

## Working Towards Health Equality: The Aboriginal and Torres Strait Islander Health Workforce

### A Rights based approach to the Aboriginal and Torres Strait Islander Health Workforce

Effective health care relies on a capable health workforce to deliver it. When access to that workforce and the services they deliver is inadequate health outcomes suffer. Article 24 of the UN Declaration on the Rights of Indigenous Peoples upholds that 'Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health'. The Aboriginal and Torres Strait Islander health workforce are critical to ensuring this right is upheld.

Building a strong Aboriginal and Torres Strait Islander health workforce offers government a clear opportunity to adopt a social and cultural determinant approach to Indigenous health policy and programmes. It requires whole-of-government co-operation, across portfolios (education, training, employment, and health) and jurisdictions; and in addition to health improvements, would deliver outcomes in education, training and employment.

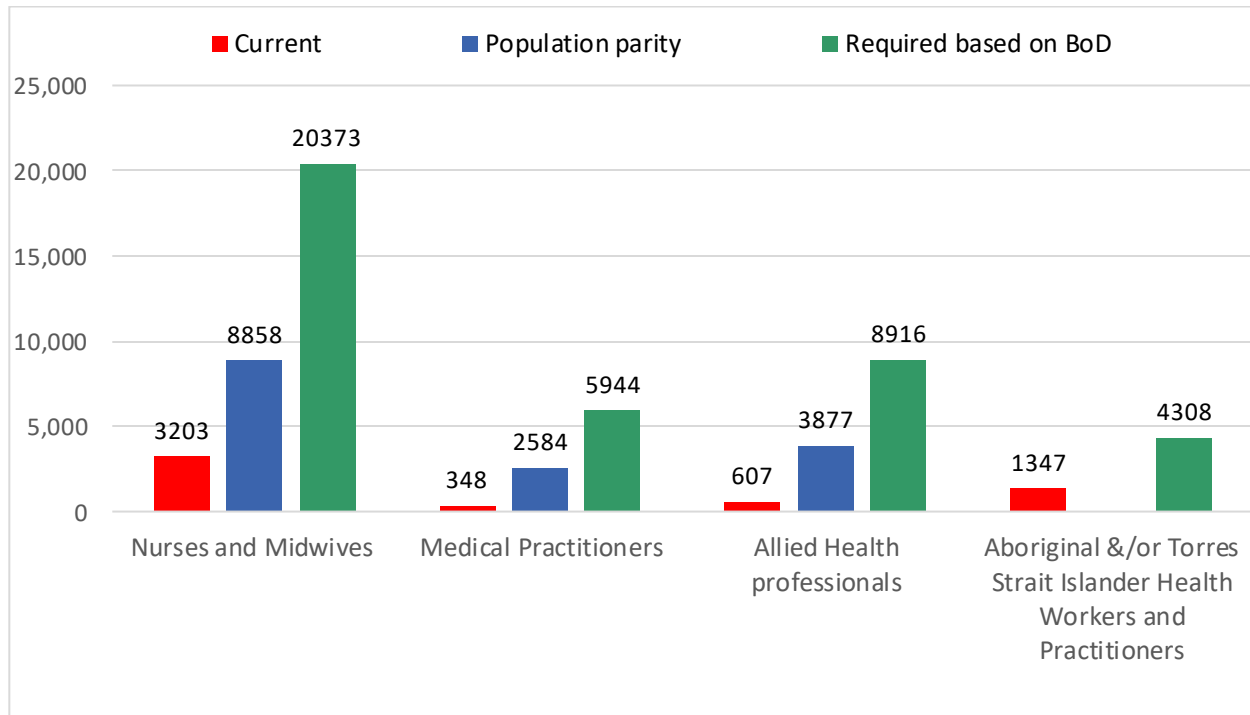
The unique skills and capabilities of the Aboriginal and Torres Strait Islander health workforce are a requirement of delivering culturally safe care. We combine clinical knowledge with a lived understanding of community and family relationships, connection to country, cultural practices, and languages. Evidence supports that we make a positive difference to service access, experiences, and outcomes for Aboriginal and Torres Strait Islander Australians.<sup>i</sup> But the current Aboriginal and Torres Strait Islander workforce levels are far below what is needed.

