EDUCATION AND HEALTH STANDING COMMITTEE

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

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT KALGOORLIE
MONDAY, 14 SEPTEMBER 2009

SESSION THREE

Members

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

Hearing commenced at 1.02 pm

DOUGLAS, DR CHARLES
Public Health Physician, Goldfields Population Health,
examined:

MAHONY, DR ANNE
Director, Population Health, WA Country Health Service, Goldfields,
examined:

MILLER, MRS KARINE
Regional Coordinator, Community Nursing, WA Country Health Service, Goldfields,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, 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 inquiries into the review of Western Australia's current and future hospital and community healthcare services and the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. The Education and Health Standing Committee is a committee of the Legislative Assembly and this hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard staff are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

Dr Mahony: I have one. You said it was the alcohol and other drugs section. I note that we have come in for community health and child health.

The CHAIRMAN: As we are travelling to different areas, because we have two reviews underway, some people are talking to us about hospital and community health services and others are talking to us about alcohol and illicit drugs. We are quite happy if you would like to discuss needs and gaps in all those areas. Often they will overlap because if there is not a service in one area, it will affect another area. Today you will have an opportunity to join in on both.

For those two areas, we are trying to find out what are the needs and gaps. From a population perspective, with the growth in the area, what will the needs be in five years' time? Where will the

growth occur? What will the needs be in five years and in 10 years and how do we fill those gaps in service provision now and in the future? Perhaps you could identify what the problems are now and also advise us on what strategies or approach you think we, and the government through our recommendations, could look at to try to stop the areas from becoming worse.

Dr Douglas: The biggest issue for public health in this region lies in Indigenous health. As is well known, the statistics are bad and they are not getting that much better. That is where we need to have a serious think about what we are going to be doing in the future. Although the life expectancy of Indigenous people is 17 years less than non-Indigenous people and they do have higher birth rates, there are a lot of young people. While the rest of the population is ageing, which is another issue, there are a lot of young Indigenous people coming through.

The CHAIRMAN: Of the 600 or 700 births at the Kalgoorlie hospital, what proportion would be Indigenous births?

Dr Mahony: About 12 per cent of our population is Indigenous. It might be a higher percentage because a lot of the women from the lands come in. The number of births at Kalgoorlie hospital could be higher.

Dr Douglas: There are a number of non-Indigenous pregnant women.

Mrs Miller: A higher percentage of non-Indigenous women that are seen as high risk deliver in Perth.

Dr Douglas: One area in which there is a major gap is that of Indigenous and environmental health. I think that is a starting point. We are not going to make major improvements in the health of Indigenous people until we get more serious about Indigenous, Aboriginal and environmental health.

The CHAIRMAN: Could you define what you mean by that?

Dr Douglas: Basically, the simple living conditions that we all take for granted that exist in Aboriginal communities in a much less effective way. In some cases there are issues of water and sanitation. Housing is obviously a big issue—inappropriate housing, overcrowded conditions and issues around domestic hygiene, rubbish and dust. A range of environmental issues impact directly on health. At the moment they fall under the responsibility of a number of different government agencies. It is clearly not being done in an effective way because people in remote communities still live in appalling conditions. Trachoma is endemic in this region and other regions in Western Australia. We are the only developed nation to have trachoma, which in itself is an indictment. That is a preventable form of blindness. We have extremely high rates of middle ear disease, otitis media, which goes on to chronic middle ear disease in Aboriginal children.

The CHAIRMAN: With middle ear diseases, earlier this year it was reported that children are not being screened. Someone reported to the committee that if Aboriginal children had hearing tests at six months and then possibly every six months, that might pick up on that problem so by the time they reached school, they are not already two years behind.

Dr Douglas: Deborah Lehmann from the Institute of Child Health Research has just secured a big grant to fund a program to do just that in the goldfields. We have had the training. We are just about to commence that. You are correct that we have undetected middle ear disease among young children, which leads to chronic ear disease and therefore language delay and difficulties at school. We have a school health program, which is picking them up effectively at school but that is too late; they have lost years of development. The underlying cause is environmental health—poor environmental conditions such as overcrowding, tobacco smoke and not washing faces enough. That is true for not only middle ear disease but also a number of other conditions.

The CHAIRMAN: Because of those environmental conditions, which relate to the Department of Housing and the Department of Health and various departments, do you have someone coordinating

the link between those departments or is the problem the lack of coordination? There are representatives from Housing and Health and from Kalgoorlie. If environmental health is the big issue, how is that not being addressed now and how could it be addressed?

