EDUCATION AND HEALTH STANDING COMMITTEE

DESTINED TO FAIL:
WESTERN AUSTRALIA'S HEALTH SYSTEM

VOLUME 2- COMMUNITY HEALTH SECTOR

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Report No. 6

Presented by:
Dr J.M. Woollard, MLA
Laid on the Table of the Legislative Assembly
on 6 May 2010

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CHAPTER 8 CHILDREN'S HEALTH

8.1 Introduction

On 11 March 2010 the Committee published an interim report, *Invest Now or Pay Later: Securing the Future of Western Australia's Children*, containing evidence it had gathered on non-acute child health issues that it thought should receive the immediate attention of Parliament. This chapter begins the second volume of the Committee's report and addresses two further issues to do with child health: the acute child health services at Princess Margaret Hospital (PMH) and the proposal for a Minister with responsibility for early childhood services.

8.2 Princess Margaret Hospital services

Many members of the public confuse the children's health services provided by the Department's Child and Adolescent Health Service (CAHS) as just the acute care paediatric services offered by PMH, which also provides services for children from birth to 16 years and:

> *incorporates all the high-end clinical services that you would expect to see in a tertiary service: both cardiac surgery and neuro-surgery in addition to a comprehensive range of other services including oncology. The oncology work done in Western Australia has an exceptional reputation in Australia and internationally. It covers a lot of services including paediatric rehabilitation which allows kids, after trauma or accidents, to access excellent services. It is the trauma centre—if that is the right word—for paediatrics and it has a very busy Emergency Department, the number of services provided touches about 60,000.*[1]

The Committee has been keen in this Inquiry and its earlier *Healthy Child- Healthy State* report to highlight the importance of the community child care services offered by CAHS and their role in keeping the State's children healthy and out of hospital. Services at PMH have been well-resourced by the current and past governments, even though the building itself was described to the Committee as a 'rabbit warren'. A new hospital, co-located with SCGH, is scheduled to open by late-2015. The new hospital is planned to have 250 beds and house the State's only paediatric trauma centre. It will continue to provide tertiary and key secondary health services including inpatient, ambulatory and outpatient care.[2] The Government intends to save funds by building the hospital as a Private-Public Partnership and has allocated $117 million for forward works on the project in the 2009-10 Budget.[3] The advantages for co-locating PMH with an adult tertiary

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1 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p2.

2 Hon Dr Kim Hames, Minister for Health, 'Planning for WA's new children's hospital begins', 21 February 2010. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=133153&minister=Hames&admin=Barnett. Accessed on 22 March 2010.

3 Department of Treasury and Finance, '2009-10 Economic and Fiscal Outlook', 14 May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/2009-10_budget_paper_3.pdf, p139. Accessed on 22 March 2010.

hospital include offering continuity of care to young adults for certain disease types, such as cerebral palsy or cleft palates, which are often dealt with from childhood through to early adulthood. Other advantages include:

- back-of-house functions, facility management, catering etc;
- access to very high-end imaging; and
- access to cancer treatments, particularly the lineate accelerators that are located at the QEII site cancer centre.[4]

Data gathered by the Committee also showed that FTE staff levels at PMH have been boosted from 1,431 in 2007-08; to 1,513 in 2008-09; and to 1,638 by August 2009. This is a 15% increase in staff in less than two years.[5] The level of staff and funds means that waiting times for outpatients at PMH is just 1-3 months, while the Committee's *Invest Now or Pay Later* report found that equivalent waiting times in the community child health services is often 12-18 months. The Committee heard that the shorter waiting times at PMH are because "the patient is normally referred back to a GP and other professionals. The retention of the child in our system will be only as long as is required for the conclusion of the management of acute illness or a chronic problem."[6] PMH, as one of the State's iconic institutions, also receives considerable support from community and corporate donations and its staff are assisted in their research by close cooperation with the Telethon Institute for Child Health Research.[7]

In terms of future planning for paediatric services, the Committee heard evidence that in the Peel-Rockingham area there is duplication in the provision of services:

> *So we have a lot of replication of services where there is a scarce international medical commodity and a nursing commodity, which makes it very challenging, to say the least, to actually run those services safely.*[8]

Rockingham Hospital is building an 8-bed paediatric unit while the Peel Health Campus (PlHC) is building a 12-bed unit. The PlHC has had to recruit midwives and obstetricians from overseas due to the lack of local staff. For these reasons, PlHC's CEO told the Committee that he preferred to

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4 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, pp3,8.

5 Dr Peter Flett, Director General, Department of Health, *Reply to Questions on Notice*, 19 August 2009, pp1-2.

6 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p12.

7 Telethon Institute for Child Health Research, 'Telethon Institute for Child Health Research', nd. Available at: www.ichr.uwa.edu.au/. Accessed on 22 March 2010.

8 Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Transcript of Evidence*, 31 August 2009, p6.

remove this service from his hospital's offerings, but this has been blocked by the Health Minister.[9]

While there may be this duplication in the SMAHS, the Committee heard that there was very good liaison between PMH and the WA Country Health Service because, "the country is separated from the metropolitan area purely from an organisational point of view; it is not separated in terms of liaison, collaboration and working together."[10]

Finding 65

The State's paediatric acute care services are generally well staffed compared to other parts of the health system.

8.3 Minister for early childhood services

Both this Committee's *Healthy Child — Healthy State: Improving Western Australia's Child Health Screening Programs* report in May 2009 and the Community Development and Justice Standing Committee's *Inquiry into the Adequacy of Services to Meet the Developmental Needs of Western Australia's Children* report in August 2009 recommended that the Western Australian Government reform the management of early childhood health and education policies along the lines undertaken in South Australia and Victoria. The Government responded to the *Healthy Child- Healthy State* recommendation by noting it and responding that "it has a dedicated Office of Early Childhood Development and Learning that reports to the Minister for Education."[11] The Minister for Education received a report from Mr Brenton Wright in late-2009 on how she might advance this recommendation, but has taken no further action and has not released the report. Mr Wright chaired the reference group in South Australia that authored the report from the Ministerial Inquiry into Early Childhood Services, which led to the establishment of a Minister for Early Childhood Development in that state.[12]

The Committee heard that prior to the March 2010 election, South Australia had four portfolios that dealt with child health and education policies: a Minister for Families and Communities, a Minister for Health, a Minister for Education and a Minister for Early Childhood Development. To support these ministers there are inter-ministerial committees and senior officer groups which

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9 Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Transcript of Evidence*, 31 August 2009, p6.

10 Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p14.

11 Whole of Government Response, Government of Western Australia, 8 September 2009, p23.

12 Mr Brenton Wright, 'The Virtual Village: Raising a Child in the New Millennium', January 2005. Available at: www.ecsinquiry.sa.gov.au/files/links/link_80568.pdf. Accessed on 22 March 2010.

assist in delivering a whole of government approach.[13] As an example of this cooperative style, the South Australian Departments of Health and Education received Federal government funding to develop a childhood centre based at a primary school, later named CaFE Enfield. This was modelled on similar overseas projects and commenced in 2001. It is managed by staff from the Departments of Health, Education and Families SA.[14] There are plans to develop about 20 centres similar to CaFE Enfield across South Australia, including an Aboriginal children's centre at Port Augusta. An important aspect of the approach taken at CaFE Enfield is the presence of family support coordinators whose role is to link the programs of all agencies, and the housing department.[15]

Similarly, in 2007, one of the first announcements made by the new Victorian Government was its plan to move the Office of Children from the Department of Human Services and into the then-Department of Education to create the new Department of Education and Early Childhood Development (DEECD). Child protection and juvenile justice programs stayed within the Department of Human Services. This new approach created an integrated policy agenda for children and young people 0-18 years that encompasses their learning, development and wellbeing. Centres run by the DEECD are co-located with schools so that the transition from early-year services into schools is as smooth as possible for families and their children. DEECD tries to make these children's centres responsive to the needs of the local area. In Victoria a children's centre incorporates kindergarten, long day care, maternal and child health and a range of ancillary services for children nought to five.[16]

To develop a whole of government approach to children's policies, the Victorian Government was required under the *Public Health and Wellbeing Act 2008*[17] to establish the Children's Services Coordination Board.[18] That board comprises the secretaries of key departments, specifically the:

- Department of Education and Early Childhood Development;
- Department of Human Services—now the Department of Health;
- Department of Planning and Community Development;

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13 Ms Kerrie Bowering, Director, Child and Family Health Service, Children, Youth and Women's Health Service, Department of Health, State of South Australia, *Transcript of Evidence*, 28 September 2009, p2.

14 Ms Sharyn Delahoy-Galwey, Clinical Services Coordinator, Children, Youth and Women's Health Service, Department of Health, State of South Australia, *Transcript of Evidence*, 28 September 2009, p4.

15 Ms Joan Gilbert, Director, Education and Care, CaFE Enfield Children's Centre, Victoria, *Transcript of Evidence*, 28 September 2009, p8.

16 Mr Andrew Abbott, General Manager, Strategy and Coordination, Department of Education and Early Childhood Development, State of Victoria, *Transcript of Evidence*, 30 September, p4.

17 Department of Health, State of Victoria, '*Public Health and Wellbeing Act 2008* and *Public Health and Wellbeing Regulations 2009'*, 13 January 2010. Available at: www.health.vic.gov.au/phwa/index.htm. Accessed on 22 March 2010.

18 Dr Sharon Goldfeld, Principal Medical Advisor, Department of Education and Early Childhood Development, State of Victoria, *Transcript of Evidence*, 30 September, pp5-6.

- Department of Premier and Cabinet;
- Department of Treasury and Finance;
- Department of Justice; and the
- Chief Commissioner for Police.[19]

The legislation requires these secretaries to meet regularly to discuss a range of issues of relevance across those departments.

Finding 66

Two other Australian jurisdictions have established portfolio responsibility for early childhood education and development. The experience in these states has shown benefits for children and their families.

Recommendation 31

That the Government establish a Department with a Minister with portfolio responsibility for early childhood education and development, family services and childcare.

19 Department of Education and Early Childhood Development, State of Victoria, 'Children's Services Coordination Board', 18 February 2010. Available at: www.education.vic.gov.au/about/directions/children/cscb.htm. Accessed on 22 March 2010.

Recommendation 32

To assist in developing a whole of government approach to child health issues, the Government establish a Children's Services Coordination Board consisting of the senior executives of:

- Department of Health;
- Department of Education;
- Commissioner for Children and Young People;
- Department of Planning;
- Department of Communities;
- Department of Child Protection;
- Department of Disability Services;
- Department of Indigenous Affairs;
- Department of the Premier and Cabinet;
- Department of Treasury and Finance;
- Commissioner for Mental Health; and
- Commissioner WA Police.

CHAPTER 9 WOMEN'S AND MEN'S HEALTH

9.1 Women's health

The Committee received limited evidence on the issue of women's health. From what has been gathered it seems that the Department of Health currently focuses on programs dealing with specific diseases (such as BreastScreen WA[20]), rather than operating according to a gender-specific State-wide strategy, as done in other jurisdictions in Australia and overseas.[21] The national women's health policy was developed by the Hawke Federal Government in 1989. The World Health Organisation's *Madrid Statement* highlighted that "To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities."[22] The Reid Report's recommendation 70 also addressed this issue:

> *The Women's and Children's Health Service should be responsible for coordinating and integrating a State-wide service for the health needs of the State's women and children.*
>
> *This will involve collaboration and consultation with a range of service providers in order to provide for the health needs of women and children from prevention and early intervention all the way through to tertiary care.*[23]

Finding 67

Western Australia does not have a women's health strategy.

Recommendation 33

The Department of Health must develop a State-wide women's health strategy by 1 July 2011.

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20 See www.breastscreen.health.wa.gov.au/home/.

21 See for example, Victorian Government, 'Women's health & wellbeing strategy', 4 February 2009. Available at: www.health.vic.gov.au/vwhp/wellbeing/index.htm; and Health Canada, 'Women's Health Strategy', 1 October 2004. Available at: www.hc-sc.gc.ca/ahc-asc/pubs/strateg-women-femmes/strateg-eng.php. Accessed on 11 March 2010.

22 World Health Organisation, 'Madrid Statement', 14 September 2001. Available at: www.euro.who.int/document/a75328.pdf. Accessed on 17 March 2010.

23 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pxx.

While the material below focuses on the State's hospital services provided to women, especially maternity services, the Committee was reminded by Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, that:

> *most of the women's health clinical services are provided out in the community by general practitioners, for example. Funding for women's health is really quite complex. The hospital setting is only a very, very minor part of addressing a woman's holistic needs.*[24]

Evidence gathered by the Committee supports the proposal that women from lower socio-economic backgrounds suffer worse health than women from more affluent backgrounds. Australian research indicates that while GP use was roughly the same between wealthier and poorer women, those better off were more likely to report having used dental services, specialists, allied health practitioners, and alternative health providers. This suggests that inequalities in care are to some extent shaped by the health care system itself, where out-of-pocket costs and private care influence access to services for women.[25] For country women, long distances are another barrier to access health services.

The State's Women and Newborn Health Service (WNHS) is located at the King Edward Memorial Hospital (KEMH), the State's only tertiary hospital for maternity, neonates and gynaecological health. The hospital is also Western Australia's only major teaching hospital in obstetrics and gynaecology, and is a centre for midwifery training and postgraduate medical training. Administratively the WNHS is part of DOH's North Metropolitan Area Health Service, but provides the following state-wide services:

- urogynaecology referral service;
- a referral service for women with significant psychiatric illness, both during pregnancy and post-partum;
- Sexual Assault Referral Centre;
- community-based services, including breast screening;
- the management of the contracts for various women's health clinics that are located around the State;
- an obstetric support unit; and

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24 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

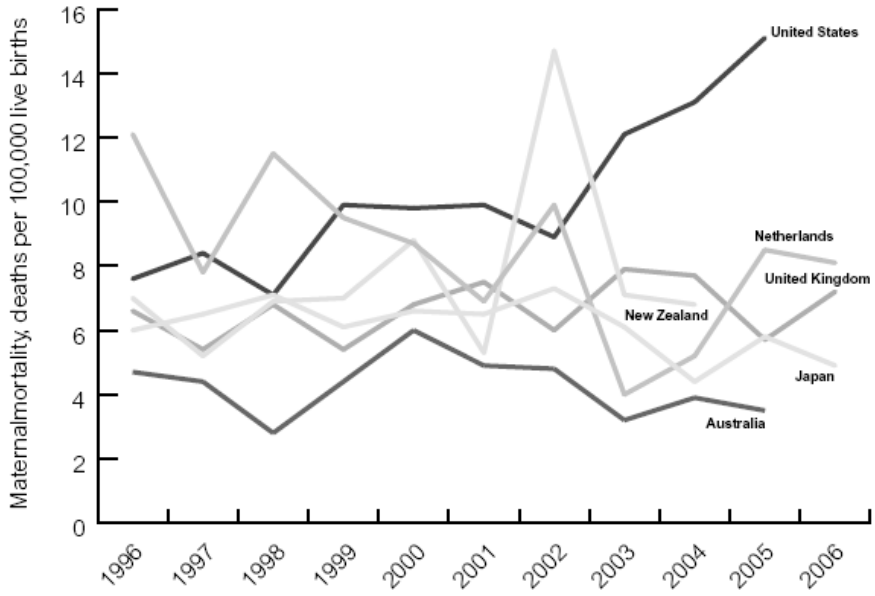
25 Crikey, 'The question that Health Ministers should be asking', 14 October 2009. Available at: http://blogs.crikey.com.au/croakey/2009/10/14/the-question-that-health-ministers-should-be-asking. Accessed on 17 March 2010.

- clinical reviews if there are adverse health events involving women.[26]

(a) Maternity services

The provision of maternity services is a particularly controversial area, especially with the increased popularity home births, and the use of smaller birthing centres located closer to a mother's home. Even so, in 2006, 97% of Australian women gave birth in a hospital setting. Public hospitals delivered 55% of antenatal care, private obstetricians 30%, while GPs delivered 15%.[27] Australia is among the world's safest countries for childbirth. Data from the OECD shows that over the past decade Australia has had consistently lower maternal (see Figure 9.1) and peri-natal (Figure 9.2 below) death rates than comparable countries.[28]

Figure 9.1- Maternal mortality, international comparison, 1996–2006

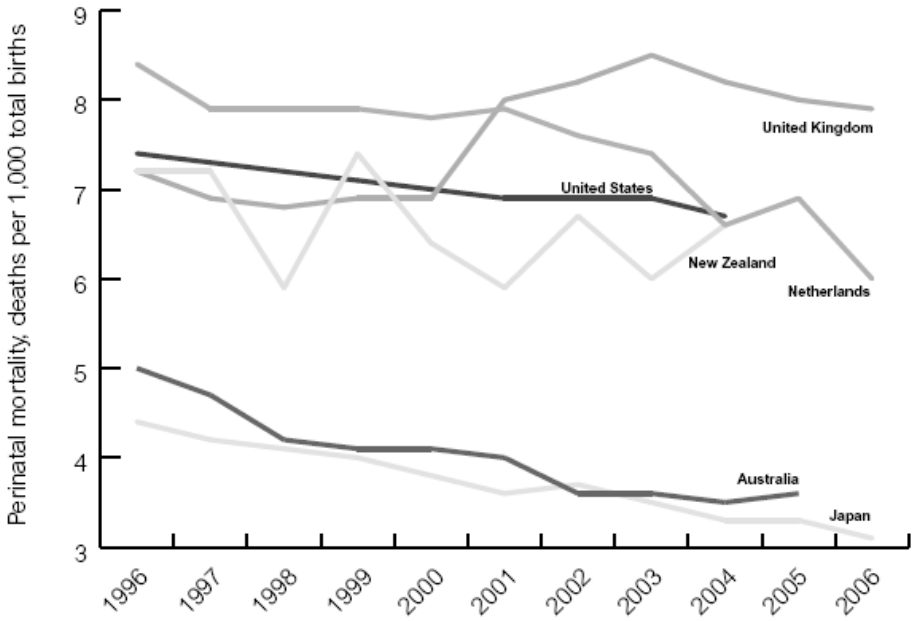


26 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, pp1-2.

27 Commonwealth of Australia, 'Report of the Maternity Services Review', February 2009. Available at: www.healthyactive.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf, p3. Accessed on 16 March 2010.

28 Commonwealth of Australia, 'Report of the Maternity Services Review', February 2009. Available at: www.healthyactive.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf, pp8-9. Accessed on 16 March 2010.

Figure 9.2- Peri-natal mortality, international comparison, 1996–2006

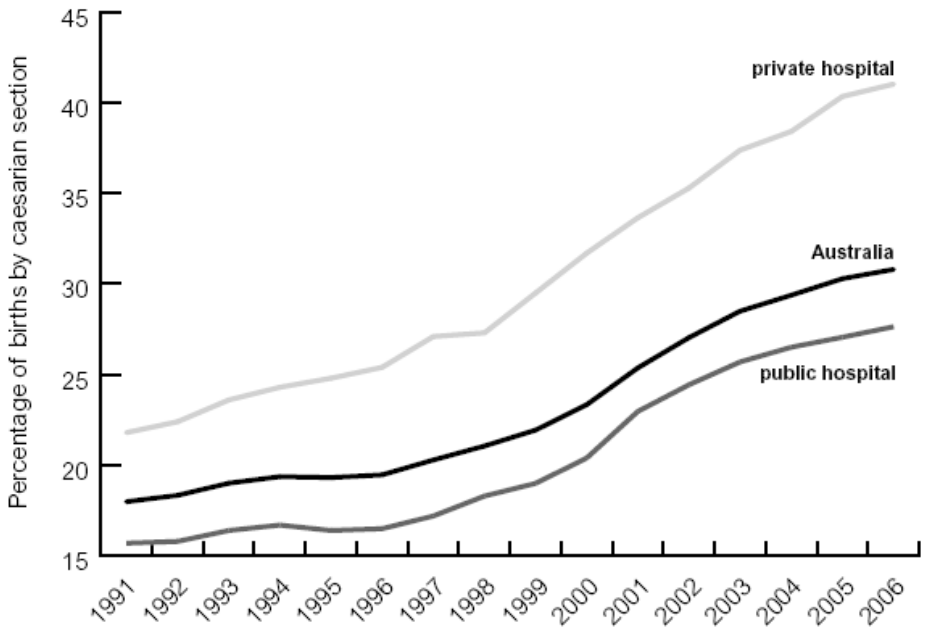


The most controversial aspect of the nation's maternity services seems to be the rising levels of caesarean sections over the past two decades, especially in private hospitals (see Figure 9.3 below). The recent *Report of the Maternity Services Review* described a range of factors that could be behind the costly increases in caesarean section rates:

- increasing maternal age;
- increasing comorbidities such as obesity, diabetes and hypertension;
- changes in care for pre-term deliveries and those involving assisted reproductive technologies (ART);
- consumer choice and demand;
- medico-legal risks; and
- defensive practice.[29]

[29] Commonwealth of Australia, 'Report of the Maternity Services Review', February 2009. Available at: www.healthyactive.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf, pp10-12. Accessed on 16 March 2010.

Figure 9.3- Rates of caesarean section by hospital sector, Australia, 1991–2006



(i) Reports on maternity services

Despite the low level of maternal and peri-natal deaths in Australia, in the past 10 years there have been nearly a dozen inquiries, reports or policy launches about aspects of maternity services by State or Federal governments.

State reports

- **Child and Glover Review - 2000**

In 1999, the Chief Executive Officer of King Edward Memorial Hospital, Mr Michael Moodie, wrote to the Metropolitan Health Service Board (MHSB) providing evidence of major quality and safety deficiencies at the hospital. After some delay, the MHSB commissioned a review of the Hospital's Obstetric and Gynaecology services by an independent clinician. The review raised more management and clinical performance issues and recommended further investigation. In consultation with the Health Commissioner, the Minister, and the Chief Medical Officer, Mr Moodie commissioned the Child and Glover review. This two-week review identified significant system and performance issues and the Minister, in consultation with the Premier, commissioned Mr Neil Douglas QC to lead an inquiry into obstetrics and gynaecological services at KEMH from 1990-2000.[30]

[30] Medical Journal of Australia, 'Three Australian whistleblowing sagas: lessons for internal and external regulation', 2004. Available at: www.mja.com.au/public/issues/181_01_050704/fau10254_fm.html. Accessed on 16 March 2010.

- **Douglas Report - 2001**

The Douglas Report was delivered to the Premier and Minister for Health in November 2001. A redacted version that removed some sections of the Report to protect patient confidentiality was tabled in the WA Parliament and made available to the public in December 2001. The Report contained 237 recommendations and in January 2002, the Director General of Health established an Implementation Group to ensure that the recommendations arising from the Report were carried out. The former Minister for Health, the Hon Bob Kucera, announced that the Implementation Group had completed its work and presented his final report to Parliament on 18 June 2003. In October 2003, the Women's and Children's Health Service Douglas Inquiry Audit Committee was established to monitor compliance with recommendations identified as requiring ongoing review.[31]

- **Homebirth Policy and Guidelines for Management of Risk Factors - 2001**

This policy was an update of the State's 1990 policy and was developed to guide the practice of community-based midwives who care for women choosing the option of homebirth.[32]

- **State-wide Obstetric Services Working Group Review - 2003**

In December 2001 the State-wide Obstetric Services Working Group was established by the State Health Management Team to review obstetric and childbirth services provided in public facilities in Western Australia. Dr Cohen was asked to convene a service review from a clinician's perspective. The immediate goal was to provide a vision of a new way forward that reaffirmed the important role of obstetrics in the community - a way forward that considers the rights, diversity and cultural dignity of the consumer to be paramount.[33]

- **Legislative Council Standing Committee Report on a Petition on Primary Midwifery in WA - 2004**

The Committee conducted preliminary inquiries into the content of a petition and reported on the important issues raised in the submissions received from key stakeholders in relation to the inadequacy of publicly funded primary midwifery services available to Western Australian

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31 Department of Health, 'About the KEMH Douglas Inquiry', nd. Available at: www.kemh.health.wa.gov.au/general/KEMH_Inquiry/about.htm. Accessed on 16 March 2010.

32 Principal Nursing Adviser's Office, Department of Health, 'Homebirth Policy and Guidelines for Management of Risk Factors', August 2001. Available at: www.ocno.health.wa.gov.au/publications/docs/Homebirth_Policy_2001.pdf. Accessed on 16 March 2010.

33 Department of Health, 'Western Australian State-wide Obstetrics Services Review: Report of the Project Working Group', April 2003. Available at: www.health.wa.gov.au/publications/wa-obstetrics-discussion-paper.pdf. Accessed on 16 March 2010.

women. The report provides a summary of the key benefits associated with primary midwifery services and the continuity of care approach to maternity services.[34]

- **Reid Report - 2004**

The Reid Report argued that the four general hospitals were most appropriate for the delivery of obstetric services and could provide safe and high quality, high volume clinical services while allowing people to be treated closer to the communities in which they live. Recommendation 42 was dedicated to Women's Clinical Services and endorsed the 2003 State-wide Obstetric Services Review's recommendations that recognised KEMH as the centre of excellence for the State. Recommendation 26 supported the transfer of obstetric services from Woodside Maternity and Kalamunda Hospitals to the four general hospitals.[35]

- **Legislative Council Select Committee into Public Obstetric Services - 2007**

The Select Committee was established on 24 May 2006 to inquire into the adequacy of the Government's decision-making process (including public consultation and the consideration of relevant evidence) leading to the determination to restrict metropolitan public obstetric services to certain key hospitals as outlined in the Clinical Services Framework 2005-2015.[36]

- **Improving Maternity Services: Working Together Across Western Australia - 2008**

The Improving Maternity Services policy outlines the direction the Department of Health will take in the development of maternity services over the period 2008-13. DOH used the plan to develop greater choices and support during pregnancy and birth for healthy women with low risk pregnancies outside the current tertiary and secondary hospital system.[37]

- **Review of Homebirths in Western Australia - 2008**

The Department of Health commissioned a review of homebirths in Western Australia in December 2007. The aim of the report was to assess essential homebirth health outcomes including morbidity and mortality. The review was to identify any concerns with the practice of homebirths in WA and recommend ways in which the safety of homebirths could be improved.

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34 Legislative Council, 'Report of the Standing Committee on Environment and Public Affairs in Relation to a Petition on Primary Midwifery Care', November 2004. Available at: www.parliament.wa.gov.au/parliament/commit.nsf/(Report+Lookup+by+Com+ID)/4FC250A069B9018948256F4F000805E3/$file/ep.050.041116.rpf.013.xx.a.doc.pdf. Accessed on 16 March 2010.

35 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp45-47.

36 Legislative Council, 'Select Committee into Public Obstetric Services', August 2007. Available at: www.parliament.wa.gov.au/parliament/commit.nsf/(Report+Lookup+by+Com+ID)/1DBE55000CB91E1EC8257347001A04AD/$file/ob.obs.070830.rpf.001.xx.a.pdf. Accessed on 16 March 2010.

37 Department of Health, 'Improving Maternity Services Policy Framework', nd. Available at: www.healthnetworks.health.wa.gov.au/projects/mat_services.cfm. Accessed on 16 March 2010.

The review identified that the Community Midwifery Program had the potential to provide a safe service.[38]

National reports

- **Report of the Maternity Services Review - 2009**

The report presents the findings of the Maternity Services Review conducted by the Department of Health and Ageing and led by the Commonwealth Chief Nurse and Midwifery Officer, Ms Rosemary Bryant. The Review is a key step towards delivering the Government's election commitment to develop a National Maternity Services Plan.[39]

- **Senate Community Affairs Legislation Committee Report on Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills- 2010**

On 23 November 2009, the Senate referred the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills, together with the Government's proposed collaborative arrangements amendments, to the Community Affairs Legislation Committee for inquiry and report by 1 February 2010. The inquiry generated considerable interest and received 933 submissions, 430 comment letters and 900 form letters.[40]

(b) Obstetric services

There are around 30,000 births across Western Australia each year. The general metropolitan hospitals offering obstetric services deliver around 1,100-1,500 babies per year except for Bentley Hospital (600 deliveries),[41] which will be closed when the Fiona Stanley Hospital is opened. The Committee heard that the obstetric service at the Peel Health Campus (PlHC), which delivers about 1,100 babies each year and is growing at 10% per annum, "is definitely running at capacity."[42] The Department of Health's SMAHS is reviewing the State's obstetric services

38 Department of Health, 'Review of Homebirths in Western Australia', August 2008. Available at: www.healthnetworks.health.wa.gov.au/publications/docs/11284_HOMEBIRTH.pdf. Accessed on 16 March 2010.

39 Commonwealth of Australia, 'Report of the Maternity Services Review', February 2009. Available at: www.healthyactive.gov.au/internet/main/publishing.nsf/Content/64A5ED5A5432C985CA25756000172578/$File/Improving%20Maternity%20Services%20in%20Australia%20-%20The%20Report%20of%20the%20Maternity%20Services%20Review.pdf. Accessed on 16 March 2010.

40 Commonwealth of Australia, 'Report on Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills', 1 February 2010. Available at: www.aph.gov.au/Senate/committee/clac_ctte/health_leg_midwives_nurse_practitioners_09_nov09/report/index.htm. Accessed on 16 March 2010.

41 Department of Health, 'Bentley Hospital'. Available at: www.kemh.health.wa.gov.au/having_a_baby_in_perth/bentley.htm. Accessed on 8 March 2010.

42 Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Transcript of Evidence*, 31 August 2009, p2.

beyond 2014 and this "may require a consolidation of services across six sites".[43] This may mean that obstetric services may no longer be provided by hospitals such as Armadale, Kaleeya or the PlHC.

In Perth there is a private maternity ward at St John of God Hospital in Subiaco which offers an 18 bed, high dependency, Level 2 nursery with facilities to care for 20 babies[44] and another private maternity ward operated by the Mercy Hospital.[45]

The majority of the births in the State are normal, however as a tertiary hospital, KEMH cares for the sickest women throughout their pregnancy and postnatal period. It also provides services for women who live near the hospital, and it has an eight-bed mother-baby unit on site for women suffering postpartum depression. These women can be admitted with their babies, on a voluntary or involuntary basis.

DOH's policy is to encourage women to have choice in how they have their babies delivered. The Committee heard that:

> *in many, many surveys women always say they want continuity of care from the care provider, be it obstetrician or midwife, and clearly we try to support that where possible. Of course, women want a good, safe outcome for the mother and the baby. They also want the care to be family focused. Women generally want to be supported in breastfeeding and postpartum.*[46]

While the maternity services at KEMH offer women a choice over whether to use their GP, a midwife or hospital staff for the delivery of their babies, this hospital also offers mothers the highest level of surgical specialists for:

> *what is called maternal foetal medicine, and that is very high level sub-specialist obstetricians who have done many years of training, and they will manage various complex medical situations such as twin- to-twin blood transfusions in utero, and they do a lot of interventional work. They might drain ascites from a foetus in utero, or give blood transfusions in utero. That is very complex work.*[47]

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43 Submission No. 33 from Department of Health, 18 August 2009, p6.

44 St John of God Subiaco, 'Neonatal Unit', 2008. Available at: www.sjog.org.au/portal/page?_pageid=422,72592&_dad=portal&_schema=PORTAL. Accessed on 8 March 2010.

45 Mercy Hospital, 'Family Birthing Unit', 2010. Available at: www.mercycare.com.au/hospital/hospital-services/family-birthing-unit/. Accessed on 8 March 2010.

46 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p2.

47 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p2.

(c) Screening and other programs

The WNHS offers a variety of screening programs for women. The BreastScreen WA program is the State component of the national breast cancer screening program that began in 1991. Women have a 1-in-11 risk of developing breast cancer and mammograms are performed to detect this cancer at an early stage. Women aged 40 years or over are eligible to have a free mammogram every two years, although the target age group is women aged 50–69 years.[48] Excluding non-melanoma skin cancer, breast cancer is the most common cancer affecting Australian women, with an incidence of 88.3 new cases per 100,000 in 2005. It is the second most common cause of cancer mortality behind lung cancer, with a mortality of 16.1 deaths per 100,000 women in 2006.[49]

Similarly, the State's Cervical Cancer Prevention Program (WACCPP) is part of the National Cervical Screening Program while the WNHS operates the Cervical Cytology Registry (CCR). The CCR compiles and maintains a confidential, computerised database of Pap smear, cervical biopsy and human papillomavirus (HPV) DNA test results for women screened in Western Australia, and:

- acts as a safety net by sending reminder letters when Pap smears and other cervical tests are overdue;
- assists in the follow-up of abnormal cervical test results;
- provides a comprehensive history of a woman's cervical test results to GPs and laboratories when requested; and
- provides feedback to laboratories about test results, to assist with quality control.[50]

Regular Pap smears every two years can help prevent up to 90% of the most common type of cervical cancer. The rate of Indigenous women who die from cervical cancer is much higher than that of non-Indigenous women.[51] It is now possible to be vaccinated against cervical cancer. Currently available vaccines protect against HPV types that account for up to 80% of cervical cancer cases and the majority of pre-cancerous cervical abnormalities. The Australian Government funds the cervical cancer vaccine for 12-13 year-old girls in the first year of secondary school,

48 Australian Institute of Health and Welfare, 'BreastScreen Australia monitoring report 2005-06', 26 August 2009. Available at: www.aihw.gov.au/publications/index.cfm/title/10784. Accessed on 8 March 2010.

49 Australian Institute of Health and Welfare, 'BreastScreen Australia monitoring report 2005-06', 26 August 2009. Available at: www.aihw.gov.au/publications/can/can-44-10784/can-44-10784.pdf, p2. Accessed on 8 March 2010.

50 Department of Health, 'CCR– the WA Cervical Cytology Registry', nd. Available at: www.health.wa.gov.au/cervical/ccr/index.cfm. Accessed on 8 March 2010.

51 Department of Health and Aging, 'Information for Health Professionals', 1 September 2006. Available at: www.health.gov.au/internet/screening/publishing.nsf/Content/professionals. Accessed on 8 March 2010.

while for women aged up to 45 years of age, the cervical cancer vaccine is available as a private script from GPs.[52]

Both breast and cervical cancer have met the World Health Organisation (WHO) criteria for approved population-based screening programs such as those carried out in Western Australia. However, a number of media articles in 2009 and early 2010 have raised doubts about the age at which women should commence to have mammograms and Pap smears, and how often they should have them. Some experts have cast doubt on the benefits of mammography, saying there were few differences in death rates between women who are screened and those who are not screened. However, a recent study of 80,000 Swedish and English women found that mammograms are effective and the lives saved is greater in absolute terms than the harm caused by any over-diagnosis.[53] New guidelines in the United States say women 30 years and older who have three consecutive Pap tests that were normal, and who have no history of seriously abnormal findings, can stretch the interval between screenings to three years. The American College of Obstetricians and Gynaecologists, who developed the new guidelines, felt it was safe to test women less often because cervical cancer grows slowly, so there is time to catch pre-cancerous growths.[54]

KEMH also serves as the major public referral centre in Western Australia for women with issues relating to menopause. Over 1,250 women are seen each year at its Menopause Service.[55] The State's Sexual Assault Resource Centre (SARC) is located at KEMH. It is a free 24 hour-7 days a week emergency service that offers assistance and support to any person aged 13 years and over who has experienced unwanted sexual contact or behaviour in the preceding two weeks. A free counselling service is also available (during business hours) to people who have experienced sexual assault or sexual abuse in the past (more than two weeks prior).[56]

Finally, KEMH provides programs for female drug addicts, with alcohol being the main substance of addiction. The Committee was told that KEMH is "one of the largest substance abuse clinics, I will call it, in Australia"[57] due to the number of patients affected by alcohol, cannabis and amphetamine use.

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52 CSL Biotherapies, 'Protect Yourself', nd. Available at: www.cervicalcancer.com.au/protect-yourself. Accessed on 8 March 2010.

53 Ms Jane Kirby, 'Study vindicates breast cancer screening', *The Independent Online*, 31 March 2010. Available at: www.independent.co.uk/life-style/health-and-families/health-news/study-vindicates-breast-cancer-screening-1931930.html. Accessed on 31 March 2010.

54 Ms Denise Grady, 'Guidelines Push Back Age for Cervical Cancer Tests', *NY Times Online*, 20 November 2009. Available at: www.nytimes.com/2009/11/20/health/20pap.html. Accessed on 8 March 2010.

55 Department of Health, 'The Menopause Service', nd. Available at: www.kemh.health.wa.gov.au/services/menopause/. Accessed on 8 March 2010.

56 Department of Health, 'Sexual Assault Resource Centre', nd. Available at: www.kemh.health.wa.gov.au/services/sarc/index.htm. Accessed on 8 March 2010.

