EDUCATION AND HEALTH STANDING COMMITTEE

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

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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

[12.45 pm]

LANDAU, PROFESSOR LOU
Dean, Faculty of Medicine and Dentistry,
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The DEPUTY CHAIRMAN: Good afternoon, welcome and thanks for joining us. You know me. I am also the member for Murdoch and I am chairing the committee today. Before I formally introduce everybody, I want to say that we are a little short on numbers. Carol Martin, our chairperson, is ill and, unfortunately, we have lost the member for Roe who had to return to Esperance this afternoon. Paul Andrews is the member for Southern River and Shane Hill is the member for Geraldton. Erin Gauntlett and Peter Frantom are the committee's research officers. These proceedings are a procedure of the Parliament and any deliberate misleading of the Parliament is a contempt. Opinions and attitudes are fine. Did you sign and understand the witness form?

Professor Landau: Yes.

The DEPUTY CHAIRMAN: Thank you for your submission, which is critical to our inquiry. I will give you an indication of what we are trying to do and why we are doing it. There appears to be some emerging models around the world and a change of direction in the interaction between various health professionals, the way in which they are trained, the flexibility in that training and whether both federal and state legislation gives an opportunity for that change in training requirements. We want to see how in a bipartisan way we can assist, at least from the State's perspective, to dovetail in a framework which would allow people to get on and do what they need to do, how that will meet with community expectation and the change in demands from the community about the delivery of health services, and whether the models we currently have in place, which are stretched, are the best way to achieve it. It is quite a broad approach and we hope to do something fairly constructive. We have received a lot of submissions from all levels of allied health professionals including nurses. After you, we will hear from members of the Australian Nursing Federation. The University of Western Australia is obviously critical to the training of general practitioners, which is critical to the whole exercise. We have some questions to ask you as a result of your submission but I ask you to bounce the ball a bit and talk about what you do in the university, where you are hoping to take it, and possibly touch on how the clinical school in Kalgoorlie is going. You could also touch on postgraduate efforts and where they sit currently with the Commonwealth.

Professor Landau: Yes, I would be delighted to do that. Ms Gauntlett sent me a list of those items. I will go through those briefly and you can ask me further questions. I will also leave with the committee the strategic plan that Ms Gauntlett can use for reference. They are the documents on where our curriculum is going and they give an idea of our plans for developing the medical course. Clearly, as you indicated, we must think a lot more broadly than just medicine. I will go through the matters highlighted by Ms Gauntlett. To initiate the process, we set up an education centre - or core head centre - within the faculty to develop the program. Most good medical schools around the world have now done that. I have an associate in charge of teaching and learning who has made enormous advances. She has a team of about 10 people who have experience in medical education, problem-based learning, evaluation, assessment and curriculum development. One thing they are doing is, firstly, outcome-based education. We are the first group within the university to move in this direction, to actually define what skills graduates should have and make sure they do by constructing the whole curriculum behind that.

[1.00 pm]

The second is to develop a graduate entry medical school. We do not believe we should go all the way to graduate entry at this stage, because Queensland tried that a few years ago and it lost a lot of its bright students to other States. When you are the only medical school in the State, you actually lose your top school leavers, because if they have good scores and perform well they can get into any undergraduate school around the country, and they obviously take the chance of getting in and move interstate. Therefore, starting this year, Queensland will reserve a number of places and give them to students who perform well in their tertiary entrance examination, and even though they will have to do another degree they will still get into medicine. We do not want to go that way and lose them in the short term. However, on the other hand, we believe we should increase our graduate entry numbers, because it is much better to have a mix of medical graduates. People who have had different experiences and have come from other disciplines and have had a chance to think about what they want to do and how they can be part of the health service are better to have as mix. We are certainly working in that direction.

We are also looking at collaborating with other medical schools around the world, and we are part of a consortium called IVIMEDS, which is working out curricula with other schools in most continents. We are also looking at having greater collaboration with other health disciplines. I will come back to this when I talk about the rural clinical school that is referred to in our submission, and some other projects. We have actually started it in dentistry. We are looking at better curriculum development and assessment, and problem-based learning. The other thing at the education centres is to teach the teachers. For years essentially medicine was taught by people who had learnt it themselves and had practised, and then other people would come along and they would teach them. Some of those people are brilliant teachers, but a lot of them are pretty terrible. We are teaching people to teach.

