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
WEDNESDAY, 27 NOVEMBER 2002

SESSION TWO

Members

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

[10.30 am]

DOUGLAS, DR CHARLES
Public Health Physician,
Member, Western Australian Regional Committee,
Australasian Faculty of Public Health Medicine,
East Metropolitan Population Health Unit,
examined:

HART, DR BRET
Medical Co-Director,
North Metropolitan Health Service Population Health Unit,
examined:

MAK, DR DONNA BING-YING
Chair, Western Australian Regional Committee,
Australasian Faculty of Public Health Medicine,
examined:

MAHONY, MS ANNE
Senior Public Health Nurse,
Kimberley Public Health Unit,
examined:

The CHAIRMAN: Welcome to the committee. I am required to advise you that the committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament.

Have you completed the details of witness forms and do you understand the attached notes?

The Witnesses: Yes.

The CHAIRMAN: Donna, I believe you have not yet received your form.

Dr Mak: No, I do not have a form.

The CHAIRMAN: It will be faxed to you. Please return it as soon as possible by fax, and you can mail the original form at a later stage. For all intents and purposes, do you understand that we are meeting as a parliamentary standing committee?

Dr Mak: Yes.

The CHAIRMAN: Okay. Have you read the "Information for Witnesses" briefing sheet regarding the giving of evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: I take this opportunity to thank you all for coming. As a result of your submission, we have written to you to ask for some further information on certain points. We would like to go through the questions that we have. However, if

you would like to start with any burning issue that you might have, that would be great. Did you hear that, Donna?

Dr Mak: I can hear you very well, Carol, but I am finding it very difficult to hear other people when they speak. I do not know whether that is because they are further away from the telephone.

The CHAIRMAN: I am sorry, Donna. There is not much we can do about it. The telephone has been set up on a little pedestal as much as possible in the middle of the room. If you do not hear everything, we might be able to relay it to you.

Dr Mak: Perhaps everyone could make a point of speaking very loudly, so that I can hear.

The CHAIRMAN: We will give it a go. Do any of you have a burning issue that you would like to start with? Here is your chance.

Dr Douglas: Not at this stage.

Dr Hart: I guess the burning issue is investment in public health. We have some concerns with that. Over the past several years there has been less investment in public health than there may have been in the past. That is of concern to the Australasian Faculty of Public Health Medicine, because that has an implication in terms of positions for public health physicians. In Western Australia, the number has gone down. Although the faculty obviously has a vested interest in ensuring that there are sufficient public health physicians, it is also a concern in terms of public health. I am not sure whether this is a symptom of a lack of appreciation of the need for public health and the prevention side of things and more of a focus on treatment, which we are not involved with. However, we can potentially prevent the need for a lot of treatment. That is one of our pressing concerns at the moment.

Mr M.F. BOARD: Can I explore that a bit, because it is very important to the development of both our inquiry and the delivery of health in this State. I guess, traditionally, because of the pressures on government and the health system it has been very easy to put the majority of the money into the service delivery end. The prevention end is the sleeper end, yet it is probably more important. We are seeing that with type 2 diabetes and a range of other issues. This inquiry is concentrating on not only delivery but also who delivers these things, how they are trained and whether there should be some generic training up-front, so that medical practitioners and other health professionals can become more aware of being integrated parts of public health, or the decision makers can become more aware of where the money goes. Can we explore the emerging trends? There seems to be a recognition across government that there needs to be more done in the public health arena; yet I do not think the dollars would actually follow in that sense. I do not want to get into the politics of it, because this is a bipartisan committee. However, we need to talk about how we can, in a competitive environment, make sure that public health is better resourced. That may involve the education process for people who enter a stream of the medical and allied health professions. Perhaps public health needs to be a greater part of their training profile. I am interested in your thoughts on that matter.

The CHAIRMAN: I will tack on one more bit, because this is a really important point. Perhaps we could frame it in the context of what we know to be a fact; that is, that there is a worldwide shortage of doctors and medical professionals. I understand the dollar issue - I do not have a problem with that. It does not matter how many dollars there are if professionals are not available. That context would be really

helpful, because it comes to the guts of what we are talking about, which is the interaction between health professionals. We know that we can get nurses, but there are specialty areas. Those are the things that we are trying to get to.

