Workforce Development

A study of Pacific non-regulated workers

Phase One
Literature Review

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1.1 Introduction

This literature review serves two purposes. It constitutes Phase One of the 'Workforce Development, A Study of Pacific non-regulated workers' study and informs the development of Phase Two of the same study. It is also intended as a stand-alone publication and contributes to existing literature on the Pacific non-regulated workforce (PNR) in New Zealand.

The findings from the PNR study will assist in the development and implementation of the Ministry of Health (MoH) and Health Research Council of New Zealand's (HRC) strategic plan for the non-regulated health workforce in New Zealand.

For the purposes of this study, Acqumen Quality Solutions' (2006) definition of non-regulated workforce was adopted:

> *"People who have direct personal care interaction with clients, patients or consumers within the health and disability sector and who are not subjected to regulatory requirements under health legislation. This includes all people (paid or unpaid) who interact with clients, patients or consumers within the health and disability sector, who are not subject to regulatory requirements under legislation or other means. This workforce also provides a lot of social, practical (including information, coordination, advice and cultural support) and advocacy that supports the full continuum of care." (2006: 4)*

The terms 'community health workers' (CHWs), 'village health workers' (VHWs), and 'non-regulated health workers' are widely utilised within international literature. In New Zealand, the commonly used terms are non-regulated health workers, volunteer health workers (VHWs) and CHWs. These terms are used interchangeably throughout this document.

1.1.1 Review aims

Consistent with the overall aims of the Phase One study, the aims of this literature review were to:

- Identify the composition and main characteristics of the (Pacific and non-Pacific) non–regulated workforce

- Identify how the (Pacific and non-Pacific) non-regulated workforce contributes to (Pacific) health outcomes

- Explore developmental pathways accessible to the (Pacific and non-Pacific) non-regulated workforce

- Examine areas of effectiveness of the (Pacific and non-Pacific) non-regulated workforce in meeting the health needs of the (Pacific and non-Pacific) population in New Zealand.

1.2 Review Methodology

1.2.1 Study selection

A comprehensive review of available literature relevant to the non-regulated workforce and the Pacific population was undertaken. The literature search was conducted by accessing The University of Auckland databases: Medline, Cochrane Library, Expanded Academic, ABI/Inform, Social Science Citation Index and Anthropology Plus and supplementing these with the more publicly accessible on-line databases, such as SearchNZ and others offered by Google Scholar. Electronic searches were supplemented by searched paper indexes, using references listed in bibliographies and snowballing from cited references. Journal articles (including electronic databases), technical reports, policy manuals and unpublished reports were also accessed. Searches were limited only to the English language.

1.2.2 Electronic bibliographic indexes

1) *Medline* is produced by the U.S. National Library of Medicine. Medline is widely recognised as the premier bibliographic database covering the fields of medicine, nursing, dentistry, veterinary medicine, the healthcare system and the pre-clinical sciences. Medline contains bibliographic citations and author abstracts from more than 5,000 biomedical journals published in the United States and 80 other countries. The database contains over 15 million citations dating back to the 1950s. Coverage is worldwide, but most records are from English-language sources or have English abstracts. This version of Medline uses Ovid software.

2) *The Cochrane Library* is coordinated by the Cochrane Collaboration (an international network committed to preparing, maintaining and disseminating systematic reviews on the effects of healthcare) and by the UK's National Health Service (NHS) Centre for Reviews and Dissemination at the University of York. It is a resource for information on the effectiveness of healthcare interventions, with the following sections:

   a) *Cochrane Database of Systematic Reviews (CDSR)*: each systematic review is a regularly updated full text article reviewing the effects of a healthcare intervention. Also included are Protocols (reviews not yet completed).

   b) *Database of Abstracts of Reviews of Effectiveness (DARE):* abstract only, giving critical assessments of systematic reviews done by groups outside the Cochrane collaboration.

   c) *Cochrane Central Register of Controlled Trials (CENTRAL/CCTR):* a bibliography of all controlled trials so far identified by Cochrane review groups.

   d) *NHS Economic Evaluation Database (NHS EED):* abstracts only; each summarises in detail a published economic evaluation of a healthcare intervention and provides a qualitative assessment of the results.

   e) *Health Technology Assessment Database (HTA):* abstracts only; detailing published assessments of healthcare technologies.

   f) *The Cochrane Methodology Register (CMR):* bibliography of articles and books on the methodology of the systematic review process.

   g) *About Cochrane:* information about the Cochrane centres and review groups.

3) *Expanded Academic* produced by The Gale Group, has indexed and full text academic journals, magazines and newspapers. From arts and the humanities to social sciences, science and technology, this database meets research needs across all academic disciplines. It incorporates many interdisciplinary journals, national news magazines and The New York Times. Expanded Academic has over 3,000 indexed titles, with over 2,000 publications available in full text. It also includes book reviews.

4) *ABI/Inform Global* is a comprehensive business database that includes in-depth coverage for over 2,700 publications, with more than 2,000 available in full text. ABI/ Inform Global offers the latest business and financial information for researchers at all levels. Subjects covered include business conditions, management techniques, business trends, management practice and theory, corporate strategy and tactics and the competitive landscape. ABI/Inform Global also contains coverage of EIU ViewsWire, Going Global Career Guides, ProQuest Business Dissertations and Business Cases. ABI/Inform Archive is included in ABI/ Inform Global. The ABI/Inform Archive provides cover-to-cover, full images complete with illustrations and advertisements. The archive contains complete runs of key business and management journals. Topics include corporate strategies, management techniques, marketing, product development and industry conditions worldwide.

5) *Social Science Citation Index (SSCI)* is a multi-disciplinary index, with searchable author abstracts to the worldwide literature of the social sciences. Subject areas cover all social sciences, including anthropology, business, criminology, economics, environmental studies, family studies, geography, health policy, history, law, management, marketing, nursing, philosophy, political science, psychiatry, psychology, public health, social work, sociology, urban studies and women's studies. SSCI provides references and abstracts to articles in more than 1,725 journals in the social sciences, plus items relevant to the social sciences from an additional 3,300 science journals.

6) *Anthropology Plus* covers journal articles, chapters in edited books and essays in anthropology and archaeology. It indexes articles two or more pages long in works published in English and other European languages from the 19th century to the present. Anthropology Plus holds more than 800,000 records including all records from the Harvard University Anthropological Literature database and the Royal Anthropological Institute Anthropological Index Online database.

1.2.3 Specialist libraries

Various governmental departments have websites that include searchable databases and/or libraries that detail publications and reports that were relevant to informing this literature review. The databases or libraries were accessed for a wide-range of information, for example, policies that affect the non-regulated workforce; Pacific population demographics and health status and so on. The following websites were accessed for these reasons:

- MoH (http://www.moh.govt.nz)
- New Zealand Institute of Economic Research (http://www.nzier.org.nz)
- CMDHB (http://www.sah.co.nz)
- Statistics New Zealand (http://www.stats.govt.nz)

1.2.4 Grey literature

Grey literature refers to reports not widely available to the public. Professional and informal networks were utilised to access these reports that were either newly published or not accessible through library or electronic databases.

1.2.5 Key search terms used

Terms and phrases used in the search included:

- Pacific
- Pacific health
- Pacific health workers
- Occupations health workers
- Health promotion
- Non-registered
- Community health worker(s)
- Multicultural
- Community based health worker
- Minority groups
- Indigenous health workers
- Cultural health workers
- Culture and health
- Workforce/labour/labour market/workers/ health workers
- At risk populations
- Hispanics
- Barriers
- Multiracial

Under these search terms or phrases, the search found varying numbers of relevant articles. There were also varying degrees of overlap between the databases. A full list of titles and/ or abstracts was obtained from each search and those articles deemed relevant were accessed electronically and viewed.

1.2.6 Review structure

The review structure is organised to highlight the historical, social and political context of the non-regulated workforce in New Zealand including the emergence of the PNR; the development of PNR as part of government strategies; recent and current areas of developmental work undertaken and pathways to the future.   The methods, its strengths and limitations are discussed in detail in the Review methodology section (Section 1.2).   A demographic overview of Pacific peoples in New Zealand by location, Socio Economic Status (SES), education, employment and health status (Section 1.3) provides context to the issues surrounding the development and maintenance of a PNR. Section 1.4 highlights key characteristics of the PNR workforce which includes definitions, a brief history, and a background to development, recruitment and selection, payment and workforce locations. Workforce development and approaches that have directly or indirectly affected the development of PNR workers are explored in Section 1.5 with an emphasis on government strategies. Further, the review explores the current service delivery models that are utilised by this workforce (Section 1.6). It also provides a section detailing the effectiveness of this workforce (Section 1.7). This is followed by a description of the developmental pathways available to current and potential PNR workers (Section 1.8) and concludes with a brief discussion of present and potential challenges for the PNR (Section 1.9).

1.3 A Profile of Pacific Peoples in New Zealand

Pacific peoples represent 6.9% (i.e. 265,974 people) of the total New Zealand population. Samoan people comprise the largest ethnic group (131,103) and make up 49% of the Pacific population. The next largest group are Cook Island Maori (58,011) followed by the Tongan population (50,478), Niue (22,406), Fiji (9,864), Tokelau (6,822) and Tuvalu (2,625) (Statistics New Zealand, 2007). The Pacific population is one of the fastest growing ethnicities in New Zealand and is projected to grow from 301,600 people in 2006 to 482,300 in 2026 (Statistics New Zealand, 2006). Changes in population patterns indicate an increase in the numbers of Pacific people born in New Zealand compared to migrants from the Pacific islands. At the time of the 2006 Census, six in ten Pacific people were born in New Zealand. A significant characteristic of the Pacific population is the high percentage of young people. In 2006, 38% of Pacific peoples were aged under 15 years (SNZ, 2007). The Pacific population is also characterised by high fertility rates (Mental Health Commission, 2001; Statistics New Zealand, 2007)

Pacific peoples are predominantly urban-based, 93.4% lived in the North Island with a population of 177,933 (67%) concentrated in Auckland. Of all the cities and districts in New Zealand, Manukau City had the highest number (86,616) of Pacific people (one in three people were of Pacific ethnicity). The Wellington region had the next highest Pacific population with 13% of Pacific peoples living there (Statistics New Zealand, 2007).

The 2001 census identified that a high proportion of Pacific peoples (42%) live in decile one areas (most deprived) and that this population are over-represented (22%) in the total New Zealand cohort (dwelling in decile areas) (Ministry of Health, 2005b).

Despite slight improvements over the years, Pacific peoples continue to be over-represented among the unemployed, lower-skilled workers and low income earners (Ministry of Pacific Island Affairs & Statistics New Zealand, 2002).

In 2004, 25% of Pacific males were in factory work and 15% worked in elementary occupations. It was also found that half the Pacific female workforce were employed in clerical or low-skilled sales and service occupations. In contrast, Pacific peoples were markedly under-represented among employer, manager and professional roles (Ministry of Health & Ministry of Pacific Island Affairs, 2004b). Recent figures show that:

- Majority of Pacific people (68%) worked in semi or low skilled occupations with lower pay
- Men were most likely to be employed as labourers (23%), machinery operators and drivers (21%), and technicians and trade workers (20%)
- Women were equally likely to be employed as clerical and administrative workers (19%), labourers (19%), professionals (15%), or community and personal service workers (15%)

  (Ministry of Pacific Island Affairs, 2008)

Many Pacific peoples also undertake various forms of 'unpaid work', which is an often unseen and unrecognised contribution to society and the economy. In 2001, 38% of Pacific adults stated they were involved in this activity, compared with 30% of the total New Zealand adult population. A greater proportion of Pacific peoples also spend time looking after an ill or disabled member of their household. In 2001, 12% of Pacific adults were involved in unpaid work of this nature, a figure almost double that of those adults in the New Zealand population (7%) who do the same type of work (Ministry of Pacific Island Affairs & Statistics New Zealand, 2002).

The average annual income for Pacific peoples remains lower than the rest of New Zealand (Ministry of Health & Ministry of Pacific Island Affairs, 2004b; Ministry of Pacific Island Affairs & Statistics New Zealand, 2002). In 2006, the median annual income was $20,500 in comparison to European ($25,400) and Maori ($20,900) (Statistics New Zealand, 2007). In addition to household outgoings, a high number of Pacific people (75%) send money remittances

to assist families, church, and village activities in their Pacific countries (Ministry of Pacific Island Affairs, 2008).

Compared to national trends, fewer Pacific peoples are likely to own their own homes. In 2001, 25% of Pacific families owned their own homes (compared to 55% nationally). While household crowding has reduced since 1996, 21% of Pacific peoples experienced crowding[1] (compared to 3% nationally) (Ministry of Health & Ministry of Pacific Island Affairs, 2004b). In 2006, 43% of Pacific peoples lived in households requiring extra bedrooms compared to 23% of Maori and only 4% of European New Zealanders. In the same year, home ownership dropped to 21.8%. Statistics New Zealand notes that this is partly due to the younger age structure of Pacific ethnic groups (Statistics New Zealand, 2007).

Despite slight improvements in education, Pacific students are less likely to stay at school longer. Between 1990 and 2001, the numbers of Pacific students enrolled in tertiary education increased from 3,300 to 12,400. In 2001, they made up 4.4% of all tertiary enrolments, but participation rates were lower than those of the total New Zealand population (Ministry of Pacific Island Affairs & Statistics New Zealand, 2002). The Ministry of Social Development (2008) noted that although Pacific (and Maori) students have the greatest increase in the proportion of students leaving with an NCEA Level 2 qualification or better, of all the ethnic groups, Pacific and Maori populations have the lowest proportion of school leavers with NCEA Level 2 or above qualifications.

