

Australian Aboriginal trainee health service management program: a new initiative

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Abstract

This paper explores the development, implementation and evaluation of the Australian Aboriginal trainee health service management program in New South Wales. In 1997, the two-year pilot program commenced with ten trainees. The program consisted of a combination of work-based placements, formal university education and Australian College of Health Service Executives (ACHSE) professional development sessions. The program has allowed trainees to gain professional skills and knowledge and broader work experience, in order to increase their employment opportunities throughout the Australian health care system.

Introduction

The concept of health has broadened in recent years to include a more comprehensive view of contributing factors that impact on the health of individuals and communities. With the inception of the social model of health care, a need has arisen to view health care service approaches towards populations rather than to individual health needs. The following work examines the rise and implications of this new health movement on Australia's health system with particular emphasis on the Australian Indigenous population. An examination of several national documents on Australian Indigenous health care reveals there is a need for strategies that increase the involvement and participation of the Australian Indigenous people in the prioritising, planning and decision making about their health care needs. The Australian Aboriginal Trainee Health Service Management Program (AATHSPM) is discussed as an initiative to address these matters.

The new public health movement

During the 1970s, a shift in health focus from the biomedical approach occurred with the production of a new model of health that considered how to reduce the costs of the health system and provide action to lessen the inequities of service provision and resource allocation (Do Rozario 1994, pp 2-3; Dean & Kickbusch 1995, p 36). The emergence of this new social health model shifted the focus of health from individual responsibility and behavioural change actions to the promotion of public policy for population needs and the notion of enhancing lifeskills (O'Connor & Parker 1995, p 21).

The social model of health recognises a broader framework of health that takes account of the social, economic and environmental determinants of the health of people as well as the biological determinants. The primary strategies adopted to improve the health of individuals and communities are defined as primary health care, health promotion and community development. Significant statements were made at the 1978 International Conference on Primary Health Care, and within the Alma-Ata Declaration of 1978 and Ottawa Charter for Health Promotion in 1986, which incorporated these strategies to advance the 'Health for All by the Year 2000' goal established by the World Health Organisation (WHO) in 1979. Implicit in all of these documents is the notion of change. This change requires the implementation of the democratic principles of equity, social justice, intersectoral collaboration, and freedom to participate thereby enabling the social change required to empower the community to determine and meet its health needs. To achieve this power and control of the distribution of resources and services decision making needs to be devolved to local and regional levels (Egger, Sparks & Lawson 1990, pp 6-7; Labonte 1993, pp 6-7; O'Connor & Parker 1995, p 26).

The Australian Government undertook a commitment to plan and build a health infrastructure reflecting this model of health as a signatory to the Declaration of Alma-Ata and subsequent WHO documents (Wise & Nutbeam 1994, p 9). It attempted to develop this infrastructure with the formation the National Better Health Program and the release of a number of policy documents including the 'Health For Australians', 'Improving Australia's Health: the role of primary health care', and the 'National Goals and Targets 1988'. These documents forged a national approach and direction for health care in Australia and assisted state and territory governments to analyse, identify and prioritise population health needs and reduce inequalities in health service provision (Oldenburg et al 1994; Nutbeam & Wise 1994).

Subpopulation groups identified in 'National Goals and Targets 1988' are that require priority consideration for their health care needs. Australian Aborigines were identified as one of these subpopulations (Macklin 1992). Spark et al (1991, p 10) cite the National Aboriginal Health Strategy Working Party 1989 as stating that Australian Aborigines have the worst health of any definable group within Australia, a high level of health need and levels of mortality far in excess of any other Australian subpopulation.

Australian indigenous health status

Spark et al (1991, p 10) and O'Connor and Parker (1995, p 92) indicate that in traditional Aboriginal society there is no one word or expression for health. Health is described as not just the physical well being of an individual but it also encompasses the social, emotional, spiritual and cultural well-being of the whole community. This incorporates a whole of life view, including the cyclical concept of life-death-life.

