
ANALYSIS OF ABORIGINAL HEALTH WORKER WORKFORCE DATA



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1. Introduction

The Northern Territory (NT) has long recognised the employment of 'Aboriginal Health Workers' (AHW) as an important way to provide services especially to communities in remote locations. AHWs primarily bridge the "cultural chasm" separating the traditional and mainstream world views — they act as a cultural broker. They help to relate mainstream beliefs to an Aboriginal framework making it possible for Aboriginal patients to understand what is being said and to assess the validity of the statements. They make it possible for the non Aboriginal health clinic staff to communicate with Aboriginal people in language and concepts that they understand. In most remote communities, people's entry into the mainstream health system is through the AHW who may then refer them on to a nurse or doctor.

The AHW's core duties may also include:

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

The actual work undertaken, particularly in small remote Health Clinics, can vary depending on the nature of the work in the clinic, the type and number of other health professionals, and the competence of the individual AHW.

The major employer of AHWs in the NT is the Department of Health and Families (DH&F) who manage the majority of Community Health Clinics and all hospitals (with the exclusion of the Darwin Private Hospital). Other employers include the Community Controlled Health Boards such as Sunrise, Katherine West and Malabam and a small number of community controlled clinics.

2. Approach to data analysis

Unlike all other jurisdictions across Australia, AHWs are recognised health professionals in the NT and are registered with the NT Aboriginal Health Worker Registration Board.

Registration is an important means of quantifying a workforce size and beginning to understand workforce composition. The register of course

provides theoretical parameters around an estimate of the *current active* AHW workforce size and the potential *inactive* workforce since only those who are registered can work in the NT in AHW positions.

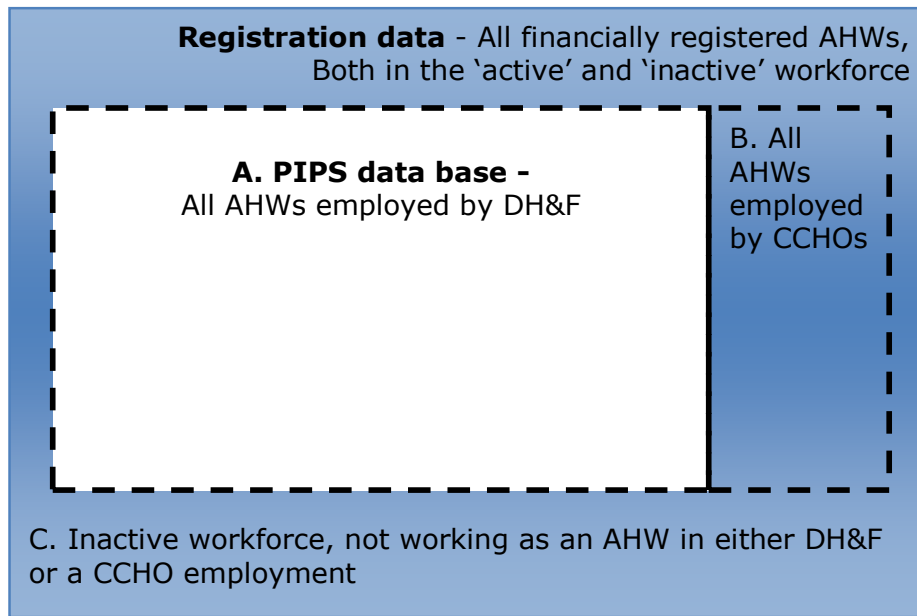
The other main source of data on the AHW workforce is the Personnel Integrated Payroll System (PIPS)¹. This database captures information on all persons employed in the Northern Territory public service. Thus, data on all AHWs employed in NT DH&F are captured for every pay period (26 pay periods per year) and this forms an estimate for the active workforce, at least that part of it which works in public sector health services. Most observers estimate that the number of AHWs employed in Community Controlled Organisation clinics are considerably less than the number employed in public health services².

There are thus two main sources of secondary data that can be interrogated:

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

The relationship between these two data sources and what elements of the AHW workforce they cover is shown in the diagram below.

Figure 1: Relationship between Data sources for AHW Workforce



¹ PIPS data is collected and assembled from payroll data centrally but the data was supplied to this study by the System Performance & Aboriginal Policy Branch of the NT DH&F. In particular the consultant is grateful to Peter Kelly from that section for supplying additional analysis of the data.

² A later component of this Review project will survey all service providers and might therefore be able to develop better estimates of the Community Controlled Organisation workforce.

The two data sources will provide essentially a slightly different (and equally imperfect) perspective on workforce size as follows:

Registration board data allows an estimate of the total active (A + B) and inactive (C) AHW workforce. One assumes that the inactive workforce consists of persons willing at some stage in the comparatively near future to return to the active workforce; otherwise why would they maintain their registration. However, the flaw in this logic is that some registrants maintain their financial status even when they may have no immediate intention of being active as an AHW. This could especially be the case with the AHW register since it is such a low cost (\$10 per year) to renew registration. Discussion with the Health Professions Licensing Authority suggests another source of possible error results from the difficulty at times in ensuring all persons active in the workforce register before the September 30 cut-off point each year. Registration board data may therefore under or over-estimate workforce size.

The PIPS data base of course estimates only the active AHW workforce, and then only those active in public sector employment (B in the above diagram).

In drafting this report both these data sources were interrogated.

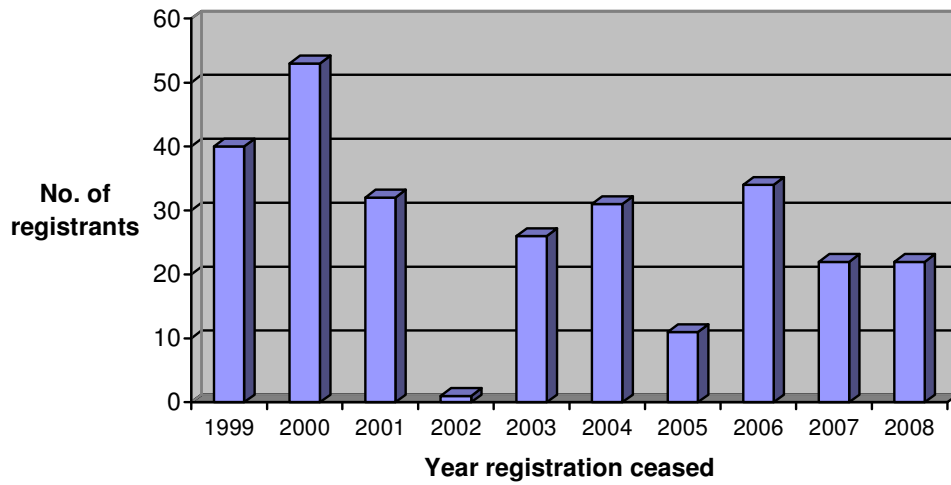
3. Workforce size

The total number of currently financial AHW registrants is 294. This includes both the active and inactive workforce. There is no way of knowing the exact distribution of registrants between the active and inactive workforce, this data is not collected by the Board.