Most Pacific people have a regular primary healthcare provider. Approximately 10% were regular users of 'by Pacific for Pacific' healthcare providers (Ministry of Health & Ministry of Pacific Island Affairs, 2004b). In 2007, 64,879 (24 percent) of Pacific peoples were enrolled with a Pacific Primary Healthcare Organisation (PHO) and 209,318 (76 percent) were enrolled with a mainstream PHO (Ministry of Health, 2007). In 2008, the PHO enrolment figure for Pacific people was 274,197. In comparison to the total New Zealand population however, Pacific peoples have poorer health status, have

exposure to risk factors for poor health, and continue to experience barriers to accessing health services (Ministry of Health, 2007b).

Literature identifies that Pacific peoples are more likely not to have seen a doctor despite a perceived need (Ministry of Health, 2005b). The New Zealand Health Surveys 2002/03 and 2006/07 (Ministry of Health, 2008b) however, do indicate a decline in the numbers of Pacific peoples reporting that they did not see a doctor despite a perceived need. Apart from secondary prevention visits for, for example diabetes and blood pressure checks, Pacific peoples are also less likely to take up primary prevention and screening services or visit the dentist. They are also relatively low users of community mental health services (Ministry of Health, 2006) as well as hospital outpatient care services (Ministry of Health & Ministry of Pacific Island Affairs, 2004b).

The rates for accessing public hospital inpatient services in New Zealand by Pacific peoples are higher than the national average. Pacific peoples frequently present late and/or when an illness is in an acute condition (Ministry of Health & Ministry of Pacific Island Affairs, 2004b). This latter finding is consistent with experiences within health of the Pacific migrant population in the United States (Barwick, 2000).

Davies et al. (2005) identified that, of the Pacific patients utilising the New Zealand healthcare system, the majority were socially disadvantaged and almost 50% resided in the lowest decile areas. Clinicians in this study identified this group as having relatively poor social support and as being much less fluent in English than patients overall (Davies, Suaalii-Sauni, Lay-Yee, & Pearson, 2005; Ministry of Health, 2002a). Evidentially, health outcomes among Pacific people (and most ethnic groups) reflect a combination of socio-economic and cultural factors (Ministry of Pacific Island Affairs & Statistics New Zealand, 2002).

Overall, the literature identified that Pacific peoples living in New Zealand face a number of social and economic disparities, in the areas of health, education, employment, income and housing when compared with the total New Zealand population (Mental Health Commission, 2001; Ministry of Pacific Island Affairs & Statistics New Zealand, 2002).

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1 Crowding is defined as more than two occupants per bedroom.

1.4 A Profile of the Non-Regulated Health Workforce

1.4.1 The history and development of CHWs and VHWs

The theory and practice of Community Health Workers (CHWs) and Volunteer Health Workers (VHWs) has existed for almost 40-50 years. These roles were initially developed in response to an inability of conventional health services to deliver basic healthcare to those of marginalised communities (Lehmann et al.2004).

In 1987, Berman, Gwatkin and Burger reported on community-based health systems throughout the Third World and identified that they were not only widespread, but that they had been in operation since the 1940s (Berman, Gwatkin, & Burger, 1987). This finding is premised on a community health worker scheme in Peru that provided *"curative care, health education and other preventative activities"* (Berman et al., 1987, p. 448) and the *"barefoot doctors"* movement in China (WHO, 2008). Barefoot doctors were farmers who received minimal basic medical and paramedical training and worked in rural villages in the People's Republic of China to primarily bring health care to rural areas where urban-trained doctors would not settle. They promoted basic hygiene, preventive health care, and family planning and treated common illnesses. The system of barefoot doctors had a significant influence on international health ideology and was one of the most important inspirations for the WHO conference in Alma Ata, Kazakhstan where the Alma Ata Declaration was signed in 1978. It called for the participation of local communities in deciding health care priorities, an emphasis on primary health care and preventative medicine, and sought to link medicine with trade, economics, industry, rural politics and other political and social areas (WHO, 2008).[2] This movement, which allowed paid CHWs

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2 The barefoot doctor system was dismantled in 1981 with the abolishment of the commune system of agricultural cooperatives. Barefoot doctors were given the option to take a national exam, and if they passed they became village doctors, if not they would be village health aides.

to receive a year's training to serve in their communities, led to a number of countries experimenting with the CHW/VHW concept (Berman et al.1987; Lehmann et al.2004). In 1989, Walt, Perera and Heggenhougen identified that CHWs had become a *"prominent feature of many [Primary Health Care] PHC programmes in developing countries"* (Walt, Perera, & Heggenhougen, 1989, p. 599). These programmes were either small-scale non-government, non-profit projects or large-scale national programmes that were supported by respective ministries of health as part of their primary healthcare system (Walt et al., 1989). In the U.S., the use of CHWs emerged in the 1960s (Swider, 2002; Witmer et al.1995) and re-emerged in the 1980s (Swider, 2002). In addition, since the 1970s, the World Health Organisation (WHO) promoted the use of community health workers. This was instigated by *"reports of successful experiences of numerous small-scale, locally initiated community health worker projects throughout the world"* (Berman et al.1987, p. 444).

The early roles of CHWs/VHWs were as advocates for the community and agents of social change. These workers functioned as a community voice in the combat against inequities, and advocated the rights and needs of communities to government structures and officials. As well as being advocates, CHWs/VHWs were also healthcare workers. More recently, the VHWs' role has shifted to a predominantly technical and community management function, responsible for providing links between the community and health services (Andrews et al.2004; Lehmann et al.2004; Ramontja, Wagstaff, & Khomo, 1998).

There is an emphasis worldwide on developing the non-regulated health workforce, which is predominantly influenced by workforce shortages in the health sector. There is an increasing demand for workers, particularly since these workforce shortages are projected to continue (Acqumen Quality Solutions, 2006; Chen et al.2004; Health Workforce Advisory Committee, 2005a; Ministry of Health, 2006a). Internationally, global trends affecting health

employment and labour include an ageing population, increasing globalisation and the role of migration (Acqumen Quality Solutions, 2006; Chen et al.2004; Health Workforce Advisory Committee, 2002a; Hongoro & McPake, 2004; Lehmann et al.2004).

In New Zealand, the development of the non-regulated workforce has been a recent phenomenon, with the mental health sector undertaking a significant amount of work towards developing this workforce (Acqumen Quality Solutions, 2006; Mental Health Commission, 2001b; Ministry of Health, 2002; WHO, 2007). There is increasing importance being placed on the non-regulated health workforce with calls to attract, resource, support and develop the competencies of this workforce to provide high quality care and increase workforce retention (Ministry of Health, 2006b).

Nationally and internationally there is increasing recognition of the cultural and holistic ideologies of health for cultural and ethnic minority populations (Mental Health Commission, 2001b; Ottawa Charter, 1986). In particular, a need to increase and develop the Pacific health workforce has gained significant political momentum and MoH has recognised that the number of Pacific workers in the health sector should at least match the population profile *(Pacific Health and Disability Workforce Development Plan,* Ministry of Health, 2004). Various factors have influenced the recognition

of the need for an increased Pacific health workforce, these include:

- Growing health disparities and inequalities between Pacific peoples and European New Zealanders
- 'Failure' in existing delivery systems to provide adequate and accessible services to this population group[3]
- Understanding the importance of cultural values and practices in the efficacy of assessment, treatment and rehabilitation. (Health Workforce Advisory Committee, 2002a).

These trends have influenced changes within New Zealand's health service delivery and influenced the development of Pacific (and Maori) workforces to assist in meeting these needs (Health Workforce Advisory Committee, 2002b). The implementation of the Primary Healthcare Strategy has seen improvements in access to some services (e.g. GPs) since the Health Workforce Advisory Committee (HWAC) report.

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3 These failures are partly explained by the poor responsiveness of current health practitioners to the needs of Pacific peoples.

1.4.2 Defining the non-regulated workforce

Within New Zealand and internationally, two main workforce bodies play a significant role in the provision of healthcare services. These bodies are the 'non-regulated' and 'regulated' workforces (each differs in terms of for example, their governance protocols, their roles, funding priorities, and training opportunities). While there is a plethora of literature informing the health sector on the regulated workforce, there is a scarcity of information on the non-regulated workforce.

Non-regulated workers are defined by Witmer et al. (1995) as:

> "[those[4]] who work almost exclusively in community settings and who serve as connectors between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, [they] respond creatively to local needs."
> (Witmer et al.1995, p. 1055)

Acqumen Quality Solutions (2006) provides the following definition:

> "People who have direct personal care interaction with clients, patients or consumers within the health and disability sector and who are not subjected to regulatory requirements under health legislation. This includes all people (paid or unpaid) who interact with clients, patients or consumers within the health and disability sector, who are not subject to regulatory requirements under legislation or other means. This workforce also provides a lot of social, practical (including information, coordination, advice and cultural support) and advocacy that supports the full continuum of care."
> (Acqumen Quality Solutions, 2006: 4)

Literature identifies that there is no single definition of the non-regulated workforce.

International and national literature also illustrates that there are many terms and titles used to describe non-regulated workers. Internationally, there are numerous terms and, in particular, in the UK there are approximately 300 titles used. Usually the terms used are according to the issue they are intended to address and respond to. These terms include: healthcare assistant workers (HCA), community-based workers, cadre, village health workers (VHW), community resource persons (CORP), community rehabilitation facilitators (CRF), HIV/AIDS communicators (HAC), home-based care (HBC) workers, first aid workers, lay health workers, auxiliary health workers, canvassers, community health advisers, community health advocates, community health aides, community health representatives, community health workers (CHW), community helpers, community workers in human services, *consejera*,[5] family health counsellors, family health promoters, health aides, health assistants, health education aides, healthcare expediters, health facilitators, health guides, health hostesses, health liaisons, health outreach workers, health promoters, indigenous environmental workers, indigenous health aides, indigenous health professionals, indigenous lay workers, indigenous workers, informal helpers, lay community health workers, lay health advisers, lay workers, natural caregivers, natural helpers, navigators, neighbourhood-based public health workers, neighbourhood representatives, non-professional workers, outreach workers, paraprofessionals, peer counsellors, peer educators, *promoters*,[6] public health aides, *raid at refits*,[7] resource mothers, and volunteer health educators, nutritional educators, paravets, community captains, technical assistants, paralegals, tutor farmers, pump attendants, research assistants, social workers, traditional birth attendants and village health guides (J. Andrews et al., 2004; Lehmann et al., 2004).

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5 *Consejera is a term referred to lay health advisors from migrant farm worker camps in Northern California.*

6 *Promotoros is a Latino term for health advocate*

7 *Radiat Rifiat is the Arabic term for community worker.*

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4 *Referred to in the article as 'community health workers'.*

In New Zealand, the following terms have been used to describe non-regulated workers: community health workers (CHW), healthcare assistants (HCA), orderlies, cultural support workers, support workers, community homecare workers, whanau ora workers, Plunket workers, mental health workers, youth workers, compulsory care coordinators, cultural assessors, care givers, care workers, care assistants, care managers, care support workers, mental health support workers, nurse assistants, care givers, nurse aides and rehabilitation assistants. Pacific-specific terms include matua, interpreters, consumer advisers, traditional healers, community support workers, cultural advisers, family advisers, interpreters and service administrative staff (Kirk et al.2006; Mental Health Commission, 2001, 2001b; Parsons et al., 2004; Suaalii-Sauni et al., 2007).

1.4.3 Role definition

The roles undertaken by CHWs are broad and have numerous definitions and classifications (WHO, 2007). Although it is difficult to identify all CHWs roles, studies have attempted to identify role descriptors (Andrews et al.2004; Hongoro & McPake, 2004; Lehmann et al., 2004; Rosenthal, 1998; Swider, 2002).

Rosenthal (1998) identifies that seven core roles are undertaken by CHWs. These include:

1) cultural mediation

2) informal counselling and social support

3) providing culturally appropriate health education

4) advocating for individual and community needs

5) assuring that people get the services they need

6) building individual and community capacity

7) providing direct services.

Similarly, the Center for Public Awareness (1999 as citied in Swider, 2002) describes four main functions, which include:

1) increasing healthcare access for clients

2) strengthening the local economy

3) strengthening clients' families and their community

4) decreasing healthcare costs.

In a review on the use of CHWs with ethnic minority women, Andrews et al. (2004) identifies that CHW roles vary and depend on the circumstance of clients. These authors summarise four primary roles that are undertaken by CHWs to fulfil the functions noted by Rosenthal (1998) and the Center for Public Awareness (1999 as citied in Swider, 2002). These primary roles are educator, outreacher, case managers and/or data collectors.

A review conducted by Swider (2002) implies that there are two role categories for CHWs that are defined by a) target population groups, such as teenagers, mothers, ethnic minorities and older people, or b) clients with particular health conditions.[8] In line with Swiders view on role categories, Lehmann et al (2004) elaborates further and defines CHW roles by generic and specialist roles. However, these roles are differentiated by levels of expertise, training and knowledge on particular health interventions rather than by target groups. Lehmann et al. (2004) exemplifies generic roles through CHWs working on African health programmes that perform not only health related but also developmental functions (for example, treatment of diarrhoea, simple wound treatment and family planning tasks). Specialist CHWs are identified as those who work within particular focus areas such as maternal, child and reproductive health and family planning, malaria, food security and nutrition and community rehabilitation (Lehmann et al.2004).

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8   Health conditions may include and are not limited to diabetes, cancer, asthma, substance abuse (Swinder 2002).

In line with Lehmann et al. (2004), Hongoro and McPake (2004) define CHW roles by general primary care functions and specific activities. General primary care functions include the treatment of diarrhoea, immunisations, health education and nutrition, environmental sanitation and malaria control, whereas specific activities include DOTS[9] supervision, family planning, rehabilitation and nutrition.

Overall, a consistent role description for CHWs is the undertaking of tasks that are required to address particular health issues and that require direct, multiple and non-clinical interaction with client(s) to improve health outcomes.

1.4.4 Demographics of the non-regulated health workforce in New Zealand

Internationally, it is estimated that the general health workforce consists of 100 million people, 24 million doctors, nurses and midwives and at least three times more uncounted informal, traditional, community and allied workers (Chen et al.2004). Comparatively in New Zealand, there is a serious lack of accurate and timely data on the non-regulated health workforce, which makes it very difficult to ascertain recent and actual numbers of all PNR health workers, where they are located and the work that they undertake (Acqumen Quality Solutions, 2006; Health Workforce Advisory Committee, 2002b; Ministry of Health, 2007).