In Australia, it is widely accepted that the term 'Indigenous' refers to Aboriginal and Torres Strait Islander peoples. Sometimes these words are used interchangeably where statistical information pertaining to Indigenous health encompasses data collected for Aboriginal and/or Torres Strait Islander peoples. The majority of Indigenous people reside in southeast Australia, with New South Wales having the highest recorded proportion (23% of the total Indigenous population) (Madden, 1995; National Health and Medical Research Council (NHMRC) 1996). Indigenous people in New South Wales are Aboriginal people who predominantly live near Richmond River, Bourke, Brewarrina, Kyogle, Central Darling and Lachlan areas (Ishak 1998, p 124). This is consistent with national findings which report Indigenous people are located in rural and minor urban areas with poor economic and physical environments (Madden 1995, p 94).

The Indigenous population pyramid shows a high percentage of the population is represented in younger age groups and the percentage is rising. Approximately 40% of the total Indigenous population are less than 15 years of age compared to 22% for the non-Indigenous population. In terms of life expectancy, Australian Indigenous people live 15-20 years less than non-Indigenous people (only 6% of the Indigenous population is 55 years of age or older as opposed to 20% for non-Indigenous people) and their age-specific death rate is higher than that of non-Indigenous people, with a marked contrast in the 25-54 years age group. It is noted however, that this rate of death from all causes has decreased by 10% during the period between 1988 and 1994. The main causes of death are stated as disease of the cardiac and respiratory systems, external causes of injury, and poisoning. Australian Indigenous people experience a variety of other illness that impact on the health of their population. For example, there are high rates of hospitalisation for treatment of respiratory diseases, circulatory diseases, kidney disease, sexually transmitted disease, and mental health concerns resulting

from trauma and grief issues. Australian Indigenous people in New South Wales are reported as three times as likely to be admitted to hospital than non-Indigenous people. Reflected in these admission rates are high percentages of people aged 45 years and over or in childhood age groups (Madden 1995; Johnstone 1996; McLennan 1996; NHMRC 1996; National Centre of Aboriginal and Torres Strait Islander Statistics 1997; Ishak 1998).

Other major factors that impact on the health of the Australian Indigenous population include: overcrowded living conditions and poor housing (1 in 10 Australian Indigenous people reported having difficulty with basic amenities, such as water, toilets or electricity); limited access to health services in regional and remote areas; a high need for housing assistance and income support; sickness related to smoking (Australian Indigenous people are twice as likely to smoke), unsafe levels of alcohol consumption (the problem with alcohol is among people who already have heavy drinking patterns), being overweight or obese; and injuries from violence (Madden 1995; McLennan 1996; National Health and Medical Research Council (NHMRC) 1996; National Centre of Aboriginal and Torres Strait Islander Statistics 1997).

It is significant to note that, aside from the stark findings reported on Indigenous health and welfare issues, the majority (88%) of those surveyed in the National Aboriginal and Torres Strait Islander Survey (1994) considered themselves to be in good or excellent health, although there were high reports of recent illness during the two weeks prior to the survey (Madden 1995, pp. 11-12). Johnstone (1996, p 48) comments that this highlights the social context within which the health expectation of Indigenous people is interpreted, therefore a recommended strategy is health awareness education campaigns within these communities.

Infrastructure guiding Australian indigenous health implementation strategies

Johnstone (1996, p 44) states that the 1994 United Nations Conference on Population and Development report identified strategies that Australia has developed to improve the health status of Australian Indigenous people. For example, the Aboriginal and Torres Strait Islander Commission Act 1989 established the Aboriginal and Torres Strait Islander Commission and the regional councils for decision making about funding and priority action areas for their region. The Royal Commission into Aboriginal Deaths in Custody prompted government to implement the initiatives and recommendations outlined in the National Aboriginal Health Strategy report. The National Aboriginal and Torres Strait Islander Survey in 1994 provided a comprehensive set of data about Indigenous population needs.