In addition to the number of current financially registered AHWs there are a further 312 AHWs that have been registered in the past but are now unfinancial. Just over 60% (61.5%) of unfinancial registrants have been unregistered for more than 5 years. The distribution of unfinancial registrants by their year of ceasing registration is shown in Figure 2.

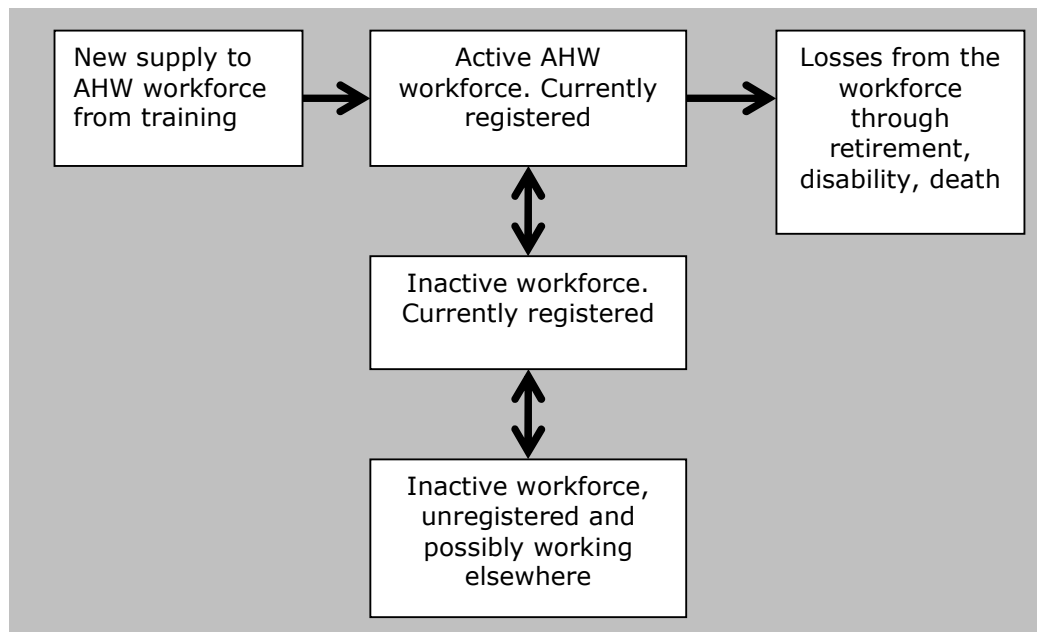
In subsequent sections of this report the differences between the financial and unfinancial registrant populations will be explored. In other studies undertaken by HCA though where registration authority data has been analysed, the great majority of persons who have allowed their registration to lapse for any significant time period invariably have determined on a different career or life path, one which will not lead them back to their original profession.

Figure 2: Distribution of unfinancial AHW registrants by year of ceasing registration



More broadly the AHW workforce can be conceptualised as in Figure 3 below, which attempts to convey more the dynamic flow of persons in and out of the active AHW workforce.

Figure 3: Overview of AHW workforce dynamics



The size of the public sector AHW workforce is 123 based on PIPS data from the December 2008 payroll. If popular opinion that the AHW workforce employed by organisations in the community controlled sector is significantly less than the public sector workforce, then there must be a

high proportion of current registrants in the 'inactive' workforce. This population (rather than the population who has allowed their registration to lapse) would seem to be a better target for workforce re-entry.

4. Workforce status

That part of the AHW workforce that is employed in the public sector is mostly working full time. The 123 workers employed make up 104.96 full time equivalent (FTE) workers (total hours worked of the 123 workers divided by the full time award hours). This is a FTE conversion factor of 0.85; that is on average an AHW works 85% of a fulltime person. Employment in some sectors of DH&F is more fulltime than others as shown with the following FTE conversion factors:

Acute Care	0.96
Health & Well Being	0.83
Public Health	1.00
People & Services	1.00

The Health & Well Being section is dominated by the 'Remote Health' area of services which employs the bulk of the AHW workforce. Their FTE conversion factor is 0.82, suggesting there is more part time employment in remote areas.

Just under two thirds of the DH&F AHW workforce (64.5%) is employed on a 'permanent' basis. A third (33.9%) is employed as 'temporary' staff, while only 1.6% is employed as casuals. Casual employees are paid each pay period on the hours they work, while 'temporary' staff work fixed weekly hours under a contract but that contract may only be for a short period of time (between 3 and 12 months). The Review team were advised that in some respects there can be abrupt movement between the proportion of the workforce in 'permanent' and 'temporary' employment status because of the flexible way in which DH&F allows budget re-allocation between 'positions'³. This does not imply an individual will normally change status (although clearly one could progress from temporary to permanent) but rather an influx of new workers could contribute to a higher proportion of 'temporary' employees.

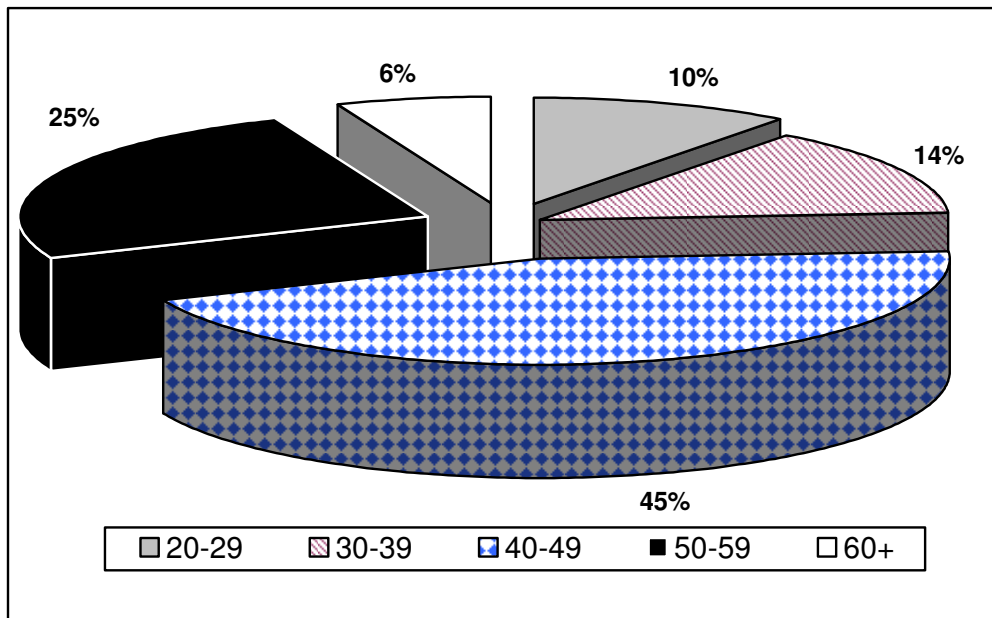
Thus, there was a noticeable reduction in the proportion of permanent status AHW employees between 2007 and 2008 from 69.5% to 64.5%, but it is difficult to interpret the significance of this change.