In 2002, there were approximately 67,000 health practitioners (i.e. doctors, nurses etc), 30,000 support workers and 10,000 alternative/complementary health workers that delivered health services to the New Zealand population. The non-regulated health workforce accounted for 40% of the total health workforce (Health workforce Advisory Committee, 2002). More recently, a study by Parsons et al. (2004)

found that there were 30,301 support workers employed by the disability support services. However, these authors predict that there could be between 40,000 and 50,000. Data for the number of non-regulated workers within the mental health field is currently unavailable. However, it can be assumed that the total population of non-regulated workers across all health sectors is above the projections of the disability sector (Parsons et al., 2004b).

Recent evidence suggests that Pacific people are significantly under-represented in both the regulated and non-regulated health workforce (Acqumen Quality Solutions, 2006; Foliaki & Pearce, 2003; Ministry of Health, 2006a). Despite this, there remains a paucity of literature and research specific to the PNR workforce. General population research on the non-regulated workforce provides a small insight into PNR workers.

General population research illustrates that the non-regulated health workforce is largely characterised by females, with no or lower level of qualifications, and largely an older-aged workforce between the ages of 40 and 60 years[10] (Acqumen Quality Solutions, 2006; Brandt et al.2004). Brandt et al. (2004) also identifies that the majority of workers in the disability support workforce (excluding mental health) are part-time. Parsons et al. (2004) identifies that the number of hours worked in a week by support workers varies greatly. On average, all support workers work a total of 24 hours, while home-based and residential support workers work an average of 13 and 25 hours respectively. Staff turnover is high and varies considerably between the residential sector (29%), home-based sector (39%) and the mix of residential and home-based sectors (22%). Generally, high levels of recruitment indicate a growing industry. Alternately, it can also suggest high staff turnover rates and poor retention. Another characteristic of this workforce population is that many in the

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9 *Directly Observed Therapy Short-Course*

10 *Of interest, the non-regulated workforce also has a large number of workers who are of 70+ years.*

Auckland region have language difficulties with spoken and written English. Of interest to the current study, Parsons et al. (2004) indicates that there is a sizeable number of disability support workers (37%) who have a Pacific language as a primary language.[11] Figures from Parsons et al. (2004b, p33) suggest that in 2004, Pacific peoples composed 3.7% (n=71) of the total disability support worker group (n=1, 926).[12]

The Mental Health Commission (2001) estimates that Pacific peoples make up 2.5% of the mental health workforce (i.e. n=149) and, of those, approximately 54.9% are non-regulated workers (i.e. n=82)[13] (Mental Health Commission, 2001). The mental health service study identified that over half the Pacific workforce (including both regulated and non-regulated workers) is aged between 25 and 38 years and that the majority of workers fall in the 25 to 52 years age bracket. It also suggests that about two-thirds of the Pacific mental health workforce have been in their current position for three years or less. Just over half the survey participants had a certificate, diploma or degree qualification in a health area. It is important to note that, although all participants claimed to have formal qualifications, anecdotal evidence suggests that a high number of the Pacific workforce do not. It is likely that a majority of those who did not respond to the question have no formal qualifications (Mental Health Commission, 2001).

1.4.5 Location and types of service delivery

Non-regulated health workers operate out of a number of service delivery sites in New Zealand. Barwick (2000) identifies two typical general service delivery locations. These are:

1) community health centres, which provide a wide range of services and are located close to the practice of one or more General Practitioners (GPs)

2) centres that offer a wide range of services delivered by a range of health professionals and community health workers, often from a range of locations.

In addition, there are also increasing numbers of programmes operating out of church and marae settings (Barwick, 2000).

The typical service-type areas that many non-regulated workers operate from include aged care, community health, Maori health, mental health and addictions (MHA), Pacific health providers, primary health providers, youth and family services and District Health Boards (DHBs) (Central Region's Technical Advisory Services Limited (TAS), 2006).

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11 This percentage is based on the question: "For those who do NOT have English as a first language, please list primary languages" (Parsons et al., 2004: 90).

12 It is important to note that this study may have selection bias in their sample and no reliable way to determine whether the survey population reflected the target population. This alludes to the possibility that there may be an under-representation of Pacific peoples in this population group.

13 The classification of non-regulated workers included: community support workers; residential caregivers; matua; alcohol and drug workers; youth workers. There were also 18 non-respondents that may affect the number of workers noted.

1.4.6 Recruitment and selection

Currently in New Zealand, there is a significant drive from MoH to recruit more community health workers and health promoters within the health sector (Ministry of Health, 2006b). To date there is a lack of information documenting recruitment and selection processes in New Zealand.

Internationally, Ramontja et al. (1998) identifies that selection criteria have been developed but it is argued that this needs to be revised. These authors contend that the inclusion of community and health professional inputs are required to determine the needs of the community and to ensure that an acceptable selection process, training, support and accountability of workers are put in place for successful health outcomes (Ramontja et al.1998).

Research carried out in Africa identifies factors taken into account when selecting non-regulated workers and includes relationships with the community, age, marriage status, literacy, gender and qualifications. Ratings of these characteristics differ according to the region and community served. Some African villages utilise village health committees to select VHWs. Their selection criterion considers age (ideally between 20 and 45 years) and marriage status. Others consider literacy, gender and qualifications. With a few exceptions, CHWs are expected to have several years of primary school education, reading and writing skills, either in English or in the local language (Andrews et al.2004; Hongoro & McPake, 2004; Lehmann et al.2004).

A study by Ramirez-Valles (2001) identifies that females' motive to become CHWs fall into four categories: getting out, serving, learning and women's betterment. These motives are not mutually exclusive. This study concluded that identifying the motives of people wanting to become CHWs is useful for recruitment and retention. This information could help to decrease turnover and tailor activities, tasks and responsibilities to fit potential workers' motives (Ramirez-Valles, 2001).

A report from the Philippines suggests that skilled professionals migrating overseas retrain in a lower level workforce (e.g. from doctors to nurses) in order to ease migration pressures (Hongoro & McPake, 2004). Of interest is a New Zealand programme designed to assist Pacific trained health professionals.

The Pacific Return to Nursing programme developed by Counties Manukau DHB (CMDHB) and funded by Ministry of Health is a recent training initiative (2008) designed to assist Pacific trained nurses become registered to practice in New Zealand. There is presently no transferable nursing registration agreement between New Zealand and Pacific nations and registration rules require people from overseas to pass International English Language Testing System (IELTS) exams as evidence of proficiency in the English language. The programme was established to assist nurses with passing the IELTS. It is currently being run at Manukau Institute of Technology (MIT), and work with AUT, MIT, Unitec and the three Auckland DHBs is in the process of exploring the establishment of a Pacific Nursing Programme for the whole Auckland Region. A similar programme is the Bachelor of Nursing Pacific Programme which has been running for some years at Whitireia Polytechnic in Wellington (Ministry of Health, 2008).

1.4.7 Payment

Compensation for CHWs is important. Some CHW programmes rely on the generosity of volunteers, whilst others financially compensate these workers. The latter identifies that financial recompense has a significant impact on workers' experiences and validates the importance of their work (Mock, Nguyen, Nguyen, Bui-Tong, & NcPhee, 2006). It is well documented both nationally and internationally that the payment for the non-regulated workforce varies and is at the lower end of the wages/salary scale within the health sector (Andrews et al.2004; Lehmann et al.2007; Parsons et al., 2004). In New Zealand, the typical remuneration figure for support workers is estimated to be around $10.80 per hour for support workers within the disability sector and around $18.00 per hour for coordinators. Support workers within residential facilities tend to have higher salaries, whereas most of those employed as home-based support workers are not reimbursed for travel time or costs. This finding, in conjunction with generally lower working hours, could have a significant and negative impact on the pay rates of home-based support workers (Parsons et al., 2004). It is important to note that the New Zealand minimum wage rate was increased in April 2009.

1.5 Non-Regulated Health Workforce Development

1.5.1 The workforce development movement

1.5.1.1 Community development

There has been an increasing global awareness and shift towards meeting the health needs of minority groups (Brach & Fraserirector, 2000; Ministry of Health, 2007; WHO, 2002). The Ottawa Charter[14] provides a platform to develop local community development models of health promotion. This international agreement has had a significant influence on recognising community development models of health provision. The Charter identifies five action areas for health promotion:

1) developing personal skills

2) strengthening community action

3) creating supportive environments

4) building healthy public policy

5) re-orientating healthcare services toward prevention of illness and promotion of health.

The Charter prioritises that individual citizens and their communities must be empowered to take ownership and responsibility for their own wellbeing. There is a profusion of literature on community development and empowerment. Much of this is premised on CHW programmes in the U.S. (Dower, Knox, Lindler, & O'Neil, 2006; Gary et al., 2004; Hiatt et al., 2001; Krieger, Takaro, Song, & Weaver, 2005; Levine et al., 2003; Plescia, Grobleski, & Chavis, 2006; Schulz et al., 2001; Staten et al., 2004; Thomas, Eng, Clark, Robinson, & Blumenthal, 1998).

In New Zealand, Pacific community development and empowerment projects have also been conducted. However, few have been evaluated (Braun et al., 2003; Pacific Heartbeat Foundation Programme & Supported by the National Heart Foundation of New Zealand and Ministry of Health, n.d; Renhazo, 2004).

In the recent past, New Zealand has also experienced significant restructuring within the public sector (Devlin, Maynard, & Mays, 2001; Hornblow, 1997). In 2001, 21 DHBs[15] were established. Guided by the MoH and as stipulated in the New Zealand Health and Disability Act (New Zealand Public Health and Disability Act, 2000), these DHBs have assumed the responsibility for planning, funding, negotiating and managing a wide range of health services to meet the needs of everyone in their district. This new structure supports many aspects of the WHO Primary Health Care strategy. This strategy emphasises the need for:

1) a single district funder responsible for population outcomes and the full range of services to support them

2) health improvement rather than inputs

3) greater community participation in the DHBs

4) equitable population-based funding

5) better integration across health services (WHO, 2002, p. 37).

Under this regime, there has been a fast growth of Pacific and Maori services which the government supports as part of improving access to services towards equity (WHO, 2002). The growth of 'culturally appropriate' services has been most apparent over the past 10 years and has been attributed to the inability or unresponsiveness of mainstream services to deal with the needs of Pacific service users (Barwick, 2000).

As a result, one of the government's priorities is to improve social and economic outcomes for Pacific peoples. Improvements in Pacific health

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14 The Ottawa Charter for Health Promotion is a 1986 document produced by the World Health Organization. It was launched at the first international conference for health promotion that was held in Ottawa, Canada.

15 Auckland DHB; Bay of Plenty; Canterbury DHB; Capital & Coast DHB; Counties Manukau DHB; Hawke's Bay DHB; Hutt Valley DHB; Lakes DHB; MidCentral DHB; Nelson Malborough DHB; Northland DHB; Otago DHB; South Canterbury DHB; Southland DHB; Tairawhiti DHB; Taranaki DHB; Waikato DHB; Waiparaira DHB; Waitemata DHB; West Coast DHB; Whanganui DHB (see http://www.moh.govt.nz/districthealthboards).

are expected to come about through two key mechanisms:

1) improving responsiveness and accountability of public sector agencies to Pacific health needs and priorities

2) building the capacity of Pacific peoples to deliver health and disability services and to develop their own solutions to health issues (Mental Health Commission, 2001b) through provider, workforce and professional development.

Consequently, the Health Workforce Advisory Committee (HWAC) notes an increasing recognition that the 'models of care' approach developed by Pacific providers is effective in addressing Pacific health issues. Common elements in Pacific models of care and service provision include: multi-disciplinary teamwork, a mix of clinical and non-clinical approaches (consistent with the ethos underpinning PHOs), services wrapped around families to support individuals' care, and an understanding by practitioners of Pacific communities and settings and the affect of those settings on health status (Health Workforce Advisory Committee, 2002b; WHO, 2002).

Similarly, the mental health workforce in New Zealand adopts a model of care that seeks to move away from seeing professions in isolation, but which considers the total skill mix available in the statutory and non-statutory sectors. It recognises the inherent value of multidisciplinary teamwork and identifies the need for developing training standards and education to underpin the team approach in meeting consumer needs. This approach involves a patient focus and user involvement. A similar approach is illustrated by the maternity lead carer model (see Technical Report Appendix 2) (Health Workforce Advisory Committee, 2002b; Ministry of Health, 1996). The strengths associated with the use of a community-based model within mental health service development is that it taps into the wealth of talent, expertise and altruism that conventional mainstream methods of service delivery under-utilise (Mental Health Commission, 2001b).

1.5.1.2. Workforce development and management

Literature suggests that workforce development and planning is key to ensuring accessibility to hard to reach groups (Barwick, 2000) and appropriate workforce planning and strategies can generate enormous efficiency gains (Chen et al.2004).

There are a number of international frameworks that have been established to deal with workforce development and planning. A useful example developed in Canada is 'the Canadian framework'. This was designed for the public health sector and proposes a building block approach to strengthening the public health workforce for the 21st century (see Technical Report Appendix 3). This approach requires that the public health sector assemble all the pieces required, to support the right mix of public health providers with the right skills, deployed in ways that best utilise their expertise. This framework takes a systems-based and needs-based approach to human resources, in which planning for public health and human resources (PHHR) is driven by assessing the population's public health needs (rather than past utilisation trends), as well as the needs or requirements of the different service models that jurisdictions use to deliver public health programmes (Advisory Committee on Health Delivery and Human Resources and Advisory Committee on Population Health and Health Security, 2005).

In New Zealand, based on De Geyndt's workforce model (2000 as cited in HWAC, 2002b), the three major components of workforce development include:

1) planning for the quantity and configuration of the workforce

2) educating and training to ensure the quality of the workforce

3) managing to ensure the performance and retention of an appropriately trained workforce (De Geyndt, 2000 as cited in HWAC, 2002b).