57 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

(d) Reid Report recommendations

In terms of hospital services offered to women, the Committee heard that there has been a major departure from one of the key recommendations contained in the Reid Report:

> *we have probably strayed over the past few years from one of the recommendations of the Reid Report. The committee probably know that the Reid Report essentially recommended that the main women's hospital providing tertiary care should be co-located with the Princess Margaret Hospital for Children, and that both hospitals should be co- located to a tertiary hospital site.*[58]

The Government has indeed moved to re-locate Princess Margaret Hospital (PMH) to the QEII site by 2015,[59] but the Committee heard that KEMH would "not be relocating for some 10 to 15 years".[60] There are key medical and cost efficiency reasons for both the women's and children's tertiary hospitals to be co-located with an adult tertiary hospital, such as Sir Charles Gairdner Hospital (SCGH):

- Access to PMH- As well as its own 100-bed unit, KEMH operates a neonatal nursery for children less than 6-weeks-old at Princess Margaret Hospital. This is because PMH houses CAT and MRI scanners that are required in the event of emergencies during child birth. PMH is where the paediatric medical and surgical expertise is based. If, for example, a baby is born at KEMH with a congenital heart disease, then it needs to be transferred to Princess Margaret for corrective surgery. Both medical outcomes and family support options would be enhanced by sharing neonatal infrastructure and expertise across a co-located facility.

  KEMH and PMH had been one service under the same CEO before the Reid reforms placed KEMH into the NMAHS and PMH into the Child and Adolescent Health Service. Both hospitals work closely together, but miss certain synergies, particularly for mothers and children with mental health issues. Women with chronic mental health conditions during pregnancy are more likely to have significant difficulties in the postpartum period which, if not addressed, can have a major impact on the long-term mental health status of their child.[61]

- Access to SCGH- KEMH does not have access to critical care infrastructure, such as CAT and MRI scanners. Additionally it does not have interventional radiology to assist a

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58 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

59 Minister for Health, 'Planning for WA's new children's hospital begins', 21 February 2010. Available at: www.mediastatements.wa.gov.au/Pages/ByPortfolio.aspx?ItemId=133153&search=&admin=&minister=&portfolio=Health&region=. Accessed on 8 March 2010.

60 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p4.

61 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p7.

woman who starts to bleed—"it can sometimes come out of the blue; bleeding after a caesarean section, a D and C or a post-partum haemorrhage".[62] Every month KEMH sends 2-6 women by ambulance, in an emergency setting, to Sir Charles Gairdner Hospital where the interventional radiology infrastructure is available. Additionally, KEMH does not have an intensive care unit with dedicated medical officers on hand '24/7' which means additional travel to SCGH for very sick patients.

Finding 68

The Government has deviated from a key recommendation of the Reid Report by not proceeding to co-locate Princess Margaret Hospital and the King Edward Memorial Hospital at the QEII site. This has major medical implications for the treatment of the patients and their very young children.

(e) Clinical Services Frameworks

Table 9.1 below collates data from the Clinical Services Framework 2005-2015 and 2010-20 for obstetric and neonatal beds across the metropolitan and WACHS health services and data provided by DOH for existing bed numbers. The Committee was unable to compare the number of beds provided in CSF 2005 and CSF 2010 as both documents report these beds in different categories. However, it seems that CSF 2010 does provide for an increase by 2014-15 in metropolitan obstetric and neonatal beds over the existing number (560 versus 522). This could be due to a belated recognition by DOH of the higher birth rates experienced in Western Australia over the past five years since the publication of the CSF 2005, which used low population growth rates (see Chapter 4 above).

62 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

Table 9.1- Obstetric and neonatal beds in metropolitan hospitals, 2007-16[63]

Hospital	Beds 2007-09	CSF 2005 for 2015-16	CSF 2010 for 2014-15
State-wide Services			
KEMH*	266	210	271
Princess Margaret	25	0	25
TOTAL STATE-WIDE	**291**	**210**	**296**
SMAHS			
Fiona Stanley	0	27	48
Fremantle	25	0	0
Rockingham	14	20	26
Bentley	23	0	0
Armadale	30	23	36
Peel	17	N/A	11
TOTAL SMAHS#	**109**	**70**	**121**
NMAHS			
Swan	17	25	28
Osborne Park	35	0	25
Joondalup	35	30	53
TOTAL NMAHS	**87**	**55**	**106**
TOTAL BEDS	**487**	**335**	**523**

* Includes all beds at KEMH other than the paediatric ones.
# Does not include obstetric beds at Peel Hospital as these weren't reported in CSF 2005.

While the CSF 2010 seems to provide an increase in the overall obstetric and neonatal bed numbers for Perth, the Committee heard conflicting advice:

63 Department of Health, *WA Health Clinical Services Framework 2005-2015*, Government of WA, Perth, 2004, pp11c-11d and Department of Health, *WA Health Clinical Services Framework 2010-2020*, Government of WA, Perth, 2009, pp21-22.

> *we have enough physical beds in the system to cope with maternity services; it is a matter of actually accommodating women's need for choice and to make sure that our staffing is appropriate so that when things go wrong, we can escalate care appropriately, so that we get a good, safe outcome.*[64]

Table 9.1 above does not include data on obstetric beds in regional Western Australia provided by WACHS. The CSF 2010 provides information on the multi-day beds at the Regional Resource Centres (RRCs) and Integrated District Health Services (IDHS) which includes a wide range of services - medical/surgical, palliative, obstetrics, neonates, paediatrics, rehabilitation and non-APU mental health. The six RRCs offer Level 4 obstetric services, with Bunbury Hospital moving to Level 5 services by 2014-15. The 15 IDHS offer a variety of obstetric care, from basic Level 1 services at hospitals such as Moora, Merredin and Newman through to Level 3 services at Esperance, Derby and Busselton hospitals.[65]

While there seems to be an increase in projections for 2014-15 of metropolitan obstetric beds at the major hospitals between the CSF 2005 and CSF 2010, CSF 2010 also includes the retention of a small obstetric unit at Osborne Park Hospital, which was not going to be continued under the Reid Report's recommendations. This decision directly increases the costs to the DOH budget compared to following the recommendations of the Reid Report to close it.

As outlined in Chapter 4 above, the decision to retain the obstetric unit at Osborne Park Hospital was one made by the Liberal Party while it was in Opposition, and defended as a way of not increasing pressure on services at KEMH by adding another 1,500 births per annum to their workload. CSF 2010 indicates that the number of mental health or rehabilitation beds at Osborne Park will not be reduced to allow the retention of its 25-bed obstetric unit. The costs, therefore, of retaining this unit are an additional burden for the health budget.

The decision to retain the Osborne Park Hospital obstetric beds is unusual, especially given the 36 additional obstetric and neonatal beds to be added to the system in other hospitals by 2014-15, and the recent media reports over a recent poor medical outcome at this hospital. The Coroner made scathing criticism of Osborne Park Hospital's care of a 38-year-old mother, saying **a litany of errors** had led to her death and that "the case highlighted risks associated with the limited provision of senior medical staff at the metropolitan hospital."[66] DOH's efforts to comply with the Coroner's recommendations will further increase health costs at Osborne Park Hospital compared to moving this small unit to a larger hospital, as Reid had recommended and the CSF 2005 had endorsed.

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64 Dr Amanda Frazer, Executive Director, Women and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

65 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp23-24.

66 Ms Christiana Jones, 'Hospital 'failed' mother-of-four', *The West Australian*, 4 March 2010, p9.

Finding 69

The Government has deviated from a key recommendation of the Reid Report by not closing the small obstetric unit at Osborne Park Hospital.

(f) Country women's health

Country women have unique health challenges, although the WA Country Health Service web site seems to contain little information that would assist them. A regional seminar organised by the Department for Community Development identified some of these challenges that need addressing by the Government and the Department of Health:

- many women in regional areas are victims of verbal and emotional violence, and there is a lack of support services for victims (and perpetrators) of violence against women;
- a lack of female General Practitioners, often due to costly indemnity insurance that leads to doctors not offering obstetric and gynaecological practice;
- practitioners often lack sufficient cultural awareness when treating Indigenous and Muslim women;
- depression for rural women is exacerbated by their isolation from services and other community members; and
- there are no female Indigenous or Muslim mental health workers or counsellors in the region.[67]

(g) Conclusion

One of the difficulties in reviewing women's health services in Western Australia is that there is no specific reporting by DOH on its women's health services in either its annual budget or annual report. Therefore, it is difficult to assess over a period how the State is tracking in terms of women-specific programs and their outcomes.

[67] Department for Community Development, Katanning, 'Katanning Community Engagement Forum Report', 4 May 2004. Available at: www.community.wa.gov.au/NR/rdonlyres/197D7D79-2254-4B49-AB3A-CE49CF9E5795/0/DCDRPTOWPKATANNINGFORUMDRAFTREPORT.doc. Accessed on 17 March 2010.

Recommendation 34

The Department of Health provide an estimate in its annual report of the proportion of its budget that is spent on women's health services for the current financial year and the out-years.

9.2 Men's health

The Committee collected little evidence on men's health during this Inquiry but noted three similarities with women's health:

(i) the State does not have a men's health strategy;

(ii) a greater emphasis needs to be placed on preventative health programs relative to acute care services; and

(iii) there is a controversy over the usefulness of gender-specific screening tests; in this case the prostate specific antigen (PSA) test for men.

Western Australia does not have a stand-alone men's health policy but is participating in the development of the national approach launched by the Rudd Government in June 2008. As part of this policy, the Federal Government also expanded the National Bowel Cancer Screening Program at a cost of $87.4 million over three years as:

- Australian men have the second highest rate of bowel cancer in the world (after New Zealand);
- it is one of the most preventable cancers; and
- bowel cancer is the second most common cancer in Australian men, after prostate cancer.[68]

The health of Indigenous men is significantly worse than for any other group in Australia, with an average life expectancy of only 59 years –20 years less than non-Indigenous Australian males**.** DOH does have a focus on trying to bridge this gap between Indigenous and non-Indigenous men through programs run from its Office of Aboriginal Health.[69] While its budget for 2009-10 does not list separate expenditure items for Indigenous male health programs, it did report that a recommendation from the primary care key stakeholders' workshop titled 'Reducing the Gap: Improving the Quality of Indigenous Primary Care through Evidence and Experience' led to the

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68 Hon Ms Nicola Roxon, Minister for Health and Ageing, 'First Ever National Men's Health Policy', 8 June 2008. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr08-nr-nr094.htm. Accessed on 16 March 2010.

69 Department of Health, 'Programs and policy for Aboriginal men's health and wellbeing', nd. Available at: www.aboriginal.health.wa.gov.au/mens_health/programs.cfm. Accessed on 16 March 2010.

establishment of the Western Australian Aboriginal Primary Health Care Advisory Group. This Advisory Group has developed a work plan addressing four key issues for Indigenous people:

- increasing access to services;
- improved management of the interface between primary and tertiary care;
- better use of resources; and
- workforce design.[70]

(a) Primary health care for men

The WA Country Health Service utilises a unique health program called 'Pit Stop' to try and connect with men in rural and regional Western Australia. The reasons behind this program are:

- each hour, five men in Australia die from conditions that are potentially preventable;
- 50% of men in Australia are overweight, compared to one third of women;
- men are three times more likely to commit suicide than women;
- men live on average six years less than women; and
- in Australia in 2006, more than 48,000 men succumbed to diseases that may have been prevented by a trip to the doctor.[71]

The Committee heard evidence on the value of 'men's sheds' as a way of providing health information to men. These communal meeting places have been shown to be an ideal vehicle for improving men's social and emotional wellbeing, as well as being a suitable setting for providing primary health care, including health promotion activities.[72] Men's sheds offer an opportunity to reach men who might otherwise be unlikely to be involved in more formal active learning programs or men's health promotion programs. The Men's Resource Centre in Albany acts as a broker between the male residents of Albany and the many health agencies who wish to facilitate the delivery of primary health care services for men in the Great Southern.[73] There do not appear to be any men's health centres in Western Australia north of Geraldton.

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70 Department of Treasury and Finance, 'WA Health', nd. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p164. Accessed on 16 March 2010.

71 WA Country Health Service, 'Pit Stop', 2006. Available at: www.health.wa.gov.au/health_index/m/mens_health.cfm. Accessed on 16 March 2010.

72 MensSheds, 'National Men's Health Policy', 2009. Available at: www.mensheds.com.au/index.php?id=nationalhealth. Accessed on 16 March 2010.

73 Mr Andrew Markovs, Manager, Men's Resource Centre, *Transcript of Evidence*, 11 September 2009, p13.

Each year in Australia around 20,000 new cases of prostate cancer are diagnosed and about 3,300 men die from this disease (similar to the number of women who die annually from breast cancer). Men in rural and regional Australia have a 21% higher prostate cancer mortality rate than men in capital cities.[74] Just as there is some controversy about the value of aspects of women's screening programs, so debate has emerged over the merit of the prostate specific antigen (PSA) test for screening men. Two large medical trials have not clarified the argument over the PSA test. One showed a 20% reduction in the chances of dying of prostate cancer in screened men over 10 years. But 10,000 men had to be screened for seven lives to be saved. Of those men found to have prostate cancer, nearly 50 had to have a radical prostatectomy for one man's life to be saved.[75] An American study showed that over a period of 7 to 10 years, screening did not reduce the death rate in men aged 55 years and over. The most recent controversy has been sparked by the founder of the PSA, Dr Richard Ablin, who now describes the test as "hardly more effective than a coin toss" because:

> *men have a 16% lifetime chance of receiving a diagnosis of prostate cancer, but only a 3% chance of dying from it. That's because the majority of prostate cancers grow slowly. In other words, men lucky enough to reach old age are much more likely to die with prostate cancer than to die of it.*[76]

Finding 70

Neither the State nor Federal Governments currently have a men's health strategy.

Finding 71

There are limited men's health centres in regional Western Australia, especially in the Pilbara and Kimberley.

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74 Prostate Cancer Foundation of Australia, 'Prostate Cancer Statistics', 2010. Available at: www.prostate.org.au/articleLive/pages/Prostate-Cancer-Statistics.html. Accessed on 16 March 2010.

75 Dr Norman Swann, 'How effective is PSA testing?', ABC Online, 6 April 2009. Available at: www.abc.net.au/health/minutes/stories/2009/04/06/2532189.htm. Accessed on 16 March 2010.

76 Dr Richard Ablin, New York Times, 'The Great Prostate Mistake', 9 March 2010. Available at: www.nytimes.com/2010/03/10/opinion/10Ablin.html?src=me&ref=general. Accessed on 16 March 2010.

Recommendation 35

The Government should increase its resources for men's preventative health programs, especially those aimed at men in rural regions of the State.

CHAPTER 10 *BY NOT ACTING, WE ARE KILLING PEOPLE*[77]- PRIMARY & PREVENTATIVE HEALTH PROGRAMS

10.1 Introduction

This chapter focuses on preventative and primary health issues and is a key one because:

- the importance of the proper provision of these programs was acknowledged by the Health Reform Commission by including it as the first chapter of the Reid Report;
- Western Australia's budget for these programs is less than 3% of the total health budget; and
- the additional funds needed to make dramatic inroads into chronic illness rates in this State is small compared to the new funds being spent on new hospital infrastructure.

Australia has one of the highest life expectancy rates of any country. Despite this many Australians suffer from chronic illness, such as diabetes, heart disease, cancer and arthritis. These diseases are estimated to be responsible for nearly 80% of the total burden of disease and injury in Australia, and more than 66% of all health expenditure. Diabetes and heart disease alone cost the Australian health system more than $6 billion per annum.[78] According to DOH:

- in 2006, 64% of Western Australian deaths of people aged under 75 years were potentially avoidable;
- in 2006-07, about 8% of hospitalisations could have been prevented; and
- between 1997–2006, 43% of deaths among Indigenous Western Australians aged under 45 years were avoidable, and considerably higher than the 18% rate for their non-Indigenous counterparts.[79]

While considered a healthy country by world standards, about 20% of the nation's illnesses stem from chronic disease associated with just obesity, tobacco and excessive consumption of alcohol. Australia has a significantly higher rate of hospitalisation than comparable countries – double that

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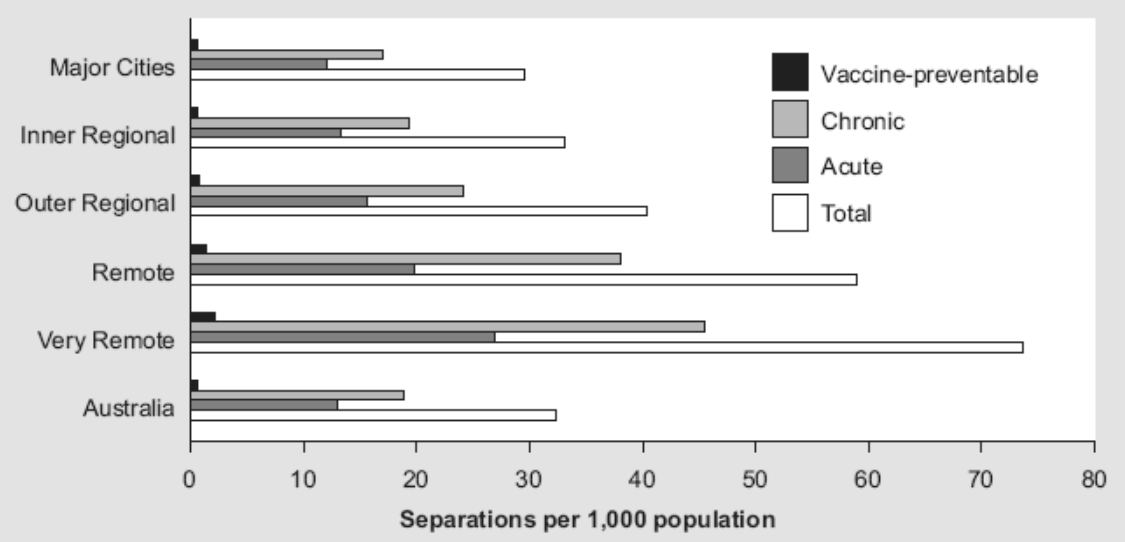
77 Hon Ms Nicola Roxon, MP, Minister for Health and Ageing, 'Fat chance – in pursuit of a healthier nation', 14 September 2009. Available at: http://education.theage.com.au/cmspage.php?intid=135&intversion=287. Accessed on 25 March 2010.

78 Department of Health, 'Australian Better Health Initiative- Background', nd. Available at: www.healthnetworks.health.wa.gov.au/abhi/home/background.cfm/. Accessed on 25 March 2010.

79 Dr Tarun Weeramanthri, *et al*, 'Western Australian Chief Health Officer's Report 2010', March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_chief_health_officers_report_2010.pdf, pviii. Accessed on 25 March 2010.

of Canada and significantly higher than the United States, the UK and New Zealand. It is estimated that in 2009, some 441,000 potentially preventable hospitalisations (PPHs) (or about 10%) could have been avoided through providing better care in the community.[80] Separation rates for PPHs were highest in very remote regions, with rates almost 2.3 times the national average see Figure 10.1). Rates consistently dropped as isolation from major cities decreased, and were lowest in the major cities. Rates also varied between categories of socio-economic status. Separation rates for PPHs in the most disadvantaged areas were 64% higher than those of the most affluent areas (see Table 10.1 below). Western Australia had one of the highest PPH rates of any jurisdiction, at 46%, higher than the national average.[81]

Figure 10.1- Separation rates for potentially preventable hospitalisations by remoteness, 2005–06



80 Hon Nicola Roxon, MP, Minister for Health and Ageing, 'Five Million Extra GP Services', 17 March 2010. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr052.htm. Accessed on 27 March 2010.

81 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, p335. Accessed on 29 March 2010.

Table 10.1- Separation statistics for potentially preventable hospitalisations (PPHs) by quintile of socio-economic advantage/disadvantage, 2005–06[82]

	Most disadvantaged	Second most disadvantaged	Middle quintile	Second most advantaged	Most advantaged
PPHs - Acute conditions	4.0%	3.8%	3.7%	3.5%	3.2%
PPHs - Chronic conditions	6.9%	6.0%	5.7%	4.9%	3.7%
Total PPHs	**11.1%**	**10.0%**	**9.5%**	**8.5%**	**7.1%**

The mounting social and economic costs of such preventable diseases have prompted a different approach to the problem by the Federal Government, away from the traditional notion of curing diseases in an acute hospital setting and towards preventing them occurring. The Federal Government believes prevention programs, used successfully in Australia in anti-smoking, road safety and HIV/AIDS campaigns, now have a serious role to play in health. At the September 2009 launch of the National Preventative Health Taskforce's report *Australia: the Healthiest Country by 2020- National Preventative Health Strategy- the roadmap for action*, the Federal Minister for Health and Ageing said "By not acting, we are killing people."[83] The need for more government-funded preventative health programs is particularly urgent for Indigenous Western Australians, with the Committee being told that if Indigenous smoking rates were at the same levels as the rest of the community, the life expectancy gap would drop by about four years from this one measure.[84]

The difficulty faced by governments in this policy area is clearly displayed in the case of obesity. State and Federal governments have done little in the face of dramatic changes to eating and exercise habits, leaving eating habits in the hands of 'the market'. Now they are facing the enormous costs of this neglect, such as providing lap-band surgery in expensive public hospitals systems for obese patients.

As another example of the costs from these chronic conditions, in light of the growing rate of obesity in WA, planners at the new Fiona Stanley Hospital are making adjustments such as purchasing hospital beds for obese patients that cost $37,000 compared to about $4,000 for a

82 Australian Institute of Health and Welfare, 'Australian Hospital Statistics 2005–06', May 2007. Available at: www.aihw.gov.au/publications/hse/ahs05-06/ahs05-06.pdf, pp339-343. Accessed on 29 March 2010.

83 Hon Ms Nicola Roxon, MP, Minister for Health and Ageing. See quote in 'Fat chance – in pursuit of a healthier nation', 14 September 2009. Available at: http://education.theage.com.au/cmspage.php?intid=135&intversion=287. Accessed on 25 March 2010.

84 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p6.

normal hospital bed.[85] The National Preventative Health Taskforce predicts that if nothing changes, by 2025 nearly 75% of Australia's adult population will be overweight or obese. This chapter summarises these important challenges for the State Government and the need for an urgent injection of new funds into preventative health programs.

10.2 The need for reform in Western Australia

The Committee was told the "record in this state in public health is very, very good. The first State legislation on public health was in 1842"[86] and a vaccine program was introduced to eradicate smallpox in 1878.[87] Even so, the need for further government efforts on primary and preventative health care was clearly explained six years ago in the Reid Report:

> *Much of the demand for hospital services is for conditions that are clearly preventable with appropriate health promotion and prevention strategies. Substantial investment in these strategies is warranted and necessary.*[88]

The importance of the proper provision of primary and preventative health programs to the State's health system was acknowledged by the Health Reform Commission by including it in the second chapter of the Reid Report. This chapter included 18 recommendations to government, five of which dealt with primary and preventative health issues. The Reid Report clearly documented that 50% of cancers, 75% of cardiovascular disease and 90% of type 2 diabetes can be prevented.[89] The then-Health Minister, Hon Jim McGinty, told Parliament:

> *I hope that when we all look back in five or 10 years at the health system, there will be two big things that we will be able to say were dramatic changes from what was the situation at the turn of the century. … The second will be the tremendous emphasis away from hospitals as the way in which people are treated to more ambulatory care in the community. … keeping people healthy in the community. We are making a very big investment as a means of shifting resources away from hospital based care. I think we are too hospital-centric in the way in which we approach health care.*[90]

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85 Mr Joe Spagnolo and Mr Anthony Deceglie, 'Big fat bill for hospital', *The Sunday Times*, 28 March 2010, p7.

86 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p3.

87 Department of Health, 'Western Australian Chief Health Officer's Report 2010', March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_chief_health_officers_report_2010.pdf, p1. Accessed on 25 March 2010.

88 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

89 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p23.

90 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), 24 May 2006, pE307.

Finding 72

The Reid Report provides clear evidence from the Western Australian health system of the potential for large reductions in the number of patient presentations to the State's hospitals if the Government was to increase funding for long-term preventative health programs.

The Reid Report did caution, though, that "public health systems have traditionally ranked their priorities in favour of hospital and other intervention services to the detriment of prevention, promotion and early intervention programs."[91] This has indeed been the case since the Reid Report was published. Both the previous and current Governments have failed to increase the budget for the State's preventative health programs despite both agreeing with these recommendations.

The Committee was told that the budget allocation in 2007-08 for all public health programs (not just preventative health programs) was 2.6% of the total recurrent health expenditure.[92] This figure of 2.6% over-estimates the State's actual allocation to preventing future chronic disease in Western Australians. In DOH's 2009-10 budget, only $9.3 million is allocated for the year for all programs addressing chronic disease and health promotion. The allocation for the whole Public Health Division is $81.8 million, or 1.5% of the health budget. Other PHD programs include:

- Communicable Disease Control- $47.4 million;
- Environmental Health- $10.5 million;
- Disaster Management, Regulation and Planning- $7.0 million;
- Public Health Intelligence- $2.8 million; and
- Genomics- $1.7 million.[93]

Finding 73

The Government allocated only $9.3 million in the 2009-10 health budget to programs addressing chronic disease and health promotion.

Traditionally the allocation for these programs was incorporated into DOH's budget item 'Service 8- Prevention and promotion services'. The Barnett Government combined the preventative health

91 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p23.

92 Dr Peter Flett, Director General, Department of Health, *Reply to Questions on Notice*, 3 November 2009, p2.

93 Dr Peter Flett, Director General, Department of Health, *Reply to Questions on Notice*, 10 November 2009, p2.

services allocation with the health protection services (Service 9) in the 2009-10 Budget, making it difficult to compare the performances of both governments. Appendix Nine provides details on these two services and the budget and staff which are now being reported as one service. The additional staff and budget allocation in 2009-10 seems to have been allocated to protection programs (such as vaccination) rather than preventative ones.

In its last budget in 2008-09, the Carpenter Government increased the overall health allocation by 8.9% from actual expenditure in 2007-08, but increased funding for prevention and promotion services by just 4.1%. Over the five-year period since the launch of the Reid Report, the Gallop and the Carpenter Governments increased the overall health appropriation by 39.7%, but increased the funding for prevention and promotion services by just one-third of this, at 14.1%.[94]

Compared to the estimated actual figures expended in 2008-09, in its first budget the current Government:

- increased the overall government expenses by 6.6%;
- increased overall health appropriation by 8.3%; and
- increased the services costs for prevention and promotion programs by 8.2%.[95]

Finding 74

Since the publication of the Reid Report in 2004, and its summary of the clear economic benefits to the State health system from a greater focus on preventative health programs, all State governments have increased funding for these programs at a lower rate than the acute health services.

94 See Department of Treasury and Finance, 'WA Health', 11 May 2006. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2006_-_2007/bp2_vol2.pdf?n=2279, p542 and Department of Treasury and Finance, 'WA Health', 8 May 2008. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2008_-_2009/bp2_v2.pdf?n=2721, p560. Accessed on 29 March 2010.

95 Department of Treasury and Finance, 'WA Health', 14 May 2009. Available at: http://www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, pp,161,174. Accessed on 29 March 2010.

The reason behind this focus on acute rather than community health care programs was articulated by Professor D'Arcy Holman:

> *There is a longstanding principle—it existed long before I was born and even before the generation before me was born—in the world of public health that you cannot satisfactorily run a service that has the dual responsibility on the ground level to provide both reactive health services and proactive health services. The reactive health services will always command the resources, the attention and the spotlight to the detriment of the need for the more proactive side.*
>
> *I think that history shows that any move in that direction will always lead to a lack of attention to the proactive aspects of early intervention and prevention, which will take second place to the needs of providing for the acute-care needs of the population. It is completely understandable. It is not some sort of mysterious bit of alchemy; it is just human nature that where the noise is—where the demand is expressed and manifest in front of your very eyes, so to speak—will always command the attention.*[96]

In a similar vein, the Committee heard from the Heart Foundation that:

> *the Minister for Health never receives a telephone call from a member of the community thanking him for the heart attack that she or he did not have. It just does not work like that. Whereas, if your father has a heart attack tonight and you cannot get into Royal Perth within what you think is an acceptable period of time, you will be on the blower within minutes saying, "What the hell is going on?" No-one rings the Minister for Health saying, "You know, that Quit campaign that you got going back in 1983, I quit smoking in the first year of that campaign. You know, I'm 70 now. I'm really grateful for having given up smoking because I understand that it reduces my risk of a whole raft of nasty diseases." That is the difference in the two areas.*[97]

There is a similar low level of expenditure on preventative health programs in other Australian jurisdictions' health budgets despite the rising tide of severe chronic health challenges, such as obesity. In terms of Western Australia's programs, the Committee heard that "Our public health system stands up very well in interstate comparisons. We have strong public health leadership."[98] This area just lacks the funding to produce long-term savings to the State's health system that have been outlined by the Reid Report, amongst others.

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96 Professor D'Arcy Holman, Chair in Public Health, University of Western Australia, *Transcript of Evidence*, 26 August 2009, pp3-4.

97 Mr Maurice Swanson, Chief Executive Officer, National Heart Foundation, *Transcript of Evidence*, 31 August 2009, p9.

98 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p2.

10.3 The main challenges

The National Preventative Health Strategy says that 32% of Australia's total burden of disease can be attributable to risk factors that can be modified. It provides data which shows that the main preventable risk factors are:

- obesity- 7% of total health burden;
- smoking- 7% of total health burden; and
- alcohol- 3% of total health burden.[99]

Since the release of this report, new data shows that obesity has now overtaken smoking as the main risk factor influencing disease. It now contributes to 8.7% of all disease while tobacco has dropped to 6.5%.[100] The other main risk factors include high blood pressure, physical inactivity, cholesterol and low intake of fruit and vegetables. The impact of these risk factors is particularly hard on children, with the National Preventative Health Taskforce (NPHT) reporting:

- about 25% of Australian children (600,000) are overweight or obese;
- nearly 33% of children do not meet the national physical activity guidelines; and
- only 20% of 4-8 year-olds and 5% of 14-16 year-olds meet dietary guidelines for vegetable intake.[101]

The World Health Organisation (WHO) has called the rise in obesity rates a 'global epidemic'. The Australian Institute of Health and Welfare (AIHW) has found that Australian men aged 45-64 years have the highest average body mass index (BMI), with a weight loss of 8 kg required to bring them into the 'healthy' category. People aged 75 years and over have the least weight to lose, with a loss of 0.4 kg enough to bring them into the healthy range. The prevalence of overweight and obesity has increased across all age groups from 1995 to 2004-05. The most marked increases were among those aged 25-44 years and 75 years and over, where rates increased by over 10% over that period. ABS results from 2004-05 for adults aged 18 years and over show that people in the most socio-economically disadvantaged 20% of the population had the highest rates of

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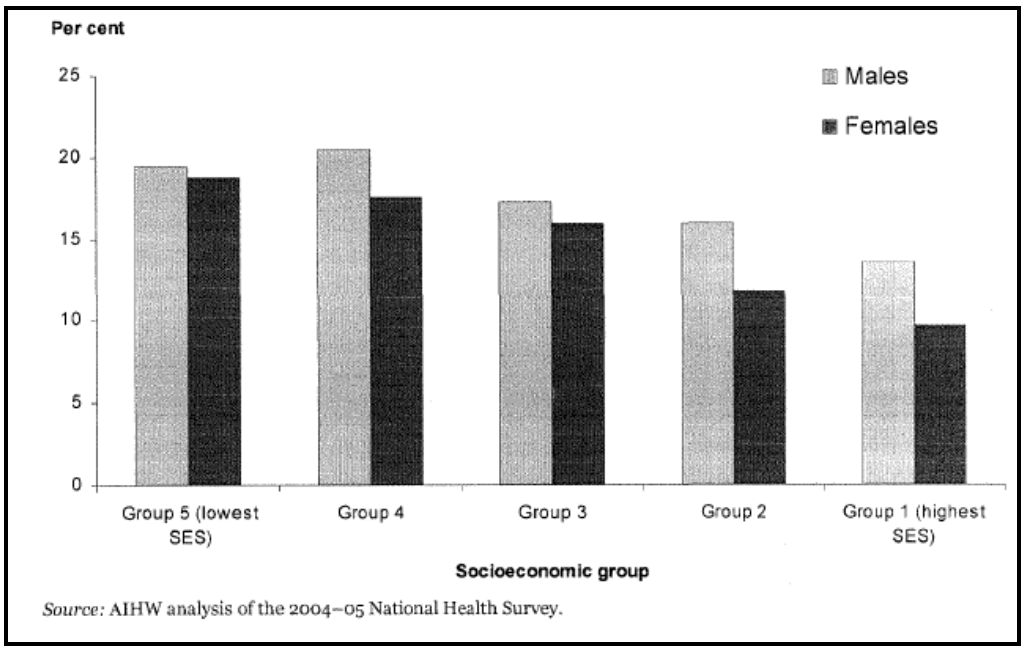
99 National Preventative Health Taskforce, *Australia: the Healthiest Country by 2020- National Preventative Health Strategy- the roadmap for action*, Commonwealth of Australia, Canberra, 2009, p7.

100 Ms Amy Corderoy, 'Obesity is now more deadly than smoking', 9 April 2010. Available at: www.smh.com.au/lifestyle/wellbeing/obesity-is-now-more-deadly-than-smoking-20100408-rv5l.html. Accessed on 19 April 2010.

101 National Preventative Health Taskforce, *Australia: the Healthiest Country by 2020- National Preventative Health Strategy- the roadmap for action*, Commonwealth of Australia, Canberra, 2009, p7.

overweight and obesity (see Figure 10.2). For them, 50% were overweight or obese, compared with 45% of adults in the wealthiest 20% of the population.[102]

Figure 10.2- Rates of obesity and overweight by socio-economic group, 2004-05



Due to lifestyle changes over the past two decades (such as a greater consumption of take-away foods and sugar-based soft drinks), Western Australian children are now at risk of developing new chronic diseases, such as type 2 diabetes. This preventable disease is often associated with people in their 60s and 70s but figures now reveal that it is an ever-increasing health issue for people aged in their 20s and 30s.

As outlined in Chapter 12, the highest rates in the world for diabetes are in Western Australia's Central and Western Desert regions. Incredibly, a recent pilot study in the Western Desert indicated that young people are showing signs that the next generation of Indigenous Western Australians will have even higher rates of diabetes than the present generation of Indigenous adults. This study found 33% of primary school and early high school-aged children had signs of proteinuria, the presence of an excess of serum proteins in the urine, which is a reliable sign of likely kidney damage. Western Australia and other jurisdictions are slowly responding to these health threats, especially in light of the costs associated with their treatment.

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102 Australian Institute of Health and Welfare, 'Submission to House of Representatives Standing Committee on Health and Ageing- Inquiry into obesity in Australia', May 2008. Available at: www.aph.gov.au/House/committee/haa/obesity/subs/sub010.pdf, pp2-3. Accessed on 25 March 2010.

Finding 75

Some of the most severe physical costs from the main chronic illnesses will be faced by Western Australia's future generations. Effective preventative health programs aimed at children may deliver the largest cost savings to the State's health system.

In early 2010 Western Australia's Chief Health Officer released a report that outlines many of the challenges that can be addressed by preventative health programs. Some of the report's key information is included in Figures 10.3, 10.4 and 10.5 below.[103]

Figure 10.3- Leading causes of avoidable mortality by gender for Western Australians aged 0-74 years, 1997-2006

	Males				Females		
	Condition	Deaths	Per cent		Condition	Deaths	Per cent
1	Ischaemic heart disease	4,770	15.8	1	Ischaemic heart disease	1,547	8.8
2	Lung cancer	2,543	8.4	2	Breast cancer (Females only)	1,524	8.7
3	Suicide and self-inflicted injuries	1,818	6.0	3	Lung cancer	1,240	7.1
4	Colorectal cancer	1,329	4.4	4	Colorectal cancer	804	4.6
5	Cerebrovascular diseases	1,028	3.4	5	Cerebrovascular disease	776	4.4
6	COPD	870	2.9	6	Diabetes	511	2.9
7	Diabetes	728	2.4	7	COPD	496	2.8
8	Alcohol-related diseases	640	2.1	8	Suicide and self-inflicted injuries	495	2.8
9	Accidental poisoning	454	1.5	9	Birth defects	281	1.6
10	Stomach cancer	433	1.4	10	Selected invasive bacterial and protozoal infections	251	1.4
	Total Avoidable Mortality	**19,793**	**65.5**		**Total Avoidable Mortality**	**10,891**	**62.1**
	Total Mortality under 75 yrs	**30,207**	**100**		**Total Mortality under 75 yrs**	**17,534**	**100**

[103] Department of Health, 'The Western Australian Chief Health Officer's Report 2010', March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_chief_health_officers_report_2010.pdf. Accessed on 29 March 2010.

