Final Report
Aboriginal Health Worker Profession Review

November 2009
IN – CONFIDENCE

FOR THE
NORTHERN TERRITORY DEPARTMENT
OF
HEALTH & FAMILIES

Human Capital Alliance
Human capital specialists

The Aboriginal Health Worker Profession Review was undertaken by:

Human Capital Alliance (International) Pty Ltd
PO Box 2014, Normanhurst NSW 2076 Australia
Suite 2, 2a Pioneer Ave, Thornleigh NSW 2120
Ph: +61 2 9484 9745
Fx: +61 2 9484 9746

in partnership with:

HK Training & Consultancy
PO Box 42291
CASUARINA NT 0811
Phone: 08 89457865
Fax: 08 89457975

The final report was written by Lee Ridoutt and Victoria Pilbeam of Human Capital Alliance with assistance from Kate Lee, HK Training & Consultancy.

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Background

The Northern Territory Department of Health & Families (DH&F) has long recognised the employment of 'Aboriginal Health Workers' (AHW) as an important way to provide health services to Aboriginal and Torres Strait Islander (Aboriginal) people, especially in communities in remote locations. This was recently confirmed in an important draft planning document, Universal Core Services Framework (Josif, 2009). More generally it is agreed that better health outcomes are achieved for Aboriginal people when health services include Aboriginal health staff and managers, and where the community participates in the management decisions (Tregenza and Abbott, 1995).

Following these principles, the Aboriginal Health Worker 'brand' has been synonymous with quality services in the Northern Territory for Indigenous communities for many years. Slowly though, the brand image has become tarnished and the iconic status in the Northern Territory of the AHW has come under threat. The AHW workforce has reached a 'crossroad' from which the AHW may emerge stronger, but just as easily may become even weaker, and destined for hard times.

AHW workforce Review

DH&F engaged the services of Human Capital Alliance (HCA) to undertake an important review of the Aboriginal Health Worker profession. The DH&F and the Liquor, Hospitality and Miscellaneous Union agreed to a review of the Aboriginal Health Worker profession after discussions associated with the implementation of the most recent Enterprise Bargaining Agreement that covers AHWs.

The specific purpose of the Review was to provide accurate information about the current AHW profession and advice on strengthening its size and capability, as well as career development for Aboriginal Health Workers. The Review's scope included both the government and Aboriginal community controlled sectors.

This Review was undertaken against a background of many previous reviews (Tregenza and Abbott, 1995, Josif and Elderton, 1992 and Josif and Franks, 1994) — the findings of those reviews identified similar workforce issues and problems as those recognised in this Review. In response to previous reviews attempts have been made to address identified issues, though often at an individual employer or health service level but not with respect to the entire AHW workforce or health system — as a consequence the outcomes have been 'patchy' and difficult to sustain. The lack of progress in regard to these longstanding AHW workforce issues has hence led to a significant build up of frustration. On the one hand the workers themselves, and allied interest groups, have lost trust in the system to seriously address the perceived concerns. On the other hand, policy makers and service administrators lament that reasonable investment in the AHW workforce has not delivered expected returns. This has resulted in questions around ongoing support of the AHW workforce.

This Review attempts not to buy into either of these views and instead acknowledges (1) there are longstanding and complex problems undermining the vitality of the AHW workforce and these problems have defied simple solutions, and (2) the inability to resolve these problems has created a situation with the AHW workforce that can now be considered a crisis point.

Review findings and direction

This Review unequivocally supports embarking on a pathway to a stronger AHW workforce. In the recently concluded *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (December 2008) it was agreed that there was a need to:

> *"… significantly expand access to and coordination of comprehensive **culturally secure** primary health care, allied health services and related services." (p. 6, author's emphasis)*

It is impossible to see how in the short and medium term (next 5-15 years) the above principles and the ambitious outcome expectations of 'Closing the Gap' will be achieved without a vibrant Aboriginal Health Worker workforce.
The Review provides a great window of opportunity for DH&F and the Aboriginal Medical Services Alliance Northern Territory (AMSANT) as the major (but not only) stakeholders and most direct influences on AHW experiences, to do something positive and translate past rhetoric into future reality. Both DH&F and AMSANT have recognised the potency of this moment and affirmed their desire to achieve something more tangible from this Review. AMSANT have emphasised in their response to drafts of this report the urgency of required action.

Like most areas of health services endeavour, but especially the area of Indigenous health, there are many responsible parties. In regard to the AHW workforce, in addition to DH&F and AMSANT, there are other elements of the Territory Government (e.g. Department of Employment Education and Training), and the Commonwealth Government (the Department of Health and Ageing, Department of Education, Employment and Workplace Relations). Each of these sources of funding or service delivery (or both) needs to formally agree (1) generally on the value of AHWs and the ongoing support that this workforce needs and (2) specifically on the recommendations of this Review. This then implies that requisite energy and resources are committed in a sustained way to achieve the desired outcome for the AHW workforce to ensure that it is viable in the longer term.

The suggested directions from this Review aim to bring vibrancy back to the AHW workforce which will inspire confidence in the services that employ AHWs and create strong job futures for AHWs. A workforce needs to be created where compensation for the level of work required is competitive and fair, a clear career pathway is evident, support and professional development is available and job security is strong for those who perform to expectations. It is essential to enhance the education and training of AHWs to improve their chances of progressing within and beyond the AHW classification.

Issues with the AHW workforce will not be resolved unless:

- clarification of the role(s) is achieved;
- major training and support structures are put in place;
- improved training models are developed;
- professional mentoring support structures are in place;
- job classifications are accepted and more enticing career pathways established;
- management practices are adopted that better demonstrate human resource management best practice; and
- working structures/ relationships with other health staff are in place.

List of recommendations

In all 23 recommendations are provided in this Review largely targeting each of the above dot points. They are listed below.

Recommendation 1:
AHW employers must ensure each AHW under their employ has a clearly stated job description and duty statement. DHF and AMSANT, in conjunction with a relevant professional association need to create an agreed 'template' set of AHW 'roles' which employers can modify to construct job descriptions specific to their community and individual AHW context.

Recommendation 2:
Health services should redesign the work in health services to (1) be entirely consistent with the needs of the community and (2) satisfy the needs of AHWs and other health services staff to better utilise their skills and clinical judgement.

Recommendation 3:
It is recommended that an initial target to increase the AHW workforce annually be set at 10% or 30 new registered AHWs per year for the next three years.

Recommendation 4:
The NT Aboriginal Health Forum should undertake, as a matter of urgency, work to review the current AHW workforce benchmark and establish an agreed AHW workforce size with an annual target and timeframe for the number of new entrants to meet the needs of Aboriginal Primary Health Care in the Northern Territory.

Recommendation 5:
All non-Aboriginal staff working in Aboriginal Primary Health Care services in the NT should receive periodic ongoing cultural awareness training and support in order to complement ongoing community experience and assist in resolving workplace issues such as absenteeism and avoidance.

Recommendation 6:
An acceptable model and mechanism for the cultural mentoring of resident non-Aboriginal staff working in Aboriginal Primary Health Care services in the NT needs to be fashioned from existing approaches and its implementation appropriately funded.

Recommendation 7:
The Review identified that health services with the following management practices were most successful in retaining their AHWs:

- consultative and collective decision making processes;
- building confidence in AHWs by affirmation of their skills and providing ongoing skills development on the job;
- reciprocal support and mentoring between AHWs and RNs in cultural awareness and professional development respectively;
- facilitating AHWs working as a team with the benefit of managing cultural requirements such as gender issues;
- making available a network of relief AHWs;
- allowing AHWs to express a preference to work as a team or to set individual work plans;
- promote AHWs as the first contact for health centre patients and then either treated by an AHW or referred on to an RN or doctor if required;
- grievance processes established and if already in place appropriately adhered to for all staff; and
- ensure RNs understand the role of AHWs and support their professional development.

It is recommended that appropriate parameters and expectations be set for each health service in line with the above management strategies and that manager practices are monitored and managers held accountable.

Recommendation 8:
Employers recruiting AHWs from outside a given community should in principle offer housing/accommodation on the same terms as nursing staff and other resident health professionals or NT Aboriginal Community Police Officers.

Recommendation 9:
AHWs recruited from within their local community should ideally be offered housing/accommodation on the same terms as nursing staff and other resident health professionals or NT Aboriginal Community Police Officers as:

- a recruitment strategy/benefit; and
- a means to ensure a minimum standard of home environment for AHWs in the workforce.

Recommendation 10:
Work be undertaken by AHW employers to identify any gaps and provide parity in the conditions of service of AHWs and other health professionals working in the same health services.

Recommendation 11:
Leadership and management programs be provided to empower AHWs to be in senior AHW and management positions in both government and community controlled health services.

Recommendation 12:
AHWs be involved in all aspects of the move to community controlled health services and in order to empower their role within these services clear AHW roles definitions in community controlled health services be established (see Recommendation 1).

Recommendation 13:
Clear training pathways from Certificates II and III to registration level training requirements for existing and prospective AHWs need to be established.

Recommendation 14:
The Review identified that health services within town centres had utilised their senior AHWs to recruit prospective AHWs from within the community and high schools. It is recommended that a concerted effort be made to promote AHW careers to high school students by existing AHWs and AHW employers.

Recommendation 15:
A coordinated effort by the AHW profession and AHW employers needs to be undertaken to 'market' the AHW profession utilising television and other popular media.

Recommendation 16:
The Review recommends that DH&F and AMSANT request the NT Department of Education and Training undertake an audit into AHW education, training and student outcomes for the past five to ten years.

Recommendation 17:
The Review recommends that DH&F and AMSANT request the NT Department of Education and Training to review their user choice policy and funding for AHW training to allow RTOs other than BIITE to access funding.

Recommendation 18:
It is recommended that for the medium term a thorough review of AHW training in the NT be conducted to provide lasting improvement by:

- creating *regional* training centres in larger urban and town centres across the NT for example, Darwin, Katherine, Gove & Alice Springs;
- ensuring each trainee AHW has a suitable designated supervisor/mentor in the health services, preferably in a community based service;
- ensuring sufficient and suitable AHW educators who will provide regular clinical support and on the job training to all AHW trainees by visiting all trainees in their health services;
- reviewing the current 'block release' mode of delivery; and
- accepting that for some trainees the period of the training course could realistically be up to three years and include language and literacy alongside or as a pre-requisite to the conceptual and clinical training of the Certificate IV.

Recommendation 19:
It is recommended that whatever training model is adopted in the future that each AHW trainee must receive regular, local access to AHW educators for clinical support and on the job training. To facilitate this outcome AHW training and support needs to be included in the core work of health services and put into the job descriptions and responsibilities of senior AHWs and other health service staff.

Recommendation 20:
It is recommended that a review of AHW ongoing professional development strategies and mentoring / support systems be undertaken and resultant strategies put in place to ensure the ongoing professional development, support and empowerment of individual AHWs is achieved at all levels of the workforce.

Recommendation 21:
To ensure that AHWs achieve representation at all levels of the NT health industry it is recommended that key stakeholders for the AHW workforce discuss the best way to assist AHWs achieve representation and that all AHW employers and their representatives support the National AHW Association.

Recommendation 22:
The Review recommends that DHF and AMSANT should consult relevant stakeholders to review AHW classifications and job evaluation systems using the classification structure presented by this Review as a starting point.

Recommendation 23:
The Review recommends that DH&F, AMSANT and the NT AHW Registration Board consider the merits and challenges of establishing a separate but linked classification stream for AHWs wishing to practice in acute services such as hospitals.

Sustaining a focus on implementation of recommendations that may take some years to satisfy is not easy. Hence the search for an appropriate, long term oversight body is essential. It is possible that the NT Aboriginal Forum could be responsible to ensure that the recommendations of this Review are implemented and the necessary resources applied or another body may be created.

Introduction

Context for the Review

The Northern Territory DH&F has long recognised the employment of AHW as an important way to provide health services to Aboriginal and Torres Strait Islander (Aboriginal) people, especially in communities in remote locations. This was recently confirmed in an important draft planning document, Universal Core Services Framework (Josif, 2009). It is widely agreed that better health outcomes are achieved for Aboriginal people when health services include Aboriginal health staff and managers, and where the community participates in the management decisions (Tregenza and Abbott, 1995). An August 2009 submission to the Review from the AMSANT notes:

> *"... AHWs are vital for effective functioning of PHC (primary health care) teams serving Aboriginal communities. In fact we can't imagine these teams operating successfully without the strong presence of AHWs."*

AHWs are believed to be critical in bridging the "cultural chasm" separating the traditional and mainstream world views, thus acting as a cultural broker as well as a primary health care worker (Tregenza and Abbott, 1995). They help to relate mainstream health beliefs to an Aboriginal framework making it possible for Aboriginal patients / clients of health services to understand what is being said and to assess the validity of the statements. They also make it possible for the non Aboriginal health centre staff to communicate with Aboriginal people in language and concepts that they understand. The AHW's core duties may also include:

- Clinical Work – Initial diagnosis and treatment with the support of the Doctors and other allied health professionals;
- Health Education and Promotion – talking to the community about disease prevention;
- Medical Administration – Patients' medical records, ordering medical supplies and writing reports, submissions and patient support letters;
- Outreach Work – visiting and treating clients at home; and
- Referrals – making appropriate referrals to doctors etc when required.

In most (but not all) remote communities, Indigenous people's entry into the health system is through the AHW who may then refer them on to a nurse or doctor.

