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
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THIRD 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

BOWER, MRS VIRGINIA MIDORI
Chief Podiatrist, Royal Perth Hospital,
Representing the Australian Podiatry Association (WA),
examined:

TINLEY, DR PAUL
Head of the Podiatry Department at Curtin University,
Representing the Podiatry Department of Curtin University and the Australian Podiatry Association (WA),
examined:

HALL, MR NEIL
President of the Australian Podiatry Association (WA),
examined:

The DEPUTY CHAIRMAN: These committee proceedings are to be treated as a proceeding of the Parliament. As such, any deliberate misleading of our committee will be seen as a contempt of Parliament. That does not mean that you cannot give your opinion. Have you read and signed the witness statement sheets?

The Witnesses: Yes.

The DEPUTY CHAIRMAN: Thank you for your attendance and your submission. We want to explore that today. Before we ask you questions, would you like to elaborate on the submission. You can raise any pressing or major points to start the discussion.

Mr Hall: Of the three of us, Virginia currently works in the public health system and has an intimate understanding of its current difficulties. I would like her to lead off and discuss some of the key issues.

Mrs Bower: I want to give the committee a brief understanding of the role of podiatry and its current situation within the Western Australian public sector. We are probably one of the smallest allied health professions in terms of our representation in the public sector in Western Australia. Currently, only 21.3 full-time equivalent public podiatrists are employed in the State. About 73 per cent of those podiatrists are employed in the metropolitan area. Only a very small proportion - just over 20 per cent - are employed in rural areas, which is one of the major issues that we would like to canvass today. In comparison with our eastern States and national colleagues, the numbers of public podiatry positions are very light on the ground in WA. We have probably half of the number of podiatrists working on the ground as our national colleagues.

Podiatrists in the public sector play a very large role in the management of people with diabetic foot complications. That is one of the most essential and important areas in which we are involved. We work with people who have vascular and rheumatic diseases and we also work with the geriatric population, which will be a bigger concern in the future. Podiatrists work within different levels of care. They work in the community health services and in the secondary hospitals in the metropolitan area; for example, at the Armadale-Kelmscott Memorial Hospital and Bentley Hospital. They also work in the metropolitan tertiary hospitals and in regional areas such as the Albany Regional Hospital. There are three departments within the major tertiary teaching hospitals. We are concerned about the very small number of podiatrists who work in the public sector, which reflects on their career structure opportunities. We mentioned that issue in our report and hopefully we will touch on that today. That is an overview of some of our major concerns. Paul would like to

briefly discuss some of the issues regarding education requirements for podiatrists in Western Australia.

Dr Tinley: For the past six years, I have been the head of the Podiatry Department at Curtin University. Currently, the university has a three-year undergraduate program, which attracts about 100 people who either want to be podiatrists or to include podiatry on their lists. However, there are only 20 places for undergraduate podiatrists. There is a high demand for only a small number of places. Every one of our graduates gets a job. Generally, there are twice as many positions as there are qualified podiatrists. Currently, over 50 jobs are on the board nationally for podiatry positions. There is a huge demand for them, yet one of the big problems is getting extra places for our programs. We must extend the way the university is looking at its undergraduate program. Curtin University is planning on cutting the undergraduate podiatry course in 2004 because it costs too much. Currently, the dean is considering implementing a graduate entry masters-type program. That will mean that a prospective student must have completed a previous degree in order to study podiatry. We believe that will limit the number of podiatrists we produce. From a dollar perspective, there will be a change in the number of podiatrists who are likely to graduate from universities in Western Australia, which will create problems with demand. For example, Tasmania does not have a teaching school for podiatrists and, therefore, the State cannot get podiatrists. The masters-type program would be a big issue if it were to happen. In comparison, every other State, except the Territories and Tasmania, has a podiatry school. Approximately 180 to 200 podiatry students graduate across the country. Unlike Curtin University, most other schools have four-year, not three-year programs. That is an inequity with our teaching environment in Western Australia.

The committee asked us to provide a scope of the industry's practice. I have a copy of the relevant Act. Until recently, I was on the board. I will make the copy of the Act available to the committee. The Act describes the legal responsibility of podiatrists. It includes everything from surgical, mechanical, electrical and medical interventions of the foot and lower limb. In Western Australia, we are limited to the foot and ankle but in every other State, the lower limb is used as part of the podiatrists' therapies or potential therapies. That Act gives the committee a broad overview of the scope of practice of podiatrists. We are very underutilised in hospitals. An adequate number of podiatrists are not being trained to meet the demand. It is a small profession that does not necessarily get the support it should.

