

Supporting workers and communities nationally through recognised skill development and qualifications

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Workforce development comprises improving the capacity of occupations to respond to health needs of the community by systematically identifying and addressing the many complex factors that influence the skill level and sustainability of the workforce. Training is only one of a number of related strategies to this end. Sustainable development of the community services and health (CS&H) workforce may require changes to workplace structures and structural supports, information supports and sometimes incentives for employees.¹ This paper focuses on the development of competency standards as a tool for workforce development.

One of the issues affecting skilled labour supply has been the lack of a national training framework for all Workers providing services within the health system. The Health Training Package has provided a skills framework to cover Australia's Vocationally Trained workers, to facilitate ready access to training and structured skill development pathways that other industries take for granted.

Within the health sector, the focus is often on training for University qualified staff, and the needs of other workers may be overlooked. This workforce is however an equally essential component of the delivery of health services throughout Australia and comprises over half of the employment base. In some remote areas the percentage may be higher. The bottom line is that all workers in the industry ought to have essential skills that will guarantee that clients receive the best and safest services and that our workers are able to do their job without risking injury and ill health.

In some areas of the industry covered by the Health Training Package, there is a very high percentage of workers without any formal post-school training or qualifications. Some of these may suffer additional disadvantage by having language or cultural barriers to acquiring new skills. A further challenge in developing the health workforce of the future has been the belief that "Health care provided by Indigenous people is an important strategy to improve health care and increase the health status and life expectancy of the Indigenous population".

The challenge for us in the health industry is to develop new and better ways to provide for skill development and enable lifelong learning in the workplace for all its participants.

THE ROLE OF THE ISC IN WORKFORCE PLANNING AND DEVELOPMENT OF THE CS&H INDUSTRIES

The **Community Services and Health Industry Skills Council** (ISC) declared by the National and State Training ministers provides Vocational Education and Training (VET) leadership to these two major industry sectors, which between them cover 9.7% of the total Australian workforce. The ISC is the official voice on VET needs of Australia's second fastest growing combined industries.

The overall strategic direction for the ISC is captured in its simple yet powerful vision as follows:

Australia will have a community services and health workforce with sufficient competence such that, if deployed and managed well, it will always respond appropriately to the needs of the Australian population so that their health and wellbeing is promoted, maintained, and where necessary restored.

The ISC manages two Training Packages: Community Services (CHC02) and Health (HLT02), both of which were endorsed in 2002. In these Packages all qualifications have some requirements of competence relevant to improving the health of Aboriginal and Torres Strait Islander people through defining the workplace standards of competence for skilled workers in the industries. We have recently completed work on a new stream of qualifications for the Health Training Package called Population Health. These competencies and qualifications also include a stream of qualifications for Indigenous Environmental Health Workers, incorporating qualifications from Certificate II in Indigenous Environmental Health to Diploma in Indigenous Environmental Health.

FACTORS UNDER CONSIDERATION

1. Population factors

At 30 June 2001, the experimental estimated resident Indigenous population of Australia was 460 140, or 2.4% of the total estimated resident population of Australia the Indigenous population is considerably younger than the non-Indigenous population and is over represented in most indicators of ill health when compared to the non-Indigenous population.²

The overall Australian population will however experience further ageing of its population over the next four decades. Overall, the proportion of the population that is very old (over 85 years of age) is expected to triple, while the proportion in the prime working age range of 15 to 64 is expected to fall. As fertility declines, this will accentuate the financial and social impact of an ageing population. In the past century, the proportion of the population aged over 65 has risen from just over 4 per cent to nearly 12.5 per cent. By 2042, around 24.5 per cent of Australia's population are expected to be aged over 65.³

Workforce profile

Health and community services labour force, 2001, ABS/AIHW

In 2001⁴, there were **798 295 people employed in health and community services industries** (representing growth of 10.6% since 1996). There were 450 792 people employed in health occupations and 237 055 employed in community services occupations (representing growth of 11.4% and 26.8% respectively, since 1996), i.e. a total of **687 848⁵ people employed in health or community services occupations**. The health and community services industries employed 9.7% of the Australian workforce in 2001, and are a major employer of women, employing a much higher proportion (17.1%) of the female workforce. These industries are also predominantly female: females make up 74% of the health industry and 86% of the community services industry. (Although Numbers of men and women are much more equally distributed in disability, youth work and drug and alcohol work. In these areas, males are often in management positions).

