ADOLESCENT DIABETES CLINIC — CLOSURE

Motion

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [5.49 pm]: I move —

> That the house condemns the Barnett government for its decision to close the dedicated adolescent diabetes clinic when it is moved to the consolidated outpatient space in the deficient new children's hospital.

The ACTING SPEAKER (Ms J.M. Freeman): This is a very important issue that the member for Kwinana is raising. If members wish to speak, can they take it outside; otherwise, can we let the member for Kwinana be heard in silence.

Mr R.H. COOK: Madam Acting Speaker, as you have observed, this is a very important issue. It is a debate about health cutbacks in Western Australia and whether adolescents suffering from type 1 diabetes will have a stand-alone clinic as part of their ongoing journey in dealing with their chronic disease or simply an extension of the current child services that are run out of the endocrinology unit at Princess Margaret Hospital for Children. This is a very important clinic and one that has gained some media attention. We rise today to discuss this issue to further highlight the issues associated with this development. In rising to speak on this today I declare a conflict of interest from the get-go; that is, I have a child who attends this clinic. My daughter Isobel is one of the patients who go there. I want people to be aware that this is in part an important issue for the WA Labor opposition but it is also important to me personally.

We will discuss the impact of the government's decision on this clinic and that it is a consequence of its ongoing poor planning in the area of health. As we continue to move towards the completion of the new children's hospital we will see that this service, like the number of beds available for child cancer services, is one of the areas that will suffer. I also want to spend some time talking about the importance of this clinic and why it is important as a stand-alone clinic for adolescent diabetes services. I want to discuss the way this issue has unfolded and what we believe the government must now do to make sure this dedicated facility remains open for adolescent sufferers of type 1 diabetes to ensure we have for these kids a quality standard of service not a second-rate standard of service.

There has been a lot of discussion around the planning of the new children's hospital. Indeed, it was discussed during part of our time in government in the early 2000s following the Reid review. It has been the subject of two clinical services frameworks, the clinical services framework 2005–2010 and the clinical services framework 2010–2015. The minister himself has tabled documents in this place that show that, while we were looking for a new children's hospital from 2007–08 of about 269 beds, that was transitioning forward to a new children's hospital of about 279 beds in 2020–21. We are not seeing a significant increase in the number of beds available at the new children's hospital. For the benefit of members who have not been following this debate, the minister says we do not need so many beds at the new children's hospital because we are developing general paediatric or child health services at both the new Fiona Stanley Hospital and the Joondalup and Midland Health Campuses. But as everyone knows, when our children are sick, we take them to the hospital that we believe will care for their needs. When they present to that hospital, it is every parent's expectation that the child will receive the care the child needs, regardless of whether in the clinician's view that child is in need of a tertiary hospital service or simply a secondary hospital or general paediatric service. The minister will not be standing at the door of the new children's hospital vetting patients as they come through, "No, sorry; you only have gastro; you need to go up the road. You have a more serious condition. Your child can come in." The fact remains that this hospital will continue to serve all kids presented to it for care. We stand with the Australian Medical Association in saying that the government has not done the hard work to futureproof this hospital, and that by the time it is built and commissioned in 2016, we will see a hospital that will continue to struggle with the demand we currently see Princess Margaret Hospital struggling to deal with.

Dr K.D. Hames: It'll be finished in 2015.

Mr R.H. COOK: It is projected to be finished by late 2015, so its commissioning will not happen until 2016.

This is a very important debate because it has not popped up recently. The issue of demand for hospital services has not occurred overnight. It has been going on since this government came to power in 2008. In the Clinical Services Framework 2010–2020, the Department of Health made the observation that the demand modelling utilises population projections from the Australian Bureau of Statistics series C released in 2008. The department observes that these figures were the low-growth projections of the estimated resident population from the 2006 Australian census. This means that the planning for our health services of Western Australia is based upon woefully inadequate population projections. At the time of the clinical services framework, it was pointed out to the government by a number of observers and a number of people in Parliament, particularly in the northern

suburbs where the population was galloping well ahead of these lower average forecast figures, that to plan our hospital services based on these ABS statistics was quite simply setting up our hospital system to fail.

That is indeed the observation that the Standing Committee on Education and Health made in its 2010 report "Destined to Fail: Western Australia's Health System". The committee observed in its report that despite recent record population growth in Western Australia, the Department of Health has moved from using medium-growth projections provided by the Australian Bureau of Statistics to low-growth ones. The committee went on to observe —

Dr K.D. Hames: I think they substituted Department of Health and a different agency—that is, Treasury.

Mr R.H. COOK: I have heard Treasury being blamed in the past. However, they are the minister's planning documents and he cannot disown them in that manner; in fact, he is on the record as defending the clinical services framework on a number of occasions.

Dr K.D. Hames: Not C-grade population.