Mr Hall: Recently, the association has had fairly significant concerns about the developments at Curtin University, which seem to have been led without any consultation with the industry. To this date we have had virtually no consultation about the changing structure of the podiatry course. That causes us some concern. We have not seen any reason to believe that the current program to go to a masters level will attract people. Essentially, it means it will cost probably $50 000 or more to educate someone to become a podiatrist, which feeds back into some of the bigger issues the public sector has of attracting people. An analysis of why people choose not to go into the public sector shows that it is not only because of the limited number of placements, but also the private industry offers more rewards. Currently, a career structure in the public sector does not exist. We believe that that situation will be devastated even further by people being required to fund their own education. This is a big issue. I have written to a couple of state ministers, including the Minister for Health and the Minister for Community Development and some federal ministers. Universities are somewhat independent bodies; however, it would be good if the issue of the lack of consultation within our industry was addressed. That matter should proceed in a sensible and reasonable fashion. Although that is not necessarily directly a part of this committee's investigation, we believe that it will impact on the public sector quite dramatically if it is not managed properly. That is one of the great concerns that the association has for the potential effects on our profession.

Paul has touched on the registration Act. All the Acts have been subject to review of late, and we believe there are some deficiencies in the registration Act. One of those matters to which Paul related reflects on the limitations of podiatrists dealing with any problem above the ankle. We

believe that the quality of the education in this State is of the highest order both nationally and internationally and that podiatry could and should be utilised to a greater extent in the public sector. That would provide efficiencies in the system. Data from podiatrists who specialise in the surgical field show that those efficiencies can be achieved. We have only a limited area of specialisation. We are far more efficient on a cost basis per procedure. They are some of the many issues that we could canvass.

The DEPUTY CHAIRMAN: Thank you. Some of the points that have been made are critical to this inquiry, including the education provided by the universities, the number of places offered and their interrelationship with the industry, and where the other jurisdictions are going. We need to explore those matters because most people who have come before this committee, either in their written submissions or verbally, have said the same things. To some degree the universities are also saying the same things. They do not like the way events are unfolding, yet there does not seem to be a mechanism for change. This inquiry is necessary because the community needs health services to be delivered differently, for example, how and where they are delivered and who delivers them. Various models and changes are emerging from around the world. Although we have first-class health care and education services in Australia - that is not the issue - we do not seem to have the flexibility to move as quickly as other jurisdictions. We are exploring that issue and why some things are developing. There are a growing number of issues regarding geriatrics and the trend of ageing populations is occurring everywhere. We do not seem to be addressing that matter very well. It is not being incorporated into a generic education program in the health system. Occupations, including podiatry, now have greater workloads as a result of the ageing population. We want to explore that issue and any ideas you might have. I am interested in a comment made by either Virginia or Neil with regard to the three-year and four-year training programs. Considering the mutual recognition of education standards in Australia, I assume that the qualification of a podiatrist who graduates from Curtin University is recognised across Australia. How has the one-year difference come about?

Dr Tinley: That is a very good question. Essentially, the other universities have realised that the amount of knowledge that a podiatrist is required to learn has increased. The universities have given due space for that in the curriculum. Curtin University, which has a similar curriculum to South Australian universities, conducts boutique courses that are limited to about only 20 students. Curtin University would not provide extra full-time equivalent student places into those environments. Therefore, instead of students attending university for 18 hours a week, they must attend between 24 and 26 hours a week. Podiatry students must spend more time at university than most students in the other courses. Students also do clinical placements during their holidays.

The DEPUTY CHAIRMAN: In other words, they still have to do the same course, but it is squashed into three years instead of four years. Does that have anything to do with the way the universities are funded?

[1.30 pm]

Dr Tinley: Yes, absolutely. The funding issue is the key factor. We have had probably five submissions for extra numbers of students to allow us to go to a four-year program, but that is not available to us, unfortunately. If we look at the scores that students give us at the end of the year as to how they liked the program, the biggest single factor is overload in terms of the amount of hours that they are doing as a university student.

