EDUCATION AND HEALTH STANDING COMMITTEE

INVEST NOW OR PAY LATER: SECURING THE FUTURE OF WESTERN AUSTRALIA'S CHILDREN

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Education and Health Standing Committee

Invest Now or Pay Later: Securing the Future of Western Australia's Children

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INVEST NOW OR PAY LATER: SECURING THE FUTURE OF WESTERN AUSTRALIA'S CHILDREN

Report No. 5

Presented by:
Dr J.M. Woollard, MLA
Laid on the Table of the Legislative Assembly
on 11 March 2010

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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. The annual report 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

That the Committee review Western Australia's current and future hospital and community health care services to determine whether population needs are taken into account in assessing, planning, implementing and evaluating those services with particular reference to:

(a) monitoring the compliance with and any departure from the Reid Report and the Clinical Services Framework 2005-15;

(b) identifying any outstanding needs and gaps in health care services; and

(c) considering the ramifications of the Royal Perth Hospital Protection Bill 2008.

The Committee will report its recommendations to the Legislative Assembly by 6 May 2010.

CHAIRMAN'S FOREWORD

I am hopeful that this report will act as a catalyst to the Government to stop the neglect of children's health in their early years. Many Western Australian mothers and fathers who have children in need of therapy are currently suffering because they know that for every week that help is delayed, their children will require months of additional therapy support.

This report could have been titled 'Abandoned by the State: Children's Health Care Services in WA'. Instead, knowing that every dollar invested in children's health and education in the early years will both improve their's and their families' quality of life, and save the Government millions of dollars in the future, this Report has been titled *Invest Now or Pay Later: Securing the Future of Western Australia's Children*.

Ten months ago I presented on behalf of the Education and Health Standing Committee a report on child health screening programs. That report recommended the Government address the lack of funding for community child health services. The *Healthy Child- Healthy State: Improving Western Australia's Child Health Screening Programs* report documented 366 FTE staff shortages in community child health services. Those shortages were the result of decades of funding oversight. The failure to fund those services would have resulted in tens of thousands of children in WA being abandoned by the State because of governments who have failed to listen and act.

In January 2010 there were 6,405 children in the metropolitan area waiting for child development services and waiting times are getting progressively worse.

A business plan was prepared for the Government in 2008 to address the 366 FTE shortages. With the subsequent increase in population and the additional time children will need in therapy due to the extended waiting lists, there could well be a shortage of 400 FTE required now in 2010 to treat children in need. I am hopeful that this Report will assist the Minister for Health to argue and gain funds for child health in the forthcoming 2010-2011 State Budget.

Many of the children who were not given the support as they were growing up are now young adults who may never reach their full potential.

Health care services are meant to support everyone. Unfortunately many children fall behind because they cannot hear fully, or see clearly, or talk normally, or walk correctly, or co-ordinate the control of their body, or they have eating disorders, or behavioural disorders that prevent them from being able to relate to other children when they are young and as they get older.

Parents of these children in need often avoid publicising the fact that their child needs help because they do not want their children to be further isolated from society. When a child needs help this puts a great strain on the parents, other children in the family and other extended members of the family.

The Western Australian Government is made up of men and women who have families of their own and yet we as politicians have failed to ensure that a large number of the most vulnerable

members of our community, our children who cannot speak for themselves, are able to enjoy their childhood and grow into healthy young adults.

The Health Department and the Minister for Health have described community health nurses, school nurses and child development staff as front line services, and said that budget cuts will not affect front line services. This Report shows these while these statements are well intentioned they do not reflect reality.

The Department of Health have admitted they have achieved budgetary savings in the community child health services by not backfilling front line positions when staff are on annual leave, maternity leave or reduced work hours. In 2009, 22 positions were not backfilled for varying amounts of time, from two weeks up to 12 months. We were also informed that 12 FTE front line positions created to deal with the transition to a single child development service and to decrease waiting lists, were also not renewed even though waiting lists have grown.

By the Department's own admission, budget cuts have had an impact on front line services resulting in increased waiting times and loss of continuity of care, amongst other things.

Conflicting information has been provided regarding recent cuts to community child health services. In September 2009, the Minister for Health indicated that there had been an increase of $900,000 on the community child health budget between 2008-09 and 2009-10. This week, the Minister indicated that in fact there has been an increase of more than $1.5 million for the same period of time. This information conflicts with evidence provided to the Committee by the Department of Health in February 2010 in which it stated that community child health had already achieved savings of $560,000 and reductions of approximately five FTE in 2008-09, with projected savings of $1.75 million and a further reduction of 22.5 FTE for the whole of 2009-10.

While community child health services are being cut, the Government has increased its investment in the acute sector through the new children's hospital and additional staffing for Princess Margaret Hospital (PMH). While the increased investment in PMH is commendable, it is now time to invest in community health services so that children do not end up in our hospitals.

The Committee heard of the terrible strain on the whole family when a child needs support. Currently the support is not accessible for many families unless they can afford to pay for the services. Private child health services are not cheap, so families go without to try and make ends meet while ensuring their child receives the therapy they require. Chapter Two of this Report details some of the stories of parents who have children in need. I am sure I am not the only member of the Committee whose admiration grew for the strength and determination of these parents who have to deal with a multitude of difficulties to enable their child and their family to survive on a day to day basis.

In addition, this Report highlights the fact that Indigenous children in Western Australia are more disadvantaged than Indigenous children in other states. More are born with low birth weight, less of these children are immunized, many perform below national standards at school in grade 5 literacy and numeracy tests, there are more deaths, and more teenage births.

The lack of funding for community child health services has been compounded by the fact that this State has had a large growth in population and that the Government has not quarantined money for community child health.

Birth rates have increased from 24,644 in 2002 to 31,068 in 2009. Notifications of births sent to child health nurse have increased from a rate of 149 per FTE in 2002, to 167 in 2006 and 230 in 2009. Birth rates have increased by thousands yet there has been no comparable increase in child health nurses to enable them to support families.

The increase in population has led to more children requiring child health services and children having to wait longer periods before they can see a child health nurse. The Department of Health accepted that these delays can result in missed opportunities to identify and respond to problems in a child's development.

The government of the day is meant to ensure it responds to community needs. People often say that funding is only allocated to the 'squeaky wheel', rather than areas where the need is greatest. One way of ensuring that early childhood health and education are no longer neglected would be for the Government to create a new Minister for Early Childhood. This approach has been adopted by other state governments who have given a firm commitment to no longer play lip service to the care of children.

Whenever the Government talks about 'waiting lists' - they are talking about adult elective surgery waiting lists. Because ambulance ramping can be seen, these waiting lists often get front page coverage in the newspaper. Waiting lists for community child health services are not publicly available. Parents are reluctant to have their child further isolated by media attention. This lack of accountability has led to many children and their families being abandoned by health care services.

The time has come for the Government to present a report card to the community on the State's child health services waiting lists. The Government should report on the funding and provision of child health services. Report cards are being used nationally and internationally by government and non-government organizations to ensure child health is not neglected.

Regular annual reports should be given on waiting lists for each of the professional groups a child may need to see to enable them to develop normally. These waiting list data should include speech pathology (current waiting times 16 months), occupational therapy (current waiting times 13 months), paediatrics (current waiting time 10 months), physiotherapy (current waiting time 11 months), clinical psychology (current waiting times nine months), social work (current waiting time five months), as well as unacceptable shortages in school and community health nurses.

An annual child health report card should provide an account of progress in staffing and service delivery; should provide information to explain where there are shortfalls in service delivery; and should explain how the government is going to improve these service the following year.

It is all very well for members of Parliament to pay lip service to the current needs of children and to criticize the funding shortfalls of the past – but the time to act is now. Not in 2012 as a future election promise. We provide evidence in this Report that waiting lists have grown. We have the

evidence that many children and adults are admitted to hospitals for conditions that could have been avoided if there were adequate child health services in the community. These avoidable hospital admissions could be costing the State's health service up to $60.6 million per year.

The Minister for Health has repeatedly acknowledged that community child health services are under-resourced. Health is a big portfolio. Many, including me, have congratulated the Government on appointing a Minister for Mental Health to address the neglect of people with a mental illness. Child health has also been neglected. I urge the Government to appoint, a Minister for Early Childhood. This person would be responsible for not only bringing this State up to national standards, but to see Western Australia become the leader in the provision of early childhood services.

It is indeed a privilege to chair the Education and Health Standing Committee. I thank the Members of the Committee for their enthusiasm and commitment to identifying vital areas for reform. I again thank our dedicated and professional research officers. Our Principal Research Officer, Dr David Worth, and Research Officer, Mr Tim Hughes- the assistance, advice and guidance given by both these staff are highly valued by the Committee.

I would like to thank the Minister for Heath for his ongoing support to the Committee. I know that as a former member of this Committee he is aware that it relies predominantly on him to argue for the adoption of the recommendations in this Report which have budgetary implications.

I would like to thank the dedicated staff in Child and Adolescent Community Health. These people even though they are understaffed are able to provide so much support to families in need. Finally, I ask the Government to ensure that children in Western Australia are no longer 'Abandoned by the State'.

We must invest now to secure a brighter future for WA children in need.

Janet Woollard

DR J.M. WOOLLARD, MLA
CHAIRMAN

ABBREVIATIONS AND ACRONYMS

ABS	Australian Bureau of Statistics
AEDI	Australian Early Development Index
AHMC	Australian Health Ministers Council
AIHW	Australian Institute of Health and Welfare
ARACY	Australian Research Alliance for Children and Youth
CACH	Child and Adolescent Community Health
CAHS	Child and Adolescent Health Service
CALD	culturally and linguistically diverse
CCYP	Commissioner for Children and Young People
CDIS	Child Development Information System
CDJSC	Community Development and Justice Standing Committee
CDS	Child Development Service
CDSMC	Community and Disability Services Ministers' Conference
CHN	Community Child Health Nurse (also knows as Child Health Nurse)
COAG	Council of Australian Governments
CSF 2005	Clinical Services Framework 2005-2015
CSF 2010	Clinical Services Framework 2010-2020
DOH	Department of Health (Western Australia)
DTP	diphtheria, tetanus, and pertussis vaccine
EHSC	Education and Health Standing Committee
FTE	full time equivalent
GDP	gross domestic product
Hib	Haemophilus influenza type B vaccine
HRC	Health Reform Committee
HRIT	Health Reform Implementation Taskforce

NAPLAN	National Assessment Program – Literacy and Numeracy
NHMRC	National Health and Medical Research Council
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
PMH	Princess Margaret Hospital
SA	South Australia
SHN	School Health Nurse
UK	United Kingdom
UNICEF	United Nations Children's Fund
VIC	Victoria

GLOSSARY

Audiologist: an expert in hearing, balance and related disorders, specialising in the evaluation, treatment and prevention of hearing impairment. An audiologist uses tests to determine hearing function and to diagnose any hearing problems. An audiologist can help children with speech and communication problems and hearing rehabilitation.[1]

Dietician: provides advice on food and nutrition that meets an individual's health and lifestyle needs. They can help manage and prevent diet-related diseases (such as diabetes,), and assist with the social and psychological factors affecting eating habits. They offer healthy eating strategies to prevent or manage overweight and obesity issues. They can also create realistic eating plans for those with special needs (including food allergies or intolerances).

Occupational therapist: helps people overcome limitations caused by a range of issues including developmental delay. In their work with children, they particularly help those with fine motor and eye-hand coordination problems. Their work is focused on children whose participation in everyday life is limited in some way, and their goal is to help them learn independent living skills.

Paediatrician: a doctor who specialises in the medical care of babies, children and adolescents. They are also experts in how babies, children and teenagers grow and develop. They have a broad perspective on children's health, welfare and education throughout the developing years.

Physiotherapist: assesses, diagnoses and treats movement problems, cardio-respiratory and neurological disorders, and pain caused by joint, muscle and nerve ailments. Children with developmental disability, can benefit greatly from physiotherapy. Physiotherapists help people to move and be physically independent and give them information about ways to stay healthy.

Podiatrist: a physician that specializes in the diagnosis and treatment of diseases affecting the foot, ankle and related structures of the leg.

Psychologist: deals with how people think and behave. Most psychologists work directly with people to help them find better ways of coping or managing parts of their lives. Psychologists help children with learning difficulties and also help parents to manage difficult behaviour. For example, a developmental psychologist might help a child with developing social skills.

Social worker: helps people find their way through the system of health and welfare services. They provide counselling and work with individuals, families, and groups.

Speech pathologist: assesses and treats people who have communication problems or disorders. Speech pathologists are experts in speech, writing, reading, signs, symbols and gestures.

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[1] Edited from the Raising Children Network. Available at http://raisingchildren.net.au/a_z_disability.aspx?letter=P. Accessed on 3 March 2010; and Medicine Net. Available at www.medterms.com/script/main/hp.asp. Accessed on 3 March 2010.

EXECUTIVE SUMMARY

This is an interim Report of the Education and Health Standing Committee's *Review of WA's Current and Future Hospital and Community Health Care Services*. This Report has been tabled because the Committee has gathered disturbing data showing that the performance of the State's community child health services has deteriorated since the publication of the Committee's *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs* report in May 2009. This earlier report painted a bleak picture of long waiting times and large numbers of children unable to access key government health services. The new Health Minister, Dr Kim Hames, concurred with the dramatic findings in the Committee's report:

> *… I agree with the member, and with the comments in the Committee report, that there are significant shortages across the system. I will highlight some of those shortages. I think these figures are actually in the report. For school nurses, we are 135 full time equivalents short; for child health nurses we are 105 FTEs short; and for Aboriginal health workers we are about 23 FTEs short.*

Governments from both sides of politics have not addressed these service shortfalls. As the Director General of Health reported to Parliament in 2009:

> *No additional funding has been applied to this area … certainly for the last four years. … Outside CPI increase, there has been no additional funding. The problem has been that Western Australia has had a substantial population growth, in both people coming to the state and birth rates. The pressure on us is that if we do not address this issue, there will be subsequent downstream effects when these children reach adulthood with greater cost then to the community.*

The Government is requiring the Department of Health (DOH) to find $607 million in savings over the period 2008-13. The Acting Director General of Health reported to the Committee that the application of the 3% efficiency dividend to community child health services in the current year had led to:

- *Increased waiting times;*
- *Increased numbers waiting for assessment, thus delayed assessment appointments;*
- *Immediate cessation of treatment/therapy/intervention plan – including cancellation of therapy groups where parents were already notified, cancellation of review appointments, further delays that* [sic] *initially reported;*
- *As many contracts were declined with short notice, parents and families often had to deal with sudden cancellation of appointments – thus an increase in complaints to the service; and*
- *Many clients had developed relationships with the child's therapist, when their contracts were declined, thus loss of continuity of care.*

As at January 2010 there were a total of 6,405 children in the metropolitan area waiting for services. Generally there is an influx of referrals at the beginning of the school year, so it is reasonable to assume that number of children waiting for these services has increased further since January. This increasing number of children on waiting lists, and the growing delays they face, is not attributable to a significant spike in children with these health conditions. Rather it is a function of reduced resourcing within the Child and Adolescent Community Health service.

The Committee acknowledges that there have been recent changes to the way DOH waitlists are managed and that the data provided from the past may not be directly comparable. However, the figures provided to the Committee indicate that there has been a significant increase in waiting times over the past 15 months. For example, speech pathology waiting times have increased by 10% in just the past three months, and seem to have doubled since October 2008.

Table ES.1- Changes in waiting times for child development services, 2008-09

Discipline	Waiting time between referral and assessment (months)			
	October 2008[2]	September 2009	December 2009	Change 2008-2009
Speech pathology	8	15	16.6	**+108%**
Occupational therapy	8	11	13	**+62%**
Paediatrics	9	9	10	**+11%**
Physiotherapy	6	10	11	**+83%**
Clinical psychology	6	9	9	**+50%**
Social work	4	4	5	**+25%**

The Department of Health told the Committee that there was limited value in comparing the averages from 2008 with those produced by the CDIS in 2009 as "Data was not collected consistently across child development services prior to 2009 and is therefore not considered as reliable, for comparison purposes." However, previous waiting time data from 2004 and 2005 provided to Parliament by DOH for the South Metropolitan Health Service and the North Metropolitan Health Service are less than, or similar to, the average for 2008 - another indicator that waiting times have dramatically increased.

Chapter One of this Report provides the background to the conduct of the Inquiry and the way in which data on community child health services was collected. Chapter Two outlines the need for further investment by the Government based on the current situation in Western Australia, particularly in regard to areas in which the health and development of the State's children lags behind those in other parts of Australia, and other developed nations.

[2] On average children also waited an additional three months between assessment and treatment so the total waiting time was significantly higher than these figures.

The parents' story- "a treasure hunt with no map"

While preparing this interim Report the Committee was privileged to receive oral evidence from three women regarding their experiences of community child health services. All three mothers have children with complex developmental issues and painted a powerful picture of hope and optimism when their children were able to access the therapy they require; juxtaposed with despair and frustration as they struggle to cope with the personal and financial pressures imposed on them by an under-resourced community health system. To them, suffering families were on a "treasure hunt with no map" as they tried to negotiate a complex health system. The women spoke passionately about the benefits of early intervention and have all observed significant improvements in their children following therapy and treatment.

