EDUCATION AND HEALTH STANDING COMMITTEE

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON WEDNESDAY, 6 NOVEMBER 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

BARTON, MS ANNETTTE DAWN
Occupational Therapist,
OT Australia WA,
examined:

The DEPUTY CHAIRMAN: Welcome, and thank you for attending this committee hearing. The proceedings today are to be treated as though they were a proceeding of the Parliament, which means that even though you are not on oath, you cannot mislead the committee in any way; so tell it as it is. Have you read the "Details of Witness" form and do you understand the information contained therein?

Ms Barton: Yes.

[11.15 am]

The DEPUTY CHAIRMAN: I thank you for your attendance and for your submission. We have some questions with which we wish to explore your submission. However, before we do so, would you like to summarise your position? Do you understand the nature of our inquiry? I will explain. We are looking at the interaction of health professionals in Western Australia; emerging occupations in health, as there are in other disciplines around the world; training and the integration of that training; and how we get a better result for what we are doing, if that is possible. We are looking at the emerging changes in health, who can do what, and why we might be corralled a little at present. We are looking at it from the patient's point of view.

Ms Barton: It is broader than allied health.

The DEPUTY CHAIRMAN: Yes. We have heard from the top specialists as well. It is all disciplines. In fact, your submission is one of 45 major submissions we have received across the whole spectrum. We are looking at it in totality. However, you are appearing in your capacity and that will add to our inquiry. Would you like to give us a snapshot of how you feel about where you sit in the health provider system at the moment? Perhaps you might like to take up some points from your submission before we ask you some questions.

Ms Barton: There are some issues. Occupational therapy comes under the allied health banner. It has very similar issues to those in allied health, but equally it has similar issues to nursing and doctoring. Although allied health and occupational therapy - a sub group of that - is even smaller, we have exactly the same issues as the nursing profession, such as training, retention, job satisfaction, career structures and pay. We also have the same issues as the medical profession. Graduates come in and the public health system trains them to a level so that they can specialise and then they go into private practice. Trying to keep those specialised therapists is very difficult. I do not think our profession is any different from allied health. It probably has the same sorts of issues that people from the medical and nursing professions will raise.

The DEPUTY CHAIRMAN: From your perspective, what would you do at the moment? What is your biggest issue? If you were in Mike Daube's position, what would you do to change things?

Ms Barton: There is a flat career structure within the public health system. We need ways to retain staff; that is, reduce their case loads, give them time for professional development, not burn them out, give them a career structure and so on. There just are not enough graduates coming out of university, and the public health system is the poor relative. It is struggling to get the best graduates and it is struggling to keep them.

The DEPUTY CHAIRMAN: What would you do to keep them - give them a better career structure ?

Ms Barton: Yes, give them a better career structure. We need to reduce their case loads so that they do not burn out so quickly. We need to give them professional development and time to do research. The career structure is a big issue. At the moment our clinical specialists come in at a base grade. They can go up one level and stay a clinical specialist and that is it. Many of them then go into private practice and they have flexibility, more money and more prestige. There are a lot more advantages in going into private practice.

Mr P.W. ANDREWS: How would you change the structure? What would you do?

Ms Barton: I would allow the clinical specialists to go higher than a first level of seniority. At the moment we have base grades. Clinical specialists go to the first level of seniority and then they have to go into management. They cannot go any higher and continue to be clinical specialists.

Mr P.W. ANDREWS: Are we talking simply about different pay scales?

Ms Barton: It is not only pay scales. They need room to do some research, go to professional development and do evidence-based practice. At the moment our clinical specialists are so busy just treating patients that they do not have time to do anything else. Their case loads are very full and tight.

The DEPUTY CHAIRMAN: There are not enough positions for a start.

Ms Barton: Yes. Certainly money would fix a lot of problems. However, it is not only money; it is the career structure, so that they can go higher, be clinical specialists and train the juniors. They have such busy case loads that they do not have time to train the juniors as much as they want to. Then they do not have time to do their own research, evidence-based practice, present at conferences and all those types of things.