Mr R.H. COOK: Nevertheless, the Education and Health Standing Committee recommended that —

> The Department of Health must use at least the ABS Series A (high-growth) population projections in its demand modelling for its current planning for recurrent and reform-based funding requirements. This will present the Government with a more realistic account of the future operational and financial needs of the State's health system.

That is in the committee's 2010 report, so this is not a new issue. It has been confronting the minister for some time and it is very sad that we are now midway through the construction of a new children's hospital and are having a public debate about the deficiencies in the capacity of that hospital and that it will simply not meet the needs of the Western Australian population going forward.

I move to the issues associated with adolescents and their treatment in the WA health system for their type 1 diabetes. For members' information, currently, a child the age of 13 or over will transition from receiving services from the endocrinology unit at Princess Margaret Hospital and go to the Dorothy Surman Centre. It sounds like a grand building but it is a small residential cottage in Hay Street near Princess Margaret Hospital. It is because of this setting that it is most effective in the work it does. What does it do? It takes those children on their very important journey with type 1 diabetes and assists them to transition from a child having predominantly their diabetes managed daily by their parents or carer to managing their diabetes on their own account as an adult. My daughter has been going to the Dorothy Surman Centre for about 12 months now. The change in the way those patients are treated is significant. They are not surrounded by pink walls and pictures of Dorothy the Dinosaur and those sorts of images that we see in children's hospitals, which are there to set children at ease and make them feel more comfortable.

Dr K.D. Hames: I can see pictures flipping from Dorothy the Dinosaur to a guitar, or something.

Mr R.H. COOK: What is the difference between Justin Bieber and Dorothy the Dinosaur!

An adolescent diabetes clinic is a very different environment. It is a much more inclusive environment. It is a cosier environment. It is an environment in which the kids start being treated like adults. As parents, we go from a position whereby the diabetes educator and the doctor and nurses working in the clinic stop talking to us and, all of a sudden, they start talking to our kids. They start to have a dialogue with our kids about managing their diabetes. It was quite off-putting when I first went to the clinic to go from being front and centre of the treatment process to simply an observer as my child continues to develop the skills to manage the treatment. The children are aged from 13 years upwards to probably 16 or 17 years before they transition to the adult service. I am yet to have that experience. I understand that it is not a pleasant experience, and many parents report to me that attending the adult diabetes clinic is a much more depressing process. As adolescents, these children are going through that very important transition process.

I have spoken to a number of parents, and I acknowledge the presence today of Janelle and Natalie and their family, and Gabbie, who is one of the young patients who attends the Dorothy Surman Centre. All these parents report on the importance of adolescent diabetes services and how different they are from the child type 1 diabetes services. Anecdotally, we are also told the reason it is important that they are separate is that these kids are growing up. They are teenagers now and they do not want to go to the child clinic. By virtue of having a separate and very different clinic, they are more likely to attend their appointments and be engaged in the process. Members should not forget that at this stage of their lives they are going through puberty, with a lot of emotional and physical changes that impact on the way they manage their diabetes. They have issues relating to self-esteem, which can revolve around managing their diabetes and learning about how to deal with drugs, menstrual cycles and those sorts of issues that they are starting to confront. That is very different from the sorts of issues they would deal with as children. It is not the sort of thing that child or adult clinics are set up to do, but

an adolescent clinic is absolutely there for that and its clinicians have the skills required to undertake this work and the environment in which they can do it. These kids are taken into this new environment, treated like adults and allowed to transition through their adolescence through this very important program.

It was drawn to my attention that the government intended to close this clinic. I thought, surely that cannot be the case. I know that shadow ministers for health are often accused of leaping too quickly on media opportunities, and I am sure we have all been guilty of that at times.

Dr K.D. Hames: And I think when you hear the explanation, you will think the same again!

Mr R.H. COOK: I did not believe the government would do this, so Hon Samantha Rowe asked a question in the other place seeking assurances from the Minister for Health that the Dorothy Surman Centre would continue to function as a separate clinic in a separate location. Through his representative in the other place, the minister said that the adolescent diabetes clinic at the Dorothy Surman Centre would not close until the new children's hospital was commissioned in late 2015. He said that the centre is a leased building and it was not intended to extend the lease once the transition of services to the new children's hospital had occurred. He said that the adolescent diabetes clinic would be transferred to the new children's hospital at that time. The minister provided an assurance that we would have a separate clinic as part of the new children's hospital and we would continue to have this separate arrangement.

Dr K.D. Hames: Where did I say that? I did not hear you read that out.

