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, 16 OCTOBER 2002

SESSION ONE

Members

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

Committee met at 9.35 am

MARSTON, MR KENNETH GODFREY
Policy Officer,
Council on the Ageing (WA) Inc,
examined:

JOHNSTON, MRS LOIS RUTH
Member of the Policy Committee,
Council on the Ageing (WA) Inc,
examined:

The CHAIRMAN: Thank you for attending today. This 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 the Parliament. Have you completed the Details of Witness form and do you understand the notes attached to it?

Mr Marston: Yes.

Mrs Johnston: Yes.

The CHAIRMAN: Did you receive and read an Information for Witnesses briefing sheet regarding giving evidence before parliamentary committees?

Mr Marston: Yes.

Mrs Johnston: Yes. Prior to retirement, I was in the health field for about 40 years.

The CHAIRMAN: The committee has received your submission. Do you propose any amendments to it?

Mr Marston: No.

The CHAIRMAN: Will you give us a brief overview of the points you wish to discuss?

Mr Marston: The committee has asked us to give evidence on the multipurpose services, which are services for rural areas. We support those. It is a really good scheme and it assists all people in rural and remote areas, particularly seniors. Obviously we are here to talk about seniors' interests, but seniors' interests permeate the whole community. We are particularly interested in training in gerontology. With our ageing population, it is important that all health professionals fully understand the needs of seniors and are well trained in that area, because it has some very special needs. The next question related to the role of patient care attendants and community care workers. We are looking broadly at all levels of patient care, including nurses and ancillary staff. We think it is very important that people are well skilled and multiskilled, and that there is a good interface between community care and acute care. Would the committee like me to talk any further on those issues? That is briefly where we are coming from.

Mr M.F. BOARD: First, this inquiry is not a witch-hunt. We are genuinely looking at issues affecting some of the major health developments, and particularly new developments with the training of staff and the delivery of services in Western Australia - particularly some of the emerging occupations that are resulting from the developing trends in other countries - and where we in Western Australia might be able to improve our services as a result. Obviously we have an ageing population. We need to look at care awaiting placements; the transition from tertiary hospitals into placements. In remote areas the multipurpose service system has been of great benefit. We have looked at those matters. We know where the positives are. Do you think these systems could be improved; what would be better from a state resourcing or a training point of view; and how might the system be better able to meet the demands or needs of ageing people in this State?

The CHAIRMAN: And have you identified any issues that you want to raise?

Mr Marston: Maybe we can run through the whole gamut. I will start off with multipurpose services. Those services have been very successful and hinge on the interaction between the State and Commonwealth; this has been one of those programs where the State and the Commonwealth have worked very well together. The programs have been tried nationally and have been shown to work really well. The third factor is the interaction of the community. The program works very well because we have the State, the Commonwealth and the community all engaged together. They have pooled funding arrangements, which is really important. We are not looking at quarantining buckets of money, and therefore people are not saying, "Oh, they have heaps over there and we have nothing." The pooled funding arrangements are fantastic and if we could extend that concept closer to the metropolitan area it would be better. This works in the bush; why can it not work closer to the metropolitan area, and why can it not work in the metropolitan area? Joint cooperation with the States, the Commonwealth and the community really works; we would like to see more of it.

Mr R.A. AINSWORTH: Have you seen any problems with the MPS system as far as the cooperation between state and federal bodies is concerned as it relates to funding or any other issues that might impact on that system working efficiently? Is there a downside anywhere, or is it all good news?

Mr Marston: We are not specifically aware of any downside, but there is always the caveat that there can be a burden on the community. People are often busy and need support to do what they do. It is often easy for a Government to say, "Let the community do this." The community needs help and support to be engaged in that process.

Mrs Johnston: And perhaps a bit of education. Some communities may lack the skills to manage a multifaceted enterprise like an MPS. We believe the strength of the multipurpose service concept is if it were transported to urban areas, patients could receive care in the acute teaching hospitals and then be transferred to a multipurpose service closer to home where they would have community support and their families could visit, instead of needing to take a packed lunch and compass to get into the city through the urban sprawl. The level of staffing would perhaps be less highly skilled than in a teaching hospital. This brings us to the role of patient care attendants and community care workers. There will always be a place for, say, registered nurses who are highly skilled and highly educated, but there is a nursing shortage at the moment. The ageing of the nursing work force is likely to get worse rather than better, so we

need to look at alternative means of delivering care. We could have the highly skilled professionals supervising the work done by lesser skilled people - call them whatever; we have called them patient care attendants - and they could be aides to the allied health professionals, such as physiotherapists, doing the simpler tasks of assisting people with mobility, coughing, deep breathing, passive limb exercises and those sorts of things. They could also help with diversionary therapies. They could assist nurses by undertaking responsibility for many of the activities of daily living, such as ablutions, getting dressed, feeding and mobility. There is a place for that lower level and the highly skilled professionals.