The DEPUTY CHAIRMAN: Does that happen in the private sector ?

Ms Barton: The pay is better, as is the flexibility. The public health system is not as prestigious or glamorous. Private practice has that, plus flexibility and more money. They can work reduced hours and then do some research and professional development, present at conferences and those types of things.

Mr P.W. ANDREWS: Do they do that though? They have more money and more time, but do they actually do that?

Ms Barton: I think most do. We in occupational therapy have an accredited occupational therapy program, to which a lot of therapists belong; that is, the continuing education model and lifelong learning-type model. Most public and private therapists are in that program.

Mr P.W. ANDREWS: You said that they are so busy treating patients. I think to myself, yes, it is good to treat patients. What is wrong with my thinking?

Ms Barton: You are right; it is good to be busy treating patients. However, they need to be able to lift their heads and think about what they are doing. They need to be able to go onto a computer and see that what they are doing is the best practice. As a senior they need to be able to see what their junior graduates are doing with their patients. They need to be able to look up and see what else can be done to make their practice better. When they just treat patients, they do not have time to do any of that.

Mr R.A. AINSWORTH: What you are saying about the career prospects within the public health system indicates to me that after you have reached the second level of specialisation or the second level of pay, for personal progression beyond that you must go into administration rather than hands-on practice, which seems to be a huge loss of expertise. Although people need a bit of technical background for the management role, surely what is really needed is a professional manager as opposed to a professional hands-on health carer.

Ms Barton: Yes. They have no choice. If they want to be promoted, they must go into management.

Mr R.A. AINSWORTH: It seems a retrograde step to me.

The DEPUTY CHAIRMAN: What sort of relationship do occupational therapists have with a clinical team or other allied health professionals? Do you think that area needs to be improved?

Ms Barton: Those types of things can always be improved, but I would not say that it is a major issue at all. When I considered issues for my submission, it did not even come into my top 10 points.

The DEPUTY CHAIRMAN: Do you think that where you deliver your services is appropriate at the moment, or do you think it could be more flexible?

Ms Barton: Are you thinking across agencies?

The DEPUTY CHAIRMAN: Yes .

Ms Barton: It could be a lot more flexible. Anything across agencies or hospitals or from public to private hospitals is very difficult. Probably money and the busyness of the therapists' case loads are the major problems. For example, we have patients in the Swan region. Rather than someone from our hospital, Sir Charles Gairdner Hospital, driving all the way out to that area to take a person home and set that person up, we are trying to get the Swan service to do it. However, it is struggling with its own patients, let alone helping another hospital struggle with its patients. When we try to get someone to visit a person in Esperance, that service is full to the brim and has a waiting list; yet we are asking it to do more. Because everyone is so busy and tight, helping each other is really difficult. We have some off-the-record relationships. For example, we said that we would do one for the Swan service that is close to us if it did one for us. We try to do that, but it is not easy to do because everyone is full to the brim. There are already waiting lists of several weeks and we just add another person to those waiting lists.

The DEPUTY CHAIRMAN: Let us return to the profession itself. Are you proposing a new discipline in your career structure or just one with higher credentials? Are you talking about a progression just through experience? Can you give us an idea of the positions that are there now and then tell us what you think should happen?

Ms Barton: At the moment we have base grade positions, which we call level 3/5. We have our clinical specialist positions, which are level 6, and that is as far as specialists can go and stay clinical specialists. We then have level 7s, which are managers, and levels 8 and 9, which are heads of departments. I envisage that a clinical specialist could go from a level 3/5 to a level 6 to a level 7 and even to a level 8 if the specialist has postgraduate qualifications and presents at international conferences. At the moment we have a hand therapist who does that. She presented at an international conference in Turkey. She is a level 6 and has a masters from America, but that is as far as she can go and stay a clinical specialist.