Mr R.H. COOK: That is my interpretation of the answer that the minister's representative gave in the other place. I am happy with the minister's explanation. I would like to see the Dorothy Surman Centre continue to function, not as part of the new children's hospital but as a separate stand-alone clinic, albeit in these new facilities. On 13 September, an article in *The West Australian* put paid to those reassurances that I was given by the government. It was made clear that the clinic would transition through to the new children's hospital, but it would be a section of the consolidated outpatient clinic. Therefore, in the morning the clinic might be used for children's services and in the afternoon for adolescents. The space might be used for a whole range of clinics and not simply endocrinology. It was clear that the government, through its representatives in the Department of Health, was seeking to justify this position. The representatives said that moving to the new children's hospital and co-locating with Sir Charles Gairdner Hospital would allow for greater opportunity to transition into adult care. The Child and Adolescent Health Service chief executive Philip Aylward said that the new hospital's outpatient department had clinics that could be scheduled for specific age groups. The government is talking about a consolidated outpatient clinic. This does not acknowledge that it is dealing with adolescents and not children, or that this clinic is most effective when it is part of a dedicated space that will provide that unique level and type of care that is important for these kids to transition into adulthood. It was observed by one doctor that we will have a diabetes service at the new hospital, but it will not have a separate clinic to look after adolescents, and he thought that was a backward step. That is our concern. We agree with that doctor that this would be a backward step. This is the concern of parents and the young adults who are going to that clinic; and, indeed, this is a concern for a community that I must say has taken great pride in juvenile diabetes services in this state. We have some of the best services in Australia. I have never failed to be impressed with the level of service we receive from Princess Margaret Hospital for Children, communities like Diabetes WA, the Juvenile Diabetes Research Foundation and other groups associated with supporting people suffering from diabetes. The government has to play its role as well. It cannot simply use the opportunity of the new children's hospital to fold these services into the mainstream building environment, which will undermine the important treatment that these services provide.

We are looking for a commitment from the minister today that he will make sure that the adolescent diabetes clinic continues in a separate location from the children's clinic; that it can continue in a dedicated space. When I say "dedicated space" I do not mean in the same pink-walled rooms of the new children's hospital that other clinics in this area might share. I am talking about a dedicated space that adolescents identify with and feel comfortable with so that they can deal with the issues that they confront as young adults transitioning to adulthood and management of their own condition. I think it is very important that we take the opportunity when we move to the new children's hospital to enhance the services available to kids in this state. It is important that the new children's hospital represents an opportunity to improve the services that our young people receive. Sadly, it appears that that is not the case when it comes to the adolescent diabetes services. From the comments of the Department of Health in the media and the reports from parents and clinicians who work in this area, it appears that the government simply wants to fold the Dorothy Surman Centre into the other services that will be run from the new children's hospital. That will not do, because then we will lose those essentially unique features of the clinic and we will lose the patients who benefit from these clinical services.

I emphasise again that the effectiveness of this service in assisting young people to manage their transition through puberty to adulthood impacts on the effectiveness of their medications and the way in which their

attitude towards diabetes impacts on them. What I am told by the clinicians and the parents of young adults with diabetes and from what I believe as a parent of a young adult with diabetes is that this level and style of treatment is absolutely crucial in assisting young adults to deal with their chronic disease. If we do not undertake the service in this way, we will lose them. We hear stories of young people who for a range of emotional and physical reasons reject the fact that they have diabetes. So rather than their transition to adulthood being a managed and mentored process, they reject the process because they are angry about their condition. These young people say, "Other kids don't have to deal with this, why should I?" As a result, they neglect their medication and their health and set themselves up for long-term problems in the management of their diabetes. We see these young people slip out of the system and their capacity to then move through to adult services is further undermined. That is what we want to avoid. We want to maintain the Dorothy Surman Centre in its independent and effective form because we know that it creates that environment.

I am aware that the member for Warnbro is very keen to speak on this motion, too, but it would appear that he has been delayed by his other —

Dr K.D. Hames: You're the only one there!

Mr I.C. Blayney: You look a bit lonely over there!

Mr R.H. COOK: I am not lonely, member! I have very broad shoulders and some would say an even broader back.

Dr K.D. Hames: If you sit down, I'll talk for 20 to 25 minutes and then give him space before seven.

Mr R.H. COOK: If that is okay, I will scurry out.

Dr K.D. Hames: You can find a way to get him on the phone while I'm talking.

Mr R.H. COOK: Indeed; I will do just that.

I look forward to the minister's contribution tonight because I know that this is an issue that he cares about. I note that he is concerned about the nature of these sorts of services. He wants to see the very best for people with diabetes in Western Australia. We are looking tonight for absolutely clarity from the minister about what is going to happen to the adolescent diabetes clinic. We can make sure, therefore, that we preserve this service in the form that these clinicians wish to see so that it can maintain its effectiveness and continue to transition our young adults through to adulthood and make sure that they continue to manage their diabetes effectively.

