthy that the document, which is freely available through government websites, is signed by all states except Tasmania. The silent discourse here is that the absence of Tasmania as a signatory could imply that Tasmania is exempt, or not a party to the agreement, and therefore does not have a commitment to improving Aboriginal and Torres Strait Islander health. The reason for not signing the document is left without explanation and could be explained by a simple omission, a conflict between political authorities at a state or federal level. These are only assumptions and without any further evidence to explain this omission, nothing is certain and leaves the discerning reader to wonder why this occurred. However, this study focuses on NSW, which is clearly a willing participant in the national agreement.

5.1.2 Collocation and concordance

A close examination of the way language is used within these texts can facilitate an understanding of the silent discourses of which the reader may not be fully aware (Fairclough, 2003, 2010, 2015). As both of the seminal texts are government documents written by policy makers, it is unsurprising that some words are repeated more often than others (collocation).
The focus of these documents is to outline the way the governing body aims to improve the health of Aboriginal and Torres Strait Islander people. It is acknowledged that the overall health status of Aboriginal and Torres Strait Islander people as a population group is significantly lower than that of the non-Indigenous population within Australia. The use of certain words and phrases (concordance) within these texts implies that the author of these documents (the government) has the ability and power to make changes to the health and well-being of Aboriginal and Torres Strait Islander people.

The use of the word ‘Indigenous’ had the highest incidence of occurrence (594 and 999 times, respectively) within both documents, yet the use of the word ‘Aboriginal’ was used 10 times less (69 and 79 times, respectively). The agreed use of politically correct terminology when referring to Aboriginal and Torres Strait Islander people has been the subject of discussion for some time (NSW Health, 2004). Although Aboriginal can be used as a noun or an adjective, a derivative of the noun is Aborigine, which has been used in a negative way and is not acceptable vernacular (Korff, 2018; NSW Health, 2004). The word Indigenous avoids this confusion and is less likely to offend Aboriginal and Torres Strait Islander communities, setting the standard for government entities (Commonground, 2018; NSW Health, 2004). The terms Aboriginal and Indigenous sway in popularity as the preferred vernacular. Within this study, I have used the term Aboriginal and Torres Strait Islander people more frequently than Indigenous; however, these terms are synonymous in describing the same population group (please see this document’s Glossary for further explanation). The terms Indigenous and Aboriginal both refer to a wide and varied collective of Aboriginal and Torres Strait Islander cultures that have their own languages and customs. Therefore, the use of these terms within these seminal documents is less likely to cause offence to the wider community than are other words or terms that have been used in the past to describe this population group in an offensive or culturally insensitive way (Korff, 2018).

In the NVivo analysis, the words that appeared with a high frequency were ‘gap/s’ (209 and 208 times); ‘health/y/iер’ (179 and 373 times); ‘community/ies’ (206 and 327 times); ‘people’ (117 and 197 times); ‘children’ (99 and 100 times); and ‘close/ing’ (83 and 117 times). The use of the word ‘gap’ infers that a deficit exists, yet subliminally, the use of this word implies that gaps can be mended or filled. Use of the words ‘closing’ or ‘close’ (which appear most commonly near the word ‘gap’) suggests to the reader that the deficit can be reduced. Thus, the term ‘closing the gap’ engenders an emotive response as it
implies that there is something lacking that could be addressed. The words ‘community/ies’ and ‘people’ appear in the text at a high rate and often along with the words ‘health/y/ier’ and ‘gap’ (concordance). This suggests that this group’s general health and well-being is inadequate or unsatisfactory.

The word ‘children’ appears more often than expected in both texts, whereas the word ‘adult’ is not prominent. Focusing on children draws an emotive response from the reader, who is likely to accept that any actions implemented are the ‘right thing to do’ (Reyes, 2011). This strategy is enforced further in both documents with an emphasis on child mortality rates, which are higher for this population than for the general population, as shown in the following examples:

- to halve the gap in mortality rates for Indigenous children under five within a decade. (COAG, 2008, p.3)
- In the period 2002-2006, Indigenous children under five died at around three times the rate of non-Indigenous children. (COAG, 2012b, p.A17)
- Increased provision of maternal and child health services for Indigenous children and their mothers. (COAG, 2012b, p.A35)

Such a focus on children makes it more likely that public acceptance for the agreement would be more likely to occur, legitimising the planned action of ‘rescuing or saving’ such a vulnerable group. In this way, the policy document writers were seeking to gain support by drawing attention to a social imbalance (Reyes, 2011).

The word ‘jurisdiction’ was evident in both documents (6 and 65 times, respectively) and although this was not as frequent as other words, this is notable because the word itself carries connotations of power as seen in the following excerpts:

- This Agreement seeks to realise change in all jurisdictions for all Aboriginal and Torres Strait Islander peoples regardless of whether they live in urban, regional or remote locations. (COAG, 2008, p.4)
- Each State and Territory has developed costings for activity in their own jurisdiction independently. (COAG, 2008, p.14)
- The strategy requires jurisdictions to leverage Indigenous specific and mainstream funding agreed by COAG… (COAG, 2012b, p.5)
- Jurisdictions will contribute to regular meetings as a mechanism for ongoing accountability to review policies and programs. (COAG, 2012b, p.12)
In general, jurisdiction means to have the legal authority to make laws, rules or legal decisions and the power to enforce them (Federal Court of Australia, 2018). In these documents, jurisdiction consigns a level of responsibility or accountability to the assigned party to undertake an action. Within these texts, it is implied that power is held by the governing entity over the population group for which the action is being (or is meant to be) delivered. The implication, therefore, is that the population group, in this case the Aboriginal and Torres Strait Islander people of Australia, have less power to make change within their communities, as the power is held and reinforced by governments.

Another interesting term used within first seminal document is the term ‘culturally secure’, as shown in the following examples:

Primary health care: to significantly expand access to and coordination of comprehensive, **culturally secure** primary health care, allied health services and related services. (COAG, 2008, p.6)

Hospital and hospital-related care: to deliver better clinical outcomes through quality, **culturally secure** hospital and hospital-related services that include rehabilitation, allied health care and transition care case management. (COAG, 2008, p.6)

At the time that this document was written in 2008, awareness of cultural competency was gaining momentum (Betancourt, Green, Carrillo, & Ananeh-Frempong, 2003; Ranzijn, McConnochie, & Nolan, 2009). However, the writer of these seminal documents deliberately chose to use the term ‘culturally secure’ rather than ‘culturally competent’. This adoption of this phrase may imply that the actions outlined were to be enforced rather than implemented, or that perhaps it may mean to protect, which only reinforces the paternalistic view of the policy writer.

A range of other repeated words (e.g., performance, outcomes, improve, progress, leadership, funding, reform, targets, objectives, initiatives and action), which appear in both documents, are examined further in the ethnographic sociolinguistics section. As these terms could be considered jargon, in this study I have labelled them ‘political speak’ (Glynos et al., 2009). The way in which certain words such as ‘performance’, ‘targets’ and ‘outcomes’ are used within the text assumes that the reader is privy to a secret world of data and evidence that is not explained within the text, yet is used to justify the need for the agreement.
Within the Closing the Gap annual reports 2009 to 2017 (secondary-level documents; see Chapter 4), the frequency of certain words and terms in these are similar to those in the seminal texts. This is to be expected, as these documents aim to support the delivery of the agreement and the strategy. Even though they may not have been written by the same person, the style of writing and the use of political speak are similar. The only notable exception is the significant reduction in the term ‘jurisdiction’ (Australian Government, 2009, 2010, 2011, 2012, 2013, 2014, 2015; Commonwealth of Australia, 2016b, 2017). This can be explained in that these documents serve different purposes. The two seminal documents, the agreement and the strategy, outline objectives and scope, whereas the subsequent annual reports provide a snapshot of progress towards the intentions of the agreement and the strategy.

I have included two word clouds (see Figures 5.1 and 5.2) as a visual representation of the frequency of words within the seminal texts. The prominence of some words indicates a higher occurrence of those words. These images assisted my analysis of the texts to support the statistical analysis obtained through NVivo.
Figure 5.1: Word Cloud for ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008)

Figure 5.2: Word Cloud for ‘National Indigenous Agree Reform Agreement (Closing the Gap)’ (COAG, 2012b)
5.1.3 Assumptions and contradictions

When analysing a text, it is useful to examine the presence of assumptions within the language used. Interrogation of the document to identify any specific language used highlighted that there was an assumption that readers would have an understanding of the social contexts that existed when the document was written and/or would be familiar with the language that was particular to this social group, in this case political rhetoric (Fairclough & Fairclough, 2012; Fairclough, 2010). This could be confusing to readers when no explanation or glossary was provided to define terms or statements used throughout the documents. The following example is provided from the first seminal document (the agreement):

broadest possible spectrum of government action. (COAG, 2008, p.3)

A reference to something as vague as ‘broadest possible spectrum’ may leave the reader wondering what might be included here. The document indicated that the government would access all available means to enact this agreement, which seems highly idealistic and unrealistic. This vague terminology allows the writer to indicate that a lot will be done without specifying what will be done; thus, they cannot be held accountable for future performance, whether good or bad.

In the next example, the reader is left to ponder whether there had been any sustainable outcomes in the past:

Investment in health care will be complemented by measures designed to maximise the impact of this investment through both prevention and followup, and together produce more sustainable health outcomes for Indigenous people. (COAG, 2008, p.4)

Here, the writer has indicated that sustainable outcomes from past efforts were insufficient and that their intent now, in using the term ‘more sustainable’, is for their future efforts to be far superior to those provided in the past. However, there is no clear indication of what these past efforts were, nor what they would be in the future to make them ‘more sustainable’. Within the primary document, it is only implied that data are available to demonstrate these poor health outcomes. The first annual government report on the Closing the Gap agreement provides some data to support the claim; however, it acknowledges that data collection needs to be improved to allow a clearer picture of the
current health status of Aboriginal and Torres Strait Islander people (Australian Government, 2009).

There are two possible explanations for this: either the previous governments did not wish to know what the alleged state of Indigenous health outcomes in Australia was, or it was assumed there was sufficient data to illustrate an urgent need for action. While the first seminal document noted that ‘research’ showed statistical data to support the claim that health outcomes were poor (COAG, 2008, p.4), there was no acknowledged source for this data.

Reflection

If the data was inaccurate, then were the targets that were set within the agreement reasonable and achievable?

The second seminal document reinforces these claims of alleged health disparity, seeming to support the declaration that previous outcomes had been insufficient (COAG, 2012b, pp.10–12). This strategy document indicates that baseline data, meaning a starting point, would be obtained from 2004 to 2011, to provide evidence that the agreed targets from 2008 would demonstrate a level of improvement.

The following example indicates that at the time of developing this policy, changes to the existing health workforce were required. Any change to the health workforce would have the potential to affect the nursing profession, which is the focus of this study. There is an assumption that the reader of this text has an intimate knowledge of current workforce systems. As the potential impact of this document has a wider audience than those who work within government this could demonstrate an imbalance of power where knowledge is withheld:

**Sustainability:** to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models. (COAG, 2008, p.6)

Here, the writer is acknowledging that the workforce practices of that time were not meeting the needs of Aboriginal and Torres Strait Islander people and that changing the health workforce would have an effect on health outcomes. This text assumes that the
reader has an intimate knowledge of the evidence to support this statement, as there is no reference to literature to support these assertions. To increase the number of Aboriginal and Torres Strait Islander people within the health workforce implies that this alone could be the solution for future practice and the literature certainly supports increasing this representation (Best & Stuart, 2014; Indigenous Nursing Education Working Group, 2002; West et al., 2010). However as numbers remain low, there is no tangible evidence that this approach would realise change. Sustainability will require both Aboriginal and Torres Strait Islander and non-Indigenous employees within the health sector to work collaboratively to improve health outcomes ensuring responsibility is shared. This could also potentially eliminate blame being directed at one specific group when workforce reforms and funding models are either not sustained or withdrawn by the decision makers.

In the following statement, the writer implies that Aboriginal and Torres Strait Islander people would accept changes in the way health care was delivered and that they had an expectation that what was currently in place should be ‘fixed’. There is no indication in the documents regarding which groups of Aboriginal and Torres Strait Islander people would be consulted with either prior to, or during the development and implementation of, the agreement. The document implies that the level of engagement with Aboriginal and Torres Strait Islander communities will be improved by the agreement (COAG, 2008). Once again, this reinforces a paternalistic view that the government has the sole responsibility and accountability for this population group, indicating that they have the power to make the change ‘to’ rather than ‘with’ Aboriginal and Torres Strait Islander people:

Fixing the gaps and improving the patient journey (COAG, 2008, p.7)

Improved level of engagement between Aboriginal and Torres Strait Islander patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes. (COAG, 2008, p.7)

Reflection

With such a large number of Aboriginal and Torres Strait Islander groups, I am left wondering how this would be achieved.

Using deficit language such as ‘fixing’ places the reader in a ‘rescuer’ position, as this indicates that by changing the delivery of health care, the gaps in health outcomes would
be reduced. Moreover, there is an assumption that Aboriginal and Torres Strait Islander people would be compliant with any implemented changes. The paternalistic view portrayed in the document and the lack of Aboriginal and Torres Strait Islander voices are a warning to the discerning reader about the balance of power within this document and its effect on this population group.

Within the second seminal document (COAG, 2012b), the writer indicates that working in partnership with ‘interested parties’ would be a way forward and again, makes the assumption that Aboriginal and Torres Strait Islander people and communities would be compliant. The ‘interested parties’ could be a range of different groups, from Aboriginal and Torres Strait Islander communities to businesses (who may or may not be Aboriginal and/or Torres Strait Islander led) in a range of employment sectors. Using the term ‘interested parties’ means the parties with which they intended to engage was not specified.

**Reflection**

*I am left wondering, once again, about the level of consultation with Aboriginal and Torres Strait Islander groups.*

There is a change between the first seminal document and the second seminal document in the dialogue with regard to the parties, other than government, that would have an interest in improving health outcomes. However, it is interesting to note that it took four years to progress from the original agreement to the second seminal document (the strategy). Even though the second seminal document had the potential to have a significant effect on Aboriginal and Torres Strait Islander people’s health, the lengthy time that elapsed between these two documents (being the agreement and the strategy) is a cause for concern. Perhaps a reaction from community and political groups to such social change contributed to this delay (Daley, 2018; Freri, 2014; Gooda & Parker, 2015).

Another useful way to analyse these documents is to probe for contradictions in language. An example of a contradiction, such as an oxymoron or statement that is unclear or contrary, can be seen within the first seminal document, which seems to counter the writer’s intent, such as:
**Reduced excess** mortality and morbidity among Aboriginal and Torres Strait Islander men. (COAG, 2008, p.6)

Here, the intention of the writer was to explain that death and disease rates are higher among males in this population group than in males of the non-Indigenous group in Australia, yet while the word ‘excess’ implies a large amount, there is no suggestion of urgency to change this, which seems counter to the writer’s intent.

Another implied contradiction in the text is contained within the following extract:

On 2 October 2008, COAG agreed to six **ambitious** targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas. (COAG, 2008, p.3)

The word ‘ambitious’ suggests that the government believed these targets might not be achievable, thus providing an excuse at the outset for poor performance in the future.

An example of an assumption and a contradiction in the second seminal document leaves the reader to wonder what may have been in place previously:

Individuals and communities should have the opportunity to benefit from the mainstream economy — **real jobs**, business opportunities, economic independence and wealth creation. (COAG, 2012b, p.7)

This statement implies that Aboriginal and Torres Strait Islander people have never had a ‘real job’, or that jobs undertaken by Aboriginal and Torres Strait Islander people in the past have been only of token value. In addition, it implies that no Aboriginal and Torres Strait Islander person has had the opportunity to participate in the ‘mainstream economy’. To the contrary, there are many examples of successful Aboriginal and Torres Strait Islander people, such as Professor Tom Calma AO, diplomat, former Social Justice Commissioner and academic (Gigante, 2019); Dr Sally Goold OAM, the first Aboriginal registered nurse in NSW, author and one of the founding members of CASTIN (Goold & Liddle, 2015; National Australia Day Council, 2018); and Stan Grant, news and political journalist and television presenter (Indigenous Australia, 2019). Other success stories are evidenced in publicly available government reports (Australian Institute of Health and Welfare, 2010, 2011, 2012, 2013, 2014, 2015, 2016) and in publications that show Aboriginal and Torres Strait Islander people holding 'real jobs’ such as nursing (Deravin, Anderson, et al., 2017).
However, in contrast, there is evidence in government documents of the perpetuation of jobs that were not designed to be sustainable. One example is the Community Development Employment Projects (CDEP), which were specifically developed for Aboriginal and Torres Strait Islander people and were solely reliant on government funding (Australian Government, 2014; Steering Committee for the Review of Government Service Provision, 2011). It is no surprise to discover in subsequent annual reports that when government funding was no longer available, these jobs disappeared, contributing to the poor employment rates for Aboriginal and Torres Strait Islander people (Australian Government, 2014). When governments commit to this kind of short-term funding strategy, rather than to sustainable long-term initiatives, the term ‘real jobs’ becomes credible. Further discussion on creating employment pathways into professions such as nursing, to address the issue of ‘real jobs’, is provided in subsequent chapters of this thesis.

This linguistic analysis has demonstrated that the language of a document can influence the reader towards holding a particular view. Placing these terms within a social context allows further interpretation of these texts, as described in the next section.

5.2 Ethnographic Sociolinguistics

Ethnographic sociolinguistics is another approach adopted within critical discourse analysis that seeks to identify whether particular social groups have their own form of communication or language that is understood by that group (Fairclough, 2015). Another common term for this is ‘jargon’. In this study, political jargon is referred to as political speak. As mentioned in the previous section, there is evidence of jargon language in both of the primary seminal documents. As noted by Fairclough (2015), this can result in inequality between social groups, as the meaning of the words is not fully and equally understood by both parties.

An example of jargon in these documents is the term ‘health’. The Australian Government’s understanding of health includes all physical, emotional and social well-being (Australian Bureau of Statistics, 2006). For Aboriginal and Torres Strait Islander people, health encompasses not just an individual’s physical, social and emotional well-being but also their cultural well-being (National Aboriginal Community Controlled Health Organisations, 2018). Culture, kinship and connection to country are essential components of cultural well-being (Bourke, 1993). This illustrates that the context within
which words are used, as well as the duality of their meaning to specific groups, should be considered.

**5.2.1 Political speak**

Within both of the primary seminal documents, there were many frequently used words that could be considered jargon (performance, outcomes, benchmarks, activity, improve, progress, leadership, funding, reform, targets, analysis, reporting objectives, initiatives and action). Some examples extracted from both documents appear below:

Contribute to the achievement of **objectives** and **outcomes** under the National Healthcare Agreement or contribute to the aggregate pace of **activity** in progressing COAG’s agreed **reform** agenda, these **performance benchmarks** may be the subject of **analysis and reporting**. (COAG, 2008, p.11)

Contribute to the aggregate pace of **activity** in progressing COAG’s agreed **reform** agenda, these **performance benchmarks** may be the subject of **analysis and reporting**. (COAG, 2008, p.11)

Comprise an **analysis** of factors affecting **progress** and the sequence of causal effects and would inform the COAG Reform Council’s analysis of **progress** against the trajectories. (COAG, 2012b, p.12)

The context within which these words were used was framed to encourage the reader to believe that there would be accountability for implementing the signed agreement and that the agreement and strategy (including health workforce reform, a particular area of interest in this study), would change the status quo by holding all parties responsible for any and all action. The two seminal documents indicated that effecting these changes would prove to the nation that the government was trying to address the disparities in health status. In addition, both documents indicated that actions must be prioritised and that there would be consequences for not adhering to the agreement, as indicated in the statement below. In these excerpts, the exertion of power is evident and is reinforced by using political speak:

The Commonwealth will not make reward payments to the States and Territories until an independent assessment by the COAG Reform Council demonstrates that performance benchmarks have been achieved. Facilitation payments will not be paid to any State or Territory until the Minister has approved the implementation arrangements of that State or Territory. (COAG, 2008, p.5)

Achievement of these targets will be key precursors to $350 million of reward payments. (COAG, 2012b, p.B57)

The terminology used within these documents reflects a business orientation. With the repetition of words such as ‘targets’, ‘performance’ and ‘outcomes’ (often occurring
The Parties are committed to addressing the issue of social inclusion, including responding to Indigenous disadvantage. That commitment is embodied in the objectives and outcomes of this agreement. (COAG, 2008, p.3)

COAG agreed to six ambitious targets for closing the gap between Indigenous and non-Indigenous Australians. (COAG, 2008, p.3)

The use of jargon indicates that the writer assumes the reader has an intimate knowledge of this terminology; however, political speak has a reputation of saying a lot without saying too much (Fairclough, 2015; Johnson, 2011). Were these documents crafted to assure the nation that the government of the time would make these changes happen by adopting a non-negotiable stance, or was the strategy designed to provide a scapegoat/s if the targeted outcomes were not achieved?