Figure 10.4- Leading causes of avoidable mortality by Indigenous status for Western Australians aged 0-74 years, 1997-2006

	Non-Indigenous				Indigenous		
	Condition	Deaths	Per cent		Condition	Deaths	Per cent
1	Ischaemic heart disease	5,612	12.8	1	Ischaemic heart disease	408	11.6
2	Lung cancer	3,537	8.1	2	Diabetes	273	7.7
3	Suicide and self-inflicted injuries	2,034	4.7	3	Alcohol-related diseases	162	4.6
4	Colorectal cancer	2,034	4.7	4	Suicide and self-inflicted injuries	139	3.9
5	Cerebrovascular diseases	1,603	3.7	5	Cerebrovascular disease	132	3.7
6	Breast cancer (Females only)	1,444	3.3	6	Selected invasive bacterial and protozoal infections	118	3.3
7	COPD	1,254	2.9	7	Lung cancer	81	2.3
8	Diabetes	911	2.1	8	Birth defects	78	2.2
9	Melanoma of skin	631	1.4	9	COPD	73	2.1
10	Alcohol-related disease	624	1.4	10	Road traffic injuries other transport injuries	70	2.0
	Total Avoidable Mortality	**27,152**	**62.1**		**Total Avoidable Mortality**	**2,186**	**62.0**
	Total Mortality under 75 yrs	**43,741**	**100**		**Total Mortality under 75 yrs**	**3,524**	**100**

Figure 10.5- Number of potential preventable hospitalisations in Western Australia, 2006-07

PPH condition	No. hospitalisations	Percent
Diabetes and its complications (excluding renal dialysis)	14,177	1.9
Dental conditions	7,252	1.0
Dehydration and gastroenteritis	4,550	0.6
COPD	4,549	0.6
Pyelonephritis	4,447	0.6
Congestive heart failure	3,846	0.5
Ear, nose and throat infections	3,097	0.4
Epilepsy	2,880	0.4
Iron deficiency anaemia	2,875	0.4
Asthma	2,862	0.4
Cellulitis	1,454	0.2
Influenza and pneumonia	840	0.1
Angina	695	0.1
Perforated/bleeding ulcer	562	0.1
Gangrene	501	0.1
Pelvic inflammatory disease	477	0.1
Appendicitis	447	0.1
Hypertensions	424	0.1
Rheumatic heart disease	251	0.0
Other vaccine preventable conditions	235	0.0
Nutritional deficiencies	26	0.0
Total PPH Hospitalisations	**56,447**	**7.7**
Total Hospitalisations in 2006/07	**735,620**	**100.0**

(a) Programs in other jurisdictions

In 2006, the Australian state and territory governments established a four year program called the 'Australian Better Health Initiative' (ABHI) which "aims to reduce the prevalence of risk factors for chronic disease".[104] The Australian Government contributed $250 million nationally over four years to the ABHI and the Western Australian Government contributed $25 million for state-based activities. The ABHI launched 'Measure Up' a social marketing campaign in October 2008, which included $30 million for advertising on TV, print and radio, as well as a website and brochures and other information provided throughout the community.[105] An evaluation of this program found that both the primary (25-49 year-olds) and secondary (45-65 year-olds) audiences showed

104 Department of Health, 'Australian Better Health Initiative', nd. Available at: www.healthnetworks.health.wa.gov.au/abhi/home/. Accessed on 25 March 2010.

105 Australian Better Health Initiative, 'Measure Up', 5 February, 2010. Available at: www.measureup.gov.au/internet/abhi/publishing.nsf. Accessed on 25 March 2010.

similar increases with regards to knowledge of the dangers of being overweight, but there seemed to be little change to personal activities to address this problem.[106]

In total the Federal Government has spent over $870 million as part of the COAG process on preventable health issues. Most recently it offered, as part of its proposal for a National Health and Hospitals Network, to invest $436 million to improve the health outcomes for the nearly one million Australians living with diabetes –many of whom end up being treated in hospitals. In 2007-08, around 237,000 hospital admissions were related to complications from diabetes that could have been avoided through better management. This is 32% of all avoidable hospital admissions.[107]

Last year the Federal Government responded to the release of *Australia: the Healthiest Country by 2020* by legislating for the establishment of a new Australian National Preventative Health Agency (ANPHA). The legislation is currently stalled in the Senate by the Opposition, despite enthusiastic support for it by many health organisations, including the AMA.[108] The ANPHA's role will be to facilitate best practice in the delivery of preventable health programs and activities. The CEO will be responsible for working with all Australian health ministers in their own efforts to combat preventable diseases. The Federal Government will provide $133 million over four years to the ANPHA to establish the agency, and provide for some social marketing campaigns, if the legislation is agreed to in the Senate.[109]

Recommendation 36

The Premier request all Western Australian Senators to support the legislation to establish the new Australian National Preventative Health Agency.

As an example for Western Australia to consider, the Queensland Government has recently established targets for a 33% reduction in the main preventable diseases, including melanoma, by

106 Australian Better Health Initiative, 'Australian Better Health Initiative Phase I - Campaign Evaluation', July 2009. Available at: www.measureup.gov.au/internet/abhi/publishing.nsf/Content/4F930B8BEB932DEFCA257630007D6B18/$File/phase1-evaluation-research-1.pdf, pp7-14. Accessed on 25 March 2010.

107 Hon Ms Nicola Roxon, Minister for Health and Ageing, '$436 Million To Take Pressure Off Our Hospitals By Delivering Personalised Care For Diabetics', 31 March 2010. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr057.htm. Accessed on 31 March 2010.

108 Australian Medical Association, 'AMA urges Senate to pass Preventative Health Agency Bill', 27 October 2009. Available at: www.ama.com.au/node/5078. Accessed on 25 March 2010.

109 Ms Julie Collins, MP, House of Representatives, *Parliamentary Debates* (Hansard), 22 October 2009, p10806.

2020. Surveys over a weekend in the summer of 2008 found 13% of adult Queenslanders suffering sunburn.[110] A similar rate could be expected in Western Australia.

The lack of a similar targets in Western Australia, and specific key performance indicators (KPIs) on preventable health outcomes for the Department of Health, was raised as a major weakness of the State's health system by Professor Daube, the Deputy Chair of the National Preventative Health Taskforce.[111] DOH's annual reports are comprehensive in terms of measuring the cost of specific medical interventions and patient stays in hospital, but have few measures on keeping Western Australians out of hospital.

The State Budget includes KPIs for the DOH applicable to prevention, promotion and protection. However, DOH's annual reports mainly provide measures such as the percentage of children who are immunised or have mumps, and the cost per capita of programs such as breast screening or DOH's population health units.[112] This is important data to collect but more needs to be done in terms of setting and meeting targets for the reduction of the major risk factors identified above.

Finding 76

Currently the Department of Health does not publish in its annual report a clear set of key performance indicators, and its performance in meeting them, for the main chronic disease challenges faced by Western Australians.

Recommendation 37

The Department of Health should publish in its annual report a clear set of key performance indicators, and its performance in meeting them, for the main chronic disease challenges faced by Western Australians.

110 Government of Queensland, '2020 Target: Cut obesity, smoking, heavy drinking and unsafe sun exposure by one third', 23 February 2010. Available at: www.towardq2.com.au/tomorrow/health/preventable_diseases.aspx. Accessed on 25 March 2010.

111 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, Transcript of Evidence, 14 October 2009, p3.

112 Department of Health, 'Metropolitan Health Service Annual Report 2008-09', nd. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, pp65-66 and 'WA Country Health Service Annual Report 2008-09', nd. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, pp46-48. Accessed on 25 March 2010.

(b) What needs to be done in Western Australia?

In 2004 the Reid Report clearly identified that an improvement in future health outcomes (and a lower growth rate in health spending) would be provided by "the quarantining of a limited, but significant, amount of funding … to support this shift in priorities."[113] The Committee was advised that, as a start, the State's health budget for preventable programs should be increased by 50% over a 2-year period, and accounted for separately by DOH in its annual report.[114] This proposal for a separate fund was supported by Professor Holman, "as long as that budget was separate and, of course, had a senior official who was ultimately responsible for that, with all the supports around that individual."[115] The quarantining of public health funding in DOH was also seen by the Heart Foundation as an essential step to ensure the effectiveness of the funding.[116]

Another proposal put before the Committee was to re-establish a research function within DOH to ensure that the Department had the most up-to-date data on population epidemiology. Such a 'public health intelligence group' would build on earlier public health research which saw Western Australia as a world-leader, and would follow a model used in some UK and European health departments.[117] This group could also include other sections from DOH, such as women's screening programs, and the food health section now contained in the Department of Environment.

Recommendation 38

The Government must urgently increase the Department of Health's budget for health prevention, promotion and protection programs. It must aim to double the budget for these programs by the end of 2012 from $9.3 million to $19 million, with a further doubling by the end of 2015.

These funds should continue to be listed as separate line items in future health budgets.

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113 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p23.

114 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, Transcript of Evidence, 14 October 2009, p3.

115 Professor D'Arcy Holman, Chair in Public Health, University of Western Australia, *Transcript of Evidence*, 26 August 2009, p6.

116 Mr Maurice Swanson, Chief Executive Officer, National Heart Foundation, *Transcript of Evidence*, 31 August 2009, p11.

117 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, Transcript of Evidence, 14 October 2009, p3.

Recommendation 39

The Department of Health should establish a health research centre, with collaboration from universities, other government departments and the private sector, to ensure that the Department has the most up-to-date data on population epidemiology and the challenges posed by chronic diseases.

This research centre should have the capability to track the long-term savings accruing from the State's investment in preventative health and promotion programs.

The Reid Report's recommendations on new structures to handle the State's public health programs led to a 'Review of Public Health' in 2007 by George Rubin and Anne Marie Thow.[118] This review looked at the main changes effected by DOH, which were the transfer of almost all of the North Metropolitan public health unit (PHU) staff to Child and Adolescent Health Services (CAHS), and the separation of central health promotion and Aboriginal health from other central public health functions in the Department of Health. These changes created a perception that public health services were uncoordinated and patchy, and lacked vision and clear accountability mechanisms. The main issues the report identified were a lack of senior public health leadership and fragmentation of public health functions. It found that public health staff reported low morale and reorganisation fatigue and that:

> *fragmentation of function had resulted in little formal communication between central components of public health, inconsistent public health service provision between Area Health Services (AHS), confused lines of accountability and lack of structure for communication/ accountability between Central and AHS staff.*[119]

The recommendations in the Committee's Report, if accepted by the Government, should address many of these issues raised by Rubin and Thow.

A completely different paradigm was needed in public health services compared to hospital-based ones. Professor Holman explained:

> *In a reactive* [hospital] *health service, the focus on the ground is very much on the therapeutic relationship: the relationship between, these days, a team of health care providers and a patient of some sort who has various needs. That tends to, I guess, lead to an approach to administration that is very much about trying to get people through the door, meeting some type of quality, fixing them up and putting them back out in the community again—hopefully in better shape than when they came in.*

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118 Professor George Rubin and Ms Anne Marie Thow, *Review of Public Health in Perth, West Australia*, Department of Health, Perth, May 2007, p36.

119 Professor George Rubin and Ms Anne Marie Thow, *Review of Public Health in Perth, West Australia*, Department of Health, Perth, May 2007, p36.

> *In a proactive* [public] *health service, the focus needs to be very much at the population level. So often, the most important people are the ones who are not turning up to your front door. Accordingly, we need to have, firstly, a totally different sense of caseload and information systems; we need to be constantly aware of how you can get information about the people that we are not seeing so that we can understand where the real problems are; and then we need to know how we can mount outreach and other ways of referral or of making contact with those in need—even when the people who actually need these services do not realise or recognise that someone could assist them. That requires a totally different administrative style.*[120]

The Committee heard from Professor Daube that there was an enormous opportunity for prevention activities outside of the health portfolio—such as in education, planning, transport, Indigenous health, local government and sport and recreation, agriculture, and training. Such a whole-of-government approach was being taken by the South Australian government under its 'Health in All Policies' (HiAP) framework.[121] For example, the South Australian Government has created a 'Health in All Planning Officer' position in the Department of Planning and Local Government in order to promote better health through urban planning in South Australia.[122]

Recommendation 40

The Minister for Health should obtain Cabinet approval for a 'Health in all Policies' project in Western Australia as part of the State's strategy to contain health costs.

10.4 Primary health care

Primary health care (PHC) incorporates personal care with health promotion, the prevention of illness and community development. The philosophy of PHC includes the connected principles of equity, access, empowerment, community self-determination and collaboration between health sectors. The World Health Organisation developed the Alma-Ata declaration on Primary Health Care in 1978 and defines it as:

> *essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it*

120 Professor D'Arcy Holman, Chair in Public Health, University of Western Australia, *Transcript of Evidence*, 26 August 2009, p4.

121 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, Transcript of Evidence, 14 October 2009, p4.

122 Healthy Places and Spaces, 'Case Studies- Health in All Policies, South Australia', 12 June 2009. Available at: www.healthyplaces.org.au/site/casestudies.php?task=show&id=8. Accessed on date27 March 2010.

> *is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.*[123]

(a) Federal programs

In developing its national PHC Strategy, the Federal Health Minister said:

> *We know that preventative care, primary health care and acute care are all intertwined and interdependent elements of our health system – and our reform agenda acknowledges that interconnection.*
>
> *Improvements in primary health care are critical to improvements in the overall health system. In particular, primary health care is vital in turning our health care system more towards keeping people well and participating in life and work, rather than just looking after people when they are sick.*[124]

The majority of PHC is provided in Western Australia by the network of general practitioners (GPs), with the major costs subsidised through the Medicare Benefits Schedule (MBS). Around 18 million Australians (or about 85%) see a GP at least once a year and about 25% see a GP in any two-week period. In 2006–07, a total of $4.03 billion was paid in Medicare benefits for 103.4 million visits to GPs, accounting for about 90% of total Medicare benefits paid to Western Australians.[125] Figure 10.6 below outlines the national Medicare payments to GPs and other practitioners. Figure 10.7 shows the changes over the past decade in the management of chronic diseases by GPs. It indicates a rise in treatments for conditions related to heart disease and diabetes.

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123 World Health Organisation, 'Declaration of Alma-Ata', 1 April 2006. Available at: www.euro.who.int/AboutWHO/Policy/20010827_1. Accessed on 27 March 2010.

124 Australian Government, 'Towards a National Primary Health Care Strategy', 2008. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/D66FEE14F736A789CA2574E3001783C0/$File/DiscussionPaper.pdf, p5. Accessed on 27 March 2010.

125 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, pp315-318. Accessed on 29 March 2010.

Figure 10.6- Medicare items processed for general practise and other non-specialist services, 2004–07[126]

Broad type of service	Items per person (Number) 2004–05	2005–06	2006–07	Average annual change (%)	Items in 2006–07 Number ('000)	Proportion of total (%)	Benefits paid ($ million)
Non-referred medical attendances[a]	4.83	4.91	4.93	1.0	103,433	90.6	4,029.6
Practice nurse	0.13	0.16	0.17	14.8	3,664	3.2	38.9
Optometry	0.25	0.26	0.26	1.9	5,473	4.8	239.8
Other allied health	0.01	0.03	0.07	144.8	1,554	1.4	97.5
Total non-specialist items[b]	**5.22**	**5.35**	**5.43**	**2.0**	**114,124**	**100.0**	**4,405.8**

(a) Includes GP attendances, emergency attendances, attendances after hours, other prolonged attendances, group therapy and acupuncture.

(b) Excludes dental services covered by Medicare.

The recent *Australia's Health 2008* report showed the changes over the past decade in visits to GPs for some chronic illnesses and the greater willingness of non-Indigenous Australians to have an annual voluntary checkup. Medicare Benefits Schedule (MBS) items for annual voluntary health assessments for older Australians were introduced in November 1999. These assessments provide an opportunity for a GP to undertake an in-depth assessment of a patient's medical, physical, psychological and social function. Health assessments enable timely preventive and treatment actions for a patient. The eligible population for these assessments are defined as ages 75 years and over for non-Indigenous Australian people and ages 55 years and over for Aboriginal and Torres Strait Islander peoples.

Between 1999–00 and 2005–06, the proportion of the eligible population who received an annual voluntary health assessment increased from 6 — 22% for the non-Indigenous population, and from 2 — 7% for Aboriginal and Torres Strait Islander peoples (see Figure 10.8 below).[127]

126 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, p317. Accessed on 29 March 2010.

127 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, pp328-330. Accessed on 29 March 2010.

Figure 10.7- Changes in management rate of selected chronic problems, 1998–99 to 2006–07[128]

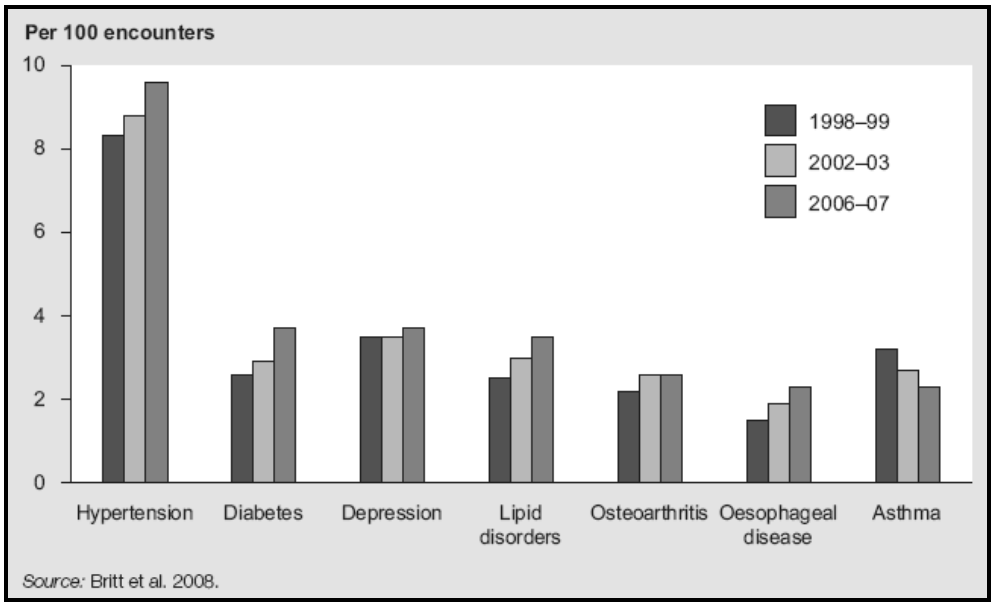
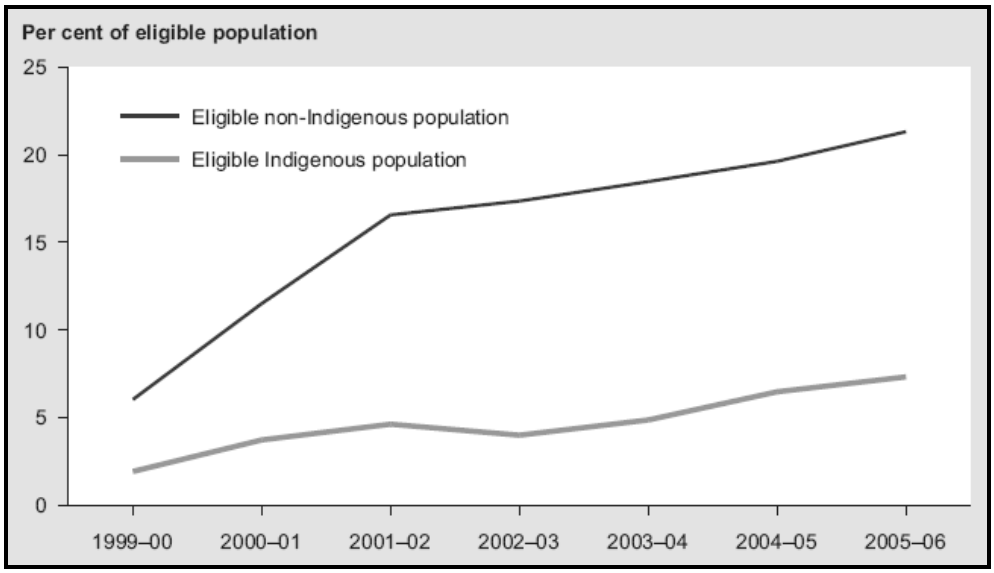


Figure 10.8- Rate of enhanced primary care health assessment by Indigenous status, 1999–00 to 2005–06[129]



128 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, p323. Accessed on 29 March 2010.

129 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, p330. Accessed on 29 March 2010.

While the MBS is funded Federally, state and territory governments are supporting many new PHC initiatives that seek to improve the integration between government, and reduce fragmentation of services (especially in rural areas). These initiatives include:

- 31 *Primary Care Partnerships* in Victoria. PCP member agencies include hospitals, community health, local government, divisions of general practice, area mental health, drug treatment and disability services and some PCPs have engaged with the police, schools and community groups;[130]
- 15 *Connecting Healthcare in Communities* local collaborations in Queensland;[131]
- NSW's *HealthOne* initiative which brings together GPs, community health and other health professionals in multidisciplinary teams;[132] and
- South Australia's plan for 10 *GP Plus* centres.[133]

These new initiatives are similar to primary care programs such as New Zealand's Primary Healthcare Organisations (PHOs), the UK's Primary Care Trusts (PCTs) and the Evercare model in the US.[134] Locally, there is a plan to build three 'Super GP Clinics': the first at Midland will be owned and operated by Health Integra.[135] The other two proposed locations will be at Wanneroo and Cockburn. The Cockburn clinic is the 25th GP Super clinic to be established by the Federal Government around Australia at a cost of about $220 million.[136] Primary health care interventions such as these Super GP Clinics have been criticised as the programs the "GP Super Clinics are currently designed to deliver have had a low impact on behaviour, particularly with regard to the key challenge: ensuring the long-term retention of lifestyle changes."[137]

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130 See www.health.vic.gov.au/pcps/about/index.htm, accessed on 27 March 2010.

131 See www.chicpartnerships.com.au/, accessed on 27 March 2010.

132 See www.health.nsw.gov.au/initiatives/HealthOneNSW/index.asp, accessed on 27 March 2010.

133 See, www.health.sa.gov.au/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=303&mid=1112&table=SSSA_Documents&field=ItemID&id=291&link=T%3a%5c_Web%5cWWW.health%5cSA+Health+Care+Plan%5cFact+sheets%5cgp-plus-health-care-centres.pdf, accessed on 27 March 2010.

134 Ms Jennifer Doggett, Centre for Policy Development, 'A New Approach to Primary Health Care for Australia', June 2007. Available at: http://cpd.org.au/paper/new-approach-primary-health-care-australia, p15. Accessed on 27 March 2010.

135 Hon Mr John Day, Minister for Planning, 'Approval for Midland Super GP Clinic', 25 February 2010. Available at: www.mediastatements.wa.gov.au/Lists/Statements/DispForm.aspx?ID=133169. Accessed on 27 March 2010.

136 ABC News, 'Third GP super clinic for WA', 31 August 2009. Available at: www.abc.net.au/news/stories/2009/08/31/2672397.htm. Accessed on 27 March 2010.

137 Mr Jeremy Sammut, Centre for Independent Studies, 'The False Promise of GP Super Clinics- Part 1: Preventive Care', 2008. Available at: www.cis.org.au/policy_monographs/pm84.pdf, pviii. Accessed on 27 March 2010.

The Australian Government has recently committed to increase medical and allied health workforce supply through various initiatives including: an increase in medical schools and medical student numbers; maintenance of policies to recruit International Medical Graduates (IMGs); a substantial investment through the COAG agreement to increase clinical placements including in expanded settings such as general practice; and an increase in a range of workers in Aboriginal health. Its most recent announcement was for a four year plan for training an additional 1,200 new GPs a year by 2014, with half the new places to be provided in rural and regional areas. The Federal Government believes this $632 million investment will deliver around five million extra GP services across Australia during the next 10 years. These will be provided by an additional 5,500 new or training GPs, and 680 extra medical specialists.[138]

(b) Lack of rural GPs

Given their importance in primary health care programs, the lack of GPs is of special concern to Western Australia. Country areas of the State have an even poorer ratio of GPs to population than metropolitan areas, and have difficulty filling vacant positions. This issue is developed in more detail in the next Chapter. The Committee also heard that in many of these small communities residents are coming to WACHS hospital Emergency Departments for not only emergency care:

> *but also primary health care because there is not a GP in town or they are full or you have to wait two weeks or you have to pay twice the going rate of bulk billing, so they end up in our facilities.*[139]

As a result, WACHS country hospitals see more emergency presentations than DOH's metropolitan ones do.

In primary health care, the Western Australian government is faced with getting GPs into regional areas or developing an alternative primary care workforce, such as nurse practitioners and Aboriginal health workers. The Committee heard that most of the WACHS workforce, particularly in the North West, is built around a model of experienced, well trained nurses and GPs as district medical officers, and Aboriginal health workers. Federal Government is also trying to assist in addressing this problem and offers incentives of up to $130,000 for GPs to transfer to a remote location and set up practice.[140] However, the Committee heard that in remote areas the investment in primary health care in prevention and early intervention through a good primary health care network is falling to the State Government. The WACHS Executive Officer said:

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138 Hon Nicola Roxon, MP, Minister for Health and Ageing, 'Five Million Extra GP Services', 17 March 2010. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr052.htm. Accessed on 27 March 2010. The AMA (WA) told the Committee that in 1996 "the Federal Government argued to decrease medical school numbers from 1,200 down to 1,000 and it was argued vociferously and repeatedly in the media that there were 5,700 too many GPs across Australia." Mr Peter Jennings, Deputy Executive Director, Australian Medical Association (WA), *Transcript of Evidence*, 25 August 2009, p17.

139 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p13.

140 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p11.

> *You see cracks elsewhere; they are chasms when you get to the Kimberley, Pilbara, or the Goldfields for that matter. Therefore, they would be the two areas where I would be putting in the* [primary health] *investment.*[141]

Finding 77

One of the most critical challenges facing the Western Australian Government is obtaining, and sustaining the required health work force in remote and regional areas of the State.

A key issue is developing new approaches to delivering health services in the face of the current severe shortage of GPs.

10.5 Opposition to investment in preventative health programs

While there is widespread acknowledgement by governments of the need for further investment in preventative health programs, there has been some recent opposition to this strategy. Whilst acknowledged that the rising cost of treating lifestyle-related chronic disease threatens the sustainability of Medicare as the Australian population ages, the Centre for Independent Studies claims that:

> *decades of spending on prevention has not worked and is unlikely to work in the future. Spiralling rates of obesity and lifestyle-related chronic disease suggest that forty years of public health policies that have targeted diet and exercise habits have had limited effect on behaviour, especially in relation to long-term retention of lifestyle modification.*[142]

The CIS Report does not suggest how Australian governments might fund the future treatment of lifestyle-related chronic disease if preventative programs aren't pursued. Its attack on preventative health and PHC initiatives such as Super GP Clinics is intellectually dishonest.

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141 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p13.

142 Mr Jeremy Sammut, Centre for Independent Studies, 'The False Promise of GP Super Clinics- Part 1: Preventive Care', 2008. Available at: www.cis.org.au/policy_monographs/pm84.pdf, pvii. Accessed on 29 March 2010.

The Report outlines several successful Australian programs such as the anti-smoking campaigns funded by governments for three decades, but labels these successes as:

> *an example of public health regulation rather than health promotion. It is more like traditional public health measures and the way governments have compelled seatbelt use and attacked drink-driving, through legislation and enforcement.*[143]

Nevertheless, most such government health programs are managed by regulation and legislation, with reporting to parliament for the public funds expended on them.

This attack on preventative health programs, and government-sponsored action, seems to have been spurred by an article in the New England Journal of Medicine in 2008. This article explores the appropriate criterion for the funding of preventive medicine and public health and uses cost-effectiveness ratios. It gives an example of a poor program where "the screening costs will exceed the savings from avoided treatment in cases in which only a very small fraction of the population would have become ill in the absence of preventive measures."[144]

But all such efforts to evaluate preventative programs in this fashion seem to fail, as they rely on trying to estimate how much it costs to purchase a gain in health outcomes. Unfortunately, there is no clear standard for what constitutes good value for government health funds spent on these programs. One article explores this issue and finds references on the annual screening mammography for women 55 to 65 years of age using a range of values between US$20,000 to $90,000 per life-year gained, while another study on hemodialysis for end-stage renal disease uses a different range of US$60,000 to $128,000 per quality-adjusted life-year (QALY).[145]

10.6 Australian preventative health successes

While there are a small number of academics wanting to challenge the success of government-funded programs operating outside of the 'the market', in Australia there have been many such successes.

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143 Mr Jeremy Sammut, Centre for Independent Studies, 'The False Promise of GP Super Clinics- Part 1: Preventive Care', 2008. Available at: www.cis.org.au/policy_monographs/pm84.pdf, p7. Accessed on 29 March 2010.

144 Dr Joshua Cohen, Dr Peter Neumann and Dr Milton Weinstein, 'Does Preventive Care Save Money? Health Economics and the Presidential Candidates ', 14 February 2008, *New England Journal of Medicine*. Available at: http://content.nejm.org/cgi/content/full/358/7/661#R5. Accessed on 29 March 2010.

145 Mr Milton Weinstein, 'High-Priced Technology Can Be Good Value for Money', 18 May 1999, *Annals of Internal Medicine*. Available at: www.annals.org/content/130/10/857.full?ijkey=2d64d7772e6e6190aae39fde814b8b69b2d297fb&keytype2=tf_ipsecsha. Accessed on 29 March 2010.

In describing them, Professor Simon Chapman labels prevention's track record in Australia as 'spectacular':

- **lung cancer**- the leading cause of cancer death in Australia, was a rare disease at the beginning of the 20th century. With the advent of cheap cigarettes, lung cancer rose until about 1982. Today's rate of male lung cancer is similar to that in 1963;
- **chronic obstructive pulmonary disease**- thanks almost entirely to tobacco control, current rates per 100,000 of this disease (which cannot be cured but which is the fourth largest killer of Australians today) are similar to those in the late 1950s;
- **male rates of heart disease deaths**- are now as low as they were in 1945, and female as low as they were in 1947. Some of this success is due to treatment, but much of it is due to primary and secondary prevention;
- **cervical cancer**- deaths are at all time lows thanks to the long term health promotion via education campaigns and the use of Pap smears;
- **vaccine preventable diseases**- hospitalisation rates fell 22% from 7,238 in 1996-2000 to 5651 in 2000-2002. Deaths fell 55% in the same period;
- **road toll**- Australia's is 44% lower today (1,616) than it was in 1986 (2,059);
- **suicide rate**- has fallen to its lowest on record. There were more than 2,700 deaths in 1997, falling by a third to 1,800 in 2006.
- **HIV**- the epidemic that threatened Australia in the 1980s failed to materialise thanks to community health promotion campaigns and harm reduction policies; and
- **SIDS**- due to epidemiology and the health education campaigns based on it, the SIDS death rate per 100,000 live births declined 52% from 189/100,000 in 1982-86 to 81/100,000 in 1992-96.[146]

Not all preventative programs need to be expensive, nor delivered by government. A new program initiated in the US called 'mall walking' is a very low-cost way to encourage older people to exercise regularly and to provide a convenient location to offer health education material.[147] In

146 Professor Simon Chapman, 'Actually, preventative healthcare has been a spectacular success', 29 July 2009. Available at: www.crikey.com.au/2009/07/29/actually-prevention-has-been-a-spectacular-success/. Accessed on 29 March 2010.

147 Associate Professor Paul Dugdale, 'Mall-walking: the next big thing in health reform?', 1 September 2009. Available at: www.crikey.com.au/2009/09/01/mall-walking-the-next-big-thing-in-health-reform/. Accessed on 29 March 2010.

Western Australia the Injury Control Council of WA (ICCWA) supports such structured mall walking groups in Karrinyup, Booragoon, Armadale, Belmont, Spearwood and Bull Creek.[148]

Recommendation 41

The Department of Health engages the community by sponsoring a competition for suggestions for new low-cost preventative health programs.

10.7 Future challenges

The key challenge for governments at all levels in Australia in dealing with the obesity epidemic and associated chronic diseases is to mimic the success of the 30-year long campaign to lower smoking rates. The success of this public health campaign was due to a number of factors, but a key part was the willingness of governments to control the sale of tobacco products by government regulation and legislation. One important measure in this campaign was a constant increase in the price of cigarettes, associated with a public health education campaign. Public health officials recently called for a levy related to the advertising spend for 'junk' foods and alcohol that might raise $60 million per year.[149] This additional funding could be used to provide alternatives to junk food and alcohol sponsorships, and to inform consumers about healthier food and beverage products that are not advertised as heavily— for example, fruits and vegetables, or beverages with a lower alcohol content.[150] However, current Federal and State governments are limiting their actions on chronic health issues to just funding education campaigns, such as the 'Life Be in It' or 'Find 30' campaigns.

Significantly, in the US a number of state governments are proposing additional taxes on products with high levels of sugar and salt, especially those consumed by children:

- small excise taxes on soft drinks are already in place in Arkansas, Tennessee, Virginia, Washington and West Virginia;
- Chicago imposes a 3% retail tax on soft drinks;
- Mississippi is considering legislation that would tax the syrup used to sweeten drinks;

148 Injury Control Council of WA, 'Mall Walking', nd. Available at: www.iccwa.org.au/mall-walking/. Accessed on 29 March 2010.

149 Ms Danielle Cronin, 'Experts call for levy on junk food ads', *The Canberra Times*, 5 April 2010, p2.

150 Mr Todd Harper and Mr Gavin Mooney, 'Prevention before profits: a levy on food and alcohol advertising', 5 April 2010, *Medical Journal of Australia*. Available at: www.mja.com.au/public/issues/192_07_050410/har10982_fm.html. Accessed on 12 April 2010.

- the mayor of Philadelphia is considering a tax on soft drink and other sugar-sweetened drinks;
- Governor David Paterson of New York has indicated that he will recommend a penny-per-ounce tax on sugared beverages in his 2011 budget; and
- during 2009, new 'sugar taxes' were proposed in at least 12 other American states.[151]

Additionally, the Obama administration has announced a plan to ban candy and sweetened beverages from schools. In Australia, the National Preventative Health Taskforce (NPHT) promoted a new taxation regime targeting unhealthy food based on a model introduced by the Denmark Government in 2009. Under the new Danish system, ice cream, sweets and chocolate will see a duty increase of 25%. The NPHT called for a review of such economic policies as a way to help lower the consumption of unhealthy foods, and increase the intake of healthier foods and beverages.[152]

The New York Times says such measures as these new taxes address two child health issues:

> *The problem is that at roughly 50 gallons per person per year, our consumption of soda, not to mention other sugar-sweetened beverages, is far from moderate, and appears to be an important factor in the rise in childhood obesity. This increase is at least partly responsible for a rise in what can no longer be called "adult onset" diabetes — because more and more children are now developing it.*[153]

The focus on increasing the cost of soft drinks is because a typical 500ml sports drink may contain up to 21g of pure fructose. To get a similar amount of fructose, a child would have to consume 10 teaspoons of sugar. Besides adding to issues of overweight, a study confirmed that the consumption of fructose directly causes high blood pressure. It does this by raising uric acid levels in the blood. High uric acid levels are known to cause kidney disease and 80% of patients with failed kidneys have high blood pressure.[154] Figure 10.9 below highlights the dramatic amount of sugar in a US child's modern diet. The situation for Australian children is likely to be similar.

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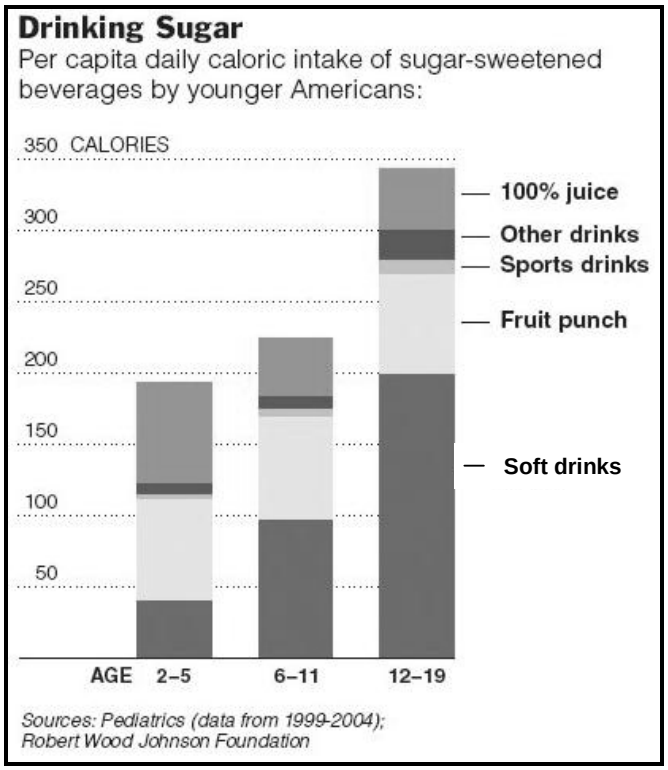
151 Mr Mark Bittman, 'Soda: A Sin We Sip Instead of Smoke?', 12 February 2010. Available at: www.nytimes.com/2010/02/14/weekinreview/14bittman.html. Accessed on 29 March 2010.

152 National Preventative Health Taskforce, 'Australia: The Healthiest Country by 2020', 30 June 2009. Available at: www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/A06C2FCF439ECDA1CA2574DD0081E40C/$File/discussion-28oct.pdf. Accessed on 29 March 2010.

153 Mr Mark Bittman, 'Soda: A Sin We Sip Instead of Smoke?', 12 February 2010. Available at: www.nytimes.com/2010/02/14/weekinreview/14bittman.html. Accessed on 29 March 2010.

