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Research Article

An Australian National Survey of First Nations Careers in Health Services

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A strong First Nations health workforce is necessary to meet community needs, health rights, and health equity. This paper reports the findings from a national survey of Australia's First Nations people employed in health services to identify enablers and barriers to career development, including variations by geographic location and organisation type. A cross-sectional online survey was undertaken across professions, roles, and jurisdictions. The survey was developed collaboratively by Aboriginal and non-Aboriginal academics and Aboriginal leaders. To recruit participants, the survey was promoted by key professional organisations, First Nations peak bodies and affiliates, and national forums. In addition to descriptive statistics, logistic regression was used to identify predictors of satisfaction with career development and whether this varied by geographic location or organisation type. Of the 332 participants currently employed in health services, 50% worked in regional and remote areas and 15% in Aboriginal Community-Controlled Health Organisations (ACCHOs) with the remainder in government and private health services. All enablers identified were associated with satisfaction with career development and did not vary by location or organisation type. "Racism from colleagues" and "lack of cultural awareness," "not feeling supported by their manager," "not having role models or mentors," and "inflexible human resource policies" predicted lower satisfaction with career development only for those employed in government/other services. First Nations people leading career development were strongly supported. The implications for all workplaces are that offering even a few career development opportunities, together with supporting leadership by Aboriginal and Torres Strait Islander staff, can make a major difference to satisfaction and retention. Concurrently, attention should be given to building managerial cultural capabilities and skills in supporting First Nations' staff career development, building cultural safety, providing formal mentors and addressing discriminatory and inflexible human resources policies.

1. Introduction

The First Nations (from here on, we respectfully refer to Aboriginal and Torres Strait Islander people in the Australian context and First Nations when referring to the international context and literature.) of Australia, Aboriginal and Torres Strait Islander people, are the world's oldest continuing cultures with a holistic concept of health and wellbeing and deep connections to family, community, and the environment [1]. However, like First Nations people globally, poorer health outcomes are experienced compared with others in the population [2]. The "burden of disease among Aboriginal and Torres Strait Islander people is 2.3 times that of other Australians," with chronic disease

being the largest direct contributor, accounting for over 70% of burden of disease [3]. Underscoring disparity are poor social determinants of health with inequities experienced across education, housing, employment, income, and power in decision-making [4]. Ongoing disempowerment occurring from colonisation and colonialism is well documented with racism frequently experienced [5–7]. These issues are compounded by the relative inaccessibility of government-run health services due to cost, lack of cultural safety, and racism [8, 9].

It is now widely recognised that increasing the presence and power of Aboriginal and Torres Strait Islander people in the health system leads to improved health and wellbeing outcomes [10–12]. There is mounting evidence of the urgent need for health services to use the strengths of First Nations people and implement culturally safe care to achieve improved health outcomes [13–15]. Central to this is a strong First Nations health workforce [16–20]. A First Nations health workforce brings shared history and experience, including exclusion and discrimination [7]. The benefits to healthcare organisations in providing culturally safe services are now acknowledged in Australian legislation [21].

Culturally safe services must be responsive to individual and local community needs [10, 14, 17, 22]. A systematic review of the rural health workforce, which focused on improving Aboriginal and Torres Strait Islander health outcomes, found that health provider attitudes and behaviours have a direct effect on service delivery design and models of care and highlighted the importance of "an empowered, supported, and skilled Aboriginal health workforce" to meet the health care rights and needs of Aboriginal and Torres Strait Islander people [14].

Despite the growing body of evidence and policy framework statements recognising the value of a First Nations health workforce, there remains a substantial shortfall in Australia [22], including in key professions such as nursing, medicine, and allied health [23]. The Aboriginal and Torres Strait Islander population is 3% of the total Australian population, on average [23]. To be at least proportionately represented in the workforce, at least 3% should be Aboriginal or Torres Strait Islander people. To be proportionate to address equity and need including the burden of disease, the proportion should be much higher. At present, very few health occupations meet the 3% target [23]. Moreover, recent Aboriginal and Torres Strait Islander health workforce growth has been concentrated in low-status and lower-paying jobs, with limited promotion prospects including "poor articulation to other roles and professional careers" [23]. Workforce geographical distribution also needs to be considered. Almost two-thirds of First Nations Australians live in regional and remote areas outside major cities and make up 30% of the total population in remote areas [24]. The National Aboriginal and Torres Strait Islander Health Performance Framework (2020) states that "staff recruitment and retention are particularly important in rural and remote areas to ensure First Nations Australians in these areas have access to health professionals for their health care needs" [22].

Workforce development must occur within a human-rights-based framework that should underpin health system design and service delivery [25]. A human-rights-based approach to health is founded on empowering rights holders to effectively claim their human rights, the elimination of all forms of discrimination, and the upholding of principles of participation, equality, transparency, and accountability [25]. Further, First Nations people have the right to selfdetermine, design, and deliver services and programs to meet needs and aspirations. Given the expertise of First Nations people in leading and delivering culturally safe care, there is a need to go beyond a "pipeline view" of numbers entering the workforce [26] to understand the experiences of First Nations staff and how roles in the health system can be better supported and developed [11, 13, 26, 27]. Alongside this focus on strengthening the First Nations health workforce is the need to develop the cultural capabilities of non-First Nations staff and the cultural responsivity of the organisations that employ them [11, 13, 26]. These challenges are not unique to Australia and are also reflected in the experiences of First Nations people in New Zealand, Canada, and the United States [2, 12, 16, 28].