DR K.D. HAMES (Dawesville — Minister for Health) [6.16 pm]: The member talked about the government doing this and the government doing that and it is true that we are responsible for what happens at the end of the day at the hospital and the construction and the size of the hospital. I will go into those issues of size in a moment. But if the member thinks for one second that the government is saying, "Okay, we're going to shut down the Dorothy Surman Centre because we don't want it anymore and we're going to do this alternate version at the new hospital", he is absolutely wrong. In fact, clearly, the member knows what the Dorothy Surman clinic is because he goes there. But I have to say that until tonight, I had not heard of the Dorothy Surman Centre, nor would I necessarily, unless I had had a briefing on it, it was pointed out to me or I was involved in discussions about the service it provides, and I just have not.

The point I make is that this is clinician-led. I know that the member heard a clinician who clearly does not like the concept say it is a backward step, but there must also be lots of other clinicians who do not agree with him. Perhaps they do not work in the same area, but there has been enormous opportunity for clinicians in a range of services in that hospital to provide their view, so clearly there must be others who think that what is proposed is, in fact, a good idea.

I see the member for Fremantle is in the chamber. She was not here earlier, but the member for Kwinana was chasing the member for Warnbro to speak, if she can perhaps assist him to get here.

This is not led by government; it is led by clinicians and they say that this is the optimal service. I do not know whether people understand necessarily about the difference—the member for Warnbro is now in the chamber. I will give him 15 or 20 minutes to speak at the end; I have only just started.

Mr R.H. Cook: He's managing two functions.

Dr K.D. HAMES: The member for Warnbro can come back when he is ready; I can keep talking.

I do not know whether people understand what the size of the new hospital will be. The current hospital is over 5 000 square metres. I forget the exact size, but it is something in the order of 5 200 or 5 300 square metres. The new hospital is 11 000 square metres. That includes open spaces, lifts and all those other empty spaces, but it is a big hospital; it is more than double the size of the existing hospital. Princess Margaret Hospital for Children is an ageing, space-constrained hospital that wanted to have an adolescent clinic because it is a good idea to have one,

so it found a building down the road and leased it. That was a really good idea. As I said, I have not been there, but I am told it is also used for multiple other non-adolescent paediatric medical clinics. Therefore, also going into that building where the adolescents go are younger children who go to that same clinic at different times. The clinic is twice a week. Clearly, it does not have lots of dinosaurs and things for those kids in the building; nevertheless, those kids use the building now. The building is also used for refugee health clinics, so presumably refugee families go there at different times to seek clinical treatment.

Mr R.H. Cook: The point was, minister, that it's not a child clinic that adolescents go to; it's a clinic but —

Dr K.D. HAMES: Sure, but let us look at what the new hospital will be like. The new hospital will be enormous, so there will be much greater space within it. Therefore, instead of having a space-constrained hospital such as PMH having to use the building down the road, the service will not have to do that because it will have a much bigger clinic. So what do we do? Do we want those adolescents to be part of a diabetic treatment program for kids? No, we do not. We want them to be separate, so we separate the times. We do not want to put them where there are pictures of dinosaurs on the wall, so we put them where there are not pictures of dinosaurs on the wall. The new clinics are being designed to be multipurpose. The interior design brief for the facility detailed that the decor within the outpatient area be neither age nor gender specific. The interior design of this area has been done in consultation with the youth advisory committee. The youth advisory committee is a great group of teenagers who are providing us with advice. They currently do it for Princess Margaret Hospital for Children. They have been involved in giving advice on decor construction at the new hospital. The very adolescents we are worrying about are giving advice on the decor at the new outpatient clinics. The clinics will be very adolescent friendly—much more so than the existing clinics. The critical point for adolescents is not the pictures on the wall; it is making sure that they have a separate time, a different identity and, in particular, staff who look after them differently, who recognise that they are becoming adults and who will look them in the eye and talk to them, not to mum and dad on the side. The same doctors and nurses who currently work with those children in the clinic will be the same staff at the new children's hospital, and they will continue their treatment at that location. Adolescents will get all those recognitions that they need in their transition. It is hard to know where to put adolescents. I get a lot more complaints about 16-year-old adolescents who are sent to an adult hospital. I had a complaint yesterday from an adolescent who had been referred to PMH but was sent to Royal Perth Hospital because they were 16 years of age. As children get to that more mature age, we do not necessarily want them to be around lots of young children. That adolescent was in a ward full of adults and felt intimidated. It is a tough cut-off.

Mr R.H. Cook: My son has done a similar thing; he has gone from an outpatient clinic at PMH to Fremantle Hospital. It is a scary difference.

Dr K.D. HAMES: It is a tough transition, but those adolescents are not the only adolescents in town. Just imagine all the other adolescents at Princess Margaret. There are heaps of kids with cystic fibrosis who have to be admitted to wards with young children. It is a tough gig for them. It is especially the case for cancer patients. I looked at the cancer chairs in the cancer ward. There are babies in prams, little kids and 15 and 16-year-olds who are almost adults all sitting in their row to have their treatment. It is not practical in that sense to separate them. It is good to do that and it is important to do that when it can be done. I would like to separate a lot more of the other kids into areas so that they do not have to be with little kids and pictures of dinosaurs. We need to try to have more adolescent days at the outpatient clinics so that the cystic fibrosis kids and children with other medical conditions can come in on the same day.