154 Ms Maggie Fox and Ms Xavier Briand, 'Fructose tied to higher blood pressure: study', 23 September 2009. Available at: www.reuters.com/article/idUSTRE58M6D820090923. Accessed on 29 March 2010.

Figure 10.9- Daily intake of sugar-sweetened beverages, United States



A wide range of beverages contain high levels of sugar, and therefore calories. Table 10.2 below lists the sugar and calorie content of common sizes of drinks.

Table 10.2- Energy and sugar content of common drink sizes[155]

Drink	Size	Energy content (kJ)	Sugar content (g)	Teaspoons of sugar
Soft drink mini can	200ml	349	21.6	**5.4**
Soft drink	250ml	437	27	**6.7**
Soft drink can	375ml	657	40.7	**10.2**
Soft drink bottle (small)	600ml	1051	65	**16.2**
Soft drink bottle	1.25L	2,190	135.6	**33.9**
Soft drink bottle (large)	2L	3,504	216.9	**54.2**
Fruit juice	250ml	394	21.5	**5.4**
Full fat milk (4%)	250ml	700	12	**3**
Reduced fat milk (2%)	250ml	525	13.6	**3.4**
Skim milk (0.1%)	250ml	377	13	**3.2**
Beer, full strength	250ml	368	0.5	**0.125**
Wine, white	250ml	690	2.75	**0.7**
Coffee (white, instant, no sugar)	250ml	654	12.6	**3.15**

In terms of policy measures beyond pricing, especially given the limited ability of state governments to levy taxes, the Committee heard that state governments could use other means to limit children's access to 'junk' food containing high levels of salt and sugar. One idea the Committee was presented with was curbing the large number of public vending machines. Nonetheless it was acknowledged that:

> *As you know, the community acceptance around point of sale restrictions for tobacco is very high. We are not there yet with food, whether that is junk food or junk drinks. We are a long way away from that. I think there is probably about 20 to 25 years difference in*

155 Kilojoule and sugar content derived from: Mr Allan Borushek, 2009, 'Calorie Fat and Carbohydrate Counter', *Family Health Publications*. Available at: www.familyhealthpub.com/index.php. Accessed on 29 April 2010.

> *terms of when we started talking about it with tobacco, and when we are introducing it. With junk food, we are really dealing only with the past five years and starting to come to terms with that.*[156]

The previous State Government introduced a campaign in this area using traffic light colours for school canteen foods and compulsory physical activity for Years 1 to 10.[157] Healthways has recently announced $160,000 in new funding over two years for the Perth Zoo. This program's major focus is a ban on smoking in the Zoo, but it also includes a requirement that the vending machines in the Zoo be stocked with healthier food and drink items for sale.[158]

Future governments will need to go further in intervening in the market process if they wish to ensure that future generations of Western Australians are healthier than the current cohort and are less of a burden on the State's hospitals. In this long-term process, the Government can count on the many non government organisations already working on preventative health programs and the Australian Medical Association (AMA), whose members deal day-to-day with patients with chronic illnesses. The Committee heard that the AMA "has been fantastic on prevention; just fantastic. We would not have the measures we want, a lot of them, if the AMA had not been often leading the charge. They have been absolutely and consistently supportive."[159]

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156 Professor Rob Moodie, Chair, National Preventative Health Taskforce, *Transcript of Evidence*, 4 February 2009, p8.

157 Hon Mr Alan Carpenter, Premier, 'Red light for fatty foods and green for sport in WA's public schools', 2 December 2006. Available at: www.mediastatements.wa.gov.au/ArchivedStatements/Pages/CarpenterLaborGovernmentSearch.aspx?ItemId=128043&minister=Carpenter&admin=Carpenter&page=3. Accessed on 29 March 2010.

158 Ms Cathy O'Leary, 'Zoo bars smokers in health deal', *The West Australian*, 30 March 2010, p3.

159 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p5.

CHAPTER 11 COUNTRY HEALTH

11.1 Introduction

This chapter summarises key issues affecting the health of people living in the State's rural and regional areas. Many of these factors are considered in later chapters (eg the transport services provided by the Royal Flying Doctor Service and St John Ambulance) as is the issue of the health of the State's 78,000 Indigenous people (see Chapter 12). The approach taken by both the previous and current Governments to provide health services in country areas is similar, and recognises:

- the large distances that need to be covered, especially in northern and eastern Western Australia;
- the small number of people living in many of the communities (especially remote Indigenous communities); and
- the need to locate, for cost and efficiency reasons, the State's tertiary health services in Perth.

The evidence collected by the Committee indicates that the major challenges facing the WA Country Health Service (WACHS) are:

- obtaining and retaining the appropriate staff;
- working with other organisations to provide non-acute care, transport and accommodation services; and
- securing sufficient resources to fund new capital works.

The Committee heard that the provision of health care in regional areas in the State, in particular the North West, differs markedly from the metropolitan area:

> *in the North West, the Kimberley and the Pilbara, the sort of traditional elements of the Australian health-care system are not operating, so we do not have private hospitals in the north west of the state, whilst in the metropolitan area, of course, private hospitals provide a very significant part of the hospital services to the community. For someone with private health insurance, if you are in Kununurra, unless you use essentially the local public hospital, you do not have a choice in terms of a private hospital, other than moving to Darwin or Perth. The other side is private general practice, which is also not present to a large degree in the North West of the State.*[160]

[160] Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p2.

In spite of these challenges, the Committee heard that each year WACHS hospitals see more emergency presentations than DOH's metropolitan network and they deliver a similar number of babies as the King Edward Memorial Hospital in Perth.[161] The WACHS hospitals operate differently to the metropolitan ones because:

> *people are coming to accident and emergency for not only emergency care but also primary health care because there is not a GP in town or they are full or you have to wait two weeks or you have to pay twice the going rate of bulk billing, so they end up in our facilities.*[162]

(a) Overview of WACHS operations

WACHS is the largest country health system in Australia, providing an extensive range of health services across an area of 2.55 million square kilometres for a combined population of 454,000. This is almost one quarter of the State's population and includes over 44,900 Indigenous people. WACHS employs about 8,500 people (or 6,200 FTE) and operates 71 facilities, including:

- 6 large hospitals;
- 50 small hospitals (including 29 multi-purpose services);
- 26 mental health services;
- 3 multi purpose centres;
- 8 gazetted nursing posts and 39 remote area nursing posts;
- 2 State government nursing homes;
- Community health services (53 locations); and
- Child health services (168 locations).[163]

It provides "not only hospital services, but also primary health care in a lot of areas, as well as providing mental health services and aged-care services".[164] In the Kimberley it also operates the ambulance service. WACHS provides 1,217 beds and had over 105,000 separations from its hospitals in 2009. This represented a 0.6% rise in December 2009 over the rate for December

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161 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p13.

162 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p13.

163 WA Country Health Service, 'Foundations for Country Health Services- The WA Country Health Service Strategic Plan 2007 – 2010', 2007. Available at: www.wacountry.health.wa.gov.au/uploaddocs/publications/foundations.pdf, p6. Accessed on 13 April 2010.

164 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p2.

2008. It had over 49,400 elective surgery separations, a drop of 1.1%. The number of people waiting for elective surgery in the WACHS regions in December 2009 had risen by 19% to 3,128 patients. In terms of efficiency gains, WACHS was able to decrease the average length of stay for overall acute hospital separations by 3.7% to 2.48 days in the December 2009 quarter.[165]

Chapter 10 highlights the problems the WA health system faces from the rapidly rising rates of diabetes, particularly in the Indigenous population. The latest data from DOH shows WACHS provided 21,400 renal dialysis separations in 2009, a 5.1% increase in the December 2009 quarter over the corresponding period in 2008.[166]

The WACHS hub-and-spoke network model of health facilities is based around its six Regional Resource Centres (RRC). The RRCs are based in Albany, Broome, Bunbury, Geraldton, Kalgoorlie and Port Hedland, and their brief is to:

> *be not only a referral point for services as a hospital; it is actually about providing services out to the broader community, and not just hospital services, but other services as well, whether they be screening, allied health, community health, child health and so on. They become a base for those services to provide outreach to the broader and smaller communities.*[167]

Chapter 4 outlined the Government's plans in the *Clinical Services Framework 2010-20* to increase the current number of beds in the RRCs by 33% by 2021.

(b) Planning for the future

WACHS has its own annual operational plan[168] and a strategic plan for 2007-10 titled *Foundations for Country Health Services*.[169] This three-year plan was published after a year-long review of its operations. Initially WACHS and the South West Area Health Service were formed in 2002 from 40 separate organisations configured mainly around individual towns, with services governed by individual health boards. These two organisations were later merged in July 2006. An important DOH initiative in 2009 was to incorporate data for WACHS' six RRCs and 15

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165 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, pp1,3,7,11,13. Accessed on 13 April 2010.

166 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p6. Accessed on 13 April 2010.

167 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p9.

168 WA Country Health Service, 'WA Country Health Service Operational Plan 2009/10', 2009. Available at: www.wacountry.health.wa.gov.au/uploaddocs/wachs%20op%20plan%20final%205%20nov%2009.pdf. Accessed on 13 April 2010.

169 WA Country Health Service, 'Foundations for Country Health Services- The WA Country Health Service Strategic Plan 2007 – 2010', 2007. Available at: www.wacountry.health.wa.gov.au/uploaddocs/publications/foundations.pdf. Accessed on 13 April 2010.

Integrated District Health Services into the *Clinical Services Framework 2010-20.*[170] This data flows from the WACHS Clinical Services Plans that are now prepared by each of its regions and allow a State-wide approach to issues such as workforce planning and equipment purchases.

The Department of Health gave evidence that there has been no planning undertaken to provide any tertiary-level services at WACHS facilities and the CSF 2010 did not consider this in its scenarios. While the Government is planning to develop major cities in the North West, DOH said that the provision of Level 6 (tertiary) services was not just dependent on population levels but "it is also important to consider the availability of qualified and experienced staff, access to building and technical infrastructure and related support services."[171]

Finding 78

The Department of Health's planning to 2021 does not include the development of any Level 6 tertiary medical services to be provided in WA Country Health Service regions.

11.2 Health outcomes

The greatest demonstration of the inequality in health is the lower life expectancy facing the State's 78,000 Indigenous people. Contributing to this is relatively poor access to appropriate care, particularly in remote areas. This topic is covered in greater detail in the next Chapter.

In some areas of health service provision, patients in country areas actually seem to do better than patients in metropolitan areas. The Committee's *Healthy Child — Healthy State* report in 2009 provided data showing that waiting times for child allied health services were often shorter in country WA. The latest WACHS annual report also shows that patients' waiting time for elective surgery in WACHS hospitals had improved since the previous year — with the number outside the performance targets dropping from 291 patients in June 2008 to 177. In the period 2008-09, the number of cases admitted for elective surgery increased by 8% to 15,423. However, 24% of the most-urgent, category 1 patients were waiting longer than the 30-day target.[172] This figure and the median waiting time of 15 days for category 1 patients is similar to the metropolitan situation

170 Department of Health, 'WA Health Clinical Services Framework 2010-20', 3 December 2009. Available at: www.health.wa.gov.au/publications/documents/CLINICAL_SERVICES_FRAMEWORK_WEB.pdf, pp22-24. Accessed on 13 April 2010.

171 Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p1.

172 Department of Health, 'WA Country Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_WACHS.cfm, p27. Accessed on 13 April 2010.

where 21% of patients were waiting longer than the target, and the median waiting time was 13 days.[173]

Another way of measuring performances of hospitals is the rate of unplanned readmissions within 28 days for a patient with a related condition. Here, outcomes for country patients are worse. The WACHS rate of 2.9% in 2008 is higher than the 2.3% for the metropolitan area. Table 11.1 provides data from the annual reports for both the WACHS and metropolitan health services. While the rate for all WACHS patients has not altered much since 2006, the mental health rate has deteriorated from the 2006 rate of 5.2% to 7.6% in 2008.

Table 11.1- Patient unplanned readmission rates, 2008[174]

	Target rate	WACHS rate	Metropolitan rate
All patients	<2.3%	2.9%	2.3%
Mental health patients	<8.3%	7.6%	5.0%

DOH provides data on the survival rates for hospital patients admitted with three sentinel medical conditions — heart attack, stroke and fractured hips. For 2008 there was little difference in the survival rates for these conditions between patients admitted to metropolitan hospitals and WACHS ones, although country patients had better survival rates for stroke than metropolitan patients, for all patients other than those over 80 years old.[175]

DOH data shows that low birth-weight babies (under 1.5kg) born in WACHS hospitals were more likely to be distressed than those born in metropolitan hospitals. Of the 4,680 births in 2008 in country areas, just nine were low-birth weight babies.[176] The Committee's *Invest Now or Pay Later* report in March 2010 presented more data on this issue when it discussed child health issues.

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173 This represented a deterioration from the 2007-08 figures for metro patients of 14% waiting longer and a median waiting time of 11 days. Department of Health, 'Metropolitan Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, pp35-36. Accessed on 13 April 2010.

174 Department of Health, 'WA Country Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_WACHS.cfm, pp28-29; and 'Metropolitan Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, pp37-38. Accessed on 13 April 2010.

175 Department of Health, 'WA Country Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_WACHS.cfm, pp30-31; and 'Metropolitan Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, pp39-40. Accessed on 13 April 2010.

176 Department of Health, 'WA Country Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_WACHS.cfm, p32; and 'Metropolitan Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, p41. Accessed on 13 April 2010.

An area where country patients seem to do better than metropolitan patients is the proportion seen within recommended times at hospital Emergency Departments. DOH has the same target for both country and city patients and the results for 2008 show that the rates for country patients are better in all categories other than triage category 1 (see Table 11.2 below). There were 10 triage category 1 patients in 2008-09 seen outside of the recommended times in WACHS hospitals compared to 18 in metropolitan hospitals. The latest data for the December 2009 quarter shows a further fall in the proportion of WACHS triage category 1 patients seen within the targeted time.

Table 11.2- Proportion of Emergency Department patients seen within recommended times[177]

Category	Target rate	WACHS rate (Oct-Dec 2009)[178]	WACHS rate (2008-09)	Metropolitan rate (2008-09)
Triage category 1 (within 2 minutes)	**100%**	93.7%	98.7%	99.6%
Triage category 2 (within 10 minutes)	**80%**	91.4%	92.4%	68.8%
Triage category 3 (within 30 minutes)	**75%**	88.3%	88.2%	44.6%
Triage category 4 (within 60 minutes)	**70%**	91.1%	90.0%	50.3%
Triage category 5 (within 2 hours)	**70%**	99.0%	95.5%	81.4%

DOH's annual reports show that the WACHS average cost per casemix separation for non-teaching hospitals is about 4% more expensive than metropolitan hospitals in 2008-09. Table 11.3 below includes this cost data compared to metropolitan hospitals, as well the average costs for patients in small rural hospitals and mental health units. In all cases it is more expensive to provide health care in WACHS facilities.

177 Department of Health, 'WA Country Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_WACHS.cfm, p33; and 'Metropolitan Health Service Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/annual_reports_2009_MHS.cfm, p42. Accessed on 13 April 2010.

178 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p30. Accessed on 13 April 2010.

Table 11.3- Comparison of some health costs between WA Country Health Service and metropolitan hospitals, 2008-09

	WACHS Target Cost	WACHS Actual Cost	Metro Actual Cost	Comparison of Actual Costs
Average cost per casemix separation, non-teaching hospitals	$4,421	$5,006	$4,838	+3.5%
Average cost per bed-day, small hospitals	$1,301	$1,189	$948	+25.4%
Average cost per bed-day, mental health units	$1,081	$1,125	$1,002	+12.3%
Average cost per non-admitted hospital service, rural hospitals	$180	$182	$60.44	+301%

This summary of DOH performance data for 2008-09, and data reported previously by the Committee on child health, shows that in some services, WACHS is delivering a similar level of service to country patients as patients receive in Perth. In some areas country patients seem to receive better treatment although patients have to be transported to Perth for all tertiary-level services. Still, it is important to note that the health status of country communities can be influenced by the demographics of the region. The Pilbara has a fairly young and healthy cohort living in Karratha that have been attracted to the region by resource developments. It also contains small Indigenous communities (such as at Roebourne) whose residents suffer very poor health.[179]

One of the greatest gaps in country WA for residents at either end of the socio-economic scale is access to non-WACHS health services, such as those provided by GPs. This is covered in greater detail below.

11.3 Staffing of country health services

(a) WA Country Health Service staff

A recurrent theme from the Committee's hearings and investigative travel was that workforce management was the biggest challenge WACHS faces in providing quality health care to the State's rural and regional populations.

[179] Ms Jessica Strutt and Ms Philippa Perry, 'Roebourne poverty amid wealth 'a crime'', 17 March 2010. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/6941417/roebourne-poverty-amid-wealth-a-crime/. Accessed on 15 April 2010.

In 2008 DOH reported to the Federal Government a WACHS workforce shortage of:

- nurses- 89 FTE;
- allied health- 40 FTE; and
- private and public medical staff- 60 FTE.[180]

WACHS employed 176.8 FTE medical practitioners in 2009 and reported to the Committee that there were only six unfilled positions. Of the 100 doctors WACHS needs to hire annually to maintain current staff levels, about 60 of these are trained overseas, 30 come from interstate and 10 are locally educated. The cost of employing new medical staff in regional health facilities can be very high. The Committee was told that at the Kalgoorlie Hospital:

> *Between the time of the previous general surgeon leaving and the new surgeon coming—18 months—it cost us about $500,000 to cover the costs during that 18 months. There were locum costs. He had to work in Perth for three months before he could come here, and we had to pay for that.*[181]

The cost of trying to attract locally trained staff can be even higher:

> *We have overseas-trained surgeons so they accept the base award. If we were to try to get Australian-trained surgeons, we would have to pay them substantially more. We get a lot of Australian and New Zealand doctors who are willing to come here and work but only for the locum rates, which are between $2,000 and $2,500 a day. That is probably about 50 per cent more than they would get if they were salaried.*[182]

WACHS employed 452.5 FTE allied health workers in 2009 with just 14.6 FTE vacancies (3.2%). Two-thirds of these vacant positions were for physiotherapists and speech pathologists (8.7 FTE).[183] However, the situation was very different for nursing staff. WACHS employed 2,522 nurse FTEs in July 2009 and reported that there was a 20-22% vacancy rate for midwives. The rate was greater in smaller hospitals. These staffing gaps for nurses are not evenly distributed. WACHS provided data to the Committee of a nursing shortage of about 140 staff (full-time, part-time, contract and casual vacancies) (see Table 11.4). Nearly 60% the vacancies are in the Kimberley, Pilbara and the South West WACHS regions — home to over 33% of the State's Indigenous population.

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180 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Reply to Questions on Notice*, 22 October 2009, p4.

181 Dr Peter Barratt, Medical Practitioner, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p3.

182 Dr Peter Barratt, Medical Practitioner, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p3.

183 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Reply to Questions on Notice*, 22 October 2009, p2.

Table 11.4- Nurse vacancies by WA Country Health Service region, 30 August 2009[184]

Region	Vacancy (staff)
Goldfields	12
Great Southern	14
Kimberley	26
Midwest	14
Pilbara	15
South West	40
Wheatbelt	19

WACHS' key strategy is to develop a generalist model of workforce with staff such as nurse practitioners and Indigenous health workers to 'future-proof' its workforce. WACHS is sponsoring the education of about 100 nurse practitioners, and had a target of creating 25 nurse practitioner positions by 2010. Positions are already filled at Albany, Kalumburu, Marble Bar, Nullagine and Bremmer Bay.[185] Currently about 3% of the WACHS staff are Indigenous. The Committee was told that WACHS was "attempting to get more people with education and training happening in the country so that they can see how to work in a multidisciplinary team"[186] to deliver the wide range of services offered by WACHS.

Finding 79

A key challenge for the WA Country Health Service is retaining sufficient nursing staff, including nurse practitioners, especially for regions such as the Kimberley.

Recommendation 42

The WA Country Health Service should prioritise programs to attract nurses, nurse practitioners and Aboriginal health workers to staff its health facilities in the Kimberley.

184 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Reply to Questions on Notice*, 22 October 2009, p3.

185 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Council, *Supplementary Information C1* (Hansard), 18 June 2009, p755.

186 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, pp8-9.

State program to boost interns

The Government is boosting the training of interns coming into the State's health system, both for regional and metropolitan areas. There will be an increase of 100 students at the University of Western Australia and 80 at the University of Notre Dame, phased in over a three-year period.[187] The Department of Health has prepared a five-year business case for the nearly $220 million cost to train the 1,369 new staff (see Table 11.5). The cost for training interns in rural regions will be $35.6 million over five years. This business case proposes a framework that combines alternative and traditional methods of clinical training but has yet to be accepted by the Government.

Table 11.5- Expected quota and training cost of interns entering Western Australia's health system, 2009-14[188]

Financial Year	2009-10	2010-11	2011-12	2012-13	2013-14
Annual quota of interns	247	278	285	275	284
Cost to train interns- metropolitan regions	$2.2 million	$22.0 million	$42.3 million	$52.9 million	$68.3 million
Cost to train interns- rural regions	$1.9 million	$4.4 million	$8.6 million	$10 million	$10.7 million

(b) General practitioners

The Committee was told that Western Australia is one of the poorest serviced jurisdictions in terms of access to general practitioners (GPs). Country Western Australia has fewer GPs, the services of which are "not present to a large degree in the north west of the State."[189] WACHS provided the Committee with data on GPs in Western Australia compared to other jurisdictions that clearly shows this State's relative disadvantage, even against two similarly-sized jurisdictions with large Indigenous populations (see Table 11.6).

187 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Council, *Supplementary Information C1* (Hansard), 18 June 2009, p755.

188 Dr Peter Flett, Director General, Department of Health, *Reply to Questions on Notice*, 10 October 2009, p3.

189 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p2.

Table 11.6- General practitioners per 100,000 population by remoteness area, 2006-07[190]

	Cities	Inner regional	Outer regional	Remote	Very remote	Total
National average	**97.0**	**83.1**	**74.2**	**68.2**	**47.1**	**91.3**
WA	81.0	65.4	76.1	61.6	34.9	**76.8**
SA	96.9	83.4	88.5	87.2	60.3	**93.7**
QLD	97.0	90.3	79.2	59.3	52.9	**91.6**

The lack of GPs in WA is consistent with that of QLD and SA in cities and regional areas but worse in remote areas. Data provided by DOH shows a rate of 223 medical practitioners per 100,000 people in WA in 2005 compared to a national average of 287 (and an average of 227 for QLD and 302 per 100,000 for SA).[191]

The consequences of the rural GP shortage are three-fold. Firstly, there are poorer outcomes for country patients. The Committee heard from the Acting Director General of Health who described the prospect facing many people throughout the State:

> *If people cannot get in to see a GP, they go to our Emergency Departments and often, if they are not able to see a GP, they wait too long. If they wait too long, their diseases progress further than would be expected if they had seen a GP, and those are a lot of the avoidable cases that we are seeing.*[192]

Secondly, there are often unmanageable workloads in country hospitals. WACHS confirmed that 68-96% of Emergency Department presentations at its medium-sized district hospitals could potentially be managed by a GP, were they available. For the larger regional hospitals, this figure is between 66-84%.[193]

Thirdly, there is a heavy cost burden to the State through foregone Medicare income. Primary care treatments undertaken in the Accident and Emergency Departments of rural hospitals have not been funded via the Medicare Bulk Billing service used by GPs. The Australian Medical Workforce Advisory Committee (AMWAC) released a report in 1996 that estimated there were 4,400 too many urban GPs and 500 too few in rural areas. Looking to tackle the problem and curb the rising costs of Medicare, the newly elected Howard Government restricted medical graduates'

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190 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Reply to Questions on Notice*, 22 October 2009, p1.

191 This figure includes specialists, GPs, hospital-based doctors and doctors employed in a non-clinical role. Mr Kim Snowball, Chief Executive, WA Country Health Service, *Reply to Questions on Notice*, 22 October 2009, p2.

192 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, pp14-15.

193 Submission No. 31 from WA Country Health Service, 12 August 2009, pp11-12.

access to provider numbers until they had undertaken vocational training. International graduates were restricted from obtaining provider numbers until 10 years after gaining registration. This policy decision is seen as the basis for the current under-supply of GPs around Australia, and particularly in Western Australia.[194]

The Committee was told that failure to access Medicare payments due to some towns not having GPs could be costing the State in the order of $220 million per annum. The Federal Government has recently moved to allow public rural hospitals in communities of 7,000 people or fewer to claim Medicare payments for GP-type services offered at a hospital.[195]

Federal governments have historically offered incentives to attract GPs to rural areas. Initiatives have included the current offer of up to $130,000 for doctors to transfer to a remote location and set up practice.[196] Under the Rudd Government's proposal for national health and hospital reform, currently being negotiated, there is a promise to deliver:

- 1,375 more GPs practising or in training by 2013, and 5,500 new GPs or GPs undergoing training in the next decade ($339 million);
- 975 places each year for junior doctors to experience a career in general practice during their postgraduate training period ($148 million);
- 400 more clinical training scholarships over four years for allied health students in rural and regional areas ($6 million); and
- a rural locum scheme to support 400 allied health professionals, to help them access ongoing education and holiday cover ($5 million).[197]

Traditionally, Federal initiatives have failed to achieve additional GPs in country areas. For many potential candidates, Commonwealth enticements fail to outweigh concerns over lifestyle or burnout risk. Dr du Preez, a GP in Katanning, explained:

> *For the new doctors that come out, lifestyle becomes quite an important issue. If I want to recruit somebody to Katanning—you have come here and you have seen what it is like—I have to compete with Bunbury, Busselton and Perth and all sorts of other places, and they go there. They do not come here. They get much better offers as far as lifestyle goes from*

194 Ms Jenny Pogson, '31-Short-changed on workforce', 17 July 2009, *Australian Doctor*. Available at: www.australiandoctor.com.au/Common/ContentManagement/AusDoc/pdf/TOP50_09.pdf, p22. Accessed on 23 April 2010.

195 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, pp3-4.

196 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p11.

197 Commonwealth of Australia, 'A National Health and Hospitals Network: Further Investments in Australia's Health', 12 April 2010. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/B5E2F0FD961B3F65CA257703001981AE/$File/NHHN%20Report%20two.pdf, p49. Accessed on 13 April 2010.

> *places that are nicer than Katanning in the sense that they have a beach or mountains or are closer to schools. Schooling is a problem. A lot of people leave because of schooling. That is especially high schools. Some people send their kids to boarding schools, but a lot of people prefer not to do that. They would rather move at that stage.*[198]

In terms of retention, the key factor for many DOH doctors in country regions is to be able to maintain their skills to undertake a broader range of tasks than GPs in the city. This might include doing anaphylaxis and obstetrics and being able to intubate and ventilate patients. Doctors have to travel to get to their training and this might involve driving 600 kilometres in a day. When a doctor has to be away for training or when they want to have a holiday, they often are not able to get a locum to replace them. The other key factor is the workload of a rural GP:

> *The problem with smaller towns is that the people burn out. I was up last night at six o'clock, and I was called at who knows what time of the night with various phone calls from the different hospitals. Today I am here again at the hospital. Your call frequency is quite high. I am not going to moan about it, because it is my choice to be here, but last night I was putting my daughter down for the night and I had a phone call in the middle of it, or I will be in the shower and the phone rings. It is non stop. It is not like being on call and being called twice a week. You get phone calls all the time. After a while, people get fed up with it. They want to have a life. I think the generation that just worked has gone. People want to have a lifestyle. The problem is that it is very difficult to provide that in smaller towns. It is very, very difficult.*[199]

Local support to obtain new GPs

Consequently, further support for obtaining new GPs for country towns often has to come from various sources, including directly from WACHS. Dr du Preez paid $30,000 from his own funds to obtain two new colleagues "because the only way I could get them was through a recruiting agency."[200] Elsewhere, State agencies such as the Great Southern Development Commission (GSDC) assist the Department of Health with sponsorship issues for placing overseas medical staff in country towns.[201] The GSDC is responsible for certifying permanent visa nominations under the Regional Skilled Migration Scheme but has no role in the certification of applications for any other visas including the employer nominated temporary visas (subclass 457), employer nominated permanent visa (subclass 856), independent skilled visas (885) or the Medical Practitioners' visa (subclass 422).

Over the past 10 years the GSDC has certified nominations for permanent visas for the:

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198 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p4.

199 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, pp4,7.

200 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p5.

201 Mr Russell Pritchard, Regional Manager, Great Southern Development Commission, *Transcript of Evidence*, 11 September 2009, p2.

- six Enrolled/Registered Nurses (five sponsored by hospitals and one by a nursing home);
- one Orthopaedic Surgeon (sponsored by WA Country Health Services);
- one General Practitioner (sponsored by a private practice);
- one Clinical Psychologist (sponsored by a private practice);
- one Physiotherapist (sponsored by Albany Health Services);
- one Dental Assistant (sponsored by a private practice); and
- one General Manager for a Medical Practice (sponsored by a private practice).[202]

The small Shire of Merredin reported to the Committee that "Over the five or six years before that, the shire put in well over $1 million to attract and house GPs."[203] It has finally secured an overseas-trained GP after having to rely for several years on a number of locums.

Finding 80

Western Australia has far fewer general practitioners (GPs) per capita of population than other jurisdictions and this has been known to State governments for many years. Despite the recruitment of GPs being a Federal Government responsibility, the State Government can help entice and retain GPs to country areas through a variety of measures, including the provision of quality accommodation.

Recommendation 43

The Government should urgently boost the funds available to provide housing in country Western Australia for health staff, especially nurses and medical staff employed by the WA Country Health Service, to assist in the recruitment and retention of these staff.

11.4 Capital for health projects and 'Royalties for Regions'

The Committee was consistently told at its rural hearings of deficiencies in the physical infrastructure of WACHS facilities. The most commonly cited problems were run-down hospitals

202 Mr Bruce Manning, Chief Executive Officer, Great Southern Development Commission, *Reply to Questions on Notice*, Great Southern Development Commission, 9 October 2009, pp1-2.

203 Councillor Ken Hooper, Shire President, Shire of Merredin, *Transcript of Evidence*, 7 September 2009, p2.

and the lack of sufficient residential aged-care and mental health accommodation. While these issues are specifically dealt with in later chapters, this section examines the broad impact of the Government's 3% efficiency dividend on WACHS capital works planning.

It is apparent that the WACHS' capital plan has suffered under the Government's 3% efficiency dividend and cuts to the 2009-10 health budget. Parliament was told "The Busselton integrated district health service had money taken out of the budget and pushed back by three or four years. Funding for the Harvey District Hospital redevelopment and for the Esperance Integrated District Health Service has been pushed back over the forward estimates."[204]

The Government has made up for some of these cuts to country health infrastructure with one-off grants from the Royalties for Regions (RFR) program. Regional Development Minister, Hon Brendon Grylls, launched RFR on 16 December 2008. The RFR fund comprises 25% of the State's mining royalties (about 4% of the State budget) and are being distributed through three channels:

- **Country Local Government Fund** — funding of $500 million over the years 2008-13 to assist country local governments build and maintain community infrastructure;
- **Regional Community Services Fund** — designed to improve the access to services in the regions. It supports services that have shown they are effective in enhancing the quality of life for residents in regional areas and in providing better access to government services and infrastructure, and include:
  - Patient Assisted Travel Scheme.
  - Boarding Away from Home Allowance.
  - Royal Flying Doctor Service.
  - Community Resource Centres.
  - Country Age Pension Fuel Card.
- **Regional Infrastructure and Headworks Fund** — supports large-scale, strategic regional infrastructure and headworks projects that do not fall neatly into the responsibilities of one State Government department or local government for implementation, such as the Ord-East Kimberley Expansion Project and the Regional Airports Development Scheme.[205]

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204 Hon Ken Travers MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 19 November 2009, p9388.

205 Department of Regional Development and Lands, 'The Funds', 30 June 2009. Available at: www.royaltiesforregions.wa.gov.au/Content/TheFunds/Default.aspx. Accessed on 13 April 2010.

Over 2009-13, the RFR program will total about $3 billion with an estimated $644 million to be distributed in 2009-10.[206] Major RFR capital projects for health facilities include $15.8 million of funding for the redevelopment of Kalgoorlie Hospital in addition to that provided by DOH's budget, $10 million for the redevelopment of the Nickol Bay Hospital in Karratha[207] and $60.9 million for the Albany Regional Hospital.[208]

The Regional Community Services Fund supports large health related-projects. Examples include $29.9 million for the Royal Flying Doctor Service and $30.8 million over four years for the Patient Assisted Travel scheme.[209] The 'Regional Grants Scheme' (RGS) is part of the Regional Infrastructure and Headworks Fund and has provided some capital for smaller health-related projects in country regions. The first round of RGS grants funded 320 projects throughout regional Western Australia totalling $32.4 million. Appendix Six outlines the 44 health-related grants funded in the first round of the RGS, which totalled $3.59 million, or about 10% of the total funds.[210]

Parliament was told of other medical-related projects funded from other RFR channels:

> *In the Goldfields-Esperance region, the Rural Clinical School of Western Australia, which incorporates the University of Western Australia and the University of Notre Dame Australia, has invested some money in the western desert kidney project and the Esperance computerised tomography scanner project... Money has been invested to secure a CT scanner for Esperance District Hospital, which is vitally important for the health of people who live in that region. The Shire of Gnowangerup, through the Great Southern Development Commission, has chosen to apply for some money under the regional grants scheme to upgrade its medical centre.*[211]

Public information on all of the health-related projects funded by the RFR program is unavailable. From what can be gathered, approximately $100-150 million (or 4-5%) of the $3 billion distributed through the RFR between 2009 and 2013 has been allocated to health-related projects.

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206 Hon Ms Helen Bullock MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 25 November 2009, p9720.

207 Department of Regional Development and Lands, 'Kalgoorlie Hospital', 30 June 2009. Available at: www.royaltiesforregions.wa.gov.au/Content/MajorProjects/KalHospital.aspx; and 'Nickol Bay Hospital', 30 June 2009. Available at: www.royaltiesforregions.wa.gov.au/Content/MajorProjects/NBHospital.aspx Accessed on 13 April 2010.

208 Hon Dr Kim Hames, Minister for Health, 'State Budget 2009-10: Health Care', 14 May 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemId=131839. Accessed on 13 April 2010.

209 Hon Mr Jim Chown MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 25 November 2009, p9721.

210 Hon Mr Brendon Grylls, Minister for Regional Development, 'Key Royalties for Regions grants go to communities', 29 June 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132127&minister=Grylls&admin=Barnett. Accessed on 13 April 2010.

211 Hon Ms Mia Davies MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 25 November 2009, p9717.

The Minister for Health argued in Parliament during the Estimates hearings that the funds for major capital works at country hospitals such as Kalgoorlie, Nickol Bay and Albany, which might be considered as 'normal' DOH expenditure and hence outside of the RFR program, were "things not on the original [DOH] budget but things for which the community wishes to use its RFR funding and be a part of."[212]

Finding 81

The Royalties for Regions program has committed substantial funds for country health projects, but there is no single location that records all of the health-related projects funded by the scheme.

Recommendation 44

The Department of Health include in the WA Country Health Service annual report all of the projects funded, or partially-funded, from the Royalties for Regions program.

Recommendation 45

To alleviate some of the major challenges facing the WA Country Health Service, the Government should commit at least 10% of the Royalties for Regions funds (or about $300 million between 2009-13) to health projects in regional and rural areas. This extra funding should be directed towards improving WACHS' physical infrastructure and clinical equipment.

[212] Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 May 2009, pE546.

CHAPTER 12 CLOSING THE GAP - INDIGENOUS HEALTH

12.1 Introduction

The Committee's interest in Indigenous health flows from an earlier inquiry in the 37th Parliament on successful Indigenous programs, *Ways Forward- Beyond the Blame Game: Some Successful Initiatives in Remote Indigenous Communities in WA,* and the evidence that it received for its *Inquiry Into The Tobacco Products Control Amendment Bill 2008* on the effect smoking has on increasing the gap in life expectancy between Indigenous and non-Indigenous Australians. Evidence for this Inquiry was gathered in rural Western Australia, from Kalgoorlie to Albany.

The Reid Report noted that Indigenous health required urgent redress and described as 'untenable' the existing inequities in health status and in access to health care for Indigenous Western Australians. Recommendations 14 to 17 were specific to Indigenous health and said that a primary care strategy involving the informed preferences of the communities themselves was called for, in particular to address chronic disease management and unsafe lifestyle factors. It recommended a new inter-agency approach (at both the Federal and State level) and a preventive framework to Indigenous maternal health 'from conception onwards' as a way of improving the health outcomes of future generations of Indigenous Western Australians.[213] The *Clinical Services Framework 2010-2020* gives limited coverage to Indigenous health issues but does discuss the Indigenous Health Partnership Agreement that the State has entered into with the Federal Government (see below for more information). DOH reports that it has developed an 'implementation plan' for this Agreement and that "detailed project plans will be prepared in close consultation and collaboration with Aboriginal communities and agencies".[214]

Finding 82

The Reid Report identified major inequities in health status and access to health care for Indigenous Western Australians.