Within the agreement, there is no indication that additional funding would be provided to assist in the achievement of these targets. However, it is clearly indicated that if these targets were not achieved, then funding to support the ongoing delivery would be withheld (COAG, 2008, p.4). Is it a realistic stance to expect that changes will be made without resourcing them adequately? Alternatively, is this a way to explain future failure, as non-achievement of performance benchmarks could be blamed on the lack of funding? It seems that funding would only be provided to groups that were successful in achieving targets, yet could lack of success be the result of the lack of prior funding, and could success hinge on being adequately resourced?

To make sustainable differences to the long-term health status of Aboriginal and Torres Strait Islander people, effecting changes in the social determinants of health would be a long-term strategy (Marmot, 2011). However, in both of the seminal documents, the focus is on achieving measurable outcomes within set periods. This removes the human factor by indicating that the problem would be solved if the government could reach the indicated targets. This does not take into account the people who are most affected by the implementation of these targets (Aboriginal and Torres Strait Islander people and communities), the health system and other government departments tasked with the responsibility of implementing the required changes. As seen in supporting annual performance reports, several of the targeted outcomes required later modification when it

5.3 Chapter Summary

Conducting a linguistic analysis of the texts allowed this researcher to identify the presence of overt or covert messages that may be hidden within the policy documents under review. These documents showed evidence of jargon (political speak), which can be confusing to the uninitiated reader, who may not understand such nuances. Word repetition has been employed to guide the reader towards a particular view in support of correcting a social wrong (Fairclough, 2010).

Overall, the consistently paternalistic stance evident within these documents raises concerns about the potential level of success of the policy, particularly when there is a power imbalance between the government entities (federal and state levels) expected to resource the anticipated changes. Also evident is the power imbalance between those who have the resources to make the change and those who would be most affected by the change, the Aboriginal and Torres Strait Islander people and communities. The effect that the Closing the Gap policy has had, and will continue to have, on generations of Aboriginal and Torres Strait Islander people requires further examination, as well as the way this has influenced the nursing profession. These issues are discussed in the ensuing chapters.
Chapter 6: POLICY AND POWER

‘Reconciliation means bringing two cultures together: maru munu piranpa tjun-gurin-ganyi: black and white coming together. The two laws need to become one to keep the land.’

Nganyinytja, Aboriginal Elder, Pitjantjatjara (date unknown)

To understand the reasons for the implementation of the Closing the Gap policy, a review of the events that were the impetus for its development is important. As an approach to critical discourse analysis, a retrospective or historical review is useful in identifying inconsistencies or inequalities related to the perceived or actual power of one group over another (Fairclough, 2015; Glynos et al., 2009). In this study, the two seminal documents were examined to determine whether there were any power dynamics existing between the groups within the specific social context: the writers of the policy and the group that the documents sought to influence (Aboriginal and Torres Strait Islander people).

6.1 The Relationship Between Government Policy and the World and Community for Which it was Created

To consider why policies are developed, what do they aim to do and for whom are they developed, helps us to understand the relationship that may or may not exist between groups within a social context (Fairclough, 2015; Glynos et al., 2009). Governments are formed to create, enact and enforce laws and rules and have the overall responsibility and authority to ensure that the ‘common good’ is provided for all citizens who reside within its geographical boundaries (Australian Government, 2016). The Australian system of government is based on the British legal and parliamentary system, despite the fact that the British were not the first to live in or ‘discover’ Australia. However, they were the first European nation to claim ownership of the land and establish a government to rule, as part of a Commonwealth of Nations. Part of the process of being able to govern for this ‘common good’ requires the government to provide direction through laws, policies and agreements that are supported by funding to resource their implementation (Arts Law Centre of Australia, 2012; Australian Government, 2016). These laws and rules are provided for the benefit of the community, to ensure fairness and to protect human rights (Attorney-Generals’ Department, 2018).
As previously established in this thesis, the Closing the Gap policy is a national agreement between both levels of government (federal and state), which was developed in response to a national and global outcry about the treatment and health status of Aboriginal and Torres Strait Islander people within Australia (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Australian Human Rights Commission, 2010; National Preventative Health Taskforce, 2008). As this government document is an agreement, it is a legal contract between these two government entities to work towards a predetermined goal, in this instance the improved health of Aboriginal and Torres Strait Islander people (Arts Law Centre of Australia, 2012). Examples of where the policy writer has indicated that there is a need for a change are illustrated below:

The Parties are committed to addressing the issue of social inclusion, including responding to Indigenous disadvantage. That commitment is embodied in the objectives and outcomes of this agreement. (COAG, 2008, p.3)

Through this Agreement, the Parties agree to work in partnership to contribute to closing the gap in health outcomes and achieving key goals as agreed by COAG by implementing initiatives under the following five priority areas. (COAG, 2008, p.5)

In addition, the policy writer indicates that with the implementation of this policy, the government has the power and authority to affect the outcomes of an identified population group and therefore, affect the ‘common good’ for this population:

This Agreement comprises a package of health reforms that are consistent with the evidence, which broadly acknowledges that to overcome Indigenous health disadvantage, a holistic life stage approach is required that builds sustainable social change and embeds system reform. (COAG, 2008, p.4)

Here, the policy writer acknowledges that Aboriginal and Torres Strait Islander people are disadvantaged. This indicates that the government acknowledged that the welfare of this population group had not had an equal share of the ‘common good’. While change to social policy and systemic reform would be required to correct this, a significant effort through a multidimensional approach is needed (Deravin, Francis, & Anderson, 2017). This travesty is further reinforced in the second seminal document, which contains the same and consistent message:

COAG recognises that overcoming Indigenous disadvantage will require a long-term, generational commitment that sees major effort directed across a range of strategic platforms or ‘Building Blocks’ which support the reforms aimed at Closing the Gap against the six specific targets. (COAG, 2012b, p.4)
All of the Parties will work co-operatively to realise the objectives and commitments made in this Agreement, including, where agreed by the Parties, through the development of Overarching Bilateral Indigenous Plans under this Agreement (incorporating implementation plans developed under all Indigenous specific National Partnerships). (COAG, 2012b, p.8)

Once again, the writer indicates that all parties should work together and a number of policies, plans and agreements would be developed to support this change. Again, I am left wondering why Aboriginal and Torres Strait Islander people were not signatory parties to this agreement. Since European colonisation, Aboriginal and Torres Strait Islander people have been subject to a variety of government policies such as Protection, Control and Assimilation policies that were implemented from the 1830s to the 1960s for this group’s general welfare (Australian Human Rights Commission, 2009). However, in reality, the Aboriginal and Torres Strait Islander experience of government policy has not always been favourable (Australian Human Rights Commission, 2009; Australian Law Reform Commission, 1986; Kelly, 1975; McCallum, 2011; United Nations [UN] General Assembly, 2007).

6.2 History Shapes the Present

To gain an understanding of the current reality, it is necessary to consider the actions of the past through a historical perspective. Events that have occurred through history have an influence on the present. Existing social relationships have been sculpted by history. To understand the power dynamics between certain groups, it is important to examine what may have occurred previously, as the past shapes the existing reality. In undertaking this analysis on the nominated policy documents, it was crucial to understand the impetus for the development of this policy by looking for both dominant and silent discourses within the texts (Fairclough & Fairclough, 2012; Fairclough, 2015).

6.2.1 Impetus for the Closing the Gap policy

Understanding the circumstances that led to the compilation of the two seminal documents being analysed in this study was essential to this research. As noted in Chapter 1, the Social Justice report that was published in 2005 and the subsequent UN (2007) Declaration on the Rights of Indigenous People drew significant attention, both nationally and globally, to the existing health disparity between Aboriginal and Torres Strait Islander and non-Indigenous people in Australia (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; United Nations General Assembly, 2007). In fact, in
2016 the Aboriginal and Torres Strait Islander people of Australia were identified as having among the worst health status of any known Indigenous population globally (Anderson et al., 2016). The global outcry after the Social Justice report drove governments into action and was the impetus for the development of both the agreement (COAG, 2008) and the strategy (COAG, 2012b). Multiple reports and further policy documents were then developed to support the national agreement and strategy, as a way to enact the agreement and provide a way forward to address this disparity in health outcomes, including ways to increase the Aboriginal and Torres Strait Islander health workforce. An example in NSW was the updated policy document titled ‘Good Health – Great Jobs, Aboriginal Workforce Strategic Framework 2016–2020’ (Workforce Planning and Development, 2016).

With the inception of the Closing the Gap policy, the government of the time was acknowledging that it had a moral obligation to improve the health of Aboriginal and Torres Strait Islander people. It seems that it was not until this issue was raised at both the national and international level that the plight of Aboriginal and Torres Strait Islander people in Australia was brought to the attention of the wider community (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; United Nations General Assembly, 2007). Was the government shamed into taking action when it was highlighted on the world stage that the health outcomes for Aboriginal and Torres Strait Islander people in Australia were, in fact, similar to health outcomes in third-world countries? For a Westernised culture that prides itself on being a ‘lucky’ country, being compared to a third-world country may have caused some level of embarrassment (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Anderson et al., 2016).

Developing a government policy to provide an overarching direction in addressing the inequity in health outcomes and social disadvantage would seem to be a way of correcting this imbalance. However, it is questionable whether the intended outcomes of the policy could ever come to fruition, as government priorities change depending on who holds political dominance at any given time.

To be successful, initiatives such as Closing the Gap require resources to support their implementation. The federal government has the authority to distribute funds to support the agreement; the responsibility for achieving the outlined targets lies jointly with both the federal and state governments. Yet the strategy document contains the threat of
withholding funds from federal to state government should achievement of the outlined targets not be met:

Facilitation payments will not be paid to any State or Territory until the Minister has approved the implementation arrangements of that State or Territory. (COAG, 2008, p.5)

After reviewing the two seminal documents, I am left questioning, once again, the motives for developing the agreement. Government assumes all power and responsibility for the health of the Aboriginal and Torres Strait Islander population and clearly indicates that if targets are not met, then there will be penalties. If governments fail to deliver on the expected outcomes, they will not receive the financial assistance required. The group who would suffer the most from this lack of support is the Aboriginal and Torres Strait Islander people. This seems to be counter to what the federal government is asking state governments to facilitate and be responsible for, in enacting the change to improve health outcomes.

One of the challenges in implementing the Closing the Gap policy is maintaining the support of the successive governments who hold the power to enforce the agreement. When expected outcomes are not realised, it seems that shifting the blame to previous governments who have held power is a way of excusing poor performance. This continual shifting of blame is common in political rhetoric, when one entity wishes to claim that they are better than the other entity. However, where does that leave the people who are affected by the policy? The following text does not engender hope that significant change will be seen that realises improved health outcomes for Aboriginal and Torres Strait Islander people:

Despite the concerted efforts of successive Commonwealth, State and Territory governments to address Indigenous disadvantage, there have been only modest improvements in outcomes in some areas such as education and health, with other areas either remaining static or worsening. (COAG, 2012b, p.4)

It appears that the paternalistic view of government being able to remedy the situation is perpetuated in government documents. In the following examples, it is clear that the government believes it has the ability to guide the way people and communities should live their lives to improve their own health and well-being, which again perpetuates a system of government paternalism. The writer indicated that consultation had occurred with leading Aboriginal and Torres Strait Islander individuals, but as noted earlier, this appears to have been only nominal. The following excerpts are indicative of a system that
supports the view that the government knows what is best for the people and communities that they serve:

The Closing the Gap agenda was developed in response to concerns raised with governments by Indigenous and non-Indigenous persons, including through the Close the Gap Campaign and the National Indigenous Health Equity Summits. (COAG, 2012b, p.A16)

provide public leadership which encourages the community to recognise and embrace the importance of the nationally agreed outcomes for Indigenous Australians. (COAG, 2012b, p.9)

As the ‘National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes’ (COAG, 2008) is a government document, in the form of an agreement, the language used is formal, with legal terminology. As this is an agreement between government parties, the structure and rules of language are to be expected. What is notable, however, is that once again, governments are purporting a paternalistic view of what they believe is required to change a social wrong (poor health status), on behalf of Aboriginal and Torres Strait Islander people, as shown in the following excerpts:

In entering this Agreement, the Commonwealth and the States and Territories recognise that they have a mutual interest in improving outcomes in the area of closing the gap in Indigenous health outcomes and need to work together to achieve those outcomes. (COAG, 2008, p.4)

This Agreement seeks to realise change in all jurisdictions for all Aboriginal and Torres Strait Islander peoples regardless of whether they live in urban, regional or remote locations. (COAG, 2008, p.4)

There is no evidence that any Aboriginal and Torres Strait Islander representation or any leadership from Aboriginal and Torres Strait Islander communities agreed to the government making decisions on their behalf. Nor did they sign the original agreement or the subsequent ‘National Indigenous Agree Reform Agreement (Closing the Gap)’ (COAG, 2012b). The documents noted only that consultation would occur in the future.

Reflection

How can something be national and represent a group when they have not participated in the designing of these agreements?
Clearly, in the next example, the policy writer indicates that government has the authority to determine the priority areas for the proposed work. As previously demonstrated throughout the two documents that are the focus of this study, the government had determined the areas that would require significant effort to effect change, yet there is little evidence of consultation with Aboriginal and Torres Strait Islander people to focus these efforts:

The disadvantage experienced by Indigenous people has many aspects. COAG has chosen to address fundamental interrelated issues. (COAG, 2012b, p.A17)

There is no justification provided in either document for speaking on behalf of the Aboriginal and Torres Strait Islander population. There is only an acknowledgement that because of previous government policies, the government of the day felt a responsibility to right a social wrong. However, would this have been the case if it had not been brought to the attention of the Australian people and in fact the world, through the Human Rights Commission? Was this a case of blaming and shaming, to bring attention to the plight of Aboriginal and Torres Strait Islander Australians? And was this a situation where the government of the time needed to be seen as doing the right thing, to gain public favour and increase popularity, which would support future re-election campaigns?

There is no doubt within these documents that government of the time was blaming the health status of Aboriginal and Torres Strait Islander people on previous governments and their associated policies, which had such a significant effect on Aboriginal and Torres Strait Islander people. To understand how this may have occurred, it is important to examine briefly the effect of colonisation, through European settlement, on the Aboriginal and Torres Strait Islander people of Australia.

6.2.2 Influence of colonisation

The reasons for Aboriginal and Torres Strait Islander people suffering from such a poor health status have been explained as being a result of colonisation, the effects of foreign settlement and the introduction of new diseases to which the previously established people of Australia (Aboriginal and Torres Strait Islander people) had little or no immunity (Dowling, 1997). Further, social inequities where this minority group has had limited power or control over decisions that affect their lives has contributed to this poor health status. Previous Australian governments have directed a wide range of policies that have had a significant effect on the Aboriginal and Torres Strait Islander population, such
as Protection, Control and Assimilation policies that have been in place in one form or another from the 1830s up until the 1960s (Australian Human Rights Commission, 2009). It is no surprise that once again, in seeking to ‘manage’ the Aboriginal and Torres Strait Islander population, the government of the day developed another policy that would have a significant effect on the lives of the people for whom it had determined it should manage (McCallum, 2011).

Historically, representation of Aboriginal and Torres Strait Islander people within the federal government has been limited. In 2017 there were three senators and two members of the House of Representatives (Gobbett, 2017), which represents 2.2% of the total number of politicians within the federal government. While Aboriginal and Torres Strait Islander people are now gaining these positions, the policy-making and decision-making processes in government have been undertaken historically by non-Indigenous. Consistent underrepresentation of Aboriginal and Torres Strait Islander people within the Australian Government contributes to their lack of voice at the level of decision making. This is further compounded by the lack of recognition of Aboriginal and Torres Strait Islander people within the Australian constitution as being ‘first nation’ people. In some of the Closing the Gap policy reports it is frequently mentioned that this needs to be amended; however, to date there has been no change (Australian Government, 2013, 2014; Commonwealth of Australia, 2016b). Unlike New Zealand, which has had four designated positions since 1867 for their Indigenous people (Maori) within their government (New Zealand Electoral Commission, 2018), Australia has no such designated allocation. As such there is continuing debate about recognising Aboriginal and Torres Strait Islander people within the Australian constitution.

Protectionist policies were introduced in the 1830s and resulted in Aboriginal and Torres Strait Islander people being moved to missions at various geographical locations, regardless of their natural cultural and family ties. These missions were established to segregate and control this population, with their own special laws to ‘protect the inhabitants’. Missions had their own separate education systems, curfews were imposed, bans on alcohol were enforced on Aboriginal people (but were not applied to non-Indigenous people), and there were no social benefits provided to support Aboriginal and Torres Strait Islander people living on these missions economically (Human Rights and Equal Opportunity Commission, 1997; Kelly, 1975; McCallum, 2011). Many of these missions were on special reserves outside main town limits or in remote areas, meaning
access to general welfare services, including health services, was limited (Australian Law Reform Commission, 1986).

These Protectionist policies were enforced until the 1930s, when the Assimilation policy was implemented. This policy stated that Aboriginal people who were not of ‘full blood’ should be absorbed into the general and wider community. This resulted in family units being destroyed, with children being taken away from their parents (the Stolen Generation) and placed in foster homes or institutions (Kelly, 1975; Latukefu, 2014). The psychological and physical effect of these policies is still felt by many Aboriginal and Torres Strait Islander people of today, with the loss of connection to culture and identity (Human Rights and Equal Opportunity Commission, 1997). These policies were introduced to make the ‘Aboriginal problem’ eventually go away (Australian Law Reform Commission, 1986).

With such shameful treatment of Aboriginal and Torres Strait Islander people through previous policy implementation in the past, it is reasonable to be sceptical about the intention of the current government policy, which continues with a paternalistic view of knowing what is best for the Aboriginal and Torres Strait Islander population. The government has the power and authority to implement policy and laws, yet the Aboriginal and Torres Strait Islander people have never signed a treaty accepting that the government has the right to make decisions on their behalf. As a conquered people, they are subject to the whims and laws of another culture that is very unlike their own. Throughout Australian history, since European colonisation, the voice of the Aboriginal and Torres Strait Islander population has been minimised. However, it seems that with the Closing the Gap policy, there is an opportunity for this situation to change. Effective engagement and consultation with Aboriginal and Torres Strait Islander groups would be required to enact this change. However, the Closing the Gap policy (both the agreement and the strategy) does not indicate that any robust or meaningful consultation occurred, nor with whom the government would engage. It is hard to see how the government could achieve the ‘genuine’ partnership noted in the following excerpt:

> in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services. (COAG, 2008, p.6)

As an after-effect of colonisation, some Aboriginal and Torres Strait Islander people have become isolated from their communities because of past traumas, yet they identify as
being of Aboriginal and/or Torres Strait Islander origin (Bennett, 2015). The first seminal document outlined who qualifies as being an Aboriginal and/or Torres Strait Islander person:

Aboriginal or Torres Strait Islander person: is a person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander and is accepted as such by the community in which he (she) lives. (COAG, 2008, p.5)

That is, the government determines who qualifies as an Aboriginal and Torres Strait Islander person and therefore, who can benefit from health initiatives created for the Aboriginal and Torres Strait Islander people. It appears that people who may consider themselves to be Aboriginal and Torres Strait Islander but are not accepted by their communities would not be included in the Closing the Gap government agreement and therefore, could be excluded from the health care arrangements embedded in the documents. In addition, by defining the parameters of being an Aboriginal and/or Torres Strait Islander person, discord may be created between Aboriginal and Torres Strait Islander people as they debate who is and who is not of Aboriginal and/or Torres Strait Islander descent (Bennett, 2015).

By gaining an understanding of what has happened in the past, we can begin to understand what has influenced the present (Fairclough, 2003). How, then, can the government successfully implement real change when they continue with their paternalistic view of knowing what is best for the Aboriginal and Torres Strait Islander population? How will this change occur and will it be effective?

### 6.3 Policy Implementation

The health and well-being of Aboriginal and Torres Strait Islander people has suffered from the implementation of previous government policy. Life expectancy and overall health outcomes are significantly poorer for them than for the general population (Anderson et al., 2016). The Closing the Gap policy seeks to improve the health of Aboriginal and Torres Strait Islander people; but how can this be achieved when there has been a long-standing mistrust of the government and its policies? Included in this mistrust is the experience of Aboriginal and Torres Strait Islander people within the health system and its ‘Western’ medicine (Fredericks, 2010; Nielsen et al., 2015; Stuart & Nielsen, 2011). The Closing the Gap policy aims to address the significant barriers that for many years have prevented Aboriginal and Torres Strait Islander people from
accessing health services and participating equally from an economic viewpoint. However, it is questionable that it will make any actual difference.