Research to date has largely focused on how best to increase the volume of Aboriginal and Torres Strait Islander people entering the health workforce and on how to retain people in secondary education and recruit them into tertiary education, with little attention to how to retain or develop the careers of those currently employed [3, 10, 29]. A recent study identified some of the barriers to workforce development, including persistent challenges at organisational and structural levels [15]. A study of Aboriginal mental health workers in rural and remote areas found that a range of issues, including professional development and career opportunities, were important in staff retention, with career satisfaction being a key factor in retention [30]. Further, a systematic review of the Aboriginal and Torres Strait Islander health workforce identified professional development opportunities as a key factor in facilitating retention, career progression, and strengthening the existing workforce [10]. To date, there has been no national study across all roles and health professions to understand the experiences of career development in the Aboriginal and Torres Strait Islander health workforce.

This paper reports on a national career development survey, conducted as part of a larger study, which aimed to provide understanding and guidance to enhance the capacity of workplaces, and the system more broadly, to improve retention and support the careers of Aboriginal and Torres Strait Islander people working in health care [13]. Career development is understood as the process of gaining and experiencing planned and unplanned activities that support an individual's career across time [29]. This definition recognises these may occur within an organisation enhancing an individual's skills and employability or it may be individually driven outside of an organisational structure [31]. The analysis reported here identifies predictors of satisfaction with career development among Aboriginal and Torres Strait Islander staff currently employed in health

services and particularly examines the impact of work location and organisation type on career development satisfaction, including the provision of enablers to career development and barriers in these differing contexts.

1.1. The Setting. Funding for Australia's health system comes primarily from the national (Australian) government and the eight states and territories. States and territories largely devolve management and responsibility for service delivery to local health networks or districts though they maintain a health policy and regulatory role. The Australian government funds primary health networks and Aboriginal and Torres Strait Islander-specific primary health care services which provide prevention, diagnosis, and treatment services in a range of health settings such as community clinics, Aboriginal Community-Controlled Health Organisations (ACCHOs), and other health care facilities [22] ACCHOS are defined as *"a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community that controls it, through a locally elected Board of Management"* [32]. Currently, there are over 140 ACCHOs across Australia.

Among all primary health care services, ACCHOs are the largest employer of Aboriginal and Torres Strait Islander staff, accounting for almost 90% of this workforce [24]. Despite their large First Nations' workforce, ACCHOs also experience challenges in filling positions. These relate to a small potential workforce in rural and remote locations, different employment awards, which disadvantage them in offering competitive salaries compared to "mainstream" or government health services. An entrenched pattern of vacancies in critical health workforce domains has been identified in recent data including among Aboriginal and Torres Strait Islander health workers/practitioners [24]. The Aboriginal and Torres Strait Islander health worker/practitioner workforce was developed to respond to the need to provide culturally safe clinical and primary health care services to Aboriginal and Torres Strait Islander people including those provided by mainstream services - distinct from other health professionals, this worker/health practitioner role can only be occupied by an Aboriginal and/or Torres Strait person [24]. The practitioner role includes (i) clinical services, (ii) health promotion, and (iii) cultural brokerage), nurses/midwives, social and emotional health workers, and other health workers such as health promotion and outreach workers [24].

2. Materials and Methods

The data were well collected in a cross-sectional online survey of First Nations health staff across professions, roles, and jurisdictions in Australia from September to December 2018. Its development was guided by the project's Aboriginal Reference Group (ARG) [13]. Ethical approval to conduct the national survey was granted by the Aboriginal Health and Medical Research Council Human Research Ethics Committee (HREC) in New South Wales (Ref 1306 17), the Central Australian Aboriginal HREC (CA-17-2948), the Menzies University HREC in the Northern Territory (2017-2943), the South Australia Aboriginal HREC (04-17-732), the Western Australian Aboriginal HREC (822), and the St Vincent's Hospital Ethics Committee in Melbourne, Victoria (HREC 186/18) and was supported by the Queensland Aboriginal and Islander Health Council.

2.1. Data Collection. The survey was administered using the Qualtrics software online. Questions were largely precoded. An online (computer, mobile, and iPad/tablet) and a paper version were pilot tested with the ARG and a group of six health staff and managers with minor wording changes made and response categories expanded or collapsed for some questions.

The survey was open to current First Nations health staff as well as those who have previously worked in the sector, and it included health professionals and other staff in any role in a health service. The survey was promoted nationally through key health professional forums and networks, including the peak National Aboriginal Community-Controlled Health Organisation (NACCHO) and its other state and territory affiliates, and ACCHOs and mainstream health services that were partners in the larger research project [13]. This occurred via e-mail and Twitter and at conferences and other events likely to attract the target group. This approach was combined with snowball sampling, where participants invited others to participate.

The survey was designed to be completed online in various locations including at home, work, or conferences and forums where IPads were made available. The latter strategy was designed to access people who may not have a good Internet connection at home or work, particularly in remote worksites. The research team also actively promoted the survey in sites where qualitative data collection occurred and in regional (outside of major cites) and remote settings [13]. This sampling was purposefully designed to increase the number of regional and remote participants who are not well represented in routine national data collection [23]. The sampling was designed to obtain a broad cross-section of people in different locations, roles, and organisations.

