EDUCATION AND HEALTH STANDING COMMITTEE

AN INQUIRY INTO IMPROVING EDUCATIONAL OUTCOMES FOR WESTERN AUSTRALIANS OF ALL AGES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 6 SEPTEMBER 2012

Members

Dr J.M. Woollard (Chairman)
Mr P.B. Watson (Deputy Chairman)
Dr G.G. Jacobs
Ms L.L. Baker
Mr P. Abetz

Hearing commenced at 11.00 am

SNOWBALL, MR KIM
Director General, Department of Health, examined:

AYLWARD, MR PHILIP
Chief Executive Officer, Princess Margaret Hospital for Children, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into improving educational outcomes for Western Australians of all ages. At this stage I would like to introduce myself, Janet Woollard, and next to me, Mr Peter Abetz. On my left we have Brian Gordon and Lucy Roberts, and from Hansard today we have with us Amanda McQuillan and Liam Coffey. The Education and Health Standing Committee is a committee of the Legislative Assembly. This hearing is a formal procedure of Parliament and as a public hearing Hansard will be making a transcript 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: 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 to 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 in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Again, thank you very much for coming along; I know it is a busy time for you, because I am sure the government is putting a lot of pressure on you because of what it wants to get through before the end of the year, but it is also a busy time for us because we are hoping to table our reports before Parliament rises, so we very much appreciate your coming in to assist us with our inquiry. The first questions we would like to ask you relate to hearing problems. As you are aware, when the committee visited the north west we were horrified to hear that at one school, for instance, 94 per cent in grades 1, 2 and 3 had some form of hearing loss. Since we were told about that, we have found out that this is not a new problem; this problem has been going on for decades. I am sure, Kim, that you will know about that from your previous role with the WA Country Health Service because the research was done for you then. Really, as a committee, we are trying to look at—the problems may have been there for a decade or two, but we want to stop those problems and see what Parliament can do and what others can do to try to stop the middle ear infections or, I guess initially with the newborns, identify the children who might have inner ear problems and then look at how we can ensure that infants and children are being picked up with middle ear infections and treated so that they do not develop those long-term hearing problems that will then cause them problems at school and at home and after school, whether as children or in terms of employment. Maybe, Kim, we will come to you first because you have that background in regional areas. Could you tell us what the traditional government approach has been to these problems, and what you are

looking at? I know the government is looking at this now, so what the government is looking at now to try to address these problems for the future.

Mr Snowball: By all means. In terms of the background, I will give my own kind of potted history, if that is helpful, as to the progress, because I think otitis media in these communities is not new, as you described, but it is also not the only health condition that has been prevalent for quite some time. We could go to rheumatic fever; these are conditions that you would not normally see in a First World country, certainly at these rates of prevalence or, in fact, their existence at all, in the case of rheumatic fever, so one side of this is: it has been embedded. There are a lot of reasons and a lot of causes that are not all entirely related to health services. There are a lot of community services, dust in the communities —

The CHAIRMAN: Poverty.

Mr Snowball: Yes, poverty is at the heart of most of that. When you ask what the Health response is, the Health response has been there, but unless you actually deal with those underlying conditions, many of them environmental conditions as well as a long history in those communities, not much is going to change, so I think we have an obligation in terms of ear health and other similar conditions to actually look at the full program that needs to go into those communities.

The CHAIRMAN: When you say "and other conditions"—because we were obviously shocked when we found out that the ear problems, the percentage, was so high—if you had to rank them, one, two, three, four, how would you rank them? Ear health, then —

Mr Snowball: Diabetes, renal disease, smoking, suicide —

The CHAIRMAN: Would that be for children and adults?

Mr Snowball: Yes.

The CHAIRMAN: So ear health, diabetes —

Mr Snowball: Sorry; are you asking me to rank the priorities?

The CHAIRMAN: Rank the problems.

Mr Snowball: All of them are seriously out of whack with statewide averages or comparisons.

The CHAIRMAN: But children in particular—hearing problems; what would be next?

Mr Snowball: Hearing problems is the key one. General infections—a large part of this, as you know, actually goes right back. When we focus on children, much of the future health risk for those children and, in turn, adults, is actually set even further back, so it is part of maternal health, it is birth weights, it is breastfeeding, it is early child development; so it is not only health issues, but also environmental issues and education all the way through. Pulling one out from that group becomes quite difficult. There are different levels of burden as a consequence of those issues, and we all know that hearing loss is a major, major issue for learning, so it has those major implications. So, too, do the other issues at that early stage—exposure to —

The CHAIRMAN: So tell me —

Mr Snowball: Cigarette smoking in Aboriginal communities is over 50 per cent; you lose parents earlier. If you lose your parents earlier, then you do not have the same level of support, encouragement, learning and stability in the family. That is why I am saying it is actually quite difficult to draw out of that alcohol effects —

The CHAIRMAN: But are there specific—like the hearing, we could identify with the children, and now we can put in measures to maybe the plastic ears we are looking at. You have started discussions with the government and with non-government organisations in terms of providing a bus, which I will ask you to talk about, and in terms of fee for services and salaried doctors. Where we have identified hearing problems, yes, we accept that smoking affects the children, but what

would be the next three big, I guess, acute-cum-chronic problems for children in the regional areas? If we forget the social and we look at the physical presentation of diseases, what would be the top four?

[11.10 am]

Mr Snowball: Gastro conditions rate right up there, as does renal disease.

The CHAIRMAN: How early is that starting?

Mr P. ABETZ: Can I just ask a question there? From what I have seen of the Aboriginal communities, diet is absolutely critical for health.

Mr Snowball: Yes.

Mr P. ABETZ: You can feed a kid all the antibiotics you want to if it has an ear infection, but if breakfast consists of Coke and a packet of chips, nothing for lunch, and whatever they can scavenge in the evening from somewhere else, we are not really addressing the issue. To what extent would you view the lack of a good balanced diet to be affecting these kids, therefore making them much more vulnerable to ear infections and all the other things that go with it?

Mr Snowball: It is right up there. That is not only about good nutrition as a developing person, but it is also what sort of foundation that lays for you for the future and your future risk. That is what I say; there are actually some common elements to this. Good hygiene in communities is important for a whole range of conditions, including ear infections and respiratory conditions; overcrowded housing creates a higher risk for a whole set of conditions as well. That is why I was really keen, when the focus came on ear health, to make sure it is not a one-dimensional focus, and that it takes into account where the best investment from health is to get the best return for those kids and the broader community. So, yes, we need to fix an acute problem that is here and now—potentially there is the ear bus and other vehicles to do that—but it is equally as important to get behind that with communities themselves. Part of this is programs with the community councils to talk about what the health conditions are and how they might contribute to improving health outcomes in that community, instead of a fly in, fly out clinical service—treat what you see, fly out again—which does not leave a resilient community.

