

A national profile of Aboriginal and Torres Strait Islander Health Workers, 2006–2016

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The role of Aboriginal and Torres Strait Islander Health Workers is considered important in the health workforce for Aboriginal and Torres Strait Islander peoples. There is increasing evidence that the inclusion of Aboriginal and Torres Strait Health Workers in models of care facilitates culturally appropriate care, reduces communication gaps, reduces discharges against medical advice, provides cultural education, increases inpatient contact time, improves follow-up practices and enhances patient referral linkages.^{1–3} For example, Taylor et al.² demonstrated improved Aboriginal cardiac inpatient experience and outpatient care when an Aboriginal Health Worker was included in the health care team. However, others have identified challenges in the retention and recruitment of this workforce stemming from issues such as poor job role definition, clinical restriction and lack of support from other health professions, and move to professional registration.^{4–7}

Over the past 10 years, several government policy documents have called for action to build a competent workforce to deliver equitable health outcomes for Aboriginal and Torres Strait Islander people and to increase the number of Aboriginal and Torres Strait Islander people in the health sector.^{4,8–10} The seminal 2011 Health Workforce Australia, *Growing our future: the Aboriginal and Torres Strait Islander Health Worker Project final report*, listed 27 recommendations to support the development of this workforce, including recommendation 5 for better workforce data and recommendation 10 to develop a strategy to increase numbers of Aboriginal Health Workers.⁴

Abstract

Objective: To undertake a descriptive analysis of the Aboriginal and Torres Strait Islander Health Worker workforce to quantify the changes from 2006–2016.

Method: We analysed data on Indigenous Health Workers from three waves of Australian Census: 2006, 2011 and 2016. We described the workforce by gender, age and state/territory.

Results: There has been overall growth in the number of Indigenous Health Workers (from 1,009 in 2006 to 1,347 in 2016), but this is not commensurate with Aboriginal and Torres Strait Islander population growth (221 Indigenous Health Workers per 100,000 people in 2006 to 207 Indigenous Health Workers per 100,000 people in 2016). The growth is in Indigenous Health Workers aged ≥45 years, with declines in the proportion of Indigenous Health Workers aged ≤44 years. There was growth in workers in two states only, Queensland (increase 4.2 percentage points) and New South Wales (increase 6.6 percentage points).

Conclusion: There are pressing concerns regarding the lack of growth and the ageing workforce of Aboriginal and Torres Strait Islander Health Workers. We remain concerned that little is being done to increase the retention and recruitment of this workforce.

Implications for public health: Greater effort is needed to improve the recruitment and retention of Aboriginal and Torres Strait Islander Health Workers, particularly for younger age groups and males. A National Aboriginal and Torres Strait Islander Health Workforce Strategy needs to be implemented.

Key words: Aboriginal Health Worker, Indigenous, workforce, retention, models of care

In 2012, the Australian Government introduced national registration for Aboriginal and Torres Strait Islander Health Practitioners, which created the Health Practitioner in National Health Workforce dataset. However, as this only captures Aboriginal and Torres Strait Islander Health Practitioners, the Health Workforce dataset does not provide sufficient coverage of the entire Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce. Alternatively, the Census data includes an 'Indigenous Health Worker' variable, which is intended to capture both roles. Health Workforce Australia⁴ provided a national snapshot of the Aboriginal Health Workers in 2006, but did

not look at trend data or the changes in states and territories across time. Other reports have tended to focus solely on Aboriginal and Torres Strait Islander Health Practitioners data from Health Worker dataset.⁹ As such, current reporting does not describe trends within the entire workforce.

It is critical to have a comprehensive understanding of the entire Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce and to examine trends in workforce numbers, identify areas of success and opportunities for further research. Our aim was to undertake a descriptive analysis of the Indigenous Health

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Workers to quantify the changes from 2006–2016.

Method

We undertook a cross-sectional study of Indigenous Health Workers using the ABS Census data 2006, 2011 and 2016. Indigenous Health Workers are identified in the Census by individuals answering these questions: *In the main job held last week, what was the person's occupation? What are the main tasks that the person usually performs in the occupation reported?* Responses were intended to capture Health Workers and Health Practitioners, with the data variable known as 'Indigenous Health Worker'. We analysed the aggregate data on Indigenous Health Workers using descriptive analysis, including calculating the number and proportion of Indigenous Health Workers by gender, age (in 10-year age groups) and state/territory (denominator was total number of Indigenous Health Workers). We also calculated the number of Indigenous Health Workers for the total Aboriginal and Torres Strait Islander population at year of census. We accessed Census data via the Australian Bureau of Statistics' Table Builder.

