A case study in using VET qualifications to rejuvenate learning and change in a complex and disparate rural Area Health Service

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Abstract

The Boggabri Health Service is typical of many rural and remote public health facilities. Twenty-four staff, only a third of whom work fulltime, service the needs of a population of 1601. Change from a focus on acute care to a model of wellness through redevelopment as a Multi Purpose Service is providing staff with a unique opportunity for continuing professional development, particularly in regard to aged care standards, their core business.

Use of flexible delivery and self-directed learning has transformed this facility from ignorance about the value of undertaking vocational education and training (VET) to 80% enrolment in certificate and diploma qualifications, over a six month period from January 2001. Some twenty-five facilities comprise the New England Area Health Service, of which Boggabri is but one. The learning innovation demonstrated at Boggabri is being duplicated across other facilities. Interest in VET qualifications from staff at all levels is a remarkable renaissance.

Background

Provision of public health care is in flux (Menadue 2000), particularly in rural and remote areas of New South Wales (Sinclair 2000). A significant morphing in small, rural areas is the redevelopment of local hospitals as Multi Purpose Services (MPS), with considerably reduced emphasis on the illness model of care (acute, hospital based) to a wellness model. This is an extraordinarily challenging change in mindset for staff in these facilities who, by and large, may be ill equipped in terms of the knowledge, skills and attitudes (that is, competencies) to forge these important changes. Against this backdrop, New England Area Health Service (NEAHS) rethought its in-house training philosophy, endorsing flexible delivery of a variety of pertinent certificate and diploma vocational education and training (VET) qualifications as a way to upskill staff capable of delivering the Area's strategic plan. This paper describes the model in action at a small remote hospital servicing a town of 1601 people.

NEAHS provides a comprehensive range of health services to a population of 175,208 living in a rural area in the north of New South Wales. The geographic area covered by NEAHS is 98,000 square kilometres, stretching from Quirindi in the south to the Queensland border in the north, from Tenterfield in the east to the borders of Moree and Narrabri shires in the west. There are 20 public and 2 private hospitals in the region.

The region has a diverse population density pattern, ranging from rural and remote in the western areas to a rural industrial city of 50,000 people, Tamworth, when the surrounding shire is included. Several small towns and villages, with populations of less than 200 people, have very poor infrastructure and negligible public transport.

The region contains 20 Local Government Areas and within these there is considerable variation in population mix. This means that, compared with the State average, some have a higher proportion of children and young people while others have a higher proportion of people over 65 years of age. The social effects of the changes to rural industry and its lower employment requirements were clearly demonstrated in the 1996 census. There has been a general downturn in population numbers across the area.

A major issue for NEAHS is the population distribution in relation to infrastructure and service provision - multiple small villages of ageing populations, high levels of socio-economic disadvantage, and no public transport. Delivery of health service (community and acute) to these communities is expensive due to lack of economies of scale, distances from specialist services, and Ambulance retrievals (Figure 1).

Historical, social and political factors have meant that changes to the health services themselves have not matched the changes to the population base or health service delivery in the 1990s. Recent changes in government policies, however, are attempting to address these deficits. The redevelopment of local hospitals as MPSs illustrates this. Several sites in NEAHS are approaching this transformation: Boggabri, Emmaville, Walcha, Guyra, Bingara, Warialda, and Barraba.

Boggabri, typical of MPS towns, is a small rural community located in the Narrabri Shire between Gunnedah and Narrabri. It has a high level of socio-economic disadvantage and unemployment although Narrabri Shire is one of the richest Shires in the State. The major industry is broad acre farming (cotton and wheat), with some benefit from nearby coal mining. Health status statistics for Narrabri indicate that there is higher mortality from all causes. There is no public transport or taxi within the Boggabri area and over 10% of households have no motor vehicle (Boggabri Multi Purpose Service - Service Plan 2000).

According to the 1996 Australian Bureau of Statistics Census, the population of the Boggabri catchment, postcode 2382, was 1,601 persons. Narrabri Shire had a total population of 14,101. The Boggabri catchment represented 11.4% of the population of Narrabri Shire and 0.9% of NEAHS's population. As with the majority of rural areas, particularly those west of the Great Dividing Range, the population of NEAHS is projected to decline over the coming years. Department of Health projections suggest a decrease of 4.8% by 2006.