The CHAIRMAN: If you had to list four, you said hearing firstly—I do come back—and then you said probably gastro problems?

Mr Snowball: It depends on the question; if the question is: what presents most at our hospitals —

The CHAIRMAN: In infants and children.

Mr Snowball: Gastro is right up there, as are other infectious diseases, as is injury and poisoning.

Mr Aylward: Yes, poisoning; and emotional distress and mental health.

Mr Snowball: And emotional distress.

The CHAIRMAN: You also mentioned kidney problems; what age are you hearing about?

Mr Snowball: In the early teens. They are identifying risk factors in early teens at a very high level. We have a number of programs where we are actually—together with Unity of First People of Australia, which is Ernie Bridge's organisation—jointly visiting communities and doing full screening in those communities. So that looks at all the different risk factors—it goes through about eight or nine different stations—which identifies for the community their health issues and health risks. There is then a combination of response; one response is, "Well, we now know that there are these acute conditions; here is what the clinic has to focus in on", and so the health system and service responds that way. But the community itself also gets to understand what the underlying issues are that it can as a community respond to and address. We have had great success from that. If you have a one-dimensional response about ear health, it is great—you fly in the team and everybody focuses in on that and you get it done—but you have not left anything behind so that the

communities can say, "How do we make sure that never happens again?" That is about hygiene, ear toilets—all those measures that can be adopted. We have been really keen to make sure there is a model of care for ear health. We do not jump to solutions too early; we actually consider carefully what is the best investment and where can it come from.

The CHAIRMAN: I want to follow on from Peter's question. You have said, basically, that poverty and social conditions are a factor. Peter asked you about the diet, and one of the things put to us as a committee was that something that would make a big difference—possibly we should have had Education sitting at the table with you today because we were advised that if children were given, on a regular basis, breakfast at school or an orange or a piece of fruit each day that would make a difference. I know you do not have authority for what happens in schools, but because poverty and those poor diets influence children's health and their ability to recover from whatever infection or disease they have, has the health department ever considered funding—depending on the area—a piece of fruit for the children there? It could be something done by the school health nurses, so that each child gets some vitamins.

Mr P. ABETZ: In the old days—I do not know if it was the same in Western Australia—in Tasmania every schoolkid got a little bottle of milk at morning recess time; that sort of thing.

Mr Snowball: The short answer is yes we have and we do. I will give you an idea of a number of the programs we run: I have mentioned the one with Ernie Bridge, but we also work with a group called EON Foundation, which is a group that, basically, is there to support gardening in those communities. Sabrina from the gardening show on ABC radio has joined it, with a whole range of others.

The CHAIRMAN: But they are not going to get a piece of fruit from that garden every day for every child at the school.

Mr Snowball: No.

Mr P. ABETZ: They will get vegetables.

Mr Snowball: It is surprising, but they do. They go into those schools and the kids work on the gardening, but it is not just gardening; it is actually budgeting and cooking. So they are able to demonstrate that it is actually cheaper to have your own garden producing that than it is to go and buy your bucket of chips or your Coke, and it is also better for you.

The CHAIRMAN: So you are working with that?

Mr Snowball: Yes.

The CHAIRMAN: Would you be able to give us a list of what communities are actually involved in that program?

Mr Snowball: Yes, sure.

The CHAIRMAN: Maybe there are some communities that are not currently involved that we can, through our contacts, try to encourage.

Mr Snowball: We just think that as a very comprehensive way forward this is the right approach, because it engages with the community in a very fundamental way with the schools. We get lots of cooperation from Education on that. We fund both of those programs going into the same community, so you have the screening program, plus initiatives under that screening program that include things like school breakfast.

The CHAIRMAN: Before you carry on then, for that screening program that is going on with Ernie Bridge we want to know which communities it is in. We spoke with Ernie, and he told us how much work he puts in for that program.

Mr Snowball: Personally.

The CHAIRMAN: Personally, yes, to get a community involved. So, yes, it is a wonderful program, but considering how many communities we have in the north west, I think only a handful of those communities have that program. Therefore, again, we come back to: would you be willing to have discussions with the education department about, until it is rolled out across all communities, maybe providing children with either a breakfast or a piece of fruit every day? We know that diet is so essential.

Mr Snowball: We do.

The CHAIRMAN: Would you be willing to have discussions with Education in relation to that?

Mr Snowball: We do.

The CHAIRMAN: You do?

Mr Snowball: Yes. If I can just elaborate on this program further. This program has been running for about four years now; it is in communities like Djarindjin, Looma and Noonkanbah. I have been to many of them to actually see how it is running and how connected it is with the community, and that is what attracts me the most about that program. Alongside that, when they do the screening program and, for example, identify nutrition as a key issue, a nutritionist is part of the program as well, and that person actually looks at the community's diet. The nutritionist looks at what is in the community store, because often the community store is the sole source of nutrition. So if the store is busily flogging all the wrong stuff, from a health point of view, then that is what people eat. But there are lots of breakfast programs as well. We have lots of organisations that have an interest in doing it; we work with Foodbank to make sure those communities get access to that cheap food.

[11.20 am]

We have programs with the stores with our public health units, and that is really fundamental to the communities' nutritional needs. I agree with you it is important to provide breakfast for the kids, and as I said there are some breakfast programs. I am happy to give you a list of which communities have those programs —

The CHAIRMAN: Which communities have which, and then maybe we can have a look at that.

Mr Snowball: Yes.

The CHAIRMAN: The next question is: when we became aware that in Roebourne—I think it was Roebourne—it was 94 per cent, that was a WACHS study that had been done. So, what other towns were done in there? Could we have that by way of supplementary information? Have we the document here? I have not seen it this morning if it is here. Thank you very much for this information on the number of children screened and referred, but this does not tell us the figures that we got from Roebourne, which was that 94 per cent of the children had hearing problems. What we would like to know further to this data that was carried out at each of those schools, is in each school in Karratha, Peg's Creek, Millars Well, Wickham, Roebourne, Dampier, Tranby, Port Hedland, Baler, Cassia, St Cecilia's, South Hedland and Newman the number of children screened, how many of those children had hearing problems or hearing loss, and how many of those children had —

Mr P. ABETZ: They would be the referred ones, would they not, so the answer is there? If there is no hearing loss, they would not need referring.

The CHAIRMAN: No, it is not, because the number of children screened at Roebourne was 98; the number of children referred was 63. We were told that 94 per cent had hearing problems.

Mr P. ABETZ: Yes, but I do not think that measure was a scientific measure of what the person said. I think that was more —

The CHAIRMAN: If we could have the percentages for each of those who had the hearing problems.

Mr Aylward: Madam Chair, could we get a copy of that just so we can reference it, because we did not bring that along?

The Principal Research Officer: You can have a copy.

Mr Aylward: Thank you.