Nursing is my background. It is the nature of nursing rather than the pay that is a deterrent for many nurses, certainly in the acute hospital setting. Most nurses are motivated by wanting to care for people, and the reward they get from caring is one of the satisfiers for doing some of the not too pleasant jobs associated with the occupation. However, with the productivity increases or efficiencies in public hospitals and the high turnover rate and increased acuity of patients, there is no time to care or to give TLC, so that the satisfaction nurses get from doing the caring is lost. They then become dissatisfied with nursing and move somewhere else where they can get some sort of job satisfaction. It would be a very expensive business to provide them with the number of hands on deck that would be required to do all the work, but if those highly skilled and highly paid professionals could be supported by lower skilled people, in a team approach, it would work. Some of the nursing unions have already looked at nurse-patient ratios, patient dependency rates and all those sorts of things. There are methods of assessing how many hours of care a person requires depending on his or her medical condition. If those people were supplied, not with the top-of-the-range professionals, but with a mixture of multiskilled people, that may go a little way towards alleviating the nursing shortage by giving the nurses some satisfaction in their work. Translating this into the community setting, with the provision of community services, there is often a multiplicity of people, like a revolving door, going into people's homes and what have you, and if we multiskill those community care workers - however titled - and have them do a whole range of things, it would cut down a lot on administrative costs. We could teach those people to pick up variations from the norm so that they would be health promoters and illness preventers. They could help prevent falls or supervise the use of medicines, or they might see that somebody is getting a bit forgetful and report it to the right person, which may be an indication of the early onset of Alzheimer's disease and early intervention may help.

Mr M.F. BOARD: Taking up your point about gerontology, are you suggesting that we might have patient assistants or even enrolled nurses, rather than registered nurses, who may be specialised in gerontology, and who may follow a career within the ageing area?

Mr Marston: Yes.

Mrs Johnston: I think there is a career path.

Mr Marston: We are talking about the whole spectrum, including Aboriginal health workers. We have a whole range of health professionals who can all be multiskilled and who can interact at various levels, according to the needs of the patients.

Mr M.F. BOARD: Have you had any success in getting educational institutions or the Department of Health to look at specific training in caring for the aged?

Mr Marston: There is a whole range of programs and facilities. Perhaps the most recent is the Freemasons Centre at the Curtin University of Technology. We have received a large amount of money from the masons, which is wonderful, but that is at an early stage. There are various programs. The Australian Nurses Federation has a set of competency standards for gerontological nursing. Things are happening. First, we would like to see more; we would like to see all health professionals receive gerontological skills both during their initial training and their professional development. We are looking at the whole range from technical gerontological issues to the more mundane things like communication skills. We find that a lot of health professionals do not have communication skills as good as we would like.

Mrs Johnston: They talk to the carer and not to the person.

Mr P.W. ANDREWS: Following on from that point, what has been the effect of having the Chair in Gerontology at Curtin University?

Mr Marston: It is early days; we have not seen a lot as yet, but we have high hopes. I am not sure when the person was appointed.

Mr M.F. BOARD: I assume the role of that chair is to develop programs and courses within the university that will flow into some of the various occupations. It is something we should look at. I think somebody from Curtin University is providing us with a submission, so we can raise that issue with them.

Mr Marston: The great thing is the opportunity of being within Curtin and having the links with nursing, physiotherapy and Aboriginal health. There is the opportunity for these issues to extend across the whole range.

Mrs Johnston: There is also a place in the community colleges. We have the ACE program in community education for the community care workers who are currently delivering services in that area. Getting back to the education of health professionals, I am not saying there is not a place for university-based nursing education - I firmly believe there is - but some people who make excellent carers do not have the tertiary or academic ability and we need to harness the talents and the caring skills of those people to provide care for people who are ageing.

Mr M.F. BOARD: On an unrelated issue, do you make submissions regarding the availability of drugs for patients under the PBS program?

Mr Marston: Yes, nationally we do. Western Australia is part of the national federation. National issues cover Australia and we certainly have a lot of input, and they have been talking a lot about the PBS and the increase in co-payments and restrictions on lists.

Mr M.F. BOARD: Could you report to us on any trend that you have seen where an area of need for the ageing is not being met?

Mr Marston: We are hearing a lot of complaints about two things: the increase in the co-payment, even though it is relatively small, does affect people; and the ceiling for the safety net means that the annual increase is only $50, but $50 is a lot to a person on the aged pension. It does make a big difference. With the lists being curtailed, we are hearing that people do not have access to PBS-listed drugs any more, or that newer drugs are not on the list, so they are faced with quite significant bills. I have received a call from a person with a prostate problem, which is obviously common amongst older men, who was prescribed medication that was going to cost him $300 for three months, and that was way beyond his means because it was not listed. We

have also found and recently publicised the fact that non-PBS medicines are not price controlled. We assume that when we go to the chemist the price of the drug is the price of the drug, and we do not realise that if we shop around for non-PBS-listed medicines we may be able to get them cheaper down the road.

Mr M.F. BOARD: There is a big trend for people to sell cheaper drugs across the Internet as well.