An overarching goal of both the agreement and the strategy is that government will determine how, where and when the policy will be implemented and under which terms:

In 2007–08, the Council of Australian Governments (COAG) agreed to a number of ambitious targets to Close the Gap in Indigenous disadvantage by improving outcomes between Indigenous and non-Indigenous Australians in the areas of life expectancy, health, education and employment. (COAG, 2012b, p.A16)

The following brief commentary, titled ‘Are Closing the Gap Targets Being Met?’, was published in the Australian Nursing and Midwifery Journal in 2017. It questions the success of the implementation of the Closing the Gap policy (see Figure 6.1). The journal is published by the Australian Nursing and Midwifery Federation, an industrial organisation that has a wide readership base and a strong political voice that represents nurses and midwives across Australia.
Figure 6.1: ‘Are Closing the Gap Targets Being Met?’ (Deravin, Francis, et al., 2017)
To implement any change, there needs to be leadership and concordance between all parties to work towards a common goal (Stanley, Malone, & Shields, 2016). The government has assumed responsibility for implementing this change by gaining agreement between government bodies and setting targets towards which it will work. Of particular interest to this study is the way the policy could motivate Aboriginal and Torres Strait Islander people to join the health workforce and in particular, nursing. The policy writer indicates that as part of a multifocal approach to effecting health reforms, developing an Aboriginal and Torres Strait Islander health workforce, and a health workforce that is culturally competent, is required, as shown in the following extracts:

Workforce strategies developed in partnership with Aboriginal and Torres Strait Islander communities to improve continuity of care and coordination with health services. (COAG, 2008, p.8)

ensure the ongoing development of a suitably skilled Indigenous workforce. (COAG, 2012b, p.9)

Hospital and hospital-related care: to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management. (COAG, 2008, p.6)

Strategies to improve the cultural security of services and practice within public hospitals. (COAG, 2008, p.8)

Pivotal to the success of the implementation of the Closing the Gap policy will be the supportive and subsequent health workforce strategies required to enact it. In the next extract, the policy writer indicates that the sustainability of a future Aboriginal and Torres Strait Islander workforce will be essential to assist health reform:

Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs. (COAG, 2008, p.6)

However, the actual success of government-led employment programs such as CDEP ceased when funding was redirected to other areas of priority in a change in government leadership. As shown in the next extracts, this program relied heavily on government funding, with a view to developing a skilled workforce and ensuring employment for Aboriginal and Torres Strait Islander people in the future (Commonwealth of Australia, 2016b):
Reforms to the Community Development Employment Projects (CDEP) Program and the Commonwealth Indigenous Employment Program (IEP), from 1 July 2009, ensure more Indigenous Australians have the skills they need to get and keep a job. The reforms see CDEP and the IEP working in partnership with employment services to provide greater support to Indigenous Australians in finding sustainable employment. (COAG, 2012b, p.A30)

creating real sustainable employment for up to 2,000 Community Development Employment Projects (CDEP) participants in areas of government service delivery that have previously relied on subsidisation through the CDEP program. (COAG, 2012b, p.B58)

This leads me to wonder that if no long-term funding is set aside to support initiatives for long-term change, and if the people at whom these policies and strategies are targeted are not involved or consulted regarding what they believe needs to change, then how successful will the Closing the Gap policy be?

6.4 Chapter Summary

Throughout history, population groups who are considered a minority group within a society have been subject to the power and authority of dominant groups such as the government. In Australia, the Closing the Gap policy provides a platform for Aboriginal and Torres Strait Islander people to gain recognition of existing health inequities and to provide an opportunity for change. The Aboriginal and Torres Strait Islander population has had little influence over government policy in the past and previous policies have contributed to the poor health outcomes experienced by Aboriginal and Torres Strait Islander people.

The Closing the Gap policy purports to have the best interests of the Aboriginal and Torres Strait Islander people as its primary intent, but how can this be realised when governments change, funding is never assured and the people who are the subject of the policy have not had a say, nor are official parties to the agreement. The policy writers of the two seminal documents under review indicated that they have learned from history that the government’s treatment of Aboriginal and Torres Strait Islander people needs to change and that a multifocal approach, incorporating areas such as employment, education and health, are essential in supporting this change.

If the government acknowledges that they need to learn from the past, then authentic inclusion of, and consultation with, Aboriginal and Torres Strait Islander people needs to be enacted, rather than spoken about in obtuse terms. The implementation of this policy
has had mixed results, as evidenced through the modification of the imposed targets set by government. With an ever-evolving change to the political landscape, I am left questioning how the policy will support Aboriginal and Torres Strait Islander people to improve their health and well-being and more specifically, how strategies to increase the number of Aboriginal and Torres Strait Islander people joining the health workforce (and specifically, nursing) will be supported and implemented through policy.
Chapter 7: SOCIAL ACTION OR INACTION

‘A good decision is based on knowledge and not on numbers.’

Plato (380 BC)

When conducting a discourse analysis, Fairclough (2015) advocates identifying and including evidence of dialectical argumentation. Building on the previous chapter’s discussion about the power of government to enforce policy, this chapter provides evidence of action towards social change and arguments either for or against the reasons for this social change. Through this process, evidence of the way the government policy (Closing the Gap policy), seeks to address the underrepresentation of Aboriginal and Torres Strait Islander people within the health workforce, and more specifically, in nursing, is established.

To achieve transformative action that supports social change, deliberation regarding the alternatives is required. According to Fairclough (2010), government decisions are based on relationships. Meaning can be gained by examining the way the relationships exist within a current reality. At this point, it is relevant to revisit Foucault’s three axes of discourse (explained in Chapter 3, Figure 3.1), to understand why certain decisions are undertaken. Fairclough (2010) draws on Foucault’s foundational work, explaining that to critique any social discourse, it is important to understand how the relationships between knowledge, power and ethics guide decision making. These relationships can influence or control actions either on or over ‘things’. In this study, the effect of this government policy on the number Aboriginal and Torres Strait Islander people joining the nursing workforce is explored in relation to these three axes.

In understanding how the three axes of discourse intersect, it is possible to attribute meaning to events that occur and gain an understanding of both the dominant and silent discourses that may come into play with the development and implementation of government policy (Fairclough, 2003). Dialectical argumentation is a form of explanatory critique in which events that determine why decisions are made are considered (Fairclough, 2015). This chapter offers an interpretation of dialectical argumentation and the events that may have influenced the decision making around the development and implementation of the Closing the Gap policy.
7.1 Policy in Action or Inaction – the Social Context

In Chapter 6, possible reasons for the ‘Closing the Gap’ policy being implemented were presented, based on a historical perspective. To understand what effects this policy could have, the way this policy is being enacted is examined and the reasons for making some choices rather than other alternatives are explored.

In deciding on the priority areas for its policy, COAG (the federal government) used the knowledge (axis of discourse) they had already gained to determine the changes that were required to improve the health of Aboriginal and Torres Strait Islander people. These priority targets (as listed in Chapter 1 Section 1.2) were set by the government. Interestingly, the policy writer noted that these goals were ‘ambitious’ (see Chapter 5 for further discussion on this aspect). The choice to focus on these targets was, perhaps, because of a belief that they were achievable and that focusing on the improved health and well-being of children would be well received by the wider community. The term ambitious could have duplicitous meanings depending on the context within which it is used. In this instance the policy writer may have meant that such goals were highly aspirational thus setting the scene for a positive and forward momentum that might facilitate the required social change. However, the word ‘ambitious’ subliminally indicates to the reader that they are possibly unachievable and provides an excuse for poor performance particularly when the reason for making this decision on targets is not fully explained.

In its paternalistic role, the federal government decided what areas should be the focus of its efforts to improve the health of Aboriginal and Torres Strait Islander people. The policy writer set the scene regarding the players who would be expected to participate in making the required changes, as outlined in the following extracts:

In entering this Agreement, the Commonwealth and the States and Territories recognise that they have a mutual interest in improving outcomes in the area of closing the gap in Indigenous health outcomes and need to work together to achieve those outcomes. (COAG, 2008, p.4)

The Parties are committed to addressing the issue of social inclusion, including responding to Indigenous disadvantage. That commitment is embodied in the objectives and outcomes of this agreement. However, the Parties have also agreed other objectives and outcomes – for example, in the National Indigenous Reform Agreement – which the Parties will pursue through the broadest possible spectrum of government action. (COAG, 2008, p.3)
In the agreement, both federal- and state-level government were considered the ‘parties’ that would make decisions on behalf of Aboriginal and Torres Strait Islander people. However, as identified in Chapters 5 and 6, what is notable is that representation from Aboriginal and Torres Strait Islander people was absent from the agreement. As established in Chapter 6, the government holds the power (one of the axes of discourse) to make decisions. Within government, parliament makes laws for the society it serves, the executive implements them and the judicial system enforces the rules and regulations. By doing this, government clearly indicates that it has the power to make decisions.

In the following extract, the policy writer noted that implementation of the Closing the Gap policy would be influenced by subsequent future agreements that the ‘parties’, being government, have made a commitment to, and on behalf of, the Aboriginal and Torres Strait Islander people of Australia. Yet there is no evidence that Aboriginal and Torres Strait Islander people had given this decision-making power to the government:

The National Indigenous Reform Agreement, like other National Agreements, is a living document subject to enhancement over time to reflect additions and changes to existing and new National Agreements and National Partnership agreements. (COAG, 2012b, p.3)

The policy writer then defined who would have responsibility and accountability for the improvements in health outcomes. Health services were identified as one of the major contributors that would have an effect on the policy and strategy. Health services in Australia are predominantly administered, funded and operated by government and they were tasked with implementing the following:

all governments need to make a concerted effort to work together, acknowledging the contribution that effective health care can make towards closing the gap. Investment in health care will be complemented by measures designed to maximise the impact of this investment through both prevention and follow up, and together produce more sustainable health outcomes for Indigenous people. (COAG, 2008, p.4)

Next, the policy writer indicated that it had the power to enforce changes and the knowledge (axes of discourse) to understand why these changes were required, as well as the expertise to know what would work best for the Aboriginal and Torres Strait Islander people of Australia. A threat within the document clearly indicates that there would be a consequence for failing to meet the identified targets. In doing this, COAG was enforcing the decision that these goals would be the only ones considered for action and that alternative targets were not within scope. COAG would withhold further funding unless
state governments embraced and implemented the already predetermined changes, as shown in the following extracts:

Facilitation payments will not be paid to any State or Territory until the Minister has approved the implementation arrangements of that State or Territory. (COAG, 2008, p.5)

The strategy requires jurisdictions to leverage Indigenous specific and mainstream funding agreed by COAG, and other existing resources, to improve Indigenous Australians’ outcomes in urban and regional areas. (COAG, 2012b, p.5)

As the federal and state government control the public health system, it is doubtful that any private health system, including profit-based aged care services, would consider that social inclusion and improved access and delivery of health care to Aboriginal and Torres Strait Islander people would be a priority (Deravin-Malone, 2017). In the following extracts, the policy writer indicated that all health services would need to comply, yet the government does not have a monopoly on all health services across the nation, even though they assumed here they had the power and knowledge to achieve change:

Making Indigenous health everyone’s business. (COAG, 2008, p.7)

All health services play an important role in providing Indigenous people with access to effective health care, and being responsive to and accountable for achieving government and community health priorities. (COAG, 2012b, p.6)

Once again, the writer has indicated that they knew best with regard to the key priorities to implement change that would result in improved health outcomes. Yet I am left wondering what gave them the right to speak on behalf of Aboriginal and Torres Strait Islander people, ignoring their right to their own sovereignty.

Reflection

Ethically (axis of discourse), is this an acceptable practice? By leaving this unchallenged, is the community at large being complicit to the dominance of one group over another?

Alongside the Closing the Gap policy and strategy that has been implemented in Australia by the federal government, a Close the Gap Campaign has been running simultaneously (Wright & Lewis, 2017). This campaign, supported by the Human Rights Commission,
seeks to raise awareness of the health disparity as well and it provides an independent commentary on the progress of the government policy and strategy, reporting on its success or failure to effect change for Aboriginal and Torres Strait Islander people. Within this campaign, Aboriginal and Torres Strait Islander people, represented by this high-level committee, have a platform to voice what they believe their needs are, as well as the priorities that are important to them. The Close the Gap Campaign highlights that the federal government has continually failed to listen to the recommendations from this group’s expert knowledge and experience of being Aboriginal and Torres Strait Islander people (Wright & Lewis, 2017). The ability of this group to influence decisions on health priorities for the people they represent continues to be minimised.

The next extract assumed that Aboriginal and Torres Strait Islander people wished to change their lifestyle, yet there was no concrete evidence provided in the documents to suggest that this was what Aboriginal and Torres Strait Islander people actually wanted. Once again, the government was taking on a paternalistic role, knowing what is best for this population group:

In addition this initiative will support life style changes by individuals, families and communities. (COAG, 2008, p.4)

In the next extracts, the policy writer implied (in a nondescript and undefined way) that future Aboriginal and Torres Strait Islander initiatives would be forthcoming with ‘consultation’, indicating that Aboriginal and Torres Strait Islander people would have a say in their own future direction. However, the silent discourse remains, that the government would make the decisions and be fully responsible and accountable for the required changes, based on the knowledge they had gained through ‘evidence’ (COAG, 2008):

This Agreement comprises a package of health reforms that are consistent with the evidence, which broadly acknowledges that to overcome Indigenous health disadvantage, a holistic life stage approach is required that builds sustainable social change and embeds system reform. Further, this proposal’s effectiveness will be influenced and supported by the successful implementation of other Indigenous initiatives. (COAG, 2008, p.4)

Improved level of engagement between Aboriginal and Torres Strait Islander patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes. (COAG, 2008, p.7)
Since European colonisation, there has been a lack of cultural understanding between the government that holds the power and the Aboriginal and Torres Strait Islander people (Downing et al., 2011; Mazel, 2018; Neville, Oyama, Odunewu, & Huggins, 2014). In the following extracts from the Closing the Gap policy recognises that understanding culture is an important and foundational step to implementing change within a social context (however, there is no mention of how this would be measured):

This Strategy acknowledges the importance of Indigenous culture, and engagement and positive relationships with Indigenous Australians. (COAG, 2012b, p.A16)

Assuming, promoting and supporting a strong and positive view of Aboriginal and Torres Strait Islander identity and culture are important ways to reduce social exclusion for Indigenous Australians and to support them in their endeavours and aspirations for a positive future. (COAG, 2012b, p.A19)

Cultural awareness and competency on the part of policy makers and people implementing government programs, the elimination of overt and systemic discrimination, and the development of programs that meet the cultural needs of Indigenous people will be an important part of the Closing the Gap initiatives. (COAG, 2012b, p.A19)

Changing embedded cultural attitudes requires significant effort, explanation, education and a willingness to change. While making an effort to recognise that there is an issue is a positive step towards bringing about change, this is a long-term strategy. Changing the government’s past attitude towards, and treatment of, Aboriginal and Torres Strait Islander people and the way they are treated currently, particularly in the health system, will require people to think differently and behave differently (Downing et al., 2011; Goold, 2011; Stuart & Nielsen, 2011). Within the ‘Closing the Gap’ policy, there is an opportunity to increase the awareness of cultural bias and discrimination, with the future prospect of implementing ways to overcome racism, fear and misunderstanding.

### 7.2 Addressing the Aboriginal and Torres Strait Islander Health Workforce Shortage

To support the wide range of initiatives that were generated by the initial Closing the Gap agreement and strategy, a number of policy and strategy documents and subsequent progress reports have been developed since the inception of the agreement in 2008. Examples of these have already been listed in Chapter 4, Table 4.1. The federal government’s aim to rectify the underrepresentation of Aboriginal and Torres Strait
Islander people within the health workforce was embedded within the Closing the Gap agreement and strategy, as shown in the following extracts:

Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs. (COAG, 2008, p.6)

Workforce strategies developed in partnership with Aboriginal and Torres Strait Islander communities to improve continuity of care and coordination with health services. (COAG, 2008, p.8)

Increase number and quality of training of Indigenous health workforce. (COAG, 2012b, p.A37)

Workforce strategies will have as core components the acquisition of recognised and accredited mainstream qualifications and articulated training pathways for Indigenous Australians. In particular, those reforms targeted specifically at the Closing the Gap targets should also support achievement of the target to halve the gap in employment outcomes. (COAG, 2012b, p.B59)

As nurses represent the majority of health professionals in the Australian health workforce, there is an opportunity within the Closing the Gap policy to examine ways to increase the numbers of Aboriginal and Torres Strait Islander people entering the profession. Further discussion on these possibilities is explored in Chapter 8. Clearly there is a need to increase the numbers of Aboriginal and Torres Strait Islander people within the health workforce as indicated in the agreement and strategy, and there is also a need for the existing and future workforce to address issues of cultural insensitivity. Increasing the representation of Aboriginal and Torres Strait Islander people within nursing can have a significant impact on changing the culture within the health sector and supports both the policy and the strategy’s intent. Another flow on effect which supports the importance of cultural awareness could also help address issues such as the perceived ‘whiteness in nursing (Stuart & Gorman, 2015). This was highlighted in both of the seminal documents under study, as shown in the following extracts:

Primary health care services that can deliver… Provision of improved cultural security in services, and increased cultural competence of the primary health care workforce. (COAG, 2008, p.7)

Strategies to improve the cultural security of services and practice within public hospitals. (COAG, 2008, p.8)
Evidence of implementation of cultural competency frameworks across the applicable health workforce. (COAG, 2008, p.10)

Primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services. (COAG, 2012b, p.6)

Aboriginal and Torres Strait Islander people have lower life expectancies than non-Indigenous people (Australian Bureau of Statistics, 2006, 2014). A key focus within the Closing the Gap policy agreement and strategy (see the following extracts) is increasing the engagement of Aboriginal and Torres Strait Islander Australians with ‘Western medicine’, to improve their health and well-being (Nielsen et al., 2015; Oliver, 2013; Reeve et al., 2015) and address areas of significant health disparity:

Ensure that primary health care services have the capacity to deliver the coordination and continuity of care necessary to meet the needs of Aboriginal and Torres Strait Islander clients. (COAG, 2008, p.8)

Primary health care services that can deliver – the Commonwealth and the States and Territories will work together to improve access to culturally secure primary health care for all Indigenous Australians, with improved access to quality primary health care through better coordination across the care continuum, particularly for people with chronic diseases and/or complex needs. (COAG, 2012b, p.B53)

While the gap in life expectancy has improved marginally since the introduction of the Closing the Gap agreement (Australian Government, 2010; Commonwealth of Australia, 2017), the incidence of chronic conditions has remained disproportionately higher in the Aboriginal and Torres Strait Islander population (Australian Health Ministers’ Advisory Council, 2017; Australian Institute of Health and Welfare, 2018; Deravin-Malone & Anderson, 2016). Nurses, as part of the health workforce, could have a significant influence on improving health outcomes in this area.

To achieve the aspiration of increasing the engagement of Aboriginal and Torres Strait Islander with Western health care, trust must be established. As a way to gain trust, the policy documents suggested increasing the representation of Aboriginal and Torres Strait Islander people within the health workforce. A number of supportive strategies were developed to work towards this, such as the ‘National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015’ (Health Workforce Australia, 2011b), the ‘National Agreement For Skills and Workforce Development’ (COAG, 2012a) and the ‘National Partnership Agreement on Hospital and Health Workforce
Even though there are a number of government policy strategies aimed at increasing the representation of Aboriginal and Torres Strait Islander people within the health workforce, being able to reach population parity has not been achieved since the inception of the Closing the Gap agreement (Australian Government, 2013, 2015; Australian Institute of Health and Welfare, 2016; Commonwealth of Australia, 2017). I am left wondering how long it might take to implement the required changes without continued support through funding and political favour, commitment from future governments and authentic engagement with Aboriginal and Torres Strait Islander people.

