Community Services and Health Industry Skills Council

Submission to Productivity Commission: Health Workforce Study –

Issues Paper

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Basic Premise

The Community Services and Health Industry Skills Council (ISC) strongly contends that any examination of the Health workforce in isolation from community services and its workforce is limited at best. The activities identified as 'health' activities in the definition included in the Productivity Commission Report 2004 Report on Government Services[1] occur in both health and community services settings. It is therefore not possible, given the continuum of care across health and community services, particularly in relation to aged care but also across the broader areas of health and community services, to consider one in isolation from the other.

The community services sector has an important role to play as a co-participant in better health outcomes for Australians. Health promotion roles are currently undertaken by a myriad of job roles within community services and scope exists to extend this beyond current practice for better and more efficient health outcomes. Strategies which address prevention and early intervention, thereby reducing the need for costly treatment and long hospital stays, contribute to a more efficient and effective health and community services system.

1 The Role and Coverage of the Community Services and Health Industry Skills Council

Industry Skills Councils were established during 2004, and have a broad range of functions. They have primary responsibility for the development and maintenance of Training Packages and support products. They are also **responsible for providing strategic advice on the current and future skills needs of their industries to the vocational education and training VET sector generally**. This advice includes information on the drivers of demand for skills.

The Community Services and Health Industry Skills Council (ISC) is recognised as the peak national body providing advice on the training and skills development needs of the community services and health workforce to government and industry, and has a critical role to play within the VET sector. Specifically the ISC carries out these functions in ways including the following:

i. rationalising Training Packages across industries and identifying cross-industry skills and units of competency to facilitate greater transferability of qualifications across industries and occupations;
ii. improving information and Training Package support materials for recognition of prior learning (RPL), so that more options are available for existing workers seeking to have their skills recognised;
iii. maintaining an appropriate membership, including broad representation from employers and employees; and
iv. embedding employability skills and transparent assessment of these skills into Training Packages.[2]

In preparing this submission for the Productivity Commission's Issues Paper, the ISC has drawn on extensive research and literature most notably its Draft Industry Skills Report May 2005. The purpose of this report was to identify implications for the skills base of the community services and health workforce and identify skills strategies. In developing the Industry Skills Report, the ISC sought feedback from stakeholders on a draft. The draft report was downloaded almost 1,000 times from the ISC website, www.cshisc.com.au, in the month of January 2005, distributed in hard copy to 155 industry organisations, and electronically to over 5,000 stakeholders. Approximately 40% of the organisations specifically invited to provide feedback did so and this feedback came

[1] Health services raise awareness of health issues and promote health; diagnose and treat illness and injury; and provide rehabilitation and palliative care. Government and non-government providers deliver services in a range of settings

[2] Skilling Australia – New Directions for Vocational Education and Training, Department of Education Science and Training, February 2005 section 4.2.2

from a variety of government and non-government employers, unions, peak bodies and other key stakeholders.

2 The Role and Coverage of VET

- The VET sector involves competency based training and qualifications. Basic premises include work readiness and demonstrating the skills and knowledge to do a job. Competencies themselves must be directly relevant to a job role. Employers and employees are an integral component of the development of competencies. The development, endorsement and review processes ensure the relevance and currency of competency standards and qualifications.

- The contribution VET has to make to the skills shortage debate is highlighted in the following principles:
  - i. workers can and do learn on the job;
  - ii. as a minimum, training should be aligned to a vocational outcome;
  - iii. industry should be able to have confidence in the consistency of skill sets they seek to purchase;
  - iv. the recognition and training process should be based on competence achieved not training hours.[3]

- National competency and qualification benchmarks in Training Packages are increasingly being used by employers as part of workforce planning strategies, to improve job design and career pathways, and recruit and select staff.[4]

- Improvements required in VET include recognising the competence of the large number of unqualified workers, upskilling unqualified workers, advancing the skills of Certificate III and IV qualified workers and providing practical competencies to professionals through national competency benchmarks.[5]

- In the health industry, only 47% of workers have qualifications delivered by the higher education system. In community services, the figure is 17%.[6] The Health and Community Services Training Packages cover a large section of the workforce across a myriad of job roles. See Appendix One. Additionally see Appendix Two and Appendix Three for existing listings of the work areas reflected by the two Training Packages.

