



Industry Skills Council

**Identifying paths to skill growth or skill
recession: Decisions for workforce
development in the community services and
health industries**

**Research Report
(Executive Summary)**

February 15 2008

Identifying paths to skill growth or skill recession: Decisions on workforce development in the community services and health industries

Executive summary

Purpose

This executive summary distils the findings of research and a literature review on the depth of the workforce challenge faced by the community services and health industries in Australia and overseas. The research identifies preconditions for work-related training growth directly relevant to the operating environments that exist in both health and community services. The report presents what might be described as two 'absolute' or artificial scenarios – one leading toward skill growth, the other leading to skill atrophy (see attached diagram).

Seven possible preconditions for skill growth are presented in order to provide a starting point for discussion. Rather than aiming to offer the definitive word on 'solutions' to training challenges, the notion of preconditions is used to provide a structured way to present some key contemporary debates on training. This approach also makes the material more amenable to stakeholder evaluation, discussion and input.

Background

In the research reviewed for this analysis, there is consensus that VET will continue to play a pivotal role in positioning the health and community services workforces to be ready for the challenges ahead. For community services, great numbers of workers are commencing from a very low skill baseline (Meagher & Healy 2006), yet face increasingly complex social and welfare environments (Productivity Commission 2005). In health, technological change requires that workers are able to develop and maintain skill levels to keep pace with these changes (ACIRRT 2003). For both industries, changing models of care delivery (including changing expectations associated with client need) means that workforce skills require updating. For workers currently in the labour market, the composition of skills held may have to change. For workers who have engaged in a high level of training before workforce entry, continual refinement of these skills throughout the course of a career will be necessary.

Training policy makers and stakeholders face a number of challenges in seeking to manage the impacts of widespread workplace change and the 'new economy', while simultaneously ensuring that skill development occurs in a sustainable and uniform way. To date, no consensus exists between stakeholders on a theoretical framework suitable to direct policy interventions in this field, nor shape research protocols for exploring these issues.

The literature review has identified seven key factors as significant in progressing debate surrounding training, its formation and its growth. The review also notes that factors can combine to act as powerful impediments to training. Strong cost control strategies by both state and federal governments for example, when considered in the context of the historical devaluation of care work, can jointly contribute to a situation in which leveraging wage improvements to maintain labour in-flow is particularly challenging. This means that, in engaging with debates over preconditions for training, solutions must be both highly creative, and seek to counteract multiple obstacles in order to lift training access across a sector.

Findings

A brief summary of the debates associated with the seven preconditions for skill growth is presented below (and outlined in the attached diagram).

I Funding model is important. The type of broad funding model influences sector wide 'propensity to train' on a macro scale. A low cost funding environment undermines the potential for training growth to occur.

Over the last twenty years in Australia, there has been a major re-alignment in the roles and resources provided by government, non-government organizations, the private sector, and indeed clients themselves, in order to deliver essential health and community services. This realignment has deeply influenced the funding context in which the health and community service industries are required to operate. Australia is not alone in these transitions, and the world-wide trend to explore alternative funding models for growing service demands anticipated to occur in health, social and community care is well noted. While there remains a degree of debate over how to calculate and define low and high cost environments, the literature generally classifies Australia to fall within the 'low cost' funding category.

Understanding the operating pressure created by a low cost funding model is an important first step in understanding the latitude afforded to employers with regard to training and skill formation. This latitude creates the preconditions for skill formation at the workplace level, and employer responses to and readiness to train. 'Low cost' models create what is best described as 'efficiency pressure' on those working in the system (Blendon et al 2003). This impacts the ability to directly fund participation in training, and the ability to release staff and backfill in order to facilitate participation in training. This impact is profound and broad-based because it limits the ability to access both on and off the job training. Across the system, low funding levels limit the ability of organizations to recruit and fill higher skill positions, or pay for upskilling of the existing workforce.

A low cost funding environment creates what might be described as 'training tensions'. For the health and community services workforces, this is a particularly potent observation because two policy forces (VET policy and social welfare policy) converge in a unique way to influence the amount of funding support for training. A number of themes are evident in the literature on low cost environments, as these exist in health and community services.

The increased emphasis on a low cost, high efficiency funding model has either introduced or intensified the degree of competition felt within both industries. It is widely acknowledged that competitive forces are at work in community services and health industries, in a way that has not been the case historically (Productivity Commission 2002; Health & Family Services 1998). Creating a policy framework which introduces and bolsters competition in these industries could be argued to deliver benefits in the form of keeping costs low, and ensuring there is less 'waste' in service delivery as organisations are required to refine and deliver closely to the targets specified (Productivity Commission 2002). However, there is also evidence that these competitive elements can undermine attempts to build a sustainable and appropriately skilled supply of labour.

