EDUCATION AND HEALTH STANDING COMMITTEE

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

Report No. 6

2004

Published by the Legislative Assembly, Parliament of Western Australia, Perth, May 2004.

Printed by the Government Printer, State Law Publisher, Western Australia.

Education and Health Standing Committee
The Role and Interaction of Health Professionals in the Western Australian Public Health System
ISBN: 1 920830 23 5
(Series: Western Australia. Parliament. Legislative Assembly. Committees.
Education and Health Standing Committee. Report 6)
328.365

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

Report No. 6

Presented by:
Hon. M.F. Board, MLA
Laid on the Table of the Legislative Assembly
on 13 May 2004

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TABLE OF CONTENTS

COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on:

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual reports of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

INQUIRY TERMS OF REFERENCE

At a meeting on 26 June 2002, the Standing Committee resolved to conduct an inquiry into *The Role and Interaction of Health Professionals in the Western Australian Public Health System* and resolved to adopt the following Terms of Reference:

That the Standing Committee examines and reports on –

1. emerging models of health care delivery;

2. the adequacy of current training methods;

3. the availability of defined career paths for health professionals; and

4. any other matters deemed relevant by the Standing Committee.

CHAIR'S FOREWORD

I am pleased to present for tabling the sixth report of the Education and Health Standing Committee, which was first appointed on 30 May 2001. The Education and Health Standing Committee is one of three portfolio-related standing committees appointed by the Legislative Assembly at the commencement of every Parliament. Pursuant to Legislative Assembly Standing Orders, the Committee may inquire into any matter within its portfolio responsibilities. The departments within the Committee's portfolio responsibilities are Education, Health, Indigenous Affairs and Sport and Recreation.

I believe it is important to acknowledge at the outset that on the whole, Western Australia's individual health professionals provide an excellent service under considerable pressure. The inquiry leading to this report was initiated by the Committee following its discussions on the need to find innovative ways for Western Australian health professionals to work together to improve health care for patients. The inquiry was broad in its scope, investigating a wide range of issues that impact on the health workforce. Of particular interest to the Committee were the roles played by the different health professional groups in the delivery of health services and the manner in which these different health professional groups interacted with one another.

Attracting and retaining health professionals in rural and remote regions, as well as in the outer urban areas, was a major issue raised in the inquiry. Western Australia is perhaps one of the most remote populations in the world and the challenge of providing equitable services in country regions is an issue of great concern to all Committee members. The inquiry also focussed on the capacity of current health professional training programs to supply a health workforce capable of meeting the changing needs of the Western Australian community.

It became clear to the Committee that the nature of funding arrangements and the number of places education and training institutions can offer are matters that cause some problems for all concerned. Significant attention was focused on the issue of clinical placements in hospitals and other health industry settings for students prior to entering the workforce, while the issue of funding places for students interested in the allied health professions proves problematic. Of further concern to the Committee is whether career structures within the public health sector have either the ability to offer long term job satisfaction or the capacity to be professionally competitive with the private sector.

The Committee looked at broader system issues that have an adverse impact on the way in which health professionals work and interact to deliver health services and considered many emerging models of health care delivery and the mechanisms by which they are developed and implemented. To address these issues, the Committee

met with representatives from various public and private health organisations as well as individual health professionals. The Committee travelled to Canada and the United Kingdom to meet with a number of health organisations, which had been identified as being at the forefront of either developing new innovative ways of dealing with emerging health problems or were already in the process of implementing new health programs.

Extensive research into strategies being implemented by other health bodies within Australia allowed the Committee to develop a further understanding of some of the common problems confronting every state and those problems that are unique to Western Australia. To address all these issues, the Committee has endeavoured to incorporate a blend of local, national and international knowledge into the report. The Committee is of the opinion that the findings and recommendations that have been developed in response to the inquiry will go some way in improving the delivery of public health care. In closing, I would like to extend my thanks to all individuals and organisations that contributed time and resources to assisting the Committee in its inquiry. The submissions received and the evidence heard by the Committee formed the basis of much of the Committee's deliberations and provided valuable insight into the workings of the Western Australian health system.

I would like to thank my fellow Committee members for their individual and collective contributions over the course of this inquiry and commend the Principal Research Officers, Erin Gauntlett, Karen Hall and most recently Liz Kerr and the Research Officer, Peter Frantom, for their professionalism, dedication and support. I would also like to thank Helen Lünsmann and Parliamentary Assistants, Glen Whitting and Peter D'Cress, for their invaluable assistance throughout the life of this inquiry.

MRS C.A. MARTIN, MLA
CHAIR

ABBREVIATIONS AND ACRONYMS

"A&E"	Accident and Emergency
"AASW/WA"	Australian Association of Social Workers/Western Australia
"ABS"	Australian Bureau of Statistics
"ACAT"	Aged Care Assessment Team
"ACT"	Australian Capital Territory
"ADHD"	Attention Deficit Hyperactivity Disorder
"ADMU"	Acute Demand Management Unit
"AHPMC"	After Hours Primary Medical Care
"AMS"	Aboriginal Medical Services
"AMWAC"	Australian Medical Workforce Advisory Committee
"ANNP"	Advanced Neonatal Nurse Practitioners
"ATS"	Australian Triage Score
"BCMA"	British Columbia Medical Association
"BEACH"	Bettering the Evaluation and Care of Health
"CACP"	Community Aged Care Packages
"CAMHS"	Child and Adolescent Mental Health Services
"CAP"	Care Awaiting Placement
"CCF"	Congestive Cardiac Failure
"CHD"	Coronary Heart Disease
"CSP"	Clinical Site Practitioner
"CWP"	Changing Workforce Programme
"DALY"	Disability-Adjusted Life Years
"DAWA"	Diabetes Australia Western Australia
"DCD"	Department of Community Development
"ED"	Emergency Department

“EDIS”	Emergency Department Information System
“EPC”	Enhanced Primary Care
“EPCP”	Eskasoni Primary Care Project
“ESC”	Emergency Services Collaborative
“FHG”	Family Health Group
“FHN”	Family Health Network
“FP”	Family Physician
“FTE”	Full Time Equivalent
“GDP”	Gross Domestic Product
“GMS”	General Medical Service
“GP”	General Medical Practitioner
“GPAH”	General Practice After Hours
“GPDWA”	General Practices Divisions of Western Australia
“GPwSI”	General Practitioners with Special Interests
“HCC”	Healthy Communities Collaborative
“HECS”	Higher Education Contribution Scheme
“HTF”	Health Transition Fund
“ICR”	Intensive Community Rehabilitation
“IPA”	Independent Practitioner Associations
“IV”	Intra Venous
“JAG”	Joint Advisory Group on General Practice and Population Health
“LADS”	Learning and Attentional Disorders Society of Western Australia Incorporated
“LOS”	Length of Stay
“MBS”	Medical Benefit Scheme
“MDS”	Medical Deputising Services
“MPS”	Multi Purpose Service
“NHAC”	National Health Advisory Council

"NHMRC"	National Health and Medical Research Council
"NHS"	National Health Service
"NICS"	National Institute of Clinical Studies
"NP"	Nurse Practitioners
"NPCC"	National Primary Care Collaborative
"OECD"	Organisation for Economic Co-operation and Development
"OFHN"	Ontario Family Health Network
"OHCWA"	Oral Health Centre of Western Australia
"ONP"	Orthopaedic Nurse Practitioners
"PBS"	Pharmaceutical Benefit Scheme
"PCD"	Primary Care Demonstration
"PCT"	Primary Care Trusts
"PHCAP"	Primary Health Care Access Program
"PHCO"	Primary Health Care Organisations
"PHCTF"	Primary Health Care Transition Fund
"PHI"	Private Health Insurance
"PHO"	Primary Health Organisation
"PMS"	Personal Medical Service
"QAHCS"	Quality in Australian Health Care Study
"RCDI"	Rural Chronic Disease Initiative
"RCN"	Royal College of Nursing
"RFDS"	Royal Flying Doctor Service
"RRMA"	Rural, Remote and Metropolitan Areas
"RRT"	Rapid Response Team
"SAU"	Surgical Assessment Unit
"SNAP"	Smoking, Nutrition, Alcohol and Physical Activity Framework

"TAFE"	Technical and Further Education
"TCP"	Transitional Care Pilot
"VMO"	Visiting Medical Officers
"WACHI"	Western Australian Centre for Health Innovation
"WYCLOS"	Whole of Year Cumulative Length of Stay

GLOSSARY

Access Block	Refers to the situation where patients occupy emergency department cubicles and corridors whilst awaiting admission to inpatient beds.
Acute Sector	Refers to the provision of health care in a hospital environment.
Allied Health	Refers to four broad categories: the hands on group which includes physiotherapy, social work, occupational therapy and speech pathology; the information and dispensing group, which includes medical librarians, pharmacists, medical records technicians and specialists; the diagnostic group, which includes audiology, radiography and a broad range of others; and the technical group, which includes medical technology specialists.
Ambulance Diversion	Refers to the situation where ambulances have to bypass an Accident and Emergency department due to overcrowding and access block. The ambulance and patient are then diverted to the next closest Accident and Emergency department with patient access availability.
Capitation Based Funding	Refers to a fixed per capita amount that is paid to a hospital, clinic or doctor for each patient seen.
Clinician	Refers to a suitably qualified or trained health professional who administers to the care and/or treatment of a patient.
Debrief	Refers to the forum that allows health personnel to formally discuss, with their peers, any questions, ideas or concerns they have pertaining to a particular (often stressful) work related incident or ongoing event.
Didactic Learning	Refers to instructional learning with minimal opportunity for practical experience.
Disability-Adjusted Life Years	Refers to the index of years of healthy life lost due to disability and premature mortality.
Enrolled Nurse	Refers to an individual who possesses a certificate or diploma from a TAFE institution or private provider and is accomplished in the practical skills of nursing. An Enrolled Nurse works under the supervision of a Registered Nurse.
Exit Rate	Refers to the rate at which health personnel leave a profession, particularly applicable to nursing.

Health Professional	Refers to a health worker who is either tertiary or vocationally trained in a health discipline. Within the context of this report, the term 'Health Professional' excludes those employed within the administrative, ancillary, clerical, domiciliary and hospitality support services.
Holistic Care	Refers to a philosophy of health care that encompasses the physical, emotional, socio-economic and spiritual needs of a patient.
Patient Centred Care	Refers to the view that the patient outcome (patient care and treatment) must remain the focal point of all health care delivery.
Primary Care	Refers to the provision and co-ordination of preventative and curative care at the initial point of patient/clinician contact.
Quarantining	Refers to the perception that certain senior health management positions are only accessible to those with a background in a particular discipline.
Ramping	Refers to the practice whereby ambulances cue at hospital Accident and Emergency departments to deliver individuals requiring medical care.
Rate of Attrition	Refers to the rate of health personnel leaving the health industry.
Registered Nurse	Refers to an individual who possesses a Bachelor of Nursing degree or diploma equivalent (tertiary). A Registered Nurse has a higher level of responsibility than an Enrolled Nurse.
Service Provider	Refers to an institution/organisation that provides a recognised health service to the general public.
Silo Working	Refers to the concept that health professionals within one health discipline function in almost complete isolation to all others.
Training	Refers to the process whereby health personnel undergo initial and additional educational and practical learning in order to develop and improve their expertise and proficiency.

EXECUTIVE SUMMARY

This is the final report of the Education and Health Standing Committee into *The Role and Interaction of Health Professionals in the Western Australian Public Health System*. The inquiry set out to explore the following questions in the context of the current health system:

- What roles do different health occupations play, and how well do health professionals work together in the delivery of health services?
- Are there systemic, behavioural or legislative barriers that prevent health professionals from working together optimally?
- Are education and training practices appropriate to equip health professionals to meet current and future health care needs? and
- Do existing career paths offer health professionals a challenging and fulfilling long-term career?

Chapters Two to Five explore these questions and consider some of the problems that health professionals encounter in fulfilling their roles and interacting with one another. Broader system issues are considered in Chapter Five. Chapters Six and Seven examine some of the innovative strategies that have been adopted, both locally and in other jurisdictions, to try to overcome these issues. Chapter Eight attempts to match problems with innovative strategies to offer a way forward for health in Western Australia.

The roles and interactions of health professionals

The Committee found that submissions and evidence concentrated largely on the negative aspects of the roles and interactions of health professionals. It is important to acknowledge, therefore, that the views represented in the report may not necessarily represent all views on the subject, rather those that individuals and organisations felt compelled to address.

The issues that appear to generate the greatest concern across the health sector are:

- The need for more effective leadership at a system, organisational and clinical level;
- The absence, in many settings, of effective teamwork between health professionals of different disciplines;
- The sometimes poor communication between health professionals of different disciplines, and between health professionals and their patients and/or carers;

- The diminishing capacity of our health professionals to attend to patients' non-medical needs;
- Low morale and high rates of attrition, due at least in part to inadequate support in a stressful working environment, lack of recognition, and lack of involvement in planning and decision making; and
- Inadequate support and recognition of some non-government organisations, for the contribution they make to delivery of health services.

Health professional training

Concerns raised in relation to education and training focused largely on the content of health professional curricula and the mechanisms by which these are determined. Of significant concern to stakeholders are the following issues:

- Health professional training programs do not place sufficient emphasis on communication skills or patient-focused health care;
- There is limited interaction between the education sector and the health industry with regard to curriculum development for health professionals;
- Clinical training places significant strain on scarce resources in the health industry, particularly in the face of workforce shortages;
- Funding of clinical placements is a highly contentious issue, with disagreement amongst the stakeholders as to where responsibility should lie;
- There is insufficient practical experience gained by nurses during undergraduate training; and
- The current funding arrangements for undergraduate health professional training, coupled with the limited interaction between the education and health sectors, do not allow for the allocation of discipline specific training places on the basis of current and future health workforce needs.

Career progression in the public sector

The limited or flattened career structure in the public sector is perceived as a major impediment to attracting and retaining health professionals, particularly amongst the allied health professions. For some, the private sector is a more attractive option.

The diversion of senior, experienced health professionals into management/administration positions, results in a loss to the system of some of the best and brightest clinicians. As a corollary, good clinicians do not necessarily make good managers, and they are not always provided with management training opportunities. Poor management has implications for patient care and for staff recruitment and retention.

Other prominent health issues

A number of broader systemic issues are inextricably linked to the roles and interactions of our health professionals. There were six issues in particular that the Committee felt should be further investigated.

(i) *Commonwealth State relations in funding and delivery of health services*

The current divide between funding and service delivery acts as a major impediment to true coordination and integration of services, as well as preventing a coordinated approach to health workforce planning.

(ii) *Rising health costs and efforts at containment*

As we search for more cost-effective ways in which to deliver health services, staff to patient ratios fall, health professionals are largely restricted to attending only to patients' immediate medical needs, and less qualified health professionals take on the tasks once undertaken by more qualified (more costly) health professionals.

(iii) *Shortages of health workers and maldistribution of the health workforce*

Even with the most innovative clinical practices, a health workforce will not be in a position to provide optimal services for patients when there are workforce shortages. For a number of years now, shortages of health workers and maldistribution of the health workforce have been two of the most pressing issues facing policymakers and health leaders.

(iv) *Meeting the health needs of an ageing population*

Population ageing has implications for the future roles and interactions of health professionals and for the health system in a broader context. Catering for the current and future needs of older Western Australians will require careful consideration in the areas of training, workforce planning and coordination of services across the spectrum of health and aged care.

(v) *Increasing demand on public hospitals*

Frequent access block and subsequent ambulance bypass are relatively new phenomena, arising almost simultaneously around the country in 1999/2000[1]. The presence of access blocked patients leads to too few cubicles to unload ambulances and treat patients in the emergency department, which leads to ambulance diversion.

At the 'back-end' of the hospital, delayed discharge can tie up beds for longer than is necessary. There are measures that can, and have been, put in place to streamline the

[1] Access block is the term used to describe the situation when patients occupy emergency department cubicles and corridors whilst awaiting admission to inpatient beds.

discharge process, however these measures are not always appropriate. In the case of Care Awaiting Placement (CAP) patients, discharge depends on availability of residential aged care beds, and where blockages occur at this point, measures within the hospital to streamline discharge are largely ineffective.

(vi) *Issues surrounding primary care*

Although private practitioners essentially deliver primary health care, there are a number of features of the private sector that significantly impact on the delivery of services in the public sector. Whilst there appears to be an acknowledgment amongst General Practitioners and in the broader community that non-medical health workers could be used to great advantage in primary care, the current fee-for-service funding model that applies to general practice is a major impediment to exploring innovative models of service delivery.

Emerging models of health care - system changes

The Committee's investigations of emerging models were largely limited to four countries - Canada, the United Kingdom, New Zealand and Australia. The Committee examined emerging models related to strengthening primary and sub-acute care.

Strengthening primary care

There are a number of challenges associated with re-aligning primary care from a disease-oriented to a health-oriented approach, and with re-orienting the health system toward a greater primary health care focus. These include the willingness of primary care providers to adopt a health-oriented approach, the capacity of the primary care sector to deliver the stated objectives, and the scope within the system to engage an appropriate skill mix of health professionals to optimise delivery of primary health care.

Canada

One of the features of primary health care reform in Canada is a move away from fee-for-service physician remuneration toward a capitation-based system. Concerns about the inability of the current fee-for-service model to support a primary care system with a strong emphasis on preventive care and chronic disease management were echoed by many of the health professionals and policy makers the Committee met with across Canada. The Canadian Government launched the Primary Health Care Transition Fund in 2002 to facilitate the transition of the current system into a primary care system characterised by:

- an increased number of community-based primary health care organisations;
- care provided by multi-disciplinary teams;
- better linkages with other parts of the health system;

- greater emphasis on health promotion, disease prevention and management of chronic disease; and
- expanded access to 24/7 primary care.

The United Kingdom

In the United Kingdom, particularly in England, Primary Care Trusts (PCTs) are freestanding GP-led bodies accountable to the local health authority for purchasing care for their population. PCTs are the focus of local service provision and more responsibilities are being devolved to them, particularly from the current health authorities and regional offices. By 2004, PCTs are expected to control 75 percent of the NHS budget, and will be free to set priorities for their local population.

A further British initiative is the extension of the role of the General Practitioner. Extending the roles of GPs is one of a number of measures intended to reduce the waiting lists for diagnosis and treatment in an acute setting. It also has the potential to strengthen the interface between primary and acute settings

New Zealand

In March 2000, the New Zealand Minister of Health began consultation on primary care reform with the release of The Future Shape of Primary Health Care: A Discussion Paper. Feedback from meetings and written submissions was used to develop The Primary Health Care Strategy. The strategy involves a realignment of primary care to a system that includes a focus on populations rather than individuals, involves a multi-disciplinary team based approach to care and is integrated with other health and non-health agencies.

One of the central tenets of the Primary Health Care Strategy is the devolution of health care purchasing from the Health Funding Authority to District Health Boards (DHBs), established by the *New Zealand Public Health and Disability Act 2000*. DHBs will be funded on population based formulae and will have responsibility for purchasing a wide range of services, including hospital and primary care.

Australia

In the Australian context, at the 2002 Health Minister's Conference, the following priority areas were identified for primary care reform:

- Improving the interface between hospitals and primary and aged care services;
- Achieving continuity of care between primary, community, acute, sub-acute, transition and aged care services, initially focussing on a stronger continuum of care for cancer and mental health services;
- Establishing a single national system for pharmaceuticals; and

- Improving access to services for Aboriginal and Torres Strait Islander people.

From 2000-01, the Commonwealth committed $49.5 million over 4 years for the employment of more allied health professionals, including psychologists, dieticians, podiatrists, social workers, physiotherapists and registered nurses. The More Allied Health Services program is aimed at providing additional allied health services for people living in rural communities. The program is expected to encourage stronger links between local GPs and allied health professionals.

Sub-acute care

Sub-acute (or intermediate) care services are designed to provide an alternative to hospital admission for some carefully selected patients and to provide supported discharge back to the community for others. Timely access to sub-acute care programs has the potential to significantly reduce the number of occupied bed days in acute hospitals. The Committee examined two successful intermediate care programs in Peterborough, England, as well as some of the strategies that are being implemented in Australia.

United Kingdom

The Rapid Response Team (Peterborough, England) was established five years ago to provide short-term nursing care in the home for patients with acute, non life-threatening injuries and illnesses. The multi-disciplinary Rapid Response Team's general charter is to keep people out of hospital.

The multi-disciplinary Intensive Community Rehabilitation (ICR) team, consists of a community physician, a team leader (physiotherapist), community rehabilitation nurses (linked with the Rapid Response Team), physiotherapists, occupational therapists, social workers, a technical instructor, therapy assistants, health care assistants and clerical and administration support. The aim of the ICR team is to provide rehabilitation within the home or residential care setting, with the objective of maintaining or regaining optimal independence.

Western Australia

Development and implementation of sub-acute programs in Western Australia has begun only recently and there remains considerable scope for expansion. Sub-acute care sits between Commonwealth-funded primary and State-funded acute care, and between acute and Commonwealth-funded aged care. As a result, neither jurisdiction has clear responsibility for funding and delivery of services.

Integrated care

Integration of health care services has a number of potential benefits, such as minimising costly duplication of resources, making more efficient use of staff and improving patient outcome and experiences with the health system. The current

Commonwealth/State divide in funding and delivery of services largely prevents integration of health care in the Australian context.

Shared governance and clinical leadership development

Shared governance empowers health professionals to make decisions around clinical care, and in a broader context, to ultimately affect an organisation's performance. Leadership, both at an organisational and at a clinical level, can have a profound effect on organisational culture. Both shared governance and leadership also ultimately affect patient care.

Understanding the system - information acquisition

In recent years, there has been a concerted push toward adopting an evidence-based approach to clinical practice. The mandate of the National Institute of Clinical Studies (NICS), established in 2000 by the Australian Department of Health and Ageing, is to close the gaps between evidence and clinical practice. During the course of the inquiry, the Committee came across several initiatives aimed at informing system/organisational behaviour through the acquisition of detailed information about system/organisational characteristics.

Emerging models of health care - new ways of working for health professionals

The Committee explored some exciting examples of health practitioner roles that are breaking down the traditional boundaries and, in so doing, enhancing patient care. In most developed countries there is an ongoing shortage of medical and nursing personnel, as well as other health professionals. The emergence of new health roles can potentially alleviate such shortfalls. Similarly, changing health needs of the population, such as ageing and the increasing prevalence of chronic disease, can provide the impetus for the emergence of new roles.

Redefining boundaries

The Committee examined a number of initiatives aimed at redefining clinical roles in Western Australia and other jurisdictions, including:

- Advanced Neonatal Nurse Practitioners;
- Orthopaedic Nurse Practitioners;
- Clinical Site Practitioners;
- Extended role radiographers; and the
- Enhanced role midwife project.

The Committee found that improved patient care, more efficient use of resources, creation of more attractive career options for health professionals and increased clinical capacity are some of the driving forces behind the development of extended scope health practitioner roles.

Creating new roles

In most developed countries there is an ongoing shortage of medical and nursing personnel, as well as other health professionals. The emergence of new health roles can potentially alleviate such shortfalls. Similarly, changing health needs of the population, such as ageing and the increasing prevalence of chronic disease, can provide the impetus for the emergence of new roles.

Designing health professional roles around patient needs

Ideally, forward planning of the health workforce would, to some extent, anticipate changing health needs. There exists a perception that, to a large extent, as policy makers we struggle to keep pace with changing demands rather than pro-actively plan our health workforce to meet future needs. Australia is not alone in this phenomenon; it is a problem that is experienced by most developed countries around the globe. The Committee encountered a number of examples of how other jurisdictions are designing the health workforce to meet patient needs. These are expanded upon within Chapter Seven and include:

- The Changing Workforce Programme (United Kingdom);
- Modern matrons in the NHS (United Kingdom);
- The New Generation Project (United Kingdom);
- Structured collaborative practice (Canada);
- Nurse-led rheumatology ward (United Kingdom); and
- Community and Mental Health program (Barwon, Vic).

Experience at the front-line

Patients who present to hospital emergency departments are generally seen by a number of health professionals and are often confronted by lengthy waits, both in terms of times to assessment and treatment, and sometimes between the decision to admit and the actual admission to a ward. The Committee examined a number of programs that address these issues, including replacing junior doctors at the front-line of emergency care with more experienced medical and nursing personnel and the establishment of strategies to improve the flow of non-urgent patients through the emergency department.

The way forward for Western Australia

Chapter Eight contains the Committee's 39 recommendations and brings together the problems discussed throughout the report with potential solutions to provide a way forward for health in Western Australia. The intention of this report is to raise awareness of the need for innovative approaches to addressing our health issues, to identify some of the impediments that currently stand in the way of innovation and to suggest strategies to overcome these impediments.

The Committee recognises that emerging models must be tailored to suit local conditions. Throughout the inquiry, the Committee was repeatedly advised that innovative strategies that apply in one location cannot simply be transferred to another location with guaranteed success. Furthermore, a number of witnesses to the inquiry emphasised that a 'top-down' approach on its own rarely works - 'clinical champions', practitioners at the front-line with vision, leadership and determination for change, are an integral ingredient for change.

That is not to say that innovation does not occur in Western Australia's health system - on the contrary, the Committee learned that innovation is common. However, whilst there are isolated pockets of excellent knowledge and rapport with national organisations, the average clinician is not well acquainted with such organisations, and thus probably has at best a superficial appreciation of the clinical innovations that are continually being piloted around the nation.

This report does not offer any 'quick fixes' to the problems in our health system. It is hoped however, that it will act as a catalyst for change.

FINDINGS

Page 3

Finding 1

The inquiry was viewed by many health occupational groups as an opportunity to highlight the negative rather than the positive aspects of the roles and interactions of health professionals.

Page 6

Finding 2

Effective leadership at a system, organisational and clinical level is essential to achieve good patient care, to improve teamwork and to facilitate change within the system. There are calls from across the health industry for more effective leadership on all levels.

Page 8

Finding 3

There is widespread acknowledgment that the ability to work within a health care team is an integral trait required of all health professionals. However, effective teamwork is often stifled by a 'silo' mentality, whereby each profession focuses on its 'domain' and is reluctant to interact or overlap with other disciplines.

Page 10

Finding 4

Communication between health professionals of different disciplines is often poor and may compromise patient care. Poor communication may relate to a lack of understanding of each others' roles in patient care.

Page 12

Finding 5

Poor communication on the part of health professionals is one of the most common complaints made by patients in relation to their experiences with the health system.

Page 14

Finding 6

Patients expect to be treated as individuals, with due consideration of their health needs within a broader sociocultural context. Increasing pressure in our health system diminishes the capacity of health professionals to attend to the 'non-medical' needs of patients.

Page 16

Finding 7

For some health professionals, particularly in the nursing and social work professions, the pressures within the health system create an ethical conflict between what they believe to be their role, and the role that the system allows them to perform.

Page 19

Finding 8

Many health professionals feel that the system does not adequately support them in their roles. Lack of professional, clinical and emotional support contributes to low morale and may ultimately lead health professionals to leave the system.

Page 20

Finding 9

Health professionals from many disciplines feel that their efforts are not adequately recognised and valued within the system.

Page 22

Finding 10

Lack of involvement in planning and decision making and lack of representation at senior levels contributes to low morale in nursing and allied health professions.

Page 26

Finding 11

Many non-government organisations have developed a level of expertise in their area of interest that greatly complements services within the public sector. Some of these organisations believe the services they provide are not adequately recognised and supported by government. Those that receive little or no financial support from government face ongoing financial uncertainty.

Page 30

Finding 12

Health professional training programs do not place sufficient emphasis on communication skills or on teaching health students to focus on the patient as a person.

Page 31

Finding 13

There is widespread concern across the health industry about the level of clinical experience gained by nursing students during their undergraduate training.

Page 31

Finding 14

In a pressurised health system, new graduates need considerable support to attune to organisational processes.

Page 34

Finding 15

A number of options are being considered to increase the clinical experience of nurses, including additional clinical placement time, employment during training and an internship year. There is also some support for an internship year for other health graduates to assist with the transition into the workplace.

Page 37

Finding 16

There is a lack of clarity and coordination about funding sources and their intended uses between the universities, Department of Health and health services in regard to clinical placements.

Page 37

Finding 17

Clinical training places significant strain on scarce resources in the health industry. In the face of workforce shortages, finding clinical placement opportunities is becoming increasingly difficult within many disciplines.

Page 40

Finding 18

In recognition of the fact that greater interaction between health professionals during training is an important prerequisite for effective teamwork in the health workforce, there is some move toward increasing the level of interaction between students of different health disciplines during training. Medical students, who train apart from most other health professional students, are largely excluded from this process at present.

Page 41

Finding 19

With the exception of medicine, which is determined at a Commonwealth level, location of discipline specific training places is determined within universities on a largely historical basis. Each health discipline must compete with other health disciplines for a finite number of places. The current arrangement leaves little scope for consideration of current and future workforce needs.

Page 43

Finding 20

Graduate entry health training programs are viewed as a possible solution to overcoming some of the constraints imposed by the Higher Education Contribution Scheme, hence providing an alternative means to address workforce shortages in some disciplines. However, the imposition of a significant cost to obtain qualifications may worsen the shortfall of health professionals in some disciplines.

Page 45

Finding 21

There is limited interaction between government, the health industry, professional associations, registration bodies and the education sector in curriculum development and health workforce planning. Better communication between these groups has the potential to improve the State's ability to respond to current and emerging health issues.

Page 49

Finding 22

Career paths within the public sector provide little recognition for advanced clinical expertise. Inadequacy of career structures are a major impediment to attracting and retaining health professionals across a range of disciplines, particularly amongst the allied health professions.

Page 51

Finding 23

For many health professionals, the only avenue for career advancement involves a shift into management/administration. This arrangement results in a loss to the system of some of the best and brightest clinicians.

Page 52

Finding 24

There is some support within the health industry for the creation of 'dual stream' career pathways to provide health professionals with an option to progress along either clinical or administrative pathways.

Page 53

Finding 25

There is little recognition in the public sector for health professionals who undertake postgraduate qualifications, either in terms of career progression or financial reward. When coupled with the high cost of postgraduate training, there is little incentive for health professionals to undertake such training.

Page 63

Finding 26

There is a broad consensus within our health industry that the constraints imposed by the current Commonwealth/State divide in funding and delivery of health services is a major impediment to true coordination and integration of health services, and prevents a coordinated approach to health workforce planning.

Page 64

Finding 27

On a state by state basis, Western Australia was second only to the Northern Territory in annual real (inflation adjusted) growth in health expenditure, averaging 6.7 percent per annum between 1997-98 and 2001-02. Despite the marked growth in Western Australian health expenditure, per person expenditure in 2001-02 was close to the national average.

Page 67

Finding 28

Growth in government health expenditure in the decade to 2001-02, was largely driven by increased expenditure on pharmaceuticals (via the Pharmaceutical Benefits Scheme), private hospitals (brought about by the effect of the rebate to holders of private health insurance) and professional (non-medical) services. Growth in non-government health expenditure was largely driven by increased expenditure on pharmaceuticals and other health services.

Page 68

Finding 29

Like Australia, most other Organisation for Economic Co-operation and Development countries experienced significant growth in health expenditure in the previous decade. Development and integration of new technologies and new pharmaceuticals were among the major cost drivers of rising health expenditure.

Page 69

Finding 30

Chronic diseases are estimated to account for 80 percent of the total burden of disease, mental illness and injury in Australia, as measured in terms of 'disability adjusted life years'.

Page 71

Finding 31

Behavioural (i.e. lifestyle) risk factors, such as tobacco smoking, physical inactivity, poor diet and excessive alcohol consumption, are estimated to account for the loss of 21 percent of disability adjusted life years.

Page 73

Finding 32

The biomedical risk factors of high blood pressure, excess weight and high blood cholesterol are estimated to account for the loss of 12 percent of disability adjusted life years. In 2003, the Organisation for Economic Co-operation and Development warned that obesity, and its related health problems, is an important potential driver of future health costs.

Page 75

Finding 33

There is an estimated shortfall of 300-600 General Practitioners and 100 medical specialists in Western Australia.

Page 76

Finding 34

A 2002 Access Economics report estimated that throughout Australia, 13 percent of people in urban areas and almost half the population in rural areas live in areas of 'severe' General Practitioner shortfall.

Page 77

Finding 35

Department of Employment and Workplace Relations data indicate that as of January 2004, there was a State-wide shortage of registered nurses, registered midwives, registered mental health nurses and enrolled nurses.

Page 77

Finding 36

Department of Employment and Workplace Relations indicate that in 2003, there was a State-wide shortage of physiotherapists, sonographers, radiation therapists and nuclear medicine technologists, a regional shortage of pharmacists and recruitment difficulties for occupational therapists in aged care facilities.

Page 78

Finding 37

Although today's General Practitioners generally work shorter hours than were worked by General Practitioners in the past, a recent Access Economics survey found that long hours remains a key deterrent to medical graduates choosing general practice as a career option. Comparatively low remuneration and concerns about bulk billing were also identified as important contributing factors.

Page 79

Finding 38

Many factors contribute to the ongoing nursing shortage, including the high rate of attrition in the nursing workforce due to the working environment.

Page 81

Finding 39

Shortage of training places, coupled with an inadequate career structure in the public sector contribute to the shortage of physiotherapists and other allied health professionals in the public health system.

Page 82

Finding 40

Despite a numerical increase in our health workforce, a progressive increase in the proportion of part-time workers has led to an overall decrease in Full Time Equivalent rates per population for both nursing and medical workers.

Page 83

Finding 41

Increasing female participation in the medical workforce is likely to have a substantial impact on future supply of medical practitioners, as females are more likely than their male counterparts to work part-time and are more likely to be attracted to areas of practice with flexible working hours, such as general practice.

Page 84

Finding 42

There are significantly fewer health workers per capita in rural and remote areas of Western Australia compared with metropolitan Perth.

Page 86

Finding 43

Long hours, family considerations, business difficulties and the rural lifestyle are key deterrents to attracting General Practitioners to rural practice. Monetary incentives and spouse/family considerations are the most likely factors to attract General Practitioners to rural practice.

Page 87

Finding 44

General Practitioners practising in rural and remote areas consider professional factors, such as good on-call arrangements and availability of professional support, to be the most important factors to influence their decision to remain in rural and remote settings.

Page 88

Finding 45

Many General Practitioners indicate that they would rather work in inner than in outer urban areas because remuneration is better and practice is easier - patients can be readily referred to specialists and acute hospitals, there is less pressure to bulk bill, and a greater opportunity to provide quality care with commensurate higher job satisfaction.

Page 90

Finding 46

Despite recent advances in medical workforce planning, Australia might continue to experience a shortage of doctors in the future. Increasing female participation, globalisation and increasing community expectations are expected to be major driving factors in future medical workforce shortages.

Page 90

Finding 47

Based on current policy settings, workforce trends and changing population demographics, Access Economics predicts a shortfall of 10,000 Full Time Equivalent General Practitioners by 2020.

Page 91

Finding 48

Based on current graduate output, increasing rates of attrition as the nursing workforce ages and a continuing trend toward decreasing average working hours, the Commonwealth Department of Education, Science and Training predicts that Australia will have a shortfall of 40,000 registered nurses by 2010.

Page 92

Finding 49

The proportion of people aged 65 and over will increase substantially in coming years. By 2021, it is estimated that people aged 65 and over will account for 18.4 percent of the population.

Page 94

Finding 50

People aged over 65, who represented 12.6 percent of the Australian population in 2001-02 accounted for 47 percent of total hospital patient days. Utilisation of General Practitioner services and expenditure on pharmaceuticals is also disproportionately high in this age group.

Page 96

Finding 51

Growth in demand for hospital and other health services over the next two decades will increase markedly as the population ages. Planning for our future health workforce must take adequate consideration of the ageing of our population.

Page 99

Finding 52

As at June 2002, there were 82.8 funded residential aged care places per 1,000 Western Australians aged 70 and over, well below the Commonwealth target of 90 places per 1,000. Fifty-eight percent of patients were classified as high dependency, well in excess of the Commonwealth target of 44 percent.

Page 100

Finding 53

There is some concern that difficulties in attracting and retaining qualified nursing staff may have contributed to increasing reliance on untrained health workers in the aged care sector.

Page 101

Finding 54

Despite a significant increase in the number of persons in residential aged care, coupled with an increase in the proportion of high dependency residents, the number of nurses working in aged care decreased by 14 percent between 1995 and 2001.

Page 102

Finding 55

Lack of career prospects, heavy workloads, poor professional image and wage disparity with other fields of nursing contribute to difficulties in attracting and retaining nurses in aged care.

Page 105

Finding 56

Recent data compiled by the Acute Demand Management Unit found that bed availability for acute admissions in our metropolitan teaching hospitals tracked closely with patient demand. However, there was a consistent shortfall of around 50 beds, termed the Gap of Neglect of Acute Demand. Closure of hospital beds in the face of known demand minimises pressure on over-stretched budgets by forcing patients to go elsewhere.

Page 107

Finding 57

As people age, they are more likely to present to emergency departments with complex problems, which require a significant proportion of emergency department resources. Data collected in Perth teaching hospitals since 1995 indicate that increasing demand on public hospital beds is largely driven by growth in the number of high complexity patients over 50.

Page 109

Finding 58

Using mathematical modelling, an average bed occupancy rate of 90 percent can be predicted to cause 'access block' in a hospital on around 20 days per annum (approximately 5 percent of the time). Beyond 90 percent occupancy, the system is predicted to be regularly subject to bed crises.

Page 109

Finding 59

Data collected by the Acute Demand Management Unit indicate that during winter 2003, the 4am average bed occupancy in Perth's adult teaching hospitals was 105 percent (i.e. 105 patients for every 100 beds). 'Excess' patients were occupying emergency department beds awaiting access to an inpatient bed.

Page 110

Finding 60

Based on data collected by the Acute Demand Management Unit, an estimated 200 extra beds will be required to maintain an occupancy rate of 98 percent in Perth's teaching hospitals by winter of 2004.

Page 112

Finding 61

Between 1 July 2002 and 30 June 2003 Care Awaiting Placement patients occupied an average of 123 State funded public hospital beds (4.1 percent of total bed capacity), 99 in metropolitan public hospitals (3.5 percent) and a further 24 in psychogeriatric facilities (16.3 percent).

Page 113

Finding 62

During 2002-03, an average of 600 older Western Australians were awaiting placement in residential aged care facilities at any given time.

Page 116

Finding 63

The Private Health Insurance Rebate, while temporarily alleviating the demand for elective surgery on public waiting lists, overall appears to have had little impact on demand for public hospital beds. Apart from a temporary fall in 2000-01, coinciding with the introduction of lifetime cover for Private Health Insurance membership, the total number of patient bed days in public hospitals has been stable since 1998-99. The median waiting time for elective surgery in public hospitals has remained constant since 1999-00, while the proportion of people who waited more than 12 months has risen slightly.

Page 117

Finding 64

The inability of the Private Health Insurance rebate to relieve pressure on the public hospital system is thought to relate to the pattern of membership uptake, which is skewed toward younger people, who place fewer demands on the public system and to the propensity for people with Private Health Insurance to continue to use the public system to avoid out of pocket costs associated with 'front-end deductibles'.

Page 121

Finding 65

Western Australia has substantially fewer Full Time Equivalent General Practitioners per head of population than any other state in Australia, with the exception of the Northern Territory. In the metropolitan area, the Canning and Rockingham/Kwinana Divisions of General Practice have the lowest number of General Practitioners per head of population. In the regions, the Kimberley and Central Wheatbelt Divisions have the lowest number of General Practitioners per head of population.

Page 124

Finding 66

In the December quarter 2003, just 64.7 percent of General Practitioner consultations were bulk-billed in Western Australia. For those patients who were not bulk-billed, the average contribution was $14.03. Primary care co-payments can act as a barrier to access for low-income earners.

Page 127

Finding 67

Of the six Divisions of General Practice in metropolitan Perth, only the Perth Central Coastal Division, which covers some of the most affluent suburbs in Perth, is considered to have adequate After Hours Primary Medical Care coverage.

Page 129

Finding 68

Access to After Hours Primary Medical Care in regional areas is generally more limited than in the metropolitan area, due to the critical shortage of General Practitioners in regional areas.

Page 129

Finding 69

Research undertaken by the General Practice Divisions of Western Australia suggests that the amount consumers are willing to pay for After Hours Primary Medical Care is at odds with the amount that General Practitioners expect to earn. As such, sustainable After Hours Primary Medical Care services are more likely to exist where there is a sufficient catchment of consumers to pay the gap, or where external funding provides some form of infrastructure support.

Page 132

Finding 70

General Practitioner presentations generally do not represent a significant drain on resources in metropolitan teaching hospitals. However, a significant proportion of emergency department presentations in secondary hospitals, particularly after hours, could potentially be treated in a primary care setting.

Page 133

Finding 71

A recent Australian Capital Territory study found that the main reasons General Practitioner patients chose to present to the Emergency Department were a perception that the health issue required urgent attention, a perception that the Emergency Department was the only option for after hours services and referral from another agency. Less than ten percent of patients indicated that they had attended because the service was free.

Page 138

Finding 72

Australia's primary care system ranks relatively highly in comparison with other Organisation for Economic Co-operation and Development countries. However, research suggests that it could be further strengthened through improvements in coordination with other parts of the health system, greater community orientation of primary care practices, longitudinality of patient care, more equitable distribution of primary care resources and improved access through reduction in the level of co-payments.

Page 139

Finding 73

Access problems, lack of integration with other parts of the health system and questions about affordability and quality of care within the existing fee-for-service arrangement have prompted redesign of primary health care services across Canada.

Page 141

Finding 74

The Canadian Government launched the *Primary Health Care Transition Fund* in 2002 to facilitate the transition of the current system into a primary care system characterised by:

- an increased number of community-based primary health care organisations;
- care provided by multi-disciplinary teams;
- better linkages with other parts of the health system;
- greater emphasis on health promotion, disease prevention and management of chronic disease; and
- expanded access to 24/7 primary care.

Page 142

Finding 75

In February 2003, primary health care was one of three areas identified by the Canadian Government for funding as part of the five-year *Health Reform Fund*. By the end of the five-year *Health Reform Fund*, fifty percent of Canadians are expected to be covered by multi-disciplinary primary health care organisations. Beyond the life of the *Health Reform Fund* the provinces will receive ongoing funding, subject to meeting the agreed reforms.

Page 145

Finding 76

In British Columbia, Canada, strong opposition from the British Columbia Medical Association with regard to the introduction of other health providers in primary care, has led to a primary health care reform strategy that is largely one of incremental change and voluntary participation. It is hoped that by 2006, 10-15 percent of primary care practices in British Columbia will operate as Primary Health Care Organisations, which meet all of the criteria established by the Federal Government as part of the *Primary Health Care Transition Fund*.

Page 147

Finding 77

Primary health care reform in Ontario, Canada centres on the development of Family Health Networks. Despite initial resistance to the proposed primary care reform strategies, the Ontario Medical Association agreed to co-sponsor implementation of the Ontario Family Health Network program, provided certain conditions were met. By January 2004, approximately 20 percent of Ontario's family physicians were practising in Family Health Networks or Family Health Groups.

Page 148

Finding 78

Primary health care reform in Nova Scotia, Canada will focus on expanding the use of multi-disciplinary primary health care teams, largely through greater involvement of nurse practitioners.

Page 151

Finding 79

Throughout England, following on from the strategic directions laid out in the *NHS Plan* (2000), General Practitioners, nurses and allied health professionals with special interests are being supported to undertake a range of procedures in primary and community care settings that were previously carried out by specialists in an acute setting. In 2001-02, primary care staff carried out 600,000 procedures previously carried out in hospitals.

Page 154

Finding 80

As part of the primary care reform process, registered nurses, midwives and pharmacists in England can now train to become Independent or Supplementary Prescribers. Independent Prescribers take responsibility for the assessment, diagnosis and management of patients within a defined set of conditions and prescribe from the Nurse Prescribers Extended Formulary. Supplementary Prescribers work with patients who have been assessed by a doctor and take responsibility for ongoing care, including prescribing.

Page 159

Finding 81

In June 2003, General Practitioners in the National Health Service in England voted to accept a new General Medical Services contract, which is designed to improve working conditions for General Practitioners, improve quality of care for patients and shift the focus of primary care toward health promotion and disease prevention. Whilst the General Medical Service applies to the majority of General Practitioners, by November 2003, more than 30 percent of General Practitioners were working in Personal Medical Service pilots. Under Personal Medical Service agreements, General Practitioners have greater flexibility to tailor services to meet the needs of the local population.

Page 161

Finding 82

Nurse-led National Health Service Walk-in centres in England have provided primary care services to more than 4 million people since opening in 2000. A national evaluation reported that Walk-in centres are clinically safe and well used, although the cost per consultation is higher in Walk-in centres than in general practice, and there is no clear impact on demand for local emergency departments and General Practitioner services.

Page 162

Finding 83

Across the English National Health Service, initiatives such as the *National Primary Care Collaborative* and the *Healthy Communities Collaborative* have achieved significant reductions in waiting times to see General Practitioners and nurses, reduced mortality rate due to coronary heart disease and decreased incidence of falls in older people.

Page 165

Finding 84

The *New Zealand Primary Health Care Strategy* aims to realign primary care to a system that:

- focuses on populations rather than individuals;
- places a stronger emphasis on disease prevention and health promotion;
- involves a multi-disciplinary team based approach to care;
- incorporates capitation funding;
- is culturally competent; and
- is integrated with other health and non-health agencies.

Page 179

Finding 85

There is no overarching strategy for fundamental reform of primary care in Australia. However, numerous initiatives have been developed to:

- improve access to allied health professionals in the community;
- improve coordination between primary care and other sectors;
- increase emphasis on disease prevention and health promotion; and
- improve access to primary care.

These strategies are largely targeted at older Australians and people with chronic or complex illnesses, people who live in rural areas, including Aboriginal and Torres Strait Islander people.

Page 182

Finding 86

A recent Health Canada review of primary care reform in Finland, the Netherlands, the United Kingdom, New Zealand, Australia and the United States identified a number of essential elements for reform. Australia stood out from the others in possessing significantly fewer essential elements.

Page 186

Finding 87

Sub-acute or intermediate care programs have the potential to significantly reduce the number of occupied bed days in acute hospitals. For example, in Peterborough, England, a Rapid Response Team assesses and organises nursing care for patients with acute, non-life threatening conditions who would otherwise be admitted to hospital. It is estimated that 70 percent of referrals would be admitted to hospital if the Rapid Response Team did not exist.

Page 190

Finding 88

Integration of health services can reduce duplication of resources and improve care for patients. In Nova Scotia, Canada, an integrated primary and community health model of care, piloted in a remote Aboriginal community, achieved impressive outcomes, including:

- a 40 percent reduction in use of outpatient/emergency departments;
- a 60 percent decrease in the frequency of visits to a family physician;
- an 850 percent increase in referrals to the nutritionist/health educator for diabetes management; and
- significant savings on medical transportation and prescription drug costs.

Page 197

Finding 89

Organisational characteristics such as shared governance and leadership can affect recruitment and retention of health professionals and can also impact on patient care. Magnet accreditation, which originated in the United States, is based on a foundation of leadership and empowerment of nursing staff to improve recruitment and retention. In Manchester, England, the first organisation outside the United States to gain Magnet accreditation identified three critical elements to ensure the success of Magnet: an investment in clinical leadership and education; project management of the process and involvement of clinical ‘champions’.

Page 200

Finding 90

At a system/organisational level, improved information acquisition and analysis can be used to inform system/organisational change. The Acute Demand Management Unit, recently established in Western Australia, collates and analyses emergency department statistics to predict future trends in utilisation.

Page 207

Finding 91

Improved patient care, more efficient use of resources, creation of more attractive career options for health professionals and increased clinical capacity are some of the driving forces behind the development of extended scope health practitioner roles. For example, in Peterborough, England, the waiting time for orthopaedic surgery has been significantly reduced by the introduction of orthopaedic nurse practitioners, advanced practice nurses who have taken on a proportion of tasks historically undertaken by orthopaedic surgeons.

Page 210

Finding 92

The creation of new health professional roles is driven by a number of factors, including changing health needs of the community, workforce shortages and population ageing. In West Hampshire, England, for example, the (Associate) Mental Health Practitioner role, was designed to address workforce shortages by tapping into a previously under-employed pool of health graduates.

Page 216

Finding 93

Patient care can be improved by redesigning the roles of health professionals around patient needs. The process requires consideration of the changing health needs of the community as well as acknowledgment of the expectation of patients to be treated as individuals. The re-introduction of matrons in the National Health Service, for example, was largely patient driven and is expected to improve patient care by providing clinical leadership to professional and direct care staff and by providing a visible, accessible and authoritative presence at ward level to deal with patients' concerns.

Page 224

Finding 94

Effective multi-disciplinary teamwork can be achieved by implementing appropriate strategies during training and in the workplace. The New Generation Project in England is centred on Interprofessional Learning, a model of education based on the premise that the genesis of silo working can be prevented only when interactive learning takes place, not simply when health professional students train side by side.

Page 229

Finding 95

Replacing junior doctors at the front-line of emergency care with more experienced medical and nursing personnel can improve patient transit time and reduce hospital admissions. For example, since the establishment of a Surgical Assessment Unit with dedicated registrar coverage in Eastbourne, England, the number of emergency admissions to surgical wards has been reduced by more than 30 percent, resulting in significant reductions in cancellations in elective surgical admissions and trolley waits in the emergency department.

RECOMMENDATIONS

Page 235

Recommendation 1

The Committee recommends the establishment of a locally based organisation, the Western Australian Centre for Health Innovation, to facilitate and support a coordinated approach to the development, implementation and evaluation of new models of health care delivery in Western Australia. The organisation would also assess emerging models of health care delivery in other jurisdictions with a view to evaluating their applicability to Western Australia.

Page 235

Recommendation 2

The Western Australian Centre for Health Innovation should have equitable representation from all stakeholders, including the various health professional groups, the different health sectors and policy makers.

Page 236

Recommendation 3

The Committee recommends the allocation of quarantined funding, supplementary to recurrent health expenditure, to assist health service providers to develop, implement and evaluate new models of health care delivery in a number of priority areas.

Page 236

Recommendation 4

The Committee recommends the utilisation of Expert Advisory Groups to provide advice to the Western Australian Centre for Health Innovation and to facilitate resolution of legislative, educational and clinical practice issues with regard to new models of health care delivery.

Page 237

Recommendation 5

The Committee recommends that at an organisational level, changes are instituted to ensure that: staff are encouraged to critically appraise existing clinical practices and to consider new ways of working; staff are recognised for their achievements in innovation; innovation is regarded as a mainstream, fundamental part of working in the organisation; and resources are invested in promoting and supporting innovation.

Page 237

Recommendation 6

Health professional educators should foster innovation by instilling in their students an expectation that they will enter an environment where innovation is mainstream and that during their careers they will be expected to constantly appraise the existing clinical practices and devise better ways of doing things.

Page 239

Recommendation 7

The Committee recommends incorporation of the principles of Interprofessional Learning into health professional curricula to promote a greater awareness of the contribution of each discipline and a more collaborative approach to patient care. The distinction must be drawn between learning side by side and truly interactive learning. Undergraduate medical students, who currently train apart from other health disciplines, must be included in the process.

Page 239

Recommendation 8

The Department of Health should make a concerted effort to develop and implement strategies aimed at improving the level of understanding and communication between health professionals of different disciplines in the workplace.

Page 239

Recommendation 9

The Department of Health should facilitate the development of more effective teamwork in health care settings by providing teamwork training for all health professionals.

Page 241

Recommendation 10

The Department of Health should prioritise the allocation of funding and resources to improve recruitment and retention of nursing staff in public hospitals through implementation of interim measures that are consistent with the principles of the Magnet accreditation framework. Consideration should be given to extending the Magnet framework to other health professionals.

Page 241

Recommendation 11

The Department of Health must prioritise the development of strategies to increase the level of clinical, professional and personal support for nurses, particularly new graduates, in the workplace.

Page 241

Recommendation 12

The Department of Health must recognise the increasing contribution of allied health professionals to the delivery of health services and, accordingly, allied health should be represented within the senior management structure.

Page 242

Recommendation 13

Training in communication skills and an emphasis on patient-centred care should form an integral part of all health professional curricula.

Page 242

Recommendation 14

Funding should be provided to support redesign of health services toward more holistic models of care.

Page 243

Recommendation 15

The State should recognise the important contribution of non-government organisations to the delivery of health services in Western Australia and provide adequate remuneration to ensure the ongoing provision of these services. In line with the shift toward a greater population health focus, there is scope for a number of non-government organisations to play a greater role in delivery of health services, therefore increased government funding should be considered where appropriate.

Page 245

Recommendation 16

The Committee recommends that a Consultative Group on Curriculum Development and Health Workforce Planning should be established to identify health needs of the community and guide ongoing curriculum developments as well as allocation of discipline specific training places. The universities and vocational bodies, health service providers, the Department of Health and professional associations and regulatory bodies should be represented on the Group.

Page 246

Recommendation 17

The State, in consultation with the nursing profession, should make a concerted effort to develop and implement strategies to ensure that nurses receive increased clinical experience during training.

Page 246

Recommendation 18

The education sector and the health industry must accept joint ownership of funding responsibility for health professional clinical placements. The Department of Health should facilitate the establishment of a partnership between the education sector and service providers with the aim of finding a sustainable solution to funding of clinical training.

Page 246

Recommendation 19

The Department of Health should facilitate constructive dialogue between the education sector and health service providers to identify avenues for expansion of clinical placement opportunities.

Page 247

Recommendation 20

The Department of Health should place greater emphasis on the development of leadership roles at a clinical and organisational level.

Page 248

Recommendation 21

The Committee recommends that the State and Commonwealth governments pursue the aggregation of health funding to achieve coordinated service delivery.

Page 249

Recommendation 22

In line with the proposal of the Health Reform Committee, the Committee recommends the establishment of a national Inter-Agency Commission with representation from the Commonwealth, States/Territories, education sector and national professional bodies to address health workforce planning, education, training, registration and employment issues collaboratively.

Page 250

Recommendation 23

The Committee recommends that exploration of new and redesigned roles to address workforce shortages should be a priority for exploration through the Western Australian Centre for Health Innovation.

Page 250

Recommendation 24

The Committee recommends that the State develop comprehensive strategies to attract and retain health professionals to rural areas, in particular in the areas of nursing and allied health.

Page 251

Recommendation 25

The Committee recommends that the State and Commonwealth should collaborate with the Divisions of General Practice to significantly improve services in outer urban areas.

Page 252

Recommendation 26

The Committee recommends that greater priority be given to providing access to primary health care, particularly after hours and in outer metropolitan areas, to alleviate pressure on emergency departments.

Page 253

Recommendation 27

Growth in the number of Commonwealth funded aged care places must be commensurate with the changing population age structure.

Page 254

Recommendation 28

The Committee recommends the expansion of sub-acute care strategies.

Page 255

Recommendation 29

The Committee recommends that the State examine ways to remove the current disincentives for patients to make use of their private health insurance when admitted to public hospitals.

Page 257

Recommendation 30

The Committee recommends that, in consultation with the Divisions of General Practice, the State should invest in strategies aimed at enhancing the population health focus of the primary care sector.

Page 258

Recommendation 31

The Committee recommends the State make a greater commitment to population health strategies aimed at reducing the prevalence of risk factors associated with chronic disease. Strategies that should be considered include:

- realignment of health professional training to include a greater population health focus;
- supported expansion of community based non-government agencies; and
- promotion and implementation of preventive strategies at schools.

Page 260

Recommendation 32

In consultation with the Divisions of General Practice and the Consultative Group on Curriculum Development and Health Workforce Planning, the State must work toward increasing the capacity of the primary care sector and re-aligning the health system toward a greater primary care focus. Given the current shortfall of General Practitioners, consideration should be given to expanding the capacity of primary care through the introduction of other health professionals, whose primary role would be disease prevention, health promotion and education.

Page 261

Recommendation 33

The State must evaluate the impact of the ageing population on future health service utilisation and develop strategies to ensure that our health system has both the capacity to meet the level of demand and the configuration to provide appropriate services. Health services will need to have greater emphasis on chronic disease management, rehabilitation and sub-acute care.

Page 262

Recommendation 34

In collaboration with the Consultative Group on Curriculum Development and Health Workforce Planning, the State must plan a future health workforce with the appropriate skill mix to deliver health services for an ageing population.

Page 262

Recommendation 35

Health professional training must contain sufficient emphasis on care for older patients, as older people account for an increasing share of encounters with the health system. Particular attention should be paid to communication skills and caring for psycho-social needs.

Page 263

Recommendation 37

The Department of Health should examine options to enable experienced health professionals to pursue career advancement without being diverted from clinical practice into management/administration. Consideration should be given to establishing dual career pathways, whereby health professionals have the option to become advanced clinical practitioners or administrators.

Page 263

Recommendation 38

Health professionals who assume management positions should be required to complete management training programs.

Page 264

Recommendation 39

In view of the need to retain skilled allied health professionals within the public health system, the Committee recommends expanded clinical career pathways be developed as a priority.

MINISTERIAL RESPONSE

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Education and Health Standing Committee directs that the Minister for Health report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

CHAPTER 1 INTRODUCTION

1.1 Background to the inquiry

The Education and Health Standing Committee was first appointed on 30 May 2001. Pursuant to the Assembly Standing Orders, the Committee may inquire into any matter within its portfolio responsibilities. The departments within the Committee's portfolio responsibilities are:

- Education;
- Health;
- Indigenous Affairs; and
- Sport and Recreation.

The Education and Health Standing Committee (the Committee) comprises five members of the Legislative Assembly. For the purpose of deliberations, three members constitute a quorum. For the purpose of taking evidence, two members constitute a quorum.

At a meeting on 26 June 2002, the Committee resolved to conduct an inquiry into 'The Role and Interaction of Health Professionals in the Western Australian Public Health System'. The terms of reference for the inquiry were also adopted on 26 June 2002.

1.2 Conduct of the inquiry

An advertisement calling for public submissions to the inquiry was placed in the *West Australian* on Saturday, 6 July 2002. The Committee also wrote to more than 180 organisations inviting them to make written submissions.

The Committee received 61 written submissions from health service providers, professional associations, training institutions and consumers. Appendix One contains a list of submissions to the inquiry.

The Committee held eight public hearings, taking evidence from 61 witnesses, between 16 October 2002 and 4 December 2002. Witnesses who gave evidence at the public hearings are listed in Appendix Two.

In addition to public hearings, the Committee was briefed by a number of key organisations and individuals relevant to the inquiry. These are listed in Appendix Three of the report and include briefings held in Canada, the United Kingdom and Western Australia.

In September 2003, the Committee wrote to more than 170 interstate health service providers, inviting them to provide information on emerging models of health service delivery in their jurisdiction. Written responses were received from 14 organisations.

1.3 Scope of the inquiry

The inquiry is broad in its scope, investigating a wide range of issues that impact on the health workforce. The report includes, but is not limited to, detailed consideration of the following issues:

- The roles played by different health professional groups in delivery of health services;
- The manner in which health professional groups interact with one another to deliver health services;
- The capacity of current health professional training programs to supply a health workforce to meet the changing health needs of the Western Australian community;
- The capacity of current health career structures to offer a long-term career path for health professionals;
- Broader system issues that adversely affect the way in which our health professionals work and interact; and
- Emerging models of health care delivery and the mechanisms by which they are developed and implemented.

CHAPTER 2 THE ROLES AND INTERACTIONS OF HEALTH PROFESSIONALS

The Committee would like to acknowledge at the outset that Western Australia has an excellent health system, underpinned by a dedicated, highly skilled health workforce. Despite the outstanding record of our health system, it is widely acknowledged that our health professionals work in a highly stressful environment.

The following information is largely derived from written submissions and evidence provided in hearings and briefings. The Committee notes that submissions and evidence concentrated mainly on the negative aspects of the roles and interactions of health professionals, training methods and career pathways, and acknowledges that it may appear as though the positive aspects of our health professionals have not been considered. However, the Committee received little information highlighting the positive aspects of the roles and interactions of our health professionals. It would appear, therefore, that many health occupational groups viewed the inquiry as an opportunity to voice their concerns. The Committee would like to emphasise that Chapters Two, Three and Four do not necessarily represent all views on the subjects examined, only those that individuals and organisations felt compelled to bring to light.

Few submissions dealt with innovations and emerging models of health care. The Committee gained an appreciation of these aspects through targeted research and meetings with health professionals both within Western Australia and in other jurisdictions. On reflection, it is not surprising that the Committee's inquiry would be considered an appropriate platform for individuals and organisations to express their concerns and for different occupational groups to put forward their perspective on a range of problems in these areas. A comprehensive analysis of emerging models of health care, many of which address some of the concerns expressed here, is included in Chapters 5 and 6 of this report.

Finding 1

The inquiry was viewed by many health occupational groups as an opportunity to highlight the negative rather than the positive aspects of the roles and interactions of health professionals.

2.1 Leadership

Health leadership can be considered at a system level, at an organisational level and at a clinical level. Concerns were expressed in submissions[2] and in evidence[3] about leadership at each level across our health system.

Dr Chris Skinner, Senior Lecturer at Edith Cowan University, emphasised the important distinction between management and leadership:

> *The distinction that is increasingly being drawn between leadership and management is interesting. We need some clear visionaries who have the competence to lead. We also need a range of skilled management/operational people at the level that is slightly below what I would call leadership. That distinction is very important and worth noting*[4].

The Division of Health Science, Curtin University of Technology, suggested in its submission that poor leadership and management performance contribute to recruitment and retention problems in our health system:

> *The Health Department has not adequately addressed the need for more and better leaders and managers of clinical services ... Not only are services not managed, the bureaucratic attitudes and leadership behaviours of some managers are making it difficult to recruit and retain nurses, for example. Despite the universities increasing the number of nurse graduates, an increasing number are unwilling to be employed in health care delivery*[5].

This view was supported by Associate Professor Kate White, Acting Head, School of Nursing and Public Health at Edith Cowan University, who identified lack of

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2 Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p7; Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p6; and Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p8.

3 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p6; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p2; Dr Chris Skinner, Senior Lecturer, Edith Cowan University, Transcript of Evidence, 23 October 2002, p2; Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, pp2-5; Ms Sue Rowell, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p7; and Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p9.

4 Dr Chris Skinner, Senior Lecturer, Edith Cowan University, Transcript of Evidence, 23 October 2002, p2.

5 Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p6.

leadership as an important factor in the failure to address ongoing nursing workforce issues:

> *Report after report has identified that some of the major factors in the nursing shortage relate to work relations or flexible work practices. We do not see that changing because we are not getting good leadership or a willingness on the part of the system to adopt those recommendations.*
>
> *...It is one of the biggest challenges we face in the clinical arena and, to a certain extent, in the academic arena. ... We need the leadership to empower the system at the institutional level*[6].

There is widespread recognition of the importance of effective clinical leadership, although there appears to be little investment in leadership development. Professor Michael Quinlan, Dean of the College of Health at the University of Notre Dame stated:

> *Teamwork is the catch-cry of the current approach to Health care delivery, but enlightened leadership is essential in order to efficiently achieve good patient care and prevent buck passing*[7].

The Australasian Association of Social Workers (WA) sees lack of leadership as an impediment to effective teamwork, and called for leadership training to be included in health professional training:

> *Another underdeveloped key area is team leadership skills within so-called "multi-disciplinary teams". Those with leadership roles often do not understand how to use these important skills well, which results in decisions being made with insufficient consultation and service structures being used inefficiently*[8].

The medical profession, from which the majority of clinical leaders have traditionally been drawn, was identified by a number of witnesses as being in need of particular attention in the area of leadership development. Ms Penelope Mogridge, Social Work Manager, Hollywood Private Hospital, made the following comments:

> *... it would be fair to say that the medical model, as we understand it, is still alive and very healthy in the hospitals. By that I mean that it is driven by consultants. Sometimes, if a consultant leads a team, he may not necessarily have the same managerial or leadership training as somebody else who may lead that team. Encouraging leadership training for anybody in the health*

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6 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p3.

7 Professor Michael Quinlan, Dean, College of Health, Notre Dame University Australia, Submission, 11 October 2002, p8.

professions who is leading a team is very important, so that it will bring out the best in all the members of that team. Having said that, I mean no disrespect to any consultant, but sometimes the consultative process, and perhaps the maximum utilisation of a multi-disciplinary team, does not happen. It could perhaps be assisted through leadership training[9].

Finding 2

Effective leadership at a system, organisational and clinical level is essential to achieve good patient care, to improve teamwork and to facilitate change within the system. There are calls from across the health industry for more effective leadership on all levels.

2.2 Teamwork

Numerous submissions touched on the importance of health care being delivered by a 'multi-disciplinary' team of health professionals. Some organisations see the team approach to health care as an emerging model[10], while others consider it well established[11]. Regardless of whether it is seen as an existing or emerging model, there was universal acknowledgment that the ability to work within a health care team is an integral trait required of all health professionals[12]. Many organisations, however, indicated that although our health professionals are often required to work in teams, there is sometimes little evidence of effective teamwork.

The following account of a consumer's experience with a 'team' of health professionals suggests that there may be some way to go before our health professionals are able to work as effective teams:

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9 Ms Penelope Mogridge, Social Work Manager, Hollywood Private Hospital, Transcript of Evidence, 16 October 2002, p9.

10 General Practice Divisions of Western Australia, Submission, 28 August 2002, p2; Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, Submission, 10 September 2002, p1; Health Consumers; Council, Submission, 12 September 2002, p2; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p4; and Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p2; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p5.

11 Glenda Trevaskis, Public Health Nutritionist, *et al*, Submission, 29 August 2002, p5; Mr Eamon Ryan, Director, Office of Health Review, Submission, 30 August 2002, p1; Metropolitan Allied Health Council, Submission, 23 September 2002, p5; Mr Ian Cooper, Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p4.

12 Dr Bronwyn Jones, Head, School of Nursing and Public Health, Edith Cowan University, Submission, 29 August 2002, p1; Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, p3; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p7; Arthritis Foundation of WA, Submission, 30 August 2002, p4; Department of Health, Submission, 18 September 2002, p6; Metropolitan Allied Health Council, Submission, 23 September 2002, p5.

> *Recently, we helped an elderly woman whose husband was admitted to hospital, as she said, 'quite ill, then he became very ill indeed, and then he died.' Mavis sat with her husband during those long days and reported seven different groups of health professionals were involved in her husband's care (I think this is what we call the multi-disciplinary team).*
>
> *The health professionals did not talk to each other, so there was no dialogue within the team or across the team much to Mavis's frustration. She said there appeared to be as she described it 'territorial sensitivities' and a lack of mutual respect.... And guess what? Neither the patient nor their family were members of the team*[13].

A number of submissions stressed the importance of teamwork training as a means of building teamwork skills[14]. Mr Brian Dodds, Vice President, Australian Association of Social Workers (WA Branch), commented:

> *We tend to think that we can throw a bunch of people together and call them a team, and there is no process involved. The process becomes important - how to negotiate and discuss issues and come to an agreed position*[15].

(a) Silo working

Numerous witnesses pointed to the fact that some health professionals view their profession as their own and are reluctant to allow other professionals to encroach upon what they perceive to be their 'domain'[16]. Delineation of roles between the various health professions is largely historical and can lead to 'silo' working, whereby each health profession focuses on its domain, with little overlap or interaction between disciplines.

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13 Health Consumers' Council, Submission, 12 September 2002, p2.