Mr R.H. Cook: Is that the intention?

Dr K.D. HAMES: No; I had not even thought about it until this debate. I will certainly suggest that; it is a good idea. It does make sense. We talk jokingly about the pictures on the wall, but it would not be that hard to do. I do not know why we could not have areas that are dedicated to adolescent outpatient clinics rather than areas specifically for diabetic clinics. I presume that the clinics are reused so much because there is such demand for them that they need to be flexible, as has been stated. It is not like a child's ward where it is good to have pictures of dinosaurs on the wall. The old-fashioned paediatric units have blank walls and curtains and look like adult wards. In the units in the little country hospitals, the staff have really made an effort to get artists to paint pictures on the walls and the like. It makes an amazing difference to a child's experience when they can go into a ward like that. We need to do that, but that is more for the wards rather than the clinics. I cannot remember how many children the member has. My bet is that sometimes mum in particular will take in one adolescent child, but other small children will go as well. I do not think it is a bad idea to also have child-friendly areas where kids can play and not feel intimidated when other kids come in. The critical thing is the way that the patient is treated—the transition from treating someone as a child to treating them as an adult. They need to be more involved in understanding and controlling their care and making sure that they know what they have to do as opposed to having it done by their parents. That is a very important and careful transition that needs to occur.

I want to talk a bit about the size of the hospital and the debate that occurred about the construction. We all remember the history. The Labor Party was going to put it where L, M and N blocks are. When we came to government, I promised to have it opened by 2014, because there was nothing that said that those blocks had to be demolished. There was no money in the budget to demolish them; in fact, there was no money in the budget, apart from about $200 000, to build a hospital with a $1.2 billion cost. Nevertheless, it was going to be at that location. When we finally started getting the designs done, it was nowhere near big enough. We had to make it much bigger than the existing hospital. That is why we came up with the new location. We then had to fund moving the plant, and then look at the construction of a multistorey car park. We now have the ideal location for the hospital and the teaching building next to it. The square metre space is double that of the existing hospital.

Mr R.H. Cook: Is that the overall hospital or the outpatient clinics?

Dr K.D. HAMES: It is the overall hospital. The total area space will be about 11 000 square metres as opposed to the current 5 000 square metres. That includes the open space, the big entrance and all of those things. A lot of additional airspace has been created so it is not seen as a crowded, closed-in environment. Not only will it be double the size, but also there is a great opportunity for expansion. Firstly, the Reid review stated that the bed numbers needed to be downsized. The plan was to get people out of the central hospitals and to get the secondary patients out to the periphery hospitals. The Reid review put it at 180 beds, but they were multiday beds. It did not include dialysis chairs, same-day beds or anything like that. The number of beds is always a moveable feast, so it was really hard to work out what 180 beds meant. I think it probably meant in the order of 220 or 230 beds, whereas the new hospital will have around 250 beds. It involved downsizing while the patients were moved out to the periphery hospitals. We recalculated on the B-series, which is what we were told we could do, and we came up with 269 beds, plus the eight shell beds that were available to be opened. The structure was built within that. It has a 20 per cent expansion capacity. The central component of the hospital is reinforced to enable an additional four storeys to be built by a future government. Somewhere down the track when the hospital needs to be expanded—I presume it will cost hundreds of millions of dollars—it is all there ready to happen, so an extra four floors of space can go straight up in the middle.

The other thing is that the neonates are currently at Princess Margaret Hospital for Children—the King Edward Memorial Hospital for Women ones. But the proposal is still, by both our parties I think, to move the King Edwards at some stage to the new site. But the trouble is that that is a $1.2 billion exercise, and nobody has the money at the moment to be able to do that. But it is in the plan, and when that happens 24 beds will be freed up in the existing hospital. So there will be four floors of expansion available for a government to build in the future. When the new King Edward hospital is built in the future, that will create 24 beds within the existing hospital, plus there is a 20 per cent expansion capacity in the existing hospital, and 270 beds, which the calculations show should be enough. Except with the surge in capacity, that shows that in the total number of state beds, by 2017 we will be short about 10 beds, and by 2020 we will be short 45 beds. So, where do those 10 beds go? That is, two years after opening, suddenly we will be 10 beds short in the system. But they do not have to be 10 beds within the hospital, and the 45 beds by 2020 do not have to be within the hospital, because outside that there is a paediatric implementation plan that still goes on and recommends the expansion of the peripheral hospitals. That is advising that there should be, on top of what is at Joondalup now, an additional 13 beds, there should be an additional eight beds either between Armadale or Midland, and better use of the Peel Health Campus beds.