### 7.3 Effect of Government Policy on Nursing Today

Nurses work across a broad spectrum of health areas. As such, nurses are well placed to make significant differences to health outcomes, including for vulnerable populations in Australia such as Aboriginal and Torres Strait Islander people; those with chronic conditions and/or disabilities; the elderly; children; and other minority groups, such as non-English-speaking community groups (Miles, Latham, & Biles, 2016; Nursing and Midwifery Board of Australia, 2016a, 2016b, 2018). Within the Closing the Gap policy agreement and strategy, the writers clearly articulated the expectation that significant improvements were required within the health system to support the achievement of the required targets set by COAG for Aboriginal and Torres Strait Islander people. Some examples include the following:

- In genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services. (COAG, 2008, p.6)

- Improved access to quality primary health care through improved coordination across the care continuum, particularly for people with chronic diseases and/or complex needs. (COAG, 2008, p.7)

- Increased provision of maternal and child health services for Indigenous children and their mothers. (COAG, 2012b, p.A35)

Nurses are often the first point of contact for health care and can have a significant influence on the way Aboriginal and Torres Strait Islander people engage with health services (Miles et al., 2016; Stuart & Nielsen, 2011; West et al., 2010). Two strategies to assist with achieving the goals noted in the above extracts were increasing the number of Aboriginal and Torres Strait Islander people working in the nursing profession, and
fostering cultural awareness in those who do not identify as Aboriginal and Torres Strait Islander. In this way, addressing the ‘whiteness of nursing’ (Stuart & Gorman, 2015) that is experienced by Aboriginal and Torres Strait Islander people who are within nursing may change the perceived culture for those who may engage with health services. This may also in turn improve recruitment of Aboriginal and Torres Strait Islander people to the nursing profession. These goals, which have since been embedded in Australia’s nursing standards of practice (Nursing and Midwifery Board of Australia, 2016a, 2016b), are expressed in the following extracts:

Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and co-ordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs. (COAG, 2008, p.6)

increasing the number of Indigenous people in the health workforce; and promoting respect and understanding of Aboriginal and Torres Strait Islander cultures in the delivery of quality health care. (COAG, 2012b, p.B54)

Increasing the number of Aboriginal and Torres Strait Islander people in the nursing profession would require increased access to further education through financial support (scholarships) and/or educational support (mentors and tutors). The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) is an organisation, led by Aboriginal and Torres Strait Islander people, that employs a strengths-based approach to offer culturally appropriate education and a variety of scholarships specifically designed to support Aboriginal and Torres Strait Islander nurses and midwives to complete and participate in professional education (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2014). Even though CATSINaM is federally funded, much of this organisations’ success can be attributed to the fact that it is managed by Aboriginal and Torres Strait Islander people who lead a range of initiatives to support the growth of an Aboriginal and Torres Strait Islander nursing and midwifery workforce. As a leading voice in the nursing and midwifery industry, CATSINaM provides advice and support to the Nursing and Midwifery Board of Australia regarding the understanding of Aboriginal and Torres Strait Islander culture and cultural safety training, as well as advice regarding professional standards to which nurses and midwives should adhere (Nursing and Midwifery Board of Australia, 2016a, 2016b, 2018).
As a social determinant of health, having employment and an education can significantly affect the health and well-being of individuals (Marmot, 2011). The policy writers of the Closing the Gap policy and strategy documents implied that funding would be available to support these goals, as shown in the following extracts:

[To ensure sustainability within primary health care services will support more..] Aboriginal and Torres Strait Islander people in tertiary education for health related disciplines. (COAG, 2008, p.12)

Increased employment participation impacts positively on life expectancy. (COAG, 2012b, p.A35)

Pathways to real post-school options. (COAG, 2012b, p.A42)

Human capital development through education is key to future opportunity. Responsive schooling requires attention to infrastructure, workforce (including teacher and school leader supply and quality), curriculum, student literacy and numeracy achievement and opportunities for parental engagement and school/community partnerships. Transition pathways into schooling and into work, post school education and training are also important. (COAG, 2012b, p.6)

Again, the sustainability of funding programs to support these goals is reliant on the whims of political favour. In NSW, it is notable that other supportive strategies have taken direction from the Closing the Gap policy and strategy documents. These strategies include ways to increase the number of nurses within the health system, such as ‘Good Health–Great Jobs: Aboriginal Workforce Strategic Framework 2016–2020’ (Workforce Planning and Development, 2016), ‘NSW Aboriginal Nursing and Midwifery Strategy’ (Nursing and Midwifery Office, 2016).

At a tertiary education level, national policy guidelines inform education providers on ways to support Aboriginal and Torres Strait Islander people to undertake further education in health: for example, ‘Aboriginal and Torres Strait Islander Health Curriculum Framework’ (Commonwealth of Australia, 2016a). Further discussion on the success of these strategies is provided in Chapter 8.

Reflection

Will policy guidelines and strategy documents actually make any difference?
7.4 The Difference Between Policy and Reality (Nine Years Later)

The Closing the Gap policy provides a direction for improvements in society to reduce the disparity in health outcomes for Aboriginal and Torres Strait Islander people. The dominant discourse is that the government knows what is best for the Aboriginal and Torres Strait Islander people of Australia and has the power and resources to implement any prospective changes. This paternalistic view is perpetuated in current policy, with Aboriginal and Torres Strait Islander people having only a limited voice about the changes they believe are needed to improve the health of their own people and communities. With such a wide range of initiatives to address the required social changes to improve the health of Aboriginal and Torres Strait Islander people, accountability for the success or failure of this policy is held within the responsibility of different levels of government. Successive governments have blamed poor performance on the previous governments who held power (COAG, 2012b). Again, I am sceptical; if the targets are not achieved, will the blame be turned upon the people for whom this policy was developed?

Reflection

*If high-level and long-range targets are being amended or not met and the goalposts keep moving, how will this affect the health workforce and any initiatives that the nursing profession is trying to implement, or wishes to implement in the future?*

To understand whether the Closing the Gap policy has been successful or has failed, a progress review of the Closing the Gap policy and its implications for the nursing profession was undertaken, and published in the International Nursing Review journal in 2018. This article is presented in full in Figure 7.1.
Figure 7.1: ‘Closing the Gap in Indigenous Health Inequity: Is it Making a Difference?’ (Deravin, Anderson, & Francis, 2018)

Closing the gap in Indigenous health inequity – Is it making a difference?

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Aim: This paper will review progress towards the identified targets within the Australian government policy document commonly known as ‘Closing the Gap’ and examine the role of nurses in supporting its implementation.

Background: Australia is not alone in seeking to address the health inequity between Indigenous and non-Indigenous people. Globally such health inequities are similar and require interventions supported by governments in conjunction with health and education systems to affect desired change. For this reason, it is timely to undertake a review of progress on the impact of the Closing the Gap initiative.

Sources of evidence: The Australian national partnership agreement and subsequent annual performance reports issued between 2010 and 2017.

Discussion: Targets set within the Australian government national partnership agreement have had a range of success. Those targets not on track require significant long-term investment to ensure their success.

Nurses as a large professional group are powerful advocates to speak up and support policy change that affects disempowered social groups.

Conclusion: Long-term social change takes time, yet without the commitment of Australian Governments through effective policy and economic support, the inequity in the health of Indigenous people will continue both now and in the future.

Implications for health and social policy: Nurses, as the largest health professional group, are uniquely placed to support and implement social change at all levels of health care (primary, secondary and tertiary) and to lobby government to amend policy alongside those who are disempowered.

Implications for nursing practice: Health promotion and education programmes that are led by nurses can make an impact to health disparities within groups who are most at risk.

Keywords: Australia, Closing the Gap, Indigenous health, Policy

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Funding
This research received no specific grant from any funding agency in the public, commercial or not for profit sectors.

Conflict of interest
No conflict of interest has been declared by the authors.

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Chapter 7 Social Action or Inaction

Aim
The disparity in health outcomes of Indigenous people is a global concern. In countries that are considered to be economically 'wealthy', such as the USA, Canada, New Zealand and Australia, the health of Indigenous people remains poor compared to non-Indigenous people and requires serious consideration and action (Anderson et al. 2016; Kunitz 2000). In these countries, governments are actively seeking to improve the health status through a range of health programmes and initiatives (Health Canada 2016; Indian Health Service 2016; Ministry of Health 2016). Within Australia, the health status of Indigenous people is significantly worse than other Indigenous peoples from other developed countries (Anderson et al. 2016; Kunitz 2000). In recognition of the disparity in health outcomes between Indigenous and non-Indigenous people of Australia, the 'National partnership agreement on closing the gap in Indigenous health outcomes' (Council of Australian Governments 2008), commonly referred to as the Closing the Gap policy, between the federal and state governments agreed to make a concerted effort to improve the health status of Indigenous people. While it is recognized that social policy takes time to demonstrate any real changes, the Closing the Gap policy initiative has achieved some successes. Ongoing funding for this agreement is essential to ensure that targets are achieved. This paper will review government progress towards the identified targets within the national agreement and examine the role of nurses in supporting the implementation of the national agreement.

Background
The Social Justice report released in 2003 by the Australia and Torres Strait Islander Social Justice Commissioner, called for all levels of government in Australia to make a serious commitment to reducing the inequality of health and life expectancy within one generation for all Indigenous people (Australian Indigenous HealthInfoNet 2015). Human rights organizations provided support to the Closing the Gap public awareness campaign, which then gained the attention of the Australian public and government. In 2008, concordance was reached between federal and state governments so that the Closing the Gap policy (Council of Australian Governments 2008) could be implemented. The timeframe of this agreement was July 2009 until June 2013. In April 2013, the federal government committed additional funding to this agreement for a further 3 years until June 2016 (Australian Indigenous HealthInfoNet 2015). A range of health and education initiatives were put in place within this timeframe, which are reliant on continued government funding to ensure their long-term success.

Australia is not alone in seeking to tackle the disparity in health outcomes between Indigenous and non-Indigenous people. Other countries such as New Zealand, Canada and the USA have similar inequities (Anderson et al. 2016; Health Canada 2012; Indian Health Service 2016; National Health Committee 2007). Internationally, social determinants of health play a large part in establishing the inequalities experienced by Indigenous populations. Focussing on areas of significant disadvantage such as access to education and the ability to gain employment can help to overcome these health inequities. Although this article focuses on the Australian perspective, the health inequities experienced by Indigenous people are similar internationally and require comparable government, along with health and education system support, to realize effective sustainable change.

Nurses are the largest professional group of health professionals and are therefore at the forefront of supporting and implementing social change. Within Australia, nurses have a responsibility to support initiatives such as the Closing the Gap policy that can have both a direct and indirect effect on the work that nurses do. Nurses see the results of poor health outcomes in specific socio-economic groups including Indigenous populations. Many Indigenous people in Australia live with chronic conditions that affect all aspects of their lives (Deravin-Malone & Anderson 2016). Nurses, alongside other health personnel such as Aboriginal health workers, lead and participate in health promotion and education programmes that address health disparities within groups who are most at risk (Aboriginal Health Council of South Australia 2017; Aboriginal Workforce and Workforce Planning & Development 2012).

A change of government can lead to a change in political favour and influence when allocating health funds to programmes that support the Closing the Gap initiative (Kearst & Drago 2015). In 2013, there was a change in federal leadership and government within Australia. It is therefore timely to review the effects of the Closing the Gap initiative under different government parties and what might be the implications for the delivery of healthcare services in which nurses play such a vital role.

Sources of evidence
Documents accessed in this review included the 'National partnership agreement on closing the gap in Indigenous health outcomes' (Council of Australian Governments 2008) and subsequent annual performance reports issued by the federal government published between 2010 and 2017. Other non-government sources such as Indigenous community websites and journals were accessed as a cross-reference to the
data provided within the government report and are included in the discussion section of this paper.

**Overview of progress of government targets**

Six targets were identified within the original national agreement that aimed at supporting long-term change to improve the health status of Indigenous people of Australia. Progress on each target is discussed as follows.

**Life expectancy**

The first and possibly the most ambitious target subject to this review is to “close the gap in life expectancy within a generation” (Council of Australian Governments 2008, 3). Initially, this target was to close the gap in life expectancy within one generation yet in 2014 this target was amended to closing the gap by 2031 (Australian Government 2014). Making such a significant change to the health and well-being of an entire population group requires considerable resources and effort (Marmot 2011). Identified within the report of 2010, the difference in life expectancy was 9.7 years for females and 11.5 years for males. This difference in life expectancy was attributed to higher incidence of chronic illness and death resulting from injury or poisoning (Australian Government 2010). In a subsequent report published in 2014, this margin in life expectancy narrowed to 9.3 for females and 10.6 years for males showing minimal improvement (Australian Government 2014). In a positive light, it is recognized that mortality rates between 1998 and 2014 declined for Indigenous people by 16 per cent and that the gap between Indigenous and non-Indigenous Australians was reduced by 15 per cent. It was also noted that life expectancy had increased for non-Indigenous people being 79.7 for males and 83.1 for females, which was offered as an explanation for why improvements in this target have not been better. It is highlighted in the 2017 report that between the years of 2005–2007 and 2010–2012, there was a minor reduction in the gap in life expectancy between Indigenous and non-Indigenous people of 0.1 years for females and 0.8 years for males (Commonwealth of Australia 2017). In real terms, there is very little difference. The realization that this target will not meet the end goal of eliminating the gap in life expectancy within a generation has significant implications for Indigenous people, government and health leaders.

**Mortality rates for Indigenous children under five**

The next target identified for action within the national agreement was to ‘halve the gap in mortality rates for Indigenous children under five within a decade’ (Council of Australian Governments 2008, 3). This target has realized considerable success in the reporting period 2010 to 2017. From 1998 to 2015, the child mortality rate within the Indigenous population reduced by 33%. In 2017, a significant improvement is seen in the gap related to child mortality rates between Indigenous and non-Indigenous people, which narrowed by 31% (Commonwealth of Australia 2017). Interestingly, nationwide statistics on actual mortality rates are not available within this report but are provided at a state to state level. Programmes such as pre- and post-natal care for Indigenous mothers along with parenting programmes that have a whole of community approach are having an impact and need to be continued if this target of halving the gap is to be realized. Such programmes include initiatives where cultural humility-incorporating respect, awareness, sensitivity and competency (Yeager & Bauer-Wu 2013) amongst healthcare workers where culturally friendly health services are promoted and supported by local Indigenous communities are making a difference.

**Early childhood education**

This target aimed ‘to ensure all Indigenous 4-year-olds in remote communities have access to early childhood education within 5 years’ (Council of Australian Governments 2008, 3). In subsequent performance reports, this target was amended to provide a timeline of completion by 2013. Even though this was ambitious, considerable success is being made to achieve this target. In the baseline year of 2008, it was reported that enrolments were estimated at 60% (Australian Government 2010), whereas in 2013 enrolments were identified as being up to 85% (Commonwealth of Australia 2016). Even though the target of 95% was unmet in 2013, significant progress was being made. Programmes in place included 15 h per week per child that support early childhood education regardless of location. Funding for the incorporation within disadvantaged communities of schooling programmes, which included family support, as well as maternal and child health services, is also having a positive impact. This required significant government investment to establish these programmes. This target has now been extended until 2025 and amended to include all Indigenous children, not just those in remote communities (Commonwealth of Australia 2017).

**Reading, writing and numeracy in Indigenous children**

Having ‘the gap in reading, writing and numeracy achievements for Indigenous children within a decade’ (Council of Australian Governments 2008, 3) is also having mixed success. Progress on improving literacy and numeracy skills have been demonstrated to show a significant increase between the reporting years of 2010–2016 where reading skills for
Indigenous students in grade 5 (about 10 years of age) improved from 63.4% to 82% (Commonwealth of Australia 2017). Of interest is the result for remote areas that remain well below expectations with only 38% of Indigenous students meeting national benchmarks (Commonwealth of Australia 2017). Geographic isolation continues to be a significant disadvantage as access to resources is limited despite initiatives such as school of the air, synchronized and asynchronous online education developments and the expansion of telecommunication systems across the nation. Crucial to the improvement of health and well-being is having an education, which is identified as a social determinant of health (Marmot 2011; Wilkinson & Marmot 2003). The government has acknowledged that tailored programmes based on individual community needs will be needed to help achieve this target. Notably within the annual reports, there is no identified programme offered as an example of success to address this target (Commonwealth of Australia 2017). Without such support to improve education for children, the cycle of disadvantage will continue.

Completing secondary-level education
Another ambitious target was to ‘halve the gap for Indigenous students in year 12 (or equivalent) attainment rates by 2020’ (Council of Australian Governments 2008, 3). As a follow-up from increasing the number of children that enrol in school and that achieve the minimum benchmark for literacy and numeracy, reviewing the results on those that complete all years of schooling shows significant progress. In the 2011 report, data from 2006 showed that the gap between non-Indigenous students and Indigenous students completing their final years of schooling was 36.4% (Australian Government 2011). In 2013, the gap reduced marginally to 32.1%. In the next couple of years, according to the annual reports, there was a marked reduction where the gap was reported as reducing to 11.6% (Australian Government 2013, 2015). Programmes that have been introduced to support this target are as follows: the Australian Indigenous Mentoring Experience (AIMIE) and the Role Model and Leaders Australia programme, an initiative of the Clontarf Foundation, which seek to engage, encourage and inspire young Aboriginal and Torres Strait Islander people to complete their secondary level of education (Commonwealth of Australia 2017). A range of various scholarships and financial support have also been provided by government and Indigenous community organisations to support children to stay longer at school. In completing school education, opportunities to continue with further tertiary education are supported and thereby reducing possible disadvantage of employment limitations. A higher level of education correlates with higher incomes and therefore improved health and well-being (Wilkinson & Marmot 2003).

Employment
The final target under consideration was to ‘halve the gap in employment outcomes between Indigenous and other Australians within a decade’ (Council of Australian Governments 2008, 3). As evidenced within this review, this target has the most disappointing outcome. Even though it has been shown that more Indigenous children are completing their basic and secondary education, employment rates have not improved. In 2008, 53.8% of the Indigenous people between the ages of 15-64 years were employed. Figures provided in the 2015 report (latest data) showed that employment rates had dropped to 48.4% (Commonwealth of Australia 2017). The gap has in fact widened rather than narrowed.

The federal government is providing government contracts to Indigenous businesses as a way to influence the employment of Indigenous people yet they can only encourage private funded organizations and other states to follow their example (Commonwealth of Australia 2017). This is a short term strategy, ‘a quick fix’, yet what will happen when governments change their favour? It is widely acknowledged that the links between education, health and employment will help to close this gap (Marmot 2011) yet more needs to be done in this area. This is an alarming result and demonstrates that substantial investment and support is required to address this disparity.

Discussion
When changes in government occur, and budgets are reviewed and modified, initiatives such as the Closing the Gap policy are at risk. Projects with limited funding and cuts to government spending allocated for Aboriginal health services have an impact on long-term initiatives such as maternal and child health programmes. When governments change, supportive measures such as scholarships, government contracts and a range of health programmes and initiatives are also in jeopardy. In Australia, we are already seeing the impact of changes to allocated funding resulting in targets that were set in 2008 not being achieved, for example, the target of having all Indigenous 4-year-olds in remote communities accessing education within 5 years’ (Australian Government 2014, 9). Funding for a diverse range of long-term initiatives that impact on the health and well-being of Indigenous people needs financial commitment from all levels of government if the gap is to be closed (Keast & Dragon 2015). Projects such as these should not be reliant on political ideology or favour, as to do so
Chapter 7 Social Action or Inaction

Closing the Gap in Indigenous Health Inequity

directly affects the overall health and well-being of Indigenous people both in the short and long term. A long-range view of supporting Indigenous people to close the gap in inequity should not be reliant on political motives and requires the effective engagement of Indigenous people to ensure that their needs are met and that they are empowered to influence government decision-making.

Nurses are at the forefront to support health initiatives that will improve health outcomes for Indigenous people and can play a significant role in supporting social change. Much of the work that nurses do can either directly or indirectly support the Closing the Gap initiatives. Nurses are engaged in the care of people with chronic conditions at all levels of health service delivery: primary care, acute and secondary care settings (Deravin-Malone & Anderson 2016). The work of nurses and midwives involved in pre- and post-natal care, paediatric services along with early childhood programmes, contributes to improving the health and well-being of children and thereby has a positive effect on infant mortality and morbidity rates. The outcomes realised by these efforts include greater numbers of Indigenous children attending school and being successful. Early childhood, school and primary care nurses are ideally placed to identify children at risk and those who are not meeting growth and development milestones (NSW Department of Health 2011). Facilitating children’s access to early intervention initiatives, encouraging healthy eating programmes, education about immunization programmes, ensuring access to health services through ‘fly-in-fly-out’ clinics in remote areas are just some of the many ways in which nurses can and should be involved in promoting better health in disadvantaged communities (Australian Government Department of Health 2008).

Employment incentive programmes that positively discriminate for Indigenous people have been introduced and must be sustained and enhanced to ensure this inequity does not worsen. Creating opportunities for more Indigenous people to join the health workforce through careers such as nursing can have a twofold effect; improving individual health and health for Indigenous communities. Nurses are the largest group within the health workforce; however, representation of Indigenous nurses within this workforce in Australia is only 1.3%, which is lower than the 3% of people who identify as Aboriginal or Torres Strait Islander within Australia (Australian Institute of Health and Welfare 2016; Deravin et al. 2017). Increasing the numbers of Indigenous nurses is desirable yet in order to achieve this goal, the cooperation of tertiary education providers, government and Indigenous communities will be required (Deravin et al 2017; Deravin-Malone 2016). The positive work of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) in advocating for the support of the recruitment and retention of Aboriginal and Torres Strait Islander people into professions such as nursing and midwifery demonstrates both Indigenous community involvement and support from government (CATSINaM 2014). Celebrating and promoting successful role models, providing scholarships and grants to those who are financially disadvantaged will create education opportunities (NSW Health 2016; Victoria State Government 2015) yet this requires ongoing commitment.

Expanding roles of nurses to work with Indigenous communities through an increase in nurse practitioners may also support initiatives to improve health outcomes (Deravin-Malone 2017; Keast & Dragon 2015). Established Indigenous community controlled health services are well placed to develop and support these roles. These services require ongoing funding and support to deliver culturally appropriate care to the community within which they are based (NSW Health 2013). Working in partnership in this way creates opportunities for nurses to support health initiatives that create better access for Indigenous people who reside in remote and rural regions. Enhancing the numbers of Aboriginal health professionals employed in all healthcare settings will accelerate the closing of the gap, as Indigenous Australians will be more likely to access health care when it is culturally inclusive (Francis et al. 2015).