The Australian Medical Association's (AMA) Indigenous health report card for 2009 collates the tragic facts of the health of Indigenous males, including that "An Indigenous boy born during 2005-07 can expect to die at age 67, nearly six years earlier than an Indigenous girl, and 11.5 years

213 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp34-38.

214 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p32. For a copy of the WA Implementation Plan, see www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/closing_the_gap/Closing_the_Gap_on_Indigenous_Health_Outcomes_WA_Implementation_Plan.pdf. Accessed on 1 February 2010.

earlier than a non-Indigenous boy born in the same period."[215] A decade ago the Australian Bureau of Statistics (ABS) found that Indigenous Australians were admitted to hospital at twice the rate of non-Indigenous Australians. Care involving dialysis (used in the treatment of kidney failure) accounted for 29% of hospital admissions for Indigenous Australians (compared to 8% for non-Indigenous) while Indigenous males had admission rates six times that of non-Indigenous males, and females 14 times that of non-Indigenous females.[216] The principal diagnosis for Indigenous patients in hospitals was 'care involving dialysis' and the next three most commonly recorded principal diagnoses were 'pregnancy and childbirth', 'injury and poisoning' and 'respiratory diseases'.[217]

The dire situation surrounding Indigenous health led the current Federal Government to develop a long-term strategy to 'close the gap' between the life expectancy of Indigenous and non-Indigenous Australians. The recent United Nations *State of the World's Indigenous Peoples* report found that the gap between Indigenous and non-Indigenous Australians was the worst of 90 countries, and twice that found in New Zealand.[218] In 2008, the Council of Australian Governments (COAG) agreed to six targets relating to Indigenous life expectancy, health, education and employment and committed a $4.6 billion budget to provide a framework to invest in basic health, education and other services needed to put Indigenous Australians on an equal footing with other Australians. The six key targets are to:

(i) close the life expectancy gap within a generation;

(ii) halve the gap in mortality rates for Indigenous children under five within a decade;

(iii) ensure access to early childhood education for all Indigenous four years olds in remote communities within five years;

(iv) halve the gap in reading, writing and numeracy achievements for children within a decade;

(v) halve the gap for Indigenous students with year 12 attainment or equivalent attainment rates by 2020; and

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215 Australian Medical Association, 'AMA Report Card Series 2009- The Health of Indigenous Males', 10 November 2009. Available at: www.ama.com.au/system/files/node/5114/AMA+Indigenous+Health+Report+Card+2009.pdf. Accessed on 16 December 2009.

216 Australian Bureau of Statistics, '4711.0 - Occasional Paper: Hospital Statistics, Aboriginal and Torres Strait Islander Australians, 1999-2000', 11 December 2002. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4711.01999-2000?OpenDocument. Accessed on 15 December 2009.

217 Australian Bureau of Statistics, '4711.0 - Occasional paper- Hospital Statistics- Aboriginal and Torres Strait Islander Australians, 1999-2000', 11 December 2002. Available at: www.ausstats.abs.gov.au/ausstats/free.nsf/0/80D5EF00E1DD149FCA256C8D000A59FA/$File/47110_1999-2000v2.pdf, p17. Accessed on 15 December 2009.

218 Mr Daniel Emerson, 'Aboriginal life expectancy an 'international disgrace'', *The West Australian*, 16 January 2010, p19.

(vi) halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.[219]

The COAG funding has been incorporated into national partnerships between the Federal government and the states and territories. These partnerships are the:

- National Partnership on Indigenous Health Outcomes;
- National Partnership on Remote Indigenous Housing;
- National Partnership on Indigenous Early Childhood Development;
- National Partnership on Indigenous Economic Participation; and the
- National Partnership on Remote Service Delivery.

The National Partnership on Indigenous Health Outcomes commits $1.57 billion over four years to reduce the biggest risk factors, such as smoking, to improve chronic disease management and follow-up, and to expand the capacity of the health workforce to tackle chronic disease. This investment will result in:

- more than 133,000 additional health checks;
- 400,000 additional chronic disease management programs for Indigenous people with a chronic condition;
- support for more than 160 new Indigenous outreach working positions;
- 75 extra health professionals and practice managers in Indigenous healthcare services;
- 38 new GP registrar training posts in Indigenous health services; and
- expanded nurse scholarship and clinical placements.[220]

The Health Minister, Dr Kim Hames, reported to Parliament that the Government would work closely with the Aboriginal Medical Service (AMS) and community organisations such as Rotary to deliver programs. The Minister said "We will contract through the AMS to provide a range of services not just to manage diabetes, which is critical, but also a range of other health problems

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219 FaHCSIA, 'The Government's approach to Indigenous policy', 3 March 2009. Available at: www.fahcsia.gov.au/sa/indigenous/pubs/general/documents/closing_the_gap/p1.htm. Accessed on 15 December 2009.

220 FaHCSIA, 'COAG - a new partnership with all governments', 27 February 2009. Available at: www.fahcsia.gov.au/sa/indigenous/pubs/general/documents/closing_the_gap/p3.htm. Accessed on 15 December 2009.

throughout the state."[221] The State's program was launched on 16 March 2010 and Dr Hames announced the roll-out of a $128.7 million reform program under the COAG National Partnership agreements to improve Indigenous health in Western Australia in the next four years. Significant aspects of the new program include:

- involvement of Indigenous people in both the planning and development process to improve Aboriginal health services;
- more than 80 health programs and services to be funded;
- 180 dedicated positions to be created for Indigenous people across health services;
- a network of Aboriginal Health Liaison Officers employed to provide support for Aboriginal patients in their journey through the hospital and primary health care systems;
- an additional investment of $17.1 million from the Federal Government directed towards Indigenous early childhood development programs; and
- a significant investment into dedicated Indigenous mental health services of more than $44 million over the next four years.[222]

12.2 Background

The ABS estimates that in 2006 there were nearly 78,000 Indigenous Western Australians (3.8% of the population), an increase of 18% over the figure for 2001. This increase was the largest of all Australian jurisdictions for 2001-06, and meant that 15% of Australia's Indigenous population lived in Western Australian. The ABS has developed a reporting mechanism for Indigenous Regions (IREGs) largely based on the former Aboriginal and Torres Strait Islander Commission Region boundaries. Table 12.1 below lists the Western Australian Indigenous people living in these regions in 2006.[223]

221 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 November 2009, p9794.

222 Hon Dr Kim Hames, Minister for Health, '$128.7million reform roll-out to improve Aboriginal health', 16 March 2010. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=133236. Accessed on 23 March 2010.

223 Australian Bureau of Statistics, '4705.0 - Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006', 15 August 2007. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4705.0Main+Features12006?OpenDocument, pp45-52. Accessed on 15 December 2009.

Table 12.1- Indigenous population of Western Australian Indigenous regions

IREG	Population	Proportion of IREG Pop.
Broome	3,560	27.3%
Derby	4,431	63.3%
Geraldton	5,496	10.1%
Kalgoorlie	5,220	9.9%
Kununurra	4,336	46.9%
Narrogin	8,456	2.6%
Perth	21,321	1.5%
South Hedland	5,660	13.1%

DOH does not allocate a specific budget for Indigenous health programs but reported to Parliament that its total expenditure per person on health in 2004-05 was $3,844 for Indigenous and $1,369 for non-Indigenous persons. This compares with national figures of $4,471 for Indigenous and $3,820 for non-Indigenous Australians.[224] It is unclear how these figures were derived.

12.3 Administrative arrangements

Nearly three-quarters of Indigenous Western Australians live in regions where health care is provided by the WA Country Health Service (WACHS), the largest country health system in Australia covering an area of 2.5 million square kilometres. They can access health services either via an Aboriginal Community Controlled Health Organisation (ACCHO) or the mainstream services offered by WACHS.[225] The Kimberley region has Aboriginal community-controlled services in each of the major centres—Derby, Broome, Halls Creek, Fitzroy Crossing and Kununurra—and these organisations also service a number of outlying communities from those centres. WACHS also has an arrangement with the Northern Territory Government whereby many of the health services for Warburton and 'the lands' are provided in Alice Springs.

About half of the State's Indigenous population live in Perth or the South West, and it was claimed that the State Government had no strategic plan for this region, despite having one for remote regions. The Kimberley seems better served by health services compared to the South West, and is home to the Aboriginal Medical Service Council (AMSC) which consists of 13 Aboriginal medical services or nursing outposts. The AMSC provides support services around

[224] Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Council, *Supplementary Information No C1* (Hansard), 18 June 2009, pp745a-761a.

[225] Private hospital services outside of Perth are limited to Bunbury and Geraldton.

governance, financial management, human resources, and backup services for equipment. Mr Darryl Kickett told the Committee that the Nyoongah are the largest single-language Indigenous group in Australia, and unlike the Kimberley:

> *apart from the South West Aboriginal Land and Sea Council, we do not have any regional structure that addresses the governance of [health] service delivery. In fact, one of the keys to improving the situation is these regional structures.*[226]

The Committee heard that a key concern for many Indigenous people is the ability to access a similar level of service as that available to non-Indigenous people:

> *I wish we could get the help from down in the city, especially so that in country areas we can get the same treatment. Just because we are out in the bush, we are all forgotten about. We need to close the gap, like people have been talking about for years and years and are still talking about it. That is all it is—just talk.*[227]

The Committee received conflicting evidence about what was the preferred model of access for Indigenous patients. For example, some favour mainstream access:

> *The difference between Albany and Bunbury and other places is that we do not have an AMS down here. We have Nyoongahs who have access to general practitioners, the hospital, Lions, Silver Chain and all the others. They are all, particularly Silver Chain, held in the highest regard amongst Nyoongah people. We have mainstream access right away. … After all, we are all taxpayers, whether we are unemployed or not, so we are entitled to use the services, and I am happy to come back here after 15 or 20 years away and see that Nyoongahs have their own GPs and they are accessing our hospital and our community services.*[228]

This view was confirmed by Katanning GP, Dr Nicolas du Preez:

> *I think that some Aboriginal people do not want to see the Aboriginal health workers because of family connections or because it is confidential, or whatever. … The impression that I get—I may be wrong; this is a personal opinion—is that they want to be treated like everyone else and not differently from everyone else. They have got separate issues that need to be resolved, but they want to go through the same process and be seen as the same and not have different treatment.*[229]

On the other hand, evidence was also received that Indigenous patients prefer to access services run by their own people. The Nyoongah clinic in Merredin offered services 'from preconception to

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226 Mr Darryl Kickett, Former CEO, Aboriginal Health Council of Western Australia, *Transcript of Evidence*, 23 September 2009, p3.

227 Mr Michael Hayden, Chairperson, Merredin Aboriginal Project, *Transcript of Evidence*, 7 September 2009, p9.

228 Mr Lester Coyne, Manager- Aboriginal Health, Great Southern Aboriginal Health Service, WA Country Health Service, *Transcript of Evidence*, 11 September 2009, p4.

229 Dr Nicolas du Preez, General Practitioner, *Transcript of Evidence*, 21 September 2009, p13.

the grave.' The clinic was established for two reasons — the severe financial impact of a lack of bulk billing by GPs and the lack of access for antenatal services in the hospital:

> *Back then in 2001, if clients did not cancel an appointment, they would be charged a non-attendance fee, and the fee would compound; it would go up to $50, and if they did not pay that, a bailiff would be sent around to claim $250 worth of their possessions. If they owed an account to the surgery, they could not be seen by the GP or present to the hospital if they were pregnant to ask for a check-up because it was not an accident or emergency situation; nor could they present for a check-up if they were suffering from diabetes.*[230]

What does seem of importance is the deep attachment Indigenous people have with their families. For example, in the Albany region there are about 2,000 Nyoongahs from 13-14 families. Some of these families are worried about the access to their health records by Indigenous health staff from other families and therefore prefer accessing mainstream services. The evidence from a health counsellor reflects this uncertainty over who should provide services:

> *We did a bit of a thumbnail sketch for our Indigenous clients and asked, "Would you prefer a Nyoongah—an Indigenous counsellor—non-Indigenous, or you don't mind?" There was about a third in each domain. Indigenous people made the comment that for some issues they would like to see a white person, for other issues a Nyoongah person, and sometimes they did not mind, and so on and so forth. I think that is a fair representation amongst the clients that we see; sometimes they will ask for an Indigenous counsellor, but not always.*[231]

It would seem that the best approach is for WACHS to offer a choice in services for Indigenous people by supporting mainstream services while also enhancing a range of Indigenous health organisations that have the backing of their communities.[232] For example, in 2009 WACHS strengthened its relationship with the Indigenous organisation Unity of First People of Australia (UFPA) to improve the health of Indigenous communities in the Kimberley. The State Government funding of $500,000 per year for four years, will enable the UFPA to expand the *Roadmap Towards Better Health Program* to more Indigenous people in the Kimberley.[233]

The benefits of working closely with Indigenous communities was acknowledged by WACHS:

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230 Ms Suzann Franklin, Clinical Nurse, Eastern Wheatbelt Aboriginal Health, *Transcript of Evidence*, 7 September 2009, p4.

231 Mr Bryan Taylor, Palmerston- Association Inc, Great Southern Community Drug Service Team, *Transcript of Evidence*, 11 September 2009, p7.

232 The Committee was told "the majority of Aboriginal people do not actually use those services; they use the generic services." Professor D'Arcy Holman, Chair in Public Health, University of Western Australia, *Transcript of Evidence*, 26 August 2009, p9.

233 WA Country Health Service, 'Annual Report 2008-09', 17 September 2009. Available at: www.health.wa.gov.au/publications/documents/annualreports/2009/WACHS%20Annual%20Report%202008-09_Final.pdf, p9. Accessed on 15 December 2009.

> *Fitzroy Crossing is a good example of a very effective partnership between, in this case, the WA Country Health Service and Nindilingarri Cultural Health Service, with co-location on the same site and a clear partnership agreement around who does what in terms of services in the community. With the added benefit of alcohol restrictions, there has been a marked reduction in presentations to accident and emergency for trauma, domestic violence and so on, but also being shown how best to do business with Aboriginal people and communities. That partnership allows that to occur in a very effective way, so we think that that is an important place to start. A similar agreement has occurred in Norseman and north of Kalgoorlie. There has not been a lot of publicity around it and it is a voluntary thing, including publican volunteers, about restrictions in terms of alcohol. That has been a very community-driven approach. The factual part of what I have seen is that when one works with the community, one will have a much more sustainable and lasting impact that will benefit the community.*[234]

The Committee also heard of a successful program run at Sister Kate's which identified about 15 families who required one-on-one support to be able to deal with issues such as alcohol, drugs and education outcomes. Mr Kickett said:

> *I believe that that is something that probably has merit with the revolving door stuff that is happening around welfare and police. If you track it down, you will find that it is only a few of those families who are actually involved with it all, even in each town, and there ought to be some concentration on those families to help them better adjust to make a better contribution in the community.*[235]

While the Committee heard powerful evidence from a range of witnesses on the importance of family to Indigenous Western Australians, DOH's planning (such as its Implementation Plan for the Indigenous Health Partnership Agreement signed in June 2009) continues to focus on regions.[236]

Finding 83

Indigenous people's primary identification is to their own extended families.

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234 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p8.

235 Mr Darryl Kickett, Former CEO, Aboriginal Health Council of Western Australia, *Transcript of Evidence*, 23 September 2009, p9.

236 Department of Health, 'National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan Western Australia', June 2009. Available at: www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/closing_the_gap/Closing_the_Gap_on_Indigenous_Health_Outcomes_WA_Implementation_Plan.pdf, p3. Accessed on 1 February 2010.

Recommendation 46

In addition to gathering regional data, the Department of Health should establish processes that monitor the health of Indigenous Western Australians in regional areas. Services should be provided based on regional needs, and where appropriate, within a family context.

(a) Indigenous health workers

An example of a large Indigenous health organisation, the Bega Garnbirringu Health Service (BGHS) in Kalgoorlie, was established 26 years ago and offers the following services:

- a clinic;
- an outreach post at Mulga Queen;
- a chronic disease program;
- a visiting dentist once every five weeks for a week;
- a small sexual health unit;
- eight visiting specialists who visit, primarily from Perth (eg. an ophthalmologist, an ear, nose and throat specialist, a podiatrist, a dietician and a renal specialist); and
- a social support unit, offering the breakfast program, the fringe-dweller support program and the Sobering Up Centre.[237]

In terms of government services, about 3% of the WACHS total workforce is Indigenous.[238] The figures for the WACHS-Goldfields population health team is 12-15%, but doesn't include any doctors or nurses.[239] The other area where the Committee received conflicting advice was the importance of providing either more Aboriginal health workers or more highly-trained nursing staff.

For example, the Committee heard:

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237 Ms Sue Cristopoulos, Manager- Clinical Services, Bega Garnbirringu Health Service, *Transcript of Evidence*, 14 September 2009, p2. For more information about the BGHS see www.bega.org.au/welcome.htm.

238 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p8.

239 Dr Anne Mahony, Director- Population Health, WA Country Health Service, Goldfields, *Transcript of Evidence*, 14 September 2009, p7.

> *We would like more workers in the area, but I would like to see an increase in qualified Aboriginal personnel, mainly in enrolled nursing. I think the Aboriginal health workers as a screening tool is fine, but the issue is that supply has to match demand. If we are going to have Aboriginal people working in these areas, we need more people with qualifications, primarily in health but in all manner of different areas. A person qualified as an enrolled nurse can get a job anywhere. Health workers cannot.*[240]

On the other hand, the Committee heard that the Merredin region didn't have enough health workers.[241] WACHS gave evidence that it needed an increase in both workforces. It has also invested heavily in the development of an Aboriginal allied health assistant model, whereby an allied assistant works directly under the supervision of a therapist and implements programs with relevant clients. There are two pilot sites for this program — Leonora in the Goldfields and Derby in the Kimberley — however, there are only three students currently undertaking the TAFE Certificate 3 course.[242]

Finding 84

A greater number of Indigenous health staff within the Department of Health is an important part of the strategy to deliver health services to Indigenous Western Australians.

Recommendation 47

The Western Australian Government needs to increase its support for the education of more Indigenous people to work in the health system, either as nurses and doctors, or as allied health workers.

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240 Mr Lester Coyne, Manager, Aboriginal Health, Great Southern Aboriginal Health Service, WA Country Health Service, *Transcript of Evidence*, 11 September 2009, p7.

241 Ms Suzann Franklin, Clinical Nurse, Eastern Wheatbelt Aboriginal Health, *Transcript of Evidence*, 7 September 2009, p2.

242 Ms Karen De Bonde, Goldfields Regional Nurse Director, WA Country Health Service, Goldfields, *Transcript of Evidence*, 14 September 2009, p5.

Recommendation 48

In its annual report to Parliament, the Department of Health should report the total expenditure on Indigenous health programs in Western Australia broken down by:

(a) State funding.

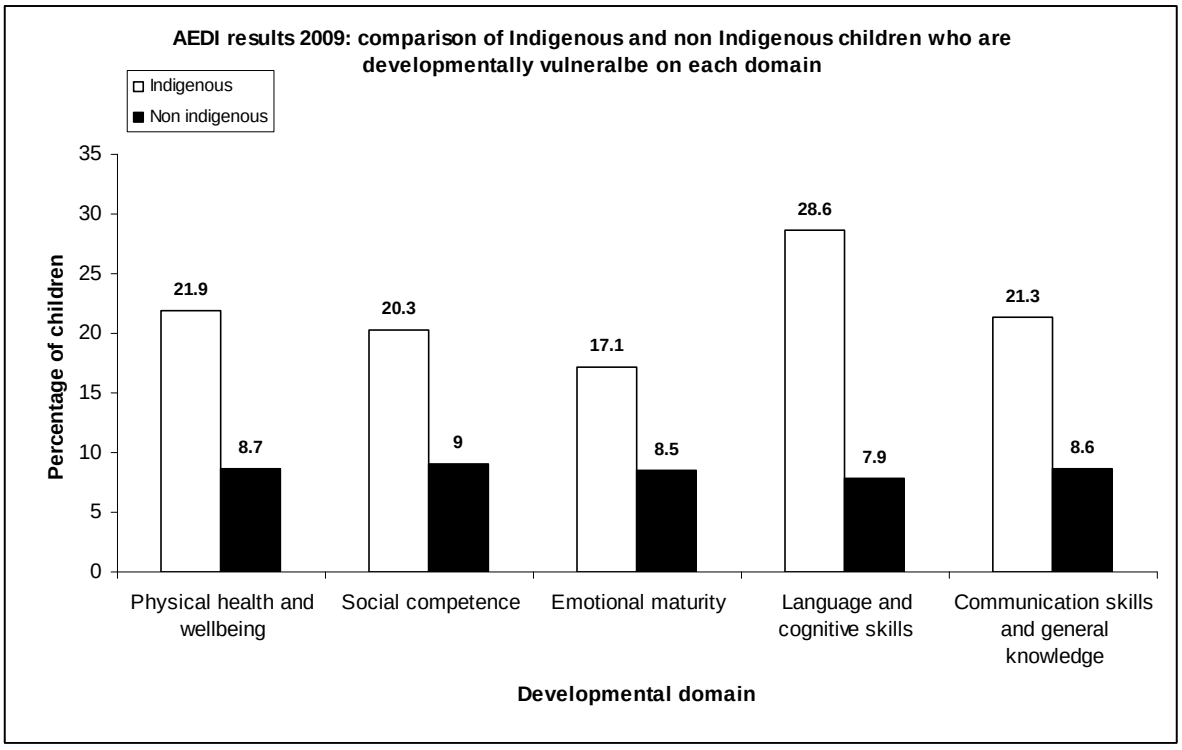
(b) Federal funding.

This should include data on the number of Indigenous and non-Indigenous staff employed in these programs.

(b) Early childhood programs

Results from the *Australian Early Development Index* (AEDI) indicate that a greater proportion of Indigenous children are vulnerable on all developmental domains. A total of 47.3% of Indigenous children were vulnerable on one or more domain, which is twice the rate of non-Indigenous children (23.4%). About 29.5% were vulnerable on two or more domains (about two-and-a-half times the rate of non-Indigenous children (11.8%)) while performance in the language and cognitive skills domain is particularly concerning with 28.6% of Indigenous children being vulnerable, and a total of 51.9% being either vulnerable or at risk (see Figure 12.1 below).

Figure 12.1- Comparison of Indigenous and non-Indigenous children outcomes



Nationally, compared to their non-Indigenous counterparts, Indigenous children are:

- 2.9 times more likely to die at birth.
- 5.4 times more likely to die from sudden infant death syndrome (SIDS).
- 2.6 times more likely to have a neural tube defect.
- 5.4 times more likely to be born to a teenage mother.
- 9.2 times more likely to be in out of home care.
- 3.2 times more likely to die from an injury.
- 2.0 times more likely to be born with a low birth weight.[243]

243 AIHW, 2008, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58, April, p134.

As the Committee's *Invest Now or Pay Later* report confirmed, Western Australia's rates in several instances are worse than the national rate, placing Indigenous children at even greater disadvantage in this State:

- The percentage of Indigenous children born of low birth weight in Western Australian is higher (16.2%) than the national average (12.5%).[244]
- Western Australia's rate of Indigenous teenage births per 1,000 (114) is nearly 50% higher than the national rate (79.6).[245]
- Western Australia's immunisation coverage for Indigenous two year olds (85.7%) is lower than the national rate (90.7%).[246]
- Fewer Western Australian Indigenous children achieved at or above the grade 5 minimum literacy and numeracy standards: 51.8% of Indigenous children performed at or above the minimum standard for literacy compared to 63.4% nationally; and 61.6% of Indigenous children performed at or above the minimum standard for numeracy compared to 69.2% nationally.[247]

Indigenous staff offering services to their local communities recognise the importance of preventative and primary health programs, such as early years playgroups where mothers can receive information on health programs (eg immunisation). As was recognised in the Committee's report *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*[248], these programs often have additional benefits for Indigenous children. This was confirmed by evidence received during this Inquiry:

> *For instance, you can get young families to attend regular health assessments for the health of their children, and you can encourage them to get involved in playgroups and things like that. You can support them socially. You can facilitate them becoming involved in schools so that school is not so intimidating for them and so that when the children become eligible to start kindy, they attend regularly, and then when they get to pre-primary they are attending full-time.*[249]

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244 P. Laws and E. Sullivan, 2009, *Australia's Mothers and Babies 2007. Perinatal statistics series no. 23 Cat. no. PER 48*, AIHW National Perinatal Statistics Unit, Sydney, p71.

245 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

246 Australian Institute of Health and Welfare, 'Children's Headline Indicators'. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 9 February 2010.

247 AIHW, 2008, *Key National Indicators of Children's Health, Development and Wellbeing: Indicator Framework For A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, Bulletin 58, April, p163.

248 Education and Health Standing Committee, 2009, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Parliament of Western Australia, Perth.

249 Ms Suzann Franklin, Clinical Nurse, Eastern Wheatbelt Aboriginal Health, *Transcript of Evidence*, 7 September 2009, p10.

In terms of improving the health and education of Indigenous children, the State Government is aiming to halve the gap in reading, writing and numeracy achievements between Indigenous and non-Indigenous children within the next 10 years using $42.4 million provided by the Federal Government over the next six years for infrastructure, staff and resources. As part of its Indigenous Early Childhood Development National Partnership, the Minister for Education, Dr Constable, said that five new children and family centres will be established across Western Australia by 2014. The first centre would be established in Halls Creek followed by facilities in Fitzroy Crossing, Kununurra, Roebourne and the Swan region.[250]

The Committee was told of a new program coordinated by the Aboriginal Health Council of WA in partnership with the Fiona Stanley Institute to set up centres of excellence within the Aboriginal Medical Service for child and maternal health "…ensuring that women who become pregnant have access to care in each trimester, that they stop smoking and all those kinds of things."[251] The initial centres will be established at Kununurra, Roebourne and Geraldton.

Another early childhood program funded by the Federal Government is the *Footprints in Time* research project which is tracking the long-term development of 1,687 children and will give researchers the capacity to look in depth at the early childhood experiences of Indigenous children and how these experiences influence their future. The study follows Indigenous children aged between six months and five years from 11 sites across Australia (including Derby, Fitzroy Crossing and Broome in Western Australia) along with their parents and carers. The families will be interviewed yearly over at least four years. The first results of the study show that while almost all parents (97%) rated their children's health as either excellent, very good or good, it revealed common conditions such as ear problems (20%), chest infections (15%), asthma (13%) and eczema (11%).[252]

Finding 85

Early childhood programs for Indigenous children need to address both their education and health outcomes.

250 Hon Dr Elizabeth Constable, Minister for Education, 'New centres to help close Aboriginal health and education gap', 2 October 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=132559. Accessed on 16 December 2009.

251 Mr Darryl Kickett, Former CEO, Aboriginal Health Council of Western Australia, *Transcript of Evidence*, 23 September 2009, pp6-8.

252 Hon Ms Jenny Macklin, Minister for Families and Indigenous Affairs, 'Indigenous culture key in first Footprints in Time', 20 October 2009. Available at: www.jennymacklin.fahcsia.gov.au/internet/jennymacklin.nsf/content/footprints_wave_20oct2009.htm. Accessed on 16 December 2009.

Recommendation 49

The Western Australian Government should increase the funding for early childhood programs for Indigenous children, especially in regional areas.

12.4 Indigenous smoking rates

As an earlier Committee report found up to 50% of Indigenous people smoke in many rural and remote communities, and smoking is the cause for about one-third of the 17 year life expectancy 'gap' between Indigenous and non-Indigenous Australians. Evidence was gathered that the effects from smoking kill more Indigenous Western Australians than anything else and that it "has so many side effects attached to it—respiratory problems and financial problems."[253] The need for more government-funded anti-smoking programs is particularly urgent, with the Committee being told that if Indigenous smoking rates were at the same levels as the rest of the community, the life expectancy gap would drop by four years from just this one measure.[254]

There are a number of government and non-government programs currently underway to encourage Indigenous people to quit smoking, such as the one run by the Aboriginal Health Council of WA. In 2008, the Federal Health Minister committed $14 million to address high smoking rates among Aborigines, and the Australian Government has also placed tobacco products on the list of banned products for Indigenous families on the Family Income Management scheme.[255] The State Opposition health spokesperson, Mr Roger Cook, recently announced that smoking should be banned in some Western Australian Aboriginal communities.[256]

However, given the evidence of success over the past three decades in cutting smoking rates in Australia to nearly 15% of the adult population, there is great potential to quickly turn around current Indigenous smoking rates using similar programs targeted at Indigenous communities. The Aboriginal Health Council reported that Aboriginal health workers undertake anti-smoking educational activities but "are absolutely under-resourced, underpaid and absolutely overworked."[257] Western Australia will receive additional funds from the Federal *National*

253 Mr Lester Coyne, Manager, Aboriginal Health, Great Southern Aboriginal Health Service, WA Country Health Service, *Transcript of Evidence*, 11 September 2009, p5.

254 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p6.

255 Education and Health Standing Committee, 2009, *Inquiry Into The Tobacco Products Control Amendment Bill 2008*, Legislative Assembly, Parliament of Western Australia, Perth, p112.

256 Mr Anthony Deceglie, 'Aboriginal smoking ban plan', *The Sunday Times*, 21 March 2010, p12.

257 Ms Christine Ivan, Project Officer, Aboriginal Health Council of WA, *Transcript of Evidence*, 16 February 2009, p3.

Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, which includes smoking as one of its five priority areas.[258] The Minister for Health reported to Parliament that the State's proportion of these funds for tobacco control and smoking prevention programs would be $6.95 million between 2009-13.[259] DOH's implementation plan for expending these funds remains unclear, with plans for a 'working party' to be established and totals of as little as $1.5 million of the Federal funds per annum to be spent on the program.[260]

Finding 86

Significantly reduced levels of smoking by Indigenous people is a major factor in closing the gap between Indigenous and non-Indigenous life expectancies, and would reduce future health costs for the Western Australian health system.

Recommendation 50

Consistent with the Reid Report and CSF 2010, the Western Australian Government should provide additional funds to the Department of Health and non-government agencies to make an urgent priority the cutting of Indigenous smoking rates over the next five years to a level closer to that of the general population.

The Western Australian Government did not agree to a recommendation for a special smoking reduction plan for Indigenous smokers when it responded to the recommendations of the Committee's *Inquiry into The Tobacco Products Control Amendment Bill 2008*. It reported that the Western Australian Tobacco Action Plan 2007-11 (WA TAP) would achieve the same results.[261] However, the Committee has no evidence that the WA TAP strategy has had any success at lowering Indigenous smoking rates since 2007.

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258 Education and Health Standing Committee, 2009, *Inquiry Into The Tobacco Products Control Amendment Bill 2008*, Legislative Assembly, Parliament of Western Australia, Perth, p113.

259 Government Response, Western Australia, Legislative Council, *Parliamentary Debates Estimates* (Hansard), 18 June 2009, pE752.

260 Department of Health, 'National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan Western Australia', June 2009. Available at: www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/closing_the_gap/Closing_the_Gap_on_Indigenous_Health_Outcomes_WA_Implementation_Plan.pdf, accessed 1 February 2010, p9. Accessed on 1 February 2010.

261 Hon Dr Kim Hames, Minister for Health, *Response of the Western Australian Government to the EHSC Report No. 1*, June 2009.

The Committee's earlier report included expert testimony that if passive exposure to tobacco smoke was eliminated "we estimate that we could reduce ear infections by 27% in Aboriginal children". Another added that "up to 60% of young Indigenous Australians with asthma reported being current smokers".[262] The report also cited Collins and Lapsley's calculations that "smoking costs the Western Australian community $2.4 billion per year."[263] The Committee recommends that the Government re-considers the suggestion of a separate quit plan for Indigenous Western Australians.

Recommendation 51

The Minister for Health fund and develop a smoking reduction plan for Indigenous people by the end of 2010 and provide additional funding to employ people to work in this area throughout the State.

In early 2010 the Federal Minister for Indigenous Health, Hon Warren Snowdon, provided funding to two anti-smoking projects aimed at Indigenous smokers in Western Australia. The Asthma Foundation of WA was provided with $477,000 for a project to encourage pregnant Indigenous women, new mothers and their families to create smoke-free environments to protect the developing foetus and newborn babies from exposure to harmful tobacco smoke. DOH's South Metropolitan Area Health Service was also provided with $742,000 for an educational project in the Rockingham and Kwinana area.[264] These programs are a start and may be able to be replicated in other places, but they need to be part of a State-wide strategy.

The two cohorts of smokers that would most easily be addressed by a Quit campaign would be the 21,000 Indigenous people living in Perth (about a quarter of the total Indigenous population) and the State's Indigenous prisoners who smoke. In 2005, Indigenous juveniles accounted for 75% of 10 to 17 year olds in juvenile detention across Western Australia (compared to the national

262 Education and Health Standing Committee, 2009, *Inquiry into the Tobacco Products Control Amendment Bill 2008*, Parliament of WA, Perth, pp112-113.

263 Education and Health Standing Committee, 2009, *Inquiry into the Tobacco Products Control Amendment Bill 2008*, Parliament of WA, Perth, pxviii.

264 Hon Mr Warren Snowdon, Minister for Indigenous Health, '$10.7 Million to Combat Indigenous Smoking', 5 March 2010. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-ws-ws015.htm. Accessed on 23 March 2010.

average of 52%).[265] The ABS reports that in mid-2009 there were about 2,296 Indigenous Western Australians in prison.[266]

Recommendation 52

The Department of Corrective Services and the Department of Health undertake an urgent campaign to lower smoking rates among Indigenous prisoners in Western Australia's prisons and to make the State's prisons smoke-free by the end of 2011.

12.5 Indigenous diabetes rates

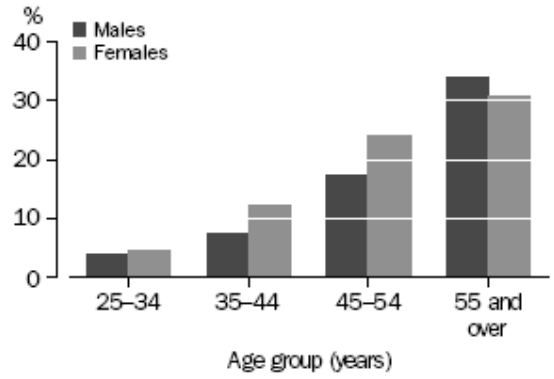
The major health issue facing Indigenous people is chronic kidney disease associated with type-2 diabetes. Research has shown that, within the Indigenous population, diabetes is more prevalent among females than males and the difference in rates is greatest in the 45–54 year age groups — 17% of males and 24% of females (see Figure 12.2 below). In 2004–05, nearly one-third (32%) of Indigenous people aged 55 years and over reported having diabetes. Significant increases in prevalence are witnessed almost 20 years earlier among Indigenous people. For example, in 2004–05, the diabetes prevalence among Indigenous people aged 35–44 years (10%) was similar to that among non-Indigenous Australians aged 55 years and over (12%).[267]

265 Australian Institute of Criminology, 'Diversion of Indigenous juvenile offenders', 13 July 2009. Available at: www.aic.gov.au/publications/current%20series/tandi/341-360/tandi355/view%20paper.aspx. Accessed on 14 December 2009.

266 Australian Bureau of Statistics, '4512.0 - Corrective Services, Australia', June Quarter 2009. Available at: www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6D40D47262413E35CA257633001D3A2F/$File/45120_jun%202009.pdf, p22. Accessed on 14 December 2009.

267 Australian Bureau of Statistics, '4102.0 - Australian Social Trends, 2007', 7 August 2007. Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/0/5AB12BE9F12ABBC7CA25732C002082BD?opendocument#DIABETES. Accessed on 14 December 2009.

Figure 12.2- Diabetes rate by age, for Indigenous Australians



(a) Includes high sugar levels.

Source: ABS 2004–05 NATSIHS.

The highest rates in the world for diabetes are in Western Australia's Central and Western Desert regions. Incredibly, a recent pilot study in the Western Desert has indicated that the rates of diabetes in the next generation of Indigenous Western Australians will exceed the unacceptably high current rates. The Western Desert Kidney Health study at Mt Magnet indicated that 3% of Indigenous residents were already suffering renal failure. This is 60-times the national rate of 0.05%.[268] At this rate, this region would produce 240 people requiring dialysis, while the Kalgoorlie hospital currently only has 24 places available for dialysis. This hospital only offers haemodialysis in a unit which treats 24 dialysis patients and has capped its dialysis patients with 8 patients on a waiting list. To add another two beds would require another 2.2 nursing FTEs.[269] The Committee heard that:

> *There is not a manager for that unit. We do not have any senior nurses, such as a SRN3 or a nurse practitioner, as stated in the Northern Goldfields Health Services plan, for the dialysis for the future. We do not have anyone at the senior level who can coordinate the education of the patients on renal replacement therapy programs or to get those people who are identified as being a potential end-stage renal failure patients so that we can do some preventive education with them.*[270]

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268 The rate of end-stage renal disease notifications between 2004-07 was 1,076 per 1,000,000 population for Indigenous people in WA, more than 11 times the rate of 99 per 1,000,000 for non-Indigenous West Australians. See, www.healthinfonet.ecu.edu.au/health-facts/overviews/selected-health-conditions/renal-disease, accessed 14 December 2009.