Mr R.H. Cook: But do you honestly think, minister, that that will take pressure off the new children's hospital in terms of capacity?

Dr K.D. HAMES: To a degree, it will. What happens is that people bypass now because there are not the doctors; paediatricians and high-level specialists are needed within a hospital to make people confident about going there. We were talking to Dr Alessandri, who does the oncology care at the hospital, and she said it is quite feasible for them to expand and have outreach services to Joondalup hospital, for example, and provide that cancer care. Hospitals like Joondalup will expand and get specialists in, so that someone who has a not-so-severe injury that does not need intensive treatment and who lives all the way out in that Joondalup region can be seen there. They would be silly if they trekked all the way into the tertiary hospital. At that tertiary hospital at present—I keep getting different figures—there is somewhere between 40 per cent and 50 per cent tertiary care, and between 50 per cent and 60 per cent secondary care. There will always need to be a mix; there will never be all tertiary care in a tertiary hospital, and nor should there be. That does not happen in any of the other tertiary hospitals. There needs to be training and opportunities for people to deal with lesser things within a normal tertiary hospital. The member is right; people will bypass, but when we are talking about a shortage of only 10 beds across the whole system by 2017, that is not many people to decide to go to an expanded Joondalup hospital paediatric unit or an expanded Midland paediatric unit.

But in saying all that, we are looking at exactly what has been suggested by clinicians within our hospitals and echoed by the Labor Party and the Australian Medical Association in that we would be silly now if we did not

put in additional beds. We will make a decision on that in the next two months. We are getting costings done and looking at the two options. One is that there is capacity within the hospital structure to change some areas that are currently lower-level care into wards, and have that lower-level care take up some of the 20 per cent space within the hospital; a cost will be associated with that. The other option is to put an extra 48 beds on top of the existing ward structure, which is what some people are suggesting. We are currently looking at those things, and I am certainly not ruling it out; we will make a decision on that. In looking at futureproofing the hospital, that would certainly do that because there would be 48 additional beds that would probably be shelled at the start but available for future demand; we would still look at expanding the peripheral hospitals; and of course there is the opportunity in the future when King Edward comes and another four storeys are added to look 50 years down the track at whatever that demand may be.

But we are concerned, and the physicians who are expressing this are concerned. It does not matter how good we are at providing those peripheral beds, people do exactly what the member said and what I have done. I dropped my eldest son on his head when he was a young fella. Please, do not ever lift your children up by the elbows and put them on your shoulders—things can go wrong! He went straight over backwards and I could not catch him. He whacked his head on the floor and knocked himself out. I was straight in that car and straight to Princess Margaret. That is what most parents will do. We thought my granddaughter might have had a little turn in the back of the car—a febrile convulsion; we still do not know if she did or not—same thing; straight to Princess Margaret. People do that because they trust the hospital. They trust its history, they trust its staff, and they know that is where they are going to get the best of care. The biggest difficulty we have is getting people to decide not to go there. As to our peripheral hospitals, currently Fremantle, I think, runs at 50 per cent occupancy; Armadale is 60 per cent to 70 per cent; Peel is —

Mr R.H. Cook: In the children's wards?

Dr K.D. HAMES: In the paediatric units. The paediatric wards are nowhere near full occupancy, and part of the reason is that if a child even down in Peel has appendicitis and needs surgery on a Sunday, the physician, the paediatricians, the paediatric anaesthetists or the specialists are not down there because it is not big enough to provide that sort of immediate care, so they get shipped straight up to Princess Margaret. Even though it is our intention to try to expand those hospitals and the services provided there, we just cannot have standing and waiting people of that calibre and training for the number of patients they get coming to them. That is the importance of having a tertiary hospital that has such a great record. It is a fantastic hospital. I think it might be worth getting the member for Warnbro from the dining room—I am leaving in 20 minutes; I will be finished shortly.

I think it is really important to make sure that people understand that the government is looking at those big numbers again, because there has been a population surge. We know there has been a surge for a while—that is true; what I am finding, though, is that some of the clinicians, planners and designers are still of the view that we have enough. They still think that that 20 per cent expansion, four floors, the King Edward 24 beds, and dealing with the peripheral hospitals by expanding beds will be enough. There are others—the ones who signed that petition—who have varying views. Some of them think option 2 is enough—expanding the space within the hospital; some of them—probably staunch AMA members—are supporting the extra floor view. But whichever it is, the government will make a decision in the relatively near future. We have to make it in a short period of time because the hospital is still under construction. Make no mistake though, it is a reasonably costly exercise to put on that additional floor at this late stage, and it will result in a slight delay in opening. We are advised it will be something in the order of four months' delay, so I would say it will be opening in 2016 instead; that would be likely if we make that choice. I am a bit concerned; after what happened at Fiona Stanley, I sort of want to make the choice to stay as we are so that I do not have the member having a go at me for being late opening it.

Mr R.H. Cook: I think you can rest assured that I will!

