EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 23 OCTOBER 2002

SESSION 2

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

[10.20 am]

THOMSON, MRS SANDRA GAIL
National President,
Australasian Association for Quality in Health Care, and
Acting General Manager, Peel and Rockingham-Kwinana Health Service,
examined:

SKINNER, DR CHRIS
University Senior Lecturer,
Edith Cowan University, Joondalup Campus,
examined:

The CHAIRMAN: Thank you very much for coming. I am required to advise you that the committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Although you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the "Details of Witness" forms and do you understand the notes that were attached to them?

The Witnesses: Yes.

The CHAIRMAN: Have you read the "Information for Witnesses" briefing sheets about giving evidence before parliamentary committees?

The Witnesses: Yes.

Mrs Thomson: I am also the General Manager of the Peel and Rockingham-Kwinana Health Service but I am here in my capacity as National President of the Australasian Association for Quality in Health Care.

Dr Skinner: I work as a senior lecturer at Edith Cowan University, and I have responsibility for health service management as part of the faculty of communication, health and science at Joondalup campus.

The CHAIRMAN: We want some more information on the submission you have tendered to the committee. Is there something that you have a passion for that you would like to start with and that you want to share with the committee?

Mrs Thomson: I have been in health services management for more than 15 years in Western Australia. In my role at both the state and national levels the future development of health services management is a key passion of mine. With the emerging models of health care delivery and the complexities of the environment in which we are operating, I believe we have a contribution to make to this process.

Dr Skinner: I have been working in the area of health services management for the past 15 years. I have had comparative links to the United Kingdom's National Health Service and to other models in Western Australia and other parts of Australia. It is critical to get together the area of health management and health development for the future of health service provision. Often in the past, it has had a history which has not always been the most positive and which has been quite episodic. This is an ideal

opportunity to consider some of the key issues for its future direction and to work together.

Mr M.F. BOARD: Thank you both for joining us. The summary in your submission is the key to where the committee wants to go with this matter. We are trying to home in on what is referred to as the development of multidisciplinary teams, flexible models and so forth. It appears to the committee that although those aspects are developing, the flexibility, training, and movement in occupations and the development of new occupations to meet changing needs in the community are not as flexible as they could be.

[10.25 am]

We are looking at emerging models around the world, what we can do in this State while dovetailing with other States and how we can get the best out of what we already have while changing some aspects of the system to provide better delivery for the customer or patient. We are interested in how that can be implemented at the training, primary and delivery level. Do you want to add anything to that? We will ask some questions, but what thoughts do you have?

Mrs Thomson: A number of the objectives of the Australian Council for Safety and Quality in Health Care relate to the leadership, development and management of health services. The issue is about safety and quality; providing a safe system of care for our patients, who are the ultimate users of the services. We must provide that environment. We need to shift our thinking. It is no longer about hospitals or community; it is about the whole health system. Quite a few changes have occurred in Western Australia recently. Many of us have moved from operational to strategic management and asked to balance the issues facing us.

Mr M.F. BOARD: Dr Skinner, would you like to expand on that?

Dr Skinner: My area is management development, which is about direction and vision. The distinction that is increasingly being drawn between leadership and management is interesting. We need some clear visionaries who have the competence to lead. We also need a range of skilled management/operational people at the level that is slightly below what I would call leadership. That distinction is very important and worth noting. The other area in which I am interested and which is also relevant relates to how competencies, specifically relationship competencies, are vital in health. The concept of working with people and of valuing the people management aspect of health does not need to be lost. It needs to be valued and asserted in competencies and training development, along with the traditional content competencies.

Mr P.W. ANDREWS: How?

Dr Skinner: An increasing range of methods look at areas such as emotional intelligence and leadership behaviour. We are starting to look at context training and development, which involves seeing how people negotiate and communicate and what methods they use, and providing 360-degree feedback, which is from not only the self but also the peers and the patients. The whole context provides feedback to the person.

Mr P.W. ANDREWS: Can you put it into a clinical setting?

Dr Skinner: In a clinical setting, it would be in relation to a regional or general manager, for instance, getting feedback on his performance through evaluation

instruments, of which there are many. Those instruments evaluate leadership behaviour and even emotional intelligence. Feedback for such managers would involve how their staff and a range of their peers and bosses see them in their roles. That feedback can help to develop a person. It is not an easy task.