The CHAIRMAN: So for those areas and for other areas in the north west, we wanted to ask you—because we heard that children are either classified as level 1, level 2 or level 3—when they are classified as level 1, how long do they wait to get their treatment? When they are classified as level 2, how long do they wait? I ask that because we have heard of children who are being classified as level 1 who five years later still have not been treated, which means that somehow there is a hole somewhere that these children are falling through, which is why we are looking at this mobile surgical unit so that as soon as they are identified, they get treated straightaway. We were told that the classification influences the federal funding that goes to the north west, and that national waitlist targets impact on how much money WA receives from the commonwealth if it does not meet the target. I think that is probably a Philip question rather than a Kim question. Could you tell us about the national waitlist targets and the statistics for the children in the north west and the funding that comes?

Mr Aylward: I guess there are potentially two parts to that. If they have been assessed and ready for care in terms of surgical care, then they would either be on one of the waitlists. So they could be on a hospital waitlist in the Kimberley or the Pilbara where there is a visiting ENT service. And as we know, some of those surgeons mainly visit monthly or they go up there in a block of three months to clear things out. But I have seen the figures; it would be helpful to get sort of specifics if somebody has got a name. But the records that I keep at PMH, I have nobody waiting now over 365 days—and that is for category 3—and nor has country waiting for surgery.

The CHAIRMAN: We actually were told by ENT specialists of children who were waiting for five years. We have been officially told that, so if you are saying that you believe they are seen on the visits, and I am not sure but I know you spend a lot of time trying to get your data systems up and running in Perth —

Mr Aylward: Yes.

The CHAIRMAN: What are your data systems like for the regional areas? Can you give us say—and this would be by supplementary information—for the last 12 months or maybe from June last year to June this year how many children were identified with hearing problems at level 1, level 2 or level 3? And say for level 1 it was 50 children, then we would want to know how many of those children have received treatment, be it medical treatment, which might have been antibiotics, or surgical treatment. So how many were identified at level 1 requiring medical treatment or surgical treatment; and for the medical treatment have they been treated, and for the surgical treatment have they been treated? How long did they have to wait? What was the minimum, the average and the maximum time they had to wait? Then for level 2, how many children were identified at level 1 with medical problems and hearing problems needing surgical intervention; and for each of those, again, how long they had to wait for treatment. So, how many have been treated and how long had they to wait, so that we can see that maybe it was, you know, 50 children identified as needing the surgical treatment or only 25. I think from what we are hearing, what is missing in the way the government could possibly support you more in this area would be to have a hub in Perth—so we are looking specifically at hearing problems—a hub-and-spoke approach where someone is collecting those statistics and making sure that it is not just identification that goes on but it is identification and treatment. We want to make sure that wherever those loopholes are, and there obviously are at the moment because ENT specialists are telling us that —

Mr Snowball: Can I ask —

The CHAIRMAN: I will give you one last thing before you speak. They are also telling us that they are being asked to reclassify children because of those national waitlist targets. We want the money to come into Western Australia but it does not seem appropriate that they are being asked to reclassify them.

Mr Snowball: I would be really disturbed if that were true. I would be very keen first of all to identify the ENT surgeons because as far as I am concerned all the data I get on elective wait—and these are children or adults who have been listed on the waitlist for surgery—I can tell you right now in the WA Country Health Service they are doing them within the recommended time, and I know that an extraordinary amount of effort has gone in to achieve that result. If there are any other delays between getting to the point where you are listed for waitlist, I want to know that. The ENT surgeons come into our north west in different ways. Most of them come as private ENT surgeons. So they set up their private clinics in Karratha or Port Hedland; they will see the patients; they will list them for surgery for the next time they come up; the next time they are up, they do the surgery; and then the following day they will do another clinic for the next visit. So they go through that process constantly. I would be intrigued to find that there was a five-year wait for those private ENT surgeons. So, if there has —

The CHAIRMAN: Yes, that is what they are saying.

Mr P. ABETZ: I think what you need to keep in mind too is that what sometimes happens in those remote communities is that families move on; they do not keep their appointments.

Mr Snowball: There is a lot of that.

Mr P. ABETZ: There is a lot of that, and so then the kid goes up to the Northern Territory or somewhere else and then suddenly fronts up again three or four years later and that kid then has their treatment and they have not actually been on a waiting list for four years; they just have not fronted up. So I think we need to actually separate that out.

Mr Snowball: Find the cause.

Mr P. ABETZ: Yes, what is actually the cause, and I think there is not much point in discussing this further unless we actually can provide you with a specific name of an individual that you can actually then follow through in the system and say what actually has happened, because we can talk about generalities but that does not help anybody.

[11.30 am]

The CHAIRMAN: Does the Department of Health have a special hearing coordination unit for the metropolitan area and the regions? That is the gap that we believe is there.

Mr Snowball: Each of our regions has regional operational plans; they include their health programs. Different levels of service come out of those area health programs. It is also eyes. There are a range of health conditions that each of the regions develop their clinical service plans around. Those service plans are informed by our health networks and their models of care. An advice goes out and says, "Best practice for whatever the condition is—say, otitis media—is this, from primary right through to tertiary services". That is what our area health services draw on to inform them about what service they need to provide locally in their region. When you ask: is there a central point responsible for it? I would say that the key part is getting the expert advice around the right model of care. If you ask an ENT surgeon what is the best model of care, it is about surgery.

The CHAIRMAN: You are talking best practice; we are talking statistics and children. It is wonderful that the health department develops the best practice guidelines.

Mr Snowball: But that is a focus on children. The best practice is to say, "Let's diagnose the problem." It is about children and prevalence and how that compares nationally or internationally and whether we have a problem. That is when you bring the experts together to say, "The best way to solve this problem from a clinical point of view is to deliver these services in this way."

The CHAIRMAN: This really goes back almost to the problems we had in community health: how is the data being collected and for whom in the Pilbara. You control the funding. If you know there is a big problem with hearing in town X, you can say, "Look, with the money we give you, we want this done here; we don't want these statistics like this." That is why I am asking you about a special hearing coordination unit, because, from what we have heard, that is what is missing and what could possibly help in this area. It has been suggested to us to have not just neurosurgery at Fiona Stanley Hospital for the children who may have inner ear problems, so there is a second theatre for them, but have a centre in the grounds of the Fiona Stanley Hospital that becomes the special hearing coordination unit so that we get the statistics for the whole of WA and someone monitoring the problems throughout WA.

Mr Aylward: Certainly my staff through the policy directorate provide policy advice and support for things such as the clinical networks, but we do have a centre and we work effectively on a referral pattern that is part of the model of care. So, primary care–providers have secondary-level care providers; that means PMH takes on the tertiary quaternary role. We have line of sight across the whole spectrum. In terms of private practice, it is only at the point that a patient is referred for surgery that we capture that and pick up that, particularly in the country and rural sector. In the metropolitan area, as you know, probably the most significant paediatric practice in the private sector is ENT work. We probably, fortunately, deal only with the tertiary-level stuff and it is quite appropriate in our role to do that.