The National Aboriginal Health Strategy (1989) was developed to improve access to health services and facilities as a means of improving the health status of Australian Aboriginal people. This document promotes the adoption of an empowerment and self-determination approach through the implementation of strategies that promote participation in health decision-making processes. The NHMRC Report (1996) also identified the need to build an infrastructure and allocate resources to bring about a change in mainstream health system processes to allow Indigenous people the right to determine their health priorities and to plan and deliver appropriate health care programs. Recommended strategies include the development of appropriate health care standards for the delivery of services to Indigenous people in mainstream health services; and the education and training of Indigenous people to meet the professional demands of the existing health infrastructure (which includes specific action to support programs that assist Indigenous health professionals to take up management roles in mainstream as well as Indigenous specific services). There is also a need for a cross-government approach to the education and training processes of mainstream health professionals and Indigenous health professionals to promote the formation of partnerships and provide a broader understanding of Indigenous health issues throughout mainstream health services.

An important element in the education of Indigenous health workers and professionals is the opportunity to access appropriate education facilities that recognise the diversity of their social, political, and economic circumstances as well as their cultural values. This has, in part, been overcome with the National Aboriginal and Torres Strait Islander Education Policy of 1990 (McLennan 1996, p75). However, more recently the Aboriginal and Torres Strait Islander Health Standing Committee has developed a national training and employment strategy for Indigenous health workers and professionals working within Aboriginal and Torres Strait Islander health. This strategy document states the specific training requirements for Indigenous health workers and outlines the rewards associated with the varied health worker and professional positions available.

Following this document, national competency standards for Aboriginal and Torres Strait Islander health workers were developed in 1997 by Community Services and Health Australia Ltd. Once endorsed, these standards will detail the knowledge, skills and attributes needed for health workers (entry level health workers to service managers) to provide appropriate health services (NHMRC 1996, p xxiii; Aboriginal and Islander Journal 1997, p 22). Aboriginal and Torres Strait Islander health care workers will therefore be more likely to be examining existing training courses that can offer them educational opportunities whilst recognising their current health care skills.

There is a need for locally driven actions, to assist the Australian health system in its adoption of an infrastructure reflective of a social model of health to achieve the 'Health for All' goal and address the health needs of the Australian Indigenous people. The Australian Aboriginal Trainee Health Service Management Program is an example of a state initiative to implement the recommended strategies suggested by the various national health and education documents.

Overview of the Australian Aboriginal trainee health service management program

The Australian Aboriginal Trainee Health Service Management Program arose from a recognition that there have been limited management opportunities for Australian Aboriginal people in the mainstream health system. Most of the health management opportunities are within Community Controlled Aboriginal health services or specifically defined Aboriginal employment positions (for example Aboriginal Health Co-ordinators). The program proposes therefore to broaden and increase the number, location and range of management opportunities for Australian Aboriginal people in the full range of Australian health services.

During 1994-5, the Armidale Aboriginal Medical Service and the University of New England provided Management Training for a Regional Aboriginal-Controlled Co-operative Health Service. The NSW Branch Council of the Australian College of Health Service Executives (ACHSE) became interested in the establishment of a program for Aboriginal management trainees as this was similar to a mainstream program that it had successfully run for some twenty-five years. The Aboriginal Health and Medical Research Council (AH&MRC) added its support to this initiative and a steering committee was established in January 1996 to develop a proposal for funding and to construct an education and training program for the proposed Aboriginal Health Management Trainees. The steering committee consisted of representatives of the College, the AH&MRC and possible funding authorities.

The program and funding proposal developed by the Steering Committee through a series of sub-committees was subsequently funded as a two-year pilot by the then Department of Education, Employment, Training and Youth Affairs, the Commonwealth Department of Health and Family Services and NSW Health. The Steering Committee, under the chairmanship of the AH&MRC, was then given responsibility for the implementation and management of the program. A co-ordinator was appointed and accommodated at the College's office at the Macquarie campus, North Ryde with responsibilities to oversee the program and report to the Steering Committee. The aims of this program were to:

- provide opportunities for the trainees to develop skills and knowledge to enable them to move into management positions within the Australian health system;
- improve communication and understanding between Aboriginal Medical Services and the mainstream health system via trainees gaining experiences and exposure to individuals in both settings;
- make mainstream health services more accessible and responsive to Aboriginal communities by opening up leadership opportunities for Aboriginal managers in the mainstream health system;
- provide a balance of work-based and academic-based management experience;
- facilitate links between Aboriginal and non-Aboriginal health management trainees to provide long term benefits for both; and
- develop a collegiate network that will provide ongoing support after graduation to the trainees in their career and continuing professional development.