Mrs Thomson: It is about being able to talk to clinicians - whether they be in the nursing, allied health or medical professions - as well as having corporate responsibilities, and being able to bring all those views together to influence decision making. It applies across a range of skills.

Mr P.W. ANDREWS: Can you tease it out for me? What is the decision making process?

[10.30 am]

Mrs Thomson: The big focus is on population and health. We are working outside hospital boundaries, right across the primary health spectrum. We need to bring the information in the community and the hospitals together to make more informed decisions. We will then bring the parties together to consider all aspects, not just about managing a hospital. We are talking about managing health services. One of the key things for a successful manager is being able to talk to doctors, clinicians, shires or general practitioners and respect their views and use those views to make informed decisions.

The CHAIRMAN: Would that be inclusive of patients?

Mrs Thomson: Absolutely.

Mr M.F. BOARD: I want to explore that area. What is the point of all of these things if the output or the result is not improved? How do you judge whether or not those things are worthwhile? Are the patients included in the process?

Mrs Thomson: I will provide an example of how I think that has happened in my own jurisdiction. I am responsible for 15 sites from Kwinana through to Waroona and we are working with a rural community about a hospital that has had its role significantly downsized and changed. As a result of an incident, the local shires have become involved with local community representatives and general practitioners. With that information we have started to redesign services that fit the needs of the local community by getting that input. The health service in that area is now starting to get a purpose back. The input has helped us make those good decisions.

The CHAIRMAN: Are you talking about a community development management model?

Mrs Thomson: Very much so. I am involved in a range of community development models in the Peel area.

The CHAIRMAN: Would any of that relate to social entrepreneurship at different levels, such as local government and private?

Mrs Thomson: It includes all stakeholders. One of the big things is about bringing people together and ensuring that policy changes are worked through to gauge the effects in whatever jurisdiction. It gets back to the point that Chris was making: it is about understanding the need for building relationships and making good, informed decisions.

Dr Skinner: I will be working in the south west for the next two days. This is interesting in the process of shifting managers from the traditional model of managing

a hospital concept towards getting the competencies for middle level managers and leaders to move towards a framework that is more community based and is oriented around community forums, for instance, for getting information about what the needs and the priorities are in quite difficult areas of prioritising. The mood is there; it is a question of how we do it. It is a question of getting the managers and leaders of the staff to have a different sense of the paradigm. Even though management is important, the management in the community and the linkage with the community, and the models, the philosophies and values should be developed conceptually and then worked through.

The CHAIRMAN: And then integrated into the health service?

Dr Skinner: Yes; integrated so that the hospital is not out there, the community out there and the tertiary institution out there. There should be a sense of working together.

The CHAIRMAN: So it is ownership?

Dr Skinner: It is ownership, development, planning and prioritising.

Mr M.F. BOARD: Should that be from a professional point of view - not from a patient point of view? It is being done on the job, as it were. Should it be incorporated more as part of formal training?

Mrs Thomson: Yes. We are both looking at the whole health service management and we believe we need to shift and look at those areas and any of the professional development courses to bring these issues to the forefront.

Mr M.F. BOARD: I am not talking about post-training; I am talking about integrating into primary training whatever discipline is required so that this becomes the normal approach rather than the trial or the exceptional model.

Dr Skinner: It is a difficult question, because there is such an emphasis on professional skilling. The classic question in medical education is how do we bring more management into clinical medical education. It is a matter of how we do that, develop the curriculum and factor that in when there are so many things within different professional groups. You are right; it would be great to do that and get the mindset right.

Mr M.F. BOARD: From a patient point of view, rather than the professional point of view, it is all in the delivery. It is a bit like having the fastest racehorse in the world, but if it cannot run around the bend it is not much good. In the end, we must have people who can deliver their knowledge in an integrated way, which will improve the outcome for the patients. Do you think flexibility ought to be emerging now and maybe there should be a different role for training?

Mrs Thomson: It is difficult, because we are increasingly specialising in the professions. There should be flexibility, but one of the things I have found in my management experience is that the award system is well out of step with the health delivery needs. Most awards are based around the hours of 9.00 am to 5.00 pm, whereas health care is 24 hours a day, seven days a week, and there is not much synergy between the two. It is very difficult from a management perspective to try to introduce flexibility when we are governed by a lot of industrial barriers.