The CHAIRMAN: No; maybe it was appropriate in the past.

Mr Aylward: For tertiary care?

The CHAIRMAN: Maybe it was appropriate in the past for you to have just that tertiary-level dominant control, but because there are so many hearing problems, can you not as a health department say to the child health workers, the Aboriginal health workers—all the community health workers—"We want notification from town A to town Z of hearing problems and what needs to be done for hearing problems"?

Mr Aylward: I guess a child health nurse in a community or in a locality in Perth, basically looks at, in some cases, the end-to-end problems of all the kids in that community, which as we said before, could be a multitude of issues and problems, and works with that community to start from point A to point B. We certainly now, as we spoke of before, from an information system in the metropolitan area—and, hopefully, adopted in the country at some point—have line of sight of all that screening information around a multitude of conditions: mobility, nutrition, viruses and other respiratory problems, plus chronic disease problems.

The CHAIRMAN: But the line of sight is not there currently for the regions.

Mr Aylward: It is being developed and they do have their own subset information.

Mr Snowball: That is right.

Mr Aylward: And we can link that data.

Mr Snowball: We focus on particular priority areas around Aboriginal kids, so in each of our regions we have an Aboriginal regional health planning forum and that planning forum has an Aboriginal health plan that focuses on those health priorities and risks that are out of whack with the rest of the state. That goes across not just the public-funded health system; it includes Aboriginal community controlled sector as well, and NGOs and other providers.

The CHAIRMAN: Does that health plan then have the annual statistics on the line of sight?

Mr Snowball: It does.

The CHAIRMAN: Can we have maybe the last two years' annual reports from each of those—what do you call them?

Mr Snowball: They are Aboriginal regional planning forums. They are not annual reports. This is a collection of state-funded services, not-for-profit community controlled sector and so on. The purpose of that is so that they agree where the priorities are and agree who is best placed to deliver against them and they hold each other basically accountable for achieving that.

The CHAIRMAN: If you say they do not put out an annual report —

Mr Snowball: No —

The CHAIRMAN: They do?

Mr Snowball: They have a regional Aboriginal health plan. Every one of our regions—nine in all, including the metropolitan area—has a focus on Aboriginal health and a plan that they all work to.

The CHAIRMAN: Can we have the regional Aboriginal health plans then? Can we also have the regional child health plan from infants to—I think you go up to 17, Philip now—for those areas so that we can look at those plans and see what are the —

Mr Aylward: They will be integrated.

The CHAIRMAN: Is it all in one plan?

Mr Aylward: It would be, yes.

The CHAIRMAN: Can we have those plans for maybe the last two years so that we can see how they tie in with what we are hearing are the problems. I might come to you now then, Kim. Peter, on my way in I briefly mentioned to Kim that I met with Rotary this week to discuss their supporting some fundraising for a mobile surgical unit. Kim was saying that the government—or it might be Rotary or lotteries—came together to fund one. Apart from the initial outlay in terms of the cost of the mobile surgical unit and the equipment, which could be used not just by ENT but by other surgeons, I was asking Kim how the staff would be funded for that service. He said it would be a fee for service or salaried. Can you explain how those two would work?

Mr Snowball: There are two different ways. If it were to operate in that way, as we currently do, which is with private ENT surgeons in particular, it could be developed as a private service, which we would contribute to or provide a grant to or fundraise for. That is one offering.

The CHAIRMAN: That would be case based. For every child that had a grommet, the ENT specialist would be paid so much. General practitioners—I have worked in the general practice area—build in all the costs for the staff et cetera. Is that the same thing the fee for service covers for the ENT?

[11.40 am]

Mr Aylward: Yes, that is right.

The CHAIRMAN: So would that fee for service for the ENT specialist cover the surgical nurse that will be required and the driver that will be required, and hopefully the surgical scrub nurse could maybe also function as the technician?

Mr Aylward: Okay.

Mr Snowball: We would consider that. At the moment, of course, that surgery happens in our hospitals. At the moment if you are an ENT surgeon and you are providing a fee for service to our hospital, salaried, we provide the theatre nurses and so on. We will often provide the ENT surgeon and the anaesthetist on a fee-for-service basis, which is when they are operating as private businesses, if you like, providing that surgery. That is the current model. If you then introduce a mobile unit that is capable of doing that, we would have to consider how best to provide the rest of that support service around our private ENT. It would not preclude it being done; it is just a case of what is the best model for the participants and of course from the community's and government's point of view.

The CHAIRMAN: Would you be willing to consider either increasing the fee and they pay for the nurse and the driver, or maybe the Department of Health funding a nurse who works in that area with them, so a scrub nurse–technician, and a driver for them to transport that unit around?

Mr Snowball: We are probably jumping to a solution. I am aware that a lot of work has gone into thinking this through and that there is more work yet to be done, particularly around what is the right model of care. I do not want to see a situation where we end up with a white elephant that is touring around looking for work. I am sure it will not right at the moment, but we need to be sure that that is the right answer and it is going to have long-term sustainability in those remote communities. I will just give an example. When I worked in Geraldton—this was six or seven years ago—Meekatharra, for example, used Geraldton for its surgical services. What we used to do was that where kids were identified as needing to have grommets inserted, there would be a bus that would pick those kids up. A nurse would travel on the bus down to Geraldton. They would stay overnight in Geraldton and have their grommets done, and then stay overnight again and then go back home. That way you did not have a situation of a person not turning up for surgery—I mean these kids are not that keen to have the surgery, I have got to tell you. You can have environments where they simply cannot be found. It needs to be well thought through; otherwise, you are going to turn up in that community and all those kids are not there.

Mr P. ABETZ: Everybody is gone; they are in the bush!

Mr Snowball: Exactly.

The CHAIRMAN: So it would need to be looked at in terms of whether it was a pure fee for service, a combination of fee for service and salaried —

Mr Snowball: All those options are open. I have got to say, certainly going back some time, that it is not due to a lack of access to ENT surgeons. Part of the issue is actually getting the primary care work, so it is actually about the ear toilets, getting the GP services available and antibiotic treatment. All the research that comes out actually says that on balance, in terms of efficacy, antibiotic treatment is more effective and longer lasting than grommets, so we have to think carefully about how we are responding to these issues.

