# EDUCATION AND HEALTH STANDING COMMITTEE

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

**TRANSCRIPT OF EVIDENCE TAKEN**
**AT PERTH**
**THURSDAY, 21 NOVEMBER 2002**

## FOURTH SESSION

**Members**

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

**WHITE, ASSOCIATE PROFESSOR KATE**
**Acting Head of School of Nursing and Public Health,**
**Edith Cowan University,**
**examined:**

**The DEPUTY CHAIRMAN**: Welcome. This committee is a session of the Parliament, and you must treat it that way. That means that you cannot deliberately mislead the committee, as it is seen as misleading Parliament. That is very naughty, so we do not allow that! Have you signed your "Details of Witness" form?

**Associate Professor White**: Yes.

**The DEPUTY CHAIRMAN**: Do you understand the information contained in that?

**Associate Professor White**: Yes.

**The DEPUTY CHAIRMAN**: It is great to have you here. Thank you for the submission. We have some questions as a result of that, and we might develop more questions about things that you elaborate on. Can you give us an idea about what Edith Cowan University is doing with the provision of training in public health and nursing, and where it is trying to take things?

**Associate Professor White**: I will start with the public health area. Within the School of Nursing and Public Health we offer a Bachelor of Health Science in public health. That recognises key subspecialities or course streams, which are, in general, health promotion, addiction studies, women's health and men's health. We also have postgraduate programs in those areas that allow people to subspecialise. Students can pick up different components of degrees across the faculty or in different faculties. For example, people within the area of sports may wish to pick up something to do with health promotion as part of their program. That is allowed. The philosophy of the health promotion area is broad-stroke population-based health promotion. It looks at a breadth of issues primarily dealing with well populations, although it has more lately been recognised that health promotion is not something that happens only with well people and that we need to look at health promotion for people living with chronic illnesses. The marrying of the two areas within the one school has allowed us to identify those sorts of opportunities. There has been a historical perspective that areas like nursing and medicine look at ill health and other areas look at something else; that there are two different camps that do not communicate that well. We are moving forward to develop programs that would, particularly from a community perspective, incorporate people such as health promotion officers or community nurses in looking at how we can provide those sorts of services at a community level rather than simply an individual level as they come through our relative workplace doors. We are taking a more planned community perspective. That is where we are going with health promotion. The programs we develop that are specific to that area and, from a research point of view, to the area of masters and PhD studies are geared towards ensuring that we have the clinical and academic expertise to maintain and grow those areas.

The nursing section focuses on three key areas. Our undergraduate program is the biggest. It is a very large program. That is kind of reassuring when we consider what we are dealing with in nursing not only within Australia but also internationally. We are looking at a range of initiatives within that area, which I will talk about. The postgraduate nursing section focuses on two key areas. One is postgraduate clinical speciality or subspecialisation. These programs are developed as a starting point for people who want to work in speciality areas such as, for example, intensive care or emergency nursing. The participants are not specialists or experts in those areas when they come in. We give them introductory academic training that is very much linked with clinical practice. Through these programs, we have a close collaboration with clinical centres and industry partners. The students spend the majority of their time in those areas. The programs are articulated

into what we call a master of clinical nursing program. As the nurses become more proficient and expert within that speciality, they get additional training to prepare them for more advanced levels of practice. The other postgraduate area in nursing is of course our research area, which is our Master of Nursing and PhD programs. Again, they are geared towards ensuring that we have the research base to inform the clinical nursing practice. We see that as something that is crucial to being closer linked with the industry and what is happening in the clinical area.

**The DEPUTY CHAIRMAN**: Through our terms of reference we are looking at the developing roles in the delivery of health, the roles of various health professionals and the interaction between the two new models. We are also looking at changing occupations and even new occupations. We are interested in what is happening around the world and the flexibility of our system. Representatives from Curtin University have appeared before us today. One of the general themes that has come through from the associations that have made submissions on behalf of their speciality areas is that although we have an emerging need and demand at the customer end and although the nature of health is changing through technology, drugs and the different demands on a range of occupations, the system to provide the outcome for that is not as flexible as what is happening in the marketplace. In other words, we are dragging behind for some reason. Do you share that view and would you like to elaborate on that?