- The value of considering the community services and health industry workforce as a continuum of skills across VET and higher education is indisputable. Such consideration allows not just for a better focus on the vexed issue of articulation between VET and Higher Education, but also brings greater scope and flexibility to thinking about skill requirements and skill formation strategies.[7]

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[3] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p7
[4] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p7
[5] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p7
[6] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p18
[7] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p11

3 Regulation of the Health Workforce

- Industry sectors and regulatory bodies must consider whether licensing requirements are necessary and whether they can be modified so they do not unnecessarily impede entry into the workforce, particularly in professions suffering from acute shortages.[8]

- The licensing requirements and accreditation processes must be reviewed for VET workers who are relied on more heavily to reduce acute shortages in the workforce.[9]

- Competencies relating to quality and continuous improvement must be included in Training Packages and implemented across workplaces. The latest evidence-based practice must be identified and systematically incorporated into Training Packages to instil a culture of self-regulation.[10]

- The incidence of workplace injuries is currently higher in the community services and health industries than the all industry average. Health and safety is also a concern for patients and clients, with a significant number of hospital admissions resulting from adverse events.[11]

- Workers must have the appropriate competencies to protect workers and patients and the organization's culture must make safety a priority. The competencies required to implement this culture are available in the Community Services and Health Training Packages.[12]

- Various areas of competency need to be addressed including:
  1. the ability to design a systems approach to safety
  2. the ability to continuously assess the competency of personnel with respect to quality assurance, consumer and workplace safety, and compliance with hygiene standards
  3. the ability to assess and manage risk, with a focus on prevention
  4. the ability to work well and communicate well in teams within extremely complex systems
  5. an understanding of worker and client/patient rights and duties and an understanding of legislative requirements as they apply to specific occupations
  6. an understanding of how to deal with occupational hazards such as manual handling, violence, or harmful equipment or substances.[13]

[8] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p74
[9] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p74
[10] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p74
[11] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p74
[12] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p71
[13] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p71

4 Job Redesign

- There is a need to redesign job roles in a manner which breaks down traditional functional silos, supports hybrid roles and is based on the premise that work should be undertaken by those who are competent to carry out the tasks not necessarily by those who have traditionally undertaken these roles. The blurring of boundaries in the health workforce is reflected by the increased flexibility expected from the health workforce. One challenge for the Revised Health Training Package is to meet the needs of these emerging hybrid roles, and fluid shifts between roles whilst maintaining the quality of the training provided and the vocational outcomes demanded by industry.[14]

- The changing demography of the health workforce and their consumers requires the health worker to be more flexible in their skills and knowledge as they take on broader responsibilities. In particular is the importance of skills and knowledge to facilitate smooth responses to change, skills and attitudes to improve productivity, skills to improve responses to compliance requirements and skills to improve customer service. To facilitate this, changes will need to be made to work roles, training and support, and legislation.[15]

- In the United Kingdom the National Health System (NHS) is undertaking research on the Skills Escalator Activity. The aim of this initiative is to attract a wider range of people to work in the NHS whilst supporting career potential and development across the workforce. Investing in life long learning which extends current skills contributes to wider service/process redesign and improvements in health services.[16]

- In Australia examples of strategies already in use by industry include the use of credentialing. Credentialing involves the task being broken down into component parts so that it becomes routine and then having the RN observe that the staff member is competent to perform the task. The staff member is then re-credentialed as required. In this way employers are able to utilise other parts of their workforce to perform tasks previously performed by RNs.[17]

- A lot of new developments in the sector eg behaviour intervention design and increased training and techniques to provide rehabilitation, development and assistance to consumers has changed the face of the work in health and community services. Scope exists to develop jobs and career pathways which are attractive to a wider range of potential recruits and to run recruitment campaigns which highlight these new opportunities.

[14] Health Training Package Scoping Report, March 2005 p24
[15] Health Training Package Scoping Report, March 2005 p22
[16] Mapping the progress of Skills Escalator Activity Phase 1 July 2004 Manchester School of Management UMIST Executive Summary
[17] Feedback provided by industry stakeholders on Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005

5 Workforce Planning

- The lack of comprehensive and up to date information about the health and community services workforce is a stumbling block for effective workforce planning. The NILS Report identified that 'no single data source provide(d) an accurate and detailed appraisal of direct care employment in residential aged care facilities in Australia, especially not the kind that would inform complex workforce planning.' The NILS Report aimed to do this in the area of residential aged care. Other research work of this type is needed to cover other areas of the health and community services workforce.[18]

- It is an ongoing challenge to accurately reflect the level and type of training which takes place within the existing workforce. This is in part because of difficulties with data capture, nomenclature of training type and contradictions between categorisation across the different data sources e.g. ABS, ANZIC and AVETMIS. These sources of training activity data do not reflect all the training which is undertaken in health and community services.[19]

- Additionally, there are limited workforce plans to harness this data, and the lack of inter-governmental collaboration in the planning for and provision of services undermines this process. At strategic levels of decision making there is a need for a single body which addresses Health AND Community Services AND Education and Training. Until these strategic links are in place and a commitment to a coordinated and concerted approach to decision making and resource allocation is effected, there will be limits to the effectiveness of workforce planning activity in health and community services.

- The complexities involved in the shared role in policy development and service provision between the States and Commonwealth are identified as undermining outcomes of strategies to promote workforce participation of identified groups such as over 45s, people with disabilities and persons from culturally and linguistically diverse (CALD) backgrounds.[20] The report further identified policies from different government departments which were at cross purposes and undermined the effectiveness of strategies aimed at assisting targeted groups participate in the workforce.[21]

- The use and role of volunteers in health and community services must be considered as must the role of areas such as public and social housing in the overall health and well-being of significant segments of our population. Effective models of service delivery which utilise efficiencies across sectors cannot be developed when some sectors are excluded from initial consideration and planning.