Figure 1 Map of New England Area Health Service, showing towns in relation to Tamworth (Base Hospital)

Establishment of an MPS at Boggabri focuses on providing local delivery of appropriate hospital and community health services, with an emphasis on overcoming difficulties in accessing services. Additionally, it will provide accommodation for those requiring hostel and nursing home care (to the current standards for care provision and safety) and become the focal point within the community for integrated health and community care services.

Services proposed for inclusion in the Boggabri MPS, with its staff of 24, include:

- 4 inpatient hospital beds (including 1 palliative care bed)
- 7 high care places (nursing home beds)
- 9 low care places (hostel beds)
- respite care (either high or low care depending on need)
- 24-hour emergency department
- clinics for primary care services
- x-ray and pathology services
- a wide range of community health services provided either by local or visiting health professionals
- 2 community aged care packages
- general practitioner surgery
- ambulance service - physical co-location
- consulting and education rooms with cabling to access future developments in 'telehealth'.

Quite reasonably, staff of the Boggabri MPS might be expected to be in a state of instability, anticipating major change yet not clearly understanding potential effects on them personally. What made Boggabri interesting from a learning perspective, however, was that a significant proportion of staff are shift and part time workers, many of whom have no formal qualifications. Clearly, innovative approaches to learning were required.

Genesis of VET qualifications

VET refers to providing people with knowledge, skills and attitudes that enable them to adequately perform and succeed in their jobs. Historically, VET was principally the domain of TAFE, though with deregulation of the VET sector over the last ten years, there are now some 5000 providers, many of which are private or organisation based.

The Australian National Training Authority (ANTA), a Commonwealth Statutory Authority, commenced operations in January 1994, and is the driver of change in VET delivery. It was concerned that Australia was being disadvantaged in the world arena because of a relatively untrained or poorly trained workforce by global standards. ANTA's response was the introduction of the National Training Reform Agenda (NTRA), which emphasised that workplace training should positively value-add to an organisation and industry. The ANTA website provides an extensive and integrated menu to these changes (www.anta.gov.au).

NTRA recognised that the notion of training and gaining qualifications might challenge the majority of workers. To mitigate this, several innovations were endorsed: more flexibility in training delivery, legitimising on-the-job learning, wider choice of courses and qualifications proffered, introduction of national and industry standards, and recognition of prior learning. Perhaps most significant was the endorsement of an Australian Qualifications Framework (AQF). The AQF, for the first time, allowed people to use lower level qualifications, and experience, to work towards gaining higher qualifications. To this end, many universities now recognise VET qualifications and provide advanced standing to under- and post-graduate degrees, though some universities have acquiesced more quickly than others (Hanson and Isouard 2000).

The significance of this genesis to staff at Boggabri is that, for the first time, a mechanism existed whereby they could potentially access training without recourse to distance learning packages, or attending night school at TAFE in adjacent towns. Further, the notion that they could use their current knowledge and skills to gain meaningful and nationally recognised industry qualifications piqued their interest. In other words, ANTA's visionary outcome was starting to be realised in a very small, remote facility, nascent as it was.

NSW Health as a Registered Training Organisation (RTO)

NSW Health, with about 100,000 staff, has an annual budget of $8.5 billion. It covers 210 general public hospitals, 15 approved MPSs, 280 community health centres, 500 early childhood centres and 15 nursing homes. It has a strong learning ethos. However, there is no centralised learning function in NSW Health, neither financial nor other accountabilities, apart from the Director-General providing the imprimatur for the RTO. To provide VET-accredited qualifications in NSW, the provider must first undergo accreditation with the Vocational Education & Training Accreditation Board (VETAB).

In March 2000, the Learning Services within each Area Health Service (AHS) joined forces to become the NSW Health RTO, with obvious cost savings and efficiency gains.

It is a redoubtable feat that Learning Services across NSW Health voluntarily joined forces to gain accreditation for the common good of all staff. This makes the NSW Health RTO unique. Never before in the history of NSW Health has there been a more focused and strategic learning ethos, predicated on previously unavailable VET sector qualifications, and fully supported from the top. A fuller account of the evolution of the NSW Health RTO is provided by Hartley (2001).

The NSW Health RTO's strategic vision is to provide staff with wider choices in VET qualifications proffered, and access to a variety of learning pathways, to improve organisational performance by which to drive changes in the way health care is delivered to the people of NSW. In so doing, better sharing of scare resources across the RTO will ensue.

