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The non regulated Māori health workforce:

**Perspectives on role, utility, and workforce
development in a Whānau Ora environment**

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Prepared by Mauri Ora Associates for Hauora.com Trust

Contact details

Provider Name Hauora.com Trust

Address c/- 4a Maple Street
RD8
Palmerston North 4478

Contact Person Riripeti Haretuku
Chair

Mobile 027 210 9779

Telephone Number 09 486 7148

Fax Number 09 486 7150

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Background

Currently, a clinician-centered and output orientated approach to health care operates. As a model of best care practice, it suffers in its delivery and effectiveness in a multicultural context. This is principally because the health sector derives its conventions and practices primarily from a Western cultural context.

The formal establishment of the role of Community Health Worker (CHW), 1985, in New Zealand recognised the effectiveness of community-based health care. This approach to health care is consumer or community-based and outcome-oriented, and cultural differences can be taken into account. Effective delivery of health care to particular communities involves the recruitment of CHWs who have the prerequisite knowledge to effectively support these communities. They are ostensibly insiders with strong advocacy skills who have a very strong connection, whether by blood relationship or affinity, to the people they hope to help and support. For Māori communities, Māori CHWs fulfill this role in Māori communities.

Māori individuals still fare worse than non-Māori. Two explanations have been offered to account for the difference. First, a cultural or ethnic factor may be associated with different lifestyles or experiences that increase risk and vulnerability. Second, society may react differently to Māori than to other members of a community. But whatever the explanation, 'being Māori' introduces a risk factor that cannot be entirely accounted for by social or economic disadvantage.

Executive Summary

What has emerged from discussion with research participants is that the non regulated workforce plays a critical role in the provision of health care to communities. Within the health sector there is huge potential to provide better, sooner and more convenient services with adequate resourcing, planning and Government support around this development.

The key issues that have emerged from the informants are:

- There is a need to better define the CHW role and all its iterations in a New Zealand context, if it is to be mobilised effectively and provide optimal community health outcomes;
- There are inadequate resources, insufficient funding and low pay rates/salaries which threaten the sustainability and quality assurance of health care services;
- This role is critical in terms of supporting the strategic intention of the MoH health care strategy;
- A framework needs to be developed that provides effective management in terms of recruitment, retention, training/education, career pathways, oversight and feedback mechanisms for organisations and workers;

- There is consensus that research is important for both monitoring and measuring health outcomes;
- All sectors need to collaborate to provide better integration and coordination of services to Māori communities;
- Better systems for data collection and evaluation need to be put in place within health organisations;
- Te Whiringa Trust needs to be resourced appropriately to manage this development since they have been established for this purpose.

Research Aims

The key purposes of this research was to survey opinion and generate discussion amongst health providers and health care workers about the status of the non-regulated Māori health workforce in a Whānau Ora environment, identify potential barriers to their career advancement and consider ways to more efficiently and effectively deploy this workforce to better meet the needs of Māori communities.

An examination of these considerations and issues is particularly relevant as key health providers are preparing to deliver Whānau Ora services. The requirement as outlined in Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives (Durie et al 2010) challenges providers to re-examine their services, resources, staff competencies, processes, approaches to ensure they can meet the tenets set out in the report.

Research Methodology

The methodology employed to generate this report was to:

- Conduct a literature review;
- Interview Community Health Workers (CHWs); and
- Interview key stakeholders, e.g., Maori health provider managers.

Research Limitations

The timeframe of the research project was short and carried out primarily within the boundaries of Auckland. Respondents were primarily women and there was a wide variance between each informant's workforce needs and perceptions. Despite this variance there were areas that they all strongly agreed needed immediate attention eg workforce training.

Research Findings

1. There is a lack of clarity in the health sector, concerning the non-regulated, community-based, health workforce's roles, potentialities and place in the health sector. As a consequence there are poor supervision processes in place, poor/minimal opportunities in the areas of recruitment, retention,

training/education and career pathways. As the need for this workforce increases so will the need to recruit more trained and experienced workers.

Recommendation: Provide accessible, affordable, up-to-date and quality training nationally for this workforce. Ensure the deliverers are competent practitioners in these areas.