³ Unlike some public service systems in other jurisdictions, in DH&F there is no 'establishment' of positions against which employment occurs. Services appear therefore to be more flexible in their application of funds to staffing; thus funds can be fairly easily transferred from one category of worker to another. In the case of AHWs budget controls are applied only on level of position especially in remote health, where a notional sense of AHW numbers (and job classification levels) is linked to the size of the community being served by a community.

5. Workforce demographics

The AHW workforce is predominantly female. Of the financially registered population, 213 or 72.4% are female. A similar proportion (72.8%) of unfinancial registrants is female. In the DH&F workforce, based on FTE, the proportion of women workers is slightly lower (71.8%) but still dominant. Almost half (45%) of the currently registered AHW is aged between 40 and 49 years old, and well over half (76%) is over 30 years old. The age distribution of the currently registered workforce is shown in Figure 4 below.

Figure 4: Distribution of the current registered AHW workforce by age



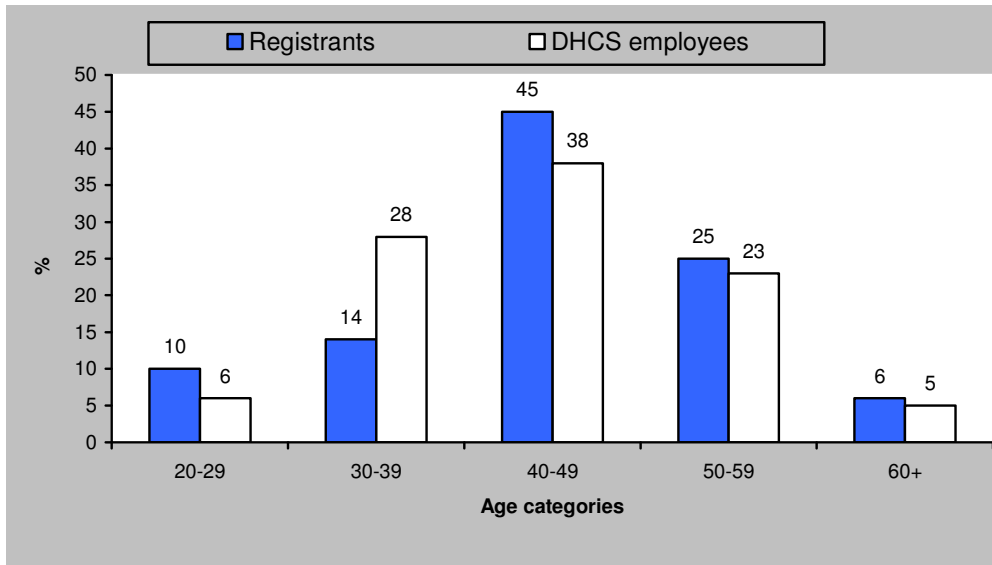
The DH&F workforce appears to be slightly younger than the current registrant population. In Figure 5 below a comparison of the DH&F workforce and total current registrant population is provided (figures are in percentages).

6. Geographic distribution

The geographic distribution of the AHW workforce can be established from registration data which keeps last known postal address. The Review was not supplied full addresses but rather postcodes, which were then translated into specific and broad locations (according to health service regions)⁴.

⁴ These are not the current 'official' health regions but they are quite widely understood.

Figure 5: Comparison of registrant and DH&F employee populations by age categories



A small number of postcodes map poorly to these regions (for instance some Groote Eyland locations share Darwin District postcodes) however overall the picture is accurate. The geographic distribution of current registrants is shown in Table 1 below.

Table 1: Distribution of currently registered AHWs by geographic location (n = 293)

Location / Health service region	Number	%
Not known	3	1.0
Darwin	47	16.0
Darwin District (includes Batchelor, Bathurst Island / Nguiu, Daly River, Galiwinku, Goulbourn Island, Howard Springs, Herbert, Humpty Doo, Maningrida, Mcminns Lagoon, Milingimbi, Oenpelli, Pularumpi, Pulumpa, Ramingining, Wadeye)	49	16.7
Palmerston and Surrounding Area	16	5.5
Katherine	33	11.3
Katherine District (includes Barunga, Beswick, Borroloola, Daly Waters, Edith River, Elsey Station, Kalkaringi, Larrimah, Manbulloo, Mataranka, Ngukurr, Numbulwar, Pine Creek, Timber Creek, Tindal, Victoria River Downs)	29	9.9
Barkly District (includes Tennant Creek, Brunchilly, Cresswell Downs, Elliott, Newcastle Waters, Warrego,	11	3.8

Location / Health service region	Number	%
Wollogorang Station, Wycliffe Well		
Alice Springs	47	16.0
Alice Springs District (includes Ali Curung, Amoonguna, Areyonga, Atitjere, Docker River, Erldunda, Ernabella, Finke, Haasts Bluff, Hermannsburg, Imampa, Kaltukatjara, Kintore, Mount Liebig, Papunya, Pitjantjatjara Homelands, Santa Teresa, Ti Tree, Uluru, Wallace Rockhole, Willowra, Yuelamu, Yuendumu, Yulara)	28	9.6
East Arnhem District (includes Alyangula, Gapuwiyak, Gove, Nhulunbuy, Yirrkala)	17	5.8
Jabiru	4	1.4
QLD	5	1.7
Other interstate including SA, NSW, WA	1	1.4

Table 1 shows that much of the workforce (nearly half or 48.8%) is located in the larger centres (Darwin, Palmerston, Alice Springs, Katherine). The other half is located in quite remote service areas. This distribution makes the AHW workforce fairly unique in comparison with other health profession workforces that tend to be much more concentrated in urban and regional centres.

The distribution of the DH&F AHW workforce, at least that part which can be properly located⁵, is slightly different to the total AHW as determined through registration board data (see Table 1). Details of the numbers of staff working at the different DH&F service locations are provided in Table 2 below.

