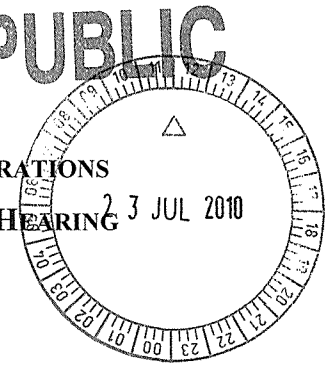

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

ADDITIONAL QUESTIONS FOR 2010/11 ONGOING ESTIMATES HEARING

DEPARTMENT OF HEALTH HELD ON

FRIDAY, 2 JULY 2010

HON GIZ WATSON MLC ASKED -

1. *I refer to the references in the Budget to substantial increases in funding for community child health. They appear at pages 179 and 193. I have a constituent who is the father of a baby born very prematurely, who is concerned that newborns are not included and that his local community health nurse is actually having her hours of paid work cut. Are newborns to benefit from the increases in funding for community child health?*

Response:

Yes. The 'community child health' funding in the 2010-11 budget is specific to child development services. These services respond to concerns about developmental delay in children. In the first 6 months of 2010 (1 January to 30 June 2010) 557 children under 1 year of age were referred and accepted into the metropolitan Child Development Service.

2. *If yes to (1):*

2.1 *how much extra funding is specifically for newborns?*

Response:

This can not be provided. If a newborn is identified as being at risk of developmental delay (e.g. premature baby) they would be referred to the child development service as per current practice. Some newborns will therefore directly benefit from this investment strategy

2.2 *what increases in community health nurse FTEs will that funding make available for newborns?*

Response:

No funding for community child health nurse FTE was provided in the 2010/11 Budget.

3. *If no to (1), why not?*

Response:

At this stage, funding for Child Development Services, for which the Government has allocated $49.7 million, has been the priority.

4. *If community health nurse FTEs are not increasing in this budget, have any changes been made to the number of clients some or all of those nurses are expected to visit in a given week?*

Response:

Western Australia has experienced an increase in population with a 22% state-wide increase in the number of births between 2002 and 2008. The ratio of birth numbers per community child health nurse FTE in the metropolitan area has increased from 1:149 in 2002 to 1:183 in 2008.

Community child and maternal health services are voluntary with a focus on health promotion, prevention and early intervention. At a clinic level, services are prioritised to families with children under 1 year of age and families who are assessed to be vulnerable or as having higher needs. The Department is reviewing staff work loads and reallocating staff to centres under greatest pressure.

5. *If some or all of those nurses are expected to visit more clients within comparable numbers of paid hours in any given week, why has such a service cut been implemented?*

Response:

There have been no cuts in the numbers of community child health nurses in Western Australia. The numbers of child health nurses have not kept pace with the increase in birth numbers and as a part of business management, child and adolescent community health services monitor service demand and routinely reallocate staffing resources according to health priorities. As a result of rapid growth in some areas across the State some disparities in work loads between regions have been identified and staffing positions have been moved accordingly. This strategy has been long standing in community child health.

6. *Mother and baby unit at KEMH*

6.1 *I refer to the Budget at page 196, Asset Investment Program, reference to King Edward Memorial Hospital. There does not seem to be any reference to expansion of the 8 bed Mother and Baby Unit for mothers with post natal depression. Will the Minister please outline the levels of funding, and briefly the types of service, to be provided by the KEMH Mother and Baby Unit in the budget estimates and forward estimates periods?*

Response:

Expenditure at the Mother and Baby Unit (MBU) at KEMH in financial year 2009/10 was $3.493M. The 2010-11 allocation has yet to be finalised.

The MBU is created for admission, comprehensive assessment and management of mothers with their babies experiencing perinatal mental health disorders.

The Treatment team is multidisciplinary and headed by Associate Professor J Rampono. The team includes consultant psychiatrists, clinical psychologist, social worker, registered and enrolled nurses with training in mental health, midwifery, child health, mother craft and infant mental health.