### Establishing a benchmark

In 2008 the Close the Gap Statement of Intent drew a bipartisan commitment between governments, Aboriginal and Torres Strait Islander health organisations and the community to work towards equality in health status and life expectancy by 2031. Critically, building an Aboriginal and Torres Strait Islander workforce is necessary to meet the close the gap targets. However, analysis demonstrates that workforce numbers are well below the levels required. For instance, despite strong relative growth over recent years<sup>ii</sup>, the number of Nurses and Midwives needs to almost triple to reach parity with their non-Indigenous counterparts: For Medical Practitioners and Allied Health Professionals<sup>iii</sup>, increases of around 6 to 8 times are needed. If we were to consider increased need brought about by a larger burden of disease amongst Aboriginal and Torres Strait Islander people even these figures would more than double.

For Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, there is no non-Indigenous workforce counterpoint against which to establish a point of parity – but if we were to apply a benchmark of 1 for every 150<sup>iv</sup> Aboriginal and Torres Strait Islander persons the current workforce is at around one third of what is needed.

**Graph 1. Current health workforce against population parity and burden of disease benchmarks**



Data Sources: Nurses and Midwives, Medical Practitioners, Allied Health Professionals\* - Australian Government Department of Health, Health Workforce Data Sets (HWDS)

\*Allied Health only includes information on the professions registered by 11 Professional Boards under AHPRA (i.e. estimated to cover about half the health professions and professionals considered to be allied health.) Aboriginal and Torres Strait Islander Health Workers and Professionals Data– ABS Census 2011 & 2016<sup>v</sup>; AIHW Online Services Report 2011-2015 & Department of Health, HWDS 2012-2015

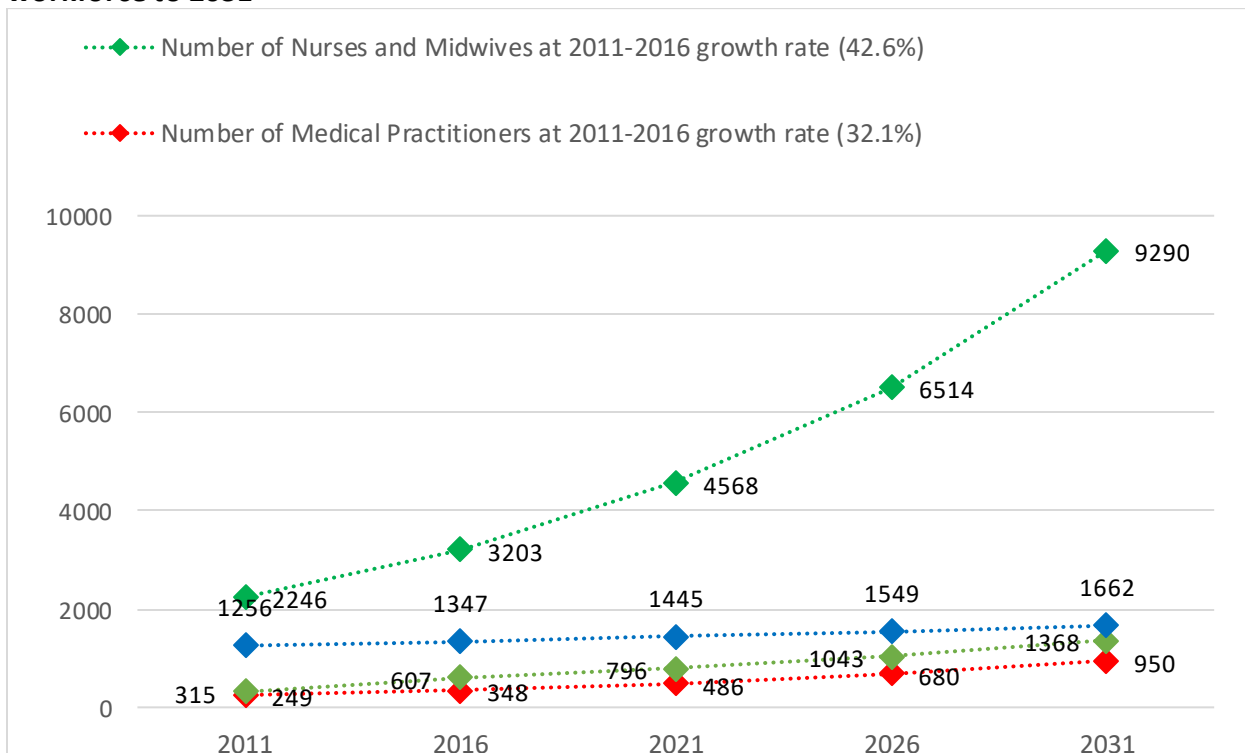
### Growing the Aboriginal and Torres Strait Islander Health Workforce