The rural clinical schools are a big venture that I will come back to. Clinical integration is another important issue. We are looking at integrating the undergraduate teaching with the pre-vocational training once they graduate, and with general practice training. We now have the contract for general practice training in Western Australia. That means that we can integrate that with the undergraduate teaching so that there is continuity. All of this is being done with a lot more feedback from the students and the community. It is backed up by an information technology unit in which we have a manager, a network administrator, a web coordinator and computer support officers. These provide the technology, particularly for the rural clinical school, but even the students who are studying in the urban health service environment still need all of that.

The clinical training is now introduced from the first week, so students know the relevance of what they are learning. They learn it as part of the management of a patient, not as a discipline. In the old medical courses students always did a bit of biochemistry, physiology, anatomy and pathology. They then did psychiatry and surgery. It was intended to be about managing patients, but it was always about managing a particular disease. It was not about the whole patient and the patient in society. Our program is now much more based on the needs of the whole patient right from the start. It is also, as I said, outcome based, which means skills development. Those skills can vary. The most important skill for anyone is to hear and listen to the patients and their families, but it goes right through to the high-tech procedures that they may need to do.

In order to do that, four themes run through the medical course. The first is the scientific basis of medicine, which is the old science part. The second is doctor, patient, which is the clinical part. The third is doctor, health and society, which puts it into the context of what the community needs are. The fourth is personal and professional development, so that the students learn about their own ethical issues and a number of other aspects of their own development. All of that is occurring at the same time, so everything is very relevant.

There are two issues with regard to the graduate medical school. The first is increased numbers. As you have said, there is real need for an increased number of health professionals in Western Australia. I believe that the federal Minister for Health and Ageing now has the latest Medical Research Advisory Committee report, which at last documents that and shows that Western Australia is in a worse position than anyone else. All of its previous documents did not do that. I think that was due to a statistical error and to how it counted people working within the system. From our own analysis, which we sent to the minister when we were seeking an increased number of graduates in Western Australia, we have just under 230 doctors per 100 000 population, whereas the mean for Australia is around 260. That alone is between 300 and 600 short for the State. We know that, because we know we have to register 300 to 400 overseas-trained doctors each year to fill vacant places. We need to fill that gap and maintain it. We have put in a submission for an increased number. We know that we can take 40 very easily without major costs, because most of our laboratories and lecture theatres would cope with that. However, we do not believe that would address the problem quickly enough. We believe we should have at least 60 to 80 to more quickly address the problem. That would mean some set-up costs. The first part is that we are seeking a higher number of admissions into medicine.

Mr P.W. ANDREWS: Are you saying an extra 40 a year?

Professor Landau: It is really between 60 and 80 a year. We would then have 300 to 400 coming through the system at any one time. Those are the increased numbers that we are seeking. Also, because of the factors that I mentioned before that suggest that graduate entry is a good way to go, we feel - and we have done a consultancy to identify the justification for that - that we should move towards at least a 50-50 input of undergraduate and graduate entry. We think we should probably do that progressively. Our aim is to eventually have between 40 and 80 more graduates each year with an even number of undergraduate and graduate entries.

The rural clinical school that you mentioned is certainly based in Kalgoorlie, but it is not only in Kalgoorlie. We put forward a model to the Commonwealth that we could not set up a rural clinical school in one area because we do not have any rural area that is big enough to sustain the numbers that we would like to put through it. We can put through only 12 to 16 students in a place the size of Kalgoorlie, and we want to have at least 30 to 32 people train in a rural centre. Our rural clinical school includes Geraldton, Broome-Derby, Hedland-Karratha and Esperance. The head office is in Kalgoorlie. We have already made some terrific appointments there. The head of the rural clinical school is someone whom we recruited from New Zealand. He is a Scotsman originally, but he has been involved in general practice training and setting up courses in New Zealand, the Middle East and Malaysia. He has settled in well and has got things moving there. We have also appointed medical coordinators, who are general practitioners, in each of the sites I have mentioned. We have also appointed a nurse in Port Hedland, who is helping us to set up the programs on those sites. We have some curriculum support from Perth.