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[18] The Care of Older Australians – A picture of the residential aged care workforce National Institute of Labour Studies 'The NILS Report' Flinders University February 2004 Executive Summary p1
[19] Quote from Department of Human Services Victoria provided as feedback on Draft Industry Skills Report p 84
[20] Engaging the Untapped Workforce - Training Solutions for the Community Services and Health Industry, Community Services and Health Training Australia (now CS&H Industry Skills Council), Sept 2003 p35
[21] Engaging the Untapped Workforce - Training Solutions for the Community Services and Health Industry, Community Services and Health Training Australia (now CS&H Industry Skills Council), Sept 2003 p36

6 Education and Training

- Currently a key blockage within VET relates to the inefficiencies inherent in endorsement. Despite the highly structured consultation processes involved in the development and review of training packages, the current system allows one state or territory to 'hold the rest of the country to ransom' by refusing final sign-off. Alternative mechanisms are then followed whereby competency units or qualifications are endorsed at a state level and then placed on the national register. This current structure undermines the spirit and purpose of a nationally recognised training framework.

- There are insufficient resources within the VET structures to effectively support recognition of current competency. This includes funding for the activity of assessment itself and an unwillingness on behalf of key stakeholders to undertake this activity as a viable pathway in part or whole, to achieving qualifications.

- Variations in the quality of training delivery, as with any variations in consistency of quality, undermine the overall system. Frameworks are in place to set standards and monitor and maintain these. Despite these frameworks, variable standards of training delivery exist.

- There is a significant lack of investment in training resources; this is especially true in areas which are considered 'thin markets' where take-up of training is relatively low. Additionally, if recruitment and retention strategies targeting over 45s, people with disabilities and those from a CALD background are to be effective, they will require adequate levels of funding which they don't currently receive.[22]

- Whilst some sectors of health and community services have workforce data available to assist in strategic planning, many sectors as yet do not. This absence of useful, up to date information makes meaningful prioritisation and deployment of training resources difficult.

- Consumer demand for new services and delivery modes will require the development of new knowledge and skills. In the health services industry, competencies are needed that address the needs of the ageing population, the increased emphasis on chronic diseases and disease prevention strategies, and the increased demand for complementary and alternative health care.[23] New roles in the community services and health industries must be created and existing training, for example for enrolled nurses, physician's assistants or medical assistants, must be placed into the Training Packages.[24]

- Articulation between the vocational education and training sector and the higher education sector must be improved.[25]

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[22] Engaging the Untapped Workforce - Training Solutions for the Community Services and Health Industry, Community Services and Health Training Australia (now CS&H Industry Skills Council), Sept 2003 p35
[23] Draft Industry Skills Report ISC May 2005 p27
[24] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p36
[25] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p36

- Current arrangements for short term retraining and upgrading of skills need to be more formalised and better incorporated into the VET structure especially in management and business areas.

- Take-up of training under the Health Training Package has been slow[26]. Current mechanisms for promotion of New Apprenticeships (traineeships and apprenticeships) do not effectively promote these within the health and community services sectors either to prospective employers or employees. The Department of Education Science and Training (DEST) is currently undertaking a review of these structures, namely the New Apprenticeship Centres (NACs), and it is hoped improved mechanisms better able to effectively promote the uptake of training under the Health Training Package will emerge from this review.

7 Workforce Participation

- Like many other industries, the community services and health industries are finding it difficult to attract and retain workers. The reasons are complex and vary according to occupation. The difficulties have resulted in acute shortages of registered and enrolled nurses, medical professionals and some allied health workers. There are also shortages of child care, residential aged care and mental health workers. Data from the Department of Employment and Workplace Relations (DEWR) indicate that certain occupations have experienced chronic shortages over the last 10 or even 25 years. The factors responsible for the shortages are complex and vary according to occupation. They may include low remuneration levels, barriers to entry such as length and cost of training, or the poor image of certain occupations.[27]

- Recruitment campaigns are needed to improve the image of certain professions and occupations. Appropriate retention strategies are also needed. Cooperation with employment service providers could help industries address their labour shortages. Remuneration conditions of some classes of worker need to be reviewed and relative value assessed.[28]

- Recognition is needed that youth will be a diminishing pool of labour in the coming years.[29] Promotions should be aimed at groups such as mature-aged workers, culturally and linguistically diverse workers, and workers with a disability. An extensive examination of this can be found in 'Engaging the untapped workforce – Training solutions for the Community Services and Health industry'. The report aims to identify barriers, evaluate opportunities and develop a potential strategy to facilitate greater levels of workforce participation amongst these groups.