Mr Marston: That is right. The cost of drugs is a big issue, and part of that comes from restrictions on the list. People are obviously anxious to receive new drugs, because they are often very effective, but it means they have to pay large amounts of money and often they cannot afford it.

The CHAIRMAN: Last week I was travelling with the aged care task force in the Kimberley and we visited a number of remote communities. What we saw - which was outside the terms of reference, but which I followed up - was that they have elderly people out there and they do not want them put into institutions where they have high care beds, so they are kept in the communities but they cannot access training. They are really remote, it is not just a little ride down the road, and I am wondering what sort of an impact training would have and where they could get it; where would be the best place to have a facility? We have a growing aged population in the Kimberley and they want to retire. That is fine, but we have to look after them. We also have people in remote communities who feel they have a right to aged care. What would be the best location for a facility and how could we facilitate access?

Mrs Johnston: I spent 30 years in the Northern Territory, so I am familiar with remote Aboriginal communities.

The CHAIRMAN: I am referring to the area around Fitzroy River.

Mrs Johnston: Yes, I have been there, too. First, the community must be prepared to accept the carer, so the community has to choose who is going to do the caring. We cannot educate people and plonk them in a community and have them accepted.

The CHAIRMAN: We identified four people in that community who were willing, but the one who was doing the work was also the chairperson, had a part-time job and was caring full time for an elderly mother. We found one person who was willing to take some responsibility, but they identified four other people. They will make inquiries through the aged care facilities.

Mrs Johnston: The Aboriginal health worker -

The CHAIRMAN: She has now left, by the way.

Mrs Johnston: They have grades of health workers. I think that is the line to take - to educate those people in the communities. If there are four people, it is probably worthwhile sending out an educator.

The CHAIRMAN: It is Ngalingkadji and it has been there for 20 years. It is not that far from the road, probably half an hours drive, but there are bigger communities further out that have the same issues. I was thinking of something that was mobile. It is all right having the bricks and mortar, but how do the educators get out there?

Mr Marston: Training in context is a really important tool.

The CHAIRMAN: Competency-based training as well.

Mr Marston: The trainer looks at the context and understands the situation and can train around that. To some extent the combination used at the Centre for Aboriginal

Studies, such as the block release program and on-the-job and on-site training with a person visiting is fantastic. It may be relatively expensive, but if it works it is money well spent.

Mr M.F. BOARD: The main message you have left with us today is twofold. Firstly, you are very impressed with the multipurpose service program and would like to see it expanded, particularly in secondary hospitals in the metropolitan area. Secondly, you believe there is an opportunity to expand training for patient assistance for enrolled nurses to specialise in aged care training. That would require additional resources. A lot of people in our tertiary hospitals are awaiting aged care placement. You will obviously make submissions to the federal Government about aged care facilities. What are Western Australia's needs; do you have a figure that you can quote about the number of extra beds needed?

Mr Marston: We have heard the figure of about 300. It may be a bigger number; the system overall is under pressure. With community care, we are seeing people with high care needs being pushed down the scale. That means people with the lowest care needs get pushed out of the system altogether. There are waiting lists for community care packages. The whole system is under immense pressure. There are more people who need residential care. That can be seen from the figures about placements. There is a major crisis in the system. There are not enough beds. We advocate more community care packages; more can be done in the home. We need better targeting in home community care services that will cater for the higher needs. It will also allow for the admission of people with lower needs. We need to look at the whole spectrum of care to ensure that people do not escalate in their need for care.

Mrs Johnston: As an interim, instead of having people in teaching hospitals - where the cost of a bed is very expensive - people could be admitted to urban multipurpose services at first. They could then be returned to facilities closer to their communities.

The CHAIRMAN: What about regional Western Australia? As an example, Fitzroy Crossing has a small hospital and one small aged care facility. The high care beds have only just been allocated. Where do people go? Do they go to the aged person hostel or do they go to hospital, where they can access services from skilled staff? That is the issue. Realistically, in an ideal world both types of services could be colocated. Reality states that that will not get all the resources we need. Could multipurpose facilities be integrated with hospitals?

Mr Marston: We are all in favour of integration, coordination and the continuum of care so that we are not just focused on institutions. We must focus on the individual. Regarding the multipurpose service program, we are talking about the principles of engagement with communities to meet community and patient needs. We must focus on the needs of the individual on the continuum of care. Perhaps engagement with the community of Fitzroy Crossing is needed to look at the costs and benefits to it as well as financial costs and benefits to the Government.

Mrs Johnston: It would need an outreach service from a hospital.

The CHAIRMAN: So we should soften up the Government a bit so it will look at new ways of doing things?

Mrs Johnston: We should try combined funding so that funds are not split between aged care and acute care. If we did that, we would have the money to do things that communities need.

Mr Marston: We are essentially looking at lower administrative costs in coordinating services. If we can reduce costs, we will be able to get money to where it matters.

The CHAIRMAN: Thank you for that. The committee is sorry we kept you waiting outside. We have gone over time today. I thank you both for coming. You will receive a copy of today's transcript. Please read it and make any alterations that are necessary and return it to us within 10 working days.