**Associate Professor White**: In some ways the system moves too quickly for us because of the changes that are taking place in clinical practice. In other ways it is not that the knowledge is not known but that the system does not respond to the changes. One of the classic examples is the fact that we have an ageing nursing population. This has been known for some time, but we constantly wait until things get to a crisis point before we think we should do something about them. It is then much harder to address the problem. We often look for quick fixes to address those things. We are not looking at short and long-term planning for work force issues. It is not just a problem with nursing. We have a similar situation with radiation therapists in the area of radiation oncology, for which there is an international shortage. One of the things we must be mindful of is that, for the most part, we are following the international trends, although there are always things that are unique to Australia and Western Australia. There is a limited flexibility within the system to adopt changes to introduce things like flexible workplaces. Report after report has identified that some of the major factors in the nursing shortage relate to work relations or flexible work practices. We do not see that changing because we are not getting good leadership or a willingness on the part of the system to adopt those recommendations.

<015> K/3

[2.30 pm]

I think that leads to a level of frustration that happens at all levels. It makes it difficult for people to persevere in trying to implement change. One thing in the health care system that we struggle with is the number of players. When people talk about doing new things such as introducing nurse practitioners - which you have all heard a lot about by now - it is not just about changing things from the point of view of the nursing culture. It is not just about introducing something that requires nursing education and training. It involves reforming the existing system and involving other players who want a say. In many cases, they are correct in how a role is enacted, how people become qualified, what the role should be, and who people work with. That is often what makes the process quite convoluted.

**The DEPUTY CHAIRMAN**: We know we have that problem. What do we do about it? It is a chicken and egg problem. Should the universities provide more research and the public and private health systems adapt to the research? What drives the change?

**Associate Professor White**: Leadership.

**The DEPUTY CHAIRMAN**: Where does it come from?

**Associate Professor White**: It is one of the biggest challenges we face in the clinical arena and, to a certain extent, in the academic arena. We have a volume of research that shows that nurse practitioners make a difference. We have good evidence to show the difference between registered nurses and people who are not as well qualified or trained in health outcomes. We have that sort of information. We need the leadership to empower the system at the institutional level. We also need a commitment at multiple levels. It must occur at the federal level, particularly when we are talking about nursing. We are talking about major cultural change in a system that is flexible as far as adopting technology is concerned, but it does not want to change the way it works on a day-to-day basis. That is because it involves a range of health professionals. I suppose I should be cautious here!

**The DEPUTY CHAIRMAN**: You do not need to be.

**Associate Professor White**: Yes, that is not what you said a minute ago!

**The DEPUTY CHAIRMAN**: You would be surprised how many corrections we get for the transcripts.

**Associate Professor White**: People wonder whether they really said such things! The other reporter has just left the room!

**The DEPUTY CHAIRMAN**: Yes, but another one has just taken over.

**Associate Professor White**: I will give the committee an example. I am a recent immigrant from the east. Do not hold it against me! Something I have grappled with in coming to Western Australia - although the problems here are no greater than in New South Wales - is that nursing has been in the higher education system for a longer period than in the east. The east has got over some of the teething problems that are still happening here. It has moved on to recognising nurses as professional people who do more than provide direct care to a patient. Nurses have the responsibility to direct and participate in clinical decision making. It does not happen at all levels, but it is happening more here. In the acute care system, we have a system that is run to the advantage of doctors. Clinics are not run to suit patients who may have to wait for three hours; they are run to suit the timetable of a doctor. It may be only one doctor. Everyone has to wait for one person. That is the level of cultural change we need. For that to happen there must be the willingness by those people to come to the table to look at what must be done to effect change. We still have patients requiring chemotherapy waiting for three hours for treatment when they are unwell. These are major issues that appear minor, but if we cannot get those things right we will never get other things right across all disciplines. To get things right across all disciplines there must be a willingness for people to come to the table. For that to happen, there must be recognition of everyone's contribution; that all members of the team must contribute to the decision making. That must happen at all levels, including patient care, how money is expended in hospitals, and how resources are used in the community. We must move away from the dominance of one of the smallest professional groups that has the biggest say in how the system works.

**The DEPUTY CHAIRMAN**: Some of those very groups will be at this table tomorrow. We will have the opportunity to say -

**Associate Professor White**: That Edith Cowan University says!

**The DEPUTY CHAIRMAN**: I will not quote you! You are not the first, neither will you be the last, to put those points of view. They are shared universally. We must determine how we can make the transition because change is sometimes fearful. People are very protective of their patches, particularly if it involves financial return. In world trends, other jurisdictions seem to be dealing with the issue. You have come from the east -

**Associate Professor White**: Yes.

**The DEPUTY CHAIRMAN**: You are probably aware of overseas trends. Can you point the committee to an emerging model that looks good?