Developing a culturally competent nursing workforce through education at the pre- and post-registration level is another way to support the Closing the Gap initiative (Munarriz & Clandon 2015; Rigby et al. 2011). Educating nurses to develop and support their cultural competence and subsequent proficiency moves the focus from the medical model of disease and symptoms to caring for the individual person holistically. Pivotal to this process is improving communication between the nurse and the person or people they may be caring for (Betancourt et al. 2003; Taylor & Guerin 2014). Measuring healthcare quality and ensuring the safety of recipients and providers of health services is a fundamental aspiration of the Australian Health Care System (Australian Commission on Safety and Quality in Health Care 2017). Therefore, providing culturally appropriate and safe environments for Indigenous people to receive and access health services must be encouraged, supported and critiqued if real social change is to be achieved and the health status equal to that of the non-Indigenous Australian population is to be realised.

Implications for nursing and health policy

Nurses lead and participate in health promotion and education programmes globally that address health disparities.
within groups who are most at risk. Ensuring that all nursing education is underpinned by cultural inclusiveness principles will promote practice that is reflective of understanding and accommodating of cultural diversity (Francis et al. 2015; Richardson 2015). Nurses make a significant contribution to the realization of targets highlighted in this national policy document referred to in this paper. As the largest health professional group, nurses recognize the significance of social disadvantage and are uniquely placed to lobby government, alongside those who are disempowered, to implement social change at all levels of health care (primary, secondary and tertiary) by influencing health policy initiatives. Nurses can make a difference and, as a large group of health professionals, are able to ensure that closing the gap in health inequity remains a central consideration of Australian Governments within the health and social welfare sectors.

Conclusion
The current Australian federal government acknowledges that progress towards the identified targets still requires significant effort and resources to achieve the end goal of improving the health and welfare of the Australian Indigenous people. Long-term social change takes time, yet without the commitment of Australian Governments through effective policy and economic support, the inequity in the health of Indigenous people will continue both now and in the future. Health and well-being are central areas of concern that are highlighted in the various documents that inform and report on this initiative yet some targets are not on track, have mixed success or are performing poorly. This paper has provided context and offered recommendations for the nursing profession to embrace nursing-centred approaches that support the Closing the Gap initiative, which signifies the commitment to improving unacceptable disparities between Indigenous and non-Indigenous people within the Australian community.

Author contributions
Manuscript writing: LD, KF
Critical revisions for important intellectual content: LD, KF, JA

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Closing the Gap in Indigenous Health Inequity


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7.5 Chapter Summary

Clearly, the federal government believes that it has the knowledge and power to make decisions on behalf of Aboriginal and Torres Strait Islander people. However, from an ethical standpoint, I challenge that the government has the right to do this. The question that should be asked is whether the government would have introduced the Closing the Gap policy if the issue had not drawn international and national attention, highlighting such poor health outcomes for a country that prides itself in being a first-world country. Is doing something better than doing nothing to bring about social change? I agree that change is required.

For transformative action to occur, there needs to be deliberation regarding the decision to either make a change or not make a change. In this instance, the attempt to make reparations regarding the health status of Aboriginal and Torres Strait Islander people should be acknowledged and supported. However, the challenge I present here is that the involvement of Aboriginal and Torres Strait Islander people should be incorporated, integrated and promulgated for any future policy revisions or strategic directions. The government must recognise that Aboriginal and Torres Strait Islander people have the right to sovereignty and accord them with the appropriate respect and involvement in any future decisions that affect their health and well-being.

For the nursing profession, the Closing the Gap policy provides a platform to address the underrepresentation of Aboriginal and Torres Strait Islander people in nursing. It provides opportunities to address cultural discrimination and bias within the workplace and in educational institutions, as steps towards increasing the number of Aboriginal and Torres Strait Islander people in nursing. The subject of the next chapter is an examination of what has happened in this regard, what is currently happening and provides suggestions for possible opportunities in the future.
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

Chapter 8: INCREASING THE REPRESENTATION OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE IN NURSING

‘Because of her we can.’
National Aborigines and Islanders Day Observance Committee theme for 2018

This chapter examines the way government policy (Closing the Gap) can influence Aboriginal and Torres Strait Islander people with regard to choosing nursing as a career. An overview of the current representation of Aboriginal and Torres Strait Islander nurses in the nursing and midwifery workforce is provided. The importance of cultural influences, family/community obligations, opportunities to access education, and potential career pathways that encourage or discourage Aboriginal and Torres Strait Islander people to enter, and remain within, the nursing profession are discussed.

8.1 The Effect of Government Policy

Government policy has affected the way people have lived and it affects the way they continue to live and will live in the future (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Australian Human Rights Commission, 2009; Human Rights and Equal Opportunity Commission, 1997; McCallum, 2011). Government policy can have either a positive or a negative effect on social interactions within a society. Effects have been both intended and unintended, particularly for Aboriginal and Torres Strait Islander people in Australia (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). These have included forced removal from traditional lands and country, segregation and isolation from mainstream society and the destruction of family units (Australian Law Reform Commission, 1986; Kelly, 1975; McCallum, 2011; United Nations General Assembly, 2007). Therefore, it is not surprising that when new policy is implemented by government, there can be a level of apprehension and/or suspicion about the underpinning intent.

The Closing the Gap policy was an initiative developed by government to address the inequity in health outcomes between Aboriginal and Torres Strait Islander and non-Indigenous people (COAG, 2008, 2012b). As indicated within the primary seminal
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

documents under review in this study, various levels of implementation on a wide range of areas, including education, employment and health, would be required to reduce the identified health disparity experienced by Aboriginal and Torres Strait Islander people. Long-term strategies would require ongoing funding support and the willingness of both present and future governments and communities to implement and embrace the intended changes (Deravin et al., 2018).

When I began this study, the Closing the Gap policy was in its early years of implementation. Government policy directives were being implemented rapidly within the health system in which I was employed. The expectation was that the imposed targets would be met when all of the intended changes were implemented. It was assumed that this would improve the health of Aboriginal and Torres Strait Islander people within a generation (COAG, 2008). As a senior nursing executive, I was expected to increase the representation of Aboriginal and Torres Strait Islander people within the health workforce for which I had responsibility, particularly the nursing workforce. I started to move forward with supportive strategies that were being put into place at both a state and local health service level (COAG, 2012a; Nursing and Midwifery Office, 2016; Workforce Planning and Development, 2012, 2016). At this time I was met with resistance, discrimination or complete apathy when I initiated the conversations about how to increase the number of Aboriginal and Torres Strait Islander nurses within the local health district. I wanted to understand the reason for the pervading negativity that I encountered. This led me to question whether the Closing the Gap policy was going to make a difference.

Ten years later, there has been varied levels of success in meeting the targets set within the original agreement document (COAG, 2008). This has led to a revision of some of the targets in areas such as reducing the gap in life expectancy, or the implementation of new targets in areas such as education (Australian Government, 2015; Commonwealth of Australia, 2016b; Deravin et al., 2018). To date, the government, for all its ability to focus resources, both financially and through directing public and health agencies to enact the policy, has had limited success in implementing the proposed changes. For example, while the level of recruitment of Aboriginal and Torres Strait Islander people into the health workforce proposed in the policy has led to an increase in overall numbers, these remain well below the targeted levels. With particular reference to nursing, numbers are increasing; however, as an overall proportion of the health workforce, the projected
targets have not been achieved. Reflecting on these outcomes, I pondered what the impediments to the recruitment of Aboriginal and Torres Strait Islander nurses could have been.

The Closing the Gap policy aimed to improve health outcomes for Aboriginal and Torres Strait Islander people. However, I contend that this policy has not accommodated an understanding of the diversity of Aboriginal and Torres Strait Islander people. The application of the ‘one size fits all’ approach that is inherent in this policy means the accompanying implementation strategies are unlikely to meet the needs of the people for whom they are designed (COAG, 2008, 2012b).

As Aboriginal and Torres Strait Islander people are predominantly a young population (Australian Bureau of Statistics, 2018), it would appear the Closing the Gap policy adequately directs and supports them to have better life beginnings, including education choices that may lead them into health professions such as nursing. Lockyer (2013) asserts that increasing the representation of Aboriginal and Torres Strait Islander people in nursing will have the desired effect in improving engagement with the health system, thus improving health outcomes. However, the number of Aboriginal and Torres Strait Islander people within nursing remains low and well below parity with the proportion of Aboriginal and Torres Strait Islander people within the Australian population (Australian Health Practitioner Regulation Agency, 2018; Australian Institute of Health and Welfare, 2016). Gaining an understanding of the possible reasons for this lack of progress in relation to the nursing profession is important and this aspect is explored in the next sections of this chapter.

### 8.2 Profiling the Nursing and Midwifery Workforce

At the time of writing, Aboriginal and Torres Strait Islander people represent 3.3 % of the Australian population (Australian Bureau of Statistics, 2018; Australian Health Practitioner Regulation Agency, 2017). This represents a 0.8% increase from the previous census (2011) which identified only 2.5 % of the population as Aboriginal and/or Torres Strait Islander (Australian Bureau of Statistics, 2012). There are a number of possible reasons for such a significant increase. It could be that Aboriginal and Torres Strait Islander people have become healthier than they were in the past and therefore, numbers of the population are growing. Counting of the population within Australia may have improved or people may be more willing now to identify as Aboriginal and Torres Strait
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

Islander. The Closing the Gap policy and the associated positive approaches to changing the culture and improving the overall health of Aboriginal and Torres Strait Islander people within Australia may be having an effect.

The 2017 Closing the Gap Prime Minister’s report (Commonwealth of Australia, 2017) identified the target of increasing the representation of Aboriginal and Torres Strait Islander people within the health workforce to 2.4%, to match the proportion of this population in the overall national population. In 2018 (census data from 2016), the national proportion of Aboriginal and Torres Strait Islander people within Australia had grown to 3.3%. Therefore, in NSW a target of 3.3% Aboriginal and/or Torres Strait Islander people in the health and nursing workforce has been set, to maintain parity with this national proportion (Australian Bureau of Statistics, 2018; Australian Health Practitioner Regulation Agency, 2017; NSW Health, 2017). The latest NSW Health report noted that the proportion of the health workforce in NSW (in both clinical and non-clinical roles) that identify as Aboriginal and Torres Strait Islander origin had now reached 2.5%, which on the surface would appear to be reaching the intended target (NSW Health, 2017). In 2015, the proportion of the health nursing workforce in NSW that was of Aboriginal and Torres Strait Islander origin was 1.4% (Australian Institute of Health and Welfare, 2016). Similarly in 2015 the national representation of Aboriginal and Torres Strait Islander within the health workforce was reported as being 1.1% (see Table 8.1). Thus, the representation of Aboriginal and Torres Strait Islander people in the nursing workforce, both nationally and more specifically, in NSW, is well below target.

As nursing is the largest group in the health workforce, the reaching this goal should be a priority for the nursing profession (Goold, 2011; West et al., 2010). Table 8.1 presents an updated version of the data shown in the article in Chapter 1 (Choosing a Nursing Career: Building an Indigenous Nursing Workforce, (Deravin, Anderson, et al., 2017), using data that is publicly available. Of note is that from 2016, NSW Health has not provided any updated data regarding nurses who identify as Aboriginal and/or Torres Strait Islander, even though the figures are collected annually by the Australian Health Practitioner Regulation Agency (2018).

Reflection

Is attention being directed away from poor performance by the omission of this data?
Table 8.1: Comparison of Aboriginal and Torres Strait Islander Nursing Workforce to Total Nursing Workforce in NSW and Australia (2008–2016, latest data available)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of RNs and ENs in NSW who identify as Aboriginal and Torres Strait Islander</td>
<td>598</td>
<td>650</td>
<td>862</td>
<td>865</td>
<td>994</td>
<td>1,184</td>
<td>1,188</td>
<td>Not known</td>
</tr>
<tr>
<td>% of nursing workforce in NSW</td>
<td>0.8</td>
<td>0.8</td>
<td>1.1</td>
<td>1.1</td>
<td>1.2</td>
<td>1.4</td>
<td>1.4</td>
<td>Not known</td>
</tr>
<tr>
<td>Number of RNs and ENs in Australia who identify as Aboriginal and Torres Strait Islander</td>
<td>1,598</td>
<td>1,605</td>
<td>2,246</td>
<td>2,301</td>
<td>2,601</td>
<td>3,036</td>
<td>3,187</td>
<td>3,740</td>
</tr>
<tr>
<td>% of nursing workforce in Australia</td>
<td>0.6</td>
<td>0.6</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>1.0</td>
<td>1.1</td>
<td>1</td>
</tr>
</tbody>
</table>

Notes:
- Data not available for 2010

The above table shows that the number of nurses had increased to 3,740 in 2016, almost double the number recorded in 2008. At first glance, this increase appears to be a significant gain. However, the percentage figure of 1% in 2016 compared to 0.6% in 2008 illustrates that there has only been a marginal increase of Aboriginal and Torres Strait Islander nurses within the national health workforce (Australian Health Practitioner Regulation Agency, 2018). This is cause for considerable concern and highlights the need for positive action to increase the number of Aboriginal and Torres Strait Islander nurses across Australia.

Reflections

What is deterring Aboriginal and Torres Strait Islander people from choosing nursing as a career?

Have government policy and strategic initiatives, such as the introduction of the Aboriginal health practitioner/worker role, provided opportunities for
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

Aboriginal people to enter a wider range of health professions, which are competing with nursing as a career choice?

In addition, it is important to understand the current profile of the Aboriginal and Torres Strait Islander nursing workforce. A report published by the now-defunct government agency HWA shows the Aboriginal and Torres Strait Islander gender distribution (see Table 8.2) and areas of practice (see Table 8.3). The only publicly accessible data at the time of submitting this thesis was for the year 2012.

**Table 8.2: Aboriginal and Torres Strait Islander Nursing Workforce: Gender Distribution, by Role Delineation**

<table>
<thead>
<tr>
<th>Designation</th>
<th>Male</th>
<th>%</th>
<th>Female</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>171</td>
<td>12.4</td>
<td>1,206</td>
<td>87.6</td>
<td>1,377</td>
</tr>
<tr>
<td>EN</td>
<td>100</td>
<td>13.1</td>
<td>663</td>
<td>86.9</td>
<td>763</td>
</tr>
<tr>
<td>All nurses</td>
<td>271</td>
<td>12.7</td>
<td>1,869</td>
<td>87.3</td>
<td>2,140</td>
</tr>
</tbody>
</table>

Adapted from HWA (2014)

**Table 8.3: Aboriginal and Torres Strait Islander Nursing Workforce, by Area of Practice**

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Number of Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician/Clinical manager</td>
<td>1,646</td>
</tr>
<tr>
<td>Administrator</td>
<td>56</td>
</tr>
<tr>
<td>Teacher/Educator</td>
<td>81</td>
</tr>
<tr>
<td>Researcher</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>314</td>
</tr>
<tr>
<td>Not employed or not applicable</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>2,140</td>
</tr>
</tbody>
</table>

Adapted from HWA (2014)

The majority of the Aboriginal and Torres Strait Islander nursing workforce in 2012 were female, reflecting the national nursing workforce demographic data. The highest number worked as RNs in clinical areas of practice, which is similar to the overall nursing workforce (Health Workforce Australia, 2014b). In the Closing the Gap policy, the writer’s intent was to promulgate the perception that an increase in the Aboriginal and Torres Strait Islander health workforce would be required to improve the health of Aboriginal and Torres Strait Islander people. This implies that this population group
would be managed better if health care was delivered by ‘their own’ (Commonwealth of Australia, 2017). While government policy writers have noted the need to increase the health workforce as a way of improving health outcomes for Aboriginal and Torres Strait Islander people, they have not specified that the increase in the Aboriginal and Torres Strait Islander health workforce should be in clinical roles such as nursing. As the health workforce includes non-clinical roles, the reader may mistakenly believe that this government strategy is achieving its intended outcomes. It is not until the data are scrutinised further that it becomes clear that the representation of Aboriginal and Torres Strait Islander people within clinical roles remains well below the desired levels (Commonwealth of Australia, 2017).

Within nursing, there is a distinct deficit in the practice areas of research and education for Aboriginal and Torres Strait Islander people (Health Workforce Australia, 2014b). As an outcome of these deficits, significant effort is required to recruit Aboriginal and Torres Strait Islander people to these areas of practice. However, the conundrum is that staffing these areas depends on the numbers of Aboriginal and Torres Strait Islander people in nursing growing. To increase recruitment in these areas, using positive role models would promote nursing as a career choice for other Aboriginal and Torres Strait Islander people (Lockyer, 2013; Usher, 2011). Having role models in place at tertiary institutions to support future nurses (students) through their education journey, as a pathway to a career, has been suggested as way of helping with this issue (Clark, 2013; Stuart & Gorman, 2015).

To determine whether recruiting Aboriginal and Torres Strait Islander people to nursing is a successful strategy, more than one generation of data is required and data reporting needs to improve. Annual reports should outline the actual numbers of Aboriginal and Torres Strait Islander people within various areas of the health workforce, such as nursing and medical practitioners, rather than collectively reporting them as one overall figure, as occurs currently in NSW (NSW Health, 2017). Publicly available reports should demonstrate transparency regarding the outcomes of government policy and action, rather than deflecting the reader with generalised statistics, which gives the impression of good performance when the reality is that performance is well below the established expectations.
As a population group, the number of Aboriginal and Torres Strait Islander people living in NSW is statistically higher than in any other state (Australian Bureau of Statistics, 2018). Therefore, it draws on a larger population base of people who may potentially consider nursing as a career choice. Although NSW is performing better than the national average in relation to increasing the representation of Aboriginal and Torres Strait Islander people in the nursing workforce, there remains a significant gap between the current base of 1.4% and the target of 3.3%.

**Reflection**

*What is NSW doing well that perhaps other states could learn from?*

In Australia, the majority (approximately 71.6%) of the Aboriginal and Torres Strait Islander population live in urban and metropolitan areas (Australian Bureau of Statistics, 2018). It would be reasonable, therefore, to assume that changes to the health workforce and targeted health programs, including managing chronic illness, should focus on these people. In rural and remote areas, the distribution of Aboriginal and Torres Strait Islander people is proportionately higher than that of the non-Indigenous population, compared with the metropolitan and urban centres (Bolton, 2008). This difference in distribution of the Aboriginal and Torres Strait Islander population gives the impression that most Aboriginal and Torres Strait Islander people live in rural and remote areas. This perception is perpetuated in the Closing the Gap policy reports, which focus on addressing the health needs of Aboriginal and Torres Strait Islander people in rural and remote regions (Australian Government, 2010, 2013; Commonwealth of Australia, 2016b, 2017). This only serves to perpetuate an inaccurate representation of who Aboriginal and Torres Strait Islander people are and where they live.

It is true that rurality or geographical location has a negative effect on the ability to access services such as health and education (Wakerman & Humphreys, 2012). While efforts through the Closing the Gap policy to counter this disadvantage should be acknowledged, it should be remembered that geographical location is not the sole determinant of disadvantage. The Closing the Gap policy frequently mentions that Aboriginal and Torres Strait Islander people who live in ‘remote areas’ require more resources to improve their health outcomes (Australian Government, 2010, 2012, 2013). However, evidence in other government publications shows that Aboriginal and Torres Strait Islander people who
live in remote regions are far healthier than their metropolitan counterparts (Australian Bureau of Statistics, 2014).

It appears that current recruitment strategies for Aboriginal and Torres Strait Islander nurses, in the form of additional education support, are not targeting the right geographical locations and that access to education support should be available to all Aboriginal and Torres Strait Islander people equally, regardless of location (Eley et al., 2010; Keast & Dragon, 2015; Lenthall et al., 2011). Areas of higher clinical need, such as chronic condition management and maternity services addressing infant mortality, need to be focused where the majority of the Aboriginal and Torres Strait Islander population reside (i.e., metropolitan and urban), rather than in remote areas, as continually indicated within the Closing the Gap policy and strategy documents (COAG, 2008, 2012b).

A number of factors affect whether Aboriginal and Torres Strait Islander people choose nursing as a career, including government policy that supports this career choice. In addition, Best and Stuart (2014) highlight the need for financial, academic and cultural support. The following sections provide further discussion with regard to the contributing factors that can affect whether Aboriginal and Torres Strait Islander people choose nursing as a career in relation to cultural considerations, pathways into nursing and education support.

8.3 Cultural Considerations for Aboriginal and Torres Strait Islander People in Choosing a Nursing Career

At the outset of this study, I indicated that I wanted to understand the factors that may be preventing Aboriginal and Torres Strait Islander people from choosing nursing as a career. I believe that cultural attitudes within Aboriginal and Torres Strait Islander groups continue to affect their attitude to engaging with Westernised medical services about their health needs.