Table 2: Location and Number of DH&F AHWs

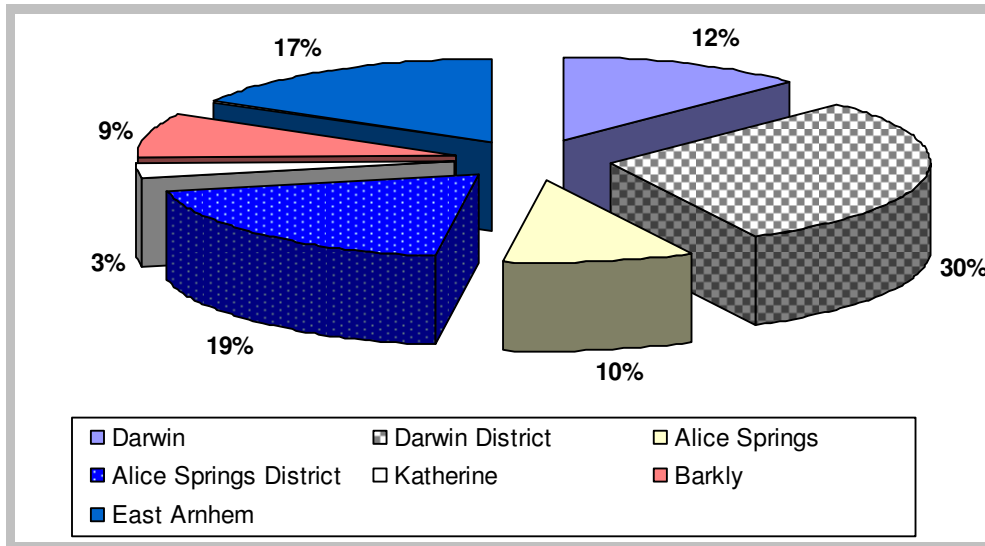
Area / Location	Description	Number of AHWs
Darwin and Palmerston	Includes Hospital, Community Health, Public Health And Policy Positions	14
Darwin District	Batchelor	1
	Belyuen	2
	Milikapiti	3
	Milingimbi	3
	Minjaling	1
	Naiyu Nambiyu	5
	Nguiu	6
	Oenpelli	3
	Pirlangimpi	4

⁵ DH&F AHWs employed in mental health and health development and oral health were not able to be associated with a particular location.

Area / Location	Description	Number of AHWs
	Tiwi For Life	1
	Umbakumba	1
	Wadeye (Port Keats)	2
	Waruwi Ahws	1
	Waruwi	1
Alice Springs	Includes Hospital, Community Health And Management Positions	11
Alice Springs District	Docker River	1
	Ali Curung	2
	Apatula	1
	Haasts Bluff	1
	Hermannsberg	4
	Laramba	1
	Maryvale	2
	Anmatjere	1
	E Arrernte	1
	Stirling Station	1
	Ti-Tree	3
	Yuendumu	4
Katherine	Includes Hospital	1
Katherine District	Borroloola H/C	1
	Robinson River Health Centre	1
Tennant Creek	Includes Hospital, cervical cancer & management	5
Barkly District	Elliott	3
	Pine Creek H/C	1
	Epenarra	1
Gove	Includes Hospital	1
East Arnhem District	Gapuwiyak	1
	Angurugu	4
	Maningrida	3
	Numbulwar	4
	Ramingining	2
	Yirrkala H/C	4
Health Development & Oral Health	Aboriginal Hearing Health Worker	1
	AGI Hearing, ENT Phase 2 Follow Ups	1
	Child Health 25 Positions	3
	Growth Assessment & Action	1
	PCDS CA	1
Mental Health	Community Mental Health	1
	Hospital Care (Ash 1)	1
	Mobile Support Remote	1
	EHSDI - Project Team	1

The figures in Table 2 are summarised in Figure 6. There it can be seen that Central Australia area employment accounts for almost 40% of total employed AHWs in DH&F, whereas registered AHWs are much more likely to reside in the Top End (67%).

Figure 6: Distribution of DH&F AHW Workforce



7. The DH&F workforce details

In earlier sections the DH&F workforce has been described (and where appropriate compared with the currently registered population) in regard to gender, age and location distribution. PIPS data allows further analysis of this workforce on the basis of:

- Area of work
- Pay classification levels
- Length of service

Area of work

There are four broad areas of work within DH&F where AHWs are employed. These are shown in Table 3 below with the number of staff employed in each area.

Table 3: Distribution of DH&F AHW staff by area of work

Area of work	Branch Name	Head count	FTE
Acute Care	AC Policy & Service Development	1	1.00
	Alice Springs Hospital	5	5.55
	Gove Hospital	1	0.26
	Katherine Hospital	1	1.00
	Royal Darwin Hospital	5	4.68
	Tennant Creek Hospital	1	1.00
	Acute Care Total	14	13.49
	Health & Wellbeing	Community Health	2

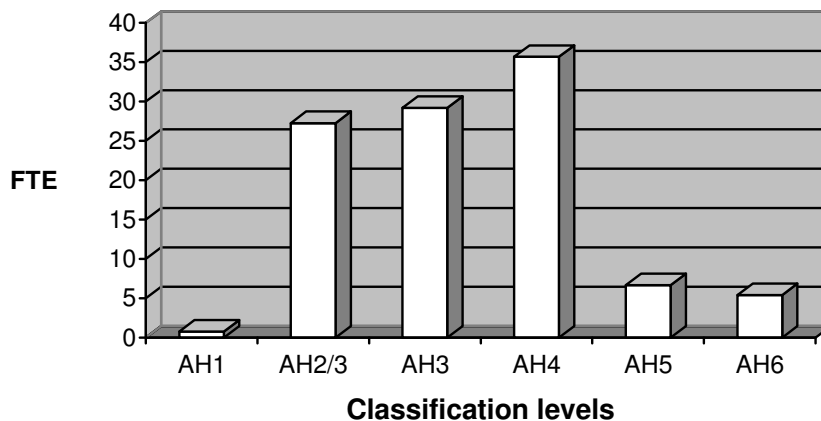
Area of work	Branch Name	Head count	FTE
Public Health	Health Development & Oral Health	10	9.10
	Mental Health	3	2.48
	Remote Health	89	72.94
	Health & Wellbeing Total	104	86.17
	Centre for Disease Control	4	4.00
People & Services	People & Organisational Learning	2	2.30

The work area of 'Health and Wellbeing' is the largest employment area within DH&F accounting for 82% of total employment. Within this area, 'Remote Health' alone accounts for over two thirds (69.5%) of total AHW employment within the DH&F.

Pay classification levels

The Determination number 1037 of 2008 under the NT Public Sector Employment and Management Act allows for six (6) designations of AHW. Entry to the lower level designations is possible with old 'Basic Skills Certificate' or former relevant Certificate III qualifications, but higher designations (4-6) can only be occupied by persons with up-to-date qualifications (relevant Certificate IV, Diploma or Advanced Diploma).

Figure 7: Distribution of DH&F AHW employees by classification level (FTE)



Because higher designations are obviously harder to aspire to, a majority of AHWs (55%) are in the lower classifications. A significant proportion of workers (34%) who have achieved the Certificate IV qualification are filling level 4 classification roles, while only 11% of the total workforce are in level 5 or 6 roles. Of those in the higher roles, most are in management functions within Remote Health or senior policy positions.

During 2008 28.3 FTE AHWs commenced new classifications with DH&F; fewer than 60% were at level 2 or 3 classification levels.

