EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 1 SEPTEMBER 2009

SESSION SIX

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 2.04 pm

KOSKY, MS MICHELE MARY
Executive Director, Health Consumers' Council WA,
examined:

DRAKE, MS MAXINE
Advocate, Health Consumers' Council WA,
examined:

MARSHALL, DR LEWIS JOSEPH
Sexual Health Physician, Infectious Diseases Department,
Fremantle Hospital,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest and appearance before us today. The purpose of this hearing is to assist the committee to gather evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services. You have been provided with a copy of the committee's specific terms of reference. This committee is a committee of the Assembly. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence either on oath or on affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As a public hearing, Hansard is making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of formal questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence before a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions about being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Would you please state the capacity in which you appear before the committee today?

Ms Drake: I am an advocate from the Health Consumers' Council.

Ms Kosky: I am the Director of the Health Consumers' Council, and I also chair the Western Australian Committee on HIV/AIDS and Sexually Transmitted Diseases, which gives advice to the Director General of the Department of Health. I am here with two hats on today.

Dr Marshall: I am a sexual health physician at Fremantle Hospital, but I am here as the deputy chair of WACHAS today.

The CHAIRMAN: I am very pleased that you have all agreed to be here, because much of the evidence you will give today in relation to needs and gaps in healthcare services applies across the board. Shall we let Maxine start?

Ms Drake: I understand that Lewis needs to be somewhere at 3.00 pm.

Ms Kosky: If we could do sexual health first and then the health material, that would be very much appreciated.

The CHAIRMAN: In that case, Lewis, would you like to present a submission to the committee? If it is okay with you, we will just stop and ask questions when necessary.

Dr Marshall: Obviously you got the letter that we sent. We wanted to make three main points that are all interrelated. The first is the lack of services for youth in Western Australia. WA has no youth health policy or strategy. Despite a couple of aborted attempts to write one, it has never been endorsed. Services for youth are sadly lacking in this state compared with those in other states. Associated with that is the lack of investment in —

The CHAIRMAN: Before we move on, you said that the services for youth are lacking in this state compared with those in other states. I do not believe that you identified in your submission what services were available in the other states for us to see where the benchmark has been set in the other states.

Dr Marshall: My understanding is that the other states and territories have youth-specific health services. They are one-stop shops, for want of a better term. They are places where people can go to get a range of services about mental health issues, drug and alcohol issues and sexual health issues; that is where the interaction is with sexual health. There are a range of issues. Adolescents generally in this state are not a priority. Understandably, a lot of attention is focused on the nought to five-year-olds, but they grow up. The services for 10 to 19-year-olds are not good. At PMH things are slowly turning around. For instance, it now has more adolescent paediatricians than it has ever had. However, there is resistance. Adolescents are a difficult group to take on. They do not have a very strong consumer voice or a great advocacy voice, as members can imagine, and therefore they tend to fall through the cracks. They also do not appear in hospital separations because except for poisonings and trauma, they do not go to hospitals very often. A lot of data shows that their mental health, their sexual health and their drug and alcohol issues are very important. I do not think WA addresses those issues terribly well. The fact that we do not have a youth policy or strategy says something. It is only a document, but documents do speak and people can be held accountable against documents. The fact that we do not have one says something. That is the first place to start. Who knows what will come out of that? We do not have the same services as other states and territories.

Mr P. ABETZ: What would you define as "youth"? Various people we have spoken to consider that a child can be up to 18 years of age. What age do you consider the youth category to be?

Dr Marshall: The problem is that the definition of a child goes up to 18. Yes, that is one definition, but the WHO definition of an adolescent is a person aged between 12 to 24 or 25 years. Whether we go that high is another matter. The teenage years in particular are the group whose needs are not well addressed, generally. Often that relates to access to health care. Sixteen-year-olds can get a Medicare card, but many of them do not know that. Do they want to go to the same GP that their parents go to? Those types of issues are very valid for young people.

I think that access to appropriate care is the real issue. Do our young people have access to appropriate care? In some cases, yes, but I think in a lot of cases, no.

[2.10 pm]

The CHAIRMAN: As part of the hearings we have met with people from child and adolescent health, and it has been very obvious that there has been a lack of funding in that area. You talked about there being a great lack of funding for children up to the age of five, as well as a lack of funding for what you see as the adolescent years. Have you put submissions in to the Child and Adolescent Health Service about what services you believe should be available for the adolescent population and in what form?

Dr Marshall: I used to be a network lead for the health networks in Western Australia, and there is one on children and youth in particular. I have raised this issue with them on a number of occasions. My experience has been that it has not been taken up with any great enthusiasm. I have not gone specifically to the department area, but I have used other methods to try to see whether we can get youth health on the agenda. I do not know if you are aware of the Clinical Senate, which is a group which meets four times a year to inform the department on matters of health. There was a Clinical Senate on adolescent health, during which this issue was raised again. My understanding is that those recommendations have gone to the State Health Executive Forum, the ultimate group that looks after health in this state. Again, I am not aware of the endorsement or otherwise of those.