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[26] 6,509 HLT02 Vocational Course Enrolments Australia wide in 2003 Data from NCVER and cited in HLT02 Review: A Discussion Paper, Community Services and Health Industry Skills Council, 2005
[27] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p45, 46
[28] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p55
[29] More than 80% of projected growth in the labour force between 1998-2016 will be in the 45 years and over age group. Community Services and Health is the third oldest workforce with a median age of 42. Source Engaging the Untapped Workforce - Training Solutions for the Community Services and Health Industry, Community Services and Health Training Australia (now CS&H Industry Skills Council), 2003

- Changes are needed to human resource management cultures so that they support, retain and nurture existing workers. Corporate awards for exemplary practice need to become more prominent and actively celebrated and acknowledged. Funding arrangements should support good human resource policies.[30] Potential exists to benefit from the learning efficiencies derived from overseas initiatives which may have application in an Australian context. A possible example of this is the Skills Escalator Activity currently being developed in the UK.[31]

- Training and development issues that detract from the attractiveness of certain occupations must be addressed so that:
    i. the length of training is not longer than absolutely necessary
    ii. a wide variety of flexible modes of training delivery and assessment is available
    iii. the competencies obtained are portable
    iv. qualifications facilitate movement across viable career pathways
    v. there is a clear articulation between vocational and higher education[32]

- Research is needed on labour movements within the health and community services industries.[33]

- Objective assessment processes for points of entry to the health and community services workforces, such as registration and area of need positions, should be based on competence not qualifications.[34]

- Several entry points and career pathways for volunteers within the Training Packages must be re-assessed and their availability guaranteed. Funding arrangements that inadvertently prevent volunteers accessing training must be reviewed.[35]

- Research is needed to understand the factors that contribute to recruitment and retention difficulties within the different industry sectors.[36] Training is unlikely to solve many of these problems, although improved training and recognition of skills could help relieve some of the shortages.

- More flexible working arrangements are needed to attract and retain mature-aged part-time workers while guaranteeing the continuity of high quality service delivery.[37]

- More creative use of part-time labour is needed to respond to fluctuating demand or consumer preferences. However, in many cases, more imaginative uses of labour

[30] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p55
[31] Mapping the progress of skills escalator activity, Phase 1: July 04 Manchester School of Management UMIST
[32] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p56
[33] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p56
[34] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p56
[35] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p59
[36] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p56
[37] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p59

are limited by a “siloed” approach to work roles and rigid professional role boundaries.

- Research is needed into how part-time employment affects social security benefit entitlements, access to training and development, and burnout rates. Part-time work conditions may have to be altered, for example wage or benefits structures that offset reduced social security entitlements may have to be introduced.[38]

- More employees need to be trained. Greater uptake of industry Training Packages will allow more flexible training and assessment that accommodates work, family and other commitments and may minimise training costs.[39]

- Multiskilling and more flexible award structures are required.[40]

8 Migration Issues[41]

- Globalisation is likely to have a growing influence on the community services and health industries. With all developed countries experiencing an ageing workforce over the next three decades, Australia may not be able to address its skilled labour shortage through migration, as it has in the past. Given relative remuneration differences between Australia and a number of other OECD countries, especially in some countries of Western Europe, Canada and the USA, a net negative migration flow in the future for some forms of health labour is possible.

- Currently, the balance of global market effects still seems to favour Australia. A net gain of 2,272 health professionals resulted from migration to and from Australia in 2001-02. The largest gains were for nurses followed by medical practitioners. Migration resulted in net losses of occupational therapists, physiotherapists, speech pathologists and other health professionals.

- Medical practitioners have been recruited from overseas to fill positions in less popular areas of Australia. Quite often these doctors speak English as a second language. Nurses are increasingly being recruited from countries outside the OECD. This raises ethical issues, particularly if source countries find themselves drained of health services workers who may be difficult, if not impossible, to replace. The Commonwealth Code of Practice for the International Recruitment of Health Workers, which is supported by the Australian Government and other key stakeholders, affords some protection in this area.

- Ensuring the competence of migrant medical workers has become a challenge for authorities. Authorities are under mounting pressure not to reject qualifications out

[38] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p59
[39] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p60
[40] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p60
[41] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 – Globalisation & the CS&H Labour Markets p54

of hand simply because they are an unknown quantity. Alternative means of assessing competence are being sought.

- Globalisation has had less of an effect on the community services industry. The aged care sector has probably suffered most, because of the role played by registered nurses in service delivery. Any shortage of nurses is felt most keenly by the aged care sector because of poorer pay and work conditions.

9 Productivity

- Less restrictive work practices and defined boundaries of practice within and between professional groups to allow more effective use of health services and workforce are needed.