Dr Douglas: At the moment a small team is operating through the City of Kalgoorlie-Boulder headed by an environmental health officer, supported by two Aboriginal environmental health officers employed by Bega Garnbirringu, the Aboriginal health service. At the moment it has a remit for the whole goldfields region. It has no resources other than salaries and vehicles. It does not have any major resources. It does the best it can. It tries to highlight issues. If there are septic tank issues, it tries to get them remediated. There is not a lot of funding available, particularly for some of the major capital improvements that need to take place. I think the current model for people in the communities and the day-to-day stuff is essentially CDEP-type funding. One of the feelings there is that it is very hard to attract people on the ground to do that. There are other models that could be trialled that involve having dedicated Indigenous people with proper training and a decent salary who are not necessarily based in every community but who might be based in, say, the northern goldfields and cover those communities and another one here covering some of the other ones. We need more boots on the ground but also training and the hardware to deal with some of the issues, whether it be the ability to fix a leaking tap or do what needs to be done on the visits to try to improve those things, plus a training program or a domestic hygiene program to ensure things like food safety.

The CHAIRMAN: Bega Garnbirringu Health Services is coming in this afternoon but it is your suggestion that rather than being just a health service, it be funded so when it does a visit it takes with it —

Dr Douglas: Bega does not do much outreach. It has these positions that it has lent to the city to help its workforce and we are very grateful for that. It has the Aboriginal environmental health worker positions. At the moment it has employed two people on traineeships. It is most welcome that it has let them work with the other two guys who work in the city but it is not enough people.

The CHAIRMAN: Who goes out?

Dr Douglas: The four of them. The environmental health officer from the city plus the field support officer employed by the city plus the two trainees from Bega. They go out and about and try to deal with some of these issues. They do a very good job with the limited resources available to them. It would be a more effective program with more staff and better equipment. Obviously, everybody says they want more money to do a better job but the model needs to be changed. It is not just a question of putting more money into it, but rethinking what the model is and what is going to happen. We need to talk to Housing and Works to get some of the capital stuff done. Again, there are funding limitations on that. To summarise that, until we have some of those really basic conditions right, it will be hard to do huge amounts with the health of Indigenous people other than patch them up. It goes to eyes, ears, skin disease, scabies, kidney disease et cetera. If all these things are not right, we are not going to make a dent in this enormous issue.

Mr P. ABETZ: What you are saying makes a lot of sense to me. The difficulty seems to be in getting education things into Aboriginal communities where people take it on board. To what extent are the environmental health officers accepted by the Aboriginal community if they go into a home and say, "You really need to fix this overflowing toilet or this dripping tap", and the floor is all wet and the kids are sleeping on a wet mattress? To get that change happening on the ground, what sort of model would you see as being most effective to actually get it into the communities? Often there is that communication barrier or lack of trust between different people or groups trying to provide services to Aboriginal people. Often it takes a lot of trust to be established before anything is actually accepted. That is my experience. We used to go to Warburton every year and run a holiday program for Aboriginal kids there. Now that we have been going there for seven years, a real trust relationship has developed, but during the first two years we almost felt that they did not want us to

be there. It has taken that long to develop that trust. To get grassroots change happening, what needs to happen?

Dr Douglas: There has to be an adequate level of energy. Going once every year to the remote community of Tjuntjuntjara, you are not getting the energy behind that and the drive for change. You need to be able to get to the places. It needs to be programmed. It is not a project. To have funding for three years and then it falls into a heap is no good. The program becomes core business. It does not matter whose core business it is but it has to be somebody's core business to deal with this issue.

You mentioned overflowing toilets and things like that. If the infrastructure is not appropriate for the significant influx of people into a house at a funeral time or at a sports carnival, you are suddenly going to end up with 30 people in a two-bedroom house. If the contractors do not have the septic tank in properly, it will leak and there will be a health issue. You have to get that right. On the whole, I do not think people deliberately live in pools of sewage. They prefer not to but that is what happens when 30 people come to your house.

The CHAIRMAN: We might move on to you, Karen.

Mrs Miller: I look after the community health nursing section of population health for the goldfields region. We basically run programs that are a bit different from the Perth area. The programs we run in community health range from birth to death. We get the whole life range.

The CHAIRMAN: So you are the child health nurse, the community nurse; you deal with women's health.

Mr P. ABETZ: Do you do palliative care as well?

Mrs Miller: We do not do palliative care but we have cancer support nurses. We go into that palliative care phase and the nurses get to follow through but they step back and they are in more of a support role. I suppose on a whole that is quite difficult cross-region because we have a certain amount of positions and we constantly have to keep a finger on the pulse, knowing which health issues are the priority and which ones in different areas are not as high as other areas.

The CHAIRMAN: We have heard in some regional areas that whilst the statistics might show that diabetes and some other diseases affect 80 or 90 per cent of the population, the funding does not necessarily go to those areas because of what is happening in the political arena at the time. Could you clarify that? What are the major disease groupings and what could be done to prevent those disease groupings? Is that where you focus your energy? Where does your energy have to be focused?