Dr Hart: I guess that where public health sits is problematic. We are attached to a so-called health system, but in reality it is an illness system. As you say, the pressure is in servicing emergency departments. I know that it is a fairly radical suggestion, but we would probably be a lot better off if we were part of a department of prevention. We now know better than we did in the past what determines health. We realise that the health system is probably not an appropriate partner, because health is determined by where a person lives, if he has a job, the sort of housing he lives in and the transport facilities available to him. Charles has just come back from a course in Queensland. I am sure he could wax lyrical about the latest evidence to back this up. We know that the further upstream we go, the more we can prevent not only health problems but also crime and all those sorts of things. We would be better off if we were part of a department of prevention, which had a cross-departmental approach. That fits in with the need for multidisciplinary teams, because you must have skills in all those areas to make a difference. It may not be that doctors and nurses are the only answer to the problem. You need other skills in the mix as well.

Mr M.F. BOARD: Let us explore that point. What are those skills? Are we talking about adapting existing occupations or about the possibility of specialised new occupations?

[10.45 am]

Dr Hart: I think a bit of both. I have had enough to say. Perhaps we should see whether Donna wants to say anything, otherwise we will dominate.

Dr Mak: I would never let you do that! In response to one of the first points that was raised about educating more health professionals and other groups of health professionals about public health, while that would be very nice and it might work, there are some basic premises on which our health system is based that make it very difficult for public health to be implemented properly. One of the big things in service remuneration for most health professionals is that the whole system of working does not support a population health approach or a preventive approach. When we have a health system that is based largely on a fee-for-service remuneration, and when the services that are remunerated are mainly curative health services as opposed to preventive services, then we can give as much education to as many health professionals in as many different fields as we like, but it will be very difficult for them to earn a living and try to practise public health at the same time. We need to realise that we need more than just education. We need some quite basic structural changes in the way that health care or prevention is delivered.

We need to remember too that we are often constrained in what we can do or say. I am feeling increasingly - I would like the others to say if they disagree with me - hampered or restrained in my ability to do my work. I work for the State Government, and that is the job that gives me an income, and as well as that I am the chair of a committee, and that does not give me an income. However, what I am allowed to do and the information that I am allowed to report and share with other people is increasingly being constrained. On the one hand we hear that the department wants more prevention and wants to strengthen public health, but on the other hand as a public health practitioner I often feel as though the thought police are onto me - and if it is not the thought police it is definitely the information

dissemination police - who say I am allowed to say this and I am not allowed to say that. It is becoming increasingly difficult for me to reconcile how I can maintain my professional and personal integrity but basically not get sacked. These are important issues. If we are talking about the education of public health practitioners, there is no point in educating people to do a really great job if they find it difficult to do that in the workplace and the workplace does not support them.

Mr P.W. ANDREWS: I am not sure exactly what you are talking about. When you say the thought police or the information police are stopping you from doing or saying certain things, can you elaborate, please?

Dr Mak: One of the functions of public health is to find out what is going on in terms of health care delivery and the health status of the population that we serve, and to use that to improve health service delivery and make things better. If we know that something is going on that is not 100 per cent the best and that the quality of care is not as good as it should be or could be, then the only way that can be improved is if it is acknowledged and if the organisation accepts that there are problems and we need to look for solutions. If I am not allowed to report on a problem, how can we ever find a solution?

Mr P.W. ANDREWS: What stops you from reporting on the problem?

Dr Mak: When I am told by my bosses that I should not say anything and I should not circulate that report to other health professionals because it may be damaging to the confidence in the Health Department.

Mr P.W. ANDREWS: Does that happen quite often?

Dr Mak: Yes; or when I am told, "You should not circulate that report because it reflects badly on people working in a certain geographical area; therefore, we would rather you quietly tried to address those issues and not actually report on everything." That happens quite often.

The CHAIRMAN: Can you give us an example?

Dr Mak: How protected am I?

The CHAIRMAN: This is a parliamentary standing committee.

Dr Mak: Then I will give you an example, and I hope I am protected.

Mr M.F. BOARD: It will be on the public record. The best way to deal with it is rather than mention any names of individuals, you should just talk about issues in a generic sense.