More must be done to increase the Aboriginal and Torres Strait Islander health workforce. While the workforce is growing, it is not growing fast enough to reach current population parity levels within the next decade – and are far below the growth rates needed to address health disadvantage. Based on growth from 2011 to 2016, we have projected estimated increase in workforce numbers. For example, if current growth levels were sustained, the Aboriginal and Torres Strait Islander Nursing and Midwifery workforce would only reach the current parity levels at around 2031. For (registered) Allied Health professionals and Medical Practitioners, the current growth levels would still find the workforce well below population parity levels in 2031. Medical Practitioners would still be approximately 70% short of achieving current parity levels and

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners would reach only 1662, a growth of only 315 and well below the required 4308 if the 1:150 target is applied.

Standard approaches to health, education and employment do not work for many Aboriginal and Torres Strait Islander people; a targeted approach must be adopted. Both the projected and required growth in workforce would require increased investment in education, training, and employment. The Aboriginal and Torres Strait Islander health professional organisations are proving to be crucial in increasing growth and retention. We need further investment in actual student enrolments and completions. This investment would help offset other costs related to workforce distribution, avoidable hospitalisations, and illness, including chronic disease.

**Graph 2. Estimated projected growth in the Aboriginal and Torres Strait Islander Health workforce to 2031**



Data Sources: Nurses and Midwives, Medical Practitioners, Allied Health Professionals\* - Australian Government Department of Health, Health Workforce Data Sets (HWDS), and Aboriginal and Torres Strait Islander Health Workers and Professionals Data- ABS Census 2011 & 2016; AIHW Online Services Report 2011-2015 & Department of Health, HWDS 2012-2015

\* Allied Health only includes information on the professions registered by 11 Professional Boards under AHPRA (i.e. estimated to cover about half the health professions and professionals considered to be allied health.)