- The health industry requires responses that will help the workforce manage change as the industry continues to seek better health outcomes from a relatively stable funding platform. Some of the more important responses are:
  i. New organisation and business structures that allow better use of available skills must be developed.
  ii. Models and skills to work in partnership with consumers and carers so they can more fully participate in care must be developed.
  iii. Training must be restructured so that more commonality in pathways is achieved.
  iv. Teamwork skills must be developed through integrated training and education approaches.
  v. Skills that contribute to quality services and productive workplaces must be remunerated.
  vi. Investment in training to improve the strategic planning ability of organisations is needed.
  vii. A feasibility study for Austrade and the community services and health industries to reassess service delivery into Asia is needed.[42]

- Both the health and community services industries will benefit from faster uptake of e-business.[43]

- Cooperative arrangements between the Community Services and Health Industry Skills Council and higher education and training representatives will help identify emerging best practice and assess education and skills development needs.[44]

- Skills development in management and governance should be offered to providers of community services. This would be particularly helpful in organisations that are managed by volunteer boards of management.[45]

- Sustainable human resource practices should be included in the Community Services and Health Training Packages.[46]

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[42] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p35
[43] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p67
[44] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p67
[45] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p67
[46] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p67

10 Demand impacts

- Population growth and the ageing of the Australian population are increasing demand for health services. Better informed consumers are demanding high quality and up-to-date health care and a greater say in their treatment.[47]
- The ageing of the population is also leading to an increased emphasis on the management and treatment of chronic diseases and an emphasis on healthy ageing strategies. A report commissioned by Alzheimer's Australia concludes that the number of people in Australia with dementia will be 12.5% higher today and 25% higher by mid-century than previously projected. It is now projected that nearly 52,000 people will be newly diagnosed with dementia in 2005. By 2050, the total number of people with dementia will exceed 730,000 people.[48]

- Changes in how health services are delivered will impact the future workforce. The trend towards de-institutionalisation and decreased lengths of hospital stay has pushed health care provision into community settings. Community health centres—which provide services either separately from, or together with, the services of registered medical practitioners—are becoming increasingly popular.[49]

- Technological advancement and its impact on industry operation and work processes is one of the main trends affecting skills needs. New technology has implications in many areas including clinical treatment, business operations, management processes and customer relations. Changing technology may reduce the shelf life of skills, necessitating accelerated skills development, particularly in computer skills. Multiskilling is increasing, as is the sharing of technologies between industries.[50]

- Three areas of technological development will influence services in the health industry: nanotechnologies, gene technologies and e-technologies.[51]

11 Regional and remote and Indigenous Health Issues

- The Community Services and Health Industry Skills Council supports the view that health care provided by Aboriginal and Torres Strait Islander people is an important strategy to improve the health and life expectancy of this segment of the population. The community services and health workforce includes:

  i 3,742 Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander health workers.

  ii 6,294 Aboriginal and Torres Strait Islander workers in the community services workforce, comprising approximately 2.7% of workers.[52]

- Incentives to work in rural areas are needed. Several programs provide incentives for health professionals to take up practice in rural areas (e.g. Rural Pharmacy

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[47] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p25
[48] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p25
[49] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p25
[50] Health Training Package Scoping Report, Community Services and Health Industry Skills Council, March 2005 p22
[51] Australian Health Ministers Council 2004 National Health Workforce Strategic Framework cited in Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p62
[52] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p38

Initiative Program, Australian Government Rural and Remote Health Professionals Scholarship Scheme). While many of these programs are still in their early stages, initial evaluations suggest they are worth pursuing. Training must support the transition from urban to rural practice.[53]

- Whilst these initiatives have merit, other strategies which better utilise available skills bases in rural and remote areas are needed. There is a need to rationalise existing skills to increase the efficiency of health service delivery in rural and remote areas. Thin populations and skills bases in rural and remote areas cannot sustain traditional silo approaches to job roles, broader, more flexible approaches are needed. An example of where this is being applied is in the area of Aboriginal and Torres Strait Islander health workers who, under Section 100 provisions are being trained to dispense a small but critical number of Pharmaceutical Benefits Scheme listed medications under (distance) supervision of a pharmacist. Similarly, telepharmacy is being introduced where the physical dispensing would be supported by advice given to the patient from a remotely located pharmacist. Similar roles could emerge in mainstream community pharmacy, as pharmacists attempt to free themselves from some dispensing duties and provide more value added cognitive pharmacy services.[54]

- Some technologies will affect future modes of service delivery. For instance, advanced communication links, particularly video broadcast technology, have made virtual medicine a possibility in regional and rural areas of Australia. Video links will allow experts located overseas to help with difficult procedures.[55]

- In April 2004, the Australian Government announced it would provide $128.3 million over the next four years to implement HealthConnect nationally. HealthConnect will allow e-prescribing, e-prescription transfer, e-signature, e-dispensing, PBS online, better medication management, admission/discharge/transfer management, CMI availability and PBS hospital reforms. These initiatives have the potential to improve access to health services in rural and remote areas. The implications for training are significant.[56]

12 After hours GP services

- The ISC raises the question of why it is only GP services which are being examined in this context. It strongly recommends that a broader range of health services is considered including nurse practitioners. Rural Australia does not have the population or skills base to support traditional and inefficient silos of information and practice.