The CHAIRMAN: That is a very good point you have raised about the antibiotic treatment. I am sure you have been working on the minister's response to our committee, which is due in the next three weeks. We only made one recommendation in our report from the north west and that was that there be a memorandum of understanding between Health and Education so that school health nurses can check children's ears and treat children with antibiotics. Obviously you cannot tell us what the minister's final response is going to be, but you can tell us, and we would like to know from you, again because you fund the school health nurses, where those school health nurses are, which high schools in the Kimberley and Pilbara have school health nurses for half a day a week or one day a week, and where the school health nurses are in the primary schools for half a day or one day a week or no days a week. Are you able to provide us with a list of the school nurses and the point FTE equivalent that they work in each high school in the Kimberley and the Pilbara and how much of a point FTE the school nurses work at each primary school in the Kimberley, so that we can see where they are going and where they are not going? Then when we know where they are not going we can say that until we get funding for them—we are hoping we will get funding in the next 12 months; we are aiming for school health nurses in the next budget—who else could maybe be linked into a model of care and maybe go into the schools and do the assessment that school health nurses could do? It looks like Philip has a response for me.

Mr Snowball: Yes, but before we do that, just a bit of clarification too. In many of these communities it is one and the same person, so we do not have a designated school health nurse. In many of these communities there is the clinic and the primary school is just next to it. Our community health nurses provide that service.

The CHAIRMAN: In that case we want to know: when the community health nurse provides that service for each of those communities, how much time—how much of a point FTE equivalent—is she given to go into the school and work with the children in the school? From what we have heard, there is so much work for those community health nurses that they are not getting into the schools. What the paediatricians recommended to us was that the school health nurse, particularly in the wet season, examines all the children in the primary school on a Monday morning and then those who have ear infections could be put on antibiotics BD, so they do not have to take the medications home. This would all have been organised in terms of a protocol, of maybe phoning the GP and parents having given consent at the beginning of the year. Then, when the school health nurse identifies middle ear infection, the school health nurse during school hours can treat it with antibiotics. Until we have a formalised FTE that those nurses, be it the school health nurses or the child health nurses, are in those schools, then that is not going to happen. That is why —

Mr P. ABETZ: The other aspect is when you have got five per cent attendance of schoolkids, how is that all going to work? In those remote communities the only thing that will really work is for the nurse to know which kids it is and she goes to the homes, wherever those kids happen to be, and does outreach. That is the only way you actually can reach those communities.

Mr Aylward: That is part of a —

Mr P. ABETZ: You cannot put that down as an FTE because the problem is she may be going to see a pregnant woman over here and she sees a schoolkid that she knows has got ear problems and says, "Hey little Johnny, come over here", and she will have a quick look. You cannot actually compartmentalise; it does not work like that in remote communities.

The CHAIRMAN: The paediatricians recommended to us that when the schools are sitting —

Mr P. ABETZ: Yes, but the kids are not there.

The CHAIRMAN: But even if it is only 50 children who are there, she does not have to —

Mr P. ABETZ: You would be lucky if you got five.

The CHAIRMAN: — just do the ear health checks. If she is given three hours and she is finished in one hour, she can go back to the role that she plays outside, but we need to have a set number of hours that she is allocated to be in the school so that those ear checks —

Mr Aylward: I guess in those smaller communities right at the moment that is not how the work is organised—that is, in a structured manner. The reason is that they chase or they follow through on a number of programs across that whole community. You are right; they will bump into issues as they go and see —

Mr Snowball: Opportunistic.

Mr Aylward: Yes, whether it is at the clinic room itself or at the school. So I think there are some appropriate but unique resource allocations within smaller communities, and it is one person who normally fulfils that role. Undoubtedly there has been growth in our schools and the population increase has put a strain on services. I think we have reported previously to the committee that that is the case. So the services are under stress. The education department does partly fund this service, so they fund an amount of about 31.5 per cent of the cost of the service that we identify. So Education is back to being fairly close partners with us. I guess in the larger towns and in the metropolitan area we are able to probably identify those points of an FTE across each of the schools.

[11.50 am]

The CHAIRMAN: Not just the larger—we want every high school. If you put down zero per cent, we will take zero per cent. But we will then show that zero per cent to the paediatricians. It might be only five who turn up, Peter, but what if one of those five is someone who has an ear infection?

Once that person has been identified, then that nurse, wearing her community health role, can go out to that family and look at the other children. This is something that has been identified to us by paediatricians, not the ENT specialists. You have the financial responsibility for school health nurses. There is a formula for the metropolitan area for school health nurses per number of students. We want to know, for each high school in the Kimberley and the Pilbara, whether those schools have a visiting school health nurse or child health nurse, or whether they do not; and, if they do, we want to know how many hours that school health nurse is able to allocate to each school that she covers, because one school nurse may cover four or five schools.

Mr Snowball: The paediatricians generally visit the larger centres. They are not GP, and they are not community based; they are a specialist service. I am not questioning their advice. But they need to bring it forward in our normal planning forums. If they have a bright idea about how best to deliver this service, it would be interesting to hear it, but it needs to also be canvassed with the community nurses and the Aboriginal health workers, who do work in those communities, and with the GPs in those communities. So rather than take the view of one group, the way we tend to operate is that we canvass across the board, including the community itself, about how best to do it. There is no point in us turning up at the school if there are not the kids there. I would rather that they identify where the screening issues are across the community. As I said earlier, we have actually screened quite a number of communities in full, including hearing. That identifies what level of hearing loss there is in the community, and what the risks are in that community, and we then focus on a plan to address it in that community. If we were to do it just on the basis of saying we will dedicate 0.1 of an FTE to every school, regardless of what the health issues are, I think we would be missing an opportunity.

The CHAIRMAN: It might come back as zero, zero, zero, and occasionally it might be a 0.4, but we want those statistics, because we plan on putting those statistics in a table, and the committee might or might not decide to include that table as part of our final report—the committee has not determined that yet. But when you return your transcript within the 10 days, if we could have the number of school health nurses that you have in the Kimberley and the Pilbara, and what schools they are responsible for, and how much time, if any, they spend at those schools. This was requested from you back on 5 June. We requested you to provide us with details of the funding for school health nurses in each of the years—1996 et cetera. But we still have not received a response.

Mr Snowball: I will cover that. But before we leave that question, can I suggest that there be some augmentation to that so that from all of the communities in which there is a community health nurse, we can get from them what they provide by way of health services. We do not want to just say, "Here is the school, and nobody does anything at the school", when they are actually still providing a screening program for kids in that community; it is just not at the school.

The CHAIRMAN: If you want to provide that to us at the same time, we will be happy. But we want this information. We do not want to have to wait for a longer period of time to get that additional information. If you can provide that information within the 10 days, fine; if not, we will just have the school health nurses, the high schools, the primary schools, and the FTEs at those schools, and then, when you get that other information at a later date, we can maybe add that to the table. But we definitely want this information.

Mr Snowball: I do not want a situation in which our community health nurses—who are busting their guts, by the way, in these remote communities to provide that service—to be seen as not delivering that service just because we have decided that we want to measure where they provide it, when we know they do not provide it in the schools.