The Northern Territory is the only jurisdiction that registers AHWs and there has been considerable interest shown by other states and the ACT in the introduction of a registered AHW workforce to their jurisdictions. The Council of Australian Governments has agreed on a national registration and accreditation scheme for health professionals in physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care (dentists, dental hygienists, dental prosthetists and dental therapists), medicine, psychology and osteopathy. The national registration scheme commences in 2010. AHWs will be included in the scheme from 2012 and will be titled Aboriginal Health Practitioners. There is

concern that following the introduction of the new title 'Aboriginal Health Practitioner' that community and health workers presently outside the (registered) AHW role will utilise this new title and the strong 'brand recognition' for the iconic 'Aboriginal Health Worker' title will be lost. Moreover, any change in title could lead to (more) confusion around the role (see later section on AHW role).

The Review

DH&F has engaged the services of HCA to undertake an important review of the Aboriginal Health Worker profession. The DH&F and the Liquor, Hospitality and Miscellaneous Union agreed to a review of the Aboriginal Health Worker profession after discussions associated with the implementation of the most recent Enterprise Bargaining Agreement that covers AHWs.

The specific purpose of the Review was to provide accurate information about the current AHW profession and advice on strengthening its size and capability, as well as career development for Aboriginal Health Workers. The Review's scope included both the government and Aboriginal community controlled sectors. This included but was not limited to:

- Providing recommendations to strengthen and grow the Aboriginal Health Worker profession in the Northern Territory (including identification of specific support and career structures for AHWs employed by the Department of Health and Families);
- Reviewing the current AHW workforce size, structure, nature, and strengths, weaknesses, opportunities and threats;
- Identifying the key factors and service models that enhance Aboriginal Health Worker employment and retention in a range of different service settings;
- Determining the number of qualified AHWs who are not currently working in the profession and the reason for this ;
- Providing advice about incentives and initiatives that would encourage AHWs currently not working in the profession to rejoin the Aboriginal Health Worker workforce;
- Identifying the barriers to AHW education and training, recruitment, retention and career progression; and
- Investigating AHW education and exploring options for the future.

The approach to the Review is detailed in the 'Methodology' section.

A sense of urgency

Many well meaning reviews (Tregenza and Abbott, 1995, Josif and Elderton, 1992 and Josif and Franks, 1994) have been undertaken in the past and the findings of those reviews identified similar workforce issues and problems as those recognised in this Review. To some extent attempts have subsequently been made to address identified issues, though often at an individual employer or health service level but not with respect to the entire AHW workforce or health system — as a consequence the outcomes have been 'patchy' and difficult to sustain. The lack of progress in regard to these longstanding AHW workforce

issues has hence led to a significant build up of frustration. On the one hand the workers themselves, and allied interest groups, have lost trust in the system to seriously address the perceived concerns. On the other hand, policy makers and service administrators lament that reasonable investment in the AHW workforce has not delivered expected returns[1]. This has resulted in questions around ongoing support of the AHW workforce.

This Review attempts not to buy into either of these views and instead acknowledges (1) there are longstanding and complex problems undermining the vitality of the AHW workforce and these problems have defied simple solutions, and (2) the inability to resolve these problems has created a situation with the AHW workforce that can now be considered a crisis point. An AMSANT submission to the Review in August 2009 similarly notes:

> *"... it is a critical time for the AHW profession in terms of its survival as a key component of the PHC workforce in the NT and its potential for healthy growth and development as an integral component of Aboriginal health care. Without definitive action in support of the profession we [believe] ... that the profession faces extinction."*

This Review provides a great window of opportunity for DH&F and AMSANT to do something positive and translate past rhetoric into future reality. Both DH&F and AMSANT have recognised the potency of this moment and affirmed their desire to achieve something more tangible from this Review.

[1] The Aboriginal Medical Services Alliance Northern Territory (AMSANT) stated to the Review team that they believe the investment by the Government has not been properly utilised. In particular they claim Batchelor Institute of Indigenous Training & Education (BIITE) has not been held to account as it has failed to deliver sufficient numbers of graduates each year — a major contributing factor to the decline of AHWs. This Review later offers the view that in general the Government investment has not only been inefficient but also insufficient. When investment is insufficient, even if considerable, the results can be very disappointing.

Methodology

The approach to the methodology of this consultancy was determined by the required outcomes of the project as outlined on the previous page and comprised the following methods of data collection:

- literature review;
- secondary data analysis;
- focus groups;
- case studies;
- stakeholder consultations;
- employer survey; and
- interview of ex-AHWs.

The relationship between the data collection components of the methodology and the achievement of the required outcomes is summarised in Table 1 below.

Table 1: Desired outcomes of methodology components

Desired outcomes	**Methodology components (see key below)**						
	A	B	C	D	E	F	G
Review the current AHW workforce size, structure, nature, and strengths, weaknesses, opportunities and threats		■	■	▒		▒	
Identify the key factors and service models that enhance AHW employment and retention in a range of different service settings			▒	■		■	
Determine the number of qualified AHW who are not currently working in the profession and the reason for this	▒	■	▒		▒		
Provide advice about incentives and initiatives that would encourage AHW currently not working in the profession to rejoin the Aboriginal Health Worker workforce	■		■	▒	▒	▒	■
Identify the barriers to AHW education and training, recruitment, retention and career progression	▒		▒		▒		
Make recommendations to strengthen and grow the AHW profession in the Northern Territory			▒		■		▒

Key to Methodology components

A = Literature / document review;
B = Secondary data analysis;

C = Focus group discussions;
D = Case studies;

E = Stakeholder consultations;
F = Survey of AHW employers;
G= Survey of AHWs who have left the profession.

Key to shading

■ Primary contribution from methodology component

▒ Secondary contribution from methodology component

Literature review

A thorough literature review was undertaken to contribute to a comprehensive understanding of the AHW workforce. It was essential to ensure that recommendations for the way forward were, wherever possible, "evidence-based" and take into consideration implementation issues of different approaches.

The literature review was submitted to DH&F as a separate project report in July 2009 titled 'Literature Review: Aboriginal Health Worker Profession Review' (HCA, 2009).

Aboriginal Health Worker workforce data analysis

Two main sources of secondary data that were interrogated to produce a workforce data analysis report were:

- The Personnel Integrated Payroll System (PIPS); and
- The NT Aboriginal Health Worker Registration Board register.

The two data sources provided essentially a slightly different perspective on the current AHW workforce and the 'Aboriginal Health Worker Workforce Data Analysis' Report (HCA 2009) was submitted to DH&F as a separate project component in June 2009.

Focus groups and interviews

Focus groups and interviews were conducted across the seven NT districts with AHWs only in order to afford them maximum opportunity to speak their mind in the absence of inhibiting forces. Other focus groups and interviews were conducted with immediate supervisors / managers of AHWs in practical and clinical settings. The possibility of gender specific groups was explored at the initiation of each focus group but was not required. Focus group discussions were guided by a list of potential questions that were flexible enough to allow adaptation to different interview circumstances. A copy of the focus group questions is annexed to this document as Annexure 'A'.

Focus groups and interviews were undertaken with AHWs at the following health services:

- DH&F Alice Springs;
- Royal Darwin Hospital (RDH);
- Sunrise Health Service;
- Wurli Wurlijang;
- Katherine District Hospital;
- Batchelor Health Clinic;
- Pine Creek;
- Wadeye;
- Maningrida;
- Yarralin;
- Timber Creek;
- Santa Teresa;

- Dagaragu; and
- Darwin - AHWs from DH&F, RDH, Danila Dilba etc.

Focus groups and interviews were undertaken with AHW employers, health centre managers and training staff as follows:

- Nathan Aucote, Sharon Milera, Ross Coles, Louise Dennis, Danny Williams, Central Australia Remote Health, DH&F;
- Esther-Rose Seaton, Irene Ogilvie, DH&F;
- Noelene Swanson DH&F;
- Margie McLean and Catherine Fisher, DH&F;
- Sunrise Health Service – CEO Graham Castine, HR Manager & Training staff;
- John Fletcher, Head Clinical Services & Training, Wurli Wurlinjang;
- Eddie Vigants, Batchelor Health Clinic;
- Maureen McGregor, Natalie Newman D&HF;
- Raenae Reeves, Katherine District Hospital; and
- Chris Masters, Santa Teresa.

Case studies

The Review conducted twelve case studies of health services across the NT in order to gain an understanding of different health service management practices and the scope of practice of AHWs in order to analyse strategies for managing the AHW workforce.

A list of suitable health services to be case studies in the Review was agreed by DH&F to be:

- Alice Springs Hospital;
- Santa Teresa;
- Yuendemu;
- Elliott;
- Ti Tree;
- Wurli Wurlinjang;
- Katherine West Health Board;
- Danila Dilba;
- Nguiu;
- Yirrkala;
- Maningrida; and
- Angurugu.

The case studies involved interviewing health service managers, human resources managers, AHW educators, medical staff and AHWs to observe both administrative and clinical processes, and to access and review relevant documentation. A copy of the case studies protocol is annexed to this document as Annexure 'B'.

In the conduct of some of the case studies some problems were encountered with the necessary staff being unavailable for interview, despite the fact that the case studies were organised well prior to the site visits. Especially the case studies of Yirrkala and Angurugu should not be considered complete as material

gathered from health service staff was not able to be verified by AHWs as they were unavailable to be interviewed.

Stakeholder consultations

Stakeholders were interviewed using a semi-structured format to promote conversational flow, build rapport, and allow ethical requirements to be completed. A list of interview questions is attached as Annexure 'C' to this document and was used as a guide during the interviews. Stakeholder consultations were conducted with the following people:

- Barbara Pitman, Human Services Training Advisory Council;
- Dr Alex Hope, Santa Teresa**;**
- Jenny Mills (Central), General Practice Network Northern Territory;
- Mark Ramjan, DHF;
- Geoff Hutchinson (Belyuen Health Centre);
- John Paterson, Rob Curry, Erin Lew Fatt, Dr Tanya Davies, AMSANT;
- Jan Schmitzer & Anne Bolton, BIITE (Batchelor Institute of Indigenous Tertiary Education);
- Kiara Garrard and Colette Pethick, Aboriginal Health Worker Registration Board;
- Peter Kelly, HR DH&F;
- Donna Ah Chee, John Liddle (Men's Health), Marita Hope (Training), Jane McQueen (Clinic Manager) Congress;
- Damien Howard;
- Shane Houston DHF;
- Cate Lynch, Office Aboriginal Torres Strait Islander Health;
- David Ashbridge DHF;
- Stephen Gelding, Janet Rigby, Daniel Vineod, DHF;
- Linda Zerna, Central Australian Remote Health Development Services; and
- Kate McTaggart DHF.

A presentation was made at the AMSANT Annual General Meeting on 22 April, 2009 to inform its members of the Review.

Employer survey

A questionnaire was constructed by HCA in close collaboration with the Principal Aboriginal Health Worker, DH&F and AMSANT in order to survey AHW employers. The survey instrument was designed to gather information from a manager or senior administrator and collected data about the human resource practices of AHW employers and the perceived and real outcomes (for instance staff turnover, staff commitment, absenteeism etc.) of these practices. Data was also collected on individual AHW employees, including basic demographic data and the scope of practice and level of responsibility, and how the boundaries to these are determined and negotiated. The results of the employer survey were submitted to the steering committee in a separate report in July 2009 titled 'Employer Survey Report: Aboriginal Health Worker Profession Review' (HCA, 2009).

Interviews of ex-AHWs

It was proposed to interview former AHWs who are no longer working in the profession who are of working age but who may or may not still be registered. The interviews were predominantly to answer the following questions:

- Why did you leave?
- What would get you back if anything?
- Are you still registered?

The recruitment of this population proved to be extremely difficult as was anticipated. Throughout the conduct of interviews, focus groups and especially case studies, where a good rapport was made with interviewees, an attempt was made to request interviews with known ex-AHWs in person, by telephone and in one case by email. A question was also made of employers in the survey for names and contacts of ex-AHWs. However, regularly organised appointments or opportunities to interview ex-AHWs were invariably unable to be consummated. Attempts at organising a group of ex-AHWs to interview in Alice Springs by the remote area health team also proved unsuccessful.

As a result, only two ex-AHW interviews were officially undertaken but in order to supplement the objectives of this component of data collection similar conversations were conducted with currently employed AHWs where it was possible to collect stories of ex-AHWs that were known to them.

Workforce issues identified by the Review

Size and composition of AHW workforce

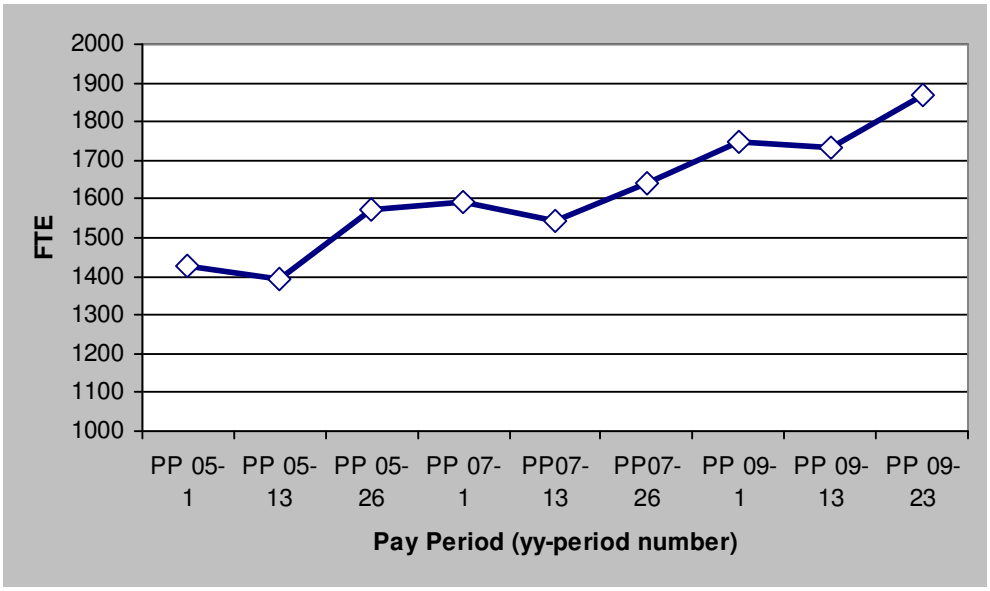
The size and composition of the AHW workforce was investigated by the Review by way of an analysis of secondary data and an employers' survey. From these processes, the Review estimates there are currently 245 AHWs employed in government and community controlled health services in the NT. The secondary data analysis report identified that 123 of these were employed by the Department and estimates arising out of the employers' survey for community controlled organisations came to 122. This latter figure can be validated in the future by analysis of service data (SAR) collected by each community controlled organisation for Commonwealth Government funding sources. There are currently 294 AHWs registered with the Aboriginal Health Workers Registration Board thus it is estimated that 49 registrants are currently not practising in clinical settings.