Mr Hall: The current proposal, or the program that is being forced upon us, is to go to a two-year graduate entry. We have issues with the clinical competency of the person at the end of that period. There has been no discussion about how that will be managed. There is already great difficulty with some of the clinical placement of students into the community for training. I am sure Virginia will explain some of the difficulties with that.

The DEPUTY CHAIRMAN: What would be the prerequisites for a two-year postgraduate training course in podiatry?

Mr Hall: I think you would need to get that information from the dean, because it will vary us across different courses.

Dr Tinley: There is no prerequisite as yet. If you look at the medicine model, the highest student recently was a plumber. That is not to say that will be the same in podiatry, because the demand may not be there. There is certainly a need for it to be a health-based discipline in terms of the degree entry level, but at the end of the day it is market forces.

Mr Hall: The other problem is that on top of this they have also been told that they will lose a staff member, so they will be required to educate in a shorter time, with one less person. These are serious issues.

The DEPUTY CHAIRMAN: You obviously have not been consulted well enough about this process?

Mr Hall: No, we have not.

The DEPUTY CHAIRMAN: We explored with the people from Curtin when they were here as to how they go about these things. They said they are not consulted all that much either about how funding goes around within the university. Obviously there is a great need for this area to be totally revamped in terms of outcomes for the customers, if I can use that term. The system is growing away from what is happening at the end. That is something that we will need to address in our report.

Dr Tinley: Particularly when we look at rural Australia, which is clearly an area with a major need for podiatry services, someone who already has a degree will not want to spend $36 000 to then become a podiatrist in that area. In my opinion, that will be another limiting factor that will inhibit people from coming into the profession.

The DEPUTY CHAIRMAN: Let us change tack a bit. That point has been made, and we can ask some more questions as we go along. Let us look at the clinical end and at how it works at the coalface. Let us stay with the public system for the moment. Do podiatrists work as part of a clinical team? Are they referred to only at the end, or are they part of an interdisciplinary team? At what stage is a podiatrist involved in issues at the tertiary hospital level?

Mrs Bower: If you are talking about tertiary hospital teams, the integration certainly is quite good. Again it depends on what site you are looking at. Royal Perth has the only full-time podiatry department in this State. We have four full-time equivalents there. The other departments in the other tertiary hospitals only have sessional staff, so that raises issues in terms of their relationship with some of the teams within the hospital. At Royal Perth we integrate very well with the other speciality teams and we are basically considered a key member of some of the major medical and surgical teams like the diabetes unit and the vascular unit. We are involved in their ward meetings and we are very much part of that team environment. In the hospitals where there are sessional staff, there are some obvious barriers that make that difficult, and that is certainly one of the issues that needs to be looked at in terms of our profession. Perhaps some of the positions in the larger hospitals and the community hospitals need to be consolidated to become full-time departments so that they can service the community better. From my perspective I see it as an issue for servicing the community more than anything else. If we have a full-time team there, we can provide that care at a greater level. The secondary hospitals and the community health services work less within teams. Again, it depends on the site. In most of our secondary hospitals, the podiatrists work as sole practitioners. That means that the demands on them are very heavy, so their relationship with some of their colleagues is harder to keep up, because of the pure clinical demands. We have found across the metropolitan region that often team involvement goes by the by if we have a huge

clinical case load. There is perhaps a bit of an issue there that we are not able to interact at that level as well as we could or would like to.

The DEPUTY CHAIRMAN: With the incredible increase in the incidence of type 2 diabetes in our community, surely that must be an incredibly growing area of demand for podiatrists. It seems to me that our manpower planning is not really ahead of the game at all.

Mrs Bower: It is not sufficient at all. Across most of the podiatry services in Western Australia a majority of our case load would be people with type 2 diabetes. At Royal Perth Hospital about 85 per cent of our patients have type 2 diabetes, and the foot problems that they come to see us for are directly related to that. Other co-morbidities are often associated with that, such as renal failure. In all of the other podiatry services in the community and elsewhere that are doing more population-based management and education programs, and one-on-one screening for risk factors and those types of things, again a very large proportion of their patients would be people with diabetes. It is a significant area, and the demand is increasing because people are being diagnosed a lot earlier, which is fantastic. However, it means that they need the services a lot earlier, particularly at the community level, where we want to do the early intervention type of management, which is what our community podiatry services are set up to do, but at the moment we do not have the manpower to be able to deliver the services.

Mr P.W. ANDREWS: In your submission you wrote about the fact that podiatrists are not working to their full legal scope and also that they are not acting as the first practitioner whom the patients see. Can you elaborate on that?