The CHAIRMAN: Are you able to provide to the committee, by way of supplementary information, a copy of the recommendations that were provided to the Clinical Senate?

Dr Marshall: I am sure we could. Kim Gibson is the Chair of the Clinical Senate; I can ask her for a copy of the recommendations. I am sure there will be no problem about providing those; they have gone to SHEF as a document, so I am sure we could get those for you.

The CHAIRMAN: That would be very useful.

Ms Kosky: From WACHAS's point of view, what would be enormously helpful from this committee would be a principle of integration for youth-friendly services. We now have a mental health service for young people in Fremantle called headspace, but a horizon scan was not done to look around at what other services young people might need; only young people's mental health issues were looked at. I cannot tell you how much faith we have in the power of this committee, and there should be an obligation for services to check out the horizon and do a needs survey—what every non-government organisation has to do whenever it starts a new program—to find out what the other needs are, to ensure that these separate services do not get established. Headspace is a great service for young people with mental health problems, but it does not cater for other matters that might benefit young people. Integration is the way to go.

The CHAIRMAN: This follows on from what Lewis said before about there needing to be a detailed strategy for adolescent health services for the next decade.

Dr Marshall: Absolutely. It is not just about creating these one-stop shops; there are a whole range of other things that could be integrated and done much better. I have a copy of the draft that was prepared for the Youth Health Strategy 2008-2013, if you are interested in seeing that.

The CHAIRMAN: Thank you; we will accept that as supplementary information.

Mr P. ABETZ: I have a question about specialised youth health services, or whatever terminology you want to use. My experience over many years has been that there is a certain amount of resentment within the community, particularly from parents, about their kids being able to access certain things without their parents' knowledge when the children are still living at home. I can certainly see the benefits of having a specialised youth service, but at the same time I can also see this undermining the integrity and the wholeness of a family if little Johnny, at the age of 13 or 14, can go off to whatever facility he chooses without his parents having any knowledge of it. If he could do that, his parents would not even be able to provide, in the home, the kind of support that ought to be provided and that most parents would probably want to provide for their children. It could bring about an individualisation of care, rather than a more holistic family approach. Would you like to comment on that?

Dr Marshall: Sure. I am a sexual physician and we deal with this issue on a daily basis. We are very keen for young children to inform their parents of these issues, but in the end, if we assess that the child is a mature minor, then we feel that we have an obligation to provide that child with good health care. I absolutely take your point that to do that in isolation from the family unit may be difficult, but sometimes it is the family unit that is causing the problem, if I may say so, so it is not always appropriate. But good counselling and good care takes that issue into account, and if it means some rapprochement with the family, then I think that is part of the care for that child. I think each case has to be taken on its merits, and whether it is appropriate to do that or not is a decision you have to make. I do not think it will be carte blanche and everyone will run off and do things without their parents' permission, but by the same token we do need to have care for children who do not have that support at home.

The CHAIRMAN: Basically, there is a hole and the hole needs to be filled for those children who have not got that support.

Dr Marshall: Yes. They are the ones who tend to slip through the net of every service that we provide. A lot of the services are school and education based, but lots of these kids are not in school. There is a group of children who I think are not being served well currently.

Ms Drake: I would like to make a comment in addition to Lewis's. There are four structures that contribute to child health that I am aware of. First, there are the community services that deal with children after birth, involving child health nurses in the community. They are, in a sense, looking at normal development and normal growth. Second, there are child development services that look at developmental problems and issues. Third are the child and adolescent mental health services—these two are sometimes in contradiction to each other because generally you do not regard children as having a mental health problem until you have ruled out that there is a developmental issue that has or has not been sorted. Fourth are the child health services. They all operate, in large part, independently of each other, without any kind of governance or oversight that would bring some of their practices into some kind of standardisation. I think that would need to happen under this plan. That is the integration that Michele is talking about.

Mr P. ABETZ: For the roughly 60 per cent of children growing up in Western Australia in a reasonably stable family with a mum and dad, if they have health issues, mum or dad take them to the doctor, that sort of thing; they are catered for quite well. It is the ones who perhaps do not have that support network, such as dysfunctional families or kids living on the street, where you feel there is a real hole. Is that what you are saying?

[2.20 pm]

Dr Marshall: That is exactly right. If mum and dad are going to be involved and take them for health care, that is fantastic and that would be the best possible outcome. Unfortunately, there are lots of kids who do not fit that category.

The CHAIRMAN: It is not always a case of dysfunctional families; it is the case that some children are growing up much earlier these days and they are not willing to discuss these issues, particularly in the area that you see these children, and they feel that they can cope. That is possibly what leads to some of the problems that we are experiencing.

Mr P.B. WATSON: They have access to the internet and they can look up a lot of things and make their own decisions too, and not necessarily the right ones.

The CHAIRMAN: Michele, would you like to follow up from what Lewis has said? Lewis has identified that there is no strategic plan for adolescents with sexually transmitted diseases. However, because you are wearing both hats, the general consumer council and the advisory committee, are you seeing this across the board or is this lack of identification and planning specific to adolescent health?

Dr Marshall: It is much greater than that.