14 Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p7; Department of Health, Submission, 18 September 2002, p6; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p4; Metropolitan Allied Health Council, Submission, 23 September 2002, p5.

15 Mr Brian Dodds, Vice President, Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p9.

16 Mrs Sandra Thomson, National President, Australian Association for Quality in Health Care, Transcript of Evidence, 23 October 2002, p6; Ms Patricia Marshall, Nutritionist-Diabetes Educator, East Metropolitan Population Health Unit, Transcript of Evidence, 23 October 2002, p4; Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p2; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p1; Mr Peter Robinson, Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p5; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, 21 November 2002, p6; and Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p9.

While conceding that part of the problem with silo working can be traced back to health professional training, Professor Louis Landau, Dean of the Faculty of Medicine and Dentistry at the University of Western Australia commented:

> *Part of it is the health professions. They do not communicate well and let other people know about them. Whenever they are asked, they are very defensive because they are always worried about protecting their own turf. We have to break down those barriers. Unless we do, it is just not going to work*[17].

Silo working can stifle innovation, as advised by the Australasian Association for Quality in Health Care:

> *Too often issues of "turf", "professionalism", "culture" and historical approaches have thwarted system improvements that will ultimately improve patient care*[18].

Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, concurred with this observation, suggesting that territorial issues have prevented us from picking up health care initiatives that have been implemented overseas, where the environment has been more conducive to change[19].

Finding 3

There is widespread acknowledgment that the ability to work within a health care team is an integral trait required of all health professionals. However, effective teamwork is often stifled by a 'silo' mentality, whereby each profession focuses on its 'domain' and is reluctant to interact or overlap with other disciplines.

2.3 Communication between health professionals

Effective communication between health professionals is essential to good patient care. Several organisations raised the issue of poor communication between health

17 Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, pp8-9.

18 Australasian Association for Quality in Health Care, Submission, 2 September 2002, p2.

19 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, 21 November 2002, p6.

professionals of different disciplines[20]. The need for improved communication between health professionals of different disciplines was also raised in submissions[21].

A number of organisations suggested that the poor communication between health disciplines may relate to a lack of understanding or appreciation of each others' roles in patient care[22,23]. Mr Eamon Ryan, Director, Office of Health Review, had the following to say:

> *In terms of interaction between health professionals, there is a danger of patient care being compromised when health professionals do not adequately interact with each other in relation to the care of a patient. It is important that all health professionals understand what others are doing and what others cannot do.*
>
> *Our experience suggests that there are occasions where problems arise from either a lack of understanding of the roles, or a breakdown in communication between health professionals involved in the care of the patient*[24].

For allied health professionals[25] in particular, a lack of understanding of their contribution may preclude their consultation in the planning of patient services:

> *We are continually behind the eight ball, because when the services are planned, they are planned by perhaps a surgeon and his immediate team who are providing the surgical procedure. That will mean that the nurses and the*

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20 Dr Sandra Thompson, Public Health Physician, on behalf of the Public Health Association of Australia (WA Branch), Transcript of Evidence, 23 October 2002, pp5-6; Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p8; Ms Sue Rowell, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p6; and Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p1.

21 Arthritis Foundation of Western Australia, Submission, 30 August 2002, p2; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p7; Mr Eamon Ryan, Director, Office of Health Review, Submission, 30 August 2002, pp1-3.

22 Mr Neil Hall, President, Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p7; Mr Brian Dodds, Vice President, Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p5; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p3.

23 Mr Eamon Ryan, Director, Office of Health Review, Submission, 30 August 2002, pp1-2.

24 Mr Eamon Ryan, Director, Office of Health Review, Submission, 30 August 2002, p2.

25 There are four broad categories of allied health professionals: *the hands on, face-to-face group* of physiotherapy, social work, occupational therapy and speech pathology*; the information and dispensing professionals group*, which includes medical librarians, pharmacists, medical records technicians and specialists; *the diagnostic group*, which includes audiology, radiography and a broad range of others; and *the technical group*, which includes medical technology specialists.

> *doctors are planned for, but they forget to plan for physiotherapy, occupational therapy, social work, speech, dietetics and all those services that need to surround that*[26].

The Office of Health Review provided the Committee with several examples where patient care had been compromised by poor communication between the treating staff. The following account encapsulates potential problems for both patients and their carers:

> *An elderly woman was a patient at a public hospital. She was ready to be discharged, but needed occupational therapy aids to be installed in her home in order to be safe following discharge. The discharge was to occur around the Christmas period, and the hospital was not able to schedule installation of the necessary aids until after Christmas. The doctor was trying to get the patient discharged because he felt that clinically she was able to go home. However, the woman's daughter, who was her carer, refused to agree to the discharge because she knew that additional occupational therapy aids were required and had not been installed. This led to a conflict between the doctor and the carer.*
>
> *Examination of the hospital notes revealed that the Occupational Therapy staff supported the carer's position that the patient should not be discharged without adequate aids being installed in the home. However, the doctor's notes seem to ignore this element and he appeared to be more concerned with the fact that the patient herself was ready for discharge. Clearly, there was some conflict between the two areas responsible for the total care of the patient*[27].

The Office of Health Review stressed that this situation could have been avoided by better communication between the medical and occupational therapy staff[28].

Finding 4

Communication between health professionals of different disciplines is often poor and may compromise patient care. Poor communication may relate to a lack of understanding of each others' roles in patient care.

2.4 The clinician patient interface

There is a concern amongst many organisations about the focus of patient care. The two issues that arose most commonly in submissions and in evidence in relation to the

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26 Ms Sue Rowell, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p3.

27 Office of Health Review, Submission, 30 August 2002, p2.

28 *ibid*.

clinician/patient interface were poor communication[29,30] and lack of attention to 'non-medical' needs[31,32].

(a) Communication with patients

Poor communication on the part of health professionals is one of the most common complaints made by patients in relation to their experiences with the health system. The Health Consumers' Council provided the Committee with a report, *In our own words: Western Australian Health Consumers Speak on their experiences in the Health System*, which collated qualitative and quantitative data relating to the Councils' handling of advocacy cases between January 2000 and June 2001. Of the 169 cases reviewed, almost 22 percent related to complaints surrounding communication between the clinicians and patient/carers, the second most prevalent complaint category after issues surrounding treatment[33].

Complaints surrounding communication problems included:

- Service provider arrogance;
- Dismissive providers;

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29 Council on the Ageing (WA), Submission, 29 August 2002, pp11-12; Cancer Foundation (WA), Submission, 28 August 2002, pp11-12; Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2; Ms Dilys Payne, Submission, 13 September 2002, p9; Dr Bronwyn Jones, Head, School of Nursing and Public Health, Edith Cowan University, Submission, 29 August 2002, p2; Office of Health Review, Submission, date, page; and Health Consumers' Council, Submission, 30 August 2002, pp3-4.

30 Mr Ken Marston, Policy Officer, Council on the Ageing (WA), Transcript of Evidence, 16 October 2002, p4; Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p6; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p8; and Ms Lynette Dimer, Health Promotion Officer, National Heart Foundation of Australia (WA), Transcript of Evidence, 22 November 2002, p3.

31 Council on the Ageing (WA), Submission, 28 August 2002, p8; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p5; Health Consumers' Council, Submission, 12 September 2002, pp2-3; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, pp4-5; and Ms Dilys Payne, Submission, 13 September 2002, pp7-9.

32 Mr Renato Forlano, Executive Director, Arthritis Foundation of Western Australia, Transcript of Evidence, 23 October 2002, p4; Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, pp6-7; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, pp6-7; and Ms Maxine Drake, Advocate, Health Consumers' Council of Western Australia (Inc.), Transcript of Evidence, 23 October 2002, p4.

33 Health Consumers' Council, *In our own words: Western Australian Health Consumers Speak on their experiences in the Health System*, 2002, p51.

- Insufficient information;
- Problems arising from consumers asking questions or challenging doctors;
- Provider resentment at consumers' involvement in their own treatment; and
- Consumer/carer involvement in treatment punished/ignored[34].

The Council concluded from its research:

> *Good communication is not a secondary issue to clinical treatment, an additional 'extra', but forms the foundation of good relationships, of professionalism and therefore of optimum health care in clinical settings.*
>
> *Consumers expect to be acknowledged, cared for, respected, informed, responded to, consulted with and involved in treatment choices concerning their bodies. In short, they expect to be involved as a member of their body's treating team.*
>
> *... it seems practitioners are not always happy to be asked questions or have their clinical judgement questioned. Consumers may not know what questions to ask and rely heavily on clinicians to meet a minimum duty to disclose and explain[35].*

Ms Susan Rooney, representing the Cancer Foundation of Australia (WA), emphasised the link between good communication skills and patient wellbeing:

> *... the wellbeing of people, how they respond to treatment and the information they retain is dependent on the communication skills of the practitioners who deal with them, such as clinicians, doctors, nurses and allied health people. Basically, the evidence in the guidelines indicates that when people are trained well in communication, information given to patients is retained better and they feel more comfortable and more involved[36].*

Finding 5

Poor communication on the part of health professionals is one of the most common complaints made by patients in relation to their experiences with the health system.

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34 Health Consumers' Council, *In our own words: Western Australian Health Consumers Speak on their experiences in the Health System*, 2002, p14.

35 *ibid*, p18.

36 Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p6.

(b) Holistic patient care

As well as expecting their health care providers to communicate effectively and appropriately, patients expect to be treated in a 'holistic' manner. That is, they expect to be treated as individuals, with due consideration of their health needs in a sociocultural context, not simply according to the illness or injury with which they present. To a large extent, increasing pressures in our health system diminish the capacity of health professionals to attend to patient needs other than their immediate medical needs. In a system characterised by increasing patient acuity, coupled with an expectation of increasing productivity, it appears that there is little time for nurturing bedside contact:

> *You can no longer go in and convalesce for any period of time. People are expected to be discharged sicker and quicker. We are not necessarily told this as a community, other than by default, through the human interest stories in the paper, and various other editorials.*
>
> *One of the things that patients know is that the element of nursing care that is hardest to quantify but is most missed is attention, nurturing and the caring bedside contact. You cannot put a unit cost to that. When you put it into somebody's job description, how do you quantify it? What people hope for is that the nursing staff have the capacity to give the time that is needed to attend to their individual needs*[37].

Ms Dilys Paine, a retired nurse, described to the Committee her experiences of patient care during a recent period of refresher training. Ms Paine's appraisal of patient care in the hands of some of her nursing colleagues was scathing. The following example was included:

> *I was deeply saddened and very angry when the patient with whom I was sitting was silently weeping. Her carer (a graduate nurse) was 'doing' the dressing. I said out loud that perhaps the nurse would get the patient something for pain. The hostile glare from the graduate nurse was self-explanatory. The screen was swished back and away she went. I had time to try and relax the mid 70 year old patient and at the same time avert her eyes from the ugly now left exposed wound. The screens were parted and in flounced two nursing staff. The patient's name-tag was checked against the records. The patient was asked her birth date and into the IV infusion was injected a solution. Swish….again….as the screen was flicked and only partly re-drawn further exposing the patient's very large wound. Suddenly the effect of the injected fluid 'hit' the patient. She looked terrified and clung to my arm "What is happening?"*[38].

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37 Ms Maxine Drake, Advocate, Health Consumers' Council of Western Australia (Inc.), Transcript of Evidence, 23 October 2002, p4.

38 Ms Dilys Paine, Submission, 13 September 2002, pp4-5.

Finding 6

Patients expect to be treated as individuals, with due consideration of their health needs within a broader sociocultural context. Increasing pressure in our health system diminishes the capacity of health professionals to attend to the 'non-medical' needs of patients.

2.5 Morale

As in any industry, 'happy' workers can be beneficial for the health industry, for example through improved performance and lower rates of attrition, illness and absenteeism. Far from being a happy workforce, the Committee was advised that staff morale is low amongst allied health and nursing professionals. A number of factors contribute to low morale:

(i) working in a stressful environment;

(ii) lack of support;

(iii) lack of recognition; and

(iv) lack of involvement in planning and decision making.

(a) The work environment

There is no disputing the pressure under which our health professionals work. Increasing patient acuity, population ageing and budgetary constraints all contribute to ever-increasing pressure on the system. A number of organisations[39,40] commented on the demands on health professionals and how this affects their roles. Ms Maxine Drake, representing the Health Consumers' Council, provided the following example of the pressures on nursing staff and its impact on patient care:

> *An elderly woman was admitted to a hospital for assessment of dizziness. She needed to go to the toilet. A nursing staff member came and got her, took her to the toilet and then went off to tend to other patients. The woman tried to get back to her bed, and fell and broke her hip. It is a classic scenario. When we followed this through the system, the health service admitted that previously nurses would have been able to stay by the room until the patient had finished*

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39 Council on the Ageing (WA), Submission, 28 August 2002, p8; Australian Physiotherapy Association (WA), Submission, 27 August 2002, pp1-2; Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, p1; Australian Association of Social Workers, Submission, 30 August 2002, p6.

40 Ms Maxine Drake, on behalf of the Health Consumers' Council, Transcript of Evidence, 23 October 2002, pp4-5; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, p2.

and lead her back to the bed safely. Because of the pressures on nursing staff from having to attend to too many patients, they felt compelled to tend to another patient in the interim period and then come back[41].

For some health professionals, system constraints result in an ethical conflict between what they believe to be their role, and the role that the system allows them to perform. Nurses[42] and social workers[43], in particular, appear to experience conflict between their expectations and the reality of their roles. For some nurses, the inability to provide 'holistic' care for patients has a significant impact on morale::

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[44].

While there is individual variation in how nurses see their roles, most nurses subscribe to a holistic philosophy of care and their work has most meaning when they are able to attend to all aspects of a patient's health. In the contemporary healthcare environment, the nursing model of caring often takes second place to a treatment-oriented medical model. Due to high workloads, nurses only have time for tasks related to patients' immediate physical needs. As a result they often become discouraged and feel guilty when they neglect patients' psycho-social and spiritual needs[45].

For some social workers, the economic pressures that drive the rapid turnaround of patients can challenge their ethical principals:

... some social workers from the health sector have reported to me that they feel that their ethical position is under pressure, particularly with the moving on of patients and the care awaiting placement situation, in which decisions are sometimes made and patients moved without significant or any

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41 Ms Maxine Drake, on behalf of the health Consumers' Council, Transcript of Evidence, 23 October 2002, pp4-5.

42 Associate professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, pp6-7.

43 Ms Penelope Mogridge, Social Work Manager, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p4.

44 Mrs Lois Johnston, Member of the Policy Committee, Council on the Ageing (WA) Inc., Transcript of Evidence, 16 October 2002, p3.

45 Baumann, A, *et al* (2001), Commitment and Care: 'The benefits of a healthy workplace for nurses, their patients and the systems', cited in *National Review of Nursing Education 2002, Our Duty of Care*, Commonwealth of Australia 2002, p45.

consultation with the social worker who has been working with that family. They feel that the rug has been pulled from beneath them. That has made us feel that we need to reassert our ethical perspective[46].

Finding 7

For some health professionals, particularly in the nursing and social work professions, the pressures within the health system create an ethical conflict between what they believe to be their role, and the role that the system allows them to perform.

(b) Support

Health professionals need support at a number of levels: professional support to facilitate their professional development; clinical support to ensure optimal patient care; and emotional support to help them to cope with the stressful environment within which they work. Numerous organisations that gave evidence indicated that health professionals, across the nursing, allied health and medical professions, are generally not adequately supported at a professional, clinical or emotional level[47]. The issue was also frequently raised in submissions[48]. Associate Professor Kate White, Acting Head of the School of Nursing and Public Health at Edith Cowan University advised the Committee:

There is a range of issues, some of which we do not talk about. In clinical care these days, there are more higher acuity patients, more technology and greater demands on nurses. However, we do not look after nurses[49].

With regard to support for junior nurses, Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, had the following to say:

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46 Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p4.

47 Mr Brian Dodds, Vice President, Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p4; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p5; Dr Paul Tinley, on behalf of the Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p8; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p6; and Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p4.

48 Glenda Trevaskis, Public Health Nurtirtionist, *et al*, Submission, 29 August 2002, pp2-10; Nurses Board of Western Australia, Submission, 30 August 2002, p2; National Heart Foundation (WA), Submission, 3 September 2002, p2; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p6; Metropolitan Allied Health Council, Submission, 23 September 2002, p4.

49 Associate Professor Kate White, Acting Head of School, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p6.

> *Junior nurses in hospitals quite often do not find themselves in a nice environment. Some senior nurses who are not graduates ... are pretty tough on people who are there. There are exceptions; there are terrific, supportive senior nurses. However, there is a real tension amongst some senior members who want to prove that the younger ones are not really up to it, so for some there is not a warm and friendly atmosphere*[50].

As indicated by Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, lack of support in the face of excessive demands forces some nurses to leave the profession:

> *A nurse employed in a public facility must undertake additional responsibilities - as a professional does - such as performance management, continuous quality improvement, preceptorship and mentorship, all of which are additional tasks on top of their clinical role - which is why they are there - with no additional support or resources. There comes a time when you say enough is enough.*[51]

Lack of support is particularly problematic for health professionals working in rural, regional and remote locations[52,53]. The issue is common to nursing, medical and allied health professionals, and is of greatest concern for lone practitioners. On social workers in rural areas, Ms Penelope Mogridge, representing the Australian Association of Social Workers (WA), made the following comments:

> *... social workers in the rural sector feel greatly under pressure. They have huge geographical areas to attempt to cover and service. They are very isolated and unsupported ... Like any social worker, those who work in the rural sector have completed their training and demonstrated that they have the skills to cope. However, there is the value of the critical mass. When you are a part of a social work department ... you bounce off, support and learn*

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50 Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10.

51 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p4.

52 Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p5; Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p9; Mrs Virginia Bower, on behalf of the Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p8; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p5; Mr Peter Robinson, on behalf of the Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p7; Dr Charles Nadin, Director, General Practice Divisions of Western Australia, 22 November 2002, p6; Ms Melita Brown, Deputy Convenor, Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, pp4-5; and Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p5.

53 Commonwealth Department of Health and Ageing (WA Office), Submission, 3 September 2002, pp7-8.

> *from each other. People in isolated situations suffer because they do not have access to that*[54].

On the issue of support for nursing staff in rural and remote areas, Ms Margaret Watson, Chief Executive Officer of the Nurses Board of Western Australia, advised:

> *There are difficulties for rural and remote nurses. They are a special group of nurses. They work under extremely difficult circumstances, with absolutely limited support. The problem the board has is that they often work outside their scope of nursing practice, in the best interests of their patients, because they cannot get any support, because there is no-one at the end of the phone and because they know what must be done*[55].

The opportunity to debrief is considered an important element of support for health professionals. Debriefing enables health professionals to 'work through' problems and it is a useful means through which issues of an ethical nature can be resolved. The lack of opportunity to debrief appears to be of particular concern to the nursing. Associate Professor Kate White, Acting Head of the School of Nursing and Public Health, Edith Cowan University, advised the Committee:

> *Nurses are constantly dealing with people who are suffering some form of crisis. Nurses are providing to the best of their ability emotional and physical care to the patient and the patient's family. If nurses do not receive appropriate support in the form of opportunities for debriefing after crises or traumatic events in the clinical area, there becomes a limit to their capacity to maintain their position*[56].

The connection was drawn between the inability to debrief and the growing number of nurses leaving the profession. There is a very strong belief amongst nursing staff that there is no emotional support for them within the public health system.

> *If no-one helps the staff work through the issues that they are left with, such as emotional problems and stress with decisions that are made, eventually there comes a point at which they say they cannot keep doing it*[57].

A study currently being undertaken by the Edith Cowan School of Nursing, examining neonatal intensive care nurses and the ethical problems they encounter, confirms the importance of debriefing:

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54 Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, pp4-5.

55 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p5.

56 Associate Professor Kate White, Acting Head of School, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p6.

57 *ibid*.

When nurses talk about leaving nursing, they do not talk about not loving nursing any more ... They are not saying that they hate the job but that they cannot do it any more; that they cannot keep giving without something coming back ... We are currently involved with a project looking at ethical problems experienced by neonatal intensive care nurses ... It is almost overwhelming to sit and listen to those nurses' stories for a range of reasons. You realise the responsibility that nurses carry, the difficulties they deal with and their lack of involvement in decision making[58].

Finding 8

Many health professionals feel that the system does not adequately support them in their roles. Lack of professional, clinical and emotional support contributes to low morale and may ultimately lead health professionals to leave the system.

(c) Recognition

Health professionals, understandably, expect to be recognised and valued for their contributions. Lack of recognition, at a professional and at an organisational/system level, was commonly raised in submissions[59] and in evidence[60]. The problem is not limited to one professional group, health professionals from many disciplines feel that their efforts are undervalued.

On the lack of recognition of nurses' contributions, Associate Professor Jill Downie appearing on behalf of the School of Nursing and Midwifery, Curtin University of Technology, made the following comments:

The crux of the matter of why people are leaving ... is multifactorial. It is about valuing nurses, including when they pursue further education ... The

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58 Associate Professor Kate White, Acting Head of School, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p6.

59 Australian Physiotherapy Association (WA Branch), Submission, 28 August 2002, p3; Council on the Ageing (WA), Submission, 28 August 2002, p5; Australasian Faculty of Public Health, Submission, 28 August 2002, p3; Metropolitan Public and Community Nutritionists, Submission, 30 August 2002, p10; Office of Health Review, Submission, 30 August 2002, p1; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p6; Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p7; Western Australian General Practice Education and Training Ltd, Submission, 2 September 2002, p2; National Heart Foundation (WA Division), Submission, 3 September 2002, pp1-2; Australian Association of Occupational Therapists, Submission, 20 September 2002, pp6-7; and Metropolitan Allied Health Council, Submission, 23 September 2002, pp5-6.

60 Ms Nancy Da Costa, Clinical Nurse Manager (Community Health), Bentley Health Service, Transcript of Evidence, 16 October 2002, p5; Dr Charles Douglas, Public Health Physician, on behalf of the Australasian Faculty of Public Health Medicine, Transcript of Evidence, 27 November 2002, p10; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10; and Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p1.

value of nurses in the workplace is really important and will change things two or three years down the track, which is when they are leaving the profession[61].

In our undergraduate program, for example, every student is required to go to a rural area and spend four weeks there. They fund that themselves; they have no travel assistance or accommodation assistance. They receive no help whatsoever, which is a very big deterrent ... They learn a lot, but they cry continuously that they are not supported and ask why nurses are not valuable[62].

Ms Lynette Dimer, Health Promotion Officer with the National Heart Foundation (WA) advised the Committee that lack of recognition was a significant issue for Aboriginal health workers:

Aboriginal health workers are not given the status that is their due, because they have specific skills that non-Aboriginal people may get in 25 or 30 years of being mentored by Aboriginal people, but those people do not know about the kinship networks and other things that you spoke about[63].

Finding 9

Health professionals from many disciplines feel that their efforts are not adequately recognised and valued within the system.

(d) Involvement in planning and decision making

For many health professionals, their sense of worth may be linked to their ability to become involved in planning and decision making. Many of our health professionals feel excluded from these processes at a clinical[64] and/or a strategic level[65]. For nursing professionals, the greater concern appears to relate to lack of involvement in clinical

61 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p11.

62 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p9.

63 Ms Lynette Dimer, Health Promotion Officer, National Heart Foundation (WA), Transcript of Evidence, 22 November 2002, p7.

64 Australian Physiotherapy Association (WA Branch), Submission, 28 August 2002, p1; Ms Maxine Drake, Health Consumers' Council, Transcript of Evidence, 23 October 2002, p2; and Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p2.

65 Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p6; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, pp4-6; Ms Coby Rudd, Chief Executive, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p3; and Ms Angie Paskevicius, Chair, Allied Health Task Force on Work Force Issues, Transcript of Evidence, 6 November 2002, p5.

decision making. Ms Margaret Drake, Chief Executive Officer, Nurses Board of Western Australia, provided the following example of a situation with which many nurses could identify:

> *... a young registrar who had been in obstetrics for three months was dealing with a situation with three midwives, who between them had 47 years of experience. The registrar had the power to ring the consultant to inform him of the situation. The midwives were telling the registrar what they thought was necessary to convey to the consultant, but they had no power to go to the consultant over the head of the junior doctor ... many nurses train and practise for many years, and never have the authority they need within the scope of practice allowed to them, to contribute to some of the critical decision making in an acute care setting*[66].

For allied health professionals, the greater concern appears to be lack of involvement in planning and decision making at an organisational/strategic level. In their submission to the Committee, the Metropolitan Allied Health Council summed up the problem as follows:

> *There is inadequate involvement of Allied Health professionals in senior management structures within the public health system. Efforts to achieve involvement are resisted by senior (non-Allied Health) managers. This impacts negatively on the morale of Allied Health professionals, and also robs the health system of a source of considerable health and management expertise*[67].

As well as the lack of involvement in planning and decision making, witnesses who appeared on behalf of allied health groups advised that there are limited opportunities for allied health professionals to secure senior management roles, as these positions are often restricted or 'quarantined' to nursing and medical professionals. There is a belief amongst the allied health professions that in some cases appropriately skilled allied health professionals could undertake these senior management positions:

> *Several senior management jobs, such as directors of Clinical Care Units are only for doctors and nurses but it must be recognised that allied health social work managers can be well trained and experienced for these positions as well. The AASW/WA believes that there needs to be recognition and opportunity for social workers to work as project leaders and managers…*[68].
>
> *...many general management positions in health service settings are quarantined now to nurses so that they may concurrently fill a Director of Nursing or similar role in the health service, and the management of Clinical*

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66 Ms Maxine Drake, on behalf of the Health Consumers' Council, Transcript of Evidence, 23 October 2002, p2.

67 Metropolitan Allied Health Council, Submission, 23 September 2002, p5.

68 Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p6.

Service units are restricted to a manager (finance person) a doctor and a nurse. There are no opportunities at this level for an Allied Health professional[69].

The access of allied health professionals to some senior health management positions is restricted due to apparent quarantining of these positions to certain professions (for example, nurses or doctors). Given the nature of some of these jobs, they could be undertaken just as adequately by an appropriately skilled person with an Allied Health background[70].

Finding 10

Lack of involvement in planning and decision making and lack of representation at senior levels contributes to low morale in nursing and allied health professions.

2.6 The role of non-government organisations

Non-government health service providers highlighted a range of concerns, some of which mirrored the concerns raised by the health industry in general. Several non-government organisations, however, raised concerns that relate specifically to their role in the provision of health services[71]. Submissions and evidence from Diabetes Australia (WA), Ngala Family Resource Centre and the Learning and Attentional Disorders Society expressed concerns about issues relating to funding and to the optimal use of their expertise. Not all non-government groups expressed concerns about their involvement in provision of health services. The Cancer Foundation, Arthritis Foundation, Alzheimers Association and National Heart Foundation focussed on broader issues surrounding our health professionals[72].

Diabetes Australia (WA), was the most vocal in their criticism of the interaction between government and non-government organisations:

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69 Australian Association of Occupational Therapists (WA) Inc., Submission, 20 September 2002, p7.

70 Metropolitan Allied Health Council, Submission, 23 September 2002, p4.

71 Diabetes Australia, Western Australia, Submission, 27 August 2002, pp3-5; Mrs Jocelyn Hart, Manager Health Services, Diabetes Australia WA, Transcript of Evidence, 16 October 2002, pp1-3; Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, p5; and Ms Michele Toner, Executive Officer, Learning and Attentional Disorders Society, Transcript of Evidence, pp1-4 [evidence taken during this Committee's concurrent inquiry into *Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder in Western Australia*].

72 Cancer Foundation of Western Australia, Submission, 29 August 2002; Arthritis Foundation of Western Australia, Submission, 30 August 2002; National Heart Foundation (WA Division), Submission, 3 September 2002; and Alzheimer's Association WA, Submission, 15 October 2002.

The issue for DAWA, and also of other non-government organisations/providers, is that commitment to the roll out of public policy ... has a price. There seems to be an expectation by government that such involvement is of significant advantage to the organisation/provider and that we should be "grateful" for the opportunity to be involved.

...There remains a historical belief amongst Government health management and health professionals within the health system that DAWA or such organisations will lay theirs and their organisations lives on the line for the greater good[73].

(a) Funding issues

The Committee was advised that some non-government organisations are expected to play a major role in providing health services within their area of expertise, a situation that can place these organisations under considerable financial pressure:

We are finding it very difficult to deal with an increasing expectation to service public health policy in the area of diabetes. We are increasingly finding that we have been wandering into having to allocate funds from, for example, membership fees towards what we see to be the responsibilities of the public health system[74].

Volunteering organisational/personal time and resources to what is largely a public health issue needs to be mediated and such public policy activity should consider this as part of the implementation. This lack of awareness of the impact is equally at work in the funding arrangements between the Department of Health (D0H) and non-government organisations such as DAWA[75].

Of particular interest to the Committee was the revelation that service providers that have previously received funding from the Department of Health, but are now privately funded, are still expected to provide the same level of service. The expectation for the continuation of service comes from several areas:

.....we no longer have any employees paid by the department. The organisation lost that along with half of the funding at the time, so we became completely private. However, in both the Government's and health professionals' and the public's perception, we still hold that position of service provider, as an extension of the health service[76].

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73 Diabetes Australia, Western Australia, Submission, 27 August 2002, p3.

74 Mrs Jocelyn Hart, Manager Health Services, Diabetes Australia Western Australia, Transcript of Evidence, 16 October 2002, p1.

75 Diabetes Australia, Western Australia, Submission, 27 August 2002, p3.

76 Mrs Jocelyn Hart, Manager Health Services, Diabetes Australia Western Australia, Transcript of Evidence, 16 October 2002, p3.

Also on the issue of funding, Ngala Family Resource Centre[77] advised the Committee:

> *Most of our funding comes from the Department for Community Development and most of our good liaison is with that department. We have one contract with the Department of Health worth $74,000, which is our only real link with that department. We are concerned with the lack of recognition and integration with Ngala within the public health system. We find that very frustrating and devaluing to our work as we support about 25,000 families a year*[78].

The Learning and Attentional Disorders Society of Western Australia Inc. (LADS) is a primarily volunteer based support group for people with attention deficit hyperactivity disorder. Mrs Michele Toner, Executive Officer with LADS, advised the Committee:

> *We find at LADS that we are being referred very complicated cases, and more often than not by government departments. As you are aware, ADHD is a very co-morbid condition and very often parents come to us with children who have bipolar disorder, ADHD, severe behavioural problems and are not quite getting the help they need from DCD and are being referred to us by DCD and CAMHS. We actually have a letter from CAMHS where they referred a parent to LADS because they were not able to supply counselling and help for a child with a psychiatric disorder*[79].

Like Diabetes Australia (WA), LADS relies on non-government funding for survival. There is no ongoing government funding and the Department of Health has provided emergency funding on only two occasions.

> *We do not receive any ongoing funding from the Government …We find it very hard to stay open. The only reason we manage to do so is because people give so freely of their time and do not take payment for it. We have had emergency funding from the Health Department twice - $5 000 a couple of years ago and $10 000 this year - when we have been a couple of months away from closing. Our position is dire, actually. Our continued existence is not assured. We rely on a membership fee of $33, or a concessional membership fee of $16.50. We also fundraise*[80].

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77 Major funding is sourced from the Department of Community Development, the Commonwealth Department of Health and Ageing, the Department of Family and Community Services and the Lotteries Commission.

78 Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, p2.

79 Mrs Michele Toner, Executive Officer, Learning and Attentional Disorders Society of Western Australia Inc., Transcript of Evidence, 27 October 2003, p1 [evidence taken during this Committee's concurrent inquiry into *Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder in Western Australia*].

80 *ibid*, p4.

(b) Knowledge partnerships

As well as concerns about funding, the above organisations suggested that their expertise could be better utilised for the benefit of the public health system. Representatives from Ngala Family Resource Centre also pointed to a lack of interaction between departments and organisations, government and non-government alike, with regard to pooling of resources and knowledge over common areas of interest:

> *.....the new beginnings program is intergovernmental. However, the whole community is not involved. It involves bureaucrats from the Department of Health, the Department for Community Development and the Commonwealth Department of Family and Community Services who think within their own programs. They do not look at other programs in the non-government sector*[81].

Mr George Donald, Manager of Early Parenting at Ngala Family Resource Centre, also advised the Committee that a lack of communication between the different health organisations has created confusion amongst those charged with developing and implementing early parenting programs:

> *Things are quite confusing in the early parenting arena at the moment. There is so much different language that it is very difficult to obtain an understanding of who is doing what. There is the new beginnings program, the best beginnings program, the parent-centred model and the family partnership model. Professor Hilton Davies is from the United Kingdom and is currently training many Department for Community Development and Department of Health staff as well as Meerilinga Youth Children's Foundation staff. Unfortunately, Ngala was not a member of that consortium. We are having difficulty trying to get in, yet it is appropriate to the work we do*[82].

Many non-government organisations have developed a level of expertise in their area of interest that greatly complements services within the public sector. Despite their criticism of the interaction between government and non-government organisations, these organisations are eager to play a role in provision of health services, provided adequate consideration is given to their operational requirements:

> *The challenge for the public health sector is to use our expertise more effectively wisely, fairly and well. This should be achieved by meaningful acknowledgment in concrete terms of our in kind commitment to the health of the WA community rather than an ongoing expectation of this sector to carry*

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81 Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, p5.

82 *ibid*.

an increasing responsibility for health policy and outcomes for the community with insufficient support[83].

There is no question as to the appropriateness of using privately funded non-government organisations to assist in the delivery of public health services, however, arrangements should be underpinned by adequate financial support to ensure that neither the cost burden nor the drain on physical resources is detrimental to the organisation involved.

Finding 11

Many non-government organisations have developed a level of expertise in their area of interest that greatly complements services within the public sector. Some of these organisations believe the services they provide are not adequately recognised and supported by government. Those that receive little or no financial support from government face ongoing financial uncertainty.

83 Diabetes Australia, Western Australia, Submission, 27 August 2002, p5.

CHAPTER 3 HEALTH PROFESSIONAL TRAINING

3.1 Background

For the purposes of the current inquiry, the term 'training' encompasses all aspects of health professional preparation to enter the workforce. It incorporates theoretical and practical preparation within universities, vocational education institutions and the health system.

There are a number of challenges associated with making the transition from training institutions into the health workforce. The Committee found concern amongst health professionals that current training methods do not contain an appropriate amount of 'patient focus' or provide graduates and trainees with adequate communication skills or clinical experience. Furthermore, a number of submissions questioned the relationship between Commonwealth funding and the allocation of training places. The issues raised can be broadly grouped into the following themes:

- The focus of health professional training;
- The balance between didactic and practical learning;
- Interaction between health disciplines during training;
- Allocation of training places; and
- Interaction between the health industry, training institutions and other stakeholders in health workforce planning and curriculum development.

3.2 Focus of health professional training

Many organisations and individuals raised concerns in relation to the focus of health professional training. While some focused on specific disciplines, many also commented on the focus of training in a broader sense, across the disciplines. In the broader sense, most comments related to the importance of health professionals being trained to communicate effectively and to focus on the patient as a person rather than

as a disease (patient-focused care)[84]. Team work skills[85], greater emphasis on population health[86], leadership training[87], training in geriatrics[88] and spiritual care training[89] were also seen as important by some organisations.

(a) Patient- focused training

On the issue of patient focus, the Health Consumers' Council submitted the following comment:

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84 Cancer Foundation of Western Australia, Submission, 29 August 2002, p3; Health Consumers' Council, Submission, 12 September 2002, p2; Mrs Dilys Paine, Submission, 13 September 2002, p5; Mr Gary Phillips, on behalf of the Australian and New Zealand College of Mental Health Nurses, Transcript of Evidence, 13 November 2002, p1; Mrs Lois Johnston, Member of the Policy Committee, Council on the Ageing (WA), Transcript of Evidence, 16 October 2002, p3; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p2; Mr Ric Forlano, Executive Director, Arthritis Foundation of Western Australia, Transcript of Evidence, 23 October 2002, p5; Mrs Sandra Thompson, National President, Australasian Association for Quality in Health Care, Transcript of Evidence, 23 October 2002, p6; Ms Maxine Drake, on behalf of the Health Consumers' Council, Transcript of Evidence, 23 October 2002, p4; and Ms Sue Rowell, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p5.

85 General Practice Divisions of Western Australia, Submission, 28 August 2002, p2; Nurses Board of Western Australia, Submission, 30 August 2002, p2; Health Consumers' Council, Submission, 12 September 2002, p2; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p4; and Metropolitan Allied Health Council, Submission, 23 September 2002, p5.

86 Dr Donna Mak, Chair, WA Regional Committee, Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, p1-4; Metropolitan Allied Health Council, Submission, 23 September 2002, p5; Glenda Trevaskis, Public Health Nutritionist, *et al*, Submission, 30 August 2002, p6; School of Public Health, Curtin University of Technology, Submission, 30 August 2002, pp1-2; Public Health Association of Australia (WA), Submission, 30 August 2002, pp1-2; Commonwealth Department of Health and Ageing (WA Office), Submission, 3 September 2002, p9; and Ms Cobie Rudd, Chief Executive, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p3.

87 Cancer Foundation of Western Australia, Submission, 29 August 2002, p4; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p7; Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p6; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p9.

88 Council on the Ageing (WA), Submission, 28 August 2002, p12; Mr Ken Marston, Policy Officer, Council on the Ageing (WA), Transcript of Evidence, 16 October 2002, p1; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p5; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Transcript of Evidence, 27 November 2002, pp7-8.

89 Christian Science Committee on Publication for Western Australia, Submission, 30 August 2002, p4.

> *There is a yearning from older consumers for a return to hospital-based training for nurses. The move to university training is seen to compromise practical caring skills and focus on other issues*[90].

There is a perception that in attempting to meet the challenges of changing technology and increasing specialisation, the 'human' aspect of patient care has been stripped away. As a result, students are failing to appreciate the importance of 'bedside manner' and administering to the non-medical needs of patients:

> *We need to reconsider how we educate health care professionals. We are educating them for technology and high productivity. We are also educating them for, "quicker, sicker - out the door." We must re-establish the ability to communicate across disciplines and cut through boundaries. In all health professions, we must return to the milk of human kindness. We sometimes lose that, although I understand why that happens. I am not being critical of our health care providers except that we are so bent on productivity and technology that we forget the human beings involved*[91].

(b) Communication skills

As well as being trained to 'care' for patients, several submissions and witnesses to the inquiry emphasised the importance of training in communication skills to ensure that our health professionals are able to communicate effectively with patients[92]. The most vocal proponent was Ms Susan Rooney, representing the Cancer Foundation of Australia (WA), who made the following comment in relation to health professionals caring for cancer patients:

> *... the evidence in the guidelines indicates that when people are trained well in communication, information given to patients is retained better and they feel more comfortable and more involved. I am talking about training for example, for undergraduate medical students who have communication training now, but there is an issue about when that training occurs. It might be early on in their training, but it should be continued in the clinical setting ... People working in public hospitals should at least participate in a communication-training course and have an ongoing program to make sure their skills are retained*[93].

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90 Health Consumers' Council, Submission, 12 September 2002, p2.

91 Ms Sue Rowell, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p6.

92 Health Consumers' Council, Submission, 12 September 2002, p3; Department of Health, Submission, 18 September 2002, p6; and Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2.

93 Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p6.

Finding 12

Health professional training programs do not place sufficient emphasis on communication skills or on teaching health students to focus on the patient as a person.

3.3 Balance between didactic and practical learning

(a) Adequacy of clinical training

A number of witnesses who appeared before the Committee raised the issue of preparedness to enter the health workforce in relation to the level of clinical experience gained during training[94]. The issue is of particular concern to the nursing profession[95]. Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, indicated that the health system is not responsive to the needs of graduate nurses, nor are graduate nurses adequately prepared to enter the health system:

> *Many years ago in this State we changed the educational preparation for nurses but we did not change the system in which they work. We are about the only profession in which new graduates are expected to hit the ground running as soon as they are registered. The full responsibilities of a registered nurse are expected to be met, but they are not prepared for that. They are prepared as a beginning practitioner.*
>
> *On the issue of graduate nurses hitting the system, it is not the knowledge that they lack; it is the system knowledge that they lack, and they do not have time to understand that. Some will get to the end of their graduate year and survive; others just find it all too much*[96].

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94 Australian Physiotherapy Association (WA), Submission, 28 August 2002, p2; Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p4; Metropolitan Allied Health Council, Submission, 23 September 2002, p5; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, pp4-5; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p4; Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p2; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p5.

95 Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p5; Australian and New Zealand College of Mental Health Nurses, Submission, 18 September 2002, p4; Nurses Board of Western Australia, Submission, 30 August 2002, p2; and Mr Mark Olsen, State Secretary, Australian Nursing Federation (WA), Transcript of Evidence, 22 November 2002, p5.

96 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, pp4-5.

Mr Mark Olson, State Secretary, Australian Nurses Federation (WA Branch), added:

> *... For 15 years, ever since we moved over from hospital-based training to university education, the longest and loudest complaint has been that there has not been enough practical experience. What have the university academics done about it? They have sat in their ivory towers and pretended that it is not their fault but that it is the industry's problem*[97].

Mr Olsen went on to say that many nursing students have been forced to practice on dummies in university laboratories what they would normally do on live patients in hospitals because of a lack of clinical placement opportunities[98].

Finding 13

There is widespread concern across the health industry about the level of clinical experience gained by nursing students during their undergraduate training.

The Department of Health indicated that while the majority of training programs equip health professionals with the necessary knowledge and skills for employment, they may not make them "job ready"[99]. As well as being afforded the opportunity to gain sufficient practical experience, in a system as pressurised as our health system, new graduates need considerable support to attune to organisational processes. In this regard, Mr Brian Dodds from the Australian Association of Social Workers (WA) made the following comments:

> *When [graduates] come into a system that is so pressurised, they need a lot of support to learn about the processes of the organisation within which they are working. That is where it basically falls in a hole. It is quite difficult to provide that service. Until the graduates are able to learn the processes of their agency, they are less effective in social work than they should be. The pressure is greater these days than it was five or six years ago in terms of new graduates getting that on-the-ground support in an agency*[100].

Finding 14

In a pressurised health system, new graduates need considerable support to attune to organisational processes.

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97 Mr Mark Olson, State Secretary, Australian Nurses Federation, WA Branch, Transcript of Evidence, 22 November 2002, p8.

98 *ibid*.

99 Department of Health, Government of Western Australia, Submission, 18 September 2002, p6.

100 Mr Brian Dodd, Vice President, Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002.

(b) Transition into the health workforce

A number of options have been considered to address the issue of insufficient clinical experience during nursing training. In an effort to produce "industry ready" graduate nurses, when the University of Notre Dame began its nursing course, it deliberately chose to offer a course with double the clinical content of other nursing courses. The academic year runs for 41 weeks, instead of the usual 26 or 27 weeks, with most of the extra time devoted to formal clinical practice. Upon graduation, an intensive transitional education program is provided to enable graduate nurses to become confident and competent[101].

Associate Professor Jill Downie advised that Curtin University of Technology is considering changes to their nursing curriculum:

> *We are looking at making some changes in the final semester so that students are in the clinical area for virtually four days a week with one day at university, which would mean that we could improve the transition period. We have had discussions within the health care system about it, and most areas are quite keen about our moving to that sort of model so that there is a better transition for nurses*[102].

As well as expanding clinical experience during training, there is support from training institutions[103] and the Nurses Board of Western Australia[104] for the use of an 'internship' or 'graduate program' to support the transition of nurses into the workforce. Support for an internship year, however, is not unanimous. The Australian Nurses Federation strongly opposes such a strategy, suggesting that rather than imposing an internship year on graduate nurses, the onus is on the training institutions to provide sufficient practical opportunities for students during their undergraduate training[105].

Associate Professor Kate White, Acting Head of the School of Nursing and Public Health at Edith Cowan University informed the Committee that data from New South Wales recommends an internship of at least six months to allow graduates the

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101 Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Transcript of Evidence, 27 November 2002, p5.

102 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10.

103 School of Nursing and Public Health, Edith Cowan University, Submission, 29 August 2002, p2; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10.

104 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p6.

105 Mr Mark Olsen, State Secretary, Australian Nurses Federation (WA), Transcript of Evidence, 22 November 2002, p8.

opportunity to learn time management skills and to familiarise themselves with the system[106].

While most comments were made in relation to a transitional year for nurses, there was also support for a formal internship year for other new health graduates. Dr Bronwyn Jones, Head of the School of Nursing and Public Health at Edith Cowan University suggested employers accept responsibility for thorough induction, orientation and ongoing support for new graduates[107].

There is a school of thought that graduate years/internships could be used to supplement rural health services. This is not a new concept. The Committee was informed that rural placement for an internship/graduate year or an equivalent is operating in South Australia. The Health Consumers' Council advised the Committee that the idea of placing students in rural and regional Western Australia is strongly supported by consumers[108].

Although internships or graduate years could be beneficial for undergraduates, concerns were raised as to the capacity of experienced clinicians to take on the additional responsibility for new graduates, given their already considerable workload. The Podiatry Association of Western Australia indicated that providing clinical placement for undergraduates was already placing additional burden on limited resources, providing placements for an internship program would only exacerbate the situation[109].

As well as expansion of clinical placement and internship programs, employment of student nurses during training is also being considered as a means to increase the level of clinical experience. Associate Professor Jill Downie from the School of Nursing and Midwifery, Curtin University of Technology, indicated that employment of student nurses as patient care assistants was being explored.

> *... negotiations are currently under way in one of the major private health services under which they would employ some of our students as patient care assistants during the course of their education. We are working with them on some of the competencies that students might be able to acquire while they are in that work force. Registered nurses would supervise those students, thereby perhaps reducing their learning time and helping them in that way. There are models that we can promote. We can work with not only the private sector but also the public sector if it is interested in order to give the students more*

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106 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p5.

107 Faculty of Communications, Health and Science, Edith Cowan University, Submission, 29 August 2002, p2.

108 Health Consumers' Council WA (Inc), Submission, 12 September 2002, p2.

109 Podiatry Association of Western Australia and the Department of Podiatry, Curtin University of Technology, Submission, 30 August 2002, p8.

> *experience in the workplace. Obviously, having additional experience is very beneficial*[110].

Mr Mark Olson, State Secretary, Australian Nurses Federation, advised that discussions with a group of student nurses at the University of Notre Dame revealed that many were already working as patient care assistants, although without University involvement, their role is poorly defined:

> *It was interesting to find out that more than two-thirds were already working in hospitals or nursing homes as patient care assistants. If they were there under the auspices of a university, they would be able to do a range of things, but because they are not there under the auspices of a university, they are allowed to do nothing. What a preposterous situation. They find it frustrating, because they get pressure from those they work with to do a blood pressure, take out a catheter, take out an IV or check drugs. The students know they can do it, but they know there is a legal dilemma for them and if they did it, they would be breaking the law. That is the problem for them*[111].

Mr Olsen also advised that there was broad support amongst the nursing profession for employment of student nurses to increase their level of practical experience[112].

Finding 15

A number of options are being considered to increase the clinical experience of nurses, including additional clinical placement time, employment during training and an internship year. There is also some support for an internship year for other health graduates to assist with the transition into the workplace.

(c) Funding of clinical placements

The Committee learned that the issue of insufficient clinical experience cannot be addressed by simply increasing the amount of clinical training. Funding for clinical placements is a contentious issue[113] and the Committee received conflicting evidence as to the amount of funding contributed by various stakeholders. There is a lack of agreement as to where the responsibility for funding of clinical placements lies. The

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110 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p11.

111 Mr Mark Olson, State Secretary, Australian Nurses Federation WA Branch, Transcript of Evidence, 22 November 2002, pp5-6.

112 *ibid*.

113 Nurses Board of Western Australia, Submission, 30 August 2002, p2; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p4; Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, pp3-4; and Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p4.

Department of Health considers the funding of clinical placements to be the responsibility of the universities[114], while the universities contend that they cannot continue to meet the high costs associated with clinical education. Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, advised that universities are struggling to ensure a good practical component in their programs and must rely on the goodwill of industry partners to support them[115]. The Committee was also advised that universities are under pressure to pay hospitals to accept students for clinical placements and while some provide payments, others do not.

In its submission, the Division of Health Science, Curtin University of Technology, suggested that constructive discussion between the stakeholders was necessary to ensure the universities could continue to provide clinical training during undergraduate courses:

> *Universities are facing great difficulties in the funding of clinical training. In this state, the requirements of accrediting bodies and the chief clinicians in major hospitals mean that current undergraduate programs in areas such as nursing and speech pathology are close to being non viable…The impact of this is that the funds available for undergraduate nursing education are inadequate to support this amount of clinical experience. Unless there is constructive discussion between the Health Department, the professional representatives in hospitals and the universities, the universities may be forced in the future to largely abandon clinical training at the undergraduate level and leave this training to the health care system after the individuals graduate.*
>
> *These issues of support for clinical training and the decisions about the amount of clinical training required apply in the areas of nursing, physiotherapy, podiatry, occupational therapy, human communication science (speech pathology), psychology and pharmacy. In the area of dietetics, the number of dieticians who can graduate in Western Australia is severely limited by the number of designated training places available*[116].

Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, advised that in relation to medical students, the Department of Health provides funding for various academic posts within the teaching hospitals, while the hospitals provide infrastructure support around these posts. With regard to nursing students

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114 Information provided by the Department of Health, March 2004.

115 Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p4.

116 Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, pp3-4.

from Notre Dame, the university pays volunteer mentors from the hospitals nominal amounts and the university supplies mentoring training for those services[117].

Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, expressed concerns about diversion of funding designated for clinical training:

> *Funding allocated to health facilities for student training is often not specifically targeted and may be absorbed within the general revenue pool*[118].

The Committee also heard anecdotal evidence that Commonwealth funding allocated to universities to support academics assigned to provide clinical education for medical students, is not always used for this purpose. Similarly, claims have been made that amounts designated for support of clinical placements in hospital budgets are used for other purposes. Although these claims have not been substantiated, the Committee believes they provide an indication of the level of mistrust between stakeholders with regard to funding of clinical education.

The National Review of Nursing Education noted that the costs of clinical education for nurses have increased to a point of being unsustainable and that ownership of the funding by all the parties involved in clinical education would promote greater responsibility on the part of the various services for the clinical experience. The Review recommended that new quarantined funding should be provided for clinical education in addition to the operating grant for undergraduate nursing courses. The Review also recommended that funding should be administered through a new program that 'promotes cooperative arrangements between those sectors preparing nurses for initial registration and those employing them'[119].

Professor Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, advised the Committee that Commonwealth funding to support clinical training for fourth year physiotherapy students was approximately $100,000 short of the cost associated with providing staff to deliver the clinical program. The cost of providing clinical training for undergraduate students is cross-subsidised from funding generated by fee paying graduate entry Masters students[120].

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117 Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Personal Communication, March 2004.

118 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Submission, date, p2.

119 Patricia Heath (Chair), *National Review of Nursing Education*, August 2002, pp165-167.

120 Information provided by Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, March 2004.

Finding 16

There is a lack of clarity and coordination about funding sources and their intended uses between the universities, Department of Health and health services in regard to clinical placements.

(d) Opportunities for clinical placements

As well as imposing significant costs, clinical education places a significant strain on scarce resources in the health industry. In the face of workforce shortages, finding clinical placement opportunities is becoming increasingly difficult within many disciplines[121]. On this issue, Professor Anthony Wright, representing the School of Physiotherapy at Curtin University, had the following to say:

> *Due to the shortage of physiotherapists, it becomes hard to get enough of them to train the next generation of students coming through. You can really get into a downwards spiral; as the numbers of physiotherapists decline, the pressure on the individuals working in the system to provide the clinical service is very high and their capacity to take on students in addition to providing that service provision becomes more limited. Therefore, one of the difficulties we encounter is getting enough clinical practice opportunities…*[122].

Finding 17

Clinical training places significant strain on scarce resources in the health industry. In the face of workforce shortages, finding clinical placement opportunities is becoming increasingly difficult within many disciplines.

3.4 Interaction between students of various health disciplines during training

Poor communication and interaction between health professionals in the workplace may stem from the lack of interaction between students of different health disciplines during training. Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, conceded that the universities are partly to blame for

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121 Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p3; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p4; and Mr Gary Phillips, Australian and New Zealand College of Mental Health Nurses, Transcript of Evidence, 13 November 2002, p6.

122 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3.

health professionals lack of awareness of the roles of other health disciplines, as curricula in the past have made no attempt to address this issue[123].

There is widespread recognition that greater interaction between health professionals during training is an important prerequisite for effective interaction in the health workforce. The Australian Association of Occupational Therapists (WA) [124] and Metropolitan Allied Health Council[125] stressed the importance of inclusion of training in awareness of the roles of other professions in the base curricula of all health professionals.

(a) Inter-professional learning

There is support for the creation of common learning areas, whereby students from different health disciplines can interact. Ms Melita Brown, Deputy Convenor with the Metropolitan Allied Health Council stated:

> *...there are commonalities whereby nursing, medical and allied health professionals could perhaps be trained together initially in some disciplines and have a greater opportunity to interact and then subsequently specialise.*[126]

Associate Professor Kate White, Acting Head of School of Nursing and Public Health at Edith Cowan University, cautioned that an attitude of elitism surrounding certain study programs may act as a barrier[127]. However, Associate Professor White indicated that significant change had been brought about in the area of inter-professional learning at the University of Newcastle:

> *Significant change was brought about in New South Wales by the medical program at the University of Newcastle. It revolutionised medical training and made people think about how medical students are trained and what is required. One of the advantages of the program is that it is positioned in a university that has a lot of cross-fertilisation at the undergraduate level. That breaks down the barriers before they become established. Particularly in the first year of nursing, medical and physiotherapy programs, there is an opportunity to bring the groups together to look at educational issues. It can*

123 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, Transcript of Evidence, 22 November 2002, p8.

124 Australian Association of Occupational Therapists (WA), Submission, 20 September, p4.

125 Metropolitan Allied Health Council, Submission, 23 September 2002, p5.

126 Ms Melita Brown, Deputy Convenor, Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p6.

127 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p4.

> *also be used to address the interdisciplinary stuff and look at the cultural changes that need to occur*[128].

There is some move toward inter-disciplinary training in Western Australia. Professor Landau held up the Oral Health Centre of Western Australia (OHCWA) as a model for inter-professional education:

> *We were able to encourage Curtin University of Technology and TAFE [Technical and Further Education] to move in when we set up OHCWA, so that now dentists, dental hygienists, dental therapists and dental assistants are all taught together in OHCWA, and they are already working together and interacting as undergraduates. That will be a major help in promoting their roles. ... We need to ensure that in our medical education structure we have that same interaction so that they respect each other's role within the health system*[129].

Dr Phillip Della, Chief Nursing Officer, advised the Committee that there is "cross-fertilisation" between nursing and allied health professionals at Curtin University, where there is a philosophy to try to make training a multi-disciplinary process, and where nurses and allied health students cross over in core units. The Spinrphex Club, a rural students club established through the Western Australian Centre for Rural and Remote Medicine, promotes socialisation during training by bringing together student doctors and nurses in a social and work experience environment[130].

To date the Spinrphex Club appears to be the only attempt to encourage medical students, who train apart from most other health professionals at the University of Western Australia, to interact with other health professional students during training. A new postgraduate medical course at the University of Notre Dame, due to start in February 2005, will see medical, counselling, nursing, physiotherapy and health and physical education students train side by side[131].

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128 *ibid*.

129 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p4.

130 Dr Phillip Della, Chief Nursing Officer, Department of Health, Transcript of Evidence, 22 November 2002, p7.

131 Dr Michael Quinlan, Dean College of Health, University of Notre Dame, Transcript of Evidence, 27 November 2002, p7.

Finding 18

In recognition of the fact that greater interaction between health professionals during training is an important prerequisite for effective teamwork in the health workforce, there is some move toward increasing the level of interaction between students of different health disciplines during training. Medical students, who train apart from most other health professional students, are largely excluded from this process at present.

3.5 Allocation of training places

The majority of health professional training places are subject to HECS fees. The total number of University HECS places allocated to each University is determined at the Commonwealth level. Although the States are able to put forward a case for increased funding, the decision is ultimately unilateral.

With the exception of medicine, the Commonwealth Government provides no direction as to the number of health professionals that should be trained in each discipline. Medical places are a special case, whereby the Commonwealth government allocates a specific number of places. There is broad agreement that we have not and are not training sufficient doctors in Western Australia[132].

With regard to other health disciplines, once funding has been allocated, the decision as to how many places are allocated to each course is determined within the University. In this way, each health discipline competes not only with other health disciplines, but also with any other course being offered by the University.

Professor Anthony Wright, representing the School of Physiotherapy at Curtin University of Technology, made the following comments in relation to current arrangements:

> *Basically it is historical - how many places there were in the past for geology, economics, architecture or physiotherapy; therefore, those numbers move forward. Small changes occur yearly on the basis of demand in particular areas. If a course has a low demand with very few students applying for it, the university will lose a few places to the higher demand areas. …There has been a gradual growth in the number of students and student-funded places that we have, but it is a very slow change and not under any direction. It comes down to my applying every year for, say, 50 more places for physiotherapy education. The vice-chancellor will look at that application and*

132 Mr Mike Daube, Director General, Department of Health, Transcript of Evidence, 22 November 2002, p3; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3.

say that he can give three to physiotherapy and three to pharmacy, because that is how much we move around[133].

The Committee encountered criticisms from a number of organisations with regard to this approach and was advised that if a university decides to have more positions in one discipline, it must do so at the cost of graduating fewer students in another field[134].

Finding 19

With the exception of medicine, which is determined at a Commonwealth level, location of discipline specific training places is determined within universities on a largely historical basis. Each health discipline must compete with other health disciplines for a finite number of places. The current arrangement leaves little scope for consideration of current and future workforce needs.

Professor Charles Watson advised that Commonwealth funding restrictions were a major problem for some of the smaller disciplines, such as podiatry, medical imaging, dental hygiene and therapy, which graduate around 20 students each year. A number of these courses are no longer financially sustainable in most Australian universities[135]. In the case of radiation technicians, there is no local course, as there is insufficient local demand for a course to be financially viable[136].

(a) Graduate entry health training programs

Professor Watson added that the University viewed graduate entry programs as a possible solution to overcoming some of the constraints imposed by the HECS scheme. As graduate entry programs are subject to full fees, universities are able to provide additional training places to supplement Commonwealth funded places. While expansion of graduate entry programs is seen as a means to address workforce

133 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p8.

134 School of Physiotherapy, Curtin University of Technology, Submission, 21 November 2002, p8; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3; Dr Paul Tinley, on behalf of the Australian Podiatry Department (WA), Transcript of Evidence, 21 November 2002, p2; Mr Peter Robinson, Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p3.

135 Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, pp1-2.

136 Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence16 October 2002, p2.

shortages in some disciplines[137], Mr Neil Hall, President of the Australian Podiatry Association (WA) and Dr Paul Tinley, Head of the Podiatry Department at Curtin University of Technology, cautioned that such an approach could could in fact have the reverse effect:

> *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*[138].
>
> *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*[139].

Recent discussions with Cameron Kippon, from the School of Podiatry at Curtin University of Technology confirmed that the undergraduate podiatry course was being phased out, with the last intake of students commencing training in July 2003[140].

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137 School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p3; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p6; Ms Susan Rooney, Cancer Foundation of Western Australia, Transcript of Evidence, 16 October 2002, p2; Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p2; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3; and Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Transcript of Evidence, 27 November 2002, p6.

138 Dr Paul Tinley, Head, Podiatry Department, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p2.

139 Mr Neil Hall, President, Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p2.

140 Mr Cameron Kippon, Lecturer, School of Podiatry, Curtin University of Technology, Personal Communication, March 2004.

Finding 20

Graduate entry health training programs are viewed as a possible solution to overcoming some of the constraints imposed by the Higher Education Contribution Scheme, hence providing an alternative means to address workforce shortages in some disciplines. However, the imposition of a significant cost to obtain qualifications may worsen the shortfall of health professionals in some disciplines.

3.6 Interaction between the health industry, training institutions and other major stakeholders in curriculum development and health workforce planning

Difficulties surrounding Commonwealth funding allocation for health training places are compounded at a State level by a lack of interaction between stakeholders in curriculum development and health workforce planning. In a sense, the education sector can be regarded as a supplier: it supplies health professionals (the product) to the health industry.

There is some concern about the level of interaction between the major stakeholders: government, the health industry, professional associations, registration bodies and the education sector. The Committee learned that there is limited interaction between industry and its supplier as to the nature and volume of the product it supplies[141].

Mr Gary Phillips, Mental Health Nurse Clinician made the following comments:

> *We wonder who owns the curriculum for nursing. Is it the workplace or is it the universities? There is a lot of contention in the workplace over that because they are not producing what we want*[142].

On the level of communication between stakeholders, Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, commented:

> *...are we getting the right level of communication between these groups? The answer is no. To solve some of the difficult questions, we must have tight collaboration between government health services and the private health*

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141 Faculty of Communications, Health and Science, Edith Cowan University, Submission, 29 August 2002, p1; Dr Bronwyn Jones, Head, School of Nursing and Public Health, Edith Cowan University, Submission, 29 August 2002, p1; Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p6; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p3; Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p7; and Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3.

142 Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p7.

> *industry, the professional associations, the registration boards and the universitie*[143].

The Committee believes that better communication between these groups has the potential to improve the State's ability to respond to current and emerging health issues and to ultimately benefit the community, through re-aligning health professional training with changing health needs. Further, the Committee concurs that coordinated strategic planning across both government institutions and the private sector may enhance the educational institutions' ability to forward plan for existing course intakes, new course development and the acquisition and distribution of student places to disciplinary areas [144]. As stated by the Division of Health Science, Curtin University of Technology:

> *There is an opportunity for the Health Department to collaborate with universities in the construction of education and training processes that will lead to the provision of competent professionals in specific areas desired by the Health Department and the community*[145].

Interaction between the groups should not be restricted to undergraduate training. Development of curricula for ongoing professional development of health professionals should also be a consultative process:

> *While health departments and hospitals have a strong interest in professional development, it is not their core business and it should be noted that universities are often excluded from the processes of professional development…*[146].

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143 Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3.

144 Faculty of Communications, Health and Science, Edith Cowan University, Submission, 29 August 2002, p1.

145 Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p6.

146 *ibid*, p1.

Finding 21

There is limited interaction between government, the health industry, professional associations, registration bodies and the education sector in curriculum development and health workforce planning. Better communication between these groups has the potential to improve the State's ability to respond to current and emerging health issues.

CHAPTER 4 CAREER PROGRESSION IN THE PUBLIC SECTOR

The Committee encountered widespread concern about the inadequacy of career paths for health professionals in the public sector. Two main issues were identified: the inability to progress without being diverted into management/administrative roles; and, in a broader sense, the lack of any substantial career progression for many professional groups. Issues surrounding career progression are a significant impediment to attracting and retaining health professionals in the public sector.

4.1 Opportunities for career progression

There was widespread criticism, in submissions[147] and evidence[148], of the lack of career pathways in the public health sector. Representatives from nursing, physiotherapy, occupational therapy and Aboriginal health in particular, identified the inadequacy of career structures as a major impediment to attracting and retaining health professionals in the public sector. There is limited scope for career progression in recognition of advanced clinical expertise[149]. For many allied health professionals, the private sector is a more attractive option[150].

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147 Ms Nancy Da Costa, Clinical Nurse Manager (Community Health), Submission, 15 August 2002, p2; Australian Physiotherapy Association (WA), Submission, 28 August 2002, p3; Cancer Foundation of Western Australia, Submission, 29 August 2002, p5; Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, p4; Glenda Trevaskis, Public Health Nutritionist, *et al*, Submission, 29 August 2002, pp10-11; Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, pp5-6; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, pp5-6; Andrea Way Child Development Centre, Submission, 2 September 2002, p3; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, pp6-7; and Metropolitan Allied Health Council, Submission, 23 September 2002, p6.

148 Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p2; Mr Peter Robinson, on behalf of the Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p5; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p6; Mr Neil Hall, President, Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p2; Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, p3; Ms Ilse O'Ferrall, President, WA Branch, Public Health Association of Australia, Transcript of Evidence, 23 October 2002, p5; Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p4; Ms Nancy Da Costa, Clinical Nurse Manager, Bentley Health Service, Transcript of Evidence, 16 October 2002, p5; Ms Lynette Dimer, Health promotion Officer, National Heart Foundation of Australia (WA), Transcript of Evidence, 22 November 2002, p4; and Ms Cobie Rudd, Chief Executive, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p4.

149 Australian Physiotherapy Association (WA Branch), Submission, 28 August 2002, p3

150 Andrea Way Child Development Centre, Submission, 2 September 2002, p3.

Frustration at the lack of opportunities for clinical progression in the public sector is illustrated in the following comments:

> *There is a flat career structure within the public health system. We need ways to retain staff; that is, reduce their case loads, give them time for professional development, not burn them out, give them a career structure and so on. There just are not enough graduates coming out of university, and the public health system is the poor relative. It is struggling to get the best graduates and it is struggling to keep them*[151].

> *Part of the problem is the career structure, which is very flat. People start at a certain level and there are salary progressions to other levels where people remain in the clinical realm. The perception amongst many clinicians is that the career structure is very flat and that there is no real progression for a therapist. If therapists want to move within the public sector, they must become involved in management and administration, perhaps still in physiotherapy but not necessarily, and they must largely lose a lot of that clinical progress. That would be an issue for many of our colleagues*[152].

> *In 1991, the Department of Health employed nurses from levels 1 to 5. A level 5 nurse would have about 132 staff reporting to him or her. That structure was removed in the early 1990s, so that level 4 nurses reported to a hospital's director of nursing. The level 4 nurses were downgraded last year and there was another round of redundancies. Generally speaking, the most senior nurses are a level 3 or, under the new registration system, a level 1, 2 or 3*[153].

> *Someone can do further training and attend 20 short courses to improve his knowledge and skills and still not move any further. Some of those [Aboriginal] health workers have been in the job for 25 or 30 years and are still sitting on level 2. That is sad. That is the grim picture of the situation out there. Health workers are actually leaving the field. I can understand why. The passion to work in that capacity is leaving them, because nothing seems to be moving for them*[154].

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151 Ms Annette Barton, Manager Corporate Services, Australian Association of Occupational Therapists (WA), Transcript of Evidence, 6 November 2002, p2

152 Mr Peter Robinson, Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p5.

153 Mr George Donald, Manager, Early Parenting, Ngala Family Resource Centre, Transcript of Evidence, 23 October 2002, p3.

154 Ms Lynette Dimer, Health Promotion Officer, National Heart Foundation of Australia, WA Division, Transcript of Evidence, 22 November 2002, p5.

Finding 22

Career paths within the public sector provide little recognition for advanced clinical expertise. Inadequacy of career structures are a major impediment to attracting and retaining health professionals across a range of disciplines, particularly amongst the allied health professions.

4.2 Progression into management/administration

For many health professionals, the only option for career progression involves a shift into management/administration[155,156]. The Committee is of the view that this situation is detrimental to health professionals and to the health system. In many ways the diversion of practitioners into administrative roles can be likened to a syphoning effect, whereby the more senior and experienced personnel are being promoted and then removed from positions of clinical practice.

Dr Charles Nadin, Director of the General Practices Division of Western Australia, advised the Committee:

> *One of the problems…is that nurses can only go as far as clinical nurses in a hospital situation before they are suddenly taken out and moved into administration. That is a shame, because it takes out the cream of the nurses - the very bright, motivated and well-qualified ones - who have done course after course*[157].