## Recommendations

- 1. National targets and accountability.** The *Australian Governments Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* was developed as a guiding document, containing both broad strategies and specific actions to build this workforce. However, a lack of activity under the framework has shown that more clearly defined actions must be established, and resources outlined. We call for the establishment of national health workforce targets and a national strategy established and resourced. These targets and resources must reflect increased health workforce need based on current health inequalities and incorporate cultural safety training and development for the non-Indigenous workforce. All health systems and the services within them must be held accountable for increasing Aboriginal and Torres Strait Islander health workforce levels and Aboriginal and Torres Strait Islander individuals and organisations must be part of monitoring the progress.
- 2. Increased pathways.** Culturally safe learning environments are key to recruiting students and graduating more health professionals. There must be increased investment in pathways to health careers for Aboriginal and Torres Strait Islander people. This will require macro-level reform to link health, education, and employment systems to ensure the continued access and success of Aboriginal and Torres Strait Islander students. Case studies such as the Indigenous Health Leaders Workforce Expo, Allied Health Academy, Griffiths Hands Up program and Murra Mullagari are examples of good practice.
- 3. Aboriginal and Torres Strait Islander leadership and governance.** Aboriginal and Torres Strait Islander individuals and organisations must play a role in the governance and leadership of strategies and initiatives relating to health workforce policy, education, and accreditation if we are to achieve sustainable growth. The National Health Leadership Forum holds a wealth of collective knowledge and experience on what works and must be sustainably resourced.
- 4. Development of the non-clinical workforce.** Researchers, educators, and administrators are a critical component of the Aboriginal and Torres Strait health workforce and must be considered, along with the clinical workforce, in initiatives aimed at increasing capabilities to meet health need.
- 5. Data quality and collection.** Aboriginal and Torres Strait Islander health workforce data quality must be improved. There are several, serious limitations for specific workforces, including lack of data on (around half of the) Allied Health professions and the number of Aboriginal and Torres Strait Islander Health Workers in the Australian Government Health Workforce Data Set. The mapping health needs, workforce and capacity project must look at and address the health workforce data gaps. Data from Department of Education must be included in this work to look at attraction, retention, completion, and transitions from study to practice.

6. **Building on the successes of the Aboriginal Community Controlled Health Sector.** There is a lot to learn on workforce issues from the Aboriginal Community Controlled Health Sector. Within the Commonwealth Department of Health there must be increased links between Aboriginal and Torres Strait Islander health workforce and primary health care initiatives. This should include initiatives and resources to maximise the training and employment opportunities generated by ACCHS.

### **Additional information**

In compiling this paper, we acknowledge the complexities of presenting a comparative picture across inconsistent data and incomplete data sets. IAHA and NATSIHWA in particular have issues with the data available through the National Health Workforce Data Sets (NHWDS), which draws on Australian Health Practitioner Regulation Authority (AHPRA) registrations and is the primary source of information on Aboriginal and Torres Strait Islander health workforce levels.

In the instance of NATSIHWA, only Aboriginal Health Practitioners are registered, Aboriginal Health Workers who make up the majority of their workforce are not captured. Similarly, for IAHA, while 11 allied health professions are registered under AHPRA, this leaves a large number of professions (including dietitians, social workers, counsellors, and speech pathologists) who are not. For IAHA the majority of these self-regulated professions (i.e. not registered through AHPRA) do not collect workforce data and some, such as social work and paramedicine, are believed to have a comparatively large number of Aboriginal and Torres Strait Islander professionals among their workforce.

This data snapshot relies heavily on the NHWDS, which only captures clinical workforce. There are many other skilled Aboriginal and Torres Strait Islander people working as part of the Aboriginal and Torres Strait Islander health workforce as educators, administrators and researchers who are not captured in this snapshot but must be considered in workforce policy development.

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<sup>i</sup> AIHW: Aboriginal and Torres Strait Islander health organisations – Online Services Report key results 2015-2016

<sup>ii</sup> Workforce growth has increased with the work of the Aboriginal and Torres Strait Islander health professional organisations (ATSIHPOs).

<sup>iii</sup> There is no available data for many allied health professions. For the 11 Allied Health Professional Boards registered under AHPRA data is collected and made public. For the self-regulated allied health professions – around half of allied health professions – no reliable, public data is available. The AIHW reiterated this problem in Australia's Health 2018 (page 67), released 20 June 2018.

<sup>iv</sup> A figure of 1:150 is used in line with NATSIHWA's Policy Position Statement on the importance of the Aboriginal and Torres Strait Islander Health Workers and Health Practitioners in Australia's Health System.

<sup>v</sup> The ABS Census collects information about respondents' profession but the information regarding allied health professions is not consistent or categorised to enable detailed comparisons across Census periods or for specific professional groups.