We did a pilot this year, and we identified seven students who wanted to try the program. That was very successful. All seven of the students were very positive and had a great experience, and they promoted it so well for next year that we have exceeded our expectations for next year. We are aiming to get 30 to 32 students to go to the rural clinical schools by 2004, but we thought we might try for 14 next year. However, when we advertised and got the people who went though the school this year to promote it, we had 32 applications to spend all of next year in one of the rural centres. We could not cope with that, so we are taking 22, but we will certainly get up to 30 or 32 next year. That looks as though it will work well and is very positive so far.

Erin highlighted our reference to the subdean of health service liaison. That is a new appointment that I made about three months ago. That was because we want to move our teaching to the outer metropolitan area, because it is much more appropriate that they train with other health professionals and do a lot more team work and work at the community level. I have appointed a

subdean in health service liaison to work with the hospitals to help build up that program. I called it an urban clinical school, because I am trying to set it up like the rural clinical school so that the students will do all their learning around their patients rather than the disciplines, as is done in the major teaching hospitals. We also wanted to coordinate with all the other health services in those teaching regions.

Indigenous health issues is another area that is most important to us. We set up the centre for Aboriginal medical and dental health within the faculty six years ago. That has worked very well. David Atkinson, who is a non-Aboriginal person, because no Aboriginal person was available at the time to do that, has done an excellent job. It is involved in two areas. The first is the recruitment of indigenous students into medicine and supporting them and getting them through. We used to get just one indigenous student every five years, at the most. We have only ever had three Aboriginal graduates. At the peak we had 17 in this program in medicine, and the number is still around 12 to 14. It is improving, but we still want to build that up a bit. David has now moved up north and will be our medical coordinator in Broome-Derby, so he will still be involved, but we are appointing a new director for the centre. We have just interviewed three Aboriginal people. We have offered the job to an Aboriginal medical practitioner, and we hope he will take it on. That will be very valuable in helping us develop the indigenous health component of the curriculum and in maintaining support for the students whom we recruit. The other way we will be doing it is through the rural clinical school, because the Aboriginal medical service in each of the places that I have mentioned is integrally involved with the curriculum, and all the students spend part of their week in Aboriginal medical services in those centres.

With regard to joint appointments, once again we are looking at developing more appointments with other health services and professionals, particularly within clinical services. We are looking at clinical schools within the urban areas as well to do that, and we have already done it in the rural clinical schools. We are looking at coordinating it with nursing education in the major hospitals as well.

With regard to inter professional education, the model for that has been the Oral Health Centre of Western Australia. We were able to encourage Curtin University of Technology and TAFE to move in when we set up OHCWA, so that now dentists, dental hygienists, dental therapists and dental assistants are all taught together in OHCWA, and they are already working together and interacting as undergraduates. That will be a major help in promoting their roles. It is very similar to the other needs you have mentioned. We will not be able to provide dentists for the whole of the State very quickly., but we will need dental hygienists and school therapists, and the dentists will have to interact properly with them and recognise their contribution. The same will apply to nurse practitioners. We need to ensure that in our medical education structure we have that same interaction so that they respect each other's role within the health system.

[1.15 pm]

In the case of rural and remote areas, the university has had an active program working in that area and, again, it is doing well but we still have a little further to go. We are aiming to get at least 25 per cent of the intake from rural areas. We have a 20 per cent intake now, which was below 10 per cent only three or four years ago. Therefore, we have been able to increase that intake each year. The number of students sitting the admission test this year is more than ever before. We send a team out to all the rural high schools to promote the course to students in year 10 and identify anyone who has any chance or is interested in getting into medicine and we nurture them through years 11 and 12. We then pay their fares to come to Perth to sit the undergraduate medicine and health sciences admission test and have an interview. We also give them some tutoring beforehand to help with the test. We believe that those students are disadvantaged and have not had the same support that the kids who go to private schools in Perth have had. We try to maintain the balance by giving them the opportunity and the little more confidence that they need to get into the course.