The expected outcomes to be achieved over the duration of the program were to increase the numbers of Australian Aborigines in middle to senior management positions; increase the accessibility and cultural awareness of the mainstream health system to Aboriginal communities; provide improved networks and relationships between Community Controlled Aboriginal Medical Services and mainstream health services; and ensure that the membership of the ACHSE more accurately reflects the full range of health service management.

Selection of trainees

Criteria were devised to assist with the selection of suitable trainees for the program. Applicants were assessed against their ability to fulfil these criteria from their submitted applications. The selection criteria included:

- the ability to be confirmed as an Australian Aboriginal person;
- evidence of previous work experience and an academic record in health or a related field;
- evidence of participation in continuing educational activities (both personal and professional);
- a demonstrated interest in management activities, for example participation in a governing body, staff supervision, initiation of a program;
- evidence of verbal and written communication skills, and interpersonal skills;
- a willingness to be flexible in terms of travel, working hours and work settings; and
- a demonstrated commitment to understand community needs and the role of management.

This unique program initially recruited six trainees in March 1997 and a further four trainees in July 1997. The trainees were placed in a variety of Area Health Services and Aboriginal Medical Services for a two-year work-based rotational experiential and academic program.

Program training components

Over the two-year program the trainees undertook work-based placements, formal education, and professional development sessions. Figure 1 provides a flow-chart of anticipated progression for the trainees over the two-year program. These experiences assisted the trainees to complete the required core competencies set in the program. The core competencies (see Table 1) were developed on the premise that they represented some of the most effective performance indicators for contemporary health service managers. Each trainee brought to the program a variety of experiences, therefore there was a need for personal prioritising of the competencies to be undertaken. This enabled individual tailoring of the program experiences for the trainees to assist in addressing as many competencies as possible over the time span.

Work-based Placements

The work-based placements were undertaken as two-year placements in a variety of health settings. The work-based experience was guided by management competencies which are currently being reviewed in the light of the 'Frontline Management Competencies' developed by the Australian National Training Authority (1998). The competencies were developed as a recommendation from the 1995 Karpin Report 'Enterprising Nation' where the Australian Task Force on Leadership and Management Skills recognised the need for an improvement in management and the creation of new skills. The twenty-one placements used in this program extended across the range of public Area health services, including the NSW Ambulance Service, NSW Health Department and twelve placements in rural environments.

The trainees worked closely with senior executive staff in mainstream and Community Controlled Aboriginal Health Services, undertook specific placements and project work. Some workplace experiences have involved development of quality improvement ventures within an area health service, learning hospital management skills, updating and amending policy and procedure manuals, assisting with local area social research projects, training staff in the use of computer software, working on AHRC/NSW Health Partnership Agreement Plans, attending executive meetings, drafting submissions, assisting chief executive officers of the Aboriginal Medical Service, learning negotiation skills for tendering, budgeting, and participating in the human resource functions of recruitment and selection.

Formal Education

The trainees were required to undertake eight units of the Graduate Diploma in Health Management (see Table 2) at the University of New England. This course was modified to include two elective units specific to Australian Aboriginal studies. The formal education component included the provision of study leave one day a week from the place of employment, fully paid attendance at two one-week residential schools held each year, and payment for study materials used.

Professional Development Experiences

The professional development experiences included attendance at two mandatory Professional Development sessions (two days for each session) each year during the program. This curriculum component was conducted by ACHSE in Sydney. Exploration of various professional topics that were covered in these sessions included: Community Health; Finance and Casemix; Rural Health; Policy Making; Private Health Insurance; Marketing and Media; Quality Improvement; the 1997 Partnership Agreement; and various Human Resource issues such as Recruitment and Selection, Conflict Resolution, and Occupational Health and Safety.

Support and mentoring were provided throughout these experiences for the trainees. An on-site Supervisor was selected within the work placement area. The Supervisor's role was to provide ongoing support, supervision and encouragement. The Program Co-ordinator had regular contact with the Supervisor. The ACHSE (NSW Branch) and Steering Committee were responsible for organising the trainees' formalised access to appropriate mentors throughout the duration of the program.