2. There is inadequate provisioning of resources, funding and pay rates/salaries with consequent implications for sustainability and quality assurance. This is because the workforce is unregulated and has no overarching rules or conditions around their employ.

Recommendation: That a recognised national body is responsible for establishing the necessary standards and training that supports the development of the non regulated workforce.

3. Current evidence suggests that the repositioning of this workforce will support the aims and objectives and tenets of the MoH Primary Health Care Strategy 2001 and a Whānau Ora approach.

Recommendation: More effective ways to mobilise this workforce should be explored and resourced appropriately by Health Workforce New Zealand (HWNZ)

Data Analysis

The Non-regulated Health Workforce

CHWs make up a large part of the non-regulated and voluntary health workforce. They assist individuals and communities to access timely and appropriate health care. They also often act as interpreters and translators for clinicians and the health systems. Non-regulated health workers are thought to mitigate health workforce shortages and financial constraints experienced by health providers, and increased community healthcare demands. They are essentially the cultural brokers between the tertiary health services and the communities they serve. Their roles typically cross sectors and they facilitate multiple issues that affect families. Their remuneration and importance of their role in the health workforce is negligible when compared with the regulated workforce. More often they tend to be used to implement the directives and instructions of clinicians.

There is a worrying imbalance between this unregulated role compared to the regulated health workforce. In the author's opinion they are complementary roles and both are critical to the health of communities.

The Non-regulated Māori Health Workforce

'Community Health Worker' is the umbrella term that embraces a diverse number of specialised and narrowly defined roles and positions associated with: health education and promotion; health care delivery; and targeted health campaigns. Therefore, there is no common agreement, internationally, over the role of CHWs. However, what is generally acknowledged is that "who and what CHWs are must respond to local societal and cultural norms and customs to ensure community acceptance and ownership" (Lehmann, U. and Sanders, D., 2007, p.1).

In discussions with some Māori CHWs, PHOs and Whānau Ora Providers (WOPs), it has emerged that they recognise three main categories of community health workers: CHWs (community-based); Caregivers (home-based); and Health Care Assistants (HCAs) (clinically-based). These distinctions are based upon the nature of the roles performed. The Manager of Raukura Hauora o Tainui, Martin, affirms that the general Māori population are increasing (McCormack, Hauora Standards of Health IV, 2000-2005), and this will mean that the demand for the Maori non regulated workforce will likely increase.

The Role of Caregivers

Caregivers work with individuals suffering from chronic or special medical conditions. They work in a domestic setting to provide patients with companionship and general services such as shopping, cooking, bathing, house cleaning, toileting and administering medication. A stress associated with this role is that they are always 'on call'. Caregivers provide emotional, mental and physical support to their patients '24/7'. Whilst this is probably not a part of their defined roles or responsibilities, they undoubtedly become close to the people they care for over time. Mahoney reports that caregivers establish informal networks and use professional support groups to help them manage the stressors associated with their role.

Caregivers often lack formal training, education, supervision and regulation. Chronic care exposes these caregivers and their patients to a high level of risk. Training, regular supervision and opportunities to improve their role is needed in order to ensure that appropriate safety mechanisms are in place for the caregivers and the individuals they care for.

Caregivers act in a very intimate capacity to deliver care. The facilitation of this care is improved when caregivers are accepted by, and integrate readily with, a family's frame of reference. The CEO of Ngāti Whatua Orakei Health Services, Mahoney, states that a number of issues exist with regards to role of caregivers. First, training was considered minimal and inadequate for the working context of the role. There was a lack of supervision of these workers and an inability for the workers to provide feedback about their work experiences and needs.

A set of instructions, known as need or care plans, is what typically informs caregivers about the patients in their care. According to Mahoney, communication between the caregivers and clinical and managerial personnel is limited. He felt this was a particularly acute problem because it meant the caregiver tended to work mainly in isolation. Mahoney was also concerned that the lack of caregiver training and the absence of any feedback mechanism to share their concerns and work experiences was very risky for families, individuals, the caregivers and ultimately the organisation responsible for everyone's care. Mahoney considered the lack of supervision in the caregiver's role and the fact that there were no formal standards for this role. He strongly advocated for the regulation of this part of the non-regulated workforce.