Once they get into the course, the next step for all students is to attend rural week, which was introduced a few years ago and which has been very successful. At the beginning of the course all students live in the country for one week. They then get to know what rural life is like. Many of them have had no experience with rural life except for stopping at a service station somewhere in the country.

Mr S.R. HILL: Whereabouts do you send the students for rural week? Is it to the regional centres like Geraldton and Bunbury?

Professor Landau: No, it is usually to the smaller places. In the past we have used Katanning, Northam and Moora and we will be going somewhere in the mid west for the next one - I am not sure where though.

Mr S.R. HILL: Could it be Meekatharra?

Professor Landau: It could be. We try to go to smaller towns where the students can get that rural feeling. There are rural components right through the course. The rural students club - Spinrphex - is the most active club in Australia and promotes rural week.

I have referred to vertical integration with regard to pre-vocational training, graduation and general practice training. Team work is important to us because we select students on their ability to work in a team, which is part of the undergraduate medicine and health sciences admission test and their interview; they must demonstrate that they understand how working in a team is important, certainly as part of personal and professional development. The curriculum has moved from being discipline based to addressing the health care needs of the community. With regard to developing skills and life long learning, we use the collaborative training and education centre - the schools training centre on the university campus - where students learn a lot about evidence-based medicine. In the future we will consider increasing student numbers or graduate entry, understanding the health needs of the community and getting an affinity for the areas of need such as rural and indigenous areas and integration with postgraduate training and life long learning. We now have combined degrees so students can do a BA and a MBBS or a PhD and a MBBS, which, again, adds to the students' breadth of knowledge.

Our faculty is very active in community education. Most of the specialists are members of lay organisations that talk to their members about their areas of interest. However, we are all very keen to assist the media, when it does not change too much what is said, but you are all more experienced in that than we are.

The DEPUTY CHAIRMAN: That is one way of putting it.

Professor Landau: The aim of the curriculum is to take a more holistic approach. I have tried to address the points Erin raised but that is the direction of the faculty. I am now happy to answer any questions the committee may have.

The DEPUTY CHAIRMAN: That was a fantastic outline. It has brought us up-to-date with where the faculty is going and the flexibility that the University of Western Australia is applying through the school. However, that is all based on making the role of the general practitioner more accountable to the community and more flexible in fitting in. Where do you think the GP will be in 15 years time?

Professor Landau: That is a difficult question to answer because there are so many facets to the answer. GPs will have a different role but it will be for so many reasons. Other health professionals will take on some of the roles, which will need to evolve over time.

The DEPUTY CHAIRMAN: We will explore how you feel about those sorts of things.

Professor Landau: However, the corporatisation of general practice is a major area of concern. The prime motive for a corporation is to make a profit and not necessarily develop services. It may need to have the services to attract patients to make a profit, but it is distanced from the patient; that

is, there is another step involved. A corporation's manpower will determine who takes on what responsibilities. The community will want - we already acknowledge that it deserves - better management closer to home so that is does not interfere with peoples' lifestyle if they need to be away from home. There will be a small number of services that will have to be centralised. For example, it is not economic to do heart transplants in Meekatharra. Some services can only be offered in major centres. However, the numbers will get smaller. Renal dialysis used to be done in only major centres but now it can be done at home. Other services still need to be centralised but many more will become peripherally based. The GP will be taking on more of those services. He will be affected by his employer, whoever that may be, and he will be influenced by the components of his current job description that are taken over by others. It will all change and he will take on more of the central functions that are now done by specialists. However, nurse practitioners and other professionals will take on some of the other services also.

The DEPUTY CHAIRMAN: Do you think that the GP will still be the first port of call in primary health care in 15 years time?