[53] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p44
[54] Health Training Package Scoping Report, Community Services and Health Industry Skills Council, March 2005 p20
[55] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p62
[56] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p55

Appendix One: Table Showing Enrolments in Main Qualifications in Health and Community Services Training Packages 2001 to 2003

Enrolments in main qualifications under Training Packages, 2001 to 2003, Community Services and Health

Publicly-funded training

	2001	2002	2003
CHC20399 - Certificate II in Community Services (Children's Services)	1,647	1,576	1,673
CHC30102 - Certificate III in Aged Care Work	0	0	1,016
CHC30199 - Certificate III in Community Services (Aged Care Work)	16,900	19,612	20,450
CHC30399 - Certificate III in Community Services (Children's Services)	9,902	13,792	16,555
CHC30699 - Certificate III in Community Services (Community Work)	2,426	2,410	2,486
CHC30799 - Certificate III in Community Services (Disability Work)	3,126	3,307	3,985
CHC30999 - Certificate III in Community Services (Youth Work)	1,590	1,593	1,740
CHC40199 - Certificate IV in Community Services (Aged Care Work)	2,274	2,177	1,826
CHC40299 - Certificate IV in Community Services (Alcohol and Other Drugs Work)	1,056	1,344	1,354
CHC40699 - Certificate IV in Community Services (Community Work)	2,280	2,597	1,877
CHC40799 - Certificate IV in Community Services (Disability Work)	2,759	3,650	4,739
CHC40999 - Certificate IV in Community Services (Youth Work)	1,646	1,601	1,714
CHC50399 - Diploma of Community Services (Children's Services)	11,568	13,625	14,136
CHC50699 - Diploma of Community Services (Community Work)	2,286	2,504	2,657
CHC50999 - Diploma of Community Services (Youth Work)	1,134	1,244	1,179
HLT20402 - Certificate II in Health Support Services (Grounds Maintenance)	0	0	1,005
Total Health qualifications	1	153	6,526
Total all Community Services and Health qualifications	67,959	79,014	92,291

Source: NCVER

Appendix Two: Listing of Health Training Package Qualifications

Ambulance

HLT30202 Certificate III in Non-Emergency Patient Transport
HLT31902 Certificate III in Ambulance Communications (Call Taking)
HLT41102 Certificate IV in Ambulance Communications (Despatch)
HLT41002 Certificate IV in Basic Emergency Care
HLT50402 Diploma of Paramedical Science (Ambulance)
HLT60302 Advanced Diploma of Paramedical Science (Ambulance)
HLT60202 Advanced Diploma of Paramedical Science (Supervision)

Dental Technology and Dental Prosthetics

HLT50502 Diploma of Dental Technology
HLT60402 Advanced Diploma of Dental Prosthetics

Dental Assisting

HLT31802 Certificate III in Dental Assisting
HLT40702 Certificate IV in Dental Assisting (Dental Radiography)
HLT40602 Certificate IV in Dental Assisting (Oral Health Education)
HLT40802 Certificate IV in Dental Assisting (Assistance during General Anaesthesia and Conscious Sedation)

Complementary and Alternative Health Care

HLT40902 Certificate IV in Complementary and Alternative Health Care Assistance
HLT40302 Certificate IV in Massage
HLT41202 Certificate IV in Ayurvedic Lifestyle Consultation
HLT40202 Certificate IV in Shiatsu
HLT40102 Certificate IV in Traditional Chinese Medicine Remedial Massage (An Mo Tui Na)
HLT50102 Diploma of Traditional Chinese Medicine Remedial Massage (An Mo Tui Na)
HLT50202 Diploma of Shiatsu and Oriental Therapies
HLT50302 Diploma of Remedial Massage
HLT60102 Advanced Diploma of Western Herbal Medicine
HLT60602 Advanced Diploma of Homœopathy
HLT60502 Advanced Diploma of Naturopathy
HLT60702 Advanced Diploma of Ayurveda

General Health Services Delivery

HLT20802 Certificate II in Health Support Services (Cleaning Support Services)
HLT20302 Certificate II in Health Support Services (Laundry Support Services)
HLT20602 Certificate II in Health Support Services (Food Support Services)
HLT20402 Certificate II in Health Support Services (Grounds Maintenance)
HLT20502 Certificate II in Health Support Services (General Maintenance)
HLT20702 Certificate II in Health Support Services (Client/Patient Support Services)
HLT20102 Certificate II in Health Support Services (Stores)
HLT20202 Certificate II in Health Support Services (General Transport Support)
HLT31602 Certificate III in Health Service Assistance (Client/Patient Services)
HLT31702 Certificate III in Health Service Assistance (Allied Health Assistance)
HLT31402 Certificate III in Health Service Assistance (Hospital & Community Health Pharmacy Assistance)
HLT30102 Certificate III in Pathology Specimen Collection
HLT31202 Certificate III in Health Service Assistance (Pathology Assistance)
HLT31302 Certificate III in Health Service Assistance (Operating Theatre Support)
HLT31502 Certificate III in Health Service Assistance (Nutrition and Dietetic Support)
HLT31102 Certificate III in Health Service Assistance (Sterilisation Services)
HLT30902 Certificate III in Health Support Services (Cleaning Support Services)
HLT30402 Certificate III in Health Support Services (Laundry Support Services)
HLT30502 Certificate III in Health Support Services (Grounds Maintenance)
HLT30602 Certificate III in Health Support Services (General Maintenance)
HLT30802 Certificate III in Health Support Services (Client/Patient Support Services)
HLT31002 Certificate III in Health Support Services
HLT40402 Certificate IV in Health Support Services (Supervision)
HLT40502 Certificate IV in Health Service Assistance (Hospital and Community Health Pharmacy Technician)