The Australian Association of Occupational Therapists (WA) expressed a similar sentiment:

> *Occupational Therapy clinicians that develop their skills to a very high level are unlikely to have this recognized by appropriate remuneration/classification, and so may have to face the choice of*

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155 Australian Physiotherapy Association, Submission, 28 August 2002, p3; Dr Donna Mak, Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, p4; and School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p6.

156 Mr Peter Robinson, on behalf of the Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p5; Dr Charles Nadin, President, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p9; Mr Gary Phillips, Mental Health Nurse Clinician, Transcript of Evidence, 13 November 2002, p5; Ms Nancy Da Costa, Clinical Nurse Manager, Bentley Health Service, Transcript of Evidence, 16 October 2002, p5; Mrs Christine O'Farrell, Executive Director, Country Services, Department of Health, Transcript of Evidence, 22 November 2002, p6; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p2.

157 Dr Charles Nadin, Director, General Practices Division of Western Australia, Transcript of Evidence, 22 November 2002, p9.

> *abandoning clinical work for the opportunity of advancement through entering either a profession-specific management role or a generic health manager role. (The latter resulting in them leaving the profession)*[158].

The Committee heard that the link between professional progression and a general move into an administrative role was also a major problem for community health nurses:

> *There is no defined training program for community health nurses, and the career path is less well defined than for nurses in the clinical areas. Often nurses will have to move away from a nursing path and into a generic management position in order to advance*[159].

The Australian Physiotherapy Association pointed out in their submission:

> *The current career path allows for little recognition for the advanced clinical expert. The model as it stands only allows for career advancement to be made if a clinician moves away from their clinical role into a management stream. There needs to be recognition for advanced clinicians who meet the criteria to remain within their chosen clinical stream*[160].

The Royal Australian College of General Practitioners suggested that a system of financial rewards could be a possible enticement to keep senior 'experienced' health professionals from moving away from clinical practice into administrative positions[161].

The corollary to loss of experienced, senior clinicians to administration/management is that good clinicians do not necessarily make good managers/administrators. Inadequate preparation, lack of management skills and limited knowledge of management practices impairs the ability to manage effectively. Poor management has implications for both patient care and for health professional recruitment and retention. To assist those who are moving into management positions, additional training in management is important[162]. Management/administrative expertise could be developed through educational and mentorship programs[163].

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158 Australian Association of Occupational Therapists (WA) Inc., Submission, 20 September 2002, p6.

159 Australasian Faculty of Public Health Medicine, Submission, 29 August 2002, pp3-4.

160 Australian Physiotherapy Association (WA Branch), Submission, 28 August 2002, p3.

161 Royal Australian College of General Practitioners (WA), Submission, 3 September 2002, pp1-2.

162 Division of Health Sciences, Curtin University of Technology, Submission, 30 August 2002, p6; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p6.

163 School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p6.

Finding 23

For many health professionals, the only avenue for career advancement involves a shift into management/administration. This arrangement results in a loss to the system of some of the best and brightest clinicians.

4.3 Dual pathways

The Committee was advised that the introduction of 'dual stream' pathways would provide health professionals with the option to progress along either clinical or administrative pathways. Mr Peter Robinson of the Australian Physiotherapy Association commented:

> *.....the way in which the Western Australian model works is that people go through clinical progressions and through merit or through their own choice they might become an administration manager in physiotherapy. That is the point at which they stop clinical practice. The United Kingdom has dual streams that run side by side. People can choose to become clinical practitioners and progress to a level of expertise, authority and supervision. The same thing happens within the administrative level; the two run side by side. There is dual recognition that each of those roles is of equal merit, rather than is the case with the Western Australian model in which when people reach a certain clinical level they move onto administration and leave the clinical practice behind*[164].

Constructing clear dual stream promotional pathways would allow many health professionals to continue to practice and, more importantly, would allow the retention of a significant amount of experience and corporate knowledge at the delivery end of the public health system.

> *Career pathways which give options of clinical or management specialisations are extremely important. Social workers can easily move outside the health sector, so it is vital that their specialised health work skills are retained by creating satisfying opportunities for work and for promotion*[165].

There is recognition within the Department of Health that a lack of distinct promotional pathways has a major impact on public health staffing numbers:

> *Career path structures should not only support the delivery of quality health services but enhance the career aspirations of employees. The lack of opportunity for career advancement and diversification are reasons cited for*

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164 Mr Peter Robinson, Member, Australian Physiotherapy Association, Transcript of Evidence, 21 November 2002, p6.

165 Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p5.

employees leaving the health sector (e.g. allied health professionals) and certainly factors that impact upon staffing of country health services[166].

Finding 24

There is some support within the health industry for the creation of 'dual stream' career pathways to provide health professionals with an option to progress along either clinical or administrative pathways.

4.4 Incentives to undertake postgraduate training

The lack of incentives, either in terms of career progression or financial reward, for health professionals in the public sector to undertake further training, was frequently raised in submissions[167] and in evidence[168]. With regard to the nursing profession, Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, compared our system with those adopted in other States:

Western Australia has adopted a slightly different model from the rest of the country, which is unfortunate because other States are made to look more attractive to nurses than this State, and we do not want that. The development of higher education, postgraduate courses and postgraduate specialisation at universities in the eastern States has been very much linked to the industrial award. If people go on and do further study, as with teachers, they can potentially get a higher position and stay at the bedside and not become managers. They could get financial reward for that. The most recent award in Western Australia has tried to address that by giving financial reward at a postgraduate certificate level. I would like to have seen that a little higher and a lesser award for a masters degree. There is no incentive for people to undertake the additional work that we really need the profession to be doing in order to move the profession forward and also care so that we know what

166 Department of Health (WA), Submission, 18 September 2002, p7.

167 Australian Physiotherapy Association (WA), Submission, 28 August 2002, p3; Australian Association of Social Workers (WA Branch), Submission, 30 August 2002, p5; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p6; National Heart Foundation of Australia (WA), Submission, 3 September 2002, p2; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p6; and Metropolitan Allied Health Council, Submission, 23 September 2002, p6.

168 Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p11; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p2; Mr Mark Olsen, State Secretary, Australian Nurses Federation (WA), Transcript of Evidence, 22 November 2002, p3; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p5.

> *we are doing in providing appropriate care. It is one of the biggest barriers to keeping nurses in the profession*[169].

Not only can health professionals expect little recognition for postgraduate qualifications, they can also expect to incur significant costs, as postgraduate courses are subject to full fees. Professor Anthony Wright, from the School of Therapy at Curtin University of Technology, advised the Committee that the introduction of full fee paying postgraduate courses has resulted in a decline in the number of physiotherapists undertaking further study:

> *Since the federal Government made postgraduate education full fee-paying, we have noticed a decline in the number of local and Australian fee-paying students in our post graduate programs… We had a significant review of postgraduate education during the second half of last year. One of the things that review highlighted was the need for some incentive, either financial support for people paying fees for undertaking postgraduate studies, or career progression opportunities based on the higher levels of clinical expertise that have been developed*[170].

Finding 25

There is little recognition in the public sector for health professionals who undertake postgraduate qualifications, either in terms of career progression or financial reward. When coupled with the high cost of postgraduate training, there is little incentive for health professionals to undertake such training.

169 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p5.

170 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p2.

CHAPTER 5 OTHER PROMINENT HEALTH ISSUES

In addition to issues surrounding the roles and interactions of our health professionals, a number of broader health issues arose during the course of the inquiry that are inextricably linked to the roles and interactions of our health professionals. Although these issues were raised in submissions and evidence, for the most part they were addressed only at a superficial level, and the Committee felt it was appropriate to explore them further in order to gain a better understanding of both their origin and their impact. As such, the following chapter contains a considerable volume of information derived from sources other than evidence and submissions. There were six issues in particular that the Committee felt should be further investigated.

First, the current Commonwealth-State division of responsibility for funding and delivery of health services has important implications for education and training of health workers, workforce planning and the interaction between health workers across the health system.

Second, health costs are escalating at a rapid rate and efforts to curtail these costs, often through measures aimed at increasing efficiencies, may place constraints on the way in which health workers work. While many of the cost drivers of increasing health costs will not be easily curtailed in coming years, there may be scope to rein in the increasing cost burden of chronic diseases.

Third, the way in which our health professionals interact is largely constrained by the critical shortage and maldistribution of many health workers. At a national level, Western Australia is poorly supplied compared with other states and territories, and within Western Australia, rural and regional areas are poorly supplied compared with the Perth metropolitan area.

Fourth, we have a rapidly ageing population, which has numerous implications in terms of the interaction between the aged and health care sectors, current and future workforce training and planning and the capacity of the health system to cope with demands for services.

Fifth, increasing demands on the hospital sector means that health workers are generally working under considerable pressure. Increasing hospital occupancy rates, budgetary constraints and the flow on effect from the shortage of beds in the residential aged care sector all contribute to the increasing demand on our acute sector.

Finally, the ability of the primary care sector to meet the health needs of the community, both in terms of the range of services provided as well as access and affordability of services, has implications for health workers in both the community and hospital sectors.

The following section touches on each of these issues, both in the context of the terms of reference of the current inquiry and in the broader context of important health issues facing this State.

5.1 Commonwealth - State relations in funding and delivery of health services

A number of issues surrounding Commonwealth/State relations in funding and delivery of health services were raised in submissions[171], as well as in evidence[172]. The current divide between funding and service delivery acts as a major impediment to true coordination and integration of services, as well as preventing a coordinated approach to health workforce planning. Inherent in the fragmentation of funding and service delivery, is the futility of any attempts to provide a continuum of care for patients.

Issues brought to the Committee's attention included:

- Disagreement over which level of government should take responsibility for funding particular area;
- Practices that lend themselves to duplication and overassessment of patients;
- Lack of integration in the context of health care reform;
- Poor communication between State and Commonwealth departments;
- Lack of coordination of resources and programs;
- Lack of cooperation between Commonwealth and States on workforce strategies;
- No overriding framework to determine effective and systematic prioritisation of resources;

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171 Council on the Ageing (WA), Submission, 28 August 2002, p6; Nurses Board of Western Australia, Submission, 30 August 2002, p2; Commonwealth Department of Health and Ageing (WA), Submission, 3 September 2002, pp4-5; Department of Health, Submission, 18 September 2002, pp6-12; Professor Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, pp3-6.

172 Ms Penelope Mogridge, Social Work Manager, Hollywood Private Hospitals, Transcript of Evidence, 16 October 2002, p9; Dr Grant Russell, National Manager, Quality Care and Research, Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p2; Ms Belinda Bailey, Manager, State Policy and Membership, Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p9; Mr Mike Daube, Director General, Department of Health, Transcript of Evidence, 22 November 2002, pp2-7; Mr Andrew Chuk, Deputy Director General, Corporate and Finance, Department of Health, Transcript of Evidence, 22 November 2002, p11.

- Lack of collaboration, coordination and flexibility in delivery of primary care;
- Disputes about priorities;
- Restrictions at a State level in terms of innovation and health policy development; and
- Shortage of Commonwealth funded university places and difficulty in aligning the number of health graduates in each discipline with the health workforce needs of the State.

Mr Mike Daube, Director General, Department of Health, summed up the situation as follows:

> *The present system is way outdated. The commonwealth-state divide does not serve us well. We have different decision-making processes and delivery of services, disputes between the Commonwealth and the State about priorities, argument about whose responsibility lies where and probably more time spent on discussions of cost shifting than on how services can and should be delivered in certain contexts. At some stage in the not too distant future there needs to be a radical rethink of the whole system.*
>
> *...To give you again a personal perspective, it is not flexible enough for several reasons. The first is the reason that we discussed earlier; namely Commonwealth-State issues and the fact that we are not in control of our destiny and that on a whole range of issues, even when we are working with other States or when we are dealing with the Commonwealth, we are not the decision makers. We can develop the best policies that we like, but we can then get a large steamroller driven over them and the policies remain pretty flat*[173].

Mr Andrew Chuk, Deputy Director General, Corporate and Finance, Department of Health, provided a specific example of the impact of the current inflexibility of the system:

> *It is commonsense to all in the community that the community cannot access GPs after hours because of the economic viability of running GP clinics, given what a GP can earn and what he believes he deserves to earn if he works until three o'clock on a Sunday morning or whatever. As a result there has been a fairly massive reduction in after-hours and weekend clinics, which puts a severe impost onto the community and the public health system. It disadvantages the community in that the care that it probably gets best from a GP is not provided and disadvantages the public health system because those patients then go to the public health system emergency departments to get service. Most of us understand this fairly well, but the inflexibility in the State*

[173] Mr Mike Daube, Director General, Department of Health, Transcript of Evidence, 22 November 2002, pp3-7.

> *not being able to subsidise a GP clinic to enable it to be viable out of hours, which would take people out of the EDs and enable those departments to work more efficiently in dealing with emergencies* [174].

Professor Professor Michael Quinlan, Dean, College of Health, University of Notre Dame commented on the effect of Commonwealth health policy on the State's ability to innovate and how this impacts on health professionals:

> *The ability to introduce significant innovation at State level [is] consequently limited; particularly as the States' delivery is dictated by Policies made at Commonwealth level. Much effort goes into putting out 'fires' at the expense of proper planning and, of necessity, involves too much of the time of Senior members of the Health Department. Self interest by components of the States' system promotes discord, unreasonable use of the media and a sense that all are not working together in achieving the common goal, i.e. the provision of the highest quality of care within the limits of available resources and people. The absence of the ability to think about innovation brought about by the difficulty to change and innovate, stultifies and demoralises those working within the system. Those who cannot stand it leave or become bitter, cynical and as a result, counterproductive*[175].

The debate about Commonwealth/State relations is not new. At a national level, the Senate Community Affairs References Committee recently highlighted the issue of the Commonwealth/State health funding divide in relation to public hospital services. Foremost in the examination of Federal/State relations was consideration of the longstanding practice of cost shifting. The Senate Committee's report, *Healing our Hospitals,* was highly critical of current arrangements, stating:

> *…genuine integration of care is stymied by Australia's current arrangements for funding and delivering health and public hospital services. Systemic fragmentation, a lack of transparency of funding arrangements, lack of knowledge about many key areas and differences between jurisdictions limit the extent to which Australia can claim to have a national health system*[176].

The report further asserted that current funding arrangements have led to a lack of transparency in the relative funding efforts of each level of government for public hospital services, making it easy for each level of government to 'blame shift' the

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174 Mr Andrew Chuk, Deputy Director General, Corporate and Finance, Department of Health, Transcript of Evidence, 22 November 2002, p11.

175 Professor Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p3.

176 Senate Community Affairs References Committee, *Healing our Hospitals. A Report on Public Hospital Funding*, December 2000, p6.

responsibility of perceived shortfalls in the funding available for public hospital services[177].

Although the Senate Committee acknowledged that indisputable evidence on the extent and value of cost shifting was elusive, numerous examples of cost shifting were provided in evidence.

Examples of cost shifting from Commonwealth to States and Territories include:

- Capped funding for Commonwealth programs. For example limits on the funding and therefore the available beds for aged care facilities forces some older nursing home type patients to be placed inappropriately in acute public hospital beds rather than in aged care facilities;

- Failure of medical workforce policy resulting in fewer GPs in rural and remote areas, compelling the State-funded public hospitals or community health centres to address and fund the primary care needs of these communities;

- Lack of after hours services by GPs forcing patients to attend the (State-funded) emergency departments of public hospitals for primary care; and

- Inadequacies in the funding and delivery of health services for Indigenous Australians compelling the States and Territories to provide extra services (and therefore funding) through the public hospital system[178].

Examples of cost shifting from States and Territories to Commonwealth include:

- Early discharge of patients shifting costs to the Commonwealth through patients needing to consult (Commonwealth-funded) GPs;

- Limitations on and privatisation of outpatient services in public hospitals shifting costs, because these services are then billed to (Commonwealth-funded) Medicare;

- Small quantities of pharmaceuticals provided to patients on discharge from public hospitals forcing the patient to consult a GP (Commonwealth-funded) in order to obtain a prescription to be filled at a community pharmacy (also Commonwealth-funded); and

- In emergency departments of public hospitals, patients who do not require admission being directed to a (Commonwealth-funded) GP[179].

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177 Senate Community Affairs References Committee, *Healing our Hospitals. A Report on Public Hospital Funding*, December 2000, p14.

178 Senate Community Affairs References Committee, *Public Hospital Funding and Options for Reform*, July 2000, p19.

Examples of cost shifting from governments to patients include:

- Privatisation of services previously provided free-of-charge in public hospitals (such as outpatient services) now attracting a patient payment (State to patient);

- Patients discharged from public hospitals with only a small supply of pharmaceuticals paying a co-payment for each prescription filled at a community pharmacy. These same pharmaceuticals would be free-of-charge in the public hospital (State to patient);

- Capped funding of programs or non-coverage of certain health services and/or products by governments requiring patients to meet some or all the cost of the service/product. For example, Medicare subsidises access to out-of-hospital medical services but not out-of-hospital allied health services (Commonwealth to patient); and

- Access by patients to certain aids, dressings and equipment previously provided free-of-charge are being withdrawn by some public hospitals, requiring patients to provide their own supplies (State to patient)[180].

In its interim report, the Senate Committee noted that the most concerning impact of cost shifting was when patients are encouraged to use a particular service on the basis of who pays for those services rather than what may be the most effective service to meet their needs[181].

Many submissions called for major reform of funding and delivery of health services *viz a vis* rationalisation of Commonwealth and State roles. The major impetus for reform was to reduce duplication and overlap between the Commonwealth and States/Territories, reduce the scope for political game playing around funding issues and remove incentives for cost-shifting. Three broad options for reform of Commonwealth/State roles were proposed:

- Commonwealth to take responsibility for funding and delivery of health services;

- States/Territories to take responsibility for funding and delivery of health services; and

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179 Senate Community Affairs References Committee, *Public Hospital Funding and Options for Reform*, July 2000, pp19-20.

180 *ibid*, p20.

181 *ibid*, p23.

- Pooling of Commonwealth and States/Territories funds at the regional/population group level[182].

In its final report, *Healing our Hospitals*, the Senate Committee made the following comments:

> *It is time to put patients first. The Committee believes that rather than constantly fighting over who pays, it is time that Governments restored hospital budgets and agreed on a basis for future sharing of responsibility so that there can be confidence in the future of our public hospitals*[183].

With regard to reform strategies, the Senate Committee stated:

> *The option for reform of the current funding arrangements that received the most support was a 'single fund' or 'joint account' model at State-wide level. This would combine State and Federal funds across a number of programs, which are currently partially funded by both levels of Government. This would also provide flexibility to enable funds to be delivered to the most appropriate and effective forms of care.*
>
> *There was some support for a trial of pooled funding in a large geographical area to test some of the impacts of a single fund approach. It was acknowledged that the complexity of the health sector made it hard to predict all the consequences of major change and that trials were a good way to identify unforeseen issues*[184].

More recently, the Health Reform Committee released a discussion paper that addressed the issues surrounding current Commonwealth/State relations in the broader context of the health system in its entirety[185]. As well as potential cost shifting, the Committee highlighted the following limitations imposed by the current arrangements:

Lack of coordination of care between treatment levels can lead to difficulties as people move across treatment levels (e.g. acute to primary), or when individuals require simultaneous care from a number of professionals in different sectors. The lack of coordination can create anxiety and confusion in the patient, and patient information can be lost or delayed when care is transferred[186];

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182 Senate Community Affairs References Committee, *Public Hospital Funding and Options for Reform*, July 2000, p73.

183 Senate Community Affairs References Committee, *Healing our Hospitals. A Report on Public Hospital Funding*, December 2000, px.

184 *ibid*, pxi.

185 Finance and Information Group, Western Australian Department of Health for the Health Reform Committee, *Commonwealth/State Relations*, October 2003.

186 *ibid,* p10.

Duplication and gaps in services can occur if State and Commonwealth governments plan their services in isolation. Additionally, bureaucratic duplication can introduce inefficiencies and create unnecessary difficulties for service providers[187];

Lack of long term comprehensive planning is unavoidable, when each level of government can only plan for the services for which it is responsible, even if a different configuration might be more efficient at a system level and offer greater benefit to the patient. Improvements in one sector can lead to costs on another sector, which can reduce the overall benefit and ultimately lead to disagreements about funding[188];

The purpose of funding provided by **Specific Purpose Payments** (SPPs) is determined by the Commonwealth, and as such may not be aligned with State priorities. Funding through SPPs is also uncertain, in that the Commonwealth may withdraw funding, leaving the States to decide whether to pick up the funding or cease the program. The Commonwealth Dental Health Program is a good example of a program that was funded for a number of years and then withdrawn, leaving the States to deal with raised community expectations[189]; and

Inability to adequately plan the health workforce: There is interdependence between the Commonwealth, States/Territories, educators and professional bodies, and optimal planning requires close liaison and cooperation between the different groups. For example, the Commonwealth has a significant impact on the medical workforce - it determines the number of subsidised medical school places; controls access to Medicare provider numbers; and determines the number and distribution of GP trainees each year[190].

In August 2003, a paper presented at the Australian Health Care Summit estimated that if Commonwealth, State and Territory Health systems were rationalised into a single national health system, or alternatively, if the Commonwealth's role was reduced to one of funding only, savings in the order of $3-4 billion and $2 billion per annum respectively could be realised[191].

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187 Finance and Information Group, Western Australian Department of Health for the Health Reform Committee, *Commonwealth/State Relations*, October 2003, p10.

188 *ibid*, p11.

189 *ibid*, pp11-12.

190 *ibid*, pp12-13.

191 Mark Drummond, *Estimates of Savings Possible if Commonwealth, State and Territory Health Systems were Rationalised into a Single National Health System (e.g. by Assigning Powers and Responsibilities for Health Care to the Commonwealth via a Constitutional Referendum) OR if the Commonwealth's Role in Health Reduces to one of Funding Only*, Australian Health Care Summit, Canberra, 19 August 2003.

Finding 26

There is a broad consensus within our health industry that the constraints imposed by the current Commonwealth/State divide in funding and delivery of health services is a major impediment to true coordination and integration of health services, and prevents a coordinated approach to health workforce planning.

5.2 Rising health costs and efforts at containment

A number of submissions and evidence made reference to rising health costs and how attempts to contain costs have or could potentially affect the roles of health professionals[192]. As we search for more cost-effective ways in which to deliver health services, staff to patient ratios fall, health professionals are largely restricted to attending only to patients' immediate medical needs, and less qualified health professionals take on the tasks once undertaken by more qualified (more costly) health professionals. Ultimately, attempts to contain health costs can result in our health professionals working under ever more pressure.

Whilst the Committee acknowledges that there may be potential cost savings in redefining or redesigning the roles of some of our health professionals, any attempts to do so could prove futile without adequate consideration of the major drivers of rising health costs. There are numerous factors that contribute to rising health costs, including population growth and ageing, as well as non-demographic factors such as new pharmaceuticals and procedures. The following section examines some of the factors that have driven growth in health expenditure in the previous decade, and identifies some of the factors that are predicted to have the greatest impact in the near future.

(a) Recent health expenditure trends

Total health expenditure in Australia in 2001-02 was estimated at $66.6 billion, an increase of $5.7 billion (9.3 percent) over the previous year. Allowing for inflation, real growth between 2000-01 and 2001-02 was estimated at 6.0 percent[193].

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192 Glenda Trevaskis, Public Health Nutritionist, *et al*, Submission, 29 August 2002, p3; Council on the Ageing, Submission, 28 August 2002, p11; Arthritis Foundation of WA, Submission, 30 August 2002, p2; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p2; Ms Margaret Watson, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p2; and Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p8.

193 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, p6.

Spending on health represented 9.3 percent of GDP in 2001-02, an increase of 0.2 percent on the previous year. An increase in the ratio of health expenditure to GDP can represent an increase in the level of use of health goods and services compared to general goods and services (volume effect), or an increase in the cost of health goods and services in excess of the increase in cost of general goods and services (price effect)[194].

Australia's health inflation has tended to move ahead of the general inflation in most years over the last decade. However, in the three years to 2001-02, health inflation averaged slightly less than general inflation, suggesting that the real growth in health expenditure was predominantly due to a steep rise in the use of health services (i.e. a volume effect) over this period[195].

Real growth in health expenditure averaged 4.6 percent per annum between 1991-92 and 2001-02. Growth in the second half of the decade was greater than that in the first half of the decade (5.4 versus 3.9 percent)[196]. On a state by state basis, Western Australia was second only to the Northern Territory in annual real growth in health expenditure, averaging 6.7 percent per annum between 1997-98 and 2001-02[197]. Despite the marked growth in health expenditure in Western Australia, per person expenditure in 2001-02 was almost identical to the national average[198].

Finding 27

On a state by state basis, Western Australia was second only to the Northern Territory in annual real (inflation adjusted) growth in health expenditure, averaging 6.7 percent per annum between 1997-98 and 2001-02. Despite the marked growth in Western Australian health expenditure, per person expenditure in 2001-02 was close to the national average.

194 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, p8.

195 *ibid*, p9.

196 *ibid*, p10.

197 *ibid*, p12-13. More recent health expenditure data are not yet available. The Australian Institute of Health and Welfare is currently collating 2002-03 data.

198 *ibid*, p14.

(b) Funding sources

In 2001-02, the Commonwealth spent an estimated $30.7 billion on health (46.1 percent of total health expenditure)[199]. Medical services accounted for 30.7 percent, public hospitals 27.3 percent and pharmaceuticals 16.0 percent of Commonwealth expenditure[200]. Real growth in Commonwealth expenditure averaged 5.9 percent per annum in the decade to 2001-02. Annual growth in expenditure in the latter half of the decade was significantly greater than in the first half of the decade (6.4 versus 5.4 percent)[201], largely as a result of the Private Health Insurance rebate, which was introduced in January 1999.

States and Territories and local governments spent $14.8 billion on health (22.3 percent of total expenditure)[202]. The majority of funding from this source (64.4 percent) was spent on public hospitals, with a further 21.8 percent going to community and public health[203]. Real growth in expenditure averaged 4.2 percent per annum in the decade to 2001-02[204].

Non-government funding sources accounted for $21.1 billion, 31.6 percent of total health expenditure in 2001-02[205]. Out-of-pocket expenditure by individuals accounted for 58.6 percent ($12.4 billion) of total non-government expenditure on health. The proportion of non-government health expenditure contributed by individuals rose by 7.4 percent in the decade to 2001-02, from 51.2 percent. Private health insurance funds contributed 24.1 percent ($5.1 billion) of total funding, down significantly from the 35.1 percent contribution in 1991-92[206].

(c) Major growth areas in health expenditure in the past decade

As health inflation exceeded general inflation by an average of just 0.7 percent (i.e. small price effect) in the decade to 2001/02, the major determinant of growth has been an increase in the level of use of health goods and services (i.e large volume effect). In other words, people have come to use increasingly greater quantities of health goods and services.

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199 This figure includes expenditure on high dependency residential aged care, which is classified as health care rather than welfare.

200 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, pp17-27.

201 *ibid*, p24.

202 *ibid*, p17.

203 *ibid*, p29.

204 *ibid*, p24.

205 *ibid*, p17.

206 *ibid*, p29.

A breakdown of expenditure provides an indication of the major growth areas. Between 1991-92 and 2001-02, the area that experienced the greatest average real growth in total (government plus non-government) expenditure was pharmaceuticals, which averaged 9.4 percent per annum (compound) growth[207] (see Table A4.6).

The major growth areas in government expenditure in the previous decade were private hospitals, at an average real increase of 25.7 percent per annum, pharmaceuticals, at an average real increase of 12.0 percent per annum and professional services (other than medical services[208]), at an average real increase of 8.3 percent per annum[209]. The growth in expenditure on private hospitals was largely a transfer between the non-government sector (private health insurance funds) and the Australian Government brought about the effect of the Private Health Insurance rebate. The increased use of private hospital services by veterans funded by the Department of Veterans' Affairs also contributed to the rapid real growth in government funding.

In the decade to 2001-02, private hospitals increased their share of government expenditure from just 0.7 to 3.9 percent, pharmaceuticals increased from 6.3 to 11.6 percent and other professional services increased from 0.95 to 1.25 percent [210]. Whilst public hospitals maintained the greatest share of total government health expenditure, that share fell from 39.4 percent to 36.6 percent. High level residential aged care also decreased its share of government expenditure from 9.7 to 7.7 percent in the decade to 2001-02[211].

The major growth areas in non-government expenditure were pharmaceuticals and health services other than hospital and medical services[212], which grew by an average of 7.0 and 5.0 percent per annum respectively. Pharmaceuticals increased its share of non-government health expenditure from 14.7 to 21.5 percent and other health services increased from 26.7 to 32.5 percent in the decade to 2001-02. Conversely, private hospitals decreased their share of non-government expenditure from 22.9 to 17.2 percent, and public hospitals decreased their share from 7.7 to 4.9 percent in the decade[213].

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207 *ibid*, pp20-22.

208 Other professional services include physiotherapy, chiropractic, osteopathy.

209 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, p20.

210 *ibid*.

211 *ibid*.

212 Other health services are all those not listed in another category and includes aids, appliances, ambulance, administration, hospitality.

213 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, p21.

Finding 28

Growth in government health expenditure in the decade to 2001-02, was largely driven by increased expenditure on pharmaceuticals (via the Pharmaceutical Benefits Scheme), private hospitals (brought about by the effect of the rebate to holders of private health insurance) and professional (non-medical) services. Growth in non-government health expenditure was largely driven by increased expenditure on pharmaceuticals and other health services.

(d) International comparison

A comparison with selected Organisation for Economic Co-Operation and Development (OECD) countries (Canada, France, Germany, Japan, the Netherlands, New Zealand, Sweden, the United Kingdom and the United States) indicates that Australia has the fifth highest health expenditure as a proportion of Gross Domestic Product (GDP), behind Canada, France, Germany and the United States[214]. All countries, with the exception of France and Germany, experienced significant growth in health expenditure as a proportion of GDP in the five years to 2001. Australia is ranked sixth, behind the United States, Germany, Canada, the Netherlands and France in per person expenditure[215]. Between 1991 and 2001, Australia had the third highest rate of excess health inflation[216], behind Japan and the United Kingdom.

Development and integration of new technologies and new pharmaceuticals are considered to be among the major cost drivers of increasing health expenditure. In the past decade there has been a rapid rise in availability of diagnostic technologies such as computed tomography scanners and magnetic resonance imaging (MRI) in most OECD countries. For example, between 1990 and 2000, the number of MRI units per capita increased 7 fold in Australia. With 4.7 units per million population, Australia ranked twelfth amongst OECD countries[217].

Rapid growth in the use of new surgical procedures has also contributed to growing health expenditure. For example, the number of cardiac bypass and coronary angioplasty procedures rose dramatically during the 1990s. By 2000, Australians were undergoing 89 cardiac bypass procedures and 114 coronary angioplasty procedures per

214 *ibid*, p57.

215 Adjusted to allow for the different purchasing powers of different currencies in different countries.

216 Difference between general inflation and health inflation.

217 Organisation for Economic Cooperation and Development, *Health at a Glance 2003 - OECD Countries Struggle with Rising Demand for Health Spending*, http://www.oecd.org/documentprint/0,2744,en_2649_201185_16560422_1_1_1_1,00.html, accessed on 27 November 2003.

100,000 population, ranking the nation sixth and eighth respectively amongst OECD countries for these procedures[218].

Australia, along with Sweden, led the way in growth in pharmaceutical expenditure, which doubled between 1990 and 2001. Not far behind were Canada, Finland, Ireland and the United States, with increases of more than 70 percent[219].

Finding 29

Like Australia, most other Organisation for Economic Co-operation and Development countries experienced significant growth in health expenditure in the previous decade. Development and integration of new technologies and new pharmaceuticals were among the major cost drivers of rising health expenditure.

(e) The health burden of chronic disease

In Australia, as in other developed countries, demographic and lifestyle changes have contributed to the rising incidence of chronic disease[220]. The cost to the Australian health system is considerable, and yet many chronic diseases are largely preventable. Chronic diseases are estimated to be responsible for 80 percent of the total burden of disease, mental problems and injury in Australia[221], as measured in terms of disability adjusted life years (DALY)[222]. Chronic diseases often lead to disability, ultimately causing an individual to lose independence.

In a recent report, the Australian Institute of Health and Welfare examined the prevalence, impact and health costs of 12 common chronic diseases in Australia in 2001[223]. The selected diseases and conditions[224] were estimated to account for 42 percent of total DALYs in 1996[225]. The estimated health system costs of the selected

218 *ibid.*

219 *ibid.*

220 Chronic diseases are complex conditions, are often long-lasting and persistent in their effects and can produce a range of complications. Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p2.

221 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p5.

222 An index of years of healthy life lost due to disability and premature mortality.

223 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p5.

224 Coronary heart disease, stroke, lung cancer, colorectal cancer, depression, diabetes, asthma, chronic obstructive pulmonary disease, chronic renal disease, oral diseases, arthritis and osteoporosis.

225 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p7.

diseases and conditions were in excess of $7.3 billion in 1993/94, 21.5 percent of total recurrent health expenditure for the year[226] (see Table A4.8). More recent cost estimates are not readily available, although most indicators would point to an increase in the proportion of health expenditure on chronic diseases. Although the incidence of some chronic diseases, such as coronary heart disease and cerebrovascular disease, are declining, population ageing and lifestyle changes are increasing the overall burden of chronic disease.

Finding 30

Chronic diseases are estimated to account for 80 percent of the total burden of disease, mental illness and injury in Australia, as measured in terms of 'disability adjusted life years'.

(i) Lifestyle risk factors and chronic disease

There are numerous risk factors that contribute to the onset and progression of chronic diseases. Behavioural (i.e. lifestyle) risk factors, which are completely preventable, are estimated to account for the loss of 21 percent of DALYs. Tobacco smoking is responsible for the greatest burden of chronic disease (9 percent of DALYs), followed by physical inactivity (7 percent of DALYs), poor diet (3 percent of total DALYs) and alcohol consumption (2 percent of DALYs)[227].

People who use tobacco are at increased risk of coronary heart disease, stroke, lung and other cancers, depression, asthma, chronic obstructive pulmonary disease, oral diseases and osteoporosis[228]. Many of the health risks associated with smoking are also associated with 'passive' smoking (exposure to sidestream smoke from someone else smoking). Despite innumerable public health campaigns and strategies, the 1998 National Drug Strategy Household Survey found that 25 percent of males and 20 percent of females aged 14 and above were regular smokers. A further 4 percent indicated that they were occasional smokers, and 43 percent of males and 36 percent of females indicated that they were ex-smokers[229].

Insufficient physical activity increases the risk of coronary heart disease, stroke, colorectal cancer, diabetes, osteoarthritis and osteoporosis. It can also contribute to intermediary risk factors, such as high blood pressure, high cholesterol and excess

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226 Australian Institute of Health and Welfare, *Health system costs of diseases and injury in Australia 1993-94*, September 1998, p8.

227 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p8.

228 *ibid*, p97.

229 Australian Institute of Health and Welfare, P Adhikari and A Summerill 2000, *1998 National Drug Strategy Household Survey: detailed findings*, as cited in: Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p109.

weight[230]. In 1999, around 29 percent of the Australian adult population reported undertaking a level of physical activity that was deemed to be insufficient, and a further 15 percent reported undertaking no physical activity[231].

Poor diet plays an important role in several chronic diseases, such as coronary heart disease, stroke, colorectal cancer, type 2 diabetes, chronic renal disease, oral diseases and osteoporosis. It also contributes to a number of intermediary risk factors, such as high blood pressure, high blood cholesterol and excess weight[232]. Information on dietary habits in Australia is somewhat limited, although data from the ABS National Nutrition Survey indicated that:

- two in three adults consume too little vegetables;
- four in five consume too little fruit;
- one in two males and two in three females consume too little cereal; and
- two in three consume too much fat[233].

In recent times, there have been numerous Commonwealth and State government initiatives aimed at improving health through better food and nutrition. While these programs can claim some success, recent statistics on overweight and obesity indicate that the message has failed to hit home with a large proportion of the population, and more aggressive strategies may be required.

People who consume excessive quantities of alcohol are at increased risk of coronary heart disease, stroke, colorectal cancer, diabetes, various forms of cancer, depression and osteoporosis[234]. The 1998 National Drug Strategy Household Survey found that between 7 and 16 percent of males and 4 and 10 percent of females drink at hazardous

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230 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p97.

231 Australian Institute of Health and Welfare, T Armstrong, A Bauman and J Davies 2000, *Physical activity patterns of Australian adults: results of the 1999 National Physical Activity Survey*, as cited in: Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p7.

232 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p97.

233 Cancer Council Australia 2001, *National cancer prevention policy 2001-2003*, as cited in: Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p100.

234 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, pp97-115.

or harmful levels[235]. A greater proportion of Indigenous males (12 percent) and females (3 percent) are classified as drinking at hazardous levels (more than four drinks per day) compared to non-Indigenous males (5 percent) and females (1 percent)[236].

Finding 31

Behavioural (i.e. lifestyle) risk factors, such as tobacco smoking, physical inactivity, poor diet and excessive alcohol consumption, are estimated to account for the loss of 21 percent of disability adjusted life years.

(ii) Biomedical risk factors and chronic disease

Biomedical risk factors are estimated to contribute 12 percent of DALYs: high blood pressure accounts for nearly 5 percent, excess weight 4 percent and high blood cholesterol a further 3 percent[237].

High blood pressure contributes to coronary artery disease, cerebrovascular disease and renal disease[238]. The Australian Institute of Health and Welfare estimated that approximately 3 million Australians aged 25 and above (28 percent) had high blood pressure in 2001[239]. The Australian Diabetes, Obesity and Lifestyle Study found that more than half of those people with high blood pressure were untreated, and of these, more than three-quarters had at least one modifiable lifestyle factor (e.g. smoking, insufficient physical activity, excessive alcohol consumption)[240]. The Australian Burden of Disease and Injury study estimated that 11 percent of all deaths in 1996 were attributable to high blood pressure, over half due to coronary heart disease[241].

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235 Australian Institute of Health and Welfare, P Adhikari and A Summerill 2000, *1998 National Drug Strategy Household Survey: detailed findings*, as cited in: Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p115.

236 Australian Bureau of Statistics and Australian Institute of Health and Welfare 2001, *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2001*, as cited in: Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p115.

237 Australian Institute of Health and Welfare, *The burden of disease and injury in Australia*, November 1999, p8.

238 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p119.

239 Australian Institute of Health and Welfare, *Heart, stroke and vascular diseases - Australian facts 2001*, April 2001, p53.

240 EM Briganti *et al*, *Untreated hypertension among Australian adults: the 199-2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab)*, Medical Journal of Australia, 179, August 2003, pp135-139.

241 Australian Institute of Health and Welfare, *The burden of disease and injury in Australia*, November 1999, pp120-121.

High blood cholesterol is a major risk factor for both coronary heart disease and stroke. In 1999-00, more than 6 million Australians aged 25 and over were estimated to have a blood cholesterol level in excess of the level deemed to constitute an increased risk for coronary heart disease[242]. While some people have a genetic predisposition to high cholesterol, for most people, the most important contributor is a diet high in saturated fats. Physical inactivity and excess body weight can also contribute to high cholesterol levels[243].

Excess weight is a risk factor for coronary heart disease, cerebrovascular disease, colorectal cancer, depression, diabetes, asthma, chronic renal disease and osteoarthritis. It also contributes to the intermediary risk factors of high blood pressure and high blood cholesterol[244]. In both adults and children, the prevalence of overweight[245] and obesity has increased markedly since the 1980s. In 1980, 48 percent of males and 27 percent of females were overweight or obese[246]. By 1999-00, the corresponding figures were 68 and 52 percent[247], representing around 7 million adult Australians. Most alarmingly, the prevalence of obesity has increased 2.5 fold from 7.1 percent in 1980 to 18.4 percent in 1999-00[248]. Data for children and adolescents is more difficult to obtain, due to the lack of standard definitions for measuring overweight and obesity in younger age groups, however the trends appear to resemble those for adults. Between 1985 and 1995, the prevalence of overweight children almost doubled and the prevalence of obese children more than tripled[249]. There is no reason to believe the rapid rise in prevalence has not continued.

Australia is not alone in its increasing incidence of overweight and obesity, it is a global phenomenon. In a recent publication, the OECD identified obesity, and its related health problems, as an important potential cost driver of future health costs. It

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242 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p123.

243 *ibid*, p125.

244 *ibid*, p97.

245 Overweight is defined as a Body Mass Index (BMI) of 25 or more and obesity is defined as a BMI of 30 or more. Body Mass Index is calucalted by dividing weight in kilograms by height in metres squared. These cut-off points have been adopted for use internationally by the World Health Organisation.

246 Commonwealth Department of Health and Ageing, *About Overweight and Obesity*, http://www.health.gov.au/pubhlth/strateg/hlthwt/obesity.htm, accessed on 12 December 2003.

247 AJ Cameron *et al*, *Overweight and obesity in Australia: the 1999-2000 Australian Diabetes, Obesity and Lifestyle Study (AusDiab)*, Medical Journal of Australia, May 2003, 178:427-432.

248 *ibid.*

249 AM Magarey, *Prevalence of overweight and obesity in Australian children and adolescents: reassessment of 1985 and 1995 data against new standard international definitions*, Medical Journal of Australia, June 2001, 174: 562-565.

warned that the time lag between the onset of obesity and related health problems will likely lead to significant upward pressure on health costs into the future[250].

Finding 32

The biomedical risk factors of high blood pressure, excess weight and high blood cholesterol are estimated to account for the loss of 12 percent of disability adjusted life years. In 2003, the Organisation for Economic Co-operation and Development warned that obesity, and its related health problems, is an important potential driver of future health costs.

Our increasing propensity for excessive energy intake, coupled with a sedentary lifestyle has enormous implications not only for future health costs, but for quality of life. The onset and progression of chronic diseases and conditions can be delayed, if not prevented, through lifestyle changes. Broadly speaking, whilst many of the drivers of future health costs leave limited scope for containment (e.g. new technologies, pharmaceuticals, procedures; changing demographics), there is considerable scope to lessen the cost burden of chronic disease through aggressive prevention and health promotion strategies.

5.3 Shortages of health workers and maldistribution of the health workforce

Even with the most innovative clinical practices, a health workforce will not be in a position to provide optimal services for patients when there are workforce shortages. For a number of years now, shortages of health workers and maldistribution of the health workforce have been two of the most pressing health workforce issues plaguing policymakers and health leaders.

The following section provides an overview of the profile of our health workforce, some of the factors that contribute to the shortage and maldistribution of health workers, and a brief outline of how the health workforce is shaping up for the future.

(a) Workforce shortages

The Committee received submissions and evidence from numerous witnesses who commented on the shortage of health workers, including doctors, both specialists[251]

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250 Organisation for Economic Cooperation and Development, *Health at a Glance 2003 - Organisation for Economic Cooperation and Development Countries Struggle with Rising Demand for Health Spending*, http://www.oecd.org/documentprint/0,2744,en_2649_201185_16560422_1_1_1_1,00.html, accessed on 27 November 2003.

251 Department of Health, Submission, 18 September 2002, p11; Cancer Foundation of Western Australia, Submission, 29 August 2002, p4; Dr Sandra Thompson, Public Health Physician, Public Health Association of Australia (WA), Transcript of Evidence, 23 October 2002, p2.

and general practitioners[252], nurses[253], physiotherapists[254], radiation technicians[255] and a range of other allied health workers[256]. As well, the Committee was advised of the maldistribution of health workers, particularly doctors[257].

With regard to the magnitude of the shortage of doctors in Western Australia, Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of

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252 General Practice Divisions of Western Australia, Submission, 28 August 2002, p1; Department of Health, Submission, 18 September 2002, p11; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p6; Ms Sandra Thomson, National President, Australasian Association for Quality in Health Care, Transcript of Evidence, 23 October 2002, pp5-6; Dr Charles Nadin, Rural General Practitioner and Director of General Practice Divisions of Western Australia Ltd, Transcript of Evidence, 22 November 2002, p2; Dr Peter Maguire, on behalf of the Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p5; Professor Lou Landau, Dean, Faculty of Medicine, University of Western Australia, Transcript of Evidence, 22 November 2002, p3; and Dr Bernard Pearn-Rowe, President, Australian Medical Association (WA), Transcript of Evidence, 4 December 2002, p1.

253 Department of Health, Submission, 18 September 2002, p12; Ms Nancy Da Costa, Clinical Nurse Manager, Bentley Health Service, Submission, 15 August 2002, p2; Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 october 2002, p6; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p2; Ms Lois Johnston, on behalf of the Council on the Ageing, Transcript of Evidence, 16 October 2002, p2; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p7; Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p12; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p2; and Ms Sandra Thomson, National President, Australasian Association for Quality in Health Care, Transcript of Evidence, 23 October 2002, pp5-6.

254 School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p2; Department of Health, Submission, 18 September 2002, p14; Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p1; and Mr Ian Cooper, Australian Association of Physiotherapists, Transcript of Evidence, 21 November 2002, p3.

255 Cancer Foundation of Western Australia, Submission, 29 August 2002, p4; Department of Health, Submission, 18 September 2002, p14; Mr Harry Sheiner on behalf of the Cancer Foundation (WA), Transcript of Evidence, 16 October 2002, p2; Associate Professor Kate White, Acting Head, School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p2.

256 Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p4; Department of Health, Submission, 18 September 2002, p14; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p4; Metropolitan Allied Health Council, Submission, 23 September 2002, p6; and Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, pp1-2.

257 Dr Bernard Pearn-Rowe, President, Australian Medical Association (WA), Transcript of Evidence, 22 November 2002, p1; University of Notre Dame, Submission, 11 October 2002, p6.

Western Australia, advised the Committee that some 300 - 600 extra doctors were needed[258]. Dr Bernard Pearn-Rowe, President, Australian Medical Association provided a similar estimate of the shortfall[259]. The Committee was further advised that the need to register 300 to 400 overseas-trained doctors each year to fill vacant places was evidence of the shortfall[260]. Western Australia has eight times the number of overseas-trained doctors as does New South Wales, the state next most dependent on overseas-trained doctors[261].

Professor Landau also advised the Committee that there is an overall deficit of 100 medical specialist across the specialties[262].

Finding 33

There is an estimated shortfall of 300-600 General Practitioners and 100 medical specialists in Western Australia.

Both the Australian Medical Workforce Advisory Committee (AMWAC) and Access Economics (through a survey conducted on behalf of the Australian Medical Association) have reported a shortfall in the general practice workforce, although there is some disagreement as to the extent of the shortfall. The two groups used different methodologies to estimate GP shortage, AMWAC using a more conservative estimate of demand relying on the assumption that utilisation of GP services in major rural centres represents the benchmark, whereby supply of services is balanced with demand for services (i.e. no over or undersupply) [263].

The Australian Medical Workforce Advisory Council concluded that in 1998 there was a net national surplus of 1,060 GPs (700 FTEs) - a shortage of 1,240 GPs in rural and remote areas and an oversupply of approximately 2,300 GPs in metropolitan

258 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3.

259 Dr Bernard Pearn-Rowe, President, Australian Medical Association, Transcript of Evidence, 4 December 2002, p6.

260 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3.

261 Professor Michael Quinlan, Dean, School of Health University of Notre Dame, Submission, 11 October 2002, p6.

262 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2.

263 Utilisation of GP services in major rural centres (RRMA3) was used as the benchmark of a balance between supply and demand. Only 9 percent of the population live in major rural centres and GP utilisation in those areas is significantly lower than the Australian average (4.7 services per capita per annum *versus* 5.3 Australia-wide).

areas[264]. However, according to the more recent report published by Access Economics, there was an estimated shortfall of between 1,200 and 2,000 GPs in 2002 - 700 FTEs (16%) in rural areas and 500 FTEs (3.7%) in urban areas[265]. The Access report indicated that one in eight (13%) people living in urban areas are in areas of 'severe' GP shortfall (a shortfall of more than 20% in relation to estimated needs), while nearly half the rural population live in areas of 'severe' shortfall[266].

Finding 34

A 2002 Access Economics report estimated that throughout Australia, 13 percent of people in urban areas and almost half the population in rural areas live in areas of 'severe' General Practitioner shortfall.

The Australian Medical Workforce Advisory Council has also identified shortfalls in a number of medical specialties, including emergency medicine, geriatric medicine, ear nose and throat surgery, dermatology, obstetrics and gynecology, intensive care, psychiatry, medical and haematological oncology, radiology and anaesthesia. The specialties identified as having the greatest shortfall (percentage-wise) were emergency medicine, radiation oncology, medical and haematological oncology and intensive care. In some fields the shortfall has been most pronounced in rural and remote areas and in the public sector (see Table A4.1). As of September 2002, around 90 percent of the training adjustments recommended by AMWAC to address workforce shortages had been implemented[267].

The more recently formed Australian Health Workforce Advisory Committee (AHWAC) has examined the critical care nursing and the midwifery workforces. As of 2002, there was an estimated 537 shortfall in critical care nurses, representing 5.4 percent of the total critical care nursing workforce. The midwifery workforce is also reported to be experiencing a shortfall, with an estimated 1,847 additional midwives (15.4 percent of the existing workforce) required to cater for current needs. Some 19 percent of the midwifery workforce is currently made up of registered and enrolled nurses with no formal midwifery training, therefore alleviating the shortfall.

In support of information provided to the Committee through evidence and submissions, workforce data compiled by the Department of Employment and

264 Australian Medical Workforce Advisory Council, *The General Practice Workforce in Australia, Supply and Requirements 1999-2010*, August 2000, p2.

265 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, p9.

266 *ibid*.

267 Australian Medical Workforce Advisory Council, *Annual Report 2001-02, September 2002*, pp11-18.

Workplace Relations[268] indicates that there was a State-wide shortage of nurses, both registered and enrolled, across all categories of nursing as of February 2003. Shortages of numerous other health professionals were also identified: pharmacists; occupational therapists (particularly in aged care facilities and in rural areas); physiotherapists (particularly for paediatric physiotherapists and for physiotherapists in rural areas); diagnostic radiographers (in regional areas only); radiation therapists; nuclear medicine technologists; sonographers; and audiologists.

Finding 35

Department of Employment and Workplace Relations data indicate that as of January 2004, there was a State-wide shortage of registered nurses, registered midwives, registered mental health nurses and enrolled nurses.

Finding 36

Department of Employment and Workplace Relations indicate that in 2003, there was a State-wide shortage of physiotherapists, sonographers, radiation therapists and nuclear medicine technologists, a regional shortage of pharmacists and recruitment difficulties for occupational therapists in aged care facilities.

(i) Factors contributing to health workforce shortfalls

The reasons put forward for the shortage of health professionals were numerous. Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, advised the Committee that the shortage of doctors is partly a result of insufficient student places. Professor Landau indicated that there was a significant reduction in the number of medical school places throughout the country, as a result of a Commonwealth policy decision. More recently, these lost places were reinstated, and an additional 100 to 200 rural and other special places have been created. Professor Landau indicated, however, that an additional 60 to 80 medical student places would be necessary to address the shortage of doctors in Western Australia[269].

Dr Charles Nadin, Rural General Practitioner and Director, General Practice Divisions of Western Australia, indicated that as well as the issue of insufficient student places,

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268 Commonwealth Department of Employment and Workplace Relations, Submission to Senate Committee on Employment, Workplace Relations and Education Inquiry into Current and Future Skills Needs, May 2003, http://www.aph.gov.au/senate/committees/EET_CTTE/skills/submissions/sub095b.pdf, accessed on 23 March 2004.

269 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3.

the ethos of people training as doctors was changing. New graduates are not prepared to work the long hours that were worked by doctors in the past[270].

The 2002 Australian Medical Association commissioned Access Economics survey, completed by 7,500 GPs (around one third of the GP workforce), identified a number of key issues as contributing to the problem of overall GP shortage:

- Low remuneration (average $47.14 per hour before tax) compared to other self-employed professional remuneration rates and to jobs requiring less responsibility, study, training and ongoing professional development;
- Long hours - average 53 hours per week;
- Bulk-billing pressures and expectations - many GPs facing a conflict between responsibility to the patient and their own survival, both financial and psychological;
- Rural conditions - many country GPs enjoy their work but are becoming increasingly disillusioned and disenfranchised with workforce conditions; and
- Increasing complexities of training, accreditation and administration[271].

Low remuneration was the most commonly cited problem, and was ranked number one by 43% of respondents[272].

Finding 37

Although today's General Practitioners generally work shorter hours than were worked by General Practitioners in the past, a recent Access Economics survey found that long hours remains a key deterrent to medical graduates choosing general practice as a career option. Comparatively low remuneration and concerns about bulk billing were also identified as important contributing factors.

A number of factors are thought to contribute to the shortage of nurses. Associate Professor Kate White, Acting Head of the School of Nursing and Public Health, Edith Cowan University, advised the Committee that numerous reports had identified work practices as a major factor in the shortage, and that despite an awareness of the problems, there was a lack of leadership and willingness on the part of the system to

270 Professor Charles Nadin, General Practitioner and Director, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p2.

271 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, p12.

272 *ibid*, p13.

adopt recommendations aimed at improving the working environment for nurses[273]. Other witnesses supported Associate Professor White's comments on the work environment contributing to the high rate of attrition, and hence shortage, of nurses[274].

As well as work environment *per se*, Mr Mark Olsen, State Secretary, Australian Nurses Federation (WA), suggested that the high rate of attrition is partly due to the level of practical experience nurses gain during undergraduate training. Without sufficient exposure to clinical practice, nurses are not adequately prepared for what awaits them, and they leave the profession[275].

Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia suggested:

> *That with more career choices available, fewer women now choose nursing as a career than was the case in the past*[276].

Finding 38

Many factors contribute to the ongoing nursing shortage, including the high rate of attrition in the nursing workforce due to the working environment.

Professor Anthony Wright, School of Physiotherapy, Curtin University indicated that shortages in the allied health workforce are a direct result of a shortage in the number of students being trained. Professor Wright stated:

> *One of the issues for physiotherapy and a number of the allied health disciplines - certainly speech pathology - which may have been highlighted by the allied health task force, relates to the actual shortage in terms of numbers of graduating physiotherapists. The limiting factor is having enough funded places for them within the university system. The number of federally funded places available is a distinct issue and it seems difficult to influence the*

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273 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p2.

274 Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p10; Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p11; Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p2.

275 Mr Mark Olsen, State Secretary, Australian Nurses Federation (WA), Transcript of Evidence, 22 November 2002, p5.

276 Ms Margaret Watson, Chief Executive Officer, Nurses Board of Western Australia, Transcript of Evidence, 21 November 2002, p2.

numbers based on the particular needs of particular professions in each of the States[277].

Professor Wright further advised that the process by which training places are determined allows little scope for rapidly increasing the number of places in a particular discipline to accommodate rapid changes in workforce requirements[278]. As well as insufficient training places, the Committee was advised that the inadequate career structure within the public sector compels many physiotherapists to move into the private sector or to leave physiotherapy, worsening the shortage[279]. The same holds for the majority of allied health disciplines[280]. These issues are explored in further detail in Chapters 3 and 4.

Radiation therapists are somewhat unique, in that the shortage of trained practitioners in this area is largely due to the fact that there is no training program in Western Australia. Western Australians who are interested in becoming radiation technicians must train outside the state, and sometimes they do not return[281]. Podiatry may also be in a similar situation in the future, with consideration being given to switching from an undergraduate to a full-fee paying graduate entry program[282]. The prospect of a reduction in the number of graduating podiatrists is of concern, as, even with the current graduate output, there are considerably more podiatry positions than there are graduates to fill them.

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277 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p1.

278 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p1.

279 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, pp8-9.

280 Cancer Foundation of Western Australia, Submission, 29 August 2002, p4; Ms Glenda Trevaskis, Public Health Nutritionist, *et al*, Submission, 29 August 2002, p2; Andrea Way Child Development Centre, Submission, 2 September 2002, p3; Australian Association of Occupational Therapists (WA), Submission, 20 September 2002, p5; and Metropolitan Allied Health Council, Submission, 23 September 2002, p6; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p2; Mr Neil Hall, President, Australian Podiatry Association (WA), Transcript of Evidence, 21 November 2002, p2; Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p4.

281 Ms Susan Rooney, Chief Executive Officer, Cancer Foundation, Transcript of Evidence, 16 October 2002, p1.

282 Dr Paul Tinley, Head of Podiatry Department, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p2.

Finding 39

Shortage of training places, coupled with an inadequate career structure in the public sector contribute to the shortage of physiotherapists and other allied health professionals in the public health system.

(ii) Workforce demographics and changing work practices

Data recently compiled by the Australian Institute of Health and Welfare provides a snapshot of recent changes to the health workforce. These data offer some insight into how changing work practices and workforce demographics affect the capacity of the health system.

In the year 2001, there were some 451,000 people employed in health occupations[283] and a further 107,000 employed in the health industry[284] throughout Australia. By far the largest occupational group is nursing, accounting for around 50 percent of health workers[285]. Registered nurses in turn make up around 50 percent of the nursing workforce[286].

Despite a sizeable increase in the Australian medical workforce between 1995 and 2000, average weekly working hours for medical practitioners decreased from 48.2 to 45.5 hours. Medical practitioner rate increased slightly (i.e. growth in the number of medical practitioners exceeded population growth), however, when converted to a FTE (full time equivalent) rate, there was a decrease. In other words, there was an increase in the number of practising medical practitioners, but they were working fewer hours, thereby providing fewer total service hours[287].

Between 1995 and 2001, the average working week for nurses decreased from 32.4 to 30.5 (a 5.9 percent decrease)[288]. Further adding to a reduction in supply of nursing services, growth in the nursing workforce failed to keep pace with growth in the population. For example, there was a 3.4 percent increase in the number of employed nurses and a 7.4 percent increase in the population[289]. The decreasing rate, coupled

283 Australian Institute of Health and Welfare, *Health and community services labour force 2001*, September 2002, p51.

284 *ibid*, p46-47.

285 *ibid*, p59.

286 *ibid*, p59.

287 Australian Institute of Health and Welfare, *Medical labour force 2000*, June 2003, p10.

288 Australian Institute of Health and Welfare, *Nursing labour force 2002*, December 2003, p6.

289 *ibid*, p6.

with decreasing hours, resulted in a 9 percent decrease in FTE nurses[290]. Western Australia fared worse than other states, with a decrease of 22 percent in this period[291].

The number of allied health workers increased markedly between 1996 and 2001 (26.6 percent), with the numerically large professions of physiotherapy, clinical psychology and occupational therapy increasing 15.1, 44.1 and 22.7 percent respectively. As with the medical and nursing workforce, a large proportion of allied health workers work part-time (42.1 percent).

Finding 40

Despite a numerical increase in our health workforce, a progressive increase in the proportion of part-time workers has led to an overall decrease in Full Time Equivalent rates per population for both nursing and medical workers.

In addition to the increasing propensity for part-time work amongst our health workers, progressive feminisation of the medical workforce has a significant impact on the service capacity of the health workforce. The health industry as a whole is predominantly female (74 percent female), although there are variations within the industry[292]. Unlike nursing, and many other health professions, which have been traditionally female dominated, the medical workforce has been traditionally male dominant. In 2000, female medical practitioners comprised 30.0 percent of the medical workforce[293]. In the same year, 44.7 percent of medicine student course completions were female[294]. It is estimated that by 2025, females will represent 42 percent of the medical workforce[295].

Females tend to leave the practice of medicine or practise at lower activity levels for a period of time, and also retire at an earlier age than males. An analysis of working hours suggests that the 'lifetime contribution'[296] of females is 63 percent of the male contribution in general practice and 75 percent across medical specialties.

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290 Australian Institute of Health and Welfare, *Nursing labour force 2002*, December 2003, p18.

291 *ibid*, p18.

292 Australian Institute of Health and Welfare, *Health and community services labour force, 2001*, September 2003, p15.

293 Australian Institute of Health and Welfare, *Medical labour force 2000*, June 2003, p5.

294 Information supplied by the Australian Medical Workforce Advisory Committee, October 2003.

295 Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare, *Female participation in the Australian medical workforce*, July 1996, p1.

296 The total contribution that a person will make to the workforce during their working life, taking into account the average number of hours worked per week, absences from the workforce, periods of higher or lower activity (e.g. due to family responsibilities) and the total number of years worked.

Finding 41

Increasing female participation in the medical workforce is likely to have a substantial impact on future supply of medical practitioners, as females are more likely than their male counterparts to work part-time and are more likely to be attracted to areas of practice with flexible working hours, such as general practice.

(b) Maldistribution of health workers

As well as the overall shortage of health workers, there is a marked maldistribution of many health professions, with people living in rural and remote areas hardest hit. The issue of workforce shortages in rural and remote areas was addressed in submissions and evidence[297], and many organisations commented on current or potential strategies to address the issue. Strategies include:

- Increased rural exposure during health professional training[298];
- Targeted recruitment of rural students to health professional courses[299];
- Financial incentives for health professionals to work in rural/remote areas[300]; and

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297 Mr Mark Wiklund, Branch President, Australian Physiotherapy Association (WA), Transcript of Evidence, 21 November 2002, p4; Ms Melita Brown, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p4; Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2; and Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p6.

298 Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p3; Mrs Marita Sealey, Chief Executive Officer, Western Australian General Practice Education and Training Ltd, Transcript of Evidence, 23 October 2002, pp4-5; Dr Paul Tinley, on behalf of the Australian Physiotherapy Association (WA), Transcript of Evidence, 21 November 2002, p9; Dr Charles Nadin, Director, General Practice Divisions of Western Australia, Transcript of Evidence, 22 November 2002, p2; Dr Peter Maguire, on behalf of the Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p7; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3; and Dr Bernard Pearn-Rowe, President, Australian Medical Association (WA), Transcript of Evidence, 4 December 2002, pp1-3.

299 Mr Ian Cooper, on behalf of the Australian Physiotherapy Association (WA), Transcript of Evidence, 21 November 2002, p8; Professor Lou Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, 22 November 2002, p3; and Dr Bernard Pearn-Rowe, President, Australian Medical Association (WA), Transcript of Evidence, 4 December 2002, pp1-3.

300 Professor Anthony Wright, School of Physiotherapy, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p7; and Ms Melita Brown, on behalf of the Metropolitan Allied Health Council, Transcript of Evidence, 6 November 2002, p5.

- Student scholarships[301].

There is a wealth of statistical evidence in support of comments made in submissions and evidence on maldistribution of the health workforce. Data collected by the Australian Institute of Health and Welfare shows a progressive decline, from major cities to very remote areas, in the number of health workers per 100,000 population, with double the rate of health workers in major cities compared to very remote areas. In WA there were 3,190 persons per 100,000 population employed in health industries in major cities, compared to just 1,368 in very remote areas (Table A4.2)[302].

There are significantly lower rates of most health professionals working outside capital cities. Nursing and complementary therapies workers are the exception (Table A4.3). The higher rate of nursing workers is largely due to the higher rates of enrolled nurses (74 and 151 in capital cities and other regions respectively) and nursing assistants/personal carers (252 and 278 in capital cities and other regions respectively). There are slightly fewer registered nurses per capita outside capital cities[303].

Finding 42

There are significantly fewer health workers per capita in rural and remote areas of Western Australia compared with metropolitan Perth.

(i) Attracting health professionals to rural and remote areas

Considerable effort has been expended in recent years in trying to understand why health professionals, particularly doctors, are reluctant to work in non-urban areas. As part of the Australian Medical Association commissioned survey into GP services, Access Economics examined some of the reasons for deficits in rural and remote areas[304]. The reasons cited fell into four categories:

- Work intensity: Long hours, especially after hours, on-call hours and lack of holidays, with lack of locums or relief is a major problem, causing stress and burnout. The greater diversity and skills challenges of rural work also contribute to increased work intensity;

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301 Australian Physiotherapy Association (WA), Submission, 28 August 2002, p3; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p5; Associate Professor Jill Downie, School of Nursing and Midwifery, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p9.

302 Australian Institute of Health and Welfare, *Health and community services labour force 2001*, September 2003, p101.

303 *ibid*, p106.

304 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002.

- Family conflicts and costs: Partner's career, children's schooling and lack of family support are important issues. These issues were raised by two thirds of respondents and were considered non-negotiable;

- Business difficulties: small business administration, difficulty attracting partners or selling a business, higher practice costs, lack of capital appreciation, medical indemnity insurance premiums (particularly for obstetric and procedural work) and red tape were commonly cited barriers to rural GP practice; and

- Many GPs also perceive the rural lifestyle to be lacking in social choices, amenities and peer interaction[305].

A postal survey of doctors in vocational training in 2002 identified some of the key factors that might attract doctors to work in rural areas[306]. When asked where they would prefer to be practising, 82.6 percent indicated that they would prefer to practice in an urban location. A greater proportion of doctors with a rural background, compared with doctors without a rural background (28 versus 9.5 percent), indicated a preference for rural practice[307].

Of the doctors who responded to the question 'If you are not considering rural practice, please specify at least one factor that would influence you to take up rural practice', the top five responses were (in order of frequency):

- Monetary incentives;

- Spouse/family considerations (e.g. if partner prepared to move, once children have finished school, proximity to family and friends);

- Available jobs for self and partner/available part-time work;

- Good hours/time off/on-call hours; and

- Lifestyle of rural area[308].

Nine percent of doctors indicated that nothing would influence them to take up rural practice[309].

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305 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, pp14-15.

306 Australian Medical Workforce Advisory Committee, *Career decision making by doctors in vocational training*, May 2003.

307 *ibid*, p20.

308 *ibid*, p21.

309 *ibid*, p22.

Increasing female participation in the medical workforce may have important implications for future geographic distribution of medical practitioners, as female practitioners are more likely than their male counterparts to be working in a capital city or major urban area (83 percent of primary care practitioners and 93 percent of specialists compared to 77.5 percent and 87.3 percent for males)[310].

Finding 43

Long hours, family considerations, business difficulties and the rural lifestyle are key deterrents to attracting General Practitioners to rural practice. Monetary incentives and spouse/family considerations are the most likely factors to attract General Practitioners to rural practice.

(ii) Retention of GPs in rural and remote areas

As well as attracting doctors and other health professionals to non-urban areas, retention can also be a difficult undertaking. In a survey of more than 1,300 practising GPs in rural and remote areas, Humphreys *et al* recently explored some of the factors that help induce doctors to remain in rural and remote settings[311].

Almost without exception, professional factors were considered to be more important than social or external factors. Good on-call arrangements were overwhelmingly the most significant factor for all rural and remote regions, regardless of respondent age, sex or practice location. Proximity to a city or large regional centre was, in almost all cases, the least important consideration. The key workforce problem for rural doctors is inability to get time away for recreational leave and family activities, and for emergency relief and continuing professional development[312].

There were significant differences according to demographic profile. For GPs who are younger, female, with children or working part-time, good on-call arrangements and availability of professional support are still generally the most important factors, but local availability of services and local geographic attractions assume a greater importance. Variety of practice was a more important consideration for male than for female GPs.

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310 Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare, *Female participation in the Australian medical workforce*, July 1996, p7.

311 JS Humphreys, MP Jones, JA Jones and PR Mara, *Workforce retention in rural and remote Australia: determining the factors that influence length of practice*, Medical Journal of Australia, May 2002, pp472-476.

312 *ibid.*

Finding 44

General Practitioners practising in rural and remote areas consider professional factors, such as good on-call arrangements and availability of professional support, to be the most important factors to influence their decision to remain in rural and remote settings.

(iii) Shortage of GPs in outer urban areas

In addition to shortages of medical practitioners in rural and remote areas, some low-income areas, which typically occupy the outer urban fringe, are also experiencing shortfalls. Dr John Harvey, Medical Director, Rockingham Kwinana District Hospital advised the Committee that people in Rockingham/Kwinana have considerable difficulty accessing GPs[313]. Dr Harvey indicated that there are just 55 FTE GPs in the area to service a population of almost 100,000, giving a GP to population ratio of just 1:1,800, considerably higher than the WA average of 1:1,200[314].