**Associate Professor White**: There are some interesting trends to look at. The biggest change in medical training that I noticed was with the graduate medical program, particularly when such program curriculums have become patient-outcome focused as opposed to being disease focused. Significant change was brought about in New South Wales by the medical program at the University of Newcastle. It revolutionised medical training and made people think about how medical students are trained and what is required. One of the advantages of the program is that it is positioned in a university that has a lot of cross-fertilisation at the undergraduate level. That breaks down the barriers before they become established. Particularly in the first year of nursing, medical and physiotherapy programs, there is an opportunity to bring the groups together to look at educational issues. It can also be used to address the interdisciplinary stuff and look at the cultural changes that need to occur.

**The DEPUTY CHAIRMAN**: Do you think there should be some generic training for all medical and associated degrees? As I understand it, the National Health Service in Britain has started its own university. First-year training is generic across all professions for that very reason. I received that information second-hand so I am not a full bottle.

**Associate Professor White**: There are lots of questions about the outcome. We will have to wait to see what are the outcomes and impacts. It is a fairly costly endeavour and it is good to have that happening in a place like England where large numbers of students can go through and information about the benefits can be gained quite quickly. We must also look at opportunities to do something similar on a smaller scale. We will always struggle with the cultural attitude that elitism surrounds certain study programs. For example, it is perceived to be better to do medicine than occupational therapy, and that it is better to do physiotherapy than nursing. In trying to get students together to do the same program initially, we may actually lose numbers. We do not want that to happen. Sometimes starting softly by identifying core units and running a trial is better. It helps identify barriers.

**Mr P.W. ANDREWS**: I have some different questions. I believe that you support the idea of an internship year or a period of internship.

**Associate Professor White**: I definitely support it.

**Mr P.W. ANDREWS**: The arguments against it include whether it is really necessary to establish clinical competence, the cost, and the opportunities for clinical placement. How valid are those three arguments?

**Associate Professor White**: I do not think they are valid at all. An undergraduate program lets someone graduate in any discipline, whether it is nursing, medicine, architecture or engineering, as a beginning practitioner. Data from New South Wales recommends strongly that an internship should be at least six months. After six months, people are regarded as being up to scratch. Programs can be shortened, and that is the way to do it. It gives people time to learn things such as time management and to become part of the system. It reduces people's anxiety. It cannot be achieved any other way. There is no way someone could graduate from a medical school and be expected to work in an intensive care unit, or in any area, without a year of internship. It cannot be done. I am sure that the committee has had every university tell it that the cost of clinical practicum and undergraduate nursing programs is considerable and that the universities are not funded to meet those costs. The universities are struggling to ensure a good practical clinical component in their programs. The universities rely on the goodwill of industry partners to support them. If we were to take out the six or 12-month new graduate program, we would have to somehow try to increase the study program. That is not financially feasible. I am yet to meet a new graduate who does not say that that was the most valuable thing in his or her clinical practice.

**Mr P.W. ANDREWS**: I will take a totally different tack. We keep focusing on the concept of moving away from traditional labels such as "nurse" and "physiotherapist". Regarding aged care, is there an argument for the establishment of a new profession that deals specifically with aged persons - in other words, training people with some aspects of nursing, podiatry and physiotherapy, and possibly even dental screening? Is there room for a discrete profession in aged care?

<016> D/3

[2.45 pm]

**Associate Professor White**: It is an interesting question. It sounds appealing. What sort of aspects of physiotherapy do we give them? Registered nurses, because of their training, can undertake certain degrees of physiotherapy. It certainly would not be the sort of work people would get from physiotherapists. When I think of issues involving untrained and unenrolled nurses providing the majority of care in those areas, trying to find something between registered nurses and those people will end up costing more. Given the cost restrictions in that area and how difficult we are finding staffing it with unqualified and more junior staff, we might find it quite difficult. I am not saying that we should not explore the idea a bit more.

**Mr P.W. ANDREWS**: Because it is so difficult to recruit people to that area, we might solve the problem by developing a different profession in that area. Given that the State has an ageing population, it might be one of the ways that we go in the future, might it not?

**Associate Professor White**: The reasons for the barriers against people working in that area will not be addressed by creating a new profession. We must look at the perception of aged care in the community. The Commonwealth is currently funding us to undertake a very large project that is looking at clinical practice guidelines for providing palliative care in an aged care setting. It is very interesting when you talk to palliative care people. They see it as very negative, yet the experience in the aged care setting is that they are doing a lot of it already. If you talk to somebody outside that sector, you find it is an awful area that they do not want to go into. That is what we must address. We must look at the real barriers against making it an inviting place in which people can go and work.