> *His language is improving out of sight. He could not speak. After two months of weekly therapy, he is putting two to three words together.*

As part of a previous inquiry, this Committee received evidence that the Department of Health's Child Development Service has adopted a range of waitlist management strategies in response to increasing demand. Strategies include offering an initial block of five or six therapy sessions and then placing the child at the bottom of the waitlist again. A mother described her frustration with the lack of continuity of care which results in 'two steps forward, one step back':

> *We get back to the OT* [occupational therapist] *after five and a half months and we probably only get really two weeks' benefit out of it because we are retracing old steps again. … Yes, it peaks and troughs. Hip, hip hurray when we get out of there after a six-week session because he can do this and this is fantastic, and, yet, in three months' time, or when it rolls over again to start again, we are back at square one. … It is not fair on the children, it is not fair on the school, it is not fair on the parents; it is not fair on anyone.*

When faced with the reality of extremely long waiting lists in the public system, two of the women decided to use private services. As one mother put it:

> *We went private because we could not afford to wait. They basically said that he needs weekly therapy for speech, so when I called Southwell in February 2009, the wait list was 12 months. She told us, "You cannot wait." He is at the critical age of two to three, when the neurological pathways can be changed; they are not set. They can actually change those pathways and help them speak if they get early intervention between the ages of two and three, not five and six. … She also said that if we waited, even 12 months at that stage, he would have severe developmental issues and we would require much more intensive therapy and it would cost us even more.*

Another mother said:

> *He is our son; we would sell everything before we would affect him. But some people get to the point where they cannot cut the groceries or the utilities or the stuff any more, and it is very distressing.*

For one of the mothers, accessing private services simply was not an option:

> *If I had the money, I could go and do it privately, but I cannot. … I cannot afford private in any way, shape or form. There would be hundreds, if not thousands, of people in my predicament.*

The women also relayed stories of social isolation and children who are not able to participate in simple every-day activities that most families take for granted:

> *… that means that a child cannot visit friends, no-one wants us over there, no babysitters and no day care.*

> *Even your best friend and even your family do not want to have you around when your child is such a burden on everybody.*

The stories of how the situation had impacted on the women's own health, and that of the rest of their family, were equally moving:

> *There is a lot of pressure on families. We have been through counselling. We have been together for 19 years but I do not know whether we can make it. That is very common.*

A mother told the Committee that her child's health issues had impacted on her:

> *I have had my own health issues, as most mums do when they have a child with a lot of problems. I have had to go on antidepressants. I have had to be hospitalised—exactly the same thing. … that has a huge impact that you cannot allow; you cannot afford for that to happen. We are kind of burning the candle at both ends, I guess. It is just something that we do for our children.*

These mothers will do anything in their power to ensure their children get the support they need, but it comes at an enormous cost to them and their families and all of the women spoke about feeling let down by the system:

> *… we are denying them the right to be the potentially wonderful people that they can be. … Our kids are so resilient and they never give up. It seems like it is the government that is giving up on them.*

The need to invest

Early childhood experiences have a profound and lifelong impact on a range of health, social, emotional, educational and employment outcomes. Early identification and management of developmental and behavioural problems is associated with better health outcomes and improved school performance, along with a reduction in teenage pregnancy, welfare dependency, and crime. A recent study found that children who do not reach key developmental milestones at just nine months old are far more likely to struggle at school. The *Millennium Cohort Study* found that babies who were slow to develop their motor skills at nine months were much more likely to be identified as behind in their cognitive development. The economic benefits of early intervention are substantial with reported returns on investment of up to $17 for every dollar spent.

The benefits of early intervention have also been expressed in terms of avoidable hospital admissions and reduced hospital bed-days. In 2001-02, 8.7% of all hospital admissions in Australia were avoidable (about 552,000 admissions). Western Australia reflected the national average figure, which equated to 55,102 avoidable admissions each year. These avoidable admissions may be costing the State up to $60.6 million per year.

The response in Western Australia

In 2003, the Health Reform Committee was appointed to *develop a vision for the Western Australian Health System while ensuring that the growth of the health budget was sustainable*. Subsequently, the Reid Report found that a fundamental reprioritisation of the health system was required and outlined a 10-year plan for reform with a total of 86 recommendations. The report has subsequently received bipartisan support (with the exception of 2 recommendations) and has had a major influence on Western Australia's health policy in recent years. Investment in prevention and early intervention were seen as key elements of the reform process:

> *Good health and well being in the early years of life provides a solid basis for maintaining good health throughout adulthood. Investment in child, maternal and adolescent health is therefore an important component of reducing the burden of disease in the future.*

The Education and Health Standing Committee's report *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, was tabled in Parliament in May 2009 and found:

> *There is an urgent priority for the Western Australian government to increase the number of school and child health nurses, especially for metropolitan primary schools.*

This Report also made a number of specific recommendations regarding the need to invest in community child health services:

> *Recommendation 10. As an urgent priority, the Government should increase the number of school nurses employed in the school health system and approve the proposed business case for additional school and child health nurses to be employed within the Department of Health's Child Development Services.*
>
> *Recommendation 25. That the Government give a high priority to provide additional staff and other resources to address the current inadequacies in Western Australia's speech and language services.*
>
> *Recommendation 34. The number of school health nurses, community child health nurses and allied health professionals employed within Western Australia's child health services should be urgently increased as per the business cases developed by the Department of Health. The new staff required are: 126 full-time-equivalent (FTE) in the Child Development Services, 105 FTE Community Child Health Nurses and 135 FTE for school nurses.*

The Government tabled its response in September 2009 indicating support for 34 out of the Report's 37 recommendations. All of the recommendations regarding the need for additional investment in community child health services were fully supported by the Government. In

relation to the need for additional staff, the government acknowledged the gaps in services and capacity issues and indicated that "these matters are subject to government consideration and will be considered in the budget process". In subsequent parliamentary debates the Health Minister, Dr Hames, expressed support for the need for additional resources:

> *I agree with the member that there is a major deficiency in the services that are being provided in this area* [child development services]. *The situation may well be getting worse, because the funding is the same, yet the demand is growing. I am determined that over the next three years of our time in government … we will address this issue. … It is an issue that I take very seriously. In fact, just last week I mentioned to all our senior health staff that not only is this an issue that is a major challenge for our government, but also this is an issue on which I believe we should be judged. … My job now as the minister … and the member's committee having tabled a report that proves that there is indeed a severe deficiency in the provision of these services, is to fix that deficiency.*

Investment in children

Australia's investment in young children is one of the lowest of all countries in the Organisation for Economic Cooperation and Development (OECD), with expenditure in 2005 of 0.1% of GDP on pre-primary educational services. This is well short of UNICEF's benchmark of 1.0% of GDP, and significantly lower than the UK's current expenditure, which is estimated to be 1.2% of GDP. According to UNICEF, Australia currently ranks 23rd out of 25 countries in meeting minimum standard benchmarks for childhood services. The UNICEF report card on child health is based on a range of indicators, including 1.0% of GDP being spent on early childhood services and universal provision of essential child health services. According to the Department of Health, Western Australia's expenditure on all prevention programs accounts for 2.6% of the total healthcare budget. This is also significantly lower than other comparable OECD countries.

Indigenous children

The appalling state of Indigenous health has been the subject of numerous reports and inquiries and has been identified as a priority by all Australian jurisdictions. As is the case for the general population, poor health outcomes for Indigenous people are often the result of early childhood experiences. Australian Early Development Index (AEDI) results indicate that a greater proportion of Indigenous children are vulnerable on all developmental domains. A total of 47.3% were vulnerable on one or more domains and 29.5% were vulnerable on two or more domains. Performance in the language and cognitive skills domain is particularly alarming, with 28.6% of Indigenous children being vulnerable, and a total of 51.9% being either vulnerable or at risk.

In some instances, Western Australia's indicators of Indigenous child health are worse than the national rates, placing the State's Indigenous children at even greater disadvantage:

- The percentage of Western Australian Indigenous children born of low birth weight is higher (16.2%) than the national average (12.5%).
- Western Australia's rate of Indigenous teenage births per 1,000 (114) is far higher than the national rate (79.6).

- Western Australia's immunisation coverage for Indigenous two year olds (85.7%) is lower than the national rate (90.7%).
- Fewer Western Australia's Indigenous children achieved grade 5 literacy and numeracy standards: 51.8% of Indigenous Western Australians performed at or above the minimum standard for literacy compared to 63.4% nationally; and 61.6% of Indigenous grade 5 children performed at or above the minimum standard for numeracy compared to 69.2% nationally.
- Western Australia's rate of Indigenous deaths from injury per 100,000 is higher (24.8) compared to the national rate (21.4).

The Department of Health agrees that more needs to be urgently done for Indigenous children:

> *… we would need to spend around 40% to 70% more on health care for Indigenous children compared with non-Indigenous children in order to reflect the discrepancies in health and wellbeing and address Indigenous health disadvantage. Currently though, health care expenditure for Aboriginal and Torres Strait Islander peoples is only 18% higher than for other Australians and at this level of funding we have not been able to reduce the disparity in health status.*

Gaps in community child health services - population growth

In Western Australia, the annual number of births increased by 21.3% over the period 2002-07. There has also been a reported annual increase of 5% in the 0-4 year old population since 2005. This growth is predicted to continue with the projected population of 0-8 year olds in Western Australia estimated to reach around 250,000 by 2011. In the absence of additional resources, this population growth has resulted in a significant increase in the ratio of birth notifications per child health nurse FTE: from 149 in 2002 to 167 in 2006 and this has reportedly increased to 230 in 2009. As noted by the Department, population growth has an immediate impact on all areas of community child health services:

> *As a result of this, families with older children (1-3 years) have longer waiting periods before they can access the child health nurse, as families with newborn babies are a priority. This may result in missed opportunities to identify and respond to parental concerns about their child's development at critical developmental ages.*

The impact of the 3% efficiency dividend

As part of the 2009-10 State Budget, the Department of Health committed to savings of $126 million as part of the 3% efficiency dividend, $51 million of which was attributed to "FTE efficiencies". There have been repeated commitments from both the Minister for Health and the Director General of the department that these efficiencies would not affect 'front line services':

> *We know that there will not be any reductions in front-line services. In fact, I will not let there be any reductions in front-line services. … I have told those senior managers that that is not how they should reduce their costs.*

> *… the 3% applies to all areas that are not in the front line, and it certainly applies in all areas that would not affect any front-line activity.*

While there has been some debate about what constitutes a 'front-line service', evidence from the Department of Health (DOH) confirms that community health nurses and child development staff are considered 'front line services'. Community child health services reported savings of $560,000 and approximately 5 FTE for 2008-09 with a projected saving of $1.75 million and 22.5 FTE for 2009-10, and a further $1.1 million and 13.3 FTE for 2011-11. A number of strategies have been adopted in DOH to achieve savings, including not backfilling positions when staff are on annual leave, maternity leave, or reduced work hours.

The decision to not backfill contracts has a significant impact on overall staffing levels. As at September 2009, there were a total of 140 authorised FTE in the metropolitan Child Development Service. A decision to not backfill annual leave alone would result in a 7.7% reduction in staffing, or 10.8 FTE. According to the Department of Health, there were 22 positions that were not backfilled during 2009 for varying amounts of time; from two weeks up to 12 months.

There has also been significant debate surrounding the decision to not renew 12 FTE contracts within the metropolitan Child Development Service. These FTE were created to "… deal with the transition of child development centres, but also to deal with what were long waitlists at the time." It is clear that this reduction in staffing would further exacerbate the extremely long waiting lists and jeopardise the health of the many thousands of children waiting for services, especially those seeking assistance from speech pathologists. The 12 FTE were comprised of:

- 5.0 speech pathologists;
- 2.4 occupational therapists;
- 1.9 physiotherapists;
- 1.1 clinical psychologists;
- 0.9 social workers;
- 0.4 dieticians; and
- 0.4 audiologists.

Metropolitan Child Development Service waiting lists

The Committee received evidence that prior to 2009 there was significant difference in the way waitlists were managed across the various CDS sites. This resulted in some centres completing an assessment appointment relatively quickly; while for some children that was all that was required, for others this resulted in a significant wait between initial assessment and treatment. At other sites, there may have been a significant wait for the initial assessment, but therapy would commence immediately following the assessment. Even if the comparison of waiting lists is limited to figures for September 2009 and December 2009, following the implementation of the new service model, waiting lists continue to grow. DOH's figures are provided as averages across the service and reflect the waiting time between referral and initial assessment. Various methods for managing waiting lists were in place in 2008 and resulted in children waiting an average of three months between assessment and treatment. The September 2009 and December 2009 figures

reflect the new service model in which children receive treatment within four weeks of assessment.

Finally, Chapter Three outlines a number of proposals which the Government can immediately undertake to address this bleak situation affecting thousands of children in Perth.

Inadequate resourcing of community child health services

The Committee received evidence in its earlier inquiry that the Department of Health submitted a business case for 2008-09 that identified an existing staffing shortfall of 366 FTE across community child health services. The Committee is aware that these business cases have recently been updated and submitted as part of the 2010-11 budget process. The critical gaps for child health identified in the business cases are now two years out of date, and has been compounded by more reductions in metropolitan staffing levels: 5 FTE in 2008-09 and projected reductions of a further 22.5 and 13.3 FTE in 2009-10 and 2010-11 respectively. At the same time, Western Australia continues to experience the strongest population growth of all jurisdictions.

In order to avoid a further deterioration, it is important that community child health services are quarantined from any further reduction in existing staffing levels and that the business cases are approved as part of the 2010-11 State Budget. Western Australia can afford these additional staff, as it appears the State has already emerged from the economic downturn with strong growth predicted over the coming years:

> *… 2010 looks set to mark the beginning of a new wave of growth and prosperity for the State. … the WA economy is expected to grow by 4¼% in 2010-11, 5% in 2011-12 and 6% by 2012-13. A return to growth in the world's major economies is expected to boost the State's export returns, and provide the impetus for the State's investment cycle.*

Information supplied by the Department of Health indicates that between 2007-08 and 2008-09 there was an increase of 82 FTE of staff employed at Princess Margaret Hospital (PMH). Also, the Clinical Services Framework 2010 published late in 2009 includes an additional 101 beds at PMH by 2014-15, compared to the projections made in the CSF 2005 document. The Committee welcomes the Government's increased investment in acute services at PMH. However, this information highlights the different approach to the Government's resource allocation priorities for acute and community child health services.

Monitoring the health and wellbeing of our children

Report cards have been used by governments and non government organisations around the world as a mechanism to identify areas for improvement in children's health and wellbeing. However, dedicated reports on children's health and wellbeing have only emerged in the past two decades. The Australian Institute of Health and Welfare (AIHW) is the main source of data in this area and its most recent publication, *A Picture of Australia's Children 2009*, includes information on the recently developed national headline indicators for child health, development and wellbeing. Other report cards include Australian Research Alliance for Children and Youth's, *The Wellbeing of Young Australian*s, and the Victorian Government's *The State of Victoria's Children 2008: A Report on How Children and Young People in Victoria are Faring.*

Western Australia currently has no mechanism for articulating the future for children's health that we aspire to, and no way of measuring whether we are meeting our goals. An annual report card would:

- enable better targeting of services;
- provide government with evidence of where progress is being made; and
- promote accountability where improvements are not being seen.

FINDINGS

Page 8

Finding 1

There has been a vast amount of research into the benefits of early intervention and the costs associated with a failure to provide timely therapy and treatment. However, much of the research focuses on the negative outcomes experienced by the individual requiring therapy (and the flow on effect to society) with little attention to the significant emotional and financial cost borne by other members of the child's immediate family.

Page 18

Finding 2

Over the last nine months, the Government has publicly acknowledged that community child health services in Western Australia are under-resourced. No additional resources have been provided to date by the Government.

Page 19

Finding 3

Western Australia's investment in children, and public health and prevention is one of the lowest of all jurisdictions in Organisation for Economic Cooperation and Development countries.

Page 20

Finding 4

The Government may save up to $17 in future health costs for every dollar spent on prevention and early intervention programs. Annual health savings could be as high as $60.6 million through avoided hospital admissions and $390.5 million through a reduction in bed-days across the acute care sector. This demonstrates the case for Western Australia to increase its expenditure on public health and prevention from its current level of 2.6% of the total health care budget which is substantially lower than other Organisation for Economic Cooperation and Development countries, including the USA (3.3%), New Zealand (4.9%) and Canada (7.3%).

Page 25

Finding 5

Western Australia's performance is below the national average on a range of child health indicators. This includes a higher rate of teenage births; lower immunisation coverage; a greater proportion of children who are overweight or obese; fewer children achieving literacy and numeracy benchmarks; and greater proportions of children who are developmentally vulnerable on the language and cognitive domain, and the physical health and wellbeing domain of the Australian Early Development Index.

Page 27

Finding 6

Western Australia performs below the national average for Indigenous child health on a range of indicators. This includes a higher rate of children born of low birth weight, lower immunisation coverage, a higher rate of teenage births, a higher rate of deaths from injury, and fewer children achieving literacy and numeracy benchmarks.

Page 30

Finding 7

Despite significant population growth and increased demand, there has been a chronic failure to invest in Western Australian child community health services over the last two decades.

Page 37

Finding 8

As a result of strong population growth, and no corresponding increase in resources, there has been a significant increase in the ratio of birth notifications per child health nurse full time equivalent (FTE). Child health and school health nurses have been forced to prioritise services to those most in need, resulting in many children and families missing out on services. This is contrary to best practice evidence which highlights the critical importance of all children and families having access to a mix of universal and targeted community health services.

Page 38

Finding 9

With more than 3,000 children in care, the development of health plans will have a significant impact on child health nurses' capacity to deliver services to children and families. This was not factored into the Department of Health's business cases and further demonstrates the urgent need for additional community child health resources.

Page 42

Finding 10

Despite increasing demand and unacceptably long waiting lists, the number of full time equivalent (FTE) staff in community child health services is declining. There was a loss of 5 FTE in 2008-09 with a projected loss of 22.5 FTE in 2009-10 and 13.3 FTE in 2010-11.

In addition, the metropolitan Child Development Service has been subject to a range of budget management strategies including not backfilling staff when they are on leave or have reduced their hours for a variety of reasons, as well as the decision to not continue 12 temporary FTE that were established in 2008-09 to support reforms and deal with waitlists.

Page 46

Finding 11

As at January 2010, there were 6,405 children waiting for child development services and waiting times are getting progressively worse. In the three months between September 2009 and December 2009, waiting times have increased for all disciplines with the exception of clinical psychology which remained constant. The most recent data indicates that children are waiting an average of:

- 16.6 months for speech pathology;
- 13 months for occupational therapy;
- 10 months for paediatrics;
- 11 months for physiotherapy;
- 9 months for clinical psychology; and
- 5 months for social work.

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Finding 12

The situation for Western Australia's children is unacceptable and it will continue to deteriorate unless there is an immediate and significant increase in community child health resources. The current situation has developed over a number of years and there have been a range of contributing factors including:

- Western Australia's strong population growth which has resulted in a significant increase in demand for services;
- A chronic lack of investment in community child health services over the last two decades; and
- The lack of an adequate resource allocation model for community child health services that reflects population growth and service demand.

Page 47

Finding 13

The current business cases for additional child health nurses, school health nurses and child development staff are based on staffing needs that were identified in 2008. The number of full time equivalent (FTE) required is already two years out of date and during this time Western Australia has continued to experience strong population growth, child development service waiting lists have continued to grow and child health nurses have been required to take on additional work associated with implementing a health plan for children in care.