Dr Mak: I had an experience several months ago when I was asked by various practitioners to look into the quality of how a particular health service was being delivered. The reason they were concerned was that there had been some talk that nurses were not doing a particular procedure properly; therefore, they wanted to stop the nurses from doing the procedure. The situation in which many of these nurses work is that if they are not allowed to do the procedure, no-one will be able to do the procedure because they do not have enough doctors; some of these places have a doctor only once a fortnight. This is a preventive procedure that is required by women on a regular basis; it is recommended worldwide that women have this procedure on a regular basis as a preventive health measure. The nurses were concerned about whether their performance really was that bad and they were not doing this procedure properly. I felt I had a duty to find out. They needed to know, because, good or bad, they have a right to know the quality of the work that they are

doing. I investigated it. I contacted the laboratory where the information about the quality of the procedure is available, and I produced a report that was as anonymous as was reasonably possible. The postcode area in which the practitioners concerned were working was not identified, and the practitioners were identified as nurse 1, nurse 2, doctor 1 and doctor 2, etc. I felt that was an anonymous way of reporting something. I said at the end of the report, "If you want to know what your own quality is, you can contact me and I will let you know. I will not name you in the report, and I will not divulge who anyone else is."

However, before this report was circulated to the health professionals in the region, a very senior member of the health service was in my office quite fortuitously, and I thought this is a good opportunity to show this person what I have been doing, because it is something that really bothers me. It concerned me that the quality of the procedure that was performed was uniformly not good, regardless of whether the practitioner who was doing the procedure was a nurse or a doctor, and I thought that was something that needed to be said. I showed that person the report and said, "Have a look at this." I talked the person through it and explained what the procedure was, and I said, "I will be circulating this today or tomorrow. You have had a chance to look at it." The person did not say, "No, do not do it." I cannot remember exactly what the person's words were, but the person was very concerned. The person looked at it and did not say, "No, do not circulate it", so I circulated it. Of course there was some fallout. Some people were upset. As a result, I was given a letter from this very senior person who had seen the report beforehand, basically criticising me for writing the report. One of the concerns that was raised was actually quite legitimate. As a result of that person's concern, I had to go back to the laboratory and I said to it, "Someone has raised a concern about the quality of the data that you have given me, and I think that there probably is something wrong with the data. Can you please check on it." Therefore, together with the laboratory we looked at it and we realised that some data was missing. I subsequently circulated an amended report that included the missing data and an interpretation of how the missing data could cause people to come to the conclusion that they could draw. That report was circulated to all of the people who had the first report. I stated clearly in the report that it was an amended report, and I gave the reason that that data was missing. That is the sort of environment that I am working in. It is very likely that other public health practitioners are working in a similar environment. Would it have been better if I had not circulated that report? I do not think so, because I have had some very reasonable informal communication from the laboratory that indicates that it looks as though the quality is getting better. That may be impossible to prove one way or the other, but it is hard to know how things could have been turned around in such a short space of time if people had not been given any feedback on the quality of their work.

Mr M.F. BOARD: Thanks for sharing that with us. That probably highlights issues in not only health but also other public sector areas. It is something that we probably need to address in a bipartisan way to try to encourage stronger professional development. The health area has been politicised - as the opposition shadow health minister, I can assure you that health is politicised - and that is accelerated by the extent of the population and media interest. What you are saying as also a victim, Donna, is that people are very concerned about the way these things will be treated in the media and whether it will affect their funding applications. Having put that on the record, we probably need to concentrate and move in a positive way and try to get some thoughts on the record about where we need to take this and whether as a

committee we need to recommend some legislative framework or other sorts of changes that can be implemented so that we can move things forward. I am interested in your thoughts on where we go from here. You have mentioned that we can perhaps have a new department. How will that change the issues that Donna has raised? A new department is all very well and good, but unless we have some structural changes in outcome-based systems rather than a system that promotes service delivery, then we may be wasting our time. What are your thoughts on that?
[11.00 am]