Professor Landau: It depends on the area to which you are referring. The GP may not be the first port of call for preventive health because a lot of that will be covered by a range of people, including GPs. However, it is likely that he will be the first port of call for intervention or an emergency situation and he will be involved with the patient either directly or at arm's length. The real dilemma at the moment in rural centres is that it is not always feasible to have a doctor in every centre. However, people need to be able to see someone in their town and the doctor must work with that person, whoever it may be. In some cases the people will be able to go to a doctor directly but in others cases, the doctor will be working at arm's length with someone else involved. There will be a range of models and we must consider each of them and the needs of each community and what blend of health service providers are feasible and would best provide the service that community needs. Then we have to train the people to fit into that model.

The DEPUTY CHAIRMAN: You referred to the current shortage of GPs around Australia and, in particular, in Western Australia and the need for an additional 40 to 80 students. However, a cap is still applied to the number of students because of full fee-paying higher education contribution scheme places and provider numbers. Do you think that the Medicare system and federal intervention - you should be able to speak freely here - limits the flexibility of how we can deliver services within this State ?

Professor Landau: There are many different components to that question. Part of it comes down to the student places available, which has certainly limited us. It was the policy of the previous federal health minister to not increase numbers. In fact, he publicly put forward the philosophy that increased numbers of doctors would increase health costs and that they should be cut back. His original aim was to cut back the total number around Australia from around 1 200 to 1 000. He cut it back to 1 100 but then realised that it was not working and we are now back to 1 300 or 1 400 with all the extra rural scholarships and special places. I am now hoping that the now federal health minister will increase that figure even more. That has always been a restriction that has not been accepted. The other issue is related to non-HECS places. That area also has many aspects to it and is very complex. The more opportunities we have to train people in health professions, the easier it is to gradually fill up the gaps that are there. On the other hand, however, we must ensure that the training program is appropriate. At present strict criteria monitors our programs. We must go through an intensive evaluation by the Australian Medical Council. We should not eliminate that because, if we do, it will restrict our flexibility even more. We would then end up with what is going on in the United States and many other countries where there are a range of medical schools - private, public, state and local. Therefore, there is no guarantee of quality with the output. In the United States every graduate must sit a licensing exam. Australia would then have to introduce a national licensing exam. Everyone in Australia would have to sit for this exam and, therefore, students would not want to learn about the needs for individual States but rather, what they need to

know to pass that exam. That is why it is better to have the quality control we already have and not open it up too much to allow programs that could not be guaranteed and therefore standardise everyone. That would restrict us.

We then get onto the issue of graduates. Provider numbers limit the opportunities available for students. There are many opportunities to take advantage of the community's needs and hopefully there will be more flexibility with provider numbers. Again, provide numbers were also being used to restrict graduate numbers and it is clear now that that was not a good strategy. Hopefully, now that the data strongly supports the need for increased numbers and better distribution of health professions, provider numbers will become more flexible to allow for that.

The DEPUTY CHAIRMAN: You talked about the distribution of medical providers. How do we achieve that?

Professor Landau: We hope to do that by training -

The DEPUTY CHAIRMAN: Through the school?

Professor Landau: Yes, and by introducing the idea into the culture early so that people will think about it. That is why we hold the rural clinical school in the first few weeks of the course. People initially said that we should wait until the students had done their clinical work in fourth or fifth year but that is too late. By then students have decided if they want to be a neurosurgeon or an orthopod and they have seen how medicine works in the big teaching hospitals. That is all they know and they base their decisions on that. We want them to see what country life is like at the beginning of the course so that when they start to think about their future, working in the rural areas is considered as one of their options. Up until recently it has never been the option except for less than 10 per cent of the student population.

[1.30 pm]

The DEPUTY CHAIRMAN: I know that the numbers are not there, but has there ever been an opportunity to consider taking city kids to the country as well? Is there an opportunity for an annexe or medical school in the country rather than to just carry out the clinical side of things there?

Professor Landau: It would be very difficult because of the numbers. It would not be cost effective. It would be difficult to give them, in any one centre, the full range of experiences and support that they would need.

The DEPUTY CHAIRMAN: Does that currently happen in New South Wales? They have a medical school in the country as well.