Mrs Miller: To take your point, we have a certain amount of positions but with all the research that has come out over the past few years, we do put our major focus on the early years. Whatever we can do in the early years we know will have a greater impact on the latter years so hopefully by doing a lot more there, we can reduce things like diabetes, asthma, cancer and bits and pieces. One of the things we are lacking in the early years is antenatal programs. That is not preparation for birthing. People talk about antenatal programs and education. It is very much around birthing. We need to move into antenatal early parenting type programs. We definitely need to get in early so we can promote breastfeeding, parenting strategies, and caring for yourself, your family and the community. We do not have any resources from a community health point of view. We were part of a pilot project looking into that, and the report is out—I do not know whether it has been made available to you—about how important that is. We have to wait for resourcing.

The CHAIRMAN: Are you aware of the Australian Research Alliance for Children and Youth?

Mrs Miller: Yes.

The CHAIRMAN: Are you connected to that group?

Mrs Miller: We are not formally members. We know about it.

The CHAIRMAN: Our committee went to their conference and listened to what was happening around Australia. All that needs to be put together so that people are not reinventing the wheel all over the place.

Mrs Miller: Currently with the staffing that we have, we are only just managing our workload.

The CHAIRMAN: Coming back to your workload, one of the things that we found in the metropolitan area—it is very pleasing to hear you say that you are focusing on the early years first—is that some children who are not having their hearing tests or visual tests are starting school way behind the eight ball because they cannot hear what is being said or they cannot read the board. Do you get notified about all the births in the area by the hospital?

Mrs Miller: Yes.

The CHAIRMAN: Do you have a register? How do you check that all the children who are born are going through not just their immunisation program but are having their 18-month check, their preschool check, their check for hearing and vision? How do you do that in this area?

Mrs Miller: We get all the regional notifications not only from Kalgoorlie hospital but also from all the babies delivered in Perth. We get electronic birth notification. That goes to the child health nurse, depending on where they are. They are covered under the universal program under child health. They get the first visit hopefully within the first 10 days of birth. They are not always able to do that due to distance. From there, there are the recommended universal visits that the children go through.

The CHAIRMAN: If someone does not come in for one of those universal visits, how do you follow up?

Mrs Miller: The first one is a home visit. That is in the first 10 days. We tend to have quite a good contact. We are in the high 90 per cent level. Then they start to drop off. Six to eight weeks is not too bad. By eight months they are starting to drop off. The 18 months and three and a half year tests are down in the 25 per cent range. How do we chase them up? We do not. If we know that the client is what we consider a high risk or a complex family case, we make every effort to visit them.

The CHAIRMAN: If they are a high risk, how many visits do you make?

Mrs Miller: As many as it takes. We have a couple of those types of clients on our workload at the moment and they can be getting weekly visits by two or three different health practitioners depending on the complexity of their health issues.

The CHAIRMAN: They are the children or the families that you have identified are in an extreme level of need but from what you have just said, possibly 70 or 80 per cent of the population are missing out on all of the other tests that might pick up that they have a hearing deficit or a visual deficit before they go to school. Are they getting missed because you do not have the staff?

Mrs Miller: Yes. Some of them are being missed and some of them choose not to come back. It might be their second, third or fourth child. They say, "Thanks for the offer but no thanks. We have been through it two or three times and we are quite happy. If we have a problem, we'll come to you." A lot of the parents have access to the internet and other types of resources. They do not wait for programs to come. They get onto the internet. They get their information and they make a few phone calls.

The CHAIRMAN: If one of the nurses sees a child and believes that they have a speech deficit, how long would it take for them to be referred for an assessment in this area? Following that assessment, how long might they wait before they enter into a treatment program? I believe the treatment program is based at Kalgoorlie hospital. If someone is picked up because they might have a problem, how long might they have to wait?

Mrs Miller: We have a program in Kalgoorlie where the child health nurses can do a referral. They will do the referral within a day of seeing the child. They can see an allied health practitioner within

two to four weeks. From there, a plan has to be put in place depending on the assessment and what comes out of that assessment.

The CHAIRMAN: Do you have enough allied health professionals to help those children?

Mrs Miller: I would not say we have enough. The audiologist has just left so when it comes to hearing, we can do a lot of screening and ear checking. However, the biggest problem arises when we refer and there is nothing to refer to. We have to wait for visiting services from Perth. It depends on which allied health professional we are looking at. With speech, we are okay at the moment. I am not sure how we are doing with occupational therapists. That fluctuates with recruitment and retention. We can be quite flush at times and children will get seen a lot quicker and at other times, the waiting lists can go right out.

The CHAIRMAN: Within an annual report, from 600 births five years ago, could we see who has had what and who has missed out? Are you able to provide us with those statistics over five years?

[1.30 pm]

Mrs Miller: I do not believe that our data system can actually provide that level of detailed data.