Results

There was an overall increase of 338 people who reported their occupation as an Indigenous Health Worker (1,009 Indigenous Health Workers in 2006 to 1,347 Indigenous Health Workers in 2016) (Figure 1A). The total

number of Indigenous Health Workers was not commensurate with population growth; there were 221 Indigenous Health Workers per 100,000 Indigenous people in 2006 and 207 Indigenous Health Workers per 100,000 Indigenous people in 2016. There was a greater proportion of female Indigenous Health Workers in the workforce (71.0% in 2006 to 73.3% in 2016) and declines in the proportion of male Indigenous Health Workers (29.5% in 2006 to 26.8% in 2016).

There were declines in the proportion of Indigenous Health Worker aged 15–24, 25–34 and 35–44 (decline of 12.5% across these age groups) (Figure 1B). In comparison, for all the older age groups (45–54, 55–64, 65+) there were substantial increases in the proportion of Indigenous Health Workers. In particular, there was an increase of 7.5% in Indigenous Health Workers aged 55–64 (9.2% in 2006 to 16.7% in 2016) and a 3.6% increase in Indigenous Health Workers aged 45–54 (25.7% in 2006 to 29.3% in 2016).

There were increases in the proportion of Indigenous Health Workers in Queensland and New South Wales (Figure 1C). In Queensland, the proportion of Indigenous Health Workers increased by 4.2%, from 23.6% (n=238) in 2006 to 27.8% (n=375) in 2016. In New South Wales, the proportion of Indigenous Health Workers increased by 6.6% (n=158), from 20.6% (n=207) in 2006 to 27.1% (n=365) in 2016 (Figure 1C). There was a marked decline in the proportions of Indigenous Health Workers in the Northern Territory (NT), South Australia, Victoria and Western Australia (Figure 1C). This decline

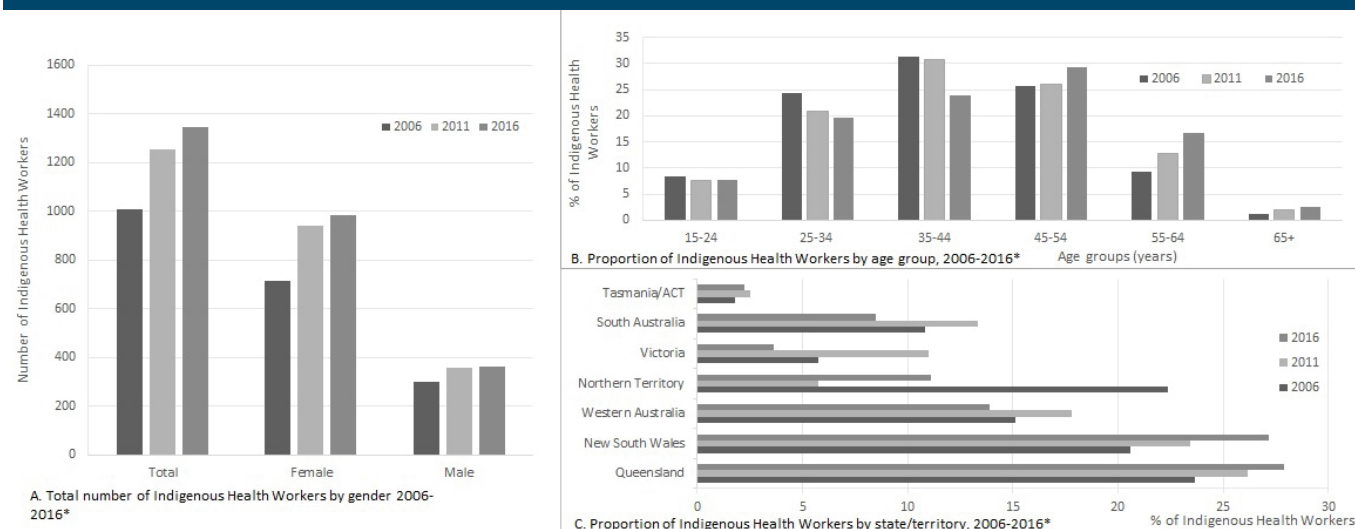
was largest in the NT, with the proportion of Indigenous Health Workers decreasing by 11.2%, from 22.3% in 2006 to 11.1% in 2016.