Health Technicians

HLT32002 Certificate III in Mortuary Practice
HLT32102 Certificate III in Prosthetic/Orthotic Technology
HLT41302 Certificate IV in Audiometry
HLT41402 Certificate IV in Cast Technology
HLT41502 Certificate IV in Hyperbaric Technology
HLT41602 Certificate IV in Mortuary Practice
HLT41702 Certificate IV in Neurophysiology Technology
HLT41802 Certificate IV in Pathology Collection
HLT41902 Certificate IV in Sleep Technology
HLT42002 Certificate IV in Health Service Assistance (Operating Theatre Technical Support)
HLT42102 Certificate IV in Cardiac Technology
HLT42202 Certificate IV in Health Services (Supervision)
HLT50602 Diploma of Anaesthetic Technology
HLT50702 Diploma of Hyperbaric Technology
HLT50802 Diploma of Prosthetic/Orthotic Technology
HLT50902 Diploma of Sleep Technology
HLT60802 Advanced Diploma of Neurophysiology Technology

Population Health – soon to be endorsed

HLT20902 Certificate II in Population Health
HLT32202 Certificate III in Population Health
HLT42302 Certificate IV in Population Health
HLT51002 Diploma of Population Health

HLT21002 Certificate II in Indigenous Environmental Health
HLT32302 Certificate III in Indigenous Environmental Health
HLT42402 Certificate IV in Indigenous Environmental Health
HLT51102 Diploma of Indigenous Environmental Health

Appendix Three: Listing of Community Services Training Package Qualifications

Child Protection

CHC41802 Certificate IV in Community Services (Protective Care)
CHC51202 Diploma of Community Services (Protective Intervention)
CHC51302 Diploma of Statutory Child Protection

Children's Services

CHC30402 Certificate III in Children's Services
CHC40402 Certificate IV in Out of School Hours Care
CHC50202 Diploma of Out of School Hours Care
CHC50302 Diploma of Children's Services
CHC60202 Advanced Diploma of Children's Services

Community Services Work – General

CHC10102 Certificate I in Work Preparation (Community Services)
CHC20202 Certificate II in Community Services Work
CHC20302 Certificate II in Community Services (First Point of Contact)
CHC30802 Certificate III in Community Services Work
CHC40902 Certificate IV in Community Services Work
CHC50702 Diploma of Community Welfare Work
CHC60302 Advanced Diploma of Community Services Work

Community Services Work – Specialisation

CHC41702 Certificate IV in Alcohol and Other Drugs Work
CHC51102 Diploma of Alcohol and other Drugs Work
CHC30902 Certificate III in Telephone Counselling Skills
CHC41002 Certificate IV in Telephone Counselling Skills
CHC41102 Certificate IV in Mental Health Work–(Non-clinical)
CHC41202 Certificate IV in Community Services Advocacy
CHC41302 Certificate IV in Community Mediation
CHC41402 Certificate IV in Community Services (Information, Advice and Referral)
CHC41502 Certificate IV in Marriage Celebrancy
CHC41602 Certificate IV in Community Services (Lifestyle and Leisure)
CHC50802 Diploma of Community Services (Lifestyle and Leisure)
CHC50902 Diploma of Community Services (Case Management)
CHC51002 Diploma of Community Services (Financial Counselling)

Community Services Work – Specialisation

Aged Care and Disability Work

CHC20102 Certificate II in Community Services Support Work
CHC30102 Certificate III in Aged Care Work
CHC30202 Certificate III in Home and Community Care
CHC40102 Certificate IV in Aged Care Work
CHC40202 Certificate IV in Service Co-ordination (Ageing and Disability)
CHC30302 Certificate III in Disability Work
CHC40302 Certificate IV in Disability Work
CHC50102 Diploma of Disability Work
CHC60102 Advanced Diploma of Disability Work

Community Development

CHC41902 Certificate IV in Community Development
CHC51402 Diploma of Community Development
CHC51502 Diploma of Community Education

Employment Services

CHC30502 Certificate III in Employment Services
CHC40502 Certificate IV in Employment Services
CHC50402 Diploma of Employment Services