Mr P. ABETZ: In Warmun the best place to do it would be the swimming pool, and the local disco that the police run once a week, where they can mix with the kids and have a look then.

The CHAIRMAN: You understand what we are trying to do with this one. Your department identified in 2007 that we were 135 school health nurses short. Twenty-three of those were for high

schools. That means there must have been 100-and-something for primary schools. That was in 2007, and we have had a big population increase since then. I know that putting in a table that possibly has zero, zero, zero is a bit harsh on you, but hopefully from that, when we give those statistics to the government as part of our report, you may have a bit more success in your approach to the government to get funding next year for those school health nurses.

Mr Aylward: Can I just make an observation? In collecting that information, we will have to ask the school community health nurses to apportion their time, and we will then have that definitional thing —

The CHAIRMAN: No. We do not want the apportionment. If you want to ask the community health nurses —

Mr P. ABETZ: In the remote communities, they do go into the schools, but they are not called school health nurses.

The CHAIRMAN: We want to know what is provided in the schools.

Mr Aylward: Also, I think that in absolute fairness we need to identify where they are undertaking those school functions, but in other settings, because that is what is appropriate for that community. I just feel as the operational manager—my colleague Ian is not here—that we have to fairly represent what the situation is. We are not shying away from what we have provided to the committee before. But we have to be fair to the staff in those communities, because if the committee does decide to use that information, I think they will want to be recognised. But we want to make it accurate as possible for the committee as well and not put in information that is —

The CHAIRMAN: If you want to do that, then rather than 10 days, we will give you 15 days. But you realise that the pressure is on for us to table these reports, so we cannot give you longer than that. If it is going to take longer, then we want just the school health nurses, because it was identified in 2007 that we were 135 school health nurses short, and we want funding for those school health nurses.

Mr Snowball: But that also homes in on one of our problems here, which is that in country areas, community health nurses provide the full range of services, including the school, but we do not call them school health nurses. So when you get a definitional question about how many school health nurses do we have in the country, more often than not, if you ask it exactly like that as a parliamentary question, you would get —

Mr P. ABETZ: Zero.

Mr Snowball: Yes, but when you say how many of these school-type health services for children of that age are provided, we can provide that.

The CHAIRMAN: But we want to know about those community health nurses who go into the schools.

Mr P. ABETZ: But going into the schools physically is an irrelevant statistic.

The CHAIRMAN: It is not if that is what the paediatricians want.

Mr P. ABETZ: I have been going to those remote communities for many years and I can tell you that that is a totally misleading statistic. The school nurse may for 15 years never have set foot inside the school, but if you have a community of, say, 40 or 50 houses, and she knows which kids tend to have ear infections and she ducks down in the afternoon or whenever to where those kids hang out and she checks out the kids, that is 100 per cent productive. She could go to the school when hardly any of the kids are there and sit there for two hours and say she has put in two hours working and tick the box, and it is a total waste of time. What we want to know is to what extent they have engaged with the target audience, if I can put it that way. That is what we need to know.

[12 noon]

The CHAIRMAN: We want to know who is doing the ear assessments. Who is looking in those children's ears and seeing if they have otitis media? Are those community health nurses going into the schools and checking their ears? Otherwise —

Mr P. ABETZ: Whether or not they do it in the school is irrelevant.

The CHAIRMAN: But they do not all go to the child health centre. That is why the paediatricians have said —

Mr P. ABETZ: The communities do not work that way. They just do not work that way.

The CHAIRMAN: We will have the statistics because —

Mr P. ABETZ: It will be a totally meaningless statistic. From my experience of being in those communities, Janet, what we need to know is what percentage of kids in the community —

Mr Snowball: Are screened.

Mr P. ABETZ: — are actually screened by the community health nurses on whatever basis, whether it is two-monthly or three-monthly. That is what we need to know. If when mum comes in with a baby with gastro and the four other kids are in tow, at that point if they could check all the kids' ears, that would be great. That would be a much better use of their time. I actually question whether the community nurses even have the ability—it would be a very rough estimate is about all they could provide, because I know how they work. That is all you can do in those communities.

The CHAIRMAN: If Kim and Philip want to give us the information you provided on top of the information that we have asked for in terms of the schools, that would be great. If you are not able to, then it will just go down as not done. We will put in a statement saying that you are saying this has been done by the community health nurses, but we want to know where the school nurses are.

We might move to infants. Another thing that we were told as a committee was that, sadly, WA is behind the other states in terms of cochlear implants for children. The WA Department of Health funds only one cochlear implant, whereas all the other states fund two cochlear implants. I am not sure if you are prepared for that question and can answer it or whether you would like to give us a response to that by way of supplementary information.

Mr Aylward: I can provide a response. We have undertaken the cochlear implants. In 2011–12, we did the single implants, which are the unilateral implants. We did 13 of them and three bilateral ones. That is a total of 16 cases.

Mr Snowball: Where did the one come from?

Mr Aylward: I will come to that. We know that there is a shift more towards bilateral cochlear implants from a clinical perspective in the other states. At the moment, the decision for doing bilaterals is made because the chairman of surgical services at PMH makes a decision on a clinical basis. We are looking at the change in practice and whether we can instigate that in the coming years, where we do the bilateral implants simultaneously, but at the moment we do not as a matter of practice, but we do look at each case and if it is a compelling clinical case, then the clinicians certainly have the discretion to do that.

The CHAIRMAN: So, you are saying that it is not a unilateral cochlear implant that is being done then because of finances; you are saying it is because the chairman of—what committee was it you said?

Mr Aylward: Surgical services.

The CHAIRMAN: Because the chairman of surgical services made that decision.

Mr Aylward: If I go back over the numbers over the years, there was some fluctuation in the demand. Fortunately, it is not growing at a rate in line with the population growth. For example, in 2009–10, we did a total of 15 unilateral implants and 10 bilaterals. In 2011–12, which I mentioned,

we did 13 and three. There is not a burgeoning demand, but clearly we try to match the demand with the available finances.

The CHAIRMAN: Is he an ENT specialist, because the ENT specialists are the people who are telling us that bilateral is best practice.

Mr Aylward: That is what our head of surgery is looking at now.

The CHAIRMAN: But is he an ENT specialist?

Mr Aylward: No, he is not. But he will take advice—as I would take advice—from the specialists.

The CHAIRMAN: Do we have the name of the committee that he is the chair of?

Mr Aylward: He is the head of surgical services at Princess Margaret Hospital.

The CHAIRMAN: So we would need to let the ENT specialists know that this is the person they should be discussing the practice with.

Mr Snowball: They know.

Mr Aylward: They are advocating for a change in practice. That will involve additional resources and require a unilateral change. What I have to do is satisfy ourselves with the ENT surgeons and the chair that the best practice—the shift—is what it is, which is best practice, and therefore we have to accommodate it.