Cultural understanding is a key component in Aboriginal and Torres Strait Islander people’s willingness to engage with health services. An inherent mistrust of government and its agencies that deliver health care, which are in contrast to the traditional healing methods of Aboriginal and Torres Strait Islander people, has been identified as a contributing factor (Stuart & Nielsen, 2011). The health workforce, including the nursing
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing profession, must be culturally competent to address the long-entrenched issues of racial discrimination and bias that have been experienced by Aboriginal and Torres Strait Islander people (Carr, McCormack, Keeping-Burke, & Hansen, 2012; Nielsen et al., 2015; Stuart & Gorman, 2015).

To help dispel these barriers of cultural difference, the Closing the Gap policy indicates that increasing the representation of Aboriginal and Torres Strait Islander people within the health workforce (of which the nursing profession constitutes the largest portion) is a way to engage Aboriginal and Torres Strait Islander people with health services successfully. Once engaged, the argument assumes that Aboriginal and Torres Strait Islander people may become part of the health system through employment opportunities when confidence and trust is established then cultural barriers such as the perceived ‘whiteness of nursing’ may be addressed (COAG, 2008, 2012b; Health Workforce Australia, 2014a; Stuart & Gorman, 2015). Culture is an important part of Aboriginal and Torres Strait Islander people’s identity (see Figure 8.1). Therefore, people employed in the health system must have an understanding of the needs of the specific cultural groups. This includes employees attaining cultural humility, which is an understanding of an individual’s own culture that may affect their behaviour towards, and perceptions of, others (Betancourt et al., 2003; Durey, 2010; Gorman, 2017; Usher & Best, 2011). Cultural education, which may lead to cultural humility, is a critical component that needs to be addressed before significant gains will be seen (Deravin-Malone, 2017; Gorman, 2017; Keast & Dragon, 2015; Usher, Lindsay, Miller, et al., 2005).
A factor that may be contributing to the low numbers of Aboriginal and Torres Strait Islander people entering nursing is the lack of cultural understanding within the health and education systems, which have promulgated bias and discrimination towards Aboriginal and Torres Strait Islander people, as well as in the wider community. For society to move past this, what could be some of the impediments to cultural understanding?

8.3.1 Impediments to cultural understanding

Cultural differences exist between Aboriginal and Torres Strait Islander people and the other population groups that reside within Australia (Keast & Dragon, 2015; Stuart & Nielsen, 2011; Usher, Lindsay, Miller, et al., 2005). As discussed previously, a number of factors have influenced the way in which Aboriginal and Torres Strait Islander people view government policy and government organisations. These include the appalling treatment of Aboriginal and Torres Strait Islander people mandated by previous government policies (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; McCallum, 2011). Thus, it is understandable that current government policies may be viewed by Aboriginal and Torres Strait Islander people with some reservation.

The Closing the Gap policy recognises that work is required to bridge the existing gap in cultural understanding between Aboriginal and Torres Strait Islander people and those not from this population group. A way forward is to provide cultural awareness and
sensitivity education for health care providers, as a first step towards cultural humility (Blackman, 2011; Downing et al., 2011).

My experience as a senior health executive was a stimulus for me to undertake this doctoral study. The pressure to implement policy, along with acknowledging the bias and cultural attitudes that I had experienced and observed, made me want to gain a deeper understanding of the way government policy could affect whether Aboriginal and Torres Strait Islander people choose nursing as a career option. If cultural bias is present within the health workplace and the people in positions of power and influence contribute to cultural discrimination, there will be a negative effect on the implementation of policy directives (Stuart & Gorman, 2015). Therefore, the efforts of health organisations may be seen as being inauthentic if the enforced implementation of any predetermined workforce targets is based solely upon funding incentives, rather than on social justice motives. Concurrently, being subject to cultural bias and discrimination may deter Aboriginal and Torres Strait Islander people from entering the nursing profession (Best, 2011; Blackman, 2009; Downing et al., 2011; Goold, 2011; Nielsen et al., 2015).

8.3.2 Changing cultural attitudes

Entrenched cultural attitudes are hard to shift (Betancourt et al., 2003; Blackman, 2009, 2011; Douglas et al., 2014; Durey, 2010). As identified in the seminal documents under review (COAG, 2008, 2012b), implementing cultural safety education and training for staff within health services and in tertiary education organisations would be a first step in providing culturally appropriate health care. Cultural safety education and training may be a way to influence and challenge individual beliefs that perpetuate discrimination and bias such as the perceived ‘whiteness of nursing’ (Stuart & Gorman, 2015). Once this initial training is complete, individuals then have an opportunity to extend their understanding and perhaps attain cultural competency and humility (Betancourt et al., 2003; Douglas et al., 2014).

Cultural safety education and training is not the only way to change or influence people’s perceptions. The manner in which Aboriginal and Torres Strait Islander are portrayed within our society, through both the media and policy documents, must change (Mesikämmen, 2016). It is my contention that the Closing the Gap annual reports portray Aboriginal and Torres Strait Islander people negatively (Australian Government, 2010; COAG, 2012b). The Closing the Gap policy and subsequent reports imply that Aboriginal
and Torres Strait Islander people are uneducated and unemployed, have poor health, and that the majority will be incarcerated at some stage in their lives. Unfortunately, it is true that the proportions of Aboriginal and Torres Strait Islander people in all of these areas are higher than for the general population; yet to reinforce this image continually in government documents and policy reports only strengthens a deficit discourse (Australian Government, 2010, 2015; Commonwealth of Australia, 2017; National Congress of Australia’s First Peoples, 2016). The impression given is that all Aboriginal and Torres Strait Islander people are this way, which is simply untrue. It seems that to gain the favour and support required to make changes through the Closing the Gap policy, it is essential to highlight areas of need; but this reinforces a negative portrayal of Aboriginal and Torres Strait Islander people, which itself reinforces the unconscious bias towards this population group from the wider community (Maddison, 2012; Nielsen et al., 2015). Changing this perception will take significant work. Raising awareness of the way Aboriginal and Torres Strait Islander people are represented within the media, within government policy and elsewhere will take time (Mesikämmen, 2016).

As mentioned previously, cultural competency and humility are a key component in changing people’s attitudes (Blackman, 2011; Downing et al., 2011). Aboriginal and Torres Strait Islander people who wish to enter a career in nursing and remain within the profession want to feel that they are working within a space that is free from discrimination and bias (Downing et al., 2011; Stuart & Gorman, 2015). Therefore, cultural safety education, as a first step towards cultural competence and humility, is required within both tertiary education and health organisations. This is supported in a variety of ways, as outlined in the next section.

8.3.3 Supporting cultural change

The importance of cultural safety within tertiary education institutions and health organisations cannot be overstated. The tertiary education sector is well placed to address issues of cultural competence through education programs for its employees and through embedding cultural content within all curricula (Commonwealth of Australia, 2016a; West et al., 2010). Usher (2011) suggests that the successful attainment of cultural competence within tertiary education institutions may encourage more Aboriginal and Torres Strait Islander people to enter nursing. At the tertiary education level, the federal government released the *Aboriginal And Torres Strait Islander Health Curriculum*
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Framework (Commonwealth of Australia, 2016a), which advocates the inclusion of Aboriginal and Torres Strait Islander content within curricula and outlines ways to develop a culturally competent future health workforce. While the onus is on individual tertiary institutions to adopt and implement this framework, there does not appear to be any penalty for not engaging with or adopting this policy measure. In addition, the Framework suggests that the inclusion of elders and incorporating Indigenous pedagogies within curricula will help to build cultural competency. This will require the development of significant community partnerships and the fostering of trust between all parties (Universities Australia, 2017; Yunkaporta, 2009).

The Nursing and Midwifery Board of Australia (NMBA) has recently updated the Standards of Practice for RNs, registered midwives (RMs) and ENs to include a professional standard of behaviour. It mandates that nurses and midwives must be respectful of Aboriginal and Torres Strait Islander cultures and experience (Nursing and Midwifery Board of Australia, 2016a, 2016b, 2018). While this covers the regulated component of the nursing profession, the unregulated AINs do not have the same professional obligations.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) recognises the importance of developing cultural understanding within its RN, RM and EN workforce. It mandates that curricula must include a ‘subject specifically addressing Aboriginal and Torres Strait Islander people’s history, health, wellness and culture’ (ANMAC, 2012, p.14), recognising that culturally safe care should be embedded within nursing practice (ANMAC, 2012, 2014, 2017). While this is a significant step towards breaking down the barriers of cultural misunderstandings, policies are only good if they are implemented and adopted in practice.

Another option for providing cultural support to Aboriginal and Torres Strait Islander people who enter tertiary study is through the provision of mentors or tutors (Hinton & Chirgwin, 2010). These two roles have very different purposes. The role of a mentor is to assist students with navigating the stress of university life and to provide an alternative method of support to students (Mills et al., 2007a; Power & Albaradura, 2018). A tutor provides academic support for curriculum content. Academic tutors are provided to Aboriginal and Torres Strait Islander students at most universities, should they wish to have one. The use of cultural mentors is less common. Beyond university study, the value
of profession-based mentors and tutors within the workplace and particularly, in rural areas, has been shown to be of benefit in retaining new graduates (Mills et al., 2010; Mills et al., 2007b). There is little within the literature that examines the value of cultural mentors in both the tertiary education sector and the health workplace. This is an area for future exploration.

For Aboriginal and Torres Strait Islander people who enter the tertiary education sector as either students or employees, the existence of Indigenous Student Support Units have been shown to have positive benefits where cultural support and understanding is offered (Best & Stuart, 2014; West et al., 2013). For tertiary education students, access to both academic and cultural mentors while undertaking studies has been demonstrated to improve student success (Best & Stuart, 2014; Usher, Lindsay, Miller, et al., 2005; West et al., 2013). Continuing these centres and establishing additional Indigenous Student Support Units should be supported as testament to the willingness of the government and tertiary education providers to support Aboriginal and Torres Strait Islander people. While academic mentors/tutors are offered at many institutions to Aboriginal and Torres Strait Islander people, there are few cultural mentors. Many of these could be drawn from local Aboriginal and Torres Strait Islander communities (Hinton & Chirgwin, 2010; Usher, Lindsay, Miller, et al., 2005; Yunkaporta, 2009). Within the health system, the ability to access cultural mentors to support new and existing graduates is lacking. The Closing the Gap policy provides an opportunity to support the attainment of cultural competency training within health organisations and potentially, to develop cultural mentoring programs for Aboriginal and Torres Strait Islander people.

8.3.4 Family and community support

Aboriginal and/or Torres Strait Islander people are a diverse population group. The concept of kinship is different from the non-Indigenous people’s understanding of who constitutes family (Bourke, 1993). Within Aboriginal and/or Torres Strait Islander groups, connections to family and obligations to an individual’s own communities places additional stressors on Aboriginal and Torres Strait Islander people who choose to study and work away from home (Best, 2011; Clark, 2013; Hinton & Chirgwin, 2010). As demonstrated by the University of Southern Queensland Indigenous nursing support model, Helping Hands (Best & Stuart, 2014), supporting students with culturally competent academics, Indigenous Student Support Units and cultural mentors while
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Studying has been shown to improve the number of successful completions through nursing courses. This model of practice could be adopted to provide cultural support to new Aboriginal and Torres Strait Islander nursing graduates within health services. The importance of culture to Aboriginal and Torres Strait Islander people needs to be recognised if we are to build relationships between Aboriginal and Torres Strait Islander people and health systems. Doing so could have a flow-on effect for the recruitment and retention of Aboriginal and Torres Strait Islander people into nursing (Best & Stuart, 2014; Indigenous Nursing Education Working Group, 2002).

The delivery of Westernised health care does little to accommodate the spiritual and cultural beliefs of Aboriginal and Torres Strait Islander people. This lack of understanding affects Aboriginal and Torres Strait Islander people’s willingness to engage with health services (Downing et al., 2011; Stuart & Nielsen, 2011). There is an inherent fear/mistrust of health services and a lack of understanding of how to provide care to Aboriginal and Torres Strait Islander people (Blackman, 2011; Deravin-Malone, 2017; Downing et al., 2011). It is logical to assume that this situation may be affecting the willingness of Aboriginal and Torres Strait Islander people to consider nursing as a career option.

Cultural barriers within health systems and poorer health outcomes for Indigenous people are not unique to Australia. Similar experiences have been observed in other countries such as New Zealand, Canada and the USA (Anderson et al., 2016; Douglas et al., 2014; Goold & Usher, 2006). In the USA, the creation of Indigenous-only tertiary education institutions has provided culturally safe places to learn and develop Indigenous pedagogies and knowledge (American Indian Higher Education Consortium, 2019). This model of Indigenous-only tertiary education institutions, supported by the government and Aboriginal and Torres Strait Islander communities that are in a financial position to do this, could be considered in Australia. Within these universities, students would be taught by Aboriginal and Torres Strait Islander academics and professionals, who would be aspirational role models for students.

Another option would be for existing universities to have Aboriginal and Torres Strait Islander-specific cohorts in health and nursing courses, so that students can learn in a culturally safe space. One example of this model is the nurse education program implemented on Torres Strait Island through James Cook University (Usher, Lindsay, &
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Mackay, 2005). Another example is the Djirruwang program at Charles Sturt University, which provides a culturally specific Bachelor of Health Science program (Mental Health) for Aboriginal and Torres Strait Islander students only, delivered by Aboriginal and Torres Strait Islander academics (Charles Sturt University, 2019). Currently, Indigenous-only cohorts are uncommon within Australia (Australian Catholic University, 2019; Charles Sturt University, 2019). However, this option may be a ‘double-edged sword’, in that isolating Aboriginal and Torres Strait Islander people in this way might foster further discrimination and bias from the wider community.

As the Closing the Gap policy supports educating people about the culture of Aboriginal and Torres Strait Islander people, then the possibility of achieving cultural understanding across the Australian population exists. Implementing cultural safety education and embedding cultural content within health curricula (Commonwealth of Australia, 2016a), combined with ongoing support to break down the existing cultural barriers, are needed both now and in the future, to address the disadvantage and underrepresentation of Aboriginal and Torres Strait Islander people in education and health care. However, culture is not the sole challenge when considering the recruitment to, and retention of, Aboriginal and Torres Strait Islander people in nursing. Pathways into nursing pre-service education (RN and EN educational programs) are pivotal to this success as well (Best & Stuart, 2014; Deravin, Anderson, et al., 2017; Stuart & Gorman, 2015; West et al., 2013). These are discussed in the next section.

8.4 Pathways Into Nursing

When trying to understand the way government policy influences Aboriginal and Torres Strait Islander people to enter and remain in nursing, it is important to consider what is currently available to support Aboriginal and Torres Strait Islander people to enter the nursing profession, as well as reasons for them staying on or leaving it. As I began this study, I realised that I needed to examine the existing pathways to higher education and the supports that are available to assist Aboriginal and Torres Strait Islander people to complete their studies successfully and enter the nursing workforce.

Limited ability to access education and to complete foundational education in the primary and secondary education systems limits people’s employment opportunities and their ability to undertake tertiary studies that would lead to careers in areas such as nursing and health (Australian Government, 2013, 2015; Commonwealth of Australia, 2017). The
Closing the Gap policy presents an opportunity to move past some of these barriers by making resources available to support Aboriginal and Torres Strait Islander people.

A number of scholarships and grants are available to assist potential and current Aboriginal and Torres Strait Islander nursing students to complete their studies including programs such as the cadetship program through NSW Health (2016b) or specific Indigenous Access Programs offered at various universities. However, the attrition rate for this population group in nursing courses remains high (Commonwealth of Australia, 2016a; Indigenous Nursing Education Working Group, 2002; Keast & Dragon, 2015). While the Australian Government has taken steps towards increasing the representation of Aboriginal and Torres Strait Islander people within the health workforce, these workforce policies and strategies do not necessarily favour entry into nursing and midwifery alone (Health Workforce Australia, 2011b, 2014a; NSW Government Public Service Commission, 2012; Workforce Planning and Development, 2016). They support pathways into other career options as well, as described in the next section.

### 8.4.1 Career options within the health workforce

A range of career choices are available to Aboriginal and Torres Strait Islander people who want to enter the health workforce, including support staff roles that are non-clinical. Both clinical and non-clinical roles are included in the reporting of the overall composition of the health workforce (Workforce Planning and Development, 2012, 2016). This wider choice of health career options means that many who may have chosen nursing in the past are now considering careers in other professions within the health sector (Health Workforce Australia, 2012). As individual choice should always be encouraged and supported, the onus is on the nursing profession to make their occupation the preferred career choice for many Aboriginal and Torres Strait Islander people.

The effect on established professions such as nursing of the government’s health workforce policy, which has created other career options such as the Aboriginal Health Practitioner/Worker role, has not yet been explored (Health Workforce Australia, 2011a; Workforce Planning and Development, 2016). The establishment of the Aboriginal Health Worker role, which was introduced with the support of government policy in 2011 (Health Workforce Australia, 2011a, 2011b, 2014a), was a positive initiative for Aboriginal and Torres Strait Islander people. However, this has had a negative effect on
Aboriginal and Torres Strait Islander representation within the nursing workforce, for reasons explained later in this section.

As nursing is the largest group of health professionals, it is essential that representation Aboriginal and Torres Strait Islander people is increased so that the improvements in the health of Aboriginal and Torres Strait Islander people that are being promoted through government policy can be achieved (COAG, 2012a, 2012b; Deravin et al., 2018). Nursing has a broader scope of practice than many roles that are now being offered as an alternative career option within health (Aboriginal Health Council of South Australia, 2017; Nursing and Midwifery Board of Australia, 2016a). Nurses work in a variety of settings in a range of different health specialties, whereas other roles that are now being introduced do not have the same scope, autonomy and career progression opportunities (Deravin, Anderson, et al., 2017; West et al., 2010). The nursing profession must consider ways to encourage people to choose nursing in preference to other options.

When I commenced this study, one of my challenges was to gain an understanding of the composition of the Aboriginal and Torres Strait Islander health workforce in relation to regulated and unregulated workers. Publicly available reports no longer show the composition of the Aboriginal and Torres Strait Islander workforce within NSW Health, including the difference between clinical and non-clinical areas of work. However, in 2017, a report released by the NSW Health identified that that the majority of Aboriginal and Torres Strait Islander people working within NSW Health were receiving salaries that were between $0 and $45,000, the lowest income bracket (NSW Health, 2017). As clinical roles are generally paid more than non-clinical roles, such as housekeeping, this may indicate that most of the Aboriginal and Torres Strait Islander people were working in non-clinical roles (Industrial Relations Commission of New South Wales, 2018a, 2018b, 2018c). The 2017 NSW Health report indicates that 3,103 individuals identifying as Aboriginal and Torres Strait Islanders were working within their system: of these, 93 were medical practitioners, 793 were nurses and six were in senior executive roles. The remaining 2,211, approximately two-thirds of the Aboriginal and Torres Strait Islander health workforce, were in unspecified roles. (NSW Health, 2017, p.36). Thus, it appears that the priority has been meeting the performance target of increasing the overall number of Aboriginal and Torres Strait Islander people in the health workforce in NSW, rather than increasing the representation of this population group in clinical roles. To the unaware reader, it would seem that meeting the first target is progressing well, at 2.5% of
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

The health workforce in NSW; however, the missing information and the data that is reported masks the reality of the situation with regard to representation of this population group in clinical roles.

The Closing the Gap policy indicates that the Aboriginal and Torres Strait Islander health workforce needs to be increased to meet the needs of Aboriginal and Torres Strait Islander people and communities, with the intent of improving health outcomes (COAG, 2008, 2012b). This aspiration can be considered in the following two ways:

- Employing more Aboriginal and Torres Strait Islander people within health, in areas such as ancillary, administrative or housekeeping non-clinical roles, has a positive and direct influence on improving people’s health and well-being (Marmot, 2011).

- Having more Aboriginal and Torres Strait Islander people in clinically oriented roles such as nursing not only provides employment but also can have a greater effect in the delivery of health care, where trust can be established between the health care provider and the person seeking health care treatment (Best & Stuart, 2014; Indigenous Nursing Education Working Group, 2002; Lockyer, 2013).