Management of the workforce in this country occurs at two levels. Firstly, central agencies such as the MoH and regulatory bodies set policies at the macro level, and secondly, DHBs

and other providers (public and private) deal with operational matters (Health Workforce Advisory Committee, 2005a). Internationally, De Raad (1998) notes that employers are an important management group since they will shape and direct decisions made in the labour health market. This author also shows that central forms of workforce planning have been ineffective and argues that health service providers need to be able to access or develop the skills and knowledge to match the different ways in which health and disability services are best managed and delivered, and to keep abreast of changes in clinical practice and technology. This claim is particularly important to management since empirical studies show that 30–70% of the tasks undertaken by general practitioners can be done, and sometimes are, by nurse practitioners and 'physician extenders' at the same level of quality and patient satisfaction and at much lower cost (Richardson and Maynard, 1995 as cited in DeRaad, 1998).

Chen et al. (2004) identifies three core objectives of workforce management that bring together health and educational sectors for improved performance:

1) coverage

2) motivation

3) competence.

Coverage strategies promote numeric adequacy, appropriate worker skill mixes and outreach to vulnerable populations. Motivation strategies focus on adequate remuneration, positive work and career environments and supportive health systems. Competence is developed via appropriate attitudes and skills education, training for continuous learning, cultivating leadership, entrepreneurship and innovation. Chen et al. (2004) states that these efforts are needed to build national capacity and progress and setbacks need to be monitored for making mid-course corrections to these objectives (see Technical Report Appendix 4) (Chen et al.2004).

With regard to the Pacific population in New Zealand, the need for increased capacity within the health workforce and training for a competent and sufficient Pacific mental health workforce is well documented (Mental Health Commission, 2001b; Ministry of Health, 2004a;

Ng Shiu, 2007). Evidence within the mental health sector suggests that, since there are many Pacific health workers employed in non-regulated roles, there is a clear need for a Pacific Mental Health Workforce Development Organisation (PMHWDO) that allows for capacity building and continues to develop the strengths of this workforce. Kirk et al. (2006) explored the feasibility of such an organisation and found that, in order for PMHWDO to be effective it requires the following:

1) a focus on empowering Pacific consumers and families

2) a focus on actively recruiting and retaining Pacific workers

3) a focus on effective training strategies

4) a focus on developing Pacific mental health managers and leaders

5) a relevance to current mental health practices

6) the capability to secure sustainable core funding (Kirk et al.2006).

1.5.1.3. The New Zealand Health Strategy

Workforce development and planning of the non-regulated workforce has been a relatively recent phenomenon in New Zealand. Only within the mental health sector has there been a significant amount of work conducted to develop the non-regulated workforce. Several New Zealand strategies have some focus on the non-regulated workforce. These include the New Zealand Disability Strategy (2001), the Primary Health Care Strategy (2001), the Pacific Health and Disability Action Plan (2002), Health of Older People Strategy (2002), He Korowai Oranga – Maori Health Strategy and Te Tahuhu 2nd Mental Health Plan (2005) and Te Uru Kahikatea – Public Health workforce development plan. In addition, the District Health Board of New Zealand (DHBNZ) has identified eight priorities that are crucial to sustainable health workforce development and, of these, the non-regulated workforce and Pacific health workforce are identified as important groups (Acqumen Quality Solutions, 2006).

The New Zealand Health Strategy provides the framework within which DHBs and other organisations across the health sector will operate. It highlights the priorities the government considers to be most important, which includes reducing inequalities in health (Ministry of Health, 2002). The government seeks to reduce inequalities in health status by ensuring accessible and appropriate services for all New Zealanders, including Maori and Pacific peoples (Ministry of Health, 2002).

1.5.1.4. Pacific peoples workforce development

Workforce development is defined as any initiative that influences entry to and exit from the health and disability sectors (i.e. education, training, skills, attitudes, rewards and the associated infrastructure) (Health Workforce Advisory Committee, 2003a).

In New Zealand, there is clear recognition of the need to increase capacity and capability of Maori and Pacific public health workforce (Potter, Ley, Fertman, Eggleston, & Duman, 2003). A number of government documents show a commitment to Pacific workforce development. For example:

- Pacific provider development and workforce development is priority 4 of the Pacific Health and Disability Action Plan (2002) (Ministry of Health, 2005a). The related goal is 'to develop a competent and qualified Pacific health and disability workforce that will meet the needs of Pacific peoples'. The plan contains objectives and actions for Pacific workforce development to achieve this goal (Ministry of Health, 2002). Workforce goals from the Plan have been progressed through the development of the Pacific Health and Disability Workforce Development Plan (Ministry of Health, 2004).

- The Pacific Provider Development Fund Purchasing Strategy (PPDF) seeks to increase the accessibility and effectiveness of health services for Pacific peoples. PPDF funding seeks to improve access to health services for Pacific peoples by assisting the development of Pacific health providers and

the Pacific health workforce. A key objective of the PPDF is to develop a competent and qualified health workforce that will meet the needs of Pacific peoples. Given that a tertiary qualified workforce is considered a priority by the MoH, funding is available for providers of Pacific staff to undertake relevant training. Pacific leadership development is a key component of Pacific workforce and provider development. This ministry funding also supports Pacific health workforce awards purposed to develop a tertiary qualified Pacific health workforce (Ministry of Health, 2005a). The CMDHB Pacific Return to Nursing programme has 50 fully funded places for trained Pacific nurses to study to become practicing registered nurses in New Zealand. There are two phases to the programme: the first phase (15 weeks) focuses on assisting students with passing their IELTS. The second phase (10-12 weeks) focuses on clinical competency. In 2008, 32 nurses were completing the training and 14 had sat their IELTS tests (Ministry of Health, 2008).

An evaluation recently conducted on the PPDF reveals that it is an important source of funding for most Pacific providers' capacity and capability development (CBG Health Research Ltd, 2007).

Pacific workforce development requires a trained, experienced and culturally competent Pacific mass of professional people, both clinical and non-clinical, specialist and non-specialist, community and institution based, who are capable of delivering services across the entire health and disability support sectors. Within the mental health sector, developing a sustainable workforce is said to involve implementing proactive practices of recruitment, retention and training of Pacific peoples at all levels, promoting a culture of learning and also Pacific cultural competency standard development and training (Mental Health Commission, 2001b; Ministry of Health, 2002).

1.6 Service Delivery Model Approaches

Although no single CHW model is applicable to all communities and circumstances, there are studies that have identified common characteristics of successful programmes. Success is measured by completion of programme objectives, sustainability or impact on healthcare access, cost and quality (Witmer et al.1995). Other elements of successfully funded, sustainable CHW programmes include having a mandate or mission, identification of specific healthcare needs, a big picture view, an individual or small group of champions, solid outcomes and targeted training (Dower et al.2006).

In addition, a review by Barwick (2000) of almost 100 British studies identified that the following key programme characteristics are important to health outcomes and effectively increasing access to care:

1) a systematic and intensive approach

2) multifaceted delivery

3) a multidisciplinary approach, where there is collaboration between agencies and/or between lay and professional groups

4) face-to-face interaction

5) consideration of whether group or individual strategies are more appropriate to achieve their objectives

6) consideration of the setting within which a programme is to be delivered

7) needs assessment to inform intervention design

8) the implementation of culturally appropriate interventions

9) recognising the importance of the 'agent delivering the intervention' – whether it be health professional, education professional, outreach worker, ethnic health worker, volunteer or peer educator

10) tailored support material for their purpose,

11) recognition that information alone is often insufficient

12) utilising prompts or personal reminders to encourage people to use services or keep appointments (Barwick, 2000).

These characteristics are similar to those identified in the Pacific and mental health models of care.[16] Similarly, the MoH has identified nine best practice principles regarding interventions. They conclude that any intervention should:

1) not make inequalities worse

2) increase people's control over their own lives

3) actively involve users of health services and communities

4) favour the least advantaged

5) take a comprehensive approach, targeting individuals, whanau population groups and the environment

6) foster social inclusion and minimise stigmatisation

7) be effective both in the short and long-term

8) adapt to changing circumstances

9) work with and build the capacity of local organisations and community networks (Ministry of Health, 2002a).

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16 Discussed in more detail in section 1.6.2

1.6.1 A move towards a team-based, multidisciplinary, inter-sectoral approach

Traditionally, models of clinical practice have focused on developing the workforce as a series of discrete occupational groups. Past models of clinical practice and provision of healthcare have not achieved the desired effects with increasing disparities amongst ethnic groups (Ministry of Health, 2006a). There have been increasing expectations for a new public health movement calling for new models of clinical practice.

Previous health workforce structures are not an adequate guide to direct us into the future since emerging technologies generate new and different mixes of competency requirements (Health Workforce Advisory Committee, 2002a). HWAC (2002a) argues that new methods to foster and facilitate positive working relationships between different services and different groups of health practitioners are required to achieve integrated patient-centred care. Scopes of practice can vary within and between occupational groups and these arrangements may be setting-specific. Regardless, these differential scopes should be clearly understood by all concerned. Interaction between health workers from different occupational backgrounds will usually be complementary, but some role extension for various health practitioner groups may be feasible in situations where efficiency gains can be made without sacrificing quality standards, including patient/consumer satisfaction (Health Workforce Advisory Committee, 2002a).

There has been a global shift from individual-practitioner practice towards team-based service delivery, which is multi-disciplinary in nature. These multi-disciplinary team based approaches (MDTs) are required if working in a more patient-centred manner and across primary, secondary and community-based care settings (Health Workforce Advisory Committee, 2002a). As a result, professional roles in many healthcare systems are changing to meet increasing demands for care. The boundaries between professional groups have become blurred, and this has implications for the roles

of others working with them, in particular for assistants (i.e. non-regulated workers) to professional groups (Chang et al., 2000; Spilsbury & Meyer, 2004).

In New Zealand, there is an ongoing evolution of public health theory and practice from a vertical approach to disease prevention and control through public health services, to an integrated approach that is strongly based on inter-sectoral collaboration, working with communities and comprehensive programmes across all of society (Ministry of Health, 2003b). HWAC has deliberately moved away from the traditional disciplinary silo[17] workforce planning approach to a person-centred approach, with an emphasis on interdisciplinary development around people's health needs. Complementing this, the committee has also adopted a systems approach, which considers the systems that influence the work environment and workforce education (Health Workforce Advisory Committee, 2002a).

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17 Disciplinary silo refers to separate professional groupings.

1.6.2 Ethnic specific services

For many who have migrated from the Pacific and who have not been through the Western based education system, a barrier to accessing information and services is the inability to understand or speak English. Making available healthcare providers who are from the same ethnic group (or who can speak the same language as a population facing barriers to access of health services), is cited as a highly effective strategy for improving provision of services to underserved groups (Barwick, 2000; Betancourt, Green, Carrilo, & Ananeh-Firempong, 2003; Clough et al., 2002; Robinson et al., 2006).

There are strong arguments that support the provision of ethnic specific healthcare services, and that services run 'by Pacific for Pacific' give the most benefit to Pacific health consumers. Consultation with Pacific communities in New Zealand since the mid-1990s has shown a consistent preference for 'by Pacific for Pacific' models of care and service provision and the opportunity to access Pacific services whenever possible (Health Workforce Advisory Committee, 2002b; Malo, 2000; Ministry of Health, 2003b). The Mental Health Commission (2001) argues that stronger community-owned Pacific mental health service provision would also lead to better use of hospital-based and specialist mental health services due to greater individual and family awareness of services that effective community involvement would generate (Mental Health Commission, 2001).

In a workforce projection report conducted by the CMDHB (considering the ramifications of growing and developing a Pacific workforce), it was suggested that one third to one half of Pacific consumers might elect to be treated by a Pacific worker given the choice (Counties Manukau District Health Board , 2006a). The Pacific Mental Health community, supported by the MoH and the Mental Health Commission, are adamant that community-based care will deliver greater mental health outcomes for Pacific communities (Pulotu-Endemann, Annandale, & Instone A, 2004). Despite this evidence, it is recognised that not all Pacific people have preferences for services and treatment by someone from their own ethnic group (Counties Manukau District Health Board, 2006).

Opinions on the definition of a Pacific mental health service vary. Some will argue that there is no simple definition of a Pacific mental health service. The concept of a 'Pacific' service is a generic one, yet it must be recognised that Pacific peoples are diverse in culture, language and background. Currently Pacific providers are developing their own models of Pacific health service delivery (including mental health services) according to local needs and priorities. Pacific services may operate in a range of settings. They may be delivered in Pacific NGOs or be delivered by Pacific teams in mainstream settings (Mental Health Commission, 2001b).

A definition by MoH of a Pacific provider is, *"one that is owned and governed by Pacific people and is providing services primarily but not exclusively for Pacific people"* (2005a, p. 6). There is a distinction between Pacific-governed Pacific services and those Pacific services located within a mainstream organisation. Those within mainstream organisations operate within the governance of that organisation and do not meet the definition of a Pacific provider.

The Mental Health Commission (2001) notes that for Pacific NGOs and the DHBs there are some key elements that need to be considered when determining whether a service can be called a Pacific service:

- service delivery that is culturally appropriate for Pacific people
- services provided are for Pacific users, but non-Pacific people may access the service
- the philosophy of the service is based on Pacific values and beliefs
- the service is based on Pacific models of health or models of health that encompass Pacific beliefs and values
- Pacific people are involved in the governance and management of the service
- Pacific people provide a significant number of the staff and health professionals (Mental Health Commission, 2001b).

If one or more of these key factors is absent then a service cannot be considered a Pacific service (Mental Health Commission, 2001b). For many Pacific services, the mode of governance is either an NGO or DHB. While expectations for both NGO and DHB services are similar, there are differences relating to infrastructure and organisational development needs (Annandale & Richard, 2006; Suaalii-Sauni & Samu, 2005).