The scope for collaboration between service and care providers narrows, or closes. A recent report conducted in the ACT compared a range of social welfare occupations in the community versus government sectors and found direct competition between these sectors is contributing to some alarming pay differentials between the sectors. There are further dangers created by competition, because it closes the scope for collaboration between providers on a range of key HR and management issues. When service providers, as employers, are required to compete for labour, the ability for these agencies to work cooperatively across a sector to meet service need becomes constrained. Individual agencies are encouraged to behave strategically in order to maintain competitive advantage over rival operators. This, some industry insiders contend, is an anathema to the sector because operators could genuinely benefit by sharing information on these core HR issues.

In an operational sense, low cost funding models undermine organisational ability to centrally monitor training options. This also impacts organisational capacity to forward plan for skills development, assess and nominate preferred training providers, let alone monitor the outcomes of any training provided. The low cost environment also constrains the ability to use pay to lever improvements to skill. The literature notes that the 'third party financing model' can pose specific threats to training. In a third party model, money is provided by interests who are not consumers of the service (Buchanan et al 2001: 13). Increasingly governments use this model to finance an intermediary to deliver a program, but remain at 'arms length' in the administration and management of affairs pertaining to the program. In this model, training is frequently overlooked because of its perception as a cost, rather than a long term investment. This model allows government to squeeze or compress the overall costs associated with service delivery, because they have no responsibility in working out the details of the actual service delivery. As one community service agency notes there is an increasing "gap between the 'cost' of services and the 'price' offered by Government" (CWAV 2001: 7). This funding environment also creates problems for the tenability (security) and longevity (contract timeframes) of the employment arising from these contracts and this in turn, has implications for training arrangements.

Down-time to up-skill? A low cost funding environment also directly and indirectly affects workload management strategies, and these impact both on and off-the-job training access. On-the-job training opportunities become compressed or disappear because workers are required to service greater numbers of clients during the course of a shift (ACIRRT 1999) or are required to balance a greater share of administrative

and processing tasks with direct care work (Gordon, Buchanan & Bretherton 2008). This affects managers' ability to actively mentor and train (ACIRRT 2003), and the ability of workers to use so called 'down time' to 'upskill'.

II Understanding the ownership profile of employers is important in formulating training policy. The employer ownership profile in both of these industries is becoming less easy to discern.

In addition to the operating pressures associated with a low cost model, many organizations operating within the health and community services sector have to contend with increasingly complex funding chains. Historically, the health sector has been dominated by large, often publicly owned operators. Community services too, has historically been characterised by a slightly more diverse profile, but with the not-for-profit operators making an important and significant contribution.

There is a body of work that points to the fact that the conditions under which training occurs, and the impetus to train is sparked, vary depending on the size, profile and culture of an organization (Raper et al 1997). Training behaviours vary between large and small organisations and, it is argued, understanding of these forces can help policy makers and stakeholders understand and anticipate the training response of these organisations, and draft policy responses accordingly (Donovan 2001). This field of literature represents an area of VET that remains largely underdeveloped, beyond the broad observation that small businesses have a higher risk in investment because their turnover is higher, they often have low internal planning capacity, and can generate no economies of scale in training (Bosch 2003).

This more complex funding environment makes it difficult to formulate a training strategy that is responsive to employer need, because definition of employer need is increasingly difficult to distil. Understanding the nature and pattern of the ownership profile in the sector is critical to understanding how best to develop an appropriate workforce development response (Carson et al 2006). In community services and health, more than many other industries, the conditions at the workplace level important are critically important to VET access. Both the health and community service industries have long recognised the importance of on-the-job learning as central to coherent regimes of skill formation (Franco et al 2002). Hospitals have long been regarded as sites of learning as much as sites of service delivery (Towle 1998). In community services, on-the-job training has played a critical role in developing and supporting workers through both lateral and hierarchical mentoring (Eby 2002).

Both health and community services are characterised by great diversity in the form and size of organization. For example, ABS data on industry profile indicates that greater organisational diversity exists in the health and community services sectors, than in other sectors. While health has a more homogeneous profile (characterised by mostly large institutions), community services has wide variation in workplace cultures, ownership profile, and size of institution. Child care, for example is a significant employer in the sector yet most organizations (approximately 80 per cent) have less than 20 employees. Overall, small businesses (organizations with up to 20 employees) account for 42 per cent of employment overall. Accommodation for the aged, in contrast, is dominated by large operators, yet are the other larger employment group within the community services sector (ACIRRT 2002: 12). All of this amounts to a multitude or ever expanding profile of employer types in the sector. Accompanying this is an equally confusing industrial system in which it is unclear

what state, federal award pertain to which agencies, and whether they are incorporated trading corporations under the jurisdiction of Work Choices legislation (ASU 2007: 17).