Professor Landau: Yes. The New South Wales Government has just given approval for a new rural medical school in Canberra. Canberra is the only place it could be based to provide the critical mass, but they say that it will still be rural-based because it will service the area around Canberra. That is the solution. The Canberra medical school will get 30 of the rural places as half its complement. It is getting that basically as a rural school. That is the dilemma we have. I do not know anywhere in the world that has been able to have a whole school in a small centre. A population of half a million would probably be a minimum to provide the infrastructure.

The DEPUTY CHAIRMAN: Is the University of Western Australia looking at the development of any other kinds of medical training in terms of widening -

Professor Landau: We are looking at widening the opportunities in a range of health professions.

The DEPUTY CHAIRMAN: Existing health professions?

Professor Landau: Yes. We are certainly prepared to look at them. They exist, but in a slightly different way. We set up a clinical audiology course after the course was dropped by Curtin University of Technology, because the State was in desperate need of audiologists. We have set up a centre for musculoskeletal studies for physiotherapists, particularly in the areas in which they

need special skills training, such as back pain, which affects so much of the population. They can then work with our orthopaedic surgeons, pain specialists and neurologists, which they do. That has been developed into an excellent program. They are looking at developing a graduate entry physio course, once again for people who decide late that they want to do physio and have an interest in a particular area. We hope to get rural people involved in that. They are the sorts of things we are looking at. We are looking at some of the allied health professions. I have been asked at times by nurses to set up specialist nursing courses. We have been happy to do that. You will find that out from your next witness.

The DEPUTY CHAIRMAN: I would be interested to explore that point. There seems to be a general drift by the universities away from some of the smaller medical disciplines in undergraduate studies to graduate entry courses. Is that solely an issue of funding? Is it because of the restriction and tightness on the costs of delivery?

Professor Landau: It is hard for me to comment on that because most of that has occurred at the other universities. It is a mixture of funding issues and the philosophy to provide generic training and then specialisations. Universities are restructuring their courses. I guess restructure comes down to two components; one is philosophy - what you think is a better way to teach - and the other is obviously funding - the cost of everything.

The DEPUTY CHAIRMAN: You said, for example, that you were looking at graduate training in physio. The Australian Physiotherapy Association indicated that it was not entirely happy with the movement in this regard and felt that there has not been a lot of consultation. They were not singling out you or UWA, but that it is a general trend. I would be interested to know what is causing that change. It is obviously because of the increasing costs of delivery.

Professor Landau: That is an important point. They did get negative responses from most of the other bodies on graduate training. Both Curtin University and the University of Notre Dame Australia pulled out of doing it. That is why the head of the centre is having discussions with them to find out their needs, so that we can find out why these problems arose in the past. It is a difficult one. It is not about cost saving in a way. It is because the students do another degree. They do a shorter course.

The DEPUTY CHAIRMAN: We have heard that the national health system in Britain has started providing some generic training at the front end of some of the medical disciplines. There are some core elements. How do you feel about that?

Professor Landau: I think that is a good option. That is again where the graduate programs have an advantage. We have introduced a Bachelor of Health Science, which is incredibly popular. The course is half science and half public health. The students can do it as a combined degree with economics. Graduates can go into the health service in many areas, particularly administration, laboratories and things like that. They are also then prepared to be able to go rapidly and easily into a graduate program in any health science. That is one way to do it. I think it is a good alternative. I do not think it is necessarily the best way to go for everyone. We need to look at the dynamics.

The DEPUTY CHAIRMAN: Just about every health discipline that has come before us has said, "If only they knew more about our occupation, we would have a much better system", particularly when we talk about multidisciplinary teams, triage, casualty and so forth. Whether it is podiatrists, physios, allied health professionals, nurse practitioners, mental health workers or people in aged care disciplines, everybody wants everybody else to know a bit more about their discipline so that they can somehow streamline the system and be more efficient at the front end. What is happening to deal with that in terms of curriculum development at your university?

Professor Landau: I guess we are trying to get the students to be much more aware of those sorts of things from the start in a couple of areas. Part of it is our fault in that our curricula in the past have not done that. Part of it is the health professions. They do not communicate well and let other

people know about them. Whenever they are asked, they are very defensive because they are always worried about protecting their own turf. We have to break down those barriers. Unless we do, it is just not going to work.