Ms Kosky: There is an overuse of the word "planning" and not that much improvement in patient care. There seems to be a lot of activity with not a lot of outcome. I would suggest that those people who are most disadvantaged by the health system are Aboriginal people, people from non-English speaking backgrounds, people with mental illness and young people. Of those groups, we have a plethora of Aboriginal health plans, but no apparent improvement in Aboriginal health outcomes. That is the great problem that this current government faces, and the Premier certainly identified that at the COAG meeting, which was very pleasing indeed. We have worked very hard to encourage the department to provide interpreter services for people from non-English speaking backgrounds, as was well as for Aboriginal people from the Kimberley whose first language is not English. We have tried to influence the language services policy of the department and to gain access to interpreters much more effectively. That is less around the sort of planning that Lewis is talking about and more about how people can access services more effectively. I do not think, for those groups, there is a lack of planning; there is too much planning and, in our opinion, not enough action. There is a lot of talk and an endless series of meetings, but when the improvement comes to the services we will be very grateful.

The CHAIRMAN: One of the things that the committee discussed earlier was that female circumcisions are still going on in various sectors of the community. Have you had to deal with problems related to that?

Dr Marshall: Personally, no. We have not seen anyone with genital mutilation who has come to our clinic, that I am aware of. I would suspect that is kept quite quiet. They do not tend to come to sexual health clinics for that.

The CHAIRMAN: Has your council discussed that issue at all?

Ms Kosky: We have discussed it, but have not had complaints or done advocacy about it in the past 15 years. I think that it happens in a closed, select group.

The CHAIRMAN: Maxine, would you like to discuss from your perspective —

Ms Kosky: We probably need to complete the sexual health stuff so that our great man can leave, and then Max and I can do the consumer stuff, if that is okay?

The CHAIRMAN: That is fine.

Dr Marshall: The second item we want to draw to the committee's attention is the lack of investment in sexual health services in this state over many years. I will give the committee a quick history. Up until 1994 there was a very large sexual health clinic called the Murray Street clinic— before that there was the Moore Street clinic. It had significant staffing. That was closed after a report was written in 1994 and two very much smaller clinics were established at Royal Perth Hospital and Fremantle Hospital. There was nothing at Sir Charles Gairdner, which I think is interesting. The number of staff has decreased since the initial establishment in 1994. Currently, only two sexual health physicians are employed in the state of Western Australia. That is Jenny McCloskey at Royal Perth Hospital and me at Fremantle Hospital. That is against a background of increasing chlamydia rates. Chlamydia has increased by 300 per cent in the past 10 years. Gonorrhoea is also going up. Syphilis has now re-established itself in the metropolitan area, which we have not had for many years. We even now have established in this state an exotic disease called lymphogranuloma venereum; we had never had that in this state. I am also a pragmatist, and I used to be a GP, so I know that most of this work happens in general practice, as it should do. General practice does this very well, but general practitioners need support. They need places to refer their patients to and they also need education and mentoring; and with just the two of us that is quite difficult. In fact, the two of us are both employed by the South Metropolitan Health Service, but we also take on board that we need to support people out in the rural and remote areas where in fact the rates are much higher. The Kimberley rates for gonorrhoea are 60 times higher than in the metropolitan area. We need to look at how we can invest better in sexual health services from an

education and training perspective as much as from a clinical care perspective. Equally, we feel we are often the clinic of last resort. People often do not want to go to their GP about sexual health matters. Often it is something they are embarrassed about that has brought them to the clinic and they do not want to see their GP, whom they see about a range of other things. When the clinics were first established at Royal Perth and Fremantle hospitals, they were referral-only clinics, just like any other tertiary hospital. We fought quite hard to get that overturned.

The CHAIRMAN: That is right, because the previous clinics were walk-in. I cannot remember what they were called, but I remember the one in Murray Street where people could walk in.

Dr Marshall: Yes, they were walk-in clinics. We fought hard for them to become self-referral clinics; in fact, probably 70 per cent of our patients are now self-referred, and 30 per cent are referred by GPs.

The CHAIRMAN: They are now self-referred?

Dr Marshall: Yes, because we fought to say that we could not be just a referral clinic as we did not think that was appropriate and we had to give people another point of access into the health care system. Again, a lot of the people we see are people who do not have a lot of money and it is not easy for them to go to GPs because not many GPs bulk bill. We can give people access to free care, essentially, in this area, which from a public health perspective is really important. If someone is not going to a doctor when they have chlamydia or gonorrhoea, then they will infect a lot of other people along the way until they finally get treated. From a public health perspective, it is an imperative that we provide this sort of service. As I said, what is currently available is located at Royal Perth and Fremantle Hospitals. Royal Perth, being in the middle of the city, has as much longer waiting list than we do at Fremantle Hospital, and waiting lists for STD clinics are very problematic, as you can imagine. If someone has a disease they do not want to be waiting, and also we do not want them to wait because we do not want them to infect other people along the way. That is all that is currently available in the metropolitan area. Non-government services are provided by the Family Planning Association, but from a government perspective that is all that is available. For instance, there is nothing in Joondalup. We provide a small service from Fremantle down to the Rockingham-Kwinana area, but that is very limited without the appropriate staffing levels.