The CHAIRMAN: If you have missed out on someone —

Mrs Miller: That is it. It is not that we like it, but it does happen.

The CHAIRMAN: We might move to Anne from a moment as she is the director. We are actually here to help you, Anne, so please do not take this as a criticism. We recognise that there is a need, particularly in the regional areas, and that children are suffering because of this. Bearing that in mind, how do you think this hole that exists in children's health can be addressed in this area? Have you not thought about a business plan? You need to have a business plan for the Department of Health. A specialist cannot say that he needs this or that now because he does not have this or that. Have you put together a business plan based on that? If you have not, by way of supplementary information for this committee, would you be able to look at those statistics and put to us a business plan that would address those needs?

Dr Mahony: We would be happy to do that. In the goldfields and in some of the other WACHS regions, allied health comes under population health. The services are a lot better integrated in many ways and we are certainly working towards that. The physio, occupational therapist and child health nurses run programs together so that the children are picked up. As Karine was saying, there are gaps sometimes and we do not have the reporting mechanisms. Unfortunately, H-care presents an occasional service, which means nothing for population health. It is okay in an acute setting, but for us there is nothing. It does not develop a care plan for when somebody is referred. We do not have an easy data source. Each team within population health fits into a very neat structure and they collect information. It may not be ideal information, but we would certainly have that information to put together. Also, not so much in allied health, where the practitioners are often younger—they are new graduates who come for a couple of years and then go—community health is different, particularly for mothers from groups of nurses in hospitals and whatnot. It is a very stable population and often they are from the area. People from community health usually stay for at least three years or more. They are very stable and they know the populations. Apart from the people who come and go or who choose not to offer services, we actually know the populations quite well. Although some people slip between the cracks, it does not happen so much here because of the knowledge about the population and the integrated teams within population health, but there are gaps.

The CHAIRMAN: Because we know that there are gaps, it would be nice if you could put to us what could be used as an instrument to assess the needs to work with families and the various departments to try to address those needs. I know that they do not get back to the problems that Charles has just identified by saying that we must fix up the environmental things first. Hopefully, we can work on both at the same time.

Dr Douglas: You have to.

Dr Mahony: I agree. Going back to Charles' and Karine's points, the population health units were set up in 2003-04. Our core reason for being is to prevent ill-health and to protect the community. Our major programs certainly focus on that. I believe that we need to look at this and deal with the things that we unearth and provide appropriate outcomes. However, without doing prevention work and putting in the resources at the very beginning, we will continue on the track that we are going on. It really needs to be there. We work in partnership with a lot of organisations. Population health looks at whole populations and at a lot of new programs. We are not doing that alone. We have very strong partnerships. However, we do not have the resources to prevent a lot of the problems that are occurring. In our team we have community health, public health and a disease-control team that deals with the outbreak of diseases. The other public health programs like trachoma and immunisation are huge for us and they protect the community. We also have a health promotion team that needs to be beefed up. We are trying to link all parts of our team and other outside areas.

The CHAIRMAN: How many people are in each of those and how many Indigenous people are working in those areas?

Dr Mahony: Our Indigenous workforce mirrors the population. Probably about 12 or 15 per cent of the population health team is Indigenous.

The CHAIRMAN: Does that include doctors and nurses?

Mrs Miller: There are no Indigenous doctors or nurses.

Dr Mahony: We have only one doctor. They work in all the teams. They work in the public health team by doing health promotion and community development.

The CHAIRMAN: How many work as Aboriginal health workers? What level are your Indigenous health workers?

Dr Mahony: We have Aboriginal health workers, but in many cases we have veered away from the Aboriginal health worker and we employ them under the Health Services Union—HSU—award because it gives us more scope and we can employ people with a lot of life skills, who are mature and who are respected by the community. They can do what Peter was talking about. They are respected by the community. Our Aboriginal health workers do not work in a very clinical role. They work in a health promotion and community development type of role. We prefer to bring them in under this award and they can be supported to do training and education. We probably just need more of them. We also need to be flexible because we work with the communities and we need to work at their pace, at their time when they are ready to go. Excellent work has been done in Norseman. The Norseman community is driving it. It was ready for it and we need to be able to respond. We need to be a lot more flexible in the way that we work.

Mr P. ABETZ: What do you call these workers?

Dr Mahony: They all have different titles. In Charles' team we have two sexual health promotion workers.

Dr Douglas: Plus a community development officer.

Mr P. ABETZ: Is just one term not used?

Dr Mahony: No.

The CHAIRMAN: An Aboriginal elder who met with the committee suggested that the Aboriginal health program, because it does not step into enrolled nursing and registered nursing, was perhaps too narrow and that we should look at running in the regional areas more enrolled nurse programs for the local Aboriginal people. They would then have a vision for the future and could move up.