The AHW workforce is predominantly comprised of ageing, female workers. The secondary data report identified that the registered population contains 213 females AHWs (or 72.4% of the total AHW workforce). Almost half (45%) of the currently registered AHWs are aged between 40 and 49 years old, and well over half (76%) is over 30 years old.

This skewed workforce composition respectively creates issues of access to health services for Aboriginal communities and causes concern for the sustainability of the workforce. First, with the majority of health workers being women this can cause a reluctance by some Aboriginal men to access and utilise health services as they view health services as 'women's' and 'children's' business. In health centres where there are male AHWs, separate entrances for men and women to the health centre, or health workers from other communities, men are more comfortable accessing health services (Tregenza and Abbott, 1995). Second, with almost half of the currently registered AHWs being between 40 and 49 years old, there is obvious concern that the AHW workforce is ageing and that there will be a substantial loss of workforce numbers in the next ten to fifteen years creating a high 'replacement demand'. When considered with the current poor training rate (see later section on 'Training'), this causes genuine concerns in regard to the long term sustainability of the AHW workforce.

The AHW workforce numbers appear to have been comparatively stable for many years. In relative terms, this 'stability' translates into a proportionate reduction in workforce size since the rest of the health workforce in the NT (especially nurses and doctors) has grown significantly. By way of example, in the report on secondary data analysis the growth in the nursing workforce in the NT was demonstrated. The steady growth in the nursing workforce since 2005 is shown in Figure 1 below, extracted from the secondary data analysis report (HCA, 2009).

Figure 1: Trend in nursing FTE employed from the 2005 to 2009 financial year



Since the low point of DH&F nursing employment of period 14 in financial year 2004/5 of 1358 FTE until pay period 23 of 2009 when the number employed was 1869 FTE, the number of nurses employed has grown by 511 FTE. This represents approximately a 38% growth in the nursing workforce over five years, or around a 7.5% growth per annum[2]. Despite its supposed importance in the delivery of health services, the AHW workforce currently accounts for only 3% of total clinical staff employed by DH&F; within a decade at current relative rates of growth the proportion will be less than 1%.

A major reason the AHW workforce is not growing (and therefore in relative terms shrinking) is that 'vacancies' when they arise are not always filled. Vacancies in the NT government services are more difficult to define than in most other jurisdictions since an 'establishment' of positions is not maintained (against which 'filled' and 'vacant' counts can be undertaken)[3]. Rather, budgets for workforce categories are created in which there is room for growth. As positions are thus created and advertised from this budget, so 'vacancies' in the

[2] Some observers were at pains to point out that comparing the AHW workforce with the total nursing workforce was problematic and that instead a better comparison was with the component of the nursing workforce employed in 'rural' services (essentially the same setting as for most AHWs). Based on figures provided by Corporate Reporting from within DHF, it is true that the growth in permanent nursing staff in rural service settings has been less spectacular at close to 2.5% per annum. However this figure underestimates nurse employment because it does not include nurses employed through Nursing labour hire firms In our case studies shown to be a significant number in most clinics), or transfers of employees to and from the NGO sector (responsible for some significant one-off losses from DHF to community controlled services. These anomalies undermine the quality of the data for comparison purposes, although in any way the data is interpreted and whatever data is used, AHW growth is negligible whereas growth in nursing labour is between 2% and 7%, probably in regard to rural services somewhere in the middle of that range.

[3] This broad government approach is confused at a local or regional level where sometimes an historical understanding exists of what the staffing of a health centre 'should be' (that is invariably what 'used to be'). This understanding of a de facto establishment can be persuasive and frequently referred to when attempting to understand and resist an erosion in AHW workforce numbers. One senior DH&F administrator for instance referred during the Review to a 48% vacancy rate, however this is difficult to substantiate given the current approach to creating positions.

true sense of the word are created. In the financial year 2008 / 2009 the DH&F budget for AHWs allowed for a progressive increase in positions so that an additional 25 positions would be funded by the end of the year; effectively therefore creating 25 'vacancies'. The problem for the AHW workforce was that when (if) these positions were advertised they were not filled, and the funds ultimately were transferred elsewhere. Conceptually from a workforce planning and fiscal management perspective the NT government approach is sound. Practically though the approach makes it hard to know what the AHW workforce size could or should be, and AMSANT argues allows for AHW positions to be eroded.

Irrespective of the approach to creating and counting positions, there is widespread agreement in the literature and anecdotally that the number of AHWs employed should in fact be much greater, especially to provide for greater AHW numbers at the remote health service interface. A range of methods have been proposed to estimate what the optimum size of the workforce might be, ranging from simple practitioner to population ratios (e.g. Bartlett et al., 1997) to more sophisticated models based on service demands (e.g. Universal Core Services Framework; Josif, 2009).

Based on work undertaken through this Review alone, two estimates of the 'required' AHW workforce size are possible:

- The current AHW : Nurse ratio in health services is 2:3. If this were reversed (while growth in nurse numbers was held stable) then the total requirement for AHWs would be 550, an increase of 305 over the current workforce size.

- The nursing workforce has grown by approximately 10% per annum over the last 5 years. If the AHW workforce were to grow by a similar amount over the next 5 years then the projected workforce size would be 405, an increase of 160 over the current workforce size.

Neither of these two methods is necessarily being advocated by this Review, however they do illustrate the order of magnitude of potential AHW workforce size, and therefore the need for the AHW workforce to increase rapidly (and this is in line with government goals to increase the number of Aboriginal workers at all levels of the workforce).

Ideally, any estimate of a required AHW workforce size should be calculated on the basis of the work that they would do, and this in turn requires a better and more sophisticated understanding of the direction of care and service models and the role of AHWs in such models. The current lack of an AHW role definition (see later section on 'AHW role') makes workforce estimates difficult and it was suggested to the Review that the primary health care service delivery goals need to be developed to better define the role of each function in the health service team in order to assist in the clarification of desirable AHW workforce numbers. This work is outside the terms of the Review, but it is agreed that it would assist in clarifying the required numbers of practising AHWs for the NT.

Occupational health and safety issues for AHWs

Many issues were reported to the Review that effect the health and safety of AHWs in the workforce. Many of these issues appear to be persistent and have been oft reported in previous AHW reviews. They include:

- health problems of AHWs themselves eg, diabetes and hearing problems;
- living in crowded housing with other family members who are not working and therefore interrupting the sleep of AHWs;
- humbug from family and community members, which in the case of AHWs working in their own community, can be significant and contribute to considerable occupational stress;
- emotional involvement of treating patients from within an AHW's own family or community discussed by Williams, Thorpe and Chapman (2003) as obligatory community labour or emotional labour;
- fear of 'payback' from the community if a patient dies.

These issues lead to occupational health and safety problems for AHWs. Many AHWs reported experiences of 'burnout' and the way they dealt with it was to 'walk away' from their positions often temporarily or sometimes permanently in the absence of good management, appropriate human resources practices and support systems.

AHW role

When AHWs were first introduced their role was comparatively clear and the training processes simple. As some observers noted their role revolved around them being the only constant health staff within communities as many medical and nursing professionals work on short contracts and come and go frequently. As well, they were intended to be the 'bridge' between understanding the processes of health services and the Aboriginal community. At a clinical level, their tasks were comparatively procedural and designed to respond quickly and well to high presentation levels of a comparatively small range of infectious diseases.

Nothing stands still, and over time the role of the AHW has evolved as the service demands have changed (proportionally less infectious disease and instead increasing level of chronic and complex illness presentations to health services), the type of service staffing has changed (increased number and proportion of nurses), and the processes of professionalization have attempted to push the boundaries of AHWs and their skill and knowledge requirements.

The Review identified the current AHW role as an extremely challenging set of functions (see the Employer Survey Report) which can include any of the following:

- advocating for individuals and families;
- maintaining medical records;
- working in teams;
- providing first aid;
- delivering counselling;

- responding to community emergencies;
- providing environmental health care;
- providing a screening service;
- collecting information on the community's health;
- delivering health education and promotion;
- using medical equipment;
- responding to medical emergencies;
- delivering interpreting services;
- assessing client's physical well being;
- following treatment practices using the CARPA manual;
- supporting client's social and emotional wellbeing;
- planning and implementing health care;
- monitoring health care;
- working with medicines;
- providing nutrition guidance for specific health care;
- management;
- research;
- education and training;
- cultural brokerage; and
- providing and utilising traditional medicines.

The actual work undertaken, particularly in small remote health centres, can vary depending on the nature of the work in the health centre, the type and number of other health professionals, and the confidence and competence of the individual AHW and the willingness of service management to commit to the fullest utilisation of AHWs. The results of the survey indicated that the most important factor influencing the role was management and colleagues' perception of capability.

While work allocation and hence, by default, defining the role of the AHW at the individual service and worker level makes sense from the perspective of sound human resource management practice, the ambiguity that now surrounds the AHW role along with the clear and significant differences in role from the most competent to least competent AHW causes problems. Compared to 20 years ago when a reasonable vision could be fashioned of the AHW role by most if not all stakeholders, today a single role or even a series of roles are not able to be well articulated. This has implications for broader service planning and workforce deployment, and micro level implications for calibrating expectations on AHWs and for tension in relationships between AHWs and other health professionals. While some individual presentations to the Review were anxious about any effort to more closely define the AHW role (and thereby both pigeon hole their role and place unrealistic expectations on some AHWs), most stakeholder interests see great urgency in better defining AHW roles at least generically. This they believe will help service and workforce planning, development of career and pay classification structures, initial training and professional development planning, work allocation and performance appraisal, and facilitate less ambiguous relationships between AHWs and other health professionals.

In regards to a generic role description, the Qualifications Framework for the Health Training Package (HLT07), which includes the HLT43907 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) (Certificate IV) qualification, defines the role as:

> *"... workers who provide a range of primary health care services to Aboriginal and/or Torres Strait Islander clients, including specific health care programs, advice and assistance with medication. These workers are expected to flexibly assume a variety of job roles and undertake a broad range of tasks."*

In the Northern Territory the requirement to be registered with the NT Aboriginal Health Worker Registration Board provides another set of parameters. To achieve registration the primary requirement that AHWs must achieve is to complete the nationally accredited Certificate IV or Certificate III Aboriginal Health Work (Clinical) studies awarded in the NT prior to 30 June 2008. To maintain registration, there are minimum annual requirements on levels of *clinical* practice.

In the Employer Survey Report, a broad AHW role was fashioned from health service employer survey responses to a series of scope of practice questions. The following functions were the most commonly nominated and one presumes the most widely allocated areas of work to AHWs:

- Providing first contact for 'walk-in' patients to a health service setting where, depending on their level of skill, they might provide a triage / referral service or offer treatment;
- Contribute in a team environment (maybe even leading) to provision of clinical programs, for instance a child and maternal health program. This might involve screening, home visits, treatment compliance checks, etc.;
- Advocate for individual, family and community health needs (this is different to providing cultural brokerage services); and
- Contribute to or even implement / manage health education and health promotion interventions.

In truth, this might be just one of several roles an AHW could play, and that past efforts to define the role, even generically, may well have been less successful by adopting too narrow (or too comprehensive) a focus. Clearly the above set of functions describes a 'program' role (for instance by focusing work effort on what the Core Service Framework might describe as a 'life stage').