Page 50

Finding 14

Western Australia's economy has emerged from the economic downturn with strong growth predicted over the coming years. Western Australia can clearly afford the additional staff required for community child health services.

Page 51

Finding 15

In the absence of a resource allocation model for community child health, the Department of Health is not able to plan and respond appropriately to projected population growth and increased demand for child community health services.

Page 56

Finding 16

The development of an annual report card for Western Australia's children is critical to enable the Government to monitor the progress of children's health and wellbeing, and identify future priority areas for action.

RECOMMENDATIONS

Page 9

Recommendation 1

That the Government request the Auditor General to prepare a report that outlines the numerous costs to families when their children are unable to receive timely therapy services in the public health system. This should include the cost of accessing private services as well as the costs associated with the poor social, emotional, health, educational and employment outcomes experienced by other members of the family. The report should be completed and tabled in Parliament by the end of 2010.

Page 20

Recommendation 2

That the Government increase its expenditure on public health and prevention from its current level of 2.6% of the total healthcare budget to at least 4% in the 2011-12 budget with a plan to increase the level to 6% by 2014-15. This investment is imperative in order to create strong, healthy communities by increasing the number of children who are school-ready, reducing the burden of chronic disease, reducing the rate of infant mortality, and limiting the future burden on Western Australia's hospitals.

Page 31

Recommendation 3

That the Department of Health report separately in its annual budget on the total allocation for community child health services, including a detailed breakdown of program funds.

Page 35

Recommendation 4

That the Department of Health approve the business case for the development of a database for child health nurses and school health nurses and that the project is progressed as a matter of urgency.

Page 42

Recommendation 5

In light of increasing demand and an already under-resourced service, the Government's 3% efficiency dividend should not continue to be applied to community child health services.

Page 47

Recommendation 6

The Department of Health provide an annual report on child development service waiting lists for each discipline including the waiting time between referral and assessment, and the waiting time between assessment and treatment by age group (such as 0-3 year-olds, 3-6 year-olds, 7-12 year-olds, 12-16 year-olds).

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Recommendation 7

That a copy of the updated business cases for child health nurses, school health nurses and child development staff submitted by the Department of Health as part of the 2010-11 State Budget process, be tabled in Parliament when the Budget is presented in May 2010.

Page 51

Recommendation 8

There should be no further attrition of community child health staff employed by the Department of Health, and the Government should provide funding in the 2010-2011 State Budget for the additional 105 child health nurses, 135 school health nurses and 126 child development staff identified in 2008. The funding needs to be in addition to existing staffing levels and quarantined for child community child health services.

Page 52

Recommendation 9

That the Department of Health develop and implement a resource allocation model for child community child health services within 12 months. The model should be based on established benchmarks for staff to client ratios and informed by population based planning that is weighted for a range of factors including age, Aboriginality, socio-economic status, culturally and linguistically diverse (CALD) status, and Australian Early Development Index (AEDI) results.

Page 57

Recommendation 10

In the absence of a single early years' agency, the Departments of Health, Education, Communities and Child Protection, and the Disability Services Commission should provide an annual report to Parliament on children's health and wellbeing in Western Australia. The report should provide an update on Western Australia's performance against established benchmarks and identified targets in relation to at least the following:

- The national headline indicators for children's health, development and wellbeing;
- Australian Early Development Index (AEDI) results;
- The Department of Health's resource allocation model for community child health services; and
- A range of key performance indicators including waiting lists and waiting times, the number of health care plans completed for children in care, and the number of child health home visits completed within 10 days of birth.

Information should be presented for all Western Australian children as well as focusing more specifically on groups at risk of poorer outcomes including Indigenous children, children living in rural and remote areas, and newly arrived refugees. The first report should be tabled by the end of 2010.

Page 58

Recommendation 11

That a process is established by the end of 2010 to monitor and report on a government's implementation of the recommendations arising from a parliamentary inquiry. This should include a requirement for governments to provide a subsequent annual update on the progress of implementing recommendations, along with an explanation for any delay or incomplete actions.

MINISTERIAL RESPONSE

In accordance with Standing Order 277 (1) of the Standing Orders of the Legislative Assembly, the 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

This interim Report presents to Parliament urgent evidence that the Education and Health Standing Committee has gathered as part of its *Review of WA's Current and Future Hospital and Community Health Care Services*. The final report will be tabled later in 2010. This Inquiry has had a major focus on the Western Australian hospital system, but the Committee has also collected evidence on the current state of community child health services as per the term of reference seeking to identify any outstanding needs and gaps in the State's health care system.

Community child health services provide a range of universal and targeted services to children and families. These services support the healthy growth and development in a child's early years and promote wellbeing during their childhood and adolescence. In Western Australia, the services are delivered through three main areas: child health, school health and child development.

This Report follows the Committee's *Healthy Child- Healthy State: Improving Western Australia's Child Health Screening Programs* report tabled in Parliament in May 2009. That report found that approximately 35,000 pre-primary and 119,000 primary school students were screened by hard working and committed health and education staff across the State who have regularly suggested ways in which the system could be improved. This current Inquiry has found little that has improved in the past 12 months since the tabling of the *Healthy Child- Healthy State* report, and many indicators, such as waiting times, have got substantially worse.

Some areas of the State's child health services, particularly mental health services and child health services in regional Western Australia, have been excluded in this Report. The Committee's final report will include material on these topics.

1.2 Inquiry conduct

This Inquiry's Terms of Reference were announced to the Legislative Assembly on 4 December 2008 and were placed on the Committee's web site following the Speaker's Statement. Advertisements inviting submissions to the Inquiry appeared in *The West Australian* on 27 June 2009 and in *The Countryman* on 2 July 2009. Submissions were also sought from a number of State Government agencies, as well as other relevant stakeholders. In response, the Committee received 45 submissions, five of which are used in this interim Report. The submissions referred to in this Report are listed in Appendix One. More than 60 public hearings were conducted during which the Committee heard evidence from over 120 witnesses. Witnesses who gave evidence to the Committee and whose evidence is used for this Report are detailed in Appendix Two. A full list of submissions, hearings and witnesses will be included in the Committee's final report.

The Committee has also gathered evidence from those involved in delivering the State's child health services in the four regional centres of Merredin, Kalgoorlie, Katanning and Albany, as well as from witnesses in Perth. It recently heard moving evidence from parents on the broader

social impacts of children requiring treatment in the under-resourced metropolitan Child Development Service. Given the personal nature of their evidence, the Committee resolved to remove the names of these parents from the footnotes of the sections of their transcripts that have been included in this report.

The Committee was also briefed on initiatives which other jurisdictions had implemented to address similar concerns about child health issues, including the establishment by the Victorian Government of a Minister for Children and Early Childhood Development to have shared responsibility for the Department of Education and Early Childhood Development.[3] Members of the Committee attended the Australian Research Alliance for Children and Youth (ARACY) National Conference in Melbourne between of 2-4 September 2009 and heard of research that confirmed that delayed interventions for a child's health actually cost the government more in the long run, as it extracts a greater demand on future health services to provide therapy and treatment requirements. These people in other jurisdictions who provided information to the Committee are listed in Appendix Three.

[3] See www.education.vic.gov.au/about/ministers/ministerchildren.htm.

CHAPTER 2 COMMUNITY CHILD HEALTH SERVICES IN WESTERN AUSTRALIA

2.1 The parents' story

The Committee was privileged to receive oral evidence from three women regarding their experiences with community child health services. All three have children with complex developmental issues: two are currently receiving therapy and treatment from the metropolitan Child Development Service while one remains on the waiting list.

These mothers painted a powerful picture of hope and optimism when their children were able to access the therapy they require; juxtaposed with despair and frustration as they struggle to cope with the personal and financial pressures imposed on them by an under-resourced community health system. What follows is a brief summary of their stories - stories that are shared by thousands of parents and children across Western Australia.

I could see my son shining brightly after it …[4]

> *I know when my son does attend, his self esteem is through the roof. … It was a beautiful service, a fantastic service, because I could see my son shining brightly after it.*[5]

The women spoke passionately about the benefits of early intervention and have all observed significant improvements in their children following therapy and treatment.

> *His language is improving out of sight. He could not speak. After two months of weekly therapy, he is putting two to three words together.*[6]

> *The difference it has made to our son has been incredible …* [7]

> *I think a lot of the anxiety can be helped with really good psychotherapy, intervention and teaching them to control their emotions, to control their impulses and to learn the consequences of their actions. I have seen that with my own son. He has gone from not being able to play with two or three kids - from a total terror at age six to being someone who gets angry but is much more able to control himself.*[8]

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4 *Transcript of Evidence*, 12 February 2010, p8.

5 *Transcript of Evidence*, 12 February 2010, p8.

6 *Transcript of Evidence*, 12 February 2010, p7.

7 *Transcript of Evidence*, 12 February 2010, p3.

8 *Transcript of Evidence*, 12 February 2010, p4.

> *It has been brilliant, fantastic. … I would also like to give a few bouquets to Rheola Street for their social support. That has been invaluable to myself and my family as far as giving Lochie a more stable life.*[9]

Two steps forward, one step back …[10]

As part of a previous inquiry, this Committee received evidence that child development services have adopted a range of waitlist management strategies in response to increasing demand and a chronic lack of investment in community health services. Strategies included providing an initial block of five or six therapy sessions, and then placing the child at the bottom of the waitlist again.[11]

This issue was raised again in the Committee's current inquiry with one of the mothers describing her frustration with the lack of continuity of care which results in 'two steps forward, one step back':

> *We get back to the OT* [occupational therapist] *after five and a half months and we probably only get really two weeks' benefit out of it because we are retracing old steps again. … Yes, it peaks and troughs. Hip, hip hurray when we get out of there after a six-week session because he can do this and this is fantastic, and, yet, in three months' time, or when it rolls over again to start again, we are back at square one. … I know that if my son went to OT and physio once a week for one year, the improvements would be out of sight; I know that. It would be an amazing thing to achieve, but it is just not happening and it is unfair. It is not fair on the children, it is not fair on the school, it is not fair on the parents; it is not fair on anyone.*[12]

You need to at least double the places to meet the demand …[13]

> *Your language development centres are perfect. They are fantastic, but you need to at least double the places to meet the demand. I have called the department and I have anecdotal evidence—it can only be given to me under freedom of information, which I have not had the time to get—that of about 40 applications received for that year* [for the Language Development Centres], *only 20 get in, so 20 kids who meet the criteria for this school miss out. What do they do? The Telethon Institute runs a speech program, but their waitlist is even longer.*[14]

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9 *Transcript of Evidence*, 12 February 2010, p5

10 *Transcript of Evidence*, 12 February 2010, p9.

11 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, p51.

12 *Transcript of Evidence*, 12 February 2010, p9.

13 *Transcript of Evidence*, 12 February 2010, p6.

14 *Transcript of Evidence*, 12 February 2010, pp6-7.

We went private because we couldn't afford to wait …[15]

> *… the current wait time now is two years for speech for a two to three-year-old. For occupational therapy, it is 18 months and for a developmental paediatrician, it is a year.*[16]

When faced with the reality of extremely long waiting lists in the public system, two of the women decided to use private services. As one mother put it:

> *We went private because we could not afford to wait. They basically said that he needs weekly therapy for speech, so when I called Southwell in February 2009, the wait list was 12 months. She told us, "You cannot wait." He is at the critical age of two to three, when the neurological pathways can be changed; they are not set. They can actually change those pathways and help them speak if they get early intervention between the ages of two and three, not five and six. … She also said that if we waited, even 12 months at that stage, he would have severe developmental issues and we would require much more intensive therapy and it would cost us even more.*[17]

The financial implications are huge …[18]

> *We had probably about a year of private OT* [occupational therapy]*, spending between about $20,000 to $30,000 on occupational therapists. We sent him to a speech and hearing centre, before he was diagnosed, for a year so that was about another $5,000 or $6,000 for that. He went there concurrently with the school and then we basically have been taking him to therapy two or three times a week since.*[19]

> *The financial implications on us are huge. It is $90 a week just for speech. The private system is very good but it is for those who have a lot of money. We are struggling. … I earn a very good wage. My husband works too and we are struggling.*[20]

> *He is our son; we would sell everything before we would affect him. But some people get to the point where they cannot cut the groceries or the utilities or the stuff any more, and it is very distressing.*[21]

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15 *Transcript of Evidence*, 12 February 2010, p6.

16 *Transcript of Evidence*, 12 February 2010, p6.

17 *Transcript of Evidence*, 12 February 2010, p6.

18 *Transcript of Evidence*, 12 February 2010, p6.

19 *Transcript of Evidence*, 12 February 2010, p3.

20 *Transcript of Evidence*, 12 February 2010, p6.

21 *Transcript of Evidence*, 12 February 2010, p8.

Another mother describer her family's plight:

> *Yes, look, it is really, really difficult. We had a property to sell and we have sold it … We have mortgaged our house and we are continuing to do so, even after having sold this property.*[22]

> *So we are fine. My mum quit work; she has my children whilst I take him [to therapy]. How many other families can have their parents quit work, because now they are affected financially? We are "rich"; we can afford the private system—well, we are just affording the private system. How many are not?*[23]

For one of the mothers, private services were not an option:

> *If I had the money, I could go and do it privately, but I cannot. … I cannot afford private in any way, shape or form. There would be hundreds, if not thousands, of people in my predicament.*[24]

One of the women succinctly summarised the issue as follows:

> *If you do not have the money, they* [the children] *get lost in the system.*[25]

We don't get invited anywhere …[26]

The women relayed stories of social isolation and children who are not able to participate in simple every-day activities that most people take for granted: like play dates, or a trip to the beach or the local park, or playing sport on the weekend.

> *… that means that a child cannot visit friends, no-one wants us over there, no babysitters and no day care.*[27]

> *Even your best friend and even your family do not want to have you around when your child is such a burden on everybody.*[28]

> *He requires constant supervision in that respect. I do not have day care as an option.*[29]

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22 *Transcript of Evidence*, 12 February 2010, p8.

23 *Transcript of Evidence*, 12 February 2010, p7.

24 *Transcript of Evidence*, 12 February 2010, pp5,10.

25 *Transcript of Evidence*, 12 February 2010, p7.

26 *Transcript of Evidence*, 12 February 2010, p4.

27 *Transcript of Evidence*, 12 February 2010, p11.

28 *Transcript of Evidence*, 12 February 2010, p4.

29 *Transcript of Evidence*, 12 February 2010, p6.

The other thing was the impact on families. It is incredibly stressful...[30]

The financial burden is significant and not to be underestimated. However, the stories of their children, and how the situation has impacted on their health, and that of their family, were equally moving:

> *It is a treasure hunt with no map. It really is. That is part of a mother's stress even before the diagnosis. You ask yourself, "What do I do here?"*[31]

The women spoke of children who are bullied at school; of siblings who want to be heard, who struggle to make sense of the situation resulting in confusion, anger and anxiety; of marriages that have been put under enormous stress; and of their own battles with depression, anxiety and social isolation.

> *There are two other kids who want to be heard as well … who are feeling completely ignored because they do not get the attention the little one gets. He screams at them and he punches them. There is a bruise under my chin.*[32]

> *There is a lot of pressure on families. We have been through counselling. We have been together for 19 years but I do not know whether we can make it. That is very common.*[33]

> *We are struggling so much that we are in counselling. Our family nearly broke apart over Christmas time because I have to work to meet his bills, but I cannot work because I have to be there in his therapy sessions.*[34]

> *I ended up, basically, having to go to Perth Clinic for a while and then subsequently left there and then admitted myself to Charlie's* [Sir Charles Gairdner Hospital] *because I was in such a bad state. That is the sort of down time that a family like ours can do without, because you have to stay on things. You have to be able to support all your children and you have to be able to keep the therapy up and not burn out. It is just such a common occurrence.*[35]

> *I have had my own health issues, as most mums do when they have a child with a lot of problems. I have had to go on antidepressants. I have had to be hospitalised—exactly the same thing. … that has a huge impact that you cannot allow; you cannot afford for that to happen. We are kind of burning the candle at both ends, I guess. It is just something that we do for our children.*[36]

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30 *Transcript of Evidence*, 12 February 2010, p4.

31 *Transcript of Evidence*, 12 February 2010, p11.

32 *Transcript of Evidence*, 12 February 2010, p4.

33 *Transcript of Evidence*, 12 February 2010, p12.

34 *Transcript of Evidence*, 12 February 2010, p6.

35 *Transcript of Evidence*, 12 February 2010, p4.

36 *Transcript of Evidence*, 12 February 2010, p10.

As one mother stated:

> *… we are all just trying to keep our heads above water.*[37]

Our kids have so much strength and determination and they are being let down …[38]

Despite the daily struggles, these women continue to do everything within their power to support their children, knowing that with the right treatment they can "do fabulously well", but without it they will become a "complete recluse and basket case, literally".[39] However, their commitment and dedication comes at an enormous cost to them and their families and all of the women spoke about feeling let down by the system:

> *… we are denying them the right to be the potentially wonderful people that they can be. … Our kids are so resilient and they never give up. It seems like it is the government that is giving up on them.*[40]

A final comment:

> *With intervention, you can help, and that is why this part of the health system matters.*[41]

Finding 1

There has been a vast amount of research into the benefits of early intervention and the costs associated with a failure to provide timely therapy and treatment. However, much of the research focuses on the negative outcomes experienced by the individual requiring therapy (and the flow on effect to society) with little attention to the significant emotional and financial cost borne by other members of the child's immediate family.

37 *Transcript of Evidence*, 12 February 2010, p5.

38 *Transcript of Evidence*, 12 February 2010, p10.

39 *Transcript of Evidence*, 12 February 2010, p13.

40 *Transcript of Evidence*, 12 February 2010, p10.

41 *Transcript of Evidence*, 12 February 2010, p12.

Recommendation 1

That the Government request the Auditor General to prepare a report that outlines the numerous costs to families when their children are unable to receive timely therapy services in the public health system. This should include the cost of accessing private services as well as the costs associated with the poor social, emotional, health, educational and employment outcomes experienced by other members of the family. The report should be completed and tabled in Parliament by the end of 2010.

2.2 The need to invest

(a) The importance of the early years

> *Every two minutes a baby is born in Australia. What happens - or doesn't happen - to this child in their earliest years of life will affect not only their immediate well-being but will also lay the foundations for their future.*[42]

Evidence supporting the benefits of early intervention has been cited many times: it is unchallengeable and is accepted by the Government:

> *Lack of adequate care for children in their early years … actually costs government a huge amount of money in having to then treat them at a later stage.*[43]

This Report does not revisit the overwhelming body of research on this topic. However, a brief summary has been included to provide a context for the need for the Government to support current Department of Health business cases to invest further in this critical area.