Understanding the culture between and within firms and organizations is critical to training policy and response. Thursfield & Holden (2004) note two deep seated problems - that learning is not central to the culture of many firms, nor is learning distributed equally across firms. Different occupational pockets often have differential access to employer-sponsored training. Research by Keep (2002) notes that employers will not, of their own free will, train for the purposes of meeting a long term goal. If this assumption is accepted, moves to alter the supply of training (which has characterised much of the VET response in the UK) will be ineffectual in the long term. As Keep describes it, skills and training are generally issues of third order importance following competition and people management (Keep 2000). Keep & Mayhew further argue that a vicious cycle of low skills training will result from this approach (1999).

Data on training patterns within health and community services indicates that availability of training is not even across the sector, and that profile of the employer does appear to have some bearing on training access. Organisational profile shapes management practices and these in turn influence the organization of work, scheduling of work, and workload management practices at the workplace level. How labour is engaged and deployed is absolutely critical for all health and community service agencies, but again, organisational profile influences the choices made regarding this deployment. In particular, for-profit organizations, compared to not-for-profit organisations exhibit some distinctly different operating practices. Carson et al (2006) note that employer ownership profile is deeply linked to employment downsizing with heavy rationalisation of community sector employment in the for-profit sector particularly, over the period 2000 to 2006. Carson et al argue that in average employment terms, not-for-profit organizations grew on average by 9.7 employees, while average employment in each of the for-profit organisations reduced significantly overall (in the order of 31 per cent). Trends in employment rationalisation bring important insights because they indicate that organisations appear to be opting to downsize (cull workers with unsuitable skill sets) rather than explore ways to refine the skills sets held by the existing workforce. This is a powerful observation given that 'labour' and issues of labour quality are keystone issues for the sector because of the prominence of 'care' roles in both industries. Employment rationalisation is also alarming given that agencies from child care, aged care to disability services are reporting high levels of unmet demand (ACOSS 2006).

III Fragmented employment structures (use of agency employment, high levels of casual work) have created a number of challenges for skill formation in both industries.

Research identifies that atypical forms of employment have more difficulty accessing employer-supported training. Part time, casual, contract, and agency-based workers are all workers identified as facing additional challenges in the VET sector (Buchanan 2005). Data on agency-based employment (on a national scale), which provides industry specific detail is notoriously difficult to compile. However, the ABS regularly publishes data on both part time and casual work, and on both of these measures, the health and community services workforces reveal a fragmented employment profile.

Casual work is important to health and community service industry operation. While the broad literature argues that atypical workers face challenges in accessing training, this does not give insights on whether these issues reverberate similarly within health and community service workplace environments. The literature review reveals that casual workers in these industries indeed face challenges in accessing training. On every measure used by the ABS, casual workers in the health and community services industries fare worse with regard to training access. Almost half of all casual workers in these industries did not complete training of any kind, and the average hours committed to training were lower for casual workers when compared with permanent workers. In addition, as the literature suggests, casual workers, by virtue of their employment relationship with the employer, tend to experience limitations on their access to employer-provided or sponsored training. Permanent workers were more likely to attend training organised by an employer, with almost one in three permanent workers attending this kind of training compared to roughly one in five casual workers.

IV Care roles remain devalued, and labour intensive.

The ability to reshape perceptions of care activities and tasks remains a profound challenge for the industries. In real terms, the wages associated with performing care work are lower than other forms of work, and this remains a significant deterrent to attracting and retaining workers for the industry. This 'devaluation' creates significant problems for both community services and health, because it affects turnover within the industries, and because workers can find better pay arrangements working in other sectors without having to commit to further training or upskilling in any way (Meagher & Healy 2006: 103). In health, the situation is rather more complex because of the polarised and 'stretched' nature of the skill spectrum – from very high end skill work (doctors, dentists, clinical practitioner nurses) stretching to low skill work (hospital cleaners). However, to some extent the patterns are also present within health, as although some occupations can consistently command higher salaries because of the demand and niche nature of the skills held, core caring roles continue to remain at the low pay end of the spectrum (Treweek 2003).

Care as 'core' labour – the intransigent categories of skill

Care work is not only devalued as a form of labour, there is also a wider body of literature that notes upward trajectories of skill are linked to upward trajectories of technological change. Technological change has profoundly changed the quantity of and composition of skills required by manufacturing and blue collar sectors (Millgrom & Roberts 1990). Lehndorff (2002) contends that work that is inherently labour intensive is 'intransigent'. Put another way, labour intensive work is more difficult to de-construct or segment in order for greater distinction to be drawn between high and low skill components of that work. However, when technological change is introduced into this environment, the scope for de-constructing or reclassifying labour intensive work is expanded (Hult & Svallfors 2002). This is because technological change and/or mechanisation forces or prompts a revision of all tasks surrounding the production of the good or service in question. In Canadian research, for example, Weber (2000) shows that 'upskilling' and the tendency for workplaces to exhibit higher levels of workplace training, and lower levels of turnover, are strongly correlated to the technology intensive sectors.