A more complex AHW clinical role might be envisaged that requires greater clinical competence. A difference in 'clinical' roles can be envisaged by comparing skills achieved from completion of the HLT33207 Certificate III Aboriginal and/or Torres Strait Islander Primary Health Care qualification (Certificate III) with those who have completed the Certificate IV. Differences in clinical skills for Certificate III qualified and Certificate IV qualified AHWs are depicted in Table 2 below:

Table 2: Comparison of Certificate III and IV clinical skills

AHW Clinical Skill	Certificate III	Certificate IV
History		
SOAP		
Assess client's physical well being		
Assess client's social and emotional wellbeing		
Special senses		
Ear examination		
Ear management		
Eye examination		
Eye examination – lid eversion		
Eye management		
Visual acuity		
Skin		
Skin assessment		
Simple dressing		
Wound closure		
Removal of wound closure		
Complex dressing		
Nervous system		
Pain assessment		
Neurological observations		
Peripheral nerve assessment		
Neurovascular assessment		
Vital signs		
TPR		
BP		
BGL		
Other clinical practices		
Head circumference		
Height		
Weight – adult/child/infant		
Cardiovascular system		
ECG		
Pulse Oximetry		
Haemoglobin		
Circulation observations		
Respiratory		
Peak flows – adult/child		
Spirometry		
Chest sounds		
Suction		
Gastro-intestinal		
Abdominal auscultation/palpation		
Waist circumference		
Oral assessment		
Basic life support		
DRABCD		

AHW Clinical Skill	Certificate III	Certificate IV
Medications		
Oral medication		
Sublingual		
Inhalers DPI – dry powder		
Inhalers MDI – metered dose/spacer		
Nebulisers		
Oxygen therapy		
Topical medication		
Suppositories		
Injection IDI, SCI, IMI, IVI, Z-track		
IV infusion/cannulation		
Cold chain		
Specimen collection		
Venepuncture		
Urinalysis		
Urine specimen collection		
MSU		
Application of paediatric bag and collection MSU		
Wound		
Nose		
Throat		
Faeces		
Tissue		
Sputum collection		
Eye swab		

Another AHW role might focus on public health interventions and require limited clinical skills (but a strong preparation in the methods of public health including health promotion). Of course there are still many stakeholders who argue that the original key ingredients in the AHW role; cultural brokerage, liaison and interpreting; remain as needed as ever and could potentially embody a single role.

The absence of a strategic vision for the role (we would argue roles) of AHWs means that it then becomes difficult to develop a range of important human resource interventions all of which are dependent on a strong specification of the work to be performed. This includes:

- Preparation, training and professional development (the work defines the competencies required);
- Performance management (allocating work appropriately to optimal ability and supervising / managing performance); and
- Rewarding work completed (the work defines the level of responsibility and accountability).

At the heart of any properly functioning HR management system is a clear and precise job / position description. Can anybody be expected to perform optimally in the absence of a clear specification of the work they are meant to do and the objectives they are expected to achieve? AMSANT is in agreement with the

requirement for clear and precise job / position descriptions but has advised the Review that in the case of Aboriginal community controlled health services (ACCHS), clear work specifications and objectives need to be developed by each individual ACCHS in response to its particular mix of health professionals and requirements with due regard for the national AHW competencies laid out within training programs.

Relationships with other health professionals

It was noted in the previous section how the ambiguity in the AHW role can undermine relationships with other health professionals since there is no benchmark for those workers to form a reasonable set of expectations on AHWs. Other than by trial and error and careful communication in each service and with each individual AHW, work allocation can be 'hit and miss', causing frustration for nurses and doctors when they get it wrong with too high expectations, and despondency for AHWs when they get it wrong with too low expectations.

There are other equally deep problems though that impact on relationships with other health service staff. At the core of the issues is that AHWs see their role as an *equal* member of the health service team – a team that comprises at least doctors, nurses and AHWs who bring their own equally critical personal and professional skills to the service of the community. However, in practice AHWs experience inequality with other health professional staff and are often perceived as the 'bottom of the pile'. Many overt and covert aspects of health service life promote and reinforce this message. The positioning of AHWs as the lowest level in health services is due to:

- as noted above, widespread underestimate of the AHW role by nursing and medical staff;
- poor preparation and induction of nursing staff in how to work with AHWs and what potentiality of their role;
- high turnover of nursing staff in particular which does not allow for strong personal relationships to develop which might overcome any deficiencies in preparation or current role ambiguity;
- a degree of professional rivalry that promotes the perception amongst many nurses that AHW skills as a primary health care worker are less important and developed than the acute care/clinical skills of nurses; and
- poorer pay and conditions for AHWs in comparison with nursing staff (this will be discussed further in a later section), which reinforces the impression that AHWs are 'worth less'.

Of course relationships can also be debilitated by poor personal behaviour, doctors and nurses for instance behaving in culturally inappropriate ways either through ignorance or intent based in racist beliefs, or AHWs being unwelcoming possibly because of past bad experiences or because of fatigue with a constant parade of new faces. Many AHW presentations to the Review lamented the too common propensity of nurses to impose their practice approach and standards without first attempting to understand what is already in place and why.

The professionalization of the AHW role has not had the desired effect of significantly increasing its status within health services. Part of the problem is that AHW training is continually playing 'catch up', and indeed is always likely to

lag other professions in terms of prestige (if this is associated, as it normally is, with length of training, type of qualification, and type of academic setting). In this regard, several stakeholders argue that advocacy for the equality of AHWs should be based more on what they bring that is unique to the service setting. This is often a combination of cultural competencies, relationship skills, and clinical skills developed specifically for remote area primary care practice.

Efforts to define the AHW role should take these thoughts into consideration.

Recruitment of AHWs

Recruitment to Aboriginal health work has traditionally been by community selection of appropriate community members with the correct status and generational place to undertake Aboriginal health work. This was argued by many in the past to be a critical principle in the development and effectiveness of the AHW workforce (Tregenza and Abbott, 1995) and following this practice has led, if to nothing else, to comparative employment stability within the most remote service centres in Australia. There are currently, according to the employer survey findings, almost half the employed AHWs (government and non government) working in their 'own' communities. As well, a large proportion of AHWs interviewed by the Review team reported that the reason that they had become AHWs was to care for their communities. Many of these AHWs had also received encouragement from family members who were AHWs.

The traditional approach to recruitment has changed in recent years, the result of change or at least a softening in ideology and in response to emerging labour market difficulties. These difficulties have been created by an inexorable increase in the demand for skilled labour to fill AHW roles, without a similar rise in the capacity of communities to deliver sufficient labour with appropriate skill levels. At the heart of this problem is the current requirement to be registered in order to be employed as an AHW; for new sources of supply to the profession this means completion of the Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care.

There currently appears to be a limited pool from which to select community based people with adequate numeracy and literacy skills who could successfully complete the requirements of the Certificate IV. Even those who might be able to meet the academic demands with assistance may be dissuaded from trying for fear of the shame of not being able to complete the course. The Certificate IV training has also been a major disincentive to the recruitment of AHWs for other reasons:

- the process of going to block release training creates problems with AHWs leaving their communities and families for two weeks at a time;
- support for the development of clinical skills and assessment components (workbooks) required in the clinical setting is absent for the majority of trainee AHWs; and
- not receiving an income during the period of training is difficult for many AHWs who have families for which they are responsible to provide care.

AMSANT advised the Review that it believes that the shifting of AHW training from the health sector to the education sector in 1990 has exacerbated problems

in recruiting AHWs. This shift has created a disconnect between training and the workplace which has limited its effectiveness and made the AHW profession less attractive. It believes that this will be overcome by clear agreements between the training provider and primary health care services to ensure there is sufficient resourcing for training time on the ground in health services. This suggestion is addressed later in this report.

New recruitment strategies are being considered. AHWs have been successfully recruited from town centres and have gone on to work within town based health services, some hospital settings and in communities in which they are not indigenous. AHWs who work in communities that they are not originally from have discussed the benefits in being able to circumvent some cultural restrictions in treating certain people. For instance clan or skin group demarcations that might limit the capacity of 'local' AHWs to treat all of the community may not apply to AHWs from outside the community. A number of AHWs also advised that they prefer to work in different communities to their own to reduce the amount of humbug that they experience as they find it easier to say no to non family or community members.

Town centres of course generally have a population with better developed literacy skills, and will have more high school students as a potential recruitment source. Younger people recruited from schools in town centres who have achieved the appropriate language and numeracy skills do not always have the status to practice as AHWs within communities. Older and respected AHWs could mentor the younger ones and 'lend' them their community status; and the younger ones could support older AHWs with literacy and numeracy requirements.

One advantage of recruiting within communities is that it is a relatively 'closed' labour market where the AHW role is comparatively well paid and still of some status within the community. In a more open labour market such as a town centre AHW recruitment faces stiffer competition not just from other health professions (for instance nursing where genuine candidates for the AHW training program would almost certainly also qualify for entry to nurse training) but also from other occupations in mining, construction, communications technology, etc.). The AHW profession needs to therefore project a strong and positive image in this market. Instead there are sometimes further recruitment disincentives to address such as:

- the perception of decreased status in the AHW role and the number of AHWs who have become 'burnt out' which has been seen by the community as a disincentive to join the profession;
- the lack of managerial and mentoring support for AHWs in the workplace; and
- fear of humbug and payback from the community once in a employed position.

The data analysis report submitted to the Department in June identified a number of currently registered AHWs who were no longer working in the profession. This was estimated at 49 AHWs, although it is possible some of these

are working in other areas of the health or welfare system[4]. While such efforts have yielded poor results elsewhere (for instance return to work campaigns aimed at nurses and allied health practitioners (HCA, 2008)), nevertheless there has been no organised strategy to recruit from this pool of AHWs back into the AHW workforce. Interviews with ex-AHWs and currently employed AHWs identified a necessity to promote the importance of Aboriginal health work within the communities and provide support structures and opportunities to be employed within a team to encourage ex-AHWs to return to the workforce.

Another way of changing the recruitment context would be to create and facilitate multiple entry points to the profession and not channel all interest into a single Certificate IV pathway. Entry at Certificate II or equivalent could be envisaged which would open the door to those who would like to become AHWs but would need greater support in achieving the required qualifications. Recommendations are made later in this report in regard to recruitment and job classifications.

AHW entry level training

There are three entry level training courses / qualifications for AHWs identified in the Health Training Package (HLT07):

- HLT21307 Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care;
- HLT33207 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care; and
- HLT43907 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice).

In other jurisdictions all three qualifications can provide entry to the profession, albeit at different entry levels. In the Northern Territory, the Certificate IV qualification only enables AHWs to be registered with the Aboriginal Health Workers Registration Board, and thus in theory this is the only qualification which provides a genuine vocational outcome[5]. Prior to the introduction of the current Health Training Package the requirement for registration was a Certificate III qualification.

The approved nominal hours for the HLT21307 Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care (Certificate II) is 256–383 equating to a one year course for trainee Aboriginal and/or Torres Strait Islander health workers, working as assistants in a rural or urban environment delivering limited health care services to clients living in communities that are isolated from mainstream health services.

The nominal hours for HLT33207 Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care (Certificate III) is 880–940 nominal hours equating to a twelve to eighteen month course regarded by many jurisdictions as the minimum level for Aboriginal and/or Torres Strait Islander health work.

[4] For instance advice was provided to the Review that some former AHWs were employed in Family services roles.

[5] Of course, there are other health worker roles in the NT health system that do not require registration and the Certificate II and III may be appropriate qualifications to apply for and perform such roles.

Certificate III qualified AHWs provide health care services to Aboriginal and/or Torres Strait Islander clients, usually as part of a health service team with ongoing supervision and guidance.

The HLT43907 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) (Certificate IV) is a two year course aimed at developing sufficient competence for AHWs to:

- provide a range of primary health care services to Aboriginal and/or Torres Strait Islander clients;
- deliver specific health care programs;
- provide advice and assistance with medication;
- assume a variety of job roles and undertake a broad range of tasks;
- develop breadth and depth of skills and knowledge in assessment and treatment of a wide range of presenting health problems;
- have an overview of key areas of health work;
- gain knowledge of key people and outside agencies to assist in addressing health issues; and
- possess skills in providing clinical treatment, support and information to individual's, families and community members in relation to health and primary health care outcomes.

All three courses comprise 'block' or classroom training for a period of approximately two weeks at a time interspersed with supervised work placements for the duration of the course. In the case of Certificates III and IV clinical supervision by a registered health professional is required to complete the clinical skills component of the course.

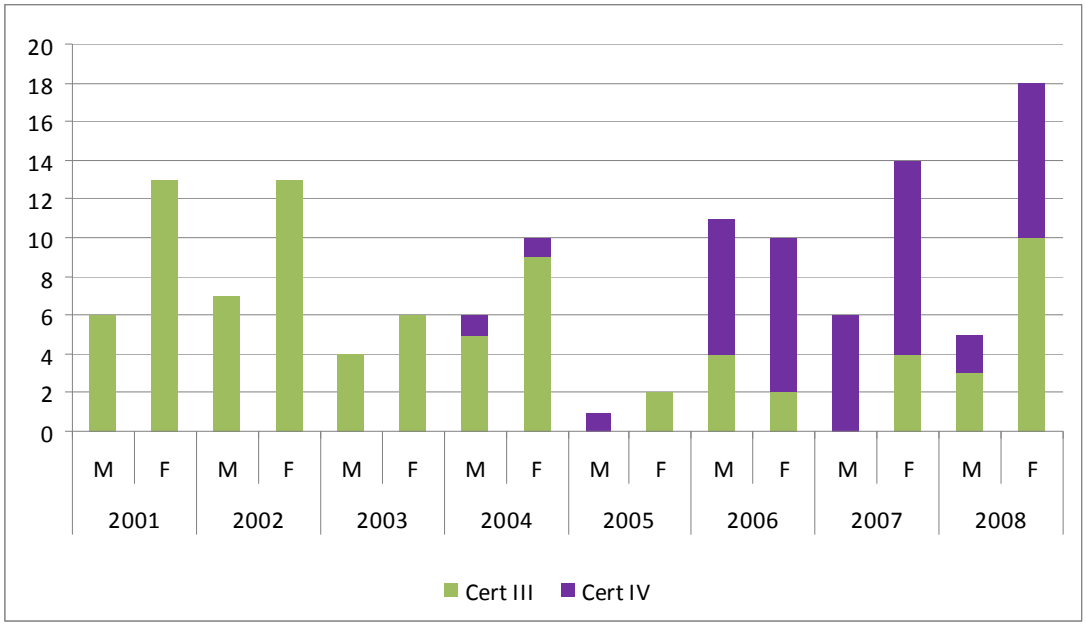
Currently, AHW entry level training is delivered by BIITE in Batchelor (with students from all over the Northern Territory the majority of which are from remote communities) and Congress Central Australian Aboriginal Congress Education and Training Branch (Congress) in Alice Springs.