A study looking at a case-mix classification for mental health services was conducted by Pulotu-Endemann et al. (2004) with DHBs and two Pacific teams within mainstream services. This study was the first of its kind. Despite limitations, the study identified that Pacific people expected mental health services to be culturally safe by way of acknowledging their belief systems and reflecting a holistic approach to wellness. Many Pacific people also preferred to be treated by staff who understood their culture and belief systems. It also identified that Pacific people are not accessing mental health services to the extent that might be expected. The pattern shown was that Pacific people presented late with acute conditions. Evidence also strongly indicated that services need to be in the community and provided 'by Pacific for Pacific'. These findings support the need for more research to be undertaken in the development of appropriate models of care for Pacific mental health consumers (Pulotu-Endemann et al.2004).

Similarly, a U.S. comparative study on Asian American clients using ethnic-specific and mainstream mental health services identified that better treatment outcomes were found for clients using ethnic-specific services (even after controlling for certain demographics, pre-treatment severity, and diagnosis). The average cost of providing the ethnic-specific services was generally higher than for mainstream programmes, but clients tended to utilise these more. There was no such relationship between usage and outcomes for mainstream services (Lau & Zane 2000 as cited in Barwick, 2000).

Another New Zealand study by Davies et al. (2005) compared Pacific patterns in accessing primary healthcare and visits to doctors and found that Pacific patients attending community-governed non-profit providers received much higher levels of service than those at private GPs. This study also found that visits lasted longer, more treatment items were provided (both prescription and non-prescription) and referral rates were higher. This identifies that the levels of service recorded for private GPs were unexpectedly low, although private GPs saw more patients on average than the community-governed non-profit providers (Davies et al.2005).

Mainstream services have also identified the benefits associated with having Pacific staff (Malo, 2000). Malo (2000) identifies that mainstream providers perceive that access to Pacific mental health support workers has greatly improved service delivery. In addition, anecdotal evidence suggests high levels of Pacific consumer satisfaction and mental health gains as a direct result of access to Pacific support workers. It is perceived that these workers have considerably benefited Pacific service users and assisted mainstream providers to better understand the needs of those users (Malo, 2000; Mental Health Commission, 2001b).

Despite these findings, Pulotu-Endemann et al. (2004) claims that there is an insufficient number of Pacific specific community-based mental health services to meet service users' demands. This means that mainstream services must improve in order to meet the needs of Pacific people. Specialist services must be able to provide culturally appropriate treatment to Pacific people in cultural or family settings where possible for the improvement of the inadequacies in health for Pacific peoples. These authors also contend that, regardless of whether a service is 'by Pacific for Pacific' or mainstream, it must provide care that is appropriate to treat the condition that a particular consumer has. Services must also be located close to where consumers live or be easily accessible by public transport.

1.6.3 Church – a vehicle for promoting health for Pacific peoples

In New Zealand an example of easily accessible services are those that are based within church/faith organisations. Over the years, these organisations have combined missionary work with practical work to improve the health, education and social conditions of communities. They also undertake roles similar to non-regulated workers, however their rationale and the challenges that they confront are different. Nonetheless, they provide services to complement the secular providers and are worthy of further investigation (Graddy & Ye, 2006; Lehmann et al., 2004).

The role of the church as a vehicle to promote health and wellbeing for Pacific people has gained momentum over the years. Church-based programmes are increasingly being designed to help improve the health of Pacific people and many utilise the skills of non-regulated workers (Barwick, 2000; Ministry of Health, 2007; Simmons, Conroy, & Scott, 2001). A study by Simmons, Conroy and Scott (2001) suggests that these are effective interventions. This study was conducted on Samoan church congregations in South Auckland. It aimed to look at the impact of health and diabetes education and exercise. Key findings from the study demonstrated that there was an overall improvement of health, reduction in waist circumference and no weight gain in the intervention group over a two year period as well as increase in diabetes knowledge (Simmons et al., 2001).

Another example of church based initiatives is the Health Promoting Church Project (HPC) (a community based/community action initiative aimed at promoting healthier lifestyles in the church setting). The project has been piloted as a partnership between the Pacific Islands Heartbeat (the Pacific health promotion arm of the National Heart Foundation of New Zealand) and two Samoan churches in South Auckland. It aims to assess the appropriateness and effectiveness of the church setting as a vehicle for delivery and promotion of heart health messages. Project components include heart health education programmes focusing on nutrition/cooking demonstrations, physical activity and awareness of heart disease, providing resources, training and support for church health workers. Twenty-five churches in Auckland and five churches in Wellington are involved in the HPC project to-date. These groups are maintaining their healthy lifestyle activities under the leadership of their church ministers and trained team (Komiti) members. The Pacific Islands Heartbeat provides support through regular contact and ongoing training opportunities for Komiti members (Pacific Heartbeat Foundation.n.d).

1.7 The Effectiveness of Non-Regulated Health Workers

The effectiveness of non-regulated workers to the health sector can be assessed by the impact that these individuals have on healthcare access, client/patient responsiveness and perceived quality of care, improved health outcomes and costs. Several studies validate the role of CHWs in improving the health of those they care for (Andrews et al.2004; Barwick, 2000; Brach & Fraserirector, 2000; CBG Health Research Ltd, 2005; Dower et al.2006; Grayson, Horsborough, & Lennon, 2006; Hadley & Maher, 2000; Lam et al., 2003; Lehmann et al., 2004; Levine et al., 2003; S. A. Lewin et al., 2006; S. A. Lewin, Dick, J., Pond, P., Zwarenstein, M., Aja, G., van Wyk, B., Bosch-Capblanch, X., Patrick, M, 2005; Ministry of Health, 2006b; Primoro et al.2006; Pulotu-Endemann et al., 2004; Schmeller, 1998; Schulz et al., 2001; Swider, 2002; Thomas et al., 1998; Tse et al., 2004; Wagner, Engelstad, McPhee, & Pasick, 2007; Walker & Jan, 2005). International literature describing the effectiveness and impacts of non-regulated heath workers is discussed within the following sub-sections:

- increased access
- increased client knowledge
- behaviour change
- improved health outcomes
- cost effectiveness
- other outcomes.

1.7.1 Increased access

There are conceptual and methodological issues in measuring access to care with the main concern being that various measures are used across different studies. Barwick (2000) argues that the traditional method of measuring access (i.e. focusing only on one's ability to enter the health system) requires supplementary efforts to measure whether or not individuals have access to *effective* and *appropriate* healthcare. Notwithstanding these issues, it is important to illustrate studies that have addressed the role of non-regulated workers in this area.

Barwick's (2000) study showed that lay workers who have the trust and respect of their communities can facilitate access for other health professionals and services (Barwick, 2000). Brach and Fraserirector also found that members of minority communities were used to reach out to other community members, as well as to provide direct services such as health education and primary care. These members were known and respected by the community and were mandated to act as liaisons and guides to the health system. They effectively introduced individuals (who had not previously sought care) to health services, provided cultural linkages, overcame distrust and contributed to clinician-patient communication that worked to increase the likelihood of patient follow-up. These members were also able to provide cost-effective health services to isolated communities that previously had little access (Brach & Fraserirector, 2000). Consistent with these studies, the CBG Health Research (2005) showed that CHWs successfully overcame many of the intangible barriers to access by building trust and relationships with marginalised clients (CBG Health Research Ltd, 2005).

In the U.S. an integrative analysis of 24 studies by Andrews et al. (2004) identified that CHWs improved access for ethnic minority women to prenatal care, mammography screening, pap testing, sick-child visits, pre- and postnatal care, STD testing, smoking cessation programmes and maternal-child health visits (Andrews et al.2004). Also, a literature review by Swider (2002) examining the effectiveness of CHWs in community health promotion and disease prevention efforts, identifies a plenitude of studies acknowledging the effectiveness of CHWs on increasing access to care, particularly in hard-to-reach, low income and ethnic minority populations. The review also illustrated outcomes in the areas of increased health knowledge, improved health status outcomes and behavioural change, with some demonstrating inconclusive results. Some of the studies in Swider's (2002) review illustrate the effectiveness of CHWs on increasing mammogram rates amongst low-income

African American women and increasing Vietnamese women's recognition, receipt and maintenance of pap tests, clinical breast exams and mammograms. Interventions that influenced these positive behavioural changes were CHW educational sessions, health fairs and distribution of culturally appropriate health education resources in local GPs. It is suggested that, whilst mass media is appropriate for raising awareness, multiple face-to-face CHW contacts are required for behavioural change. Another study examining the effectiveness of CHWs on helping low-income women access care for basic screening services such as mammography and pap tests found that the CHW group had higher rates of screening follow-up for those who were overdue for screening, across age and insurance status (Swider, 2002).

1.7.2 Increased client knowledge

Five studies analysed by Andrews et al. (2004) showed positive outcomes in participant knowledge following CHW interventions. For example, a study on Latino farm-working women found that they had increased knowledge about general health practices; Cherokee and Lumbee women had increased knowledge of cervical cancer; African-American women reported knowledge of diabetes-related self-care priorities and African-American and Hispanic homeless women showed increases in AIDS knowledge as a result of CHW educational interventions. Two studies that did not show improvements in knowledge change had several limitations such as high attrition rates, small sample sizes and a lack of standardised instruments.

Two studies assessed the effectiveness of CHWs in increasing client knowledge in relation to health maintenance and disease prevention. One study group were newly diagnosed diabetics who were all attending a diabetic education seminar/workshop. CHWs were found to be effective in keeping clients in this programme thus leading to increased knowledge, changes in health behaviours and improvement in health status (Corkery et al. 1997 as cited in Swider, 2002). The other study documented knowledge improvement and

decreased needle and sexual risk behaviours among those receiving the CHW intervention in a population at risk for HIV (Birkel et al., 1993 as cited in Swider 2002).

A study by Brach and Fraserirector (2000) found that CHW intervention led to improvements of breast screening practices and a higher retention in patient education programmes, increased follow-up and better cervical cancer knowledge and screening practices.

A University of Auckland Pacific SIDS (Sudden Infant Death Syndrome) prevention programme employed community SIDS educators whose roles included community consultation, raising awareness and printing of materials. The use of community SIDS educators was noted as enhancing community participation as well as awareness. It was also noted that the most efficient and culturally appropriate strategy to advance SIDS awareness in the Pacific community was to train CHWs from different language groups. A total of 30 participants were recruited and trained using a unique and pioneering training approach (Finau, Finau, Fuamatu, & Tukuitonga, 2003).

1.7.3 Behavioural change

In the integrative studies looked at by Andrews et al. (2004), five found that, following CHW educational interventions, clients showed positive behaviour change. For example, weight loss was observed in a church-based African-American population and a longer duration of breast feeding was found amongst African-American women who received CHW interventions. Also, reductions in non-injection drug use and the number of multiple sexual partners, and an increase in contraceptive use with homeless ethnic minority women was identified, as well as an increase in physical activity in African-American women with Type II diabetes (Andrews et al., 2004).

Other studies reviewed by Swider (2002) confirm via self-reports that CHW interventions have a positive impact on changes in behaviour. For example, changes in HIV risk behaviours and recruitment of people from hard-to-reach communities into smoking cessation programmes have been observed.

Noel (2005) explored the effectiveness of utilising health educators charged with promoting larval control of Aedes aegypti, the vector of dengue fever in New Caledonia. These health educators hired for their communication abilities were given training about dengue fever and in communications, and they were then supported and assessed right through to the end of the programme. A two-part assessment made it possible to verify the quality of the agents' work and its impact on the population's behaviour towards larval breeding areas over time. Results showed a significant decrease in the percentage of dwellings with potential breeding areas after the health educators' visits, an impact that was maintained at least three weeks later (Noel, 2005).

1.7.4 Improved health outcomes

Positive changes in health status are the ultimate objective of all health interventions. Such changes have been identified in CHW interventions (Primoro et al.2006; Schmeller, 1998) and, whilst it is not possible to explore all interventions, some examples are provided below that demonstrate the effectiveness of CHWs in this regard.

Swider (2002) identifies three studies that document positive health outcomes. Two studies examined CHW effectiveness on child health outcomes in low-income families. A study of pregnant women with a family history of the genetic disorder PKU[18] demonstrated that the active involvement of a CHW significantly influenced participation in the study and led to improved health outcomes. The study found statistically significant increases in standardised measures of infant head circumference at birth and infant development scores, as well as a decrease in time required for the mothers to achieve metabolic control. Similarly, in the review conducted by Lewin et al., (2005), CHWs were found effective in promoting immunisation uptake and improving outcomes

for acute respiratory infections and malaria, when compared with usual care. There were also promising benefits of CHW interventions in increasing breastfeeding and in decreasing death in the elderly through home care services (Lewin et al.2005).

Swider (2002) also identifies that CHW home visits and education to low-income African-American families with infants suffering from non-organic failure to thrive resulted in significant growth increases and fewer decreases in language development. In addition, these children were exposed to a more child-centred environment than other intervention groups. Another study reviewed by Swider (2002) of homeless mentally ill clients showed that, of two community interventions, the one provided by a CHW resulted in a significant decrease in psychiatric symptoms compared with traditional case management.

A study in the U.S. looked at the effect of a bicultural CHW on the completion of diabetes education in an inner-city Hispanic population. It evaluated the impact of the programme on patient knowledge, self-care behaviours and glycaemia control. It found that there were improved rates of programme completion and improved patient knowledge, self-care procedures and glycaemia control amongst those patients in the group managed by the bicultural CHW, resulting in improved health outcomes (Corkery et al., 1997 as cited in Barwick, 2000).

In a New Zealand study, the role of a diabetes midwifery educator[19] in a pregnancy service at Middlemore hospital revealed improved health outcomes. Overall, the introduction of this role was associated with substantial reductions in resource utilisation with an improvement in glycaemic control and postnatal follow up. In particular, these included the reduced use of insulin therapy, maternal glycaemia and total pregnancy length of stay. Birth weight and the proportion receiving Caesarean delivery were found to be low and the proportion starting

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18 PKU stands for 'phenylketonuria' which is a genetic disorder. It is a rare condition in which the body does not properly break down (or metabolise) an amino acid called phenylalanine. PKU is inherited and passed down through families.