269 Ms Karen De Bonde, Goldfields Regional Nurse Director, WA Country Health Service, Goldfields, *Transcript of Evidence*, 14 September 2009, p6.

270 Ms Lucy Murphy, Coordinator of Nursing, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p10.

Regarding dialysis services in the Goldfields, the Committee was told "we are all just muddling along out there."[271] It was claimed that there was no action plan as to how the region will address the increase in people coming out of renal replacement therapies. On average about 11% of patients move from chronic renal failure to end-stage renal disease (ESRD) each year. If they are fortunate, they will get a transplant but few compatible organs become available for transplant. An Edith Cowan University report found that Indigenous people are less likely to be placed on the transplant waiting list and less likely to move from the waiting list to transplantation. For those who do receive a transplant, the success rate for Indigenous people remains about two-thirds that for non-Indigenous people. Logistical issues associated with service delivery in remote areas, problems posed by infections or poor compliance, miscommunication between Indigenous patients and health professionals, also contribute to the low rates of transplantation for Indigenous people.[272]

Peritoneal dialysis is done in the patient's home and the Government is trying to increase the number of people who can administer this treatment. However, patients need to be educated on how to operate the machines. Fresenius Medical Care Australia is contracted to conduct education for peritoneal dialysis and is based in Perth. There is a wait list of up to six months for people wanting to complete this education program.[273] Table 12.2 below provides the cost of the various dialysis treatments.

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271 Ms Lucy Murphy, Coordinator of Nursing, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p10.

272 Australian Indigenous HealthInfoNet, 'Summary of Indigenous health: End-stage renal disease', Available at: http://archive.healthinfonet.ecu.edu.au/html/html_health/specific_aspects/chronic/renal/reviews/AHWJ_renal.pdf, p3. Accessed on 14 December 2009.

273 Ms Lucy Murphy, Coordinator of Nursing, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p10.

Table 12.2- Cost of dialysis and peritoneal dialysis, 2008-09[274]

Location of treatment	Cost per treatment,
Home peritoneal dialysis	$121.25 per day
Metropolitan hospital	$853.72
Kimberley*#	$431.33
Pilbara	$435.66
Goldfields	$333.60
Midwest	$374.4 2
Wheatbelt	No service
South West*	$342.81
Great Southern	$332.27

* Provided by non-government organisations under service contracts managed by WACHS but with payments from DOH.
# Includes the cost of GP supervision.

Finding 87

It is cheaper to provide dialysis treatment for non-metropolitan diabetes patients either in their home or in WA Country Health Service hospitals, rather than providing it in metropolitan hospitals.

The need for planning interventions that lower the rate of diabetes is very urgent as the Western Desert Kidney Health study found that 33% of people tested had proteinuria, including 33% of primary school and early high school-aged children. Proteinuria is the presence of an excess of serum proteins in the urine and is a reliable sign of likely kidney damage.[275] Professor Christine Jeffries-Stokes explained that people get high insulin levels before they get diabetes, and she had found elevated insulin levels in some Aboriginal children as young 4 years old. Professor Jeffries-Stokes said that the pancreas produces insulin in response to sugar, which comes from a

274 The costs for haemodialysis set out above represent the direct costs and do not include general distribution of regional, WACHS Area Office or Department of Health system overheads, nor do they include the cost of the Nephrologists. Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p2.

275 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p9.

carbohydrate load. Carbohydrate foods include rice, potatoes, bread and pasta. The traditional diets of Indigenous people around the world consist mainly of meat, which has very small amounts of carbohydrates, which leads to Aboriginal people in the Central and Western Desert, having an excessive response to a carbohydrate load. For example, the:

> *insulin level of a Caucasian (whose normal insulin level is below 11) might go up to 12 or 14 after eating a sandwich. Studies with Indigenous people have found that their insulin level can increase to up to 200 after receiving the same load of carbohydrates. They receive a big burst of insulin and the sugar is stored away. They still have circulating insulin, which makes people hungry and cranky, and they crave carbohydrates so they eat more and get another big burst of insulin….*
>
> *That is why Indigenous people get diagnosed with diabetes and in just two years they have renal failure, whereas if most Caucasians people were diagnosed with type 2 diabetes, they would not expect to have renal failure for 20 years.*[276]

A high insulin level doesn't only produce diabetes; it also causes the blood levels to thicken in the kidneys, heart and brain, which predisposes Indigenous people to kidney disease, heart attack, stroke and all the associated complications. To combat this, prevention is a key strategy.

Access to fruit and vegetables is a major problem in this region of Western Australia. For example, the Committee heard that the town of Menzies has no shops, so no fruit and vegetables are available. People must buy their food from Kalgoorlie and transport it to their communities, meaning that they buy what will last and what will get home without being spoiled.[277]

Finding 88

High insulin levels in Indigenous people indicate future adverse health impacts for them far beyond just diabetes.

Finding 89

Well-run preventative health programs are the key to lowering insulin levels in Indigenous people.

The need to access nutritious food has been recently recognised by both the State and Federal governments. In October 2009 the Minister for Community Services, Hon Robyn McSweeney,

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276 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p9.

277 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, pp9-10.

launched a nutrition resource kit to assist Aboriginal parents to understand the importance of good nutrition and ongoing health requirements for their young children. The resource kit: *Strong Babies - Solid Start Taste Bubs* was developed by the Meerilinga Young Children's Foundation in consultation with Aboriginal families and health professionals across Western Australia. The kit was developed because consultations held with Indigenous families in Broome, Port Hedland, Albany and Kalgoorlie-Boulder found many parents did not have access to culturally appropriate education on the nutritional needs of infants transitioning from breastfeeding to solid foods.[278]

A Federal parliamentary committee has also called on the Federal Government to do more to ensure that Indigenous Australians have access to fresh food. That Committee found that local stores could play a key role in improving the welfare of people in remote communities by selling healthy food, but said this would require logistical and financial support from the Government. The Committee Chair, Hon Bob Debus, said that "supplying nutritious food is the most fundamental way to improve health in Indigenous communities."[279] This Committee's 33 recommendations included the need for the Government to set up a national office to coordinate the food supply chain so that remote communities can receive fresh food every week and for the Government to establish an infrastructure fund to help remote community stores buy critical equipment such as refrigerators.

Finding 90

Access to fresh food is an important part of any strategy to lower the rate of diabetes in Indigenous people.

Recommendation 53

The Western Australian Government work with the Federal Government to establish a national office to coordinate the food supply chain to remote communities.

Communities should be encouraged and supported to produce fresh food for their own consumption. Assistance should be provided to help remote communities to purchase and maintain equipment to grow and store fresh produce.

278 Hon Mrs Robyn McSweeney, Minister for Community Services, 'Launch of Aboriginal infant nutrition kit to kick off Children's Week', 20 October 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=132654. Accessed on 16 December 2009.

279 ABC News, 'Indigenous communities starved of fresh food, Govt told', 17 November 2009. Available at: www.abc.net.au/news/stories/2009/11/17/2745338.htm. Accessed on 16 December 2009.

(a) Impact of poor rural transport

As explained in Chapter 11, the WACHS hospital system is based on a hub and spoke model. This means that Indigenous people needing dialysis have to travel long distances to suitable hospitals in Perth, Kalgoorlie or Alice Springs, unless they are able to be put onto peritoneal dialysis. For patients from the Kimberley and Pilbara, the RFDS provide transport to hospitals, and seek to provide return transport if they are able to. For those in the remote Goldfields regions, patients rely on road transport for non-emergency transport since the demise of the air service some years ago. The RFDS CEO explained that the Ngaanyatjarra Air service was:

> *a really good service. It used to come and pick people up every day if they had been in the big smoke in Kalgoorlie for some reason, whether it be medical or not, and take them back home. It was great. So it is unfortunate that service has gone.*[280]

The dire impact of the demise of this service was explained to the Committee:

> *It is worse if you come from Tjuntjuntjara, where there is no public transport. If people come out of* [Kalgoorlie] *hospital, they cannot get back until they have enough money or know someone with a car to be able to get back. Tjuntjuntjara is 700 kilometres away, a 12-hour journey. Last year we had three people die because they broke down on the road. A child died of dehydration and two old men died.*[281]

A new bus service will soon operate a weekly return service from Warburton to Kalgoorlie and from Warburton to Alice Springs.[282] This service could be utilised as a means of providing transport to and from remote communities. Financial incentives could also be offered by government to route transport operators to use 'dual cab' vehicles for contracted patient transport.

The Committee heard that in the Goldfields region, the RFDS often did not have enough resources to do patient transfers in the time required. Four hours is the absolute maximum amount of time it should take to transport a critically ill patient who needs intensive care at the Kalgoorlie Hospital. This time was often extended to seven hours, or beyond, with doctors and nursing staff sitting up all night with patients.[283]

(b) Housing and the lack of health accommodation

Housing for dialysis patients is a critical issue in regional Western Australia. Houses are needed to allow the families of patients to care for them while they undergo dialysis, and there is an urgent

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280 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p10.

281 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p4.

282 Mr Robert Hicks, Chief Executive Officer, Goldfields-Esperance Development Commission, *Transcript of Evidence*, 14 September 2009, p6.

283 Dr Peter Barratt, Medical Practitioner, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p7.

need for some form of 'step-down' facility to house patients before they have recovered enough to return to their communities. In terms of the need for accommodation, Professor Jeffries-Stokes explained to the Committee:

> *The waiting time for priority housing is more than a year, even if you are on dialysis. If you do not have a particular reason, it is four years. The average occupancy of an Aboriginal household is about 15 people. There are places that provide short-term accommodation but people can only stay there short term and they have to be able to pay for it. It is all inclusive of meals. It is difficult for families. If you are Aboriginal, there is no way you are going to get into a caravan park or a private rental.*[284]

This difficulty applies both to those who are on dialysis, and those about to enter the program:

> *We had a lady today who has had to come down from Leonora because she is a step away from going on to dialysis. The doctors are waiting for her to get sick so she can be put on dialysis. Who knows how long that will take. In the meantime, provision has not been made for her to stay anywhere. She does not have a wheelchair yet she cannot walk. The family ended up staying with the mother-in-law, who is on dialysis, but she does not have rails in her bathroom or rails next to the toilet to be able to move around so it is a struggle for her.*[285]

Ceduna in South Australia was cited as a location with a very well-run self-contained step-down facility which housed patients after their dialysis. They did not have to stay there all the time but slept there each night and had access to the relevant medical care that they required. This type of facility is critical as the patient:

> *might go to the hospital for dialysis or something similar, or a lot of clients have pneumonia and things like that. They are well enough to be released from hospital but they are not well enough to go back to the camps. There is nowhere for them to go so they end up on the streets.*[286]

Evidence was given that what was needed was a facility which patients could use for a week or two as presently some patients were sleeping under bushes in the dirt after being released from hospital and waiting to be well enough to be transported home. The facility would need to provide about 60 beds for 10 patients and their families.[287]

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284 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p4.

285 Ms Karen Kujawski, Manager - Social Support Unit, Bega Garnbirringu Health Service, *Transcript of Evidence*, 14 September 2009, p4.

286 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p4.

287 Ms Sue Cristopoulos, Manager - Clinical Services, Bega Garnbirringu Health Service, *Transcript of Evidence*, 14 September 2009, p5.

Finding 91

Many Indigenous patients who travel long distances for treatment find it difficult to return to their homes after being discharged from a Regional Resource Centre.

Recommendation 54

The Department of Health must organise, prior to discharge, transport home for Indigenous patients attending Regional Resource Centres from remote communities.

The Department should include in its annual report the statistics on transport assistance offered in this way for each WA Country Health Service Regional Resource Centre.

12.6 Alcohol accords and bans

The Western Australian Government should be commended for the liaison it has undertaken with local communities in expanding throughout the Kimberley region the alcohol restrictions established at Fitzroy Crossing by the previous Carpenter Government.[288] The Barnett Government recently announced an extension of the liquor bans into the Kimberley communities of Yakanarra and Bayulu using section 175 of the *Liquor Control Act 1988*.[289] The Committee will be making further recommendations on the topic of alcohol management at the conclusion of its *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*. However, it has taken evidence at its hearings for this Inquiry which indicates that, in many cases, alcohol abuse is comorbidly related to other health issues, such as illicit drug taking, domestic violence and mental illness. In every region where the Committee took evidence, alcohol was seen as a greater health issue than other addictive substances. For example, in the Goldfields:

> *Alcohol would definitely be number one while cannabis and amphetamines tend to fluctuate at two and three. There is quite a big gap between those three main drugs and then your opiates, hallucinogens and those sorts of drugs. There are pockets of areas that*

288 Education and Health Standing Committee, 2008, *Ways Forward — Beyond the Blame Game: Some Successful Initiatives in Remote Indigenous Communities in WA*, Legislative Assembly, Parliament of Western Australia, Perth, pp105-109.

289 Hon Mr Terry Waldron, Minister for Racing and Gaming, 'Minister announces alcohol bans for Yakanarra and Bayulu communities', 14 April 2010. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=133327. Accessed on 10 April 2010.

> *have issues around solvents and volatile substance use but in Kalgoorlie-Boulder itself and the region, alcohol would be number one.*[290]

The Committee heard that in most regional centres there are 'liquor accords' coordinated by the Police. However, because these accords are voluntary some hotels are getting around these arrangements to maintain their sales.

In Kalgoorlie the Committee heard that:

> *These* [Aboriginal] *people are not going to the pubs and getting drunk, which is what an accord addresses. These people are buying alcohol from the back doors of pubs that are selling within their hours but are well and truly aware that these people are going to the parks and drinking. There is not enough evidence for the police to take that next step.*[291]

Importantly, the Committee was told that these accords do not seem to address the problem of why people are drinking. Unless this problem is addressed and there is a way of treating the illness that has resulted in addiction "it does not matter what we do. They move on to something else."[292] In Kalgoorlie, Aboriginal people have access to a range of counsellors to try and address these underlying cultural issues and causative factors they are not able to discuss with non-Aboriginal people:

> *we get people referred by the courts to get alcohol drug counselling or for domestic violence due to drugs and alcohol. When we get our drug and alcohol counsellor into it, we find that the problem it is more related to bringing them home issues, which has led them to the alcohol and drug abuse. They are on-referred to the 'bringing them home' counsellor who deals with those issues before they can deal with the alcohol and drug issues.*[293]

The second ingredient missing from a successful campaign in dealing with Indigenous drinking is the lack of a process to divert juveniles out of the justice system and into some form of education and employment process that might also help them curb their drinking, as explained by a Police Superintendent from Albany:

> *When we have a young juvenile of maybe 16 who is street drinking or binge drinking, or whatever, we might give him a liquor caution, if we do not want to use a liquor infringement because of his age and his ability to pay it. If we had found him with cannabis, he would have been diverted through our drug system. However, we do not have*

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290 Ms Deborah Clark, Chairperson, Kalgoorlie Local Drug Action Group, *Transcript of Evidence*, 14 September 2009, p3.

291 Ms Karen Kujawski, Manager, Social Support Unit, Bega Garnbirringu Health Service, on, *Transcript of Evidence*, 14 September 2009, p5.

292 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p6.

293 Ms Karen Kujawski, Manager, Social Support Unit, Bega Garnbirringu Health Service, on, *Transcript of Evidence*, 14 September 2009, p7.

any way of diverting youth with alcohol. It is at that point, when we come in contact with juveniles, that we need to be able to move them somewhere.[294]

(a) Foetal alcohol spectrum disorder (FASD)

The dramatic impact of Foetal Alcohol Spectrum Disorder (FASD) on Indigenous children was described in the Committee's Report *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*. FASD is not a clinical diagnosis in itself, but describes a range of irreversible disabilities and a continuum of effects that may arise with prenatal alcohol exposure by pregnant women. Research by the Telethon Institute for Child Health Research highlights the dire impact of FASD. Data from the WA Birth Defects Registry suggests the overall incidence of FASD is 0.18 per 1,000 live births, but with very large differential rates for Indigenous and non-Indigenous mothers:

- 0.02 per 1,000 non-Indigenous live births.
- 27.6 per 1,000 Indigenous live births.

In the 2001–02 *WA Aboriginal Child Health Survey*, the mothers of an estimated 23% of Aboriginal children reported that they had consumed alcohol during pregnancy, while a media report suggested 80-90% of pregnant Aboriginal mothers in Halls Creek had drunk during their pregnancy.[295]

Low birth weight (<2500 grams) is associated with an increased risk of lengthy hospitalisation after birth, the need for resuscitation, and death. Children with low birth weight are also more likely to have a range of neurological and physical disabilities, such as FASD.[296] Australia ranked 7 out of 18 OECD countries in 2005 with 6.4% of infants being of low birth weight.[297] The percentage of children born in Western Australia of low birth weight reflects the national average,[298] but the percentage of children born of low birth weight is higher in disadvantaged populations and very remote areas. Western Australia had the greatest difference between rates for

294 Supt Dene Leekong, WA Police, Great Southern District Office, *Transcript of Evidence*, 11 September 2009, p14.

295 Education and Health Standing Committee, 2009, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Legislative Assembly, Parliament of Western Australia, Perth, pp19-22.

296 Australian Institute of Health and Welfare, 2009, *A Picture of Australia's Children 2009*, Australian Institute of Health and Welfare, Canberra, p72.

297 Australian Research Alliance for Children and Youth, 2008, *Report Card: The Wellbeing of Young Australians*, Australian Research Alliance for Children and Youth, Canberra, p4.

298 P. Laws and E. Sullivan, 2009, *Australia's Mothers and Babies 2007. Perinatal Statistics Series no. 23 Cat. no. PER 48*, AIHW National Perinatal Statistics Unit, Sydney, p68.

low socio-economic (8.5%) and high socio-economic areas (5.3%): the largest gulf between rich and poor in all Australian jurisdictions.[299]

As the Committee's earlier *Invest Now or Pay Later* Report made clear, these statistics highlight the need to invest in community child health services, which are proven to be an effective strategy for addressing poor health outcomes for Indigenous children.

A comparison between Indigenous women who attended five or more antenatal sessions with those who did not attend any antenatal sessions reveals the following:

- of those who attended antenatal sessions, 8.5% had babies of low birth weight, while this figure increased to 41.6% for women who did not attend antenatal sessions;
- of those who attended antenatal sessions, 8.6% had pre-term babies, while this figure increased to 40.2% for women who did not attend; and
- of those who attended antenatal sessions, 0.7% resulted in peri natal deaths while this figure increased to 9.3% for women who did not attend.[300]

The Western Australian Government supported recommendations to address FASD made by this Committee in its *Healthy Child — Healthy State* Report in May 2009 and described how WACHS was working with the Child Development Service to implement the 4-digit FASD diagnosis tool in the Kimberley region. However, data gathered during this Inquiry suggested that in other regions FASD is a major problem and the WACHS is seeing second-generation FASD, with mothers who were FASD babies themselves now having children affected by FASD due to their alcohol drinking during pregnancy.[301]

Finding 92

There is evidence that mothers who have been affected by Foetal Alcohol Spectrum Disorder are now having their own children, resulting in second-generation Foetal Alcohol Spectrum Disorder babies.

299 Australian Institute of Health and Welfare, 'Children's Headline Indicators', nd. Available at: www.aihw.gov.au/chi/index.cfm. Accessed on 11 February 2010.

300 Steering Committee for the Review of Government Service Provision, 2009, *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, Canberra, pp5-6

301 Mrs Karine Miller, Regional Coordinator- Community Nursing, WA Country Health Service- Goldfields, *Transcript of Evidence*, 14 September 2009, p10.

Recommendation 55

With 15% of Australia's Indigenous population living in Western Australia and a growing incidence of second-generation Foetal Alcohol Spectrum Disorder, funding should be provided by the Department of Health for Foetal Alcohol Spectrum Disorder programs in regions beyond the Kimberley.

(b) Alcohol and Indigenous mental health

The Committee heard that one of the chief comorbidities of alcohol abuse are mental health issues and subsequent suicide attempts by young Indigenous people. The Australian Medical Association (AMA) reported that in 2004-06 Indigenous males were more than twice as likely to be hospitalised for mental health and behavioural disorders than non-Indigenous males. In addition, 12% of Indigenous males aged 12-17 years had thought about ending their lives in the previous 12 months, and 4% had attempted to do so in this period.[302] The Committee heard that it would assist local communities if there were mental health promotion programs in the school system as this would allow health staff to intervene earlier to pick up juveniles who might have symptoms of depression or anxiety. This meant that they could be assisted before they go on to develop a mental health condition.[303]

One outcome of the Committee's evidence gathering is that it uncovered that the term 'mental health' is not one that Indigenous people welcome. Mr Lester Coyne told the Committee:

> *The minute you mention 'mental health', in Nyoongah terms that is* kartwar*, which means that they are mad. They do not like that title. It is more of an issue around health and wellbeing. I mentioned before the body, mind and spirit as being a wellbeing issue. I would say that it is better to refer to 'solving, helping, alleviating' or 'soothing' the wellbeing of a person to get more cooperation, rather than saying that someone has a mental health problem. We do not identify someone with a mental health problem as being born with it; it is something that is grown out of anxiety, maybe disadvantage or other different things. The terminology is one to be used with great caution.*[304]

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302 Australian Medical Association, 'AMA Report Card Series 2009- The Health of Indigenous Males', 10 November 2009. Available at: www.ama.com.au/system/files/node/5114/AMA+Indigenous+Health+Report+Card+2009.pdf. Accessed on 16 December 2009.

303 Ms Sandra Crowe, Population Health Director, WA Country Health Service, Great Southern, *Transcript of Evidence*, 11 September 2009, p9.

304 Mr Lester Coyne, Manager- Aboriginal Health, Great Southern Aboriginal Health Service, WA Country Health Service, 11 September 2009, p10.

Finding 93

The Department of Health needs to ensure its staff are culturally sensitive in their description of mental health conditions in programs provided within Indigenous communities.

Mental health is also an area where there is a mix of State and Commonwealth funding. The Committee heard that in regional WA not every town had a mental health worker and the mix of funding was 60% Commonwealth, and 40% State and because of this Indigenous people with acute mental health issues often missed out on services:

> *So mental health would go and do so much and then you picked up so much under your home and community care program. But, as I said, as soon as an acute phase or an acute episode happened, that was it; you* [community care program] *had to pull out. …Under HACC they can provide any type or range of HACC-funded services to someone with a mental health issue, as long as they are not at an acute phase and they are not under another program or receiving funding from another source, such as a package of care. They are able to provide it, as long as they are not acute.*[305]

Many Aboriginal Medical Services have received Federal funding to establish social and emotional wellbeing units through the *Bringing Them Home* ('stolen generations') program. The Committee heard that much of the work of these AMS units address social and emotional wellbeing issues for all the community, rather than for just the 'stolen generations' people. Mr Darryl Kickett told the Committee:

> *With the State Government, if you take a measure of a continuum, for example, from one to 10—10 being the worst case in mental health—the state mental health services are dealing with the people who are within the seven to 10 bracket, so the one to six people are not being addressed effectively. …So we need to develop a strategy around the people who are not diagnosed as having a mental illness but who are suffering from trauma and grief.*[306]

Mr Kickett described a program in Narrogin funded by Oxfam Australia and run by psychologist, Mr Darrell Henry, to address strengthening families having to deal with the grief and trauma from deaths or suicides in a more strategic way. This program involves a community-development approach to build the strength of these families and empower them to negotiate services with the mainstream health system, and to be able to shepherd them into the appropriate mental health services. This program has not been supported by the State Government, who have instead negotiated additional Federal funds from FaHCSIA for the Department of Indigenous Affairs to run their own programs.

Mr Kickett reported:

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305 Ms Suzanne Millar, Regional Manager- Aged-care, WA Country Health Service, Great Southern, *Transcript of Evidence*, 11 September 2009, pp6-7.

306 Mr Darryl Kickett, Former CEO, Aboriginal Health Council of Western Australia, *Transcript of Evidence*, 23 September 2009, p7.

> *clearly, what the people are wanting up there* [Narrogin] *is an Aboriginal-specific service that is controlled by the Aboriginal community itself, because they want to deal with that internal grief and trauma in a way that they can do better with someone like Darrell Henry… and they were able, with his help, to set up a 24-hour watch to prevent suicide, and that has been rather successful since June last year.*[307]

Those towns with hospital inpatient facilities for acute mental health patients, such as Albany, report very high occupancy rates of between 80-90% at all times. Workforce shortages mean that there are only two nurses on staff at any one time and that the security of these staff is of great concern.[308] Smaller centres, such as Merredin, 'special' their patients until mental health staff can review them and make a plan on how they will be treated, or stabilise them and arrange to fly them out to larger centres.[309] Regions with high number of Indigenous residents, such as the Kimberley, the Pilbara, and the Goldfields, have a lower number of FTE mental health community clinicians per capita than other regions.[310]

Recommendation 56

The Department of Health should ensure that culturally appropriate mental health programs are associated with the development of alcohol management accords and alcohol and drug education programs in Indigenous communities.

12.7 Emerging health issues

The Committee was disturbed at evidence that the Goldfields region has the highest rate of sexually transmitted diseases in Australia, with high rates of chlamydia and gonorrhoea. Additionally, human immunodeficiency virus (HIV) is starting to become more of a problem in this region for both Indigenous and non-Indigenous people.[311] The Goldfields has a large number of HIV cases which are predominately heterosexually transmitted and many of them are people from overseas who have been brought in to work in the mining industry. Also, it was reported that miners go overseas to Thailand or Papua New Guinea for work or holiday and bring HIV back to

307 Mr Darryl Kickett, Former CEO, Aboriginal Health Council of Western Australia, *Transcript of Evidence*, 23 September 2009, p7.

308 Ms Suzanne Seeley, Nurse Director, WA Country Health Service, Great Southern, *Transcript of Evidence*, 11 September 2009, pp4-5.

309 Mr Cecil Stones, Health Service Manager- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p9.

310 Mr David Bowdidge, Operations Manager- Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p10.

311 Associate Professor Christine Jeffries-Stokes, Paediatrician, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p3.

Australia. This development is important for WACHS and its future planning as it is very resource intensive disease. Dr Charles Douglas told the Committee that:

> *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. … Because we need to follow them up, some as often as daily, some slightly less often.*[312]

Finding 94

Sexually transmitted diseases and human immunodeficiency virus are major issues for Western Australia's Indigenous populations, especially in regions with mining operations.

Recommendation 57

The Government should urgently increase the resources allocated to dealing with sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), especially in regional areas. In its annual report, the Department of Health should report on new initiatives, including:

- any additional WA Country Health Service funds for education programs on STD and HIV;
- the establishment of additional sexual health clinics in regional areas; and
- programs to encourage companies involved in the mining sector to pay for the assessment and treatment of staff with STDs.

312 Dr Charles Douglas, Public Health Physician- Goldfields Population Health, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p11.

CHAPTER 13 TRAVELLING TO HEALTH- THE ROYAL FLYING DOCTOR SERVICE AND THE ST JOHN AMBULANCE

13.1 Introduction

This chapter reports on the activities of the Royal Flying Doctor Service (RFDS) and St John Ambulance Australia (Western Australia) Inc (SJA) - two not for profit organisations that provide key transport services for WA Health, especially in rural areas of the State. Both organisations receive the majority of their funding from the Western Australian Government under service contracts, while also successfully raising funds from donations and grants. Both organisations have been the focus of media attention in the period leading to the initiation of this Inquiry.[313]

The Reid Report recognised the need for the services of the RFDS and SJA to transport patients to Perth, especially for trauma victims, while moving local patients to Regional Resource Centres. It said that:

> *The development of Regional Resource Centres (RRCs) has been proposed to address these issues. This would help retain within the regions secondary-level acute care activity, limiting, as much as clinically appropriate, the need for patient transfers to Perth for reasons other than tertiary-level care.*[314]

The Reid Report's Recommendation 21 endorsed the proposal of building RRCs in Broome, Port Hedland, Geraldton, Kalgoorlie, Bunbury and Albany. While not discussing the RFDS and SJA, the *Clinical Services Framework 2010-2020* proposes an additional 200 beds for the six RRCs by 2020-21, with about half of those in the Bunbury Hospital.[315] This should over time reduce the need for patient transport by either the RFDS or SJA, to Perth hospitals.

13.2 Royal Flying Doctor Service

(a) Background

The RFDS has been operating in WA since 1935 with its initial bases in the North West. Its first base was established in Port Hedland with the second in Wyndham. Today it has staff and aircraft based in Derby, Port Hedland, Meekatharra, Kalgoorlie and Jandakot. RFDS has its Western Australian corporate headquarters at Jandakot. Staffing levels at each of its country bases consist of four medical officers, five nurses and five or six pilots. This enables the RFDS to provide 24/7

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313 St John Ambulance provides a wide range of non-ambulance services such as first aid training, provision of first aid at events, industrial paramedic services and the sale of first aid and medical equipment.

314 Department of Health, 2004, *A Healthy Future for Western Australian*, Report of the Health Reform Committee, Department of Health, Perth, p42.

315 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p23.

roster coverage for emergency patient transport service using the 14 aircraft in its fleet. In 2008-09 these aircraft flew over 19,000 hours and covered 5.7 million kilometres. In October 2009 the first RFDS jet was added to its fleet, with support provided by the State and Federal governments, Rio Tinto
($5 million), local fundraising of RFDS volunteers and the Victorian branch of the RFDS ($3 million). State funds consisted of $3 million over three years from the Royalties for Regions program.[316]

While best known for its patient transport emergency aircraft, the RFDS also operates substantial primary healthcare (PHC) programs in country areas. In 2008-09 it answered and provided medical consultations over the phone to 35,300 calls. It held 1,852 clinics attended by 31,535 patients, including the *RFDS on the Road* project in the Pilbara sponsored by BHP Billiton[317] (expanded in 2009 to the Goldfields to undertake skin cancer screenings). PHC programs consist of:

- medical chests;
- rural women's GP program;
- primary healthcare clinics; and
- medical phone advice.

Over 570 medical chests are placed throughout Western Australia in remote locations, stations, Aboriginal communities, mine sites and ships that trawl off the North West coast. These chests are subsidised by the Federal Government and are comprehensively stocked with emergency medical supplies. They are usually used in conjunction with phone advice from an RFDS doctor. RFDS doctors also staff the Meekatharra hospital and undertake about 10,000 consultations to in-patients and out-patient clinics each year.[318]

Funding

The RFDS budget for 2009-10 is approximately $55 million and the largest expenditure will be $3-4 million for aircraft maintenance, which is done in-house. Over the past three years the RFDS has secured substantial assistance from both the Commonwealth and the State Governments and now has a 10-year plan for aircraft replacement.[319] Like other areas of the health sector, the RFDS receives a mix of funding from the State and Federal Governments:

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316 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p2 and p7.

317 Hon Mr Vincent Catania, MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 17 October 2006, p7006b-7007a.

318 Ms Alison Batchelor, 'Telehealth service provides lifeline', *The West Australian*, 3 February 2010, p3.

319 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p2.

- State funding — $24.2 million in 2008-09 to move patients between hospitals.
- Federal funding — $13.1 million in 2008-09 for primary emergency evacuations, visiting clinics and medical chests.[320]

The State Government's most recent Budget increased funding to the RFDS by $29.9 million over five years. This was in addition to the increase of $38.6 million over five years allocated in the Health budget to the RFDS in July 2008 by the previous State Government. The combined increase of $68.5 million over five years brings the total funding provided to the RFDS by DOH to $171.9 million over the period 2008-13.

The additional funding of $29.9 million provided in the 2009 Budget will enable the RFDS to replace two of its ageing aircraft with jets and purchase one additional aircraft to further expand its fleet. It will also provide for the additional crew and running costs associated with the new aircraft and fund increased operational costs associated with staff salaries and training. The increase of $68.5 million over five years will result in the replacement of five existing aircraft and the purchase of three additional aircraft and associated crew and running costs. The additional aircraft will be based at Kalgoorlie from 2008-09, Port Hedland from 2009-10 and Jandakot from 2010-11. A sum of $14 million has been allocated for increased staffing, with $8.4 million over five years from 2008-09 being allocated for additional staff associated with the new aircraft based at Kalgoorlie and Port Hedland, including the purchase of accommodation for staff finding it difficult to rent in these locations.[321]

(b) Main challenges

Patient transfers

The DOH's strategy to base all tertiary health facilities in Perth, and move to a 'hub and spoke' model in country regions, has led to the biggest challenge facing the RFDS — keeping up with the increasing workload for patient transfers.[322] In 2008-09 the RFDS moved 6,226 patients around the State (including about 1,000 from the Kimberley and another 1,100 from the Pilbara) and 75% of those came to Perth for treatment, usually at one of Perth's tertiary medical facilities. The Committee was told by the RFDS that:

> *The evidence is that in each of the past 10 years at least …there has been a significant 3-5% increase in demand, in terms of patient numbers. Fortunately, within this current*

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320 Royal Flying Doctor Service- Western Operations, 'Annual Report 2008-09', 2009. Available at: www.flyingdoctor.org.au/IgnitionSuite/uploads/docs/RF_009_RFDS_AR_WESTOPS%20FINAL%2008-09.pdf, p26. Accessed on 11 January 2009.

321 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 11 December 2008, p1138.

322 There is a recent agreement between the governments of Western Australia and Northern Territory to reserve six beds in Royal Darwin Hospital for patients from the East Kimberley. Mr Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p7.

> *state contract* [2009-14], *increments are built in for additional resources. But beyond that period, if the demand continues to increase, there will need to be another increment.*[323]

Most of this rapid increase in demand has occurred in the Pilbara and the Kimberley regions and is due to the increase in mining activities and population growth. The increase in patient transfers was at the centre of the controversy in 2008 over the negotiations for the 2009-14 contract between the RFDS and DOH. In January 2008 a business case was submitted to the Department of Treasury and Finance by DOH to provide funding over five years to recapitalise the RFDS to meet the increased demand for patient transfers to Perth. The business case identified that the RFDS required three additional aircraft and associated flight teams, and that five aircraft need to be replaced over the next three years. At that time, the State Government's funding represented about 49% of the RFDS operating budget, but the patient transfer flights represented about 80% of the RFDS operations.[324] However, the RFDS only received an increase of $2 million in the 2008 Budget.

In the subsequent debate about this decision, the then-Health Minister was quoted in the media, in discussing the criticism, as saying "You always expect when you deliver a Budget for interest groups to come out and if you give them something, for them to say that it's not enough, there's nothing unusual in that."[325] This statement seemed to miss the important role played by the RFDS in the State's health system, particularly in moving country patients to Perth's tertiary health facilities in a timely fashion. This role had increased with changes to the DOH strategy for its country hospitals. Parliament was told that for the period 2003-08, RFDS patient transfers from Karratha had increased by 37%, Port Hedland and Newman by 27% and Bunbury by 32%.[326]

Given the major hospital facilities in Bunbury and the excellent road access to Perth, it is unusual that patient transfers had increased by this margin. However, other data provided to Parliament by the then-Health Minister for the year 2006 for the South West region shows that there were about 2,100 patient transfers from this region to Perth, with about 660 being completed by the RFDS.[327] This number had grown to 835 by 2009, or about 14% of the RFDS transfers — see Table 13.1.

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323 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, pp3-6.

324 Hon Mr Kim Chance, Minister for Agriculture, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 15 May 2008, p3076. Since the first ALP Government Budget in 2001-02, the State funding to the RFDS had increased from $11.1 million to $19.1 million.

325 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 13 May 2008, p2857.

326 Hon Mrs Robyn McSweeney MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 15 May 2008, p3071.

327 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 20 March 2007, p399.

Table 13.1- Royal Flying Doctor Service patient transfers, 2008-09[328]

Region	Emergency evacuations	Interhospital transfers	Total patients carried	Proportion of total patients	Perth destination
Goldfields	280	812	1,092	17.7%	69%
Great Southern	1	423	424	6.9%	100%
Kimberley	210	803	1,013	16.4%	39%
Midwest	208	807	1,015	16.4%	94%
Perth metro	43	51	94	1.5%	100%
Pilbara	202	869	1,071	17.3%	58%
South West	1	835	836	13.5%	100%
Wheatbelt	29	593	622	10.1%	99%
Other	1	5	6	0.1%	100%
TOTAL	**975**	**5,198**	**6,173**		**75%**

The increase in patient transfers from across the State by the RFDS places enormous pressures on its ability to respond to emergency flights. The Committee heard that in the Goldfields region, the RFDS often did not have enough resources to do patient transfers in the time required. Four hours is the absolute maximum amount of time it should take to get a critically ill patient who needs intensive care out of Kalgoorlie Regional Hospital. Often this time was extended to seven hours or beyond with doctors sitting up all night with a patient and nursing staff.[329]

The RFDS also completes a small number (about 50-60 per year) of patient transfers from private hospitals in Bunbury and Geraldton to a private hospital in Perth, for which they do not yet seek cost recovery.[330] In May 2009 the RFDS introduced a service called the 'patient repatriation service', whereby they have a dedicated aircraft, nurse and pilot operating between nine o'clock and five o'clock dedicated to taking bookings from the teaching hospitals and moving patients back home — either to the local hospital to convalesce or, if it is appropriate, to their home. Prior to this, the RFDS was bringing around 5,000 to 5,500 patients per year to Perth but taking back

328 Supplementary submission from Royal Flying Doctor Service, 16 September 2009, p1.

329 Dr Peter Barratt, Medical Practitioner, Kalgoorlie Regional Hospital, WA Country Health Service, *Transcript of Evidence*, 14 September 2009, p7.