For most GPs working in low income areas, there is considerable pressure to bulk-bill. Access Economics, in its 2002 GP survey, reported that hundreds of respondents indicated that they were gradually increasing their private billing, or, more often, moving to higher socioeconomic areas where they feel more comfortable about private billing[315].

The most commonly cited reason for bulk-billing (and hence lower remuneration) was working in a practice located in an area of genuine need (aged, unemployed, working poor, disabled, students, drug and alcohol patients). Private bills would not be paid, and pursuing them would not be cost-effective. Many GPs also feared for the health outcomes of patients, particularly children, who would not have their health needs met if they were not bulk-billed[316].

Many GPs working in low income areas believe the situation has deteriorated to such an extent that it has become largely untenable. A number indicated that they cross-subsidise some of their patients' health, either by higher private billing for those patients who are deemed to be able to afford to pay, or by doing better-paid work elsewhere part-time, or sometimes out of their own pockets. When faced with the

313 Dr John Harvey, Medical Director, Rockingham/Kwinana District Hospital, Briefing, 22 September 2003.

314 Written information provided by Dr John Harvey, Medical Director, Rockingham/Kwinana District Hospital, Briefing, 22 September 2003.

315 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, pp15-16.

316 *ibid*.

choice of charging lower income patients on the outer urban fringe or re-locating to a higher socioeconomic area, many GPs would rather re-locate[317].

The maldistribution of GPs in urban areas is not difficult to understand. In simple terms, GPs are attracted to inner urban practices because remuneration is better and practice is 'easier' - patients can be readily referred to specialists and acute hospitals, there is less pressure to bulk bill, and a greater opportunity to provide quality care with commensurate higher job satisfaction[318].

Finding 45

Many General Practitioners indicate that they would rather work in inner than in outer urban areas because remuneration is better and practice is easier - patients can be readily referred to specialists and acute hospitals, there is less pressure to bulk bill, and a greater opportunity to provide quality care with commensurate higher job satisfaction.

(c) Forward projections for the health workforce

(i) Driving factors and the future medical workforce

In February 2000, the Australian Health Ministers' Advisory Council initiated the first review of AMWAC. Whilst acknowledging AMWAC's success in advancing medical workforce planning in Australia, the review team suggested that Australia might be heading towards a significant shortage of doctors[319].

As the review team noted, the number of medical student places in Australian universities had been capped for more than a decade. The recent opening of the James Cook Medical School in North Queensland and the Medical Rural Bonded Scholarships have only replaced the more than 100 medical student places that were lost in the early 1990s. The shortage of medical personnel is most marked in general practice, where the number of vocational trainees declined from around 1,900 in 1994 to just over 1,400 in 2002[320].

317 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, pp15-16.

318 *ibid*, p16.

319 PM Brooks, HM Lapsley and DB Butt, *Medical workforce issues in Australia: "tomorrow's doctors - too few, too far"* Medical Journal of Australia, August 2003, pp206-208.

320 Australian Medical Workforce Advisory Committee, *Annual report 2001-2002*, 2002, as cited in: PM Brooks, HM Lapsley and DB Butt, *Medical workforce issues in Australia: "tomorrow's doctors - too few, too far"* Medical Journal of Australia, August 2003, pp206-208.

The review team identified a number of driving factors in the medical workforce shortages: feminisation of the medical workforce; globalisation of the health workforce; and increasing patient and community demands for healthcare.

Increasing female participation in the medical workforce is likely to have a substantial impact on future supply of medical practitioners, as female practitioners' work practices differ from their male counterparts. In 1994, female clinicians worked an average of 39 hours per week compared with 51.4 hours per week for their male colleagues[321]. Female practitioners are also more likely than their male counterparts to work part-time.

A strong preference by females for general practice is thought to be due to the more flexible working hours[322]. Specialist practice is comparatively more demanding of the clinicians' time, particularly in the surgical specialties, and it is believed that this is an important contributing factor to the low female representation in most specialties (average 14 percent). Higher proportions of female trainees would indicate that there will be a gradual trend toward greater female participation in medical specialties over the coming years, a trend that may result in future workforce shortages in medical specialties.

A second factor driving the need to increase doctor numbers is globalisation. The Australian healthcare workforce is well trained and highly sought after in the international marketplace. A devalued Australian dollar, coupled with a lack of career opportunities in the public hospital system has led to an increasing number of doctors being recruited to overseas jobs[323].

Increasing community expectations and the use of progressively more advanced technology also drive increased use of medical services[324]. Today's average health consumer is more aware of the range of treatment options and expects access to the best available treatments and technology. Australians have one of the highest life expectancies in the world, second only to Japan. There is an expectation that, with access to appropriate and timely health care, everyone has the potential to live well into their eighth decade of life and even beyond. The progressive ageing of our population, with accompanying chronic illness, greatly increases the burden of disease in our community.

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321 Australian Medical Workforce Advisory Committee, *Female Participation in the Australian Medical Workforce*, September 1996, p11.

322 *ibid*, p9.

323 PM Brooks, HM Lapsley and DB Butt, *Medical workforce issues in Australia: "tomorrow's doctors - too few, too far"* Medical Journal of Australia, August 2003, pp206-208.

324 *ibid*.

Finding 46

Despite recent advances in medical workforce planning, Australia might continue to experience a shortage of doctors in the future. Increasing female participation, globalisation and increasing community expectations are expected to be major driving factors in future medical workforce shortages.

(ii) Predicted shortfalls in the future GP workforce

Access Economics recently estimated that demand for GP services would increase by 1.27 percent per annum between 2000 and 2010 (and an average 1.23 percent per annum between 2000 and 2020)[325]. AMWAC estimated the requirement for GP services would grow by 1.13 per cent per annum in the decade to 2010[326].

Access predicted that if medical training provisions continue along similar lines to the current arrangements, supply of FTE GPs will reach around 23 000 by 2010, at which point demand will reach around 27,000. By 2020, supply will still be around 23,000 FTE GPs, and demand will exceed 33,000, a shortfall of more than 10,000 FTE GPs[327].

Finding 47

Based on current policy settings, workforce trends and changing population demographics, Access Economics predicts a shortfall of 10,000 Full Time Equivalent General Practitioners by 2020.

(iii) Predicted shortfalls in the future nursing workforce

Shortages in the nursing workforce too are expected to worsen over the coming years. A recent publication by Karmel and Li, of the Commonwealth Department of Education, Science and Training, examined the balance between nursing workforce supply and demand to 2020[328].

The authors predicted an average increase in demand for registered nurses of 2.56 percent per annum between 2000 and 2010, and an increase for enrolled nurses of 3.06

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325 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002.

326 Australian Medical Workforce Advisory Council, *The general practice workforce in Australia*, August 2000, p1.

327 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, p24.

328 T Karmel and J Li, Commonwealth Department of Education, Science and Training, *The nursing workforce - 2010*, http://www.dest.gov.au/archive/highered/nursing/pubs/nursing_worfforce_2010/nursing_workforce_default.htm, accessed on 23 March 2004.

percent per annum[329]. The prediction is based on population growth and changes in age structure and on the assumption that the trend toward decreased working hours that was observed in the preceding decade will continue.

The 'exit rate', that is the rate at which nurses leave the profession, increases with age. As the nursing workforce is ageing, the aggregate exit rate is expected to increase significantly in the next 20 years. The authors predict that the exit rate will increase between 2000 and 2020, leading to a decrease of almost 10 percent in the pool of registered nurses during this time[330]. In other words, the current output of nurses is insufficient to maintain the current workforce, let alone cater for any increase in demand for nursing services in the future. The situation is a little different for the population of enrolled nurses, which will begin to age after 2010[331].

The authors predict a shortfall of registered nurses in the order of 40,000 by 2010[332]. They estimate that an increase in new graduates in the order of 120 percent would be required to avoid the predicted shortfall[333]. The predicted shortfall for enrolled nurses is less dramatic, with an increase in the order of 17 percent required to balance supply and demand in 2010[334].

Finding 48

Based on current graduate output, increasing rates of attrition as the nursing workforce ages and a continuing trend toward decreasing average working hours, the Commonwealth Department of Education, Science and Training predicts that Australia will have a shortfall of 40,000 registered nurses by 2010.

5.4 Meeting the health needs of an ageing population

As with most other developed countries, Australia's population is ageing. The changing population profile is largely driven by declining fertility and mortality rates. Population ageing has enormous implications for the future roles and interactions of health professionals and for the health system in a broader context, as older Australians use a disproportionately large share of health services. Many organisations made reference to our ageing population, particularly with regard to re-alignment of

329 T Karmel and J Li, Commonwealth Department of Education, Science and Training, *The nursing workforce - 2010*, http://www.dest.gov.au/archive/highered/nursing/pubs/nursing_worfforce_2010/nursing_workforce_default.htm, accessed on 23 March 2004.

330 *ibid*.

331 *ibid*.

332 *ibid*.

333 *ibid*.

334 *ibid*.

health professional training[335] and the challenges associated with meeting the health needs of older people[336]. Catering for the current and future needs of older Western Australians will require careful consideration in the areas of training, workforce planning and coordination of services across the spectrum of health and aged care.

(a) The changing age structure

As at June 30 2001, there were an estimated 2.4 million people aged 65 and over in Australia, representing 12.5 percent of the total population[337]. Between 2001 and 2011, the number of people aged 65 and over is projected to increase to 3.0 million, an increase of 26 percent on 2001 numbers[338]. Growth in the remainder of the population is projected to increase by just 7 percent[339]. According to Australian Bureau of Statistics projections, the 10-year growth rate of the 65 and over age group is expected to peak at 39 percent between 2011 and 2021, as the baby boom generation reaches retirement age[340]. Between 2011 and 2021 the under 65 population will grow by just 2.5 percent. By 2021, 18.4 percent of the population will be aged 65 and over[341]. This change in the distribution of the Australian population is critical with respect to our health needs as a nation.

Finding 49

The proportion of people aged 65 and over will increase substantially in coming years. By 2021, it is estimated that people aged 65 and over will account for 18.4 percent of the population.

335 Council on the Ageing (WA), Submission, 28 August 2002, pp11-12; Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p5; Arthritis Foundation of Western Australia, Submission, 30 August 2002, p5; and Mr Kenneth Marston, Policy Officer, Council on the Ageing (WA), Transcript of Evidence, 16 October 2002, p1.

336 Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p1; Mr Kenneth Marston, Policy Officer, Council on the Ageing (WA), Transcript of Evidence 16 October 2002, p1; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p7; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3; and Mr Ric Forlano, Executive Director, Arthritis Foundation of Western Australia, Transcript of Evidence, 23 October 2002, p2.

337 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *Older Australia at a glance*, October 2002, p4.

338 *ibid*.

339 *ibid*.

340 *ibid*.

341 *ibid*.

(b) Utilisation of health services by older Australians

In financial year 2001-02, people aged 65 and over represented 12.6 percent of the Australian population (11.1 percent of the Western Australian population) and accounted for 10.9 million or 47.0 percent of total hospital patient days (0.95 million or 44.7 percent of total patient days in Western Australia)[342]. In other words, Australians over the age of 65 used an average of 4.43 hospital inpatient days per annum (4.46 in Western Australia). By comparison, people under 65 years of age used an average of 0.72 inpatient days per annum (0.69 in Western Australia).

People aged 65 and over also utilise proportionately more medical services than people aged under 65. In 1999-00, approximately 24 percent of all GP services were provided to people aged 65 and over[343]. The rate of use of GP services for people over 65 was more than double that for someone under 65 (9.6 services per person versus 4.7 services per person per annum)[344]. Most older people sought GP services in relation to chronic problems. The most common problem managed by GPs was hypertension, which accounted for 23.4 percent of all chronic problems managed[345]. In all, chronic conditions were present in 93.2 percent of patients aged 65 and over[346].

The level of use of medications also increases with age. In 1998-99, people aged 65 and over accounted for 31 percent of total expenditure on pharmaceutical services[347]. Approximately 86 percent of people aged 65 or over used medication, compared with 59 percent of the general population. The number of medications used also differs: more than 50 percent of people aged 65 and over used three or more medications, compared with about one quarter of the general population. In encounters with general practitioners, medications were prescribed, supplied or advised for purchase over the counter at a rate of 131.6 per 100 encounters[348]. Antihypertensives were the most commonly prescribed medication in this age group.

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342 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, June 2003, p130.

343 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *Older Australia at a Glance*, October 2002, p68.

344 *ibid*.

345 J O'Halloran, H Britt, L Valenti, C Harrison, Y Pan and S Knox, Australian Institute of Health and Welfare*, Older patients attending general practice in Australia 2000-02,* August 2003, p58.

346 *ibid*, p59.

347 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *Older Australia at a Glance*, October 2002, p61.

348 J O'Halloran, H Britt, L Valenti, C Harrison, Y Pan and S Knox, Australian Institute of Health and Welfare*, Older patients attending general practice in Australia 2000-02,* August 2003, p31.

Finding 50

People aged over 65, who represented 12.6 percent of the Australian population in 2001-02 accounted for 47 percent of total hospital patient days. Utilisation of General Practitioner services and expenditure on pharmaceuticals is also disproportionately high in this age group.

(c) Future demands for health services

Demand for hospital beds is expected to rise as the population increases. If the population increased without any change in the age distribution, simple population growth could be used as a useful predictor of demand for hospital beds into the future. This, of course, makes no allowance for improvements in operational and clinical efficiency or technological advances, factors that cannot be readily predicted. Another factor that will have a profound impact on growth in demand, and which can be readily predicted, is the changing population distribution. Demand for hospital beds is expected to grow at a rate that far outstrips growth in the overall population.

A few simple extrapolations provide an indication of the magnitude of the increase in demand. Based on ABS population projections, there will be 2.94 million persons aged 65 and over in 2011 (14.0 percent of the Australian population) and 5.05 million by 2031 (21.3 percent of the population)[349]. If it can be assumed that current requirements for patient days per annum will be maintained for both the over and under 65 age groups (i.e. 4.43 and 0.72 days respectively), by 2011 persons in both age groups will require a total of around 13.0 million inpatient days per annum in Australian hospitals. Compared to the 22.2 million patient days required in 2001/02, this represents a 12 percent increase in the total number of patient days (1.2 percent per annum over 10 years), although the population is projected to increase by only 7.7 percent during this period.

By 2031, persons over 65 can be expected to utilise 22.4 million patient days per annum, 62.5 percent of total patient days (35.8 million). This represents a massive 54 percent increase from current demand, with only a 21 percent increase in population. Between 2011 and 2031, demand will increase by 37.7 percent, almost 1.9 percent per annum. The greater projected increase between 2011 and 2031, compared to 2001-2011, coincides with the youngest of the baby boom generation turning 65 in 2031.

Changes in age distribution within the over 65 group (i.e a greater proportion over 80) may further increase the demand for inpatient beds. Persons aged 65-74 use an average of 1.93 patient days per annum, compared to 3.68 for people aged 75-84, and 6.54 for people aged 85 and over. While the number of people aged 65 is expected to double in

[349] Australian Bureau of Statistics, *Australian Social Trends 1999, Population - Population Projections: Our ageing population*, http://www.abs.gov.au/ausstats/abs@.nsf/0/B7760619C3973594CA25699F0005D60F?Open, Accessed on 22 October 2003.

the next 30 years, the number of people aged 80 and over is expected to undergo a proportionately larger increase.

The Commonwealth Department of Health and Ageing predicted that the combined effect of population growth and ageing will lead to a 1.2 percent per annum real (inflation-adjusted) growth in health costs[350] between 1996 and 2051. The Department predicted that the annual rate of increase would peak at around 1.6 percent, remaining at this level until 2018, declining to around 1.4 percent by 2026, and thereafter declining rapidly to 0.5 percent by 2051[351]. The rapid decline beyond 2026 is expected as a result of the waning influence of the ageing of the baby boomer generation.

Growth in demand for other health services can similarly be predicted to outstrip growth in the general population. Based on 1999-00 estimates of utilisation rates of GP services (9.6 services per person aged 65 and over, compared to 4.7 services per person aged under 65), and projected changes in population, it can be estimated that by 2011, the number of GP services will increase by 8.6 percent (0.8 percent per annum). Between 2011 and 2031, the total number of GP services can be projected to increase by 20.3 percent (1.0 percent per annum), and people aged 65 and over will account for more than 35 percent of all GP services. This projection makes no allowance for the fact that older people generally present with more complex health problems and hence require longer consultation.

Access Economics predict that demand for GP services will increase by 1.27 percent between 2000 and 2010 (1.23 percent per annum over the 20 years to 2020)[352]. 'GP services' encapsulates both the number of services and the length of consultation times, both of which are greater in people aged 65 and over than in the rest of the population. The Australian Medical Workforce Advisory Committee has projected that requirements for GP services will grow by 1.13 percent per annum in the decade to 2010[353].

As well as demographic factors, non-demographic factors can influence growth in health spending. In fact, the Intergenerational Report[354] identified non-demographic factors, such as new medications and greater use of diagnostic procedures, rather than population growth and changing age structure, as the key drivers of the real increase in health spending over the past decade. The report estimated that real growth in

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350 Note: estimate includes total Commonwealth hospital, medical and pharmaceutical costs.

351 Commonwealth Department of Health and Ageing, *The Ageing Australian Population and Future Health Costs: 1996-2051*, August 1999, p37.

352 Access Economics Pty Ltd, *An Analysis of the Widening Gap between Community Need and the Availability of GP Services*, February 2002, pp17-18.

353 Australian Medical Workforce Advisory Committee, *The General Practice Workforce in Australia, Supply and Requirements 1999-2010*, August 2000, p12.

354 Commonwealth of Australia, *Intergenerational Report 2002-03, 2002-03 Budget Paper No. 5*, May 2002.

Commonwealth health spending averaged 4.9 percent per annum between 1989-90 and 2000-01. Population growth and ageing were estimated to account for just 1.2 and 0.5 percent respectively, while non-demographic changes were predicted to account for 3.2 percent[355].

As stressed by many organisations that prepared submissions or gave evidence before the Committee, planning for our future health workforce must take adequate consideration of the changing structure of our population[356]. It takes a minimum of 10 years to train a general practitioner, 12 years to train a medical specialist[357]. Our current intake of students should therefore reflect projected demand in 10 to 15 years times, allowing for the fact that demand for patient bed days in hospital will have increased by around 1.2 percent per annum in the intervening period, as will demand for GP services.

Finding 51

Growth in demand for hospital and other health services over the next two decades will increase markedly as the population ages. Planning for our future health workforce must take adequate consideration of the ageing of our population.

(d) Provision of aged care

Any discussion on the health needs of an ageing population must necessarily broach the subject of aged care services, as health and aged care are inextricably linked. As people approach their eighth decade and beyond, the prospect of requiring some level of support, whether it be community or institution based, must be considered. And as people age, the likelihood of encounters with the health system ultimately resulting in an assessment of eligibility for aged care services increases. It is only when health and aged care services work in concert that the wellbeing of our older population can be adequately catered for.

355 *ibid*, p36.

356 Professor Louis Landau, Dean, Faculty of Medicine and Dentistry, University of Western Australia, Submission, 10 September 2002, p2; School of Physiotherapy, Curtin University of Technology, Submission, 30 August 2002, p1; Mr Kenneth Marston, Policy Officer, Council on the Ageing (WA), Transcript of Evidence 16 October 2002, p1; Ms Penelope Mogridge, on behalf of the Australian Association of Social Workers (WA Branch), Transcript of Evidence, 16 October 2002, p7; Professor Charles Watson, Executive Dean of Health Science, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p3; and Mr Ric Forlano, Executive Director, Arthritis Foundation of Western Australia, Transcript of Evidence, 23 October 2002, p2.

357 Professor Michael Quinlan, Dean, College of Health, University of Notre Dame, Submission, 11 October 2002, p6.

(i) Commonwealth funded residential and community aged care places

The Commonwealth government has set a target of 90 residential aged care places per 1,000 people aged 70 and over. This comprises 40 high care and 50 low care places per 1,000 (44 and 56 percent respectively). The proportion of permanent residents classified as high care at 30 June 2002 was 63.6 percent[358], considerably higher than the Commonwealth's target of 44 percent. In addition to residential aged care places, a target of 10 places per 1,000 people aged 70 and over has been set for Community Aged Care Packages[359].

Under the Aged Care Act 1997, newly allocated aged care places and packages have two years to become operational[360], such that there may be a considerable lag between allocation and operation, during which time the shortage of places intensifies.

Despite steady increases in the number of funded aged care places over recent years, population growth in the over 70 age group has greatly outstripped supply of residential aged care places, and as a result the ratio of places per 1,000 persons aged 70 and over has steadily decreased from a high of 92.2 in 1995 to a low of 81.6 as at 30 June 2002 (an 11.5 percent drop in just 7 years)[361].

As at 30 June 2002 there were an estimated 152,000 people in Western Australia aged 70 and over (7.9 percent of the population)[362]. There were 12,580 residential aged care places, giving a ratio of 82.8 places per 1,000 persons aged 70 and over[363]. When this figure is adjusted to include Indigenous persons aged 50-69, the ratio decreases to 79.9 places per 1,000 persons[364], well below the Commonwealth's target of 90 places per 1,000.

The most recent statistics (2001-02) for WA residential aged care facilities indicate:

- Average occupancy of 92.9 percent[365];
- Residents aged 80 years and over represented 73.3 percent of all residents[366];

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358 Australian Institute of Health and Welfare, *Residential aged care in Australia 2001-02, A statistical overview*, June 2003, p75.

359 *ibid*, p74.

360 *ibid*, p2.

361 *ibid*, p2.

362 *ibid*, p18.

363 *ibid*, p20.

364 *ibid*, p20.

365 *ibid*, p26.

366 *ibid*, p29.

- High care patients represented 58.3 percent of all permanent residents[367];
- Average length of stay for permanent residents of 2 years 9 months[368]; and
- More than half of all residents had been in residence for two years or more, and almost one quarter had been in residence for five years or more[369].

The Community Aged Care Packages (CACP) program began in 1992 with the introduction of 235 funded places, and has grown steadily to 26,425 places as at 30 June 2002 (14.7 places per 1,000 people aged 70 and over)[370]. In the 2002-03 Budget, the Federal Government indicated its intention to fund an additional 6,000 CACPs over the next four years, increasing the ratio of packages to 18 per 1,000 persons aged 70 and over by 2006[371]. The program began as a community based alternative to low-level residential care and provides home-based care for frail or disabled older people.

As with residential aged care, persons 80 years and over represent the majority of CACP recipients (58.0 percent in Western Australia and 59.7 percent nationally)[372]. A significant proportion of CACP recipients are ultimately admitted to residential aged care facilities (37.5 in WA and 45.7 nationally)[373].

The residential aged care system experiences frequent access crises, as evidenced by the lengthy delay between determination of eligibility and admission. The average time between assessment and entry to a residential care facility was 34 days in 1999-00, 55 days for those admitted for low dependency care and 24 days for those admitted for high dependency care[374]. As highlighted in section 5.5(e), a significant number of older people awaiting entry to residential aged care facilities occupy acute hospital beds during the waiting period.

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367 *ibid*, p75.

368 *ibid*, p61.

369 *ibid*, p46.

370 *ibid*, p2.

371 Australian Institute of Health and Welfare and Australian Bureau of Statistics, *Older Australia at a glance*, October 2002, p80.

372 Australian Institute of Health and Welfare, *Community aged care packages in Australia 2001-02, A statistical overview*, June 2003, p21.

373 *ibid*, p44.

374 Australian Institute of Health and Welfare, *Residential aged care in Australia 2001-02, A statistical overview*, June 2003, p77.

Finding 52

As at June 2002, there were 82.8 funded residential aged care places per 1,000 Western Australians aged 70 and over, well below the Commonwealth target of 90 places per 1,000. Fifty-eight percent of patients were classified as high dependency, well in excess of the Commonwealth target of 44 percent.

As well as failing to meet the target number of residential aged care places, there is evidence to suggest that the level of Commonwealth subsidies may be falling progressively further behind the level of funding requirements of the aged care sector. A recent report released by the Australian Institute for Primary Care at La Trobe University[375] noted that current indexation arrangements do not adequately adjust for wage cost increases. The level of under-funding was estimated in the range of $32.5 to $50.7 million per annum in the eight years to 2003/04[376].

(e) The aged care workforce

The Committee encountered numerous comments in submissions and evidence in relation to declining skill levels and recruitment and retention difficulties in the aged care workforce. In its submission to the Committee, the Division of Health Science, Curtin University, indicated that there is currently a crisis in aged care facilities with regard to staffing:

> *In the area of aged care services, significant deterioration of the quality of staffing of aged care services over the past 10 years has led to a crisis in Australia. If the situation is not addressed the crisis can only become more severe in the future with the projected expansion of the older age group cohorts in our population. At the present time, very few qualified nurses are found in these settings and most of the work is done by patient care assistants of various kinds. There is also a lack of specialist aged care clinicians in all of the allied health professions. This area requires a wholesale re-evaluation and perhaps the use of incentive funding to encourage more professionals to specialise in the area of aged care. However, initiatives in this area will only be addressed successfully if disparities in salary levels and conditions of service between the aged care sectors and other sectors of health care are addressed*[377].

In relation to the increasing reliance on untrained workers in aged care, Associate Professor Kate White had the following to say:

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375 Australian Institute for Primary Care La Trobe University for the National Aged Care Alliance, *Residential Aged Care Funding*, October 2003.

376 *ibid*, p21.

377 Division of Health Science, Curtin University of Technology, Submission, 30 August 2002, p2.

> *I am talking about people who are not trained. There has been a big push in the aged care industry to employ those people. There is a perception that the assistants need only know how to shower and lift a patient; however, there is much more to it than that. Patient assistants must be able to communicate with people. The communication skills needed to work in aged care are far greater than virtually any other setting because it is so complex*[378].

The use of workers with lower qualifications in place of qualified nurses is largely due to difficulties in attracting and retaining qualified nurses in the aged care sector:

> *At the moment, aged care facilities rely on nurses graduating through the standard nursing course and hope that they might get interested in the long run, but many do not. When they work in the facilities, they find the conditions are not what they want so they drift away. We have a lot of trouble holding qualified nurses. We are then left with the next level down - enrolled nurse patient care assistants*[379].

Finding 53

There is some concern that difficulties in attracting and retaining qualified nursing staff may have contributed to increasing reliance on untrained health workers in the aged care sector.

There is extensive evidence in the literature in support of comments made in submissions and in evidence to the Committee.

Despite a 19 percent increase in the number of operational residential aged care places and Community Aged Care Packages between 1996 and 2001[380], the number of persons employed in nursing homes, accommodation for the aged and residential care services fell by 15 percent[381]. Nursing workers account 94.6 percent of all health and community services workers who are employed in the aged care sector[382]. Nursing workers include registered and enrolled nurses, as well as nursing and personal care assistants.

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378 Associate Professor Kate White, Acting Head of School of Nursing and Public Health, Edith Cowan University, Transcript of Evidence, 21 November 2002, p8.

379 Professor Charles Watson, Executive Dean of Health Science, Division of Health, Curtin University of Technology, Transcript of Evidence, 21 November 2002, p5.

380 Australian Institute of Health and Welfare, *Residential aged care in Australia 2001-02*, June 2003, p2.

381 Australian Institute of Health and Welfare, *Health and Community Services Labour Force 2001*, September 2003, p9.

382 *ibid*, p51.

(i) Registered and enrolled nurses in aged care

In 2001 there were 33,182 registered and enrolled clinical nurses working in aged care, a 14 percent decrease from 1995[383]. In a submission to the Senate Community Affairs References Committee Inquiry into Nursing, the Queensland Nurses Union expressed concern that the nursing skill mix and staffing levels in many nursing homes are failing to meet the acuity levels of residents[384].

The decline in number of registered nurses in residential aged care between 1995 and 2001 has coincided with an increase in dependency levels of residents. Between 30 June 1998 and 30 June 2001 the proportion of residents classified as high care (Resident Classification Scale levels 1 to 4) rose from 58 to 63 percent[385]. The loss of registered nurses and the resulting substantial skill loss has placed considerable pressure on the residential care sector.

Finding 54

Despite a significant increase in the number of persons in residential aged care, coupled with an increase in the proportion of high dependency residents, the number of nurses working in aged care decreased by 14 percent between 1995 and 2001.

(ii) Recruitment and retention of nurses in aged care

Recruitment and retention of the nursing workforce in general has been identified as a significant problem, but the issue is particularly pressing in the aged care sector. The Senate Community Affairs References Committee Inquiry into Nursing identified aged care as the area of nursing in greatest crisis[386].

Aged care has long been considered a low status area of nursing. There is evidence to suggest that nurses would prefer to work in acute care settings and often find themselves working in aged care because it suits family commitments or because they are unable to gain suitable employment elsewhere[387]. The New South Wales Health

383 Australian Institute of Health and Welfare, *Nursing Labour Force 2002*, p21.

384 Queensland Nurses' Union, *Submission to Senate Community Affairs References Committee Inquiry into Nursing - 2001*, June 2001, p12.

385 Australian Institute of Health and Welfare, *Residential aged care in Australia 2001-02, A statistical overview*, June 2003, p7.

386 Senate Community Affairs References Committee, *The Patient Profession: Time for Action, Report on the Inquiry into Nursing*, June 2002, pp147-159.

387 JA Stevens, *A career with old people: Do nurses care for it?* Unpublished Phd Thesis, University of New South Wales, 1995 as cited in: Commonwealth Department of Education, Science and Training, *National review of Nursing Education, Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, http://www.dest.gov.au/highered/nursing/pubs/asut_aged_care/3.htm, accessed on 27 November 2003.

Department identified aged care as a gateway to re-enter other areas of nursing for nurses seeking to re-enter the workforce[388].

The nature of work in the aged care sector, coupled with the low status and rapid rate of structural change means that the sector is characterised by low morale and high rates of turnover and absenteeism[389]. A recent survey of 435 Directors and Deputy Directors of Nursing[390] in the aged care sector reported that close to 90 percent found that workload and stress had increased in the preceding 12 months and a similar proportion had difficulty recruiting qualified nurses, especially registered nurses. The study also found that nurses were resigning due to lack of career prospects, heavy workloads and the poor professional image associated with aged care nursing. The wage disparity between aged care and other fields of nursing (11.3 percent difference in WA in 2001) is also thought to be an important contributing factor in the reduction of nursing numbers in aged care[391].

Finding 55

Lack of career prospects, heavy workloads, poor professional image and wage disparity with other fields of nursing contribute to difficulties in attracting and retaining nurses in aged care.

388 New South Wales Health Department, *Estimation of Requirements for and Supply of RN in the NSW Nursing Specialty Workforce Groups of: Rehabilitation, Paediatric and Aged Care* as cited in: Commonwealth Department of Education, Science and Training, *National review of Nursing Education, Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, http://www.dest.gov.au/highered/nursing/pubs/asut_aged_care/3.htm, accessed on 27 November 2003.

389 I Stein, J Heinrich, C Payne and F Hannen, *Aged care career pathways: a successful aged care workforce strategy*. Geriaction, 18(2), 2000, pp5-6, as cited in Commonwealth Department of Education, Science and Training, *National review of Nursing Education, Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, http://www.dest.gov.au/highered/nursing/pubs/asut_aged_care/3.htm, accessed on 27 November 2003.

390 T McDonald, The last nurse has left the building, The Lamp, Dec/Jan, 2001, p28 as cited in Commonwealth Department of Education, Science and Training, National review of Nursing Education, Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings, http://www.dest.gov.au/highered/nursing/pubs/asut_aged_care/3.htm, accessed on 27 November 2003.

391 Australian Institute of Health and Welfare, *Nursing labour force 2001*, June 2003, p55.

5.5 Increasing demand on public hospitals

(a) Emergency department overcrowding, access block and ambulance diversion

In recent years the lay media has contained frequent reports of emergency department overcrowding and ambulance diversion. Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, presented the Committee with data on the link between ambulance diversion and 'access block'. Access block is the term used to describe the situation when patients occupy emergency department cubicles (and corridors) whilst awaiting admission to inpatient beds. The presence of access blocked patients leads to too few cubicles to unload ambulances and treat patients in the emergency department, which leads to ambulance diversion.

Dr Sprivulis' data explores the relationship between emergency department admitted patient cubicle occupancy and average daily ambulance bypass. Not surprisingly, an increase in the number of daily hours on ambulance bypass for the three main teaching hospitals (Fremantle, Royal Perth and Sir Charles Gairdner) coincides with an increase in the number of admitted patients occupying emergency department cubicles[392].

Frequent access block and subsequent ambulance bypass are relatively new phenomena, arising almost simultaneously around the country in 1999/2000[393]. Prior to this time, access block was an irregular occurrence. Each year since then, the situation has worsened, despite the concerted efforts of emergency departments to tackle the problem through measures aimed at improving emergency department efficiency. It is now clear that ambulance bypass is not simply a symptom of emergency department inefficiency, it is a reflection of system-wide problems. Efficiency of patient flow aside, there are a number of important factors that place increasing pressure on our public hospitals. The following section will briefly describe these factors.

(b) Budgetary constraints

Despite rapidly increasing hospital budgets, there is evidence to suggest that budgetary increases may not be keeping pace with increasing demand for acute services. Decisions around hospital expenditure have an important impact on ambulance diversion/access block. Recent data compiled by the Acute Demand Management Unit indicates that bed availability for acute admissions tracks very closely with patient demand, although there is a shortfall of around 50 beds. In Figure 5.1 below, the upper

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392 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

393 Various authors, *Access Block: Responses to Access Block in Australia*, Medical Journal of Australia, February 2003, pp103-111.

curve represents the total number of patients needing a hospital bed in the three teaching hospitals at 4.00 a.m. every day over a three-month period. The lower line represents the number of beds made available for patients. The space between the lines is termed the 'Gap of Neglect of Acute Demand' and represents the number of admitted patients occupying an emergency department cubicle at 4am each morning waiting for an inpatient bed. This is a static measure of access block[394].

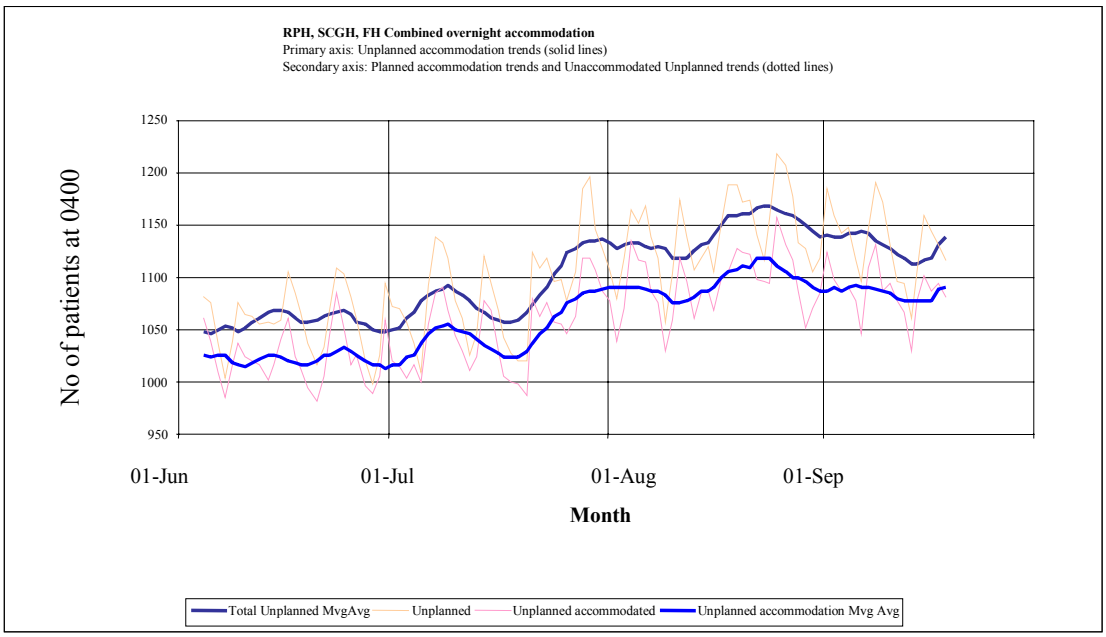


Figure 5.1

Gap of Neglect of Acute Demand for Perth metropolitan teaching hospitals[395].

Dr Peter Sprivulis emphasised the consistency of the Gap of Neglect of Acute Demand, despite the obvious capacity of the system to increase the overall bed pool. Dr Sprivulis asserts that the gap exists because of system disincentives to reduce or eliminate it: as each health service has a separate budget, keeping beds closed in the face of known demand can minimise pressure on an over-stretched budget, by diverting patients elsewhere. In other words, by keeping inpatient beds closed, one hospital renders its emergency department full to capacity and forces any additional patients to seek care at another hospital, thus shifting the costs of admitting patients elsewhere. Dr Sprivulis suggested that this practice occurs in all teaching hospitals[396].

394 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

395 Figure reproduced with permission from Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health.

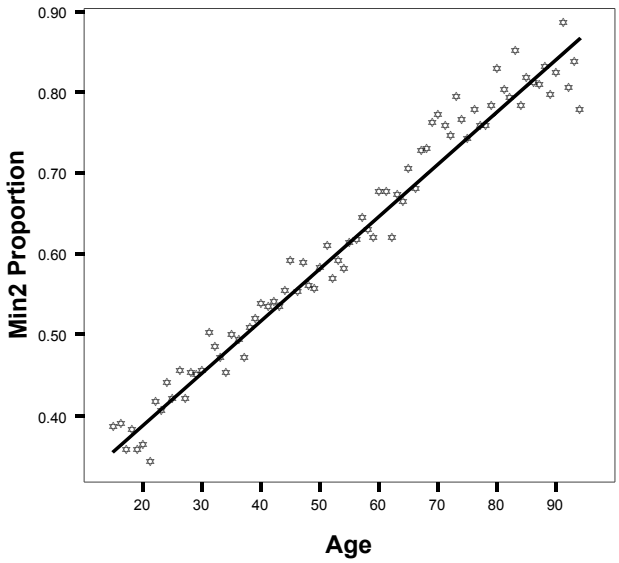
396 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

Finding 56

Recent data compiled by the Acute Demand Management Unit found that bed availability for acute admissions in our metropolitan teaching hospitals tracked closely with patient demand. However, there was a consistent shortfall of around 50 beds, termed the Gap of Neglect of Acute Demand. Closure of hospital beds in the face of known demand minimises pressure on over-stretched budgets by forcing patients to go elsewhere.

(c) Age, complexity and hospital utilisation

One of the major drivers of escalating hospital costs is the increasing health care needs of our progressively ageing population. As Dr Peter Sprivulis advised the Committee, patients have increasingly complex needs as they age. Analysis of EDIS (Emergency Department Information System) data from Sir Charles Gairdner Hospital between May 2002 and April 2003 shows that age has a near perfect linear correlation with 'complexity' as defined by the number of procedures, investigations and consultations required (see Figure 5.2)[397]. An increase in emergency department workload over time, therefore, is an entirely predictable consequence of an ageing population.



397 Figure reproduced with permission from Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health. The term 'Min2' denotes high complexity patients who have a minimum of two procedures, consultations or investigations. The proportion of Min2 patients increases in a linear manner with age: relatively few 20 year-olds are classified as high complexity patients, whilst at the other end of the spectrum, most 90 year olds have complex needs.

Figure 5.2 Patient age versus complexity

About 40 percent of all emergency department presentations are classified as 'low complexity', requiring no more than one procedure, one investigation and one consultation. Low complexity patients are predominantly assigned to ATS (Australian Triage Score) 3, 4 or 5; average slightly less than one procedure, consultation or investigation; three-quarters walk in to the emergency department; less than one-quarter are admitted; and two-thirds are under 50 years of age. The remaining 60 percent of patients are classified as 'high complexity' patients, averaging more than seven procedures, investigations or consultations. High complexity patients are more likely than not to be admitted (60 percent); are more likely than not to be over 50 years of age (62 percent); cost more per bed day than low complexity patients; and account for 93 percent of the emergency department workload[398].

Although low complexity cases may spend a considerable amount of time in the emergency department, much of this time is spent waiting, and does not involve active use of staff or equipment resources. Based on Dr Sprivulis' data, halving the number of low complexity cases from 40 to 20 percent would reduce the overall workload of the emergency department by just 3.5 percent (equivalent to one year's growth in total emergency department workload). A similar reduction in emergency department workload could be achieved by effecting a 2.5 percent reduction in the number of high complexity patients[399].

A number of innovations, both locally and further afield, have improved ED flow of low complexity patients[400]. Identifying and implementing innovations to improve management of high complexity patients is one of the biggest challenges currently faced by emergency departments.

During the nineties, improvements in operational efficiency led to faster turnaround of patients (shorter lengths of stay) and ultimately to bed closures. Length of stay (LOS) for individual acute and elective episodes has remained low, when compared with LOS figures in the early nineties. However, data collated by the Acute Demand Management Unit indicate that whole of year cumulative length of stay (WYCLOS) per individual patient has been increasing by 2.4 percent per annum since 1999[401]. In

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398 P Sprivulis, *A pilot study of metropolitan emergency department workload complexity*, original manuscript, submitted for publication.

399 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

400 The Emergency Services Collaborative was established in October 2002 with the aim of helping Accident and Emergency (A&E) departments across England to meet the NHS Plan target of a maximum wait of four hours from arrival to either admission, transfer or discharge. As part of the program, a number of NHS Trusts have developed strategies to speed the flow of minors (low complexity) patients through A&E departments.

401 Acute Demand Management Unit, Department of Health, *Whole of year hospitalisation draft analysis for comment*, 2003.

other words, although LOS for individual episodes of care remains low, many individuals require more than one episode of care per year, a trend that is captured only when *cumulative* LOS data are examined.

In the under 50 age group, despite an increase in WYCLOS, total bed day utilisation has remained relatively stable since 1995. It is thought that total hospital utilisation is being contained by whole of year admission prevention (for former short, cumulative length of stay patients) at the expense of increasing cumulative length of stay for those patients who do require hospitalisation during the year.

In the over 50 group, however, total number of hospitalisations and total bed day utilisation have been increasing steadily since 1995. The increasing number of patients needing hospitalisation, coupled with increasing WYCLOS, means that demand for hospital beds is now increasing faster than the rate of growth in the over 50 age group[402]. The number of high complexity patients in the over 50 year age group is currently growing at a compound rate of 4 percent per annum[403].

Dr Sprivulis advised the Committee that the workload generated by the 70-80 year age group is the highest and is expected to double between 2001 and 2016, in line with the large increase in this population group[404].

Finding 57

As people age, they are more likely to present to emergency departments with complex problems, which require a significant proportion of emergency department resources. Data collected in Perth teaching hospitals since 1995 indicate that increasing demand on public hospital beds is largely driven by growth in the number of high complexity patients over 50.

(d) Increasing hospital occupancy rates

Despite increasing pressure on our hospital system, the number of public hospital beds per 1,000 population has continued to decrease in recent years. Throughout Australia, the number of beds decreased from a ratio of 3.1 beds per 1,000 population in 1996/97 to 2.7 in 2001/02, a decrease of almost 13 percent. In Western Australia, the ratio of beds per population decreased from 2.9 to 2.7 beds per 1,000 people in the same period of time. Bed ratio is slightly lower in metropolitan than in regional and remote

402 *ibid*.

403 *ibid*.

404 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

areas, although the decreasing ratio has been witnessed in metropolitan and non-metropolitan regions alike[405].

(i) Hospital occupancy rate and access block

Despite trends toward decreasing length of stay for admitted patients and an increase in the number of patients being treated in the community or as same day patients, falling bed ratios have been accompanied by an increase in hospital occupancy rates. Dr Peter Sprivulis informed the Committee that Perth's three metropolitan adult teaching hospitals are currently operating at over 100 percent capacity, and that most non-teaching hospitals have a bed occupancy rate in excess of 85 percent[406].

A recent study published in the British Medical Journal examined the relationship between bed occupancy rate and ability to accommodate emergency admissions[407]. The study used a well-established modelling technique to examine the relationship between flow of emergency admissions, hospital bed capacity and the risk of access block in two public hospitals in the United Kingdom.

The authors demonstrated that the risk of a hospital bed shortage (i.e. access block) is minimal, provided average bed occupancy remains below 85 percent. At an average occupancy of 85 percent, a hospital can expect to be short of beds for admission (i.e. experience access block) on four days per year. At an average occupancy of 90 percent, a hospital can expect to experience access block on around 20 days per annum (approximately 5 percent of the time). Beyond 90 percent occupancy, the system is regularly subject to bed crises, as occupancy approaches 100 percent, access block is essentially constant[408].

The authors further demonstrated that when a hospital experiences access block on one day, it takes approximately twice the average length of stay for the hospital to recover its long term demand-capacity balance. In other words, if the average length of stay in

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405 Australian Institute of Health and Welfare, *Australian hospital statistics 1996-97*, June 1998, p13; Australian Institute of Health and Welfare, *Australian hospital statistics 1997-98*, June 1999, p26; Australian Institute of Health and Welfare, *Australian hospital statistics 1998-99*, July 2000, p30; Australian Institute of Health and Welfare, *Australian hospital statistics 1999-00*, June 2001, p35; Australian Institute of Health and Welfare, *Australian hospital statistics 2000-01*, June 2002, p30; and Australian Institute of Health and Welfare, *Australian hospital statistics 2001-02*, June 2003, p30.

406 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Medicine Clinical Improvement Unit, Department of Health, Briefing, 22 September 2003.

407 A Bagust, M Place and JW Posnett, *Dynamics of bed use in accommodating emergency admissions: stochastic simulation model*, British Medical Journal, July 1999, Vol 319, pp155-158.

408 *ibid*.

an Australian hospital is 6.4 days[409], ongoing disruptions can be expected for around 13 days following each day of access block[410]. Where several hospitals are all operating close to maximum capacity, a crisis in one hospital can quickly be transmitted throughout the system - a domino effect.

The authors concluded:

> *It must be recognised [by the NHS] that maintaining some unoccupied, staffed beds is not wasteful, but is a cost which must be incurred if a quality service is to be maintained*[411].

Finding 58

Using mathematical modelling, an average bed occupancy rate of 90 percent can be predicted to cause 'access block' in a hospital on around 20 days per annum (approximately 5 percent of the time). Beyond 90 percent occupancy, the system is predicted to be regularly subject to bed crises.

(ii) Occupancy rates in Perth's adult teaching hospitals

A recent census of the three adult teaching hospitals in Perth indicated that there were 1445 admitted patients (some occupying emergency department cubicles whilst awaiting transfer to available beds on the wards) and 1397 beds, giving an occupancy rate of 103 percent[412]. During winter 2003, the 4.00 a.m. average bed occupancy was 105 percent[413]. This equates to an average of 70 admitted patients occupying emergency department beds in our tertiary hospitals every night during the winter season, whilst awaiting access to an inpatient bed.

Finding 59

Data collected by the Acute Demand Management Unit indicate that during winter 2003, the 4am average bed occupancy in Perth's adult teaching hospitals was 105 percent (i.e. 105 patients for every 100 beds). 'Excess' patients were occupying emergency department beds awaiting access to an inpatient bed.

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409 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, June 2003, p17.

410 A Bagust, M Place and JW Posnett, *Dynamics of bed use in accommodating emergency admissions: stochastic simulation model*, British Medical Journal, July 1999, Vol 319, pp155-158.

411 *ibid*.

412 Dr Peter Sprivulis, Acute Demand Management Unit and Emergency Medicine Clinical Practice Improvement Unit, Department of Health, Briefing, 22 September 2003.

413 Information provided by Dr Peter Sprivulis, Acute Demand Management Unit and Emergency Medicine Clinical Practice Improvement Unit, Department of Health, October 2003.

As at September 2003, Dr Sprivulis indicated that an additional 160 beds would have been required to reduce the occupancy rate in our teaching hospitals to 90 percent, or 255 beds to reduce occupancy to 85 percent[414]. These estimates were based on demand at the time, and made no allowance for increasing demand in the future, as the population grows and ages. By winter of 2004, a total bed pool of 1600 (200 more than in 2003) is projected to equate to an occupancy rate of 98 percent[415]. In other words, just to maintain the current crisis situation (i.e. 103 percent occupancy), the bed pool would need to increase by around 100 beds in 2004.

Finding 60

Based on data collected by the Acute Demand Management Unit, an estimated 200 extra beds will be required to maintain an occupancy rate of 98 percent in Perth's teaching hospitals by winter of 2004.

(e) Delayed discharge - Care Awaiting Placement patients

At the 'back-end' of the hospital, delayed discharge can tie up beds for longer than is necessary, thus reducing the overall pool of available beds for admitted patients. There are measures that can, and have been, put in place to streamline the discharge process (e.g. discharge coordinators, discharge lounges), however these measures are not always appropriate. In the case of Care Awaiting Placement patients, discharge depends on availability of residential aged care beds, and where blockages occur at this point, measures within the hospital to streamline discharge are largely ineffective.

The Care Awaiting Placement (CAP) program is a State funded program, developed to accommodate frail older people who are waiting for permanent residential care placement. In addition to the CAP program, a Transitional Care Pilot (TCP) has been developed to provide rehabilitation for frail older people who have been hospitalised, assisting them to return home with appropriate support[416]. The TCP began on 11 November 2002 and is a State/Commonwealth collaborative project[417].

Care Awaiting Placement patients often occupy beds in metropolitan public hospitals and in interim residential care facilities. Although ongoing high level care may be required, to meet the criteria for classification as a CAP patient, a person must be deemed medically ready for discharge from acute care. CAP beds in metropolitan public hospitals are not specifically designated CAP beds. The beds are simply

414 Dr Peter Sprivulis, Acute Demand Management Unit and Emergency Medicine Clinical Practice Improvement Unit, Department of Health, Briefing, 22 September 2003.

415 Information provided by Dr Peter Sprivulis, Acute Demand Management Unit and Emergency Medicine Clinical Practice Improvement Unit, Department of Health, October 2003.

416 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

417 *ibid*.

removed from the pool of acute beds to accommodate CAP patients on an as needs basis. Interim residential care facilities, by contrast, have dedicated CAP beds[418].

Aged Care Assessment Teams (ACATs) determine eligibility/suitability for residential aged care placements and community aged care packages. There are 15 ACATs in Western Australia, eight in the metropolitan area and seven throughout the rest of the State. ACAT teams are funded by the Commonwealth government, on the basis of population numbers for frail older people aged 70+ years and Aboriginal and Torres Strait Islanders aged 50+ years[419].

There were a total of 25,049 ACAT assessments in Western Australia in 2002[420]. Between July 2001 and June 2002, 6,332 people were admitted to residential aged care facilities for permanent or respite care[421]. A further 1,573 people were admitted to community care packages during the same period[422]. The average waiting time from referral to assessment was 5 days in the metropolitan area and 6 days in regional Western Australia[423].

In relation to CAP patients in hospitals, Ms Penelope Mogridge, Social Work Manager, Hollywood Private Hospital, made the following comments:

> *The ageing issue is one of the crisis points in hospitals…We probably have half a ward of people who are waiting for placement, which is quite a significant number of people. That brings a lot of pressure, because there is pressure from the acute consultants, who want to bring in their patients, and they want those patients out*[424].

(i) The number of Care Awaiting Placement patients in Western Australia

When asked for an estimate of the number of extra residential aged care beds that are currently needed to meet the demand in Western Australia, Mr Kenneth Marston, Policy Officer, Council on the Ageing, made the following comments:

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418 *ibid*.

419 *ibid*.

420 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

421 Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2001-02*, June 2003, p64-65.

422 Australian Institute of Health and Welfare, *Community Aged Care Packages in Australia 2001-02*, p41.

423 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

424 Ms Penelope Mogridge, Social Work Manager, Hollywood Private Hospital, Transcript of Evidence, 16 October 2002, p7.

> *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*[425].

Between 1 July 2002 and 30 June 2003, CAP patients occupied an average of 123 public hospital beds (4.1 percent of total bed capacity), 99 in metropolitan public hospitals (3.5 percent) and a further 24 in psychogeriatric facilities (16.3 percent)[426]. **On average, 46 tertiary hospital acute beds were occupied by CAP patients each day in 2002/03, a figure which is similar to the daily Gap of Neglect of Acute Demand for our tertiary hospitals**[427] (see Figure 5.1).

Finding 61

Between 1 July 2002 and 30 June 2003 Care Awaiting Placement patients occupied an average of 123 State funded public hospital beds (4.1 percent of total bed capacity), 99 in metropolitan public hospitals (3.5 percent) and a further 24 in psychogeriatric facilities (16.3 percent).

An additional 107 CAP places are located in interim residential care facilities throughout the metropolitan area, and a further 50 places were made available through the TCP. Average occupancy between 1 July 2002 and 30 June 2003 was 84 percent in residential care facilities (90 beds)[428]. Since July 2003, an average of 44 TCP places have been occupied[429].

In regional Western Australia, an annual census is conducted at the beginning of each year to determine the number of Nursing Home Type Patients (NHTPs) in rural hospitals on the day of census. Between 1999 and 2003, the number of NHTPs in rural

425 Mr Kenneth Marston, Policy Officer, Council on the Ageing, Transcript of Evidence, 16 October 2002, p6.

426 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

427 Dr Peter Sprivulis, Acute Demand Management Unit and Emergency Medicine Clinical Practice Improvement Unit, Department of Health, Briefing, 22 September 2003.

428 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

429 *ibid.*

hospitals and multi-purpose sites[430] has gradually increased from 285 to 339 (as of 18 February 2003)[431].

Figures supplied by the Department of Health indicate that an average of around 600 older Western Australians were awaiting placement in a residential aged care facility during 2002-03. This number is relatively small, in comparison to the total pool of 12,580[432] funded residential aged care places throughout the State (4.8 percent). However, average occupancy in 2001-02 was 92.9 percent[433]. Based on this high level of occupancy across the system, coupled with an average length of stay of around 2 years 9 months, a continually high likelihood of "access block" would be predicted[434]. There is also some degree of choice as to which aged care facility a patient will be admitted[435], which can further effect delays.

The average length of stay for CAP patients varies between health services. Between May and July 2003, the average length of stay for our metropolitan public hospitals ranged from 8 days at Rockingham/Kwinana to 58 days at Swan Districts (19, 21 and 14 days at Fremantle, Royal Perth and Sir Charles Gairdner respectively). The average length of stay was generally longer in the residential CAP facilities, ranging from 30 days at Carinya of Bicton to 72 days at Hawthorn Hospital[436].

Finding 62

During 2002-03, an average of 600 older Western Australians were awaiting placement in residential aged care facilities at any given time.

In theory, each acute hospital bed has the potential to supply 365 patient bed days per annum. If CAP patients occupy an average of 99 acute hospital beds in the metropolitan area each day (46 in tertiary hospitals), this represents a potential loss of

430 Multi purpose sites exist in some small rural and remote communities with populations of less than 5000. State and Commonwealth funds are pooled and health and aged care services are co-located.

431 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

432 As of 30 June 2002, Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2001-02*, June 2003, p20.

433 Australian Institute of Health and Welfare, *Residential Aged Care in Australia 2001-02*, June 2003, p26.

434 A Bagust, M Place and JW Posnett, *Dynamics of bed use in accommodating emergency admissions: stochastic simulation model*, British Medical Journal, July 1999, Vol 319, pp155-158.

435 Patient must be waitlisted for at least three residential care facilities that have a reasonable chance of admitting the patient within 8 to 12 weeks.

436 Information provided by Gail Milner, Director, Rehabilitation, Aged and Continuing Care Directorate, Department of Health, October 2003.

around 36,000 acute patient bed days per annum (almost 17,000 in tertiary hospitals). To put this figure into perspective, the total number of patient bed days in WA public hospitals occupied by all cardiothoracic and neurosurgery patients was only marginally higher, at 37,478 in 2001-02[437].

(f) The private health insurance rebate and demand for public hospital services

The *Private Health Insurance Incentives Act (1998)* saw the introduction of a 30 percent subsidy for the purchase of private health insurance from 1 January 1999. In conjunction with this scheme, a 1 per cent additional Medicare levy is imposed on high-income earners who do not purchase private health insurance. One of the fundamental premises of the Private Health Insurance (PHI) rebate was the belief that by increasing participation in private health insurance, demand on public hospitals would be significantly reduced.

(i) Pattern of uptake of Private Health Insurance membership

While health care costs are extremely skewed towards older Australians, (see section 5.4(b)) uptake of PHI membership since the rebate was introduced has been skewed toward the relatively young, who do not place a large demand on the public system.

The rebate *per se* appears to have had little impact on membership. It was not until the few months leading up to the introduction of lifetime cover in July 2000, that people were enticed to purchase PHI. In the fifteen months after the introduction of the 30 percent rebate, membership increased by just 9 percent across the country[438]. In the six months surrounding the introduction of lifetime cover, from April 2000 to September 2000, there was a 43 percent increase in membership. By September 2000, 45.7 percent of the Australian population had private health insurance membership, compared with 32.2 percent in March 2000. Overall, membership peaked in the September 2000 quarter and has declined steadily since that time[439].

The pattern of uptake of membership was skewed toward younger people. Between April and September 2000, there was a 49 percent increase in membership in the under 65 age group, compared with an increase of only 6 percent in the over 65 age group.

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437 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, June 2003, p302.

438 Private Health Insurance Administration Council, Statistical Trends, Membership and Benefits, December 2003, Australia, http://www.phiac.gov.au/statistics/trends/index.htm, accessed on 22 March 2004.

439 Private Health Insurance Administration Council, Statistical Trends, Membership and Benefits, Western Australia, http://www.phiac.gov.au/statistics/trends/index.htm, accessed on 23 October 2003.

(ii) Pattern of usage of public and private hospitals

The Private Health Insurance Rebate appears to have had little impact on demand for public hospital beds. Between 1998-99 and 2001-02 (the most recently available figures), the number of private hospital separations increased by 29.4 percent, while the number of public hospital separations increased by only 2.8 percent[440]. The total number of patient bed days in private hospitals, however, increased by just 15.1 percent during the same period[441], reflecting, as Deeble suggests[442], an increase in activity in the private sector that is largely due to an increase in the number of same-day procedures. The number of patient bed days in public hospitals decreased transiently during 1998-99 and 2001-02, falling by 3 percent in 2000-01 (coinciding with the surge in membership due to the introduction of lifetime cover), and rebounding in 2001-02[443].

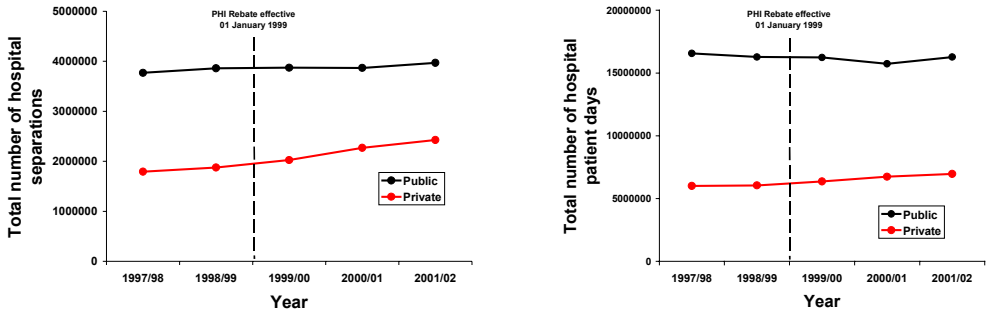

Figure 5.3 Public and private hospital utilisation, 1997-98 to 2001-02.

The Private Health Insurance Rebate also appears to have had little impact on elective surgery wait times in public hospitals. The median waiting time for patients who were admitted from waiting lists was 27 days in 1999-00, 2000-01 and 2001-02. Ninety percent of patients were admitted within 203 days in 2001-02, compared to 202 in 2000-01 and up slightly from 175 in 1999-00. The proportion of people who waited more than 12 months for admission increased from 3.1 percent in 1999-00 to 4.4 percent in 2000-01 and remained steady at 4.5 percent in 2002-02[444]. Data for 2002-03 are not yet available.

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440 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, June 2003, p107.

441 *ibid*.

442 JS Deeble, *Funding the essentials: the Australian Healthcare Agreements, 2003-2008*, Australian Health Review, Vol 25, December 2002.

443 Australian Institute of Health and Welfare, *Australian Hospital Statistics 2001-02*, June 2003, p107.

444 *ibid*.

Finding 63

The Private Health Insurance Rebate, while temporarily alleviating the demand for elective surgery on public waiting lists, overall appears to have had little impact on demand for public hospital beds. Apart from a temporary fall in 2000-01, coinciding with the introduction of lifetime cover for Private Health Insurance membership, the total number of patient bed days in public hospitals has been stable since 1998-99. The median waiting time for elective surgery in public hospitals has remained constant since 1999-00, while the proportion of people who waited more than 12 months has risen slightly.

There is an assumption that when faced with a choice between private and public services, insured patients are more likely to use the private system. In reality, many consumers choose the public system to avoid the out-of-pocket costs associated with 'front-end deductibles'[445] and because the quality of care is often perceived to be better (although the 'hotel' services may not be as good). Furthermore, despite having private health insurance, patients often choose to be treated as public patients in the public system. The Report of the Senate Community Affairs References Committee into Public Hospitals noted that less than 40 percent of people with private health insurance elect to declare it and be treated as private patients when treated in a public hospital[446].

Insured patients appear to turn to the private sector only when the waiting times are unacceptably long in the public system[447]. In a presentation to the Health Summit in August 2003, Mary Ann O'Loughlin from the Allen Consulting Group reported that 86 percent of all admissions to private hospitals were elective[448]. The average casemix-adjusted cost weight (an index of complexity) is higher in public than in private hospitals[449], indicating that public hospitals generally deal with 'sicker' patients.

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445 As at December 2003, 59 percent of insured persons with private hospital insurance had policies with front end deductibles (i.e. hospital admissions incur an up front payment). Private Health Insurance Administration Council, *Statistical Trends Membership and Benefits*, http://www.phiac.gov.au/statistics/trends/index.htm, accessed on 2 December 2003.

446 Senate Community Affairs References Committee, *Healing our Hospitals. A Report on Public Hospital Funding*, December 2000, p72.

447 R Vaithianathan, Centre for Economic Policy Research, Australian National University, *An Economic Analysis of the Private Health Insurance Incentive Act (1998)*, February 2001, p3.

448 Mary Ann O'Loughlin, Allen Consulting Group, *The Shift to Private Hospital Care: What Can We Get From Our Investment?* Presentation to the Health Summit, August 2003.

449 SJ Duckett and TJ Jackson, *The new health insurance rebate: an inefficient way of assisting public hospitals*, Medical Journal of Australia, 2000, 172: 439-442.

Finding 64

The inability of the Private Health Insurance rebate to relieve pressure on the public hospital system is thought to relate to the pattern of membership uptake, which is skewed toward younger people, who place fewer demands on the public system and to the propensity for people with Private Health Insurance to continue to use the public system to avoid out of pocket costs associated with 'front-end deductibles'.

(iii) The Private Health Insurance rebate and public hospital funding

As well as failing to relieve pressure on the public hospital system, a number of health commentators argue that the PHI rebate has siphoned much-needed funds away from public hospitals. In his report to State and Territory Health Ministers, Professor John Deeble, National Centre for Epidemiology and Population Health, the Australian National University, argued that in the three years to 2001-02, only about 40 percent of the increase in private insurance benefits has gone to supporting health services that had some possible offset on the public system. For example, ancillary benefits, benefits for upgraded hospital insurance and medical gap benefits accounted for $1.3 billion in additional benefits that simply reduced out-of-pocket expenses for insured people and had no clear offsets (i.e. produced no additional care) in the public system[450]. Deeble estimated that public patient expenditure fell by around $700 million, less than 30 percent of the cost of the PHI rebate, and less than 4.5 percent of gross public hospital outlays nationally[451].

Deeble argues that the PHI rebate has simply replaced private funding with more than $2 billion of Commonwealth funding, with minimal gain for the public sector, a view that is well supported amongst health economists[452]. Dr Peter Davoren, President of the Doctors Reform Society made the following comments:

> *This rebate has had only marginal impact on the private health fund memberships, no impact on the demand for public health services and is destined to cost the Australian taxpayers even more over the next few years as private health fund premiums continue to rise well above the rate of inflation.*

450 J Deeble, *The private health insurance rebate, Report to State and Territory Health Ministers*, January 2003, pp8-9.

451 *ibid*, p10.

452 L Segal, Deputy Director of the Health Economics Unit, Monash University, *Why support private health insurance in Australia?*, http://www.drs.org.au/new_doctor/79/Segal.htm, accessed on 30 September 2003.

> *…two billion dollars would fund over 15 extra 500 bed public hospitals. Health spending should be spent on health and not on providing a cash rebate to those generally on higher incomes…*[453].

Dr Con Costa, National Vice President of the Doctors' Reform Society added:

> *… Public hospital waiting lists around Australia could have been halved if the money that is being wasted on the private health insurance blow-out had been spent on public hospitals*[454].

The total cost of the rebate is estimated at approximately $3.7 billion per annum - $2.2 billion in funding the 30 percent rebate, $1.1 billion in taxation revenue, foregone through exemption of the Medicare levy surcharge and $0.4 billion in extra Medicare payments for medical and pharmaceutical services associated with higher private hospital use[455]. Duckett and Jackson argue that the relatively higher payment rates for private sector fee-for-service medical practice (versus hospital salaried or sessional payments) may also have an inflationary impact on public sector medical remuneration[456].

5.6 Issues surrounding primary care

Although primary health care is essentially delivered by private practitioners working in the private sector, there are a number of features of the sector that significantly impact on the delivery of services in the public sector. The following section examines accessibility and affordability of primary care services and how this impacts on the public sector.

(a) The primary care workforce

In 2001, more than 31,000 health workers worked in primary care. Medical practitioners represented 73 percent of the total primary care workforce, nursing workers 21 percent and allied and other health workers 5 percent[457]. Although nursing

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453 P Davoren, President, Doctors Reform Society, *Patients could die due to private health insurance blow-out*, http://www.drs.org.au/media/2000/media058.htm, accessed on 30 September 2003.

454 C Costa, Vice President, Doctors Reform Society, *Patients could die due to private health insurance blow-out*, http://www.drs.org.au/media/2000/media058.htm, accessed on 30 September 2003.

455 L Segal, Deputy Director of the Health Economics Unit, Monash University, *Why support private health insurance in Australia?*, http://www.drs.org.au/new_doctor/79/Segal.htm, accessed on 30 September 2003.

456 SJ Duckett and TJ Jackson, *The new health insurance rebate: an inefficient way of assisting public hospitals*, Medical Journal of Australia, 2000, 172:439-442.

457 Australian Institute of Health and Welfare, *Health and community services labour force, 2001*, September 2003, p51.

workers clearly make an important contribution to primary care, at the end of the day, the system is structured such that payment follows the GP episode, i.e. unless the patient consults with the GP, there is no way to claim payment for the service provided. That being the case, the number of general practitioners working in primary care is the principal determinant of access to primary care.