Types of services provided include:

- Cognitive Behavioural Therapy modules on managing anxiety and depression, negative emotions, panic, low self esteem, mind-fullness based CBT – managing intensive negative emotions
- Full therapy program as part of treatment whilst inpatients at MBU include: lifestyle groups on anger management, assertiveness, goal setting, positiveness, communication, relapse prevention, self esteem, stress management, change, relaxation, relapse prevention etc.
- Mother craft groups on feeding, settling, bonding, attachment and managing baby.

- Community mental health nursing follow - up support on discharge from MBU until link up with other services.
- Organisation and referral to follow up services -these include community mental health services, private clinical psychologist for follow up counselling under mental health plan, relationship counselling, GP, Ngala etc
- Full social work assessment on admission involving link up on discharge for some mothers with DCP, Wanslea, Red Cross, child care, Centrelink allowances.
- Joint link up visit with the discharging patient's child health nurse. Full hand over given to Child Health nurse. They are also notified when the patient is admitted to our service.
- Interim discharge summary sent to GP and Child Health Nurse as well as the community mental health service.
- Final discharge summary sent to GP and to community mental health service if providing follow up.
- Consultation and education service to rural and remote via tele Psychiatry link.
- Education and presentations to existing mental health services, child protection, child health, rural and remote midwives/Child health nurses.

6.2 *If the funding outlined in (6) is expected to change over those periods, why?*

Response:

The funding level is not expected to change.

6.3 *Does the Minister have a system or systems in place to gauge the unmet need for the services of what is currently WA's one and only Mother and Baby Unit?*

Response:

A new system commenced at MBU from 1 July 2010 utilising wait list function on `PSOLIS`, which is the mental health patient information system.

Using this system, MBU will be able to:

- Identify patients on wait list.
- When patients are taken off the wait list and why this has occurred
- Length of time on wait list till admission.
- Reason for not staying on wait list e.g. condition improved or diverted to another service.

6.4 *If no to (6.3), why not?*

Response:

Not applicable.

6.5 *If yes to (6.3), what does that data suggest in terms of the additional beds that are required across the State?*

Response:

Current wait list at the MBU averages 16 women at any one time.

This level of demand supports the need for the additional 8 beds scheduled at the Fiona Stanley Hospital. The MBU at FSH will be functional at the same time as the mental health unit and all clinical services when the FSH opens in April / May 2014

6.6 *Further to question (6.5):*

6.6.1 how is that unmet need being met pending opening of a similar facility at Fiona Stanley Hospital?

Response:

Currently patients with babies that are referred to MBU are waitlisted. If a further deterioration in mental state or increased risk of self harm, family members or the person are advised to go to any GP/hospital Emergency Department or call the Emergency Psychiatry services to get the situation assessed. If admission is required, the mother (and not the child) will be admitted to a psychiatric ward with the view of transfer to the MBU when a bed is available.

6.6.2 how much unmet need will remain after the opening of a similar facility at Fiona Stanley Hospital?

Response:

The recommended number of beds for perinatal mental health services is 8 beds per million people. This is generally accepted as the appropriate service planning standard for developed countries. The FSH facility, when opened, will have 8 inpatient beds, making a total of 16 perinatal beds in WA.

6.6.3 what will be done about any remaining unmet need?

Response:

The Women and Newborn Health Service is examining options to establish an Assertive Community Intervention Team (ACIT) to complement inpatient service provision.

7. *Health of Aboriginal prisoners*

7.1 *I refer to the Budget at page 185, heading "National Healthcare Agreement (NHA) and National Partnership Agreements (NPA)", second dot point, number*

4: Making Aboriginal Health everyone's business. What is the nature of the services and programs that are being provided?

7.2 *Are facilities for juveniles being included?*

7.3 *Will the facility for young adults be included when it is running?*

7.4 *Are remand centres being included?*

7.5 *Is the Perth Watchhouse being included?*

7.6 *Which facilities are receiving which services and programs?*

7.7 *What is the evidence/research in support of the particular services and programs that will be provided?*

7.8 *What is the relationship between this strategy and the recommendations of the Inspector of Custodial Services in the 2006 Thematic Review of Offender Health Services?*

Response:

WA Health tasked the Regional Aboriginal Health Planning Forums with identifying local priorities and gaps in health service provision under the Closing the Gap NPA. In a parallel process the Department of Correctives Services engaged to develop in consultation with regional prisons, Community and Youth Justice Services, Regional Health Planning Forums, and local health service providers a State-wide strategy addressing the priority area *Making Aboriginal Health everyone's business.*

The consultation process highlighted the need for a coordinated approach between the prison health system and community-based service providers, specifically related to re-entry programs targeting: social emotional well-being; chronic disease management; and, alcohol and other drugs.