Dr Mahony: I agree, but both are needed. We have got one woman who has just completed her Aboriginal health worker training and is now going to enrol in nursing training. On the other hand,

a member in Charles' team began as a health promotion officer and is now doing a degree in community development at Curtin University. There are different pathways. We need both. Often when they start, they do not know where they want to go, but once they are in and they see that they have opportunities, we can support them to take whichever road they choose. They do not necessarily need to be restricted to health. If they do community development, they can work in local councils and all sorts of different areas. We hope we can widen their horizons.

Mrs Miller: The education pathway health workers come out with a certificate 4 so they can go into EE training or onto university and are accredited for what they have done. They are not done in isolation.

The CHAIRMAN: It does move on?

Mrs Miller: It can move them through. Maybe not everyone is aware of that. A cert 4 is a cert 4.

Mr P.B. WATSON: You talked about the community-run programs that are successful. Have those seeds been planted by the Indigenous people or by the general community?

Dr Mahony: I think it is a combination of things. I really believe in timing and grasping the opportunities when they arise. We had a very dynamic person working in population health who was passionate, but the community was ready for that. The community identified alcohol as being the biggest issue. That community has developed the most amazing alcohol accord and restrictions, which has had fantastic outcomes. They are breathtaking outcomes. It was a whole combination of things, but we need to be able to respond.

Mr P.B. WATSON: When we went to the conference in Melbourne, they said if people have their own ideas, they will run with them. Sometimes you just have to light a match under the fire and pop the idea out there and they work on it and it becomes their idea. Too many times we say that this is what will be done and they do not want to do that.

Dr Mahony: That is right. You said that it is like a flame. Once you have that, you can do other things. The community I talked about started with alcohol but another community might be concerned about diabetes and another about the environment or mothers and babies. Whichever it is, they are all linked, but it is our way in.

The CHAIRMAN: Which community are you referring to?

Dr Mahony: Norseman.

The CHAIRMAN: We now have state and federal funding and initiatives that can be tapped into. How is population health and public health made aware of those federal initiatives so you can look at them and see how you can tap into them from a regional perspective? Is a mechanism in place to do that?

Dr Mahony: Yes. Population health has an area director, Kate Gatti. We are quite aware of all types of funding and what we can and cannot tap into. Often the commonwealth funding will go to Aboriginal community-controlled health organisations. Sometimes it is appropriate for us to apply and sometimes it is not appropriate to apply for the first round but we might apply for the second round.

The CHAIRMAN: Does Kate send you a summary of the new Council of Australian Governments initiatives?

Dr Mahony: Yes.

The CHAIRMAN: Will she send you a —

Dr Mahony: It has come out. Because of all the things that are happening, a few weeks ago the population health directors met when the health and hospitals reform report came out and we discussed all the new COAG initiatives. We are pretty well up to date with it.

The CHAIRMAN: In that case, when you attended that meeting, were you given documentation that explained all those funding arrangements and how you tap into them?

Dr Mahony: Yes.

The CHAIRMAN: Could you please provide us with a copy of that by way of supplementary information, because we are trying to find that out?

Dr Mahony: Yes.

The CHAIRMAN: That would be wonderful. Some people seem to want to hold onto those things and unless we get that knowledge out there, some people, particularly in WA, will miss out. We often miss out on federal funding initiatives because people are not on the ball.

Dr Douglas: I want to mention a couple of things about not only federal, but also state money. Often it is short term. That has two impacts. That relates to what I said about the environmental health projects being projects rather than programs. A project that is funded for two years will not have a huge impact. The funding tends to be directed and it might be for diabetes, for example. That might not be the community's first choice. If you say that you want to sort out diabetes and the community says that its first priority is domestic violence, you are immediately miscommunicating with the community. Another thing about short-term or long-term funding in the regions is that recruitment is an issue. A lot of funding can be made available, but it is for short-term projects and we find it difficult to recruit. Just because a bucket of commonwealth and some state money is available does not necessarily mean it can be used effectively in the way it is divided.

The CHAIRMAN: That was raised at the conference. Often short-term projects are funded. Something might get established in an area and then the funding is taken away so they are back to square one.

Dr Mahony: We are trying to get the Aboriginal health planning forum up and running. That is on the table for every region. That might make it better because if there is some agreement and consensus in a region about who will do what, the appropriate body can apply for the funding. Population health certainly does the lion's share of prevention and disease control, particularly for maternal and child health. We do some work on chronic disease but perhaps we are not the best group to do it. Perhaps it would be better done by the AMS or a GP or whatever. We need a better process and to not always be competing for bits of money. If we all had to be accountable in the same way, it would be better.