2.2. Measures. The survey was designed to understand the development needs and career pathways of the First Nations health workforce across five domains (Algorithm 1). It aimed to build on existing routine surveys, was informed by the existing literature [29], and was refined in consultation with key stakeholders and the ARG. Early qualitative data from case study sites in the larger project [13] were also used to inform response options, particularly for Domains (d) and (e). Where appropriate, existing workforce surveys [33] and Australian Bureau of Statistics Categorisations were used for response options to aid comparability to national data [23]. Following basic demographics and information about their qualifications and current and previous roles in the health sector, respondents were asked to rate their career development opportunities in their current workplace on a five-point Likert scale which had been previously used in

The questionnaire covered five domains:
(a) Worker characteristics, e.g., Aboriginal and Torres Strait Islander identifier, gender, age group, highest level of qualification, and professional memberships.
(b) Workplace and job characteristics, e.g., geographic location, employer type, current position and length of time in that position, total time employed in the health sector, and number of positions held.
(c) Current education/training.
(d) Facilitators and barriers to career progression.
(e) Suggested strategies to enhance career pathways.

Algorithm 1: Questionnaire domains.

a First Nations Allied Health Association survey of their membership [34]. They were then asked to indicate from a list of items which ones they agreed had helped to "develop their career in their time working in their current organisation?" In another section, respondents were asked to indicate from a list of items the main barriers to their career development with their current employer. They could select more than one item for both of these questions. See Supplementary Materials (available here) for a copy of the full-survey instrument.

2.3. Data Analysis. Descriptive statistics were first used to summarise participant responses. Satisfaction with career development was measured on a 5-point scale, from very dissatisfied to very satisfied. In analysing satisfaction, it was found that the distribution was symmetric across all five response categories. Thus, means and standard deviations are reported. All enablers and barriers were binary variables, coded "1" if the respondent endorsed that item and "0" if they did not. Predictors of satisfaction with career development were examined using linear regression. Each enabler and barrier was included in a simple regression to obtain the unadjusted estimate and 95% CI (Model 1) and also in a model with gender, age group, and type of organisation as covariates (adjusted estimate, Model 2). Regressions were run on the whole sample, by location and then by organisation type. With a sample size of 50, assuming SD = 1.09 in career development satisfaction and 0.5 in the predictor, the 95% CI half-width around the regression coefficient would be 0.62. For a sample of $N = 200$, the half-width would be 0.30. Assumptions of normality and homogeneity of residuals were met.

3. Results

Most respondents were currently employed in a health service organisation (89%), and this group of 332 people who were currently employed is the focus of this paper. Of these 332 participants, 89% identified as Aboriginal, 5% as Torres Strait Islander, and 6% as both Aboriginal and Torres Strait Islander. Ridoutt et al. [23] reported that just over two-thirds (67%) of Aboriginal and Torres Strait Islanders employed in the Australian health workforce were employed in the states of NSW and Queensland [23]. The survey data had most of the respondents from these two states (58%) and also included participants from every other state and territory.

From Table 1, it can be seen that most (60%) of the samples were 40 years and above with an over-representation of these workers compared to the national Aboriginal and Torres Strait Islander health workforce [23]. The survey sample, however, appears to reflect broader health workforce trends with a high number of females employed in the health workforce nationally [23], as shown in Table 1 with 77% of the sample identifying as female.

The sample included many who reported having completed a health-related qualification, with 44% having their highest level of qualification from a technical and vocational education provider (TAFE), as shown in Table 1. There were also 39% who had completed a University Bachelor's degree or higher qualification. Nationally it is estimated that 21% of Aboriginal and Torres Strait Islanders possess a degree qualification or higher [23]. Most (76%) of the respondents were currently employed in a government health service. In terms of location, half of the respondents were employed in urban locations (50%), 36% in regional and 14% in remote locations. In terms of the main role of those currently employed, most reported being employed in clinical (35%) or administrative roles (23%), which includes managers not providing clinical services.

3.1. Unique Knowledge and Skills. There were 279 respondents who answered a question about the unique knowledge and skills Aboriginal and Torres Strait Islander staff bring to the health sector, with several of the response options being endorsed by 80% or more of the sample. Almost all respondents to this question selected "cultural knowledge to inform health care," "community connections and relationships," and "knowledge about how to make services more culturally safe" as unique knowledge and skills that they bring to their role.

3.2. Career Development Satisfaction. There were 286 participants who rated their career development in their current workplace. This rating was collapsed into a three-category rating with 42% rating their career development opportunities in their current workplace as good or very good, a third (33%) rating them as poor or very poor, and 25% rating it as average.

Table 1: Participant characteristics of the currently employed ($N = 332$).