Dr Douglas: The question of whether a separate department of prevention would be able to attract funds has already been discussed in the United Kingdom, and it may not be the best way to go, although we need to get out of the sickness sector. There are two factors determining how education for public health in the health sector would sit within the health industry itself. As Bret said, the focus on training and matters of public health or health promotion and protection are very subservient to the training of people in how to patch people up when they get sick. There are also role delineation problems. People are doing things they need not be doing, because of professional boundaries, which will, in a sense, detract from promoting health. For example, doctors are doing things that nurses could be doing, which would free up everybody's time for more preventive, health promotion activities. The politicisation of health is actually the politicisation of sickness, and that is where the Press is, and that is where the politics go. The absence of any interest in public health except in a disaster is the real problem. Everything is tracking along nicely, there is no disaster, so we stop putting in resources, training and human resource development. Then a disaster occurs, for instance Garibaldi smallgoods, then millions of dollars fly through. Then suddenly somebody says it is public health again; you must get something to do with public health. This is an ongoing problem; politics and the news are all about the sickness sector and about what is happening in Sir Charles Gairdner Hospital and Royal Perth Hospital, not what is not happening on the ground. Within the health industry we need to get public health training throughout all the undergraduate levels, or diplomas, whether they be nursing, doctors or allied health professions. I believe that the University of Western Australia medical school is now promoting public health. The public health course work is now in every year. That is a positive. It is working through the University of Western Australia, and the other universities run masters degrees in public health. That is encouraging. However, there are serious deficiencies, and one of them is committing training to nurses in community health work, rather than in acute sector nursing. The opportunity to gain hands-on experience is a large part of our submission. In the medical school you get the training, or you do some course work or projects, but opportunities to get any experience in public are limited. Once a doctors has graduated, apart from the scheme that Dr Mak has managed to wangle some money for, there is no way a resident can get exposure to public health as a specialty.

The CHAIRMAN: Are you referring to the junior medical practitioners?

Dr Douglas: Yes, the junior medical practitioners.

The CHAIRMAN: Is that the one in the Kimberley?

Dr Douglas: Yes. We spend millions of dollars each year for registrars in neurosurgery, surgery, and all the medical sickness specialties, but it is only recently - and this is a positive thing - that the Department of Health now has one public health registrar, and next year will have three. Again, that is a positive thing. It is a two-

year training program, and a specialty requires three years, so there are some issues around that, but it is positive. That will get some people some experience, but in a sense you need to be already committed to that, and you must know that you want to do it to apply for it. There is no exposure to public health in their previous experience. Within nursing there is an absence of any training.

I will quickly go outside the health industry. As we now know, those things that determine the health or ill-health of populations have very little to do with the health sector. Access to health services is responsible for very little in the way of health outcomes. It has more to do with the socioeconomic environment, even the global environment, but also housing, transport, the justice system, education, and particularly support in the early years. This is the multidisciplinary team bit. All these sectors need to realise how important the work they do for health is. It is not just about getting people into good houses. Good housing is part of a good health outcome. This is a way of bringing a whole lot of people together. I know it is beginning to happen with the early years task force, in addressing the social determinants. People in those other sectors need to have some education about the effect they can have on health, and the importance they have for the health of the population. That brings us all together so that we can work together - the health sector and other sectors - to promote the health of the public, which is what we are actually about.

Mr M.F. BOARD: It is a chicken-and-egg thing, I know, but one of the things that motivates Governments, unfortunately, is money - cost-effectiveness and outcomes. Everybody wants an outcome. It does not matter what portfolio it is, if you cannot show an outcome, there is pressure on you to put money into areas in which there will be an outcome. How do you demonstrate the outcomes through the public health system. How do you compare output with output, for the dollars spent.

Dr Mak: I wish to make a comment, following on from what Dr Douglas was saying. It brought to mind a quote I read, which I think was from a past president of the World Health Organization. She said that every minister is a health minister. That is so true, because any decisions made in Parliament affect the health of people, regardless of whether they apply to roads, transport or housing, or whatever. I would also like to put on the record that I have heard that in Parliaments in Australia today, most legislation that is passed is looked at from a business point of view, so legislation must be seen to be business-friendly. When will legislation be looked at from a health point of view, and when will we have health-friendly legislation? Is there any evidence that the legislation that has been passed, which is supposed to be business friendly, actually is that? What is the outcome that proves that? Why is there so much onus on the health system to prove that there will be an outcome within a very short time, given that the diseases we are looking have incubation periods of 10 or 20 years? We are looking at lifestyle diseases, diabetes, high blood pressure and cardiovascular disease. It is very hard to measure anything within the lifetime of a Government.