Stringent financial and logistical constraints preclude most NSW Health staff attending much face-to-face learning nowadays. The challenge therefore is to deliver more, to an increasing client base, with fewer resources. To this end, flexible delivery is becoming more important. Typical of rural areas in particular but possibly also metropolitan areas, the uptake of VET sector qualifications is dismal, especially among non-clinicians, many of whom have no qualifications whatsoever. Boggabri is a case in point; prior to 2001, no-one had enrolled in a VET qualification, from the NSW Health or other RTOs. As previously highlighted, Boggabri is fairly representative among rural and remote facilities.

In the end, the Boggabri case study originated for three reasons. First, there were huge changes in service delivery from an illness to a wellness model. Second, training reform opened learning pathways previously unavailable to the majority of Australian workers. Third, the NSW Health RTO was well poised to exploit on-the-job learning and flexible delivery.

Boggabri in action

Twenty-four people staff Boggabri hospital, of which fifteen are nursing staff (eight registered nurses, seven enrolled nurses) and the rest hotel service staff. Only eight are full time; eleven are permanent part time, and five casual - and the majority female. Hourly salary rates range from $13.36 to above $30.00. Ten staff have worked with the hospital since the 1980s, nine since the early 1990s, with the three newest joining in 1997/98. Typical of small rural and remote facilities, staff at Boggabri are mostly part-time workers, not highly paid nor mobile. Prior to 2001, none even considered undertaking VET qualifications.

Yet now, twenty-two, or 80%, are successfully undertaking certificate through to diploma qualifications, three of whom are doing two qualifications. The predominant qualification is Community Services (Aged Care Work) - three at Certificate III, nine certificate IV, and one diploma level. Additionally, two are studying Assessment & Workplace Training (Certificate IV) and one Government (Project Management) at diploma level.

This is a profound turnaround made all the more significant by its speed. Qualifications in aged care predominate, as this is the core business of the facility, and arguably of NEAHS as a whole.

Carriage of VET qualifications in NEAHS lies with the Rural Health Education & Research Centre (RHERC). On offer is a range of qualifications (Table 1) from pertinent National Training Packages. National Training Packages, once developed and endorsed by industry, supersede all other VET qualifications in those industries, and all training delivered thereafter must use their endorsed competencies and qualifications.

Qualifications proffered by the RHERC are set to expand; four new ones are currently being added to the scope (certificates IVs and diplomas in Community Services (Disability Work) and Community Services (Community Work)). The imminent release of the health industry National Training Package will also result in considerably more (relevant) qualifications being proffered to NEAHS staff.

Table 1: range of certificate and diploma qualifications offered through the Rural Health Education & Research Centre

National ID code	Qualification	Level
CHC20199	Community Services (Aged Care Work)	Certificate II
CHC30199	Community Services (Aged Care Work)	Certificate III
CHC40199	Community Services (Aged Care Work)	Certificate IV
CHC50199	Community Services (Aged Care Work)	Diploma
BSZ40198	Assessment & Workplace Training	Certificate IV
BSZ50198	Training & Assessment Systems	Diploma
BSXFMI30198	Frontline Management	Certificate III
BSXFMI40198	Frontline Management	Certificate IV
BSXFMI50198	Frontline Management	Diploma
PSP40199	Government	Certificate IV
PSP40699	Government (Project Management)	Certificate IV
PSP50199	Government	Diploma
PSP50699	Government (Project Management)	Diploma

Noteworthy, fewer than four RHERC staff manage these qualifications. Yet the NEAHS undertaking is to have the majority of staff undertaking one or more.

Cupitt (2000) reported staffing reductions in the RHERC over the last seven years, from four full time educators to one, with a second part time. As a consequence, the RHERC had to develop a dynamic learning model to meet the needs of staff, the organisation and external customers. The ensuing model was determined by decreased organisational resources, increased numbers of qualifications on offer, level of access by staff (by location and position), and technological advances. Clearly, the RHERC was not going to be able to meet everyone's training needs. It had to change the way it delivered learning to stay viable in a competitive training market. The need was for inexpensive, accredited qualifications with 100% flexible delivery (Mills 2001).