From information provided to the Review it appears that BIITE has been successful in achieving 142 course completions between 2001 and 2008[6]. A profile of Batchelor's graduate population in terms of gender and type of qualification over the eight years is provided in Figure 2 below:

Since the introduction of the Certificate IV it has become the dominant form of qualification however in 2008, the first year of the 'new' Certificate IV qualification in the 2007 Health Training Package, there were more Certificate III graduations than Certificate IV. In discussions with BIITE it seemed that many of the older Certificate IV graduations were not new supply but rather existing workers upgrading their qualifications. In regard to the high proportion of current Certificate III graduations BIITE commented that it was their principal way of trying to overcome deficient levels of language and literacy skills and bring students slowly to completion of the Certificate IV.

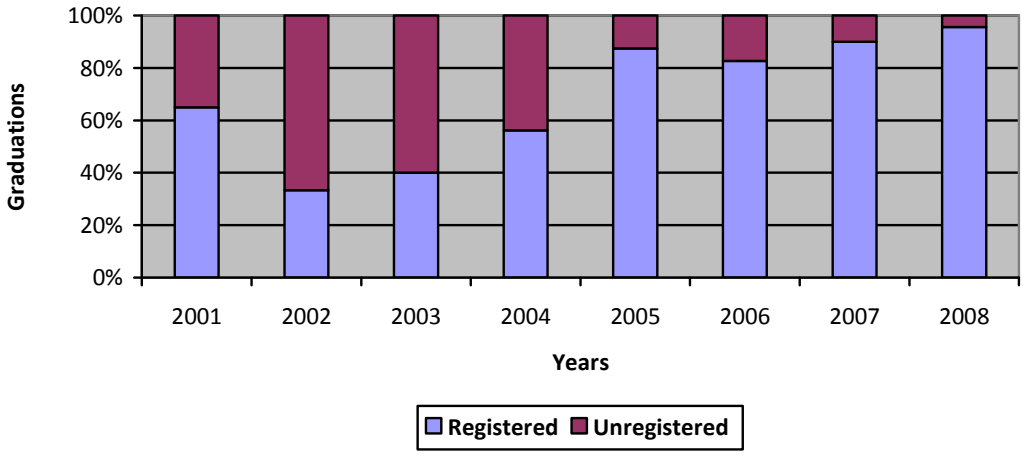
[6] Note some of these 142 are 'double-counted' in so far as they have completed the Certificate III and then the Certificate IV.

Figure 2: Profile of BIITE graduate population by gender and qualification between 2001 and 2008



In Figure 3 below, the current registration status of BIITE graduates is provided. As would be expected a higher proportion of recent graduations is currently registered; a prerequisite for employment.

Figure 3: Current registration status of BIITE AHW graduates by year of graduation: 2001-2008



Data on the employment outcomes of BIITE graduates is less accurate. It seems though that of the last four years of graduates, 26 are now employed with DH&F, while the remaining 40 are either unemployed or with community controlled organisations.

Congress has informed the Review that in the last four years they have succeeded in training 23 registered AHWs. Table 3 below sets out the employment status of the 23 AHWs trained by Congress in the last four years:

Table 3: Numbers and places of employment of Congress trained AHWs

Places of employment of Congress trained AHWS	Count
Congress	7
DH&F	7
Hetti Perkins	1
NT Hepatitis C/AIDS Council	1
Port Augusta	1
Other employment	1
Unemployed	2
Unknown	3

There is widespread concern that the training rate for the AHW workforce in the NT is very low and is restricting the growth of the AHW workforce. If we assume the data reported above is accurate, then over the last four years Congress and BIITE combined have trained 65 AHWs to Certificate IV registration level; on average sixteen registrable AHWs trained per year. If we assume that the rate of loss from the workforce annually is something between 5% and 10%[7] then the 'replacement demand' is estimated at between 13 and 25 per year. On this basis the current estimated training rate only just satisfies replacement demand and does not allow for AHW workforce growth.

Throughout the Review, many stakeholders commented that the number of graduates that BIITE has been achieving is disappointing. The low number of graduates is attributed to the following problems:

- the intensive block release mode of training that requires students to leave their home communities and travel to Darwin for two weeks of classroom based training throughout the course. This mode of learning has proven to be difficult for a large number of students. First it takes them away from home (and family responsibilities) for a considerable time, and second, the conceptual demands are excessive ... it is considered to be "too much to take in all in one go";
- the literacy and numeracy levels of students makes successful completion of a Certificate IV level qualification difficult, hence the use of the pathway through Certificate III increasing the duration of training;
- BIITE's student base is predominantly remote, a far more difficult task than delivery in an urban centre to urban based students;
- the delivery style of the subject material which is considered currently to be too difficult to absorb for some students. Additionally, some observers wondered about the relevance of some of the course content;
- limited or no "on the job" training, there is too much emphasis on classroom based delivery. BIITE in discussions were candid that they rely significantly (almost entirely) on local health service resources to provide

[7] A potentially realistic rate given the age profile of the workforce.

on the clinical, job training support. Some students work in health centres where there are no clinical educators, senior AHWs or available medical staff to supervise and support their clinical practice and are not able to complete the training effectively – especially if there is limited correspondence between the supervisors and BIITE to structure the learning outcomes of the trainee AHWs; and

- financial problems for students such as housing and providing for families whilst being unemployed during their studying period. Students are supported financially during training by a range of mechanisms including Abstudy grants and scholarships, however most people agree the amount of support is inadequate for anyone other than a young single student ... and even then there would be difficulty paying for travel and books.

In order to achieve an increased number of qualified AHWs, DH&F initiated an Apprenticeship scheme in July 2007. The Apprenticeship scheme ran on traditional lines with trainees being employed by health services (thus overcoming some problems of financial hardship) and thus becoming their responsibility. In the early days of the scheme the same problems of on the job, clinical support were experienced, but this was overcome later by a significant injection of DH&F AHW educator resources that travelled to services and provided greater on site support to apprentices. The Apprenticeship Program has seemingly been successful[8] in retaining 17 Apprentices, all of whom are due to complete the qualification this year. This was a pilot program with no recurrent funding.

AHW professional development

The Review identified a number of DH&F staff resources dedicated to AHW in-service education in Darwin and Katherine, approximately five full time equivalents, although with current vacancies it is difficult to get a firm figure. These resources serve the professional development needs of AHWs in Top End services. For the Central Australian health services DH&F have contracted Central Australian Remote Health Development Services (CARHDS) to provide in service training and regional support for DH&F and some community controlled health services AHWs. CARHDS appears to have devoted much of its limited resources in recent years to helping existing AHWs with a Certificate III upgrade to a Certificate IV, including conducting RCC activities. Some additional support is provided by managers at local and regional level.

It appeared that professional development support is provided on fairly traditional lines, with the onus largely on the individual worker to self assess for learning needs and then nominate for relevant courses from a 'smorgasbord approach' of available options. An ability to then participate in training is at the discretion of employers especially local managers. There is limited and no systematic mentoring for registered AHWs to help them analyse their needs or to place their training in the context of a potential career pathway (or even to respond to the work needs of their service). Where this support is offered it is an initiative of managers. When these managers are at a sufficiently high (regional)

[8] It is yet to be evaluated. Early lessons from the project though appear to be an enhanced understanding of the real level of support apprentices require to progress through their course and the impossibility of relying on local health service staff (nurses and other AHWs) to provide the required levels of support.

level the mentoring can be quite strategic. The lack of a structured professional development program for AHWs limits their career progression and can allow skills to become outdated and underutilised.

An interesting exception to the above is an approach to individual mentoring adopted and trialled in remote primary health care services in Central Australia (Aucote, 2008). A management mentoring program has been developed to provide training for AHWs to further their career paths. The aim is for AHWs to receive the skills to become health centre managers and/or take on other management positions within the Department.

There are limited training options for AHWs who wish to continue with further education. BIITE offer a Bachelor of Primary Health Care which offers three speciality streams, Aged and Disability, Social and Emotional Wellbeing and Health Promotion (this program currently has 38 students of which three have come through the NT AHW pathway) and CARHDS has the Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) on scope which is not currently offered. There is also an Advanced Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) that is not currently on scope for any NT based training providers.

Career Progression including pay and conditions

One of the major retention issues presented to the Review for the AHW profession is a claimed lack of career structure and pathways. Career progression for AHWs is currently limited by:

- job classifications of the Determination Number 1037 of 2008 (Determination) for Department employees;
- Community Controlled Organisations Enterprise Bargaining Agreements (CCO EBAs) which largely mirror the Department determination in structure;
- lack of structured professional development training programs tailored individually for all AHWs with career progression goals; and
- limited career path for AHWs who wish to move into management positions or specialist areas. Essentially AHWs need to move into another classification structure (or career path) in order to seek managerial opportunities.

In the analysis of secondary data (see separate report) a 'log jam' of AHW employees in the DH&F workforce was found at the 2/3 pay classification level, seemingly confirming perceptions of a limited career pathway. On examination of the DH&F AHW Determination the problem seems to lie not just with the limited number of categories (there are only six levels, the first of which is virtually unused), but also with ambiguous description of levels that makes determining progress less transparent and barriers to progress beyond level 3 that seem overly restrictive. An overview of the DH&F determination, compared with an EBA for a selected Aboriginal Community Controlled Organisation (Wurli Wurlinjang Health Service), is provided in Table 4 below.

Table 4: Outline of DH&F and Wurli Wurlinjang Health Service EBAs

Classification level	DHF Determination No 1037 of 2008	Wurli Wurlinjang Health Service Employee Collective Agreement
Trainee	Not available.	Employee being trained in Aboriginal health work but not registered as an AHW.
Class 1	Re-entry level for registered AHW with Basic Skills qualification.	Registered AHW, re-entry or competencies needing to be updated to meet AHW Registration Board new applicant's level.
Class 2	Must have AQF level 3 qualification and to advance must satisfy the requirements of the prescribed internship program.	Registered AHW, competencies should meet AHW Registration Board new applicant's level. Range of clinical skills and duties. Work under supervision in a team.
Class 3	5 years service as Class 2 and demonstrated competence within level A AQF level 3 2 years service as Class 2 and demonstrated competence within level B AQF level 4 2 years service as Class 2 and additional responsibilities as AHW in charge of a two person health centre, supervisor of beginner AHW or responsibilities in specialised area of work – defined and agreed by Branch Head.	Registered AHW, competencies exceed AHW Registration Board new applicant's level. Well developed clinical skills and broad knowledge base including some theoretical concepts. Work under limited supervision. Must have minimum of 2 years recent and satisfactory service and demonstrated willingness to mentor trainee and junior AHWs, assisting in delivery of health programs. Only move to Class 4 when there is a vacancy.
Class 4	Must have AQF level 4 qualification or equivalent and relevant workplace experience.	Registered AHW, competencies exceed AHW Registration Board new applicant's level. Well developed clinical skills with some degree of specialisation and broad knowledge base including some theoretical concepts. May work under limited supervision but willing to supervise the team when required. Must have minimum of 5 years recent and satisfactory service and demonstrated willingness to mentor trainee and junior AHWs, be responsible for particular aspects of clinical operations or implementation, delivery and evaluation of separate health programs and willingness to act in coordinator role. Should have relevant and appropriate qualifications in excess of what is

Classification level	DHF Determination No 1037 of 2008	Wurli Wurlinjang Health Service Employee Collective Agreement
		required for registration. Only move to Class 5 when there is a vacancy.
Class 5	Must have AQF level 5 and relevant workplace experience.	Registered AHW and holds minimum of Diploma of Indigenous Health Studies or equiv. Well developed range of clinical and management skills and substantial depth in knowledge of theoretical concepts. Accountable for clinical and program coordination.
Class 6	Must have AQF level 6 and relevant workplace experience.	

Table 4 shows how both EBAs rely strongly on external standards to create the structure, for instance eligibility to be registered as an AHW or achievement of certain qualifications. These external standards can often be poorly correlated with the skill and experience requirements of jobs. In the Wurli Wurlinjang Health Service EBA the start of a 'competency' based structure is introduced.

Combined with these issues of classification and career pathways is the issue of lack of parity in pay and conditions for AHWs across health services but especially in comparison to nursing staff. One ex-AHW interviewed had left the workforce to study nursing as she viewed she would have more career opportunities as a nurse, better pay and hopefully a more supportive system to work within. She had loved working as an AHW but felt limited by her qualifications and being a registered nurse would provide her with more opportunities to help Aboriginal people.

Inconsistent management approaches to the interpretation of the Determination between different AHW employers has led to variations in conditions of employment for AHWs. For example, cultural obligations such as attending funerals of family and community members is recorded as leave by some AHW employers while others view it as part of the role of AHW and are more flexible and less documented about time away from the health centre.

There is inequity with other staff categories in the health service and inequality with conditions of their employment. The issue of **accommodation** is widely discussed amongst AHWs who view the fact that nurses are provided with accommodation as a benefit, to which they believe they should be entitled. The same benefit is rarely extended to AHWs. This inequality maintains the perception that the AHW role is not equal to that of nurses.