WA Health has allocated $7.2 million under the Closing the Gap NPA to implement a State-wide framework that is currently being presented to the Regional Aboriginal Health Planning Forums for translation into local service plans.

This approach is consistent in part with the 2006 Thematic Review of Offender Health Services. WA Health will be responsible for contracting community based health services to provide continuity of health care to prisoners upon release.

8. *Assistance for Aboriginal patients to better understand and navigate the health system*

8.1 *I refer to the Budget at page 185, heading "National Healthcare Agreement (NHA) and National Partnership Agreements (NPA)", second dot point, number 5: Fixing the gaps in patient journey. What is the nature of the strategies to be provided?*

8.2 *What is the evidence/research in support of the particular strategies that will be provided?*

8.3 *What is the relationship between these strategies and the recommendations of the report of the Royal Commission into Aboriginal Deaths in Custody, particularly*

recommendations 246 to 271 inclusive under the heading "Towards Better Health"?

8.4 *Do the strategies to be provided include Statewide access to an Aboriginal languages interpreter service?*

8.5 *If no to (23), how are differences in language between patient and service providers being addressed through these strategies?*

Response:

8.1 WA Health tasked the Regional Aboriginal Health Planning Forums with identifying local priorities and gaps in health service provision under the Closing the Gap NPA. Aboriginal patients will be supported throughout the hospital and health care system through a collaborative partnership between health providers in the Regions, designed to develop capacity to deliver and coordinated culturally secure care.

Aboriginal liaison officers will be employed to work across key areas within local hospitals, and within Aboriginal controlled health services to support Aboriginal patients in their journey through the health system, including resolution of breakdowns in the referral processes or communication problems. Continuous improvement opportunities will be identified as well as brokerage within Aboriginal communities, coordination of a protocol review, and improved coordination and follow up care of the patients moving between the hospital and primary health care settings.

8.2 WA Country Health undertook a state-wide community consultation and engagement process to seek advice and information from the West Australian Aboriginal community in order to better understand community perceived health priorities. Prisoner Health was identified by the community as being a key area of concern. In particular, the prevalence of drug and alcohol use, mental health and chronic disease in Aboriginal prisoners and the lack of appropriate treatment made available during their period of incarceration. It was also identified by the community that Aboriginal prisoners, upon exit of the prison system, require specific support and follow-up on a range of health issues. A program that links Aboriginal prisoners post release to appropriate health services and programs could potentially break the offending cycle for those prisoners affected by drug and alcohol and/or mental health issues.

The Office of the Inspector of Custodial Services Thematic Review of Offender Health June 2006 report stated, at any given time Aboriginal prisoners represent about 40 per cent of the adult and 80 per cent of the juvenile custodial populations. These disparities, in comparison to non-Aboriginal prisoners and detainees, are the worst in Australia. However, they represent an opportunity to assess and intervene in the health status of a segment of the Australian population, which is disadvantaged in terms of morbidity and mortality.

Based on community feedback, discussion with key stakeholders such as the Aboriginal Community Controlled Health sector and Divisions of General Practice a Statewide proposal is being developed with Department of Corrective Services and the Regional Aboriginal Health Planning Forums.

8.3 The Prison Health proposal funded under Closing the Gap in Indigenous Health is congruent with recommendations made by the Royal Commission.

8.4 Local Aboriginal people will be employed as Aboriginal liaison offices and where possible local interpreter services accessed.