The DEPUTY CHAIRMAN: That is a good point, because people say that the best time to break down the barrier is at the undergraduate level.

Professor Landau: Exactly; I agree. We are doing that in at least two ways. You will see some examples in the pamphlet I have provided, which outlines the problems we introduce to the students. The learning is based around the problems of patients. They include all the allied health issues that need to be addressed. We are starting to try to do that at the stage at which students do their clinical school work, particularly with the rural clinical school and we hope also with urban clinical school attachments, and their options that involve them actually working in a unit at the coalface with all those health professionals and not just as students hanging on. We have done a few projects with nurses as well, such as teaching CPR with nurses. One program we conducted with them worked very well. However, there was no impetus to keep it going; it was a once off project. We need much more of that. That can be done. The University of Sydney has done that with medicine and dentistry, in which the students do the same course for the first two years and then move off into their specialised areas. We could do that with many other disciplines. That is what I am hoping we will be able to move to.

Mr P.W. ANDREWS: If you are going to introduce those other disciplines, obviously the course will become longer.

Professor Landau: No.

Mr P.W. ANDREWS: How do you do it then?

Professor Landau: If we were using the old model, under which students had to know the textbooks and we had to squeeze it all in, the course would be longer. That is no longer possible. There is no way that students can know everything that is in textbooks or available electronically any more because there is just too much knowledge now; they cannot know it all. They have to learn basic core knowledge and skills. There are still things we can cut back - the detail that they do not need to know but which they need to know how to find. Those other things could then be introduced. It is moving from one to the other. We hope to do that in our curriculum. That can be done even more.

Mr P.W. ANDREWS: My next question relates to that. My understanding is that a student who holds a degree in science, for example, who then gains entry to medicine must then redo a course such as biochemistry.

Professor Landau: There are two aspects to that. That is one of the advantages of a graduate entry program. They do not do most of those courses again. One of the disadvantages of the integrated course is that students cannot actually drop a year, even though they might have done some of the units, such as biochemistry, because they will not have done the patient or personal and professional development bits. They cannot actually save a lot of time, but they do not have to sit those exams. We give them concessions for what they have done before. They do not have to go to lectures or sit exams in areas in which they have done a particular course.

Mr P.W. ANDREWS: To someone not in the system it seems strange that if places are limited and, therefore, places in those units are limited, that someone who has already done that unit would repeat it.

Professor Landau: They do not have to repeat a unit they have already done.

Mr P.W. ANDREWS: So someone who has done a degree that included biochemistry and who then gains entry into medicine does not have to do the biochemistry again?

Professor Landau: No. What I am saying is that, unfortunately, they cannot miss six months because they are not doing only biochemistry during that time; they must do the other units that they have not studied before. It is an advantage for them because they do not have 24 contact hours a week but may have only 18 or 12 contact hours. They get that concession. It would be good it they could save a whole six or twelve months. That is the difficulty.

Mr P.W. ANDREWS: Are you saying that they do not have to do the unit again?

Professor Landau: No. If they have done the same content, we give them a concession for that. They do not need to repeat it.

Mr P.W. ANDREWS: That was different from my understanding of the situation.

Professor Landau: I am signing them all the time for people who request them.

Mr S.R. HILL: I just want to follow up the link with the three universities at the combined centre in Geraldton. I would like a bit more information about the information technology facilities and the educational centre.

Professor Landau: Basically, the experience of people in rural programs is that unless students feel that they have good communication with people who can answer their questions or provide information, or that they have access to the information the other students are getting, they do not feel comfortable or confident that they are keeping up with it. We have to be able to do that. That means we need a high bandwidth connection between Perth and Geraldton and all the other centres so that there is two-way video communication. They also need IT facilities so that they can access all our materials on the web and get immediate feedback from people down here. That is being set up.

[1.45 pm]

Mr S.R. HILL: It is the additional support for the rural students, basically.