Dr Tinley: They are highly educated in the medicine, surgery, clinical pathology, pharmacy and pharmacology areas, and as a first-line diagnostician their podiatry education provides them with an excellent background to be able to represent that first-line person. In terms of their ability to screen patients and send them to other disciplines, there would be some sense in their doing that. We are under-utilising our podiatry services, particularly when we look at our scope of practice where we deal with everything from the old lady with the ingrown toenail and the hard skin to a surgical intervention by some of my masters-qualified colleagues. For example, podiatry services in the United Kingdom have taken a dramatic step forward with the introduction of health-funded surgical intervention for foot problems. That is certainly a huge area for development in Australia, and again it feeds in with that background of expertise and a discipline that looks at extensive medical and other backgrounds.

Mr P.W. ANDREWS: How could podiatry act as a screening agent? How would that work?

Dr Tinley: For example, someone in accident and emergency or in a rheumatology clinic or an orthopaedic clinic who was seeing the patient for the first time could take a history and make an initial diagnosis and would then understand where the next port of call should be. It is like a nurse practitioner effect.

Mr P.W. ANDREWS: Let us say we have an emergency centre situation and an older patient presents. Are you proposing that a podiatrist would see that patient first?

Mr Hall: I think we have an absolute capacity to determine the scale of the problem and order appropriate diagnostic tests and ready rapid tests and so on if that is required. It can then be managed in-house by, for example, the podiatry department; or if it requires some sort of additional medical specialists, then it can be appropriated in that way. It should not necessarily mean that very busy medical specialists are required to come and see significant numbers of people who do not need their attention. Those people can be managed and distributed probably quite effectively by the podiatrists, because we are quite good at determining foot problems. That is what we do well. How that can be managed within a hospital structure is another issue.

Mrs Bower: To give you some understanding of the reverse side of this discussion, the current situation is that someone may present to the emergency department with a diabetic foot ulcer that

does not necessarily require an admission. That is probably one of the most frequent events that we would see that would require our intervention. Currently such a person would go through the full triage system. Obviously you know what the emergency departments are like in our hospitals. I am sure you are familiar with that situation. That is using up a lot of manpower and resources. It is often about two or three hours down the track, once the registrar has assessed the patient, that we would then be called in; and we certainly do get called in at that point. However, it would loosen up some of the hospital resources if we were involved at the earlier stage, because it would save that process and perhaps the involvement of some of the other team members.

Mr P.W. ANDREWS: We have taken evidence from physiotherapists, who tell us that they would be the best ones to act in that role.

Mrs Bower: We want to make it clear that the emergency process that happens in hospitals would remain; no-one is suggesting that it would not. You obviously need to have a triage process, and the nursing and medical teams would be involved in that. However, at that early point, if it was a foot problem or clearly a physiotherapy related problem, those teams could get involved at that point, whereas at the moment we either get involved down the line a bit, or the patient is told to make an outpatient appointment to come and see us, and with our wait list that may mean the patient has to wait another three or four weeks, or in some places 12 weeks, to access a podiatry or physiotherapy service. We are proposing that we integrate some of the allied health professions at the early level.

Mr P.W. ANDREWS: Would enough patients be coming through the emergency department at Royal Perth Hospital with those sorts of problems to justify having a full-time podiatrist there?

Mrs Bower: No. To be honest with you, I do not think there are enough patients with purely foot related problems that anyone could justify putting a full-time staff member there. It probably is more of a situation in which we are talking about the relationship between the emergency team and the service, where we would be available on call and could provide that service.

Mr P.W. ANDREWS: Therefore it would not be on a first-contact basis? It would be on a referral basis?

Mrs Bower: It would not be a first contact in that sense. I do not think we would ever physically have enough demand for an allied health professional, other than perhaps people like social workers who would be involved in working with the aged population. The emergency departments at Royal Perth and other hospitals certainly do that, and that is a reasonably well-known model. In our situation, we need to have a better relationship, and we can certainly provide that level of care.

Mr P.W. ANDREWS: In what circumstances would the podiatrist act as the first port of call?

Mrs Bower: The hospitals could provide an open door service to the community for foot related problems so that people would be aware that if they had a foot related condition they could come first to a podiatry service in that situation, as opposed to what tends to happen, which is that people come first to emergency.