The above figures exclude an estimated 974 000 (FTE) of household members delivering welfare services at almost no charge.⁶

Some observations about the Aboriginal and Torres Strait Islander workers in the Community services and Health industries⁷

- Health care provided by Indigenous people is one strategy to improve health care and increase the health status and life expectancy of the Indigenous population.
- There were 3742 Indigenous people employed in health occupations, comprising 0.9% of health workers – well below the 2.4% Indigenous proportion of the population. Of these workers, 853 were employed as Indigenous health workers.
- Aboriginal and Torres Strait Islanders comprised approx. 2.7% (6294) of the community services workforce.
- No nationally consistent training framework for Aboriginal Health Workers (clinical) is yet available; inadequate access to appropriate training for these health workers is acknowledged.
- Need for development of competencies and qualifications for management and governance training in Aboriginal health services.

Data collected by SAR on full-time equivalent positions at June 2001 in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services identifies⁸:

- At 30 June 2001, 2314 full-time equivalent positions were reported to exist in Australian Government-funded Aboriginal and Torres Strait Islander primary health care services.
- Western Australia reported the highest number of full-time equivalent positions (529), followed by the Northern Territory (494).
- Aboriginal Health Workers comprised 27% of this workforce, while Indigenous nursing staff and GPs represented 9.4% and 7.0% of the full-time equivalent positions in these services.
- Of specific note the data identified:
 - 71.9 substance misuse workers
 - 623.8 Aboriginal health workers
 - 25.8 Environmental health workers

2. Qualifications and training data

Data from the ABS 2001 Census of Population and Housing which are not restricted to the public sector employed health workforce identify a range of factors about the existing workforce including⁹:

- Aboriginal and Torres Strait Islander people are underrepresented in the Australian professional health workforce, representing 1.3% of the Australian health workforce.
- The states with the greatest proportion of Aboriginal and Torres Strait Islanders in their professional health workforce were the Northern Territory (9.0%) and Queensland (2.2%). Nursing was the most common profession for Aboriginal and Torres Strait Islander people working in the health services delivery sector.

- Queensland and the Northern Territory had the largest numbers of Aboriginal and Torres Strait Islander health workers.
- In the category of management and support staff, most Aboriginal and Torres Strait Islander people were employed as policy officers, project officers or administrative workers

Further data from the Aboriginal and Torres Strait Islander Health Workforce Strategic Framework while noting likely underestimation of the number of Aboriginal and Torres Strait Islanders enrolled and qualified for the 2002 calendar year identified¹⁰:

- The majority of Aboriginal and Torres Strait Islander students (57%) who qualified as Aboriginal Health Workers in 2002 completed the Certificate II course.
- Of the professions presented, enrolments in Aboriginal health work attracted the highest numbers of Indigenous students in 2002 (1653). Allied health and university nursing studies also attracted larger numbers of students.
- The majority of Aboriginal and Torres Strait Islander people who held a health qualification (822) were Aboriginal Health Workers. This was also the case for the 1653 Aboriginal and Torres Strait Islander people training.
- Queensland had the highest number of Aboriginal Health Workers (468 qualified and 306 enrolled), followed by New South Wales (301 qualified and 330 enrolled).
- There were 96 Aboriginal and Torres Strait Islander people who qualified as nurses in 2002, including university and non-university trained, and a further 586 were in training.
- There were 40 Aboriginal and Torres Strait Islander people who qualified as allied health workers in 2002, and a further 394 were in training.
- No Aboriginal and Torres Strait Islander people were qualified in dental health, and only two were enrolled in training.
- One Aboriginal and Torres Strait Islander was qualified as a pharmacist, and 10 were enrolled in training.¹¹

Some broad figures about the Australian Populations levels of education also highlight some interesting challenges for the development of the Health and Community Services Workforce.