Performance issues of AHWs

As with all workforces there are variations in the levels of performance of individuals. A common way of conceptualising performance is through the following function:

PERFORMANCE = ABILITY x MOTIVATION x OPPORTUNITY

Where:

Ability	= the knowledge and skill capability
Motivation	= functional aspects associated with money and behavioural, ethical variables
Opportunity	= the right circumstances and environment to apply and express knowledge / skills

Ability of individual AHWs will clearly and possibly appropriately vary. Apart from the current workforce being a mix of qualifications (ranging from older workers with only the Basic Skills Training through to young graduates of the current Certificate IV), individual workers would have had unique service and professional development (including mentor relationships) experiences that would have shaped their abilities.

The good manager's role is to make the most of those abilities by giving individuals the *opportunity* to work in an appropriate role. For instance an individual with largely procedural clinical skills and good organisational skills will shine in a 'program' type role, but look dysfunctional in a more challenging clinical environment. Similarly, an individual with poor clinical skills but strong community credibility, cultural knowledge, communication and leadership skills might be best employed in a health promotion / education role. As stated elsewhere, the management style and working relationships formed by health centre managers has an impact on the roles and duties undertaken by AHWs, this in turn will have an effect on performance.

The *motivation* of individual workers is a more vexed issue, and discussions about the issue can be extremely value laden and hence avoided.

Clearly though, one of the major issues that affects the performance of AHWs in their role is relationships with other health service staff, especially nurses. When AHWs are working with nursing staff who are culturally aware, respect and understand the AHW role, encourage and develop AHWs clinical skills and professional development and provide good management practices, they can perform their roles to their utmost ability and will remain in their positions for a long period of time. However, when nursing staff act in a culturally inappropriate way, (regularly due to the lack of cultural awareness training and induction processes) or are racist, do not understand the role of AHWs and treat them as assistants and 'bully' AHWs, it negatively affects their performance at work. It was regularly reported to the Review that AHWs will avoid coming to work as they feel powerless to address these issues with some nursing staff or health

centre managers. This has lead to some nurses describing AHWs as 'lazy' or 'unmotivated' and perpetuates a negative working relationship between nurses and AHWs. Interestingly, and despite nurse relationships being raised as an extremely common problem, almost every AHW interviewed could point to a period of high productivity during their career and invariably this period coincided with a strong and positive nurse relationship. During these periods of productivity also AHWs were able to develop their skills and contribute to the management of the health service with a greater development of confidence.

The working relationships of AHWs with nursing staff are complicated by the high turnover and short contracts of nursing staff to Aboriginal communities. Many AHWs reported that when they felt they had managed to create a good working relationship with some of the nursing staff that it was frustrated by the nurse leaving the community for another position. As mentioned earlier, the lack of clarity in the AHW role can exacerbate the above situation and affect the performance of AHWs as other health service staff do not immediately understand how to utilise AHW skills in appropriate ways. From the AHW perspective, it is also not clear what is or could be expected, that is what performance would actually be valued.

Further environment influences on motivation reported by AHWs are:

- Stress of community humbug on AHWs, especially those working in their own communities. At an extreme level AHWs can be held responsible for the health and well being of community members receiving treatment and risk 'payback' from the patient's family members if a patient dies; and
- Many AHWs in communities and towns are living in overcrowded housing with family members and other housemates who are able to stay up late as they may be unemployed and don't need to be rested for work the next morning. This resultant lack of sleep can affect an AHW's work performance.

All the above factors are system issues that impact upon AHWs; clearly there are also individual AHW factors that impact on their motivation. Like all other workforces, the AHW workforce will be comprised of more or less motivated individuals. At the individual level motivation can be affected by personal circumstances such as:

- Home situation, for instance family issues, marital problems, leadership obligations;
- Personal finances, etc.;
- Length of service. While there is no doubt that many current AHWs have lived and worked in their community for many years (periods of up to 20 years were not uncommon) and thus contributed to the workforce stability, most employees would likely have gone 'stale' working in the same job for more than five years without a change in job role, location or something else.

Regardless of what motivates a worker, or what other ability or opportunity circumstances delineate a particular level of performance, regular monitoring of performance is important. The Review found in regard to the AHW workforce there has been limited structured approaches to performance appraisal and performance management. Good performance is hence not being recognised

(and hopefully rewarded), poor performance is not being held properly to account.

Where performance appraisal / management is undertaken it tends to be done inconsistently and with insufficient structure and deference to due process. As a consequence for instance, mismanagement of grievance processes has led to AHWs increased absenteeism and avoidance of some components of their role within health centres. In some services AHWs are not held accountable for poor performance and remain unaffected even by high levels of absenteeism or what is now called 'presenteeism' (being at work without working). Some service managers are clearly willing to retain AHWs in the health workforce at any cost, and keen to avoid any confrontation.

On a broader canvass, the Review noticed a propensity for workforce strategy thinking to focus only on addressing 'ability' issues and failing to achieve performance outcomes because the motivation or opportunity aspects of performance have not been properly considered.

Recommendations

A basic premise for what follows in this Chapter is that a healthy and revitalised AHW profession will be a critical component in improving primary health care service delivery to Aboriginal people in the Northern Territory. It is crucial to restore the AHW profession to a central and highly functional place in the health system.

AHW role and work organisation

All human resource management and development systems start with a good job description, not to tie workers down to a single role but rather to provide sufficient structure in which to allow genuine flexibility. As the AMSANT submission made clear:

> *" … everyone needs a clear and agreed job description and duty statement"*

It is a burden on AHWs to have less clarity in this area and it is therefore necessary to create a job description for different AHW roles to:

- clarify the scope of practice of AHWs;
- clarify the AHW role within the health service team;
- provide an accurate measure of required numbers of AHWs;
- assist other health professionals within the health service team to work with AHWs effectively;
- return status to the AHW role;
- assist in the community's expectations of AHWs; and
- allow the AHW primary health care role to be utilised effectively.

Three examples of broad AHW roles, which might form the basis of development of generic job descriptions[9], are outlined below:

Aboriginal Health Worker (Program)

A 'program' role which focuses work effort on what the Core Service Framework might describe as a 'life stage'. For example, an immunisation program, a child and maternal health program, or an STI/BBV program, etc. The relevant skill level for this role might be an experienced Certificate III or a new Certificate IV.

Aboriginal Health Practitioner

For a more highly clinically skilled AHW who is nationally registered (under the proposed system to commence in 2012) a role might be envisaged

[9] We imagine a template job description will be developed which regional and even individual services in both the government and non government sector can adapt to their specific and sometimes idiosyncratic requirements. Of course too much tailoring of the generic template would defeat the purpose of seeking some common descriptions, so a regular audit of job descriptions would be appropriate. Such an audit could provide the basis also for a regular review and modification of the generic, template job descriptions.

that involves more acute care or specialist treatment work. In this case the AHW provides a genuine primary health care role

Aboriginal Health Worker (Public health)

Another role might focus on public health interventions and require limited clinical skills (but a strong preparation in the methods of public health including health promotion).

As noted in a previous section, ideally the role of the AHW and consequent role or job descriptions should be constructed within the context of achieving the best primary health care outcomes for the community and a broader overhaul of service delivery models. Consideration should be given to redesigning work systems and work flow structures to satisfy the needs of AHWs and other health service staff in consultation to best utilise their skills, allow them control over their own work and the clinical judgements they make.

Recommendation 1:
AHW employers must ensure each AHW under their employ has a clearly stated job description and duty statement. DHF and AMSANT, in conjunction with a relevant professional association (see Recommendation 24), need to create an agreed 'template' set of AHW 'roles' which employers can modify to construct job descriptions specific to their community and individual AHW context.

Recommendation 2:
Health services should redesign the work in health services to (1) be entirely consistent with the needs of the community and (2) satisfy the needs of AHWs and other health services staff to better utilise their skills and clinical judgement.

Workforce size

While it is easy to recommend a significant and rapid increase in the size of the AHW workforce and justify this from the perspective both of the sustainability of the AHW workforce and the benefit to communities, a definitive target workforce size remains a difficult objective. As the AMSANT submission notes:

> *"[despite broad support] … we can't support such a benchmark without further consultation and negotiation."*

A broader review of service delivery and role definition is a prerequisite to gaining a more structured and appropriate estimate of workforce size, based on a proper workforce planning approach to labour demand.

The draft approach suggested in the Core Service Framework offers a useful and structured starting point for debate. An additional value of this approach is that it defines the staffing mix at an individual health service level. This is one way to

overcome the current DH&F approach to vacancies — an ideal target can be set for AHW numbers and retained which is independent of the current funding process and therefore not requiring positions to be labelled as 'vacancies'.

AMSANT has advised the Review that until further consultation and review of service delivery and role definition is undertaken to ascertain the definitive benchmark for AHW workforce growth that it will accept the previously endorsed figure of 1 AHW per 100 people as advised in the PHCAP Planning Studies. The Core Service Framework offers similar ratios. These studies can broadly equate to a 10% growth in AHW numbers per annum equating to approximately 30 registered AHWs each year.

Recommendation 3:
It is recommended that an initial target to increase the AHW workforce annually be set at 10% or 30 new registered AHWs per year for the next three years.

Recommendation 4:
The NT Aboriginal Health Forum should undertake, as a matter of urgency, work to review the current AHW workforce benchmark and establish an agreed AHW workforce size with an annual target and timeframe for the number of new entrants to meet the needs of Aboriginal Primary Health Care in the Northern Territory.

Induction and cultural awareness training for nursing staff

During the data collection processes of the Review it was regularly reported that nurse behaviour towards AHWs could be offensive and lead to de-motivation of AHW staff. At times this was the result of racist thought processes, but more often it was the unintended consequences of culturally inappropriate behaviour.

Nurse preparation for work in remote Indigenous communities in terms of induction and cultural awareness training appears to be, despite the best intentions of many, of variable quality and quantity. Reports ranged from three to four week highly structured preparations (probably inefficient) to a few days, often received after having been posted for over six months. Efforts to provide proper induction are complicated by the high nurse turnover and short contracts of many nursing staff in the Northern Territory.

In order to prepare nursing staff for their role in a NT health service team cultural awareness training should be mandatory.

This training would ideally be provided prior to posting (perhaps some simple dos and don'ts) and then followed up soon after posting once some genuine community experience has been gained. Broad induction training should be provided off the job (including by the labour hire employer in the case of all contract labour), and the community induction should be provided by senior

AHWs. A thorough induction to the health centre should be provided by the Health Centre Manager and Senior AHW.

Cultural awareness training and health centre induction processes should include:

- cross cultural and cultural safety training;
- working effectively in multi disciplinary/ multi cultural teams;
- an understanding of AHW job descriptions for the role and scope of practice of AHWs;
- nurse job descriptions to clarify expected workplace behaviours with other staff and resultant disciplinary processes;
- methods for resolving communication issues between nursing staff and AHWs;
- nurse job descriptions to include AHW training and mentoring; and
- ongoing cultural awareness and management training to resolve workplace issues such as absenteeism and avoidance.

After completing any "formal" induction training, the first day at a community of a new nurse or other type of staff should be spent with a local just being shown around (where they can and can't go due to gender etc) and being informed of the community politics, dynamics, gossip, roles of individuals, meeting Traditional Owners, elders, other service providers. Hearing about what the locals think are the big health issues in the community and getting an understanding of how much "work" can be done outside the health centre are important additional benefits.

Recommendation 5:
All non-Aboriginal staff working in Aboriginal Primary Health Care services in the NT should receive periodic ongoing cultural awareness training and support in order to complement ongoing community experience and assist in resolving workplace issues such as absenteeism and avoidance.

Recommendation 6:
An acceptable model and mechanism for the cultural mentoring of resident non-Aboriginal staff working in Aboriginal Primary Health Care services in the NT needs to be fashioned from existing approaches and its implementation appropriately funded.

Management practices

From the qualitative data collection process it became apparent that the following management practices within health services and the health centre itself created a progressively culturally safe and positive work environment for AHWs and RNs:

- consultative and collective decision making processes;

- building confidence in AHWs by affirmation of their skills and providing ongoing skills development on the job;
- reciprocal support and mentoring between AHWs and nurses in cultural awareness and professional development respectively;
- facilitating AHWs working as a team with the benefit of managing cultural requirements such as gender issues;
- making available a network of relief AHWs;
- allowing AHWs to express a preference to work as a team or to set individual work plans;
- insisting AHWs are the first contact for health centre patients and then either treated by an AHW or referred on to an RN or doctor if required;
- grievance processes established and if already in place appropriately adhered to for all staff; and
- RNs understanding the role of AHWs and supporting their professional development.

The effects of management practices are a major determinant on AHW retention behaviour and the way they perform in the workplace.

In general, managers should be projecting an image (based on reality) of care and concern for their workers, so AHWs feel important and valued. In this sense in much of the qualitative data collected, the issue of housing was brought up as a major concern. AHWs viewed inequality between themselves and nursing staff who were provided with housing. AHWs are employed in some cases from the communities in which they live and in others they take a position within a new community. Generally, AHWs in communities are living in overcrowded housing which affects their work performance as they often do not receive enough rest for the following work day. Housing is just the tip of the iceberg; there is disparity with nurses on a range of other conditions, to some of which AHWs are also entitled, but will only receive if they make a strong enough claim.

Thus the issue is not only of concern because of physical housing problems for AHWs but more importantly the message that is delivered on the perceived status of the AHW role.

It is recommended that appropriate parameters and expectations be set for each health service in line with the above management strategies and that management practices should be accountable. Failure to deliver on expectations should have consequences sufficient to provide all managers within the system strong enough signals.

The aim of health centre management should be to provide good workplace social relationships to reflect mutual respect between different worker categories and between workers and management by improving human resource management practice. This will provide a clear and attractive work vision, engage workers in participative processes, demonstrate an ongoing valuing of the worth of human resources and promote an open, fair and supportive environment.