The CHAIRMAN: Do you have any views about inter-professional education in undergraduate courses?

Mrs Thomson: Inter-professional?

The CHAIRMAN: Yes. Surely some training must go all the way through the undergraduate courses that are available. I know personally that at Curtin University everybody must do four units regardless of what discipline they are involved in.

Dr Skinner: That would be ideal; it is the practicalities of how we negotiate with professional bodies in the accreditation processes. It would be ideal to have a foundation series of units or electives that could increase the diversity that you are talking about. Some universities and certain courses do that better than others. It is a question of how it fits within professional accreditation and also the flexibility of a particular award.

The CHAIRMAN: You were talking about leadership skills, which is about relationships, which is about problem solving and negotiation skills etc. I know that certain courses are available for certain professions. Foundation units must be undertaken and passed for them to get into the body of the course. You are talking about a management structure that relates to all of those things.

Dr Skinner: This is an interesting issue. Sometimes we have undergraduate programs that are professionally based, and those programs specialise in the postgraduate area. For instance, the health service management area - my area - used to have undergraduate programs in health service administration. Now they do a basic degree first and then they do their health service management as a postgraduate qualification or as a certificate after their degree. It is an interesting play between undergraduate and postgraduate.

The CHAIRMAN: Is it about professional tribalism?

Dr Skinner: In a sense.

Mrs Thomson: I agree.

Dr Skinner: I trained as a clinical psychologist. A lot of my training was professionally oriented. Rules were set by the Australian Psychological Society etc. It is sometimes difficult to bring about flexibility.

Mr M.F. BOARD: I am interested in your opinions on merging occupations. Most people who have talked to us have been asking for more specialisation; they want nurses specialised in bones and joints, age care, gerontology, renal and so forth. That is fine, but it seems that in other parts of the world two things are happening: there is a merging between nurses and doctors. The GPs seem to be becoming more specialised and there seems to be a profession between the doctor and the nurse, whether a more highly specialised nurse or a nurse practitioner under a different name, and below the nurse there is the emerging occupation of a non-specialist-type nurse who has more time to spend with the patients but is more highly trained than a patient carer or assistant. They are the two areas I am interested in. Do you support those proposals?

Mrs Thomson: I have an increasing worry about increasing specialisation, because increasing specialisation brings with it increased cost. I was responsible for introducing patient care assistants into Western Australia back in the 1990s as a result of a range of issues, and they are now almost becoming de facto involved nurses because of the pressures on the health system. We have a huge supply problem and we have lost sight of some of the basic principles of good health care. I could bring you in a book that was written in 1961, which was part of my research project that I worked on with Chris, and it referred to exactly the same issues of shortage of doctors and nurses, problems with specialisation, lack of communication and relationships.

Not a lot has changed. I do have a worry about increasing specialisation that brings with it increased cost. When we were looking at multiskilling the domestic services in the health area, we always said that at the end of the day someone would have to clean the toilets. We cannot lose sight of the basic things required in health care. Specialisation is fine, but at the end of the day we still need people to carry out basic, good bedside nursing, cleaning functions or whatever. The focus has been on specialisation as a result of increases in technology, pharmaceuticals and a whole range of things, and we are moving with that rather than stopping and saying, "Is there a better way?"

Mr M.F. BOARD: What is the solution? We do not refer to the training of nurses any more; it is not acceptable because they are being educated as nurses. We now have degrees specialising even further, and those people do not want to do that lower-end work. That is why a lot of people seem to be leaving the profession in the first year or two. They are saying, "Hang on, I was not trained to do this." Should there be another occupation at that end, where recruitment and cost of training would be easier?

Mrs Thomson: The fundamental issue is the professionalism and getting industrial minds together, because it is about turf warfare.

Mr M.F. BOARD: Forget that. That is part of a problem that must be resolved. We cannot say the barrier is too high and we will not attempt it. We are interested in what you see as professionalism and quality care, and what you think is a reasonable solution or something that is worth pursuing.

Mrs Thomson: We must continually look at re-engineering the workforce to meet demands. It gets back to the sorts of competencies that people need, such as understanding workforce design, understanding how things are linked together, to enable them to make those informed decisions.