Dr K.D. HAMES: But at end of the day what is important is making sure that we protect this state for the future. We have recently seen in Melbourne that the new hospital is not big enough to cater for the patients in that region. That is something we have to bear very strongly in mind when we make that decision.

Mr R.H. Cook: Just before you sit down, minister, can you not only for the sake of the people in the public gallery, but also for the member for Warnbro just summarise for us and create some clarity around this?

Dr K.D. HAMES: I will summarise.

This clinic will stay open until the new hospital opens. When the new hospital opens, that lease will expire and adolescent treatment will go to the outpatient clinics at the new hospital. They will be seen in a "décor-friendly" area within those outpatient clinics, in an area on a day when there are only adolescents—it may be an afternoon, I do not know. It will not be a day that is just a free-for-all and mixing with all the children, and they will be seen by the same people doing the same work they are doing now in looking after them. That is what has happened. I

will go back to see whether we can not only address issues to do with diabetic children, but also look at other adolescent children who are treated at that hospital to see whether we can create a stronger environment in which cystic fibrosis clinics will be in one part of the outpatient clinic, cancer consults will be in another and some other adolescent team will be in another. There is a range of things, including diet management, that are specific to adolescents, particularly with anorexia-type clinics for younger kids who need specialist care. I will see if there is a way to do that. Who knows—there might be enough of those to warrant an exclusive area for adolescents all the time, depending on demand. I will look to see if that is possible.

MR P. PAPALIA (Warnbro) [6.41 pm]: At the outset I would like to extend my apologies for being absent during the Minister for Health's speech. I did not expect the previous debate to extend for the length of time that it did.

Mr R.H. Cook: I did not expect people to get so excited about grapes!

Mr P. PAPALIA: No. I have guests tonight, but that aside, I thank the minister also for the indulgence of summarising his position. I say at the outset that I do not think that that will satisfy the families and adolescents involved or the doctors providing the current service. That is based on my conversations and my own personal response to the minister. It is not a criticism of the minister. I understand that that will be the line being argued by the people advising the Minister for Health. Like the member for Kwinana said during his presentation, and as the minister knows, I have a son who has type 1 diabetes. I am experiencing that progression in his life and the impact that having type 1 diabetes has, and the challenges associated with him entering puberty and starting adolescence after childhood. It is a different matter.

Dr K.D. Hames: How old is he?

Mr P. PAPALIA: He is 13 now.

Dr K.D. Hames: Is he in the same clinic?

Mr P. PAPALIA: No, he is not yet. He is the last little bit before they end up there. They give him a choice. I have not yet experienced the adolescent clinic. I have experienced watching him being confronted with that incredible moment when he was first diagnosed and going through all the emotional trauma associated with it. We had one experience post the initial diagnosis where his life was seriously threatened during a hyperglycaemic episode. It was very frightening. Again, I place on the record my thanks, appreciation and respect to all those people who work in endocrinology at Princess Margaret Hospital for Children. They provide an outstanding service.

From a parent's perspective I am concerned, after talking to parents of older type 1 diabetic children who have gone through this process—the member for Kwinana being one of them but we also have other friends in that situation. They say, and so do the doctors and nurses helping these children and young adults, that it is a very confronting and challenging time, as is being a teenager and going through adolescence anyway. Often the additional challenge of type 1 diabetes can create very serious problems. The Minister for Health is probably aware of them. I am told that frequently type 1 diabetes is used as a weapon to rebel in the same way that most teenagers rebel. That is employed as a weapon in rebelling against the system and against parents. That can be very dangerous and worrying. I am told that the introduction of a separate, dedicated facility to provide adolescent services in a clinic such as the one at PMH for younger children, or the one proposed for the new hospital, is much more effective in engaging with adolescents. I have not yet read the literature because I got this information only today, but there is literature to support maintaining a dedicated adolescent service in such a facility is much more effective. I am also told that our experience in Western Australian confirms that. I am told that prior to having a dedicated adolescent service in the two facilities that we have, there was something like a 30 per cent failure rate of transition through the adolescent-into-adult treatment.

Dr K.D. Hames: When I was on my feet I forgot to say that we have donated land at Osborne Park, with Tony Vallelonga and Jeff Newman from the Telethon Trust, to build a brand-new family diabetic support service. That is being built now.

Mr P. PAPALIA: Is that for type 1 diabetics?

Dr K.D. Hames: Yes.

Mr P. PAPALIA: I will get this on the record because I have to conclude. I was told that the 30 per cent failure rate has been reduced to between 15 and 20 per cent. I do not know how robust those statistics are. They may be anecdotal, but that is from people who would know. In the order of 30 per cent of adolescents under the previous system in which there was not a dedicated adolescent clinic was not used by younger children on another day. I am not talking about the younger children just being there. I understand the suggestion that there might be less childlike furnishings and surrounds, but I find it difficult to believe they will be able to change the environment from one day to the next to the extent that they do when they have a dedicated adolescent facility.