Expected benefits for the trainees upon completion of this program included membership of the ACHSE (NSW Branch) Alumni to provide a formal network of ex-trainees to share experiences and provide mutual support; eligibility for Associate level ACHSE membership whilst participants of the program and upon completion, eligibility to progress to higher ACHSE membership levels; completion of a Health Service Management tertiary qualification; and gaining professional skills to increase their employment opportunities throughout the Australian health care system.

Management of the program

The successful implementation of the Australian Aboriginal Trainee Health Service Management Program (AATHSMP) was largely due to the enormous amount of liaison, support and input provided by Aboriginal communities. Without their recognition of the potential long-term benefits of this program for Australian Indigenous people this program may not have proceeded.

The combined organisational management structure of the program was a major contributing factor to its successful inception. The program was established under the auspices of ACHSE (NSW Branch), and managed by a Steering Committee. The Steering Committee comprised of representatives from the Aboriginal Health Resource Co-operative (AHRC); NSW Health Department - Aboriginal Health Branch; ACHSE (NSW Branch); AATHSMP Program Co-ordinator; University of New England; Community Controlled Aboriginal Medical Services; Mainstream health service managers; Commonwealth Department of Employment, Education, Training and Youth Affairs; and Commonwealth Department of Health and Family Services.

Although this program, at the time of writing, has been in existence for only eighteen months it is viewed as a success, even though a number of the outcomes are difficult to measure and are not achievable in the short term. Nonetheless, it is encouraging that eight out of ten of the original trainees are still in the program and likely to graduate in 2000, and that four CEOs of Aboriginal Medical Services enrolled in the academic component as a result of their interest in this program. Internal student evaluations undertaken at the request of the program's Steering Committee have been highly positive.

External evaluation

The Steering Committee is anxious to see the early success continued in an expansion of the program in NSW and sees potential for its adoption in other States. As a consequence, one of the funding agencies, the Commonwealth Department of Health and Aged Care, requested an external evaluation of the program.

