

Characteristics of health and community services workers

Sex

The health and community services industries employed 9.7% of the Australian workforce in 2001, and are major employers of women, employing a much higher proportion (17.1%) of the female workforce. These industries are also predominantly female: females make up 74% of the health industry and 86% of the community services industry. Of the 105 occupations shown in this publication, men outnumbered women in only seven (Table 9).

Table 9: Persons employed in selected health and community services occupations, proportions male, part-time and earning over \$1,000 per week, Australia, 2001

Occupation	Proportion male	Proportion working part-time	Persons employed with weekly income of \$1,000 or more
	Per cent	Per cent	Per cent
Predominantly male occupations^(a)			
Ambulance officers and paramedics	80.1	8.4	45.9
Dental practitioners	74.0	24.1	75.3
Chiropractors and osteopaths	70.7	38.0	42.2
Generalist medical practitioners	64.1	22.7	76.5
Specialist medical practitioners	73.7	15.5	88.0
<i>All medical practitioners</i>	67.3	19.1	80.3
Optometrists	58.9	24.6	55.4
Occupational and environmental health professionals	57.5	15.1	31.4
Dental associate professionals	52.5	29.6	14.9
Predominantly female occupations^(b)			
Dental assistants	1.3	43.6	0.6
Pre-primary school teachers	2.0	40.2	12.5
Childrens care workers	3.8	52.8	0.7
Occupational therapists	7.0	38.9	17.4
All nursing professionals ^(c)	8.5	48.2	12.3

(a) All occupations in which the majority were male.

(b) Occupations with the highest proportions of females.

(c) Includes nursing professionals nfd. More detail on individual nursing occupations is presented in Table 10.

Source: ABS, Census of Population and Housing, 2001.

Men working in the health and community services industries tended to be concentrated in high-income occupations. By comparison, those occupations in which almost all were women had much lower proportions of workers with weekly incomes of \$1,000 or more. Part of the explanation is that men are more likely to have higher earnings as they are more likely than women to work full-time. (Income recorded by the census includes earnings as well as other sources such as investment returns, government welfare, child support etc. The ABS

Survey of Employee Earnings and Hours provides earnings data only for broad-level occupations, so income data from the census is used here as an indicator of earnings.) The predominantly male occupations shown in Table 9 tended to have much lower proportions of part-time workers than those with high proportions of females.

The sex differences persist in nursing, numerically the largest health and community service occupation. Males made up 8.6% of all nurses, but there were relatively higher proportions of males employed as health services and nurse managers and in the fields of mental health and developmental disability. These fields of nursing have more than twice the proportion with incomes of \$1,000 a week or more as general registered nurses.

Table 10: Persons employed in nursing occupations: proportions male, part-time and earning over \$1,000 per week, Australia, 2001

Occupation	Proportion male	Proportion working part-time	Persons employed with weekly income of \$1,000 or more
	Per cent	Per cent	Per cent
Registered mental health nurses	35.3	27.7	28.2
Registered developmental disability nurses	30.7	32.1	25.7
Health services managers	24.8	11.7	65.8
Nurse managers	11.7	21.7	55.3
Nurse educators and researchers	8.7	37.3	27.1
Registered nurses	7.6	50.4	11.5
Registered midwives	1.1	62.8	12.3
All nursing professionals^(a)	8.6	48.8	14.4

(a) Includes nursing professionals nfd. Excludes health services managers.

Source: ABS, Census of Population and Housing, 2001.

Age

The change in age distribution of the health and community services occupations listed in this publication is a reflection of changes in the rate of growth in practitioners in many of the occupations and, possibly, the availability of options for a higher level career in other occupations. The length of training or experience that is required for entry to some professions shown in this publication (such as medicine) acts to increase the average age of those practitioners relative to other occupations. Much of the concern about health workforce planning has focussed on the occupations of medical practitioners, nurses and retail pharmacists, which are the mainstays of the traditional model of health service delivery, and all of which have ageing workforces. Nevertheless, there is growing concern about a number of other occupations in which there is a relatively old age profile in conjunction with a current or expected shortage of practitioners.

Occupations with large proportions (one-third or more) of practitioners aged 55 years and over include managerial positions (e.g. director of nursing, medical administrator, welfare centre manager) and those that are likely to require a number of years' experience in a related occupation before entry or where there is limited career progression to occupations with other titles. Specifically, this group includes the health occupations of obstetrician and gynaecologist; ophthalmologist; pathologist; specialist physician; psychiatrist; radiologist; surgeon; director of nursing; and dental specialist, and the community services occupations of safety inspector; teacher of the sight impaired; and welfare centre manager. For example,

6.5% of employed medical practitioners and 6.4% of retail pharmacists were aged over 65 years, as were 12.4% of ophthalmologists and 9.6% of surgeons (Tables A.14 and A.15).

Three-quarters or more of the practitioners in 17 of the health occupations were aged under 45 years – medical practitioner in training, emergency medicine specialist, radiation therapist, nuclear medicine technologist, sonographer, dental therapist, dental hygienist, dental assistant, industrial pharmacist, occupational therapist, optometrist, speech pathologist, podiatrist, dietitian, orthoptist, anatomist or physiologist and health information manager. Many of these occupations underwent substantial growth between 1996 and 2001. For community services, occupations with a young age profile were confined to those concerned with youth welfare: youth worker, child care worker and nanny.