- 18% of persons aged 15–64 years attained a Bachelor degree or above;
- 30% obtained non-school qualification of Advanced Diploma or below (15% had a Certificate III or IV)
- 20% of the surveyed had Year 12 as the highest educational attainment
- Approx. 30% reported their level of highest educational attainment as being Year 10 or below.¹²

3. Policy

Some would argue an economic rationalist approach drives current management and funding practices in health. Regardless of your views, the Health Market Place is characterised by the following trends

- Increased management of outsourced workforce;

- Negotiating to determine market advantage over supply of product prices;
- Subcontracting non-core business to market conditions and those functions that are retained also being subjected to semi market contractual obligations within the organisation;¹³
- Reengineering for work efficiencies through
 - supply-chain management
 - consolidation of back-office functions
 - redesign of care delivery and
 - reorganisation of work.¹⁴

These trends bring specific needs for management competence and organisational development practices. Add to this Government policy influencing reduction of bed provision ratios, with an emphasis on reduced length of stay and expanded day hospital procedures. These trends are driven partly by pressure for increasing productivity, but also changing patterns in medical practice and improved medical technology.¹⁵

Commonwealth Health and Ageing policies are being influenced by the findings of the Treasury Intergenerational Report, 2002 and are driving a change towards investing in promoting and maintaining good health and improving productive capacity of the workforce.

4. High quality services

There is an increasing demand for quality service in all areas of business, including Health. Like all successful businesses providing responsive and flexible solutions to meet customer needs for Quality is essential. In service organisations such as health this provides particular challenges. In Health as in all other businesses the quality of service is determined in individual transactions between “servers” and customers, which occur literally thousands of times each day in large organisations. Service quality is inherently subjective and personal and not as easy to measure as tangibles such as waiting lists and bed days. However the executives and managers within the broader health services are increasingly going to have to consider their patients as customers and changes must be driven from a customer-centric perspective and all this means in a modern business.¹⁶

5. Workplace culture

It is fair to state the highly regulated environment of the health workforce, while bringing some comfort on patient safety issues provides obstacles to the establishment of modern business practices such as multi-skilling and cross functional team building, both required to move to a customer service driven culture.

Moreover the workforce of tomorrow challenges management to undertake a greater recognition of the individual as part of a total company’s outputs. The difference between competing businesses is the people. Everything else can be copied. People will be recognised as the only resource that can instantly differentiate a Company or department’s ability to deliver. Already in this paper I have highlighted some statistics, which are providing some markers about the future labour supply for health. For example; more than 80% of the projected growth in the labour force between 1998 and 2016 will be in the 45 years and over age group, an

increasingly part time and feminised workforce with 50% of the population as potential employees with Year 12 or less qualifications.

In amongst all of that, there are 3 noticeable trends that are emerging:

- people are moving very strongly towards work–life balance models
- people are motivated by a complex structure of rewards that are heavily supported by non-financial benefits
- people will move quickly if their expectations are not met.¹⁷

It is easy to forget that the work of high performance professionals depends on the knowledge and skills of many others in the organisation. Implementing concepts such as communities of practice, developing networks of knowledge and skills sharing, across all-important aspects of business, sharing ideas and developing and testing knowledge and assumptions are essential in the modern, sustainable workforce. The growth of activities that support learning organisations are a broader part of a movement not just around corporate sustainability but also human and societal sustainability.¹⁸

This is a significant challenge to the health service culture with large numbers of workers not included in decision making or considered as important to creating a customer service culture. The negative connotations of being a “Third Level” worker in Health are obvious with some workers disparagingly referred to as “blue collar” workers, “people off the streets”, “unregulated” and “untrained”. Moreover some research in Australia and New Zealand identifies that bullying by health professionals is a significant problem in the health workforce and contributes not only as a disincentive to retention of staff but has an impact on safe staffing strategies.¹⁹

SKILLS REQUIRED TO MEET THE WORKFORCE NEEDS OF THE FUTURE

Providing services and workforce development within this changing environment calls for a fluid, multi-skilled workforce. It was identified during the Project to develop the community services competencies and qualifications that the nature of work in the community services sector has changed considerably in recent years. Key changes are identified as:

- a greater emphasis on analysis of strategic need and defining outcomes in funding arrangements
- an emphasis on developing community capacity to be a stronger partner in the design, delivery and evaluation of services
- provision of stronger integrated services across agencies, sectors, areas/regions and jurisdictions
- delivery of appropriate services, especially to remote and regional locations
- greater attention to prevention and early intervention strategies.