	All, n (%) $n = 332$	Urban, n (%) $n = 148$	Regional, n (%) $n = 106$	Remote, n (%) $n = 40$	National[1] (%)
Sex (n = 331)					
Female	256 (77)	120 (81)	81 (76)	29 (73)	78
Age (n = 326)					
15–39	130 (40)	62 (43)	39 (37)	15 (38)	47
40 and over	196 (60)	83 (57)	67 (63)	24 (62)	53
Highest qualification (n = 248)					
No qualification	4 (2)	3 (3)	1 (1)	0 (0)	30
TAFE qualification	108 (44)	40 (36)	39 (47)	13 (43)	27
University bachelor's degree	78 (31)	38 (35)	24 (29)	12 (40)	17
University postgraduate degree	20 (8)	14 (13)	4 (5)	0 (0)	4
Others, not specified	38 (15)	15 (14)	15 (18)	5 (17)	8
Employer type (n = 294)					
ACCHOs	44 (15)	11 (7)	22 (21)	11 (28)	
Government health service	223 (76)	125 (84)	73 (69)	25 (63)	
A private organisation	4 (1)	4 (3)			NA
A nongovernment organisation	18 (6)	5 (3)	9 (8)	4 (10)	
Others	5 (2)	3 (2)	2 (2)		
Location (n = 294)					
Urban	148 (50)				73
Regional	106 (36)				26
Remote	40 (14)				1
Main role with employer (n = 294)					
Clinical (including managers and supervisors also providing clinical services)	103 (35)	45 (30)	43 (41)	15 (38)	29
Administrator (including managers not providing clinical services)	67 (23)	38 (26)	25 (24)	4 (10)	14
Teacher or educator (including health promotion)	31 (11)	13 (9)	13 (12)	5 (13)	NA
Policy and advocacy	17 (6)	11 (7)	5 (5)	1 (3)	NA
Others	75 (26)	40 (27)	20 (19)	15 (38)	NA

Note. Maximum flexibility was given to participants, so questions could be skipped, and samples which responded to each question therefore vary; (1) national data comparators are from Ridoutt et al. [23]; NA = not available.

Table 2: What things have been provided to help you develop your career at this organisation? ($N = 281$).

Enablers	All currently employed, $N = 281$, n (%)	Location			Organisation type	
		Urban	Regional	Remote	ACCHO	Govt. and others
		$N = 142$, n (%)	$N = 101$, n (%)	$N = 38$, n (%)	$N = 39$, n (%)	$N = 242$, n (%)
Made aware of training opportunities	140 (50)	72 (51)	46 (46)	22 (58)	19 (49)	121 (50)
Regular career development planning and reviews	103 (37)	52 (37)	35 (35)	16 (42)	14 (36)	89 (37)
Paid study leave	93 (33)	43 (30)	35 (35)	15 (39)	14 (36)	79 (33)
Traineeships and education	82 (29)	33 (23)	30 (30)	19 (50)	12 (31)	70 (29)
Opportunities to trial new duties or roles	82 (29)	39 (27)	28 (28)	15 (39)	11 (28)	71 (29)
Provided role models or mentors	72 (26)	36 (25)	24 (24)	12 (32)	8 (21)	64 (26)
Information about other roles in the health sector	70 (25)	37 (26)	20 (20)	13 (34)	9 (23)	61 (25)
Support for accommodation and travel for training/educ.	68 (20)	17 (11)	31 (29)	20 (50)	18 (46)	47 (19)
Nothing has been provided	75 (27)	40 (28)	22 (22)	13 (34)	16 (41)	59 (24)
Other/no responses selected	53 (19)	30 (21)	16 (16)	7 (18)	9 (23)	44 (18)

Note. Some respondents did not indicate location or the organisation type.

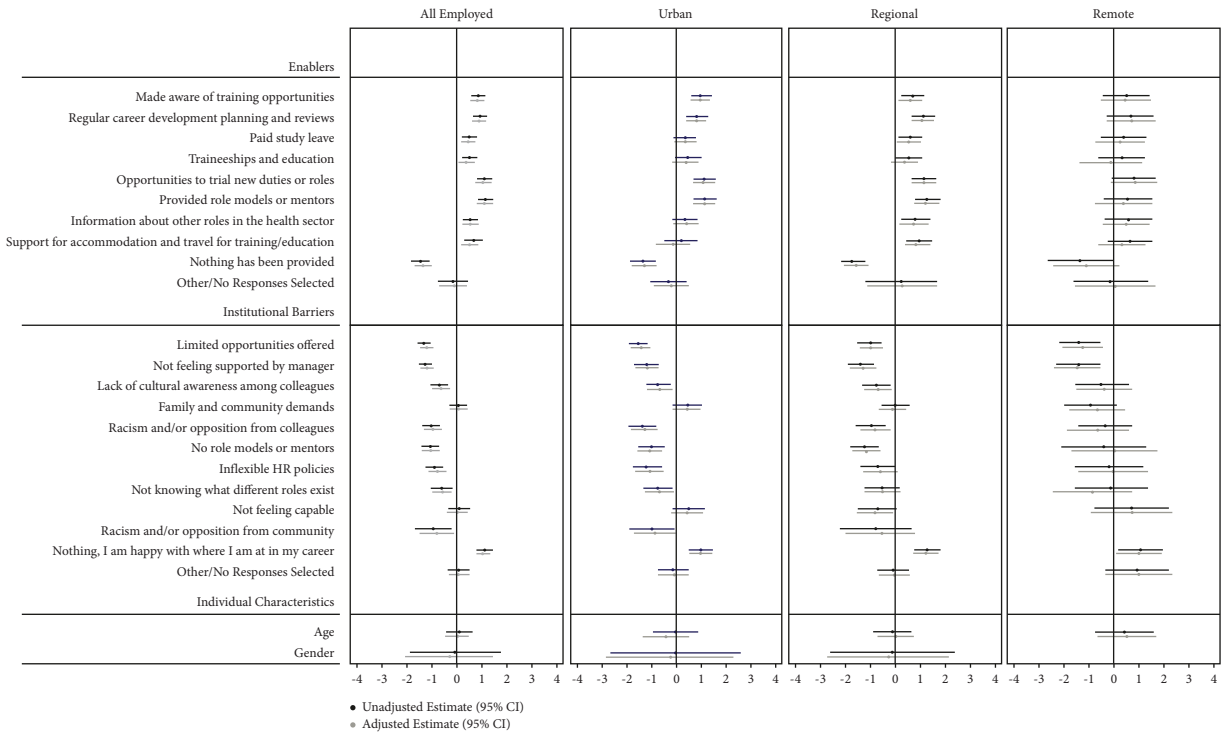

Figure 1: Enablers and barriers as predictors of satisfaction with career development by location ($n = 281$). Note: the unadjusted estimate and 95% confidence interval (CI) are in black and the adjusted (with gender, age group, and type of organisation as covariates) is in grey with 95% CI for the whole sample and for the subgroups by location.