19 The Diabetes midwifery educator combined the role of practising mid-wife and diabetes educator. The role included home visiting, telephone stabilisation, diabetes education and pregnancy/postnatal midwifery support.

insulin as outpatients and returning for oral glucose tolerance tests increased (Simmons et al., 2001).

1.7.5 Cost effectiveness

The involvement of CHWs in programmes and interventions are often touted as more cost-effective and are also seen to be more apt in accessing hard-to-reach communities than regulated health professionals. In comparison with other healthcare providers, CHWs are relatively inexpensive to train, hire and supervise (Andrews et al.2004; Lehmann et al.2004; Swider, 2002; Thomas et al.1998; Walker & Jan, 2005; Witmer et al.1995). Because of this, CHWs are expected to improve the overall coverage of services as well as equity (i.e. increased service use by marginalised communities). Despite these views, there is limited data on the cost effectiveness of CHW programmes to confirm these claims (Dower et al.2006; Walker & Jan, 2005; WHO, 2007). While some studies demonstrate the cost-effectiveness of CHWs, it is important to note that cost-effective analyses:

> "...miss key elements of CHW programmes that do not lend themselves to economic analysis, such as altruism, volunteerism, community norms, reciprocity and duty, and these tend not to be reflected well in estimates of cost-effectiveness and hence are insensitive to a range of social benefits (including community mobilization), which often constitute the strength of CHW programmes."
> (WHO, 2007, p. 2)

Notwithstanding this, examples below demonstrate, at least at a micro-level, the cost-effectiveness of CHW programmes.

Two studies in the review by Andrews et al. (2004) showed improved outcomes and reduced costs related to the use of CHWs. One study explored the use of community health aides with native Alaskan women living in remote villages. In terms of cost-effectiveness, the use of CHWs was found to provide direct pap and sexually transmitted disease testing within their own villages, which meant that travelling costs were not incurred for both the CHWs

and clients. Also, highly trained clinicians did not have to travel to the villages in order to perform pap tests (Sox, Dietrich, Goldman, & Provost, 1999). The other study by Barnes-Boyd (2001) compared two infant mortality-reducing programmes with African-American families living in Chicago. In comparison to a nurse-led team, the results of the CHW intervention team found that infant health problems and developmental levels were equivalent to the nurse-led programme, but significantly more infants were fully immunised at 12 months. This result highlights the potential to achieve desired outcomes in a cost-effective manner (Barnes-Boyd, Fordham, & Nacion, 2001).

The cost-effectiveness of CHWs is also noted in a 1997 study by Wlkinson, Floyd and Gilks. The study illustrated that the cost to both health service and patient can be greatly reduced by using community-based directly observed therapy (short course) (DOTS) for tuberculosis in South Africa (Wilkinson, Floyd, & Gilks, 1997). This strategy was found to be more cost-effective than hospitalisation or sanatorium care.[20] Similarly a study led by Floyd compared strategies for new smear-positive pulmonary patients and for new smear-negative pulmonary patients. These strategies differed in healthcare hospital and community-based settings. The authors conclude that there is a strong economic case for community-based interventions (Floyd, Skeva, Nyirenda, Gausi, & Salaniponi, 2003).

Although the above studies demonstrate the cost-effectiveness of non-regulated workers, there are other studies that show costs do not differ between the use of CHWs and other health professionals (Swider, 2002).

Measures of cost-effectiveness is difficult and many authors advocate the need for further work in this area with comprehensive measures of both costs of care and costs avoided through prevention (Lehmann et al.2004; Swider, 2002).

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20 However when compared to routine self administration of treatment at home, there was no assurance that DOT had any quantitative effects on cure or treatment (Volmink & Garner, 2006)

1.7.6 Other outcomes

Besides effectiveness in increasing access to health services, increasing client knowledge, behaviour change and improved health outcomes, evidence (qualitative data and process evaluations) also suggests that CHWs promote social support, cultural competence and are found to improve quality of life (Andrews et al.2004; Primoro et al.2006).

CHWs are considered to have inherent skills that other health professionals may lack, such as cultural knowledge and experiences with the community. On this premise, they are seen to provide culturally specific emotional support (i.e. listening, showing trust and concern), informational support (i.e. providing advice, suggestions, directives and referrals), and appraisal support (i.e. giving affirmation and feedback). CHWs are also able to assist in accessing unused resources within the community. Cultural knowledge allows CHWs to develop important capacities to provide culturally competent information and interventions (Eng & Young 1992 and Flax & Erp 1999 as cited in Andrews et al. 2004). In addition, they are shown to be effective in collecting data from consumers in an efficient and reliable manner (Clough et al., 2002; O'Shea et al., 2007). With the right training, CHWs are also able to address both lay and biomedical models and to help bridge gaps between these (Eng & Young 1992 and Flax & Erp 1999 as cited in Andrews et al. 2004). In other words, CHWs, as connectors between the healthcare consumers and providers, are able to translate health and system information into the community's language and value system (Giblin, 1989; Witmer et al.1995).

There is also a renewed interest in the potential contribution of CHWs to child survival. In several trials, there have been reductions in child mortality particularly through case management of ill children by these types of community interventions. However, CHWs are *"...not a panacea for the weak health systems. They will need focussed tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work in."* (Haines et al., 2007, p. 2121)

1.8 Workforce Training and Developmental Pathways

Advocacy for CHW and indigenous worker training and developmental pathways is not a new phenomenon. Much literature documents the need to provide opportunities for continuing education, professional and cultural recognition and career advancement (Giblin, 1989; Mack, Uken, & Powers, 2006; Sibthorpe, Becking, & Humes, 1998; Witmer et al., 1995).

> As Kash, May and TaiSeale (2006) state, "Trained and/or certified community health workers are a potential new and skilled healthcare workforce that could help improve healthcare access and utilisation among underserved populations." (p.32)

These authors assert that access to educational scholarships and low-interest loans would help foster continuing education and career development.

The goal of workforce training is captured well within the Tauawhitia te Wero report which conveys that, *"Training and education must seek to ensure that the right worker is in the right place and time to treat, support and care for users of mental health and addictions services."* (Ministry of Health, 2005c)

1.8.1 Recruitment

Within the health sector, the need for more health workers is clear, but what is less clear is how to attract and recruit Pacific workers into this area. While some international studies have looked into recruitment strategies for minority groups (Avery & McKay, 2006; Hadley & Maher, 2000; Rodriguez, 2004; Tipper, 2004), the need for more empirical evidence on diverse recruitment strategies is warranted (Ng Shiu, 2007). Ng Shiu (2007) argues that successful recruitment strategies are those that are linked to larger systematic workforce development models.

There are three main entry points into public health careers:

1) through community experience

2) as school leavers

3) through other careers (Ministry of Health, 2006b).

However, there is no information on what factors influence Pacific people to take up non-regulated health positions or on the aspirations of this workforce. A report by the New Zealand Health Workforce Advisory committee (2002b) highlights that the main recruitment issue facing non-regulated workers in the disability sector is poor employment conditions. This refers to earnings of approximately $10 per hour, which are stated to attract a workforce typified by secondary earners and people receiving benefits. Current welfare benefit levels mean many restrict their hours of employment to ensure that they are not penalised and lose their benefits. This type of work (support work) is often chosen for convenience and as a last resort rather than as an active career choice (Health Workforce Advisory Committee, 2002b).

Considerable efforts have been expended on attracting more workers through promotion of health careers, scholarships and mentoring support to Pacific peoples.

The MoH funds the Pacific Health Workforce, Pacific Mental Health Workforce Awards, and the Pacific Return to Nursing programme (Ministry of Health, 2008). Under the Pacific Health Workforce and Pacific Mental Health Workforce Awards, Pacific students studying towards a qualification in health and/or mental health are supported for one year. Through the Pacific Return to Nursing programme, Pacific nurses are supported in their studies to become registered and eligible to practice nursing in New Zealand (Ministry of Health, 2008). The MoH also has developed a health careers booklet as part of the Public Health Workforce Development Plan, an initiative designed to build New Zealand's future capabilities in public health. This booklet profiles both non-regulated health positions such as health promoters and CHWs, and regulated health roles (Ministry of Health, 2006b).

1.8.2 Training

In the U.S., the growing role of the CHW as *"a member of a multi-disciplinary team engaged in culturally appropriate health and social services delivery"* has led to the consideration of appropriate training and possible certification of CHWs in many states (Kash et al., 2006: 33).

A study conducted by Brach and Fraserirector (2000) noted that training for community health workers varied and could range from less than 20 hours to more than 100 hours (Brach & Fraserirector, 2000). Additional literature demonstrates that training for CHWs is often short, ad hoc and health-specific (Bamisaiye, Olukoya, Ekunwe, & Abosede, 1989; Schmeller, 1998; Thomas et al., 1998).

A WHO policy brief on CHWs, asserts that training should be practice- and competence-based, and located close to CHWs' working environment. The brief also notes that training materials and activities should be specifically developed for CHWs and that continuing (or refresher training) is just as important as the initial (or orientation) training. A number of studies have found that if regular refresher training is not available, acquired skills and knowledge will be quickly lost (WHO, 2007). Pilcher and Odell (2000) argue that training for CHWs needs to include both the medical and technical aspects of health, and also cover knowledge of environmental, psychological, economic, cultural and social factors that affect health (Pilcher and Odell, 2000).

> In line with this view, Lehmann, Friedman and Sanders (2004) contend, "There must be a study of social and behavioural sciences as well as the life sciences. The resulting approach should be to create a perspective that is not just orientated to curing disease but should see health promotion and provision as a social, as much as a biological science." (2004, p. 9-10)

In New Zealand, a potential career development framework based on the 'National Health Service Career Framework' has been developed (see Technical Report Appendix 5). It is envisaged that the traditional structure of workforce roles and team configurations will be reshaped to better utilise the capacity and strengths of the health workforce (Ministry of Health, 2006a). In addition, The New Zealand

Institute of Economic Research provides classifications for four types of training:

1) employer provided versus other

2) formal certification

3) generic versus specific skills

4) training content (Pells, Steel, Cox, & NZIER, 2004).

Despite these understandings, it is important to note that older workers and those on atypical contracts often fare badly in terms of participation in training. In addition, the most appropriate learning style, length of training programme and content of knowledge may differ by demographic group (Andrews, Cox, Pells & Walton 2006).

Most recently, within the disability support workforce in New Zealand, a formal training programme has been introduced that begins at the foundation level and builds upon existing induction and orientation training that all home-based service providers undertake. This training for support workers has improved knowledge and skill sets needed to work with service users within the disability sector, and positive impacts have been identified on providers, service users and non-regulated workers (Health Outcomes International, 2008).

The mental health and addictions sector in this country identifies various barriers to training for Pacific workers, which consist of structural as well as personal issues. One prominent barrier is that the cost of undertaking training can deter workers from developing a career in this sector. Other barriers include academic study costs, lack of academic support at home, English language difficulties and ongoing family and community obligations (Mental Health Commission, 2001b). Also, the stigma attached to the mental health field and the appeal of the health sector are thought to potentially inhibit training to Pacific students as they consider their career aspirations (Ng Shiu, 2007).

1.8.3 Support and supervision

It is widely acknowledged and emphasised that the success of CHW programmes hinges on reliable support and supervision. It is equally acknowledged that supervision is often among the weakest links in CHW programmes (Bamisaiye et al.1989; Lehmann et al.2004; WHO, 2007). Lehmann et al., (2004) note that clear strategies and procedures for supervision need to be defined at the outset of programmes. Skills need to be taught so that health personnel, CHWs and Community Health Committee members know what is expected of them. Guidelines for supervision should include a list of supervisory activities with the most important element of supervision needing to be a two-way flow of information. It is also vital that the supervisor acts as an appropriate role model (Lehmann et al.2004; WHO, 2007).

1.8.4 Competencies

For any health service, the need to provide optimal delivery of care involves the right provision of care and carer. It also involves the development and integration of cultural and clinical knowledge and the application of these to health service delivery (Suaalii-Sauni & Samu, 2005; Tiatia, 2008). While clinical competencies are set, cultural competencies are being developed. One of the principles of the 2002 Pacific Health and Disability Action Plan states, *"Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound."* (Ministry of Health, 2002, p.2)

The 2002 Pacific Health and Disability Action Plan and the 2004 Pacific Health and Disability Workforce Development Plan emphasise the need to build culturally competent workers. The goals relating to cultural competency include:

1) developing cultural competency standards and training programmes for mainstream organisations delivering services to Pacific populations (2002 plan)

2) promoting Pacific models of care and cultural competence (2004 plan).

The development of cultural competencies is to ensure that workers practice in a culturally safe way. It is a strategy to address ethnic disparities (Betancourt et al., 2003; Brach & Fraserirector, 2000). Acknowledging the Treaty of Waitangi as a guiding document for the treatment and recognition values sacred and important to Maori is a core component of providing culturally safe provision of care to Maori people (Mental Health Commission, 2001a). As Maori and Pacific peoples share some similar values, culturally safe provision of care is also sought. For Pacific people it encompasses the, *"...ability [of carers] to understand and appropriately apply the cultural values and practices that underpin Pacific peoples' world views and perspectives on health"* (Health Workforce Advisory Committee, 2002a, p. 80). Furthermore, the conception of the 'cultural' in cultural competency implies an appreciation of the complexities and multi-dimensional layers of culture and an understanding of the spiritual aspects of Pacific health belief systems (Suaalii-Sauni & Samu, 2005).

1.8.5 Formal certification

There have been increasing calls for the non-regulated health workforce to achieve formal certification and education requirements. Education is a key factor in determining how people fare in the labour market, with improvements in educational achievement by Pacific people being crucial to improving economic positioning. Socio-economic status in turn is likely to influence the comparatively poor health status of Pacific peoples (Ministry of Pacific Island Affairs & Statistics New Zealand, 2002).