Changes in knowledge requirements were also identified acknowledging that all work undertaken in the industry will reflect an understanding and application of:

- knowledge about the changing social, economic and political climate as it impacts on the industry
- the principles of social justice, human rights, anti-discrimination and confidentiality
- practices to address cross-cultural issues
- relevant OHS and employment equity principles and practices
- principles of a non-discriminatory service
- the impact of personal biases and experiences
- individual differences of clients and colleagues, including those relating to cultural, social, economic, physical and health
- consideration of the needs and rights of the individual, the family, the community and society
- a client-centred approach to work
- the holistic needs and rights of clients (as individuals and as a community)
- work practices include strategies to empower individuals and groups, promote individual independence, and to respect the rights and dignity of clients and colleagues.

Training packages capture the complexity of work for VET level workers in the industry. The standards developed reflect a complex interrelationship of duty of care, ethical behaviours, personal values, service delivery standards and methodologies.

However one of the challenges faced in developing the Vocational workforce is the demarcations over knowledge and skills by various professional groups, the VET goal being to establish training pathways that can be customised and support new technologies and work practices. Professions' "turf wars" challenge workforce policy makers, HR Managers and Practitioners alike as they grapple with the implementation of training and career development for the whole workforce. In conclusion, Training Packages offer all these stakeholder groups a range of tangible benefits to assist in meeting these challenges.

BENEFITS OF IMPLEMENTING TRAINING PACKAGES

There are a range of benefits for Employers, Employees and Training Providers in developing and implementing national training Packages, for example:

New recruitment pathways have been created which provide ready access to training and structured skill development pathways that other industries take for granted such as apprenticeships and traineeships. Commencing Health workers on a learning pathway, and providing opportunities and support for proceeding along that pathway will be vital for the future of the industry. This will be of particular significance in rural and remote areas where we are learning that keeping people in the local community as workers also ensures services will be provided in the long term, rather than requiring our future health workers to leave their communities to access training.

Using the Training Package can impact on organisational culture, through promoting staff through training to take personal responsibility for delivering a quality service in line with the

organisation's quality framework. It also provides a common language for different agencies within the sector to communicate with each other, negotiate, agree and understand each others' roles and responsibilities, to support each others' work and hold each other to account. This allows for the reorganisation of services and the opportunity to create a sustainable workforce.

DIFFERENT QUALIFICATIONS AND WHERE THEY FIT

The CS&H workforce consists of a range of workers with the potential to improve health and well-being of Aboriginal and Torres Strait Islander People and Communities. The following table provides a sample of this workforce and highlights those workers in the shaded boxes whose work role is covered by a Training Package.

doctors (GP, accident and emergency, medical officer, psychiatrist)	nurses (registered, mental health, community/outreach)	pharmacists
occupational therapists	paramedics	psychologists
social workers	podiatrists	epidemiologists
ambulance officers	Aboriginal and Torres Strait Islander health workers	welfare and community workers
youth worker	prison and community officers	Indigenous environmental health workers
health education officer	family support worker	community education and health promotions officer

APPENDIX 1: OTHER WORKFORCE PROFILE STATISTICS

ABS data provides the following workforce profile:

- male full time workers are 76.6% and part time are 33.4%. Female full time workers are 52.4% and part time 47.6%
- 39% of the CS&H workforce is over the age of 45. By 2016, 29% of the total population will be 55+, and the pool of labour from which the industry will draw will be increasingly aged. Indeed, there will be 80% growth in the 45+ bracket of the workforce. At the same time, young workers (where there is 30% unemployment) have not been traditionally favoured by the industry
- 26% of CS&H workers were born outside of Australia
- Aboriginal and Torres Strait Islanders make up approximately 0.9% of the health workforce and 2.7% of the community services workforce²⁰ compared with the national workforce participation rate for Aboriginal and Torres Strait Islander people (approximately 1 %)
- employment in the two industries manifests a number of unique and potentially challenging characteristics. These include:
 - is to be found in every inhabited region of Australia