3.3. Enablers and Barriers. Respondents were asked to identify the kinds of opportunities their employer has provided to support their career development. Participants were able to select more than one opportunity. From Table 2, for all currently employed, it can be seen that half of the respondents to these questions reported being made aware of existing training opportunities, over a third (37%) said regular career development planning and reviews were provided, and a third received paid study leave. Other career development options were reported as being provided by less than a third of participants, and 27% said nothing had been provided. The overall proportions on enablers by different locations suggest a similar pattern in urban and regional locations, yet for remote locations, it appears that higher proportions of opportunities have been provided. However, there was a higher proportion reporting that nothing had been provided in remote locations compared to regional and urban locations. The proportions by different organisation types suggest little difference in the provision of enablers by organisation type except for support for accommodation and travel for training and education which appears higher for ACCHO compared to government/others. There was, however, a higher proportion of ACCHOs reporting that nothing had been provided compared to government/others. These differences were not tested for significance, and the linear regression reported in Figure 1 provides further insights on differences by location.

Respondents were asked to identify the main things that held them back from developing their career in the organisation where they were currently employed (Table 3). Participants were able to select more than one response option. Limited opportunities were the main reason chosen overall (41%) and by different locations and organisation types. Not being supported by the manager was reported by almost one quarter of all respondents and by respondents in different locations, but only 10% in ACCHOs. Similarly, lack of cultural awareness among colleagues was between 22 and 25% except for those working in ACCHOs, where it was 8%, and also lower in ACCHOs for racism and opposition from colleagues. Other barriers were generally reported by more people in government/others than in ACCHOs and more respondents in ACCHOs and remote areas said they were happy with where they were in their career. These differences were not tested for significance, and the linear regression reported in Figure 2 provides further insights on differences by organisation type.

3.4. Predictors of Satisfaction with Career Development. There were 281 respondents who were included in the linear regression analyses, as shown in Figures 1 and 2.

Figure 1 depicts each enabler and barrier as predictors of satisfaction with career development by location. Age and gender were also response options when respondents were asked about barriers to career development opportunities. Using the adjusted estimate, all enablers were associated with higher satisfaction with career development for the sample overall. Those endorsing the item "nothing has been provided" were much less satisfied with their career development. This appears to hold for all

Table 3: Main things that hold you back? ($N = 281$).

Barriers	All currently employed, $N = 281$, n (%)	Location			Organisation type	
		Urban	Regional	Remote	ACCHO	Govt and others
		$N = 142$, n (%)	$N = 101$, n (%)	$N = 38$, n (%)	$N = 39$, n (%)	$N = 242$, n (%)
Limited opportunities offered	116 (41)	60 (42)	40 (40)	16 (42)	12 (31)	104 (43)
Not feeling supported by manager	68 (24)	36 (25)	21 (21)	11 (29)	4 (10)	64 (26)
Lack of cultural awareness among colleagues	63 (22)	32 (23)	22 (22)	9 (24)	3 (8)	60 (25)
Family and community demands	59 (21)	24 (17)	27 (27)	8 (21)	7 (18)	52 (21)
Racism and/or opposition from colleagues	53 (19)	25 (18)	19 (19)	9 (24)	3 (8)	50 (21)
No role models or mentors	50 (18)	27 (19)	20 (20)	3 (8)	3 (8)	47 (19)
Inflexible HR policies	42 (15)	23 (16)	14 (14)	5 (13)	1 (3)	41 (17)
Not knowing what different roles exist	40 (14)	23 (16)	13 (13)	4 (11)	4 (10)	36 (15)
Not feeling capable	33 (12)	18 (13)	11 (11)	4 (11)	2 (5)	31 (13)
Racism and/or opposition from community	12 (4)	9 (6)	3 (3)		1 (3)	11 (5)
Nothing, I am happy with where I am at	75 (27)	40 (28)	22 (22)	13 (34)	16 (41)	59 (24)
Others/no responses selected	44 (16)	20 (14)	19 (19)	5 (13)	6 (15)	38 (16)
Individual characteristics						
Age	28 (10)	9 (6)	12 (12)	7 (18)	3 (8)	25 (10)
Gender	2 (1)	1 (1)	1 (1)			2 (1)

Note. Some respondents did not indicate location or the organisation type.