(i) Current system constraints on the Primary Care workforce

Whilst there appears to be an acknowledgment amongst General Practitioners and in the broader community that non-medical health workers could be used to great advantage in primary care, the current fee-for-service funding model that applies to general practice is a major impediment to exploring innovative models of service delivery. Dr Grant Russell, National Manager, Quality Care and Research, Royal Australian College of General Practitioners, made the following comments in relation to current constraints on primary care:

> *I think there are inescapable constraints within the Medicare schedule. Two that immediately come to mind are the persistent encouragement of short contact consultations as being higher income producing and, secondly, the fact that general practitioners have limitations in their practice on how they can bill, if they wish to use a practice nurse, for example. If a practice nurse is doing a dressing or other aspects of basic and very important care, there are still constraints on how the practitioner can bill through Medicare*[458].

In a similar vein, Dr Brian Lloyd, Chief Medical Officer, Department of Health had the following to say:

> *The funding for the models are a disincentive to improvement of the model in that the service provider, in this case general practitioners, are required to do a certain volume of service to receive a certain volume of income. That tends to inhibit change models. We believe, and I think many GPs are coming to the view, that nurse practitioners and allied health people could do a reasonable percentage of a general practitioner's work. That would free up the valuable resource of the general practitioner… My impression is that in 10 or 15 years time, if we could get out of the current constraints about funding on a fee-for-service basis, we could get a much better model whereby the general practitioner did the more high-level work rather than every bit of work that confronted him or her*[459].

With regard to the type of services provided in primary care, Mr Michael Jackson, Executive Director, Population Health Department of Health, advised the Committee that not enough is being done in the area of prevention, an area in which nurses and

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458 Dr Grant Russell, National Manager, Quality Care and Research, Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p3.

459 Dr Brian Lloyd, Chief Medical Officer, Department of Health, Transcript of Evidence, 22 November 2002, p3.

allied health workers could provide a lot of support for GPs. Mr Jackson indicated that GPs are aware that on their own, they cannot cope with the level of demand for services[460].

Dr Grant Russell advised the Committee that there is strong evidence that a health care system that is orientated towards primary care will produce better health outcomes than a health system orientated towards secondary care[461]. Dr Russell pointed the Committee to research from Johns Hopkins University in this field. A recent publication by Macinko *et al* reported low rates of mortality due to chronic diseases such as asthma, bronchitis, emphysema, cerebrovascular disease and coronary heart disease in OECD countries with a strong primary health care system[462].

(b) Supply of general practitioners.

In 2002, there were 1,980 (1,254 FTE) general practitioners in Western Australia[463]. At a ratio of 1:1,530, Western Australia has substantially fewer FTE GPs per head of population than any other state in Australia, with the exception of the Northern Territory[464]. South Australia has the highest supply of GPs, with almost 20 percent more per head of population than Western Australia (see table A4.4).

Information provided by the General Practice Divisions of Western Australia (GPDWA) indicates the supply of GPs in rural regions is lower than in metropolitan regions: rural Divisions of General Practice[465] have an average FTE GP to population ratio of 1:1,997 compared to metropolitan Divisions with a ratio of 1: 1 401[466]. In the metropolitan area, the Canning (south east) and Rockingham/Kwinana Divisions have

460 Mr Michael Jackson, Executive Director, Population Health, Department of Health, Transcript of Evidence, 22 November 2002, p8.

461 Dr Grant Russell, National Manager, Quality Care and Research, Royal Australian College of General Practitioners, Transcript of Evidence, 22 November 2002, p7.

462 J Macinko, B Starfield and L Shi, *The contribution of primary care systems to health outcomes within Organisation for Economic Cooperation and Development (OECD) countries, 1970-1998*, www.findarticles.com/cf_0/m4149/3_38?103731430/print.jhtml, accessed 10 December 2003.

463 Australian Divisions of General Practice Ltd, *Division Workforce Database*, as cited in: General Practice Divisions of Western Australia, *After Hours Primary Medical Care in Western Australia*, October 2002, pp1-2.

464 General Practice Divisions of Western Australia, *After Hours Primary Medical Care in Western Australia*, October 2002, p2.

465 Divisions of general practice are geographically based organisations that bring together GPs, with the aims of enhancing communication, sharing information, supporting education and primary health care research and building linkages with other health sectors. The first local Divisions were established in 1992 and there are now 120 Divisions, representing 94 percent of GPs.

466 General Practice Divisions of Western Australia, *After Hours Primary Medical Care in Western Australia*, October 2002, p2.

the lowest number of GPs per head of population, while the more affluent Perth Central Coastal and Fremantle Regional Divisions have the highest. In the regions, the Kimberley and Central Wheatbelt Divisions have the lowest number of GPs per head of population, while the Greater Bunbury Division is relatively well supplied (better supplied, in fact, than Canning and Rockingham/Kwinana) (see Table A4.5).

Finding 65

Western Australia has substantially fewer Full Time Equivalent General Practitioners per head of population than any other state in Australia, with the exception of the Northern Territory. In the metropolitan area, the Canning and Rockingham/Kwinana Divisions of General Practice have the lowest number of General Practitioners per head of population. In the regions, the Kimberley and Central Wheatbelt Divisions have the lowest number of General Practitioners per head of population.

(c) Affordability of primary care

As well as being accessible, in order for consumers to avail themselves of primary care, it must also be affordable. For many people, whether or not they will be required to pay to see a general practitioner may be an important consideration in their decision to seek primary care in a general practice setting. In that sense, affordability of primary medical care has been progressively decreasing over the last three years.

(i) Bulk billing rates

Between June 2000 and June 2003, the percentage of GP consultations that were bulk-billed fell from 78.6 to 67.7 percent (see Figure 5.4)[467]. A further one percent drop was recorded in the September quarter, with bulk-billing rates falling to 66.7 percent. The total number of GP services per annum fell by 7.3 percent in the two years to March 2003, from 24.7 million to 22.9 million[468].

In the three years to September 2003, the total number of bulk-billed GP services fell by 18 percent from 19.2 million to 15.7 million, while the number of GP services that attracted a patient contribution rose by 31 percent from 5.4 million to 7.1 million[469].

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467 Health Insurance Commission, Monthly/quarterly standard reports, *Table 4.1: Medicare - % bill type by Broad Type of Service and various periods*, http://www.hic.gov.au/cgi-bin/broker.exe?_PROGRAM=dyn_std.monqtr1.sas&_SERVICE=default&_DEBUG=0&start_dt=0&ptype=quarter&end_dt=200306&VAR=Services&RPT_FMT=table4, accessed on 24 November 2003.

468 Community Affairs Legislation Committee, Examination of Budget Estimates 2003-2004, Additional Information Received Volume 4, Outcomes: 2 & 3, Health and Ageing Portfolio, November 2003, pp80-82.

469 *ibid*, p84.

For those patients who were not bulk-billed, the average contribution per GP consultation was $14.03 in the December 2003 quarter[470].

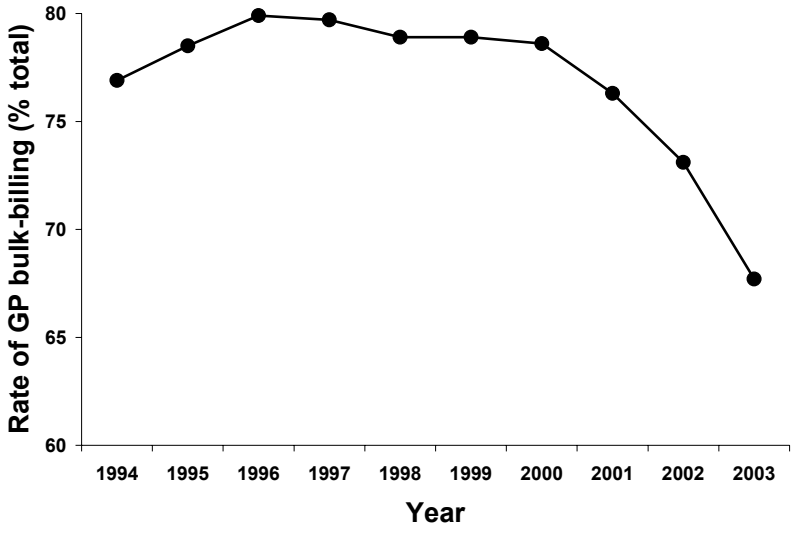

Figure 5.4 Proportion of bulk-billed GP consultations, 1994-2003.

Residents in Western Australia fare slightly worse than their Eastern States counterparts with respect to bulk billing. In the two years to March 2003, the total number of GP services fell by 8.3 percent, from 2.13 million to 1.96 million[471], and in the December quarter 2003, just 64.7 percent of GP consultations in Western Australia were bulk-billed[472]. Within Western Australia, there is considerable variability in the rate of bulk-billing. For example, in the outer metropolitan Federal electorates of Canning and Brand the rate of bulk-billing is well below national and state averages, at just 54.1 and 61.6 percent respectively[473]. These electorates contain some of the most economically disadvantaged Western Australians, whose decision about whether

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470 Commonwealth Department of Health and Ageing, Medicare Statistics September Quarter 2003, *Table B5 - Medicare: Average patient contribution per service*, www.health.gov.au/haf/medstats/tableb5.pdf - accessed on 27 February 2003.

471 Community Affairs Legislation Committee, Examination of Budget Estimates 2003-2004, Additional Information Received Volume 4, Outcomes: 2 & 3, Health and Ageing Portfolio, November 2003, p84.

472 Health Insurance Commission, *Monthly/quarterly standard reports*, http://www.hic.gov.au/cgi-bin/broker.exe?_PROGRAM=dyn_std.monqtr1.sas&_SERVICE=default&_DEBUG=0&start_dt=0&ptype=quarter&end_dt=200312&VAR=Services&RPT_FMT=table3, accessed on 27 February 2004.

473 Community Affairs Legislation Committee, Examination of Budget Estimates 2003-2004, Additional Information Received Volume 4, Outcomes: 2 & 3, Health and Ageing Portfolio, November 2003, pp70-73.

or not to consult a general practitioner will likely depend on whether the service will be free.

Around the nation, people living in rural and remote areas are less likely to be bulk-billed for GP consultations. Hardest hit are those people living in rural areas[474], who are bulk-billed only 54-55 percent of the time.

On the issue of declining bulk-billing, Dr Bernard Pearn-Rowe made the following comments to the Committee:

> *Now the most common fee for a standard GP service is around $50, which has been underpinned by the enormous relative value study that was initiated by Carmen Lawrence and concluded a year ago. The RVS [Relative Value Study] was published 18 months ago and at that time a common fee of $47.50 was recommended. Now, 18 months down the track and with the added expenses of medical indemnity insurance, the ballpark figure is $50. Yet, the Medicare rebate to patients is fractionally under half of that figure. If a doctor bulk-bills, he is effectively discounting his fee by 50 per cent…no business person in this country can survive discounting their fees by 50 per cent…However, supporting that is the belief in the community, encouraged by many Governments, that it has a right to that discount*[475].

In a statement released in March 2003, the National Medicare Alliance identified a number of factors that contribute to the falling rate of bulk-billing:

- Increased GP workload in rural, remote and outer metropolitan areas as doctor numbers decline;
- Decreased competition (including under-supply in some areas), particularly in rural, remote and outer metropolitan areas;
- A gradual decrease in the amount doctors get back through the Medicare rebate (due to inflation);
- Changing make-up of the GP workforce and preferences for shorter working hours;
- Increased administration costs of running a practice;
- Rising medical indemnity insurance premiums; and

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474 The Rural, Remote and Metropolitan Areas (RRMA) classification was developed in 1994 by the Department of Primary Industries and Energy and the then Department of Human Services and Health. Seven categories are included in this classification - 2 metropolitan, 3 rural and 2 remote zones.

475 Dr Bernard Pearn-Rowe, President, Australian Medical Association (WA), Transcript of Evidence, 4 December 2002, p7.

- Lower job satisfaction[476].

Research from the internationally renowned School of Public Health at Johns Hopkins University has identified no or low co-payments for primary care visits as an integral part of a strong primary care system and high primary care co-payments as a barrier to access[477].

Finding 66

In the December quarter 2003, just 64.7 percent of General Practitioner consultations were bulk-billed in Western Australia. For those patients who were not bulk-billed, the average contribution was $14.03. Primary care co-payments can act as a barrier to access for low-income earners.

(d) After hours primary medical care

Access to after hours primary care is a particular concern, and a concerted effort has been made in recent times by governments and professional bodies to address the problem. In December 2000, the Australian Medical Association released a discussion paper addressing some of the issues surrounding after hours primary care. The Association identified a number of key factors that act as barriers to the provision of after hours care, including:

- An inadequate total number of GP after hours workforce;
- Safety risks for GPs attending unfamiliar situations and patients alone, particularly late night and early morning;
- Extremely limited access to locums in all areas;
- Inadequate financial support for existing after hours GP arrangements;
- Access in rural and remote Australia due to geography/demography together with downgrading and closure of local hospital facilities;
- No adequate on call allowances for most rural GPs servicing state hospitals; and

476 National Medicare Alliance, *A plan to end the bulk-billing crisis*, March 2003, p2.

477 J Macinko, B Starfield and L Shi, *The contribution of primary care systems to health outcomes within Organisation for Economic Cooperation and Development (OECD) countries, 1970-1998*, www.findarticles.com/cf_0/m4149/3_38?103731430/print.jhtml, accessed 10 December 2003.

- Insufficient provision of hospital facilities for primary after hours medical care as triage and assessment centres and bases for visiting doctors[478].

Recognising that there are important issues surrounding provision of After Hours Primary Medical Care (AHPMC), in 1997 the Commonwealth agreed to fund AHPMC trials. The Australian Divisions of General Practice was contracted by the Commonwealth Department of Health and Ageing to manage the After Hours Primary Medical Care (AHPMC) Program. The Program assists Divisions of General Practice and GPs to analyse AHPMC issues and to develop innovative strategies to address these issues. Four trials of various models of care commenced in 1999, with a fifth one starting in WA in 2000. Since 2001 there have been several rounds of service development grants and seeding grants to investigate local needs and potential models of care. Many of the Western Australian Divisions of General Practice have successfully secured funding to analyse local AHPMC needs and develop strategies to address the issues[479].

(i) After hours primary care in metropolitan Western Australia

The General Practice Divisions of Western Australia provided the Committee with a comprehensive description of current after hours primary medical care services in Western Australia[480]. Within the Perth metropolitan area there are six General Practice After Hours (GPAH) clinics located in Subiaco, Joondalup, Mount Lawley, Armadale, Murdoch and Nedlands. The clinics only operate after hours, typically 5.00 p.m. - 10.00 p.m. on weeknights and 4.00 p.m. - 10.00 p.m. on weekends and public holidays.

Patients are generally charged an upfront fee. The average gap (after Medicare rebate) is $27.55, although (at the time of writing) health care card holders are bulk-billed at the Armadale GPAH clinic and the Joondalup clinic charges an up front gap payment of $5.55[481].

The location of GPAH clinics impacts on the number of GPs prepared to appear on the roster: clinics in the more affluent areas have less difficulty attracting GPs. Clinics in outer metropolitan areas have few GPs living in the area, which makes it less attractive to work in these clinics.

In addition to GPAH clinics, Medical Deputising Services (MDS) have operated in Perth for a number of years. Two MDS currently operate: the Western Australian Deputising Medical Services and the Australian Locum Medical Services. The MDS

478 Australian Medical Association, *Out of Hours Primary Medical Care*, December 2000, p4.

479 General Practice Divisions of Western Australia, *After hours primary medical care in Western Australia*, October 2002.

480 *ibid*.

481 *ibid*, p4.

provide after hours primary medical care services for the patients of more than 1,000 GPs, but they only operate in the inner metropolitan area, such that GPs with practices in outer urban areas cannot gain membership of these services[482].

AHPMC is also provided through HealthDirect, a Department of Health funded 24-hour Statewide telephone triage service. The service began in May 1999, and in its first two years of operation, averaged more than 13,000 calls per month. All telephone operators are registered nurses who have undertaken several weeks of specific training, followed by a supervised probationary period of three to six months. Three-quarters of all calls to HealthDirect are in the after hours period. There is a perception amongst public hospital emergency departments (EDs) that more people attend EDs than otherwise would have without telephone triaging. There are also anecdotal reports that there has been a dramatic increase in the number of people attending GPAH clinics since HealthDirect's inception[483].

There are six Divisions of General Practice in metropolitan Perth. Access to after hours primary medical care varies considerably within the different Divisions. Of the six Divisions, only the Perth Central Coastal Division, which covers the most affluent suburbs in Perth, is considered to have adequate AHPMC coverage.

For residents of the Osborne Division of General Practice, the GPAH clinic at Joondalup Health Campus is relatively inaccessible to a large proportion of Division residents who live closer to central Perth. A number of residents use the Subiaco GPAH clinic, but most utilise the ED at Sir Charles Gairdner Hospital (five kilometres south of the Division boundary). Almost 50 percent of the Division's population are on limited income, and therefore Sir Charles Gairdner Hospital ED may be the only viable option for AHPMC[484].

Residents of the newly amalgamated Perth and Swan Hills Division of General Practice have three public hospitals within their boundary, two of which have EDs (Royal Perth Hospital and Swan Health Service). MDS coverage within the Division is limited to the central part, with residents in the outer urban region unable to access locum services. The only GPAH clinic in the region is also located close to the city centre. Most of the general practices in Kalamunda are open for extended hours[485].

The Rockingham/Kwinana Division has a large resident population of Aboriginal as well as other disadvantaged people. Few practices are open for extended hours. A recent consumer survey indicated that a large number of residents had attended the Rockingham Kwinana District Hospital when unable to secure a GP appointment (52

482 *ibid*, pp6-7.

483 General Practice Divisions of Western Australia, *After hours primary medical care in Western Australia*, October 2002, pp8-9.

484 *ibid*, pp10-11.

485 *ibid*, pp13-14.

percent after hours and 28 percent during normal business hours). At the same time the ED was estimated to be operating at between 140 and 200 percent of capacity[486].

Residents of the Canning Division of General Practice access AHPMC through the Armadale/Kelmscott District Hospital or through the Armadale GPAH clinic. Health care card holders, who represent 70 percent of patients, are bulk-billed and others are charged a $40 up-front fee[487].

The Fremantle Regional Division of General Practice contains some of Perth's most affluent suburbs to the north and east and some of the poorest to the south. It is served by the two MDS, the GPAH clinic at Murdoch and the ED at Fremantle Hospital. A survey by the Royal Australian College of General Practitioners in Fremantle found that access to AHPMC was problematic for people who were financially disadvantaged and/or had limited mobility[488].

The Perth Central Coastal Division is thought to have adequate AHPMC, particularly for those residents who can afford to pay. The GPAH clinic in Subiaco is probably the most successful after hours clinic in Perth, despite the $60 upfront fee. The After Hours Family Medical Clinic in Nedlands is also within the Perth Central Coastal Division boundary. For those residents who are unwilling or unable to pay for AHPMC, there are Royal Perth, Sir Charles Gairdner and Fremantle Hospital EDs and the MDS[489].

Finding 67

Of the six Divisions of General Practice in metropolitan Perth, only the Perth Central Coastal Division, which covers some of the most affluent suburbs in Perth, is considered to have adequate After Hours Primary Medical Care coverage.

(ii) After hours primary medical care in regional Western Australia

In general, access to AHPMC in regional areas is more limited than in the metropolitan area, largely as a result of the critical shortage of GPs in regional areas. In those areas where a reasonable level of AHPMC is provided, GPs are working extraordinary hours to do so.

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486 *ibid*, pp16-17.

487 General Practice Divisions of Western Australia, *After hours primary medical care in Western Australia*, October 2002, p18, figures correct at time of writing.

488 *ibid*, p20.

489 *ibid*, pp2-23, figures correct at time of writing.

In the Greater Bunbury Division there is an estimated shortfall of 15 GPs. Nine of the 11 practices within the region offer after-hours services, but these are restricted to current patients and none of the practices bulk-bill[490].

In the Central Wheatbelt Division fifteen of the towns have solo GPs who are expected to be on-call for AHPMC for all residents at all times[491].

The northern chapter of the Peel/Southwest Division (Mandurah) suffers from a shortage of GPs and a lack of AHPMC. The Peel Health Campus ED provides the majority of AHPMC services for the local community. There are fewer GPs per head of population in the southern chapter (Busselton, Dunsborough, Margaret River), and most also act as Visiting Medical Officers (VMOs) at local hospitals and are on-call for specialist skills.

The Great Southern Division of General Practice has an acute shortage of GPs, with overseas trained doctors accounting for one-fifth of all GPs[492]. GPs within the Division work an average of 115.9 hours per week - 62.1 hours on-call. The majority of GPs within the Division are VMOs at the local hospitals and are expected to attend their own patients. Further adding to the GP workload, most of those practising in the three main towns are heavily relied upon by the local hospitals to supplement specialist services in anaesthetics, general surgery, orthopaedics, obstetrics and gynaecology.

All GPs in the Eastern Goldfields Division of General Practice are VMOs to the local hospitals, necessitating extended periods of on-call duties. Local hospital EDs or Health Direct are the first point of contact for AHPMC in the region. At Kalgoorlie Regional Hospital, 97 percent of ED presentations in 2000/01 were classified as ATS 4 or 5 (semi- or non-urgent), indicative of a very high number of people seeking primary care in the ED[493]. The situation in Leonora and Laverton is similar.

In the Midwest Division of General Practice, all local patients seek AHPMC in the regional hospital. Care is typically provided by their regular GP, who attends as a VMO[494].

In the Kimberley Division of General Practice, most GPs work as salaried doctors in either the Aboriginal Medical Services (AMS) Royal Flying Doctor Service (RFDS) or at the local hospitals[495].

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490 *ibid*, p24.

491 *ibid*, p26.

492 *ibid*, p29.

493 *ibid*, pp31-34.

494 *ibid*, p35.

495 *ibid*, p37.

Like those in the Kimberley, GPs in the Pilbara Division of General Practice (population 44 000, FTE GPs 17) work in AMS, hospitals and the RFDS, as well as in private practices. A major issue in the provision of AHPMC to Aboriginal people is that AMS are only open during normal business hours, and when patients visit hospitals during the after hours period, patient records cannot be accessed[496].

Finding 68

Access to After Hours Primary Medical Care in regional areas is generally more limited than in the metropolitan area, due to the critical shortage of General Practitioners in regional areas.

(iii) Balancing consumer demands and GP expectations

Some GPs may be encouraged to provide AHPMC by the prospect of adequate remuneration, and others may be driven by the satisfaction that arises from providing a valuable service to the community. But at the end of the day, GPs cannot be compelled to provide AHPMC, in most cases it will be a matter of personal choice. Given the relative shortage of GPs in Western Australia, it would appear that the majority have a sufficient workload without adding an after hours component. In its analysis of the current status of AHPMC in Western Australia, GPDWA concluded:

> *... current Medicare rebates alone do not equal GP remuneration expectations coupled with the infrastructure costs of running an AHPMC clinic. This necessitates a sizeable fee being charged to consumers which in turn excludes a large proportion of society who are either unable and/or unwilling to pay*[497].

Finding 69

Research undertaken by the General Practice Divisions of Western Australia suggests that the amount consumers are willing to pay for After Hours Primary Medical Care is at odds with the amount that General Practitioners expect to earn. As such, sustainable After Hours Primary Medical Care services are more likely to exist where there is a sufficient catchment of consumers to pay the gap, or where external funding provides some form of infrastructure support.

(e) Hospital emergency departments and primary care

There is a widely-held belief that a substantial proportion of patients who present to emergency departments could be assessed and managed in a general practice setting. The Committee met with Chief Executives from a number of our metropolitan

496 *ibid*, p38.

497 *ibid*, p39.

hospitals, both tertiary and secondary, and posed the question: What proportion of patients who present to emergency departments could be treated in a primary care setting?

(i) GP presentations to tertiary hospitals

Chief Executives from Fremantle and Royal Perth Hospital advised the Committee that so-called GP presentations represent a very small proportion of emergency department presentations in tertiary hospitals and do not constitute a problem[498].

Dr Gary Geelhoed, Director of the Emergency Department at Princess Margaret Hospital for Children, Perth's only tertiary paediatric hospital, indicated that GP patients are not viewed as a problem at Princess Margaret Hospital. He indicated that of 120 presentations per day, up to 30 may be considered GP cases, although the admission rate for these so-called GP cases is around 8-9 percent, which is more than 100-fold higher than the rate of hospital admissions for people who present to a GP. Dr Geelhoed further added that minimal resources go into treating GP cases in a hospital emergency department[499].

Comments made to the Committee with regard to GP cases presenting to emergency departments of tertiary hospitals is consistent with the findings of a study recently published in *Emergency Medicine*, based on data collected in Fremantle Hospital emergency department in 1999-2000[500].

The proportion of 'low acuity patients', defined as those patients that a GP would not be expected to refer to an ED, was estimated at 10.6-12.5 percent. Costs associated with LAP patients were estimated at 5.5-6.8 percent of total emergency department costs[501].

As might be expected, low acuity patients made up a higher proportion of total presentations outside of normal working hours. Excluding LAP presentations between midnight and 8.00 a.m., it was estimated that offering alternative services between 8.00 a.m. and midnight, seven days a week would lead to a reduction in emergency presentations of just 1.8-2.6 percent, which equates to two to three patients per day in a department seeing 110 patients per day. This would produce an estimated cost saving of 1.0-1.4 percent per day. These data suggest that provision of alternative services is

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498 Dr Bill Beresford, Director of Clinical Services, Royal Perth Hospital, Briefing, 22 September 2003 and Dr Paul Mark, Executive Director, Clinical Services, Fremantle Hospital and Health Service, Briefing, 22 September 2003.

499 Dr Gary Geelhoed, Director, Emergency Department, Princess Margaret Hospital for Children, Personal Communication, September 2003.

500 P Sprivulis, *Estimation of the general practice workload of a metropolitan teaching hospital emergency department*, Emergency Medicine, 2003, 15:32-37.

501 *ibid*.

unlikely to have a significant impact on overall emergency department workload in a major teaching hospital such as Fremantle[502].

Contrary to popular belief, GP patients do not appear to be a major drain on resources in our tertiary hospitals. Chief Executives from metropolitan non-teaching hospitals, however, paint a different picture.

(ii) GP presentations to secondary hospitals

Dr John Harvey, Medical Director of Rockingham/Kwinana District Hospital advised the Committee that up to 70 percent of ED presentations are potential GP cases[503]. The estimated GP: population ratio in Rockingham/Kwinana is around 1:1,656, considerably lower than the metropolitan average of 1:1,401[504]. After hours access to primary care is a particular problem. Only four surgeries are open on weekends (servicing a population just short of 100,000) and none are open after 8pm on weeknights. With falling rates of bulk-billing, the hospital ED is an attractive option to many patients, who cannot afford to pay to see a GP (Kwinana is the most disadvantaged metropolitan statistical local area in Western Australia)[505].

Mr Russell McKenney, General Manager, and Ms Margaret Bennett, Operations Manager, Armadale Kelmscott Health Service, indicated that around 60 percent of ED presentations are potential GP cases[506]. The Committee was advised that there is a four-day wait to see a GP in Armadale.

Dr Simon Wood, Deputy Director, Emergency Department, Joondalup Health Campus, advised that GP cases represent a significant proportion of ED presentations, particularly on Saturday and Sunday afternoons, when up to one in three patients could be seen by a GP. A private on site after hours GP clinic treats around 7,000 patients per annum, which relieves some of the burden on the hospital ED[507].

Whilst GP presentations appear to represent a significant proportion of total presentations at our secondary hospitals, their impact on emergency department resources is unclear.

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502 *ibid*.

503 Dr John Harvey, Medical Director, Rockingham/Kwinana District Hospital, Briefing, 22 September 2003.

504 General Practice Divisions of Western Australia, *After Hours Primary Medical Care in Western Australia*, October 2002.

505 Information supplied by Dr John Harvey, Medical Director, Rockingham/Kwinana District Hospital, September 2003.

506 Mr Russell McKenney, General Manager, and Ms Margaret Bennett, Operations Manager, Armadale Kelmscott Health Service, Briefing, 22 September 2003.

507 Dr Simon Wood, Deputy Director, Emergency Department, Joondalup Health Campus, Briefing, 22 September 2003.

Finding 70

General Practitioner presentations generally do not represent a significant drain on resources in metropolitan teaching hospitals. However, a significant proportion of emergency department presentations in secondary hospitals, particularly after hours, could potentially be treated in a primary care setting.

(iii) Factors contributing to GP presentations to emergency departments

There is a perception that two factors play a key role in the decision to attend an emergency department for primary care: lack of affordability and lack of access to primary care in the community.

A recent study undertaken by the ACT Division of General Practice examined the motivation behind people seeking care for non-urgent illnesses and injuries in hospital emergency departments[508]. Information was collected in the emergency departments of the Canberra and Calvary Hospitals in the ACT.

Between February 20 and March 6 2002, some 1,300 patients (44.3 percent of all category four and five presentations) completed questionnaires. It was determined, by matching unit records, that 61 percent of patients could potentially have been seen by a GP.

There were three main reasons for consumers choosing to present at the ED:

- A perception that the health issue required urgent attention (53 percent);
- The ED was the only option for after hours services (46.5 percent); and
- Patient was referred by another health agency (31.5 percent).

Whilst access was a significant issue for many people, affordability was not. Less than 10 percent of respondents indicated that they had visited the ED because it was a free service. The majority (84 percent) of respondents stated that they would prefer to see a GP and were prepared to pay for the service, within limits.

The importance of accessibility of after hours primary care comes with a caveat. Less than half of those surveyed were familiar with after hours primary care services in the region, such as the Health First Call Centre or the Canberra After Hours Locum Service. So rather than attend ED because it was the only available after hours service, people attended because of a perception that it was the only available service[509].

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508 ACT Division of General Practice, *I wouldn't be here if I could see a GP*, May 2002.

509 *ibid*, pii.

In the ACT study, 32 percent of respondents indicated that they held a Health Care Card, although the authors noted that a number of consumers did not appear to understand the difference between a Health Care Card and a Medicare card. The authors therefore considered the validity of this information doubtful and were reluctant to estimate the proportion of the study group who may have been economically disadvantaged[510].

Economic disadvantage is clearly an important determinant of capacity to pay for GP services, and in this respect, the finding of a very small proportion of respondents indicating that affordability was an important factor in their decision to visit the ED should be treated with some caution. The study population may be very different, in terms of socioeconomic status, to the population who present to Perth's outer metropolitan hospitals, which often have a high proportion of low-income earners.

The authors concluded that a considerable proportion of consumers who currently use EDs for non-urgent medical treatment would choose to see a GP after hours service if it was available, accessible, appropriate and affordable.

Finding 71

A recent Australian Capital Territory study found that the main reasons General Practitioner patients chose to present to the Emergency Department were a perception that the health issue required urgent attention, a perception that the Emergency Department was the only option for after hours services and referral from another agency. Less than ten percent of patients indicated that they had attended because the service was free.

510 *ibid*, pp9-10.

CHAPTER 6 EMERGING MODELS OF HEALTH CARE - SYSTEM CHANGES

The following two chapters provide a description of some of the innovative and very exciting models of health service delivery the Committee encountered during the course of this inquiry. Information was gathered from evidence and submissions, as well as through extensive research. The Committee's investigations were largely limited to four countries - Australia, New Zealand, Canada and the United Kingdom. Given the breadth of scope of the inquiry, the Committee considered it would be preferable to conduct a thorough investigation of emerging models in a small number of jurisdictions, rather than a superficial investigation of a large number of jurisdictions. New Zealand, Canada and the United Kingdom were identified, through preliminary background research, as being of considerable relevance to our own situation on the basis of similarities in health and socio-cultural factors. These countries were also of particular interest because of the approaches they have adopted to health reform.

The models of health care described below are presented in themes. For all the many innovative strategies being developed at any one time, in most cases, it is possible to group them together according to common themes. The themes are not always mutually exclusive, and in some instances, the examples cited may overlap several theme areas. The themes in turn represent strategies to achieve broader health system goals, which in essence, represent the major driving forces for change:

- improved patient care and outcomes;
- improved working conditions for health workers;
- more efficient use of scarce resources; and
- control over health expenditure.

Each of the jurisdictions the Committee examined is, to some extent, working toward these broad goals.

Innovation in health care delivery occurs in two ways. Through the vision and dedication of clinicians at the front-line, changes are often made at a local level in response to local needs. In this approach, organisations in other areas may not always gain from the experiences of the initiating organisation, as, without access to appropriate channels, the knowledge and experiences gained cannot be easily shared. Alternatively, innovations are encouraged, facilitated and supported by the establishment of a broader framework that assists organisations to develop, implement, evaluate and share knowledge about their innovative strategies. The Committee encountered examples of both approaches. Regardless of the approach, there appear to

be a number of factors that are essential to the success of new models of health service delivery, including:

- support and involvement of front-line staff;
- clinical champions with the vision and enthusiasm to drive change;
- support at an organisational level;
- a sound understanding of the problem(s) being tackled; and
- realistic expectations with regard to both the timeframe for change and the outcomes.

The following 'catalogue of innovations' is by no means exhaustive. It provides an overview of the reform process in each of the targeted jurisdictions and highlights some of the more promising innovations in each of these jurisdictions. Chapter Six focuses on emerging models of health service delivery at a system/organisational level, while chapter seven focuses on emerging health professional roles.

The information presented below was drawn from a number of sources: information on Canada and the United Kingdom was drawn largely from briefings with organisations in these jurisdictions; information on New Zealand was drawn partly from briefings in New Zealand and partly from targeted research; and information on Australia was drawn from briefings with local organisations, from responses to requests for information from interstate organisations as well as from targeted research.

6.1 Strengthening primary care

The last decade has witnessed a growing recognition around the globe of the importance of health promotion and disease prevention. Strategies to increase health promotion and disease prevention have been based on the premise that intervention 'upstream' can reduce health costs and improve health outcome 'downstream'. In other words, if steps are taken to prevent the onset of disease, in the long term the health system will benefit from a decreased overall burden of disease and individuals will enjoy a better quality of life. This paradigm is particularly relevant to the onset and progression of chronic diseases, many of which can be prevented, or at least delayed.

As well as recognition of the potential benefits of early intervention, is the recognition that the primary care sector is the most appropriate part of the health system in which to instil a focus of early intervention. Primary care is generally the first point of contact with the health system, and the majority of the population would have at least one encounter with a primary care provider each year. Primary care providers

therefore have considerable opportunity to employ early intervention strategies with a large proportion of the population.

There are a number of challenges associated with re-aligning primary care from a disease-oriented to a health-oriented approach, and with re-orienting the health system toward a greater primary health care focus. These include the willingness of primary care providers to adopt a health-oriented approach, the capacity of the primary care sector to deliver the stated objectives, and the scope within the system to engage an appropriate skill mix of health professionals to optimise delivery of primary health care. The following section explores primary care reform strategies and how the above challenges have been addressed.

(a) Primary care and the burden of disease

There is growing evidence to suggest that a strong primary care system has a positive influence on health outcomes and the overall cost burden of disease. Access to good primary care is also thought to reduce at least some of the health effects of social inequalities associated with income and resource distribution.

In a recent study Macinko and coworkers examined the relationship between strength of primary care systems and mortality in 18 Organisation for Economic Cooperation and Development (OECD) countries, including Australia. The authors rated primary care systems at the midpoint of each decade over a 28-year period (1970-1998) on the basis of ten components, five relating to structural (systemic) characteristics and five reflecting practice characteristics[511].

A strong primary care system is considered to exhibit the following characteristics:

1. equitable distribution of primary care providers and facilities;
2. finance is predominantly tax-based;
3. care is predominantly provided by generalists rather than specialists;
4. there are no or low co-payments for primary care visits;
5. providers maintain patient lists to track patients over time;
6. primary care is the first point of contact (gatekeeper) to the wider health system;
7. level of care is comprehensive and includes preventive, mental health, minor surgery and routine obstetric care;

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511 J Macinko, B Starfield and L Shi, *The contribution of primary care systems to health outcomes in Organisation for Economic Cooperation and Development (OECD) countries, 1970-1998*, June 2003, http://www.findarticles.com/cf_0m4149/3_38/103731430/print.jhtml, accessed 10 December 2003.

8. coordination of care with other health services through transfer/sharing of patient records;

9. patient's family environment is considered in diagnosis and treatment; and

10. treatment is considered in the larger social (community/population) context[512].

Between 1975 and 1995, Australia's rank amongst the selected OECD countries fell from fifth to seventh. Throughout the study period, Australia's primary care system rated poorly in three areas: longitudinality (care organised so as to provide a regular source of care over time, e.g. through patient lists or rosters), coordination (with other health sectors) and community-orientation. Distribution of primary care resources was also inequitable, although there was some improvement noted over the study period[513]. Throughout the study, Australia's primary care system was rated highly with respect to access (i.e. no or low co-payments), but as noted earlier, the level of primary care co-payments have risen sharply in recent years. The average co-payment is now more than 50 percent of the Medicare rebate, which constitutes a considerable barrier to access for some sections of the population.

Finding 72

Australia's primary care system ranks relatively highly in comparison with other Organisation for Economic Co-operation and Development countries. However, research suggests that it could be further strengthened through improvements in coordination with other parts of the health system, greater community orientation of primary care practices, longitudinality of patient care, more equitable distribution of primary care resources and improved access through reduction in the level of co-payments.

The authors reported a highly significant association between all-cause mortality and strength of primary care: the stronger the primary care system, the lower the mortality rate. Further analysis of mortality data revealed a link between primary care and a number of common preventable and/or treatable diseases. A strong primary care system was found to be significantly associated with lower rates of premature mortality due to asthma, bronchitis and emphysema, pneumonia and influenza, cerebrovascular disease and heart disease[514].

(b) Primary care reform in Canada

In a briefing with Ms Nancy Swainson, Acting Director, Health Policy and Communications Branch, Primary Health Care Division, Health Canada, and

512 *ibid*.

513 *ibid*.

514 *ibid*.

colleagues[515], the Committee learned that Primary Health Care in Canada has traditionally been characterised by physicians working in solo practices delivering most of the services on a fee-for-service basis. Ms Swainson emphasised that the fee-for-service model created an incentive to provide compensatable services, and that physicians have a very strong incentive to keep the fee schedules reasonably consistent with high turnover acute care episodic patients. Another problem associated with the fee-for-service model is that it impedes corroboration with other health professionals - because physicians receive a fee only if they see a patient, there is no financial compensation for care provided by other health professionals as part of the primary care team.

There are three major driving forces for primary health care renewal in Canada:

- Access to primary health care providers, especially in rural and remote areas, is problematic. In urban centres, problems of access to basic primary care have led to increasingly inappropriate use of emergency departments for non-urgent care and premature use of specialty services;
- Questions have begun to arise around affordability of the Canadian health care system and the quality of care provided within the existing fee-for-service payment arrangement in primary care; and
- Primary care is poorly integrated with other parts of the health system, resulting in uncoordinated and/or duplicated care for patients[516].

Finding 73

Access problems, lack of integration with other parts of the health system and questions about affordability and quality of care within the existing fee-for-service arrangement have prompted redesign of primary health care services across Canada.

One of the features of primary health care reform in Canada is a move away from fee-for-service physician remuneration toward a capitation-based system. Concerns about the inability of the current fee-for-service model to support a primary care system with

515 Ms Nancy Swainson, Acting Director, Lucy Falastein, Policy Analyst, and Jacquie Lemaire, Senior Program Officer, Health Policy and Communications Branch, Primary Health Care Division, Health Canada, Briefing, 24 June 2003.

516 Health Canada, *Primary Health Care Transition Fund*, http://www.hc-sc.gc.ca/phctf-fassp/english/faq.html, accessed on 12 January 2004.

a strong emphasis on preventive care and chronic disease management were echoed by many of the people the Committee met with across Canada[517].

Ms Swainson indicated that physicians are a well-established group that has historically enjoyed considerable control over their individual practices when they work alone on a fee-for-service basis. One of the problems in moving away from the fee-for-service system is the mindset that is formed during physician training. Physicians are trained to become independent practitioners and encouraged to believe that they should be the only caregiver for a particular patient. However, there is evidence to suggest that the mindset of physicians is slowly changing. The Canadian Medical Association undertakes a survey of its members each year and it would appear that the number of physicians interested in alternative payment plans increases by around ten percent each year. This figure is consistent with growth in the number of physicians entering the workforce, suggesting a generational shift[518].

As early as 1996, a report to health ministers recommended the move toward a primary care system underpinned by multi-disciplinary teamwork, greater use of nurse practitioners, increased collaboration with other providers and changes to the way in which physicians were remunerated to create incentives for more continuity of care and better attention to prevention and chronic disease management[519]. It was not until September 2000 that Canadian Ministers agreed that primary health care improvements are crucial to health reform. In response to this commitment, the Federal Government announced the Primary Health Care Transition Fund (PHCTF) an $800 million investment over four years to March 2006[520].

The PHCTF is designed to support transitional costs of implementing sustainable, large-scale primary health care renewal initiatives. Its specific purpose is to offset the costs of moving from the existing system to the new system. Funding will cease in March 2006, beyond which time the changes implemented at provincial/territorial

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517 Ms Megan Loeb, Consultant, Stakeholder Liaison, Evaluation and Education, Primary Health Care Division, British Columbia Ministry of Health and Ms Laurie Gould, Director, Planning and Development, Primary Care and Chronic Disease, Fraser Health Authority, Briefing, 23 June 2003; Mr Clive Shepherd, Site Co-ordinator, Ontario Family Health Network, Briefing, 24 June 2003; Dr Daniel Way, Director of Postgraduate Education, Faculty of Medicine, University of Ottawa, Briefing, 24 June 2003; and Dr David Gass, Director, and Ms Tracey Martin, Primary Health Care Co-ordinator, Primary Health Care, Nova Scotia Department of Health, Briefing, 25 June 2003.

518 Ms Nancy Swainson, Acting Director, Health Policy and Communications Branch, Primary Health Care Division, Health Canada, Briefing, 24 June 2003.

519 Ms Nancy Swainson, Acting Director, Lucy Falastein, Policy Analyst, and Jacquie Lemaire, Senior Program Officer, Health Policy and Communications Branch, Primary Health Care Division, Health Canada, Briefing, 24 June 2003.

520 Health Canada, *Welcome to the Primary Health Care Transition Fund (PHCTF)*, http://www.hc-sc.gc.ca/phctf-fassp/english/, accessed on 12 January 2004.

level are expected to be self-sustaining. The fundamental changes expected to result from the PHCTF are:

- An increased number of community-based primary health care organisations (PHCOs) that provide comprehensive services to a defined population;
- More interdisciplinary teams with enhanced roles for registered nurses, pharmacists and other providers;
- Better linkages with hospitals, specialists and other community services;
- Greater emphasis on health promotion, disease and injury prevention and management of chronic diseases; and
- Expanded access to essential primary care services on a 24/7 basis[521].

Finding 74

The Canadian Government launched the *Primary Health Care Transition Fund* in 2002 to facilitate the transition of the current system into a primary care system characterised by:

- an increased number of community-based primary health care organisations;
- care provided by multi-disciplinary teams;
- better linkages with other parts of the health system;
- greater emphasis on health promotion, disease prevention and management of chronic disease; and
- expanded access to 24/7 primary care.

Within the above framework, the provinces and territories have considerable latitude to develop and implement their own strategies. In many cases, PHCTF strategies have built on pilot or evaluation projects that were undertaken as part of the Health Transition Fund (HTF). The HTF, a joint initiative of Federal and Provincial governments, provided $150 million between 1997 and 2001 to '*encourage and support evidence-based decision making in health care reform*'. The HTF ultimately funded 140 pilot projects and/or evaluation studies across Canada. Initiatives in four priority areas, including primary health care, were targeted. The initiatives supported by the PHCTF are much broader in scope than those of the HTF and are expected to facilitate widespread, lasting reform.

521 Health Canada, *Primary Health Care Transition Fund*, http://www.hc-sc.gc.ca/phctf-fassp/english/faq.html, accessed on 12 January 2004.

In February 2003, building on recommendations of the Romanow Commission and other health care reform task forces, and the *First Ministers Accord on Health Care Renewal*, Primary Health Care was one of three areas identified for funding as part of the five-year Health Reform Fund[522]. The Health Reform Fund constitutes an additional $16 billion transfer over the five years from 2003/04 to 2008/09 in support of priority health reforms[523].

The preliminary target for primary health care is that within eight years, 50 percent of Canadians will be covered by multi-disciplinary primary health care organisations[524]. Subject to the provinces meeting the agreed reforms, the Health Reform Transfer will be integrated into the Canada Health Transfer[525] from 2008/09[526]. The Health Reform Fund is expected to enable the provinces to build on the reforms being implemented as part of the Primary Health Care Transition Fund.

Finding 75

In February 2003, primary health care was one of three areas identified by the Canadian Government for funding as part of the five-year *Health Reform Fund*. By the end of the five-year *Health Reform Fund*, fifty percent of Canadians are expected to be covered by multi-disciplinary primary health care organisations. Beyond the life of the *Health Reform Fund* the provinces will receive ongoing funding, subject to meeting the agreed reforms.

In meeting with representatives in several provinces, it was clear to the Committee that the PHCTF strategies being employed by different governments vary greatly from province to province. The following section describes the PHCTF reform strategies to be employed in two provinces.

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522 Hewitt Research Advisory, *First Ministers Set Health Reform Agenda*, http://was4.hewitt.com/hewitt /worldwide/canada/images/first_minister.pdf, accessed on 15 January 2004.

523 Department of Finance Canada, *Canada Health and Social Transfer*, http://www.fin.gc.ca/FEDPROV/ chse.html, accessed on 15 January 2004.

524 Ms Nancy Swainson, Acting Director, Health Policy and Communications Branch, Primary Health Care Division, Health Canada, Briefing, 24 June 2003.

525 The Canada Health Transfer is a federal transfer to the provinces and territories, providing them with cash payments and tax transfers in support of health care. As of 1 April 2004, the Canada Health and Social Transfer will be separated into the Canada Health Transfer and the Canada Social Transfer (support of post-secondary education, social assistance and social services).

526 Department of Finance Canada, *Canada Health and Social Transfer*, http://www.fin.gc.ca/FEDPROV/ chse.html, accessed on 15 January 2004.

(i) British Columbia

Ms Megan Loeb, Consultant, Stakeholder Liaison, Evaluation and Education, Primary Health Care Division, British Columbia Ministry of Health and Ms Laurie Gould, Director, Planning and Development, Primary Care and Chronic Disease, Fraser Health Authority provided the Committee with an overview of the background and progress on the PHCTF strategy in British Columbia. As in other provinces, the primary health care renewal strategy in British Columbia began with a HTF pilot project, the Primary Care Demonstration Project, which operated between 1998 and 2001. Seven community level Primary Care Demonstration (PCD) pilot sites were selected following a call for expressions of interest from the Ministry. The PCD sites had a minimum of three family physicians, at least one other health professional and a 'roster'[527] of at least 5000 patients. Physician remuneration was according to a blended capitation model. Age, sex and predicted burden of disease (according to an Adjusted Clinical Grouping score[528]) of each patient on the roster was used to determine a lump sum (capitation) per quarter payment per person for core services[529]. Non-core services[530] continued to be remunerated on a fee-for-service basis. If a patient sought care elsewhere, a deduction was made from the capitation payment. There was no financial guarantee for physicians, which was a major source of concern.

A number of lessons were learned during the HTF pilot:

- One of the major challenges faced by the pilot sites related to information technology - because they were billing in a different way, a new billing system had to be introduced. The short timeframe of the pilot project did not allow sufficient time to pilot the new billing system before implementing it;

- Initially family physicians were uncertain as to how to make use of other health professionals (e.g. nurse practitioners, physiotherapists), but with time, some clinics began to operate as very effective multi-disciplinary teams;

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527 Patients are 'virtually' rostered, in the sense that they do not physically sign up with a particular doctor. The virtual roster is based on patients' past consultation history (i.e. a patient who in the past has consulted one doctor exclusively or most of the time becomes part of that doctor's virtual roster).

528 Adjusted Clinical Grouping was based on Medical Services Plan (equivalent to our Medicare) billing (data captured on all services provided). All of the billing that came in over the previous year on a particular patient was assessed in the BC Ministry of Health. This process initially took two years, and is still being fine-tuned.

529 A defined set of routine primary care services that all family practitioners are expected to be able to provide.

530 Additional, non-routine services that are performed by some but not all family practitioners, eg prenatal and obstetric care.

- Patients were satisfied with the care they received and found that they had better access to care - pilot sites had to provide after hours access to care plus 24 hour access to information;

- Despite some of the problems encountered, most family physicians experienced increased job satisfaction. They were able to provide better coverage and their on call commitments were generally reduced; and

- Most sites had an 'outflow' or around 20 percent of patients. A site with three family physicians and two other health professionals needed to have a minimum of 5000 rostered patients to be financially viable[531].

At the end of the HTF project, the PCD sites continued as Primary Health Care Organisations and are expected to act as beacons for new PHCOs that are formed during the PHCTF phase of reform.

In progressing from the pilot phase during the HTF to the broader reforms of the PHCTF, Ms Loeb advised that the approach in British Columbia has been largely one of incremental change and voluntary participation. From the outset, the British Columbia Medical Association (BCMA) has voiced its opposition to the proposed changes. The introduction of other primary health care providers is seen as a threat to the income and status of family physicians. Because of this resistance, the decision was made not to attempt to 'impose' PHCOs on the medical fraternity. While family practitioners are encouraged to become involved in PHCOs, there is no compulsion to do so. By 2006, it is hoped that 10-15 percent of practices will operate as PHCOs and the push for greater penetration of the PHCO model will come from the public, who will demand to have services provided in this manner. The British Columbia Ministry of Health is optimistic that its PHCTF strategy will provide sufficient leverage to overcome the political strength of the BCMA[532].

The PHCTF is nearing the end of its second year. The first year was used to establish a chronic disease registry website, to set up funding structures and policy (guidelines) and to develop a framework for evaluation. The first new PHCOs began operating in late 2003, and some 50-60 organisations are expected to be in operation by the end of the four-year program. By 2006, PHCOs must be self-sustaining[533].

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531 Ms Megan Loeb, Consultant, Stakeholder Liaison, Evaluation and Education, Primary Health Care Division, British Columbia Ministry of Health, Briefing, 23 June 2003.

532 *ibid*

533 *ibid*.

Finding 76

In British Columbia, Canada, strong opposition from the British Columbia Medical Association with regard to the introduction of other health providers in primary care, has led to a primary health care reform strategy that is largely one of incremental change and voluntary participation. It is hoped that by 2006, 10-15 percent of primary care practices in British Columbia will operate as Primary Health Care Organisations, which meet all of the criteria established by the Federal Government as part of the *Primary Health Care Transition Fund*.

(ii) Ontario

Primary Health Care reform in Ontario also originated with a pilot project as part of the *Health Transition Fund*. The Primary Care Implementation and Evaluation Project developed, implemented and evaluated a model of primary care based on primary care networks, which are characterised by:

- Population based funding for physician services, either through reformed fee-for-service or global capitation models;
- Patient enrolment;
- Twenty-four hour access to care via telephone triage;
- Incentives for preventive interventions;
- Integration of information technology into practice; and
- Nurse practitioners (at some sites)[534].

As in British Columbia, the HTF pilot formed the basis for expansion of primary care reform in Ontario. However, the Ontario Ministry of Health and Long Term Care has adopted a more aggressive approach than its counterpart in British Columbia, setting a target of 80 percent of the province's physicians practising in Family Health Networks by 2004. In support of this goal, the government created the Ontario Family Health Network to oversee the expansion of primary care reform and committed $250 million, $100 million in financial incentives for family physicians and $150 million for information technology to support the new networks[535].

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534 Health Canada, *Health Transition - Fund Project Fact Sheet ON301*, http://www2.itssti.hc-sc.gc.ca/B_Pcb/HTF/Projectc.nsf/FactSheets_e/759BA4192F73E3E085256816006DD905, accessed on 14 January 2004.

535 Ontario Ministry of Health and Long Term Care, *Backgrounder - Government investments in the Ontario Family Health Network*, http://ogov.newswire.ca/ontario/GPOE/2001/03/21/c5613.html? lmatch=&lang=_e.html, accessed on 14 January 2004.

Mr Clive Shepherd, Site Coordinator, Ontario Family Health Network (FHN), provided the Committee with an overview of the primary care reform strategy in Ontario and recent progress in its implementation[536]. Mr Shepherd advised that, like British Columbia, Ontario encountered resistance to the reform process from the Ontario Medical Association (OMA). The OMA agreed to co-sponsor the FHN program, provided a) doctors were able to maintain their freedom of choice to participate, b) incentives were offered for doctors to provide the extra hours of care and c) remuneration was provided for those areas that the existing fee-for-service system did not remunerate[537].

In contrast to the British Columbia model, there is no obligation for Ontario FHNs to include other health care professionals, such as nurse practitioners, as part of the team. There is scope for FHNs to access funding for nurse practitioners, however the application is dealt with by a different section of the Ministry of Health, and each FHN must make a special case for additional funding. It is anticipated that FHNs will ultimately include other health care professionals in the model of care[538].

A network of doctors must be geographically located. It is not only voluntary for doctors to join a network, it is also voluntary for their patients to do so. If a patient does not want to commit to one doctor, he/she does not have to. In contrast to the British Columbia PHCO model, in which the patient roster is 'virtual', patients who enrol with FHN doctors physically sign an enrolment contract. There is an indirect penalty if a patient consults another doctor outside the network. Rather than a loss of capitation income, the FHN does not earn a 'bonus income' associated with meeting 100 percent of the patient's primary health care needs[539].

Similarly to PHCOs in British Columbia, remuneration for doctors who belong to Ontario FHNs is by blended capitation. Capitation rates, which are indexed annually, are adjusted on age and sex of patients. Capitation payments are for core services, which account for approximately 80 percent of services provided. Non-core services are paid on a fee-for-service basis[540].

As part of its recruitment strategy, the Ontario Family Health Network (OFHN) undertakes a revenue analysis for each physician, which demonstrates how the physician's income would be expected to change in a FHN. The average FHN physician can expect to earn 20 percent more than a straight fee-for-service physician.

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536 Mr Clive Shepherd, Site Co-ordinator, Ontario Family Health Network, Briefing, 24 June 2003.

537 *ibid*.

538 *ibid*.

539 *ibid*.

540 *ibid*.

For physicians whose patients are all high needs, the FHN model is not expected to increase their income[541].

For physicians who do not want to join Family Health Networks, an alternative model, which sits between the current system and the FHN has been devised. A Family Health Group (FHG) has many of the features of FHNs, such as providing additional hours of service, tele-triage and enrolment of patients. However, FHG physicians are remunerated on a fee-for-service basis. Although FHG physicians will earn more than straight fee-for-service physicians, the FHG model is not as lucrative as the FHN model[542].

As of January 2004, there were more than 1800 family physicians (20 percent of the 9000 total) in 156 FHNs and FHGs, serving more than 2.5 million Ontarians[543]. It is hoped that by 2008, 50 percent of Ontario's family physicians will practice in FHNs and FHGs[544].

Finding 77

Primary health care reform in Ontario, Canada centres on the development of Family Health Networks. Despite initial resistance to the proposed primary care reform strategies, the Ontario Medical Association agreed to co-sponsor implementation of the Ontario Family Health Network program, provided certain conditions were met. By January 2004, approximately 20 percent of Ontario's family physicians were practising in Family Health Networks or Family Health Groups.

(iii) Nova Scotia

The HTF project *Strengthening Primary Care in Nova Scotia Communities* saw the establishment of four demonstration sites to test new ways of delivering, funding and managing primary care services. The project simultaneously introduced a new primary care provider (a nurse practitioner), advanced information systems, and alternative payment mechanisms for physicians. To establish the new position of nurse practitioner, collaborative practice agreements between physicians and nurse practitioners were developed and approved, the Pharmacy Act was amended, and orientation, training, operational, and continuing education issues were addressed.

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541 *ibid*.

542 *ibid*.

543 Ontario Family Health Network, *Locations of Family Health Networks and Family Health Groups*, http: //www.ontariofamilyhealthnetwork.gov.on.ca/english/fhn_listing/local_networks.html, accessed on 14 January 2004.

544 Mr Clive Shepherd, Site Co-ordinator, Ontario Family Health Network, Briefing, 24 June 2003.

Nurse practitioners were well received by the communities and family physicians in each of the demonstration sites. Their time was divided between clinical practice (60 percent) and outreach (40 percent). There was considerable community pressure for outreach services, and the introduction of nurse practitioners led a major improvement in this area[545].

Building on the success of the HTF demonstration sites, further primary care reform in Nova Scotia (through the PHCTF) will focus on expanding the use of multi-disciplinary primary health care teams to enhance access to primary health services and investing in health information systems[546]. As with other provinces, Nova Scotia is also currently considering alternatives to the fee-for-service model of physician funding[547].

Nurse practitioners, who are currently provincially funded via a protected pool of money, are expected to be incorporated into the business plans of District Health Authorities in the longer term. It is anticipated that nurse practitioners will also ultimately work in other health sectors, such as emergency and long-term care. Far from being seen as an overall solution to primary care issues, nurse practitioners are considered to be part of a broader reform strategy[548].

Finding 78

Primary health care reform in Nova Scotia, Canada will focus on expanding the use of multi-disciplinary primary health care teams, largely through greater involvement of nurse practitioners.

(c) Primary care reform in the United Kingdom

(i) Primary Care and the NHS Plan

The NHS Plan[549] signalled significant reform of primary care, with the philosophy that the future of the NHS rests on the strength of its primary care services[550]. Specific targets, some of which are described in more detail in later sections, include:

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545 Dr David Gass, Director and Tracey Martin, Primary Health Care Co-ordinator, Primary Health Care, Nova Scotia Department of Health, Briefing, 25 June 2003.

546 Health Canada, Minister McLellan and Minister Muir announce more than $17 million to strengthen primary health care in Nova Scotia, http://www.hc-sc.gc.ca/english/media/releases/2002/2002_60.htm, accessed on 15 January 2004.

547 Dr David Gass, Director, Primary Health Care, Nova Scotia Department of Health, Briefing, 25 June 2003.

548 *ibid*.

549 The Right Honourable Alan Milburn, Secretary of State for Health, *The NHS Plan, A plan for investment a plan for reform*, July 2000.

- 3,000 GP premises to be substantially refurbished or replaced by 2004;
- 500 one stop primary care centres by 2004;
- At least 2,000 more GPs and 450 General Practitioner trainees by 2004;
- All Primary Care Groups to become Primary Care Trusts by 2004;
- 1,000 extra primary care mental health workers;
- 500 extra community mental health workers;
- Forty-eight hour appointment target by 2004;
- 1,000 General Practitioner specialists; and
- Nurses undertaking more roles[551].

(ii) Primary Care Trusts

Primary Care Trusts (PCTs) are free-standing GP-led bodies accountable to the local health authority for purchasing care (and in the case of level 4 Trusts, provision of community services) for their population[552]. PCTs are the focus of local service provision. More responsibilities are being devolved to PCTs, particularly from the current health authorities and regional offices. By 2004, PCTs are expected to control 75 percent of the NHS budget, and will be free to commission care and set priorities for their local population[553].

The *National Primary and Care Trust Development Programme* was established following publication of *Shifting the Balance of Power within the NHS*[554] to provide organisational development support to PCTs.

(iii) New and extended roles in primary care

Delivering the NHS Plan[555] identified the need to increase the amount of activity that takes place in primary and community settings. The NHS Plan envisaged that by 2004,

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550 Department of Health, *Primary care, general practice and the NHS Plan, Information for GPs, nurses, other health professionals and staff working in primary care in England*, January 2001.

551 *ibid*, pp2-3.

552 S Anderson, Nova Scotia Department of Health, *Canada/International Review of Primary Health Care*, December 2001, p52.

553 P Butler, Society Guardian, *Primary care: the issue explained*, 5 November 2002, http:// society.guardian.co.uk/primarycare/story/0,8150,725668,00.html, accessed on 12 January 2004.

554 Department of Health, *Shifting the Balance of Power within the NHS*, February 2002.

up to 1,000 'specialist' GPs would be taking referrals from fellow GPs for conditions in specialties such as ophthalmology, orthopaedics, dermatology and ear nose and throat surgery[556]. Extending the roles of GPs is one of a number of measures intended to reduce the waiting lists for diagnosis and treatment in an acute setting. It also has the potential to strengthen the interface between primary and acute settings.

Whilst the concept of GPs with special interests is not new, the NHS Plan has taken the concept a step further by providing a framework to guide Primary Care Trusts wishing to engage the services of these extended role GPs. From a patient perspective, the scheme is expected to provide faster access to localised services. GPs are also expected to gain, through more structured professional development and greater recognition of their extended skills and expertise.

GPs with Special Interests (GPwSI) work with the support of hospital consultants. They do not offer a full consultant service, but rather work primarily as GPs, undertaking perhaps two sessions per week in their specialty area. The Department of Health has established guidelines with recommended core activities and competencies for GPwSI in particular specialties, but responsibility lies with the Primary Care Trust to ensure the GP has the necessary competencies for the role[557].

In 2001-02, 600,000 procedures previously carried out in hospitals were carried out by primary care staff[558]. By August 2003, 1250 GPwSI were taking referrals from fellow GPs.

Following on from the guidelines for implementation of the GPwSI scheme, the Department of Health introduced corresponding guidelines for nurses[559] and allied health professionals[560]. As with GPs, nurses and allied health professionals with special interests are not new, but the frameworks provide a guide for Primary Care Trusts to design services around patient needs, whilst supporting a more formalised career pathway as well as recognising the contribution of these extended role practitioners.

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555 Secretary of State for Health, *Delivering the NHS Plan, next steps on investment, next steps on reform,* April 2002.

556 Secretary of State for Health, *The NHS Plan, A plan for investment, a plan for reform*, July 2000, p102.

557 Department of Health, *More than 1,000 Special Interest GPs now delivering treatment in the community (media release)*, August 2003.

558 National Health Service, *The NHS Plan - a progress report, NHS Modernisation Board's Annual Report 2003*, http://www.doh.gov.uk/modernisationboardreport/annualreport2003.pdf, accessed on 28 January 2004, executive summary.

559 Department of Health, *Practitioners with Special Interests in Primary Care, Implementing a Scheme for Nurses with Special Interests in Primary Care*, April 2003.

560 Department of Health, *Practitioners with Special Interests, Implementing a Scheme for Allied Health Professionals with Special Interests*, November 2003.

Examples of patients being assessed and/or treated by extended role primary care practitioners include:

- The waiting time for ophthalmology appointments in one Cambridgeshire hospital has been halved, as consultants are able to redirect a proportion of patients to a GP with a special interest in ophthalmology[561];

- In 2002, a multi-professional triage team in Southampton treated around 3,500 patients who would otherwise have been placed on a waiting list to see a consultant. The team comprises a GP, three physiotherapists and a podiatrist. Patients who previously were waiting up to 18 months can be seen within two (urgent) to six (non-urgent) weeks, and only one in four are referred to a hospital consultant[562];

- At the Wallesey Heart Centre, patient assessments are undertaken by a GPwSI. The Centre also provides a rehabilitation service for patients recovering from heart problems and an exercise and lifestyle service for people who are at high risk of developing coronary heart disease (CHD). Patients are seen within six weeks, compared with six months for traditional outpatients, and deaths from CHD have fallen below the national average since the service was established[563]; and

- In the Mid Devon Primary Care Trust, all patients being considered for hip or knee replacement, who were previously referred directly to secondary orthopaedic services, are now referred to practice physiotherapists for initial assessment and/or treatment. One fifth of patients are now managed in primary care, and the conversion rate to surgery for those who were ultimately referred to secondary care increased from 44 to 73 percent[564].

Finding 79

Throughout England, following on from the strategic directions laid out in the *NHS Plan* (2000), General Practitioners, nurses and allied health professionals with special interests are being supported to undertake a range of procedures in primary and community care settings that were previously carried out by specialists in an acute setting. In 2001-02, primary care staff carried out 600,000 procedures previously carried out in hospitals.

561 Department of Health, *Practitioners with Special Interests: Bringing Services Closer to Patients*, November 2003, p9.

562 *ibid*, p11.

563 *ibid*, p17.

564 Department of Health, *Practitioners with Special Interest, Implementing a Scheme for Allied Health Professionals with Special Interests*, November 2003, p16.

(iv) Non-doctor prescribing

As well as extended roles for nurses and allied health professionals in primary care, extension of non-doctor prescribing is an important part of primary care reform in the United Kingdom. Although the role of prescribing will encompass health professionals working in secondary care, those working in primary care are expected to see the greatest change in traditional roles and hierarchies.

The *Health and Social Care Act 2001*, passed in June 2001, follows recommendations of a review[565] chaired by Dr June Crown, past President of the Faculty of Public Health Medicine, which proposed that a raft of non-doctors, including nurses, allied health professionals and pharmacists should be given new prescribing powers. The report recommended two levels of prescribers:

- Independent prescribers take responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing where necessary and the appropriateness of any prescription[566]; and

- Supplementary prescribers work with patients who have been assessed by a doctor and take responsibility for ongoing care, including prescribing, consistent with treatment guidelines and Patient Group Directives[567].

There are two types of independent nurse prescribers. District Nurses and Health Visitors who prescribe from a limited formulary of products designed to meet the needs of their patients[568]. Legislation allowing independent prescribing by District Nurses and Health Visitors was introduced in the early 1990s. Appropriate training for the prescribing from this formulary is incorporated into the basic training of all District Nurses and Health Visitors. Following enactment of the *Health and Social Care Act 2001*, all first level registered nurses and registered midwives can now train to prescribe from the Nurse Prescribers' Extended Formulary. The Formulary includes:

- All medicines in the District Nurse/Health Visitor Formulary;

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565 Review team for the prescribing, supply and administration of medicines, *Review of prescribing, supply and administration of medicines*, March 1999.

566 Department of Health, *Mechanisms for nurse and pharmacist prescribing and supply of medicines*, http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf, accessed on 28 January 2004.

567 InPharm.com, *Nurse Prescribing and its Future*, http://www.inpharm.com/static/intelligence/pdf/ MAG_7000.pdf, accessed 28 January 2004.

568 Department of Health, *Mechanisms for nurse and pharmacist prescribing and supply of medicines*, http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf, accessed on 28 January 2004.

- All licensed Pharmacy medicines and all General Sales List medicines prescribable at NHS expense (excluding controlled drugs); and
- A range of approximately 140 Prescription Only Medicines.

These medicines may be prescribed for use in four therapeutic areas only: minor illness; minor injury; health promotion; and palliative care[569].

Training for nurse prescribing is at degree level and is funded by the Department of Health. Training is generally restricted to experienced nurses (3 years of more experience). Training, which takes place over three months (part-time) consists of 25 teaching days at a university and 12 days clinical practice with supervision from a medical practitioner[570].

Supplementary prescribing involves a voluntary partnership between an independent prescriber (a doctor or dentist) and a supplementary prescriber, to implement an agreed patient-specific Clinical Management Plan with the patient's agreement. There are no legal restrictions on the clinical conditions that may be treated under supplementary prescribing, although it is expected to be used primarily in management of chronic conditions. There is no specific formulary or list of medicines for supplementary prescribing, provided they are prescribable at NHS expense and are referred to in the patient's Clinical Management Plan[571].

Training for supplementary prescribing is the same as for extended formulary prescribing, with the addition of a short module covering the context and concept of supplementary prescribing[572].

By late 2003 there were almost 30,000 nurse prescribers, predominantly District Nurses and Health Visitors, in the United Kingdom. An additional 10,000 nurse prescribers are expected to have undertaken prescriber training by the end of 2004. Ultimately, all nursing students will learn how to prescribe in their pre-registration training[573].