Dr K.D. Hames: I pointed out before, though, that that dedicated adolescent service that he uses now is used by children on other days.

Mr P. PAPALIA: Yes, but I understand that the surrounds that they provide now are much more attractive and amenable to provide adolescent services. Whether it is suitable for younger children, I do not know. I am told that they used to suffer a "do not attend" percentage of patients who did not attend at any one time. It was in the order of 30 per cent of those adolescents in the old facilities, which were shared facilities. There has been a significant drop—in the order of a threefold reduction.

Dr K.D. Hames: They are still brought in by their parents. Adolescent kids up to the age of 16 would not go there alone, surely.

Mr P. PAPALIA: Not necessarily. I did not say they were going there without their parents. I am talking about the environment being attractive to them. A parent could take an adolescent and stay outside, and they will go in and then can be picked up. An adolescent could conceivably get there on their own. It is something that is possible. I would imagine the majority would have their parents take them.

Dr K.D. Hames: Why would parents not take them? Why would there be 30 per cent non-attendance?

Mr P. PAPALIA: The adolescent service is intended to shepherd them through maturing into adulthood and taking more and more responsibility. That service is matched, as I understand it, to the surrounds and the environment. It works. Ultimately, through refusing to accept that argument or not being willing to accept the argument, the minister is denying the evidence of our own experience in this state. I know it is not large numbers. It is probably not large numbers in comparison to some of the other problems that the minister confronts in his portfolio, but it is a significant number.

Dr K.D. Hames: I have not seen the evidence. There are other clinicians managing the same kids who do not share that point of view. I need to go back and look at that.

Mr P. PAPALIA: I would ask the minister to do that. I will not detain the minister too much longer.

Dr K.D. Hames: You need to talk until seven!

Mr P. PAPALIA: Like us, the minister will probably be seeking advice from a few people, but I can say that the people who approached us made a reasonable argument. My own anticipation of that stage is that I think I would prefer an environment in which the evidence suggests they will get a better outcome. If that is the case, the state would prefer that too. The minister knows the consequences if we do not get this right. The consequences will be in cost and suffering. The negative outcomes for type 1 diabetics who do not progress into adulthood and take control of their diabetes are dire for everyone. We all pay the costs of that.

Dr K.D. Hames: I wonder whether that applies to all the other adolescents we manage for all the other medical conditions at the hospital.

Mr P. PAPALIA: True. It has been suggested to me that the minister's last observation about the need to potentially look at other chronic diseases and the way adolescents are treated for those other areas, maybe there would be a benefit in them having a similar facility. I have had it suggested to me that that might probably be best practice as opposed to what we do. I just wanted to place on the record that I do not think that people will be satisfied with the suggestion that a new clinic will be utilised as the juniors-type clinic one day and dedicated to adolescents on a set day of the week. The member for Kwinana and I are motivated by very personal interests, but I am sure that everyone understands that it will be a better outcome for the state if we get a reduction in the number of people who transition poorly and an improvement in their transition and an improvement in their attendance and their control of their type 1 diabetes as they go through life.

Dr K.D. Hames: You can't sit down now because there are 10 minutes to go. The boss says it is all right.

Mr P. PAPALIA: It is okay. We have got something else, have we not?

Dr K.D. Hames: Yes, but not for 10 minutes.

Mr P. PAPALIA: In conclusion, I take the opportunity to pass on to anyone in the gallery and elsewhere who may watch this debate or read it at a later time that the member for Kwinana and I are highly motivated in this matter. The Western Australian Labor opposition will not accept being fobbed off on this issue. The minister has indicated that he is willing to go away and assess —

Dr K.D. Hames: What I will do is get those clinicians who have provided me with the advice I have received so far to read *Hansard* and listen to your arguments and give me a report back.

Mr P. PAPALIA: The minister is willing to have a look at it, which we appreciate.

Dr K.D. Hames: I don't know that I want to build a $1.2 billion brand-new hospital and still rent a room down the road. That is the issue I have to think about.

Mr P. PAPALIA: I understand where the minister is coming from, but also, as part of that $1.2 billion hospital, I would not want us to build a facility that might be less effective than the thing down the road. Obviously, we are seeking advice and taking advice from people within the system, because not many people in the state conduct this treatment and provide that sort of advice, so we would ask that there be no attempts to pressure anybody out of participating in this debate. I think it is a valuable thing. This is a time, as the minister knows —

Dr K.D. Hames: Whoever is complaining to you should come and complain to me.

Mr P. PAPALIA: They may not feel comfortable. Rest assured that it has not been in any underhanded way. The people who have spoken to me have done so because I am the parent of a type 1 diabetic more than a member of Parliament. I ask that that be borne in mind in whatever happens from here on in.

Question put and negatived.