Mahoney believed that this sector of the non-regulated workforce needed more training/education, better systems to monitor the delivery of this care and that direct entry into this position needs reconsideration. He further suggested that the caregiver position might be more appropriately accessed as a career path from a prior point of entry into the health workforce; in this way more training for the role would be received.

Whether there are significant differences between caregivers generally and Māori caregivers, in terms of their approach to their roles, require further investigation. How ethnicity or community connections or structural and

systemic issues affect the effectiveness of this workforce is not well understood. What is understood is that better cohesion through improved systems and structural support, supervision and training will make a difference.

The Role of Health Care Assistants

HCA's provide clinical support to nurses and health professionals working within hospitals, rest homes and in the community. Opportunities exist for HCA's to specialise in each of these areas. Their tasks are varied and include: helping people to become more mobile, wash themselves with their support, apply dressings and monitor patient conditions by taking temperatures, pulse, respiration's and weight. This appears to be an iteration of a nurse aide.

The HCA role in the provision of healthcare is facilitated when HCA's understand and can work within, a patient (and whānau) frame of reference. The Primary Health Manager of Raukura Hauora o Tainui, Muru states that the HCA role developed in health is a more cost effective resource for mobilising the clinical workforce. HCA's are cheaper to employ because they perform tasks that require minimal training. By contrast, registered nurses are more expensive to employ – as a result; registered nurses are often in short supply. Muru believed that HCA's, filled a gap in the health system and were well regarded by regulated health workers.

The Role of Community Health Workers

The role of CHW's is to act as a liaison between communities and healthcare facilities for the purpose of ensuring access to effective healthcare. Their work is more often community-based. They are strong advocates for the communities they represent and are often attached to these communities through geography or personal relationship.

This role involves:

- Providing health information, education and outreach;
- Representing communities on multidisciplinary teams;
- Bridging the gaps between communities and multiple sectors;
- Mediation and advocacy between individuals, families, communities and services;
- Facilitating access to health services for individuals, families and communities;
- Helping individuals, families and communities to navigate through systems; and
- Building community capacities to engage in, own, service and broker their own needs and development

The Role of Māori Community Health Workers

According to Lehmann and Sanders (2007), the credibility of Māori community health workers (MCHW's) is predicated primarily upon:

- their community credentials;

- being members of the communities with which they work;
- an understanding of Māori cultural norms;
- utilisation of kaupapa Māori approaches to their work; and
- unwavering commitment to supporting those communities in need.

Prerequisite Attributes

The prerequisite attributes for CHWs, as defined by the Whānau Ora providers include:

- knowledge of Mātauranga Māori-tikanga, kawa, manaakitanga and whānaungātanga;
- life experience;
- te reo;
- community networks and community standing;
- commitment;
- being a people person;
- communication skills;
- adaptability;
- non-judgmental;
- common sense; and
- computer literacy and report writing.

Additional Competencies

Additional competencies, as defined by PHOs and WOPs, include:

- acting as the interface between clinicians/other social services and Māori communities;
- supporting clinicians to be excellent clinicians;
- advising on integrated multidisciplinary teams;
- acting as a liaison between the tribe or rohe as much as colleagues and organisations; and
- closing the cultural gap between the regulated clinical workforce and Māori communities.

The Manager of Papakura Marae Trust, Tahere, believed that Māori CHWs added value to their services because they improved Māori community access, delivery, compliance and self-management of health care and social services. This was attributed in part to their mobility and presence within communities as agents humanising the face of primary health care for Māori and Māori communities.

CHWs should be part of multidisciplinary teams because they offer information directly relevant to the patients' needs and circumstances. This information should strongly inform assessment and intervention recommendations. This is consistent with Mahoney and Martin's observation that clinical health presentations are often the 'tip of an iceberg' of social service needs. If these needs or circumstances are not understood by other support services then this will lead to repeat health presentations.

Martin also suggests that CHWs have a role in fine-tuning a PHO's delivery of health services through feedback, for example, strategising for patients, clients who *do not attend* (DNA's) their appointments.

Makiha, a member of the national Māori community health workers collective, Te Whiringa, adds that the workers need to know what is expected of them from their managers and what resources they have to do their work to better meet the needs of the whānau. It is now required that they report back on the progress and outcomes achieved in their work. She also suggests that CHWs were referred by their supervisors as a last resort. This usually meant that problems that could have been easily addressed by early intervention have become complex and problematic.