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569 Department of Health, *Mechanisms for nurse and pharmacist prescribing and supply of medicines*, http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf, accessed on 28 January 2004.

570 InPharm.com, *Nurse Prescribing and its Future*, http://www.inpharm.com/static/intelligence/pdf/ MAG_7000.pdf, accessed 28 January 2004.

571 Department of Health, *Mechanisms for nurse and pharmacist prescribing and supply of medicines*, http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf, accessed on 28 January 2004.

572 *ibid*.

573 S Harrison, *What next for prescribing: nurses are still having to chase doctors for signatures on some prescriptions, even after the latest extension of prescribing rights (analysis)*, Nursing Standard, August 2003, http://www.findarticles.com/cf_dls/m0NEW/48_17/107121354/p1/article.jhtml, accessed on 23 January 2004.

The first tranche of independent prescribers began training in 2002, and the first training programs for supplementary prescribers began in 2003. In the 18 months to November 2003, more than 1200 extended formulary prescribers trained and registered, of which 1,000 qualified and registered as supplementary prescribers[574]. Expansion of the Extended Formulary to include a further 10 medical conditions and more than 30 additional medicines was announced in November 2003, with further expansion, to include emergency care, planned for 2004[575].

The first cohort of pharmacists began prescriber training in 2003 with 150 enrolled in courses by December of that year[576].

In addition to supplementary and independent prescribing, Patient Group Directions enable nurses and a number of allied health professionals to supply or administer medicines to groups of patients who may not be individually identified before presentation for treatment. Patient Group Directions are generally drawn up by a multi-disciplinary group and are signed by a senior doctor and pharmacist with authorisation by the relevant Primary Care Trust, NHS Trust or Strategic Health Authority. There are thought to be more than 100 Patient Group Directions currently in operation[577].

Finding 80

As part of the primary care reform process, registered nurses, midwives and pharmacists in England can now train to become Independent or Supplementary Prescribers. Independent Prescribers take responsibility for the assessment, diagnosis and management of patients within a defined set of conditions and prescribe from the Nurse Prescribers Extended Formulary. Supplementary Prescribers work with patients who have been assessed by a doctor and take responsibility for ongoing care, including prescribing.

574 Department of Health, *'Nurses need to be all that they can be' - Reid* (press release 14 November 2003), http://www.info.doh.gov.uk/doh/intpress.nsf/page/20030462?Open Document, accessed 23 January 2004.

575 *ibid*.

576 G Jones, *Pharmacist prescribing - from concept to reality*, Hospital Pharmacist, December 2003, vol 10: p466, http://www.pharmj.com/pdf/hp/200312/hp_200312_comment.pdf, accessed on 28 January 2004.

577 Department of Health, *Mechanisms for nurse and pharmacist prescribing and supply of medicines*, http://www.doh.gov.uk/nurseprescribing/formsofprescribingmay03.pdf, accessed on 28 January 2004.

(v) The General Medical Services Contract - a new contract for GPs

After lengthy negotiations, in June 2003, GPs overwhelmingly voted to accept a new NHS GP contract[578]. The General Medical Services (GMS) contract, which will apply to around 70 percent of GPs in the NHS, differs from previous arrangements in several respects. The new contract has three broad objectives: to improve working conditions for GPs; to improve quality of care for patients; and to shift the focus toward health promotion and disease prevention.

One of the most controversial aspects of the new contract relates to after-hours services. From April 2004, GPs will no longer be required to provide after hours care for their patients, a responsibility that will be assumed by Primary Care Trusts. At a minimum, surgeries will be responsible for providing essential services during core hours (8.00 a.m. to 6.30 p.m. weekdays)[579]. A recent poll, involving almost 1,000 GP practices in England and Wales, found that more than 80 percent plan to opt out of after hours cover[580]. Primary Care Trusts are expected to employ their own doctors, as well as other health professionals, to provide after-hours care.

Although practices will continue to hold patient lists, and patients will be free to register with a primary care provider of choice within a designated area, new formal procedures will enable providers to close lists[581]. In principle, by controlling their list sizes, GPs are expected to be able to improve the quality of care for their existing patients by, for example, offering longer consultations[582]. The new contract also provides substantial funding to employ additional staff, including nurses, a measure that is expected to enable GPs to spend more time with patients who are most in need, leaving less urgent cases to other practice staff. The appointment of additional practice staff is also expected to reduce waiting times to see GPs[583].

In line with the devolution of power to the primary care sector, investment in primary care is expected to increase by 33 percent over three years to £8 billion by 2006. Whilst the majority of GPs are expected to receive a substantial pay rise, for the first time, a large proportion of GP salaries will be linked to the quality of care they

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578 BBC News, *GPs back NHS contract*, 20 June 2003, http://news.bbc.co.uk/1/hi/health/3004750.stm, accessed 27 January 2004.

579 Department of Health, *Delivering investment in general practice, Implementing the new GMS contract*, December 2003, pp6-7.

580 ParamedicUK, *Most GPs will ditch night visits, shows survey*, http://www.paramedic.org.uk/Members/bigkev/newsarchive/News_item.2003-12-02.5439/view, accessed 27 January 2004.

581 *ibid*.

582 Royal College of General Practitioners, *Valuing General Practice* (press release, 14 March 2001), http://www.rcgp.org.uk/press/2001/9154.asp, accessed 21 January 2004.

583 BBC News, *GP Contract: impact on patients*, 20 June 2003, http://news.bbc.co.uk/1/hi/health/2771805.stm, accessed 27 January 2004.

provide[584]. The Quality and Outcomes Framework, a voluntary system of financial incentives, is designed to reward providers for good practice through participation in an annual quality improvement cycle[585].

Funding will be allocated per practice, rather than per GP as in the past, and practices serving populations with the greatest health needs will receive a proportionately greater funding allocation in accordance with a new disease prevalence factor. Incentives will also be provided for public health activities, such as smoking cessation and immunisation[586].

(vi) GP recruitment and retention strategies

The NHS Plan proposed the recruitment of an additional 2000 GPs by March 2004. Whilst the Department of Health reported that it was on target to reach this goal, with some 1530 extra GPs having been recruited by September 2003[587], the Royal College of General Practitioners assert that an extra 2000 GPs is well short of the 10,000 GPs it believes are necessary to implement the NHS Plan and National Service Frameworks[588].

In addition to attempts to improve the working lives of GPs through changes to the GP contract, a number of recruitment and retention schemes have been introduced to help boost GP numbers:

- The Flexible Careers Scheme aims to offer more centrally funded opportunities to work part-time and have temporary career breaks. Career grade doctors are able to remain on the scheme for three years, while doctors in training can remain for two years[589];
- The Delayed Retirement Scheme encourages GPs to stay working longer in the NHS. GPs aged 60 and over can receive supplementary payments of £2,000

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584 BBC News, *GP contract: at a glance*, 20 June 2003, http://news.bbc.co.uk/1/hi/health/2779473.stm, accessed 27 January 2004.

585 Department of Health, *Delivering investment in general practice, Implementing the new GMS contract*, December 2003, p8.

586 BBC News, *GP Contract: impact on patients*, 20 June 2003, http://news.bbc.co.uk/1/hi/health/2771805.stm, accessed 27 January 2004.

587 M Millar, *NHS on target to recruit more GPs*, http://www.personneltoday.com/Article20474.htm, accessed 23 January 2004.

588 Royal College of General Practitioners, *Valuing General practice* (Press release 14 March 2001), http://www.rcgp.org.uk/press/2001/9154.asp, accessed 21 January 2004.

589 National Health Service, *NHS Careers, Flexible Careers Scheme*, http://www.nhscareers.nhs.uk/nhs-knowledge_base/data/5455.html, accessed 27 January 2004.

per annum up to a total of £10,000 over five years to continue working to age 65[590]; and

- The General Practitioner Returner Scheme assists GPs to return to general practice after a period of absence. GPs who have not worked in general practice in the United Kingdom for more than two years can receive paid, individually tailored refresher training (generally 3-6 months full-time or up to one year part-time), a dedicated return coordinator and a contribution towards professional expenses[591].

(vii) Personal Medical Service Pilots

Personal Medical Services pilots enable GP practices, groups of practices, GPs in NHS Trusts and Primary Care Trusts to explore more innovative ways of delivering primary health care services. The new GMS contract does not apply to GPs working in PMS pilots, who negotiate contracts directly with Primary Care Trusts. While the GMS contract is constrained by nationally determined priorities, under PMS agreements, GPs have greater flexibility to tailor services to meet the needs of the local population. The first wave of PMS pilots were established in April 1998 and the latest wave began in October 2002, bring the total number of pilot sites to almost 2,500, involving more than 9,300 GPs. Despite its rapid expansion, the scheme is still considered a trial and PMS sites continue to be known as pilots.

Examples of PMS pilots include:

- Ormskirk: the practice changed from a solo practice to a General Practitioner-nurse clinician partnership, an arrangement that would not have been possible under the GMS contract. The partnership operates on the principle that there is significant overlap and that each clinician has his/her own strengths. The nurse clinician has the same rights of investigation and referral as a General Practitioner, mostly dealing with a similar range of problems; and

- Tipton: the practice targeted those patients attending more than eight times per annum, as well as patients with diabetes, hypertension and asthma. Patients were invited to attend an eight-week education course based on cognitive behavioural principles, run by counsellors. The course provided patients with strategies to help cope with their illness and its consequences, thus improving their sense of well-being. GP consultations for those attending the program fell from 13.8 to 9.2 per annum, the frequency of tests from 3.4 to 1.7 per annum. Prescribing rates also fell, most markedly in diabetics.

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590 M Millar, *NHS on target to recruit more GPs*, http://www.personneltoday.com/Article20474.htm, accessed 23 January 2004.

591 *ibid*.

A national evaluation of the first wave PMS pilots assessed the impact of the new arrangements in their first three years[592]. In many respects, the PMS pilots did not differ greatly from GMS practices, although there were a number of key differences that would appear to align PMS sites more closely with the primary health care system to which the United Kingdom aspires:

- PMS pilots in deprived areas underwent a shift from the General Practitioner-based medical model of primary care towards a social/public health model with emphasis on health maintenance[593];
- The roles of nurses underwent significant changes in some sites. Changes were most successful in sites where doctors, nurses and managers negotiated role changes together and nurses received appropriate training and support. Restrictions on nurse prescribing and ambiguities in relation to nurses' ability to refer to secondary care were significant barriers to role development[594];
- Increased involvement of nurses in triage and treatment of minor ailments enabled GPs to deal with more complex cases[595];
- Quality improvements were seen in both GMS and PMS sites over three years, although PMS sites generally performed better at the end of the pilots. What distinguished the most successful pilots fromthe others was strong leadership and pilot management coupled with effectiveness in changing professional relationships within the practice[596];
- PMS pilots, particularly those with an explicit mental health focus, made significant improvements in developing protocols and procedures and in becoming more patient focussed[597];
- PMS pilots made significantly greater improvements than GMS practices in care for older patients[598];
- Salaried General Practitioner contracts successfully addressed some of the factors limiting General Practitioner commitment to work in deprived areas[599]; and

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592 PMS National Evaluation Team, *National Evaluation of First Wave NHS Personal Medical Services Pilots, Summaries of Findings from Four Research Projects*, March 2002.

593 *ibid*, p21.

594 *ibid*, pp8-9.

595 *ibid*, pp8-9.

596 *ibid*, p12.

597 *ibid*, p13.

598 *ibid*, p13.

- In general, PMS sites that targeted vulnerable populations experienced high levels of success in achieving their original objectives[600].

By November 2003, more than 30 percent of GPs were working in PMS pilots.

Finding 81

In June 2003, General Practitioners in the National Health Service in England voted to accept a new General Medical Services contract, which is designed to improve working conditions for General Practitioners, improve quality of care for patients and shift the focus of primary care toward health promotion and disease prevention. Whilst the General Medical Service applies to the majority of General Practitioners, by November 2003, more than 30 percent of General Practitioners were working in Personal Medical Service pilots. Under Personal Medical Service agreements, General Practitioners have greater flexibility to tailor services to meet the needs of the local population.

(viii) Walk-in centres

NHS Walk-in centres are nurse-led primary care centres where no appointment is necessary. They are open 365 days a year, and in general from 7.00 a.m. to 10.00 p.m. weekdays and 9.00 a.m.-10.00 p.m. on weekends. Although nurse-led, the skill mix of staff will vary with local need and may include GPs and other health and social services staff[601]. All Walk-in centres administer and supply a number of pharmaceuticals under Patient Group Directions[602]. Where Walk-in centres employ nurse prescribers, patients can be prescribed pharmaceuticals from a limited formulary[603]. Walk-in centres have communication links with GPs, and, subject to patient consent, pass contact details on to patients' own doctors so that medical records can be kept up to date and continuity of care can be maintained[604]. Core services that are provided by all Walk-in centres include treatment of:

- Wounds (including dressings);
- Muscle and joint injuries;
- Minor respiratory ailments;

599 *ibid*, p17.

600 *ibid*, p20.

601 Department of Health, *NHS Walk-in Centres Briefing Pack*, May 2003, Annex F.

602 See section 6.1(c)(iv) for description of Patient Group Directions.

603 Department of Health, *NHS Walk-in Centres Briefing Pack*, May 2003, Annex F.

604 *ibid*.

- Fever;
- Headaches and dizziness;
- Minor gastrointestinal complaints;
- Minor infections (eye, ear, nose, throat);
- Skin complaints;
- Genito-urinary complaints;
- Phlebotomy;
- Cholesterol, blood glucose and blood pressure testing; and
- Emergency contraception[605].

Other services, where the emphasis is on initial assessment and advice, followed by appropriate referral, are also provided, including limited mental health and reproductive health services and pharmacy and dental advice[606].

Originally developed as centrally-funded three-year pilots, funding has now been fully allocated to PCTs as part of their recurrent funding. A national evaluation reported that the NHS Walk-in centres are clinically safe and are a well used addition to NHS services, achieving high levels of patient satisfaction. Walk-in centres also improve access for certain groups of people, including young and middle-aged men, who are traditionally low users of general practice. The cost per consultation, however, is higher in Walk-in centres than in general practice and there is no clear impact on demand for A&E and GP services at a local level[607].

Since opening in 2000, Walk-in centres have seen more than 4 million people[608].

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605 Department of Health, *NHS Walk-in Centres Briefing Pack*, May 2003, Annex A.

606 *ibid*.

607 C Salisbury *et al*, *The National Evaluation of NHS Walk-in Centres*, http://www.epi.bris.ac.uk/wic/pdf/WIC%20Evaluation%20Report%20-%20Final.pdf, accessed on 23 January 2004.

608 BBC News, *More NHS Walk-in centres unveiled*, 5 January 2004, http://news.bbc.co.uk/1/hi/health/3369125.stm, accessed 22 January 2004.

Finding 82

Nurse-led National Health Service Walk-in centres in England have provided primary care services to more than 4 million people since opening in 2000. A national evaluation reported that Walk-in centres are clinically safe and well used, although the cost per consultation is higher in Walk-in centres than in general practice, and there is no clear impact on demand for local emergency departments and General Practitioner services.

(ix) Encouraging innovation

Across the NHS, many teams are taking part in 'Collaborative' programs to improve patient care. The principle of collaborative programs is based on the work of the Institute for Healthcare Improvement in the USA. It is a time-limited program, which focuses on a specific topic. The process involves selecting a topic for improvement, developing change principles from existing evidence of best practice, identifying measures for improvement, and testing change ideas with the aim of making the system better for both staff and patients. A Collaborative program enables significant improvements to be achieved in a short time scale[609].

The ***National Primary Care Collaborative*** (NPCC) was launched in 2000 to help practices to systematically improve their services to better meet the needs of their patients. The three areas of focus are: improving access to primary care, improving care for patients with proven coronary heart disease (CHD) and improving access to routine secondary care services by improving the primary/secondary care interface. By December 2003, the NPCC had engaged more than 5000 practices covering more than 31 million patients[610].

Practice involvement in Phase I of the NPCC has occurred in four waves, each wave benefiting from the experiences of previous waves. Overall, practices involved in Phase I have seen improvements of 72 and 58 percent respectively for wait times to see GPs and nurses. Furthermore, a 2002 study of mortality data from PCTs across England found a four-fold reduction in CHD deaths in collaborative PCTs compared with those not involved[611].

Phase II of the NPCC began in late 2002, and involved practices from almost every Primary Care Trust in England. Phase II practices will focus on access to primary care and secondary prevention of coronary heart disease. Within the first four months of the pilot, practices had achieved a 36 percent improvement in GP waits and a 30 percent

609 NHS Modernisation Agency, *Setting up a Collaborative Programme*, http://www.modern.nhs.uk/ improvementguides/collaborative/1_2.html, accessed 23 January 2004.

610 National Primary Care Development Team, *National Primary Care Development Team*, http://www.npdt.org/scripts/default.asp?site_id=1, accessed 22 January 2004.

611 National Primary Care Development Team, *Bulletin*, April 2003, pp1-2.

improvement in nurse waits, a more rapid improvement than was seen in the fourth wave of Phase I practices[612].

As well as the National Primary Care Collaborative, the ***Healthy Communities Collaborative*** (HCC) pilot involved the engagement of communities to improve health and reduce inequalities, with particular emphasis on falls in older people living in disadvantaged communities. The pilot, which began in early 2003, involved three Primary Care Trusts. After only 9 months, the number of falls in the pilot areas had been reduced by 60 percent, double the target of 30 percent[613].

The reduction in incidence of falls was achieved by relatively simple measures, such as:

- In one pilot site, older people were given a 'night light' that plugs into a socket. At dusk, the light comes on automatically, as the majority of falls happen in the dark;
- In a second pilot site, the area is relatively hilly and suffers frequent power cuts. The HCC teams provided older people with battery operated lights to decrease the number of falls in the dark; and
- In all of the pilot sites, regular free Tai Chi classes were offered to help improve strength and balance[614].

Following on from the success of the pilot program, a national roll-out of the HCC was launched in September 2003[615].

Finding 83

Across the English National Health Service, initiatives such as the *National Primary Care Collaborative* and the *Healthy Communities Collaborative* have achieved significant reductions in waiting times to see General Practitioners and nurses, reduced mortality rate due to coronary heart disease and decreased incidence of falls in older people.

612 National Primary Care Development Team, *Bulletin*, April 2003, pp1-2.

613 NHS Health Development Agency, *Healthy Communities Collaborative launches nationally: 60% reduction in falls achieved in pilot sites*, http://www.had.nhs.uk/html/about/press/24092003.htm, accessed 23 January 2003.

614 *ibid*.

615 *ibid*.

(d) Primary care reform in New Zealand

(i) Primary Health Care Strategy

Prior to the recent primary care reform initiatives, the primary care system in New Zealand was dominated by private for-profit general medical practice, with services provided on a user-pays basis. Fees were set by individual GPs and were offset by government subsidies for children, high users (more than 12 consultations per year) and low income earners. GPs were expected to reduce their fees to coincide with the relevant subsidy, but in practice many GPs imposed a user part charge[616]. As is the case in Australia, the government subsidy may influence but does not control GP fees. Around 60 percent of GP income was obtained from patients and only 40 percent from government subsidies.

By late 2000, around 80 percent of GPs were members of Independent Practitioner Associations (IPAs), similar to our Divisions of General Practice[617]. Many IPAs had fundholding responsibility for laboratory and pharmaceutical services, which led to significant savings in the case of some associations[618]. IPAs were able to retain a share of any savings made from these budgets, but were generally required to invest these savings in improvements in service and access.

IPAs have been criticised on the grounds that they do not take a population health approach, they do not adequately address issues of access, and that their members are still fiercely independent and competitive in an environment in which cooperation is increasingly seen as essential[619].

In addition to IPAs, primary care has also been traditionally delivered by community-owned or 'third-sector' primary care organisations. These are non-government, community managed, not-for-profit organisations that provide care for low-income and Maori and Pacific peoples. Third sector providers, who tend to adopt broad public health definitions of primary care, began to emerge in the 1980s and by 2000 there were more than 200 in operation. Third sector primary care organisations are characterised by community management, multi-disciplinary care, salaried providers and community outreach. Many are also involved in 'pre-primary' care and

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616 Health Canada (prepared by J Marriott and AL Mable, Marriott Mable, Consultants in Health Policy), *Opportunities and Potential, A Review of International Literature on Primary Health Care Reform and Models*, August 2000, p41.

617 B Sibthorpe, *Models of Primary Health Care: The New Zealand Experience*, October 2000, http://www.drs.org.au/new_doctor/74/sibthorpe.html, accessed on 12 January 2004.

618 Health Canada (prepared by J Marriott and AL Mable, Marriott Mable, Consultants in Health Policy), *Opportunities and Potential, A Review of International Literature on Primary Health Care Reform and Models*, August 2000, p41.

619 B Sibthorpe, *Models of Primary Health Care: The New Zealand Experience*, October 2000, http://www.drs.org.au/new_doctor/74/sibthorpe.html, accessed on 12 January 2004.

community development projects, an example of which is installation of insulation in public housing using unemployed local people to help reduce the incidence of respiratory disease in winter[620].

In March 2000, the New Zealand Minister of Health began consultation on primary care reform with the release of *The Future Shape of Primary Health Care: A Discussion Paper* [621]. Feedback from meetings and written submissions was used to develop *The Primary Health Care Strategy*[622]. The *Primary Health Care Strategy* involves a realignment of primary care to a system that:

- focuses on populations rather than individuals;
- places a stronger emphasis on disease prevention and health promotion;
- involves a multi-disciplinary team based approach to care;
- is based on capitation funding;
- is culturally competent; and
- is integrated with other health and non-health agencies[623].

One of the central tenets of the *Primary Health Care Strategy* is the devolution of health care purchasing from the Health Funding Authority to District Health Boards (DHBs), established by *the New Zealand Public Health and Disability Act 2000*. DHBs will be funded on population based formulae and will have responsibility for purchasing a wide range of services, including hospital and primary care[624].

In accordance with the new model, primary care services will be based on a population approach with client enrolment or registration. Primary Health Organisations (PHOs) are the vehicle through which primary care services will be delivered. PHOs will be funded by DHBs to provide a defined set of essential services to their enrolled population. PHOs are expected to:

- Provide services that include improving and maintaining the health of the enrolled population, as well as first line services to restore health;

620 *ibid.*

621 New Zealand Minister of Health, *The Future Shape of Primary Health Care: A Discussion Paper*, March 2000.

622 New Zealand Minister of Health, *The Primary Health Care Strategy*, February 2001.

623 *ibid*, p6.

624 *ibid*, p4.

- Involve their communities in their governing process. They must also demonstrate that they are responsive to their communities' needs;
- Be able to demonstrate that all their providers and practitioners can influence the organisation's decision-making, rather than one group being dominant;
- Be not-for-profit; and
- Be fully accountable for all public funds that they receive.

Finding 84

The *New Zealand Primary Health Care Strategy* aims to realign primary care to a system that:

- focuses on populations rather than individuals;
- places a stronger emphasis on disease prevention and health promotion;
- involves a multi-disciplinary team based approach to care;
- incorporates capitation funding;
- is culturally competent; and
- is integrated with other health and non-health agencies.

(ii) Progress on implementation of the New Zealand Primary Health Care Strategy

The first PHOs started up in July 2002, and by December 2003, there were 59 PHOs covering 2.5 million New Zealanders[625] (more than 60 percent of the population[626]). PHOs are governed by Boards, which comprise health professional and community representatives.

GPs join PHOs by signing agreements with the Board. Upon joining PHOs, GPs qualify for capitation payments based on enrolment of individuals to their practice. Around 35 percent of GPs are now receiving capitation payments. It is not yet clear whether PHOs and capitation funding have improved access and availability of GPs[627].

625 New Zealand Ministry of Health, *Primarily*, www.moh.govt.nz/publications/newsletters/primarily, accessed on 26 March 2004.

626 Statistics New Zealand, *Estimated Resident Population of New Zealand as at 26 March 2004 at 06:26:11 pm*, http://www.stats.govt.nz/domino/external/web/prod_serv.nsf/htmldocs/Pop+Clock, accessed on 26 March 2004.

627 Information provided by the New Zealand Medical Association, January 2004.

(i) Extended roles in primary care

One of the intentions of Primary Health Care reform in New Zealand is to facilitate the development of innovative approaches to the delivery of primary health care. The Committee met with a pharmacist who was using his pharmacy as a fully integrated allied health professional clinic to deliver a range of health services in addition to dispensing of pharmaceuticals.

The pharmacist runs a *Medication Administration and Oversight Program*, which is designed for patients on a complex regime of medications who have a history of medicine management problems, for example, as a result of physical or cognitive impairment. The aim of the program is to keep patients as independent as possible in their own homes. Patients are referred to the program via the Disability Support Link. The pharmacist visits the patient to establish a medication regime, and thereafter, pharmacy staff, in this case a registered nurse, visit the patient's home as required to administer or assist with medication. The patient base includes a number of elderly patients, including those in 'rest' homes. The program enables some elderly patients to be managed in their own home, at a fraction of the cost of caring for them in rest homes[628].

The pharmacist also runs a mental health program, an outreach program that operates along similar lines to the Medication Administration and Oversight Program. The Diabetic Society, the Asthma Society and a palliative care service also operate out of the premises[629].

(iii) Investment in primary health care nursing

Historically, the role of nurses in primary care in New Zealand has been similar to the role that nurses play in primary care in Australia. GPs who employ practice nurses are eligible for practice nurse subsidies. GPs are not accountable for the use of nurses in their practices, and there is a criticism that nursing practice in the office setting has failed to keep pace with changes in the nursing profession in general. Although many nurses work in GP practices, they have little control over the nature of the services they provide and in general there is little evidence of real primary care involvement.

The Primary Health Care and Community Nursing Workforce Survey (2001) identified a number of barriers to their contributing fully to new health strategies in New Zealand. Among the issues raised were:

- Clinical career pathways are not available to a significant proportion of nurses;
- Many nurses are unable to take part in management or leadership roles; and

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628 Information provided by Mr Neville Puckey, Pharmacist, Hamilton New Zealand, briefing January 2004.

629 *ibid*.

- Improvements are required to enable communication and collaboration with other health professionals.

To help facilitate changes in primary health care nursing, in June 2002 the Ministry of Health committed funding for '*developing education and career pathways and creating opportunities for nurses to be involved in the development of new ways of delivering primary health care services*'. Of the $8.1 million commitment over five years, $7.1 million was allocated for Primary Health Care Nursing Innovations Funding. Funding was allocated on a competitive basis to assist nurses to explore new ways of working in their communities to address specific health needs. A further $850,000 over two years was allocated to postgraduate scholarships to enable nurses practising in primary health care to undertake further study[630].

(e) Primary care reform in Australia

Mr Michael O'Kane, State Manager (WA), Commonwealth Department of Health and Ageing provided the Committee with an overview of primary care reform strategies in Western Australia and at a national level[631]. Mr O'Kane advised that at the 2002 Australian Health Minister's Conference, the following priority areas were identified for primary care reform:

- Improving the interface between hospitals and primary and aged care services;
- Achieving continuity of care between primary, community, acute, sub-acute, transition and aged care services, initially focussing on a stronger continuum of care for cancer and mental health services;
- Establishing a single national system for pharmaceuticals; and
- Improving access to services for Aboriginal and Torres Strait Islander people[632].

The Australian Department of Health and Ageing established the Primary Care Division to oversee the primary care reform process. The mandate of the Primary Care Division is to:

- Develop a stronger focus on policy development through investment in more strategic use of research and evaluation;
- Promote more effective integration of primary care professionals and services to deliver coordinated care in the community;

630 Frances Hughes, Ministry of Health, *Nursing Sector Update*, June 2003, pp6-8.

631 Mr Michael O'Kane, State Manager, Commonwealth Department of Health and Ageing, Briefing, 24 September 2003.

632 *ibid*.

- Improve access to high quality, effective services through investing in training programs, supporting accreditation, using incentives to improve care delivery and trailing innovations;

- Utilise primary care prevention strategies to maintain the health of Australians; and

- Bring together the financing and policy aspects of the Department of Health and Ageing to work with general practices through a primary care framework[633].

Mr O'Kane went on to describe some of the primary care reform strategies currently operating in Australia, some of which are outlined below.

(i) Divisions of General Practice

Divisions of General Practice are geographically based organisations developed for the purpose of bringing together GPs to enhance communication, to share information, to support education and primary health care research and to strengthen linkages with the rest of the health system. Beginning with the establishment of the first ten Divisions in 1992, there are now 120 Divisions, of which 15 are located in WA. The Divisions are now an integral part of the health system and receive Commonwealth funding in excess of $120 million per annum (as of 2003-04) to support infrastructure and research initiatives of the Divisions[634].

Whilst the Divisions of General Practice have and are expected to make a continued contribution to reshaping primary care, a 2002 Review of the Divisions made a number of recommendations to strengthen their role in primary health care reform, including:

- That the Commonwealth give priority to the development of a national primary health care policy and implementation framework and that the Divisions play a central role in its development;

- That the policy and implementation framework form the basis for discussions between the Commonwealth and States/Territories in order to facilitate a more seamless national approach to primary health care;

- That the framework allow Divisions to tailor strategies to meet local needs and priorities; and

633 *ibid*.

634 *ibid*.

- That the Divisions of General Practice be required to undertake a stronger and more consistent role in primary health care by focussing on general practitioners and general practice in a whole of practice context[635].

(ii) Better access to allied health professionals in the community

More Allied Health Services

More Allied Health Services is aimed at providing additional allied health services for people living in rural communities. From 2000-01, the Commonwealth committed $49.5 million over 4 years for the employment of more allied health professionals, including psychologists, dieticians, podiatrists, social workers, physiotherapists and registered nurses[636]. The program is expected to encourage stronger links between local GPs and allied health professionals. Eligible (rural) Divisions of General Practice will act as fundholders, employing allied health professionals on the basis of local needs. Access to allied health professionals is through GP referral.

Better Outcomes in Mental Health.

Most people with a mental health problem seek help from their General Practitioner. In recognition of this, the Commonwealth committed $120.4 million between 2001-02 and 2004-05 to improve primary mental health services[637]. Key components of the program are: education and training for GPs; incentive payments to encourage appropriately trained GPs to manage mental health problems by means of formal assessment, care planning and review; new MBS item to allow appropriately trained GPs to provide mental health counselling to patients; access to allied health services, to allow GPs to refer patients to psychologists and other allied health professionals; and access to psychiatric services (for psychiatrists to participate in case conferencing) and a new MBS item for psychiatrists (to provide consultancy assistance to GPs). The 2002-03 funding was rolled out through 16 pilot projects, which were subject to evaluation under a national framework. Divisions of General Practice acted as fundholders and a range of models of service provision were examined[638].

(iii) Improved coordination between Primary Care and other sectors

Enhanced Primary Care Items

635 *ibid*.

636 *ibid*.

637 Minister for Health and Aged Care, *Better outcomes in mental health care*, http://www.health.gov.au/ budget2001/fact/hfact2.htm, accessed on 20 January 2004.

638 Commonwealth Department of Health and Ageing, *Access to Allied Health Services Pilots Evaluation*,http://ahpilots.strategicdata.com.au/pdfs/AccessAHPilotsEvaluation22Oct2002.pdf, accessed on 20 January 2004.

Another approach adopted by the Commonwealth to improve coordination between primary care and other sectors was the introduction of Enhanced Primary Care (EPC) Medicare Items. EPC items, introduced in 1999, are intended to facilitate the provision of more preventive care for older Australians and improve care coordination between general practitioners and other professionals providing care for people with chronic or complex care needs[639].

A Commonwealth commissioned evaluation of EPC items was undertaken in 2001-02[640]. The evaluation team reported that while most GPs had used EPC items, uptake was highly variable. Ten percent of GPs were responsible for 50 percent of health assessments claimed and 10 percent claimed 80 percent of all care plans. At the other end of the spectrum, 10 percent of GPs had claimed only one EPC item during the first two years of operation[641].

In a recent study, undertaken as part of the BEACH[642] (Bettering the Evaluation and Care of Health) project, an analysis of older patients attending general practice revealed that in the two years to March 2002, EPC items were claimed in just 310 of the 49,647 encounters with people aged 65 and over.

Although General Practitioner awareness of the EPC items was high, awareness was poor amongst allied health providers and consumers. Furthermore, as GPs generally had a limited understanding of the roles of providers in the rest of the health care team and allied health providers did not understand the requirements of EPC items on GPs, the important role for allied health professionals in extended primary care was not fully explored[643].

All stakeholders identified demand for acute and episodic care as being a major barrier to GP uptake of EPC items. Although there was a general consensus that the items provided an opportunity for more holistic health care, there was an acknowledgment

639 Mr Michael O'Kane, State Manager, Commonwealth Department of Health and Ageing, Briefing, 24 September 2003.

640 D Wilkinson *et al*, *Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items and the General Practice Education, Support and Community Linkages Program (GPESCL)*, July 2003.

641 *ibid*, pp1-2.

642 The BEACH project was launched in March 1998 by the Minister for Health. It aims to provide a greater understanding of general practice activity in Australia. A national random sample of approximately 1,000 GPs per year each records information regarding 100 consecutive patient-based encounters (100,000 consultations per year).

643 D Wilkinson *et al*, *Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items and the General Practice Education, Support and Community Linkages Program (GPESCL)*, July 2003, p2.

that historical and current practice models limited the ability of general practice to better integrate with the rest of the health system[644].

Overall, support was strong for the notion of enhancing the capacity of general practice to better meet the needs of older people and those with chronic and/or complex needs. Importantly, however, the current structure of general practice, based on fee-for-service funding, physical isolation from other providers and training and mentoring within a medical model, was seen as a major challenge to implementing a more multi-disciplinary approach to care[645].

(iv) Emphasis on disease prevention and health promotion

Sharing Health Care Initiative (Chronic Disease Management)

The Sharing Health Care Initiative is part of the Enhanced Primary Care package for older Australians and those with chronic and complex health needs. The initiative provides $14.4 million over four years to improve the health of people with chronic conditions. The program is based on the premise that improving communication between patients, families/carers and health professionals; improving patients' understanding of their conditions; and improving their knowledge and confidence in managing their symptoms can facilitate effective self-management of chronic disease[646].

The Sharing Health Initiative involves eight demonstration projects, including one in Western Australia, and four Indigenous demonstration projects. The Western Australian demonstration project, coordinated by the Canning Division of General practice, focuses on older adults with chronic and complex conditions in the areas of cardiovascular disease, diabetes and other co-morbidities including depression. GP practices in identified areas of low socioeconomic status have been targeted for project involvement[647].

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644 D Wilkinson *et al*, *Evaluation of the Enhanced Primary Care (EPC) Medicare Benefits Schedule (MBS) Items and the General Practice Education, Support and Community Linkages Program (GPESCL)*, July 2003, pp4-5.

645 *ibid*, p5.

646 Australian Department of Health and Ageing, *Chronic Disease Prevention and Management, Sharing Health Care Initiative*, http://www.chronicdisease.health.gov.au/sharing.htm, accessed on 20 January 2004.

647 Australian Department of Health and Ageing, *Chronic Disease Prevention and Management, Sharing Health Care Initiative - Demonstration Projects, WESTERN AUSTRALIA - southern metropolitan Perth*, http://www.chronicdisease.health.gov.au/demowa.htm, accessed on 20 January 2004.

A progress report six months into the project identified GP recruitment as a major barrier to implementation[648]. The project team noted that with a shortage of GPs in the local area, GPs were already stretched with waiting lists and were often not enthusiastic about additional interactions with patients and other providers. Barriers to participation included concerns about time restraints, excessive paperwork, corporatisation of practice and staff changes[649].

The project team also speculated that GPs might be resistant to initiatives that involve a third party in the GP-patient relationship, as this is not a familiar way of working for GPs. It is highly likely that a high level of trust is required before GPs refer patients to other providers[650].

Rural Chronic Disease Initiative

The Rural Chronic Disease Initiative (RCDI) is part of the Regional Health Strategy: More Doctors, Better Services. The aim of the RCDI is to assist people in rural Australia, especially those in small rural communities, to prevent and better manage chronic diseases such as asthma, heart disease, stroke, hypertension, type 2 diabetes, osteoporosis, chronic airway disease, certain cancers, depression and disabilities caused by preventable injuries such as farm accidents[651].

Phase one of the program involved the establishment of ten pilot sites in small rural communities (populations less than 5,000) to develop local models for implementing chronic disease/injury prevention and management programs. In addition to the ten pilot sites, funding has been allocated to 20 Innovative Rural Projects in communities of up to 10,000 people to test innovative strategies to prevent and manage the risk factors associated with chronic disease[652].

A Western Australian pilot, coordinated by the Lower Great Southern Health Service and based in Mount Barker (population 1,500) is trialing an asset-based community development model, whereby human, economic, infrastructure and other assets in the town are identified and mobilised to help achieve project aims[653].

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648 Health Partners, *WA Sharing Health Care Demonstration Project, Six Month Report 1st August 2002 - 31st January 2003*, http://www.chronicdisease.health.gov.au/pdfs/waexecfeb03.pdf, accessed on 20 January 2004.

649 *ibid*, p2.

650 *ibid*, p3.

651 Australian Department of Health and Ageing, *Chronic Disease Prevention and Management, Rural Chronic Disease Initiative*, http://www.chronicdisease.health.gov.au/rural.htm, accessed on 20 January 2004.

652 *ibid*.

653 Australian Department of Health and Ageing, *Chronic Disease Prevention and Management, Rural Chronic Disease Initiative*, *Pilot Site Summary*, http://www.chronicdisease.health.gov.au/ pilot_summaries.htm, accessed on 20 January 2004.

At the time of writing, consultants were collating the experiences of the RCDI projects, which will be used to assist other communities to implement similar strategies.

SNAP (Smoking, Nutrition, Alcohol and Physical Activity) Framework

Smoking, poor nutrition, excessive alcohol consumption and lack of physical activity have all been identified as major risk factors for chronic diseases. The SNAP risk factors contribute significantly to the burden of disease in Australia, including six of the National Health Priority areas (cardiovascular disease, diabetes, cancer, mental health, injury and asthma). Combined, these lifestyle factors are estimated to account for a staggering 21 percent of total burden of disease in Australia[654].

In June 2001, the Joint Advisory Group on General practice and Population Health (JAG) released a Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Framework for General Practice to *'guide the implementation of integrated approaches to behavioural risk factor modification in general practice'*[655]. JAG, which was formed in 1999 to provide advice to government on opportunities to enhance the population health role of general practitioners, lists ongoing implementation of the SNAP Framework as one of its major priorities for 2003-04[656].

The areas identified by the SNAP Implementation Group as having the greatest potential for immediate development include:

- Improving the consistency of guidelines and other information for general practice on integrated approaches to behavioural risk factors;
- Raising awareness of the SNAP Framework and the need for integrated approaches to risk factor management; and
- Improving accessibility of information to the general public.

654 Australian Institute of Health and Welfare, *The burden of disease and injury in Australia*, November 1999, pp101-131.

655 Joint Advisory Group on General Practice and Population Health, *Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Framework for General Practice, Integrated approaches to supporting the management of behavioural risk factors of Smoking, Nutrition, Alcohol and Physical Activity (SNAP) in General Practice*, June 2001, p1.

656 Australian Department of Health and Ageing, *Improving Population Health outcomes through partnership with General Practice*, http://www.health.gov.au/pubhlth/about/gp/index.htm, accessed on 21 January 2004.

Despite an acknowledgment that preventive health measures could gain Australians an extra six years of healthy life[657], implementation of the SNAP Framework has not yet received a dedicated funding allocation from the Federal Government, although new initiatives introduced in the *Focus on Prevention Package*, support the broad principles of the SNAP Framework[658].

To a large extent, implementation of the SNAP Framework is occurring on an ad hoc basis, as a number of Divisions of General Practice around the country have taken steps toward implementation at a local level. For the most part, redirection of existing resources has been necessary[659].

The New South Wales SNAP Implementation Trial is the only formal research project currently being undertaken to develop, implement and evaluate a model for the SNAP Framework. Funded by New South Wales Health, the project will be coordinated by the Centre for General Practice Integration Studies of the University of New South Wales in conjunction with the Sutherland and Hastings Macleay Divisions of General Practice and the South East Sydney and Mid North Coast Area Health Services. The trial, which is expected to run until December 2004, will involve one urban and one rural Division of General Practice[660].

In Western Australia, the General Practice Divisions of Western Australia (GPDWA) developed a proposal for implementation of the SNAP Framework across Western Australia, which was presented to the Department of Health in October 2003. Consultation is currently underway between the two organisations[661].

Chronic and Complex Disease Program (NSW)

The South Eastern Sydney Area Health Service's Chronic and Complex Disease Program began in 2000-01 as part of a Statewide initiative targeting improved and coordinated care for people with chronic or complex diseases. The program incorporates seven theme areas: Aboriginal health, Asthma, Congestive Heart Failure,

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657 Senator the Honourable Kay Patterson, Minister for Health and Ageing, *Australians could gain an extra six years life expectancy with renewed efforts in health: World Health Report*, November 2002, http://www.health.gov.au/mediarel/yr2002/kp/kp02118.htm, accessed on 21 January 2004.

658 *ibid*.

659 Dr Coletta Hobbs, Centre for General Practice Integration Studies, School of Publich Health and Community Medicine, The University of New South Wales, Personal communication, 21 January 2004.

660 The University of New South Wales, *The SNAP Implementation Trial, New South Wales, Australia*, http://www.health.gov.au/pubhlth/about/gp/nsw_trial.pdf, accessed 21 January 2004.

661 Dr Coletta Hobbs, Centre for General Practice Integration Studies, School of Publich Health and Community Medicine, The University of New South Wales, Personal Communication, 21 January 2004.

Chronic Obstructive Pulmonary Disease, Cancer, Diabetes, and Nursing Homes chronic care management. Details on two of the programs are described below:

- Diabetes Footcare - A comprehensive diabetes complication reduction strategy: The program targets people who have diabetes and existing or potential foot problems. The primary objective is to provide footcare to high-risk individuals to help prevent amputations and/or lengthy stays in hospital. A multi-faceted approach has been employed, with the use of a number of strategies, including: expanded podiatry clinics; improved and updated podiatry equipment; preventive podiatry such as foot clinics for high-risk patients, regular foot checks and education; education sessions for health professionals including specialists, GPs and nurses on examination of the diabetic foot and identification of risk factors and early signs of foot disease; patient education brochures; and educational and up-skilling opportunities for podiatrists. An average of 70 new patients per month have been enrolled in the program[662]; and

- Collaborative care for congestive cardiac failure (CCF): The program aims to improve the quality of life for CCF patients, carers and families and to reduce crisis presentations to hospitals by improving disease management. The main strategies the program utilises are: coordinated cardiac rehabilitation; improved education for patients and GPs; and the development and adaptation of clinical guidelines and pathways to improve quality of care. An important part of the program involves home-based interventions, with preliminary data indicating a beneficial impact on length of hospital stay. Other features of the program include: establishment of a shared database across facilities; improved discharge planning and extended primary care case conferencing mechanisms; establishment of education and physical activities at a number of community centres; and development of operational guidelines in consultation with medical, nursing and allied health staff[663].

(v) Improved access to primary care

Primary Health Care Access Program

The Primary Health Care Access Program was established in 1999 in response to recognition of lack of access to primary care services by indigenous people. Total per capita health expenditure on indigenous people in 1995/96 was just eight percent higher than for non-Indigenous Australians. While the States and Territories spent an average of $2.20 on each indigenous person for every $1 spent on each non-Indigenous person, the Commonwealth spent just $0.63 for every $1 spent on a non-

662 South Eastern Sydney Area Health Service, Response to request for information, 24 October 2003.

663 *ibid*.

Indigenous person. Combined Medical Benefit Scheme (MBS) and Pharmaceutical Benefit Scheme (PBS) expenditure was $535 per non-Indigenous person compared with $128 per indigenous person per annum[664]. In remote areas, where 35 percent of the indigenous population reside[665], this difference is thought to reflect, at least in part, a lack of access to doctors and pharmacists. A lack of cultural security in mainstream health services also plays a part.

The PHCAP stemmed largely from the lessons learned and foundations laid during the course of the Aboriginal Coordinated Care trials. Additional Commonwealth funds were provided in the form of 'cashed out' MBS and PBS benefits (based on a capitation formula). Pooled Commonwealth/State funding enabled a more flexible approach to the provision of health services and the involvement of local community controlled organisations facilitated the development of services that were more appropriate to the needs of the community.

Initial PHCAP funding is targeted at 17 priority areas in South Australia, Central Australia and Queensland, two capacity building sites in Queensland and for the continuation of funding for the former Coordinated Care trials in New South Wales, Western Australia and the Northern Territory[666].

Despite the enthusiasm with which the Primary Health Care Access Program has been received, there has been criticism on the grounds that the program simply does not go far enough, providing inadequate funding and extending to too few communities to make significant inroads into breaking the cycle of ill-health in Indigenous people[667].

Multi Purpose Service (MPS) Program

In 1991, a Commonwealth and State Governments' taskforce examined innovative policy development to address the health and aged care needs of people living in rural Australia. The review led to the development of a Multi Purpose Service (Multi Purpose Service) program, which was implemented in 1993.

The Multi Purpose Service concept provided the opportunity for rural communities to develop a flexible approach to design, funding and management of health and aged care services that would respond to issues such as:

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664 J Wakerman, *Access to health-care services in remote areas*, October 1999, p5.

665 J Deeble (Prepared for the Australian Medical Association), *Expenditures on Aboriginal and Torres Strait Islander Health*, March 2003, p2.

666 Senator the Honourable Kay Patterson, Minister for Health and Ageing, *Budget 2003-04 Fact Sheet, Better Health for Aboriginal and Torres Strait Island people, 56% boost to the Primary Health Care Access Program (PHCAP)*, http://www.immi.gov.au/budget/budget03/medrel_patterson.pdf, accessed on 22 January 2004.

667 IT Ring and N Brown, *Indigenous health: chronically inadequate responses to damning statistics*, Medical Journal of Australia, December 2002, Vol 177, pp629-631.

- Difficulties in maintaining economic viability of country hospitals and their ongoing ability to deliver services to small populations;
- Inability of small rural towns to provide viable nursing home facilities;
- Difficulties in attracting and retaining staff; and
- Duplication of limited infrastructure and resources[668].

The MPS program provides an opportunity for rural communities to pool Commonwealth and State health and aged care funding and apply them flexibly across all health and aged care programs according to local community needs. Areas of program funding that can be pooled include hospital services, residential and community aged care, community health, home and community care and ambulance and community transport services[669].

A recent evaluation of Multipurpose Services in rural communities around the nation identified a number of common features of the new services, including:

- A single point of entry to the health system for patients;
- A shift toward multi-disciplinary planning and delivery of care;
- Improved coordination of care;
- Greater integration of services;
- Considerable expansion of services, particularly community based services, without detriment to the provision of acute and residential services; and
- A shift from the traditional model of health care toward a more primary health care oriented approach[670].

An independent evaluation of the Multipurpose Service program in Victoria found, with regard to program effectiveness:

> *... there is site related evidence of effective targeting of community needs, high levels of service satisfaction, increased service access (particularly to community health, community care and well-being services) without loss of acute services, exemplary levels of service coordination and individual client focused service development. These service developments have been achieved*

668 Office of Rural Health, Australian Department of Health and Ageing, *The Multipurpose Service (MPS) Model*, December 2002, p3.

669 *ibid*, p3-7.

670 *ibid*, pp10-23.

> *without budget supplementation, other than that derived from additional contracts competitively attracted by Multi-Purpose Services*[671].

The evaluation team recommended that:

> *Consideration be given to the enhancement of the Multi-Purpose Services program as an exemplar model of health service delivery for small rural communities, and that specific consideration be given to expanding the range and linkage of services, including the pooling of that proportion of regional service program funds delivered to an MPS catchment in instances where the MPS has the capacity and expertise to deliver those services to the community*[672].

Evidence from a number of evaluation studies indicates that the MPS model is not appropriate for all rural communities[673].

With regard to the success of Multipurpose Services, Mr Kenneth Marston, representing the Council on the Ageing, made the following comment:

> *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* [674].

Ms Lois Johnston, also representing the Council on the Ageing, added:

> *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*

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671 Sach & Associates in association with Centre for Applied Gerontology, (Prepared for Australian Department of Health and Ageing, Victorian Department of Human Services), *Multi-Purpose Services Program Evaluation (Victoria)*, November 2000, p6.

672 *ibid*, p10.

673 Office of Rural Health, Australian Department of Health and Ageing, *The Multipurpose Service (MPS) Model*, December 2002, pp4-5.

674 Mr Kenneth Marston, Policy Officer, Council on the Ageing (WA) Inc, Transcript of Evidence, 16 October 2002, p2.

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 [675].

Finding 85

There is no overarching strategy for fundamental reform of primary care in Australia. However, numerous initiatives have been developed to:

- improve access to allied health professionals in the community;
- improve coordination between primary care and other sectors;
- increase emphasis on disease prevention and health promotion; and
- improve access to primary care.

These strategies are largely targeted at older Australians and people with chronic or complex illnesses, people who live in rural areas, including Aboriginal and Torres Strait Islander people.

(f) Essential elements of primary care reform

Early in the process of implementing primary care reform in Canada, Health Canada commissioned a team of health policy consultants to examine primary care reform strategies in other countries, with a view to utilising the experiences of other nations to help inform the direction of primary care reform in the Canadian context. The research team examined reform in six countries - Finland, the Netherlands, the United Kingdom, New Zealand, Australia and the United States. These countries were selected on the basis of their similarities to the Canadian Health System. In examining the experiences in each country, the review team identified a number of factors that facilitated reform, and others that presented as obstacles. They also identified a number of organisational and policy elements that appear to be essential to successful reform. The review is very relevant to our own primary health care system, and provides a useful insight into the collective thinking of other nations with regard to the future of primary care.

The authors found that primary care reform was consistently facilitated by the following factors:

- A combination of ***decisive direction plus incremental steps followed by on-going refinement*** for all or major elements of the process have consistently

675 Ms Lois Johnston, Member of the Policy Committee, Council on the Ageing (WA) Inc, Transcript of Evidence, 16 October 2002, p2.

proven an effective strategy. This included a sense of how it was intended to work, with clear vision and reasonable time frames for implementation;

- ***Tolerance for pluralism*** was seen in all countries to some degree at different times during the reform process. This allows for different ways of addressing elements within larger parameters, as well as respecting other models in the system that may fall outside the new framework. Tolerance for different approaches enables those who are committed to change to proceed without the need for a broad consensus;

- ***Targeted funding to provide support and incentives for change*** has been used to support new models and to encourage particular behaviour at organisational level. Examples include funding to support improving practice sites, hiring additional non-physician staff to support multi-disciplinary teams and investment in information technology;

- ***Provider support, particularly physicians***, is critical for change. Reform may not necessarily require all physicians to be on board from the outset. In most cases a strategy has been adopted to support those physicians who have been interested in the new approach, rather than trying to force all physicians to move to the new model. Importantly, achievement of complete support, or even a consensus, was not essential to the reform process; and

- The ***potential for greater autonomy and an opportunity to influence the broader health system*** was found to be a strong motivator of behaviour[676].

Barriers to reform included:

- ***Political indecision***, second guessing and direction changes can all thwart the reform process. The lack of a clear and decisive plan can result in mixed messages about direction;

- The ***temptation to micro-manage*** can lead to frustration for organisations trying to work within a framework. There is often a fine line between attempts to refine the process and actions that are contradictory to the plan; and

- ***Powerful interest groups***, both within and outside the health system, who are resistant to change, represent a major barrier. The most powerful provider group in terms of influencing primary care reform is physicians. In most countries, aspirations by other professional groups, particularly allied health

676 Health Canada (Prepared by J Marriott and AL Mable, Marriott Mable, Consultants in Health Policy) *Opportunities and Potential, A Review of the International Literature on Primary Health Care Reform and Models*, August 2000, pp74-77.

> professionals, to move to more multi-disciplinary teams and enhanced roles have been resisted, to some extent, by physicians[677].

The authors concluded that despite jurisdictional variances, a number of organisational and policy elements, as well as priorities of focus, stand out in the reform process of most countries. Australia was found to be the exception to this observation, as at the time we were not yet pursuing many of these essential elements.

The review team identified the following as essential elements of primary care reform:

- Citizen participation in governance, management or planning;
- Citizen's choice of organisation or provider for primary care;
- Rostering, the process by which patients are formally linked to or enrolled with an organisation or provider;
- Physicians working in groups, rather than in solo practices;
- The use of multi-disciplinary teams of physicians, nurses, dieticians, social workers, physiotherapists and other health providers;
- Gatekeeping (the practice whereby access to specialist/hospital care may only happen with a referral from a primary care physician, except in emergencies);
- Capitation, or funding on a per capita basis was either present or was being introduced;
- Good health information for planning, management, funding and evaluation; and
- Commitment to quality[678].

Australia stood out from all the other countries reviewed, in possessing only half of the essential elements of reform. The authors summarised primary care reform in Australia as follows:

> *Australia stands out as having little fundamental change in primary care settings or overall organisation, although there have been efforts to emphasize primary health care and population health approaches…There appear to be no examples of moving from the small fee-for-service practices, or to try rostering or capitation. Much of this is due to physician resistance to move from solo and small practices to groups.*

677 *ibid*, pp78-79.

678 *ibid*, pp87-92.

This somewhat individualistic environment has translated into a challenging one for nurses and other allied health professionals[679].

Finding 86

A recent Health Canada review of primary care reform in Finland, the Netherlands, the United Kingdom, New Zealand, Australia and the United States identified a number of essential elements for reform. Australia stood out from the others in possessing significantly fewer essential elements.

6.2 Sub-acute (intermediate) care

Sub-acute, or intermediate, care services are designed to provide an alternative to hospital admission for some carefully selected patients and to provide supported discharge back to the community for others. Timely access to sub-acute care programs has the potential to significantly reduce the number of occupied bed days in acute hospitals. Older people form the largest client group for intermediate care, although younger patients (e.g. with chronic disease) can also benefit. The British Geriatric Society recently estimated that between 5 to 10 percent of emergency admissions could be appropriately streamed into intermediate care schemes from home or from hospital emergency departments and medical assessment units[680].

The Committee had the opportunity to examine two successful intermediate care programs in Peterborough, England, as well as some of the strategies that are being implemented in Australia.

(a) Rapid Response Team (United Kingdom)

Ms Sylvia Few and colleagues briefed the Committee on the Rapid Response Team (Peterborough, England), which was established five years ago to provide short-term nursing care in the home for patients with acute, non life-threatening injuries and illnesses[681]. The team, which initially consisted of four senior nursing staff, now comprises a team leader, six senior rapid response nurses, two support nurses, community night sisters, a physiotherapist, social worker and occupational therapist.

The Rapid Response Team's general charter is to keep people out of hospital. It operates out of a primary care centre and cares for about 1200 patients per annum. Patients aged 18 and over are eligible for referral to the RRT, although the average age of patients is over 70 years. The team responds to referrals within two hours and is

679 *ibid*, p58.

680 British Geriatric Society, *Developing intermediate care to support reform of emergency care services, Report of the Intermediate Care Working Group 2003*, June 2003, p1.

681 Ms Sylvia Few, Intermediate Care Lead, Peterborough Hospitals NHS Trust and Ruth Emmins, Senior Nurse, Peterborough Rapid Response Team, Briefing, 30 June 2003.

able to provide care in the home for a period of up to 72 hours. Where necessary, the RRT will arrange for temporary (up to 96 hours) accommodation in a nursing home for patients who cannot be cared for at home. Evaluation has shown that more than 70 percent of referrals would have been admitted to hospital if the RRT service did not exist[682].

The Committee was advised that patients are referred to the RRT by general practitioners, district nurses, walk-in centres and via the hospital Accident and Emergency Department or Emergency Medical Assessment Unit. Patients cannot self-refer to the RRT and they cannot be referred by paramedics (they must be taken to A&E and then referred). Patients can, if they choose, refuse to be treated in the home by the RRT, and insist on being admitted to hospital[683].

Patients accepted for care under the Rapid Response Team include those with urinary tract infections, cellulitis (tissue/muscle inflammation due to infection), anaemia, acute chest infection, chronic obstructive pulmonary disease with acute exacerbation, soft tissue injury and factures of limbs or ribs[684]. Forty-two percent of rapid response events relate to falls.

Whilst operating out of the primary care sector, the Rapid Response Team liaises closely with:

- Local hospitals, which enables rapid access to diagnostic and other services;
- Social services, to ensure rapid access to social care support as required;
- The Intensive Community Rehabilitation Team, a multi-disciplinary team that provides rehabilitation in the home or residential setting (for patients who have had the maximum RRT input and have not yet regained previous functional ability); and
- Nursing homes, to ensure that patients who cannot be cared for in their own home have access to a nursing home bed[685].

(b) Intensive Community Rehabilitation Team (United Kingdom)

As well as the Rapid Response Team, intermediate care in the Peterborough region is provided by an Intensive Community Rehabilitation (ICR) Team[686]. The multi-

682 *ibid*.

683 *ibid*.

684 Information provided by Ms Sylvia Few, Intermediate Care Lead, Peterborough Hospitals NHS Trust, June 2003.

685 *ibid*.

686 *ibid*.

disciplinary team, established almost five years ago, consists of a community physician, a team leader (physiotherapist), community rehabilitation nurses (linked with the Rapid Response Team), physiotherapists, occupational therapists, social workers, a technical instructor, therapy assistants, health care assistants and clerical and administration support. The aim of the ICR team is to provide rehabilitation within the home or residential care setting, with the objective of maintaining or regaining optimal independence[687]. The ICR team facilitates:

- Prevention of admission to hospital (from home or residential care facilities);
- More rapid discharge from hospital; and
- Prevention or delay of admission to residential care facilities (from home or hospital).

Referrals to the ICR team are accepted for assessment from hospitals, the community (by any member of the primary care team) and from social services. Patients who are eligible for intensive community rehabilitation include:

- People with chronic disability, whose functional ability is further impaired by intercurrent, non life-threatening illness and likely need more than 96 hours to regain previous functional ability;
- People with an acute episode requiring rehabilitation that can be carried out at home (or in a residential care facility);
- People who have had the maximum Rapid Response Team input and are assessed as requiring further rehabilitation input to regain previous functional ability;
- People who have achieved sufficient functional ability to return home from hospital but require continued rehabilitation/therapy input to achieve maximum potential (this may include personal care);
- People who, by receiving intensive rehabilitation, may be able to remain in their own home environment; and
- People who, after a period in hospital, require a time of supervised re-orientation within their own home to assess the feasibility of their remaining at home long-term[688].

Following assessment, patients admitted to the ICR team receive intensive rehabilitation for a period of up to eight weeks, depending on need. Progress is assessed at a multi-disciplinary case conference on a weekly basis. The rehabilitation

687 *ibid*.

688 *ibid*.

phase is followed by a review phase, a six-week period during which the core team monitors the maintenance of the level of independence[689].

(c) Macarthur model for ambulatory services

There are four components to the Macarthur Ambulatory Services model, each of which act as entry/exit points to the system and provide alternatives to hospital based care:

- Post-Acute Care: Patients admitted and discharged from hospital with a facilitated discharge program involving ambulatory care services;
- Hospital in the Home: Patients admitted to a home program as a total alternative to hospitalisation (Hospital in the Home services);
- Rapid Response Service: Patients presenting to Emergency Department where problems are incompletely resolved, often present again and may eventually be admitted. These patients may be better managed by a primary health (community) nursing service; and
- Day Stay: A day admission area to provide medical review, diagnostic assessment and multi-disciplinary case conferencing as part of the acute ambulatory care home service.

In its first year of operation, the service averaged 100 separations per month, the equivalent of 15 inpatient beds. The majority of referrals were received from hospital (43.2 percent), followed by the Emergency Department (29.8 percent), visiting medical officers (17.9 percent) and GPs (9.6 percent). The majority of patients were referred for Hospital in the Home services (59 percent), followed by Post-Acute Care (37 percent) and Rapid Response Services (4 percent). More recently the Ambulatory Care model has been replicated in the paediatric population in the Macarthur Health Service Area[690].

(d) Sub-acute care programs in Western Australia

The Department of Health provided the Committee with an overview of sub-acute care programs currently operating or being developed in Western Australia.

The *Transitional Care Pilot* (TCP) began in November 2002. The TCP assists older people who have been hospitalised to return home. In contrast to the *Care Awaiting Placement* program, which employs a maintenance model of care, the TCP employs a rehabilitative model of care, providing support for individuals to regain independence.

689 *ibid*.

690 South Western Sydney Area Health Service, Response to request for information, 6 November 2003.

An *Enablement Package* pilot began in January 2003. This package specifically targets *Home and Community Care* eligible clients that are ready for discharge from hospital. As with the TCP, it provides rehabilitative support to assist clients to achieve their highest level of independence, to reduce the need for ongoing services or readmission to hospital and to prevent or delay further functional decline.

The *Pathways Home Program* is a Commonwealth funded initiative that targets older people, people with mental illness or chronic illness, people living in rural areas and Indigenous people. The broad aim of the program, which has not yet begun, is to maximise independence and quality of life.

The *Residential Call Line*, piloted in the north metropolitan region, assists residential care facility staff to make decisions with regard to clinical care of residents. Where appropriate, facility staff can request hospital staff to attend the facility. The aim of the program, which will be rolled out across the metropolitan area in stages, is to minimise unnecessary presentations to emergency departments and inappropriate ambulance use[691].

There appears to be a growing recognition of the potential benefit of sub-acute programs, although development and implementation of these programs in Western Australia has begun only recently and there remains considerable scope for expansion.

Dr Peter Sprivulis, Director, Acute Demand Management Unit, indicated that responsibility for funding of sub-acute programs may be a contentious issue. As sub-acute care sits between Commonwealth-funded primary and State-funded acute care, and between acute and Commonwealth-funded aged care, neither jurisdiction has clear responsibility for funding and delivery of services[692].

Finding 87

Sub-acute or intermediate care programs have the potential to significantly reduce the number of occupied bed days in acute hospitals. For example, in Peterborough, England, a Rapid Response Team assesses and organises nursing care for patients with acute, non-life threatening conditions who would otherwise be admitted to hospital. It is estimated that 70 percent of referrals would be admitted to hospital if the Rapid Response Team did not exist.

6.3 Integrated care

Integration of health care services has a number of potential benefits, such as minimising costly duplication of resources, making more efficient use of staff and

691 Information supplied by the Department of Health, September 2003.

692 Dr Peter Sprivulis, Director, Acute Demand Management Unit, Department of Health, Personal Communication, October 2003.

improving patient outcome and experiences with the health system. As highlighted in Chapter 5.1, integration of health care in the Australian context is largely prevented by the current Commonwealth/State divide in funding and delivery of services. The Coordinated Care trials set out to explore the impact of pooled funding and an integrated approach to service delivery across health sectors in people with chronic or complex illnesses. Experiences with the Coordinated Care Trials as well as an integrated model of primary and community health care in a remote Aboriginal community in Canada are described in the following section.

(a) The Eskasoni First Nations project (Canada)

Eskasoni is an Aboriginal community of approximately 3200 permanent residents in Cape Breton, Nova Scotia. The community has a high morbidity and mortality due to substance abuse, diabetes, heart disease and respiratory illnesses[693].

The aim of the Eskasoni Primary Care Project (EPCP) was to design, implement and evaluate a holistic model of health service delivery in this remote Aboriginal community. The model used a collaborative, multi-disciplinary approach to primary care, involving family physicians, nursing, health education/nutrition and pharmacy services. It also integrated primary medical care with community health programs (public health, home care, prenatal care and diabetes care)[694].

Prior to the EPCP, there was a lack of coordination and integration of health care, facilities did not adequately cater to the needs of a high-needs population and there was little support for health service providers to collaborate in the care of their patients. The EPCP sought to improve access to and coordination of services through its holistic model.

The Project involved restructure of the health system along the following lines:

- Continued devolution of responsibility for health care administration from the Federal Government to the local Band;
- Reorientation of physician services from a solo, part-time, fee-for-service medical practice to a multi-doctor, multi-disciplinary clinic based on an alternate funding model;
- Appropriate utilisation of physician services, hospital-based services, prescription drugs and health promotion programs;

693 M-J Hampton, *The Eskasoni Story, Final Report of the Eskasoni Primary Care Project*, March 2001, p19.

694 *ibid*, p11.

- Construction of a new health complex to house most of the health care services in the community, as well as services by professionals who regularly visit the community;
- Integration of primary care and community health programs; and
- Establishment of partnerships with regional Health Centres[695].

The Project was overseen by a Tripartite Steering Committee (the Eskasoni Band Council, the First Nations and Inuit Health Branch of Health Canada and the Nova Scotia Department of Health) in collaboration with the Dalhousie University Department of Family Medicine.

Key outcomes of the first year of the new integrated health care model included:

- Visits by Eskasoni residents to the outpatient/emergency department at the regional hospital decreased by 40%;
- Frequency of visits by Eskasoni residents to family doctors fell from 11 patient visits per year to approximately 4 visits per year;
- Savings to the Medical Transportation budget in the order of approximately $200,000 were achieved;
- Ninety-six percent of all pregnancies were followed from prenatal care through delivery and post-natal care involving an Eskasoni family doctor and community health nurse;
- Referrals from local family doctors to the team-nutritionist/health educator for diabetic management increased by 850%;
- Seventy-three percent of patients at the Eskasoni Health Centre reported obtaining an appointment with their family doctor within 24 hours, 90% secured an appointment within 48 hours;
- The cost of prescribed items decreased by 7 percent in three years, despite a near ten percent increase in the study population and an average 10 to 15 percent per annum increase in prescription drug costs; and
- Almost 90% of patients believe that the quality of health services in Eskasoni has improved as compared to five years ago[696].

695 *ibid*, p11.

696 *ibid*, p13.

Despite the encouraging results, the evaluation report stressed that the period of study was too short to draw definitive conclusions about the long-term effect of the new model of care on health outcomes and utilisation of resources. Nonetheless, Ms Mary-Jane Hampton, Evaluation Consultant, and Dr David Gass, Director, Primary Care, Nova Scotia Department of Health, advised the Committee that the benefits of the new primary care model to the Eskasoni community were too great to be lost with the cessation of *HTF* funding. The Nova Scotia Department of Health therefore agreed to provide financial support until such time as federal funding could be secured for its continued operation[697].

(b) Coordinated care trials (Australia)

Following a national tender process, nine Coordinated Care Trials in six States and Territories were funded by the Commonwealth to test the hypothesis that better coordination of care for people with chronic or complex health needs would improve their health and wellbeing within the constraints of existing resources. The cost of care coordination was expected to be offset by a reduction in hospital admissions. The trials ran for two years and evaluation was undertaken both nationally and at a local level[698]. The trials involved service providers working in public, private and non-government organisations; community and institutional health care settings; community support services, such as Home and Community Care; and residential Aged Care. The trials were underpinned by improved data systems between participating services and flexible funding arrangements to enable movement of funds between services.

Although participants in the intervention group appreciated the extra coordination of their care, the trials generally failed to demonstrate improved health and wellbeing of participants. Only three trials demonstrated a significant reduction in hospital admissions, and most trials experienced an operating deficit[699]. In a critique of the first round of Coordinated Care Trials, researchers from Flinders University highlighted the following shortcomings in the trial design:

- Although each trial was funded for two years, the first six months was devoted to patient recruitment and the final six months was a wind-down phase, leaving only 12 months of active intervention, a very short period to make an impact on complex disease;

- Difficulty in recruiting a sufficient number of participants force many trials to alter inclusion criteria, such that many participants had insufficiently complex problems to benefit from coordinated care;

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697 Ms Mary Jane Hampton, Director, Stylus Consulting and Dr David Gass, Director, Primary Health Care, Nova Scotia Department of Health, Briefing, 25 June 2003.