Early childhood experiences have a profound and lifelong impact on a range of health, social, emotional, educational and employment outcomes. Early identification and management of developmental and behavioural problems is associated with better health outcomes and improved school performance, along with a reduction in teenage pregnancy, welfare dependency, and crime.

> *Children who have good early childhood experiences … in stimulating, nurturing environments have better outcomes throughout their life… better school grades, better self*

42 Centre for Community Child Health, 'Early Childhood'. Available at: www.rch.org.au/ccch/index.cfm?doc_id=10693. Accessed on 11 February 2010.

43 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE543.

> *esteem, fewer social problems, and fewer health problems and are less likely to be teen parents, use drugs or be involved in crime.*[44]

The research outcomes also emphasises the importance of monitoring children's development and intervening as appropriate, from a very early age. A recent study found that children who do not reach key developmental milestones at just nine months old are far more likely to struggle at school. The *Millennium Cohort Study* of nearly 15,000 children found that babies who were slow to develop their motor skills at nine months were significantly more likely to be identified as behind in their cognitive development, and also likely to be less well behaved at age five.[45] Based on this research, every year that passes without adequate investment in this area will result in another cohort of children being left behind.

The economic benefits to government of early intervention are substantial, with reported returns on investment of up to $17 for every dollar spent. Investment in a child's earliest years results in the greatest return.[46]

The benefits of early intervention have also been expressed in terms of avoidable hospital admissions and reduced hospital bed-days. Every year there are more than half a million hospitalisations across Australia that could be avoided through prevention or access to timely and effective primary care. In 2001-02, 8.7% of all hospital admissions were avoidable, equating to 552,000 admissions. Of the avoidable admissions, 14.9% occurred in the 0-14 year age group.

Western Australia's rate reflected the national average, which equated to 55,102 avoidable admissions per year, or approximately 8,210 avoidable admissions for 0-14 year olds.[47] Based on an average length of stay of 3.15 days across metropolitan hospitals[48], and an average cost of $1,100 per day for a tertiary bed[49], avoidable admissions may be costing the State up to $60.6 million per year.

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44 Hertzman, C. cited in the Council of Australian Governments, *Investing in the Early Years- A National Early Childhood Development Strategy*, Commonwealth Government of Australia, Canberra, 2 July 2009, p6.

45 Mansell, W, 'Children can fall behind as early as nine months', *The Guardian*, 17 February 2010. Available at: www.guardian.co.uk/society/2010/feb/17/children-fall-behind-nine-months. Accessed on 18 February 2010.

46 Heckman, J.J. 'Investing in disadvantaged young children is an economically efficient policy', in *Building the Economic Case for Investments in Pre-School Forum*, 2006, cited in submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children.

47 Page, A. *etal. Atlas of Avoidable Hospitalisations in Australia: Ambulatory Care-sensitive Conditions*, PHIDU, University of Adelaide, Adelaide, 2007, pp14,21.

48 Department of Health, *WA Health Performance Report: July to September 2009 Quarter*, 2009. Available at: www.health.wa.gov.au/publications/documents/health_performance_report_jul-sept_09.pdf. Accessed on 25 February 2010.

49 Health Reform Committee, *A Healthy Future for Western Australians*, Department of Health, Western Australia, 2004, p45.

In relation to hospital bed-days, the Reid Report concluded that appropriate investment in health promotion and early intervention, and community health and other community-based services would result in a reduction of 355,000 bed-days (or 13% of total bed-days), based on 2008-09 figures. At the time of writing the report, Reid estimated that the level of investment required would be $85 million per year, which would result in net savings of around $290 million per annum by 2008-09 and $535 million by 2013-14.[50]

A failure to invest has significant costs to the individual and society, "… interventions commencing later in life are often more expensive and less effective."[51]

Recent reports

It is therefore not surprising that the need for prevention and early intervention has been identified as a priority by state and territory governments, and at the national level. This issue was also highlighted in two recent Western Australian parliamentary inquiry reports: the Education and Health Standing Committee's report *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*; and the Community Development and Justice Standing Committee's *Report on the Adequacy of Services To Meet The Developmental Needs of Western Australia's Children*.

The national level

The Council of Australian Governments (COAG) has identified the need to improve early childhood outcomes across a number of areas in order to achieve its vision that:

> *… by 2020 all children have the best start in life to create a better future for themselves and for the nation.*[52]

A number of early childhood reform initiatives are being progressed through COAG in relation to health, education, child protection, child care, parenting, housing, domestic violence, employment and the need to 'close the gap' in Indigenous disadvantage. The most ambitious of all the reforms are those aimed at 'closing the gap' in Indigenous disadvantage. Early childhood is identified as one of the key strategic platforms or 'building blocks' for driving reform in this area with maternal and child health being a focus for action:

> *For an equal start in life, Indigenous children need early learning, development and socialisation opportunities. … Action in the areas of maternal, antenatal and early*

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50 Health Reform Committee, *A Healthy Future for Western Australians*, Department of Health, Western Australia, 2004, pp114-115.

51 Submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children, 16 February 2009, p7.

52 Council of Australian Governments, *Investing in the Early Years - A National Early Childhood Development Strategy*, Commonwealth Government, Canberra, 2 July 2009, p4.

> *childhood health is relevant to addressing the child mortality gap and to early childhood development.*[53]

Investing in the Early Years - A National Early Childhood Development Strategy has also been developed under the auspice of COAG which aims to:

> *… achieve positive early childhood development outcomes and address concerns about individual children's development early to reduce and minimise the impact of risk factors before problems become entrenched. The aim is to improve outcomes for all children and importantly, reduce inequalities in outcomes between groups of children. This is especially important for some Indigenous children who, on average, have significantly poorer outcomes than non-Indigenous children.*[54]

This strategy highlights the importance of quality maternal, child and family health programs in improving outcomes for children and identifies the following areas for further action:

(i) Strengthen maternal, child and family health service delivery as a key plank of a strong universal service platform;

(ii) Improve support for vulnerable children and their families through improved service response and accessibility; and

(iii) Improve early childhood development infrastructure to support maternal, child and family health service delivery, increased access to quality early childhood education and care, and improved service response for vulnerable children.[55]

In relation to health reform, the National Health and Hospitals Reform Commission found that the health system is under increasing pressure and is ill-equipped to cope with a range of challenges including increases in demand, inequities in health outcomes and access to services, growing concerns about safety and quality, workforce shortages and inefficiencies. The report again identifies the need for a fundamental redesign of the health system, with prevention and early intervention being central to this process:

> *The evidence is overwhelming. If we act early, we can prevent or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions. Our recommendations for a healthy start to life involve ensuring that*

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53 Council of Australian Governments, 'National Indigenous Reform Agreement (Closing the Gap)', Available at: http://coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NIRA_closing_the_gap.pdf. Accessed on 8 February 2010.

54 Council of Australian Governments, *Investing in the Early Years - A National Early Childhood Development Strategy*, Commonwealth Government, Canberra, 2 July 2009, p4.

55 Council of Australian Governments, *Investing in the Early Years - A National Early Childhood Development Strategy*, Commonwealth Government, Canberra, 2 July 2009, p27

> *children and parents - and potential parents - get access to the right mix of universal and targeted services to keep healthy and to address individual health and social needs.*[56]

The National Preventive Health Strategy was also released in 2009 and aims to:

> *… prevent hundreds of thousands of Australians dying prematurely, or falling ill and suffering, between now and 2020. It is needed to minimise the impending overload of the health and hospital systems, and to increase the productivity, and therefore the competitiveness, of Australia's workforce. It will assist in avoiding the health and social costs that would otherwise be incurred if we do little or nothing.*[57]

This document identifies the need to refocus primary healthcare towards prevention as a key strategy for achieving targets related to reducing overweight and obesity, smoking, alcohol use, and the life expectancy gap between Indigenous and non-Indigenous people.

The State level

In 2004, the Health Reform Committee (HRC) was appointed to "develop a vision for the Western Australian health system while ensuring that the growth of the health budget was sustainable".[58] The final report from the HRC (known as the Reid Report) found that a fundamental reprioritisation of the health system was required and outlined a 10 year plan for reform with a total of 86 recommendations. The report has subsequently received bipartisan support (with the exception of two recommendations) and has had a major influence on the recent planning for Western Australia's health system.

The Reid Report highlights the importance of prevention and early intervention in promoting positive long term health outcomes and thereby reducing the overall burden on the health system:

> *There is significant evidence within Australia and internationally that investment in health promotion, prevention and early intervention will reduce health costs and improve health status in the long term.*[59]

Investment in this area is seen as a key element of the overall reform process:

> *Good health and well being in the early years of life provides a solid basis for maintaining good health throughout adulthood. Investment in child, maternal and adolescent health is therefore an important component of reducing the burden of disease in the future.*[60]

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56 National Health and Hospital Reforms Commission, *A Healthier Future for all Australians*, Commonwealth Government, Canberra, 2009, p5.

57 Preventative Health Taskforce, *Australia: The Healthiest Country by 2020*, Commonwealth Government, Canberra, 2009, p6.

58 Health Reform Committee, *A Healthy Future for Western Australians*, Department of Health, Western Australia, 2004, pv.

59 Health Reform Committee, *A Healthy Future for Western Australians*, Department of Health, Western Australia, 2004, p23.

All of the recommendations regarding health promotion and prevention have been supported by both political parties. This support now needs to be translated into action.

At a departmental level, health promotion and early intervention is embedded into a range of strategic documents. DOH's *Strategic Intent 2005-2010* identifies the need to increase the focus on promotion of health and wellbeing as a key driver for delivering 'healthy communities', which is one of six key priorities for the Department.

The *Framework for Child and Youth Health Services*, which provides the basis for health service planning for Western Australia's children, articulates the need to improve children's health and wellbeing through the following early intervention and prevention strategies:

- *Provide assessment for health and developmental problems for all children, especially children in care.*
- *Develop evidence-based programs for infants and children who are showing signs of delayed speech and other developmental problems.*
- *Develop guidelines to ensure quality educational programs are implemented in all childcare settings.*
- *Extend the availability of play therapy programs for children with severe behavioural problems.*
- *Implement universal neonatal hearing screening in WA.*[61]

In recognition of the importance of health promotion and early intervention, the *Western Australian Health Promotion Strategic Framework 2007-2011* was developed to promote healthier and safer lifestyles for the Western Australian population. Indigenous health is also a priority at the state level and is identified as an area of particular focus for child community health services.[62]

(b) Parliamentary inquiries

The importance of community child health services has received significant attention recently, including the initiation of three parliamentary inquiries, including this one, since November 2008.

Inquiry into child health screening programs

In November 2008, an inquiry into child health screening at pre-primary and primary school level was referred to the Education and Health Standing Committee. This allowed the completion of an Inquiry that had commenced in the 37th Parliament, with similar terms of reference, which was near completion when the State election was called. The inquiry's terms of reference were to:

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60 Health Reform Committee, *A Healthy Future for Western Australians*, Department of Health, Western Australia, 2004, p24.

61 Department of Health, *Framework for Child and Youth Health Services*, Government of Western Australia, Perth, 2008, p15.

62 Submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children, 16 February 2009, p13.

(a) Appraise the adequacy and availability of screening processes for hearing, vision, speech, motor skill difficulties and general health; and

(b) Assess access to appropriate services that address issues identified by an appropriate screening process.

The report of this inquiry, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, was tabled in Parliament in May 2009 and found that:

> *There is an urgent priority for the Western Australian government to increase the number of school and child health nurses, especially for metropolitan primary schools.*[63]

The Report also made a number of specific recommendations regarding the need to invest in community child health services:

> *Recommendation 3. That the Government provide additional funds for the Department of Health to fully meet its planned introduction of child developmental screening tools at the key developmental ages of 3-4 months, 8 months, 18 months, 3 years and school entry.*
>
> *Recommendation 5. The Department of Health should prepare a business case that would fund a six-monthly hearing test for all Aboriginal children in Western Australia.*
>
> *Recommendation 10. As an urgent priority, the Government should increase the number of school nurses employed in the school health system and approve the proposed business case for additional school and child health nurses to be employed within the Department of Health's Child Development Services.*
>
> *Recommendation 25. That the Government give a high priority to provide additional staff and other resources to address the current inadequacies in Western Australia's speech and language services.*
>
> *Recommendation 34. The number of school health nurses, community child health nurses and allied health professionals employed within Western Australia's child health services should be urgently increased as per the business cases developed by the Department of Health. The new staff required are 126 full-time-equivalent (FTE) in the Child Development Services, 105 FTE Community Child Health Nurses and 135 FTE for school nurses.*[64]

The Government tabled its response to the *Healthy Child - Healthy State* report in September 2009 indicating support or conditional support for 34 out of the 37 recommendations. All of the recommendations cited above regarding the need for additional investment in community child health services were fully supported, with the exception of recommendation five, which was conditionally supported on the basis that the Department is currently undertaking a review of the

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63 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, pxxix.

64 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, ppxxxiii - xli

evidence regarding universal and targeted hearing screening and assessments, which will inform future policy. In relation to the need for additional staff, the Government acknowledged the gaps in services and capacity issues and indicated that "these matters are subject to government consideration and will be considered in the budget process."[65]

Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children

One month after the inquiry into health screening was referred to the Education and Health Standing Committee for completion, the Community Development and Justice Standing Committee initiated an inquiry into the adequacy of services to meet the developmental needs of Western Australian children. The specific terms of reference were to report on:

(a) whether existing government programs are adequately addressing the social and cognitive developmental needs of children, with particular reference to prenatal to 3 years;

(b) how to appropriately identify developmentally vulnerable children;

(c) which government agency or agencies should have coordinating and resourcing responsibility for the identification and delivery of assistance to 0-3 year-old children;

(d) what is the best model to ensure interagency and intergovernmental integration of developmental programs delivered to 0-3 year-old children;

(e) how to best prioritise the resources available for meeting the needs identified;

(f) what is the most appropriate measure of program outcomes; and

(g) any other related matter deemed relevant by the Committee.

The report was tabled in Parliament in August 2009 with the following recommendations regarding the need to adequately resource child community health services:

> *Recommendation 6. The Committee strongly recommends that the Government, as a matter of urgency, restores the number of full time equivalent child health nurses delivering the home visitation program and operating child health centres, on a per capita basis to levels prevailing in Western Australia in the 1980s, since which time the number of child health nurses has significantly declined on a per capita basis. This improvement is critically needed to restore the efficacy of a fundamental universal community health service, thereby ensuring that all families and children receive appropriate, timely, accessible guidance and support. All evidence is that the need for such a service is increasing and not decreasing. Additional resources should be provided to allow the child health nurses to actively promote and encourage regular developmental checks on children from nine months to pre-school.*

[65] Government response to EHSC's *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs* Report, 8 September 2009, p23.

Recommendation 8. While in the long term the aim must be to reduce the need for intervention by therapists, there is nevertheless an immediate demand to dramatically improve the availability of remedial therapists. The Committee strongly recommends that to address the undersupply of therapists for children, the Department of Health, within twelve months:

- *Undertakes a comprehensive 'needs analysis' of the levels of speech pathology and occupational therapy positions required to provide both clinical therapy services, and systemic delivery of therapy services, in schools and early childhood settings;*
- *Develops targets for numbers of therapists per head of population for each Area Health Service, with equity weightings; and*
- *Allocate sufficient funding to ensure these positions are filled.*

Recommendation 10. The Committee strongly recommends that every child is screened for hearing capacity within the first six months of commencing school, be that pre-compulsory or compulsory years. Adequate resourcing for school health nurses will need to be made available.[66]

The Government tabled its response to this report in December 2009 and provided a narrative comment to recommendations that were grouped according to theme, rather than a response to each individual recommendation. The response acknowledged the "importance of child health services and associated workforce requirements" but was silent in relation to specific recommendations regarding the need to allocate additional funding to community health services.

In subsequent parliamentary debates the Government expressed support for the need for additional resources and staff for the State's community child health services. The Health Minister said:

I agree with the member that there is a major deficiency in the services that are being provided in this area [child development services]. *The situation may well be getting worse, because the funding is the same, yet the demand is growing. I am determined that over the next three years of our time in government … we will address this issue. … It is an issue that I take very seriously. In fact, just last week I mentioned to all our senior health staff that not only is this an issue that is a major challenge for our government, but also this is an issue on which I believe we should be judged. … My job now as the minister … and the member's committee having tabled a report that proves that there is indeed a severe deficiency in the provision of these services, is to fix that deficiency.* [67]

… I agree with the member, and with the comments in the committee report, that there are significant shortages across the system. I will highlight some of those shortages. I think these figures are actually in the report. For skilled [school] *nurses, we are 135 full time*

66 Community Development and Justice Standing Committee, *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, Legislative Assembly, Perth, 2009, ppxxxiii-xxxiv.

67 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 17 September 2009, p7239.

equivalents short; for child health nurses we are 105 FTEs short; and for Aboriginal health workers we are about 23 FTEs short.[68]

Finding 2

Over the last nine months, the Government has publicly acknowledged that community child health services in Western Australia are under-resourced. No additional resources have been provided to date by the Government.

(c) How are our children faring - national and international comparisons

It is of concern, therefore, that Australia is seeing increases in poor outcomes for children and young people in a number of key areas, and a widening of inequalities in outcomes between groups of children.[69]

Investment in children

Australia's investment in young children is reportedly one of the lowest of all countries in the Organisation for Economic Cooperation and Development (OECD) with expenditure in 2005 of 0.1% of GDP on pre primary educational services. This is well short of UNICEF's benchmark of 1.0% of GDP and significantly lower that the UK's 2005 expenditure of 0.45% of GDP (and is now estimated to be 1.2%).[70]

In terms of investment in public health and prevention, Australia ranks 22nd out of 26 OECD countries with only 1.7% of Australia's total healthcare budget being allocated to public health and prevention in 2006. This is substantially less than the 7.3% spent in Canada, the 4.9% spent in New Zealand and the 3.3% spent in the United States of America.[71] Evidence also indicates that Australia's expenditure on public health and prevention has declined in recent years: from 3.1% in 2001 to the current figure of 1.7%.[72]

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68 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 18 June 2009, p5271.