330 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p5.

only about 20 (the majority of which were palliative care patients). The remaining patients were finding their own way home.[331]

Staffing

Another major challenge for the RFDS is staffing, a problem also faced by WACHS in its country operations. In 2008, the then-Minister for Health reported that the vacancy rate among pilots was 14% with an annual turnover rate of 22%.[332] The RFDS provided more up to date figures to the Committee that indicate the staff turnover rate had dropped to 5% and staff vacancies of:

- pilots- 4.25 FTE.
- doctors- 4.92 FTE (vacancy rate of 35% and an annual turnover rate of 45% in 2008).
- nurses- 0 FTE (vacancy rate of 5% and an annual turnover rate of 23% in 2008).[333]

While the situation of staff vacancies has improved, the Committee was told that there remain serious staffing issues in remote areas. In the past 12 months the RFDS had moved to a fly in-fly out basis for its staff at the Meekatharra and Derby bases.[334]

Jet operations from Jandakot

The new Hawker-800 jets are presently unable to operate from Jandakot airport because of their weight. This means that patients transferred to Perth need to be picked up by SJA from Perth airport. When the Fiona Stanley Hospital opens in 2014 Jandakot airport will need to have been upgraded to allow the operation of these jets. RFDS has approached the airport operator, Jandakot Airport Holdings, to discuss making these improvements.[335] Currently the jets based at Perth Airport will take about 6-7 hours to complete a typical return trip to the Kimberley.

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331 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p11.

332 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 13 May 2008, p2855.

333 Ms Jean Byrne, Human Resources Manager, Royal Flying Doctor Service (Western Operations), Electronic Mail, 28 January 2010, p1.

334 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p10.

335 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p8.

The RFDS CEO described a typical flight in the older turboprop planes:

> *To use Kununurra as an example, flying a single-engine turboprop out of Kununurra to Perth with a fuel stop, as you cannot go all the way, and sometimes in bad weather and sometimes at sea level, because of an abdominal pressure injury, abdominal or eye injury, can take eight to 10 hours. It is a long way.*[336]

Using the jets, this represents savings to the RFDS of between 1-4 hours for these longer trips. However, the jets have hourly operating costs of $5,000 more than the turboprops. Based on an average flight, each trip to the Kimberley by a new jet might add an extra $18-33,000 to the RFDS operating costs. The RFDS currently evacuates about 2,100 patients each year from the North West.[337]

The RFDS advised the Committee that:

> *Early submissions to the WA Health Department seeking support for the introduction of a jet had it based in Port Hedland, staffed by RFDS pilots. The cost of employing the pilots (double the number in the case of a jet aircraft), accommodating them in Port Hedland, training and transporting the pilots for training, proved to be cost prohibitive and functionally difficult. Should a jet service become a permanent part of the RFDS fleet, consideration will of course be given in future to the establishment of such a service in the north west of the State but it would be entirely dependent upon the level of funding available.*[338]

Finding 95

The new RFDS Hawker-800 jets cost $5,000 more per hour to operate than the existing turboprop planes.

Recommendation 58

The Minister for Health should request the Royal Flying Doctor Service to base the Hawker-800 jets in a large centre in the North West, such as Broome or Port Hedland, as part of the trial of their use in Western Australia.

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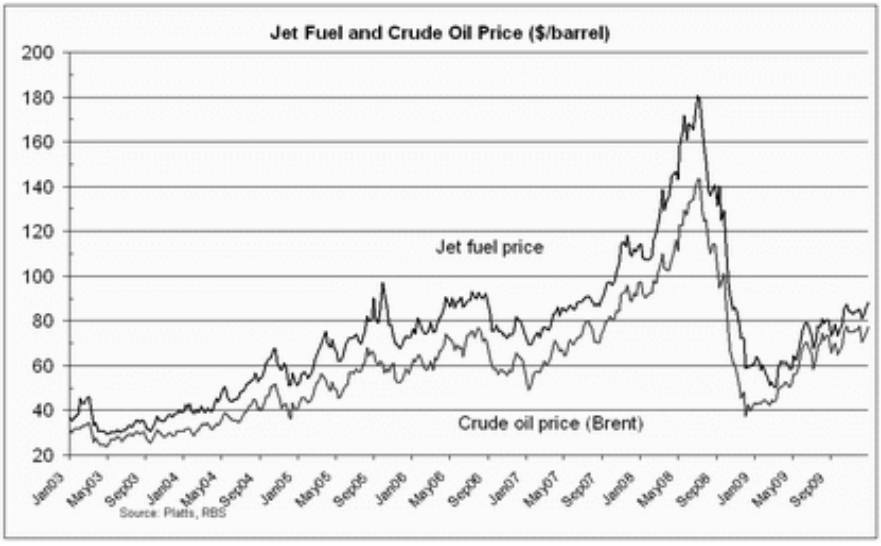
336 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p7.

337 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, pp6-7.

338 Ms Liane Papaelias, Director of Corporate Services, Royal Flying Doctor Service (Western Operations), Electronic Mail, 12 January 2010, p1.

Another aspect of the extra flying hours required by basing the Hawker-800 jets in Perth is the risk provided by future higher jet fuel prices. This risk applies to all RFDS planes as its existing turboprop fleet also uses jet fuel. Jet fuel prices rose from historical prices of about US$40 per barrel in 2003 and reached nearly US$180 per barrel in mid-2008. Figure 13.1 charts the recent price levels of jet fuel. A previous report by the Committee highlighted the impact of higher fuel prices on the regional health of Indigenous people as it required the adjustment and trimming of some RFDS regional flights.[339] Jet fuel prices are again rising and pose a threat to the transport services that RFDS provide to DOH.

Figure 13.1- International jet fuel prices, 2003-09[340]



Coordination with SJA

There is a need for close cooperation between the RFDS and SJA to ensure an efficient patient transfer system is maintained throughout regional Western Australia and from Jandakot airport to Perth's hospitals for the 5,500 patients delivered to Perth annually by the RFDS.[341] Both organisations have command and coordination centres in Perth — the RFDS at Jandakot and SJA at Belmont. In light of the longer travel times from regional areas to Perth hospitals, and the high proportion of SJA services provided by volunteers (see below), it is critical that there is good

339 Education and Health Standing Committee, 2008, *Ways Forward-Beyond the Blame Game*, Parliament of Western Australia, Perth, p100.

340 International Air Transport Association, 'Jet Fuel Price Development', 2007-09. Available at: www.iata.org/whatwedo/economics/fuel_monitor/price_development.htm. Accessed on 11 January 2009.

341 The Fire and Emergency Services Authority has operated a single rescue helicopter based in Perth since 2003. This service is sponsored by the RACWA and has a secondary role to provide essential hospital transfers. See, www.fesa.wa.gov.au/internet/default.aspx?MenuID=257. Accessed on 2 February 2010.

coordination of transport services provided by the despatching and receiving hospitals. The Committee heard that generally there was good communication, but at other times country hospitals without ICUs had to maintain critically ill patients for up to 11 hours. The RFDS and SJA have recognised this as an issue and the Committee was advised:

> *We do have detailed procedures in place for communication with St John Ambulance for their assistance in the retrieval and transport of a patient. As reported by Mr Shackleton, all patient transport requests are assessed by an RFDS Medical Officer before authorisation and prioritisation. The urgency of the case is communicated to St John's Ambulance in the process of co-ordinating the transport arrangements. At management level the two organisations communicate well, albeit informally.*
>
> *Recently we have entered into a Memorandum of Understanding with St John Ambulance for the provision of a St John's Ambulance Team Leader on a 7 day, 12 hr roster in the RFDS Operations Centre to assist in the co-ordination of road ambulance transport in co-operation with RFDS aero medical operations. So far we are finding this initiative beneficial in terms of the information available ahead of time and the improvements in communication between the two services.*
>
> *This program is to be supported by regular monthly co-ordination between the relevant management staff of both organisations. Patient transfers in which a problem has occurred are subject to a rigorous incident reporting system within RFDS, and would certainly be raised with St John's Ambulance if appropriate. The presence of St John's Ambulance staff in the Operations Centre, and the regular communication between Managers will provide an improved system of regular communication between the two organisations.*[342]

Obese patients

An operational issue of growing significance is how the RFDS deals with the bariatric (obese) patients it is required to transport. RFDS aircraft and crews have a current stretcher system that can move patients weighing up to 200 kilos, but that has been exceeded on several occasions. In 2009 a patient from Karratha weighed 216 kilograms and the RFDS staff had to remove the stretchers and put him on the floor of the plane. This issue raises many problems for RFDS—such as occupational health, mechanical and patient care while getting them in and out of the plane. If the trend in the broader WA community for heavier weight continues, the RFDS believes that "a fair proportion of the population will exceed our [current weight] limit."[343]

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342 Ms Liane Papaelias, Director of Corporate Services, Royal Flying Doctor Service (Western Operations), Electronic Mail, 12 January 2010, p1.

343 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, pp11-12.

13.3 St John Ambulance Service

(a) Background

State and Territory governments are responsible for the regulatory arrangements for protecting life and have the primary responsibility for delivering emergency services such as ambulance services to the community. Ambulance services provide critical out-of-hospital Emergency Medical Services (EMS) with SJA attending over 190,000 cases in Western Australia in 2008-09. At this stage of the Federal health reform process, EMS doesn't register in any significant way in policy discussions or receive direct funding from the Federal health budget. Nor is there a national regulatory scheme for the independent accreditation of statutory and private contract service providers, such as the SJA, and paramedics are not listed as allied health professionals by the Commonwealth.[344]

Finding 96

There is currently no registration body to regulate paramedics.

Recommendation 59

The Western Australian Government should cooperate with the Federal Government in recognising paramedics as a professional group by establishing a registration scheme to ensure accountability for their activities, enhance quality standards and support robust clinical governance of their activities.

The model of SJA providing ambulance services throughout Western Australia is unusual, as there is only one other jurisdiction in Australia (the Northern Territory) where these services are provided by non-government organisations.[345] The size of the State and the sparse, small population centres is a significant challenge to SJA as Western Australia is the largest land mass in the world covered by a single ambulance service. The SJA has provided ambulance services in the State since 1903 and took formal control of the metropolitan ambulance service in June 1922.[346] Its services are provided by a fully-paid paramedic service in the metropolitan area and

344 Mr Ray Bange, 'Paramedics forgotten in our health care debate', 30 June 2009. Available at: www.crikey.com.au/2009/06/30/paramedics-forgotten-in-our-health-care-debate/. Accessed on 23 October 2009.

345 In Victoria the ambulances were divided into three services up until July 2008- one provided by the Metropolitan Ambulance Service and the Rural Ambulance Victoria to country regions. See www.ambulance.vic.gov.au/annualreport0809/Themerger.htm, accessed 6 January 2009.

346 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, August 2009, p6.

utilises volunteers with paid paramedics on the fringes of Perth in locations such as Two Rocks, Serpentine and Mandurah (see Figure 13.2 below). Full volunteer crews operate in 101 small locations across the State, providing services to about 150 towns, such as Derby, Merredin, and Denmark. Mr Tony Ahern, the CEO of SJA, told the Committee that "about 92% of ambulance cases have either a full paramedic crew or paramedic-volunteer crew and 8% have a volunteer crew."[347]

SJA has over 430 ambulance vehicles, employs over 700 staff and utilises more than 2,500 volunteers to provide ambulance services throughout the State. In the Perth metropolitan area, during the day, there are 64 vehicles available on weekdays and 42 on weekends. At night, this drops to 31 vehicles for both weekdays and weekends. The SJA received about $24.3 million from DOH and had a total operating income of $120.7 million in the 2008-09 financial year. During this period it provided 193,100 cases (a 4% growth over the previous year), with 39,100 from country centres (20% of total cases).[348] Like other jurisdictions, demand for ambulance services in Western Australia is increasing at a faster rate than demographic increases in population.[349] SJA figures show an average increase of 5.6% per annum in Priority 1 and Priority 2 cases over the past five years. This is more than double the rate of population growth of 2.3% over the same period and managing this growing demand will be a serious issue facing SJA in the next contract period.[350]

SJA currently provide the following ambulance services in Western Australia:

- Emergency services for seriously ill or injured patients, including Priority One which involves emergency driving conditions and Priority Two which involves immediate despatch under normal driving conditions;
- Non-emergency services for patients for whom no other form of transport is medically appropriate;
- Patient transfer services for patients who do not need vehicles equipped and staffed to provide advanced life support;
- Emergency management and disaster response (eg bushfire stand-by services during summer); and

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347 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p2.

348 St John Ambulance Australia (Western Australia) Inc, 'Annual Report 2008-09', 2009. Available at: www.ambulance.net.au/docs/cms000000000021.pdf, pp12-18. Accessed on 6 January 2010.

349 Performance Review Unit, NSW Department of Premier and Cabinet, 'Review of the Ambulance Service of NSW', June 2008. Available at: www.ambulance.nsw.gov.au/docs/publications/080703dpcreviewreport.pdf, p4. Accessed on 6 January 2010.

350 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p26. Accessed on 6 January 2010.

- Cover at major sporting, community or cultural events where there is a risk of injury or medical emergency.

Ambulance services are a critical interface with the State's hospitals, especially for those patients who require urgent treatment. Table 13.2 provides details of the proportion of patients admitted to Emergency Departments who arrived by ambulance in 2007-08.

Table 13.2- Proportion of patients admitted to Western Australia's Emergency Departments who arrived by ambulance, 2007-08

Triage category	Patients	Proportion of total patients
1 — Resuscitation	3,761	83.7%
2 — Emergency	22,341	40.3%
3 — Urgent	40,203	25.1%
4 — Semi-urgent	27,471	9.4%
5 — Non-urgent	1,291	2.7%
TOTAL	**95,067**	**17.0%**

The basis for calculating the current number of SJA staff who work in a location, and whether they are employees or volunteers, is largely a historical artefact. In its negotiations with the State Government over a new funding contract, the SJA is proposing a new defined formula for the staffing of centres, especially country centres:

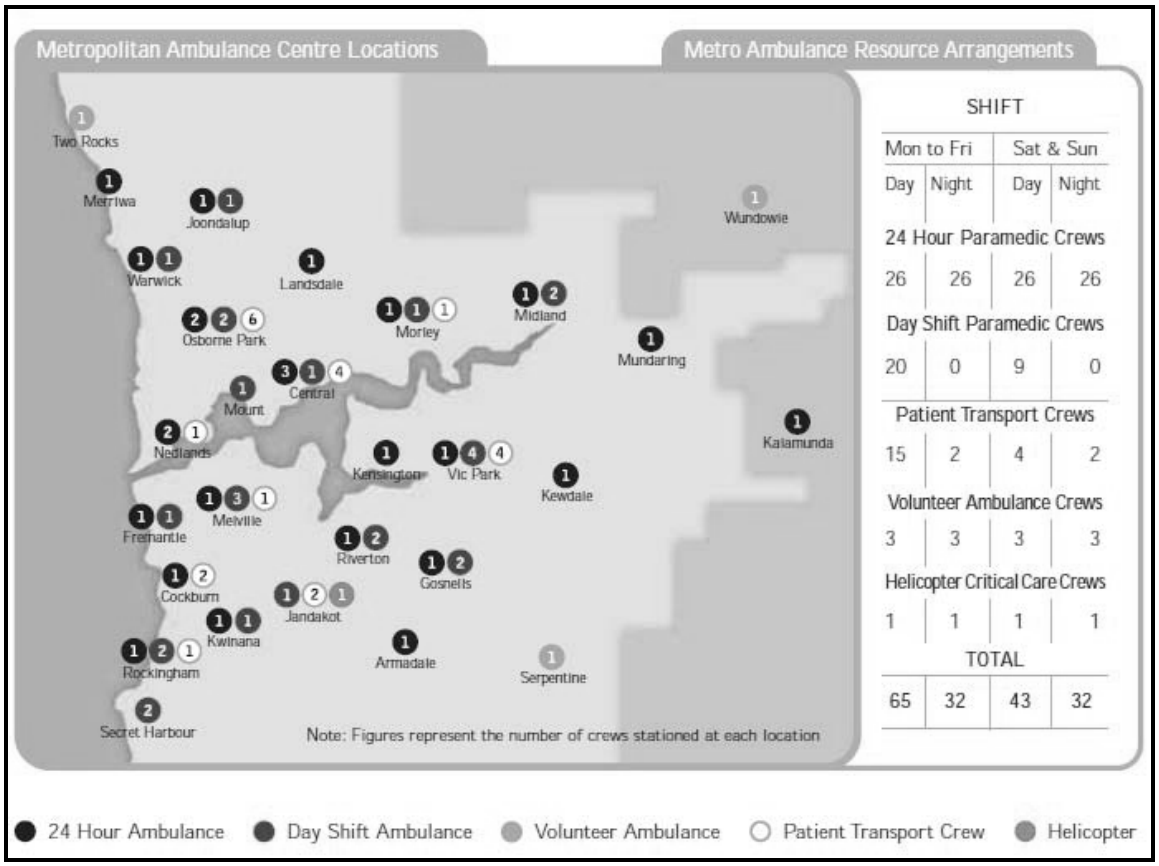
- Category 1— fully staffed with a paramedic crew with paramedic backup: 3,500 ambulance cases or more a year;
- Category 2— full paramedic cover on day shift, a paramedic working with a volunteer on night shift: 2,500 to 3,500 ambulance cases a year;
- Category 3— staffed by one paramedic working with a volunteer: 1,500 to 2,500 ambulance cases a year; and
- Category 4— staffed by volunteers: less than 1,500 ambulance cases a year.[351]

A full SJA paramedic crew consists of two paramedics working together. The full staffing of one 24-hour ambulance in a category one centre requires a total staff of 11 paramedics (which includes a station manager) while a category two centre requires a staff of eight paramedics. The only

[351] Mr Greg Joyce, Chairperson, St John Ambulance Inquiry, Community Development and Justice Standing Committee, *Transcript of Evidence*, 10 December 2009, p7.

category one centres in regional areas are those in Bunbury and Kalgoorlie.[352] The Committee received evidence that due to workforce issues, some centres are not fully staffed. For example, the Albany centre should have 8 staff (Category 2) but in late 2009 only had four paramedics and a station manager, which meant that there is generally only one of their three ambulances available for use for a regional population of about 53,000 people. It also had about 28 active volunteers to assist the SJA employees. To deal with events that required more staff, the next closest SJA centre with paramedics was Bunbury (about 350km), Busselton (about 330km) or Perth (about 410km).[353]

Figure 13.2- Metropolitan ambulance services[354]



352 Mr Tony Ahern, Chief Executive Officer, St John Ambulance, *Transcript of Evidence*, 31 August 2009, pp2-3.

353 Ms Stacey Abbott, Station Manager, St John Ambulance, *Transcript of Evidence*, 11 September 2009, pp5-6.

354 St John Ambulance Australia (Western Australia) Inc, 'Annual Report 2008-09', 2009. Available at: www.ambulance.net.au/docs/cms000000000021.pdf, p20. Accessed on 6 January 2010.

(b) Response times and future staffing levels

According to a recent report from the Productivity Commission, metropolitan Perth has the worst ambulance response capacity of any Australian capital city, with only half as many ambulances available as in the best performing jurisdiction.[355]

Table 13.3- Ambulance response capacity - Perth versus Australian best

Time of Day	Perth's Response Capacity	Best Response Capacity
10am	1 ambulance/45,000 people	1 ambulance/28,000 people (Brisbane)
3pm	1 ambulance/39,000 people	1 ambulance/18,000 people (Brisbane)
10pm	1 ambulance/57,000 people	1 ambulance/35,000 people (Adelaide and Hobart)

The SJA is seeking to introduce another 184 paramedics over their next five year contract period to allow it to return its operations to the optimal response time. This is where there is no fewer than 52% of the total ambulances capacity on standby. The current level is about 40%. This request is part of a total bid to DOH for an additional $65.3 million per year over the 2009-14 contract period to provide an additional 313 staff and 32 vehicles. The new staff would also include:

- 15 additional paramedics to introduce a new version of the Station Manager role;
- 11 additional staff to allow for growth in the Operational Management/Support areas;
- 5 additional training staff to increase the level of paramedic training staff;
- 10 additional paramedic staff to allow the reclassification of the Mandurah centre as metropolitan to replace volunteers and provide full staffing for two crews working 24 hours a day;
- 28 additional paramedics in regional centres; and
- 17 additional paramedic staff to cater for the introduction of a Community Paramedic in each centre with an annual workload of 250-1,500 cases per annum.[356]

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355 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p9.

356 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, August 2009, pp33-34.

A major factor that reduces the number of ambulances that are available is the level of 'ramping' at metropolitan hospitals. If there is a high level of ramping, paramedics are forced to look after non-urgent patients in their ambulances at Perth's hospitals. At the beginning of the previous SJA contract (for the period 2004-09) there was little ramping at hospitals, but by the last year there were more than 6,500 hours of ambulance ramping. The worst month was August 2008, with about 1,200 hours of ramping.[357] This level of ramping is not only the equivalent of about 6,500 extra cases in a year, but ramping generally occurs at a time during the day when the SJA are busiest and when they have the least staff capacity to deal with these patients. For Mr Ahern, "Purely from an ambulance response point of view, [ramping] is the greatest challenge."[358]

Under its contract with the Department of Health, the SJA should have an ambulance reach a Priority 1 patient (emergency call) within 15 minutes in 90% of cases. However, the number of Priority 1 calls falling outside the 15 minute target was over 5,000 in 2007-08, or about 14 calls per day. SJA's performance in 2008-09 is summarised in Table 13.4.

Table 13.4- St John Ambulance response times versus contract target, 2008-09

Service	DOH Contract Target	Actual Performance	Percentage of All Calls
Priority 1- Emergency calls (triple 000)	90% within 15 minutes	88% within 15 minutes	28%
Priority 2- Urgent calls	90% within 25 minutes	86% within 25 minutes	26%
Priority 3- Non-urgent calls	90% within 60 minutes	80% within 60 minutes	17%

In 2008-09 the SJA was only able to achieve the target figure for Priority 1 responses in six of Perth's 18 metropolitan suburbs (all inner city or western suburbs):

- Floreat/Scarborough;
- Fremantle;
- Mount Lawley/Dianella;
- Perth;
- Subiaco/Claremont; and
- Victoria Park/South Perth.

357 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, August 2009, p80.

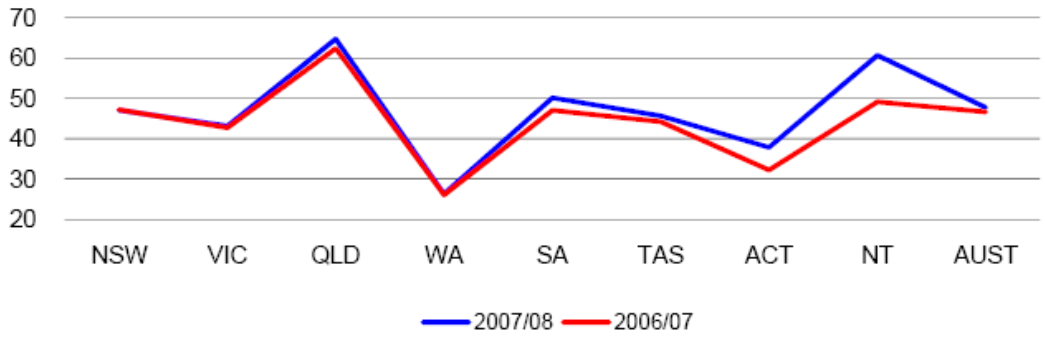
358 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p9.

In nearly 60% of Perth's suburbs, the performance for reaching Priority 1 patients has deteriorated over the last five years. There was an improvement in performance in only three suburbs:

- Floreat/Scarborough;
- Quinns Rocks; and
- Rockingham.[359]

A summary of SJA's performance is contained in the figures below provided by the SJA but sourced from Productivity Commission data.[360] It shows that Western Australia has the lowest number of ambulance staff per 100,000 population in Australia (Figure 13.3). The ACT is the only jurisdiction that is transporting fewer patients per capita to hospital than Western Australia, while Queensland is transporting nearly twice as many. The SJA also has less staff per patient than any other jurisdiction, with nearly 50% more patient services per staff member when compared to Tasmania, Northern Territory and the ACT (Figure 13.4). Overall, the SJA receives about half of the funds compared to what other jurisdictions provide to their ambulance services (Figure 13.5).

Figure 13.3- Ambulance operatives per 100,000 populations, 2006-08

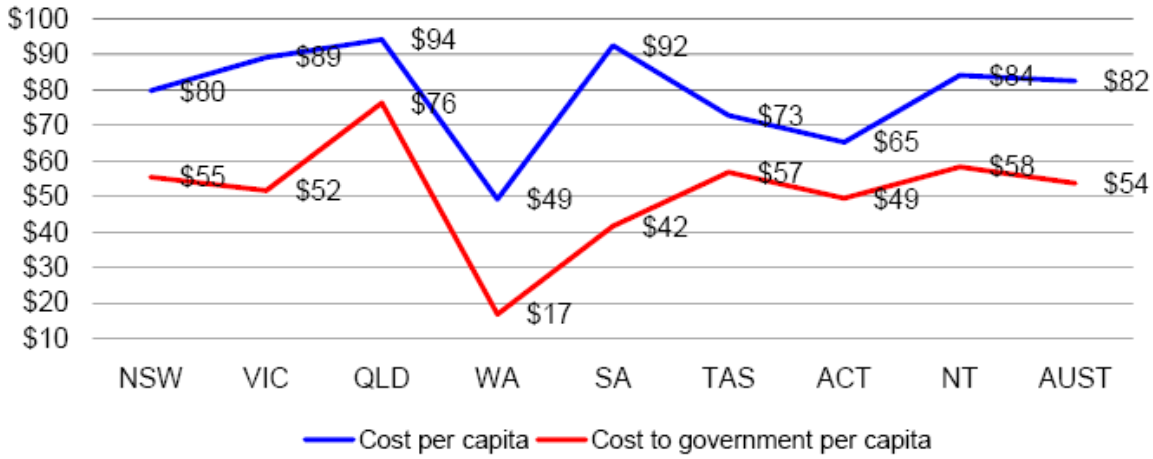


359 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, 'Submission to the 2009 Review of Ambulance Operations and Clinical Practices in Western Australia', 31 August 2009, pp59-76.

360 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, 'Submission to the 2009 Review of Ambulance Operations and Clinical Practices in Western Australia', 31 August 2009, pp24-29.

Figure 13.4- Patients per ambulance operative, 2006-08

Figure 13.5- Cost of ambulance services, 2007-08



(c) Inter-hospital patient transfers

The SJA provides the critical Inter-Hospital Patient Transport (IHPT) services to move patients between Perth's general and tertiary hospitals. The Peel Health Campus (PlHC) provided data on these transfers over the period 2008-09 that is contained in Tables 13.5 to 13.7 below.[361] PlHC CEO, Mr Stephen Wisnewski-Smith, told the Committee "we have to transfer 230 admissions a month to the tertiary system in Perth, and the significant majority of those are due to the clinical presentations being too high for our hospital to cope with."[362]

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361 Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Reply to Questions on Notice*, 11 September 2009, Part 3, p1.

362 Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Transcript of Evidence*, 31 August 2009, p7.

While generally happy with SJA's performance, Mr Wisnewski-Smith said:

> *The problem at the moment, as the committee is well aware, is St John Ambulance and its frustrations. We are left in a very unfortunate situation of holding much higher acuity patients in our Emergency Departments than we should be—sometimes for several days. …*
>
> *The issue is that there are only a limited number of ambulances in the Mandurah-Peel region, and when the ambulances are ramped up in Perth, a one or two ambulance presence must be maintained in the region if there is a priority 000. As a result, when three of four people in our Emergency Department require a transfer, an ambulance to transfer them cannot always be guaranteed. The consequence of that is we are keeping patients in our ED with no HDU or ICU backup for two days sometimes. We had five such cases on one day recently*[363]

Table 13.5- Transfer from Peel Health Campus, 2008-09

Month	Patients transferred
August 2008	137
September	151
October	134
November	128
December	151
January 2009	151
February	148
March	189
April	193
May	211
June	204
July	234

Table 13.6- Main reason for patient transfer from Peel Health Campus, 2008-09

Medical condition	Proportion of transfers
General	36%
General surgical	16%

[363] Mr Stephen Wisnewski-Smith, Chief Executive Officer, Peel Health Campus, *Transcript of Evidence*, 31 August 2009, pp7,9.

Coronary	15%
Orthopaedics	7%
Plastic surgery	6%
Psychiatry	5%
Paediatrics	4%
ICU care	4%

Table 13.7- Destination of patient transfers from Peel Health Campus, 2008-09

Destination	Proportion of transfers
Fremantle Hospital	60%
Private hospitals	15%
Princess Margaret Hospital	8%
Royal Perth Hospital	7%
Sir Charles Gairdner Hospital	7%
Alma Street Centre	3%

The SJA Inquiry in 2009 (see below) noted a 32% increase in IHPT trips, from 19,467 transfers in 2007-08 to 25,663 in 2008-09. This substantial increase raised concerns that IHPT negatively impacts upon the provision of emergency ambulance services, especially in terms of reducing stand-by time. The Inquiry heard many submissions about the 'disjointed interface between IHPT and emergency ambulance services'. Both of these services are mainly provided by SJA and tasked from its communication centre. The Inquiry suggested two solutions to this problem. Firstly, to increase the number of patient transport vehicles and associated transport officers, and to separately despatch IHPT trips. The second option proposed was a new system where patients being transferred from one hospital to another are not re-triaged at the receiving ED.[364]

364 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p58. Accessed on 6 January 2010.

(d) Community paramedic role

There are about 17 regional SJA centres in Category 4 that have between 250 to 1,500 ambulance cases a year. The SJA believes "the volunteer model is entirely appropriate in those workloads"[365] but is trialling a new role of 'community paramedic'. These paid staff are locally-based with a slightly broader role than other paramedics. They undertake other work within the health service and also have a core focus on training volunteers for their centres. A trial of this model is underway in Kununurra and Newman, and is planned for Karratha. This model is used in other jurisdictions where paramedics undertake shifts in hospital Emergency Departments or provide primary healthcare services.

The experience of a 'community paramedic' in locations such as Kununurra is similar to that of the industrial paramedic which SJA has provided to mining companies for the past 15 years. Mr Ahern described the experience of the Kununurra trial:

> *For many years we had really struggled in Kununurra. We would get just enough volunteers to manage and they would drop away. It was a constant roller coaster in maintaining the service there. We put in place the community paramedic. Through WA Country Health Services, we told the Department of Health that we would half fund the service for a year and were looking to the department to provide the other half of the funding, which it did. We put a community paramedic in and we went from literally a handful of volunteers to now having about … 32 volunteers. It is absolutely vibrant. Initially, when the community paramedic goes in, we found that he was getting dragged in to fill gaps on the roster, but that is absolutely not the role of the community paramedic; it is to have a vibrant volunteer model and someone to be there on the ground for mentoring and training.*[366]

But the evidence the Committee heard from SJA staff located outside of Perth on the Kununurra trial was different. The Committee received evidence of an SJA communication highlighting the difficulty with implementing the community paramedic model, and the expectations raised by placement of a full-time staff there:

> *Just thought I'd make you aware of an uncharacteristically busy period in Kununurra. On Friday 28th Aug, 7 jobs attended and 7 patients transferred. In the 27 hours from Saturday through to Sunday there were 11 jobs attended, 16 patients treated, 14 patients transported, three sporting events covered and four flying doctor transfers.*
>
> *The team at Kununurra pulled together very well to cover this demand due to fortuitous (and rare) availability over the weekend, although there is a fairly clear trend towards an increasing workload overall. This is only going to increase with the planned expansion of the Ord.*

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365 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p3.

366 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, pp3-4.

> *The workload for the Paramedic Manager position is also steadily increasing, and to be perfectly honest is becoming unrealistic for one person. Despite my best efforts to have some quality down time, I have to date been unable to achieve this. On the two occasions since starting here on the 22nd July that I have turned my work phone off, both Wyndham and Kununurra Sub-Centres have struggled to raise crews to respond to ambulance calls, and expressed disappointment that I was not able to be contacted. This morning I was woken by a volunteer at my residence informing me of a high speed vehicle rollover 90 kms out of town requiring my attendance.*
>
> *There is a very real expectation from the hospital, other emergency services, the volunteers and the general community that a paramedic will be available 24/7 to respond to emergencies in this large and remote region. In anticipation of your response, I do not think it is sufficient to simply educate everyone on the need for respite, or to enforce the message that this is fundamentally a volunteer staffed service. Non availability of a Paramedic in times of emergency is likely to reflect badly on the Ambulance Service and potentially create disharmony within the Sub-Centre itself.*
>
> *It is definitely time to seriously consider placement of an additional Paramedic in Kununurra … Please don't consider this information a general whinge, I am … enjoying the challenges of this role.*[367]

In Kununurra, the total cost for providing a community paramedic is estimated by the SJA as about $250,000 per annum, including costs for the additional vehicle, housing, training, and maintaining staff skills. The SJA estimate that they would need the community paramedic for SJA activities for about 50-60% of their time, and is seeking funding from the WA Country Health Services for an additional 14 community paramedics beyond those in the three trials.

(e) Country services

The proposal for community paramedics in smaller SJA centres is one response to the pressures created by DOH's strategy to base all tertiary services in Perth. While the majority of Priority 1 and 2 emergency patients in Perth can be assured that they will be serviced by an ambulance in 15-20 minutes, country patients may have to wait for 1-2 hours for an ambulance. An additional 2-10 hours may then be required to reach a tertiary hospital in Perth. For example, Southern Cross is 1.5 hours from the Merredin hospital and all ambulance services in this region of the Wheatbelt are provided by volunteers, who may need time to arrange to stop work and undertake a SJA task. If there is good coordination between hospital, RFDS and SJA, then waiting times in a town such as Merredin may be short:

> *If we call the ambulance on our calling system, it is not that long. From a volunteer perspective, we sometimes get a fly out and the estimated time is 10 minutes when we need to be at the airfield. Within 10 minutes we need to call an ambulance, load the client and take them out. We will get back from the airfield within 15 minutes.*[368]

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367 Mr John Thomas, Station Manager, St John Ambulance, *Transcript of Evidence*, 1 September 2009, p4.

368 Mr Cecil Stones, Health Service Manager- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p11.

Data in Table 13.2 above showed that about 17% of Perth patients are taken to an ED by ambulance, while in country areas the ambulance service is a far more important aspect of hospital operations. The Committee heard that "…90% of clients come into Merredin from other hospitals and were taken to the hospital in an ambulance."[369]

While acknowledging the great distances between towns, and small populations outside of metropolitan suburbs, the proposal for community paramedics also stems from the criticism the SJA faces from many rural centres due to its reliance on volunteers. The Committee heard that in Merredin:

> *Out of a dozen or 15* [ambulance] *volunteers, we have a core group of three or four who do the majority of the work. A couple of those are getting very close to … the point at which they will no longer provide the service. That is a real concern. The amount of work on about half a dozen people—with fly outs and attending accidents—is a real problem.*[370]

Evidence provided to the Committee by SJA highlighted the important role volunteers plays in allowing the SJA to provide excellent service across the State. However, the decision to provide two fully paid paramedics in Norseman for a caseload of just 100 calls a year[371] highlights the real difficulty the SJA faces in obtaining sufficient trained volunteers to provide ambulance services in some small or remote towns. The Chief Executive of WACHS, while acknowledging the positive role of community paramedics, said that "…it is just increasingly problematic to rely on a volunteer ambulance service in some of our country communities. They are too big and people are too heavily occupied in their work."[372] The SJA downplays the difficulty in obtaining volunteers:

> *…there is a little bit of a myth, both within our organisation and outside it, about there being a lack of volunteers. We operate at about double the number of volunteers that we had in the 1980s. Everybody thinks that 1980s, 70s and 60s people were more inclined to volunteer, but we operate with about double the number that we had then. The challenge with volunteers is the daytime.*[373]

SJA staff who gave evidence to the Committee agreed on the difficulty in obtaining volunteers during daylight hours due to work commitments, and dispute the actual number of active volunteers available to SJA centres. The Chairperson of the SJA Inquiry acknowledged the difficulty of reconciling the different claims on the number of the SJA volunteers offered by the

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369 Mr Cecil Stones, Health Service Manager- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p11.

370 Councillor Ken Hooper, Shire President, Shire of Merredin, *Transcript of Evidence*, 7 September 2009, p9.

371 Mr John Thomas, Station Manager, St John Ambulance, *Transcript of Evidence*, 1 September 2009, p3.

372 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 1 September 2009, p13.