As might be expected, just over 70% of those workers at classification levels of 4 or above are more than 40 years old (see Table 4 below). A small proportion of younger AHWs are entering the workforce at level 4 having obtained their Certificate IV qualification.

Table 4: Distribution of DH&F employed AHWs by age and classification level

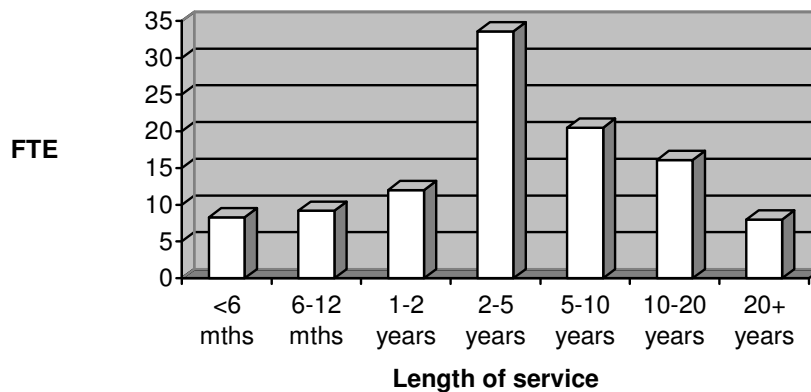
Classification	FTE Within Age Groupings				
	20-29	30-39	40-49	50-59	60+
AH1		0.50			
AH2/3	3.00	8.76	11.48	3.22	
AH3	0.00	9.45	14.75	5.03	1.00
AH4	0.81	9.27	11.88	10.13	2.45
AH5	1.00	3.00	2.00	3.87	
AH6	1.00		1.00	3.00	1.00

A significant proportion(33%) of workers employed remain at low classification levels but are over 40 years old, raising the question as to whether this cohort is likely to enhance their base qualifications and therefore their career prospects.

Length of service

Most AHWs employed by DH&F (72.6%) have been in the service for more than two years as shown in Figure 7 below.

Figure 8: Distribution of the DH&F AHW workforce by length of service (LOS)



Indeed, the AHW workforce in the employ of DH&F is quite a long serving workforce and it was indicated to the review team that it is in fact one of the 'oldest' in terms of length of service, and as was shown earlier, in

actual age. This seems to undermine to some extent the anecdotal opinion provided to the review from consultations that there is very high turnover and loss of AHWs. We will return to this theme later.

As might be expected, the overwhelming majority of AHWs employed at classification levels of 5 and 6 have been in the service for a considerable length of time. Just under nine tenths (97.4%) of AHWs employed above classification level 4 have been in the service for greater than two years. This is shown in Table 5 below.

Interestingly though, over one third of the workforce (37.1%) has been in employment for greater than 2 years but remains at classification level 3 or lower. It could not be explored, but it is assumed that this group is significantly represented by workers with qualifications that were accepted when registration was first introduced but now no longer provide eligibility for registration or advancement to higher classification levels.

Table 5: Distribution of DH&F employed AHWs by length of service and classification level

Classification	FTE Within Length of Service Groupings						
	<6mths	6mths-1yr	1-2yrs	2-5yrs	5-10yrs	10-20yrs	20yrs+
AH1					0.50		
AH2/3	1.16	1.89	2.87	11.55	5.22	2.77	1.00
AH3	4.09	6.32	3.86	5.17	3.94	6.85	
AH4	3.00	1.00	3.27	11.98	4.85	5.44	5.00
AH5				3.87	5.00		1.00
AH6			2.00	1.00	1.00	1.00	1.00
TOTAL	8.25	9.21	12.00	33.57	20.51	16.06	8.00

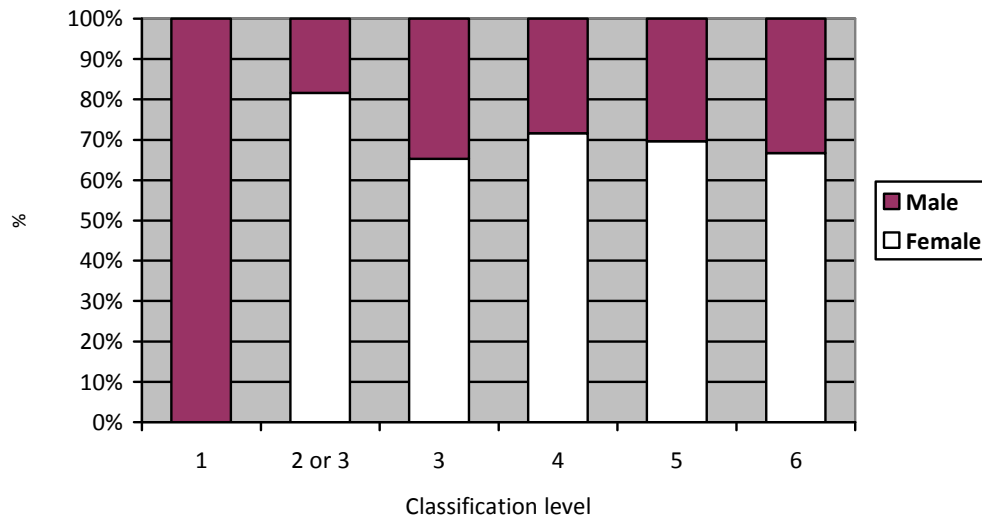
Gender differences

In an earlier section it was noted that 71% of current DH&F AHW employees are female. Just under this same proportion (70.6%) is the representation of female workers in the higher classification level population as shown in Figure 8 below.

Flows to and from the DH&F workforce

Staff turnover as a measure of losses from the workforce is measured in various ways but normally as the number of persons leaving the workforce over a certain period of time (generally a year) as a percentage of the persons who were employed at the start of the measurement period. The PIPS approach is to divide the loss of staff (in FTE) over a period of time (12 months, December to December) by the average workforce size during that period.