69 Council of Australian Governments, *Investing in the Early Years - A National Early Childhood Development Strategy*, Commonwealth Government, Canberra, 2 July 2009, p6.

70 Submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children, 16 February 2009, p8.

71 Organisation for Economic Cooperation and Development, *Health at a Glance 2009: OECD Indicators*, OECD, Paris, 2009, p165.

72 Organisation for Economic Cooperation and Development, *Health at a Glance 2009: OECD Indicators*, OECD, Paris, 2009, p73.

According to the Department of Health, Western Australia's expenditure on prevention accounts for 2.6% of the total healthcare budget.[73] Others have indicated that it is 2% at best:

> *The bottom line is still that so much is preventable: the rising tide for chronic disease and so on, but all prevention and public health services still hover around two per cent of the health spend. … The two per cent is still very generous; it includes mostly services like immunisation and screening, and the definition even includes treatment in areas like alcohol and drug services. So 2% is a generous definition.*[74]

Even at 2.6%, this is significantly lower than comparable OECD countries.

Finding 3

Western Australia's investment in children, and public health and prevention is one of the lowest of all jurisdictions in Organisation for Economic Cooperation and Development countries.

According to UNICEF, Australia currently ranks 23rd out of 25 participating countries in meeting minimum standard benchmarks for childhood services. The UNICEF report card is based on a range of indicators, including 1.0% of GDP spent on early childhood services and near-universal outreach of essential child health services.[75] Near-universal outreach of essential child health services is based on whether a country has met two of the following three requirements:

- the rate of infant mortality is less than 4 per 1,000 live births;
- the proportion of babies born with low birth weight (below 2,500 grams) is less than 6 per cent; and
- the immunisation rate for 12 to 23 month-olds (averaged over measles, polio and DPT3 vaccination) is higher than 95 percent.

According to the OECD, Australia does well for children in terms of housing, environment and educational wellbeing, however health is identified as an area for further improvement.[76]

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73 Dr Peter Flett, Director General, Department of Health, *Transcript of Evidence*, 10 November 2009, p7.

74 Professor Mike Daube, Professor of Health Policy, Curtin University, *Transcript of Evidence*, 14 October 2009, p2.

75 UNICEF, *The Child Care Transition, Innocenti Report Card 8*, UNICEF Innocenti Research Centre, Florence, 2008, p2.

76 Organisation for Economic Cooperation and Development, 'Doing Better for Children', 2009. Available at: www.oecd.org/document/12/0,3343,en_2649_34819_43545036_1_1_1_1,00.html#data. Accessed on 5 February 2010.

This Committee believes that Western Australia can, and should, do better for our children.

Finding 4

The Government may save up to $17 in future health costs for every dollar spent on prevention and early intervention programs. Annual health savings could be as high as $60.6 million through avoided hospital admissions and $390.5 million through a reduction in bed-days across the acute care sector. This demonstrates the case for Western Australia to increase its expenditure on public health and prevention from its current level of 2.6% of the total health care budget which is substantially lower than other Organisation for Economic Cooperation and Development countries, including the USA (3.3%), New Zealand (4.9%) and Canada (7.3%).

Recommendation 2

That the Government increase its expenditure on public health and prevention from its current level of 2.6% of the total healthcare budget to at least 4% in the 2011-12 budget with a plan to increase the level to 6% by 2014-15. This investment is imperative in order to create strong, healthy communities by increasing the number of children who are school-ready, reducing the burden of chronic disease, reducing the rate of infant mortality, and limiting the future burden on Western Australia's hospitals.

The Australian Early Development Index (AEDI)

The AEDI is a population measure of children's development in their first year of full-time school. It measures five areas of early childhood development from information collected through a teacher-completed checklist:

- physical health and wellbeing - physical readiness for the day; physical independence; gross and fine motor skills;
- social competence - overall social competence; responsibility and respect; approaches to learning; readiness to explore new things;
- emotional maturity - pro-social and helping behaviour; anxious and tearful behaviour; aggressive behaviour; hyperactivity and inattention;
- language and cognitive skills - basic literacy; interest in literacy, numeracy and memory; advanced literacy; basic numeracy; and
- communication skills and general knowledge.

Following a pilot in Perth metropolitan northern suburbs, a decision was made to implement the AEDI across Australia. The first national AEDI was completed in 2009. Information was collected from more than 261,000 children in metropolitan and rural communities (97.5% of the estimated five-year-old population), in their first year of full time school.[77]

AEDI scores range from 0-10 with 0 being the lowest. Results are presented as average scores with children being described as either 'developmentally on track', 'developmentally at risk' or 'developmentally vulnerable'. Children who score in the lowest 10 per cent of the AEDI population are classified as 'developmentally vulnerable'. These children demonstrate a much lower-than-average ability in the developmental domain.

According to the AEDI report, the majority of children are doing well on each of the five developmental domains. However, 23.5% of Australian children are developmentally vulnerable on one or more domain/s and 11.8% are developmentally vulnerable on two or more of the domains. These figures are significantly higher for children in very remote areas (47.2% and 37.6% respectively). A total of 47.3% of Indigenous children were vulnerable on one or more domain, and 29.5% were vulnerable on two or more domains.

Western Australia performs well in comparison to the other States and Territories in relation to the social competence and emotional maturity domains. However, greater proportions of Western Australian children were vulnerable on the language and cognitive skills domain and the physical health and wellbeing domain compared to the national average (Figure 2.1). Nearly a third (32.8%) of Western Australian children were developmentally vulnerable or developmentally at risk on the language and cognitive skills domain (Figure 2.2).

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77 Centre for Community Child Health and Telethon Institute for Child Health Research, *A Snapshot of Early Childhood Development in Australia - AEDI National Report 2009*, Australian Government, Canberra, 2009, ppiv, 2.

Figure 2.1- AEDI results for all jurisdictions, 2009

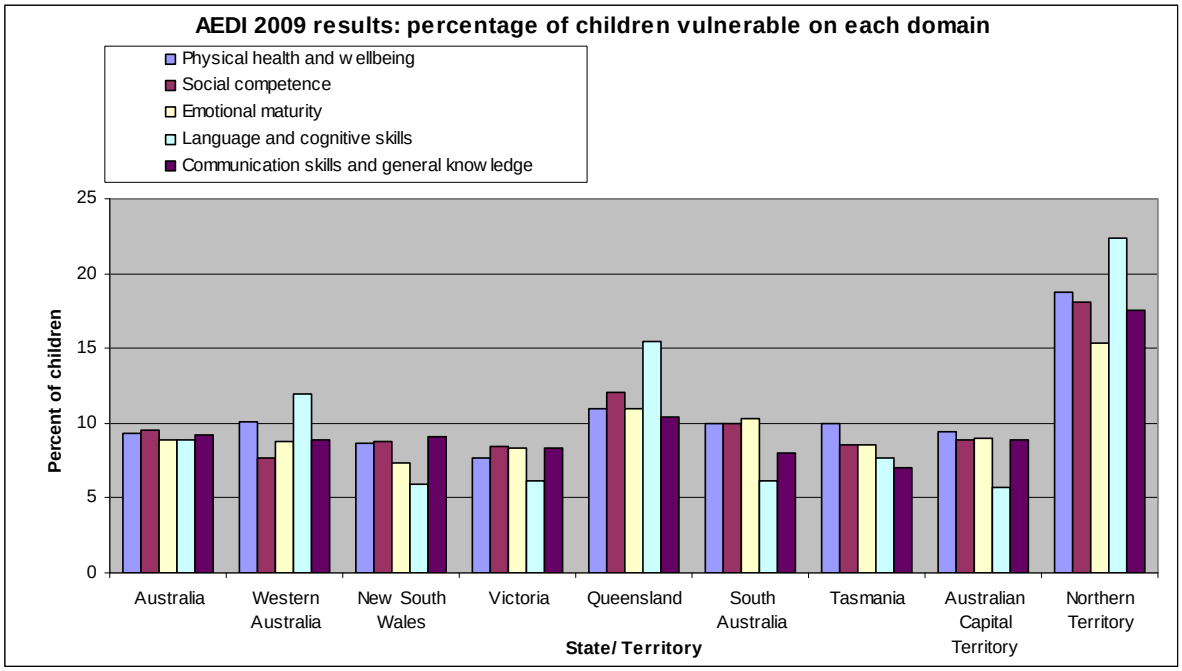
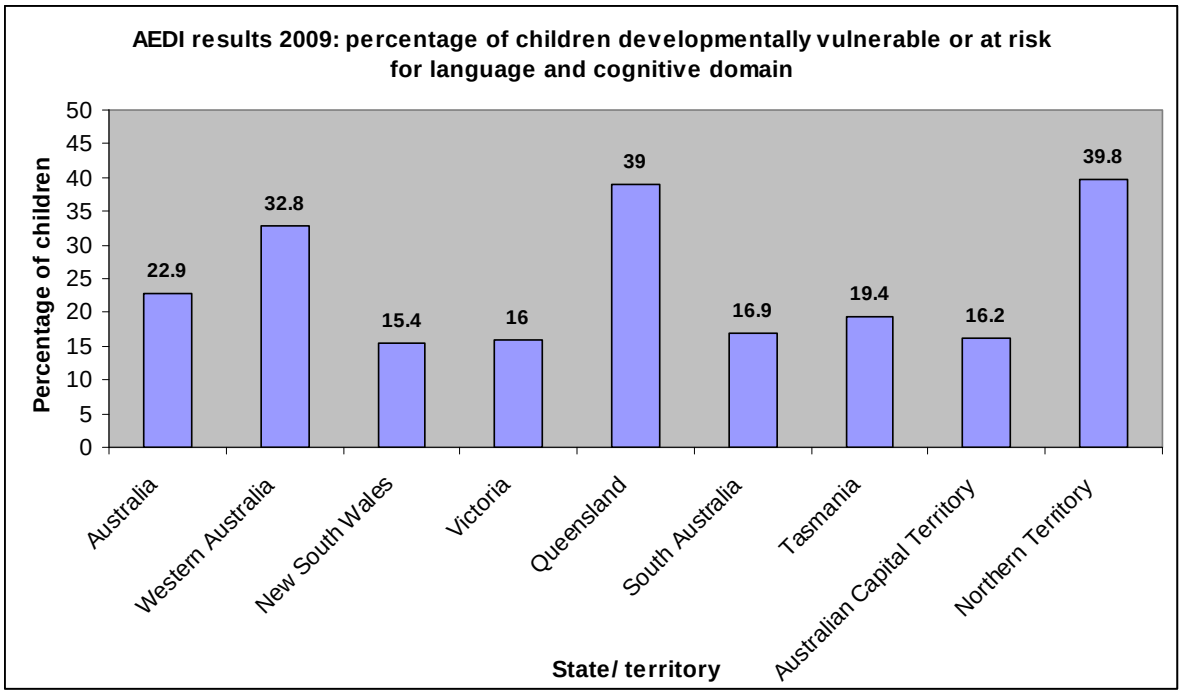


Figure 2.2- Proportion of children at risk- language and cognitive domain



Immunisation

Immunisation is a key indicator of children's health and wellbeing and is one of the most cost-effective public health interventions in preventing childhood morbidity and mortality.[78] The National Health and Medical Research Council (NHMRC) recommend an immunisation coverage of more than 90% of children at two years of age, and near-100% coverage of children at school entry age.

While Australia meets the target of 90% coverage for two-year-olds (93%), coverage for school aged children is below the near-100% target at 88%. Australia ranked 19th out of 30 OECD countries with a combined average of 93% for DTP, poliomyelititis, Hib and measles vaccine in 2007 for immunisation coverage of children aged one year.[79]

Western Australia's immunisation coverage for two-year-olds (91.2%) is the lowest of all states and territories and is slightly below the national average of 92.5%. The Australian Capital Territory and the Northern Territory have the highest coverage rate at 94.9% and 93.6% respectively.[80] Immunisation coverage of Western Australian school aged children (80.9%) is lower than the national coverage (82.6%)[81] and significantly lower than the international benchmark of near-100%.

Infant mortality

Australia ranked 20th out of 27 OECD countries with 5 deaths per 1,000 live births compared to best international practice of 2.3 deaths per 1,000 live births.[82] Western Australia's rate (4.9 per 1,000) is comparable with the national average but significantly lower than best practice.[83]

Teenage births

A range of long term risks, including poor health outcomes, are associated with children born to teenage mothers. The Western Australian rate of teenage births per 1,000 (21.5) is higher than the national rate (17.3).[84]

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78 Pollard, A., 'Childhood immunization: what is the future?', *Archives of Disease in Childhood*, Vol. 92, No. 5, 2007, pp426-33 in AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For a Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58, April 2008, p16.

79 AIHW, *A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, 2009, p125.

80 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 23 February 2010.

81 Medicare Australia, 'Australian Childhood Immunisation Register Statistics', December 2009. Available at: www.medicareaustralia.gov.au/provider/patients/acir/statistics.jsp. Accessed on 9 February 2010.

82 ARACY, *Report Card: The Wellbeing of Young Australians*, Australian Research Alliance for Children and Youth, Canberra, 2008, p5.

83 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

Low birthweight

Low birth weight (<2500 grams) is associated with increased risk of lengthy hospitalisation after birth, the need for resuscitation, and death. Children with low birth weight are also more likely to have a range of neurological and physical disabilities.[85] Australia ranked 7th out of 18 OECD countries in 2005 with 6.4% of infants being of low birth weight.[86] The percentage of Western Australians born of low birth weight reflects the national average.[87]

The percentage of children born of low birth weight is higher in disadvantaged populations and very remote areas. Western Australia had the greatest difference between rates for low socio-economic (8.5%) and high socio-economic areas (5.3%): the largest gulf between rich and poor.[88]

Overweight and obesity

Overweight and obese children are at risk of serious health conditions in both the short and long term, such as asthma, cardiovascular conditions and Type 2 diabetes. Over one-fifth of Australian children aged 2–12 years were estimated to be overweight or obese in 2007.[89] Based on a survey conducted in 2003, 21.7% of boys and 27.8% of girls were overweight or obese in Western Australia and it is estimated that the prevalence has increased since this time.[90]

Literacy and numeracy

The proportion of Western Australian children achieving at or above the national minimum standard for literacy and numeracy at grade 5 is slightly below the national figure: 89.1% of Western Australians achieved at or above the minimum standard for literacy compared to 91.0% nationally; 91.1% of Western Australians achieved at or above the minimum standard for numeracy compared to a national figure of 92.7%.[91]

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84 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

85 AIHW, *A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, 2009, p72.

86 ARACY, *Report Card: The Wellbeing of Young Australians*, Australian Research Alliance for Children and Youth, Canberra, 2008, p4.

87 Laws, P. and Sullivan E. *Australia's Mothers and Babies 2007. Perinatal Statistics Series no. 23 Cat. no. PER 48*, AIHW National Perinatal Statistics Unit, Sydney, 2009, p68.

88 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 11 February 2010.

89 AIHW, *A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, 2009, p75.

90 Department of Health, *WA Morbid Obesity Model of Care*, Government of Western Australia, Perth, 2008, p11.

91 AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58 April 2008, p163.

Finding 5

Western Australia's performance is below the national average on a range of child health indicators. This includes a higher rate of teenage births; lower immunisation coverage; a greater proportion of children who are overweight or obese; fewer children achieving literacy and numeracy benchmarks; and greater proportions of children who are developmentally vulnerable on the language and cognitive domain, and the physical health and wellbeing domain of the Australian Early Development Index.

Indigenous children

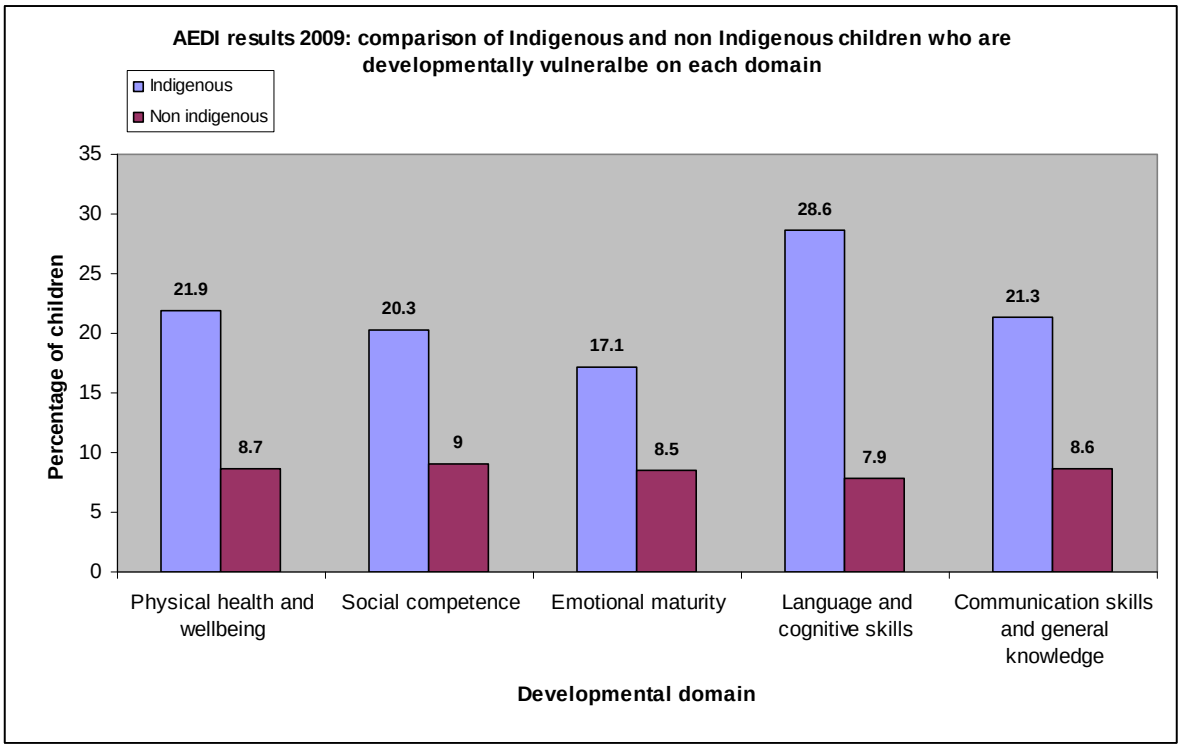
The appalling state of Indigenous health has been the subject of numerous reports and inquiries and has been identified as a priority by all jurisdictions in Australia. As is the case for the general population, poor health outcomes for Indigenous people are often the result of early childhood experiences:

> *Health disadvantage begins at an early age and continues to adversely affect their wellbeing throughout life. At all ages, the burden of disease and injury among Indigenous Australians is higher than for other Australians. For Indigenous children, this burden is driven by neonatal causes (such as low birthweight), mental disorders, congenital anomalies and asthma.*[92]

AEDI results indicate that a greater proportion of Indigenous children are developmentally vulnerable on all developmental domains. A total of 47.3% of Indigenous children were vulnerable on one or more domain, which is twice the rate of non-Indigenous children (23.4%); and 9.5% were vulnerable on two or more domains, which is two-and-a-half times the rate of non-Indigenous children (11.8%). Performance in the language and cognitive skills domain is particularly concerning with 28.6% of Indigenous children being vulnerable, and a total of 51.9% being either vulnerable or at risk.