In health and community services, a number of distinctions can be drawn between the industries around these technology arguments. In health, the penetration of technology in transforming work has occurred, albeit in a patchy way. A number of

significant upsurges in technological change (advances in medical technology) have prompted a renegotiation in the boundaries of skill, and in how practices and work roles need to be re-defined in light of technological change. Nursing, in particular, is often identified as a professional group that has benefited historically by being able to claim areas of practice from acts of care historically reserved by doctors (including dispensation of medicines) (Lyons and Petrucelli, 1979:544). In health, radiology and ultrasound technologies have also levered new categories of skill for workers engaged to undertake these activities. In contrast, community service work (child care, aged care in particular) has been less affected by technological interventions and remains 'intransigent' to re-classification around core care tasks.

The literature review undertaken also found no clear consensus on whether both industries need to focus on developing and reshaping categories of caring skills at the lower or higher ends of the skill spectrum to accommodate the changing needs of the sector. Recent reports, both Meagher & Healy (2006) and the Productivity Commission (2005) suggest a demand for more professionally skilled labour, because the way in which we define care tasks will require workers themselves to be more aware of the psychosocial components of the care transacted (ACT Taskforce 2006). Yet, there is also evidence that the industries will need to maintain sufficient levels of labour capable of delivering (what are currently defined as) low skill tasks to a large and broad client base. The need for PCAs and home help roles are two such groups of workers (Williams 2000). The question of how to differentiate between high and low skill forms of care beyond the basic and physical support elements of care remains a key question confronting community services and health and it is likely that what is considered 'over-qualified' is likely to shift significantly over time (England et al 2002). Historically, the industries, (particularly community services) has developed a reputation for the deflation of skill, so assessments about appropriateness or value of skill are likely to be highly skewed by this prism of devaluation (Healy 2004). This poses a significant challenge for skill reform.

V Networks of professional apparatus present and active within an industry are important in explanations of how keystone skill categories for a sector are formed and preserved within a sector.

For both health and community services, the way in which professions have aligned and organised around 'care' roles have shaped the skill terrain of both industries. For health, the direction of skill development has maintained a more upward trajectory, in large part because of strident doctor and nurse apparatus. For community services, the more fragmented nature of the professional apparatus present means that the assertion of 'care' work as even containing 'skilled' components remains a thorny issue, and in recent years, the industry has faced resurgence of the threat to be widely defined as less skilled.

The need for low, intermediate and high skill occupations to be aware of and active in negotiations surrounding skill within their disciplines is asserted strongly by research, and seen to be beneficial for skill development and preservation in a sectoral sense. Kendall & Lissauer, in their studies of the UK health sector for example, note that the elevation of increased emphasis on specialist care, comes at the price of a low investment in generalist skills (Kendall & Lissauer 2003: 32). However, they argue that the impact of this approach can be ameliorated if all professions and patients have 'buy in'. Without the professional umbrella, or the notion of belonging to a skill-based fraternity, workers themselves have difficulty comprehending the value of skill – both to preserve, and upgrade.

Historically professional disciplines have strongly defended valuable skill ‘turf’ and those that are successful have prevented professional encroachment. In this regard, the network of professional apparatuses have played a distinguishing role in how skills have been grouped, along professional lines, across the industries. In health for example, this pattern has worked for those previously perceived as less skilled (nurses) because they modelled the professional fortress attitude of doctors (Harrison 1999). In health, particularly, the fortification of the professional apparatus has been used as a way to simultaneously fortify preserves of skill. Research points to a wide range of examples in which this has played out historically. In Canada, in the 1960s and 70s, physiotherapy leaders fought the proposition to develop a category of training and worker known as physiotherapy technicians. Political, medical and educational policy thinkers believed this would alleviate the costs associated with health care services in Ontario, and provide a sufficient pool of physiotherapists for the health system which was undergoing serious expansion at the time. The physiotherapists association prevented the creation of this category and imposed strict educational standards on members (Heap 1998).

What is described on one hand as a ‘disciplinary turf war’ could also be described as bringing balance to the debate surrounding skill. Researchers in both the UK and Australia note that vertical and horizontal substitution strategies have been used by health administrators to deal with staff shortage, and cost cut (Mc Bride et al 2006; AHWAC 2005). This research notes that substitution strategies are more likely to result in detrimental outcomes for both worker and client, when the workers affected by these strategies have less professional ‘leverage’. In the case of AHWAC’s research, for example, a range of allied health professions were being used to cover vacant emergency unit coordinator positions (for initial assessment and processing of patients). The trial was argued to be successful, because the groups’ affected (clinical nurses, physiotherapists) had engaged with the trial, and considered the implications of the trial in terms of skill and professional integrity. Nancarrow & Borthwick argue that disciplinary boundaries come under pressure when the workforce is asked to shift skill and workforce composition (Nancarrow & Borthwick 2005: 898). Under these circumstances, the professional apparatus can play an important role in ensuring that labour deployment strategies take into account the impact for skill, and preservation of skill across a sector and the industry.