Until recently, CHWs were often employed for their personal attributes, rather than for any particular qualification. In the future, literature identifies that CHWs will at least be expected to acquire a Certificate in Community Skills or a Certificate in Health Promotion in order to competently undertake this critical role (Ministry of Health, 2006b). Currently, health promoters require certificate level entry. However there are no courses identified or specified at certificate, diploma and degree level.

There has been a recent development of formal certification standards to meet the needs of the non-regulated health workforce. In the mental health sector, a National Certificate in Mental Health (Mental Health Support Work) was established in 1998 to provide a relevant qualification for the largely unqualified workforce of support workers. In future years there will be a need to add to this generic qualification to enable support workers to develop further skills in areas such as child and youth work (Health Funding Authority, 2000 cited in Mental Health Commission, 2001b.

Other recruitment programmes and schemes in New Zealand for the non-regulated health workforce and/or Pacific health workers include:

- Certificate for Health Support Assistant (level 4) at MIT, in Auckland

- Community Worker course (level 4) Whitireia Polytechnic, in Wellington and Auckland

- Certificate in Pacific Community Health – level 4 pilot (collaborative initiative between The University of Auckland's School of Population Health – Pacific Section & Auckland UniServices, MIT, CMDHB, and WDHB) in Auckland

- Home-based support worker training initiative (MoH and CSSITO), MSD-DHBs

- Caregiver Programme (Hawkes Bay and Nelson Marlborough DHBs; Acqumen Quality Solutions, 2006), in Hawkes Bay and Nelson, Marlborough

- Affirmative Action programmes – Maori and Pacific Island Admission Scheme (MAPAS) and the Certificate of Health Science at The University of Auckland

- Internship/work placement programmes offered by the MoH and HRC aimed to place Pacific students within projects and research teams in the health sector

- Recruitment campaigns/drives – CMDHB's "Whatcha gonna do" Pacific health drive targeting high schools, and HRC "Road shows" promoting awards and seminars

- Scholarship schemes – Pacific Mental Health Workforce Awards promoted through HRC and Pacific Training Scholarship scheme.

Literature emphasises the need for a planned and coordinated approach across funders and various parts of the sector in the area of training for all health workers.

Acqumen Quality Solutions note that:

> "Strong leadership at sector level is needed to ensure appropriate and timely training for the non-regulated workforce. It is recommended that this is developed within a national framework. A trained non-regulated health workforce provides an opportunity for stair-casing into regulated roles into the future." (2006, p. 20)

1.8.6 Up-skilling

In terms of skill mix within the PNR workforce, generic or transferable skills are likely to become increasingly important in the future. This is especially true in a labour market where job tenure is falling and the number of jobs (or careers) an individual may hold in their working life is increasing. However, whether these are "new" skills or whether current skills are finally becoming recognised remains debatable (Andrews et al.2006). Interpersonal and HR skills, analytical, research, networking, negotiation and computer skills are all likely to play an increasingly prominent role. Many commentators note the increasing importance of personal attributes such as motivation, "soft skills" or "emotional intelligence". Andrews et al., (2006) implies that personal attributes are warranted given the new focus on service related occupations (Andrews et al.2006). The shift of policy emphasis from labour utilisation to labour productivity has important implications for skill development. According to the Workplace Productivity Working Group (WPWG), more skilled workers can undertake tasks more quickly and with fewer mistakes, allow more skilled tasks or technologies to be undertaken, require less supervision and perform more complex tasks as well as carry more responsibility (Workplace Productivity Working Group, 2004).

Literature also suggests that industry training is essentially an investment in human capital and it is considered that the economic benefits of this can be shared amongst:

- the individual trainee, through higher wages (a proxy for labour productivity)
- the firm, through enhanced profitability (a proxy for capital productivity)
- the society as a whole, through "externalities" (returns over and above the private returns to the individual trainee or firm who pays for the training) (Pells et al., 2004).

An abundance of literature also alludes to positive wage effects that can be associated with training. On this premise it can be inferred that an industry training qualification is likely to increase the earnings of an individual by between 5% and 20%. In other words, on average, a trainee after industry training is likely to be 5-20% more productive than they would have been otherwise. A consistency in this literature is that those groups of people who gain the most from training, such as those with lower educational achievements and economic status, in fact receive the least amount of training. This implies that returns from industry training could be relatively high, as the previous educational achievements of industry trainees tend to be quite low (Pells et al., 2004).

1.9 Key Challenges to the Non-Regulated Workforce

There are significant challenges in understanding and developing the non-regulated health workforce. This section explores barriers and concerns mainly directed at the roles non-regulated workers undertake - particularly relating to a lack of research, ambiguous job descriptions and organisational management. Also noted, are the unclear practical boundaries between the non-regulated and regulated workers' roles. Discrimination and quality of care are also areas of concern, as well as education and training, supply of workers, language, lack of support, funding, exploitation and structural barriers.

1.9.1 Lack of information

In New Zealand, the non-regulated workforce is a relatively new area of interest in research and, while the contribution of this workforce is of great value to the health sector, there is an urgent need for more information and understanding of both the mainstream and Pacific non-regulated workforce.

The MoH notes that robust and comprehensive data on the characteristics, numbers, locations and occupations of the Pacific health and disability workforce is scarce and, in some cases, nonexistent. The Health Workforce Advisory Committee (2002a) identifies the need for health researchers to investigate, examine and build the knowledge base for effective Pacific health interventions (Health Workforce Advisory Committee, 2002a).

There is little or no significant information on non-regulated health workers. Data collation from professional bodies regulating membership through annual practising certificates and licences were undertaken by NZHIS.[21] Poor recording compounded by inconsistent definitions of ethnicity (Bedford & Didham, 2000) resulted in little comparative ethnic-specific data being available. This has made it difficult to fully characterise the Pacific health and disability workforce or enable comparison with the mainstream workforce.

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21 New Zealand Health Information Service (NZHIS) and Health Pac merged into the Ministry of Health's Information Directorate on 1 July 2008

1.9.2 Ambiguous measures

One of the consistent challenges within evaluation studies of the non-regulated workforce relates to defining what function/role or quality of the non-regulated health worker is actually being measured (Swider, 2002). A literature review by Barwick (2000) that examined improving access to primary care for Maori and Pacific peoples identified that there is little information and evidence (or evidence-based research) on CHW strategies such as home visiting services, language support, transport strategies, the use of technology and multi-faceted strategies (Barwick, 2000).

Spilsbury (2004) found that studies on the HCA role have failed to capture the skills, experience, qualifications and competencies of HCAs and how this relates to their roles and activities. Unfortunately, this lack of recorded information regarding the effectiveness and development has hindered the growth of the PNR workforce. Because of this, there is a potential to undervalue the work of these health workers and even potentially exploit them. A number of studies identify this gap and support the need for rigorous research that identifies areas needed to develop this workforce.

Swider (2002) suggests that the measurement of concrete outcomes could be greatly assisted if roles were conceptualised by the health areas within which non-regulated employees worked, for example diabetes control, pap testing, smoking cessation and so on. A report by WHO (2007) concurs that measures of effectiveness require specific definitions to identify what impacts are being measured and over what period. Similarly Andrews et al., (2004) notes that improved theoretical frameworks and research designs will enhance methods for evaluating effectiveness and increased community involvement.

International evidence provides a similar view. In a review of community-based health workers in Africa, Lehmann et al., (2004) highlights that a major shortcoming in the literature is the large number of evaluations of short-term research intervention projects rather than systematic descriptions of ongoing problems. This means that there is a lack of

information on organisational and training aspects of CHW programmes and identifies that this is an area in clear need of attention. Swider's (2002) integrative literature review on "Outcome Effectiveness of CHWs" argues that documentation on the effectiveness of CHWs on important health concerns is necessary prior to the investment of public resources on activities such as curriculum development and certification. Swider (2002) also identifies that sabotage of the CHW role could be influenced by overly high expectations, lack of a clear focus and lack of documentation. This author contends that further research is required with an emphasis on stronger study design, documentation of CHW activities and carefully defined target populations. Also, further work is needed to cost out these services and determine whether the CHW's effect on access to care is cost-effective (Swider, 2002).

Chen et al., (2004) identifies the need to strengthen national data, information, analysis and research in resources for health. These authors argue that all workers should be counted and social attributes and work functions should be collated to improve planning, policy and programmes.

1.9.3 Different sets of evaluation priorities

Potter et al., (2003) highlights that a key issue in the evaluation of workforce development initiatives is that differential sets of priorities underlie the evaluation perspectives of various stakeholders and different kinds of evaluation data serve various sets of priorities. These authors note that the ideal evaluation of a public health workforce development programme should be designed to capture data within four priority areas. These priority areas include federal health agencies (who need to demonstrate accountability to taxpayers) and federal funders and agencies (whose aim is for capacity building and overall improvement in organisational performance). The trainer and trainee (who desire information about the quality and effectiveness of the learning experience and practicality and usefulness of skills) and the academic evaluator (whose research aims to advance the field of science) are also considered priority areas (Potter et al., 2003).

1.9.4 Unclear job descriptions

Literature suggests the role undertaken by non-regulated health workers is often unclear and that there is a strong need for clarity and defined parameters regarding scope of work (Doherty & Coetzee, 2005; Health Workforce Advisory Committee, 2002a; Pilcher & Odell, 2000; Swider, 2002). A further challenge is the lack of recognition, whereby disability support (a major task undertaken by non-regulated workers) is not yet recognised as a profession (Health Workforce Advisory Committee, 2002b).

Barwick's literature review broached ambiguities in the job descriptions of ethnic health workers whereby it was uncertain whether their role was to facilitate and/or provide access to services. Also, despite having job descriptions that did define roles, they were only described as providing linking and facilitating access services (Barwick, 2000). Fuller (1995) found that ethnic health workers often found themselves in positions where clients and co-workers expected them to be responsible for all aspects of healthcare, i.e., beyond their job descriptions (Fuller, 1995).

1.9.5 Health professionals

Literature suggests that traditional hierarchical structures of health professionals may contribute to barriers for inclusion of non-regulated health workers. Lehmann et al., (2004) notes that these professionals are socialised into the hierarchical framework of disease-oriented medical care systems, and have a poorly developed concept of primary healthcare. In a report on bridging the gap in human resources for health, Hongoro and McPake (2004) highlight that professional bodies protecting the interests of their members have played a part in training that promotes a level of specialisation inappropriate to the health needs of low and middle income countries where human resources are in very short supply (Hongoro & McPake, 2004). Also, Begun and Lippincott (1993 cited in DeRaad 1998) highlight that professional associations worldwide have tended to respond defensively to the challenges posed by the re-engineering of delivery processes, pointing to the complex, uncertain and risky nature of healthcare in an attempt to retain control over their domain (DeRaad, 1998). In line with this view, a sense of superiority within health personnel is considered to provide barriers for the non-regulated workforce (Sanders 1992 as cited in Lehmann et al., 2004).

Lehmann et al., (2004) also identifies that health professionals often perceive CHWs as lowly aides who should be deployed as assistants within health facilities, and often completely misunderstand their health promoting and enabling roles within communities. This attitude is considered to stem from a lack of understanding of the purposes, objectives and value of supervising CHWs (Waterston & Sanders, 1987).

Recurrent issues relating to the development of the non-regulated workforce are those pertaining to quality of care. In examining the role of HCAs in the hospital setting, Spilsbury (2004) noted that education and training, registration, regulation and formal mechanisms for reporting and documenting care would ideally introduce further safety mechanisms to ensure and improve quality of care (Spilsbury & Meyer, 2004). CBG Health Research Ltd (2005)

evaluated 35 reducing inequalities projects in New Zealand, and asserts that CHWs should be closely linked with clinical staff and that boundaries for practice needed to be specified (CBG Health Research Ltd, 2005). However, there are reservations amongst practitioners over the idea of team-based deliveries. There are concerns amongst doctors about liability issues since they consider that they are ultimately responsible for patient outcomes and are therefore liable in the event of a medical mishap. Many consider non-regulated staff a risk. As a response, the HWAC argues that risk can be mitigated through the development of appropriate systems of clinical governance and business organisation, especially where there are clear lines of responsibility (Health Workforce Advisory Committee, 2005a).

Healthcare professionals are also concerned that the employment of healthcare support workers in critical care environments to assist nursing staff in performing non-nursing duties will have an adverse effect, reducing the skill mix to an inappropriate level for the delivery of patient care. There is a concern that the workload of registered nurses would increase due to the requirement of supervision for the healthcare support worker (Pilcher & Odell, 2000). However, there are studies that have demonstrated that there can be a successful collaboration between regulated (e.g., nurses, physicians) and community health workers (Sommers, Marton, Barbaccia, & Randolph, 2000; Vetter, Bristow, & Ahrens, 2004).

A report by Daykin and Clarke (2000) explored the use, misuse and non-use of HCAs in a UK hospital setting. There was considerable overlap seen between the work of registered nurses and non-registered nurses. The registered nurses sometimes perceived this overlap of roles as a threat to their role, whereas HCAs viewed these overlaps as an opportunity for role development (Daykin & Clarke, 2000; Spilsbury & Meyer, 2004).

Although improving attitudes involves a complex process of educational and institutional reform, giving medical and health science students specific experience of working collaboratively can assist in developing positive attitudes towards CHWs (Lehmann et al.2004).

1.9.6 Exploitation and misuse of non-regulated health workers

Another challenge that non-regulated workers face is the misuse or exploitation of their role. Misuse refers to situations in practice where workers are assigned tasks beyond the expectations of job descriptions and formal policies and results in exploitation of their role.

In New Zealand, the Health Workforce Advisory Committee (2002a) identifies that Pacific health practitioners face institutional and, in many cases, peer-discrimination that creates inappropriate perceptions about skills and competencies and presents a barrier to career development. Also, organisations that recruit Pacific people are likely to capitalise on the cultural competency of their staff to provide additional services for Pacific service users and many neither acknowledge nor recompense these extra duties and cultural competencies (Health Workforce Advisory Committee, 2002a).