The CHAIRMAN: There are two full-time appointments that are currently funded through the South Metropolitan Health Service. As hospitals look at occupancy rates—you have said that the numbers of children and adults who are now contracting sexually transmitted diseases are drastically escalating—have you put a business plan to the government to open up clinics in Joondalup or other areas?

You must have the statistics in terms of where people are probably more sexually active and where the transmission is occurring. Have you put a business plan to the government; and, if so, can we have a copy of that business plan? Are you able to outline some of those areas?

[2.30 pm]

Dr Marshall: Certainly. Again, from the network perspective, there is a sexually transmitted disease model of care that was approved by SHEF in December 2007. That has really gone nowhere.

The CHAIRMAN: Thank you for submitting that.

Dr Marshall: It has been described as a dummy spit by me, but I actually resigned in July this year because of lack of movement on this model of care. I understand that this is a time of great financial difficulty for the department, absolutely, but the reality is that the big-ticket items are things like renal disease and cardiovascular disease—the things that put people into hospital. Of course that is where the big money is going to go. I did not see that there was any light at the end of the tunnel for services like sexual health, which are just about exclusively outpatient clinics, so therefore do not

appear in the hospital separations, which seems to drive where money is allocated. Also, people do not like talking about sex, basically. Sex generally puts people off. It is a pity because most people like it! But they do not like to talk about it much when it comes to health.

Mr I.C. BLAYNEY: It is one of life's great ironies I suppose.

Dr Marshall: It is indeed.

The CHAIRMAN: Did you recommend that these clinics be population based throughout the metropolitan area?

Dr Marshall: Yes. This is just one of a number of reports. A metropolitan sexual health review happened in 2006, which actually addressed those issues of taking services to Joondalup in particular. I just think there needs to be some investment. Further planning needs to be had, of course—I take your point—but I do think we need to think where we are going to put these services.

The other point that is relevant here is that with the current Poisons Act in Western Australia, we are very limited as to who can provide this treatment. Basically, it currently has to be provided by a doctor. We have been trying for the past four years, I think, to get amendments to the Poisons Act, as happens in Queensland. In Queensland, they have this category of nurse called advanced practice nurse.

The CHAIRMAN: Nurse practitioners.

Dr Marshall: No, not nurse practitioners. Nurse practitioners are actually covered under our Poisons Act. Nurse practitioners do a master's degree and then they are able to prescribe, although currently not on the PBS, but I understand from Nicola Roxon's message that that is going to change. These are called advanced practice nurses—advanced sexual health nurses in fact in Queensland. They do a six-month course online, as it turns out, with a university, so it is a diploma course. At the end of that, following very strict and well-defined protocols, they can actually treat common conditions like chlamydia. Chlamydia is a simple disease to treat if you get it early. It is more difficult if it is complicated, of course. Again, in those protocols, they would not be treating the complicated cases; they would be referring those on.

The CHAIRMAN: Are these registered nurses or enrolled nurses who do this course?

Dr Marshall: Registered nurses who then become advanced practice nurses. Under the Poisons Act, we have been trying to get it so that nurses and other health professionals who have done an approved course—approved by the director general—would be given permission to follow these protocols, which would mean that they could actually treat. It is a model that has been used in the UK for ages. I think they call them patient group directives. Again, following very close protocols, you are allowed to do X, Y and Z. You do not get full access to everything, but there are limited things you can do. We think sexual health is a fantastic area for nurses to do this. We have got fantastic nurses who work with us at Fremantle. They are hamstrung by what they can do. They can do asymptomatic screening—so patients without symptoms who need to be tested—and they do that very well with nurse-led clinics. But if a patient needs treatment, they cannot do that without a doctor being on hand; therefore, outreach clinics are fairly limited as to what they can achieve. Yet a lot of young people, in particular, could actually go to an outreach clinic, be seen appropriately, managed appropriately and referred on, if need be, if we had more flexibility within the health system. I think that the review of the Poisons Act is not just about sexual health, but that is the area I know about. I am sure that there are lots of other areas where well trained nurses—again, I do not want this to be offensive, but nurses are very good at following protocols. They are much better than doctors. If you give a nurse a protocol, it will be followed well and it will be done well. This is an area where we could really use nurses incredibly well if they were allowed to be used.

The CHAIRMAN: In the regional areas, WACHS is moving to upgrade its nurses to nurse practitioner level. But within the metropolitan area, have you approached one of the universities to

see whether they would be willing to run a course like this? If, say, the committee were to consider putting in a recommendation that so many places be funded at one of the universities, has one of our local universities expressed an interest in running a similar course—I guess it is just a one-semester course for a degree nurse—to give them these skills?

Dr Marshall: First of all, Griffith University in Queensland runs the Queensland one. They would be available to our nurses as well, because it is all online. That is the first issue. Secondly, through Family Planning WA, which does a lot of nurse education, there have been discussions with Curtin University to do the same sort of thing here. I think it is doable, but we have not gone anywhere, because what is the point of training someone if there is nowhere to put them when you have trained them? We have not actually pursued that further, but I think it is very doable. There is already a model you can copy, even if you do not use that same model.