Even in those occupations which do not require professional qualifications, case study evidence suggests that incentives to train have been built on a notion of professionalism being cultivated at the workplace level. In a case study of a Victorian home care service, one study found that programs designed to foster a sense of occupational and professional identity can have strong skill and training ramifications. In this study, the employer instigated a program to increase retention and lift the commitment to train among employees. In order to do this, the employer focused on encouraging workers to “promote a culture of professionalism” within all roles. In organisational terms, this means that all jobs had to be re-interpreted in terms of a career focus. For employees, this meant negotiating and engaging with workers undertaking similar roles to discuss their tasks, the skills required and their relationship to other disciplines within the hierarchy. The organisation argued that this represented the genesis of a professional identity for these workers, even those who did not fall within the technical definition of a ‘professional occupation’.

VI Employee receptiveness to train is deeply influenced by conditions at the workplace level.

In both health and community services, increased pressures associated with excessive workload, cost cutting, and changed management structures have increased the challenges for workers to undertake either on the job or off the job training. In a broader labour market context, researchers also note that a continued commitment to training during working life, or “*staying on the training track*” (Hill 2001), has been associated with a longer working life and later labour market exit. This has been noted to particularly be the case for women (Hill 2001), and this has powerful implications for two industries which rely so profoundly on the commitment and productivity of women workers.

Bosch (2003) notes that the incentive to learn for workers, is fundamentally shaped by experience at work, and conditions at the workplace level. There is a growing body of evidence that growing intensification at work has undermined employee incentive to train (BVET 2001, ACIRRT 2002). The failure to train, or to locate ‘space’ for training is felt at the high and low ends of the occupational spectrum (Hall & Landsbury 2007). For low waged service work, investment in training does not occur because employers have a vested interest in keeping costs as low as possible (ACIRRT 1999; Buchanan & Bretherton 1999). At the high end of service work, where there is a higher degree of professional autonomy, management can use economic ‘targets’ to ensure that workers have no ‘downtime’ (Lehndorff 2002: 6). While on-the-job training could be described as a long term investment for the firm, it is increasingly seen as an activity that takes workers away from meeting service demand or serving clients’ needs. As Lehndorff describes, the process of work has intensified for service workers in a ‘self-governed’ manner. This includes a ‘remote control’ regime (Ackroyd & Bolton 1999) in which employees are forced to adapt and are pushed to find new ways to deliver, and problem solve in a way that works for the benefit of the organization, to the detriment of the individual (Whifield 2002).

In Australia, work intensification in health is noted as a trend affecting all levels of health care professionals (White & Bray 2004). When working hours regimes change, so too do the training arrangements. Firstly, it alters management level of commitment to training, and the availability of money for training (Coffield 2002; Kendall & Lissauer). Training activities are rarely a feature of key human resource management strategy, as other ‘personnel’ issues tend to take priority (Bearfield 2006). Secondly, excessive hours regimes and fragmented hours regimes alter worker ability to access and willingness to access training. In nursing, for example, unpaid overtime has become a profound problem (ACIRRT 1999; ACIRRT 2002; AIRC 2000). In the case of excessive workload, time to train is not just compressed, in many cases, it is completely extinguished (AIRC 2000). At the workplace level, excessive workload alters day to day working practices, rostering practices and terrain and rhythm of work (Gordon, Buchanan & Bretherton 2008). On the job training in particular has been profoundly altered by these changing patterns, because of the loss of so called ‘discretionary’ elements of work time (ACIRRT 1999). This means that working time becomes ‘chargeable’ time (Lehndorff 2002), with all other activities (training, staff support and development activities) undertaken in ‘personal’ or non-paid hours (Lehndorff 2002).

In community services and health these effects are experienced even more intensely because demand for services more often than not exceeds supply of labour available (ACOSS 2005). Off the job training is less available because vacancies cannot be covered, or back filled in order for staff to participate in formal training (which occurs time away from clients and patients) (Gordon, Buchanan & Bretherton 2008), and on the job training is squeezed because senior staff do not have time available to commit to deliver training, give instruction, mentor, or delegate to others so that this training can occur (Healy 2004). This training 'squeeze' has profound implications for a sector in which on-the-job training has played an important role in the preservation and transfer of skill.