Recommendation 7:
The Review identified that health services with the following management practices were most successful in retaining their AHWs:

- consultative and collective decision making processes;
- building confidence in AHWs by affirmation of their skills and providing ongoing skills development on the job;
- reciprocal support and mentoring between AHWs and nurses in cultural awareness and professional development respectively;
- facilitating AHWs working as a team with the benefit of managing cultural requirements such as gender issues;
- making available a network of relief AHWs;
- allowing AHWs to express a preference to work as a team or to set individual work plans;
- insisting AHWs are the first contact for health centre patients and then either treated by an AHW or referred on to an RN or doctor if required;
- grievance processes established and if already in place appropriately adhered to for all staff; and
- RNs understanding the role of AHWs and supporting their professional development.

It is recommended that appropriate parameters and expectations be set for each health service in line with the above management strategies and that manager practices are monitored and managers held accountable.

Recommendation 8:
Employers recruiting AHWs from outside a given community should in principle offer housing/accommodation on the same terms as nursing staff and other resident health professionals or NT Aboriginal Community Police Officers.

It is acknowledged that with the dearth of housing stock at the moment in remote communities, and the high levels of activity to build the stock through SIHIP, this recommendation may be difficult to honour in the short term and potentially the most limiting factor on AHW workforce growth. In practice, in the medium term some degree of substitution of AHWs for nurses may be required to satisfy an AHW housing commitment.

Recommendation 9:
AHWs recruited from within their local community should ideally be offered housing/accommodation on the same terms as nursing staff and other resident health professionals or NT Aboriginal Community Police Officers as:

- a recruitment strategy/benefit; and
- a means to ensure a minimum standard of home environment for AHWs in the workforce.

Recommendation 10:
The Review recommends that work be undertaken by AHW employers to identify any gaps and provide parity in the conditions of service of AHWs and other health professionals working in the same health services.

Recommendation 11:
It is recommended that leadership and management programs be provided to empower AHWs to be in senior AHW and management positions in both government and community controlled health services.

Recommendation 12:
It is recommended that AHWs be involved in all aspects of the move to community controlled health services and in order to empower their role within these services clear AHW roles definitions in community controlled health services be established (see Recommendation 1).

Recruitment

In order to significantly increase the number of persons entering (and graduating from) the AHW training programs a new approach is required to recruitment. Traditional methods of recruiting trainees from remote communities will continue to be utilised as it has proven valuable however, this source alone will not be able to satisfy the required numbers of trainees. Apart from the absolute limitations on this pool in terms of eligible and interested persons, past experience has shown that widespread language and literacy limitations are exposed at a Certificate IV level of training. In order to maximise the supply of potential AHWs, consideration will need to be given to:

- significant investment in training resources and bridging courses within communities to address the language and literacy deficiencies;

- a concerted effort to promote AHW careers to high school students, competing with other health and other industry occupations in this critical labour market segment;
- training pathways from Certificates II and III to registration level training requirements for existing and prospective workers; and
- incentives for ex-AHWs and prospective AHWs such as provision of housing.

The most critical strategy it seems will be recruitment aimed at recruiting prospective AHWs from schools in the urban / town centres of Darwin, Katherine, East Arnhem, Tennant Creek and Alice Springs. A concerted promotion of the AHW profession in public and private schools could be accompanied by a greater push to offer VET in School AHW Certificates II and III from year nine or ten. VET in School pilot programs apparently have already been successfully trialled in some Darwin schools.

A recruitment strategy to re-engage ex-AHWs who have stopped working due to stress or burnt out can be also mounted with a view to bringing these recruits into more procedural and routine community health work or program roles. If these AHWs have kept their registration current they would have the option to re-enter the clinical component of the AHW workforce later.

At a broader level an attempt should be made to again sell the AHW 'brand' and rebuild its prestige especially within Indigenous communities. In order to illustrate and re-establish the importance of the AHW workforce within the public perception of NT health services, it is recommended that television media options be explored, especially the Indigenous targeted television channels such as NITV and Imparja. A six part series of documentary case studies for instance similar to the 'RPA' program but constructed more like the ABC's 'Australian Story', could feature high quality AHW's stories from different parts of NT.

Consideration of AHW conditions and pay structures, with a view to creating greater parity with nursing and improving the provision of housing for AHWs, would ensure a favourable promotional campaign was not undermined by demonstrably poorer pay and conditions disincentives.

Recommendation 13:
Clear training pathways from Certificates II and III to registration level training requirements for existing and prospective AHWs need to be established.

Recommendation 14:
The Review identified that health services within town centres had utilised their senior AHWs to recruit prospective AHWs from within the community and high schools. It is recommended that a concerted effort be made to promote AHW careers to high school students by existing AHWs and AHW employers.

Recommendation 15:
A coordinated effort by the AHW profession and AHW employers needs to be undertaken to 'market' the AHW profession utilising television and other popular media.

Training

As shown earlier, current AHW training arrangements are a major barrier to workforce growth; the current training rate barely covering 'replacement demand' requirements. The major concerns under the current arrangements are the capacity to provide sufficient individual, on the job AHW learner support and mentoring to ensure satisfactory completion of training. The recently completed 'Apprenticeship Program', which we would recommend be continued, provides a sobering perspective on the real level of need of trainees for clinical level support. The capacity of any system, but especially the current (BIITE and Congress) arrangements to satisfy requirements of an increase in course enrolments, will be severely tested.

A more thorough review of AHW training than was possible in this more broadly targeted Review may be required however, immediate suggestions for improvement include:

- creating *regional* training centres in larger urban and town centres across the Northern Territory. Darwin, Katherine, Gove & Alice Springs at least would be obvious regions from which to construct viable training infrastructure. The viability of creating other regional (or sub-regional) centres would need to be tested. At each of these centres a *collaboration of interests* who are committed to sound training outcomes will need to be forged between health services (both community controlled services and government health services possibly in conjunction with The Expanding Health Service Delivery Initiative (EHDSI) implementation), education institutions (an auspicing RTO (Registered Training Organisation)), and other dedicated training resources from the health system (for instance the resources utilised to support apprentices);
- ensuring each trainee AHW has a suitable designated supervisor/mentor preferably community based. To facilitate this outcome AHW training needs to be included in core work of health services and put into job descriptions of senior AHWs and other health service staff;
- ensure sufficient and suitable AHW educators who will provide regular clinical support and on the job training to all AHW trainees by visiting all trainees in

their health services (this is part of the rationale behind regionalisation to bring training infrastructure closer to health services). The importance of quality, regular and individual support, for 'as long as it takes' (within reason) cannot be underestimated;
- review the current 'block release' mode of delivery. While this methodology is comparatively efficient, innovative ways of delivering learning that does not take trainees away from family and friends for extended periods and subject trainees to overly concentrated (and stressful) periods of intense learning, should be explored. Consideration could be afforded community training blocks within health centres, including surrounding regions, and tapping into the concept of the twenty "super communities" being developed by the NT government; and
- accept that for some trainees the period of the training course could realistically be up to three years and include language and literacy alongside or as a prerequisite to the clinical training. The emphasis should be to reduce drop outs and produce competent and confident health practitioners.

However the education and training regionalisation is constructed, it would seem prudent to put out to expression of interest and ultimately competitive tender the 'regional' training contract. It is envisaged that each training centre could be able to support and train between ten and fifteen trainees each year. Similarly, DH&F should undertake a competitive tender process Australia wide to engage a RTO to deliver the Apprenticeship Program. Tender requirements could include a requirement for innovative training delivery strategies with a community based delivery focus.

In regard to developing new AHW supply into the workforce the lessons of the past and especially recent years is that investment has been insufficient to get the job done. Investing half of what is required to accomplish the job is as worthless as not investing at all.

Recommendation 16:
The Review recommends that DH&F and AMSANT request the NT Department of Education and Training undertake an audit into AHW education, training and student outcomes for the past five to ten years.

Recommendation 17:
The Review recommends that DH&F and AMSANT request the NT Department of Education and Training to review their user choice policy and funding for AHW training to allow RTOs other than BIITE to access funding.

Recommendation 18:
It is recommended that for the medium term a thorough review of AHW training in the NT be conducted to provide lasting improvement by:

- creating *regional* training centres in larger urban and town centres across the NT for example, Darwin, Katherine, Gove & Alice Springs;
- ensuring each trainee AHW has a suitable designated supervisor/mentor in the health services, preferably in a community based service;
- ensuring sufficient and suitable AHW educators who will provide regular clinical support and on the job training to all AHW trainees by visiting all trainees in their health services;
- reviewing the current 'block release' mode of delivery; and
- accepting that for some trainees the period of the training course could realistically be up to three years and include language and literacy alongside or as a pre-requisite to the conceptual and clinical training of the Certificate IV.

Recommendation 19:
It is recommended that whatever training model is adopted in the future that each AHW trainee must receive regular, local access to AHW educators for clinical support and on the job training. To facilitate this outcome AHW training and support needs to be included in the core work of health services and put into the job descriptions and responsibilities of senior AHWs and other health service staff.

Professional development and ongoing support

With such a strong focus on pre-employment or professional preparation training, the needs of the existing workforce should not be overlooked. There is worth in reviewing and adopting ongoing professional development strategies for AHWs to ensure career progression and satisfaction in conjunction with mentoring and support processes. The key to success in future professional development will be to achieve greater individualisation of the needs assessment, learning planning and learning experiences of workers. The current AHW workforce is small enough to still accomplish a high level of personalised professional development support and begin to deliver AHWs in senior clinical and service management positions.

Recommendation 20:
It is recommended that a review of AHW ongoing professional development strategies and mentoring / support systems be undertaken and resultant strategies put in place to ensure the ongoing professional development, support and empowerment of individual AHWs is achieved at all levels of the workforce.

Professional representation

AHWs are poorly represented in discussions regarding the AHW workforce in general across the NT. There is no forum for AHW representation and the LHMU (Liquor, Hospitality and Miscellaneous Union) struggles to represent the views of the AHW profession adequately. The newly formed National AHW Association could be a useful advocate for AHWs in the NT to promote AHW representation at all levels across the health industry.

Recommendation 21:
To ensure that AHWs achieve representation at all levels of the NT health industry it is recommended that key stakeholders for the AHW workforce discuss the best way to assist AHWs achieve representation and that all AHW employers and their representatives support the National AHW Association.

Retention issues and AHW role classifications

Career progress opportunities are currently limited. Motivating workers who have been doing the same job for the last ten to twenty years is not easy, which is why some degree of staff turnover is not unwelcome. Ideally, from an AHW workforce perspective, 'internal turnover' (between or within services into a new role) is to be preferred and fostered.

To improve the recruitment and retention of AHWs and improve their career progression, a revision of AHW classifications needs to be undertaken and jobs appropriately evaluated so that quality work is properly rewarded. A raw initial suggested AHW classification structure is provided in the diagram on page ~~44~~ 56 which identifies several reasonable career pathways for AHWs. The three different colours in the diagram in fact represent different career paths for AHWs as follows:

- red is a AHW Practitioner (clinical) pathway;
- blue is an AHW public health pathway;
- green an AHW educator/management pathway;
- purple is considered the AHW entry level and for community/program work. This AHW classification would be useful for existing AHWs who do not want a clinical role, AHWs who have limited numeracy and literacy, and to re-engage ex-AHWs into the workforce.

There would need to be descriptors and criteria developed for each role identified in the diagram to ensure appropriate designation of AHWs in each classification. This is beyond the scope of this Review, however some initial descriptors for the 'practitioner' or clinical pathway classifications are provided below. In constructing the criteria for each classification level the Review would recommend that capabilities to perform the role at each classification level be the primary concern rather than imposing qualification or other external requirements (that may in any case have only a weak relationship with capacity to perform the role).

AHW Trainee, Level 1

AHW Level 1 shall be an entry point to Aboriginal health work for a trainee AHW with good numeracy and literacy skills. An AHW Level 1 will commence the Certificate II, III or IV and train in the health centre under the immediate and direct supervision of a registered AHW or Nurse.

AHW Trainee, Level 2

AHW Level 2 shall be an entry point for a trainee AHW who has recognised seniority in his/her community and leadership skills but not necessarily good numeracy and literacy skills. An AHW Level 2 will commence the Certificate II, III or IV and/or the Certificate in Spoken and Written English if required. An AHW Level 2 will train in the health centre under the immediate and direct supervision of a registered AHW or Nurse.

AHW, Level 3

AHW Level 3 shall be a trainee AHW completing the Certificate II, III or IV or an AHW who has achieved the Certificate III qualification. An AHW Level 3 may also be a re-entry level for AHWs who have maintained their registration but will need to update their skills to the current new registration level competencies. An AHW Level 3 shall have the knowledge and skills to be competent in:

- cultural brokerage;
- health promotion; and
- conduct of health programs within the community.

An AHW Level 3 shall be under the direct supervision of a registered AHW or Nurse and will not perform on call duties.

AHW / Primary Health Care Worker, Level 4

AHW Level 4 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board. An AHW Level 4 shall perform basic primary health care duties, including a clinical role under limited supervision of a level 5 or above AHW or a registered nurse. An AHW Level 4 will have a range of clinical skills and a broad knowledge base incorporating some theoretical concepts to work in the primary health care team including:

- being the first contact for patients entering the health centre;
- assessment of presentations;
- treatment if within AHW Level 4 clinical competencies;
- referral to registered nurse or doctor;
- continuing care ;
- conduct of community health programs with invasive clinical skills eg immunisation programs;
- cultural brokerage; and
- health promotion.

An AHW Level 4 will not perform on call duties.

