Raising an umbrella organization?: Countering government and industry neglect of professionals

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An earlier version of this paper was presented at the “United We Stand” Conference, sponsored jointly by the Australian Association of Social Workers (AASW), the Australian Institute of Welfare and Community Workers (AIWCW), the Australian Association for Social Work and Welfare Education (AASWWE), and the Society for Professional Social Workers (SPSW), held at Fremantle, WA 19–21 Nov. 2006.

Abstract

As professional bodies representing workers and educators in the field of social and community services, we need to stand united against a tendency to ignore or dismiss us by some representatives of government and industry. The Productivity Commission report on the research into Australia's Health Workforce emphasised the increasing blurring of roles, but ignored the great overlap between health and community services work in its proposal for over-arching health accreditation and regulation boards. In this paper Negative Licensing is suggested as an alternative to additional regulation of professions. A broad concept of ‘professional’ is used as a basis for a proposed umbrella network involving the whole community services sector. This could counter neglect by government bodies and provide a focus for resources, identity and organisation within the sector.

Introduction

By way of introduction, I want to start with a mention of ‘professional identity’. There may be some who question the label “professionals” as applying to the range of workers represented at this conference. Without going into the long-lasting confusion about what is a professional, nor the now surely exhausted debate about the formal professional status of social work, I am referring for convenience to an early analysis of the “human services profession” in the USA, which is roughly equivalent to “professional welfare work” in Australia. According to a well respected human services textbook written by Woodside & McClam (1990: 179), professionals have:

1. A high degree of generalised systematic training in the knowledge, skills and values of the profession;

2. a primary orientation to a focus upon clients and their needs;

3. self-control and regulation by a personal and professional code of ethics; and

4. recognition by the community and bureaucracies; which reward work achievement and foster feelings of professional accomplishment.

There is now acknowledgement that great overlaps in the duties performed by the various professions occur in practice. What seems to be retained is an emphasis on a
body of generalised knowledge which is not necessarily exclusive to one profession, together with a client-centred and ethically guided focus. This has been applied to workers with relatively minimal formal qualifications such as a two year diploma. Human services workers in the USA with these qualifications recognise themselves as at least “beginning professionals”, and the term “para-professionals” has generally been discarded within this profession, although it still has common usage outside it (Schmolling, Youkeles & Burger 1997; Mehr 1998; Roth & Fonargy 2005).

There is external support for applying the term “professional” to two year programs in Australia. The Victorian Office of Youth Affairs (1995) determined that:

> While in the past the term "professional" in particular contexts has been reserved for people having at least a three-year tertiary-level qualification (with two year course characterised as "para-professional"), we believe that a well designed high-quality two-year program can equip its graduates to perform competently and to professional standards. (Office of Youth Affairs 1995:28).

This kind of generic professional experience can be transferable to some extent, whatever the separate theory, skills and techniques which might attach to an identified (and perhaps even regulated) profession. If a worker takes the wishes and needs of the clientele seriously, and practices with reference to ethical standards, with honesty and integrity, then this can count as valid and relevant ‘professional’ experience, even if the work has used techniques identified with quite separate disciplines such as physiotherapy, teaching, nursing or journalism.

The fourth characteristic listed above by Woodside & McClam (1990) characterises ‘professional identity’, and, as it seems to be under increasing threat, provides a focus for this paper. It is apparent that government policy and its bureaucracies, including sponsored enquiries and the proposed overarching regulatory structures resulting from them, all deny proper recognition, and withhold a sense of professional accomplishment from the professional worker, more especially those within the community services field.

Semi-government bodies, such as the Community Services and Health Industry Skills Council (CSHISC), seem well aware of the neglect of community services among wider enquiries, and it presented trenchant criticism of this in its submission to the Productivity Commission project on the health workforce. But these, like the similar protests within submissions from the AASW, were ignored by the Productivity Commission Report on Australia’s Health Workforce, which was produced in December 2005.

**Productivity Commission Report on Australia’s Health Workforce and the COAG Response**

On 14th July 2006, the Council of Australian Governments (COAG) responded to this report by accepting the major findings and most of the recommendations (COAG 2006). Agreement was reached:

- To establish a single national accreditation board (and)
• To establish a single national registration board for all health professional education and training.

• Each board to represent the “general public interest”, rather than the interests of particular stakeholders (such as professional associations).