**Mr R.A. AINSWORTH**: You mentioned your university's postgraduate training program. It raised with me the question of career structure, because in some other professions one of the barriers against people entering in the first place or staying in a profession is that they get to a certain level where they can do extra training and increase their professionalism but there is no financial recompense or career move for it. Is there a sufficient career structure for nurses who undertake postgraduate training and other qualifications, or are there some shortcomings there; and, if there are, what would you do about it?

**Associate Professor White**: I think there are some shortcomings. Western Australia has adopted a slightly different model from the rest of the country, which is unfortunate because other States are made to look more attractive to nurses than this State, and we do not want that. The development of higher education, postgraduate courses and postgraduate specialisation at universities in the eastern States has been very much linked to the industrial award. If people go on and do further study, as with teachers, they can potentially get a higher position and stay at the bedside and not become managers. They could get financial reward for that. The most recent award in Western Australia has tried to address that by giving financial reward at a postgraduate certificate level. I would like to have seen that a little higher and a lesser award for a masters degree. There is no incentive for people to undertake the additional work that we really need the profession to be doing in order to move the profession forward and also care so that we know what we are doing in providing appropriate care. It is one of the biggest barriers to keeping nurses in the profession.

**Mr R.A. AINSWORTH**: The implication of what you are saying is that nurses are being lost from this State to other States where opportunities do exist. Is that correct?

**Associate Professor White**: Yes, absolutely. In New South Wales and Victoria staff are paid much more for a range of reasons that those States justify. People will get a financial remuneration for a postgraduate diploma and substantially more financial remuneration for a masters level. It can almost be the difference of $15 000 per annum compared with nurses here working in a similar role, so it is reasonable money.

**Mr R.A. AINSWORTH**: It is an incentive to move interstate if people have no other roots in this State.

**Associate Professor White**: Yes. They could go to a nice rural town in New South Wales, like Wagga Wagga, where there are no high accommodation costs.

**Mr S.R. HILL**: You made the comment in your submission that health professionals will basically need to have information technology skills. Could you expand on that?

**Associate Professor White**: It is incredibly important. Just about everything we are doing is through a computer. One of the challenges for us as researchers is that we can do the research, but how do we get it published to influence people in a clinical practice setting. One of the barriers is that the research is not accessible. The Department of Health has picked up a project that was started in New South Wales - I do not know what it is called here. The aim of the project is to roll out information on computers. It has created a web site where staff in a clinical or community setting can find out the latest evidence and medical guidelines. All the information is there. Staff are not picking the information out of an out-of-date book or having to go to a library. The project has had an enormous impact in New South Wales. In rural and remote areas that sort of access is crucial. It also impinges on other things, like how do we better use telehealth and so forth. We can learn many things from hospitals like Royal Adelaide Hospital and Royal Darwin Hospital and how they are linking up, using cross-fertilisation and linking people to provide clinical care, be it in mental health, palliative care or oncology, without having to have a patient travel long distances. If we can get the infrastructure up and running, we could be doing that in Perth. It covers educational staff, mentoring and networking.

**Mr S.R. HILL**: It therefore gives a bit of support to the profession, does it?

**Associate Professor White**: Yes. There is no neurologist resource, which is what we have at Sir Charles Gairdner Hospital, but at least people can get on. Sometimes it is easier to have a face-to-face conversation. A general practitioner or specialist in a regional area can present the patient to a panel of people. This happens with mental health and major oncology clinics. They get advice pretty well straightaway without having to have a patient travel all the way to Perth, where they might spend a week and then have someone say that they cannot do anything for them and they must go back.

**The DEPUTY CHAIRMAN**: I asked this question of the witnesses from Curtin University. I would be interested to hear your response. The attrition rate in nursing is fairly high. Would you give your opinion of why that is? What should we do about it? Is it a question of who is recruited for training or, as some people say, there not being enough clinical practise time? Does the problem occur at the graduation end, where there is not enough of a transition program? Are the pressures too high for young people in those early years? What do you feel about it?