Mr P.W. ANDREWS: You do not think that might be a problem where someone might think "I have an ulcer on my foot", rather than "I should go to the accident and emergency department because I have a problem with my blood sugar level"?

Mrs Bower: If we are talking about someone with diabetes, the blood sugar level is very much part of it. The first thing we would do is involve the other teams. We always work within a team environment. However, it would be a direct relationship between us and the diabetes team instead of involving the emergency department in that process.

Mr P.W. ANDREWS: That is what I am saying. You are putting the onus then on the patient to decide "I have a problem with my foot; I should go to the foot specialist."

[1.45 pm]

Mrs Bower: In a way we are. For people who have existing and current problems, that is a service we already provide, of which they are aware. However, in the case of a new person with a new presenting condition, we would have to consider different strategies to promote that service - from the hospital's perspective - and provide it more to the community.

Dr Tinley: At the moment, one of the major specialisations within the hospital area is that of diabetes. In terms of our scope of practice, a huge potential exists in terms of the areas of trauma, rheumatology and orthopaedics. Students have training in all of those areas but they do not exist as entities in the hospital scenario. That is like saying that a young person coming into the hospital with a fractured ankle should not be seen by a podiatrist, even though foot ulceration may be a major complication of that condition. However, there are other trauma-type areas, for example, that podiatrists could easily become involved in as a patient's first port of call for any injury or problem with the foot; not just the diabetes related conditions. That is what exists currently but it is not necessarily the only possibility.

Mr P.W. ANDREWS: I do not want to labour the point, but if a person comes in believing that they might have fractured their foot, I cannot see that the podiatrist would be the best person to act as the first point of contact. The physiotherapists are saying that they should be the first point of contact.

Mr Hall: I do not want to get into an argument with a physiotherapist over who is better at diagnosing and dealing with foot problems - I would love to. In all honesty, the education of podiatrists compared with physiotherapists is so much in excess in relation to the foot and foot-related problems. I would hope that if any of you had a foot problem that you would go to a podiatrist rather than a physiotherapist.

Dr Tinley: You think dentists; you think teeth. Podiatrists and feet are the same thing.

Mr Hall: What we do not have at the moment is an understanding of the capacity of podiatrists. We have a rather large scope of practice with fantastic education; we have masters, surgical trainees and so on. However, the majority of that type of work is still being done in private practice and does not happen in the public sector.

The DEPUTY CHAIRMAN: If podiatrists worked in triage or were part of that patient's first hospital experience, it would cost more, but would it save money in the long-term or would it just provide better clinical outcomes?

Mrs Bower: It is about better clinical outcomes. However, in terms of the demand for resources that is currently placed on the hospital service, it would reduce that demand across the board. In hospital, people are referred from one specialist to another and, at the end of the day, they may end up in our clinic, which is where the care is delivered. However, the patient has to pass through that medical process until they finally reach the podiatrist.

The DEPUTY CHAIRMAN: Therefore, you could make the pathway more efficient?

Mrs Bower: Yes. That time-consuming process can have quite drastic outcomes for people with diabetes. If a wound deteriorates, it tends to deteriorate very quickly, and if somebody is on a wait list to see a doctor for that period, the patient may end up being a hospital admission. We know very well that that is exactly what happens, and that is where podiatry services in that area could be so important. We could reduce the cost for inpatient admissions, which are exponential, with a simple outpatient service and earlier intervention.

Mr R.A. AINSWORTH: In your submission you referred to a lack of understanding about the podiatrist's role amongst the medical and nursing professions. Is that lack of understanding part of the problem?

Mrs Bower: It is part of the problem, but it has a lot to do with the demand on podiatry services. We find it difficult to expand on where we are - as we have mentioned - because there is this

incredible demand for our services and we all have crazy caseloads. We are trying to deal with the here and now. To take that next step at the moment is not realistic. It is a key component of that issue.

Mr R.A. AINSWORTH: I will just change the topic slightly to deal with podiatrists working in rural areas. I am interested in the scope of work that a podiatrist in a country setting might encounter. Is there a major difference in the experience of a podiatrist working in the country as opposed to someone based in the city? Are those rural-based podiatrists adequately prepared for what they face?