92 AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58 April 2008, p134.

Figure 2.3- Comparison of Indigenous and non-Indigenous children



Nationally, compared to non-indigenous children, Indigenous children are:

- 2.9 times more likely to die at birth.
- 5.4 times more likely to die from sudden infant death syndrome (SIDS).
- 2.6 times more likely to have a neural tube defect.
- 5.4 times more likely to be born to a teenage mother.
- 9.2 times more likely to be in out of home care.
- 3.2 times more likely to die from an injury.
- 2.0 times more likely to be born with a low birth weight.[93]

In some instances, Western Australia's rates are worse than the national rate, placing Indigenous children at even greater disadvantage in this State:

93 AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009,* Australian Institute of Health and Welfare, Canberra, Bulletin 58 April 2008, p134.

- The percentage of Western Australian Indigenous children born of low birth weight is higher (16.2%) than the national average (12.5%).[94]
- Western Australia's rate of Indigenous teenage births per 1,000 (114) is 50% higher than the national rate (79.6).[95]
- Western Australia's immunisation coverage for Indigenous two year olds (85.7%) is lower than the national rate (90.7%).[96]
- Fewer Western Australian Indigenous children achieved at or above the grade 5 minimum literacy and numeracy standards: 51.8% of Indigenous children performed at or above the minimum standard for literacy compared to 63.4% nationally; and 61.6% of Indigenous children performed at or above the minimum standard for numeracy compared to 69.2% nationally.[97]
- Western Australia's rate of Indigenous deaths from injury per 100,000 is higher (24.8) compared to the national rate (21.4).[98]

Finding 6

Western Australia performs below the national average for Indigenous child health on a range of indicators. This includes a higher rate of children born of low birth weight, lower immunisation coverage, a higher rate of teenage births, a higher rate of deaths from injury, and fewer children achieving literacy and numeracy benchmarks.

These statistics highlight the need to invest in community child health services, which are proven to be an effective strategy for addressing poor health outcomes for Indigenous children. A comparison between Indigenous women who attended five or more antenatal sessions with those who did not attend any antenatal sessions reveals the following:

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94 Laws, P. and Sullivan E. *Australia's Mothers and Babies 2007. Perinatal statistics series no. 23 Cat. no. PER 48*, AIHW National Perinatal Statistics Unit, Sydney, 2009, p71.

95 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

96 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

97 AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58, April 2008, p163.

98 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 19 February 2010.

- Of those who attended antenatal sessions, 8.5% had babies of low birth weight, while this figure increased to 41.6% for women who did not attend antenatal sessions.
- Of those who attended antenatal sessions, 8.6% had pre-term babies, while this figure increased to 40.2% for women who did not attend.
- Of those who attended antenatal sessions, 0.7% resulted in peri natal deaths while this figure increased to 9.3% for women who did not attend.[99]

(d) Western Australia's investment in community child health services

Western Australia's investment in community health services has been the subject of significant scrutiny over the past 12 months. The issue has been raised in submissions and by witnesses in recent parliamentary inquiries, and has also been the subject of many parliamentary debates. At no point has anyone supported the view that there has been an adequate investment in this area. Several people commented that this lack of investment was a chronic issue with no additional resources provided for child community health services in the last 20 years:

> *This is not something that has happened just in the past 18 months; it has been happening for the past two decades.*[100]

Comments to this Inquiry include:

> *There has been no investment in community health for a very long time and CHNWA believes that both child and school health services are in crisis.*[101]

> *Western Australia has not been investing in early childhood services commensurate with the growth in basic population, let alone extending the services that might be required. … In each year and last year the birth rate in Western Australia was higher than other states. Despite that, in areas such as child health nurses, we have not experienced an increase in the provision of child health services; in fact, we are lagging significantly behind.*[102]

> *Child Development Services have evolved to different levels in different areas throughout the state and no new investment is being offered to allow for infrastructure and service development. The Reform process has provided for identification of gaps and it is now time to act on this information and provide the resources needed.*[103]

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99 SCRGSP (Steering Committee for the Review of Government Service Provision), *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra, 2009, pp5-6

100 Ms Michelle Scott, Commissioner for Children and Young People, *Transcript of Evidence*, 26 August 2009, p2.

101 Submission No. 41 from Community Health Nurses WA, 18 September 2009, p5.

102 Ms Michelle Scott, Commissioner for Children and Young People, *Transcript of Evidence*, 26 August 2009, p2.

103 Submission No. 23 from Health Consumers' Council, 3 August 2009, p2.

… community child health services have been chronically under-resourced in this state.[104]

Recent Western Australian parliamentary inquiries found that:

There is an urgent priority for the Western Australian government to increase the number of school and child health nurses, especially for metropolitan primary schools.[105]

The future success of Western Australia's child health screening system is contingent upon it being appropriately and adequately staffed.[106]

There are significant issues of access and resourcing. Despite the increasing population and the changing complexity of families needs, there has been a per capita reduction in the resourcing of allied health services.[107]

In Parliament it has been noted that:

There have been very long waiting periods and a significant lack of staffing across the board in Western Australia. … It has been obvious that during the time of the last coalition government, through the years of the Labor government, until the present, there has been no significant increase in numbers. [108]

No additional funding has been applied to this area … certainly for the last four years. … Outside CPI increase, there has been no additional funding. The problem has been that Western Australia has had a substantial population growth, in both people coming to the state and birth rates. The pressure on us is that if we do not address this issue, there will be subsequent downstream effects when these children reach adulthood with greater cost then to the community.[109]

This is not the budget specifically for individual child development centres; this is the budget for Child and Adolescent Health Services. Last year's budget was $55.8 million; this year's budget is $56.7 million - an increase of $900,000. The problem is two fold. One problem is that that is a minuscule increase in budget. It is not a decrease but it is a minuscule increase in budget.[110]

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104 Dr John Wray, Paediatrician, *Transcript of Evidence*, 31 August 2009, p2.

105 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, pxxix.

106 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, pxxxi.

107 Community Development and Justice Standing Committee, *Inquiry Into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, Legislative Assembly, Perth, 2009, pxviii.

108 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE543.

109 Dr Peter Flett, Director General, Department of Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE543.

110 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 22 September 2009, p7397.

There has also been significant media interest in this issue with numerous reports and editorials:

> *It is evident that availability of what should be regarded as essential services for children has fallen a long way behind demand. … There is now a clear obligation on the Government to increase significantly the health services available to children.* [111]

In relation to investment in Indigenous child health, it has been noted that:

> *… we would need to spend around 40% to 70% more on health care for Indigenous children compared with non-Indigenous children in order to reflect the discrepancies in health and wellbeing and address Indigenous health disadvantage. Currently though, health care expenditure for Aboriginal and Torres Strait Islander peoples is only 18% higher than for other Australians and at this level of funding we have not been able to reduce the disparity in health status.*[112]

Finding 7

Despite significant population growth and increased demand, there has been a chronic failure to invest in Western Australian child community health services over the last two decades.

The issue of lack of investment in child health is not limited to community health services, with other areas such as mental health also being highlighted as requiring critical investment:

> *WA psychiatrists say child mental health services are being hit hard by budget cutbacks, with fewer staff treating only a quarter of the children thought to be at risk of potentially serious conditions such as suicidal thoughts. Dr Caroline Goossens, of the Royal Australian and New Zealand College of Psychiatrists' faculty of child psychiatry in WA, said Government-funded services had been "hideously" under-resourced for some time but were now at a critical level because of a freeze on hiring staff. "We're supposed to be seeing about 4 per cent of the population from infancy to 18 with quite severe mental health difficulties and we're probably currently resourced to see less than one per cent," she said.*[113]

While there is general agreement regarding the lack of investment in child community health services, it has not been possible to determine with accuracy how the funding has changed over time or what the current allocation within the Department of Health is. Funding for Child and

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111 Editorial, 'We can't afford not to boost child health services', *The West Australian*, 23 May 2009, p20.

112 Department of Health, *Framework for Child and Youth Health Services*, Government of Western Australia, Perth, 2008, p29.

113 Cathy O'Leary, 'Child mental health critically underfunded', *The West Australian*, 16 September 2009, available at: http://au.news.yahoo.com/thewest/a/-/newshome/6037669/child-mental-health-critically-underfunded/. Accessed on 10 February 2010.

Adolescent Community Health (CACH) is not reported separately in the WA health budget, and varying figures have been cited. For example:

- In the May 2009 Estimates hearings, it was reported that CACH's expenditure was: $45,971,000 for 2006-07; $51,279,000 for 2007-08; and $54,976,000 for 2008-09.[114]
- In September 2009, it was reported that the budget for CACH was $55.8 million in 2008-09 and $56.7 million for 2009-10.[115]
- In November the budget for CACH for 2008-09 was reported as $51.3 million.[116]

Recommendation 3

That the Department of Health report separately in its annual budget on the total allocation for community child health services, including a detailed breakdown of program funds.

2.3 Overview of community health services

Child and Adolescent Community Health (for metropolitan children) and WA Country Health Services provide a comprehensive range of health promotion, early identification and community-based intervention services to children and families. Services focus on growth and development in the early years and promoting well-being during childhood and adolescence.

Services are delivered through three main areas: child health, school health and child development. Groups at risk of poorer health outcomes, such as Aboriginal and Torres Strait Islander peoples and newly arrived refugees, are a particular area of focus for these services. These services play a vital role in the early detection and prevention of child health and developmental problems across the State. A three-tiered approach is used by the Department:

- Screening - universal and targeted services aimed at detecting vision, hearing, speech, growth, and other health and developmental issues.

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114 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE594.

115 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 22 September 2009, p7397.

116 Department of Health, Response to Question on Notice from Education and Health Standing Committee, 3 November 2009, p6.

- Surveillance - ongoing monitoring of a child's health and development through to the end of schooling.
- Promotion - to try and ensure that children remain healthy and do not develop known health conditions such as obesity, diabetes, skin cancer, or addiction to alcohol and illicit drugs.

(a) Child and maternal health

Child health nurses play a key role in supporting all parents to care for their young children (0-4 years), providing important prevention, early detection and early intervention services. Universal and targeted services are offered, commencing with contact with all mothers of newborns. Child health nurses are a vital entry point for families with young children into health and social services and provide a unique opportunity to improve outcomes for families experiencing difficulties in caring for their children.

There are a total of seven universal visits made by these nurses at the key developmental ages of 0-10 days, 6-8 weeks, 3-4 months, 8 months, 18 months and three years, as well as a range of targeted and specialist services as appropriate. The universal assessments include:

- Developmental assessments.
- Screening and surveillance.
- Psychosocial assessment.
- Information regarding parenting, child health and development, child behaviour, maternal health and wellbeing, child safety, immunisation, breastfeeding, nutrition and family planning.
- Referral to other specialist services.

Parents can also seek additional support from the child health nurse if they have any concerns about the health and development of their child, or if they have any concerns about their own health.

(b) School health

School aged children undergo rapid social, emotional, mental and physical development. During this time, children are developing a range of skills, attitudes and behaviours that will affect their health both now and in the future. Schools are ideally placed to support and enhance the health and wellbeing of all children, particularly those who are disadvantaged and at higher risk of health problems.

Health services are provided by DOH on site and in collaboration with public and private schools. School health nurses provide:

- Universal and targeted prevention.
- Health promotion.
- Early identification.
- Intervention.

This includes early identification of developmental concerns regarding:

- Vision.
- Hearing.
- Speech and language development.
- Psychosocial wellbeing.
- General development, including body weight issues.

School health nurses also contribute specialist expertise to enhance the care and optimal development of students with particular health needs.

The National Health and Hospitals Reform Commission supports the important role of school health nurses and recommended:

> *… that all primary schools have access to a child and family health nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.*[117]

(c) Child development services

Child development services provide a range of assessment, early intervention and therapy services for children with, or at risk of developmental delay and disorders. Services are provided by 11 teams in the metropolitan Child Development Service (CDS) and through the WA Country Health Services. Services are delivered by a range of health professionals including speech pathologists, occupational therapists, paediatricians, physiotherapists, social workers, clinical psychologists, audiologists, dieticians, podiatrists, and nurses along with administrative staff.

Child development services also play an important role in health prevention and promotion through:

- the delivery of community education;

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117 National Health and Hospital Reforms Commission, *A Healthier Future for all Australians*, Commonwealth Government of Australia, Canberra, 2009, p20.

- professional development; and
- programs aimed at preventing the development or progression of a disorder or delay, and ameliorating the impact of any disorder or delay.

Developmental and behavioural problems are reported to occur in about 15-20% of all children.[118]

Child development service reforms

In the metropolitan area, child development services have undergone a major reform process over the last few years. The reforms arose out of a review conducted by the Health Reform Implementation Taskforce (HRIT) which found that the varied history of each child development centre had resulted in a fragmented service with different models of care and approaches to therapy for developmentally delayed children. This review referred to a 'postcode lottery' in which:

> *… many children received insufficient intervention, too late for it to be truly "early" with a commensurate increase in the need for ongoing therapy.*[119]

The reform process has resulted in the formation of a single metropolitan Child Development Service which forms part of an integrated child and adolescent community health service. Child development services in rural and remote areas remain within the WA Country Health Service.

The reforms have resulted in:

- the completion of the first service-wide evaluation (the Consumer Perspectives Project) to obtain feedback from consumers and health professions;
- the development of a continuum of care framework which articulates eligibility criteria and the full range of services offered;
- the development of clinical pathways for a range of common conditions;
- standard referral and intake processes;
- Service level agreements/Memoranda of Understanding with the Child and Adolescent Mental Health Service (CAMHS), the Disability Services Commission (DSC), and the WA Country Health Service (WACHS); and
- the development of an information management system, the Child Development Information System (CDIS).

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118 Submission No. 38 from Dr John Wray, 31 August 2009, p1.

119 Health Reform Implementation Taskforce, *Future Directions for Western Australia's Child Development Services*, Government of Western Australia, Perth, 2006, p8.

The CDIS has been described as the linchpin of the reform process, providing the mechanism for streamlining and enhancing administrative procedures, as well as enabling the collection of reliable and accurate data regarding client demographics, services provided and clinical outcomes. At the hearing into the general health screening of children, the Department of Health indicated to the Committee that the CDIS had been piloted in one site and was due to be rolled out across all metropolitan sites by June 2009.

The CDIS has now successfully been implemented across all metropolitan sites. The Department advised that as at February 2010, "some high level data is able to be extracted" with a full set of data expected "later in 2010."[120] Information that has been provided to the Committee from the CDIS for this Report includes the number of active clients and the number of children waiting for services. The development of CDIS is an extremely positive outcome of the reform process and will provide invaluable information for monitoring both service activity and clinical outcomes for children and families. Data from CDIS should be used to inform the annual report card on children's health and wellbeing that is proposed in Chapter Three.

The Committee has also received evidence that the Department is developing a similar data management system for child health and school health nurses, and that the business case for this new system is currently being finalised.[121] The development of this database is crucial to enable the collection of reliable and accurate data for all areas of the State's community child health services.

Recommendation 4

That the Department of Health approve the business case for the development of a database for child health nurses and school health nurses and that the project is progressed as a matter of urgency.

2.4 Gaps in community child health services

(a) Population growth and increased birth rates

Recent parliamentary inquiries by this Committee[122] and the Community Development and Justice Standing Committee[123] report that Western Australia has the strongest rate of population growth

120 Submission Questions on Notice from Department of Health, 24 February 2010, p1.

121 Submission Questions on Notice from Department of Health, 24 February 2010, p1.

122 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, p18.

123 Community Development and Justice Standing Committee, *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children*, Legislative Assembly, Perth, 2009, p40.

of all states and territories. The growth is attributed to increased immigration and a significant increase in the birth rate. In Western Australia, the number of births per year increased by 21.3% over the five-year period 2002-07, as shown in Figure 2.4 below.

Figure 2.4- Births in Western Australia, 1990-2007[124]

There has also been a reported annual increase of 5% in the 0-4 year old population since 2005. This growth is predicted to continue with the projected population of 0-8 year-olds in Western Australia estimated to reach around 250,000 by 2011.[125] In the absence of additional resources, Western Australia's population growth has resulted in a significant increase in the ratio of birth notifications per child health nurse FTE: from 149 in 2002 to 167 in 2006,[126] and this has reportedly increased to 230 notifications per child health nurse FTE in 2009.[127]

As reported by the Department of Health (DOH), population growth has an immediate impact on all areas of community child health services:

> *As a result of this, families with older children (1-3 years) have longer waiting periods before they can access the child health nurse, as families with newborn babies are a*

124 Submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children, 16 February 2009, p11.

125 Submission No. 24 from Commissioner for Children and Young People Western Australia, 30 July 2009, p2.

126 Submission - Question of Notice from hearing held on 19 August 2009, Department of Health, 22 February 2010, Appendix 1, p2.

127 Submission No. 41 from Community Health Nurses WA, 18 September 2009, p4.

priority. This may result in missed opportunities to identify and respond to parental concerns about their child's development at critical developmental ages.[128]

DOH has implemented a range of strategies in the metropolitan area to manage the impact of population growth on community child health services including:

- School health staff members are being reallocated to endeavour to provide a part-time service in all high schools. This means reducing services in some schools.
- Prioritisation of child health services to the very young, and children and families with higher needs.
- Reviewing all activities to ensure that standardised, core services are provided consistently. Some historic local activities are ceasing.[129]

Similar strategies have been adopted in rural areas with resources being prioritised by WACHS to areas of growth and those with the greatest need. Early intervention programs are generally "prioritised over other programs."[130]

Finding 8

As a result of strong population growth, and no corresponding increase in resources, there has been a significant increase in the ratio of birth notifications per child health nurse full time equivalent (FTE). Child health and school health nurses have been forced to prioritise services to those most in need, resulting in many children and families missing out on services. This is contrary to best practice evidence which highlights the critical importance of all children and families having access to a mix of universal and targeted community health services.