The CHAIRMAN: Going back to diagnosis within the area—I have a nursing background—we know that diabetes and cardiovascular diseases are a big problem in the regions. In Perth the number of children with autism is skyrocketing. Is that also occurring in the regions? Also ADHD is plateauing in Perth but certainly the number of people with autism is increasing and the number of people suffering from dementia will be a problem in the future. We have heard that dementia may not be as much of a problem here as it is in Perth because people from this region move to either the west coast or the south coast when they reach a certain age. You might not need as many dementia units here. How does this region fit in? Are there some diagnoses that are on a steep upward curve and that will need additional resources in the future?

Mrs Miller: I cannot comment on autism, although I know that cases of autism have been diagnosed. In our region we are looking at asthma and respiratory problems because of the dry and dusty conditions. That comes back to environmental health in the home. Cancer is a huge issue. A lot of work has been done on that. The rate of cancer is going up in some areas while it is going down in others. Diabetes is up there with the best. They are probably the main ones from a chronic disease point of view.

Dr Mahony: We do not even know the size of FASD—foetal alcohol spectrum disorder.

The CHAIRMAN: I had not heard it called that before.

Dr Mahony: There is foetal alcohol syndrome, which is the full-blown syndrome but there is also the broader spectrum disorder.

The CHAIRMAN: Is the syndrome the disorder that causes people to look a certain way?

Dr Mahony: Yes. They have very distinctive features around the eyes and the fulcrum, and those children are quite disabled. There is also a broader spectrum disorder in which the children are unable to relate to others and they do not learn well at school. They do not get a decent education and usually end up in the justice system. A statewide working group is looking at this because we are not doing anything about this. We do not know how many children are affected. It goes back to prevention. We are not preventing it. It will be difficult to collect information but we are not collecting information on how many children might be affected. When the children are born, they are not diagnosed as having the disorder. A child might not be diagnosed until the age of seven years old when the child is in year 2 or 3 at school. It is a big issue, particularly here where alcohol misuse is an enormous problem.

Mrs Miller: To add to that, we are in our second generation of FASD. We are talking about not only children, but also adults who are having children.

The CHAIRMAN: We have heard that in some areas a whole generation has been lost because of foetal alcohol syndrome disorder.

Dr Douglas: In the goldfields, apart from a significant population of Anglo-Saxon families that live in Kalgoorlie and Esperance, we have an Indigenous population, which is a special group. The mining population is also a special group. There are a lot of poor health behaviours, including smoking, drinking and the use of illicit substances. We also have an elderly population in Esperance and in our region along the southern coast. In terms of what is on the horizon, we have an elderly population who will get Alzheimer's disease.

The CHAIRMAN: That is right. It is the whole region. I was thinking just of Kalgoorlie.

Dr Douglas: I wanted to make it clear that it is the region. We have the mining population, which is a very high-risk group, and 12 per cent of the population are Indigenous people, many of whom live in small communities and are unhealthy. We have a range of populations. Each of them has long-term problems. Obviously, renal disease is one of them. Many of our patients have to live in hostels in Perth because the dialysis cannot be delivered among the Aboriginal population. We will have an ageing population and we have problems associated with alcohol and drugs as well.

The CHAIRMAN: Earlier today we discussed the possibility of training people to undertake home peritoneal dialysis. When we were discussing that earlier, I was not aware so much of some of the environmental issues that you have just mentioned. Obviously, that will have a big impact on whether you think a home dialysis —

Dr Douglas: I believe that in the Kimberley that is done a lot. It is not impossible to do.

Mrs Miller: We do have a couple.

The CHAIRMAN: Where do you have one?

Mrs Miller: There is a staff member on peritoneal dialysis in Menzies.

Dr Douglas: One of the issues is getting in adequate support. Even if someone in Menzies is able to manage the environment and everything, they still need support. Dialysis is not just the machine or the technique; it requires a lot of support. You cannot set up a program that relies on one expert who might then disappear and end up with a lot of people on home dialysis or peritoneal dialysis when it suddenly falls over.

The CHAIRMAN: It could be linked to a renal ward and a clinical nurse specialist could be in charge of the program. Therefore, other nurses in the area could be trained to conduct peritoneal dialysis so if that nurse was transferred, another nurse could step in.

Dr Mahony: It would have to be a community member because otherwise it would be unsustainable. Often these people live in little towns. It would have to involve the family and the community.

The CHAIRMAN: A clinical nurse would do the training rather than the dialysis. Charles said that some Aboriginal health workers wear different hats and have different titles. Just as there are Aboriginal health workers, other people in the community could be trained to be peritoneal dialysis assistants. A clinical nurse specialist and the staff at the hospital would do the initial training and people in the community could work with those families to help the patients.

Dr Mahony: The issue is that there must be a willingness from the community to do that. Some communities have taken issues on board and have found extended family members or community members who are willing to help. Without that help, we could not deliver it. It is dependent on that.