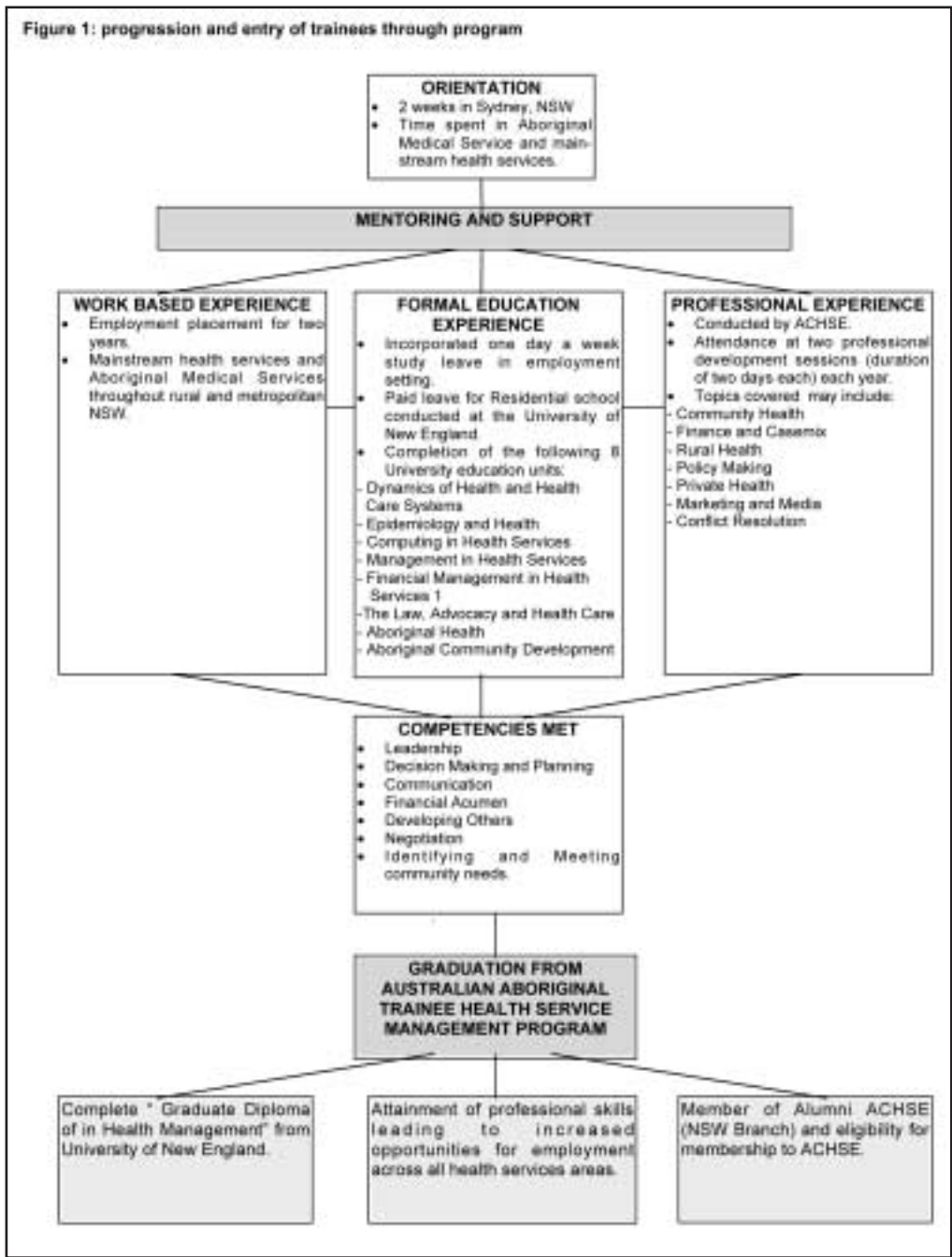
The external evaluation was completed in December 1998 by Webster Associates Pty Ltd and supported the success of the program. The report provides recommendations for future development of the program. Critical factors contributing to its success included the establishment of a Steering Committee representative of stakeholders in the program; the appointment of a competent, well qualified Aboriginal person as Co-ordinator of the program; the selection of a University program where staff were prepared to tailor a course to the specific needs of the trainees and where staff proved to be supportive, flexible and tolerant in the early stages of the program; the link between the University program and the Professional Development seminars; the provision of tutors for students where required; the personal interest and support from many Aboriginal and mainstream health services CEOs in the trainees and their development; and the provision of mentors where required.

Conclusion

The Australian health system needs to achieve the 'Health for All' goal and show progression towards a reorientation of the health system to reflect a social model of health approach. Various policies and documents support and guide the health system infrastructure to facilitate this change. However, for the Australian Indigenous people there is a greater need for implementation of strategies at the local level and the involvement and participation of local Australian Indigenous communities in these actions.

The liaison, support and guidance provided by the New South Wales Community Controlled Aboriginal communities enabled the Australian Aboriginal Trainee Health Service Management Program to be initiated. The Australian Aboriginal Trainee Health Service Management Program aims to provide management opportunities for Australian Aborigines in mainstream health services and Aboriginal health services by forging partnerships between the local government and New South Wales Aboriginal communities. It is also expected that, through the formation of these partnerships, there will be increased communication and understanding of the health needs of Australian Indigenous people and an improvement in the accessibility and response of the existing health services to these concerns and issues.

The Australian Aboriginal Health Management Training Program is a unique and innovative program. It has brought together the peak NSW Aboriginal health body, the Aboriginal Health Resource Co-operative, and the NSW Branch of the Australian College of Health Service Executives, the pre-eminent professional body of health service managers, to develop and provide middle to senior management career prospects for Australian Indigenous people based on work experience, education and training. Early indications are that the aims and outcomes of the original program are appropriate and the authors, the Steering Committee and the external review are all in agreement that, this program will have the desired positive impact envisaged at the time of development. Proposals are now in hand to seek a continuation and expansion of the program in NSW and there are indications of interest in its adoption in other States. In this regard, the originating NSW organisations, through their peak National bodies, have offered to assist in facilitating this interest and the authors of this paper are available for this purpose.