The resultant model encapsulates the following:

- Certificate/Diploma qualifications offered to all staff at their workplaces, irrespective of their positions or geographic locations, starting with (monthly) generic orientations to the wide range of qualifications.
- Deployment of local, VETAB accredited assessors and presenters to deliver short tutorials on individual competencies, as the RHERC provides no face-to-face knowledge content.
- The RHERC manages and co-ordinates all assessors and presenters and has overall responsibility for developing learning resources and assessment.
- Ongoing and flexible support for all candidates, with increased use of some other technology such as e-mail, teleconferencing and the Internet with discussion pages to facilitate learning and links between teachers and students.
- Implementation of computer-based technologies (ANTA Toolboxes, for example) and interactive multimedia - very much in development phase at present.
- Candidates direct their own learning using self-assessment activities and designing work based projects - a critical aspect of the model.

- Establishment of peer support networks in each facility to create and perpetuate a learning ethos - made easier by the fact that majority of staff undertake qualifications using identical methodologies.
- Assessment by portfolio of evidences plus interview, though variations in this are currently being trialled.
- External moderators are used to benchmark assessment standards.

While we are in an early stage, the evidence points to successful completion for all Boggabri candidates, and within 12 months. To date there have been no withdrawals. Despite a considerable network of accredited assessors (160) and trainers (250) having been established over the last three years, little use is being made of these by candidates to date. RHERC staff, however, do make monthly trips to each facility to brainstorm notions of evidences with candidates, at the same time encouraging individuals to reflect on the significance of evidences gathered to their work practices. This process appears to be working well.

Boggabri is showcased as exemplary and, in view of this, the temptation might exist to perceive it as a one-off. However, its success is already being duplicated in other facilities that comprise NEAHS. Emmaville and Barraba are well on the way to emulating Boggabri, with all other facilities due to become involved over the next twelve months. This is a remarkable achievement for learning and change in a complex and disparate rural Area Health Service.

Success, in the end, comes down to a few key notions. One is good marketing of the benefits for all staff of doing VET qualifications. Many employees already address the competencies in their daily work routines, so why not get this recognised formally with a nationally transferable qualification? For others, it provides a cost-saving pathway towards a degree. Both arguments have won favour with staff. Benchmarking whole teams against national standards is already being seen to be lifting quality within the various facilities, as candidates critically analyse what, how and why they do things. Thus the benefits to the organisation become obvious.

Finally, targeting managers themselves to become candidates and accredited assessors has endowed credibility on the value of VET qualifications. The perception is that if a professional sees value in gaining these, then the qualifications must be worthwhile. In NEAHS, it is not uncommon to see the facility manager and staff from various departments engaging in the same qualification.

Concluding comment

ANTA nowadays is investing heavily in flexible delivery and in online learning in particular. Online delivery is arguably the way ahead for delivering learning across rural and remote facilities, which will continue to be constrained financially and in other ways. Good as it may seem, however, internet-based learning remains novel and contentious. Imagine what might be possible, nonetheless, once NEAHS has its online learning up-and-running, and its candidates have the computer skills to access learning and support.

Despite this current lack, the evidence points to a willingness of health staff to participate in self-directed learning, and with minimal support, at levels previously unheralded. The Boggabri experience illustrates this to be so, and without the need for face-to-face teaching.

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References

Boggabri Multi Purpose Service - Service Plan 2000, Prepared by New England Area Health Service for the Boggabri MPS Committee

Cupitt M 2000, 'Using Flexible Delivery to Provide Education Programs in Rural Communities', *Education for Quality Healthcare Symposium*, Brisbane Australia, 12-14 November, Mater Hospital

Hanson S & Isouard G 2000, 'The introduction of the Frontline Management Initiative in South Western Sydney Area Health Service', *Australian Health Review*, vol 23, no 3, pp 209-218

Hartley R 2001, 'NSW Health becomes a Registered Training Organisation'. *The NSW Public Health Bulletin*. NSW Health, State Health Publication ISSN 1034 7674, (in press)

Menadue J 2000, 'Report of the NSW Health Council', NSW Health, Sydney

Mills M 2001, 'Designing a flexible model of learning for a rural health organisation: a case study', *Journal of Education in Rural Australia*, (in press)

Sinclair I 2000, 'NSW Ministerial Advisory Committee on Health Services in Smaller Towns', NSW Health, Sydney