Figure 9: DH&F employed AHW workforce gender balance at various classification levels



The PIPS approach is illustrated as follows:

Number of separations (17.7 FTE) between December 2007 & 2008

Average workforce size (104.6 FTE) between December 2007 & 2008

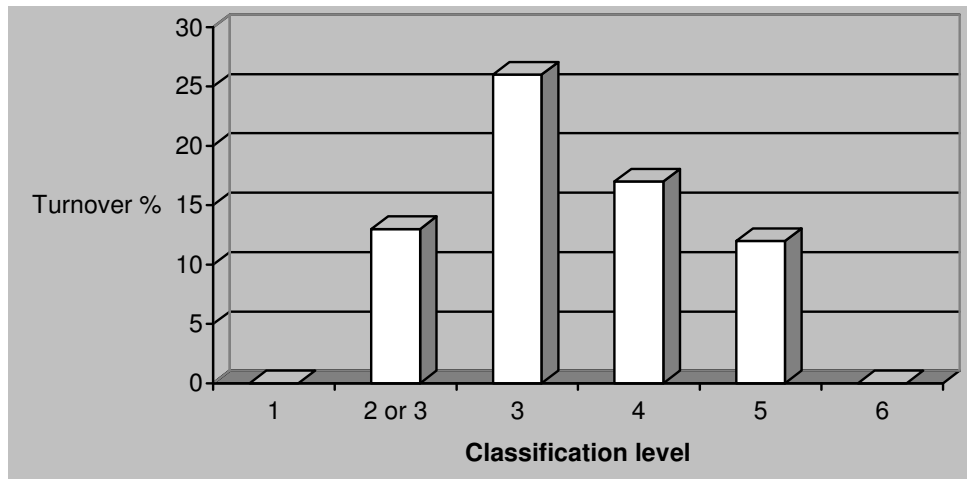
The turnover rate calculated thus is 16.9%, not an extremely high amount when compared to the turnover of many other health professional workforces. The turnover rate varies between areas of work as shown below:

Acute Care	25%
Health & Wellbeing	15%
Public Health	25%
People & Services	28%

Of course some of these areas of work employ few people and so are open to volatile turnover rates. Figure 9 below shows that turnover is highest amongst the middle level pay classification levels (3 and 4).

Between December 2007 and December 2008, 57% of the AHW workforce separations had worked for a year or less, and 68% had worked for two years or less. Similarly, just over half of the separations were under 40 years old even though this group accounts for only 34% of the DH&F AHW workforce. This suggests that once workers have settled in the role they become highly stable.

Figure 10: Turnover rates of different classification levels



Between December 2007 and December 2008 there were 23.8 FTE newly commencing AHWs in the DH&F workforce, outweighing the 17.7 FTE separations and accounting for the growth in workforce size over the designated period. Most of the new commencements (59.2%) were at the 2/3 and 3 classification levels.

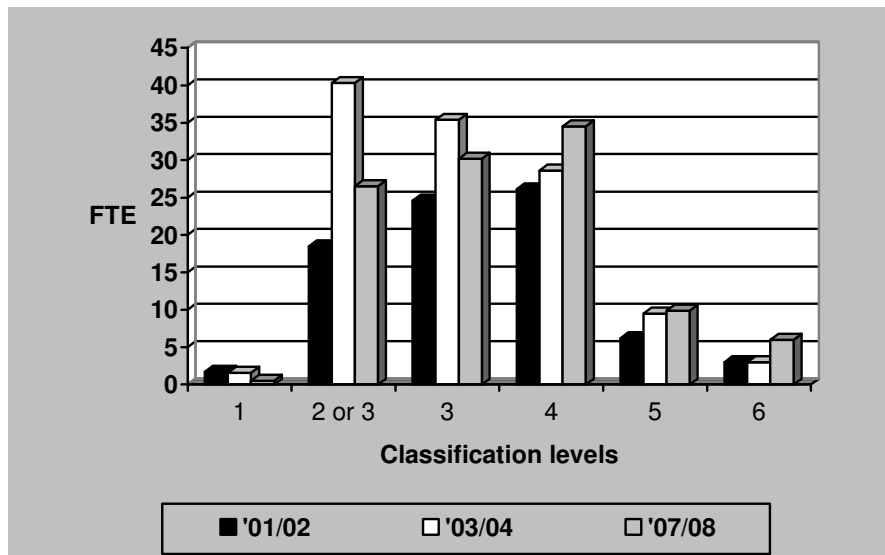
Changes in workforce size

In the last three financial years (including the current year) the number of AHWs on the payroll as at December has varied between 113 and 103 FTE. Over a longer period of time that variation appears to have been a consistent factor; the average employment of AHWs for selected years in the last nine has been:

2001/ 2002	80.18 FTE
2003 / 2004	118.35 FTE
2007 / 2008	107.60 FTE

While these figures are admittedly limited in providing for only three points in a trend and thus erratic, they do not substantiate a case for a significant fall in AHW numbers in DH&F employment. As well, apart from a significant apparent influx of AHWs at the 2/3 classification level in 2003/04, there appears little difference between years in the composition of the workforce, at least in distribution across classification levels (see Figure 10 below).

Figure 11: Distribution of DH&F AHW workforce by classification level across selected years from 2002 to 2008

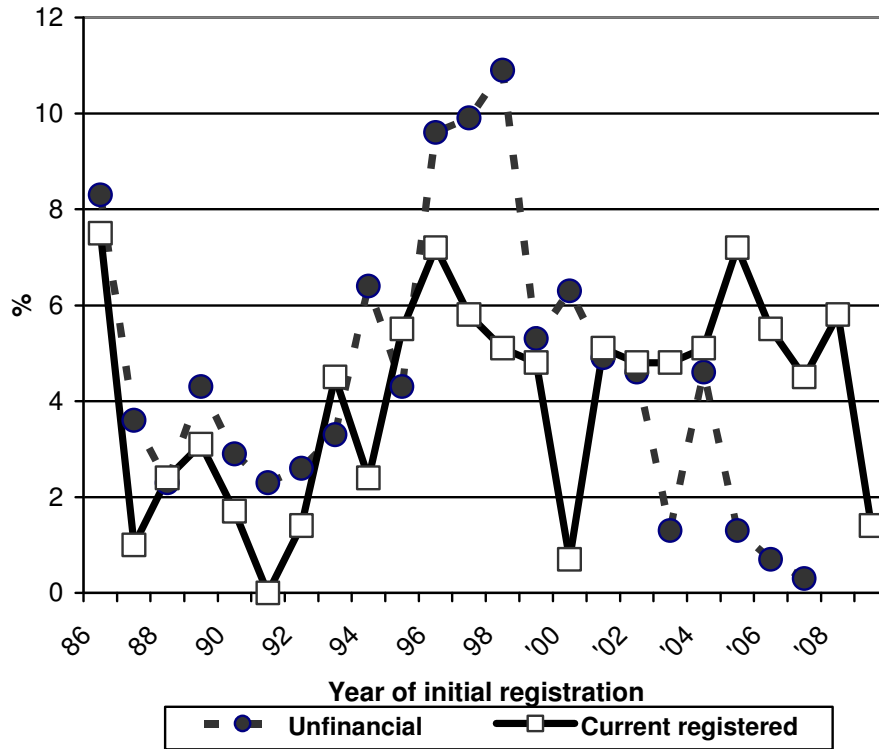


8. The inactive workforce ‘pool’ — How important?

In an earlier section it was noted there are slightly more AHWs that were registered in the past but are now unfinancial (312) than those who are currently registered (294). Of course currently registered AHWs make up the current active workforce and the most likely to return component of the ‘inactive’ AHW workforce. It is worth comparing the two populations for any differences.