The CHAIRMAN: That would require an amendment to the Poisons Act for nurses with that additional qualification to be able to assess and treat patients who have sexually transmissible diseases.

Dr Marshall: Indeed; yes. If you are looking at the Poisons Act change, it should be broader than that. It would be anyone who has done an appropriate course as designated by the director general; so that it is a bit broader than just sexual health. That would be how it would apply for us, but I would hope that there would be other opportunities to use nurses. While the nurse practitioner thing is fantastic, it does mean people committing to another two years of training post-graduate and having a place to come at the end of it. We have got a nurse practitioner in our unit who has actually done all the training, but there is no position to employ her against.

The CHAIRMAN: A lot of GP nurses may not have degree status, but they perform a wonderful role within the actual surgery. Is it just degree nurses who can do this through Griffith University?

Dr Marshall: I would have to look into that, but I would suspect, because it would be a post-graduate degree, that it would probably need something. Whether they have got some "out" for people with long experience, I am not quite sure. Practice nurses, absolutely, I think are an absolute mine that has not been at all used currently. There are some provider number issues really. Currently, under the medical benefits scheme from the commonwealth, practice nurses can actually raise a fee through the doctor for Pap smears and chlamydia screening, but you have to do both. Again, we are trying to say, "Why do you have to do both?" People might not need a Pap smear but they might need a chlamydia screen. Those anomalies are obviously not within the remit of this committee, but I think there are a whole lot of reform issues that could open up access in this difficult area. It is not all about getting more doctors—although it would be great to have a couple more of us—but it is also about improving access to care, which is a real issue for sexual health, perhaps more than other areas because of that embarrassment issue. People do get a bit embarrassed about talking about sex. Often they like to go to an anonymous third party like us. Also, when they come to us, they know they are going to talk about this stuff, and they come and talk about it and get dealt with, we think, appropriately, whereas they might not want to do that to their GP, who is time pressured, has only 10 minutes—those sorts of issues that can come up for general practice.

Mr I.C. BLAYNEY: You said the incidence of the three you mentioned here—chlamydia, gonorrhoea and syphilis—has risen. They dropped quite markedly, did they not, when the first campaigns were run on HIV? Is that right?

Dr Marshall: Yes.

Mr I.C. BLAYNEY: Have they gone back up to a level —

Dr Marshall: If you look at syphilis, I think 1992 was our peak. It has fallen quite dramatically, as you say, around that—although a lot of that was about screening in the Kimberley, and I will not go there.

Chlamydia, for instance, has been notified only since 1993, so that has gone up exponentially. With gonorrhoea, there has been about a 50 per cent increase over time, so that is doing the same sort of thing, but at nothing like the same rate that chlamydia is.

[2.40 pm]

Mr I.C. BLAYNEY: It is always said that every generation has to relearn the lessons of the past. So is it that people do not understand the danger, and, therefore, the importance of using condoms; that people do not like using condoms; or that they are not available?

Dr Marshall: I think it is probably all three of those, to be fair. This state has no mandatory sex education in schools. My understanding is that you can meet all the health curriculum outcomes in Western Australia without actually talking about sex at all. Again, I do not think this is about sex education per se. I think this is about educating kids to have good self-image and good self-resilience—all those issues—so that they make good decisions. It is not just about sex. It is about alcohol and drugs. It is about road traffic. There is a whole range of issues where how you feel about yourself is going to influence the decisions that you make. I think that in our education system, health is not taken terribly seriously.

The CHAIRMAN: Is there any evidence from the other states that when sex education is part of the school curriculum, there is a decreased level of sexually transmitted diseases among adolescent youth?

Dr Marshall: That is a good point. I do not know if I can say that absolutely. The only state that I am aware of that has compulsory sex education is South Australia. Their rates are a bit lower than ours, but I do not know whether we can draw the conclusion —

The CHAIRMAN: Whether it is statistically significant.

Dr Marshall: Yes.

Mr I.C. BLAYNEY: I do not know that school is the place to be teaching sex education. I wonder if it is one of those things whereby you can think that you have taught it to kids in school, but when they leave school they are probably going to forget what they have learnt and not be aware of the dangers that they are getting themselves into.

Dr Marshall: Absolutely, but if people have the beginning understanding and knowledge, we can work on that and build on it later. Again, who can remember any campaign, except the Grim Reaper, on any sexual health measures in the past 20 years? A lot of it is targeted, and rightly so, but we need general awareness raising of the whole population. That includes telling parents how important it is to talk to their kids about sexual matters. I think these are issues that are hidden. I think we need to have better education. That is in a broader sense. Community education about these matters is really important. And it is not all about condoms.

Mr I.C. BLAYNEY: The only time we ever see anything about condoms is when we see the sign behind the toilet door at the airport when we are going overseas. It almost seems to imply that you catch these things only when you go overseas.

Dr Marshall: Yes. There are also signs in pubs. I do not know how many pubs you go to.

Mr I.C. BLAYNEY: They are in pubs as well?