Key constraints for CHWs identified by all the participants of this research and Haretuku et al (2011), Māori Public Health Workforce Development Project (2004) and Penney et al (2003) include:

- recognition of, and support for, the role in the health system¹ generally. Muru and Martin add a precautionary note in regard to the responsiveness expected of the CHW role. They suggest that the role CHWs play must vary with differences between areas and that a standard template might not work as a fit in all situations in terms of the nature and scope of PHOs and communities in terms of effectiveness and this requires local knowledge;
- adequate pay rates/salaries (no allowance for recognised prior learning prerequisite knowledge and skills critical to the role is made);
- clearly delineated career pathways with training support. This relates to issues of recruitment, retention, training, resources and support. The implication is that unless addressed, this will adversely affect Māori health workforce development, the impact and deployment of Māori CHWs and the mitigation of Māori social and health disparities; and
- development of adequate management systems that provide supervision, monitoring, evaluation and career opportunities for CHWs. These systems are structural, systemic and organisational in nature and affect the responsive and productive utilisation of trained Māori health workers, both within the health sector and intersectorally².

¹ Lehmann, Uta and Sanders, David (2007) suggests buy-in through collaborative input into CHWs roles by the formal health services is essential to combat a lack both of background in the area and orientation to the field, which they associate with socialisation into a different medical paradigm and a subsequent poor concept of primary health care. This they suggest shapes a perception of CHWs as lowly aides and assistants. Further, they go on to suggest that if an environment of partnership and teamwork is to be created this associated sense of superiority needs to be addressed in medical training.

² Makiha raised instances of constraints and organisational oversights operating to limit CHWs effectiveness: time constraints placed upon the performance of roles, lack of resources and lack of recognition in relation to good will as an element in the

The Role of Whānau Ora Navigators

In order to best facilitate the health, justice, educational and social services needs of Māori communities, an intersectoral coordinating and facilitating Whānau Ora Navigators (WONs) or a champion role of some kind is being considered by Whānau Ora planners. They are not clear yet whether this is a CHW with a specialist role or a new role which requires specialist training. This development is currently work in progress.

Mahoney and Muru saw a critical need for, and potential for substantial growth of, the role. Most canvassed were uncertain as to exactly what the specific skills, training and limits of the role might be. The lack of career pathways was also problematic for recruitment and retention. There are no clear career pathways for the role of WONs at present.

Muru suggested a health and/or social welfare background might be important in order for WONs to be able to work between clinicians and government organisations such as the Accident Compensation Corporation and Work and Income New Zealand. This was considered a difficult role to fill because WONs would need adequate knowledge about multiple sectors and apply that knowledge in such a way as to meet the health needs of their clients.

The issue of Whānau Ora navigator training and qualifications was also raised. Further discussion is needed as to whether the role would need its own pertinent qualification and, if so, what form this might take. Mahoney also suggested that employing local Māori might not be wise as they might become “too involved” in the healthcare of their clients.

This is an interesting view given the strength of CHWs was based on their ability to genuinely be involved in the care of their communities.

Role Recognition

Participants of this research had mixed views about how Māori CHWs were perceived in their roles by other health practitioners and the health sector overall.

Mahoney commented that not much attention had been given to the CHW role, its value or use, particularly in relation to resourcing a health-led Whānau Ora model of whānau and community wellbeing and advancement. Mahoney also stated that CHWs have a role to play as advocates to lower the barriers to Māori advancement. However, training CHWs to ensure they are properly resourced, and the pressure on workers to work and train concurrently are issues.

Makiha believed that the non-regulation status of CHWs hampered the perception that others had of the community health workforce. She based this view on the limited understanding the health sector had about their roles. There are many occasions that this workforce is involved in ‘clinical situations’. This workforce manages these complex situations instinctively and makes decisions based on their understandings. Rightly or wrongly, they are doing the best with what they have, what they know and what they are given. Ideally, they would receive the

CHW’s role (‘this is not 40 hour a week job’). What would help it was suggested was monitoring to circumvent over extension or support and debriefing in some circumstances to prevent burnout.

kind of information, supervision and resources that would improve their workplace and ultimately improve the health of communities.