Mrs Bower: Podiatrists in the rural areas must be fantastic generalists because often there is only one of them, and it may not even be a full-time position. They must be good at everything. Often they will have a broader scope of practice because they will be the only person working in that area in town. As for as their preparation to deal with that, their university training prepares them well. However, all of our rural positions are level 3/5 positions that are base grade graduate entry podiatry positions. None of them are senior positions or above. You can only recruit somebody straight out of university into that job. Therefore, those podiatrists do not have the experience or that sort of preparation for the job. They are thrown out there on their own. Under the old system, which is now slowly changing with the regionalisation under the Department of Health's new structure, they were completely isolated. They did not even have someone to phone or give them a hand with a particular case. Telehealth facilities and things like that are now starting to come into place, but the line responsibility in terms of who these practitioners respond to is still not clear. That plays into some of the other areas. Rural practitioners need more support than what they have at the moment. There may only be a few of them but the ones that are there really need to be looked after. Podiatry has one of the highest turnover rates of all the allied health professions in Western Australia, which is part of the overall issue. Rural areas only have base-grade graduates, who are under significant amounts of stress and pressure.

Dr Tinley: We have the highest burnout rate of any profession in Australia, England, Canada and elsewhere. I have just finished research in this area and burnout rates among podiatrists are huge because of the isolation factor. It is one of the profession's biggest problems. We need to encourage continuing education and collegiality through postgraduate education. One of things that Curtin University of Technology has been involved with in a big way is the development of a completely distance education masters program, which allows anybody anywhere to literally come online, join a discussion group and interact with their colleagues, which is the single biggest positive about this particular course. The problem is that they are not supported in terms of that continuing education. They are given 16 hours for continuing education, which is just a recipe for disaster. Programs are certainly available that allow for interaction with colleagues and the like. The association constantly takes telephone calls from our rural colleagues and it provides a positive continuing education program in which videos and teleconferencing-type opportunities are available. That all helps with the issue of continuing education, but isolation is still a problem.

Mr Hall: One of the other issues, which has recently been researched, is that many of the positions in rural areas are only 0.5 or thereabouts. Most of those podiatrists are completely overwhelmed with demand. The current belief of the association is that many of those positions need to be brought up to full-time positions, and even then that does not address some of the areas of greatest need - the Goldfields and the Kimberley in particular - that are totally and utterly under-serviced. That is another issue that could be addressed further.

Mr S.R. HILL: With respect to the indigenous perspective, is there enough training in the curriculum for people coming through to -

Dr Tinley: Students have placements in local Aboriginal centres in Perth; however, it is an underplayed value area at the moment.

Mr S.R. HILL: Would they be placed in places like the Geraldton Regional Aboriginal Medical Service for example?

Mrs Bower: No, just at the Derbarl Yerrigan Health Service in the city.

Dr Tinley: As of next year, rural placements will be part of out clinical program because we have identified this as an area of need. However, whether that will involve large numbers of the indigenous population is yet to be seen. We are working on it, but it will depend on what is happening with the course. However, it certainly is an area in need of development. We have a centre at Curtin University that is very positive. We have worked with their health workers in incorporating podiatry and foot screening as part of their remit. It has not gone too far yet but it is an initiative that has been tried. Certainly, the undergraduates do not get as much exposure as they should. I must say that that is an area in deficit.

Mr Hall: We support any additional resources that may be put into that area. We would love to expand and progress constant improvement. As with many things, it comes down to funding issues and thinking about the problem, perhaps pulling resources from one area and integrating and doing joint proposals. We are open to any proposal that expands and develops the area. The north west region and the indigenous population cannot be separated; they are one and the same. There are so many capacities to improve on that.

Dr Tinley: The courses we have just talked about are packed full of different areas of study. If a four-year program were developed then that area could be considered for inclusion into the curriculum. For example, the South Australia course has an extra half a year on the end of its course - now a three and a half year course - and it concentrates heavily on the indigenous area. It is one of their placement options and forms a big part of the course; it is something that needs to be replicated here. However, there are so many areas to cover. When considering what is covered by the course, I am afraid those types of areas are covered superficially.

The DEPUTY CHAIRMAN: How would you go about improving the career structure for podiatrists? What would you suggest?

Mrs Bower: One of our biggest problems - I am sure you have already worked it out - is that there are not enough of us to create a career structure. One of the fundamentals is that we need more positions -

The DEPUTY CHAIRMAN: Perhaps the attrition rate is partly related to the fact that there is no career structure; it is a catch-22.