The DEPUTY CHAIRMAN: What would be better?

Ms Barton: A stream of clinical specialists who could go further than a level 6, so that they could go from a level 3/5, to a level 6, level 7 and even level 8 as clinical specialists. The management role is at levels 7, 8 and 9. That is another stream, but they should not have to swap from one stream. At the moment we have only one stream. It is clinical, and if they want to keep going, they must go into management.

The DEPUTY CHAIRMAN: Do you believe that people must go through the whole stream to go into management?

Ms Barton: I believe that a therapist needs to have a fairly strong base grade as a therapist. The therapist might be able to go from a level 3/5 to a management level 7, but he or she would need a strong level 3/5. The therapist would need to do not just one year and then jump; he or she would need a good overview of the occupational therapy service.

The DEPUTY CHAIRMAN: What happens in country and regional areas at the moment? How is that integrated into health delivery?

Ms Barton: My understanding is that there are regions and there is very little support for them. There are some senior positions and some junior positions.

[11.30 am]

Often there are no specialisations in the country, obviously because of the lack of numbers. The senior clinician positions are, therefore, more generic so that within a week they will do hand therapy, paediatrics, aged care and general medicine. In the city there are clinical specialists in hand therapy, aged care and other areas; whereas in rural areas a wide spectrum of areas is covered by clinicians.

The DEPUTY CHAIRMAN: Which do you think is the better way to go?

Ms Barton: I do not think there is a choice in rural areas because there are just not the numbers.

The DEPUTY CHAIRMAN: Do you definitely support the further specialisation of disciplines in that sense, which is happening in other disciplines?

Ms Barton: Yes. If I were a country patient who had a severe hand or head injury I would go to the metropolitan area. The specialisation for any severe injury is in the city.

The DEPUTY CHAIRMAN: It lifts the bar more and more, but is specialisation leading to a lack of promotion in that sense? Let us say there are eight different specialists in occupational therapy, does that mean there must be a hierarchy within each speciality?

Ms Barton: On a clinical level?

The DEPUTY CHAIRMAN: Yes.

Ms Barton: Not on a management level because the managers just manage all those specialities as a whole. It does happen on a clinical level, except they are all flattened into one. In hand therapy we now have a trainee therapist, a junior therapist, a middle-range senior therapist and a therapist who is one of the best hand therapists in Western Australia, all squashed in at the same level 6.

Mr R.A. AINSWORTH: Following on from the Deputy Chairman's question on the work in country areas, do you think students are adequately prepared for the sort of situations they will face at work in country areas? Is there adequate preparatory training?

Mr S.R. HILL: Do you mean dealing with indigenous issues and so on?

Mr R.A. AINSWORTH: Covering a wide cross-section. The issue is wide and we have not mentioned indigenous issues. The cultural issue constitutes another layer on top of all the other issues. Is there sufficient encouragement or preparation for people who want to go to country areas?

Ms Barton: In the past few years there has been more. The push from Curtin University of Technology is to give students a rural or country practicum in the final year of their course. However, a country therapist's position is really difficult because it has so many arms to it. Therapists do very well with the skills they were good at in the country, but when they come back from the country the skills that they were weak at are even weaker because there was no supervision or guidance for them there. If, for example, they have a case load of hand therapy, paediatrics, aged care and general medicine and they are very strong at paediatrics, in the country they will become even stronger and be very good at it because of the great demand for those services. However, if they are not very good at hand therapy, there is no-one to mentor and show them and they will probably get weaker and weaker, as opposed to metropolitan therapists who have someone around them. Students, having done pracs in the country, know what they will come across and that the work is really broad. One issue is that new graduates in rural jobs have not always set up a network with city therapists. It is vital that they have a network set up so that if they have a difficult hand patient, for example, a farmer who has lost all his fingers, they know someone to ring in Perth. Graduates who go out to those rural places also have not developed such a network.