A report by the Mental Health Commission (2001) found that Pacific mental health workers often feel isolated and unsupported, and the highly technical aspects of the job can be very intimidating. It is not always evident that their background and skills are valued, and at times this has resulted in the loss of competent Pacific mental health workers from the mental health sector (Mental Health Commission, 2001).

In the Lehmann et al., (2004) review, the use of volunteers is also described as a form of exploitation. CHWs may be expected to work under difficult conditions, without pay, while professional health workers are not willing to do so (Lehmann et al.2004). Spilsbury and Meyer (2004) note examples of exploitation and misuse of HCAs in a hospital setting. For example, although formal policies exist that outline the work and expectations of HCAs, the dictators of this work are in fact registered nurses (RN) within the wards. Although registered nurses may recognise the available skills, local community experience, knowledge of the organisation and available skills of the

HCAs, they tended not to utilise these skills or knowledge. In addition, HCAs were prevented in using their experience in practice and it was observed that registered nurses did not involve HCAs in discussions about patient care and/or discharges.

Spilsbury and Meyer (2004) also note that in other situations registered nurses in hospital settings admitted to sometimes asking HCAs to do activities that were outside the accepted HCA role. In this example, HCA workers often undertake additional activities that are the role of registered nurses. This can occur in situations where nurses have extensive workloads or inadequate staffing numbers.

Another circumstance in which HCAs are often unrecognised and unrewarded is exemplified in cases where HCAs conceal and amend mistakes and inconsistencies in the work of junior nursing staff, registered nurses or student nurses, all of whom are considered to have higher status (Spilsbury & Meyer, 2004).

Lehmann et al., (2004) identified exploitation of home carers in African settings. Home carers are another type of the non-regulated health workforce who are trained specifically to assist ill people at home (they are reimbursed for transport costs but do not receive a salary).

Home carers employed by organisations such as the Red Cross Society and St John's Ambulance generally work part-time or only a few hours per day. The problems associated with these types of workers are mostly related to exploitation by both the clients and the organisation. Once the home carer is known in the community, expectations rise and they are frequently called upon after hours to assist people. This leads to high attrition rates as the home carers work hours increase, with no pay. In contrast, many CHWs generally remain in their roles because they are remunerated for their experience and level of responsibility. There are also opportunities for CHWs to undertake continuing education and to progress to positions as co-ordinators and project managers. This contributes to the stability of staff in these projects (Lehmann et al.2004).

1.9.7 Lack of formal processes and the effects on quality of care

A lack of formal communication systems between regulated and non-regulated health workers poses considerable concerns over the quality of care provided to clients. Spilsbury and Meyer (2004) note that although HCAs can gather useful information, hospitals often lack systems for the formal transfer of this information to registered nurses. An ad hoc transfer of information often takes place between HCAs and registered nurses, which has significant implications on the quality of patient care. These authors highlight some registered nurses' perceptions that an increasing reliance on HCAs to monitor patients could eventuate, which, in post-operative situations for example, is not appropriate. Some HCAs also report the perceptions of some registered nurses that they are apt to measure and record systematic observations. These are considered erroneous beliefs since some HCAs have received no instruction or training in this area and many have performed these activities with little experience and knowledge. The implications of this on patient care, safety and on nursing systems warrant further investigation (Spilsbury & Meyer, 2004).

1.9.8 Lack of appropriate supervision, education and training programmes

Literature consistently identifies that there is a current lack of appropriate supervision, education and training programmes for non-regulated health workers (Health Workforce Advisory Committee, 2002b; Lehmann et al., 2004; Pilcher & Odell, 2000). In a review conducted by Lehmann et al., (2004) on CHWs in Africa, a need was identified for clear strategies and supervisory procedures for CHWs. These authors found that, although training was often provided for CHWs, this was frequently unrealistic given what CHWs were actually able to achieve in their situation and this has led to unclear expectations of their performance (Lehmann et al.2004).

There is a deep concern about the lack of basic and continuing education requirements or career paths for support workers. The lack of training opportunities for Maori and Pacific CHWs has long been identified as a problem, and has been addressed to some extent through a range of courses now available from Maori and Pacific training providers as well as scholarship funding. There are few nationally recognised training programmes for non-regulated health workers, but there are still concerns that there is no transferable training for healthcare workers (Health Workforce Advisory Committee, 2002b). Training is seen largely to be the responsibility of the employer with few formal links between the home, health industry, training providers and health sector standards (Health Workforce Advisory Committee, 2002b).

A further challenge identified in a report by the Ministry of Health (2004a) found that health education institutions are not effective for many Pacific people. Pathways to careers in health are ambiguous and difficult to access, particularly where schools do not provide adequate career guidance or encouragement to Pacific students. A further challenge for Pacific people in health careers is the poor access to funding and programmes that would support mid-career shifts and retraining, for example, rest home nursing to primary care and women returning from child raising (Health Workforce Advisory Committee, 2002a).

An additional challenge for non-regulated health worker training and development is the language barrier. Formal training and accreditation are delivered almost exclusively in the mainstream environment where proficiency in the English language is a prerequisite (Health Workforce Advisory Committee, 2002b; Ministry of Health, 2004a). A report by Parsons, Dixon, Brandt et al., (2004) of support workers in New Zealand, found that in the Auckland region, high numbers of workers reported to have English as a second language. This study noted that, where English was a second language, communication between service users and support workers as well as support workers and service providers was compromised. This may also have an impact on the safety of services (Parsons et al., 2004b).

An exploratory study by Hind (2000) looked at the potential role of healthcare support workers in the critical care setting and examined the attitudes of nursing staff to the development of this role. Common themes that emerged were the need for shared learning and continuing education for all staff including newly recruited support workers. In addition, training is considered an important determinant of how HCAs as well as RNs viewed the role of non-regulated health workers. RNs placed emphasis on qualifications and credentials to differentiate between the roles (Spilsbury & Meyer, 2004).

Despite this, the Parsons et al., (2004) study of disability support workers in New Zealand identifies that these workers often do not want more education and training as it may cut into family commitments. Salient to this, the more mature workforce may experience anxiety about the academic workload or feel that their days of training and education are over. This study concludes that training and education is a complex issue and that there is no simple solution to providing training for the support worker workforce (Parsons et al., 2004b).

1.9.9 Structural challenges: management and funding

The cultures and practices of health management and the professions can facilitate or hinder beneficial change, and are a significant barrier to achieving a flexible and innovative health labour market that can respond to emerging patterns (Pew Health Profession Commission, 1995). An early evaluation in 1998 commissioned by the Department of Health notes that Maori CHWs experience difficulties in fulfilling their role effectively within existing health service structures (Barwick, 2000). For Pacific providers one of the most critical areas that needs addressing is governance, especially for Pacific NGO mental health and addictions services.

There is a strong case for developing increasing numbers of Pacific people who are experienced and competent in managing complex businesses within a complicated funding environment. These managers are required to grow and develop their organisations within equally complex governance arrangements and community relationships (Health Workforce Advisory Committee, 2002a). It is known that many Pacific mental health and addictions NGOs are lacking sustainable organisational infrastructures, due largely to the lack of secure funding that in turn affects their ability to employ capable staff and managers. The evident shortage of suitably qualified and experienced staff at different levels of Pacific mental health organisations has a great impact on service delivery and user satisfaction. Those most at risk are the voluntary and community sector as they are often built with the support of self-determining communities (Annandale & Richard, 2006; Health Workforce Advisory Committee, 2002a). A response to this has been the provision of the Pacific Providers development funding (PPDF).

The approach that some Pacific leaders suggest is that providers become innovative and look beyond the mental health sector for options to recruit and attract skilled Pacific workers into the sector, especially at the governance level (Annandale & Richard, 2006).

Continued funding remains a significant barrier to the employment and evaluation of work undertaken by CHWs. International literature identifies that the challenge associated with investing in CHW programmes is that CHWs do not replace the need for basic medical services and therefore require additional financing, not only to fund high initial costs, but also recurrent costs for training, management, logistics, supervision and evaluation (Berman et al., 1987; Lehmann et al.2004). Adequate and sustained remuneration is essential to maintain the interest of the CHW and to ensure the stability of a programme (Lehmann et al.2004).
A New Zealand study by Parsons, Dixon, Brandt, Wade et al., (2004) identifies financial support would be an incentive for workers to attend work-based training.

In New Zealand, many Pacific mental health providers experience difficulties in accessing adequate funding. An ability to overcome this would help to provide appropriate service management as well as employ and develop staff with the appropriate skills to deliver services (Mental Health Commission, 2001b). According to the Ministry of Health (2003), funding for Pacific providers has increased; however, this seems inadequate in terms of meeting the demand for Pacific targeted services. A higher level of funding is required for Pacific community based services (Pulotu-Endemann et al.2004).

Funding also has an impact on the retention of Pacific staff. While DHB services are seen to provide better employment opportunities, NGO services face an ongoing struggle to retain staff. NGO staff that undergo further training are often lured away by the prospect of better pay and opportunities offered by DHB services. There is also the notion that DHB services are seen to have a higher status and perceived to have a greater level of prestige than NGO services (Annandale & Richard, 2006).

A report by the Health Workforce Advisory Committee (2002b) identified key recruitment and retention issues facing the informal support workers in the disability sector. The turnover and limited ability to recruit staff were caused by hidden costs for workers, because of under-funding in contracts and low industry morale. Poor employment conditions (wage rates of above $10 per hour) attract a workforce typified by secondary earners and people receiving benefits. Current welfare benefit levels mean many restrict their hours of employment to ensure that they are not penalised and lose their benefits. This type of work is often chosen for convenience and as a last resort, as opposed to an active career choice (Health Workforce Advisory Committee, 2002b). However, it is unknown whether this aforementioned rationale for choosing this type of work is shared by the wider non-regulated workforce. It is also important to note that in New Zealand there are three minimum wage rates: the adult minimum wage, the the new entrants minimum wage and the training minimum wage. From 01 April 2009 the adult minimum wage is $12.50 an hour (Department of Labour, 2009).

1.9.10 Supply of the health workforce

In New Zealand, the Pacific health workforce draws from a Pacific labour market that has the following features:

- Pacific students are more likely to leave school without qualifications than non-Pacific students

- Pacific tertiary students are less likely to pursue the compulsory school subjects (i.e. mathematics and sciences) to a level required for entry to tertiary training that will lead to careers in medicine and health

- Pacific students are more likely to leave tertiary institutions without a tertiary qualification (Ministry of Health, 2004a).

Anecdotal evidence suggests that the pressures of balancing an intense workload with family and cultural responsibilities are too difficult for many students (Health Workforce Advisory Committee, 2002a; Ministry of Health, 2004a).

Anecdotal evidence also suggests that a high number of the Pacific mental health workforce do not have formal qualifications (Mental Health Commission, 2001b), and that Pacific health practitioners who were trained overseas in the Pacific Island nations may be taking up non-regulated health roles due to barriers in registration and gaining employment in New Zealand. These barriers may be due to the cost and complexity of retraining and/or registering in New Zealand (Ministry of Health, 2004a).

The CMDHB Pacific Return to Nursing programme is an example of an initiative which is responding to a regional dilemma. In Counties Manukau, the Pacific workforce is 6% of the total health workforce however, Pacific people comprise 22% of the Counties Manukau district. Highly trained Pacific nurses from the Pacific are pressured to undertake work in the non-regulated workforce (as caregivers or health assistants) because they do not meet the English proficiency requirements. An 'earn as you learn' approach enables learners to manage study alongside work and family commitments. The programme is run on Saturday mornings with follow up tutorials during week evenings (Ministry of Health, 2008).

1.9.11 To regulate or not to regulate

It is worthy to note that within the U.S. there are some tensions that currently characterise and challenge the CHW workforce. Tensions are mainly associated with CHWs' attributes of "wanting to remain somewhat independent from the healthcare system (and closely connected to the community as lay people) while at the same time interested in healthcare system acceptance and reimbursement" (Dower et al.2006, p. iv).

1.10 Summary

There is a paucity of literature specific to the non-regulated workforce and very little specific to the PNR workforce. However, PNR workers are identified as playing an important role in addressing the increasing health disparities faced by the Pacific peoples of New Zealand.

International and national literature identifies that a plethora of health roles and types exist within the non-regulated workforce. In New Zealand, and consistent with findings around the world, this workforce is highly feminised, less qualified, mature and the majority work part-time. New Zealand studies also show that the PNR workforce represents a high proportion of those working in the health and disability and mental health sectors and, for many, English is a second language. In addition, payment for non-regulated workers varies within the various health sectors. Literature also suggests that there is a lack of information on recruitment and selection processes in New Zealand.

Nationally and internationally, there is little recognition of the non-regulated workforce despite the fact that it has existed for several decades in some countries. New Zealand has recently identified the need to increase the capacities and capabilities within this workforce.

There are extensive service delivery models that are utilised within this workforce with a particular emphasis on improving access to care for service users. Despite criticism, there are movements toward multi-disciplinary and team-based service provision that is inclusive of the roles undertaken by non-regulated workers. There is also evidence to support the need for ethnic-specific and Pacific-specific services provision.

Non-regulated workers in New Zealand and around the world have proven to be effective in increasing access and client knowledge, behavioural change, improving health outcomes, cost effectiveness and the provision of cultural and emotional knowledge, understandings and support.

Developmental pathways and training for the non-regulated workforce have been identified and implemented within New Zealand as well as other countries. These are premised on providing support and supervision, developing competencies, formal certification and up-skilling. Despite these, a number of barriers exist that impact on workforce development. These includes a lack of information specific to this workforce, ambiguous measures in terms of functions, roles and effectiveness, several evaluation priorities set by differential key stakeholders, unclear job descriptions, attitudinal judgments by other health professionals, exploitation and misuse, a lack of processes, supervision and training programmes. Lastly, the literature review identifies that current health systems and structures also play an important role that can either hinder or enhance developments within the non-regulated workforce.

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