The CHAIRMAN: So it does come down to dollars?

Mr Aylward: No, it is both. I recognise that there is a shift and there is strong clinical support for the shift from unilateral to bilateral implants. We then have to accommodate that within our ABF to look to see whether we can do that. While the implants and surgery are, as you know, very expensive and take a lot of time, I now need to look at the numbers and at what the implications are if we automatically flipped for them all to be bilateral, but we have not put a specific additional financial control on it other than them managing it within their budget.

The CHAIRMAN: In that case, could we have by way of supplementary information the cost for a bilateral cochlear implant for a child and the cost for a unilateral cochlear implant for a child, and the number of children? You have just given us that, basically, but maybe the number of children over the last five years so that we can say that so much has been spent. For 2008–09, there were 10 unilateral and three bilateral —

Mr Aylward: We will not have the individual financial cost of each of those over subsequent years, and we certainly would not be able to achieve that within 15 days, but we can certainly get the most current ABF. I think that is how we would frame it—so, the funding for these implants.

The CHAIRMAN: Maybe you could give us the funding and anticipated dates so that when we write this up in the report, we can say that although at the moment it is more routine to be doing unilateral rather than bilateral, maybe you could give us something by way of supplementary information that says this is being reviewed by such and such a committee by such and such a date and a determination will be made for the budget about whether this will move to bilateral. That way we are not necessarily saying that you are not doing this but that you are not doing this because traditionally it was not done but now that best practice is bilateral, it will be looked at by this or that committee to make a decision.

Mr P. ABETZ: What is the clinical follow-up evidence that dual implants—does it lead to significant gains for the child, or is it only marginal? Is it the case that best practice in medicine, like in education, keeps changing all the time because the evidence is not always there to support what was at one stage considered to be best practice? It would be interesting to know whether there is any solid scientific evidence that it is warranted always doing a dual implant.

Mr Aylward: The information I have in front of me seems to be very much about service improvements; that is, doing one bilateral at the one time so that you do it once rather than having the child coming back again to do the other ear. Therefore, it allows you some efficiency over the post-operative care. What I would like to do is find out what is the outcome benefit for the child in terms of hearing and then make a decision.

[12.10 pm]

Clearly, there is a desire and strong support to move towards a full bilateral shift in the cochlear implants, but I need to look at that and review that in the context of all matters, including the outcomes to the children but also the financial aspects.

Mr Snowball: The key point here is that the professionals have brought forward their view because things have moved on and the chair of the committee has a responsibility to review that, make a conclusion and make recommendations through to Phil about whether we should be funding bilaterals rather than unilaterals.

The CHAIRMAN: Every child that is born in WA is put now on the database. I believe that that database is then used by your child health nurses.

Mr Aylward: That is correct.

The CHAIRMAN: When a child comes in contact with the child development centre. They have access. Does that database also go through to your school health nurses?

Mr Aylward: Yes, it is used by school health.

The CHAIRMAN: What happens to children who are not born in WA? Do they get captured on that system the first time they see —

Mr Aylward: First visit, yes.

The CHAIRMAN: So, we are getting them.

Mr Aylward: Yes, we are.

The CHAIRMAN: Because of time then, we have mainly focused today on hearing, and with the hearing comes the child health nurses. We would like to congratulate you on the funding in the budget for the child health nurses. I suppose I could ask you: is there any improvement on those numbers? Last time I asked you how many child health nurses have been funded to date from the $50 million and you gave statistics. What is that like now?

Mr Aylward: We now have 13 of the 16 health nurses have been offered and accepted positions. All 16 that are to start this financial year will commence their positions by 24 September. They have been allocated to areas. The team has responded really well and got those positions in place. So, when we were last here, I think there was a handful. Now we are standing up; 13 of 16 are in place and the remaining three will be in place by the twenty-fourth of this month.

The CHAIRMAN: So, that is 19. Is there going to be 25 that come on board for each of those nurses or how are those nurses going to come on board?

Mr Aylward: Remember the split is both country and rural; the numbers I spoke to you then I believe are just at this stage the metropolitan areas. We also have a large part of that investment goes to NGO providers. So, we are in the process both in the metro and country, the final stages of the specification development. We believe that those specifications will be advertised after a solid round with NGOs probably during October. Then we will gradually assess the bids. So, we will get an idea of phasing of the actual numbers but, importantly, as I said last time, delivering the performance around screening is clearly what we need to achieve and capturing that information from a continuity-of-care point of view.

Mr Snowball: For the record, I agree with you; we have been delighted with the investment in this area from government to what has been an area that, I think, is fundamentally a terrific return for the community in giving our kids the best possible start. So, both the child health development services as well as our child health nurses and school health nurses as a response to the demands in the community not only through growth in population, but also in really meeting what we have identified too as a gap in the past. I am delighted we have got more action.

The CHAIRMAN: Well done. We are very pleased we have got that funding. I might then give you both a few minutes to summarise for us in relation to this area. I am sure there will be things that you prepared that you thought we would ask questions about or we should know about if we are so close to finishing off this report. So, this is your opportunity.

Mr Snowball: If I could, I would also like to go back to the issue about the numbers, the FTEs, since 1996, which I think you mentioned earlier. I do have a response for you, which I have got on my iPad, but I will make sure it gets through to the committee this afternoon. To give you a quick picture of this. I have to tell you it was very difficult for us to get this information back to 1996, because we had various structures and ways of recording and so on. But what we have now got—1996 there were 111 FTEs; in 2001 there were 129; in 2006 it was still 129; and in 2011, there were 168. So, the ratio of school health nurses to students over that same period: in 1996 it was 1 to 3 066; in 2001 it was 1 to 2 819; in 2006 it was 1 to 2871; and most recently in 2011 it was 1 to 2 364. We have seen an improvement terms of the —

The CHAIRMAN: Was that last one 2 000 or 3 000?

Mr Snowball: Two thousand. In 2011 it was 1 to 2 364. You go right back to 1996, it was 1 to 3 066. So, quite a substantial improvement over that period of time in terms of FTE growth. That is coming to you in writing as well, but I thought given opportunity of presenting here today, I would pass that on. I apologise for the delay in it, but as I said, part of it was actually finding out how to gather the information going back that far.

In terms of the rest, obviously we already mentioned the importance in terms of this investment for the broader community and the focus now through our child and adolescent health service and through the WA Country Health Service. For me, a key measure around this is achieving the benchmarks of progress, of identifying—for example, we talked about ear health. In each of these communities it is about identifying, through screening, the level of the problem and ensuring and advocating to getting treatment to those individuals as quickly as possible. They are the measures I want to see in place. Whilst it can be helpful to look at FTE to population and so on, that is a pretty broad measure. We want to be more sophisticated about what these people are doing for the community and how we are measuring it and how we are holding them accountable to it.