Mr M.F. BOARD: You are dealing with a very deep and complex area. I was formerly Minister for Youth, and it could equally be argued when I put money into programs for active young people, whether it be in the arts or any other activities, that it would have a health outcome. People could argue, whether it be in sport or recreation or even in education, that a whole range of government portfolios are now funding health care because they are involved in programs that, if they are active, may have a health outcome. These are difficult matters, because Governments generally

do not fund an outcome; they fund departments, in a linear. When those departments try to get together to cooperate, they do not have any discretionary funds. They cannot sit around a table and say, for example, "I am the Minister for Employment and Training, but I will give the Department of Health some extra money." It just does not happen that way. If someone gave a whole lot of money to an outcome, and it was not locked into a department, then the department, the private sector, or anyone else who delivers that outcome could bid for some of that money. Then you are working on the outcome, and everybody then has to bid for a share of those resources, depending on what they can do to contribute to the result. You are talking about turning Treasury, and the fundamental way in which things have been funded in this State, on it head. It is not done in Australia anywhere. It has been tried in a few programs, particularly some indigenous program. It worked particularly well in Geraldton, where the outcomes were funded and people had to come to the table to get their share of it. That is where you are headed with this - we should be putting resources and effort towards public health, and asking who wants to play a role in that project, and how they can get a share of the resources, depending on how they can contribute to the outcome. I assume that is what you are saying.

Dr Mak: Yes.

The CHAIRMAN: There is just another point with Aboriginal health workers, specifically for the Kimberley. I have had several comments about duplication of the public health role, between the Kimberley Aboriginal Medical Service, which also has a preventive role, and the public health sector. Is there a duplication, and what is the role of the Aboriginal health workers? Do you work with them? Is there coordination?

Dr Mak: You are asking me two questions. Firstly as to the duplication of services, the Kimberley public health unit, like all public health units in the State, does have certain statutory responsibilities, which, under the Health Act, can only be carried out by a State Government organisation, specifically part of the Department of Health. Those duties linked with the control of communicable diseases, outbreak control, notification of notifiable diseases under the Health Act, cannot be done by any other body. There is certainly no duplication in those statutory obligations.

The second part of your question concerns the Aboriginal health workers. Of course we do work with health workers, in the Aboriginal community public health system, and several levels of health workers within the state government health system. We try to work with all of them, regardless of who they work for.

The CHAIRMAN: That is good.

Dr Mak: There are also health workers employed by independent organisations, such as Mercy Community Health Services in the Kutjungka area. Perhaps Anne would like to comment more on that.

Ms Mahony: That comes in under multidisciplinary, but I think it should be interdisciplinary. Community health nurses and a lot of the others work together and overlap. It is a bit funny, because public health and community health really were together, and then they were separated. It is a bit of a dance to time, but at the moment public health nurses are separate, but they are working hand in hand with community health nurses. The community health nurses who are carrying out the public health program – whatever you want to call it - and the Aboriginal health workers fit in there as well. It depends on the area. It might be an Aboriginal health

worker coordinating the sexually transmitted diseases program, or it might be a nurse, depending on where it is.

The CHAIRMAN: In Broome, some of that is done by the Broome Aboriginal Medical Service.

Ms Mahony: - and different organisations. They do work in together

The CHAIRMAN: I have not read anywhere that BAMS, the Kimberley Aboriginal Medical Service, the Aboriginal medical services, and the public and community health services are working together, but I know it happens. I see it all the time. The 0-5 program would never be successful without that sort of collaboration, but I have not seen it documented. That is really why I wanted to get it on the agenda, because I understand the 0-5 program was started by the nuns in the Kimberley something like 27 years ago. If that is the case, we have all these protocols in place but no actual policy.

Ms Mahony: That is right. It happens across the board. An example is the trachoma program, whether it is done by the Aboriginal medical services or anyone else. Public health and community health from Derby and Broome went down to Bidyadanga, which has an AMS. It is more appropriate. They work closely together. It is more interdisciplinary.

[11.15 am]

The CHAIRMAN: Is there a model which would work for the better good of the community but which has not been identified?

Ms Mahony: Possibly.

Dr Hart: I would agree with that. This knowledge has emerged in only the past decade. These services were set up in the 1970s under a different paradigm. That is one of the reasons it is hard to demonstrate effectiveness. For one thing, there has not been the investment in public health in general, which includes evaluation and so on. Also, the paradigms change. What we are measuring now takes many years to show an impact. If we were to change what we do now, we would not be able to demonstrate the impact for many years. It would be an act of faith to invest in a new way of operating. We clearly need to do that to reflect this new understanding.