Martin suggests that the benefits of regulation might create a push by non-regulated workers for a minimal set of standards such as those offered in a Certificate Hauora Māori. All other health roles have career pathways based upon qualifications with associated salary increases. By contrast, it was generally agreed that CHWs were better regarded by PHOs using their services. Ratu from Huakina Development Trust and Muru from Turuki Healthcare, concurred that some district health boards (DHBs) such as the Counties Manukau District Health Board (CMDHB), have developed CHWs competencies and scope of practice for their workforce, and are coming to recognise and value their place in the health system.

Muru also notes that the role for CHWs in a PHO depends upon the health provider organisation itself. PHOs providing only specialised health services may have less need for CHWs and more limited requirements of the role.

Muru reported that the general consumers of health services had little understanding of the role of non-regulated workers and sometimes confused CHWs with nurses and other clinicians. By contrast, expectations of CHWs were reported as being too high when this workforce had a long established presence in an area and were based within client Māori communities.

Muru suggested that in different localities the level of uptake of non-regulated workers organisation was affected by:

- the different histories of PHOs;
- good/strained relationships between PHOs with DHBs;
- changing demographics;
- the degree of PHO proliferation; and
- if the DHB's and PHOs worked together.

All these factors impact upon a community's recognition of the CHW role and, consequently, the wider health community's understanding, appreciation and acceptance of Māori approaches in health. Thus, CHW roles were not visible as distinctive positions in the health sector; nor was the role's potential realised in terms of capabilities and capacities.

Recruitment and Retention

In order to grow the CHW role, recruitment and retention also needs to be considered, particularly the roll-out of Whānau Ora as part of the Ministry of Health (2001), Primary Health Care Strategy, to reduce disparities in funding and provision of health care.

Internationally, recruitment and retention are considered critical to community health workforce development. Generally, those spoken to reported that CHW recruitment was not an issue, as is the case in urban Auckland. In rural areas, Ratu of Huakina Development Trust reported that recruitment was an issue because the pool of potential candidates is smaller.

Lehmann and Sanders (2007)³ suggests several reasons why potential workers would be attracted to community health work. These include:

- contribution to improve the health of communities;
- opportunities for personal growth and development;
- opportunity to acquire valued skills;
- receive remuneration for doing something they are knowledgeable about.

Tahere and Makiha considered the following factors to be important to recruitment:

- the role links CHWs with the communities in which they live as client communities;
- the proximity of work and home; and
- legacy - those applying for these roles wanted to make a difference and many were already active in their communities and networks prior to becoming CHWs.

In their opinion the primary retention tool was not salary, but the opportunity to work for Māori communities or a tribe under a Māori community health/Whānau Ora kaupapa.

This could be linked with several other observations by Muru and Martin, including:

- prevalence of Māori women in the role⁴;
- CHW role as a conduit for reconnection with Māori communities and iwi in an urban context.

However, Muru, Ratu and Tahere reported that retention was an issue because work was often contract-based, part-time, short term, intermittent and inadequately remunerated. Both Tahere and Mahoney reported that not only were pay rates low, they had not increased for five to six years. Ratu reported that Huakina Development Trust CHWs were contracted for an average of three days a week and that contracts were commonly for six to twelve months.

Complicating this further, according to Makiha, is that CHW roles were not promoted as a career option in health. This is beginning to change with the recent launch of Kia Ora Hauora by the CMDHB. The aim of this initiative is to encourage people into the health workforce. It would be fair to say that there is an emphasis on the Māori clinical workforce.

Training and Career Development Pathways

Makiha, Mahoney and Muru observed that while ongoing development is expected of CHWs, it is not remunerated because training is considered part of the job.

³ See CHW incentives and disincentives.

⁴ This may be because there are fewer barriers of access and greater acceptance of women within this role by whānau and Māori communities.

CHW career pathways appear to be almost non-existent and reliant upon the ad hoc decisions of individual public health provider organisations with regards to provision.

Muru suggested that a perceived lack of value and recognition of CHWs was based in part upon a lack of industry-wide recognised training standards and courses associated with a career development pathway; and in part by limited PHO budgets for this purpose. This situation was reflected in CHWs low salaries and pay rates.

CHW training to date is reported mainly involves:

- induction into the role;
- learning social services referral processes;
- learning PHO reporting systems.