(b) Children in care

Children who have been abused or neglected experience a range of poor outcomes including low social competence, language delay, and poor school performance, along with a higher incidence of criminal behaviour and mental health problems.[131] These children are extremely vulnerable and often do not have the same access to medical and community health services as other children.

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128 Submission No. 8 from Department of Health to the Community Development and Justice Standing Committee's Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children, 16 February 2009, pp29-30.

129 Questions on Notice from Department of Health, 24 February 2010, p4.

130 Questions on Notice from Department of Health, 24 February 2010, p4.

131 AIHW, *A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, 2009, p109.

There are more than 3,000 children in care in Western Australia. Almost half are under the age of four; and 75% are under the age of 10. Of the children in care, 41% are Indigenous.

In 2006, the Government commissioned a functional review of the Department for Community Development, known as the Ford Review. Amongst other things, the Ford Review recommended that the Department of Health develop a health plan for every child in care. To progress the implementation of this recommendation, the Departments of Health and Child Protection undertook a six-month pilot project with a view to developing:

> *… a sustainable Statewide framework that helps identify and address the health and developmental needs of children in care.*[132]

The project is based on a community health nurse-led model of health care assessment and planning which covers the physical, developmental, mental and social health needs of children in care. The Committee applauds the Government's commitment and response to the Ford Review recommendations and believes that community child health nurses are well placed to undertake the health care planning for this vulnerable group of children. As noted in the Department of Health's business case, the implementation of health care planning for children in care will result in "increased workloads" for child health nurses although "the full impact has not yet been quantified."[133] Given that this project commenced in April 2009, the increased demand associated with health plans for children in care will be in addition to gaps identified in the Department's business case in 2008 for community health nurses.

Finding 9

With more than 3,000 children in care, the development of health plans will have a significant impact on child health nurses' capacity to deliver services to children and families. This was not factored into the Department of Health's business cases and further demonstrates the urgent need for additional community child health resources.

(c) The impact of the 3% efficiency dividend

As part of the 2009-10 Budget, the Department of Health committed to savings of $126 million as part of the 3% efficiency dividend, $51 million of which was attributed to "FTE efficiencies".[134]

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132 Department of Health, 'Health care planning for children in care', Paper presented at the WA Aboriginal Health Sector Conference 2009: Developing new health leadership, Perth, 25-26 March 2009. Available at: www.healthinfonet.ecu.edu.au/health-resources/bibliography?lid=15659&ref=3. Accessed on 22 February 2010.

133 Question of Notice, Department of Health, 22 February 2010, Appendix 1, p5.

134 Department of Treasury and Finance, *2009-10 Budget Papers*, Government of Western Australia, Perth, 2009, p162.

There have been repeated commitments from both the Minister for Health and DOH's Director General that these efficiencies would not affect 'front line services':

> *We know that there will not be any reductions in front-line services. In fact, I will not let there be any reductions in front-line services. … I have told those senior managers that that is not how they should reduce their costs.*[135]

> *The $51 million budgeted in 2009-10 for "Metropolitan and Country Health Services FTE Efficiencies" represents a reduction of 527 FTE to be achieved by natural attrition; reductions to casual and temporary staff levels; reductions to overtime; reductions to non-core projects; and achieving productivity improvements".*[136]

> *… the 3% applies to all areas that are not in the front line, and it certainly applies in all areas that would not affect any front-line activity.*[137]

While there has been some debate about what constitutes a 'front-line service', evidence from the Department of Health confirms that community health nurses and child development staff are considered 'front line services'.[138] As part of the 3% efficiency dividend, the Child and Adolescent Community Health (CACH) reported savings of $560,0000 and approximately 5 FTE for 2008-09 with the following projected savings:

- $1.75 million and a further 22.5 FTE for 2009-10, and
- $1.1 million and 13.3 FTE for 2010-11.[139]

Most of these current savings are in administrative staff, which has shifted some of their work load onto professional health staff. Front line health services can not function effectively without proper administrative support.

Information supplied by the Department of Health indicates that between 2007-08 and 2008-09 there was an increase of 82 FTE of staff employed at Princess Margaret Hospital (PMH).[140] Also, the Clinical Services Framework 2010 published late in 2009 includes an additional 101 beds at PMH by 2014-15, compared to the projections made in the CSF 2005 document.[141] The

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135 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 13 October 2009, p7838.

136 Hon Dr K. Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE594.

137 Dr Peter Flett, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B* (Hansard), 28 May 2009, pE572.

138 Dr Peter Flett, Director General, Department of Health, *Transcript of Evidence*, 10 November 2009, p5.

139 Reply to Questions on Notice from Department of Health, 24 February 2010, p2.

140 Reply to Questions on Notice from Department of Health, 19 August 2009, p1.

141 Department of Health, *WA Health Clinical Services Framework 2005-2015*, Government of WA, Perth, 2004, p11d and Department of Health, *WA Health Clinical Services Framework 2010-2020*, Government of WA, Perth, 2009, p22.

Committee welcomes the Government's increased investment in acute services at PMH. However, this information highlights the different approach to the Government's resource allocation priorities for acute and community child health services.

The issue of whether the 3% efficiency dividend has resulted in cuts to services has been the source of significant controversy. Evidence to this Committee indicates that a number of strategies have been adopted to achieve savings, including not backfilling positions when staff are on annual leave, maternity leave, or when staff reduce their hours for a range of reasons.

> *We have trimmed back on some of the non-clinical areas. … We might be reducing the FTE while somebody is on leave. So in terms of still trying to maintain that front-line services we might trim the FTE down somewhat to create the efficiencies needed to achieve budget, which is a core requirement for me and Health.*[142]

> *The positions have not been abolished - merely, when somebody in a position goes on maternity leave or cuts down from full time to 0.6, from one FTE* [full time equivalent] *to 0.6 FTE, whereas one would normally be able to fill the 0.4 gap. That it no longer being approved.*[143]

> *… when people are going on maternity leave they are not being replaced. That is impacting on the provision of therapy services.*[144]

The decision to not backfill contracts has a significant impact on overall staffing levels. As at September 2009, there were a total of 140 authorised FTE in the metropolitan Child Development Service. A decision to not backfill annual leave alone would result in a 7.7% reduction in staffing, or 10.8 FTE. According to the Department of Health, there were 22 positions that were not backfilled during 2009 for varying amounts of time; from 2 weeks up to 12 months.[145] In response to a question on notice regarding the impact this has had on clients, the Department stated:

- *Increased waiting times.*
- *Increased numbers waiting for assessment, thus delayed assessment appointments.*
- *Immediate cessation of treatment/therapy/intervention plan – including cancellation of therapy groups where parents were already notified, cancellation of review appointments, further delays that [sic] initially reported.*
- *As many contracts were declined with short notice, parents and families often had to deal with sudden cancellation of appointments – thus an increase in complaints to the service.*

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142 Mr Philip Aylward, Executive Director Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p4.

143 Dr John Wray, Paediatrician, *Transcript of Evidence*, 31 August 2009, p5.

144 Ms Michelle Scott, Commissioner for Children and Young People Western Australia, *Transcript of Evidence*, 26 August 2009, p6.

145 Questions on Notice from Department of Health, 24 February 2010, p6.

- *Many clients had developed relationships with the child's therapist, when their contracts were declined, thus loss of continuity of care.*[146]

There has also been significant debate surrounding the decision to not renew 12 FTE contracts within the metropolitan Child Development Service. These FTE were created from within the 2008-09 Budget to:

> *… deal with the transition of child development centres, but also to deal with what were long waitlists at the time.*[147]

The Department indicated that the decision to not renew these contracts was not related to the 3% efficiency dividend:

> *They were for a set period of time. There was no specific additional budget provided for that work. … But the contracts have now reached the end and we are not renewing them, because the funding is no longer provided. It is unrelated to the 3% efficiency changes or requested strategies that were asked of health by government. They are just part of our normal budgetary management. They have achieved the purpose.*[148]

The Committee notes that the 12 FTE were put in place for two reasons: to support the child development service reforms, and to address long waitlists. The 12 FTE was comprised of staff across the allied health services but more than half were from those services with the longest waiting times- speech pathology and occupational therapy:

- 5.0 speech pathologists;
- 2.4 occupational therapists;
- 1.9 physiotherapists;
- 1.1 clinical psychologists;
- 0.9 social workers;
- 0.4 dieticians; and
- 0.4 audiologists.

At the time the 12 FTE were discontinued, waitlists clearly continued to be a major issue with children waiting an average of:

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146 Questions on Notice from Department of Health, 24 February 2010, p6.

147 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p7.

148 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p7.

- 15 months for speech pathology
- 11 months for occupational therapy
- 10 months for physiotherapy
- 9 months for paediatrics
- 9 months for clinical psychology and
- 4 months for social work.

The Committee accepts the Department's evidence that the decision to not continue these contracts was not a direct result of the 3% efficiency dividend. However, it is clear that any reduction in staffing would further exacerbate the extremely long waiting lists that existed at that time, especially for speech pathology and occupational therapy, and would therefore further jeopardise the health and wellbeing of the many thousands of children waiting for services.

Finding 10

Despite increasing demand and unacceptably long waiting lists, the number of full time equivalent (FTE) staff in community child health services is declining. There was a loss of 5 FTE in 2008-09 with a projected loss of 22.5 FTE in 2009-10 and 13.3 FTE in 2010-11.

In addition, the metropolitan Child Development Service has been subject to a range of budget management strategies including not backfilling staff when they are on leave or have reduced their hours for a variety of reasons, as well as the decision to not continue 12 temporary FTE that were established in 2008-09 to support reforms and deal with waitlists.

Recommendation 5

In light of increasing demand and an already under-resourced service, the Government's 3% efficiency dividend should not continue to be applied to community child health services.

(d) Metropolitan Child Development Service waiting lists

Until recently, the metropolitan Child Development Service sites relied on a mixture of paper-based records and locally developed electronic databases and it was therefore not possible for the Department to extract reliable and accurate data regarding waiting lists and waiting times. The Child Development Information System (CDIS), which has now been implemented across all metropolitan sites, will enable the collection of data regarding client demographics, services

received and clinical outcomes. As of February 2010, the Department of Health has advised that CDIS is currently able to produce "high level" data with a full data set expected "later in 2010".[149]

The Committee received evidence that prior to 2009 there was significant differences in the way waitlists were managed across the various sites. This resulted in some centres completing an assessment appointment relatively quickly while for some children that was all that was required, for others this resulted in a significant wait between initial assessment and treatment. At other sites, there may have been a significant wait for the initial assessment, but therapy would commence immediately following the assessment.[150]

As part of the reform process, a new service model has been implemented to reflect the best available evidence. The purpose of this model is to ensure continuity of care with treatment commencing within four weeks of assessment. According to the Department, waiting lists vary throughout the year and can be cyclical. For example, a large number of referrals are made at the beginning of the school year and a high demand for speech pathology services exists from July to September.[151]

The Committee acknowledges that there have been changes to the way waitlists are managed and that the data is therefore not directly comparable. Nonetheless, figures provided to the Committee indicate that there has been a significant increase in waiting times over the past 15 months (Table 2.1). Even if the comparison is limited to figures for September 2009 and December 2009, following implementation of the new service model, waiting times have continued to grow with the speech pathology waiting time increasing by 10% in just 3 months.

The Committee's *Health Child- Healthy State* Inquiry heard evidence that waiting times of about 9-12 months for child health services were common in 2008, with the Health Reform Implementation Taskforce reporting varying waiting times of "between two to 18 months" between regions.[152]

With the implementation of CDIS, the Department is able to identify the total number of children waiting for services for the first time. As at January 2010 there were a total of 6,405 children waiting for services. Given the Department's advice that there is generally an influx of referrals at the beginning of the school year, it is reasonable to assume that the number of children waiting for services would have increased since then. It is clear that despite the significant reforms undertaken, child development services are unable to cope with the increasing demand that flows from ongoing population growth. There has been no evidence to the Committee that the worsening of waiting times and waiting lists is due to an increase in the rates of diagnosis of children with health conditions requiring the services provided by the CDS.

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149 Questions on Notice from Department of Health, 24 February 2010, p1.

150 Questions on Notice, Department of Health, 22 February 2010, pp2-3.

151 Questions on Notice, Department of Health, 22 February 2010, p2.

152 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, p42.

Table 2.1- Waiting times for child development services, 2008-09

Discipline	Waiting time between referral and assessment (months)			
	October 2008[153]	September 2009	December 2009	Change 2008-2009
Speech pathology	8	15	16.6	**+108%**
Occupational therapy	8	11	13	**+62%**
Paediatrics	9	9	10	**+11%**
Physiotherapy	6	10	11	**+83%**
Clinical psychology	6	9	9	**+50%**
Social work	4	4	5	**+25%**

All figures are provided as averages across the CDS and reflect the waiting time between referral and initial assessment. As previously mentioned, various methods for managing waiting lists were in place in 2008. This resulted in children also waiting an average of three months between assessment and treatment. The September 2009 and December 2009 figures reflect the new service model in which children receive treatment within four weeks of assessment. The Committee has not received any evidence to verify whether this four week target is being met.

The Department of Health told the Committee that there was limited value in comparing the averages from 2008 with those produced by the CDIS in 2009 as "Data was not collected consistently across child development services prior to 2009 and is therefore not considered as reliable, for comparison purposes."[154] However, previous waiting time data from 2004 and 2005 provided to Parliament by DOH for the South Metropolitan Health Service and the North Metropolitan Health Service are less than, or similar to, the average for 2008 provided by DOH above - another indicator that waiting times have dramatically increased (see Table 2.2 below for this older data).

153 Note that on average children also waited an additional three months between assessment and treatment so the total waiting time was significantly higher than these figures.

154 Mr Kim Snowball, Acting Director General, Department of Health, Letter, 9 March 2010, p1.

Table 2.2- Waiting time for first assessment- NMHS and SMHS, 2004-05[155]

CDS Centre	Speech pathology (months)	Occupational therapy (months)	Physiotherapy (months)
North Metro Health Service*			
Clarkson	8.3	7	7
Joondalup	8	4	8
Koondoola	6	8	12
Midland	5	8	1
Lockridge	3	7	1
High Wycombe	2	21	No service
South Metro Health Service (0-3 yrs)#			
Armadale	10	4.5	0.3
Bentley	6-9	6	1-2
Fremantle	2	3	2
Peel/Rockingham	6	4.5	1
South Metro Health Service (4-9 yrs)#			
Armadale	7	3.5	0.5
Bentley	9-12	12	3
Fremantle	2	9	12
Peel/Rockingham	12	20.5	0

As at February 2005

* As at December 2004

155 Hon S. Ellery, Parliamentary Secretary representing the Minister for Health, Western Australia, Legislative Council, *Question on Notice, Parliamentary Debates* (Hansard), 18 May 2005, pp1805-1807.

Finding 11

As at January 2010, there were 6,405 children waiting for child development services and waiting times are getting progressively worse. In the three months between September 2009 and December 2009, waiting times have increased for all disciplines with the exception of clinical psychology which remained constant. The most recent data indicates that children are waiting an average of:

- 16.6 months for speech pathology;
- 13 months for occupational therapy;
- 10 months for paediatrics;
- 11 months for physiotherapy;
- 9 months for clinical psychology; and
- 5 months for social work.

Finding 12

The situation for Western Australia's children is unacceptable and it will continue to deteriorate unless there is an immediate and significant increase in community child health resources. The current situation has developed over a number of years and there have been a range of contributing factors including:

- Western Australia's strong population growth which has resulted in a significant increase in demand for services;
- A chronic lack of investment in community child health services over the last two decades; and
- The lack of an adequate resource allocation model for community child health services that reflects population growth and service demand.

Finding 13

The current business cases for additional child health nurses, school health nurses and child development staff are based on staffing needs that were identified in 2008. The number of full time equivalent (FTE) required is already two years out of date and during this time Western Australia has continued to experience strong population growth, child development service waiting lists have continued to grow and child health nurses have been required to take on additional work associated with implementing a health plan for children in care.

Recommendation 6

The Department of Health provide an annual report on child development service waiting lists for each discipline including the waiting time between referral and assessment, and the waiting time between assessment and treatment by age group (such as 0-3 year-olds, 3-6 year-olds, 7-12 year-olds, 12-16 year-olds).

CHAPTER 3 SECURING THE FUTURE OF WESTERN AUSTRALIAN CHILDREN

3.1 Adequate resourcing for community child health services

(a) Current needs

The Committee received evidence in its previous inquiry that the Department of Health submitted a business case for 2008-09 that identified a staffing shortfall of 366 FTE across community child health services.[156] The Committee is aware that these business cases have recently been updated and submitted as part of the 2010-11 Budget process. Unfortunately the Committee was not able to obtain a copy of the updated business cases prior to finalising this Report. However, it is understood that the total number of FTE requested remains about the same.

Recommendation 7

That a copy of the updated business cases for child health nurses, school health nurses and child development staff submitted by the Department of Health as part of the 2010-11 State Budget process, be tabled in Parliament when the Budget is presented in May 2010.

The gaps identified in the business cases are now two years out of date, during which time Western Australia has continued to experience the strongest population growth of all states and territories with a 3% increase for the twelve months to June 2009.[157]

In order to avoid a similar situation developing in the future, it is important that community child health services are quarantined from any further reduction in existing staffing levels and that the business cases are approved as part of the 2010-11 State Budget. Like many countries around the world, Western Australia has been operating in an environment of fiscal restraint as a result of the global financial crisis. However, the State appears to have emerged from the economic downturn with a number of commentators predicting strong growth over the coming years:

> *… 2010 looks set to mark the beginning of a new wave of growth and prosperity for the State. … the WA economy is expected to grow by 4¼ percent in 2010-11, 5% in 2011-12*

156 Education and Health Standing Committee, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Perth, 2009, p104.

157 ABS, *3101.0. - Australian Demographic Statistics,* June 2009, Australian Bureau of Statistics, Canberra. Available at www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0/. Accessed on 12 February 2010.