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Table 1: Core Competencies for Australian Aboriginal Trainee Health Service Management Program

COMPETENCY	SKILLS DEVELOPED
Leadership	<ul style="list-style-type: none"> • Communicate desired organisational direction to facilitate action and implement change. • Delegate and get others to do tasks and accept responsibility. • Select and appoint appropriate people. • Foster and maintain an effective organisational culture. • Be versatile in leadership style. • Consult with staff and relevant people. • Recognise when it is appropriate to change the rules.
Decision Making and Planning	<ul style="list-style-type: none"> • Re-think and re-state the organisation's priorities. • Respond rapidly and appropriately to unexpected events. • Anticipate and forward plan for funding changes. • Guide and direct organisational decisions through knowledge of federal, state and local politics. • Interpret industrial changes and implications for the organisation. • Favourably position the organisation with federal, state and local politicians.
Communication	<ul style="list-style-type: none"> • Empathise, listen and respond effectively to someone else's statements • Create surroundings conducive to effective communication. • Read politics of a given situation and act accordingly. • Display a high level of confidence through forceful and impressive verbal and non-verbal interactions. • Communicate effectively in writing. • Develop effective public relations processes within the organisations. • Use the media for the benefit of the organisation.
Financial Acumen	<ul style="list-style-type: none"> • Look behind the figures. • Control budgets. • Interpret basic financial matters. • Forward plan e.g. Five to ten year fiscal plan. • Utilise performance measurements and industry averages. • Be prepared to take calculated financial risks. • Consult on financial matters.
Developing Others	<ul style="list-style-type: none"> • Develop an effective team. • Develop and maintain professional relationships between staff. • Provide spontaneous positive feedback. • Use quality assurance findings as a basis for constructive staff development. • Assume a mentor role. • Use an effective appraisal system. • Develop, promote, and review performance indicators for the organisation.
Negotiations	<ul style="list-style-type: none"> • Identify and manage conflict. • Facilitate change. • Demonstrate understanding of differing points of view. • Negotiate in a trusting positive manner. • Clarify issues of concern to the various staff groups involved. • Negotiate with a wide variety of staff, groups and unions. • Mediate between conflicting groups.
Identifying and Meeting Community Needs	<ul style="list-style-type: none"> • Collect and analyse data. • Conduct field visits and discuss needs with service providers and community. • Establish availability of resources. • Develop priorities for action and long and short term objectives. • Report findings verbally and in writing.

Table 2: Table of Formal Education Curriculum

UNITS	OVERVIEW OF UNIT
Dynamics of Health and Health Care Systems	Examines current health care provision and services in Australia within the broader context of the political, historical, demographic, economic and societal influences that have shaped this system.
Epidemiology and Health	Designed to provide an introductory understanding of the principles, concepts and methods of epidemiology. Included is the learning of skills, such as measures of disease frequency status, ability to make judgements of causality and public policy making.
Computing in Health Services	Provides an introduction to computer technology and its use in health services. Major topics covered include the structure of computer hardware and software systems commonly found in Health/ Management Information Systems.
Management in Health Services	Provides an introduction to the essentials of management and the use of management practices in health services. Students will examine issues currently affecting health services and be encouraged to develop a firm understanding of modern management practice concepts.
Financial Management in Health Services 1	Provides students with the knowledge and skill to promote effective, efficient and economic utilisation of the physical, material and fiscal resources of health services. Topics include cost analysis, case-mix understanding, understanding the hospital accounting system and approaches to budgeting.
The Law, Advocacy and Health Care	Introduces the structure and function of the Australian Legal System and its impact on health care practices. Topics covered include statutory and common law influences, ethical dilemmas for health care workers, and tools for resolving such dilemmas, such as ethics and ethical reasoning
Aboriginal Health	The unit examines the socio-economic and political factors influencing Aboriginal health from colonisation to the present. It explores issues and concerns related to systemic bias, structural violence, culture shock, cultural vitality and cultural safety in relation to general health organisations and community-controlled services.
Aboriginal Community Development	This unit explores the principles and practices underlying community development with special reference to Aboriginal organisations and communities. It provides practical skills in working with groups, developing community profiles and strategic plans utilising processes of negotiation within and between cultures and assets analysis. As such the unit will explore and expand candidates' understanding of the importance of empowerment in Aboriginal communities.

Source: University of New England, "Health Studies Prospectus", 1999