**Associate Professor White**: There is a range of issues, some of which we do not talk about. In clinical care these days, there are more higher acuity patients, more technology and greater demands on nurses. However, we do not look after nurses. I have often heard people ask in discussions what is different about a nurse. There is a range of things. Nurses are constantly dealing with people who are suffering some form of crisis. Nurses are providing to the best of their ability emotional and physical care to the patient and the patient's family. If nurses do not receive appropriate support in the form of opportunities for debriefing after crises or traumatic events in the clinical area, there becomes a limit to their capacity to maintain their position. I find it frustrating that we

look at industrial and workplace issues, but we are not getting down to the sorts of clinical problems that nurses are experiencing. Many face major ethical problems in the type of care that they are providing. The most common ethical problem that nurses identify is that they go home feeling that they have not provided the best care, which leads to an overwhelming sense of dissatisfaction. They also experience concerns about the decisions that are being made and their lack of involvement in those decisions. If they never get an opportunity to talk about them and get support, there comes a point at which they have not got much more to give. When nurses talk about leaving nursing, they do not talk about not loving nursing any more . We are not picking up on that. They are not saying that they hate the job but that they cannot do it any more; that they cannot keep giving without something coming back. That might sound really emotional and touchy feely, which is why people are reluctant to talk about it. It is kind of unmeasurable and it is hard to come out with figures that measure it. We are currently involved with a project looking at ethical problems experienced by neonatal intensive care nurses. We have been doing questionnaires and running focus group interviews. It is almost overwhelming to sit and listen to those nurses' stories for a range of reasons. You realise the responsibility that nurses carry, the difficulties they deal with and their lack of involvement in decision making. The outcome may be incredibly negative when a baby dies, or a child or adult; an outcome may be really positive. If no-one helps the staff work through the issues that they are left with, such as emotional problems and stress with decisions that are made, eventually there comes a point at which they say they cannot keep doing it.

**The DEPUTY CHAIRMAN**: There are other issues, such as hours and lifestyle, but do you think that is one of the reasons that nurses work for agencies; that is, that they do not have the same sense of responsibility?

**Associate Professor White**: Yes. They can go home and not worry about it.

**The DEPUTY CHAIRMAN**: Is it being addressed at all?

**Associate Professor White**: I do not think so. I think nurses are unable to articulate clearly that is why they are leaving. It is hard to say that they have some medical problems, because they do not want to look as though they are not coping. It is much easier to say that the hours are terrible. I can tell you that night duty is the pits. The question can be addressed. It comes back to leadership. It is about providing infrastructure, expending funds and putting in resources to provide nurses with an opportunity to receive support and professional debriefing, and recognising how we need to go back and congratulate nurses when they do a job, acknowledge that it is a difficult situation and give them an opportunity to talk about it. We must look at how we sustain them emotionally as well as the financial and educational rewards. At the moment we focus on those aspects.

**The DEPUTY CHAIRMAN**: The submission mentioned unregulated workers and licences. Does the university feel strongly about that area?

**Associate Professor White**: Yes. Surprise, surprise! The data that has come from North America and the United Kingdom about unqualified workers has identified major problems about the provision of care and patient outcomes associated with it. They show a serious decline in health outcomes and care when it happens. It does not mean to say that there are not levels of care and expertise.

<017> L/3

[3.00 pm]

**The DEPUTY CHAIRMAN**: Tell us exactly who you are talking about.

**Associate Professor White**: For example, there is a difference between an untrained worker who has responded to an advertisement for a job in the newspaper who has never before worked in an aged care facility -

**The DEPUTY CHAIRMAN**: Are you talking about patient assistants?

**Associate Professor White**: Generally, patient assistants have had some form of training. I am talking about people who are not trained. There has been a big push in the aged care industry to employ those people. There is a perception that the assistants need only know how to shower and lift a patient; however, there is much more to it than that. Patient assistants must be able to communicate with people. The communication skills needed to work in aged care are far greater than virtually any other setting because it is so complex. There are, of course, nursing assistants who have had minimal training, and enrolled nurses. People do not always understand that there is a big difference between the two. There are also registered nurses.

**The DEPUTY CHAIRMAN**: Are you suggesting that everybody who works in a health environment should have some form of training or qualification to meet the required skill levels?

**Associate Professor White**: Yes. Nurse assistants and patient care assistants must have some form of training. How would a member of the committee feel if got a nice guy off the street who looks good and employed him to look after the member's wife?

**Mr P.W. ANDREWS**: I might not trust my wife with him.

**The DEPUTY CHAIRMAN**: That is a good note on which to finish; it leaves us with a question. I thank you for your submission and for your time today. When you receive a copy of the transcript, you will have 10 working days to return it. If you think some errors have been made, please note the corrections. If you feel that you have omitted something or you want to give us additional information, you can provide the committee with supplementary information.

**Proceedings suspended from 3.03 to 3.20 pm**