Mr M.F. BOARD: What about at the other end? Nurse practitioner legislation is coming in, and various States are dealing with that in different ways. Other countries have medical assistants. The United States has a whole range of professions below a doctor, who are highly trained and skilled in various ways.
[10.45 am]

Should we be pursuing that approach as well or should we stick with our current general practitioner and specialist-type roles?

Mrs Thomson: I guess we need to consider the reason for doing it. If we are doing it to address a work force shortage, I do not agree with it. We must look at it from the patient's perspective. We have disenfranchised a number of professions over the years and there are emerging professions. We must really start to get it back to basics.

The CHAIRMAN: How do you identify the emerging professions?

Mrs Thomson: The nurse practitioner is an emerging profession. It is already in existence elsewhere. However, the issue must be brought back to focus on the patient; that is, the safety and quality of the profession and what it is doing for the patient. What are those boundaries and how do we monitor that? It brings with it a raft of other issues about the safety and quality of the services that are provided coming through the competencies. They are all linked.

The CHAIRMAN: One particular bit of evidence that we have collected, in relation to a question put by Mike, pertained to the patient. There are the professionals such

as nurses, GPs and that sort of thing, who rush to do their job because they have so many clients or patients. However, there is this gap between the basic care required and the time that must be taken to look after somebody and maintain their self-esteem. Is there the need for another occupation to fill the gap between basic domestic duties and nursing care? I know about professional variables but, as I said, this issue about this big gap between domestic services and professional care has come up time and time again.

Mrs Thomson: I tackle this problem on a daily basis. We must go back and reconsider the jobs and focus on what is best for the patient before deciding that we need a particular profession to cover this. As specialisation increases, patients fall through the gaps because of the lack of communication. Everyone wants a bit of the patient whether it is the social worker, the nurse or the doctor. Everyone wants to come in and do their particular bit. People then fall through the cracks and that is when adverse incidents occur. We must go back to what I call the basic principles of job design and consider the work flow that is needed and then work out what areas profession needs to cover. It might simply require the re-engineering of what we are already doing. Specialisation has been on the up and up but now it needs to focus on the basic functions that are needed for effective patient care.

Recently, I attended the Asia Pacific Forum in Singapore. Donald Berwick, a world renowned leader on areas of safety and quality, said that while there has been a focus on quality, the work force now needed to be re-engineered in the basic way business was done. Otherwise, specialisation will force us out because wages will continue to increase, because the two go together. The more competencies there are, the more specialised the work force becomes and the more demands are placed on the industrial area.

The CHAIRMAN: Dr Chris, you said that you had some experience in the United Kingdom -

Dr Skinner: I have been specifically examining the development of managers and some of the schemes that deal with health services managers. Programs have been set up, for instance, that involve the fast tracking of young, bright 20-year-olds who have two years paid by the National Health Service. They are linked to an award-based program that gives them a certificate and then a masters if they go on. In Australia at present, 12 are on placement, some of which are at Sir Charles Gairdner Hospital and Royal Perth Hospital on a three-month secondment. They work out their program with the chief executive officer and integrate placement, mentoring and their award as part of a fast track group. They have just started a new program in the NHS now. It used to involve 69 trainees and it will now involve 90 over the next two to three years. The trainees are rigorously selected from a large pool and then, hopefully, they become the future leaders based on a targeting focus program that involves a variety of experiences. We played around with that idea in Western Australia but we have never really bitten the bullet, partly because we are dealing with a state-based system of health and we have lacked the will on a long-term basis to start a program like that.

The CHAIRMAN: What strategies do you have to engage the health department to development new programs?

Dr Skinner: In 1996, an academic came over from Birmingham - who I had worked with over there. He said that tertiary institutions at that stage were not applied enough and were more academic. We have been increasingly developing an applied

academic program here. However, in so doing, we have been forced to get funding for that process through sponsorship and scholarships, some of which is provided by the department, some by industry and some by the Commonwealth. That is where the linkages occur. I do not know if that answers the question?

The CHAIRMAN: Yes, it does, but it does not look very good.

Mr M.F. BOARD: We have run out of time and thanks for coming in today.

The CHAIRMAN: Thankyou again for coming in today.