Mrs Bower: Yes, absolutely. In Western Australia at the moment there is only one level 8 position, which is for the chief podiatrist in the State and which I currently hold. The other tertiary hospitals only have level 7 podiatrist positions. There are two level 7 positions in the State and about four senior podiatry positions. The rest of them are all base grade positions. How long will base grade podiatrists stay in the public sector earning $35 000 a year? Therefore, that attrition issue becomes more significant.

Dr Tinley: One of the jobs advertised at the moment for a new graduate is offering $50 000 a year plus a car - that is for a private practitioner.

Mrs Bower: That is what we are battling against at the moment. In the end, one of the things about health professionals - certainly the area of podiatry is no different - is that we often do the work for altruistic reasons. Podiatrists who stay in the public sector are there for that reason and are not seeking further monetary gains. A proportion of the graduates are always interested in and prepared to work in the public sector. However, we must provide them with something else other than a monetary gain that says that it is worthwhile staying in the system.

The DEPUTY CHAIRMAN: If there are only levels 1, 2 and 3 podiatrists that are not necessarily based on achievement in the field - although they probably go together - then, once a podiatrist gets

to level 3, which I assume most podiatrists would eventually do in the public sector, do they just sit there?

Mrs Bower: Yes.

The DEPUTY CHAIRMAN: Are all the other positions administrative positions?

Mrs Bower: Yes.

The DEPUTY CHAIRMAN: Is there no additional payment for postgraduate training?

Mrs Bower: No. As part of the current award under the Hospital Salaried Officers Association enterprise bargaining agreement, which our union, the HSOA and the Department of Health are negotiating at the moment, we are trying to get some form of an additional postgraduate increment. However, it does not look like that will happen. None of the HSOA award professions, which incorporate all allied health professions, has that at the moment. It is non-existent.

The DEPUTY CHAIRMAN: Which flies in the face of the increased specialisation that is happening in the area of health. The more people become specialised, the more people become isolated by the lack of career opportunities available, something which has also arisen in other areas. It is a consistent message that keeps arising. How many more podiatrists should be trained each year?

[2.00 pm]

Mr Hall: That is a hard question to answer. I think if you were looking at the education of podiatrists nationally, there is still a fair bit of capacity to absorb across the country. If you lose one educational facility, as has been the case in the eastern States where one closed down periodically, it impacts dramatically on the supply and demand situation. We do not know what will happen with the Curtin University of Technology. If, as we expect and do not want to happen, the postgraduate degree is a failure for a number of reasons, the podiatry course will cease to exist here. That would be a nightmarish situation for the profession and also for the public.

The DEPUTY CHAIRMAN: Are you suggesting that it will have only a postgraduate course?

Mr Hall: Yes. This is all we have been given. This has been mandated; the directive has come through. Next year will be the last intake of undergraduates. In 2004, if the course switches -

The DEPUTY CHAIRMAN: That is what Curtin University was getting at when it started to say that some of these areas are so narrow that it is hard to sustain the development of them.

Mr Hall: Yes. For podiatry, it is a risk that Curtin University is taking with our profession. We are some sort of pilot or trial, and if it fails, our profession will be impacted upon in a very large way. It is one thing to do that; it is another thing to do it without any consultation with the profession, and it does concern me that it is philosophically driven.

Dr Tinley: I go back to your question of how many more podiatrists we would need. If the health system develops in the way that it should do, the number of podiatry graduates could easily be doubled, and they could be absorbed very easily within Western Australia, and as a feeder to other States too.

The DEPUTY CHAIRMAN: I take it that Curtin University is the only university that provides that.

Dr Tinley: Yes.

The DEPUTY CHAIRMAN: Why is that?

Mr Hall: I guess supply and demand at this stage.

The DEPUTY CHAIRMAN: Is that how the carve-up worked between -

Mr Hall: If we look at the past 10 or 15 years of numbers of graduates, there have been a few periods when there have been shortages. I guess there has been a small oversupply in Western Australia, but that has not been the case of late.

Dr Tinley: They enter private practice.

Mr Hall: That is right. We need to remember that 75 per cent or more immediately fall into the private practice industry. The rest are probably distributed through the eastern States and are then taken up with natural attrition. The public sector really has not grown at all.