Beyond this, training is primarily in relationship to targeted health campaigns. However, some public health providers, such as Huakina Development Trust, also provide initial training in general health and social services in the areas such as:

- first aid;
- health and safety requirements;
- food safety;
- nutrition;
- exercise and activity;
- Te Tiriti o Waitangi; and
- Tikanga.

Ratu and Mahoney also indicated that education relating to community roles would provide benefits.

Muru also points out that CHWs are generally older workers who have worked in a variety of roles. They usually come with community and cultural skills, capacities and training that could be utilised in the role (or could form the basis of particular career development pathways within the health system).

Training is also expensive in terms of time and cost to health providers. Ratu said Huakina Development Trust instituted measures such as:

- developing strong relationships with DHBs and a reputation for reliability and quality of service so that training was, in part, budgeted for within contracts as workforce development; and
- negotiating free, and often accredited, training offered by the Occupational Safety and Health Service of the Department of Labour (OSH) and other agencies.

Mahoney further states that contracting for training is an expensive option, and suggests that marae or iwi-based public health providers consider delivering CHW health training. The pay-off for this investment would be the ability to recruit locally which would benefit their communities directly.

To support this development some negotiation should be held with Māori health trainers to see what is being offered for this workforce. It is probably also useful for workers and organisations to determine what training is required since different localities are affected by the different issues.

The Māori Provider Development Scheme now provides scholarships to support training for community health workers. This scholarship was negotiated by Te Whiringa Trust, a national Māori collective that has represented the views and needs of Māori community health workers over the last eight years. This scholarship is a recent development and was made available this year, 2011.

There was general agreement amongst informants that Māori CHWs, who seek to advance their health careers with further education, have several obstacles to overcome. These include:

- the need to work and train;
- the cost of pursuing further education;
- no/minimal training budget set aside by health providers, despite this having a potential value for organisations;
- a lack of suitable courses to meet the needs of CHWs; and
- a lack of accessible courses.

Some training opportunities currently available include: a Community Health Work Certificate available through Manukau Institute of Technology (MIT); and the Certificate of Hauora Māori available through Mauri Ora Associates in Auckland, Tipu Ora in Rotorua and Rapu ki Rua in the Waikato. There are also health management papers, nursing options, and sport and recreation diplomas and certificates. In other sectors social work may be pursued. Social work is regulated and many health workers have moved into social work in order to have the security of employment and ability to follow a clearer career pathway. The concern with this movement is that the community workers will be trained to focus on the deficit behaviours displayed by individuals and communities. It would be fair to assume that this would affect the solutions posed by these workers to find solutions.

There are NZQA training courses and qualifications at the NZQA level or certification guidelines (Dower et al, 2006)⁵ that could be incorporated into a career development pathway for CHWs; however, these have not been instituted industry-wide as a standard.

Martin commented that while many PHOs support CHWs seeking educational qualifications in health as a means to career advancement and increased remuneration, the qualifications were often in areas beyond the scope of the CHW role. Mahoney points out that past a certain point there is no scope for CHWs to progress as CHWs. He also suggests that if CHWs worked for administrating or nursing managers better retention might result and referrals along health career pathways might then be facilitated.

⁵ In the US, different approaches to certification are based upon major certifications areas such as health care, community resources, communication skills, individual and community advocacy, health education, service skills and responsibilities, lifespan-specific needs; or core competencies in: communication, interpersonal skills, service coordination, capacity-building, advocacy, teaching skills and organisational skill; and knowledge based on specific health issues,

Representation

Te Whiringa Trust was mandated as a national MCHW body responsible for representing MCHWs. The expectations of the workers and the capability of the organisation remains a work in progress because of the immense ground work required to position the CHW's in the health sector. This requires political goodwill, policy support, potential regulation and standard setting and health sector 'buy in'. It was suggested by Mahoney that unification was required so health providers could share limited resources and present to the Government the importance of this workforce in meeting the tenets of Whānau Ora. This development needs to be supported at the top level of organisations and at the CHW level.

It emerges from discussion that the value and benefits of national representation⁶ is not well understood or known.

Regulation

Most surveyed had mixed opinions about the value of regulation for CHWs around whether it would erode or support cultural inputs into the Māori CHW role.