The CHAIRMAN: Are there any regional-specific programs? Is there a need for people in Perth to better understand Hansen's disease? I am asking this question because I know that 20 new cases are diagnosed in the Kimberley every year. Is it appropriate for people in a place like Perth to have that sort of specialist knowledge when the reality is that the Kimberley has 20 new cases every year? Even the Pilbara has a couple of cases, although not as many as the Kimberley. Is it appropriate to take the geographic location into account? We are talking about tropical diseases in the north west. Is there a need for special training for people up there?

Ms Mahony: I think there is.

Dr Hart: I would endorse that. I worked in the Kimberley and am now working in the metropolitan area. I see a very different sort of approach.

The CHAIRMAN: The first thing that happened when I first went to Derby - a long time ago - was that my employer, as part of its duty of care, took me through a training program at the hospital. That was run by Dr Randy Spargo. He talked to me about the disease and the implications of working at the leprosarium. Is that duty of care still in place?

Ms Mahony: It is, very much so. There are probably about five new cases each year. However, we will keep seeing new cases for the next 20 or so years because the disease is in the families. We are very aware that it is important that this knowledge be kept. People who have the expertise move out of the area, and we have to maintain the awareness and knowledge. We have to make sure that the education and awareness are retained.

Mr M.F. BOARD: I ask some specific questions for which we would like to get your opinion on the record. Are there enough health professionals in public health?

Ms Mahony: No.

Mr M.F. BOARD: I would like your opinion on that. Why is that the case? Is the career structure for public health adequate? What is missing and what should be done about it?

Dr Douglas: The area of Aboriginal health workers is the most dire. Talking about that will answer all those questions. My perspective in Aboriginal health is from a metropolitan point of view. It is largely forgotten within the health industry that the majority of Aboriginal people in the State live in the metropolitan area. They are hard to find. The funding tends to go to the rural and remote areas, for obvious reasons. However, the health outcomes for metropolitan-based Aboriginal people are pretty gruesome. Having said that, there are not enough Aboriginal health workers. They are as rare as hens' teeth and overworked. There is no career structure. It is a bit of paper. There is no follow-up. People who have been working for 20 years have had very little professional development. It is run on an ad hoc basis. For instance, Bret might want to support his Aboriginal health workers and send them to training, but if I do not want to support mine, they get nothing.

The CHAIRMAN: That is like the situation with the nurse from the Looma Remote Area Health Service. She got nothing after being in the public health system for 17 years.

Dr Douglas: It is a very hard job. It is a 24-hour-a-day, seven-day-a-week job. The workers do not get any recognition. As health professionals, our ethics and goals remain the same, but the bureaucratic limitations that are imposed on us may be inappropriate. This is not adequately recognised. There are not enough Aboriginal health workers, and they are not getting the education they need. Their basic training might enable them to be a health worker, but they get very little professional development. It does not enable them to work within a career structure. It is not in any way easy for them to cross over into mainstream health and perhaps become physiotherapists, nurses or doctors. It is not thought out. That is also reflected in the broader public health work force. Attention is not paid to training people. Resources are not put into training people in the promotion and protection of the health of the public.

Ms Mahony: There is no uniformity for the training of Aboriginal health workers. It is very hotchpotch and depends on where someone is training.

Mr R.A. AINSWORTH: In your submission you mentioned that medical professionals are largely unaware of public health as a career path. From what you are saying, it seems possible that medical professionals are well aware of the limitations of the public health system and therefore shy away from it. It might not be that they are not aware of the career path but that one does not exist. Would that be a fair assessment?

Dr Douglas: It is a self-fulfilling prophecy. As the role of the public health physician is downgraded and undervalued, positions dry up. As we said in the submission, that is what is happening in this State. There is not a career. There are not many private practitioners in public health. A couple of people in this State make a living out of it, and have saturated the market. There is not much of career. We get the registrars in place, but there is an issue about what they do afterwards.

Mr R.A. AINSWORTH: What can we do to solve the problem? That is what we need to know.