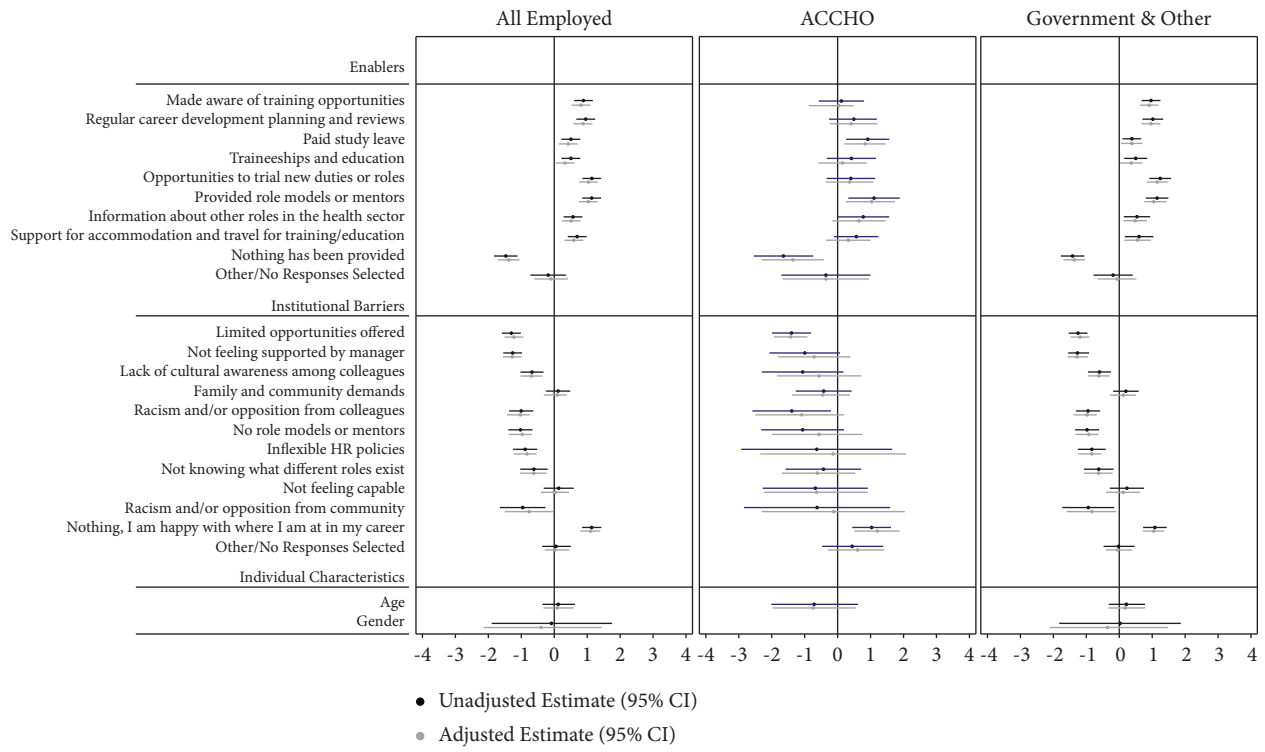

Figure 2: Enablers and barriers as predictors of satisfaction with career development by organisation type ($n = 281$). Note: The unadjusted estimate and 95% confidence interval (CI) are in black, and the adjusted (with gender, age group, and type of organisation as covariates) is in grey with 95% CI for the whole sample and for the subgroups by location.

locations though small numbers in the remote sample mean the estimate for the relationship is relatively imprecise.

For the overall sample, most barriers are associated with reduced satisfaction except for "not feeling capable" and "family and community demands" which are less institutional and more about individual and social context. "Not feeling supported by the manager" was a predictor of career development satisfaction overall and in all locations. "Lack of cultural awareness," "racism and opposition from colleagues," and "no role models or mentors" were significant predictors in urban and regional but not in remote areas though again with wide CIs for the remote sample. "Inflexible HR policies" and "not knowing what different roles exist" were the only predictors in the overall sample and in urban areas.

Figure 2 depicts each enabler and barrier included in a linear regression as predictors of satisfaction with career development by organisation type (ACCHO and government/others). Again, the unadjusted estimate and 95% CI are in black and the adjusted (with gender, age group, and location as covariates) is in grey. The same results are found in column 1 for the whole sample as in Figure 1. Using the adjusted estimates when looking at organisation type, we find those employed in ACCHOs who reported being provided paid study leave and having role models or mentors had higher satisfaction with career development. All enablers when provided by government and other organisations were found to be predictors of higher satisfaction. Most barriers were predictors of reduced satisfaction in government and others, except for "not feeling capable" and "family and community demands." Limited opportunities predicted lower satisfaction in both organisation categories. Not being supported by their manager, lack of cultural awareness among colleagues, racism and opposition from colleagues, not having role models or mentors, inflexible HR policies, and not knowing what different roles exist were all predictors of lower satisfaction with career development among those employed in government and other sectors, but not in ACCHOs.

There were 332 respondents who answered a question about what may make a difference in helping develop careers in health in general terms Table 4. They could choose more than one option. Most of the proposed strategies had 50% or more respondents indicating support. The most chosen option overall was to "increase the role of Aboriginal and Torres Strait Islander staff in leading career development," followed by "more funding to support training/education."

4. Implications for Policy and Practice

A strong First Nations health workforce is crucial for improving the health and wellbeing of communities as well as being a core foundation of the right to selfdetermination [10, 14, 35, 36]. A compelling reason for a strong, stable, and flourishing First Nations health workforce is because First Nations people in all countries, including Australia, experience significant barriers to accessible healthcare due to institutional and interpersonal racism [37].

Table 4: Key things overall you think would make the most difference to developing careers? ($N = 332$).