Unpublished data from the ABS Survey of Education and Training (SET) gives some insights on the workplace conditions which shape employee ability to train. The literature suggests that the ability of health and community service organisations to provide employer supported training (off the job) has been constrained because of the need to contain costs (Buchanan 2005; ACIRRT 2002; ACIRRT 1999). Disaggregated SET data reveals the main obstacles to training participation, from the employees point of view. Among employees who wished to undertake work-related training, but could not, more than one fifth named excessive workload as the reason. In total, more than one third of all employees who wanted to undertake work-related training were prevented because of reasons stemming directly from the workplace itself. This outstrips all other reasons such as family, or financial constraints.

VII Expanding the definition of what constitutes 'quality' care for clients poses significant challenges for both industries.

The expansion in, and re-defining of care arrangements (including non-institutional care, client-focused care and client-managed care) has deep implications for the training system. Each of these movements has the potential to impact the skill composition required by the workforce, and the conditions under which training arrangements to support these transitions will be managed. A number of factors are identified as important in current debates surrounding these issues.

Firstly, the literature review notes that the need for care models in both health and community services to be developed mindful of an expanding range of client needs is an important priority. This is particularly relevant to the issues surrounding the anticipated growth in long term care demands (arising from the ageing cohort of baby boomers, and the greater life expectancy of coming generations). On one hand, it could be argued that a consumer-directed approach can only enhance the relevance and appropriateness of a carer's skill set, because it more directly injects the needs and voices of clients themselves into the dialogue and structure of services provided to long term care recipients. However, an alternative argument is that this approach may undermine the consistency of care by encouraging fragmentation in the skill sets obtained and maintained by carers over time.

The literature review notes a number of studies of US experience (which represents some of the longest standing models of client-driven and customised care), and are worthy of inclusion in Australian debates on this issue. In the US, it could be argued that movements to empower consumers have occurred at the cost of, or without substantial consideration of broader implications for skill sustainability. Government reform efforts have rallied around the principle of preserving 'quality of the act of care', using the most narrowly defined and niche criteria and not preserving 'quality of the worker' (demonstrated through a transferable, adaptable, and developed skill

profile). There is, as yet, little research available to give insight on the impact of consumer-directed care on skill and training levels within the personal care industry (Paraprofessional Health Care Institute 2003). The only evaluation that addresses skill in its terms of reference found that where the network of social welfare and health benefits facilitated the consumer-directed model of personal care, the greatest growth in the personal care assistant labour market occurred among workers with absolutely no formal training or skill in caregiving (Paraprofessional Health Care Institute 2003).

In the US, the move to customer-focused care has ignited a highly political debate surrounding clients' rights, versus workers' rights. There is, as Bradley notes, an unresolved tension between the need to standardise support structures and expand the scope of quality assurance activities (which is far from widely supported across the US) while maintaining flexibility and individuality in person-centred supports (Bradley et al 2002: 8). At this point in time, there is very little research available to establish whether the highly devolved and deregulated customer-centred model has beneficial or detrimental quality of life outcomes for the workers affected.

Some US states have actively sought to dismantle uniform 'standards' of care, in the interests of expanding the broad definitions of appropriate care – as shaped and defined by clients alone. The most deregulated forms of 'care' exist in the states of Wyoming, Wisconsin, Kansas and Connecticut. In these states, a program named the 'DOORS' mechanism applies which bases individual budget allocations on the functional characteristics and needs of the person or client. This means the individual client (and his or her support agent – usually a family member) is entirely responsible for deployment of these funds. In Kansas, financial intermediaries are available (subsidised through a government program) to assist individual clients in the management of budgets. In Wisconsin, there is a slight variation in this model with the individual client responsible for recruiting their own support worker, but then an intermediary (the Salvation Army) is responsible for deploying the labour resource.

The findings from the US provide some important insights for health and community care in Australia. In the US, the lesson appears to be that unless the state is directive and instrumental in giving recognition and value to the carer role and the skill set required to perform this role, the market is not forthcoming in delivering these frameworks. In this scenario, the carer becomes legally liable, as an employee, for all care provided (Paraprofessional Health Care Institute 2003; University of Maryland Centre on Aging 2001). Yet this liability occurs against an occupational and professional backdrop in which the worker is disempowered, and appears unable to accumulate and develop a transferable skill profile. Training support structures are funnelled entirely to the client (as the employer) and are largely structured around a small business model of fiscal, accounting and business management training. The consumer is the 'employer of record' for the purposes of taxation, and is responsible for paying taxes and workers compensation.

Research in Australia also appears to suggest that the manner in which key regulatory authorities, including governments, are prepared to direct and shape key priority areas of care provision, and how the quality of this care is measured, will have deep implications for VET. State-based analyses of training uptake across the community services sector for example, found that levels of training uptake were (in large part) attributable to the licensing and accreditation requirements in operation. In aged care, and child care in particular, the survey found that operators were much

more likely to engage in training their employees, if they were required to meet standards of care in order to secure and maintain accreditation standing (and therefore continue to attract government subsidies in order to operate). The report found “*Where there is less impetus to undertake training for accreditation purposes, the take up of formal training is patchy across the sector*” (Carson et al 2006: 112).