AHW Senior On-Call, Level 5

An AHW Level 5 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board and should have a minimum of two years recent and satisfactory service working as an AHW. An AHW Level 5 shall perform primary health care duties with well developed clinical skills and a depth of understanding in theoretical concepts as follows:

- assessing, treating and, if required, referring on patients who present at the health centre;
- on call duties ;
- responsible for the implementation of community health programs;

- work without the direct supervision of a level 5 or above AHW or registered nurse; and
- after completion of specified skills sets and competencies (these should be developed in the future) be responsible for developing, managing and performing community health programs for example, child and maternal health, men's health, nutrition, dental health etc.

AHW Practitioner, Level 6

An AHW Level 6 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board and should have a minimum of five years recent and satisfactory service working as an AHW. An AHW Level 6 should have the skills and knowledge to perform some or all of the following roles competently:

- AHW team leader in community based health centres;
- remote relief AHW;
- AHW expert in a selected field such as midwifery, child and maternal health etc; and
- develop, manage and perform higher level clinical health programs for example, chronic disease programs.

An AHW Level 6 may develop management skills in order to be able to undertake the role of relief Health Centre Manager with the guidance and support of the Health Centre Manager and the Health Service Area Manager.

AHW Health Service Manager, Level 7

An AHW Level 7 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board. An AHW Level 7 should have the skills and knowledge to be competent as community based Health Centre Manager. An AHW Level 7 may be required to act as a community based relief AHW and community based Health Centre Manager.

AHW Director Remote Health, Level 8

An AHW Level 8 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board. An AHW Level 8 should have the skills and knowledge to be competent in the role of AHW Director, AHW Director Remote Health or Health Service Area Manager.

AHW Principal Advisor, Level 9

An AHW Level 9 shall be an AHW with the Certificate IV qualification and/or registered with the Aboriginal Health Workers Registration Board. An AHW Level 9 should have the skills and knowledge to be competent in the role of Principal AHW Advisor.

Figure 4: Proposed AHW job classification structure

In order to maintain the integrity and transparency of appointments to various classification levels, progression between the AHW levels above should not be on the basis of individual manager decision making processes. A formalised approach, and we suggest a grading committee or similar, should be established to ensure transparency, equity and reasonable probity in the process of career progression for AHWs.

Recommendation 22:
The Review recommends that DHF and AMSANT should consult relevant stakeholders to review AHW classifications and job evaluation systems using the classification structure presented by this Review as a starting point.

AHWs in acute roles

Currently there is a small number of AHWs employed in acute settings in Alice Springs and Darwin Hospitals. Some of these positions are highly valued, and like some of their counterparts in primary health care, they perform alongside other health workers. The majority of positions though are not well respected and the roles have been emptied of any clinical component. The roles have become essentially liaison, interpreting and cultural brokerage in its simplest sense.

There is value in bringing these AHW roles within the broader AHW structure discussed here, the immediate benefits being:

- Improved negotiating power for acute care AHWs, both from greater numbers and also from relationship with more supportive management structures (for instance regional AHW managers);
- Greater capacity for primary health care AHWs to rotate through hospital practice and therefore gain accelerated clinical skills development opportunities, likely in a specialised clinical area (eg nephrology, paediatrics, cardiology); and
- Greater potential for transfer between acute and primary care sectors; thus potentially prolonging the life of an AHW.

The most obvious impediment to a merging of acute care into the broader AHW framework is the very different training pathway. The AHW qualifications within the Health Training Package are inappropriate preparation for acute care practice. A more appropriate course would be the enrolled nurse training. Nevertheless this Review recommends that consideration be given to establishing a separate classification stream for AHWs who wish to practice in acute services.

Recommendation 23:
The Review recommends that DH&F, AMSANT and the NT AHW Registration Board consider the merits and challenges of establishing a separate but linked classification stream for AHWs wishing to practice in acute services such as hospitals.

Conclusion

For 20 or more years the Aboriginal Health Worker 'brand' has been synonymous with quality services in the Northern Territory for Indigenous communities. Slowly though the brand image has become tarnished and the iconic status in the Northern Territory of the AHW has come under threat, and a 'crossroads' scenario has evolved from which the AHW may emerge stronger, or weaker, and destined for hard times. This Review unequivocally supports embarking on a pathway to a stronger AHW workforce.

In the recently concluded *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (December 2008) it was agreed that health reforms were to be implemented consistent with evidence that:

> *"… broadly acknowledges that to overcome Indigenous disadvantage, a holistic life stage approach is required that builds sustainable social change and embeds system reform." (p. 4)*

The partnership documentation goes on state in regard to primary health care that it needs to:

> *"… significantly expand access to and coordination of comprehensive culturally secure primary health care, allied health services and related services." (p. 6)*

It is impossible to see how in the short and medium term (next 5-15 years) the above principles and the ambitious outcome expectations of 'Closing the Gap' will be achieved without a vibrant Aboriginal Health Worker workforce. Even in the long term, as hopefully more of other types of health workforces (nurses, medical practitioners, allied health workers) are opened to higher levels of participation by Aboriginal and Torres Strait Islanders, one could still envisage a key role for AHWs in remote area primary health care.

The recommendations of this Review aim bring vibrancy back to the AHW workforce which will inspire confidence in the services that employ AHWs and create strong job futures for AHWs. A workforce needs to be created where compensation for the level of work required is competitive and fair, a clear career pathway is evident, support and professional development is available and job security is strong for those who perform to expectations. It is essential to enhance the education and training of AHWs to improve their chances of progressing within and beyond the AHW classification.

Issues with the AHW workforce will not be resolved unless:

- clarification of the role(s) is achieved;
- major training and support structures are put in place;
- improved training models are developed;
- professional mentoring support structures are in place;
- job classifications are accepted and more enticing career pathways established;

- management practices are adopted that better demonstrate human resource management best practice; and
- working structures/ relationships with other health staff are in place.

In all 23 recommendations are provided in this Review largely targeting each of the above dot points.

One of the weaknesses of past reviews has been the lack of ownership of the recommendations and the absence of an agreed group or body that could oversight the implementation of actions relevant to the recommendations. Like most areas of health services endeavour, but especially the area of Indigenous health, there are many responsible parties. In regard to the AHW workforce this includes Territory Government (DH&F, Department of Employment Education and Training), Commonwealth Government (Department of Health and Ageing, Department of Education, Employment and Workplace Relations), and non government services providers (represented by AMSANT). Each of these sources of funding or service delivery (or both) needs to formally agree (1) generally on the value of AHWs and the ongoing support that this workforce needs and (2) specifically on the recommendations of this Review. This then implies that requisite energy and resources are committed in a sustained way to achieve the desired outcome for the AHW workforce to ensure that it is viable in the longer term.

Sustaining a focus on implementation of recommendations that may take some years to satisfy is not easy. Hence the search for an appropriate, long term oversight body is essential. It is possible that the NT Aboriginal Forum could be responsible to ensure that the recommendations of this Review are implemented and the necessary resources applied or another body may be created.

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Annexure 'A'

Focus Group Discussions/ Individual AHW interviews

- SWOT ANALYSIS (see attached)

What are the key reasons people stay in their job as an AHW

☐ Love the work
☐ Good pay
☐ Good working conditions
☐ The people they work with
☐ Helping people in community
☐ Good boss
☐ Can't get another job
☐ It is a respected job
☐ Other _____

What are some good stories about retention?

What are the key reasons people stop working as AHW

☐ Burn out
☐ The people they work with
☐ The pay
☐ The hours
☐ Got a better job
☐ Left the community
☐ Family reasons
☐ Humbug
☐ Lack of respect for the job
☐ To study nursing or medicine
☐ Other _____

What are some bad stories about retention?

What did you like about the training you did to become an AHW?

How could the training for AHW's be better?

What are some ideas that might work to help keep people in their jobs as AHW?

What are some ideas that might work to get ex-AHW's back to working as AHW's?

Aboriginal Health Worker Profession Review
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SWOT Analysis

Aboriginal Health Worker Workforce

criteria examples	strengths	weaknesses	criteria examples
Advantages of current workforce? Employment conditions? Workforce Capabilities? Competitive advantages? Experience, knowledge? Quality of service? Qualifications? Reputation? Cultural? Attitudinal, behavioural? Philosophy and values? Training system?			Disadvantages of workforce? Recruitment and retention issues? Employment conditions? Experience, knowledge, data? Reputation? Known vulnerabilities? External/Internal pressures? Morale, commitment, leadership? Qualifications? Processes and systems, etc? Management? Training system?
criteria examples	**opportunities**	**threats**	**criteria examples**
Political effects? Legislative effects? Workforce developments? Health sector growth/developments? Expansion of workforce? Improvements in technology?			Political effects? Legislative effects? Environmental effects? IT developments? New technologies, services, ideas? Sustaining internal capabilities? Obstacles faced? Insurmountable weaknesses? Loss of key staff/stakeholders?

Annexure 'B'

Aboriginal Health Worker Review
Case Study Collection Protocol

Data will largely be collected first through interview with the health service manager and / or the clinic manager / coordinator. Some data will need to be collected from an HR manager if one exists in the service. Much of the data though will need to be validated and clarified through interviews with Aboriginal Health Workers in groups or as individuals. Questions that especially need to have a AHW perspective are noted with an asterisk (*).

Initial service data

1. Name of Service

2. DHF/Health Board/independent AMS

3. Collect completed employer survey including statistics if not already received.

4. Discuss the history of the service in employing Aboriginal Health Workers.*

Work organisation

1. Discuss the actual model for delivering care in the service and the roles that each type of worker plays.*

2. What was the basis for determining the desired staff level and type of staff? Focus on the nurse to AHWs ratio? Is the current staff mix in terms of level and type of professions employed optimal? If not what is desirable and what are the barriers to achieving this?

3. What do AHWs in this service specifically do?*

    - What is the scope of their practice?
    - How is this scope determined?
    - What decisions are made about each health worker's practice area?
    - What principles are used to make these decisions?

4. How much autonomy do AHWs have in their work? Does the perceived value of working as an AHW include a level of autonomy?*

Leadership and management style

1. Discuss the external management influences from DHF, the Health Board or Community Council where appropriate.

2. What kind of manager is the health service manager?*

    - Does he/she make all the decisions, keeping the information and decision making among the senior management?
    - Does he/she explain the decisions that are made to the employees and ensure that their social/cultural needs are met?
    - Does he/she allow the employees to take part in decision making?
    - Does he/she take a peripheral role and let the staff manage their own areas of the business?

3. How involved is the health service manager in managing the work of the AHW?

4. Does the manager develop leadership competencies in the staff?

5. Is there any mentoring or coaching of staff?

Workplace & community relations

1. Discuss the social relationships in the workplace within AHWs (if more than one) between AHWs and the rest of the team in this service.

    - Do the AHWs function as a team? Do they relate more to each other or to a 'buddy' non Aboriginal Health Worker?
    - Describe the relationships between the AHWs and Nurses in the service. Are the relationships collegiate or as individuals?
    - How do the AHWs fit within the broader team of the health service?

2. Discuss the community's expectations of the AHW role. Note this is likely to be the view of an AHW or HSM – ideally it would be better answered by an AHW from own community or Community Council member.

3. Discuss how working and living in the community affects AHW relationships both in the workplace and in the community.

    - Discuss the implications of employing an AHW from outside the community that the service is in.

4. Discuss the value that AHWs achieve from their work and relations within the workplace and community. Are there intrinsic rewards for working as an AHW?

Job future

1. Discuss the history of training interventions in the service.

    - What types of training are offered to AHWs?

- What types of training are taken up?
- What types of training are not taken up?
- Who pays for training?
- What are the barriers to training?

2. What benefits have AHWs received in the past after they have completed further training?

- Enhanced status?
- Enhanced job satisfaction by being able to apply new job skills? For instance running the pharmacy dispensing function, etc?
- Management or leadership competencies developed?
- Mentoring or coaching roles?
- Promotion or better pay?

Pay & conditions

1. Discuss the pay of AHWs in the service.

    - How much is each AHW paid?
    - To what extent have efforts been made to increase salaries or not?
    - What are the barriers to increasing salaries?

2. What are the employment conditions of AHWs in the service?

    - What are their leave provisions?
    - What are the expectations of AHW attendance at work?
    - What approach does this service take for cultural leave?
    - What approach does this service take for sick leave, compassionate leave, etc.?
    - How does this service deal with perceived or real absenteeism? Have there been any perceived problems?
    - What are the expectations on AHWs with regard to their on call hours / days? Are only AHWs included in the on-call roster?
    - What entitlements are paid or available for AHWs in your service? (eg accommodation, FOIL, freight on perishables)

Annexure 'C'

Aboriginal Health Worker Profession Review

Stakeholder Interviews

1. What in your opinion are the key factors that enhance the prospects for AHW employment? What actions can services take to maximise retention of their AHWs?

2. Discuss the potential scope of practice and level of responsibilities that you understand AHWs have and how these boundaries are determined at the service level. What do you understand is the degree to which AHWs actually practice to this scope? What factors act as barriers to practice at full scope?

3. What are the common reasons you understand would contribute to AHWs leaving their jobs? Can these causes of loss be minimised or eliminated altogether?

4. In your opinion, are the reasons for leaving the profession likely to be the same as those motivating qualified AHWs not to return to the profession? Can you think of any incentives that would encourage AHWs to return the AHW workforce?

5. What is your perspective on the issue of AHW career progression?

6. Do you have any comments on AHW education and training? There seem to be some problems training sufficient new supply. Do you have any thoughts on why this should be so? How could things be different in the future?