Mrs Miller: That brings me to something I would like to put on the record. Janet kept thinking that we are just Kalgoorlie or Esperance but we have a number of other small towns. One of our biggest challenges is providing health services. We can sit here in Kalgoorlie and talk about the early years and diabetes but in most small sites there is only one community nurse and one health worker, if they are lucky. They do not all have qualifications in everything that is needed in those communities. The larger centres have to provide a visiting service to the smaller sites, which can take up a lot of time and is quite costly. The visiting services are looking at the early years for diabetes and alcohol. Because there is no other public health nurse, if Charles needs contact to help trace a disease outbreak in Norseman, for example, the community nurse must drop everything and do another job for the day. It is very hard on them. It is not only health services that visit all the little towns, but also Centrecare and private physiotherapists. All those health services plod along and they expect the nurse to be there and to round up the people. That is when it becomes very difficult.

The CHAIRMAN: I have heard about the chronic disease management network but am not sure how it works. Are you linked with that? Do you know how that works?

Dr Douglas: No, just peripherally. When I was in Perth I was much more attentive to it but it is not in my field. I am aware of it. It sends out regular email updates and has discussion groups and things.

Mrs Miller: We do not have bad IT availability in all the small sites, although it is not always 100 per cent reliable. The small sites get updates and they can look up bits and pieces. Some of the communities are getting to a size that makes them very difficult to manage from not only a health point of view, but also policing, housing and education. Not enough people are living in communities to provide the level of service that is required. It is very difficult to expect a full-time nurse to live in a community with only 40 people. The nearest nurse might have to travel from 200 kilometres away. A nurse cannot drive all that way only to stay for a couple of hours. It is quite challenging and difficult to provide on a day-to-day basis an even balance to give people what they deserve.

The CHAIRMAN: Going back to those earlier years, some of the models and approaches being used in the metropolitan area are to move the initial child health nurse assessments into kindergarten and preschool. The school within the community then becomes the focus of the intervention.

[2.00 pm]

Mrs Miller: We already do that. That is the universal school entry check. We have been doing that since pre-primary. Next year we will be doing kindergarten and mop up any pre-primary, grade one, that we have missed out on. That is a universal program across the state.

The CHAIRMAN: If someone is at kindergarten or year one and you notice that they have difficulties with reading, who are your referral sources?

Mrs Miller: Speech pathologists.

The CHAIRMAN: Would it be a problem here? Could you get them straight into a speech pathologist? I do not know whether the children get that assessment. Something used to be done at three and a half years by the child health nurse and the community health nurse and then the GP took over. I have been told that a lot of children got lost in the loop.

Mrs Miller: The child health nurse used to do child health check-ups until the age of four and a half. The pre-primary check has been around for a long time. We used to do that in year one. Then we started doing it in pre-primary. In the past couple of years the recommendation is to do it as early as possible. We brought it to the kindergarten year. Years ago not a lot of children were going to kindergarten. It was a voluntary thing. Because we brought that check to the kindergarten year, we believe there was no point in the child health nurses doing a four and a half year check any more because it was being done in school entry. That was taken out of the universal program. The child health nurse only does three and a half year checks and then it goes to the school nurse.

The CHAIRMAN: They might miss out at 18 months but you pick them up at three and a half.

Mrs Miller: Yes. If parents are concerned at any stage, they can make contact.

The CHAIRMAN: One of the things we hear is that some parents believe they might have an Einstein and when their child does not speak until the age of four or five, they say that some children take longer than others. They do not necessarily want to have their child labelled as not achieving. That seems to be the case particularly with some ethic groups. They do not like to have their children labelled in any way or form by people who think their children may need help.

I will give each of you a minute or two to quickly flag things that we have not discussed. If you do not think of things now, you can let us know by way of submission.

Dr Douglas: My area is communicable disease. The bulk of our work is in sexually transmitted diseases. We have a funded program on that, which is good. It was a three-year funded program and it is now our core business, which is excellent, and we employ three staff. The area of concern for me is HIV. It is increasing. We have a large number of cases now. It is changing significantly in the rural areas. As you are aware, it used to be a disease that affected homosexual men—men who have sex with men. The groups we are seeing now are heterosexually transmitted and many of them are people from overseas who are brought in to work in the mining industry. We have a number of those.

The CHAIRMAN: So people are coming in with HIV?

Dr Douglas: Yes.

The CHAIRMAN: Are you suggesting that people have a chest X-ray?

Dr Douglas: It depends on which visa people are applying for as to what level of testing is done. The other group that is probably equally of issue is miners who go overseas to Thailand or PNG for work or holiday and bring HIV back into this country. There is a bubbling issue with HIV. The implication of that is that a number of people with HIV will always present a management problem. It is very resource intensive. A lot of people will do what they are supposed to do—get their tests, take their tablets and behave themselves—but there is a group that does not, and it is unbelievably resource intensive.