8.5 Not applicable.

9. *Multiple Chemical Sensitivity*

9.1 *I refer to the Budget at page 188, Outcome 3, Enhanced wellbeing and environment of those with chronic illness or disability. The sole indicator measure relates to rate of receipt of Home and Community Care (HACC) services. I am chair of a Community Taskforce of people who suffer, or who work with people who suffer, Multiple Chemical Sensitivity. Their needs include such things as improved recognition of MCS by doctors and the health system and improved recognition of the impact of chemical use in public places and reduction of their use. These are relevant to MCS patients both in terms of preventable medical and hospital visits, and in terms of ensuring that they are not made more ill when they do have to attend a medical facility or hospital. What does this Budget deliver for MCS patients and those who care for them at home or professionally?*

Response:

Multiple Chemical Sensitivity (MCS) is not recognised as a classified disease entity nationally or globally due to the difficulty in defining the syndrome clinically and the lack of agreed diagnostic criteria. The DOH does recognise that individuals with MCS have difficulty in an environment where chemicals are regularly used (in the greater majority of cases, safely) every day by the general population. Some of the chemicals that trigger reactions in MCS individuals include perfumes, deodorants, soaps, disinfectants and other chemical cleaners. The use of such chemicals would be extremely difficult to regulate when they do not have adverse affects in the general population.

There is no specific funding for MCS patients or those who care for them at home or professionally. The specific health management is outlined under part 9.4 below.

WA Country Health has developed guidelines *Multiple Chemical Sensitivity (MCS) Chemical Hypersensitivity* in conjunction with the SA Task Force and MCS in South Australia and the Royal Brisbane and Women's Hospital in Queensland to minimise the effects of common hospital and health care factors which adversely impact on the health of people who identify as having MCS and require treatment in a hospital setting or need to visit the a person close to them, who is in the hospital.

9.2 *Does the $890 million investment in infrastructure described between pages 196 and 200 of the Budget include any provision anywhere in the State of a safe room for MCS patients when they have to attend a medical facility or hospital?*

Response:

No

9.3 *If yes to (9.2), will you please provide details?*

Response:

Not applicable

9.4 *If no to (9.2), why not?*

Response:

Currently, patients who suffer from MCS are managed under the operational guidelines and clinical protocols and procedures of health facilities. Some of these provisions include:

- if clinically appropriate, patients receive treatment in an alternative treatment environment (ie. a single patient room) in order to reduce the possibility of patient exposure to potentially harmful incitants.
- where appropriate the doctor who treats the patient's MCS should be contacted or should contact the hospital to provide information that will facilitate the patient's care.
- if the patient has been to one of our hospitals' before and disclosed their allergy/sensitivity then it is likely to trigger an alert on the patient information management system of the patient's condition and appropriate procedural action would then be taken.

10. *Health Service Modelling*

10.1 *I appreciate that the report of the Education and Health Standing Committee "Destined to Fail: Western Australia's Health System" was only published on 6 May 2010. However, I would like to refer to its contents regarding how the Department predicts future health needs for the purpose of planning regarding infrastructure, workforce and recurrent costs. As noted in Finding 32, failure to accurately estimate future requirements can have a profound impact on the Department's financial viability and operational efficiency. In light of this, Finding 38 is particularly concerning: 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. Recommendation 15 therefore proposes that the Department of Health 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, so that the Government has a more realistic account of the future operational and financial needs of the State's health system. Does this Budget reflect modelling using those recommended ABS Series A (high-growth) population projections?*

Response:

No

10.2 *If no to (10.1), what population growth projections have been used in the modelling reflected by this Budget?*

Response:

The demand modelling for inpatient services reflected by this budget used ABS Series C population projections, which assume lower level components of population change (fertility, life expectancy and migration).

11. *Royal Perth Hospital*

11.1 *Finding 42 of the same report is: Three major goals of the reform program for health—the reduction of health expenditure, the promotion of efficiency gains and the distribution of the most appropriate care in the most appropriate setting—have been significantly compromised by the decision to retain Royal Perth Hospital as a 410-bed tertiary facility. The Committee recommended keeping RPH, but changing its status to a facility for treating lower level emergency presentations and the provision of secondary-level care for the growing inner-city population. The redevelopment of RPH is still at the planning stage, as shown by the Budget at pages 183 and 196. I understand from the Minister's statements in Estimates in the other place on 2 June 2010 that the brief of the RPH Precinct Committee that is doing the planning is based on RPH's retention as a 410 bed tertiary hospital. Given the recent recommendations, will this change?*

Response:

No.

11.2 *If no to (11.1), why not?*

Response:

It is an election commitment to retain the Royal Perth Hospital as a tertiary facility. The Government remains committed to this plan.