Mrs Bower: If anything, in the public sector in WA over the past 10 years, our full-time equivalent positions have diminished. One example of where they have diminished is Kalgoorlie Regional Hospital which could not fill a vacancy for a couple of years, so it has been reduced from a full-time podiatry position to 0.1 of a position. There is half a day that services that hospital in that entire region at the moment. Apart from that, the only other service that they have is private practitioners. Again, we are talking of our goldfields region, which has a large indigenous population. There are huge issues. We know what those issues are. That is just one example, but that has happened across the State; that is, that we have actually lost some of our positions because we cannot fill them.

The DEPUTY CHAIRMAN: You have the role of chief podiatrist.

Mrs Bower: Yes.

The DEPUTY CHAIRMAN: How does that work? Why is there a position of chief podiatrist if it is not to develop policy or to make sure that the demand is met?

Mrs Bower: There is a difference between a chief podiatrist and a principal podiatrist. As chief podiatrist, my role is purely to look after Royal Perth Hospital. Unfortunately, I also take on a role of trying to help resolve some of the issues across the State, for which I do not get any additional pay or otherwise, because I am it. As far as my job description goes, I look after Royal Perth Hospital. The principal podiatrist, which was a position that we had over 10 years ago and which was abolished with all the other principal allied health officer positions, did have that role, and it worked very well. That was in the days when we had a lot more positions in the rural areas. When they abolished the principal positions, we started to get a drain out of the public sector. I can speak for my allied health colleagues in the other professions; they have had the same situation occur. It had a lot to do with the fact that we decentralised everything, and most of the sites started looking after themselves and were responsible purely for their own budgets and their own problems. Therefore, there was not a big picture view of what was going on throughout the State. That is where we are at now. There is now a sudden awareness that we have these issues. Therefore, by default, people like me are having to take on some additional roles in trying to resolve these issues.

The DEPUTY CHAIRMAN: Who is the champion for podiatry in the State? Is it the association?

Mr Hall: It is.

The DEPUTY CHAIRMAN: You are the only voice in that sense?

Mr Hall: Indeed.

Dr Tinley: The registration board acts only on behalf of the general public. It does not actually have a remit of pushing the Department of Health etc.

The DEPUTY CHAIRMAN: Other than your trying to knock on the door of the Department of Health, there is no-one who can work within the Department of Health in terms of emerging issues?

Mrs Bower: No.

Mr Hall: One of the issues within the proposal was to look towards the need for a principal podiatrist, not just because it is a local but because it integrates with all the regional difficulties that we face as well; and we support that in a large way.

Mrs Bower: As far as the representation of allied health professions, not just podiatry, across the board at the Department of Health level is concerned, we have none. There is a chief medical officer and a chief nursing officer, but there is no chief allied health officer. Again, we are all screaming, shouting and waving our hands around, but there is no real strategic approach in the Department of Health at the moment to help resolve some of the allied health issues. Whether or not the way to resolve that is to reintroduce the principal posts or to introduce a chief allied health officer, I do not know, but they are suggestions. However, I think at some stage a decision will have to be made to deal with it, because the way we are going at the moment, the situation will continue to get a lot worse. The National Health Service in the United Kingdom has done a circle and come back and reintroduced the position of chief scientific officer for professions like medical scientists, radiologists and people like that, and the same with allied health, because they have seen that this is a significant issue, and it needs to be looked at more strategically.

The DEPUTY CHAIRMAN: That was very valuable. Is there anything that you would like to add? I think we have a pretty good handle on this?

Mr Hall: It is good to see you taking this in, because it shows that the understanding has now been presented. We certainly appreciate the opportunity to make a presentation to a body like yours, because we know that it is a very powerful body. Hopefully, there will be some changes.

The DEPUTY CHAIRMAN: We will table a report to the Parliament. This is a bipartisan committee. We will make some recommendations to the minister and to the Department of Health. We can force the minister and the department to come back to us on those recommendations and ask for progress on them. We cannot always enforce change, but, as a committee, we can make those recommendations and try to see them through, which is what we will do. What you have done forms a part of the jigsaw puzzle, and it is a similar piece to the pieces that are already going into place. I thank you for today's contribution. It has been very valuable.

You will get a copy of the transcript. When you do, you will have 10 days to return it. You can make corrections if you think there are errors; or if you think you have omitted something or would like to add something, you can put in some supplementary information. With that, I thank you for your attendance.

Dr Tinley: If we can help in providing any other documentation, please feel free to let us know.

The DEPUTY CHAIRMAN: Thank you very much.

Proceedings suspended from 2.09 to 2.21 pm