698 AJ Esterman and DI Ben-Tovim, *The Australian coordinated care trials: success or failure?* Medical Journal of Australia, vol 177, 4 November 2002, pp469-470.

699 *ibid*, pp469-470.

- In many trials the same intervention was applied to all participants, regardless of the severity of their condition;
- Interventions varied markedly between trials; and
- The chosen measure of well-being was not optimal to assess the types of intervention, particularly over the relatively short trial periods[700].

A further round of Coordinated Care Trials began in 2002. Building on the lessons learned during the first round of trials, the new trials are for a period of three years rather than two, have better-targeted interventions, and outcome measures have been carefully selected for sensitivity to the type of intervention[701]. Six trials (three general and three in Aboriginal communities) will target frail aged, those with chronic conditions such as asthma, diabetes and heart conditions and Aboriginal communities experiencing problems associated with chronic disease[702].

Finding 88

Integration of health services can reduce duplication of resources and improve care for patients. In Nova Scotia, Canada, an integrated primary and community health model of care, piloted in a remote Aboriginal community, achieved impressive outcomes, including:

- a 40 percent reduction in use of outpatient/emergency departments;
- a 60 percent decrease in the frequency of visits to a family physician;
- an 850 percent increase in referrals to the nutritionist/health educator for diabetes management; and
- significant savings on medical transportation and prescription drug costs.

6.4 Shared governance and clinical leadership development

In Chapter 2, lack of involvement in decision making and ineffective leadership were identified as important contributing factors to low staff morale, and ultimately to high rates of attrition, particularly in the nursing profession. Shared governance empowers health professionals to make decisions around clinical care, and in a broader context, to ultimately affect an organisation's performance. Leadership, both at an organisational and at a clinical level, can have a profound effect on organisational

700 *ibid*, pp469-470.

701 *ibid*, pp469-470.

702 Mr Michael O'Kane, State Manager, Commonwealth Department of Health and Ageing, Briefing, 24 September 2003.

culture. Both shared governance and leadership also ultimately affect patient care. The Committee gathered information on two initiatives in England that are aimed at improving staff recruitment and retention and improving patient care through changes in organisational culture.

(a) Royal College of Nursing Clinical Leadership Programme (United Kingdom)

Ms Geraldine Cunningham, Director, Royal College of Nursing Clinical Leadership Programme emphasised the importance of developing effective leadership skills in health practitioners[703]. Ms Cunningham advised the Committee, research has demonstrated that leaders play a key role in setting the climate of their workplace, and that leadership style accounts for up to 70 percent of variation in climate. Research also demonstrates that workplace climate has a significant impact on performance[704].

A recent study undertaken in 85 English hospitals found that patient mortality was linked to human resource management within the organisation. Patient mortality decreased with increasing sophistication of staff appraisal systems (goal setting and feedback), with access to training (skill development) and with an increasing proportion of staff working in teams (links to role clarity, social support, effectiveness and innovation)[705]. Staff working in teams were found to experience lower levels of stress and to have better social support and greater job satisfaction[706]. Understanding the benefits of team working, access to training and appraisal is an important aspect of clinical leadership development.

Ms Cunningham briefed the Committee on the Royal College of Nursing (RCN) Clinical Leadership Programme, which is designed *to assist healthcare practitioners and their teams to develop patient centred and evidence based leadership strategies within the context of their day to day practice, their organisational climate and the policy agenda*[707]. The program, which requires participation one day a week for a period of twelve months, has been running for almost a decade and has been completed by more than 2000 health professionals.

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703 Ms Geraldine Cunningham, Director, Royal College of Nursing Clinical Leadership Programme, Briefing, 30 June 2003.

704 Information provided by Ms Geraldine Cunningham, Director, Royal College of Nursing Clinical Leadership Programme, June 2003.

705 Dr Carol Borrill, Executive Director, Aston Centre for Health Service Organisation Research, *Good People Management: Better Outcomes*, http://www.hrinthenhs2003.com/files/Breakout_Presentations/HRC%2046%20The%20relationship%20between%20effective%20HR%20management%20and%20. ppt, accessed on 12 January 2004.

706 *ibid*.

707 Information provided by Ms Geraldine Cunningham, Director, Royal College of Nursing Clinical Leadership Programme, June 2003.

The RCN program is part of a collaboration with the University of Leeds Centre for the Development of Nursing Policy & Practice and Creative Healthcare Management. Organisations, rather than individuals, participate in the program. The first stage of the program began in 1994 as the *Ward Nursing Leadership Project*, which was piloted in four NHS Trusts in England. During Stage One, a theoretical framework and toolkit were developed[708].

The *Ward Nursing Leadership Project* was a research study exploring the skills ward leaders need to promote best practice and identify how they can be developed and shared. One of the clearest messages to emerge from the research was that, alongside any employer influence, the qualities possessed by individual nurses have a direct impact on patient care[709].

Five major themes were identified as the keys to patient-centred ward leadership:

- Learning to manage self;
- Building and maintaining effective relationships with other staff;
- Focus on the patient;
- Internal and external networking; and
- Increasing political awareness.

At the end of the program, 63 percent of teams rated their leaders as more effective and 78 percent of teams believed they had increased their effort as a direct result of their ward leaders' improved skills[710].

Evaluation of the first cohort found that ward sisters had not been adequately prepared for their role: few had experienced good role models and the majority felt out of control. They did not feel supported by their professional colleagues and most viewed nursing management as primitive.

Importantly, the review team reported that in terms of receptiveness to patient care issues, it took at least nine months of the 18-month pilot before clinical leaders were able to see and hear what patients were telling them[711].

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708 *ibid*.

709 Royal College of Nursing, *What is the Clinical Leadership Programme*, http://www.rcn.org.uk/resources/clinicalleadership/whatisit.php, accessed on 9 January 2004.

710 *ibid*.

711 G Cunningham, A Kitson, *An evaluation of the RCN Clinical Leadership Development Programme: part 2*, Nursing Standard, 15, pp34-40, December 2000.

Stage Two of the program, which ran between 1998 and 2001, involved 35 Trusts in England, Scotland and Wales. Four international sites also participated in this stage of the program, two each in Belgium and Switzerland. During this stage, the program and toolkit were evaluated[712].

Stage Three (2001- 2003) involved 96 Trusts in England and a further 12 in Scotland. A formative research evaluation of the program was undertaken during this stage[713].

Stage Four of the program, which began in 2003, involves organisations in England, Scotland, Wales and Australia (Adelaide)[714]. The program was launched at the Royal Adelaide Hospital in February 2003[715].

The Department of Health also recently awarded funding to the RCN Clinical Leadership team to develop and deliver a program across 100 multiprofessional clinical teams in England. The NHS Modernisation Agency launched the program in July with the aim of improving leadership at all levels of the health service[716].

(b) Magnet accreditation

(i) United Kingdom

Magnet accreditation is a whole systems model of accreditation based on an organisation's fitness to employ professional clinical staff. The system is based on the principle that if an organisation looks after its staff, staff will manage patient care more effectively, and patient outcomes will ultimately improve. The Magnet system began twenty years ago in the United States. Its initial focus was nursing, and more specifically, facilitating recruitment and retention. The model has evolved from one of nursing accreditation to a broader application, covering the whole organisation.

Magnet accreditation is based on a foundation of leadership and empowerment. Change is achieved through the development of a leadership culture, based on a model of shared governance and devolved decision making. Thus nurses and nursing staff are able to make a corporate contribution by leading, developing and changing clinical

712 Information provided by Ms Geraldine Cunningham, Director, Royal College of Nursing Clinical Leadership Programme, June 2003.

713 *ibid*.

714 *ibid*.

715 HealthySA, *$1 million boost for the nursing profession*, 4 February 2003, http://www.healthysa.sa.gov.au/detail.asp?item=4071, accessed on 9 January 2004.

716 Nursing Standard, *RCN takes leadership programme to trusts*, 30 July 2003, http://www.findarticles.com.cf_dls/m0NEW/46_17?107929313/p1/article.jhtml, accessed on 9 January 2004.

practice. The model is underpinned by access to educational opportunities, designed to develop skills and improve standards of practice[717].

Rochdale General Hospital, which is now part of the Pennine Acute Hospitals NHS Trust (Manchester, England) became the first international pilot site for Magnet accreditation (outside USA). The Committee met with Ms Denise Houghton, Executive Director of Nursing, Pennine Acute Hospitals NHS Trust and colleagues to discuss Magnet accreditation and how it had affected the organisation[718].

Ms Houghton advised that prior to achieving Magnet accreditation, the model was piloted for 18 months, to test the hypothesis that the Magnet framework is transferable outside the United States. After the hypothesis was proven, Rochdale made a formal application for Magnet accreditation.

The Rochdale model challenged the US system, as the US Magnet accreditation system used purely a nursing model, whereas at Rochdale, other health professionals were included. When the pilot project began, medical personnel did not want to become involved, however, over time they observed a change in the way that nurses interacted with doctors, in the way that they began to challenge some of the clinical decisions affecting their patients and in the clinical care that was being delivered. Through the process physicians observed an improvement in patient outcomes, and began to better appreciate the importance of a good nursing team[719].

To the average nurse at the frontline, Ms Houghton informed the Committee, shared governance means that they will be invited to take responsibility for nursing in their clinical area. They will be enabled to make decision around quality of nursing care, implement the changes that need to be made in the context of patient care[720].

Ms Houghton indicated that there were a number of critical elements that ensured the success of Magnet. First, was an investment in clinical leadership and education. From the outset, Rochdale invested heavily in leadership development. By the time Magnet accreditation was achieved, 1800 staff (Rochdale has a 1200 strong nursing workforce) had undertaken a leadership program espousing the principles of leadership culture: responsibility, accountability and authority based decision-making. In addition to undertaking leadership training, staff were encouraged to undertake

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717 Information provided by Ms Denise Houghton, Executive Director of Nursing, Pennine Acute Hospitals NHS Trust, July 2003.

718 Ms Denise Houghton, Executive Director of Nursing, Pennine Acute Hospitals NHS Trust and Magnet Project Board Member, Ms Nicola Nicholls, Deputy Director of Nursing, Pennine Acute Hospitals NHS Trust and Magnet Project Board Member, and Mr Chris Appleby, Chief Executive, Pennine Acute Hospitals NHS Trust, Briefing, 1 July 2003.

719 Ms Denise Houghton, Executive Director of Nursing, Pennine Acute Hospitals NHS Trust and Magnet Project Board Member, Briefing, 1 July 2003.

720 *ibid*.

further education and to become involved in researching their clinical practice. As well as investing in leadership and education, Rochdale introduced clinical ladders, providing defined career pathways for nurses to progress[721].

Second was project management of the process. In addition to a project manager, there was a project board, with representatives from Rochdale Healthcare NHS Trust, the American Nurses' Credentialling Centre (the Washington based organisation that administers the Magnet system), the Royal College of Nursing Institute and the NHS Executive. A number of local and international academics also sat on the project board. There was also a project advisory group, which was made up of key stakeholders from within the organisation[722].

A third critical element was the involvement of clinical champions. It was recognised that if Magnet was to be implemented successfully and owned by staff throughout the organisation, they needed to be engaged in the project. Seventy magnet champions were appointed, many through self-nomination. They were from various grades, with representation from all clinical areas and each specialty across the Trust. They worked with project managers on interpretation of the standards, and would then return to their clinical colleagues to determine how the standards could be applied, and how evidence could be collected. Although many of these champions were relatively junior, their clinical expertise was outstanding and their leadership was very good[723].

Ms Houghton cautioned that before pursuing Magnet accreditation, organisations should be assessed to ensure that they meet certain selection criteria in terms of organisational culture and commitment. The changes implemented at Rochdale took five years in total. Prior to piloting the Magnet model, two to three years was spent investing in leadership development and changing organisational culture, systems and processes[724].

Not only did the organisation see an improvement in recruitment and retention, it also achieved an improvement in clinical capability and outcomes and in organisational performance. Within three months of achieving Magnet accreditation, Pennine was rated as a three star Trust[725], the highest possible rating for an NHS Trust.

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721 Ms Denise Houghton, Executive Director of Nursing, Pennine Acute Hospitals NHS Trust and Magnet Project Board Member, Briefing, 1 July 2003.

722 *ibid*.

723 *ibid*.

724 *ibid*.

725 Performance ratings for all NHS trusts in England are determined annually on the basis of a defined set of indicators. A three star trust (the highest rating) is one that does well on the indicators and, if a review has been undertaken, is considered to have good clinical governance.

(ii) Australia

The Committee was advised that the Magnet framework is currently being considered at a national level, although it is in the very early stages of development at this point. From a Western Australian perspective, it is hoped that the program will be approached at a national level, as the cost of implementation would be prohibitively high for individual States[726].

At a meeting of Chief Nursing Officers it was agreed that a national approach would be preferable and that the framework should be aligned to the Australian Safety and Quality Council agenda. The Royal College of Nursing, Australia is coordinating the Australian approach to the Magnet framework and was recently invited by the American Nurses' Credentialling Centre to become a member of the Board of Management[727].

A meeting of major Commonwealth, State and professional nursing leaders has been held to scope the approach to implementation and the meeting recommended that a proposal be put forward to the Australian Patient Safety and Quality Council to seek funding to support the establishment of the program in Australia[728].

(iii) New Zealand

A New Zealand Magnet Advisory Network has been established, comprising representatives from New Zealand Nursing Organisations and the Ministry of Health. The group is currently considering the transferability of magnet manuals developed in the United States to the New Zealand context and developing timeframes to progress this work[729].

Several District Health Boards have already achieved some of the Magnet organisational characteristics and principles and have undertaken a gap analysis. Four District Health Boards are currently working towards these principles and one has applied to the Magnet recognition program[730].

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726 Information provided by the Department of Health, February 2004.

727 *ibid*.

728 *ibid*.

729 Ministry of Health, *Nursing in New Zealand*, http://www.moh.govt.nz/moh.nsf/wpg_Index/-Nursing+What+we+work+on#Magnet, accessed on 26 March 2004.

730 Ministry of Health, *Nursing Sector Update*, December 2003, p4.

Finding 89

Organisational characteristics such as shared governance and leadership can affect recruitment and retention of health professionals and can also impact on patient care. Magnet accreditation, which originated in the United States, is based on a foundation of leadership and empowerment of nursing staff to improve recruitment and retention. In Manchester, England, the first organisation outside the United States to gain Magnet accreditation identified three critical elements to ensure the success of Magnet: an investment in clinical leadership and education; project management of the process and involvement of clinical 'champions'.

6.5 Understanding the system - information acquisition

In recent years, there has been a concerted push toward adopting an evidence-based approach to clinical practice. The mandate of the National Institute of Clinical Studies (NICS), established in 2000 by the Australian Department of Health and Ageing, is to close the gaps between evidence and clinical practice[731]. A number of NICS initiatives are centred on increasing the uptake of evidence-based practice:

- The *Primary Care Project* is examining ways in which NICS can contribute to support the uptake of evidence-based practice in general practice;
- The *Change Strategies Project* is focussed on developing strategies to encourage adoption of best evidence into practice;
- The *Evidence-Practice Gap Report*, shortly to be released, is designed to draw attention to specific situations where health outcomes could be improved if the application of best evidence was to become more widespread; and
- The *Cochrane Library*, internationally renowned for being one of the most comprehensive sources of reliable evidence about health interventions, can now be accessed free throughout Australia, thanks to successful negotiations by NICS[732].

As well as changing clinical practice on the basis of weight of evidence, at a system/organisational level, acquiring detailed information about the system can be used to inform change. To state that it is necessary to understand a system in order to improve it would appear to be stating the obvious. However, all too often, clinical changes are not based on sound evidence, and system/organisational changes do not

731 National Institute of Clinical Studies, http://www.nicsl.com.au/about.aspx, accessed 2 February 2004.

732 National Institute of Clinical Studies, NICS Projects, http://www.nicsl.com.au/projects.aspx, accessed 2 February 2004.

come about through developing a sound understanding of the system. How can we hope to reduce the incidence of adverse events in our health system without first quantifying the incidence of events and identifying the factors that contribute to their occurrence? How can we hope to meet the demand on our hospital emergency departments without first quantifying demand and its variations and identifying the factors that contribute to changing demand? In each case we may be able to affect the outcome if we are able to characterise our existing system.

During the course of the inquiry, the Committee came across several initiatives aimed at informing system/organisational behaviour through the acquisition of detailed information about system/organisational characteristics.

(a) Risk management (Victoria)

The Quality in Australian Health Care Study (QAHCS, 1995) estimated that adverse events accounted for 3.3 million bed days per annum, 1.7 million of which (8 percent of all bed days) were potentially preventable. In 1992 figures (the year in which records were analysed by the QAHCS), potentially preventable adverse events were estimated to account for one tenth of all hospital expenditure[733].

Analysis of the causes of adverse events from the QAHCS found that 81.8 percent of all adverse events were associated with one or more categories of human error, 20.0 percent were associated with delays in diagnosis or treatment, 19.6 percent were associated with treatment error and 10.7 percent were associated with problems with clinical investigations. Better education and training, new or better implemented policies or protocols and more or better formal quality monitoring or assurance processes were identified as prevention strategies to reduce the incidence of highly preventable adverse events[734].

Wimmera Base Hospital undertook to reduce the incidence of adverse events by analysing their incidence, identifying organisational and clinician/patient interface factors that contributed to their occurrence and subsequently implementing a risk management program[735]. Adverse events (e.g. cardiac arrest, return to operating theatre within 7 days, unplanned readmission, prolonged length of stay, transfer to another acute facility, death) were analysed by screening inpatient medical records,

733 National Expert Advisory Group on Safety and Quality in Australian Health Care, *Interim Report*, April 1998, p6.

734 R McL Wilson, BT Harrison, RW Gibberd and JD Hamilton, *An analysis of the causes of adverse events for the Quality in Australian Health Care Study, Medical Journal of Australia*, 1999, vol 170: pp411-415.

735 Wimmera Health Care Group, Response to request for information, 13 October 2003.

emergency department medical records, clinical incident reporting as well as several other relevant sources[736].

When an adverse event was detected, its likelihood and consequences were estimated. All events were ranked according to their risk severity (consequence score x likelihood score). Events with high-risk severity were given priority for analysis to determine the factors that contributed to their occurrence and identify appropriate actions to be taken to reduce their risk[737].

At the patient/clinician interface, actions taken to reduce the risk of adverse events included: simplifying systems and tasks (to reduce complexity); standardising procedures (to reduce variation); using reminders and checklists (to decrease dependence on memory); introducing constraints (to make performance of an error more difficult); and providing timely delivery of specific and accurate information (so decisions can be based on appropriate information). At a system level, actions included reducing working hours and excessive workloads; providing adequate supervision; and undertaking preventive equipment maintenance and planning replacement[738].

An analysis of inpatient medical records between July 1991 and September 1999 showed that the annual rate of adverse events fell from 1.35 percent to 0.74 percent as a result of adverse event monitoring and analysis and progressive implementation of risk management strategies. Similarly, a review of Emergency Department medical records between October 1997 and September 1999 showed that the incidence of adverse events in patients who attended the Emergency Department fell from a quarterly rate of 3.26 percent to 0.48 percent.

A review of clinical incident reports between October 1997 and September 1999 indicated that the most commonly reported incidents were patient falls[739]. In response to the number of falls, a falls risk assessment tool was developed for patients over 65 years of age. Patients assessed as high risk are now managed on adjustable-height beds and are placed in rooms close to the nurses' station. After implementing this strategy, the number of falls resulting in fractures fell from 11 to two per annum[740].

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736 AM Wolff, J Bourke, IA Campbell and DW Leembruggen, *Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program*, Medical Journal of Australia, June 2001, vol 174: pp621-625.

737 i*bid*.

738 AM Wolff and J Bourke, *Reducing medical errors: a practical guide*, Medical Journal of Australia, September 2000, vol 173: pp247-251.

739 AM Wolff, J Bourke, IA Campbell and DW Leembruggen, *Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program*, Medical Journal of Australia, June 2001, vol 174: pp621-625.

740 AM Wolff and J Bourke, *Reducing medical errors: a practical guide*, Medical Journal of Australia, September 2000, vol 173: pp247-251.

(b) Acute Demand Management Unit (Western Australia)

The Acute Demand Management Unit (ADMU), which is based in Fremantle Hospital, was established in early 2003. The ADMU was established in order to gain a more comprehensive understanding of Emergency Department utilisation in Western Australia. Through analysis of past and current data, mostly data that is routinely collected by the Department of Health or through the Emergency Department Information System (EDIS), the ADMU has been able to generate valuable quantitative information on:

- The association between Emergency Department admitted patient cubicle occupancy (i.e. access blocked patients) and ambulance bypass;
- The Gap of Neglect of Acute Demand, the difference between the number of number of beds available for acute admissions and the number of patients requiring acute admission to Perth's metropolitan tertiary hospitals, and how the gap remains relatively constant despite variability in the number of available beds;
- The relationship between age and complexity and the impact of patient complexity on Emergency Department workload; and
- Annual changes in the total number of patient bed days and how this is impacting on access block, Emergency Department overcrowding and ambulance diversion[741].

By providing a more comprehensive description of the system, information generated by the ADMU can be used to predict future trends in Emergency Department (and hospital) utilisation and therefore to plan for future demand.

Finding 90

At a system/organisational level, improved information acquisition and analysis can be used to inform system/organisational change. The Acute Demand Management Unit, recently established in Western Australia, collates and analyses emergency department statistics to predict future trends in utilisation.

741 Dr Peter Sprivulis, Clinical Director, Acute Demand Management Unit and Emergency Department Clinical Practice Improvement Unit, Department of Health, Briefing, 22 September 2003.

CHAPTER 7 EMERGING MODELS OF HEALTH CARE - NEW WAYS OF WORKING FOR HEALTH PROFESSIONALS

The Committee encountered many examples of emerging health care roles during the course of the inquiry, both in Australia and in other jurisdictions. The following chapter describes some of these emerging roles along a number of themes:

- Expanding the scope of practice for existing practitioners;
- Designing new roles;
- Working in multi-disciplinary teams;
- Redesigning roles around patient needs; and
- Placing experienced health professionals at the front-line of patient care.

7.1 Redefining the boundaries

During the course of the inquiry, the Committee came across some exciting examples of health practitioner roles that are breaking down the traditional boundaries and, in so doing, enhancing patient care. A number of examples are provided below.

(a) Advanced Neonatal Nurse Practitioners (United Kingdom)

Dr Mike Hall, Consultant, Neonatal Medicine and Helen Creedon, Neonatal Nurse Educator, Princess Anne Hospital (Southampton) informed the Committee that the notion of Advanced Neonatal Nurse Practitioners (ANNPs) began in the late 1980s[742]. The work culture was very different to the current climate, whereby junior doctors were working around 100 hours per week and the amount of clinical input that they had was quite high. These junior doctors were often very inexperienced and some were working in conditions that they would never see again, as they intended to specialise in other areas. Because doctors rotated very quickly (six months rotation), there was a proportion of the time where relatively inexperienced doctors were providing an important level of first-line care. Towards the end of their rotation, they had developed a high level of competency, however, there was recognition that during the early part of a doctor's rotation, newborns were receiving less than optimal care. From a management point of view, there was a major investment in training, which

742 Dr Mike Hall, Consultant, Neonatal Medicine and Ms Helen Creedon, Neonatal Nurse Educator, Princess Anne Hospital (Southampton), Briefing, 2 July 2003.

was often lost to the system. From the doctors' point of view, they were investing considerable time in training that may not be relevant to their future careers[743].

The first Advanced Neonatal Nurse Practitioner Course was introduced in 1992. The initial aim was to develop a new type of practitioner to staff neonatal units within the region. Over the next decade, around 120 neonatal nurse practitioners trained at Southampton, and there are now an estimated 200 practising ANNPs around the country[744].

The roles of ANNPs vary, depending on the unit in which they work. ANNPs assess babies who are unwell or potentially unwell, initiate treatment and play a prominent role in their subsequent management. The level at which they function varies from unit to unit, some operate at a level that would be regarded as the equivalent of a middle grade doctor, and others operate at a level somewhere between that of a senior nurse and a trainee doctor[745]. At the Princess Anne Hospital the advanced neonatal nurse practitioners intermesh with doctors, while in other units (such as Bristol) the ANNPs have their own rota and will look after their own group of patients - these tend to be larger units. The main limitations for ANNPs are prescribing, and, in some units, ordering of investigations.

Dr Hall advised the Committee that when the ANNP program began, it cost more per hour to employ a junior doctor than a nurse, so the case for ANNPs was argued on quality of care, rather than on economic grounds. The situation is now different, as the cost is similar to employ nurses or junior doctors in this role. Furthermore, doctors in training no longer want to spend six months in a neonatal unit, unless they plan to subsequently work in neonatology. These changes have created a favourable environment for proliferation of ANNPs[746].

(b) Orthopaedic Nurse Practitioners (United Kingdom)

Ms Kay Ruggiero briefed the Committee on her experiences as an Orthopaedic Nurse Practitioner (ONP) at Edith Cavell Hospital (Peterborough, United Kingdom). When Ms Ruggiero began two years previously, only one of the ten consultants on staff at the time was receptive to the appointment of an orthopaedic NP. The consultant, who had a two year waiting time for surgery, was open to working with a nurse

743 Dr Mike Hall, Consultant, Neonatal Medicine, Princess Anne Hospital (Southampton), Briefing, 2 July 2003.

744 *ibid*.

745 *ibid*.

746 *ibid*.

practitioner, but was uncertain as to the role he/she would play. Other consultants were either ambivalent or opposed to the role[747].

Ms Ruggiero informed the Committee that within six months of her appointment, she was able to reduce the waiting list of the first consultant to an acceptable level. Thereafter, she chose to tackle the resistance of other consultants by approaching the one who had shown the greatest resistance, approaching him for additional work. After observing Ms Ruggiero in orthopaedic outpatient clinics for several months, the consultant was happy to delegate some tasks[748].

The Committee was advised that ONPs undertake a considerable proportion of follow-up (post-surgery) work. Patients generally do not see a consultant after discharge, unless there is a problem that the ONP cannot resolve. As orthopaedic consultants are paid per session, rather than on a fee-for-service basis, there is no financial incentive to see each patient in an outpatient clinic. The ONPs receive ongoing training, as they are taught to deal with post-surgery problems. By taking on the bulk of post-surgery follow-up work, ONPs have contributed to a significant reduction in the waiting time for surgery, by freeing consultant time[749].

ONPs also see new patients for some consultants. The conversion rate (for surgery) is now higher than prior to the introduction of ONPs, as the ONP screens out patients who do not need surgery and only those who require surgery go through to consultant.

The Committee was advised that it is important for nurse practitioners to 'focus down', rather than try to master the range of skills held by consultants. Ms Ruggiero, who specialises in lower limb orthopaedics, now works with eight of the ten consultants (all lower limb specialists), and Ms Allison Dickinson, who was appointed several months after Ms Ruggiero, works with the remaining two consultants (upper limb specialists). Ms Ruggiero also emphasised the importance of a consultant mentor, without whom the ONP could not progress[750].

(c) Clinical Site Practitioners (United Kingdom)

At Great Ormond Street Hospital in London, the Committee learned about Clinical Site Practitioners, a role introduced to aid compliance with the European Working

747 Ms Kay Ruggiero and Ms Allison Dickinson, Orthopaedic Nurse Practitioners, Edith Cavell Hospital (Peterborough), Briefing, 30 June 2003.

748 Ms Kay Ruggiero, Orthopaedic Nurse Practitioner, Edith Cavell Hospital (Peterborough), Briefing, 30 June 2003.

749 *ibid*.

750 *ibid*.

Time Directive[751]. Ms Judith Ellis, Chief Nurse, advised the Committee that the evolution of Clinical Site Practitioners was possible because of a cultural change of respect for nursing[752]. Clinical Site Practitioners are senior nurses who have a paediatric intensive care background. A team of CSPs was originally established in April 2001, partly to relieve some of the workload of junior doctors in training, and partly to support junior nursing staff. The team initially comprised six senior nurses, and within two years had expanded to 11. The CSPs run a joint night team with medical colleagues, working as equals within the team. There is cross-cover of specialities between doctors and nurses working across the hospital, using wholly generic skills with very specialised cases. Doctors lead in terms of having primary specialty responsibility, but the CSP is the senior clinician on site. The introduction of CSPs has broken down historical occupational barriers, by showing that specialist knowledge is not always necessary to deal with specialised cases[753].

The Committee was advised that although some difficulties have been encountered along the way, the system works well and has resulted in a number of positive outcomes for medical staff:

- Junior doctors are much happier with their new rota, and are benefiting from increased educational opportunities during the day;
- Despite initial resistance, most staff have now accepted that traditional demarcations no longer exist at night, and there is only 'night-team' work;
- After initial surprise, rather than resistance, at being managed by a senior nurse, the doctors have responded well to cultural changes driven by the new system; and

751 The European Working Time Directive is a directive of the Council of the European Union which laid down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive formed part of the Social Charter and was intended to protect the health and safety of workers in the European Union. The Directive was enacted in United Kingdom law as the Working Time Regulations, which took effect from 1 October 1998. The European Working Time Directive applied to all workers, with a number of exceptions, one of which was junior doctors in training. From 4 August 2004 the Directive will be extended to apply to junior doctors in training, although the provisions will be phased in between 2004 and 2009 when the maximum allowable working hours per week will reduce from 58 to 48.

752 Ms Cheryl Unthank, Senior Clinical Site Practitioner; Ms Judith Ellis, Chief Nurse; Dr Hillary Cass, Director of Postgraduate Medical Education; and Dr Maggie Barker, Associate Medical Director, Public Health, Great Ormond Street Hospital (London, England), Briefing, 27 June 2003.

753 Ms Judith Ellis, Chief Nurse; Great Ormond Street Hospital (London, England), Briefing, 27 June 2003.

- An anticipated increase in consultant workload has been much less than was feared[754].

CSPs have also had a positive impact on nursing staff. A recent audit identified lack of support in sometimes very challenging clinical situations as a major contributing factor to the high rate of attrition of junior nursing staff. The audit found that junior staff felt more comfortable having a tier of nurses (CSPs) to provide a rapid response in circumstances where they are uncertain[755].

(d) Extended role radiographers and the four tier model (United Kingdom)

Mr Randle Milne, Radiology Services Manager, Peterborough District Hospital (Peterborough, England) briefed the Committee on the extended scope of practice that radiographers in England undertake, and about the four-tier career structure being developed for allied health professionals[756].

The four-tier system is currently operating throughout the workforce, although still evolving under the guidance of government and the allied health professions. The system involves four levels of professional competency: a consultant allied health practitioner, an advanced practitioner, a practitioner and an assistant practitioner. All would generally be degree qualified, with the exception of the assistant practitioner, who would have vocational training. The advanced and consultant practitioners are taking on many of the tasks traditionally undertaken by doctors. Similarly, practitioners are able to delegate many of the routine tasks to assistant practitioners. Mr Milne informed the Committee that the introduction of the four-tier system for allied health professionals has been largely an opportunistic strategy, taking advantage of the extreme shortage of doctors[757].

The underlying principles of the four-tier system are:

- the practitioner and advanced practitioner will take on more complex cases, leaving the more routine tasks to the assistant practitioners;

- generic assistant practitioners are able to switch from one allied health profession to another relatively easily;

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754 Dr Hillary Cass, Director of Postgraduate Medical Education, Great Ormond Street Hospital (London, England), Briefing, 27 June 2003.

755 Ms Judith Ellis, Chief Nurse, Great Ormond Street Hospital (London, England), Briefing, 27 June 2003.

756 Mr Randle Milne, Radiology Services Manager, Peterborough District Hospital (Peterborough, England), Briefing, 30 June 2003.

757 *ibid*.

- in theory, a person can progress from assistant practitioner to consultant practitioner through experience and by undertaking additional vocational training modules (i.e. without ever having obtained a tertiary degree). In practice, this will likely happen in very few cases. Degree qualified practitioners are expected to progress more rapidly than those who progress through experience and vocational training[758].

With regard to radiographers, of which there is an estimated 40 percent vacancy rate, one of the major driving forces for extended roles was the large number of people waiting for treatment, and in many cases not receiving treatment within an acceptable timeframe. Many patients will now see radiographers, and where appropriate, other allied health professionals, rather than doctors and only the most serious/complex cases will be referred to doctors[759].

By the time advanced practitioners become autonomous, they are generally working at a very senior level and have quite an expanded scope of practice. The evidence suggests that the allied health professionals can provide as good a service as doctors, if not better. In practice, advanced practice radiographers will service one small area to a very high degree, whereas a doctor will provide services in many areas. There is no direct evidence to suggest an increase in adverse events since the introduction of extended role radiographers and other extended role allied health practitioners[760].

(e) Enhanced role midwife project (Western Australia)

In 1998, the National Health and Medical Research Council (NHMRC) released the document "*Review of the services offered by midwives*", which endorsed an earlier report prepared by the National Health Advisory Committee (NHAC) on extended midwifery services and called for recognition of expanded midwives' roles. The review indicated that midwives commonly order and interpret routine diagnostic tests during pregnancy, as well as administer pharmaceuticals that have not been prescribed or ordered by a medical practitioner. Commenting on the report, Professor Lesley Barclay, council member of the NHMRC and member of the NHAC, stated:

> *Research shows that these mothers and their babies are just as safe with midwives as they would be with conventional medical services. In fact, women tend to experience fewer medical interventions and be more satisfied with their care when midwives play a larger part in the process*[761].

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758 *ibid*.

759 *ibid*.

760 *ibid*.

761 National Health and Medical Research Council, *NHMRC report calls for formal recognition of expanded midwives' role*s (media release), September 1998, http://www.health.gov.au/ nhmrc/media/ 98releas/midwives.htm, accessed 2 February 2004.

The report called for reviews of State and Territory laws, noting the differences that exist across states and territories and emphasised the need for professional indemnity cover to formalise the change to midwives' status and functions[762].

In 1999, the Western Australian Department of Health established a Reference Committee to consider the recommendations of the 1998 NHMRC report, with particular emphasis on recommendations relating to ordering and interpreting of diagnostic tests and administration of pharmaceuticals during uncomplicated pregnancy[763].

The enhanced role midwife project will ultimately legitimise the scope of practice of enhanced role midwives in Western Australia, who already commonly order and interpret routine laboratory tests during pregnancy, labour and delivery, as well as administer pharmaceuticals that have not been prescribed or ordered by a medical practitioner.

To date, a tender has been awarded to Flinders University to develop and deliver an extended practice course and an Advisory Group has also been established to oversee implementation and evaluation of the project[764].

Finding 91

Improved patient care, more efficient use of resources, creation of more attractive career options for health professionals and increased clinical capacity are some of the driving forces behind the development of extended scope health practitioner roles. For example, in Peterborough, England, the waiting time for orthopaedic surgery has been significantly reduced by the introduction of orthopaedic nurse practitioners, advanced practice nurses who have taken on a proportion of tasks historically undertaken by orthopaedic surgeons.

7.2 Creating new roles

In most developed countries there is an ongoing shortage of medical and nursing personnel, as well as other health professionals. The emergence of new health roles can potentially alleviate such shortfalls. Similarly, changing health needs of the population, such as ageing and the increasing prevalence of chronic disease, can provide the impetus for the emergence of new roles. The following section describes

762 Department of Health, *Interim report of Reference Committee to review recommendations from NHMRC 1998 report "Review of services offered by midwives", Enhanced Role Midwife Project*, November 2001, p9.

763 *ibid*.

764 Information provided by the Department of Health, August 2003.

two examples of new roles, both of which have been developed largely to address workforce shortages.

(a) Designing a new health professional to counter workforce shortages: the (Associate) Mental Health Practitioner (United Kingdom)

The (Associate) Mental Health Practitioner project is a collaborative venture between the University of Southampton, West Hampshire NHS Trust, Portsmouth City Primary Care Trust, Isle of Wight Healthcare NHS Trust and Marchwood private hospital. The major impetus for the project was the European Working Time Directive, which has prompted the establishment of a national program comprising nearly two dozen pilot sites around the country to examine innovative solutions to the impending restrictions on working hours for junior doctors in training. Although compliance with the European Working Time Directive has provided the impetus for developing new and extended health care practitioner roles to take on the work currently carried out by junior doctors, it is also seen as an opportunity to redesign services to better meet patient needs and provide a better working environment for NHS staff.

Mr Allan Jolly, Project Manager, (Associate) Mental Health Practitioner Project, advised the Committee that the aims of the project are to improve the quality of patient care, address local recruitment difficulties, provide an additional entry route into a mental health career and to prepare practitioners for the "modern NHS"[765].

The decision was made to increase the mental health workforce by:

- broadening the traditional access routes by introducing a new mental health practitioner role;
- preparing suitably qualified and trained staff to work across traditional professional organisational boundaries; and
- tapping into an under-employed pool of graduates (400 psychology graduates per year in West Hampshire) who would potentially consider a career in mental health if an entry route was available to them[766].

There was no precedent for the (associate) mental health practitioner role, so the project began from scratch with development of a new curriculum, tailored to the specific needs of patients. In designing the curriculum, the project team engaged in

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765 Mr Allan Jolly, Project Manager, (Associate) Mental Health Practitioner Project; Mr Steve Tee, Head of Mental Health Division, University of Southampton; and Mr Martin Barkley, Chief Executive, West Hampshire NHS Trust, Briefing, 3 July 2003.

766 Mr Allan Jolly, Project Manager, (Associate) Mental Health Practitioner Project, West Hampshire NHS Trust, Briefing, 3 July 2003.

extensive consultation with Trusts (employers), faculties, professionals and users/carers to determine the skills that would be most appropriate for these health professionals to possess[767].

(Associate) mental health practitioner students are employed full-time by a Trust (health care organisation) throughout their two year training period, their salary on a par with that of a newly qualified nurse. The cost of providing the academic portion of the course is fully funded by Workforce Development Confederations[768]. Students are not bound beyond their two-year program, the onus will be on employers to provide an environment in which the students will want to remain[769].

The minimum entry requirement for the (associate) mental health practitioner program is an undergraduate degree. The program has been deliberately pitched at postgraduate diploma level and not masters level, because with two years experience, although the students have 1,000 more hours in clinical practice than nurses, it is not considered sufficient to qualify as masters level. Students who spend two years in training and a further two years in a masters program will become Mental Health Practitioners[770].

The curriculum comprises supervised workplace learning, with four days a week spent at work and one day at University. Thirty weeks a year are spent at University for the duration of the course, the rest of the time being spent in the workplace. Each trainee is supported by a line manager, a mentor, a clinical supervisor, an academic tutor, a links tutor (someone from the University who visits the workplace on a regular basis), an action learning group (group tutorial facilitated by an academic and expert practitioner) and a project manager[771].

The first intake of students began in September 2003. The majority of students in the inaugural intake had psychology degrees. The new associate mental health practitioner will work as part of a multi-disciplinary team in mental health and social care services, providing direct care to people with serious and enduring mental illness.

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767 *ibid*.

768 Workforce Development Confederations were established in April 2001 in response to the Workforce Planning Review document *A Health Service of all the Talents*. There are 27 Workforce Development Confederations across England, with a mandate to drive an integrated approach to developing the workforce needs of the health and social care sector at a local level. More information found at http://www.wdc.nhs.uk/about_us/index.php, accessed on 30 March 2004.

769 Mr Allan Jolly, Project Manager, (Associate) Mental Health Practitioner Project, West Hampshire NHS Trust, Briefing, 3 July 2003.

770 *ibid*.

771 *ibid*.

The Committee learned that the project has encountered some resistance from other professional groups around issues such as delineation of tasks, regulation, payment for training, administration of medication, career progression and supervision[772].

(b) Changing the workforce model to accommodate workforce shortages (Bendigo, Victoria)

In response to persistent and recurring shortages of physiotherapists, Bendigo Health Care Group Physiotherapy Services developed a new model of service provision. The aims of the new model were to optimise the use of existing skills, ensure continuity of service and maintain staff satisfaction.

An audit was undertaken to identify non-clinical tasks that were carried out by assistant staff. A bank of tasks was identified, pooled and collated to create a new role for an 'unqualified assistant'. Physiotherapists identified ways in which assistants' skills could be utilised to the best advantage and also identified additional skills that could be acquired with appropriate training. An in-house training program, along with access to appropriate external training, was implemented to up-skill assistant staff. In addition, a number of post-graduate trained exercise therapists were recruited and their roles expanded into any areas for which they had the appropriate skills.

By recruiting additional exercise therapists and expanding the clinical role of assistant staff, service delivery was enhanced without the need to recruit additional physiotherapists[773].

Finding 92

The creation of new health professional roles is driven by a number of factors, including changing health needs of the community, workforce shortages and population ageing. In West Hampshire, England, for example, the (Associate) Mental Health Practitioner role, was designed to address workforce shortages by tapping into a previously under-employed pool of health graduates.

7.3 Designing health professional roles around patient needs

As outlined in section 2.4, the Committee received evidence to suggest that health services are not always delivered in a way that best meets the needs of the patient. Broadly speaking, there are two aspects to this issue: the first involves designing

772 *ibid*.

773 Bendigo Health Care Group, Response to request for information, 31 October 2003.

health occupations around the health needs of the community, as well as special populations within the community. The second relates to equipping all health professionals with a set of generic skills to enable them to care for the patient's emotional well-being.

The health needs of the community are constantly changing. Ideally, forward planning of our health workforce would, to some extent, anticipate our changing health needs and would stay slightly 'ahead of the game'. In practice rather than pro-actively plan our health workforce to meet future needs, there is a perception that, to a large extent, we struggle to keep pace with changing demands. Australia is not alone in this phenomenon, it is a problem that is experienced by most developed countries around the globe.

Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, University of Southampton, asserted that in the United Kingdom, health professionals are being trained according to a 60 year old model (the NHS was established in 1948) that simply is not appropriate to the health needs of the community today and in the near future[774]. By and large, the same criticism applies to our own health workforce - factors other than the future health needs of the community are the major determinants of health professional training programs.

During the course of the inquiry, the Committee encountered a number of examples of how other jurisdictions are designing the health workforce to meet patient needs. Some examples are provided below.

(a) The Changing Workforce Programme (United Kingdom)

The Changing Workforce Programme (CWP) is one of many national health reform strategies established as part of the NHS Plan[775], a ten year plan that is billed as the most fundamental and far-reaching reform in the history of the National Health Service (NHS). The CWP is part of the NHS Modernisation Agency's[776] New Ways of Working team and was established to examine new ways of working to improve patient care, optimise use of staff skills, address staff shortages and improve job satisfaction. The CWP provides the initiatives and supporting framework for NHS Trusts and other organisations to test and implement role redesign.

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774 Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, University of Southampton, Briefing, 4 July 2003.

775 Secretary of State for Health, *The NHS Plan, A plan for investment, A plan for reform*, July 2000.

776 The NHS Modernisation Agency was established in 2001 to support the NHS and its partner organisations in the task of modernising services and improving patient outcomes and experiences as part of the NHS Plan.

Role redesign encompasses four types of change:

- Moving a task up or down a traditional uni-disciplinary ladder;
- Expanding the breadth of a job;
- Increasing the depth of a job; and
- Creating new jobs.

The CWP began with 13 pilot sites to focus on testing, developing and implementing role redesign across specific health areas such as primary care, mental health, emergency care, and others. The objective of these pilots is to explore service problems in specific areas, develop new and amended roles, test the potential for different ways of working, identify and overcome barriers to successful implementation, and share learning experiences with other pilot sites and the wider health service. The pilots involve three phases. Phase 1, which is now complete, involved detailed exploration and implementation of roles within each of the theme areas. Phases 2 and 3, which will run concurrently, involve application of themed learning to all sites in pilot group and dissemination of information from pilot sites throughout the NHS.

The success of new roles is assessed by:

- Set targets for improved patient care;
- Improved job satisfaction and staff retention;
- Reduced vacancies and staff turnover; and
- Contribution to the Skills Escalator[777] concept.

Each new role is tested and measured to demonstrate a benefit to patients and staff and a business case is presented to the Project Management Board.

The CWP facilitates role redesign in a number of ways, including:

- A dedicated workforce designer and a project coordinator work at a local level to assist with design and implementation of role redesign;

[777] The Skills Escalator is one of the four key strategies of the *HR in the NHS Plan*. The aims of the Skills Escalator are to provide satisfying careers for NHS staff, while at the same time filling skills gaps that develop because of staff turnover and new or increased demand for services. NHS staff are encouraged, through lifelong learning, to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. Meanwhile, efficiencies and skill mix benefits are generated by delegating roles, work and responsibilities down the escalator where appropriate.

- Financial resources are available to assist with the cost of implementing change;
- When legislative/regulatory blocks and barriers are encountered, a mechanism is in place to resolve problems at a national level; and
- Dissemination of information at a local and national level.

Ms Cheryl White, Workforce Designer, and Ms Sharon Lomas, Project Coordinator, Mendip Primary Care Pilot briefed the Committee on some of the twelve roles being piloted in the Mendip region. The roles were identified through workshops (facilitated by the CWP team) involving staff, patients, carers and social services staff.

(i) Discharge facilitator (intermediate care and therapy services role)

It had previously been observed that a number of patients were being re-admitted to the community hospital after encountering post-discharge problems with medication. The role of an appropriately trained ward clerk was extended such that he/she calls patients 48 hours after discharge from the community hospital, completes a protocol form to identify problems and notifies appropriate agencies when problems arise. During the pilot phase, it was found that 21 percent of patients had problems relating to medication and 13 percent of patients simply needed reassurance (e.g. they had forgotten when the occupational therapist would come). This role was so successful, it is to be rolled out across all of the community hospitals in Mendip[778].

(ii) Early discharge worker (intermediate care and therapy services role)

A skilled support worker who provides nursing and therapy skills facilitates early discharge from a hospital setting by promoting maximum independence. Responsibilities of this new role include providing enhanced nursing and support care in the patient's own home or designated care setting for a period of up to three weeks following discharge from hospital. The early discharge worker provides social and psychological support, monitors patients' dietary needs, supervises exercises and undertakes clinical procedures such as wound care according to an agreed care plan. A team of seven early discharge workers has effected a reduction in bed stays, a reduction in care packages and prevention of admission to hospital in the first place. The average age of patients placed in the care of the early discharge team is 84 years. From a staff perspective, there is increased job satisfaction, improved morale and improved retention.

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778 Ms Cheryl White, Workforce Designer, Mendip Primary Care Pilot, Changing Workforce Programme, Briefing, 2 July 2003.

(iii) Respiratory practitioner (special interest practitioner)

A practice nurse (based in a GP surgery) with special training in asthma and chronic obstructive pulmonary disease, identified a small cohort of patients aged over 65 who had episodes of respiratory exacerbation in the previous two years or had required a GP home visit or hospital admission for respiratory conditions. Of the cohort, 32 percent had been admitted to hospital in the previous two years, 55 percent had emergency GP home visits, 82 percent had emergency GP surgery appointments, 91 percent had been prescribed antibiotics, 68 percent had been prescribed oral steroids, and only 5 percent had appropriately requested repeat medication. The practitioner visited the patients' homes to review their medication, inhaler technique, smoking status, symptoms, blood pressure, and provided advice and suggested changes to prescribed medication. Six months into the project, there had been a dramatic reduction in the number of hospital admissions (0 percent), emergency GP home visits (37 percent) and surgery appointments (37 percent), prescribed antibiotics (53 percent) and oral steroids (21 percent), and an equally dramatic increase in the number of appropriate requests for repeat prescriptions (95 percent), although the cohort had not encountered a winter since the beginning of the pilot study. It is hoped that this role will be attached to the *NHS Winter Plan* and will reduce winter bed blockages[779].

In addition to the primary care pilot in Mendip, other pilots were conducted around the country along the following themes: allied health professions (Salford, Greater Manchester); anaesthesia, critical care and pain management (Burton-on Trent); care for the older person (North Derbyshire); diabetes (Peterborough and Luton); diagnostic care and access (North Tees and Hartlepool NHS Trust); emergency care (Warwick); generalist and specialist care (North West London Hospitals and Kingston Hospital Trusts); mental health (Newcastle, North Tyneside, Northumberland and North Cumbria); scientists - cancer (Bristol); senior house officer and equivalent roles (University Hospitals of Leicester NHS Trust); stroke care (Bradford); and wider health care team (Portsmouth)[780].

The *Changing Workforce Programme* team was originally expected to be in place for a short time, however, Workforce Designers have now become permanent appointments. As well as the *Changing Workforce Programme*, an *Accelerated Development Programme* has been developed to facilitate more rapid implementation of new roles, focussing on jobs where benefits are known and models are ready for implementation. A number of health roles have been selected for this approach, including radiographers, medical secretaries, emergency and intermediate care workers. From start to finish this program will take ten months, compared to the

779 *ibid*.

780 NHS Modernisation Agency, *Changing Workforce Programme progress report*, 2003.

regular 18-month pilots. The first two areas will focus on extended roles for radiographers and medical secretaries[781].

By the summer of 2003, over 400 new or redesigned roles were registered on the CWP Role Redesign Database[782], attesting to the success of the program.

(b) Modern matrons in the NHS (United Kingdom)

When patients and the public were consulted about how the NHS could be improved, one of the most ardent responses was a call for the return of the matron figure, a strong clinical leader with clear authority at ward level. The new role is expected to enhance patient care in three ways:

- Securing and assuring the highest standards of clinical care by providing leadership to professional and direct care staff;
- Ensuring that administrative and support services are designed and delivered to achieve the highest standards of care; and
- Providing a visible, accessible and authoritative presence in ward settings - someone to whom patients and their families can turn for assistance, advice and support[783].

Over the past two years, NHS Trusts have reviewed their nursing structures and have begun to establish the new posts. Trusts were given scope to design the posts in a way that best suited their local needs. Some have created new posts, and others have re-designed their senior nurse posts. Leadership development is considered to be a fundamental element of modern matron posts. To ensure that modern matrons are provided with appropriate leadership development opportunities, more than 30,000 places have been made available on leadership courses[784].

When the program was launched in April 2001, it was expected that there would be 500 modern matrons in post by April 2002. There were in fact nearly four times this many modern matron posts across the NHS in England by April 2002 and the numbers continue to increase[785].

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781 Ms Cheryl White, Workforce Designer, Mendip Primary Care Pilot, Changing Workforce Programme, Briefing, 2 July 2003.

782 Changing Workforce Program, Role Redesign Database, http://www.modern.nhs.uk/nww/wdroles, accessed on 5 January 2004.

783 Department of Health (United Kingdom), *Modern matrons in the NHS: a progress report*, April 2002, p1.

784 *ibid*, p3.

785 Department of Health (United Kingdom), *Modern matrons in the NHS: a progress report*, April 2002, pp3-4.

During the course of the inquiry, the Committee had the opportunity to meet with Ms Katherine Fenton, Director of Nursing and Patient Services, Southampton University Hospitals NHS Trust, to discuss how the new modern matron role has been implemented at Southampton General Hospital[786]. Ms Fenton indicated that Southampton General Hospital differs from many other institutions in that modern matrons have come from a tier within the organisation, whereas other organisations have added another tier. There are approximately 70-80 modern matrons at Southampton General, although some existing senior sisters have been reluctant to take on the new role. Since taking on the role of modern matron, the senior sister has been given a new job description, a new set of competencies, a new development program and a new uniform (to make him/her easily recognisable).

One of the main roles of the modern matron is to act as someone that patients can recognise, who is in charge and who is able to deal with their problems at a ward level. Every modern matron will have a ward secretary and housekeeper, enabling him/her to spend more time on one-to-one education with junior staff, or in the clinical area working one-to-one with the team. It is more of a leadership role than a clinical role[787].

Ms Fenton advised the Committee that the change is not necessarily cost neutral, although if the modern matron is able to delegate to a ward secretary and housekeeper, who may be more appropriate to undertake certain tasks, there may be savings in the long run, partly through reduced use of nursing agency staff[788].

In addition to improving care standards, matrons throughout Southampton Hospitals NHS Trust are expected to play a key role in the Trust's recruitment and retention strategies[789].

Finding 93

Patient care can be improved by redesigning the roles of health professionals around patient needs. The process requires consideration of the changing health needs of the community as well as acknowledgment of the expectation of patients to be treated as individuals. The re-introduction of matrons in the National Health Service, for example, was largely patient driven and is expected to improve patient care by providing clinical leadership to professional and direct care staff and by providing a visible, accessible and authoritative presence at ward level to deal with patients' concerns.

786 Ms Katherine Fenton, Director of Nursing and Patient Services, Southampton General Hospital, Briefing, 3 July 2003.

787 *ibid*.

788 *ibid*.

789 Department of Health (United Kingdom), *Modern matrons in the NHS: a progress report*, April 2002, p6.

7.4 Creating multi-professional health care teams

The issue of effective multi-disciplinary teamwork was addressed in Chapter Three. As highlighted in submissions and evidence, encouraging health professionals of different disciplines to work together as effective health care teams requires intervention both during training and in the workplace. The following section explores how other jurisdictions have addressed the issue, and provides some examples of effective multi-disciplinary teams.

(a) The New Generation Project (United Kingdom)

The *New Generation Project* has evolved out of a Department of Health initiative to demonstrate interprofessional teaching and shared learning in all programs of preparation for health and social care practitioners. The gradual blurring of role boundaries and recent policy initiatives, including the Department of Health review of the health care workforce provided the impetus to review current practices in educating health care professionals. Stemming from these experiences, the *New Generation Project* was designed to place greater emphasis on issues of flexibility, multi-professional teamwork, competency and skills acquisition and problem solving, whilst maintaining the integrity of relevant knowledge base acquisition.

The *New Generation Project* is centred on Interprofessional Learning, defined as 'occasions when two or more professions learn from and about each other to improve collaboration and the quality of care'[790]. In practice, this means that students are given the opportunity to learn and work together through an interprofessional model of education. The ultimate goal of the *New Generation Project* is to develop true multi-disciplinary teamwork (interprofessional working) through Interprofessional Learning.

By the end of the program, students will be expected to be able to:

- Respect, understand and support the roles of other professionals;
- Make effective contributions in an inter-professional team;
- Understand the changing nature of health and social care; and
- Demonstrate a set of knowledge, skills, competencies and attitudes that are common to all professions, and which underpin the delivery of quality patient/client focused services[791].

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790 Centre for the Advancement of Interprofessional Education, *Interprofessional education - a definition*, 1997, as cited in University of Southampton, *A new generation, Leading the way in Health and Social Care professional education*, 2002.

791 University of Southampton, *A new generation, Leading the way in Health and Social Care professional education*, 2002.

Independent of the *New Generation* ideology, several educational/training institutions had also recognised the need to move towards interprofessional teaching (common learning). Four institutions (Kings College London with Greenwich and South Bank Universities; the Universities of Southampton and Portsmouth; the Universities of Newcastle upon Tyne, Northumbria and Teeside; and the Universities of Sheffield and Sheffield Hallam) were identified by the Department of Health as reflecting the ethos of the *New Generation Project*. These institutions received additional funding to accelerate the development of their *Common Learning Programmes*. These sites are now known as *First Wave Leading Edge Common Learning Sites*.

The Committee had the opportunity to meet with Dr Debra Humphris, Director, *New Generation Project* and Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, at the University of Southampton to discuss Interprofessional Learning and how it would affect the future health workforce[792].

The Southampton *Common Learning* site is a partnership between the University of Southampton, the University of Portsmouth and the Hampshire & Isle of Wight Workforce Development Confederation. The partnership has been developed across 11 professional streams (audiology, medicine, midwifery, nursing, occupational therapy, pharmacy, physiotherapy, podiatry, diagnostic radiography, therapeutic radiography and social work); four faculties; two universities and the health and social care organisations that support student learning in practice[793].

Dr Humphris emphasised the distinction between *inter*professional and *multi*professional learning. *Inter*professional learning is when interactive learning takes place between members of different professional groups. By contrast, *multi*professional learning is when several professions come together to learn about the same topic but do not necessarily interact with one another. It is simply not enough to place students together in groups and hope that they will learn from and about one another.

Interactive learning is thought to provide the key to preventing the genesis of silo working. It is too late to leave interprofessional training until after University, because at this point, students are already socialised along professional lines, and breaking the barriers becomes difficult. Importantly, *Common Learning* must be mainstream in the curriculum: if it is included as an afterthought, students do not take it seriously and it has little impact on future work culture[794].

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792 Dr Debra Humphris, Director, New Generation Project and Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, University of Southampton, Briefing, 3 July 2003.

793 Dr Debra Humphris, Director, New Generation Project, University of Southampton, Briefing, 3 July 2003.

794 *ibid*.

Development of the *Common Learning Programme* brought together all the schools within the University that had previously operated in silos. A series of operational groups were also established to bring together health service organisations and the Universities. This process enabled the establishment of networks across practice, to ensure that the culture instilled in students is not lost in the workplace. Evidence of the commitment of the project to creating a favourable work culture into which the students will graduate is found in the allocation of more than half of the project funding to staff development of existing staff[795].

Prior to the *Common Learning Programme*, Southampton University was piloting interprofessional education, albeit on a smaller scale. From October 2000, students from different disciplines began to be taught in small groups. The pilot began in the University of Southampton and was later extended to include the University of Portsmouth, which offers courses in pharmacy, radiography and social work. The first intake of students in the *Common Learning Programme* commenced in September 2003[796].

Interprofessional Learning is integrated throughout the curriculum. There are four Interprofessional Learning units in total, spread over the course, according to progression. The first unit is university based and the remainder are based in practice. The emphasis of Interprofessional Learning is teamwork and collaboration, service redesign, learning from failure, interprofessional problem solving and practice governance. Students are placed together in interprofessional groups of ten and assigned structured tasks to undertake. Interprofessional Learning is part of the student assessment and therefore can be failed[797].

Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, emphasised that the University is a 'service industry', delivering health workers according to the needs of the workforce. In this sense, the *New Generation Project* is not just about education, it provides the under-pinnings of a new health workforce. In this respect, the work of the NHS Modernisation Agency across the health system is a useful adjunct to the *New Generation Project*: Interprofessional Learning is now seen by NHS Trusts (service providers) as an important forerunner to the future health workforce, as health professionals of the future will need to be able to work together in teams. A number of Trusts are now stepping forward to offer training placements for students, as they can see how they, as service providers, can benefit[798].

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795 *ibid*.

796 *ibid*.

797 *ibid*.

798 Professor Jill Macleod Clark, Head of School of Nursing and Midwifery and Deputy Dean, Faculty of Medicine, Health and Biological Sciences, University of Southampton, Briefing, 3 July 2003.

Professor Macleod Clark finished by commenting the *New Generation Project* is embryonic and there are still huge pockets of resistance, but it is part of an incremental culture shift. *New Generation* stems from a vision about creating a future workforce that understands that roles and boundaries will be different and that flexibility will be an integral component[799].

(b) Structured collaborative practice (Canada)

Dr Daniel Way, Director, Postgraduate Education, University of Ottawa, briefed the Committee on the background and outcomes of the *HTF* project *Improving the effectiveness of primary health care through nurse practitioner/family physician structured collaborative practice*. The University of Ottawa began to explore creative ways of working for health professionals in community health centres in the late 1980s. The provincial government began to fund nurse practitioners (NPs) in primary care in the early 1990s, but there was no clear plan as to how they would fit into practices. The HTF project team located some of these teams and found that they were generally struggling to function as an effective multi-disciplinary team[800].

The project team developed, implemented and evaluated an educational intervention to improve structured collaboration between NP and family physician (FP). Nurse practitioner/family physician teams from two aboriginal community health centres in North Eastern Ontario and from two community health centres in rural Eastern Ontario participated in the project. One health centre in each region acted as an intervention site and the other as a control site. Participants at the intervention sites undertook a learning module, while those at control sites did not. The learning module involved:

- A two hour group introduction session;
- A self-instructional guide;
- Two, three hour small group discussions (following on from completion of exercises in the self-instructional guide); and
- Follow up contacts until the end of the study[801].

The project leaders found that intervention positively affected the way in which NPs and FPs worked together, improving job satisfaction for both practitioners, facilitating more appropriate use of nurse practitioner skills and enabling physicians to do more

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799 *ibid*.

800 Dr Daniel Way, Director, Postgraduate Education, University of Ottawa, Briefing, 24 June 2003.

801 D Way, L Jones and NB Baskerville, *Improving the effectiveness of primary health care through nurse practitioner/family physician structured collaborative practice*, March 2001, p11.

by delegating to nurse practitioners. Specific improvements at the intervention sites included:

- FPs and NPs reported an increased understanding of the NP's scope of practice and increased confidence in their competence;
- NPs provided more curative, rehabilitative and supportive care than NPs at the control site;
- NP referrals to FPs decreased dramatically, although FPs continued to refer the majority of patients to themselves; and
- NPs and FPs reported a higher level of collaboration as well as a higher level of satisfaction with their collaboration than did their non-intervention counterparts[802].

Dr Way and colleagues identified a number of barriers to collaborative practice, including: the traditional fee-for-service funding model, the lack of training in collaborative practice in current education programs; and the lack of clarity regarding medico-legal issues associated with multi-disciplinary decision making.

The findings of the *HTF* project suggest that structured collaborative practice can provide more comprehensive and appropriate care. The study sends a clear message that health professionals cannot simply be placed together and expected to work collaboratively as a team. They need to develop an understanding of one another's scopes of practice and role in the team and they need to be taught how to interact collaboratively.

Dr Way indicated that following on from the *HTF* project, funding from the Ontario government as part of the *PHCTF* will enable an additional 117 NPs to be supported in primary care, building on experiences from the first pilot[803].

(c) Nurse-led rheumatology ward (United Kingdom)

The nurse-led rheumatology ward (Foxton ward) at St Helens Hospital in Liverpool, England provides an example of care delivered by a true multi-disciplinary team. The team, which is led by nursing staff, comprises medical consultants, nurse practitioners, an occupational therapist, and a physiotherapist. In traditional rheumatology units, patients would have access to occupational therapists and physiotherapists, but these professionals are not necessarily part of the core team. Access by the patient to allied

802 Health Canada, *Health Transition Fund - Project Fact Sheet NA 342*, http://www2.itssti.hc-sc.gc.ca/B_Pcb/HTF/Projectc.nsf/FactSheets_e/87578E3CCBA19F7485256816006DEC82, accessed on 15 January 2004.

803 Dr Daniel Way, Director, Postgraduate Education, University of Ottawa, Briefing, 24 June 2003.

health professionals is often controlled by medical staff, and often by junior medical staff. The nurse-led team at St Helens is able to provide a more integrated service to patients, as members of the team recognise the skills of other team members, and are aware of tasks that can be shared.

The nurse practitioners are able to operate with a high level of autonomy and lead the rheumatology team because they have an extended scope of practice. In order to prepare for their role in the rheumatology unit at St Helens, nurse practitioners had to undertake clinical skills, examination and history taking courses.

The rheumatology unit at St Helens acquired Practice Development Unit (PDU) accreditation in 1999, four years after it was established. The PDU accreditation program is facilitated by the Centre for the Development of Healthcare Policy and Practice at the University of Leeds. The program facilitates an increase in effective leadership behaviours, strategic awareness, creative problem solving and effective team working, and through these the development of successful clinical outcomes. Some 100 units around the UK have attained Practice Development Unit status since its inception seven years ago. The accreditation process takes two years and is granted when a unit is able to demonstrate the following criteria:

- multi-disciplinary collaboration (leadership of individual projects by different professions);
- holistic care underpinned by evidence-based practice;
- individual and collaborative research;
- dissemination of research findings;
- staff development (appraisal system, individual career development plans, weekly multi-disciplinary training);
- user involvement;
- links with academic institutions; and
- communication strategies.

(d) Community and Mental Health program (Barwon, Vic)

Barwon Health has achieved a low average length of stay in the acute inpatient (psychiatric) unit, a low rate of readmission within 28 days and low bed: population ratio by developing a Community and Mental Health Program based on a multi-disciplinary, case management model of care. The Mental Health service comprises five Adult Community Mental Health Teams, a 24 bed acute inpatient unit and an Aged Community Mental Health Team. Each Community Mental Health Team

comprises a psychiatrist, a psychiatric registrar, nurses (with psychiatric registration or endorsement by the Nurses Board of Victoria, and at least one social worker, psychologist and/or occupational therapist. Key features of the service include:

- All care is planned according to individual needs and must include medical/clinical treatment of the patient's diagnosed illness, relapse prevention, emotional and social care and support of the patient and his/her family or carers/friends, and planned strategies to address sustainable living in and optimum participation in the community;

- While the treating psychiatrist is responsible for the patient's medical management, care and treatment of every patient is planned, mainly provided and regularly evaluated by a dedicated Case Manager. Staff of any discipline may act as Case Manager, depending on the patient's diagnosis and initial clinical needs, as well as availability/current caseload of the various staff. Where a particular discipline is unavailable as a Case Manager, the designated Case Manager will access the required discipline as a secondary consultant;

- One set of common documentation is utilised for each patient, regardless of where he/she enters the service; and

- As a patient's condition and social and financial arrangements stabilise, shared care with General Practitioners is utilised for ongoing care with the goal of Case Closure and transfer of case management to the GP[804].

As well as Adult Community Mental Health Teams, a Community Health Admission Risk Team serves a population of adults who have been frequent attenders (4+ presentations in 12 months) at the Geelong Hospital Emergency Department. The team includes a general nurse, a psychiatric nurse, a psychologist and a physiotherapist. A consultation/liaison psychiatrist provides secondary consultation. As with patients referred to the Community Mental Health Team, patients referred to the Admission Risk Team are assigned dedicated Case Managers. Initial contact with the team is via referral from the hospital wards or Emergency Department. Continuity of medical care is through the patient's GP, and in many cases, finding a willing GP and then engaging the patient with him/her is the first goal of the care plan. Results in the first six months of operation of the team indicate a reduction in patients' ED presentations of up to 60 percent[805].

Given the success of the multi-disciplinary case management model in both Mental Health and Health Admission Risk teams, Barwon Health are currently in the process of transferring the model to other services, including a Drug Treatment Service[806].

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804 Barwon Health, Response to request for information, 17 October 2003.

805 *ibid*.

806 *ibid*.

Finding 94

Effective multi-disciplinary teamwork can be achieved by implementing appropriate strategies during training and in the workplace. The New Generation Project in England is centred on Interprofessional Learning, a model of education based on the premise that the genesis of silo working can be prevented only when interactive learning takes place, not simply when health professional students train side by side.

7.5 Experience at the front-line

Patients who present to hospital emergency departments are generally seen by a number of health professionals and are often confronted by lengthy waits, both in terms of times to assessment and treatment, and sometimes between the decision to admit and the actual admission to a ward. The Emergency Services Collaborative, which stemmed from the UK *NHS Plan*, is a national program aimed at reducing waiting times in A&E departments and improving the patient experience. The program began in October 2002 and will run in six waves of roughly thirty-five sites each until August 2004. By providing a framework for the exchange of ideas, dissemination of information and support for implementation of new strategies, the program facilitates the development, implementation and evaluation of new practices that have been conceived at a local level, with local needs firmly in mind. Already, many sites and departments across the NHS have made changes and implemented ideas that have resulted in significant improvements in the delivery of emergency care.