The CHAIRMAN: Why are they resource intensive? I am not sure what you mean.

Dr Douglas: Because we need to follow them up, some as often as daily, some slightly less often. They are resource intensive. As the epidemic increases and as it is spreading from —

The CHAIRMAN: So it is an epidemic?

Dr Douglas: An epidemic is defined as anything above an expected level. Let us say that there are an increasing number of cases.

The CHAIRMAN: I am quite happy if there is an epidemic in HIV in this area. The health department needs to address that.

Dr Douglas: It is increasing state-wide, country wide and even worldwide. I think the issue is that the people getting it are different. There are hundreds of screenings in the metropolitan area. Health workers have a significant workload following up recalcitrant people. There was a huge group in another region a few years ago that took an enormous amount of money to bring under control. I am flagging that as a threat on the horizon.

The CHAIRMAN: We had it flagged in the metropolitan area for teenagers that there was an increase in sexually transmitted diseases such as chlamydia. They said there was chlamydia, gonorrhoea and syphilis.

Dr Douglas: We have not had syphilis but the Kimberley has had syphilis and we have gonorrhoea and chlamydia. We have a program to address that. For that particular issue, we have the resources and the strategies. We continue doing the same things and that is not always effective. We are trying to think of different strategies. HIV in particular is an issue. With this kind of case management function, as you get an increasing number of people, you get an increasing number that are going to be difficult and it stretches us quite thin when a couple of them go wrong on a daily basis.

The CHAIRMAN: One of the things that we looked at today when we met with people from Kalgoorlie hospital was that they have a formula called nursing hours per patient day. I know this is not a nursing issue but is there some kind of formula? Should you not be able to say category one, two or three should get extra assistance? How do you get extra assistance? If you are saying that the numbers are increasing, how do we support you to get the assistance that you need if you do not have a formula? You have told us that a lot more people in this area are getting HIV. How would funding come to you to assist with those increased numbers? From those numbers, how can you say you need a 0.5 for this area or a 0.3 for this area to help you ensure that those people who need medications or whatever are getting it?

Dr Douglas: I have asked.

Mrs Miller: We are waiting for somebody to do a research project.

Mr P.B. WATSON: That is a good answer.

The CHAIRMAN: Over to you, Karine.

Mrs Miller: From my point of view, our clients are definitely becoming a lot more complex, especially in our early years focus. That is becoming quite staff intensive. That is putting quite a big drain on the staff that we have. We also need to bring up the skill level of those staff because they have to deal with a wider range of issues that they normally are not used to doing. To assist those nurses, we are trying to keep our resources up because we are constantly being hit with the three per cent cut.

The CHAIRMAN: Have you lost any front-line health care professionals because of the three per cent cuts? I am asking this across community nursing.

Mrs Miller: No. I could not say that we have lost them. I have had to fight to keep what we have got.

The CHAIRMAN: Do you have anyone who has gone off on maternity leave who has not been replaced since the three per cent efficiency cuts?

Mrs Miller: No, but I have a couple of positions that I am currently in negotiations with relating to finance to make sure they are reinstated onto my spreadsheet.

The CHAIRMAN: As part of those discussions, the Minister for Health made it very clear in Parliament and outside Parliament that those three per cent cuts are not meant to be for front-line

services. Therefore, if the administration looked to be taking away, please contact the minister. If you wanted to copy me in an email or letter, I would be quite happy for you to do that.

Mrs Miller: I kept his letter. I have not got rid of that. The current staffing level is okay but that will definitely change in the future. The birth rate is not going up enormously but it is gradually going up. It is complex. You asked how many visits we do for high risk. It can be an indefinite number. That does place a challenge on future services such as bringing in antenatal care but also the resourcing, not just in staffing but vehicles. We have just been asked to try to reduce our vehicle fleet across the board. That will have a large impact because most of our services are provided in the community. A lot of our community health buildings are in an awful state of repair. It is unfortunate to have two buildings that are heritage listed. Yes, they are beautiful but how do you get enough funding every year to pour into a rising damp problem when you would rather be spending that money on service provision? It is about other bits and pieces that help you do your job.

Dr Mahony: In all honesty, we must not lose sight of the need for prevention of ill health. I fear for it because as we look to bring services outside of hospitals, community health and the population workforce might be eyed up to delivering hospital-in-the-home type services. Our situation in health and the cost of health and the cost to people and their health will just get worse and worse if we do not keep a focus on prevention of ill health and early years and the larger things that impact on health, including environmental health, which we desperately want up and running. That is probably my most important point—keep the focus on prevention of ill health.

The CHAIRMAN: I would like to thank you for your evidence before the committee today. A transcript will be forwarded to you for corrections of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information on top of the information that we have requested from you or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Once again, thank you very much for coming today.

Hearing concluded at 2.13 pm