Dr Marshall: Yes, they are in pubs as well, and there are condom machines and things.

Mr I.C. BLAYNEY: I have certainly never seen a condom machine in a pub. Are they in pubs as well?

Dr Marshall: Most pub toilets have condom machines.

Mr I.C. BLAYNEY: I remember one of my kids asking me in a service station what condoms were, and I said they are for men who have had too much to drink!

Ms L.L. BAKER: Oh no! That was a nice mature response!

Dr Marshall: It is probably not far from the truth! It is not just about condom use. It is not about going into schools and teaching every kid how to put on a condom. It is about helping kids to make the right decisions in life. That is the issue. School is a valid place to do that. It would be great if parents did it, but they do not all do it. We need to have some sort of safety net for kids so that they do get that information. I think some dialogue with the education department would be actually very useful to get health taken more seriously. There is a lot of pressure on the three Rs currently in the education department, but I think health does have a place in the curriculum and should be taught appropriately.

The CHAIRMAN: Possibly with the increase in the number of school psychologists that the minister announced a while back, they might look at what is in the school curriculum and what is not in the school curriculum, and the problems that are coming to them within schools. Lewis, are there any other matters that you want to raise?

Dr Marshall: That is me done. Thank you very much for your time. I realise that I have been rabbiting on for a bit, but it is something I feel passionate about, as you can see.

The CHAIRMAN: You have said that you are going to provide us with supplementary information in terms of the statistics.

Dr Marshall: The statistics, yes.

The CHAIRMAN: And where the services are required.

Dr Marshall: Yes. I can do that as well. Sure. I will leave these other two documents here for you.

The CHAIRMAN: Thank you very much. As you are leaving us, I need to make a closing statement. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Thank you very much again for all of the additional information that we have asked for; and, when you review the transcript, please do jot down any things that we have not had an opportunity to discuss today but that you see as a need and a gap in adolescent health services.

Dr Marshall: Sure. Thank you very much for your time.

The CHAIRMAN: Michele and Maxine, I can give you five minutes each, and then five minutes to sum up. Who wants to go first? I assumed that you were happy for Lewis to give his presentation first.

Ms Drake: Yes. That is fine. We are happy to answer any questions from the committee about the comments that we have made about the retention of Royal Perth Hospital, and any other areas that are covered in our submissions. Any questions, Lisa?

Ms L.L. BAKER: Yes!

Ms Kosky: Because you would have remembered our submission best!

Ms L.L. BAKER: Yes! I was going to suggest that you tell us about your position on the retention of Royal Perth Hospital and the impact of that on the sector. That might be a good place to start.

Ms Drake: The Health Consumers' Council was very involved in the Reid report—the writing, and the consumer consultation processes that went around the Reid report. The Reid report made the recommendation that Royal Perth Hospital be closed and Sir Charles be retained as the central hospital in the city. We did get reactions from the community and from doctors. In fact, there was a

fair bit of lobbying from Royal Perth Hospital doctors about the retention of Royal Perth Hospital, and some consumers themselves said that the eastern corridor and the natural central nature of Royal Perth Hospital mean that that population will miss out on having access to that major hospital. The Reid report of course talks about the establishment of the Midland hospital. We have always talked about some of the lovely funding basics and fundamentals of health care, which is about transport access. The Health Consumers' Council has always lobbied for the importance of public transport systems that will take people to hospitals. Wherever the hospital is, we need public transport systems that will take people there.

We have made a commitment to the Reid report's restructuring of health services, recognising the limited resources that we have in Western Australia, but we have also always recognised that there is a sentimental attachment to Royal Perth Hospital by people for lots of reasons, and that even the idea of removing from the CBD of the city a hospital is quite a significant thing to do. So the Health Consumers' Council in its regular meetings with the previous Minister for Health raised the issue of Royal Perth Hospital a number of times. In the first instance, we talked about the need to retain some form of health service in the CBD. What we regard as a service that could work in the CBD is an urgent care facility. We need a facility that can deal with urgent issues—the lacerations, the tripped over on the pavement, and all that kind of stuff—whereby people need urgent care and they cannot get it in a general practice and it probably is not appropriate for a major trauma ED.

The CHAIRMAN: So a secondary level?

Ms Drake: Yes. But given the resistance to the closure of Royal Perth Hospital, the minister said at that time, "I need to get past a point of no return before we can then start to talk about the retention of anything." So that was fair. We just stepped back and said that is fine. But we have always kept up the argument for an urgent care facility. We spoke to the shadow Minister for Health under the previous government, who is now the current Minister for Health. We made an appointment with Kim Hames, and we said that the uncertainty around the closure or the retention of Royal Perth Hospital is bad for consumers. It is also bad for morale in the health service, and anything that is bad for morale is bad for patients—you know—grumpy nurses make for unhappy patients. All the uncertainty about whether people will stay in their jobs or move on was another question. We said that it is our view that there needs to be bipartisan support for the closure of Royal Perth Hospital under the Reid review. That is what the population needs. At the time, the shadow minister said, "This is on our platform. It is on our platform now. If we lose the next election, we will drop it from our platform, because we recognise exactly what you are saying—the uncertainty is not good for anyone." So, as we know, history has dictated that Royal Perth Hospital will be retained as an election promise, and that is the situation that we are in. But we all recognise the implications that is going to have on the distribution of resources in the health system. As we have said in our submission, it will either be an accident of history that was seen as a brilliant one, or a dismal failure. Time will tell and dictate what the outcome is on that score. Is that a fair summary?