- covers a diverse range of services, service providers, delivery methods and types of locations for the delivery of services
- is found in micro businesses (health areas such as dental assistants and complementary and alternative health), medium size organisations (community services) and very large organisations (health industry workers)
- is provided by a mixture of government and non-government organisations (for profit, not for profit and charitable) with government as the main provider and funder of services a 2000 ABS survey of the community services industry alone identified 9287 organisations providing community services of which only 6% were government classified viz:
 - o 2800 'for profit' organisations
 - o 5938 'not for profit' organisations
 - o 548 government organisations
- is found in some 200 occupations in the Health Industry and 121 occupations in the Community Services industry.

APPENDIX 2: KEY VET UNDERSTANDINGS

What is VET?

Vocational Education and Training (VET) is referred to as “education and training for work”. It moves away from the traditional “classroom and curriculum approach” to training and instead recognises that there are alternative methods for people to learn. Competence may be achieved on the job, through self-study, a structured course, through the Internet, on a computer or even at home.

What is the Australian Quality Training Framework (AQTF)?

AQTF is the nationally agreed ministerial council required quality arrangements for the VET system. It forms the basis upon which competencies are developed and agreed and ultimately assessment and training will be undertaken and/or delivered. The Australian Qualifications Framework (AQF) is a feature of the AQTF and the work we undertake usually addresses AQF levels 1-6, or Certificate I to Advanced Diploma.

Training packages

Training packages (TPs) are sets of nationally endorsed²¹ components for training and skills recognition, are a critical tool in the promotion of VET, and provide the central system of VET architecture by specifying the combination of *competency standards* required to achieve a *qualification*.

Training packages²²:

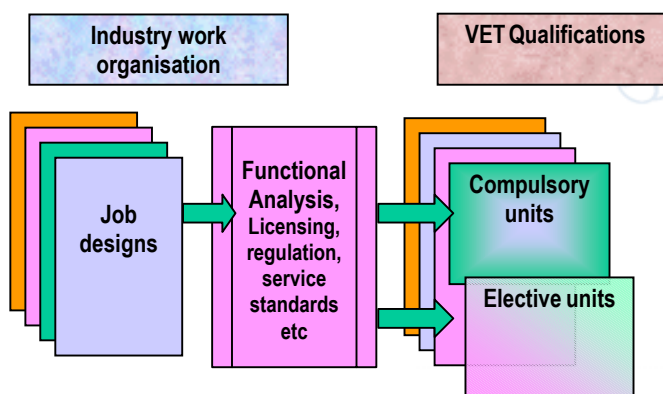
- comprise *national competency standards* which are packaged into *qualifications* and give guidance on *assessment*

- are based on evidence and job analysis
- are based on levels referenced to the Australian Qualifications Framework (AQF)
- are developed in consultation with the industrial parties (employers and unions) – (Professional bodies and RTOs are also consulted also have a determinative)
- competency standards are derived from functional analysis and therefore competency standards reflect major job functions
- compulsory competencies reflect the “core” of a family of jobs and elective units are used to reflect variations in job design (or particular contexts).

TPs do not contain learning resources i.e. they are not training manuals. They are the agreed industry requirement for performance on the job of a particular group of workers and there are a range of requirements that National Industry Skills Councils have to consider in developing them:

- qualifications based on evidence and job analysis
- levels based on AQF
- entry requirements including prerequisites
- avoid duplication and overlap (this is essential to workforce development to promote career pathways and portability of qualifications across Australia within and across industries).

Industry Jobs and Qualifications Not Symbolic: Direct Relationship



For all of these reasons, the consultation process is a tripartite process involving Government and Private Employers and all unions that have coverage of the workers. Consultation is also necessary with Regulation Authorities, State Training Authorities who fund training at a State level, and Registered Training Organisations. It is also important to note that linking learning and assessment resources to national qualifications and competency units ensures the job that people do is the driver for training outcomes. This promotes improved engagement in training by employers and learners because they know the training in which they invest is directly related to work outcomes.