• The new accreditation board to assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.

• Recognition of overseas trained health professionals.

• Eventual inclusion of those trained within the VET system, such as at TAFE colleges.

Further, the new registration board should be given authority:

• To determine which professions to register and which specialities to recognise, (but)

• It will initially cover only those professions which are currently registered.

It is apparent that these over-arching provisions ignore the overlap into non-health areas by many of the health workforce professions, which share their scope with the community services.

A Taskforce set up by COAG (2006) is to work on refinements, undertake projects, and provide advice to the Australian Health Ministers’ Conference. But prolonged attempts to alert this task force to the biases and omissions in the Productivity Commission Report, and the subsequent COAG Response, have also led to little result. The problems were outlined in more detail in a recent AIWCW summary paper (Murray 2006c), which was sent to the COAG secretariat, to the National Health Workforce Secretariat, and to the secretariat of the Australian Health Ministers’ Advisory Council, and although a response was promised by some officials, none has been forthcoming. These problems are summarised below.

Problems of omission and overlap

It is not expected that in a report which received over 370 submissions that any one submission or profession would receive individual attention, but what is striking about the Productivity Commission Report (2005) is the almost complete omission of the whole community services sector, including social work, and welfare and community services work. In addition, there is minimal mention of counselling, psychology and psychiatry. This is in contrast to the claim in the Report that: ‘[T]he term ‘health workforce professional’ [is] defined to cover ‘the entire health professional workforce’, from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical’ (2005:2).

The “community services sectors”, and case managers and counselling are mentioned only under “disabilities” in the special needs section of the Report (2005:278). There
seems to be only three passing mentions of social work in the whole report. The Australian Association of Social Workers protested about this neglect in its submission to the Productivity Commission (AASW 2005) but it seems to no effect, since the protests were ignored in the final report by the Commission.

Social workers, welfare and community workers, counsellors, and psychologists are all employed throughout the health and medical sector, and in considerable numbers, so the lack of analysis, or even much mention in either the original report or the COAG response, is therefore difficult to understand. Several organisations, including the AASW, mentioned in their submissions that their members overlapped both health and non-health employment, but there was no mention in the Productivity Commission Report (2005) of the problems this posed for uniform regulation and accreditation.

A detailed study of the health and community services workforce was undertaken by the Monash Centre of Policy Studies in 2005. For the purposes of this discussion, a partial reproduction of the analysis is outlined below:

**Table 1. Health & Community Services Workers, 2003-04**

<table>
<thead>
<tr>
<th>Occupations</th>
<th>Hospitals, Medical, nursing homes etc</th>
<th>Total community services &amp; health</th>
<th>Other industries</th>
<th>Total all industries</th>
<th>Estimated percentage change 2004 to 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Welfare Professionals</td>
<td>16,400</td>
<td>36,900</td>
<td>25,800</td>
<td>62,700</td>
<td>20.7%</td>
</tr>
<tr>
<td>Misc Health Professionals*</td>
<td>52,900</td>
<td>54,700</td>
<td>5,900</td>
<td>60,600</td>
<td>15.7%</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>53,800</td>
<td>54,100</td>
<td>2,100</td>
<td>56,200</td>
<td>6.9%</td>
</tr>
<tr>
<td>Nursing Professionals</td>
<td>170,200</td>
<td>176,300</td>
<td>9,700</td>
<td>186,000</td>
<td>10.9%</td>
</tr>
<tr>
<td>Health &amp; Child Care Managers</td>
<td>4,900</td>
<td>10,000</td>
<td>2,700</td>
<td>12,700</td>
<td>38.1%</td>
</tr>
<tr>
<td>Welfare Assoc. Professionals</td>
<td>1,000</td>
<td>11,400</td>
<td>7,500</td>
<td>18,900</td>
<td>33.9%</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>21,300</td>
<td>22,600</td>
<td>1,000</td>
<td>23,600</td>
<td>-13.6%</td>
</tr>
<tr>
<td>Aboriginal Health Workers</td>
<td>1,000</td>
<td>1,200</td>
<td>500</td>
<td>1,700</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

* This category includes a great range of practitioners, such as dentists, OTs, physiotherapists, chiropractors, podiatrists, dietitians, natural therapy and other health professionals.