Under the auspices of the Closing the Gap policy, one strategy to increase the number of Aboriginal and Torres Strait Islander people entering the health workforce and providing clinical care to Aboriginal and Torres Strait Islander people was the introduction of the Aboriginal Health Worker role (Curtis & Reid, 2013; Health Workforce Australia, 2011b, 2014a). This profession was implemented as a way to provide culturally safe care to Aboriginal and Torres Strait Islander people under a primary health care model (Industrial Relations Commission of New South Wales, 2018b). Potentially, this alternative role may be acting as a disincentive for Aboriginal and Torres Strait Islander people choosing nursing as a career when a similar role is available. The Aboriginal Health Worker role has a similar scope of practice to that of the nursing role (Aboriginal Health Council of South Australia, 2017; Nursing and Midwifery Board of Australia, 2016a). However, gaining an Aboriginal Health Practitioner/Worker qualification can be undertaken in significantly less than the time it takes to become an RN, making this profession more attractive to those who have family and community obligations and may be financially disadvantaged (Deravin, Anderson, et al., 2017).
Qualifying as an Aboriginal Health Worker is currently achieved via a certificate Level 3 Vocational Education Training program, which ranges from six weeks to six months in length (Deravin, Anderson, et al., 2017). These programs are an attractive choice compared with entering a Diploma (EN), Bachelor of Nursing (RN) or Bachelor of Midwifery (RM) program. In nursing, which offers both regulated (EN, RN and RM) and unregulated (AIN) clinical roles, the length of study may vary from 10 months to three years (Department of Education, 2019; Open Colleges, 2015). The financial effects of studying away from home and for extended periods are factors for any person wishing to undertake tertiary education to obtain a health career. If an alternative role is offered that requires less time to obtain a qualification, and has similar salaries and wages, it is logical to assume that Aboriginal and Torres Strait Islander people may prefer becoming an Aboriginal Health Worker or an unregulated worker in nursing, such as the AIN role, rather than entering the regulated nursing profession (EN, RN and RM). Table 8.4 illustrates the differences in wages between Aboriginal Health Workers and the various nursing roles.

**Table 8.4: Comparison of Wages between Nurses and Aboriginal Health Workers in NSW**

<table>
<thead>
<tr>
<th>Role</th>
<th>Entry-level Wage, Full Time, Per Week</th>
<th>Highest Salary Point for Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Worker</td>
<td>$1,017.27</td>
<td>$1,498.25</td>
</tr>
<tr>
<td>(unregulated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Health Practitioner</td>
<td>$1,152.88</td>
<td>$1,498.25</td>
</tr>
<tr>
<td>(regulated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIN</td>
<td>$862.30</td>
<td>$946.20</td>
</tr>
<tr>
<td>EN</td>
<td>$1,081.70</td>
<td>$1,211.30</td>
</tr>
<tr>
<td>RN</td>
<td>$1,200.10</td>
<td>$1,685.10</td>
</tr>
<tr>
<td>RM</td>
<td>$1,200.10</td>
<td>$1,685.10</td>
</tr>
</tbody>
</table>

Adapted from *Health Professional and Medical Salaries (State) Award 2018* and *Public Health System Nurses’ and Midwives’ (State) Award 2018* (Industrial Relations Commission of New South Wales, 2018b, 2018c)

Overall, the Closing the Gap policy has been a way forward to increase the representation of Aboriginal and Torres Strait Islander people within the health workforce. Ways to improve health outcomes for Aboriginal and Torres Strait Islander people are needed and should be supported (Best & Stuart, 2014; Deravin, Anderson, et al., 2017; Indigenous Nursing Education Working Group, 2002). However, I question whether it is ethically
sound to encourage Aboriginal and Torres Strait Islander people to make career choices (such as the Aboriginal Health Worker roles) that limit further career advancement. For example, in NSW, becoming the manager of a small rural facility requires being an RN (Industrial Relations Commission of New South Wales, 2018c). If an Aboriginal Health Worker wishes to become the facility manager, they need to undertake a program of study that can lead to licensure as an RN. These programs often require students to relocate for study and can lead to increased financial pressure through loss of income. This could potentially limit the Aboriginal and/or Torres Strait Islander person to seek advancement in a career in health when they have obligations to family and community (Clark, 2013; Hinton & Chirgwin, 2010; West et al., 2013).

Other inhibitors to accessing further education may include an inability to attend on-campus study because of family and community obligations; additional costs to attend residential schools if studying online; needing to undertake work placement away from place of residence; and loss of income while meeting study requirements (Francis & Mills, 2011; Harvey, Burnheim, & Brett, 2016). I wonder whether the covert message in the Closing the Gap policy and its subsequent strategies is that Aboriginal and Torres Strait Islander people should accept such career limiting options and undertake tertiary qualifications that are ‘token’. I am not debating the value of the role of an Aboriginal Health Worker, as I know that both that role and other health professions (such as nursing) have a definite place in improving health outcomes for Aboriginal and Torres Strait Islander people (Deravin, Anderson, et al., 2017). In fact, I contend that the nursing profession must actively seek to attract more people to its ranks from both high school leavers and those already in Aboriginal Health Worker roles.

8.4.2 Financial support

As supported by the Closing the Gap policy, opportunities exist for Aboriginal and Torres Strait Islander people to gain financial assistance for undertaking tertiary studies. These may be provided in the form of grants and scholarships, such as the Indigenous Cadetship Support Program (Queensland Health, 2009), which incorporates workplace learning. Additionally, there are grants solely for the support of tertiary study, such as the Puggy Hunter Memorial Scholarship (Department of Health, 2018). This does not mean that all Aboriginal and Torres Strait Islander people have either a scholarship or grant to undertake tertiary study; this misconception is pervasive in the wider community.
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing (Carlson, 2017). Aboriginal and Torres Strait Islander students, similar to their non-Indigenous counterparts, are obliged to repay their Higher Education Contribution Scheme debt (Department of Education and Training, 2018).

As noted above, a number of financial supports, underpinned by government policy, are available for Aboriginal and Torres Strait Islander students while undertaking their studies (Department of Education and Training, 2015). In 2018, the National Aboriginal and Torres Strait Islander cadetship program, formerly administered by the Department of Education, Employment and Workplace Relations was ‘rebadged’ to become the Tailored Assistance Employment Grant, overseen by the Department of the Prime Minister and Cabinet (2018). While changing responsibilities between government agencies is reasonably common, this could lead to confusion in employers and potential applicants in understanding how to gain access to funding options.

NSW offers a nursing-specific cadetship program, the NSW Aboriginal Nursing and Midwifery Cadetship Program, which may account for this states’ superior performance in recruiting Aboriginal and Torres Strait Islander nurses and midwives to the profession, compared with other Australian states (NSW Health, 2016b). While similar programs are available in Western Australia, South Australia, Victoria and Queensland, not all of them are specific to nursing and midwifery (Fawcett, 2010; Queensland Health, 2009; Victorian Department of Health and Human Services, 2017; Western Australia Department of Health, 2018). The NSW cadetship program offers both financial support and employment experience while studying to become an RN or RM. To qualify for this program, Aboriginal and Torres Strait Islander students must be full time and study on campus (NSW Health, 2016b). The introduction of cultural mentors to support cadets both within the workplace and at tertiary institutions should be made available to these cadets regardless of study modalities. However, as family obligations and commitments are of particular importance to Aboriginal and Torres Strait Islander people, the requirement to study on campus would preclude those who wish to remain within their communities and study via the online modality from accessing this cadetship. Resolving this issue may encourage more Aboriginal and Torres Strait Islander people to consider studying nursing and midwifery online.

Scholarships and ongoing grants are essential for supporting Aboriginal and Torres Strait Islander to live and study away from home, particularly those from low socioeconomic
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groups (Best, 2011; Clark, 2013; Hinton & Chirgwin, 2010; Usher, Lindsay, Miller, et al., 2005). Another financial support that is available for students is ABSTUDY, which is a regular government-funded payment. The amount of ABSTUDY to be paid to a student is assessed by government agencies and may be reduced or withdrawn if the student receives other forms of financial support (Department of Human Services, 2019).

Funding models in the public health service sector are primarily based on organisations achieving predetermined targets, such as those outlined in the Closing the Gap policy (COAG, 2008). For public health services, achieving performance targets is prioritised when additional funds are provided by the federal and state government to support the delivery of health care. It was not made clear in the Closing the Gap agreement and strategy documents whether funding would be provided to increase the representation of Aboriginal and Torres Strait Islander people within the health workforce; this was only implied. Further consideration should be given to what this actually means in terms of people, rather than simply meeting number-based targets (Indigenous Nursing Education Working Group, 2002). A shift in priorities within government and health organisations will be required to meet the needs of individuals and support the retention of an Aboriginal and Torres Strait Islander nursing and midwifery workforce.

Tertiary education institutions obtain their funding through student fees and the Commonwealth Grant Scheme (Department of Education and Training, 2014). Additional money is made available to higher education providers through the Indigenous Support program, based on the number of Aboriginal and Torres Strait Islander student enrolments (Department of Education and Training, 2018). However, this last program can lead to offers of enrolment being provided to people who may not succeed in tertiary studies. West (2013) argues that it is amoral to set people up to fail. Perhaps a better model to support Aboriginal and Torres Strait Islander students to complete their studies successfully, regardless of area of study, would be to provide tertiary education institutions with part of the funding when an Aboriginal and/or Torres Strait Islander person enrolls; another portion upon their progression through their tertiary course; and the balance when the student has completed their studies and graduated. In this way, tertiary education institutions would be encouraged to support the Aboriginal and Torres Strait Islander person throughout their program of study, rather than focusing only on enrolments. This model should be considered university wide and across all programs.
where Aboriginal and Torres Strait Islander people engage in tertiary study (Blackman, 2011; Goold, 2011).

8.4.3 Recognition of existing knowledge and transferable skills

Providing recognition of prior learning and the acknowledgement of transferable skills from one profession to another is a strategy that has been adopted to improve access to university and bolster enrolments. Stuart and Gorman (2015) suggest that giving recognition to Aboriginal Health Workers’ prior experience and existing knowledge and transferable skills may be a way of encouraging Aboriginal and Torres Strait Islander people into nursing programs. Mapping of existing qualifications and recognition of prior knowledge and skills against the nursing education curriculum has been suggested in the literature. However, the uptake of mapping other health profession qualifications (Best & Stuart, 2014; Stuart & Gorman, 2015) and in particular, the Aboriginal Health Worker role, which ranges from Level 2 to Level 7 in the Australian Qualifications Framework (2013c), has been limited to date. Tertiary education organisations could address the gap between different health professional qualifications and nursing by moving forward on this strategy.

Shortened pathways are available for nurses who wish to undertake further tertiary education study to become an RN (Australian Qualifications Framework Council, 2013c; Stuart & Gorman, 2015). Articulation pathways from an EN (Diploma Level 5) to an RN (Bachelor Level 7) (Australian Qualifications Framework Council, 2013a, 2013b) already exist, where an EN may be provided with recognition of prior learning in their previous study and achievements of up to 33% towards the Bachelor course. However, for those who enter study to become an RN, there are limited reverse-articulation pathways that could potentially grow a nursing workforce.

As attrition rates for Aboriginal and Torres Strait Islander people undertaking tertiary study are high (Nakata, 2012; West et al., 2010), there is an opportunity to rethink approaches for supporting these students (as well as non-Indigenous students) to complete their studies. Consideration should be given to a reverse-articulation pathway with staged exit points, where students who may have commenced an undergraduate degree (Bachelor) to become an RN can obtain a lower-level qualification, such as an AIN Certificate (Level 3) or a diploma-level qualification, which would give them the credentials to become an EN. This would require the development of partnerships with
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing vocational educational training providers and universities (Crevacore, Duffield, & Twigg, 2018). In this way, students who are struggling with the full RN study program could be rewarded and recognised for the study they have completed so far and thus, they could attain a nursing qualification that gives them the ability to enter the nursing profession.

8.4.4 Reducing attrition and successfully completing a nursing course

The attrition rate for Aboriginal and Torres Strait Islander people in their first year of nursing tertiary studies is higher than that for non-Indigenous students (Goold & Usher, 2006; Nakata, 2012; West et al., 2010). Nakata’s (2012) study showed that Aboriginal and Torres Strait Islander students were more likely to study via the distance mode, to be part time, to be mature-age students with lower university entry scores and to come from a low socioeconomic background. This significant level of disadvantage may explain why retention rates among Aboriginal and Torres Strait Islander people are poor. When policy documents continue to portray Aboriginal and Torres Strait Islander people in a negative way and when the government (the dominant culture) decides that they know what is best for a population, these factors could be influencing Aboriginal and Torres Strait Islander people to accept that they are too disadvantaged to make positive changes. However, with the Closing the Gap policy supporting ways of improving the level of successful completion of secondary education, to support Aboriginal and Torres Strait Islander people to gain authentic employment, there are opportunities to counteract this disadvantage (NSW Health, 2008). Role models who have completed their education and then gone on to have successful nursing careers should be used to contradict this negative portrayal (Deravin, Anderson, et al., 2017; Lockyer, 2013; Usher, 2011).

Thus, it is clear that to increase the representation of Aboriginal and Torres Strait Islander people within the nursing workforce, a range of options must be considered to support future applicants into nursing through improved pathways. To retain Aboriginal and Torres Strait Islander people both at tertiary institutions and within the health workforce, access to ongoing academic and cultural support should be considered, as explained further in the next section.
Chapter 8 Increasing the Representation of Aboriginal and Torres Strait Islander People in Nursing

8.5 Retaining a Nursing Workforce that is Inclusive of Aboriginal and Torres Strait Islander People

Strategies for retaining nurses within the health workforce have been detailed in the literature. They include access to clinical mentors, promotion of the caring aspect of nursing rather than remuneration, safe patient-to-staff ratios, access to ongoing professional development and opportunities for career advancement (Mahnken, 2001; Mills et al., 2010; Mills et al., 2007a, 2007b; Molinari & Monserud, 2008; World Health Organization, 2010). Aboriginal and Torres Strait Islander people have the added burden of family and community obligations (Best, 2011; Clark, 2013), which can limit career choice or progression.

Additional workforce support should be made available to Aboriginal and Torres Strait Islander people, should they choose to access it, in the form of clinical and cultural mentors (Indigenous Nursing Education Working Group, 2002). Perhaps better workforce models that offer permanent positions, rather than contracts and casual positions, may entice Aboriginal and Torres Strait Islander people to enter fields such as education and research, or to work within rural and regional areas that struggle to attract clinicians and academics. The nursing profession, as the largest component of the health workforce, has a strong voice in achieving change. Aboriginal and Torres Strait Islander nurses need to work alongside their non-Indigenous counterparts to implement ways of increasing the nursing workforce to meet the health care demand for all population groups. This can be achieved only with mutual respect and cooperation.

Even though it has been indicated that Aboriginal and Torres Strait Islander people are better cared for by Aboriginal and Torres Strait Islander people (Stuart & Nielsen, 2011), this should not preclude individual choice. Being of Aboriginal and Torres Strait Islander descent should not be career limiting to the extent of expecting that Aboriginal and Torres Strait Islander people should care only for their own communities. Aboriginal and Torres Strait Islander nurses, through self-determination, should be able to work anywhere within the health services, irrespective of who the service provider is, as long as their skills (inclusive of cultural knowledge) are congruent with the service and the work being undertaken. Aboriginal and Torres Strait Islander role models in a variety of positions could be utilised to demonstrate that nursing provides this variety of choice and that working within nursing can be a rewarding and diverse career.
Government and policy writers hold power over Aboriginal and Torres Strait Islander people. Policy can have a significant influence on increasing the representation of Aboriginal and Torres Strait Islander people in the nursing workforce. Additional factors that can affect the representation of Aboriginal and Torres Strait Islander people entering and remaining in nursing are cultural considerations (including obligations to family and community), the embedding of cultural competence and humility within the health and education sectors, and lack of access to education limiting employment choices in areas such as nursing. Pathways into nursing are influenced by government policy, with priority currently being given, through funding initiatives, to having Aboriginal and Torres Strait Islander people being part of an unregulated and less skilled health workforce, rather than in professions such as nursing.
Chapter 9: RECOMMENDATIONS AND CONCLUSION

‘We are all visitors to this time, this place. We are just passing through. Our purpose here is to observe, to learn, to grow, to love ... and then we return home.’

Australian Aboriginal proverb, date unknown

At the commencement of this study, I wanted to understand whether government policy was influencing Aboriginal and Torres Strait Islander people to choose nursing as a career option. The Closing the Gap policy has now been in place for over 10 years, with mixed success in achieving the intended outcomes (Australian Government, 2009, 2010, 2011, 2012, 2013, 2014, 2015; Commonwealth of Australia, 2016b, 2017; COAG, 2008; COAG, 2012b). The research questions presented at the beginning of this study were as follows:

- Has government policy (Closing the Gap) had an effect on whether Aboriginal and Torres Strait Islander people choose nursing as a health career?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to consider joining the nursing profession in preference to other regulated and unregulated health careers?
- Has government policy (Closing the Gap) encouraged Aboriginal and Torres Strait Islander people to remain in nursing?

Using Fairclough’s’ methodology of critical discourse analysis in this study, I have looked for evidence within the Closing the Gap policy agreement and strategy that would bring me to a deeper understanding of the way government policy may influence Aboriginal and Torres Strait Islander people to enter and remain in the nursing profession. To ensure the academic rigour of this thesis, I have utilised a qualitative research methodology – critical discourse analysis, as informed by Fairclough (Fairclough, 2003, 2010, 2015). Throughout the analysis of findings and the subsequent discussion, I have indicated when personal reflections may have affected my thinking and provided acknowledgement of any personal experience that may have influenced the interpretation of the texts under review, thus ensuring the credibility of this study (Hammarberg et al., 2016; Noble & Smith, 2015). Utilising a structured framework (dependability) in the interpretation of the two policy documents reviewed has minimised bias within this study (Liamputtong, 2013). Confirmability has been demonstrated through clear links between...
the findings, discussion and the subsequent recommendations (Cope, 2014; Liamputtong, 2013). Transferability of the research findings have been validated with reference to other literature that supports my discussion (Ambert et al., 1995; Cope, 2014; Liamputtong, 2013; Noble & Smith, 2015). Historical, political and social contexts (authenticity) that affect whether Aboriginal and Torres Strait Islander people consider nursing as a career choice have been offered (Crowe, 2005).

This critical discourse analysis has examined the use of language, provided an interpretation of the overt and covert messages within the specified policy documents and then considered the broader aspects of the way the policy is potentially influencing Aboriginal and Torres Strait Islander people with regard to entering and remaining in the nursing profession (Fairclough, 2010, 2015; Francis, 2013). The recommendations that I present to the nursing profession and the wider community from this study are offered as suggestions to bolster the numbers of Aboriginal and Torres Strait Islander people who may consider nursing as a career choice and to retain them within the nursing profession.

9.1 Implications

The intention of the Closing the Gap policy was to improve health outcomes for Aboriginal and Torres Strait Islander people, addressing the social imbalance experienced by this population group (COAG, 2008, 2012b). The way this policy has been interpreted, enacted and received within the wider community has, and continues to have, an effect on the way Aboriginal and Torres Strait Islander people are perceived within society (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Commonwealth of Australia, 2017; COAG, 2008; COAG, 2012b). As noted in previous chapters, in Aboriginal and Torres Strait Islander people’s experience, government policy historically has had both intended and unintended outcomes (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005; Australian Human Rights Commission, 2009). When policy is enforced without adequate and genuine consultation with the group that will be most affected by the policy, it is not surprising that the success of the outcomes of this policy will be mixed (Australian Government, 2010, 2011, 2012, 2013, 2014, 2015; Commonwealth of Australia, 2016b, 2017).

The paternalistic attitude of government policy writers towards Aboriginal and Torres Strait Islander people must change. It is time for the government to desist from perpetuating policies that focus on doing to, or for, and on behalf of, this population group.
and embrace an approach that embodies working with, and in true partnership, to achieve common goals. Aboriginal and Torres Strait Islander people should have the opportunity to have a say in the way they want health care delivered and what they wish their future to look like, rather than being told what it should be. This agenda can be achieved through authentic consultation with the key Aboriginal and Torres Strait Islander interest and positive action groups that represent this wide and varied population group. In this way, long-term change, which requires long-term strategies and commitment to sustain the change process, could be achieved.

Policy writers and those who develop the annual reports for the Closing the Gap policy use language that many within society may not understand (i.e., political speak). The way the annual reports are presented can lead the reader to believe that the Closing the Gap policy has been successful since its implementation, when in fact, the reality is that actual performance with regard to many of the targets are below the projected outcomes (Australian Government, 2010, 2011, 2012, 2013, 2014, 2015; Commonwealth of Australia, 2016b, 2017). Governments are accountable to the wider community for their performance. When Human Rights Organisations drew attention to the poor health outcomes of Aboriginal and Torres Strait Islander people in Australia, the government, through public pressure, was called to account (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). As the Closing the Gap policy is linked to gaining and maintaining political favour, blame has often been shifted to previous governments regarding poor performance and the failure to meet many of the targets set within the agreement (Commonwealth of Australia, 2016b). Using political speak to report on performance in the annual reports can mask reality. The format of government reports depends on who writes the report in any given year and which political party is in government at the time. The collecting and reporting of data needs to be consistent across the years so that lay people can understand what is being reported and can evaluate the achievements and/or failures of the policy and the performance of the government.

Within the Closing the Gap policy there is a commitment to increase the representation of Aboriginal and Torres Strait Islander people in the health workforce. As nursing is the largest group in the Australian health workforce, an aim of this study was to understand the way the policy would address this challenge. Workforce strategies to increase Aboriginal and Torres Strait Islander representation within the health workforce have led to the development of both regulated and unregulated roles, such as the Aboriginal Health
Worker role, which is similar in its scope of practice to the nursing role (Aboriginal Health Council of South Australia, 2017; Nursing and Midwifery Board of Australia, 2016a). This has influenced Aboriginal and Torres Strait Islander people to consider career choices other than nursing.