The pilot programs are grouped according to the four key patient flows that form the basis of the ESC program:

- Group 1: patients who can be treated and discharged relatively quickly, often following a simple diagnostic assessment. These patients will often have a minor injury or illness;

- Group 2: patients who require a longer assessment and observation in addition to diagnosis and treatment. These patients are often treated in a Medical Admission Unit of equivalent;

- Group 3: medical patients who require an admission to an acute hospital with a significant length of stay. This will include working on key hospital processes such as bed management and discharge planning; and

- Group 4: patients who are admitted for an emergency surgical procedure.

The Committee was fortunate to be able to visit three of the pilot sites during the course of the inquiry, one from each of groups 1, 3 and 4. Two of the sites achieved an

improvement in patient flow by placing experienced health professionals at the frontline and are discussed in this section.

(a) Greet and Treat (United Kingdom)

At Kettering General Hospital, the Committee met with Dr Angela Dancocks and colleagues to learn about the *Greet and Treat* approach, a strategy employed to improve flow of triage category 4 and 5[807] (non-urgent) patients through the emergency department. Dr Dancocks advised that there were nearly 60,000 patient attendances in A&E each year. Two to three years ago, Kettering had a Medical Assessment Unit (MAU), but if the MAU was full, patients simply spilled over into the A&E department leading to overcrowding (even though A&E staff did not attend to them)[808].

When the *Greet and Treat* project began, the emergency department was staffed by two full-time consultants, three middle-grade doctors (registrars), six senior house officers (residents) two trust grade doctors, 34 FTE nursing staff and one full-time Emergency Nurse Practitioner. The Emergency Nurse Practitioner had been in post for many years and could see patients quite autonomously. There was a realisation at the outset that there were many staff members in A&E whose skills were not being fully utilised.

The objective of the first phase of the project was to examine the entire patient journey, from presentation through to admission or discharge. A mapping process was undertaken to highlight delays in the pathway. Initially staff mapped the time for each stage, but this task was later assigned to patients, who were expected to generate a more reliable record of the timeframe. The mapping exercise revealed unnecessary duplications (e.g. personal details provided to more than one staff member) and delays (e.g. treatment determined by a doctor, later administered by a nurse).

The *Greet and Treat* team consists of a senior doctor, a nurse practitioner and a triage nurse (who also assists with treatment). Patients are now booked in immediately and directed to the *Greet and Treat* rooms (two rooms at the front of the department, one occupied by a senior doctor, the other by a nurse practitioner). As the scope of practice of emergency nurse practitioners is quite extensive, they are able to assess and treat most patients with minor injuries and illnesses.

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807 According to the Manchester triage system patients are assigned to one of five categories: one (should be seen immediately, arrive by ambulance), two (should be seen within 10 minutes), three (should be seen within one hour), four (should be seen within two hours), five (should not be in the A&E).

808 Dr Angela Dancocks, Consultant, Accident and Emergency Department; Marisa Shrimpling, Emergency Nurse Practitioner; and Geraint Martin, Chief Executive, Kettering General Hospital NHS Trust, Briefing, 30 June 2003.

Greet and Treat first began as a one-week pilot study in October 2001, operating between the hours of 10.00 a.m. and 7.00 p.m. The success of the pilot led to its extension for one month. Again the results were so impressive, the approach has continued since.

The average waiting times for non-urgent patients has improved significantly since *Greet and Treat* was introduced. Patients in triage categories 1-3 are not penalised, their wait times have in fact decreased as a flow-on effect. In May 2001, 52 percent of patients were seen within one hour of presentation to emergency (28 per cent within 30 minutes). During the first pilot, these figures increased to 71 and 52 percent respectively. The improvement has been sustained over time (the corresponding figures for in January 2003 were 81 and 58 percent respectively).

The NHS target for emergency care is a four-hour transit time for 90 percent of patients. For patients who present at Kettering General Hospital, the *Greet and Treat* approach has facilitated a transit time of 4 hours or less for 93 percent of patients who do not require admission. However, for those patients requiring admission, only 80 percent transit through the emergency department in 4 hours or less, because of bed blockages on the wards.

As senior doctors are confident enough to quickly make clinical decisions with non-urgent cases (whereas junior doctors are less confident), the turnaround is more rapid. When the program first began, nurse practitioners worked according to protocols, calling in doctors when uncertain. However, with experience, they have became more confident to work autonomously.

As well as improving patient flow, senior doctors and nurses also educate people who should not be in the A&E, advising when an incident could be dealt with by a GP. In the past this did not occur, as triage nurses were reluctant to turn anyone away and junior doctors were reluctant to tell people after a four-hour wait that they should have seen a GP.

Although non-urgent work accounts for a considerable proportion of A&E workload at Kettering, the *Greet and Treat* approach attracted criticism on the grounds that putting a senior doctor in the non-urgent side of emergency is not efficient use of senior staff time. However, junior doctors are generally very well trained in the management of urgent presentations (stroke, chest pain etc) and can engage senior medical staff from the minors side of emergency as required.

(b) Surgical Assessment Unit (United Kingdom)

At Eastbourne General District Hospital the Committee met with Mr Paul Rowe, Clinical Director, Surgical Services, to discuss the establishment and operation of their

recently established surgical assessment unit[809]. Mr Rowe advised that emergencies are responsible for up to half of all surgical admissions at Eastbourne General District Hospital and represent 60 to 70 percent of total surgical workload.

Several years ago, an internal audit, undertaken over a six-month period, established that up to 20 percent of surgical patient admissions could have been avoided. These unnecessary admissions led to patients waiting on trolleys for lengthy periods of time and to cancellations of elective surgery[810].

The patient pathway at the time was as follows:

- The general practitioner would contact the on call junior doctor (who may have recently qualified). General practitioners were often reluctant to accept being questioned by junior doctor, so almost all cases were accepted;

- The junior doctor would admit to one of four surgical wards, where the patient would be seen by the junior doctor and a nurse;

- Once on the ward, the nurse would complete the admission process. The patient would then be seen by the junior doctor, who would often be uncertain of the problem and would initiate some investigations or wait for the registrar;

- The surgical registrar would generally be tied up in clinic or with surgical lists for most of the day, so newly admitted patients would not be seen until late in the day. By this time, investigations would be delayed until the following day;

- If the GP could not contact the junior doctor or was not happy with the junior doctor's advice, patients would sometimes be sent to the Accident and Emergency (A&E) Department, where they would wait for some hours on a trolley for a surgical opinion; and

- The patient would often be in hospital for two to three days with little progress being made on diagnosis and treatment[811].

The decision was made to change current work practices and create a Surgical Assessment Unit to:

- facilitate an efficient and high-quality emergency assessment process, and enhance patient care and experience;

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809 Mr Paul Rowe, Clinical Director, Surgical Services, Eastbourne General District Hospital, Briefing, 4 July 2003.

810 *ibid*.

811 *ibid*.

- concentrate manpower and technological resources at the point of entry to clinical care; and

- achieve a discharge rate of 20 percent following assessment coupled with supported discharge.

In contrast to the historical pathway, a dedicated surgical registrar based in the SAU takes all phone calls (from GPs and A&E). The registrar, who is reasonably experienced, can give advice with no follow-up, give advice and refer to outpatient clinic for follow-up, or admit to SAU. Local GPs are happy with the new arrangement, as they are dealing with an experienced physician. History and examinations are undertaken within an hour of admission, investigations are undertaken and then a decision is made as to whether the patient should be discharged, admitted to the main surgical ward, or kept in the SAU.

The SAU is a short stay unit that takes emergency general surgical and urological patients referred directly from GPs, from Accident and Emergency and from outpatient clinics. The maximum length of stay is usually less than 24 hours, but the facility can house patients for up to 48 hours. Patients who are expected to stay for longer than 48 hours are transferred to the main surgical ward.

Prior to establishment of the Surgical Assessment Unit a number of goals were agreed upon:

- Twenty percent of patients to be discharged following assessment within 12 hours;

- All patients to have an initial assessment by a registered nurse within 15 minutes of arrival, followed by a more comprehensive assessment;

- All patients to be seen by doctor within one hour of arrival. Investigations to be initiated, results reviewed and a decision made within 12 hours of arrival as to the plan of care; and

- The unit to be subject to continuous evaluation and audit[812].

Of the 3, 378 patients admitted to the Surgical Assessment Unit in 2002, 22 percent were discharged within 12 hours, a further 12 percent were discharged after 12 to 48 hours, and 66 percent were admitted to the main surgical ward after assessment, giving an overall reduction in admission rate to surgical wards of 34 percent[813].

Since establishment of the Surgical Assessment Unit, there have been virtually no cancellations in elective surgical admissions due to lack of bedspace and few trolley

812 *ibid*.

813 *ibid*.

waits for general surgery or urology patients in the A&E department. Additional benefits include improved nursing morale, particularly on the main surgical wards, and improved patient experience.

Aside from initial establishment costs, preliminary estimates suggest the Surgical Assessment Unit is close to cost neutral - recurrent costs are similar to the estimated cost savings associated with the reduced admission rate to main surgical wards[814].

Finding 95

Replacing junior doctors at the front-line of emergency care with more experienced medical and nursing personnel can improve patient transit time and reduce hospital admissions. For example, since the establishment of a Surgical Assessment Unit with dedicated registrar coverage in Eastbourne, England, the number of emergency admissions to surgical wards has been reduced by more than 30 percent, resulting in significant reductions in cancellations in elective surgical admissions and trolley waits in the emergency department.

814 *ibid*.

CHAPTER 8 THE WAY FORWARD FOR WESTERN AUSTRALIA

This inquiry set out to explore a series of questions. Chapters Two to Five examined the roles and interactions of our health professionals in the context of the current health system, in terms of the following:

- What roles do different health occupations play and how well do our health professionals work together in the delivery of health services?
- Are there barriers, whether systemic, behavioural or legislative, to prevent our health professionals from working together optimally?
- Are we providing appropriate training to equip our health professionals to meet current and future health care needs of individuals and the Western Australian community? and
- Do existing career paths offer our health professionals a challenging and fulfilling long-term career?

Chapters Six and Seven explored emerging models of health care delivery and considered the options for future delivery of health services in Western Australia within the context:

- Can we improve health care delivery by utilising the skills and expertise of our health professionals more wisely?
- Can we improve on health professional training? and
- Can we offer our health professionals more satisfying careers?

In essence, Chapters Two to Five sought to identify some of the 'problems' that our health professionals encounter in their efforts to fulfil their roles and interact with one another, and Chapters Six and Seven explored some of the innovative approaches that have been adopted to address these problems, both locally and in other countries. In all, an enormous volume of information has been perused and collated in an attempt to paint an accurate picture of the problems and potential 'solutions'. This chapter attempts to match problems with potential solutions and provide a way forward for health in Western Australia.

8.1 Facilitating the emergence of new models of health care

The Committee recognises that emerging models must be tailored to suit local conditions. Throughout the inquiry, the Committee was repeatedly advised that innovative strategies that apply in one location cannot simply be transferred to another

location with guaranteed success. Furthermore, a number of witnesses to the inquiry emphasised that a 'top-down' approach on its own rarely works - 'clinical champions', practitioners at the front-line with vision, leadership and determination for change, are an integral ingredient for change. These observations aside, the Committee encountered many very exciting clinical innovations, a number of which could be appropriate for Western Australia. Metropolitan hospital Chief Executives and others gave in principle support and confirmed the applicability of programs such as the Surgical Assessment Unit (Eastbourne, England), the Rapid Response Team (Peterborough, England) and a number of the nurse practitioner roles.

The intention of this report is to raise awareness of the need for innovative approaches to addressing our health issues to identify some of the impediments that currently stand in the way of innovation and to suggest strategies to overcome these impediments. Dr Gary Geelhoed, Director, Emergency Department, Princess Margaret Hospital advised that staffing resources in our tertiary hospitals are often stretched to the limit, clinicians are often too busy dealing with day to day crises to step back, examine the bigger picture and devise innovative strategies to improve patient outcomes and/or clinical efficiency[815], a sentiment echoed by Mr Mike Daube, Director General of Health in relation to the wider health system[816]. That is not to say that innovation does not occur in Western Australia's health system - on the contrary, the Committee learned that innovation is common. Dr Peter Sprivulis, Director, Emergency Demand Management Unit, Department of Health, advised that the Acute Demand Strategies Register currently lists more than one hundred strategies that are being examined in our metropolitan hospitals.

Dr Sprivulis suggested, however, that innovation occurs in something of an ad hoc manner in Western Australia. There are numerous organisations, including the National Institute of Clinical Studies[817] and the Australian Resource Centre for Hospital Innovations[818], but Dr Sprivulis indicated that on the whole Western Australia has been relatively slow to become involved with such organisations. Whilst

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815 Dr Gary Geelhoed, Director, Emergency Department, Princess Margaret Hospital for Children, Personal Communication, 9 September 2003.

816 Mr Mike Daube, Director General, Department of Health, Briefing, 15 October 2003.

817 The National Institute of Clinical Studies (NICS) was established by the Commonwealth government in 2000 to provide a national focus for improvement in the quality and delivery of clinical practice. NICS oversees a number of national projects including the Emergency Department Collaborative and the Heart Failure Program, provides funding for targeted projects and negotiated free national access to the Cochrane Library, an on-line database of scientific research drawn from around the world, renowned for being one of the best sources of reliable evidence about health care interventions.

818 The Australian Resource Centre for Hospital Innovations (ARCHI) is funded by the Commonwealth Department of Health and Ageing. ARCHI's produces a fortnightly e-bulletin, posts a wide range of electronic documents on its website, hosts email-based discussion groups, provides and enquiry service for health professionals and conducts frequent toolkit seminars for clinical staff and health service managers.

there are isolated pockets of excellent knowledge and rapport with national organisations[819], the average clinician is not well acquainted with such organisations, and thus probably has at best a superficial appreciation of the clinical innovations that are continually being piloted around the nation.

Moreover, innovation occurs in a system whereby:

- health workers are under enormous pressure and, for the most part, all of their time and attention must necessarily be focussed on dealing with day-to-day operations, with little time to constantly appraise clinical practices and consider better ways of doing things;
- for those clinicians who have the vision and the tenacity to institute innovative changes, there is no guarantee that they will receive the necessary support and encouragement in their endeavours;
- rapid technological changes and high staff turnover are the norm, it is almost reassuring not to also have to cope with constant changes in clinical practice;
- there is no quarantined investment in innovation *per se*, funding must be squeezed from an already tight health budget; and
- front-line staff are often not encouraged to make decisions about clinical practice and to challenge existing procedures.

What, then, must happen in Western Australia to facilitate clinical innovation? There are two important ingredients:

- At an organisational level, innovation needs to become a mainstream part of the work culture in health, rather than being restricted to isolated pockets; and
- At a strategic level, a framework needs to be established to facilitate and support clinical innovation.

There is no doubt that many of our health professionals and our health leaders have a very good appreciation of the problems with our system, but the environment is not conducive to change. It is fair to say that health reform in Australia, in comparison to other jurisdictions, is incremental. Indeed we have witnessed a number of fundamental changes in the past three decades, but for the most part, and this would certainly appear to be the case at present, we are tinkering at the edges. There are no fundamental changes on the horizon, we are simply fine-tuning the existing system, within the current legislative/structural/organisational/behavioural constraints. While

819 Dr Peter Sprivulis, Director, Emergency Demand Management Unit, Department of Health, Personal Communication, 24 October 2003.

we tinker at the edges, other jurisdictions such as Canada and the United Kingdom have recently embarked on a major overhaul of their health systems.

The Committee believes that the time for incremental change has passed. With spiralling health budgets, a rapidly ageing population and increasing prevalence of chronic disease, it is time to loosen the constraints of the current system and embark on a journey of fundamental health reform.

This report does not offer any 'quick fixes' to the problems in our health system. It is hoped however, that it will act as a catalyst for change.

(a) The role of government

The Committee views the establishment of a system wide framework to facilitate and support the development, implementation and critical evaluation of innovative new models of health care as the role of government.

Clearly there already exist a number of organisations within Australia whose primary purpose is to facilitate and support innovation, but apart from isolated pockets of activity, in general, the Western Australian health system, as an entity, has been slow to become actively involved with these organisations. To gain momentum in the reform process, we need a locally based organisation that will facilitate and support innovation within this State - the Western Australian Centre for Health Innovation (WACHI).

The functions of WACHI should include the following:

- Coordinate and promote the development, implementation and evaluation of innovative models of health service delivery across the Western Australian health system, including those that arise in Western Australia and those that have been or are being trialled in other jurisdictions;

- Provide advice and support for organisations and health professionals seeking to develop, trial/implement and evaluate new models of health care delivery;

- Provide a forum for exchange of ideas and dissemination of information both within the health community and the broader Western Australian population;

- Liaise with similar interstate, national and overseas organisations to ensure an open exchange of ideas and information;

- Facilitate the development, implementation and evaluation of new models of health care delivery through the placement of facilitators with health service providers to assist them to identify and achieve their goals; and

- Assess and prioritise applications for funding for the development, implementation and evaluation of new models of health care for delivery in Western Australia.

Recommendation 1

The Committee recommends the establishment of a locally based organisation, the Western Australian Centre for Health Innovation, to facilitate and support a coordinated approach to the development, implementation and evaluation of new models of health care delivery in Western Australia. The organisation would also assess emerging models of health care delivery in other jurisdictions with a view to evaluating their applicability to Western Australia.

Government and non-government (both for profit and not for profit) organisations across primary, acute and aged care sectors should be fairly represented within WACHI. Similarly, one professional group should not be permitted to dominate; there should be equitable representation from medical, nursing and allied health professions.

Recommendation 2

The Western Australian Centre for Health Innovation should have equitable representation from all stakeholders, including the various health professional groups, the different health sectors and policy makers.

It is envisaged that quarantined funding, supplementary to recurrent health expenditure, would be made available to organisations seeking to develop, implement and evaluate new models of health care delivery. Funding will be on a competitive basis, subject to successful application through WACHI. Funding would initially be targeted at the following priority areas:

- Strengthening the population health focus of primary care;
- Expanding sub-acute care services;
- Addressing workforce shortages and maldistribution;
- Improving integration of health services;
- Improving efficiency of health services; and
- Redesigning services around patient needs.

Recommendation 3

The Committee recommends the allocation of quarantined funding, supplementary to recurrent health expenditure, to assist health service providers to develop, implement and evaluate new models of health care delivery in a number of priority areas.

Funding should be made available to private and public health service providers across the primary, acute and aged care sectors.

It is envisaged that Expert Advisory Groups, external to WACHI, would be formed to provide timely and accurate advice and to facilitate expeditious resolution of legislative, educational, and clinical practice issues with regard to new models.

Recommendation 4

The Committee recommends the utilisation of Expert Advisory Groups to provide advice to the Western Australian Centre for Health Innovation and to facilitate resolution of legislative, educational and clinical practice issues with regard to new models of health care delivery.

(b) Changing workplace culture

Clearly an organisational culture that fosters innovation is critical to the successful development and implementation of innovative models of health care delivery. There are a number of essential ingredients to changing workplace culture, including:

- Staff at all levels within the organisation should be encouraged to challenge clinical practice and to think independently, to constantly appraise the way they work and to consider new ways of working;
- The head of the organisation must have vision and commitment to change;
- Innovation must be regarded as a mainstream fundamental part of working in the organisation, not simply something that occurs as an afterthought;
- Resources should be invested in promoting and supporting innovation; and
- Staff should be recognised for their innovative ideas, their achievements highlighted.

Recommendation 5

The Committee recommends that at an organisational level, changes are instituted to ensure that: staff are encouraged to critically appraise existing clinical practices and to consider new ways of working; staff are recognised for their achievements in innovation; innovation is regarded as a mainstream, fundamental part of working in the organisation; and resources are invested in promoting and supporting innovation.

For the purposes of this recommendation, an organisation includes, but is not limited to, an area health service (e.g. North Metropolitan Health Service), a hospital (e.g. Royal Perth Hospital) or a Division of General Practice

(c) The role of training institutions

The Committee was advised during the course of the inquiry that the most appropriate time to influence future work practices in health professionals is during education and training. Undoubtedly students learn that they will enter a very dynamic environment, one that is characterised by rapidly changing technology, increasing patient acuity and changing clinical practice. Health professionals learn to think on their feet, to make decisions with potentially far-reaching consequences on a regular basis, however, they are generally not taught to challenge established clinical practice.

Clearly graduate health professionals have a great deal to learn when they enter the workforce, and there is a certain logic to them simply following instructions and not questioning established practices. On the other hand, however, their inexperience can offer the advantage of enabling them to see things from a different perspective to the health professional that has been in the system for many years. Their potential contribution to innovative thinking should not be overlooked. On the contrary, it should be encouraged. In this regard, training institutions can play a role by 'planting the seed' during training. Health professionals should be taught that they will enter an environment where innovation is mainstream and that during their careers they will be expected to be constantly appraising clinical practice and devising better ways to do things.

Recommendation 6

Health professional educators should foster innovation by instilling in their students an expectation that they will enter an environment where innovation is mainstream and that during their careers they will be expected to constantly appraise the existing clinical practices and devise better ways of doing things.

8.2 Roles and interactions of health professionals

(a) Understanding the roles of other health professionals

There was a broad consensus amongst authors of submissions and witnesses who gave evidence to the Committee that interaction between health occupational groups is stymied because one group does not fully understand the potential contribution of other groups, and communication between the groups is often poor. Provision of certain services may be delayed or even omitted, and ultimately, patient care may be fragmented and/or incomplete.

There are several components to this problem. First, there is a lack of *true* teamwork and collaboration in the workplace. Second, to some extent, the Committee gained the impression that a certain degree of 'territorialism' sometimes prevents occupational groups from referring to other occupational groups. And third, the ethos of teamwork and collaboration are not instilled in health professionals during training.

Professor Debra Humphris and Professor Jill Macleod Clark of Southampton University stressed that the ethos of teamwork and collaboration must be instilled in health professionals during their undergraduate training. If each health professional group trains in relative isolation from other groups, there is little opportunity to gain a sound understanding of the contribution of other occupational groups. This learning takes place in the workplace, by which stage socialisation has occurred along occupational lines. It is also during training that a sense of territorialism may develop, as health professionals are familiarised with their scope of practice, but do not necessarily learn how other health professionals may complement and/or supplement their contribution.

Once health professional graduates enter the health workforce, unless an ethos of teamwork and collaboration is reinforced, the principles instilled during training will be lost.

With regard to education and training, whilst the University of Western Australia recently brought together dental, dental therapy, dental technician and prosthetics and dental assistant students in the new Oral Health Centre of Western Australia, it is not clear whether these students will simply learn side by side, or whether they will be trained according to the principles of Interprofessional Learning[820].

While there is much rhetoric about a move toward a collaborative, 'multi-disciplinary' team approach to health care, the Committee formed the impression that this practice occurred in pockets, but was not a pervasive feature of the current system. One of the problems, of course, in moving toward this model of care, is that health professionals, who have worked in a different way for many years, may resist such change.

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[820] See section 3.4 (a).

Improving the level of understanding and communication/collaboration between health occupational groups can be expected to take time, but the Committee believes it could best be achieved by tackling the problem both at a training and a workplace level.

Recommendation 7

The Committee recommends incorporation of the principles of Interprofessional Learning into health professional curricula to promote a greater awareness of the contribution of each discipline and a more collaborative approach to patient care. The distinction must be drawn between learning side by side and truly interactive learning. Undergraduate medical students, who currently train apart from other health disciplines, must be included in the process.

Recommendation 8

The Department of Health should make a concerted effort to develop and implement strategies aimed at improving the level of understanding and communication between health professionals of different disciplines in the workplace.

(b) Improving teamwork

Numerous submissions emphasised the importance of teamwork in the delivery of health care. However, evidence presented to the Committee suggests that although our health professionals are often required to work in teams, there is sometimes little evidence of effective teamwork.

The lack of effective teamwork appears to stem largely from historical arrangements, whereby health professionals trained and worked in silos. Around the globe, there is recognition that health services designed around professional silos are less than optimal and a range of strategies are being developed in an effort to eliminate silo working and promote the emergence of multi-disciplinary teams.

Recommendation 9

The Department of Health should facilitate the development of more effective teamwork in health care settings by providing teamwork training for all health professionals.

(c) Improving staff morale

The Committee learned that morale was low for health professionals in every occupational group. The reasons varied for different groups, although there was often significant overlap. Low morale appeared to be a particularly pressing issue for nursing staff, contributing to the high rate of attrition in the profession. The main contributors to low morale were lack of support coupled with a stressful work environment and lack of involvement in decision-making processes.

In an increasingly stressful work environment, where decisions with significant ramifications are made on a day-to-day basis, a supportive organisational culture is critical to the well-being of staff. The high rate of nursing attrition, the profusion of nursing agencies in recent years and the high level of disillusionment in the profession are just some of the symptoms of health professionals who are not adequately supported in the workplace. This is particularly true for inexperienced nurses, who simply are not prepared for what confronts them when they first enter the workforce.

Other factors that contribute to low morale, and as a consequence high rates of attrition in nursing, include ineffective leadership, lack of support for professional education and lack of flexibility[821].

Many of the problems that contribute to low staff morale (and high attrition) are addressed in the Magnet accreditation framework[822]. While the Magnet framework is currently being considered in Australia, and there is a strong possibility that it will ultimately be adopted across the country, this process will likely take a number of years.

The Committee was recently advised that interim measures to support the Magnet concept have been introduced in Western Australia, including funding of a Nursing Leadership Course, funding of nursing scholarships for postgraduate clinical nursing specialisation courses and establishment of a Nursing Leadership Enhancement Program. The issue of organisational culture is not currently being addressed at a State level, but rather at the local health service level.

821 Dr Phillip Della, Chief Nursing Officer, Department of Health, Response to request for information, February 2004.

822 See section 6.4 (b).

Recommendation 10

The Department of Health should prioritise the allocation of funding and resources to improve recruitment and retention of nursing staff in public hospitals through implementation of interim measures that are consistent with the principles of the Magnet accreditation framework. Consideration should be given to extending the Magnet framework to other health professionals.

Recommendation 11

The Department of Health must prioritise the development of strategies to increase the level of clinical, professional and personal support for nurses, particularly new graduates, in the workplace.

Lack of involvement in decision making appeared to be particularly problematic for allied health professionals, who are often excluded from management positions and are poorly represented in health planning. Although some allied health professions have been with us for many years, the prominent role of allied health professionals in delivery of health services has been a fairly recent trend. There appears to be a lack of recognition of the contribution of these professions, with consultation and representation following traditional patterns, often being restricted to the medical and nursing professions.

Extension of the Magnet framework to include allied health professionals has the potential to address the problem of lack of recognition at an organisational level. However, at a broader system level, steps should be taken to ensure allied health professions are adequately represented and consulted.

Recommendation 12

The Department of Health must recognise the increasing contribution of allied health professionals to the delivery of health services and, accordingly, allied health should be represented within the senior management structure.

(d) Focussing on the patient

There was considerable disquiet amongst witnesses who appeared before the Committee, about budgetary and resource constraints necessitating a public health system that is focussed on maximum efficiency and productivity, sometimes at the expense of the patient's emotional well-being. There were a number of criticisms, from both health professionals and consumer advocates. The Committee was advised

that health professionals often lack the ability to listen and communicate with patients; they fail to provide patients with information; they fail to appreciate and address the social/emotional needs of the patients; and there is all too often an absence of nurturing, caring bedside contact. While much of this problem relates to system constraints, there was also criticism that health professional training was so focussed on technology and high productivity, that skills such as communication, counselling and caring were largely overlooked.

Focussing on the patient is not necessarily about providing better or more efficient medical care, in many cases it is about adopting a more holistic approach to patient care. With the ever-increasing need to constrain health budgets by maximising productivity, in many cases, our health professionals simply do not have time to attend to anything other than the immediate medical needs of their patients.

Whilst most submissions and evidence to the inquiry focussed on the absence of attention to social/emotional issues with regard to patient-centred care, in other jurisdictions, patient-centred care is seen in a broader context of making the patient the centre of the model of care and designing health and, in some cases, other services around the patient's needs.

In most jurisdictions there is increasing recognition that health services must be patient-centred, and emerging models are reflecting a greater focus on the patient. In the United Kingdom: matrons were re-introduced to the NHS in response to a consumer call for a figure at ward level who could deal with patient concerns; all NHS Trusts have introduced Patient Advice and Liaison Services to ensure that patients have an avenue through which to comment on their health care experiences; one of the primary objectives of the *Changing Workplace Programme* is to improve the patient experience; and one of underlying principles of the Royal College of Nursing *Clinical Leadership Development Programme* is the development of patient-centred leadership. In New Zealand, community representatives will participate in the governing processes of the new Primary Care Organisations, ensuring that the organisations are responsive to their communities' needs.

Recommendation 13

Training in communication skills and an emphasis on patient-centred care should form an integral part of all health professional curricula.

Recommendation 14

Funding should be provided to support redesign of health services toward more holistic models of care.

(e) Recognising the contribution of non-government organisations in provision of health services

A number of non-government, community based organisations supplement the role of the Department of Health in delivery of health services and provision of education and support in their particular area of expertise. These organisations, which include Diabetes Australia (WA), the Cancer Foundation, the Learning and Attentional Disorders Society and Ngala Family Resource Centre, provide an invaluable service to the community in general, and to affected individuals in particular. The Department of Health utilises the resources and expertise of these organisations, sometimes assisting with funding. In many cases, their funds are derived largely from membership and fund-raising activities, and some rely heavily on volunteers for provision of services.

In many cases these organisations face a constant struggle to maintain their services, as they battle for financial stability. The Department of Health clearly recognises the important contribution of these organisations, as it routinely refers members of the public to them for the services they can provide, and yet in some cases there is little financial compensation. Diabetes Australia (WA) once had Department of Health funded employees along with ongoing funding, but those were withdrawn some years ago, despite a continued expectation that the organisation would act as a service provider. The Learning and Attentional Disorders Society (LADS), which routinely receives referrals via the Department of Health, has received emergency funding on several occasions, but receives no recurrent funding.

There is generally considerable expertise within these organisations, and they are well placed to deliver the services they provide. The Department of Health would be less well placed to deliver such services, if these organisations did not exist. With appropriate financial support, many of these organisations, which fall within the public health domain, would be well placed to take on an expanded role in the provision of preventive health services.

Recommendation 15

The State should recognise the important contribution of non-government organisations to the delivery of health services in Western Australia and provide adequate remuneration to ensure the ongoing provision of these services. In line with the shift toward a greater population health focus, there is scope for a number of non-government organisations to play a greater role in delivery of health services, therefore increased government funding should be considered where appropriate.

8.3 Adequacy of current training programs

(a) Training health professionals to meet patient needs

There is no disputing that our health professionals are highly skilled and sought after around the globe. When they graduate, they are well equipped with a defined skill set that enables them to effectively and efficiently meet the medical needs of their patients. However, there is widespread concern that health professionals are not trained to listen and to communicate with their patients. Granted, there is little time for health professionals to attend to anything other than the immediate medical needs of their patients. This situation is distressing for patients, whose satisfaction with the level of care they've received may be low, and for health professionals, who feel frustrated and powerless in a system that is focussed on productivity. A way must be found to enable health professionals to improve patient experiences with the health system by adopting a more patient-centred approach to patient care.

In line with Recommendation 30, health professional training should equip all health professionals with a generic set of communication skills and an understanding and commitment to patient-centred care.

(b) Producing a health workforce that meets the changing needs of the community

The health system is in a constant state of flux, the skill-mix of the workforce and the skill sets of different professionals within the workforce must constantly change to meet the changing health needs of the community. The education sector (the supplier of health professionals) is not particularly well placed to determine how many graduates it should train in each discipline, and what skills they should possess. Health service providers (the employers of health professionals) are well placed to monitor and evaluate their ongoing health workforce needs. Yet supplier consultation with employers of health professionals appears to be somewhat limited with regard to ongoing health curriculum development and to the required mix of health professionals in the health workforce. We currently have a situation whereby the number of graduates in each discipline and health professional curricula are largely determined by the universities and vocational training centres, with limited input from health service providers.

Ideally, health professional roles and the skill mix of the health workforce should be continually monitored and education/training adjusted in line with predicted health needs of the community. This process could be undertaken by a joint consultative group, with representation from the education sector, government and non-government health service providers, the Department of Health, professional associations and regulatory bodies, and the community. The consultative group would act as a conduit to the national body described in section 7.2 (b) (Recommendation 8)

Recommendation 16

The Committee recommends that a Consultative Group on Curriculum Development and Health Workforce Planning should be established to identify health needs of the community and guide ongoing curriculum developments as well as allocation of discipline specific training places. The universities and vocational bodies, health service providers, the Department of Health and professional associations and regulatory bodies should be represented on the Group.

In line with Recommendations 6, 20, 22 and 28, health professional education and training should:

- Instil in students an expectation that they will enter an environment where innovation is mainstream and that during their careers they will be expected to constantly appraise clinical practice and explore better ways of doing things;
- Focus on chronic disease management, rehabilitation and sub-acute care strategies;
- Provide sufficient emphasis on care for older people;
- Follow the principles of Interprofessional Learning; and
- Equip all students with a generic set of communication skills and an understanding and commitment to patient-centred care.

(c) Preparing health professionals to enter the workforce

There was significant concern, particularly within the nursing profession, about the level of preparedness of new graduates to enter the workforce. Because of the intense pressure of the hospital system, graduate nurses are expected to 'hit the ground running' with little opportunity for organisational induction. For many, the situation is extremely stressful. The problem has arisen largely as a result of the move away from organisation-based to university-based nursing training. A number of options were suggested, including formal internship or preceptorship programs, although the Australian Nurses Federation did not support this idea. The ANF, however, strongly supported increased practical training during the undergraduate course. The University of Notre Dame, in designing its nursing course, consulted with the profession with regard to the most appropriate course, and ultimately established a course that includes twice the clinical training content of other nursing schools.

Recommendation 17

The State, in consultation with the nursing profession, should make a concerted effort to develop and implement strategies to ensure that nurses receive increased clinical experience during training.

A second issue that arose with regard to clinical training was the significant costs associated with providing clinical placements. Funding for clinical placements is a contentious issue. There is limited communication between stakeholders, and a lack of agreement as to where responsibility for funding lies. The universities receive some Commonwealth funding, but the level of funding is considered to be insufficient.

Recommendation 18

The education sector and the health industry must accept joint ownership of funding responsibility for health professional clinical placements. The Department of Health should facilitate the establishment of a partnership between the education sector and service providers with the aim of finding a sustainable solution to funding of clinical training.

Finally, there is the issue of clinical placement opportunities. In the face of workforce shortages, many health disciplines, particularly amongst the allied health professions, are experiencing increasing difficulty finding clinical placement opportunities for students.

Recommendation 19

The Department of Health should facilitate constructive dialogue between the education sector and health service providers to identify avenues for expansion of clinical placement opportunities.

(d) Creating effective health leaders

Effective leadership is essential to secure the best outcomes for our health system. Leaders play a key role in setting the climate of their workplace, and workplace climate has a significant impact on organisational performance. Good clinical leadership is associated with more effective team working, better patient outcome and lower levels of stress and greater job satisfaction for staff.

The distinction must be drawn between management and leadership, and there is broad recognition within our health system that it is leadership that is needed both at an organisational level, to inspire and guide organisational change, and at a clinical level, to achieve the best patient outcomes in an environment based on collaboration and

teamwork. Unfortunately, there is little evidence of investment in leadership training, either at an organisational or clinical level.

The Office of the Chief Nursing Officer, within the Department of Health, has recently established the Nursing Leadership Course and the Nursing leadership Enhancement Program as precursors to development of the Magnet framework. These are positive steps, but there is scope for further development in the areas of both clinical and organisational leadership developments. Clinical leadership programs must also be offered to medical and allied health professionals - they too assume clinical leadership roles. At an organisational level, leaders must have the vision and capacity to facilitate organisational change.

Recommendation 20

The Department of Health should place greater emphasis on the development of leadership roles at a clinical and organisational level.

8.4 Underpinning the roles and interactions of our health professionals

(a) Bridging the Commonwealth-State divide

Australia is somewhat unique in its Commonwealth/State divide in the funding and delivery of health and aged care services. Primary care is largely provided by private practitioners and purchased by the Commonwealth. It is free to some, but not all patients, as GPs are not compelled to charge patients the equivalent of the Medicare rebate. All Australians are entitled to free care in public hospitals. The States and Territories are responsible for providing hospital services, and both the Commonwealth and States/Territories contribute funding. Public health and community health services are the domain of the States and Territories, and aged care services are the responsibility of the Commonwealth.

Amongst other problems, this fragmented purchaser/provider arrangement leads to lack of coordination and integration of services, unnecessary duplication of resources, lack of flexibility in provision of services and frequent disagreement over which level of government is responsible for a particular area. As stated by the Senate Community Affairs References Committee, these inherent features of our health system '*limit the extent to which Australia can claim to have a national health system*'[823]. As well as divided funding for health and aged care services, funding for health professional training is predominantly provided by the Federal Government, and it is at this level that the number of funded University places are determined.

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823 Senate Community Affairs References Committee, *Healing our Hospitals. A Report on Public Hospital Funding*, December 2000, p6.

Whilst the current funding arrangements are in place, it is simply not possible for Western Australia to optimise the roles and interactions of its health professionals. Add to this the funding arrangement for university places and Western Australia is also in a precarious position with regard to health workforce planning.

Recommendation 21

The Committee recommends that the State and Commonwealth governments pursue the aggregation of health funding to achieve coordinated service delivery.

(b) Addressing the shortage and maldistribution of health workers

The shortage of health workers is a long-standing problem. There are many contributing factors - too few training places, high rates of attrition, decreasing average hours of work, and increasing demands on our health system as a result of, amongst other things, our ageing population and increasing prevalence of chronic disease.

In the long term, there is no doubt that we need to train more health professionals. It is therefore reassuring to find that in recent times there has been recognition, at a Commonwealth level, of the need to increase the number of training places. But are we increasing the number of training places rapidly enough to meet *future* demands? Workforce projections, based on predictions of supply and demand over the next two decades, suggest that the shortage may worsen significantly unless there are substantial increases in the number of training places over the next few years. Our health workforce is ageing, along with the population in general, and the rate of attrition due to retirement is expected to increase markedly in the next decade. An increasing propensity for part-time work is also expected to exacerbate workforce shortages.

It is important to note that a significant proportion of health professionals who train in Western Australia subsequently remain and work in the State. As such, the number of available training places is one of the most important determinants of supply of health professionals in Western Australia. Although the overall number of funded University places is determined at a Commonwealth level, the number of places allocated to specific courses is largely determined within the universities.

The Health Reform Committee, in its discussion paper on Commonwealth/State relations, highlighted the inadequacies of the current system, whereby the Commonwealth, States/Territories, education sector and professional bodies each play some role in producing a health workforce, but there is a lack of cooperation between sectors, to the detriment of appropriate health workforce planning.

The Health Reform Committee raised the possibility of a national Inter-Agency Commission, with representation from each sector, to:

- Improve communication between stakeholders;
- Provide a strategic context for health education and training planning; and
- Provide high level, coherent advice to Ministers and jurisdictions[824].

The Health Reform Committee also proposed the establishment of similar inter-agency bodies at a State level to liaise with the national Commission.

The Committee endorses the Health Reform Committee's proposal.

Recommendation 22

In line with the proposal of the Health Reform Committee, the Committee recommends the establishment of a national Inter-Agency Commission with representation from the Commonwealth, States/Territories, education sector and national professional bodies to address health workforce planning, education, training, registration and employment issues collaboratively.

Other measures must be taken in the interim to address the critical and worsening workforce shortages. A number of recruitment and retention strategies are already in place, both at a national and at State level. These measures are not enough and the Committee believes that a more creative approach to the problem is necessary. In other jurisdictions, the United Kingdom in particular, a number of strategies have been employed to deal with workforce shortages, such as the *European Working Time Directive*, the *Changing Workplace Programme* and the *Skills Escalator*. Such programs include: redesigning existing roles such that advanced practitioners are able to deal with the more complex tasks and delegate routine tasks to less qualified staff; up-skilling some workers to take on greater responsibility; and creating entirely new roles. The development of the (Associate) Mental Health Practitioner role in West Hampshire NHS Trust provides an outstanding example of workforce shortages providing the impetus for the development of a new role that tapped into a previously under-employed pool of health graduates.

We can view health workforce shortages as a problem and continue to tackle it using the approaches we have used for some time, or we can view it as an opportunity to rethink the roles of our health professionals and to begin to redesign some of these roles around the health needs of the community. It is important to point out that the Committee recognises the importance of existing recruitment and retention strategies - these will continue to play an important role in bolstering the supply of health professionals. However, there is also scope to expand our health workforce by alternative means. The Committee views WACHI as the instrument by which new and redesigned health professional roles could be explored.

824 Health Reform Committee, *Commonwealth/State Relations*, October 2003, p16.

Recommendation 23

The Committee recommends that exploration of new and redesigned roles to address workforce shortages should be a priority for exploration through the Western Australian Centre for Health Innovation.

The shortage and maldistribution of health professionals has another dimension that must be considered - retention of existing staff. As discussed earlier, attrition of health professionals relates largely to the work environment (low morale due to lack of support and lack of recognition in a stressful environment) and inadequate career structures. Recommendations are made in relation to these matters in sections 8.3 and 8.5.

Maldistribution of health workers is also a long-standing issue. Health professionals, for numerous reasons, simply prefer to work in capital cities and other large urban centres. In recent years a number of strategies have been employed to help bolster the supply of health professionals, particularly doctors and nurses, in regional, rural and outer urban areas. Although some of these strategies are relatively new, preliminary outcomes are generally encouraging.

It is important to note that the factors that *attract* health professionals to rural areas may differ from the factors that *keep them there*. In relation to GPs, for example, monetary incentives, spouse/family considerations and good hours/time off/on-call hours were all commonly cited as important factors in attracting doctors to rural practice. Good on-call arrangements and availability of professional support were the most important factors needed to keep them there. Current strategies concentrate on attraction to rural areas, less attention is generally focussed on retention. There is definitely scope for further investment in this area, not only for doctors, but also for other health professionals.

Recommendation 24

The Committee recommends that the State develop comprehensive strategies to attract and retain health professionals to rural areas, in particular in the areas of nursing and allied health.

The factors that determine supply of GPs in outer urban (generally low-income) areas are slightly different to those that apply to GPs in rural and remote areas. Most GPs working in low-income areas are under considerable pressure to bulk-bill. With the increasing gap between Medicare rebates and GP expectations with regard to income, many GPs believe the situation to be untenable. Ironically, it is patients in outer urban/low income areas that have the greatest health needs. The Committee recognises the existing collaborative approach of the Commonwealth and Divisions of General

Practice in addressing GP shortages in outer urban areas, but believes there is also scope for the State to become involved.

Recommendation 25

The Committee recommends that the State and Commonwealth should collaborate with the Divisions of General Practice to significantly improve services in outer urban areas.

(c) Meeting increasing demands on our hospitals

An increase in the number of patients being treated in the community or as same day patients and decreased length of stay for admitted patients have improved hospital efficiency and productivity in recent times, and led to a progressive reduction in bed to population ratio over the last decade. Those patients who are admitted to hospital today are of higher average acuity than patients who were admitted a decade ago. As a result, staff are faced with progressively greater workloads.

Average occupancy rate in our metropolitan hospitals is well above the level at which access block would be predicted to occur infrequently. Add to this, increasing numbers of Care Awaiting Placement patients, increasing use of hospitals emergency departments for primary care and increasing total bed day utilisation in the over 50 age group, and it is easy to appreciate why our hospital system is under steadily mounting pressure. Based on emergency department data collected over the last few years, an additional 200 beds would need to be made available in 2004 in our metropolitan teaching hospitals just to maintain the same level of service as that provided in 2003.

These pressures manifest as overcrowded emergency departments, admitted patient access block and frequent ambulance diversion and even ‘ramping’. It is important to recognise that these are symptoms of a system wide problem, not simply inefficiency in our emergency departments. As a result of our ageing population, the demand for acute care is increasing in the order of 4 percent per annum. The pressure on the hospital system is further increased by a primary care sector that is unable to deliver affordable, accessible primary care, resulting in a flow-on of primary care patients. When the aged care sector is unable to meet the demands for community and residential aged care places, patients are trapped in the acute sector.

We return again to Commonwealth/State arrangements and their impact on the health system. The problems with our hospitals cannot adequately be addressed at a State level, because primary care and aged care fall within the Commonwealth jurisdiction. The Senate Community Affairs Reference Committee found the current arrangements to be detrimental to our public hospitals and the patients they treat.

With regard to flow-on pressure from primary and aged care sectors, Western Australia has three options: allow the current situation to continue, whereby

deficiencies in primary and aged care are able to detrimentally impact on the acute sector; lobby the Commonwealth Government more vigorously to expand capacity in primary and aged care to meet demands; or invest in strategies that will take pressure off our hospitals.

The current situation cannot be allowed to continue. Certainly more pressure could be exerted on the Commonwealth Government, although there may be little chance of success in this approach. The option that will undoubtedly result in the best outcome for patients, at least in the short term, and perhaps also in the long term, is to invest in strategies that will take pressure off our public hospitals.

With regard to primary care, the three factors that probably have the greatest impact on our public hospitals are: limited access to after hours primary care in most areas; a shortage of GPs in outer metropolitan areas; and decreasing access to free (bulk-billed) primary care. There are a number of factors that contribute to these problems.

The majority of GPs simply do not want to work after hours. There is a relative under-supply, and therefore most GPs are able to make an acceptable income without working at undesirable times. There is little financial incentive for providing after hours care, as the Medicare rebate is only marginally higher. The Divisions of General Practice WA, in its analysis of After Hours Primary Medical Care (AHPMC) in WA, concluded that the amount that consumers are willing to pay for AHPMC is at odds with the amount that GPs expect to earn, such that GP After Hours (GPAH) clinics will not be viable unless supplementary funding is provided by State or Commonwealth Governments, or higher fees are charged, thus excluding patients from lower socioeconomic groups.

The situation is similar with regard to outer metropolitan areas - GPs simply prefer not to work in outer metropolitan areas. There is considerable pressure to bulk-bill and most GPs do not live in outer metropolitan areas so there may be considerable travel time to work.

Recommendation 26

The Committee recommends that greater priority be given to providing access to primary health care, particularly after hours and in outer metropolitan areas, to alleviate pressure on emergency departments.

At the other end of the spectrum, insufficient capacity in the aged care sector also flows through to the hospital sector. The impact of this deficit should not be underestimated. Care Awaiting Placement (CAP) patients occupy an average of 99 acute hospital beds in the metropolitan area each day (3.5 percent of all metropolitan public hospital beds). The average length of stay for CAP patients in public hospitals

ranged from 8 to 58 days in 2003. Assuming an overall average of around 20 days, this represents more than three times the average length of stay for acute patients (excluding same day procedures). In other words, in the time taken for the average CAP patient to gain an aged care placement, three acute patients could have been treated and discharged. Clearly insufficient capacity in the aged care sector has a major impact on emergency admissions as well as waitlists for elective surgery.

This situation should come as no surprise, given the number of available aged care places falls well below the Commonwealth target of 90 residential places per 1,000 people aged 70 and over (as at June 2002 there were just 81.6, and this has been steadily falling since 1995). Compounding the problem, only 44 percent of places are funded as high dependency care, well below the 64 percent of residents requiring high dependency care.

Not all CAP patients occupy public hospital beds. In the metropolitan area, a number of patients are located in interim residential care facilities, and others have been assisted to return home with appropriate support through the Transitional Care Pilot (TCP). Demand for public hospital beds is simply too high to allow a significant proportion of the pool of beds to continue to be occupied by CAP patients. Freeing up an additional 100 beds would go some way to relieving the pressure in our hospital system. Relocating CAP patients to interim care facilities and to supported care in the home is a step in the right direction, and these strategies should be expanded as rapidly as possible.

At the time of writing this report, some 600 older West Australians were awaiting placement in aged care facilities. Whilst awaiting placement, the State assumes financial responsibility, a prime example of the cost shifting to which the Senate Community Affairs References Committee referred in its report *Healing Our Hospitals*.

Recommendation 27

Growth in the number of Commonwealth funded aged care places must be commensurate with the changing population age structure.

As well as re-configuring arrangements for CAP patients, a number of other strategies could be beneficial with regard to older West Australians. We have begun in this State to explore sub-acute care, the step-up between primary and acute care and the step-down from acute care, but our foray into sub-acute care strategies is embryonic at this point in time. There is considerable scope for further exploration in this area, with the potential for significant gains for our hospital sector. There is considerable activity in this area in the United Kingdom, where the Committee encountered some outstanding examples of strategies that provide an alternative to hospital admissions and support more rapid discharge back to the community or residential care facility. The British Geriatric Society recently estimated that between 5 and 10 percent of emergency

admissions could be appropriately streamed into sub-acute care programs, significantly reducing the number of occupied bed days in acute hospitals[825]. In addition to sub-acute care programs, potential benefit could be gained from other strategies such as hospital outreach into nursing homes and up-skilling of nursing home staff to enable them to manage non life-threatening acute events in the nursing home.

Recommendation 28

The Committee recommends the expansion of sub-acute care strategies.

With regard to increasing demands on our hospital system from genuinely acute patients, there are two issues to consider. The first relates to our hospital system itself, and whether there is still room for efficiency gains within the system. The Committee is not in a position to act as adjudicator in this regard. It is, however, worth noting that whenever front-line staff and health leaders are presented with an opportunity to step back and examine system processes, organisational culture and clinical practice, often it is possible to develop and implement strategies, sometimes surprisingly simple strategies, which lead to improvements. The Committee encountered numerous examples during the course of the inquiry. In a system where everyone is focussed on dealing with day-to-day concerns, the opportunity to step back and reflect on the way things are done is often not available. The Western Australian Centre for Health Innovation could provide the framework whereby front-line clinicians and health leaders within the acute sector could explore new strategies for delivering acute services. Innovative strategies aimed at improving efficiencies should be one of the priority areas of the Western Australian Centre for Health Innovation.

The second issue with regard to increasing acute patient demand is understanding the factors that drive demand and predicting and planning for future demand. The recently established Acute Demand Management Unit (ADMU) goes some way to addressing this issue. It is critical that planning decisions are based on accurate and reliable information. Health innovations must also stem from a sound knowledge base, and in this respect, it is envisaged that WACHI would support information gathering, where gaps are identified in this area.

A further issue that the Committee considered worth noting is the apparent reluctance of private health fund policyholders to declare their fund membership when presenting at public hospitals. Anecdotal evidence suggests that the gap in costs between what is covered by the health fund and what is left to pay by the consumer serves as a disincentive for people to declare their private health status. There is no legal requirement that people declare their status in this regard because as Australian citizens/residents they remain fully entitled to access the public health system.

825 British Geriatric Society, *Developing Intermediate Care to Support Reform of Emergency Care Services*, June 2003, p1.

However, the Committee is of the view that the State should pursue ways of removing the disincentive for privately insured patients to utilise their health insurance in public hospitals.

Recommendation 29

The Committee recommends that the State examine ways to remove the current disincentives for patients to make use of their private health insurance when admitted to public hospitals.

(d) Curtailing health expenditure by investing wisely

In line with the rest of the world, health costs in Australia are rising rapidly in a seemingly uncontrollable spiral. Real growth in health expenditure (total growth adjusted for inflation) averaged almost 5 percent per annum in the decade to 2001-02 and there is no sign of any abatement[826]. The major determinant of growth has been an increase in the level of use of health goods and services. Pharmaceuticals (via the PBS), private hospitals (brought about by the effect of the rebate to holders of private health insurance cover) and professional services (other than medical services) have been the major cost drivers for increasing government health expenditure in the last decade. Pharmaceuticals have been the major cost driver for increasing non-government health expenditure[827]. Development and integration of new technologies, as well as rapid growth in the use of new surgical procedures have also contributed to rapid growth in health expenditure in Australia and other OECD countries[828]. These 'non-demographic' cost drivers are largely non-negotiable. In other words, there is an expectation that all Australians should have access to cutting-edge health technologies and surgical procedures and the newest, most effective pharmaceuticals. In a country that prides itself on having a first-rate health system and an average life expectancy second only to Japan, there is little room for negotiation with regard to continuing to provide the best available health care.

There are however other cost-drivers that are potentially negotiable. These are the lifestyle and biomedical characteristics that are risk factors for chronic disease.

826 Australian Institute of Health and Welfare, *Health Expenditure Australia 2001-02*, September 2003, p10.

827 *ibid*, pp20-21.

828 Organisation for Economic Cooperation and Development, Health at a Glance 2003 - OECD Countries Struggle with Rising Demand for Health Spending, http://www.oecd.org/documentprint/0,2744,en_2649_201185_16560422_1_1_1_1,00.html, accessed on 27 November 2003.

Chronic diseases are estimated to account for 80 percent of the total burden of disease in Australia and account for a considerable proportion of health expenditure[829].

Lifestyle (behavioural) risk factors, such as tobacco smoking, physical inactivity, poor diet and excessive alcohol consumption, are estimated to account for 21 percent of the total burden of disease. These behaviours are completely preventable. Biomedical risk factors, such as high blood pressure, obesity and high cholesterol, are estimated to account for a further 12 percent of the total burden of disease, and are also largely preventable[830].

The onset and progression of chronic diseases such as coronary heart disease, cerebrovascular disease, type II diabetes, chronic renal disease, various cancers, osteoarthritis and others can be delayed, if not prevented, by targeting the lifestyle and biomedical risk factors. There is considerable scope to lessen the cost burden of chronic disease, as well as improving the quality of life for many Australians, through aggressive prevention strategies.

If we are to have any success in curtailing the rapid growth in health expenditure, it is through targeting 'negotiable' or preventable expenditure through primary and secondary prevention strategies in chronic diseases. Clearly, there is recognition of the potential benefits of this approach, as evidenced by the number of prevention strategies already in place, and more recently, by the emergence of chronic disease management strategies. The level of health funding devoted to disease prevention, health maintenance and health education is still insignificant, in comparison to the funding allocated to treating these conditions once they have developed.

Around the globe, primary care systems are moving toward a more public health oriented approach to health care, by increasing emphasis on health promotion, health maintenance and education and disease prevention. The primary care sector is the most appropriate place to initiate preventive health care, although, in many ways, our primary care sector is not particularly well positioned at present to assume this role. There is a relative under-supply of GPs, particularly in areas where preventive health measures have the potential to yield the greatest long term health benefits (outer urban/low income areas). Finding the additional time to deliver health education and initiate preventive strategies would simply not be feasible for many GPs, who already have a considerable workload providing care for patients who are unwell. Indeed, a recent study published in the American Journal of Public Health concluded that physicians simply did not have enough time in the day to provide all the preventive services recommended by a US Preventive Services Task Force (USPSTF)[831]. The

829 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p5.

830 Australian Institute of Health and Welfare, *Chronic diseases and associated risk factors in Australia, 2001*, May 2002, p8.

831 KS Yarnall, KI Pollak, T Ostbye, KM Krause, JL Michener, *Primary care: is there enough time for prevention?*, American Journal of Public Health, April 2003, Vol 93: pp635-641.

researchers estimated that to fully satisfy the USPSTF recommendations, physicians would need to find an extra 7.4 hours per day.

Without a marked increase in our General Practitioner workforce, it is unlikely that we will have the capacity in our primary care sector to move toward a population health oriented model. Current funding arrangements in our primary care sector (fee-for-service) are also not conducive to a disease prevention/health maintenance oriented model of health care.

Despite the constraints of our current primary care system, there are a number of options that could be explored. Options to consider include:

- pilot public health oriented primary health care organisations in low income areas;
- expand capacity of primary care through the introduction of alternative health professionals (for example nurses) to provide disease prevention/health maintenance services;
- expand involvement of pharmacies; and
- change school curricula to incorporate a focus on disease prevention and nutrition.

Recommendation 30

The Committee recommends that, in consultation with the Divisions of General Practice, the State should invest in strategies aimed at enhancing the population health focus of the primary care sector.

There are also other strategies that could be explored to create a greater focus on disease prevention:

- Establishment of stronger links between primary care (through the Divisions of General Practice) and population health agencies;
- Expansion of the services of community based non-government agencies, such as the Cancer Foundation and Arthritis Foundation. These organisations have a level of expertise that could be more widely utilised. It is imperative, however, that they receive adequate funding to fulfil their role;
- Training of all health professionals should include a greater emphasis on disease prevention and health promotion, such that in every encounter with the health system, patients are bombarded with messages that reinforce a population health approach to health care;

- Expansion of the public health workforce;
- The introduction of daily physical activity sessions in primary schools to increase the level of physical activity. In addition to physical education, a 30-minute exercise session each day could become a core part of the curriculum;
- Facilitating the promotion and implementation of physical activity programs in workplaces; and
- The provision of a free piece of fruit each school day for all primary school children to improve their diets. A similar scheme was proposed in the United Kingdom NHS Plan in 2000[832].

Early intervention is the key to successful implementation of preventive strategies. School children are an ideal target for nutrition and physical activity programs. The potential long term-benefits of early exposure to healthy lifestyle habits are enormous.

Recommendation 31

The Committee recommends the State make a greater commitment to population health strategies aimed at reducing the prevalence of risk factors associated with chronic disease. Strategies that should be considered include:

- realignment of health professional training to include a greater population health focus;
- supported expansion of community based non-government agencies; and
- promotion and implementation of preventive strategies at schools.

(e) Getting the most from primary care

In comparison to other countries that have recently embarked on fundamental reform of their primary care systems, reform in Australia is largely confined to fine-tuning of the existing system. There is no disputing the enormous financial investment in the plethora of strategies aimed at improving access to care, improving coordination with other sectors, improving access to allied health professionals and increasing emphasis on disease prevention and health promotion. But these strategies have had variable success, and overall have failed to initiate any fundamental shift in the way that primary health care is delivered.

Our primary care sector is characterised by:

832 Secretary of State for Health, *The NHS Plan, A plan for investment, A plan for reform*, July 2000, p110.

- A shortage of GPs, particularly in rural/remote and outer urban areas, where health needs are greatest;
- Declining affordability as a result of declining rates of bulk-billing and increasing co-payments;
- Limited access to after hours care;
- Difficulty attracting medical graduates into training programs, due, at least in part, to lower remuneration and to a perception of lower status than other medical specialties;
- Fee-for-service funding arrangements that encourage high turnover, episodic care; and
- Limited scope for inclusion of non-medical health professionals as a result of funding arrangements.

Whilst our primary care system compares relatively well with other OECD countries, a number of features threaten the strength of our primary care sector [833]. As a consequence, the overall performance of our health system is placed at risk.

Although primary care falls within Commonwealth jurisdiction, the performance of the sector has significant repercussions for the way in which the health professionals in our public system work and interact. The Committee is of the view that it is in the best interests of the people of Western Australia that the sector works effectively and interacts optimally with other sectors.

Lack of coordination between primary care and other sectors prevents health professionals from interacting in the most efficient manner, through duplication of services and resources and lack of integration of patient care. Failure of primary care to provide accessible, affordable services increases pressure on the acute sector, where patients are forced to seek care. In the long term, conditions that are not adequately managed in primary care must eventually be dealt with in the acute sector, again increasing pressure on staff working in this sector.

As discussed in section 7.2 (c), in exploring avenues to strengthen primary care in Western Australia, the State need not be constrained by a fee-for-service, almost exclusively GP-delivered, medical model of care.

There simply are not enough GPs available to underpin a fundamental shift of primary care toward a public health model. The move toward such a model would require

833 Including poor coordination with other parts of the health system, lack of community orientation, lack of longitudinality of patient care (rostering), inequitable distribution of primary care resources and increasing rates of co-payment.

considerable expansion of existing capacity, and provides the ideal opportunity to introduce other health professionals into the sector. It is arguably inappropriate for GPs, with their high level of expertise, to devote a considerable proportion of their time to health promotion/education, disease prevention and chronic disease management activities. Many of these activities could be largely delegated to other health professionals, leaving GPs free to focus on assessing and treating more complex patients, or to become involved in areas of special interests (as is being encouraged in the United Kingdom to relieve pressure on the acute system).

Further to the shortage of GPs, there is a high level of dissatisfaction within the GP workforce, suggesting the climate may be conducive to change, including a move away from the traditional fee-for-service model. In Canada, there is evidence to suggest that new graduates are increasingly attracted to stable, salaried family practice opportunities, as opposed to following the traditional path of the 'entrepreneurial' family physician.

The final dimension to this issue, is recognition of the importance of primary care. Traditionally, our health system has been dominated by the acute sector. General Practice has been regarded within the medical profession as less 'glamorous', less challenging and of a lesser status than specialist care. If we are to make significant inroads into lessening the burden of chronic disease, eliminating health inequalities that are associated with underlying social disadvantage and marginalisation, and achieving the best possible health outcomes for all West Australians, it is the primary care sector that must lead the way.

Recommendation 32

In consultation with the Divisions of General Practice and the Consultative Group on Curriculum Development and Health Workforce Planning, the State must work toward increasing the capacity of the primary care sector and re-aligning the health system toward a greater primary care focus. Given the current shortfall of General Practitioners, consideration should be given to expanding the capacity of primary care through the introduction of other health professionals, whose primary role would be disease prevention, health promotion and education.

(f) Meeting the health needs of an ageing population

People aged 65 and over use a disproportionately high share of health services. Although comprising only 12 percent of the population, people aged 65 and over accounted for one in four primary care encounters and one in three hospital encounters in 2001-02.

Many encounters by older Australians with the health system relate to chronic diseases, many of which can be prevented or delayed through lifestyle changes. In 2001-02, eighty percent of GP encounters related to chronic conditions, most

commonly hypertension, osteoarthritis and diabetes. Antihypertensives were the most commonly prescribed medication, being prescribed by GPs at a rate of 17 per 100 encounters. The most common diagnoses for admission to hospital were cardiovascular disease and cancers, which together accounted for one in four admissions.

The disproportionate use of health services by older Australians, coupled with the ageing of our population, has important implications for health workforce planning, health professional training, and provision of appropriate health services.

In the next two decades, population ageing will precipitate a substantial increase in demand for hospital and medical services. Based on Australian Bureau of Statistics population estimates, people aged 65 and over will represent 21 percent of the population by 2031. Derived by current rates of health service utilisation and predicted population growth and ageing, demand for hospital and GP services would be expected to increase by around 50 and 20 percent respectively. Based on current health workforce policy settings, Western Australia is likely to fall a long way short of meeting demand for health services. Ageing of the health workforce, increasing propensity to work shorter hours and feminisation of the medical workforce will likely exacerbate any shortfall. It is now that we need to plan for future health workforce requirements and begin to train more health professionals to meet future demands.

Recommendation 33

The State must evaluate the impact of the ageing population on future health service utilisation and develop strategies to ensure that our health system has both the capacity to meet the level of demand and the configuration to provide appropriate services. Health services will need to have greater emphasis on chronic disease management, rehabilitation and sub-acute care.

As well as training more health professionals to meet the needs of our ageing population, we need to consider the appropriate skill-mix of health professionals in our health workforce in future years. People aged 65 and over will account for an increasingly higher proportion of encounters with the health system over the next two decades. If rates of health service utilisation in 2031 are similar to current rates, seven out of twenty GP encounters and five out of eight hospital inpatient days can be expected to involve people aged 65 and over. The types of services older people require often differ from the services required by younger people. A significant proportion of older people suffer from one or more chronic diseases, and as the population ages, health professionals will increasingly be involved in preventing and managing chronic diseases. Older people take longer to recover from acute illnesses and injuries, therefore rehabilitation and supported return to functional independence will become increasingly important features of our health system. Older people are the most likely to benefit from sub-acute care programs, so effective sub-acute care strategies will become increasingly important in the coming years. Allied health

professionals would be expected to play an increasingly important role in health service delivery in an ageing population.

Recommendation 34

In collaboration with the Consultative Group on Curriculum Development and Health Workforce Planning, the State must plan a future health workforce with the appropriate skill mix to deliver health services for an ageing population.

Given the increasing likelihood of encountering older people in the health system, it is imperative that training of all health professionals contains sufficient emphasis on care for older people. Effective communication skills are important when dealing with all patients, but perhaps more so for older patients, whose involvement with the health system can often be protracted and/or recurring and who will often have to come to terms with life-changing conditions. In a system that is under considerable pressure, it is not surprising to find that many health professionals do not believe they have sufficient time to deal with anything other than the patient's immediate physical needs. But, perhaps more so than ever before, a patient's psycho-social and spiritual needs will need to be considered alongside their medical needs, and a nurturing, caring bedside manner will be essential. Our health workforce planning must consider ways in which patients' non-medical needs can also be met.

Recommendation 35

Health professional training must contain sufficient emphasis on care for older patients, as older people account for an increasing share of encounters with the health system. Particular attention should be paid to communication skills and caring for psycho-social needs.

The Committee encountered several comments in submissions and evidence relating to declining skill levels and difficulties with recruitment and retention in the aged care workforce. A shortage of specialist aged care clinicians and a continuing decrease in the number of registered and enrolled nurses has resulted in an increasing reliance on untrained workers in the aged care health sector.

A related issue is the disparity in wages between aged care and other fields of nursing. Section 5.4 of this report found that in 2001 there was an 11.3 percent wage disparity between aged care and general nurses. The wage disparity, combined with limited career prospects, heavy workloads and the poor professional image associated with aged care nursing has resulted in a serious loss of qualified nurses in this area. As discussed earlier, the number of nurses working in the aged care sector decreased by 14 percent between 1995 and 2001.

Recommendation 36

The Committee recommends that the State Government develop comprehensive strategies to address the declining skill levels and high rate of attrition of qualified health professionals in the aged care sector.

8.5 Adequacy of career structures

(a) Balancing clinical and administrative roles

Perhaps the single greatest concern of health professionals with regard to career structure, was the inability to progress to senior levels without assuming a predominantly administrative/management role. As a result, some of the best and brightest clinicians are lost to management/administration, a situation that many professions find inappropriate and unacceptable, as the depth of clinical experience these health professionals have attained is simply wasted. It is inconceivable that the skills and expertise of some the best and brightest clinicians should be diverted into management/administration. It is a great loss to the system, in that inexperienced health professionals do not have the opportunity to train under their guidance, and for the clinicians themselves, they may not have the opportunity to realise their full clinical potential. There was broad support for a career structure whereby senior clinicians could continue to progress along a clinical stream, making full use of their extensive clinical expertise, without the necessity to switch to a management role.

Recommendation 37

The Department of Health should examine options to enable experienced health professionals to pursue career advancement without being diverted from clinical practice into management/administration. Consideration should be given to establishing dual career pathways, whereby health professionals have the option to become advanced clinical practitioners or administrators.

A corollary to the loss of clinical expertise to management, is that clinicians who have spent a number of years developing clinical expertise are not necessarily equipped with good management/administration skills. There was also support for management training for those clinicians who chose to assume management roles.

Recommendation 38

Health professionals who assume management positions should be required to complete management training programs.

(b) Recognising skills and experience

Another significant concern that was expressed by a number of professional groups is that there simply isn't a 'career pathway'. In most allied health professions, for example, only one level of clinical advancement is possible. Experienced clinicians are therefore tempted to progress to management roles or to leave the public health system, in favour of the private sector. Once again the public health system is losing valuable clinical skills, because of its inability to provide an adequate clinical career structure.

As well as limited reward for differential levels of skill and experience, there is little prospect of financial reward or career advancement for most health professionals who undertake post-graduate or specialist training.

Recommendation 39

In view of the need to retain skilled allied health professionals within the public health system, the Committee recommends expanded clinical career pathways be developed as a priority.