[2.50 pm]

Ms Kosky: Yes, absolutely.

The CHAIRMAN: We are all waiting to see the services framework to see what services will be there, where the duplication may be and what the cost effect will be in terms of the other tertiary hospitals and the secondary hospitals?

Ms Drake: You cannot have not quite a tertiary hospital like you cannot be half pregnant. You are either all the way there or you ain't, and a tertiary hospital has a very high list of functions that cannot be undermined. That is contained in the legislation and there is no turning back from that.

The CHAIRMAN: As part of your submission you raised deficiencies in dental care services and child development services. Although we have looked at some of the deficiencies in adolescent health services, would you like to elaborate on the problems you see in child development services

and then dental services? We are waiting to get the statistics for dental health services. We are still in discussions and have had one meeting with the child development services, but they will come back again. Perhaps we can discuss child development services first and then dental health services.

Ms Kosky: Our experience with child development services is the waiting lists and the uncertainty once again. I am probably telling you what you already know. Those services that assist parents so importantly in identifying any problems that the children have and getting those problems addressed are not working in the public sector for families and children. The waiting lists for speech pathology, audiology and all those matters for which there are good interventions are a disgrace in Western Australia. I think we would be singing from the same song book as other witnesses to this committee that child development services need a rocket; they need reform. They need to rethink their attitude to service delivery from the parents' point of view, not their own particular desire to deliver or not deliver a service.

The CHAIRMAN: Child development services themselves would like to see those additional funds. Your emphasis on support for those services needs to go up a step. We need to get the government to provide the funds. I am not sure whether you are aware, but child development services identified some savings a few years ago when they merged. However, with the three per cent efficiency cuts, in the past few months they have lost various positions in occupational therapy, speech pathology, physiotherapy, social work, audiology and psychology, and they have lost dieticians and therapy assistants. In addition, there are jobs on the line again. I certainly will, and I am sure other members of the committee will, take up with the minister that the three per cent efficiency cuts were not meant to affect front-line services.

Ms Drake: You also need the infrastructure to be intact and to be standardised across the state. If a family has identified a child with autism, it should be able to say, "This is a virtual screen. I live in this suburb. What is available to me?" If we could do that right now and provide the availability of certain services, it would be all over the map, so we could throw more money at a system that does not have its infrastructure in order. We need to make sure the infrastructure is in order. Until recently, some of the child development services had card file systems; they did not have electronic databases. If we are going to put more money towards it, it needs good clinical oversight and standardisation across the state, because services can be running in different directions. That is an issue also.

The CHAIRMAN: Child development services cover the metropolitan area. Outside the metropolitan area, WA Country Health Services covers child development services providing links to support the staff.

Ms Drake: Telehealth sometimes.

The CHAIRMAN: They have themselves identified the lack of community health nurses, child health nurses and school health nurses. As part of this review, we are now looking at the number of full-time equivalent shortages in terms of speech therapists, occupational therapists and all the other therapists and hoping to get that baseline for both metropolitan areas and regional areas so we have a platform to start with to see an improvement in services.

You mentioned autism. It has also been brought to our attention that when a child with autism comes from Queensland to WA, that child is not automatically given support in WA, even at school, because the diagnosis in WA must be by three groups.

Ms Drake: A multidisciplinary group.

The CHAIRMAN: Yes. There are lots of difficulties in relation to child health. You are not repeating information, and it is wonderful that you are giving support and that you are endeavouring to see improvement in those services, because there is a big gap.

Mr P. ABETZ: Did I understand you correctly when you said there is stuff all over the place in relation to child health services for, say, autism? Are you implying there needs to be much better coordination of what is on offer, or did I misunderstand that?

Ms Drake: There needs to be coordination as well as standardisation. It should not be a lottery according to where you live.

Mr P. ABETZ: I hear what you are saying.

Ms Drake: The other issue is the waiting time for getting that diagnosis. Parents know there is a window of time for good intervention to improve their children's chances of coping with life in getting some of those skills. It is no good if you have to wait for an appointment, wait for diagnosis and then wait for treatment. People need a very thorough approach at the beginning so they can be told, "Okay; if you go through the state system, you'll get an hour a fortnight; if you mortgage your house, you can buy the 10 hours a fortnight that you might need to get the best for your child." Parents need to be given that information. Fourteen months down the track they ask, "For God's sake, why weren't we told?"

The CHAIRMAN: We were told yesterday that rather than it being 10 hours a fortnight, it needs to be acute sessions for some of the children with their various needs. The whole funding formula needs to be reassessed.

Are the concerns you wanted to bring us in relation to dental health care services about lack of centres and lack of staffing? Is there something else?

Ms Drake: I will talk about the oral health domain, if you do not mind.