The benefits of regulation include:

- formalisation of the value and role for CHWs;
- recognition of the CHW role's Māori cultural competencies;
- requirement to implement career development pathways and an associated scaling of qualifications and pay rates; and
- validation of the CHW role as a career option;

Mahoney believed regulation was beneficial if it provided a formal training route toward a recognised qualification, for example, a diploma with a recognised prior learning (RPL) component. He says this would improve pay rates and help implement a pay scale within the role. This might encourage recruitment and retention. It might also be appropriate to accredit organisations rather than people in relation to standards. However, Mahoney doubts whether accreditation would actually increase the acceptance of CHWs and kaupapa Māori approaches by the general health system.

Most of the Māori health providers spoken to regard regulation as problematic for Māori CHWs. A key issue raised was the potential for the Māori CHW role to become more academic and institutionalised and this could result in a diminished response by workers in applying a more instinctive approach, 'community savvy'. It could be debated that this is an inherent part of being Māori; however, these selfless attributes and many more are considered essential in the delivery of healthcare to Māori communities. Another concern was that a Māori would be subsumed overtime by a European approach which was more clinically centered and output orientated.

Martin asked what the place of CHWs who had been employed 26 years ago would be if regulation were to occur. Contractual requirements specified a minimum level of training which these kuia and koroua might not possess.

⁶ For a full list of the value and benefit of a national body for CHWs see Anderson, B. (2003). Report on the Māori Community Health Workers National Hui.

Some of those spoken to were uncertain as to whether regulation would erode or support cultural inputs in the CHW role. While one provider thought regulation would not make a difference, governmental entities already require accreditation of their CHWs.

Research

Research was considered valuable by all the informants. They believed it would inform health delivery and consequent outcomes, both within the community and within healthcare settings. Value was also ascribed to monitoring whether health providers were meeting their objectives and evaluating whether health goals were being achieved.

There was general agreement about the importance of ascertaining whether a Whānau Ora approach to health and community based tenets would further improve the health of Māori communities. All participants agreed that there is a need for systems to collect data in order to monitor, evaluate and demonstrate tangible benefits beyond the anecdotal experience of individuals and public health providers. The benefits expected to result from this included:

- improved health access, provision and treatment compliance;
- an improved perception of the health system by Māori communities; and
- establishment of health efficiencies and financial viability.

Martin suggests that research of this nature is needed in order for the health sector to embrace Whānau Ora ideals. Such research was expected to promote the further development of the non-regulated Māori workforce. Muru says supporting, empowering and improving the uptake and utilisation of CHWs within the health system is critical in this current health environment.

There was general agreement that statistics collection, evaluation, dissemination to other providers, research and publication were important in reducing wasted effort across the sector. Ratu reported that Huakina Development Trust collected data that supported their work and kept track of their organisation's work in order to measure successful outcomes.

Research into whether increased remuneration for the non-regulated Māori workforce in funding contracts, or greater sustainability through other measures would improve retention, was also suggested by participants.

Research could also provide information about the work of other sectors and how they integrate or not with the health sector. This would have implications for the efficacy, recognition and development of the non-regulated Māori workforce.

Māori Workforce Development

The recruitment of CHWs was expected to increase as expectations were now raised since the formal launch of Whānau Ora services. This would mean that holistic health and wellness and community resilience would be the primary focus of WOP health care.

Low remuneration for CHWs was consistently described as a barrier to the roll-out of Whānau Ora. In order to increase CHW pay rates they had to further their education. This required them to quit their work roles because there is no surplus or specific funding for further training or education.

For some public health providers, there were concerns about their ability to implement their Whānau Ora initiatives since there had been no increase in the monetary value of their government-funded contracts. This affected both their obligation and motivation to invest in health workforce development for the non-regulated workforce.

Mahoney identified some problems with funding contracts to give CHWs increased remuneration for training and salary. A key problem is that health contracting perpetuates short term and episodic CHW employment. Secondly, that the issue of funding, remuneration and employment constraints has implications for sustainability, PHO investment decisions, organisational management and Whānau Ora implementation. How can Māori CHWs in their role be 'fit-for-purpose', productive and responsive in this environment? There needs to be a consolidation of workforce planning, training, development and purchasing/funding supported by HWNZ.

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