For any change to occur, the people for whom the change is intended need to be authentically involved in the decision-making process, as active participants in shaping their future and for the wider community that they represent (National Congress of Australia’s First Peoples, 2016). This study has examined the way the Closing the Gap policy language could be interpreted (Chapters 5 and 6); what the policy might mean to Aboriginal and Torres Strait Islander people (Chapters 6 and 7); and the implications for a health profession such as nursing, which seeks to increase the representation of Aboriginal and Torres Strait Islander people within its workforce (Chapter 8).

### 9.2 Recommendations

This study has considered the way the imbalance of power favours government bodies, which are the dominant culture, over the Aboriginal and Torres Strait Islander people. As the government is the dominant power and has control over policy implementation and direction, encouraging more Aboriginal and Torres Strait Islander people to choose nursing as a career has had an effect. This study has examined the barriers that have constrained the increase in the numbers of Aboriginal and Torres Strait Islanders people within nursing. These are cultural considerations, limited pathways into nursing and inconsistent support for Aboriginal and Torres Strait Islander people who undertake a nursing course at tertiary institutions and/or enter the nursing workforce. The following recommendations are offered as a way to address some of these barriers.

#### 9.2.1 Cultural considerations

As suggested in both of the seminal documents interrogated in this study, the provision of culturally safe health services for Aboriginal and Torres Strait Islander people is a key priority for effecting change (COAG, 2008, 2012b). To achieve this goal, the policy writers note that health programs delivered to Aboriginal and Torres Strait Islander people must be culturally appropriate. Achieving this expectation is reliant on health service staff being culturally competent in the delivery of health care (Betancourt et al., 2003). This objective can be accomplished through the delivery of cultural safety education and
training for all existing health staff and for those who may wish to join the health workforce (students in a variety of health professions) at some time in the future.

Increasing the numbers of Aboriginal and Torres Strait Islander people employed in the health sector was seen as an effective strategy for improving access to, and satisfaction with health care delivery, for this population group (COAG, 2012a; Stuart & Nielsen, 2011; West et al., 2010). As nursing is such a large proportion of the health workforce, it would seem logical that both the current and future nursing workforce should incorporate cultural competency programs as a core component of their registration and future professional development. To achieve a culturally competent nursing workforce, cultural competency programs that move beyond basic cultural safety and awareness should be implemented (Downing et al., 2011).

**Recommendation 1: Cultural safety programs should be implemented and made mandatory for all members of the nursing workforce, inclusive of both the health industry and the education sector**

As discussed in Chapter 8, the Nursing and Midwifery Board of Australia has mandated that the Standard of Practice for nurses and midwives should be respectful of Aboriginal and Torres Strait Islander culture and experience (Nursing and Midwifery Board of Australia, 2016a, 2016b, 2018). This is a positive step forward in breaking down cultural barriers. Within the accreditation of nursing courses, ANMAC has mandated that cultural content must be included into undergraduate courses for enrolled nurses, registered nurses and midwives and post-registration professional development (ANMAC, 2012). When tertiary education organisations undergo accreditation for their nursing and midwifery courses, assessment panels may or may not have an Aboriginal and/or Torres Strait Islander person as part of the team. In recognition that there are a limited number of Aboriginal and Torres Strait Islander people who are suitably qualified and available to undertake this work until this workforce grows in number then the next level of approval being the review committee should include a person who identifies as Aboriginal and o/r Torres Strait Islander. Currently, ANMAC does not indicate that the accreditation review committee for these courses should have a person of Aboriginal and Torres Strait Islander origin (ANMAC, 2016). To be authentic in the assessment of the cultural content of
curricula, the ANMAC accreditation review committee must include an Aboriginal and Torres Strait Islander person.

**Recommendation 2: The ANMAC accreditation review committee of tertiary education courses must include an Aboriginal and Torres Strait Islander person.**

In support of the inclusion of cultural content within curricula, the recently released ‘Aboriginal and Torres Strait Islander Health Curriculum Framework’ (Commonwealth of Australia, 2016a) should be implemented fully across all Australian tertiary education institutions. This strategy includes the promotion of cultural content, with the integration of Indigenous pedagogies to assist the learning experience for undergraduate students. This will require tertiary education institutions to work in true partnership with local Aboriginal and Torres Strait Islander communities (Universities Australia, 2017; Yunkaporta, 2009).

**Recommendation 3: Tertiary education providers should work in consultation with Aboriginal and Torres Strait Islander communities to integrate Indigenous pedagogies in nursing curricula.**

Aboriginal and Torres Strait Islander people who have successfully completed tertiary studies and have continued to work within the nursing profession should be actively promoted as role models within the profession. The involvement of Aboriginal and Torres Strait Islander nurses and midwives (where available) in recruitment drives to increase the representation of Aboriginal and Torres Strait Islander people in nursing should be considered. Employing organisations must prioritise identified Aboriginal and Torres Strait Islander positions within the health workforce so that parity to the wider population can be achieved and that there is a growing number of Aboriginal and Torres Strait Islander nurses to participate in recruitment drives and act as role models for the wider community.

**Recommendation 4: Promote successful Aboriginal and Torres Strait Islander nurse role models to attract Aboriginal and Torres Strait Islander people to choose nursing**
as a career option, including all clinical practice areas, nursing administration, education and research.

Once graduated, nurses and midwives have a wide and varied career choice within the profession. To gain influence over a future nursing workforce Aboriginal and Torres Strait Islander nurses and midwives should be encouraged and supported to consider positions within management, education and research. As representation of Aboriginal and Torres Strait Islander people in Australian nursing academia is significantly low (Department of Education and Training, 2017; Health Workforce Australia, 2014b), tertiary education institutions should actively recruit Aboriginal and Torres Strait Islander people to nursing academic and research roles.

**Recommendation 5: That Aboriginal and Torres Strait Islander nurses and midwives be supported and mentored to aspire to leadership roles which will benefit and strengthen the nursing workforce culture.**

The literature indicates that Aboriginal and Torres Strait people often do not complete university courses because they feel culturally unsafe (Best & Stuart, 2014; Downing et al., 2011; Indigenous Nursing Education Working Group, 2002; West et al., 2010). Apart from the implementation of cultural competence programs, another solution would be the introduction of Aboriginal and Torres Strait Islander-specific cohorts within undergraduate nursing courses. In addition, Australia should contemplate following the USA model, where Indigenous people have provided and supported Indigenous-only tertiary education institutions (American Indian Higher Education Consortium, 2019). If the government in Australia is genuine about wanting to develop the autonomy of Aboriginal and Torres Strait Islander people, then support for additional Aboriginal and Torres Strait Islander-only tertiary education institutions, similar to the Batchelor Institute of Tertiary Education, should be replicated and extended throughout Australia. These institutions should be staffed by Aboriginal and Torres Strait Islander people and would encourage and support Indigenous pedagogies and research.
Recommendation 6: Consideration should be given to the introduction of Aboriginal and Torres Strait Islander-only cohorts within nursing undergraduate courses.

To assist with the transition of students to studying at university, as well as when graduates enter the nursing workforce as RNs, the use of mentors has been shown to be useful (Clark, 2013; Indigenous Nursing Education Working Group, 2002; Stuart & Nielsen, 2011; West et al., 2010). It is suggested that this could go beyond utilising academic or skills-based mentors and include cultural mentors as well, in both tertiary education institutions and health organisations. Mentors could be drawn from existing Aboriginal and Torres Strait Islander nurses and midwives already working within both systems. If insufficient mentors are available, then reaching out to local Aboriginal and Torres Strait Islander communities to support students could be considered. A back-up option could be for appropriately educated staff who are not of Aboriginal and Torres Strait Islander origin to provide pastoral care support to Aboriginal and Torres Strait Islander undergraduate nursing students and those transitioning into clinical practice. In this way, relationships would be built between the two groups.

Recommendation 7: Cultural mentors should be offered to Aboriginal and Torres Strait Islander undergraduate nurses and those within the existing nursing workforce.

9.2.2 Access to tertiary education and ongoing support

To increase the representation of Aboriginal and Torres Strait Islander people in nursing, from the current 1% of the nursing workforce to 3.3% (the national proportion of Aboriginal and Torres Strait Islander people within Australia) (Australian Bureau of Statistics, 2018), a multi-layered approach is required.

As RNs have access to broader career opportunities, the goal to increase the number of Aboriginal and Torres Strait Islander nurses needs to be a priority for the profession. Mapping of qualifications and recognition of prior learning to enter an undergraduate nursing course already exists for AINs or ENs who have completed a certificate Level 4
or diploma Level 5 course (Australian Qualifications Framework Council, 2013b). Aboriginal Health Workers, whose scope of practice is already similar to that of RNs, should be offered shortened education pathways into nursing, in recognition of the skills they have already gained.

**Recommendation 8: All providers of nursing education should develop pathways for Aboriginal and Torres Strait Islander people that accommodate prior learning and other relevant experiences.**

As attrition rates are high among Aboriginal and Torres Strait Islander undergraduate nursing students, particularly in the first year of study (Nakata, 2012), opportunities within the RN course to exit the course but still gain a qualification at a lower level than a Bachelor degree should be identified and supported. Working in partnership with vocational training institutions to develop reverse-articulation pathways, so that students can attain a certificate Level 4 (AIN), or a diploma (Level 5) to become an EN, should be considered (Australian Qualifications Framework Council, 2013a). In this way, students will be acknowledged for the study they have undertaken. This should apply not only for Aboriginal and Torres Strait Islander people but also for the wider nursing undergraduate student population, to help to sustain the nursing profession into the future.

**Recommendation 9: Reverse-articulation pathways should be developed, through a partnership between universities and vocational education institutions, to provide exit points from a Bachelor degree into an alternative nursing qualification such as an AIN or EN.**

Obligations to community and family are a significant consideration for Aboriginal and Torres Strait Islander people who wish to undertake further education to gain employment. Even though there are scholarships and cadetship programs available to Aboriginal and Torres Strait Islander people, they are not necessarily nursing-specific. The NSW cadetship program has had reasonable success in supporting Aboriginal and Torres Strait Islander people to enter the nursing profession and may account for this states’ better performance in this area, compared with other states and the national average (NSW Health, 2016b).
Access to financial support to allow Aboriginal and Torres Strait Islander people to study away from home or to support them to undertake online study by supplementing a reduced income is essential. Online education is becoming a preferred option as a mode of study for many students. The delivery of education is changing from being provider and staff focused to consumer/student centred (Open Universities Australia, 2019; Stone et al., 2016). Eligibility for some scholarships and cadetships, such as the NSW Aboriginal Nursing and Midwifery Cadetship Program (NSW Health, 2016b), is based on the student attending on-campus study only. In this new era of student-focused education, scholarships and cadetships to support education should allow for flexibility in terms of modality of course delivery, location of the study and the nature of progression (full time or part time).

**Recommendation 10:** Additional cadetships and scholarships with no restrictions with regard to mode of study or study load should be made available to Aboriginal and Torres Strait Islander people who wish to enter into nursing.

Incentives are provided by the federal government to encourage universities to accept more Aboriginal and Torres Strait Islander people into tertiary education (Department of Education and Training, 2018; Schubert & Counihan, 2017; Universities Australia, 2017). This model rewards tertiary education organisations for increasing their enrolments but not for successful completion of courses. An alternative model that provides additional incentives for universities to support Aboriginal and Torres Strait Islander people to complete their studies successfully, with funding provided on the successful completion of predetermined milestones, should be considered, particularly in the area of health. This would ensure the tertiary education sector has a vested interest in the successful completion of tertiary-based study programs.

**Recommendation 11:** Funding provided by the federal government to the education sector to support Aboriginal and Torres Strait Islander people to undertake study should be apportioned to enrolment, successful completion of milestones (progressing through first year, second year) and then on completion.
9.3 Strengths and Limitations of this Study

This study utilised a critical discourse analysis approach to provide a structured framework that guided the research process. Within qualitative research, bias is inherent. However, adhering to a rigorous approach that aligns with the chosen methodology has been shown to minimise bias (Noble & Smith, 2015; Smith, 2007). Personal experience and bias in the interpretation of the data has been declared, contributing to the credibility of using this methodological approach. I elected to use a Westernised approach to the interpretation of social policy, rather than an Indigenous research methodology. The premise for making this decision was to present an analytical interpretation of government policy documents using a framework that is historically congruent with the dominant policy discourse and therefore, more likely to be understood and valued. In this study, I have however used my own personal lived experience as an Indigenous lens in the interpretation of the data. Adopting this approach has illuminated the way government policy has influenced Aboriginal and Torres Strait Islander people to consider or reject nursing as a career choice.

I acknowledge that a study limitation was the selection of only publicly available Australian Government policy documents and reports that provided supportive strategies to enact the intended targets identified within the Closing the Gap agreement and strategic plan between the years 2008 to 2017. Subsequent reports, which could demonstrate a change in the performance of the Closing the Gap policy targets after the specified date range, were not included in this study. However, since the release of the Redfern Statement (National Congress of Australia’s First Peoples, 2016), significant social change has been occurring, with positive action groups working closely with government departments to voice their needs in relation to improving the health outcomes of Aboriginal and Torres Strait Islander people in Australia.

9.4 Conclusion

In this study, I have examined the language within policy, offered an interpretation of its meanings by examining the overt and covert messages contained within the policy documents and I have questioned the ethics of one group speaking on behalf of another without authentic and genuine consultation. It is well known and acknowledged that Aboriginal and Torres Strait Islander people have poorer health outcomes than non-
Indigenous people. The Closing the Gap policy requires significant resources, coordination, engagement and long-term multiple approaches to make a difference.

The textual analysis of the policy revealed the overt message that the balance of power favoured the government over the Aboriginal and Torres Strait Islander people for whom the policy was developed. This issue has the potential to have a significant negative effect on increasing the representation of Aboriginal and Torres Strait Islander people in the nursing workforce. This study has identified barriers including: cultural considerations, ineffectual education pathways and the ad hoc approach to implementation and ongoing sustainability of workplace support strategies. These considerations affect whether Aboriginal and Torres Strait Islander choose nursing as a career option.

9.5 The End of the Journey

As I have progressed along this journey of discovery and understanding, I have realised how much I have learned. At times, this ‘walk along the river’ has shown me a riverbed so dry that I did not think that I could find enough ideas to complete this thesis. At other times, the river has been awash (in flood) with so many ideas that I struggled to make sense of what was important.

All through this journey, I have felt the spirit of my mother and my maternal ancestors pushing me to keep going. They walked beside me. I cannot help but think that I will be scorned for challenging Westernised policy, although I stand by my decision to do so. For me, reconciliation means forgiveness, acceptance and ways to move forward. Mine is only one voice. For change to occur, many small voices need to speak as one, so that we gain strength and can be heard. Without the knowledge that my mother passed down to me I would not have pursued this learning journey. Because of her, and for her, I did.

Figure 9.1 shows a diagrammatic representation of the influences on Aboriginal and Torres Strait Islander people with regard to choosing a nursing career. This is a symbolic representation of my PhD journey as well, the river walk mentioned at the beginning of this thesis.
Figure 9.1: Diagrammatic Representation of the Influences on Aboriginal and Torres Strait Islander People with Regard to Choosing a Nursing Career
The following poem indicates the way forward, if we are to see authentic change for the future of Aboriginal and Torres Strait Islander people and their increased representation within the nursing workforce. We cannot walk this journey alone. We need partners to help us in the future.

United We Win

by Noonuccal, Oodgeroo

The glare of a thousand years is shed
on the black man’s wistful face,
Fringe-dweller now on the edge of towns,
one of a dying race;
But he has no bitterness in his heart
for the white man just the same;
He knows he has white men friends today,
he knows they are not to blame.
Curse no more the nation’s great,
the glorious pioneers,
Murderers honoured with fame and wealth,
won of our blood and tears;
Brood no more on the bloody past
that is gone without regret,
But look to the light of happier days
that will shine for your children yet.
For in spite of public apathy
and the segregation pack
There is mateship now,
and the good white hand
stretched out to grip the black.
He knows there are white friends here today
who will help us fight the past,
Till a world of workers from shore to shore as equals live at last.
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APPENDICES

Appendix A: ‘Strategic Push to Boost Indigenous Nursing Numbers’ (Anonymous, 2016)

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**NEWS**

**STRATEGIC PUSH TO BOOST INDIGENOUS NURSING NUMBERS**

A multi-pronged line of attack involving governments, the tertiary sector, and community groups is essential in order to increase Indigenous nursing numbers, a leading academic has stated.

Speaking via live video link from the United States, Linda Deravin-Malone, a Lecturer in Nursing in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, addressed the topic of creating pathways to increase Indigenous nursing numbers at a special event convened by the Institute of Health and Nursing Australia (IHNA) during NAIDOC week last month.

The event was triggered by an article published in the ANMU in March this year where Ms Deravin-Malone explored the shortage of Indigenous nursing numbers as part of the journal’s wider focus on Indigenous health.

Ms Deravin-Malone’s article revealed how Indigenous people employed in health most commonly fill positions within auxiliary and support services rather than clinical-type roles such as nursing and midwifery.

She wrote that the establishment of the Aboriginal Health Worker role had failed to encourage people into nursing and that a review of education pathways and recognition of prior learning were strategies that could lead to Indigenous people embarking on nursing.

“It’s all about creating more choices and more opportunities to expand their professional roles,” Ms Deravin-Malone explained during the NAIDOC week discussion. “Not everybody wants to become a nurse and that’s fine. But for those people that might consider expanding their roles, I believe that we need to support that.”

“I would really like to see more Indigenous people not only looking after their own communities, but extending that and going into the broader range of healthcare.”

In response to the gap, IHNA, a registered training organisation (RTO) which offers a Diploma of Nursing leading towards qualifying as an Enrolled Nurse, will attempt to recruit Indigenous Health Workers and provide them with a seamless pathway into nursing.

IHNA will look to fast-track prospective students by investigating all opportunities for credits through recognised prior learning, thereby shortening the course.

It has also formed a new partnership with RMIT University that will facilitate entry into a Bachelor of Nursing for students who wish to pursue the path to becoming an RN.

“It’s time we reviewed these pathways and did something about it and that’s what we plan to do,” said IHNA Director of Studies Russell Freemantle.

Ms Deravin-Malone said establishing easier pathways could lead to a rise in nursing numbers. “Indigenous Health Workers have a level of skill and they should be recognised for those skills and for the success that they have already achieved.”

Ms Deravin-Malone acknowledged that Indigenous people face greater hurdles in accessing study and said that innovative solutions needed support, such as employing mentors or delivering education in unique ways.

“Why not take the classroom out to where people live? Why is it that everybody has to come in to a major centre? That can be quite restrictive for people in rural areas, Indigenous and Non-Indigenous, to have to leave their communities or their families or their support. We need to look at how we can better manage that.”
Appendix B: Extract from ‘Beating the Odds’ (Fedele, 2017)

Ms Deravin says better promoting scholarships could unlock one piece of the puzzle. “We need to encourage Indigenous communities that there are these options available. It’s getting the word out that these things are out there and available.”

She suggests other areas of potential development surround thinking laterally about expanding distance education into Indigenous communities along with recognising prior learning of people such as Aboriginal Health Workers who often struggle to transition into nursing.

Ms Deravin says Aboriginal and Torres Strait Islander people employed in health often fill positions within auxiliary and support services rather than clinical type roles such as nursing and midwifery.

Boosting the workforce, she says, requires a multi-pronged approach involving governments, the tertiary sector, the health industry, and communities banding together. “People working in isolation can only do so much but if we work together we can do so much more,” she says. “I’d like to see more representation of Indigenous people in nursing because I believe if we have more Indigenous nurses they will have a stronger voice and will be able to make change, particularly in nursing, because we are such a large workforce in health.”

Ms Deravin is currently undertaking a PhD looking into how government policy supports Indigenous people to enter, remain and advance in nursing.

At CSU, she says the progressive university is leading the way in instilling cultural competency. “What I see happening is some people identifying as Indigenous that perhaps didn’t previously because now there’s a certain amount of pride coming through which is a small cultural change.

I also see non-Indigenous students really gaining an awareness of what some of their pre-conceived ideas have been and it’s been challenging them in their way of thinking.”

EDUCATION PATHWAYS
Despite greater awareness around the need to bolster the Aboriginal and Torres Strait Islander nursing and midwifery workforce, growth remains slow. Linda Deravin, a Lecturer in Nursing in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, recalls working for a local health district in 2010 and attempting to encourage Indigenous people to consider nursing cadetships.

“The uptake was quite poor and I wondered why that was and there were a range of reasons for why Indigenous people weren’t coming into nursing at that particular time, even though scholarships were being offered. Some of those were because of a lack of support services to help them study and to help them move through into working as a nurse.”

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