In the past I think it is fair to say that the budget adjustments were almost removed from the business. The budget was about—historical budgets—CPI growth and so on. That is when I came in. In 2010–11, together with government and Treasury, we changed the way health is funded. It is now on an activity-based funding at a level of safety and quality. Each of our hospitals, for example, now receives its funding in accordance with a range of services it provides, as in-patients and emergency department presentations, at a standard rate with a standard of safety and quality. What we want to see is that same approach flow through to our community-based services as well. What government can then see is for the money we are putting in to child health, this is the level of activity we are getting from it and here is how they are achieving the benchmark.

The CHAIRMAN: Should it be the range of services or case-based, because it is one thing to have the services that you have had at a tertiary hospital maybe going through a theatre where only—say it is a theatre doing knee replacements, at a tertiary hospital where two are being done, whereas at a secondary hospital four are being done in the same time period, so is it the services then or case mix funding —

Mr Snowball: It is case mix and adjusted. It is adjusted for one will do teaching research and it will slow them down. We recognise that in the funding they are provided. A case in a tertiary hospital is usually a higher level than a case in a secondary hospital.

The CHAIRMAN: Will it be case-based as well as the services they can provide?

Mr Snowball: That is what I am looking at in the community health sector in particular. I want to get them on a different footing. So it basically says, "Here is the range of services we provide to the community. We know what the universal screening requirements are." We are able then to make sure that each of those nurses are delivering a level of service that we want to see delivered in the community for what we are investing. So rather than just going, "We'll put a community nurse there and it will all be okay", I want to make sure they are dedicated by way of activity. How much activity has gone into screening kids with ears, eyes? How many are focused around advice on nutrition, breastfeeding, safe sleeping?

[12.20 pm]

There are a whole raft of things that I want to make sure they are doing and that they are accountable for doing. In that way you roll it all up and then at a state level we are able to say to Parliament and to the community —

The CHAIRMAN: Could we borrow from you the manuals that are given to the child health nurses? I think you have two thick manuals that set out what happens at each visit. We would like to look at those in terms of what should be done at each of those visits, because if it is not in there now we wonder whether we can possibly make a recommendation that an ear check be done. It might not be necessary in the metropolitan area, but it may be in some of the regional areas that it is done at every check. If we could have those manuals, just for a few weeks, then we will return them to you.

Mr Aylward: No problem.

Mr Snowball: I was describing where we want to go with how we measure what our community health nurses are doing, so we can then measure what contribution that makes to improving health outcomes, including developmental index measures. It is one thing to say, "Let's get this activity happening," but we have to make sure it is hitting the right target and that we are measuring real achievement as a consequence. The more we can improve our systems, reporting arrangements, the way we measure what we do and can communicate that back to the Parliament and the community, the more there is recognition of the importance that these services provide to the community.

The CHAIRMAN: Following on from that, I have been amazed at those mobile buses and the different surgeons and specialists who can use those buses. If they are a go, it might not be just for ENT in the regions but for all sorts of minor operative procedures. Philip, would you like to comment?

Mr Snowball: I would prefer it was not just for ENT. Before you respond, part of it is an absolute emphasis on the primary care side and getting the community on board about what needs to happen. We can keep ramping up the surgery, dialysis and all those things, but these conditions are preventable —

The CHAIRMAN: Prevention is better than cure.

Mr Snowball: — and we need the investment in the prevention end and in primary care, and it is not just a state response but a commonwealth response. You do not have to look too far for this in the north west. Why do we have these levels of community-type illness and conditions? It is because we do not have GPs. We do not have communities of a size that are able to attract GPs, so guess who has filled in that gap? It is the state government. If you have a health condition in the Kimberley or the Pilbara, you are more likely to go to a government hospital for that GP-type service than to anywhere else. That is part of what needs to change. We need to make sure we are

getting a contribution from both federal and state governments and that we have models of primary health care that work.

Mr Aylward: I think the investment that government is making over probably six or seven years of close to $110 million in child development and child nurses will make a profound difference in outcomes. I think we have to invest the money wisely, and we are. I think it needs to be more about the outcomes and about measuring outcomes. It is not just about the inputs, as important as that is from a safety and quality point of view. The $48 million or $49 million investment in child development is in its third year.

The CHAIRMAN: We did ask you for this at the last meeting, but I do not believe we have received it yet. In our report we had a lovely table that had physiotherapists and waiting lists in 2008 and 2010, and we asked you at the last meeting if we could have the waiting lists for each of those specialists in child development services. We are still waiting for that.

Mr Aylward: That is in production at the moment. We did achieve the 50 per reduction we said we would. We are now seeing about 87 per cent of the children that need access or have developmental delay problems. In addition to that, the children that need priority 1 services are often seen within weeks. We are looking at how we present the data. As somebody mentioned to me today about a statistic, if you provide an average then 50 per cent of the children are above the average and, of course, 50 per cent are below the average. In terms of representation, I think we need to get sophisticated, so that those children who need to be seen soon are seen as a priority and those who can wait, appropriately wait for their service. We need to structure our preparation of the data, rather than grouping them around how long it takes. At the end, we now realise that it is probably not a good indicator of performance and access for the children who really do need those services, but we are doing more. As I said, the investment is in its third year and we are rolling out further resources this year.

The CHAIRMAN: You may not be aware, Kim, that when Philip last came to the committee I pointed out that in preparation for the meeting I phoned a couple of child development centres and asked about waiting lists, and I was told it was 11 months to 12 months. That is why I asked if we could have a table to see whether things had continued to progress—because the government did very well in the first 12 months—or whether in fact the rumours I am hearing that things are slipping back again are true.

Mr Snowball: I think it is true, but —

Mr Aylward: What has happened, of course, as I mentioned last time, is that now the service is available and accessible we are actually getting more cases referred to us; the growth is about seven per cent, which is a good news thing, because if we were not doing that then we would not be reaching out to those kids who really need the care.

Mr Snowball: Part of the challenge for us now is to make sure that we can maintain that. Whilst it has dipped because we have had more than we expected, we have to look at how we can bring it back up again.

The CHAIRMAN: When you provide us with that table so that our report does not show just the negative things and where it has gone backyards maybe in a paragraph underneath, if you like, you could put to us how the numbers have decreased but you could include the plans to bring this back, then we would have that so we are not just presenting something that will be page 1 or page 3 “more children suffering”.

Mr Aylward: We are very happy to do that; thank you very much.

The CHAIRMAN: In that case, I would like to thank you both very much for your evidence before the committee today. The 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 of the date of the letter attached to it. If the transcript is not returned within this period it will 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 of evidence.

Again, thank you both very much, and I hope that the reports that we table will help you, because we understand that you have to go in and bat at the table with all the other departments. Hopefully, we can help you when you are at that table to get more funding, particularly for community health.

Hearing concluded at 12.28 pm