	All currently Employed $N = 332$ n (%)
Increase role of Aboriginal and Torres Strait Islander staff in leading career development activities	228 (69)
More funding to support training/education, i.e. paid leave, travel costs	221 (67)
More traineeships and educational opportunities	212 (64)
Give opportunities to trial new duties or roles	210 (63)
Recognise unique knowledge and skills	204 (61)
Ensure a culturally safe work environment	204 (61)
Increase pay to match increased role requirements	201 (61)
Acknowledge and celebrate achievements	197 (59)
Provide mentoring and role models	195 (59)
Provide regular cultural training for all staff	192 (58)
Make sure everyone has an individual development plan regularly reviewed	188 (57)
Provide back-fill or other support for staff doing training	179 (54)
Provide more flexibility to accommodate family/community commitments	154 (46)
Other	36 (11)

This is the first national survey of First Nations health staff experiences of career development across roles, professions, and locations and in both ACCHO and "mainstream" organisations in Australia. While the survey was completed by individuals, this discussion takes a broader focus beyond the individual or a single organisation and uses the notion of enablers and barriers to also consider the implications for the broader health sector and related debates about power relations, paternalism, racism, and selfdetermination that can impact career development for First Nations people in the health workforce [11, 26]. The survey is about First Nations people's experiences of career development and selfrated satisfaction, and it is therefore important to first reflect on their reported experiences before we turn to the broader implications for organisations, health systems, and government and most importantly for Aboriginal people, communities, and community-controlled organisations.

The survey of 332 people who were currently employed in a health service is diverse being drawn from different states and territories, urban, regional, and remote locations, ACCHO, and "mainstream" services and was completed by people in a range of roles. A range of unique knowledge and skills were endorsed by many participants with most or all selecting "cultural knowledge to inform health care," "community connections and relationships," and "knowledge about how to make services more culturally safe." Previous studies have also identified similar skill sets and unique contributions to the health system from First Nations health staff [10, 14, 35].

The responses by participants showed that a range of employer-provided opportunities or enablers for career development are provided to some; however, key activities and opportunities that should be provided to all staff, such as regular career development planning and reviews, were only identified as being provided by a third of the sample. A range of barriers to career development were also reported with limited opportunities offered, not feeling supported by the manager, a lack of cultural awareness among colleagues, racism and/or opposition from colleagues, no role models or mentors, and inflexible HR policies commonly selected. Participants were also asked to rate their satisfaction with career development opportunities in their current workplace, and while just over 40% rated their career development opportunities as good or very good, a third rated them as poor or very poor. Not feeling supported by the manager was a predictor of career development satisfaction overall and in all locations. The findings by organisation type suggest different experiences. There were many institutional barriers, such as not being supported by their manager, lack of cultural awareness among colleagues, racism and opposition from colleagues, not having role models or mentors, and inflexible HR policies that were predictors of lower satisfaction among those employed in government and other sectors, but not in ACCHOs.

It is important for government and health services to understand and act on identified enablers and barriers, such as those highlighted by the current study. However, a focus on enablers and barriers is not sufficient to address the ongoing challenges for First Nations staff working in a system where power is located with "others" and in structures and systems that do not value their ways of knowing, being, and doing [37]. Decolonisation of healthcare "is the process of reclaiming ways of knowing, being, and doing that were/are considered inferior by colonial processes" [37] and "centering" Aboriginal and Torres Strait Islander peoples' ways of knowing, being, and doing work together to shift the focus from individuals to the system, policies, and structures that need to change from recruitment to promotion [11, 38]. As Bond and Singh argue "the real challenge in addressing the disparities of the health workforce representation lies in a preparedness to consider how power operates in the production and maintenance of health inequalities" [38]. In practical terms, it requires significant changes to how positions are conceptualised and structured and how people are remunerated, promoted, and supported [27]. The challenge is to move away from just tinkering at the edges of a system that has fundamental flaws which prevent First Nations people from prospering and being valued for their unique skills. It requires us to move away from a deficit to a strengths-based discourse [39].

Racism should also be high on the agenda of all health service organisations. Although racism in the health system is well documented [3, 7, 37, 40], our findings provoke consideration of the ways in which it not only manifests in individual behaviours and attitudes but is deeply embedded in institutional human resource policies and practices that explicitly or implicitly disadvantage Aboriginal and Torres Strait Islander people's career development. Elias and Paradies [41] argue that Australia's health system operates as an exclusionary system where "rights and privileges

conferred on some" are denied to First Nations Australians and serve to widen power differentials [41]. Clearly, organisational and system-level responses are required [3, 8] to address institutional racism within the healthcare system, which can also lead to inequality of opportunity in people's career development and trajectories.

There is a growing understanding in policy and practice of the importance of cultural safety in addressing racism as it impacts patients access to appropriate health care [37]. To date, there has been less attention on how cultural safety relates to strengthening the health workforce. Our findings on racism and the lack of cultural awareness demonstrate the importance of culturally safe organisational settings, policies, and practices as part of enabling career development in health for Aboriginal and Torres Strait Islander people. Cultural safety has been defined as "the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible, and responsive healthcare free of racism" [42]. Importantly, for strengthening the rights of Aboriginal and Torres Strait Islander Health Workforce to equitable career structures and opportunities, the strategy aligns its purpose with the United Nations Declaration on the Rights of Indigenous Peoples to promote selfdetermination, autonomy, and culturally safe health care workplaces to achieve full realisation of human rights. As Gatwiri et al. [37] suggested, cultural safety and antiracism are powerful tools for examining how power imbalances play out in particular ways in relation to career structures and opportunities.