PRESENTER

Di Lawson has worked as a learning and business development specialist for over 12 years. Her research, publications and consultancy portfolio includes the conduct and management of a range of national competency and training projects in health, business administration (HR) and financial services. As an HR development consultant to the public and private sector Di has assisted many organisations in finance, health, community services, and general business to implement assessment and staff development based upon national competency benchmarks. Di has particular strengths in business development and management of vocationally oriented training. Her recent achievement of turning around the business fortunes of a national registered training organisation (RTO) and group training company (GTC) in the finance sector has been her most challenging and rewarding. Di lead this organisation from one with two courses and 150 learners, in financial difficulty to a financially successful business with over 1000 learners and 10 qualifications across every state in Australia in a two-year timeframe. This work earned her a nomination as Telstra Business Woman of the year. Some of the competency projects that Di has enjoyed researching or managing have included: National HR practitioner competencies and curriculum assessment framework; Remote Area, Drug and Alcohol and Critical Care nurse competencies; Financial Services Reform Act 2001 workplace competency assessment; Australian Nursing Council review of Enrolled and Registered Nursing Competencies; Training Needs Analysis, Australian National Credit Union; CBT consultancy for Hong Kong Hospital Authority; and redevelopment and implementation of Diploma in Financial Services for Credit Union Directors. Di holds a Masters in Education and qualifications in Nursing and Women's Studies, and is presently completing an e-commerce qualification.

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- 1 Outcomes of the NSW Summit on Alcohol abuse Changing the Culture of Alcohol use in NSW May 2004.
- 2 ABS National Health Survey: Aboriginal and Torres Strait Islander Results, Australia 2002.
- 3 Intergenerational Report of Treasury 2002–2003 budget papers.
- 4 Note that all employment numbers quoted in this publication are raw counts only. "There has been no adjustment for the average number of hours worked, as this cannot be calculated from census data. As a result, it is not possible to provide full-time equivalent (FTE) numbers".
- 5 There is not a direct match between the occupations and the industries because some of those employed in health or community services occupations work in other industries, while people employed in occupations other than health or community services work within the health and community services industries.
- 6 Australia's Welfare 2001, AIHW.
- 7 CS&H Industry Skills Council Strategic Plan 2004–2008.
- 8 Full-time equivalent positions employed by Australian Government-funded Aboriginal Torres Strait Islander primary health care services (a), 30 June 2001 Determinants of Health Access to Services Indicator.
- 9 Determinants of Health Access to Services Indicator 20 p 74.
- 10 Aboriginal & Torres Strait Islander Health Workforce National Strategic Framework AHMAC May 2002.

- 11 Determinants of Health Access to Services Indicator 21 p 79.
- 12 Education and Work, Australia 6227.0, in May 2002.
- 13 The sustainable Corporation Organisational Renewal in Australia Dexter Dunphy and Andrew Griffiths 1998 p 163.
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- 15 Australia's Welfare 2001.
- 16 Senge Peter M. The Fifth Discipline The Fifth Discipline The Art and Practice of the Learning Organisation 1994 p. 333.
- 17 Information from collected articles and research from: Harvard Business Review, USA HR Planning Society, Hewitt Associates, American Society for Training & Development, Australian Business Review Weekly 2002.
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- 19 Work restructuring: A systems approach to designing the clinical workforce of the future Dr. Robin Youngson. and Safe Staffing – What are the issues? Professor Clifford Hughes. , AO. Presentations at the Health Leaders Network Conference April 2003. Melbourne www.hln.com.au.
- 20 Health and community service labour force, 2001, ABS/AIHW.
- 21 Endorsement is the formal process of recognition of Training Packages (TPs) undertaken by the National Training Quality Council (NTQC).
- 22 It is important to note that under the Australian Quality Training Framework Standards, State and Territory Registering/Course Accrediting Bodies would prohibit the accreditation of any course where it is covered by a TP qualification and that any courses submitted for accreditation must use nationally endorsed competencies if they are available.