These data (in the second column) clearly show a substantial number of “Social Welfare Professionals” (i.e. social workers, welfare and community workers, counsellors, and psychologists) engaged directly in health related settings. If the vast numerical domination by professional nurses is omitted, these workers constitute about 13% of the remainder. Also, the number of these social welfare professionals is close to that of enrolled nurses and Aboriginal Health Workers (AHWs). And yet these latter workers are given considerable attention in the original Report, and significant analysis and policy directions are applied to them in the COAG response. So one can only wonder why the Social Welfare Professionals were ignored.

It is worth noting (in the far right column) the projected increase in this category to the year 2011, compared to the other major health professions. Only managers and Aboriginal Health Workers are likely to increase at a greater rate, but their overall numbers are much smaller. The expected marked decrease in the numbers of enrolled nurses is at odds with their proposed enhanced role in the Report as generalist health workers. This study reinforces the contention that a truly generalist role might also be suitable for social welfare workers, since their overlap into community services and other industries is likely to be just as significant as any overlap in roles by enrolled nurses.

There is acknowledgement in the Productivity Commission Report (2005) that the areas of ‘special need’ such as mental illness, disabilities, and aged care, are relatively neglected (2005:280), but social welfare workers are not confined to these specialties. Many of them work in general medical settings such as hospitals, clinics, and in private practice as counsellors, as illustrated in Table 1 above.

As a comparison, and in order to provide more detail regarding some professions which remain unregulated, the following numbers are derived from the 2001 Census, but for NSW only:

**Table 2. Unregulated Health Professionals, NSW, 2001**

<table>
<thead>
<tr>
<th>Professionals</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellors</td>
<td>4397</td>
</tr>
<tr>
<td>Natural Therapy Professionals</td>
<td>1248</td>
</tr>
<tr>
<td>Speech Pathologists</td>
<td>896</td>
</tr>
<tr>
<td>Dieticians</td>
<td>781</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>1726</td>
</tr>
<tr>
<td>Welfare and Community Workers</td>
<td>8758</td>
</tr>
<tr>
<td>Massage Therapists</td>
<td>1705</td>
</tr>
<tr>
<td>Social Welfare Professionals</td>
<td>323</td>
</tr>
<tr>
<td>Other Health Professionals</td>
<td>2399</td>
</tr>
<tr>
<td>Minister of Religion</td>
<td>4892</td>
</tr>
<tr>
<td>Social Workers</td>
<td>2460</td>
</tr>
<tr>
<td>Total</td>
<td>29,585</td>
</tr>
</tbody>
</table>


The above data are distorted by the categorization of Social Welfare Professionals as only those holding a university degree. Some of those who identified as “Counsellors” for the census, might have welfare work or social work qualifications, but presumably not psychology, which is a regulated profession. Social welfare and community workers are by far the most numerous; comprising 31% of the total, with counsellors...
14% and social workers 8%. Table 2 also shows the number of categories which overlap outside the health sector.

Perhaps the omission from the Productivity Commission Report (2005) of this Social Welfare professional category reflects the problem these professions pose for the proposed regulatory and accreditation bodies. These practitioners also work in non-health occupations, as Table 1 illustrates. Of the total of 36,900 workers in community services and health, some 19,000 work in community care services. There are also significant numbers employed in other industries, such as corrections, housing, education, employment, and social security.

**Alternative Regulatory Structures**

If these professions are to be regulated or formally accredited via legislation, there could be at least three different regulatory structures. One possibility is that only those members of the profession practising in the health sector will be covered. But this ignores the difficulty in defining the boundaries of the health sector, as well as the problems in the practice setting of many of these workers, where roles and duties are very flexible. Some social welfare workers will be greatly involved in family, legal, housing, and career issues with clients whose point of contact may be a health facility.

On the other hand, a social welfare agency which specialises in housing problems may employ social welfare workers who must deal with physical or mental health issues in at least a significant minor proportion of their work.

Another possibility would be to simply regulate each of these professions right across their total scope, in whatever field they are practised. If the legislation and regulatory board is located in the health sector however, this is likely to be fiercely resisted by non-health workers, some of whom may have nothing to do with health, such as employment or corrections. Again, there would be significant problems with definitions, the drafting of legislation, and with administration.