Discussion

Despite policy rhetoric about the importance of growing the Indigenous Health workforce, we remain concerned that there has been inadequate growth in Aboriginal and Torres Strait Islander Health Workers since 2006. Our results demonstrate the slight increase in workforce numbers is not commensurate with the Aboriginal and Torres Strait Islander population growth. The most notable declines in this workforce are in the proportion of younger adults, males and workers in the NT entering the workforce. There were notable increases in Health Workers in only two states – Queensland and NSW.

The ageing Health Worker population presents both concerns and strengths. We suspect that the decline in younger Indigenous Health Workers (aged ≤44 years) is due to lack of people obtaining qualifications, traineeships and skills to enter the profession, although it is also likely that some younger Indigenous Health Workers are moving into other professions. However, the retention of older Indigenous Health Workers (aged 45+) builds expertise and experience in long-term employees who can act as mentors for the younger workforce. Felton Busch et al.¹¹ in their exploratory study of Aboriginal Health Workers, found many participants wanted career advancement

Figure 1: Indigenous Health Workers by gender (A), age group (B), and state/territory (C).



Notes:

*Data from Australian Bureau of Statistics Census 2006, 2011, 2016

in management or specialist Health Worker areas (for example, specialisation in Alcohol and Other Drugs), with fewer participants expressing interest in medicine and nursing.

The increase in Aboriginal and Torres Strait Islander Health Workers in Queensland may also highlight this jurisdiction's employment policy strengths. Queensland Health has defined a career structure for Health Workers and Practitioners in the state health care system which provides pathways to advance in the profession.¹² Queensland has also moved many state-run primary health care services to Aboriginal Community Controlled Health services, which have well-defined models of care supporting Aboriginal and Torres Strait Islander Health Worker and Health Practitioners' involvement (for example, the Institute for Urban Indigenous Health and Apunipima).

In contrast, the decline in Aboriginal Health Workers in the NT is concerning and represents an overall loss of 76 workers from 2006 to 2016. Similarly, Zhao et al.¹³ reported a 61% overall decline in Aboriginal Health Practitioners in the NT Government primary health care clinics from 2010 to 2015.¹³ Previous research has highlighted issues in retention of Aboriginal Health Practitioners due to external family pressures, lack of career progression, mismatch between clinical responsibilities and training, and the 2012 requirement of new Health Practitioners to obtain a Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice).^{4,7,13}

Limitations of our analysis include the inability to analyse Aboriginal Health Workers and Aboriginal Health Practitioners separately. Further, the use of data in ABS Table Builder meant that we had access only to aggregate data, which does not include the undercount in Aboriginal and Torres Strait Islander population (17.5% in 2016, 17.2% in 2011 and 11.5% in 2006). The differences in the numbers of Indigenous Health Workers in 2006 compared to 2016 could be partially explained by the undercount, however, including 2011 in the analysis supports our argument that the numbers of workers are not improving sufficiently.

The workforce retention and recruitment issues are complex and compromised by data limitations. Access to longitudinal individual (non-aggregated) data from the Census (and linked education and Health Practitioner registration data) would enable the ability

to track changes in individual's work and education patterns over time. An examination of completion rates of younger people and males in Health Worker courses is particularly needed. These data in combination with qualitative, contextual data would enable the interrogation of whether and why students and employees stay in this profession, move professions or leave the labour market altogether. It may better explain how employment policy (for example, career pathways, additional training, mentoring) supports Aboriginal Health Workers.

Overall, the small increase in the number of Aboriginal Health Workers nationally from 2006 to 2016 masks the issues in the workforce growth, retention and recruitment. Using simple descriptive analysis, we have highlighted immediate concerns, including growth that is incommensurate with population increases, a stagnant proportion of male Indigenous Health Workers and an ageing workforce. This analysis adds weight to the call for a National Indigenous Health Workforce Strategy and the need to address critical recommendations in the *Growing our Future* report.

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Ethics

The conduct of ABS Census (household interview components) is approved under the Census and Statistics Act 1905. Ethics approval for the current analyses was granted by the Australian National University (Protocol 2017/013) Human Research Ethics Committees.

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