Age is only one factor that can contribute to or exacerbate current or expected workforce shortages. Some of the other changes affecting supply of health professionals may include the increased number of females and an associated decrease in hours worked due to preferences for part-time work; rapid advances in technology; new approaches to service delivery; changes in the way health services are organised; changes in disease patterns (including those associated with an ageing population); and demographic shifts in the labour force, including an increased tendency for early retirement. Many of those changes are largely unpredictable, but even for those that are (such as the ageing workforce), the extent to which supply may be affected can not be fully anticipated (AMWAC 2003).

Making adjustments to student intake can only affect workforce numbers over the medium term, especially in professions requiring lengthy training. Adjustments to migrant intake and attracting qualified health practitioners into the labour force or encouraging current workers to work longer hours can have a quicker impact. For example, any undersupply of medical practitioners in rural and remote areas can in part be addressed by increasing the intake of temporary resident doctors (immigrant doctors employed for a period of up to one year in a designated area of need). This strategy can also introduce a number of younger practitioners into the workforce.

On the other hand, supply in many of the health occupations may be boosted by workers who continue to work beyond the customary retirement age of 65 years. Across all health fields, 15% of those 65 years of age with their highest qualification in a relevant field reported being employed, as did 40.2% of people aged over 65 years with qualifications in chiropractic and osteopathy, 40.1% of those with qualifications in medical studies, pharmacy (26.5%), optometry (24.3%) and dentistry (19.7%) (Table A. 9). This compares with around 5.8% of the general population aged 65 years or more who were employed in June 2001 (ABS 2001b).

Highest qualification in a health field

Highest qualification data can provide a measure of the number of people with a relevant academic qualification for a profession compared to the number employed in the profession. This can give an indication of how many qualified people are not working in the relevant field, and an approximate size of the pool of potential re-entrants to a profession. For those occupations where entry is not dependent on a particular qualification, this data can also indicate whether their workforces comprise a large proportion without relevant skills. The data has some limitations because it does not identify the initial qualification of those who have a postgraduate qualification in a different field, for example, a nursing degree followed by a postgraduate management degree. In addition, a qualification reported in the census may be from an overseas institution and not recognised for entrance to a registered health profession in Australia.

There is a close relationship between the professional employment numbers and the number with qualifications in the fields of medical studies, dentistry, dental assisting, pharmacy, optometry, radiography, physiotherapy, chiropractic and osteopathy, speech pathology and podiatry (Tables A.6 and A.9). It is noted that courses leading to these qualifications have a close relationship with training for a related profession. Despite a similar close relationship between nursing qualifications and the nursing occupation there is a substantial gap between the numbers of employed persons who have a nursing qualification (230,184) (Table A.9) and the numbers employed in the profession (171,615 registered nurses and 19,510 enrolled nurses) (Table A.6). This indicates that there are around 40,000 employed persons with a nursing qualification who are not employed in nursing.

Unemployment ranged from zero for those qualified in obstetrics and gynaecology and palliative care nursing to 3-4% for aged care nursing and most public health fields. The fields where unemployment exceeded 4.0% were: 'first aid' at 14.5% among the 1,078 persons who reported this qualification; 6.3% of the 432 persons with 'Indigenous health' qualifications; 5.9% for 'massage therapy' and all the complementary therapy occupations (e.g. naturopathy, acupuncture and traditional Chinese medicine), which together averaged 5.4% (Table A.9).

Indigenous health and community service workers

At the 2001 census, there were 410,003 people who identified as being of Indigenous origin, an increase of 16.2% from 352,970 people in 1996. The Indigenous population represented 2.4% of the total Australian population in 2001, up from 2.0% in 1996 (ABS 2003a). The current life expectancy at birth of Indigenous people is 56 years for males and 63 years for females, around 20 years less than the 77 years and 82 years for males and females respectively for the total population (ABS 2002b). Health care provided by Indigenous people is one strategy to improve health care and increase the health status and life expectancy of the Indigenous population.

There were 3,742 Indigenous people employed in health occupations in 2001, comprising 0.9% of health occupation workers (Table A.18). The occupation of Aboriginal and Torres Strait Islander health worker ('Indigenous health worker' in this publication) employed 853 Indigenous people, which comprised 22.8% of all Indigenous people working in health occupations and 93.2% of workers in this occupation. A total of 444 people reported a highest qualification in Indigenous health and, of those, 6.1% reported being unemployed and a further 24.3% as not in the labour force (Table A.9).

Excluding Indigenous health workers, 0.7% of health occupation workers in 2001 were Indigenous – well below the 2.4% Indigenous representation in the population. In the health occupations not specifically targeted at Indigenous health, those with the greatest proportion of Indigenous people were environmental health worker (3.5%), primary products inspector (2.0%), nursing assistant (1.7%), medical administrator (1.6%), ambulance officer (1.6%), personal care assistant (1.4%) and admissions clerk (1.1%). In all other health occupations there were 1.0% or fewer Indigenous workers.

There was a greater proportion of Indigenous workers in the community services occupations, with 6,294 workers, comprising 2.7% of community services occupation workers. The occupations with higher Indigenous representation were refuge worker (21.9%), family support worker (16.5%), special education teacher nec (16.2%), drug and alcohol counsellor (8.8%), welfare associate professional nfd (7.4%) and youth worker (7.1%) (Table A.19).