Professor Landau: Yes. We have invested a fair bit within the faculty. The Collaborative Training and Education Centre has more within the university, which we use. The university's statewide application to the federal Government, with the Department of Health and, I think, the Department of Education as well, gave us an $8 million grant a few months ago. We wanted $20 million but we got $8 million, which should still markedly improve the bandwidth of our communication throughout the State. That will also be an advantage for us to maintain really high quality interaction. Basically, we are looking at it so that we can actually communicate with someone who is seeing a patient, and the person down here can also see that patient. The person seeing the patient can transmit the patient's X-ray and look in the patient's eyes, and we can see what that person is seeing in the patient's eyes because of the ability to transmit that image from the ophthalmoscope through the lines. That is the sort of thing we are trying to set up. It does not replace the person-to-person contact, but it allows it to occur across distance.

Mr S.R. HILL: It is additional support.

Professor Landau: Yes.

The DEPUTY CHAIRMAN: You explored where you would like the University of Western Australia to go in that nursing area that you mentioned. Are you talking about postgraduate training? You would not have tendered for the nurse practitioner -

Professor Landau: We did not, no. That had not been brought to us as an option. That would be an interesting one. I think it would be good if we were a part of a consortium that was involved in that, because in that way we could establish the interaction between our students and the nurse practitioner students. The areas that we have been asked to look at in the past have been midwifery and mental health, and we would have been happy to progress them, but other powers did not feel it was appropriate.

The DEPUTY CHAIRMAN: When you say "powers", are you referring to people who represent the professions?

Professor Landau: Yes, they were within the professions. Some people within the professions approached us, but other groups did not see it as a good strategy.

The DEPUTY CHAIRMAN: It is a bit of a catch-22 situation for the university, because in many ways the university plays a leading role in terms of who delivers health services, but at the same time it is hamstrung to some degree in its flexibility to move with that. If you were sitting over here - you probably would not want to, and I do not blame you -

Professor Landau: I was just thinking how to answer that.

The DEPUTY CHAIRMAN: I saved you. From a state perspective, what should we be doing to assist? Obviously, we have huge needs. The reality is that if I were to get sick anywhere in the world, I would want to get sick in Western Australia. That is the truth of the matter. We have a fantastic public health system. However, that does not mean that people's expectations that need to be met are being met. If the roles were reversed, what things should we be doing from our end?

Professor Landau: I would have thought that you have actually identified them in a way from many of your questions; that is, to ensure that proper communication is occurring between all the health professionals, but in an environment in which the strategies that are adopted can move somewhere. At the moment it is all ad hoc, with one person talking to another. However, you could set up a structure under which someone was facilitating that and would not let things drop off the agenda because some people did not like them and had contacts that enabled them to discourage that progress. There could be a structure under which there was an agenda to identify the issues that are important in health care, and everyone in the system should contribute, but someone should make sure that solutions came out of it and did not just end up in a filing cabinet.

The DEPUTY CHAIRMAN: The proposed health senate seems to be very slow in coming.

Professor Landau: It is.

The DEPUTY CHAIRMAN: I am not making a political statement about that. Would that be an appropriate body if it were seen to be flexible enough, or does it need to sit outside government? Should it be an independent body?

Professor Landau: I do not know whether it needs to be totally outside government. It could be; that is one option. However, it still must be very much in touch with government. I am not sure of the structure. It is a difficult question because I have reservations about the senate, which I expressed at the time to the Health Administrative Review Committee and since. I just do not think that will work either. I feel that there always has been the need for greater community involvement, which did occur in the original boards and in the Metropolitan Health Service Board. They were not perfect by any means, but I think that totally removing some of that input will limit the senate's effectiveness. I think that it should be something like those bodies, which were not separate from government but had some degree of autonomy, and they had direct communication with government. I would need to look at the structure in a little more detail to get a feel for exactly where it should be positioned.

The DEPUTY CHAIRMAN: Thank you, Lou. Your submission was valuable, but what you have put to us verbally has been even more valuable. I really appreciate that. You will get a copy of the transcript. You can make some corrections if you feel they are needed. If you have any supplementary information, please feel free to forward that to us. Once you receive the transcript, you will have 10 working days to get it back to us. Thank you for your attendance today. It has been very valuable.

Professor Landau: Thank you for the opportunity.

Proceedings suspended from 1.52 to 3.10 pm