VIII A Call to Action! Building the Future we want and need for Workforce Development in our Industries.

The importance of the sector for the social inclusion agenda

The current Federal government has made it known that they are pursuing an agenda of ‘social inclusion’. This provides an exciting opportunity for the sector to position itself as critical to achieving improvements in social inclusion, and for the ISC to become the leader in ‘skilling for social inclusion’. Improving the productive capacity of the health and community services industries through skills development provides a tangible way for better links between social and economic policy initiatives. The ISC has a role in this link and ensuring it informs priorities in areas of economic and VET policy

Moving onto the ‘Skills Growth’ path

This paper has identified the fundamental forces that shape skill requirements. We believe that if nothing is done the preconditions for effective skill development in the health and community services sector are currently set on a path toward skill atrophy. These pre-conditions, as can be seen in the body of the paper, are complex, interconnected and almost impossible for single a service to overcome. Repositioning of workplaces against those pre-conditions will be best achieved by developing objectives and positions common across the sector. This is no easy task. Solutions clearly require significant intervention by governments in policy areas that go beyond vocational education and training. However, the peak organisations within the sector (including the Industry Skills Council) can play a pivotal leadership role in determining what changes can and need to be made in the short, medium and long term for the future of effective vocational education and training across all segments.

Issues for discussion 1: Forces driving skill requirement

Do you agree that the seven factors identified in the analysis above are the key one’s shaping the development of skills in industries and/or your sector?

Where does your segment of the Health and Community Services industries lie on the continuum of skills atrophy and skills growth?

If your sector does need to move off the skill atrophy trajectory, what are the critical factors to change?

1. Funding Model
2. Employer Ownership Profile
3. Employment Structures
4. Level of Labour Intensity Associated with Care Work
5. Structural Perceptions of Customer Need
6. Employee Receptiveness to Train
7. Professional Apparatus

Key VET policy priorities

What are the implications of this analysis for determining training and skill priorities in the short, medium to long term? Given the dramatic changes in Federal Government skills policy this is now a question that needs to be answered quickly and clearly. Funds for VET are to be allocated on the basis of 'demand' (i.e industry need). All Industry Skill Councils are required to outline what skills are in demand. Funds will no longer be determined on the supply of training (i.e following trainees and apprentices, and Registered Training Organisations educating them). Instead it will be settled, theoretically, by workplace need.

Determining skill demand is notoriously difficult. This paper outlines the key factors shaping it. In ascertaining the operational implications for VET key players in the industries need to reach agreement on what the most pressing skills needs are.

The current Training Packages for Community Services and Health represent national agreement on skills however they need to be updated to ensure they continue to reflect the industry now and into the future.

Issues for discussion 2: VET policy priorities

What processes would work best in improving the ways the industries:

- Are able to identify skill needs?
- Settle VET funding priorities?
- Campaign for get those priorities accepted?
- Monitor outcomes of plans and initiatives?

Without clear processes, objectives and strategies to achieve them, smaller and more cohesive industries, essentially those with more favourable preconditions for skill (e.g. mining and retail) will be able to make superior claims for limited VET funds.

References

- Ackroyd S. & Bolton S. 1999 It is not Taylorism: mechanisms of work intensification in the provision of gynaecological services in a NHS hospital *Work Employment and Society* 13, 2: 369-87.
- ACIRRT 2003 *Stable but Critical* University of Sydney.
- AHWAC Australian Health Workforce Advisory Committee 2006 *Health Workforce Planning and Models of Care in Emergency Departments*, October.
- ASU 2007 *Building Social Inclusion in Australia* ASU.
- Blendon R. Schoen C. DesRosches C. 2003 Common concerns amidst diverse systems: health care experiences in five countries *Health Affairs* 22, 3: 106-121.
- Bosch G. 2003 The changing nature of work: comparative perspectives *The Future of Work International Symposium*, London 23-24 June.
- Bradley V 2007 Quality of services and supports perspectives from the individual and systems level *American Association on Intellectual and Developmental Disabilities Seminar* Atlanta, Georgia 22 May.
- Bradley V. Smith G. Taub S. & Heaviland M. 2002 *Person-centred supports – how do states make them work?* Paper prepared by the Human Services Research Institute as part of the Reinventing Quality project funded by DHHS Administration on Developmental Disabilities, May.
- Buchanan J. 2005 *Life long learning* Paper prepared for Committee for Economic Development of Australia, CEDA.
- Buchanan J. Schofield K. Briggs C. Considine G. Hager P. Hawke G. Kitay J. Meagher G. Macintyre J. Mounier A. & Ryan S. 2001 *Beyond Flexibility Skills and Work in the Future* NSW BVET, Sydney.
- Carson E. Maher C. & King P. 2007 *Careers at the Coal Face?* Community Services in South Australia: Workforce Development Report to the Human Services Research Initiatives Program SACOSS and the University of South Australia Social Policy Research Group University of South Australia February.