Strengthening the workforce needs to occur within a human-rights-based framework that should underpin the health systems design, service delivery, and workforce development [25]. A human-rights-based approach to health is founded on empowering rights holders to effectively claim their human rights, the elimination of all forms of discrimination, and the upholding of principles of participation, equality, transparency, and accountability [25].

The importance of support from management found in the current study and in the case studies in the Northern Territory of Australia as part of the Career Pathways Project [43] is also highlighted in other recent studies on retention and career development for First Nations health workers [27, 44]. Supportive management has been found to play a central role in supporting cultural safety, a sense of belonging, and contribution [27, 43, 44]. While "mainstream" services can provide a supportive context and leadership to improve cultural safety and career development [27, 44], the role of ACCHOs in providing a safe space for people to begin and develop their careers in health remains critically important [45, 46] as well as providing culturally safe and accessible care for First Nations populations [47, 48]. However, the current capacity of ACCHOs in career development is constrained by an inequitable resource environment. National government funding in Australia is provided under the First Nations Australians' Health Programme (IAHP) [49] supplemented by state or territory funding. This state or territory funding is usually provided under a competitive tendering arrangement among all health services, including non-First Nations services. There has been criticism of the funding arrangements [50] and renewed calls for "reconfiguring relationships of power between First Nations and non-First Nations people" [38], including quarantined funding for the ACCHO sector to deliver services for their community.

One of the impacts of the current funding arrangements is the lack of competitive pay structures in ACCHOs compared to "mainstream" restraining ACCHOs in both recruiting and retaining staff, particularly in rural and remote settings, even though they are major employers of First Nations health staff [24]. This can translate to people leaving the ACCHO sector for better pay and opportunities to develop their careers, but moving away from the cultural safety of ACCHOs. Strengthening the ACCHO sector in terms of program scope and funding would have direct impacts on their staff retention, placing them in the driver's seat to improve the cultural safety of "mainstream" services.

The funding arrangements, health system structures, and geography in other countries, such as Canada and New Zealand, are different from Australia, yet key principles are likely transferable, including the core finding of this study to focus on career pathways and development, not just recruitment, to build a strong First Nations health workforce. The principles of leadership and selfdetermination, valuing cultural strengths and investment in workforce, training, and education are similarly transferable findings, but would need to be tailored to local contexts and structures.

The many issues related to workforce raised in the current study findings are addressed in the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 [51] codesigned between Aboriginal and Torres Strait Islander health peak bodies and governments, but are so far largely unfunded. The strategies proposed in the plan include undertaking a biennial Aboriginal and Torres Strait Islander health workforce barometer based on the survey reported in this paper, implementing strategies to retain and grow the existing Aboriginal and Torres Strait Islander health workforce, flexible workplace and education arrangements, place-based education, peer support, and mentoring and leadership programs. The framework strategies will require formal partnerships that are resourced adequately, including shared decision-making with Aboriginal and Torres Strait Islander community-controlled organisations and communities at state, regional, and local levels.

4.1. Limitations. The limitations of the study are that a representative sample was not obtained and, therefore, the results are not necessarily generalisable to all First Nations people working in health in Australia. For example, the survey had an under-representation of young people [23]. Also, as this was not a random sample, any reported differences by location or organisational type may reflect some sampling error. The sample for remote was also relatively small, and therefore, confidence intervals are wider, making it harder to draw conclusions. Lastly, missing data can bias results. Regression analyses using full-information

maximum likelihood estimation and all cases were run as a sensitivity analysis, and there were no substantive differences between the presented results. Further research is needed to validate these findings in a larger more representative sample.

5. Conclusion

This study provides important new data about career development opportunities and barriers among First Nations people working in urban, regional, and remote locations and different organisation types in Australia. It highlights the need to build managerial support for career development, address cultural safety, provide mentors, and address inflexible human resource policies, especially in "mainstream" organisations. The implications for workplaces in urban, rural, and remote locations are that providing even just a few career development opportunities can make a difference to satisfaction levels—anything a workplace can do matters. Coupled with leadership by First Nations staff, providing a range of opportunities for career development can improve satisfaction and boost retention. Attention to the broader issues of how positions are conceptualised and structured and how people are remunerated, promoted, and supported also require action.

Data Availability

These data are about Aboriginal and Torres Strait Islander people, and the sharing of data with third parties is not supported by ethical bodies who approved this research. The authors would need to seek permission to share the data from ethical review committees on a case-by-case basis, https://healthinfonet.ecu.edu.au/learn/cultural-ways/data-sovereignty/.

Additional Points

The Following Is Known About This Topic. (i) A strong First Nations health workforce is integral for health rights and health equity and to meet community needs. (ii) Increasing the presence and power of First Nations people in the health workforce leads to improved health and wellbeing outcomes. (iii) Previous studies have focused on how to increase the numbers of First Nations people entering the workforce with minimal consideration of career development. *This Paper Adds the Following*. (i) Managerial support for career development, cultural safety, and mentors and addressing inflexible human resource policies were found to be key factors that can impact career development satisfaction and retention in the workforce, especially in "mainstream" organisations. (ii) Development of managers cultural capability is essential for culturally responsive strategies that support First Nations' career development. (iii) Attention to the broader issues of how positions are conceptualised and structured and how First Nations staff are remunerated, promoted, and supported were identified as requiring concerted action at the workplace and sector level.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Supplementary Materials

Supplementary File 1: *Survey Tool*. The survey was delivered online and the supplementary file is a word version of the survey exported from the online software. (*Supplementary Materials*)

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