A third alternative is provided by the NSW Parliament (2006) which early in 2006 conducted an enquiry into unregistered health professions. The committee conducting the enquiry agreed that the Health Legislation Amendment (Unregistered Health Practitioners) Bill 2006, introduced into the NSW Parliament in September 2006, “will effectively allow the Commission to deal with dishonest or incompetent providers in the absence of a registration system.” (2006: par.10.49). This “Negative Licensing” scheme involves “the preclusion of persons deemed incompetent or irresponsible from operating in a particular industry, upon establishment of this incompetence” (2006: par.10.25). The NSW report goes on to note “In light of National Competition Policy requirements, negative licensing has been identified as a suitable first step in regulating unregistered professions, as it imposes few restrictions on the health market whilst enabling practitioners who do pose a risk to consumers to be prevented from practicing” (2006: par. 10.26). Thus it would seem that the original threat of a draconian, rigid form of registration may be averted, and negative licensing may be all that is needed.

This concept of ‘negative licensing’ could also eventually apply to the community services, where the employment of non-traditional professions and occupations has
been resisted on the grounds of inadequate protection of the public. Negative licensing could facilitate the employment of workers with less formal training who use informal networking and cross-referral and consultation among other skilled practitioners, whatever their formal qualifications and occupational identity or job title. These workers could be said to be ‘professional’, as presented at the beginning of this paper.

The Productivity Commission Report (2005) also advocated the use of ‘credentialing’ and ‘delegation’ as alternatives to additional registration of professions. Although not defined in detail in the Report, Credentialing might involve a pragmatic and presumably widespread focus upon employer responsibility for recruitment, taking into account the applicant’s experience, generic qualifications, personal attributes, and 'fit' with the current workforce and the particular vacant position. Delegation refers to the ability to undertake tasks with minimal training, while under close supervision.

**Role Boundaries and Overlaps**

The Productivity Commission Report (2005) opposed a dependence on profession-specific training that placed unnecessary and unconstructive constraints on workplace innovation and job design, and led to ‘professional silos’ which resisted the increasing overlap of roles and duties typical in multi-disciplinary team approaches to service delivery. It proposed a national accreditation scheme to integrate the existing profession-based system, but this has been vigorously opposed by some of the established professions, according to submissions to the Report (2005).

The earlier National Health Workforce Strategic Framework asserted ‘boundaries and established professional roles will need to evolve [with] a greater focus on the length … and content of education and training’ (Australian Health Ministers’ Conference, 2004:11). Not mentioned in the Framework is the substantial research evidence for the relative equivalence in outcomes of minimally trained generalists compared to highly trained specialists in counselling and psychotherapy. This research has relevance in examining the length and overall costs of training (especially ‘clinical’ training), but it is not well known or discussed, possibly because of entrenched resistance to its implications from the traditional professions, (see Roth & Fonargy 2005; AIWCW 2006: Appendix for summaries).

The national accreditation scheme proposed by the Productivity Commission (2005) and endorsed in the COAG response (2006) might break down the worst aspects of professional silos, but it might also restrict the more radical opening up of flexible work roles, if too much emphasis is placed upon qualifications alone. The National Health Workforce Improvement Agency, also proposed by the Productivity Commission (2005) plans to review the mix of generalist and specialist roles, but there is no guarantee that the overlap with social welfare work will be addressed. On 13th April 2007, COAG:
[A]greed on the arrangements for a new national system for the registration of health professions and the accreditation of their training and education programs for implementation by July 2008 … Each profession will develop standards for its profession for approval by Health Ministers. Individual registration and accreditation decisions will remain the responsibility of the professions.

(COAG 2007)

The new system is to cover only nine professions which already have registration requirements: medical practitioners, nurses and midwives, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists and dentists (including dental hygienists, dental prosthetists and dental therapists). Other professions will be able to apply to become part of the system, after it is functioning smoothly for these nine professions.

It seems possible that the overall support by COAG for national bodies to overview the health workforce may soon spread to other sectors, including community services. The fact that COAG ignored the overlap of these two sectors increases the need to make our collective voices heard. The inclusion of ‘dental therapists’ in the agreed registration scheme might indicate a future propensity to widen the scope of registration beyond the traditional professions. A mechanism to monitor and respond on behalf of the full community services workforce to the developments in national accreditation and registration proposals seems to be necessary, even if such a process is not directly represented on any formal body.