> *and 6% by 2012-13. A return to growth in the world's major economies is expected to boost the State's export returns, and provide the impetus for the State's investment cycle.*[158]
>
> *The resource boom years of 2006 to 2008 seen in the State would pale in comparison to the next round of prosperity.*[159]

While the Department of Treasury and Finance originally forecast a contraction of 1.25% in the State's economy for 2009-10, this has been revised to predicted growth of 2.25%.[160] The mid-year financial projections also paint a positive picture for the State's economy over the next few years and there is now a projected growth of 2.75% in 2010-11, increasing to 4.0% in 2011-12 and 4.75% in 2012-13.[161] Based on the State's 2008-09 Gross State Product of $156.6 billion[162], this projected growth would equate to an additional $3.52 billion in 2009-10; $4.4 billion in 2010-11; and $6.58 billion in 2011-12.[163]

Based on this evidence, Western Australia is well positioned financially to respond to the demonstrated need for additional resources to be allocated to community child health.

Finding 14

Western Australia's economy has emerged from the economic downturn with strong growth predicted over the coming years. Western Australia can clearly afford the additional staff required for community child health services.

158 CCIWA, *WA Economic Compass Outlook - December Quarter 2009*, Chamber of Commerce and Industry Western Australia, Perth, 2009, p3-6.

159 Access Economics, *Business Outlook December 2009 - The Recovery: Mild Not Wild*, Access Economics, Canberra, 2009, p107.

160 Department of Treasury and Finance, *2009-10 Government Mid-year Financial Projections Statement*, Government of Western Australia, Perth, 2009, p43.

161 Department of Treasury and Finance, *2009-10 Government Mid-year Financial Projections Statement*, Government of Western Australia, Perth, 2009, p44.

162 ABS, *5220.0- Australian National Accounts: State Accounts 2008-09,* Australian Bureau of Statistics, Canberra, 2009. Available at www.abs.gov.au/AusStats/ABS@.nsf/Latestproducts/5220.0Main%20Features22008-09%20(Reissue)?opendocument&tabname=Summary&prodno=5220.0&issue=2008-09%20(Reissue)&num=&view=. Accessed on 26 February 2010, p12.

163 Actual figures based on compounding of projected Gross State Product.

Recommendation 8

There should be no further attrition of community child health staff employed by the Department of Health, and the Government should provide funding in the 2010-2011 State Budget for the additional 105 child health nurses, 135 school health nurses and 126 child development staff identified in 2008. The funding needs to be in addition to existing staffing levels and quarantined for child community child health services.

(b) Future needs

The Reid Report found that the development of a resource allocation model that is "fair, supports the Area Health Service structure, promotes transparency and accountability, and enables protection of vulnerable groups" is fundamental to meeting the future health care needs of Western Australians.[164] Historical-based funding was described as "deficient" and the report recommended that community health service funding should be:

> *… population based with the population size to be weighted for a variety of factors such as age, Aboriginality, and socio-economic differentials.*[165]

According to the Department, community health services continue to be block-funded based on historical budget and expenditure trends.[166] Historical-based funding for community child health services has resulted in the current shortfall of at least 366 FTE. In order to avoid a similar situation occurring in the future, it is imperative that a resource allocation model is developed for community child health services as a matter of priority. The model should be informed by population-based planning that is weighted for a range of factors including age, Aboriginality, socio-economic status, culturally and linguistically diverse (CALD) status, and Australian Early Development Index (AEDI) results.

Finding 15

In the absence of a resource allocation model for community child health, the Department of Health is not able to plan and respond appropriately to projected population growth and increased demand for child community health services.

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164 Health Reform Committee, *A Healthy Future for West Australians*, Department of Health, Western Australia, 2004, p105.

165 Health Reform Committee, *A Healthy Future for West Australians*, Department of Health, Western Australia, 2004, p106.

166 Submission Questions on Notice from Department of Health, 24 February 2010, p4.

Recommendation 9

That the Department of Health develop and implement a resource allocation model for child community child health services within 12 months. The model should be based on established benchmarks for staff to client ratios and informed by population based planning that is weighted for a range of factors including age, Aboriginality, socio-economic status, culturally and linguistically diverse (CALD) status, and Australian Early Development Index (AEDI) results.

3.2 Monitoring the health and wellbeing of our children

(a) Report cards

> *What is to be gained by measuring and comparing child well-being in different countries? The answer lies in the maxim 'to improve something, first measure it'.*[167]

Report cards have been used by governments and non government organisations around the world as a mechanism to identify areas for improvement in children's health and wellbeing.

In Australia, the Australian Bureau of Statistics (ABS) has collected and published a broad range of demographic, social and economic data for over 100 years. However, dedicated reports on children's health and wellbeing have only emerged in the last two decades. The Australian Institute of Health and Welfare (AIHW) is the main source of statistical reports in this area and has produced a total of seven reports since 1996. The most recent publication, *A Picture of Australia's Children 2009*, includes for the first time information on the recently developed national headline indicators for child health, development and wellbeing. Other report cards include the Australian Research Alliance for Children and Youth (ARACY), *The Wellbeing of Young Australian*s, and the Victorian Government's *The State of Victoria's Children 2008: A Report on How Children and Young People in Victoria are Faring.* Report cards for children have also been developed in other policy areas such as education. The recent unveiling of the *My School* website to provide information on student demographics and NAPLAN[168] results for Australian schools is an example.

The AIHW Report Card: A picture of Australia's children

A Picture of Australia's Children 2009 is the fourth publication in this series and brings together a broad range of indicators that cover health status, risk and protective factors, early learning and education, family and community environments, safety and security, and system performance

167 UNICEF, *Child Poverty In Perspective: An Overview of Child Well-Being in Rich Countries, Innocenti Report Card 7*, UNICEF Innocenti Research Centre, Florence, 2007, p3.

168 The National Assessment Program - Literacy and Numeracy (NAPLAN) assesses all students in Australian schools in Years 3, 5, 7 and 9.

(Table 3.1). The national headline indicators for children's health, development and wellbeing have been included in this report for the first time. Information is reported by jurisdiction, gender, Indigenous status and remoteness.

Table 3.1- Indicator framework for a picture of Australia's children- 2009

How healthy are Australia's children?				
Mortality[a]	Morbidity	Disability	Congenital anomalies	Mental health
Age-specific and condition-specific death rates	*Hospitalisations and chronic conditions*	*Profound or severe core activity limitations*	*Selected congenital anomalies among infants at birth*	*Mental health problems*

How well are we promoting healthy child development?			
Breastfeeding[a]	Dental health[a]	Physical activity	Early learning
Exclusive breastfeeding of infants	*Children with decayed, missing or filled teeth*	*Children meeting the National Physical Activity Guidelines*	*Children who are read to by an adult*

How well are Australia's children learning and developing?				
Attending early childhood education programs[a]	Transition to primary school[a]	Attendance at primary school[a]	Literacy and numeracy[b]	Social and emotional development
Children attending early childhood education programs	*Children entering school with skills for life and learning*	*Children attending primary school each day*	*Children meeting reading and numeracy national minimum standards*	*Under development*

What factors can affect children adversely?							
Teenage births[a]	Smoking during pregnancy[b]	Alcohol use during pregnancy	Low birthweight[a]	Overweight and obesity[b]	Environmental tobacco smoke in the home	Tobacco use	Alcohol misuse
Age-specific birth rate for females aged 15–19 years	*Mother's tobacco smoking during pregnancy*	*Mother's alcohol consumption during pregnancy*	*Babies < 2,500 grams at birth*	*Children with acceptable/ unacceptable BMI scores*	*Children in households where adults smoke inside*	*Current smokers*	*Children engaging in high-risk drinking*

What kind of families and communities do Australia's children live in?					
Family functioning	Family economic situation[a]	Children in non-parental care	Parental health status	Neighbourhood safety	Social capital
Under development	*Average real equivalised disposable household income in the 2nd and 3rd deciles*	*Children in out-of-home care and other non-parental care*	*Parents with fair or poor health, disabilities, mental health problems*	*Proportion who perceive their neighbourhood as unsafe*	*Children in households that are able to get support in a time of crisis*

How safe and secure are Australia's children?					
Injuries[a]	School relationships and bullying	Child abuse and neglect[b]	Children as victims of violence	Homelessness	Children and crime
Injury mortality and hospitalisations	*Under development*	*Child protection substantiations, children on care and protection orders*	*Physical and sexual assault*	*Accompanying children in SAAP*	*Children under juvenile justice supervision*

How well is the system performing in delivering quality health, development and wellbeing actions to Australia's children?				
Neonatal screening (hearing)	Childhood immunisation[b]	Survival for leukaemia	Quality child care	Child protection resubstantiations
Children fitted with hearing aids at 6 and/or 12 months	*Children who are fully vaccinated*	*Five-year relative survival for leukaemia*	*Under development*	*Resubstantiated claims of child abuse and neglect*

National headline indicators

In 2005, the Australian Health Ministers' Conference (AHMC) and the Community and Disability Services Ministers' Conference (CDSMC) approved a project to develop a national set of headline indicators to monitor the health, development and wellbeing of Australia's children. A total of 19

priority areas were identified and 16 headline indicators have been developed. Data is currently being collected for 10 indicators with further development required for the remaining six (Table 3.2).

Table 3.2- Headline indicators for children's health, development and wellbeing[169]

Priority areas	Headline Indicators
Infant Mortality	Mortality rate for infants less than 1 year of age
Birthweight	Proportion of live born infants of low birthweight
Immunisation	Proportion of children on the Australian Childhood Immunisation Register who are fully immunised at 2 years of age
Dental Health	Mean number of decayed, missing or filled teeth (dmft/DMFT) among primary school children
Injuries	Age-specific death rates from all injuries for children aged 0–4, 5–9 and 10–14 years
Literacy	Proportion of primary school children who achieve the literacy benchmark
Numeracy	Proportion of primary school children who achieve the numeracy benchmark
Teenage Births	Age-specific fertility rate for 15 to 19 year old women
Family Economic Situation	Average real equivalised disposable household income for households with children in the 2nd and 3rd income deciles
Child Abuse and Neglect	Rate of children aged 0–12 years who were the subject of child protection substantiation in a given year
Smoking in Pregnancy	Proportion of women who smoked during the first 20 weeks of pregnancy*
Breastfeeding	Proportion of infants exclusively breast fed at 4 months of age#
Overweight and Obesity	Proportion of children whose body mass index (BMI) score is above the international cut off points for 'overweight' and 'obese' for their age and sex*
Attending Early Childhood Education Programs	Proportion of children attending an early education program in the 2 years prior to beginning primary school#
Transition to Primary School	Proportion of children entering school with basic skills for life and learning*
Attendance at Primary School	Attendance rate of children at primary school*
Social and Emotional Wellbeing	**
Shelter	**
Family Social Network	**

Notes

Shaded	Data already available for reporting
#	Data not currently being collected
*	Further development to the indicator needed before data collection and/or reporting
**	No indicator identified at present; to be developed

169 AIHW, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For a Picture of Australia's Children 2009 Cat. no. AUS 100*, Australian Institute of Health and Welfare, Canberra, 2008, pp20-21.

The ARACY Report Card: The wellbeing of young Australians

The ARACY Report Card compares indicators of wellbeing for children and young people aged 0–24 years for Australia, the Indigenous Australian population and international comparators. The report card:

> *… indicates Australia's strengths and weaknesses, and points to areas where policies are required to improve outcomes for children and young people.*[170]

The report card has eight domains with associated indicators. There are a total of 42 measures reported by ARACY and those related to the health and safety domain are outlined in Table 3.3.

Table 3.3- Health and safety related indicators

Indicator	Measure
Infant health	o Infant mortality rate o Low birth weight rate o Very low birth weight rate
Immunisation	o % of children appropriately immunised at 12–23 months
Mental health	o Intentional self-injury death rate for young people (aged 15–24 years) o % of young people (aged 18–24 years) with high or very high levels of psychological distress
Accident/injury	o Deaths from accidents and injuries under age 19 o Age specific death rates from all injuries for children aged 0–4 years, 5–9 years and 10–14 years
Child abuse and neglect	o Non-accidental deaths under age 19

The state of Victoria's children - a report on how children and young people in Victoria are faring

The Victorian Government recently produced its third comprehensive report card on the health, learning, development, safety, and wellbeing of children and young people. Data is presented for all children and in relation to population groups who experience greater disadvantage; including Indigenous children, children with a disability, children from culturally and linguistically diverse (CALD) backgrounds, and children affected by chronic disadvantage including children in out of home care. This report card is wide ranging with five overarching priorities, 29 outcomes and 134 indicators (see Table 3.4 below).

170 ARACY, *Report Card: The Wellbeing of Young Australians*, Australian Research Alliance for Children and Youth, Canberra, 2008, p1.

Table 3.4 - The state of Victoria's children: Priorities and outcomes

Priorities	Outcomes
Physical health	Prenatal and infant health; child deaths; immunisations and vaccine preventable illnesses; cancer, diabetes and asthma; hospitalisations; dental health; overweight and obesity
Staying healthy and healthy lifestyles	Nutrition and physical activity; fruit and vegetable consumption; physical activity; sexual health and health related behaviour; sexually transmissible infections; births to young mothers; alcohol and tobacco use; mental and emotional health
Safety	Children and young people's perceptions of community safety; bullying; children and young people as victims of crime; children and young people as offenders; youth justice; injuries and injury deaths; child abuse
Development and learning	Social and emotional development at school entry; achievement in literacy and numeracy; attendance and retention; completion of Year 12; pathways after leaving school
Happiness and engagement with families and communities	Social support and family attachment; engagement with school; participation in sport and recreation; involvement in arts and culture; use of electronic media; children and young people's engagement with their communities; children and young people's perceptions of their local communities; feeling valued by society and having a say

The statement that 'children are our future' has been repeated by many, but in Western Australia there is no mechanism for articulating the future we desire for our children, and no way of measuring whether we are reaching that goal. An annual report card on children's health would:

- *enable better targeting of services;*
- *provide government with evidence of where progress is being made;*
- *promote accountability where improvements are not being seen; and*
- *promote sustainability where improvements are being seen.*[171]

Finding 16

The development of an annual report card for Western Australia's children is critical to enable the Government to monitor the progress of children's health and wellbeing, and identify future priority areas for action.

171 Submission No. 24 from Commissioner for Children and Young People, 30 July 2009, p3.

Recommendation 10

In the absence of a single early years' agency, the Departments of Health, Education, Communities and Child Protection, and the Disability Services Commission should provide an annual report to Parliament on children's health and wellbeing in Western Australia. The report should provide an update on Western Australia's performance against established benchmarks and identified targets in relation to at least the following:

- The national headline indicators for children's health, development and wellbeing;
- Australian Early Development Index (AEDI) results;
- The Department of Health's resource allocation model for community child health services; and
- A range of key performance indicators including waiting lists and waiting times, the number of health care plans completed for children in care, and the number of child health home visits completed within 10 days of birth.

Information should be presented for all Western Australian children as well as focusing more specifically on groups at risk of poorer outcomes including Indigenous children, children living in rural and remote areas, and newly arrived refugees. The first report should be tabled by the end of 2010.

(b) Implementation of parliamentary inquiry recommendations

The Parliament of Western Australia has established fifteen permanent Standing Committees that undertake inquiries and report findings and recommendations to the Parliament. From time to time, Select Committees are also established for a specific inquiry and cease to exist once they have reported. A significant amount of work is undertaken by these Committees, with 25 inquiries currently in progress. Once the Committee's report has been tabled, relevant Ministers are required to provide within three months a response outlining any actions that will be undertaken to address the Committee's recommendations. There is currently no requirement for the Government to later provide Parliament with an update on the implementation of these agreed actions. For example, while the Government agreed in September 2009 to support 34 of the 37 recommendations in the EHSC's *Healthy Child- Healthy State: Improving Western Australia's Child Health Screening Programs* Report, it is unclear how many have actually received funding to be implemented. The ability to monitor progress against a government's stated commitment is critical to ensure that a government is accountable to Parliament and the Western Australian community for progressing the outcomes of a committee's investigations.

Recommendation 11

That a process is established by the end of 2010 to monitor and report on a government's implementation of the recommendations arising from a parliamentary inquiry. This should include a requirement for governments to provide a subsequent annual update on the progress of implementing recommendations, along with an explanation for any delay or incomplete actions.

APPENDIX ONE

SUBMISSIONS RECEIVED

List of Submissions received for the Inquiry.

Submission Number	Date	Name	Organisation
23	3 August 2009	Ms Maxine Drake	Health Consumers' Council
24	26 August 2009	Ms Michelle Scott	Commissioner for Children and Young People
38	31 August 2009	Dr John Wray	
41	18 September 2009		Community Health Nurses WA
45	25 February 2010	Ms Amanda Tilbury	

APPENDIX TWO

HEARINGS

List of Hearings held for the Inquiry.

Date	Name	Position	Organisation
19 August 2009	Mr Philip Aylward	Executive Director, Child and Adolescent Health Service	Department of Health
	Mr Mark Morrissey	Executive Director, Child and Adolescent Community Health	Department of Health
26 August 2009	Ms Michelle Scott	Commissioner for Children and Young People	
31 August 2009	Dr John Wray	Paediatrician	
23 September 2009	Mr Philip Aylward	Executive Director, Child and Adolescent Health Service	Department of Health
	Mr Mark Morrissey	Executive Director, Child and Adolescent Community Health	Department of Health
	Mrs Margaret Abernethy	Senior Policy Officer, Child and Adolescent Community Health	Department of Health
14 October 2009	Prof Mike Daube	Professor of Health Policy	Curtin University
10 November 2009	Dr Peter Flett	Director General	Department of Health
12 February 2010	Ms Susan Oliver		
	Ms Brigitte Rodda		
	Ms Amanda Tilbury		

APPENDIX THREE

BRIEFINGS HELD

List of Briefings held for the Inquiry.

Date	Name	Position	Organisation
28 September 2009	Ms Kerrie Bowering	Director, Child and Family Health Service	Children, Youth and Women's Health Service, SA
	Ms Sharyn Delahoy-Galwey	Clinical Services Coordinator	Children, Youth and Women's Health Service, SA
	Ms Joan Gilbert	Director, Education and Care	Children, Youth and Women's Health Service
30 September 2009	Dr Richard Matthews	Deputy Director General, Strategic Development	NSW Health
	Mr Andrew Abbott	General Manager, Strategy and Coordination	Department of Education and Early Childhood Development, VIC
	Dr Sharon Goldfeld	Principal Medical Advisor	Department of Education and Early Childhood Development, VIC

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