Mr S.R. HILL: Would the combined centre of rural health offer that opportunity for those graduates? I am thinking about whether the centre based in Geraldton offers that support?

Ms Barton: It does generally but not specifically. For example, it would not offer support for hand, head or spinal injuries or to amputees but it does generally, such as for aged care. Places such as Geraldton, Albany and Bunbury are much better off. Bunbury has 20 therapists, which is much better than Halls Creek and Karratha where therapists are on their own and people have to travel many miles to see a therapist.

The DEPUTY CHAIRMAN: Do you think the current payment for occupational therapists is adequate to meet the changing needs from a community's perspective? Are organisations like yours involved at all in any kind of curriculum development, or asked by any device to be involved in curriculum development?

Ms Barton: Certainly public health places are, so there is a mechanism for it. There is a field work coordinators group that gives feedback on the curriculum. There is a

gap between what the university is teaching and what the clinicians in the field need to do in their day-to-day job. The university does the education but there is a gap in training and we do the training.

The DEPUTY CHAIRMAN: Are there any transitional programs in this area, such as there is in nursing?

Ms Barton: No. It is a four-year degree and in that there is 1 000 hours of practical work. I guess when we are looking at new graduates, public health has a problem in that we are competing with the private health area. We are behind the eight ball with the university, in that we in public health have most of the third-year graduates, rather than the fourth-year graduates, who take a lot more work. We have more students who fail and students who do not cope well. All the private organisations say that they want fourth-year students because they can then recruit the best staff. Public hospitals want fourth-year students too because we also want to recruit the best staff; however, we get only about 10 per cent of fourth-year students and the private system gets 80 to 90 per cent. We are, therefore, the poor cousins in the whole scheme of things and that does not help us in recruitment drives.

The DEPUTY CHAIRMAN: Are there any issues we have not covered? We have talked about education, developing roles and integration. Workloads and resources are common themes that have come across. Because we are looking at other jurisdictions, do you know of any models or jurisdictions around the world that we should examine, in which you believe occupational therapists have a better integrated system or a better model of public health than in Western Australia?

Ms Barton: For career structure?

The DEPUTY CHAIRMAN: Yes, where you believe they have got it right. You said you did not believe there was a huge problem or that career structure was rated in the top 10 problems; whereas other occupations have rated not being considered part of the team at the top of the problems. Do you know of any models in other jurisdictions in Australia or overseas that have a better career structure?

Ms Barton: I am not aware of that. I thought you were referring to teamwork on a clinical level, with which we do not have major problems, although it is virtually impossible for occupational therapy or allied health areas to have a say at a health management level. It depends on whether you are looking at a clinical Mr Bloggs and his hand or his stroke or whatever; that is not an issue because we have a say in that.

The DEPUTY CHAIRMAN: Who represents your interests in the Department of Health? That is the answer: zip! Who would you talk to or relate to generally in the Department of Health about issues concerning occupational therapists? There is nobody. The allied health professionals said there needed to be a director of allied health. Would you support that?

Ms Barton: Yes. There was one about 10 to 15 years ago. I think rural health places were supported then much more than they are now. We had specialists in psychiatry, paediatrics and aged care. When country therapists had difficult patients - it did not matter whether they were in Halls Creek or Esperance - they would ring the Department of Health and a therapist would network with them, give them information and things like that. The lack of that network is a really weak point.

The DEPUTY CHAIRMAN: Yes, that has been made clear to us. I thank you and hope this was not too daunting an experience for you. This is an open inquiry and we are trying to gather information. The more intellectual property we get, the better off

we will be. We appreciate your attendance today and we thank you. We will send you a transcript of your verbal input today and if you need to change anything, such as an error or omission, that is fine, let us know. If you want to send us any additional information, that is also fine. You will have 10 working days in which to do that because we have to produce some records. Other than that, I thank you for coming today and we will be in touch as we move through the inquiry.

Committee adjourned at 11.41 am