**Raising an Umbrella Organisation?**

The needs outlined above lead to the suggestion to establish an umbrella organisation which would link the workforce of the whole social and community services and welfare sector, and perhaps act as a monitoring and lobbying body, with a watching brief on government and other external proposals which might affect us.

The tentative proposal has a number of features, all of which could be open to discussion and modification or refinement. It could:

- Be **workforce oriented** within community services. Not competing with ACOSS (Australian Council of Social Services), which is not much interested in workforce matters;

- Have a **community services identification**, but with flexibility, incorporating those who trained and now still identify with this sector, even if employed in quite separate industries, such as transport or manufacturing;

- Have an **extensive vertical basis** including those with minimal training – and maybe volunteers and students;

- **Liaise with existing professional organisations** – not replace or compete with them;
• Be **broadly professionally** oriented - client-centred, ethically guided, maybe link to a generic code of practice;

• Be **oriented to general workforce issues** rather than to individual workplaces or wages and conditions.

It would:

• Not compete with trades unions
• Encourage organisation
• Promote recognition and identity
• Be network oriented, and this is perhaps the key concept.

The metaphor of an “umbrella” relates to a place of shelter, and creates an image of inclusiveness. It could offer shelter and a counteracting influence to external criticism and neglect of the sector, under which resources can be gathered and mutually advantageous responses can be discussed and implemented. It could be a loosely organised network of associations and aggregations of workers – a network of networks, with a flexible and relatively flat, hierarchical structure. It would not be a ‘peak body’ in the usual sense of that word, although it would have a charter to promote particular viewpoints and reactions to public statements and discussion. However, it would also be a forum for discussion and repository of information and resources, perhaps making extensive use of innovations in information technology. It might therefore have links with the new AIWCW electronic journal Practice Reflexions [www.aiwcw.org.au/practicereflexions/index.html](http://www.aiwcw.org.au/practicereflexions/index.html).

A more extensive model, involving potentially all professional organisations, is provided by the Professional Association’s Resource Network (PARN), begun in 1996 in the United Kingdom by Andy Friedman. This network now has over 125 members, and it provides research results and a forum for information exchange on such matter as governance and how to retain and recruit members. A much more limited model in terms of structure might be the Australian Association for Social Work and Welfare Education (AASWWE).

An Australian umbrella organisation might encourage or facilitate currently unrepresented groupings of workers to organize at a national level, for exchange of ideas, practices or issues. Prominent among these are community development workers and youth workers, each of which have been unable to establish a national organisation with wide recognition, and especially by government and similar bureaucracies.

Ideological resistance from community development workers to establishing anything that looks like a professional organisation has been apparent in the past, but it would seem from the above discussion that there are also disadvantages in being formally unrepresented. For example, currently, “community worker” applicants for permanent residence in Australia under the skilled migrant scheme are assessed only on the basis of a vaguely relevant degree (such as sociology), without reference to any skills training within the qualification. ‘Qualifications do not need to be specifically related to your nominated occupation’ (VETASSESS 2007). Community development
workers have been subject to disparagement by some government bureaucrats (DVC 2006).

The proposed umbrella organisation could act as a guide or even as a mentor to any category of workers (such as community workers or disability support workers) which does wish to organise. They may wish to amalgamate with existing organisations (such as AIWCW), or establish a truly national representative organisation of their own, within the overall network-of-networks umbrella.

The umbrella organisation could also promote occupational and professional recognition and identity, including a concern with career paths and articulation. It would provide a positive focus for workers in the community services, and perhaps address the very vexed question of articulation between the VET sector and universities.

Conclusion

This paper provides the beginning of a discussion of the possible benefits of a Community Services Umbrella Network and the features outlined are only suggestions as to how such a network might be set up and function. The name is only a very tentative suggestion - CSUN sounds a bit strange as an acronym (but, better than CSUA – it sounds a bit like effluent). I admit, this proposal may be no more than a "dream some of us have", and perhaps it seems like a very high "kite to fly".

Nonetheless, the challenges to the community services workforce raised by the COAG initiatives deserve attention, whether or not we come up with a structure of some sort to address the challenges which may emerge for our shared professions and occupations. Raising an umbrella organisation might not be the answer, but at least I hope this paper makes us aware of some of the questions.

In the meantime, this paper has raised some alternative ways of looking at the concept of a professional, which might fit under such an umbrella, and has also promoted at least a partial solution to registration problems, in the form of negative licensing.

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