Management

CHC42002 Certificate IV Community Services (Service Co-ordination)
CHC51602 Diploma of Community Services Management
CHC60402 Advanced Diploma of Community Services Management

Social Housing

CHC30702 Certificate III in Social Housing
CHC40802 Certificate IV in Social Housing
CHC50602 Diploma of Social Housing

Youth Work and Juvenile Justice

CHC30602 Certificate III in Youth Work
CHC40602 Certificate IV in Youth Work
CHC40702 Certificate IV in Youth Work (Juvenile Justice)
CHC50502 Diploma of Youth Work

Appendix Four: Table Showing Key Drivers of Demand for Skills and Supply of Skills in Health and Community Services Industries [57]

Industry Drivers	Health	Community Services
Demand drivers Critical		
Consumer and customer service demands	• Lack of clearly articulated and documented consumer preferences • Shift from infectious to chronic disease prevalence, with a stress on population health • Increased interest in complementary and alternative health care • Increased incidence of litigation and complaints	• Lack of clearly articulated and documented consumer preferences • De-institutionalisation / decreased length of hospital stay • Demand for more flexible child care arrangements • Government legislation, standards and funding control much of the industry's ability to respond to consumer demands • Ageing population increasing demand for services • Increased focus on the provision of community aged care services
Market expansion	• Growth of 2.3% p.a. in service demand with possible continued increase in growth (depending on population growth) • Ageing population increases demand for medical services and allied health services • Growth in day-only admissions • Expansion in general medical practitioners largely a function of Medicare funding • GP supply a critical limiting factor • Number of initiatives in place to reduce impact of GP shortage • Increased corporatisation of private practices leading to greater uptake of EPC and related items • Dental services demand to be met by expanded role of dental auxiliaries	• Growth of 2.8% p.a. in service demand with possible continued increase in growth (depending on population growth) • Possible impact on child care services of falling birthrates, potentially balanced by changing female workforce participation • Increasing demand for outside school hours care with increased participation rates of women • Ageing population will drive increased demand for aged care services • Government initiatives driving expansion in drug and alcohol, mental health and other welfare services • Demand for care by older Australians will continue to increase, with demand less likely to be met by family or other informal carers

[57] Draft Industry Skills Report, Community Services and Health Industry Skills Council, May 2005 p 22

Industry Drivers	Health	Community Services
	• Increased demand for complementary and alternative health care expected	
Demand Drivers	***Strategic***	
Technological change	• Nanotechnologies, gene technology and e-technologies will have varying impacts on service delivery • Low level of web presence and integration of e-facilities in business transactions and operations	• e-technology impacting on new ways of providing information to the consumer • Lower uptake of e-technology • Low level of web presence and integration of e-facilities in business transactions and operations
Competitiveness and productivity demands	• Growth in labour productivity well below all industry average although other measures indicate some productivity gains • Competitiveness: good reputation in overseas course offerings in medicine, pharmacy, dentistry can be leveraged to export health services	• Corporatisation of child care may lead to enhanced productivity • Uneconomic organisational structures for rest of community services • Trend towards consolidation and amalgamations in rural and remote areas as a means of maintaining viability, particularly in residential aged care
Supply drivers Critical		
Worker attraction and retention	• Widespread acute workforce shortage in many areas • Labour movement resulting in net gains in some professions and net losses in others	• High turnover of child care workers • Acute labour shortage in residential aged care and mental health care • Poor perception and profile of some sectors
Demography of the workforce	• Ageing workforce with significant replacement demand an issue within the next 15-20 years • Absence of younger workers in the workforce • High level of female workers • High level of workers from culturally and linguistically diverse groups • Depletion of skills from rural to urban areas	• Ageing workforce with replacement demand an issue within the next 15-20 years • High level of female workers • High level of workers from culturally and linguistically diverse groups • Depletion of skills from rural to urban areas
Employment arrangements	• Labour hire • Part-time employment • Low levels of casualisation	• Part-time employment • Low levels of casualisation • Reliance on voluntary/ supplementary workforce

Industry Drivers	Health	Community Services
Supply Drivers	***Strategic***	
Health and safety issues	• OH&S incidence and frequency rate of workplace injuries higher than all industry average • NOHSC to set minimum targets to guide workplace safety • Public health issues that accept health and safety of the workforce • AHMC has set priority areas for national goals for increased work safety • Patient safety a priority	• OH&S incidence and frequency rate of workplace injuries higher than all industry average • NOHSC to set minimum targets to guide workplace safety • Public health issues that accept health and safety of the workforce • Community services delivered in diverse settings including clients' homes • Client safety improving
Regulatory Requirements	• Highly regulated workforce, to ensure safe workplace and service delivery	• Largely unregulated workforce except for child care and aged care sectors where accreditation standards are in place
Insurance	• Professional indemnity a barrier to entry into workforce exacerbating some skills shortages	• Public liability limiting volunteer/supplementary workforce participation and exacerbating workforce shortages • Increase in workers compensation costs are impacting on delivery of services and some organisations' viability