Children's Welfare Association of Victoria (CWAV) 2001 Response to the Inquiry into the *Definition of Charities and Related Organisations Issues Paper, submission 275*, January, Melbourne.

Donovan P. Hanigan K. Crowe D. 2001 The learning transfer system approach to estimating the benefits of training: empirical evidence *Journal of European Industrial Training* 25, 2-4: 221-228.

Eby L. 2002 Alternative forms of mentoring in changing organisational environments: a conceptual extension of the mentoring literature *Journal of Vocational Behaviour* 51, 1: 125-144.

England P. Budig M. Folbre N. 2002 Wages of virtue: the relative pay of care work *Social Problems* 49, 4: 455-473.

Franco S. Bennett S. Kanfer R. 2002 Health sector reform and public sector health worker motivation: a conceptual framework *Social Science and Medicine*, 54, 8: 1255-1266.

Gordon S. Buchanan J. & Bretherton T. 2008 *Safety in Numbers* Cornell University Press.

Harrison J. 1999 Influence of managed care on professional nursing scholarship *Journal of Nursing Scholarship* 31, 2:161-166.

Health and Family Services 1998 Family and community services: when is competition the answer *HFS Occasional Papers Series no 2*, HFS, Canberra.

Healy K. 2004 Social workers in the new human services marketplace: trends, challenges and responses *Australian Social Work* 57, 2: 103-114.

Heap R. 1998 Physiotherapists should never be mistaken for technicians. The state, the university and the training of Ontario physiotherapists 1960-1980 *International Sociological Association Conference Paper*, ISA.

Hill E. 2001 Post-school-age training among women: training methods and labor market outcomes at older ages *Economics of Education Review* 20, 2: 181-191.

Hult C. Svallfors S. 2002 Production regimes and work orientations: a comparison of six western countries *European Sociological Review* 18: 315-331.

Keep E. 2002 Joined up thinking *People Management* 12 September: 53.

Keep E. & Mayhew K. 1999 Evaluation the assumptions that underlie training policy in Ahier J. & Esland G. (eds) *Education, Training, and the Future of Work I: Social, Political and Economic Contexts of Policy Development* Routledge, London.

Kendall L. & Lissauer R. 2003 *The Future Health Worker* IPPR London

Lehndorff S. 2002 *The governance of service work: market based control and self organised intensification of work*, International Conference on Labour Process, Paris

Meagher G. Healy K. 2006 Who Cares? Volume I and II Employment structure and incomes in the Australian care workforce *ACOSS Paper 141*, January.

Millgrom P. Roberts J. 1990 The economics of modern manufacturing: technology, strategy and organisation *American Economic Review* 80, 511-522.

Nancarrow S. & Borthwick A. 2005 Dynamic professional boundaries in the health care workforce *Sociology of Health and Illness*: 897-919.

Paraprofessional Healthcare Institute (PHI) 2003 *The personal assistance services and direct-support workforce: a literature review* Paper prepared under subcontract to the MEDSTAT group for the Research on the Adequacy and Availability of Personal Assistance Services for Persons of All Ages with a Disability or Long Term Illness project, Centres of Medicare and Medicaid Services, June.

Productivity Commission 2005 *Australia's Health Workforce*, Research report, Canberra.

Productivity Commission 2002 *Managed Competition in Health Care* Workshop proceedings, Canberra.

Raper P Ashton D. Felstead A. Storey J. 1997 Towards the learning organization: explaining current trends in training practice in the UK *International Journal of Training and Development* 1,1: 9-21.

Thursfield D. & Holden R. 2004 Increasing the demand for workplace training: workforce development in practice *Journal of Vocational Education and Training* 56, 2: 291-306.

Towle A. 1998 Changes in health care and continuing education in the 21st century *BMJ* 316.

TreWeek G. 2003 Women resistance and care: an ethnographic study of nurse auxillary work in Harper D. & H. Lawson (eds) *The Cultural Study of Work* ILR Press 397-414.

Weber C. 2000 chapter 11 in Rubenson K. and Shuetze G. (eds) *Transition to the Knowledge Society: Policies and Strategies for Individual Participation and Learning* UBC Institute for European Studies, Vancouver.

Williams G. Chaboyer W. Patterson E. 2000 Australia's nursing workforce in perspective *Journal of Nursing Administration* 30: 6.

**SCENARIOS FOR SKILL EVOLUTION IN HEALTH AND
COMMUNITY SERVICES
IDENTIFYING PRECONDITIONS FOR SKILL GROWTH OR ATROPHY**