Dr Hart: It would be nice to have a simple answer. I have been impressed by the impact of the national mental health standard, which evolved from a national mental health policy. I think that if we follow a similar path and have both a state and national public health policy, followed by standards, many things will stem from it. People would have to reach a certain standard and undertake accredited training. It is likely that career paths would develop from that. However, in the absence of standards and policy, it will be as it is now - a hotchpotch.

Dr Douglas: At the state level, which is where we are operating now, there must be acknowledgment that the role of public health workers, specifically public health physicians, is a valuable one. People can argue that we do not need public health doctors. I argue the opposite. How can we prove that public health measures are working? That gets back to the question one of the committee members asked. There is ample evidence of the value of public health. We do not have a HIV epidemic to the extent that the Americans do. Cancer rates from tobacco-related diseases are falling. That is due to health promotion. There is ample evidence across a range of things that public health interventions are effective. The problem is that nothing happens when they are effective. Cost-benefit analyses for many public health interventions demonstrate their value. A work force that includes but does not solely consist of public health physicians is needed. When the State realises that, it will realise that vast areas of this State do not have the services of a public health physician and receive very limited services from any public health practitioners. It is a disaster waiting to happen. Little disasters, which may or may not be allowed to be talked about, have happened and will continue to happen. Big ones have not happened. The public health physician in Bunbury is responsible for the whole of the south west area. That is huge. There are now three public health physicians in the metropolitan area. There used to be one, then there were two and now there are three. Geraldton does not have one.

Dr Mak: Kalgoorlie does not have one.

Dr Douglas: Not only public health physicians are needed. The public health units are under-resourced. There is no doubt that public health physicians are expensive. We are doctors and we cost a lot of money. When people look at the budget for the Midwest Public Health Unit in Geraldton, they ask why they would spend $150 000 a year on a public health physician when they could get two health promotion officers for that money. That is valid, but we need to give the unit more money so that it can afford the doctors and the health promotion practitioners. The State needs to value the public health work force, including the public health physicians and community health nurses. It needs to invest in their training and create or fund the positions that will enable them to do their job of effectively promoting and protecting the health of the population. It is simple. It comes down to dollars.

Dr Mak: I am worried about whether I should say this on the public record. What is happening in the Kimberley right now with respect to a certain type of communicable disease is a very blatant example of what happens when the warnings of people from public health are ignored for years.

The CHAIRMAN: I thank you for all being here today.

Ms Mahony: Can I talk about community health nurses and education? That has been sadly neglected for many years. It is not just about the formalised training; it is the way community health is managed. We have lost a generation of community health nurses. The senior community nurse positions were banished 10 years ago. The area has been managed by directors of nursing at hospitals or generic managers. They are wonderful people; however, they do not have any community health experience. We have lost those nurses. We do not have the formalised training that Curtin University is now considering, and we also do not have the mentors. That is how the nurses are taught. We do not have that middle generation, and there are no young nurses coming through because there is no career structure in community health. Even the senior public health nurses or community health nurses are two levels lower than were our predecessors. We need to have a lot of skills.

The CHAIRMAN: What is the solution?

Ms Mahony: The area needs to be managed by senior community health nurses, as it was before. We do not want to go back 10 years. Things would have changed and moved on. However, the area must have its own management.

The CHAIRMAN: Are you talking about autonomy?

Ms Mahony: Absolutely. It should be separate.

The CHAIRMAN: You spoke about a preventive health department.

Ms Mahony: Yes. There must be nurses out in the community. The training programs that Curtin University is hopefully getting up and running would be terrific, but they would need a lot of support.

The CHAIRMAN: Have you written something about this?

Ms Mahony: I have scribbled some notes.

The CHAIRMAN: You can table those.

Dr Douglas: It gets back to the idea of a career structure. There is not one.

The CHAIRMAN: If you could table those notes, that would be great. Unfortunately, we have to go because the Parliament will sit very soon. I hate to cut you off as these are really important matters. If you feel that you want to contribute more, you can always do so in writing. That would help us. I am sorry to have to cut you off, but we have other commitments. You have provided some great information and it has been very helpful.

The standing committee will send you a transcript of your oral evidence with a letter explaining the process for making any corrections. If the transcript contains something that you are not sure of, you have 10 days to correct it and send it back. If you need to clarify anything, there is no problem with that. I again take this opportunity to thank you for attending. It has been very informative and helpful.

Committee adjourned at 11.29 am.