In Figure 11 below, the unfinancial and currently financial registrant populations are compared on the basis of year of registration. The currently registered population is more recently registered, just under half (44.9%) having been registered since 2000 whereas only 17.7% of unfinancial registrants were registered after 2000. Interestingly, over 30% of unfinancial registrants were registered in the three years 1996 to 1998.

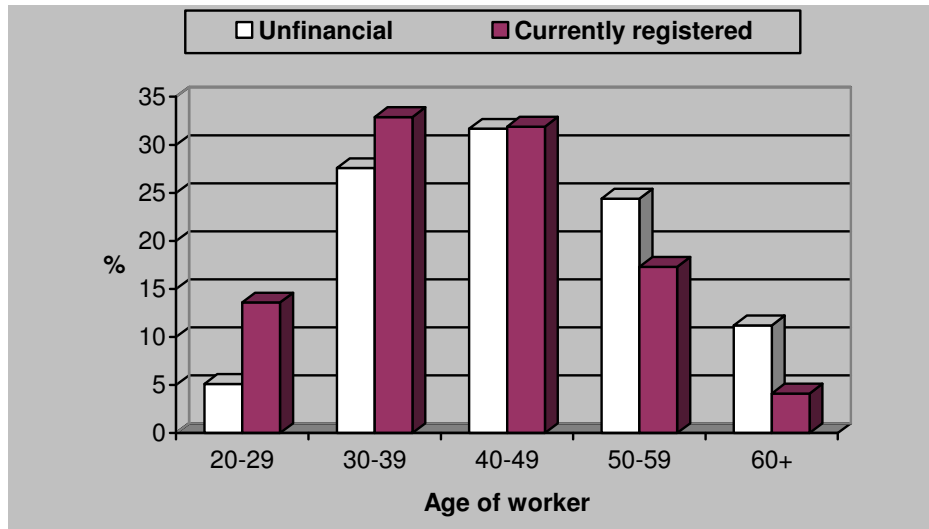
Figure 12: Comparison of current financial and unfinancial registrant populations on the basis of year of initial registration



A similar comparison between the AHW unfinancial and currently registered registrant populations on the basis of age is provided in Figure 12. The currently registered AHW population is slightly younger than the unfinancial population.

While as yet inconclusive, on the basis of the above analysis there are some qualitative differences between the populations. As a source of additional labour to the active AHW workforce, the unfinancial registrant population seems not to be a particularly fertile potential source. Because of the timing of their initial registration unfinancial registrants are most likely to experience genuine difficulties re-entering the AHW workforce and the significant cost (both financial and emotional) of upgrading their qualifications would be a barrier. Along with this, the population is of greater age with over half older than 40.

Figure 13: Comparison of current financial and unfinancial registrant populations on the basis of age category of worker



9. Discussion

This initial report has attempted to review and analyse available secondary data, viz registration board and PIPS databases. As always in analysing secondary data much of the information gathered is of a descriptive nature. It is possible to know that the AHW workforce is mostly female, old when compared to other health professions, comparatively stable once over the initial years of employment, and compared to other health professions, much more of the AHW workforce in the NT is located in remote areas. Still many questions remain, the most important being as yet no exact estimate for active or inactive workforce size is possible because employment in Community Controlled Organisations is unknown. A planned survey of these organisations as part of this review is hoped to reduce some of the uncertainty.

Prior to undertaking this analysis several strongly held perceptions about the AHW workforce were identified through various stakeholder consultations. These included:

- There is a sizable pool of potential workforce re-entry candidates;
- In the DH&F AHW workforce there is a 'logjam' of workers on middle and lower level pay classifications with little prospect of advancement;
- AHW staff turnover from the DH&F workforce is very high. This turnover along with limited new supply contributes to a widely held view that AHW numbers are dwindling.

Let us discuss these in order to establish what the available data reveals.

First, there is indeed a sizeable pool of AHWs who were once registered and now are unfinancial, indeed this is a larger population than the current number of financial registrants. Conventional wisdom though, and a large number of studies of other health workforces⁶, would suggest that those who have allowed their registration to lapse are highly unlikely to return to the workforce⁷. A more likely pool of possible workforce re-entrants is the population of registered AHWs who are currently not working. The size of this population as yet is unknown, but one estimate places the number between 80 and 90.

Second, there is a high proportion of AHWs in DH&F services employed at Level 2 and 3 (see Figure 7) and a significant proportion at these levels appear to be long serving employees. Most interpretations of the determination would suggest progress beyond the Level 3 classification would be difficult if not impossible now without obtaining a current Certificate IV qualification. A review of the current determination would seem reasonable. While a full review is beyond the scope of this project, comment on the current EBA and determination will be forthcoming in later reports for this project.

Third, and possibly of most concern to a majority of stakeholders, is the perception that AHW numbers employed, especially within DH&F, are gradually reducing. The initial evidence does not suggest this to be the case, with a fairly consistent level of employment of AHWs over the last three financial years between 100 and 110 FTE. This level of AHW employment appears to have been equally consistent as far back as 2002.

What might be fuelling the perception of reduction, in spite of the immediate evidence to the contrary in regard to absolute AHW numbers is the *relative* position of the AHW workforce. There are at least three ways that the AHW workforce can look poorer in comparison than by observing the absolute figures alone:

- When AHW numbers are compared with the rest of the health workforce;
- When actual AHW employment numbers are compared with forecast numbers; and
- When growth in AHW numbers (virtually static) is compared with growth of other categories of health worker (notably the nurse workforce).

Each of these forms of comparison is discussed below.

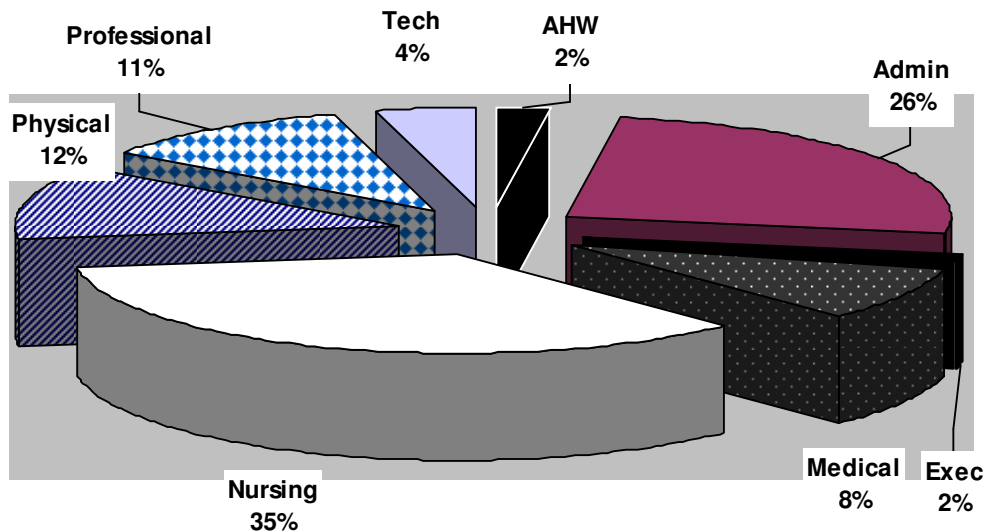
⁶ See for instance ... Human Capital Alliance (2008) *Allied Health Workforce Re-entry Research Project*. Prepared for Department of Human Services by Dr S Kendall, L. Ridoutt & Dr A. Shoo.