The CHAIRMAN: Yes.

Ms Drake: I was on the dental board for a number of years and I have done a lot of advocacy for people in the dental health area. As a result of building up some knowledge about oral health issues in WA, the Health Consumers' Council has recently initiated an oral health reform program to try to bring about some changes in the way oral health services are delivered in WA. We have argued for an oral health network as part of the health reform process, where we have health networks for a whole range of other diseases. There is an artificial and unnecessary separation between physical and oral health. Dentists will say that poor oral health is a sentinel marker for physical health. For your body to be working well, your saliva, your teeth and your gums need to be healthy. You probably know this. But at the moment dentists are not involved in assisting in the identification of illnesses. Doctors do not recognise the importance of oral health for the body's wellbeing. It is our view that if oral health had a network that could integrate it with medical and physical health in Western Australia, we would have better integration of the two areas of activity. In WA at the moment children graduate from school having gone through the school dental program.

[3.00 pm]

It is great for a lot of kids. There are some kids, of course, who do not go through school and so miss out on that, and they are most likely to be the ones who need some oral health assistance. Unless the parents have then got that child into a habit of going to a dentist—which they probably have not because they have had the school dental program—or they have got private dental cover, what mostly happens is that most people drift along until their 30s and they get their first toothache and then they have to find a dentist. For every bottom that is on a seat in their dental chair dentists need to pull about $300-odd per hour per person to keep their business turning over. So they are an interventionist treatment service and there is no incentive for dentists to sit and talk to a person for a good hour to help them understand their oral health and wellbeing. So an argument we have raised is that there needs to be an independent, allied dental health practitioner, such as a dental hygienist, for example, or dental therapist who can work in private practice to never do any irreversible treatment; only do treatment such as scale and clean, identification of dental problems and referral to other practitioners. This is the main plank of the reform program that the Health Consumers'

Council says it wants. One is for the establishment of an oral health network under the reform program and one is for the establishment of private practitioner rights for dental hygienists —

The CHAIRMAN: Dental therapists?

Ms Drake: — dental hygienists, therapists, whichever allied dental health practitioner group is the right one, to have a scope of practice that allows them to set up an independent practice, because all we have at the moment in WA are treatment services, and we have them in the public sector. We are not sure about the activity levels in dental clinics in the suburbs. We do not know whether in fact they are working flat out or whether they are not working optimally, because we do not know very much about them. We have the Oral Health Centre, which is run through UWA and which has a disassociation in a way from the state dental services, and we have the private domain, which is funded by private health insurance and people's pockets.

The CHAIRMAN: Where do they have these dental therapists, or the other term you used?

Ms Drake: They could be in a super clinic.

The CHAIRMAN: But where is the evidence of that? Where do they have these roles in other states proving the effectiveness, the evidence that creating such a position will have a positive long-term outcome for health?

Ms Drake: Pass; I do not have the answer to that. We have been working with a particular dentist who has been developing this model and I would have to get that information to you later on.

The CHAIRMAN: We will be very happy to accept that by supplementary information, because it is very important that, wherever possible, if somebody is putting something forward, there is evidence that it is going to be effective.

Ms Drake: Absolutely. Evidence from other places is also tremendous, but if there is fundamental, inherent logic within it as well, there is nothing wrong with WA breaking new ground on something like this, because it is a national issue. Western Australia used to have a tremendous place at the front of oral health nationally, and it has fallen back. In the time that I have been in this job—whoosh—it has fallen away. So I think there is certainly some scope for us to leapfrog across the others and say, "Let's work on this model. It can do no harm. It can only do good." The other thing that we know is that the population's literacy about oral health is incredibly poor. The language of dentistry is so alien and exclusive that most of us do not understand it like we do when we make parallels about the running of a vehicle or the way we run our bodies. When it comes to our teeth, we often do not understand very much about our teeth. I do not even know how many are in my head; I should make an effort to understand that. So what we understand is that private dental hygienists would provide an increased literacy in the population, and it would also demystify dental care and remove some of people's fear about going to dentists, because that is a very significant issue as well.

The CHAIRMAN: When you provide that evidence or whatever articles you are able to give us, the other thing is: can we multiskill a professional from the work that has been done? We are seeking to get additional school health nurses, we are seeking to get child health nurses, we are seeking to get community health nurses and we are seeking to get maybe therapists at a preprimary level for assessing speech and hearing. Can someone take on this role so that it is not a unique role but could be a shared role with one of the groups?

Ms Drake: What we understand from the federal government for nurse practitioners is that there is a preparedness to consider altering the scope and role of practice of a number of health practitioners to meet the community's needs, instead of following traditional demarcations. So certainly there is no issue there with who does it, but whether they are doing it well and doing it under some supervision and having done a proper course. So you are right.

The CHAIRMAN: In that case—I am very sorry—we have another hearing. Thank you for your efforts before the committee today. A transcript of this hearing will be forwarded to you for the correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, particularly given the fact that your time has been so limited with us today, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Thank you once again.

Ms Drake: Thanks.

Ms Kosky: Okay; thanks very much.

Hearing concluded at 3.06 pm