⁷ There are admittedly reasons to argue that the AHW workforce might behave differently to other even health workforces.

Figure 14 places the size of the AHW workforce in context. Based on DH&F payroll figures for the 26th pay period of the 2007 / 2008 financial year, the total workforce is proportioned on major workforce categories.

This figure shows that while the Northern Territory AHW workforce has achieved almost iconic status, and is widely regarded as critical to the delivery of services, it accounts for just over 2% of the total health workforce. Even if only 'front line' staff categories are counted, the AHW workforce still only accounts for 3% of the total service delivery workforce. The AHW workforce is dwarfed by other major workforce categories, especially nursing (nearly 20 times larger) and medical practice (four times larger).

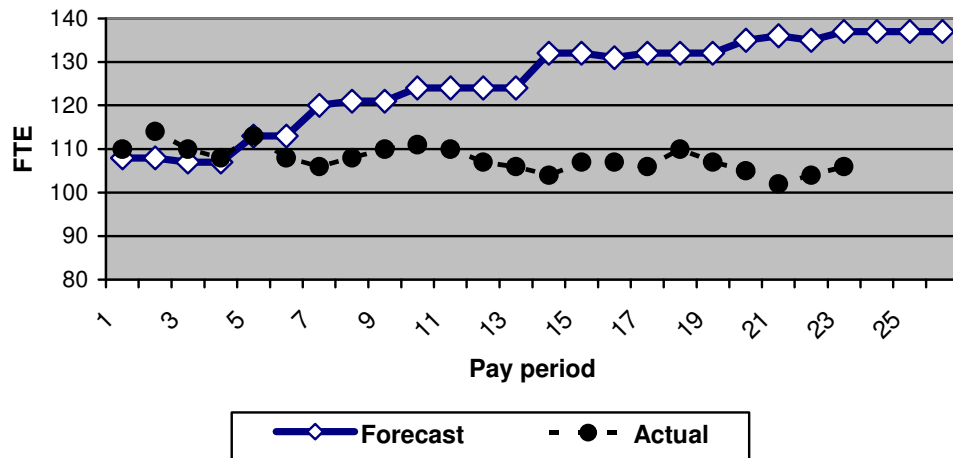
Figure 14: Distribution (%) of the total DH&F employed workforce by category of worker (June 2008)



In Figure 15, actual numbers of AHWs employed at each pay period throughout the 2008 / 2009 financial year are compared with forecast employment. 'Forecast' employment is the fulltime equivalent numbers that have been budgeted for in the DH&F funding.

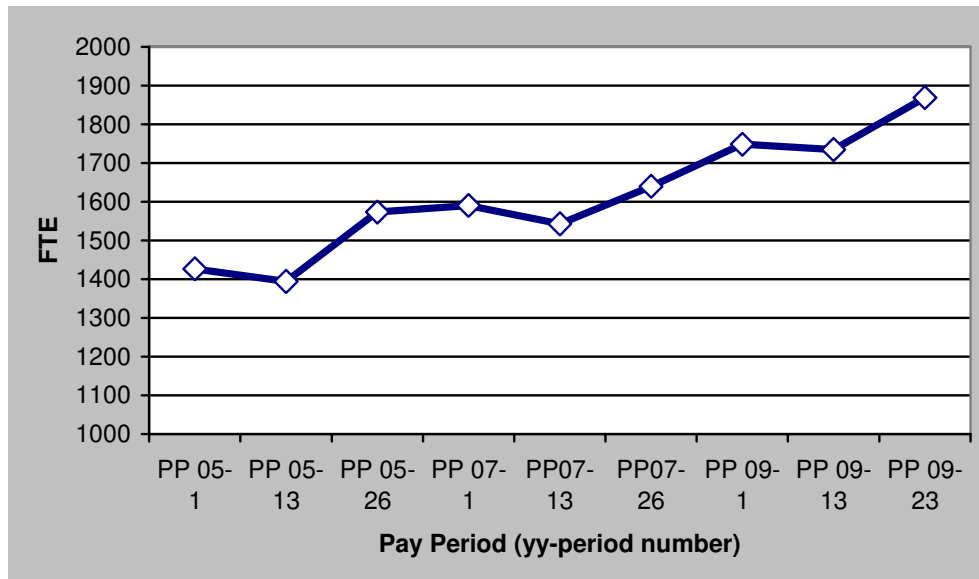
The graph shows that after starting the year with equivalence between the actual and forecast numbers, by close to the end of the year (pay period 23 in the case of actual since the remaining 3 pay periods had not yet been paid) a significant gap had developed. In essence, a 22.6% shortfall had evolved from continued rise in AHW employment expectations through the year but a virtual flat line in actual employment (ranging from a low of 102 FTE to a high of 113 FTE). This could be interpreted as unmet demand for AHW labour within DH&F, although there are other ways to estimate AHW labour demand and therefore unmet needs.

Figure 15: Trend in AHW FTE employed and forecast for the 2008 / 2009 Financial year



The outcomes for the AHW workforce in regard to achievement of forecast employment can be starkly contrasted with the nursing workforce. By pay period 23 of 2009 the actual number of employed nurses was 1869 FTE, while the forecast number for the same pay period was 1861 FTE. More generally, the DH&F nursing workforce has been steadily growing for the last several years as shown in Figure 16 below.

Figure 16: Trend in Nursing FTE employed from the 2005 to 2009 Financial year



Since the low point of DH&F nursing employment of period 14 in financial year 2004/5 of 1358 FTE until the last pay period (pay period 23 of 2009) when the number employed was 1869 FTE, the number of nurses employed has grown by 511 FTE. This represents approximately a 38%

growth in the nursing workforce over five years, or around a 7.5% growth per annum. By any standards the annual growth in the nursing workforce is high, significantly higher than for the total Australian nursing workforce, and very high when compared with the AHW workforce. During the same time period the DH&F employed AHW workforce has virtually remained constant, no doubt contributing to a perception of reduction *when compared with* the nursing workforce.

Clearly the AHW workforce, certainly within the DH&F for which we have sound statistics, is at a cross road. Left unattended and at the continuing whim of the current Departmental workforce employment trends, the already small relative workforce contribution of AHWs would inexorably be further eroded, even if absolute numbers could be maintained.

Observers are warranted in their perception that a degree of crisis surrounds the future of the Aboriginal Health Worker workforce. Future reports in this project will attempt to define the elements of this circumstance and seek potential solutions.