373 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p3.

organisation and its staff and said "it depends on who you listen to".[374] The Committee heard from SJA staff that:

> *There were 78 volunteers on the list; by the time I went through and found that most of them had left town or passed on—it was not a current list—I ended up with 17 volunteers in Busselton to staff the service, which is a very, very busy town for transfers, and of those four were fly in- fly out officers, and half of the others were basically workers, so they are only available for the nights.*
>
> *The new community paramedics will have a priority to raise the number of active and trained volunteers in their town, and Mr Ahern described the success in the trial in Kununurra "We put a community paramedic in and we went from literally a handful of volunteers to now having about—I think the latest number is 32 volunteers."*[375]

The SJA Inquiry in 2009 (see below) found that SJA had not established a dedicated country coordinator position despite this role being recommended as early as 2005 when SJA started to receive all calls from across the State. There could be many potential problems with assembling a crew and dispatching an ambulance in a country region, and a dedicated SJA position would alleviate many of these issues. Such a role could also be used to coordinate and manage the new community paramedics in country towns. A number of submissions to the SJA Review, particularly from country volunteers and paramedics, noted communication limitations such as 'black spots' in rural areas in Western Australia. In addition, the issue of Telstra providing the exact geographic location of a caller from a mobile phone was also raised in submissions.[376]

The Chairperson of the SJA Inquiry continued later in 2009 to undertake work for the Minister for Health on the country operations of the SJA and listed six main issues of concern:

- a more thorough contractual relationship between SJA and WACHS. The current contract with DOH has KPIs that all relate to the metropolitan area and not to the country;
- a decent ongoing planning process between SJA and WACHS;
- in the country areas the volunteers have received only minimal training and their scheduled refresher training has fallen behind;
- the use of the expensive helicopter service has been reduced and replaced by road transport;

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374 Mr Greg Joyce, Chairperson, St John Ambulance Inquiry, Community Development and Justice Standing Committee, *Transcript of Evidence*, 10 December 2009, p6.

375 Mr John Thomas, Station Manager, St John Ambulance, *Transcript of Evidence*, 1 September 2009, p5.

376 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p30. Accessed on 6 January 2010.

- that the emergency ambulance service was often being tasked to do patient transfers (particularly in the Peel region) which reduces the stand-by capacity to do emergency work; and

- a doctor in a country or secondary hospital may triage a patient according to some priority and then when they get to the tertiary hospital in Perth, the patient is re-triaged by another doctor.[377]

A final issue arising from the country operations of the SJA seems to be the impact of stresses in the relations between Indigenous and non-Indigenous residents of a town. The Committee did not explore this issue in its hearings but notes that in Derby, Fitzroy Crossing, Halls Creek and Marble Bar the SJA has no presence and the WA Country Health Service (WACHS) provides ambulance services staffed by nurses.[378] This strategy probably derives from the difficulty in obtaining sufficient numbers of trained volunteers in these towns. However, the Committee heard that in Kununurra "If it was an Indigenous person, the volunteers would not go out to them because they had a history, so that was one of the many triggers that put paramedics into it [Kununurra SJA centre]."[379]

(f) Choice of hospital

A key part of the changes in work practices that the SJA is managing in the metropolitan area is what hospital a patient is delivered to, especially given the current concentration of public hospitals in central Perth and the ramping at EDs. This issue impacts on the effectiveness of the SJA in meeting its DOH contract provisions, but also on patient health and hospital funding. According to Mr Ahern:

> *Not that many years ago it was pretty much the decision of the paramedic as to where a patient went. When I say "the decision of the paramedic", in consultation with the patient, but really they were not being given too much directive. They had that flexibility to go where they needed. When the public system started to come under so much pressure, we* ***ended up having a contractual obligation built into our contract with the Department of Health about the way we distribute patients across the range of public hospitals to make sure we get that distribution as evenly as possible*** [emphasis added].
>
> *One of the things with that is it started to suddenly mean that paramedics were often being directed to go to a place that was neither where they wanted to go to nor where the patient wanted to go to. That created obvious problems. So this whole issue became a fairly difficult one, and still is. There are still elements of a problem with that. In terms of the decision around public or private, we still have quite a cultural work practice challenge, I guess, in terms of getting paramedics to understand and realise that where arrangements*

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377 Mr Greg Joyce, Chairperson, St John Ambulance Inquiry, Community Development and Justice Standing Committee, *Transcript of Evidence*, 10 December 2009, pp2, 5, 9.

378 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p35. Accessed on 6 January 2010.

379 Mr John Thomas, Station Manager, St John Ambulance, *Transcript of Evidence*, 1 September 2009, p4.

have been made—so a patient in consultation with their doctor or whatever has an arrangement to go somewhere—do not take them somewhere else. Typical ones would be chest-pain patients that maybe could be going to the Mount or somewhere else where they want to go and it has been arranged, and the paramedics are much more comfortable with taking those sorts of patients to Royal Perth or Sir Charles Gairdner —or Fremantle, simply because that is the routine that they are in. There is no doubt about it; that is still a challenge for us from a work-practice point of view.[380]

Recommendation 60

The Government require St John Ambulance to offer:

- where clinically appropriate, patients with private health insurance the opportunity to be transported to a private hospital.
- patients with work place injuries the opportunity to be transported to a private hospital.

380 Mr Tony Ahern, Chief Executive Officer, St John Ambulance Australia (Western Australia) Inc, *Transcript of Evidence*, 31 August 2009, p 8.

(g) 2009 St John Ambulance Inquiry

The Committee's Inquiry coincided with the SJA ambulance service review established by the Western Australian Minister for Health after the ABC Four Corners 'Out of Time' program on the 6th July 2009 reported on four SJA cases involving delayed ambulance responses where the patients died. The Review's final report found six major issues:

(i) clinical governance issues in respect of practice guidelines, an independent sentinel reporting mechanism and audit, and a structured process in the communication centre;

(ii) the operations of the communication centre;

(iii) inadequate resourcing in respect of paramedics, transport officers and communication centre staff, ambulances and patient transfer vehicles, and training;

(iv) the inefficiency and frequency of ambulance 'ramping';

(v) the lack of support and coordination of the volunteer system in country areas; and

(vi) the impairment of the ambulance service by the demands of the hospital patient transfer system.

The Review concluded that SJA has the most efficient ambulance service model in Australia and has saved the State substantial funds over the last century, particularly by its management of volunteer ambulance officers. Their figures show that Western Australians have paid less than half that of taxpayers in other states for the same level of service. Overall, it found that SJA is meeting its contractual requirements with DOH, and in many performance areas, is exceeding them. However, gaps were beginning to appear in the ambulance operations which led to about 50-life threatening cases each month being wrongly despatched by the SJA communication centre. The Review recommended that the State needed to increase its funding to the SJA. Importantly, it recommended that ambulance needs in country areas be the subject of further assessment.[381] The Government responded to the report by announcing an immediate $1 million funding increase to provide 10 additional call centre operators, 26 patient transfer officers and a community paramedic for Karratha.[382]

Subsequent to the publication of the Review, the SJA's medical director resigned and his role was replaced by a panel of experts known as the Medical Policy Committee.[383] The issue of clinical guidance was one of the six major issues recognised by the Review and its coverage by the Review led to the recommendations being criticised by some paramedics. SJA acknowledge that

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381 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, piv. Accessed on 6 January 2010.

382 Mr Robert Taylor, 'St John plea for $60m top up', *The West Australian*, 10 November 2009, p1.

383 Mr Anthony Deceglie, 'Ambo rule change', *The Sunday Times*, 15 November 2009, p42.

there are differences between the organisation's clinical guidelines and what practice some paramedics would like to follow. The SJA claims that there is a general view from paramedics that 'doing more' in the pre-hospital field directly correlates to 'doing better'.

Further, the SJA says:

> *Where we make decisions not to proceed with a skill, medication or practice that falls into this category and where it is practiced in other services we are generally condemned by paramedics for not having the same practice as other states. This issue has been exacerbated over the past few years by virtue of the fact that we have recruited around 100 paramedics from overseas services. Often they will not be moved by arguments of "evidence-based" decisions when we will not authorize a practice that was authorized in the service from which they have come. Our view, is that this is the essence of the current issue* [Inquiry].[384]

13.4 Conclusion

This chapter has highlighted the critical role played by both the RFDS and SJA in assisting DOH to offer an efficient State-wide service while having all of its tertiary services located in Perth.

Finding 97

The transport functions provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) are a critical element of the Western Australian health system, especially in rural and regional areas.

Queensland faces similar challenges to Western Australia in that it has very large areas with sparse populations. More than five years ago the Queensland Health Systems Review recognised that transport is the key for residents to access health services in a timely fashion, particularly those living in regional areas. Its chief recommendation was to establish 'Health Related Transport Reference Groups' comprising of Queensland Health, Queensland Ambulance Service and Queensland Transport representatives, in each Health Service District.[385] This is a proposal that the Committee believes should be taken up in Western Australia, particularly to improve the communication and cooperation between the RFDS and SJA in regional areas.

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384 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, 31 August 2009, pp18-19.

385 Queensland Health, 'Access to Health Services- Implementation Plan 2005-08', June 2005. Available at: www.health.qld.gov.au/emergtrans/docs/ems/documents/transport_key_1of4.pdf, p6. Accessed on 16 December 2009.

Recommendation 61

The Department of Health (DOH) establish 'Health Related Transport Reference Groups' comprising a representative of DOH, St John Ambulance Service, the Royal Flying Doctor Service and the Department of Transport, for each area health service.

The SJA seems to face the greatest difficulties given its current reliance on volunteers in many small, sparsely populated centres. This has allowed ambulance services to be offered at a far lower government commitment than in other jurisdictions. If the Government was to fund the ambulance operations of the SJA at a similar rate to other jurisdictions it would cost approximately another $65 million per annum — a similar figure to that being proposed by SJA to DOH in their 2009-14 contract negotiations. The SJA made it clear in their submission to this Inquiry that ambulance services are only part of their operations, and their mission as a nonprofit organisation would continue to suffer if the ambulance service was not 'properly' funded in the new contract, to allow them to provide "first class ambulance services in terms of response capability, call taking and despatch and patient care".[386]

The funding situation for both the RFDS and SJA is based on contracts that have underestimated population growth in fast growing regions, such as the Pilbara, and has led to crises such as the cases that have appeared in the media. The RFDS CEO concurred, stating that "we have been living hand to mouth for the previous decade and have not been able to plan better for those sorts of eventualities".[387] The contracts for both of these services should have review clauses that allow the distribution of additional resources to towns such as Karratha that are rapidly growing.

The Government faces three options for the future provision of transport operations by both the SJA and RFDS to support the work of DOH:

(i) continue to fund the RFDS and SJA with a focus on what services should be delivered for the funds provided;

(ii) integrate the services of RFDS and SJA fully into the Department of Health or Fire and Emergency Services and run them as public agencies; or

(iii) tender the services on a regular basis to allow the possible entry of other providers.

Evidence to this Committee supported the first option of retaining the status quo with additional funding. If adopted, the other two options would probably see a loss of experienced staff and 'corporate knowledge'. There has been no discussion in Western Australia of bringing either the RFDS or the SJA into the public service, or opening the services up to competition. The first

386 Supplementary submission from St John Ambulance Australia (Western Australia) Inc, 31 August 2009, p23.

387 Mr Tim Shackleton, Chief Executive Officer, Royal Flying Doctor Service (Western Operations), *Transcript of Evidence*, 16 September 2009, p2.

recommendation of the 2009 St John Ambulance Inquiry was to "Endorse the continuation of the existing service model, namely the provision of emergency ambulance services by an external provider."[388] The Review found that the model of an external service provider (SJA) rather than a State-run system was considered the most cost effective for Western Australia. Similarly, in 1997, the Victorian Auditor General's report on the Metropolitan Ambulance Service concluded:

> *Most of the projected savings from outsourcing arrangements have not eventuated, further contributing to the Service's poor financial position and necessitating an increase in annual government contributions of almost 300 per cent to $47 million since 1993 – 94. … the capacity to achieve further efficiency gains leading to internal savings was found to be very limited.*[389]

One option that Government might consider is to place a levy on all Western Australian taxpayerss to fund the ambulance service. However, the SJA Review found that there appears to be widespread belief in the community that ambulance services in Western Australia are (or should be) free, and this may have contributed to the bad debt in emergency ambulance services. SJA's 2007-08 annual report noted bad debts of $9.6 million for the metropolitan operations and $4.0 million for country areas. The Review also found that the establishment of an ambulance levy is associated with an increase in demand for ambulance services. The Queensland Government saw a significant increase in ambulance usage with the introduction of a levy.[390]

The Committee did not form a view on these broader future funding strategies for SJA and the RFDS.

Finding 98

The roles and resources provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) are currently not incorporated into the Department of Health's *Clinical Services Framework 2010-2020* model of projecting future health resource needs.

388 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p7. Accessed on 6 January 2010.

389 Government of Victoria, 'National Competition Policy Review of the Ambulance Services Act 1986- Government Response', March 2001. Available at: http://ncp.ncc.gov.au/docs/Vic%20Ambulance%20Services%20Act%201986%20-%20government%20response.pdf, p7. Accessed on 6 January 2010.

390 Department of Health, 'St John Ambulance Inquiry- Report to the Minister for Health', October 2009. Available at: www.health.wa.gov.au/ambulance_inquiry/docs/SJA_Inquiry_Report.pdf, p17. Accessed on 6 January 2010.

Recommendation 62

The roles and resources provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) need to be incorporated into the next version of the Department of Health's Clinical Services Framework.

Recommendation 63

In light of the significant expenditure provided under contract to the Royal Flying Doctor Service and the St John Ambulance by the State Government, the Department of Health should table their annual reports in Parliament with an analysis of their performance against their contracts.

CHAPTER 14 OUT OF SIGHT: OUT OF MIND- UNDERFUNDED MENTAL HEALTH SERVICES

14.1 Introduction

(a) Background

Mental illness is widespread and affects all ages and social groups.[391] In the 2009-10 Budget, the Western Australian Government allocated 3.9% of the health budget to mental health services.[392] Mental illness will affect about 20% of Western Australian adults in any one year, representing over 337,000 people.[393] Of these, about 21% will suffer from a severe mental illness, 33% a moderate illness and just under half will experience a milder illness. National data shows that 25% of people with a mental illness had more than one mental disorder, and just under half had a chronic physical illness.[394] People with a mental illness often have comorbid health issues, such as an addiction to alcohol or illegal drugs, that makes their treatment more complex.[395] This chapter highlights the historical under-funding of this sector by state governments of every political persuasion.

A national survey of people who had suffered a mental disorder within the previous year showed:

- about 33% reported having no family members upon whom they can rely for help, compared to 5% of the general population;
- people with a mental disorder are over three times more likely to be suicidal than the general population (8.6% compared to 2.3%);
- the prevalence of mental illness among the homeless (54%) was nearly three times more than the general population (20%); and

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391 Mental illness is a term used to describe a number of disorders which significantly interfere with an individual's cognitive, emotional or social abilities. It includes illnesses such as anxiety and depression, bipolar disorder and schizophrenia, and can often result in chronic and major disability for sufferers.

392 Department of Treasury and Finance, 'WA Health', May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p163. Accessed on 24 February 2010.

393 The Committee heard that this figure is now closer to 50% of the population, if diagnosable mental illness is broadened to include those with anxiety. Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p3.

394 COAG, 'National Action Plan for Mental Health 2006-2011: Progress Report 2006-07', February 2008. Available at: www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc, p13. Accessed on 19 February 2010.

395 Mr Eric Nordberg, Regional Manager, Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions, Wheatbelt Community Drug Service Team, *Transcript of Evidence*, 7 September 2009, p3.

- about 15% of prisoners have a severe mental illness, three to five times the incidence of the general population.[396]

Mental health is also a sector where program funding is provided by both the State and Federal Governments. The State provides:

- specialist clinical care and disability support for many of the most severely ill, including some who are treated on an involuntary basis;
- counselling services and mental health awareness programs; and
- early-intervention programs through a wide range of community agencies.

Other State departments, such as Child Protection and Corrective Services, fund and deliver services that provide treatment and non-clinical support (eg, treatment for drug and alcohol abuse) to clients who are directly affected by mental illness.

The Federal Government:

- partly funds privately provided services, such as GPs, psychiatrists and, increasingly, psychologists;
- funds the Pharmaceutical Benefits System (PBS) whose services are often uncapped, constrained only by the need for consumer co-payments and the availability of service providers;[397] and
- funds a range of non-clinical services used by people with mental illnesses, including income support through disability support payments and access to Job Network services.

The approach to funding mental health services is fundamentally different between the two levels of government. The State funds agencies to provide services to specified client populations within fixed budgets while the Federal Government funds services accessed by individuals, allowing the market to drive service delivery.[398]

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396 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p12. Accessed on 18 February 2010.

397 Ms Davey, a psychologist offering services in the Wheatbelt, told the Committee of patients who come to her under Medicare's Better Access program, which allows them to have 12 sessions with her over a 12-month period. See Ms Lynette Davey, Psychologist, *Transcript of Evidence*, 21 September 2009, p2.

398 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, pp17-18. Accessed on 9 February 2010.

Finding 99

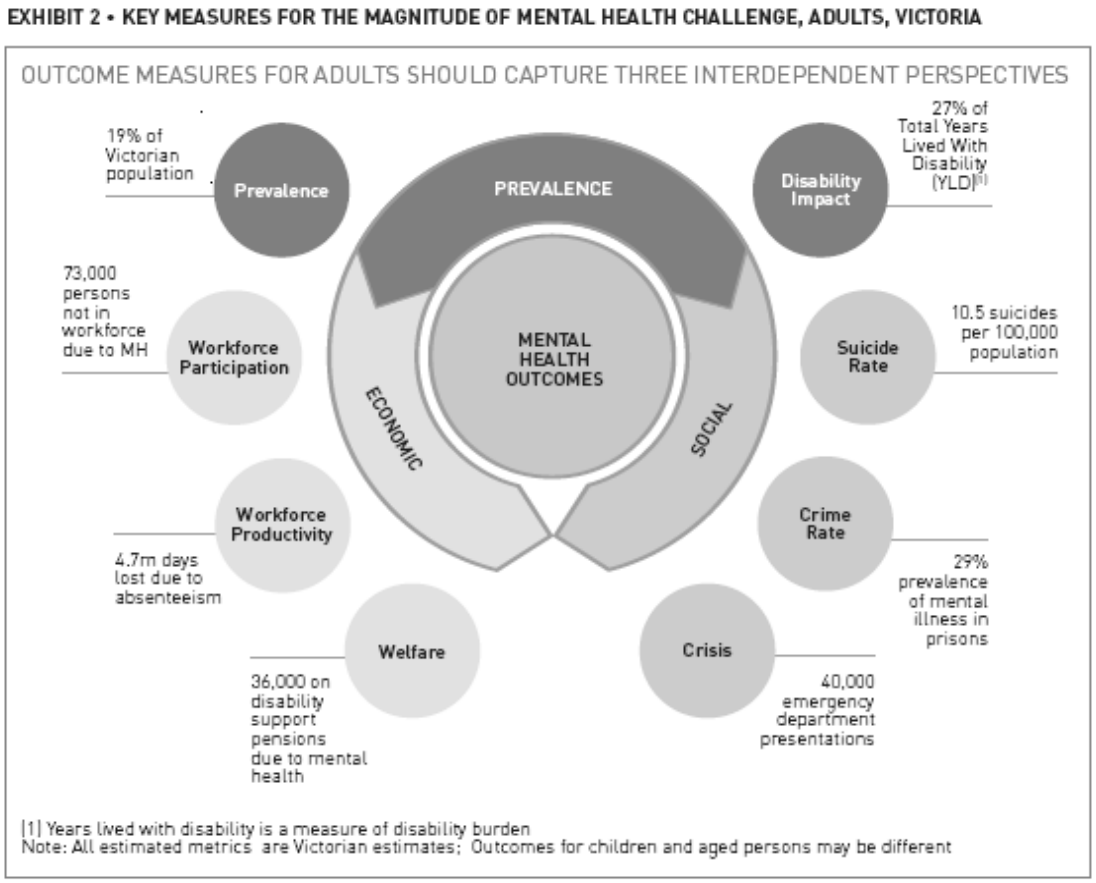
Mental health issues affect a large number of Western Australians and their families, and offer a complex challenge to health staff. Patients often have comorbid conditions including a physical illness or addiction to alcohol or illegal drugs, which require treatment over long periods.

(b) Community costs of mental health

The cost of mental illness is significant in both economic and social terms for sufferers, their families and the broader community.[399] These costs reflect the significant social impact of mental illness in terms of suicide rates, crime rates and the despair of individuals and families in crisis. The annual economic impact of mental illness was estimated to be around $5.4 billion in Victoria alone, driven in large part by the diminished workforce participation and productivity of those with a mental illness. The wide range of impacts of mental illness is summarised in Figure 14.1 below, taken from a recent report prepared for the Victorian Government.

399 Department of Health and Aging, 'National Mental Health Plan', April 1992. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/$File/plan92.pdf. Accessed on 9 February 2010.

Figure 14.1- Social and economic impacts of mental health[400]



Mental health accounts for about 13% of Australia's total disease burden and nearly 30% of the non-fatal disease burden. Other comparable western nations spend between 10-14% of their total health expenditure on mental health services. Australian governments currently spend approximately 7% (or $2.56 billion) of their health budgets on mental health services and programs. In Western Australia just 3.9% of the current health budget is reported as being spent on mental health.

Despite the increased Federal expenditure of about $778 million in mental health over the last decade, there is no evidence of an increase in Australia's proportion of total health expenditure

400 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p10. Accessed on 9 February 2010.

devoted to mental health. Increases in expenditure on mental health (46%) over this time have simply mirrored the increases in the costs of providing other forms of health care (42%).[401]

The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. While the Commonwealth did increase its contribution significantly (by 73% from $26.80 to $46.38 per capita), growth in State and Territory expenditure was only about 20% per capita (from $68.22 to $81.76). The larger states of New South Wales and Victoria recorded very low increases of 18% and 4% per capita, respectively. Western Australia spends about $96 per capita compared to New South Wales (which spends only $77 per capita), with figures of $85 in Victoria, and $86 in South Australia.[402]

The cost of the State's mental health services do not reflect the full extent of mental illness in Western Australia, as about 62% of people with mental disorders do not utilise mental health services. Reasons for this include:

- the stigma associated with mental disorders;
- fear of medical treatments;
- the poor distribution and costs associated with specialist services; and
- the inappropriate mix of medical and psychosocial services provided by government-financed programs.[403]

Although 38% of Western Australians with mental disorders do access services, this care is largely provided by general practitioners (GPs). The decline in bulk-billing by GPs is placing

401 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

402 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

403 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

further pressure on even this most basic form of mental and physical health care for people with mental disorders.[404]

Finding 100

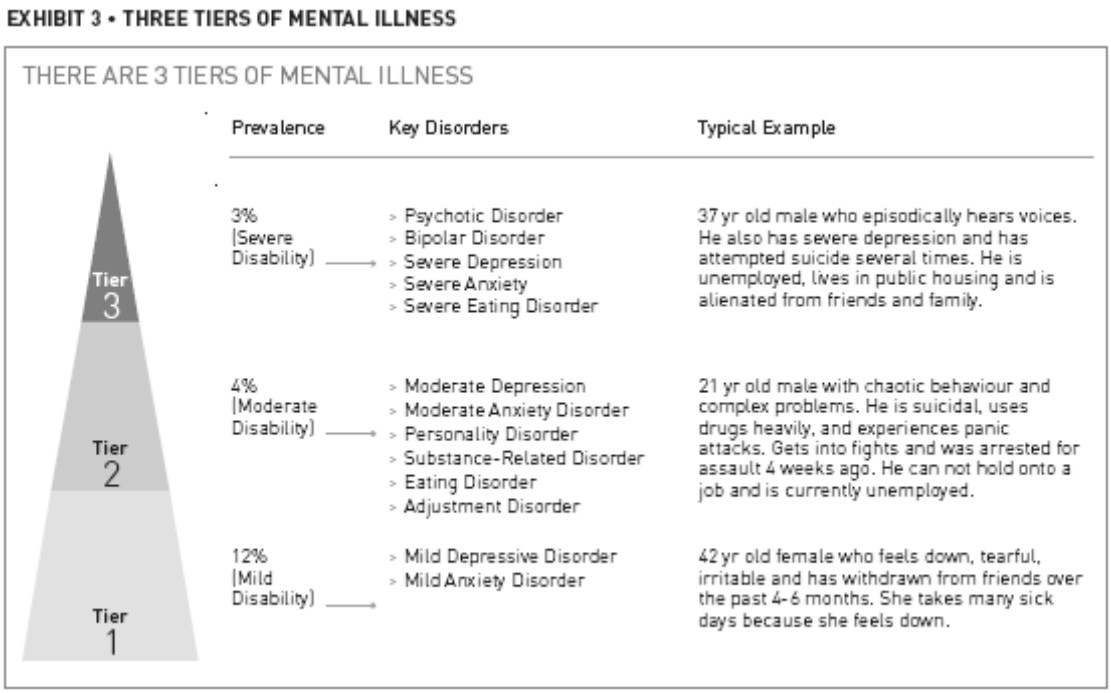
The cost of mental health is far broader than just the expenditure provided by State government departments each year and includes the health and social costs associated with suicide, crime and homelessness. The impact this has on the State health budget is under-stated as less than 40% of Western Australians with a mental illness access services. Those who do, usually see GPs who are subsidised by the Federal Government.

14.2 Needs and impact on those with mental illness

While about 20% of Western Australians suffer a mental illness, not all of them have severe symptoms. A report for the Victorian Government describes the acuity of mental illness in three tiers: severe, moderate and mild, as shown in Figure 14.2 below.

404 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

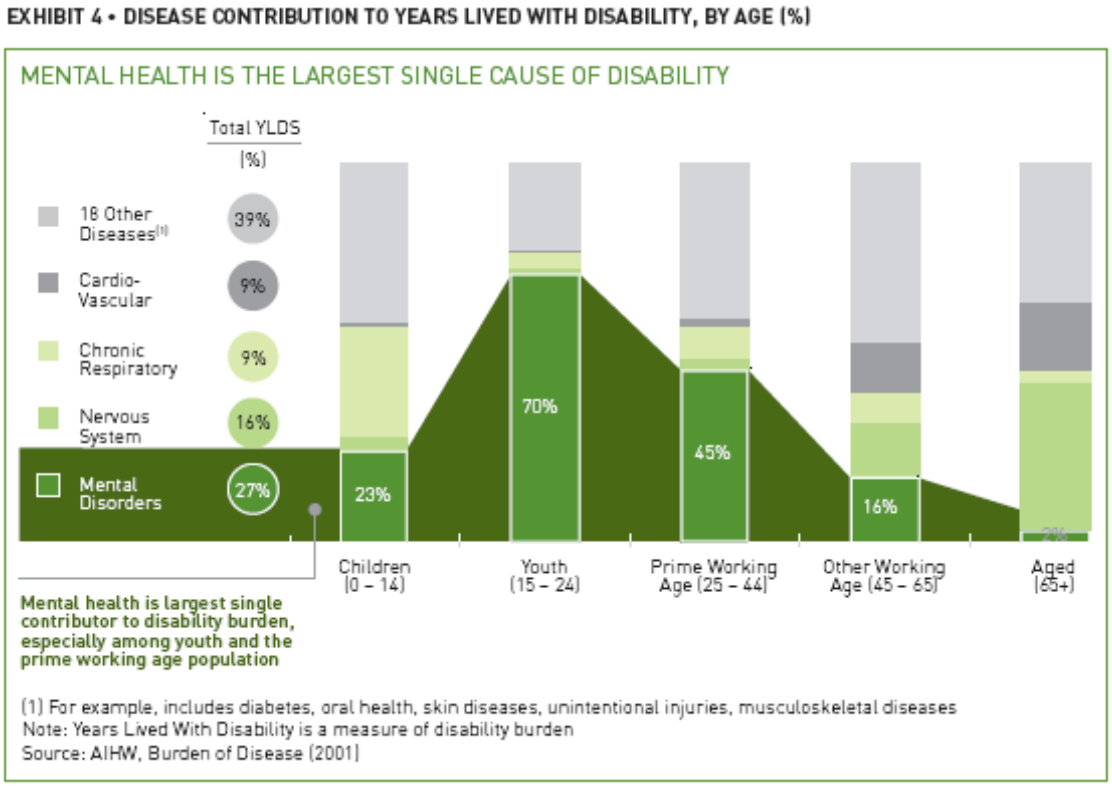
Figure 14.2- Proportion of mental health patients[405]



This report also graphically depicts the impact of mental illness on patients of different ages, and shows that it is the largest contributor to the overall 'disability burden', especial among young people and those at their 'prime' working age (see Figure 14.3 below).

405 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p11. Accessed on 9 February 2010.

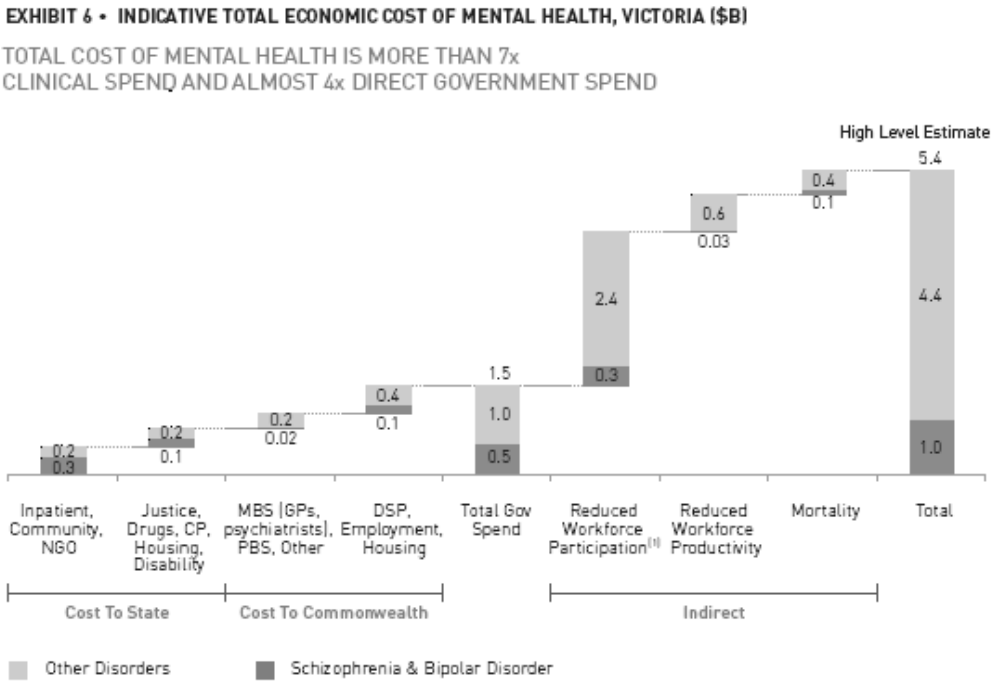
Figure 14.3- Mental health impact by age group[406]



This data on mental health allowed the Victorian Government to estimate the economic cost to that jurisdiction as around $5.4 billion per annum (see Figure 14.4 below). No similar data is available for Western Australia.

406 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p11. Accessed on 9 February 2010.

Figure 14.4- Economic cost of mental health in Victoria[407]



(a) Recent reports on mental health

The past two decades have seen a number of very graphic reports on the poor quality of the services provided to those with a mental illness in Australia, and the subsequent impact on their lives. These reports have spurred government action, but the key policy outcome of trying to develop better non-hospital services in the community has yet to be achieved. These reports include:

- 1993 - the Human Rights and Equal Opportunity Commission released the Burdekin Report (*National Inquiry into the Human Rights of People with Mental Illness)* which exposed the devastating personal consequences of grossly inadequate mental health and welfare services in Australia.[408]

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407 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p11. Accessed on 9 February 2010.

408 Australian Human Rights Commission, 'Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness', 1993. Available at: http://www.hreoc.gov.au/disability_rights/inquiries/mental/Volume%201%20(Text%20and%20pics).pdf. Accessed on 9 February 2010.

- 2003 - the Mental Health Council of Australia released the results of a national consultation of over 400 organisations and individuals in the report *Out of Hospital Out of Mind*.[409]

- 2005 - the Mental Health Council of Australia and the Human Rights Commission (HREOC) published *Not for Service: Experiences of injustice and despair in mental health care in Australia*, that detailed shocking experiences of pain, injustices, a sense of pervading hopelessness and despair in Australia's mental health system that sparked widespread mental health reform.[410]

- 2006 - the Victorian Government engaged the Boston Consulting Group to prepare a long-term vision and way forward for mental health care reform in Victoria. The report *Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform* summarises BCG's findings and recommendations.[411]

- 2006 - the Senate Select Committee on Mental Health produced *A National Approach To Mental Health - From Crisis To Community*. Recommendation 5 was that state and territory governments agree to recognise mental health as a designated ministerial responsibility in their departments of health.[412]

14.3 Policy changes

(a) Western Australian strategies

The *State Mental Health Policy and Strategic Plan 2010-20* was launched on 10 June 2009 at a function hosted by the Minister for Mental Health, Hon Dr Graham Jacobs. PricewaterhouseCoopers (PWC) was commissioned by the Government, at a cost of $493,000, to develop the strategic plan which will "provide an agreed overarching policy framework to guide

409 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

410 Australian Human Rights Commission, 'Not for Service: Experiences of injustice and despair in mental health care in Australia', 2005. Available at: www.hreoc.gov.au/disability_rights/notforservice/index.html. Accessed on 9 February 2010.

411 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf. Accessed on 9 February 2010.

412 Senate Select Committee on Mental Health, 'A national approach to mental health - from crisis to community', 28 April 2006. Available at: www.aph.gov.au/Senate/Committee/mentalhealth_ctte/report02/index.htm. Accessed on 18 February 2010.

mental health service reform in Western Australia."[413] This process was proposed in recommendation 12 by the Reid Report and was originally due to be completed by January 2010.

Dr Steve Patchett, Executive Director of WA Mental Health, advised attendees at the launch that this project reflects Western Australia's commitment to the objectives of the Commonwealth's ongoing National Mental Health Strategy, which calls on states to develop their own mental health strategic frameworks. Critically, in launching this initiative, the Minister suggested this project would address earlier failings by:

> *break*[ing] *down the 'medical model' that has dominated earlier discourse and placing a greater emphasis on community care and input. Moreover, it would fulfil the Liberal Party election commitment to review current mental health services and to develop a State strategy and policy plan through to 2020.*[414]

The earlier *Mental Health Strategy 2004-2007* commenced in October 2004 and aimed to boost mental health services in the State. The Government provided new funding of $82 million to implement the strategy's initiatives, such as increasing adult inpatient beds, and supported community accommodation places. The strategy's major aim was to relieve demand pressures on the mental health system, especially where these pressures impact on other parts of the health system, such as Emergency Departments in hospitals.[415] The Committee heard the importance of this initial State-wide strategy:

> *The* WA Mental Health Strategy 2004-2007 *is really important in terms of accommodation. It focused on that. We had very little, and we are still behind the rest of the nation in terms of stable accommodation with high level support. What is required—I am hopeful our strategic planning exercise will identify this because it is the way the rest of the world is going—is that mental health services need to be organised around districts; an identifiable region. We need a full range of services available in regions.*[416]

This strategy expired in 2007 and there has since been no State framework to guide the development of mental health services in Western Australia.

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413 WA Mental Health, 'State Mental Health Policy and Strategic Plan 2010-20 for Western Australia', nd. Available at: www.health.wa.gov.au/mentalhealth/reforms/strategy.cfm. Accessed on 23 February 2010.

414 Hon Dr Graham Jacobs, Minister for Mental Health, 'WA Government welcomes national mental health plan', 4 March 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=131455&search=strategy&admin=Barnett&minister=Jacobs&portfolio=&region=. Accessed on 23 February 2010.

415 Department of Health- Health Reform Implementation Taskforce, 'Western Australia's Mental Health Strategy 2004-2007', October 2004. Available at: www.health.wa.gov.au/hrit/publications/docs/Mental_Health_Strategy_2004-2007.pdf. Accessed on 23 February 2010.

416 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p3. See the DOH report on the strategy at the end of the 2004-07 period: www.health.wa.gov.au/docreg/Reports/Annual_Reports/Mentalhealth_annual_report.pdf, Accessed on 23 February 2010.

(b) Reid Report and Clinical Services Frameworks

Reid Report (2004)

The Reid Report found that there had been a significant rise in mental health conditions and this had seen psychiatric services exert a greater demand for hospital bed-days. It also found that access to quality health care appeared, to some degree, to be socially determined with evidence suggesting "that the gap in health status between the healthiest and least-healthiest is substantial and widening."[417] Aboriginal populations, the mentally ill, and people from lower socio-economic backgrounds were cited as particularly illustrative of this trend. The Reid Report called for a 'coordinated, multi-sectoral approach', including non-government services and the broader community. As part of this approach, it suggested that a greater emphasis should be given to improving awareness, prevention and early intervention programs, and supportive accommodation services within the community.[418]

Importantly for current health budgets, the Reid Report foresaw that mental health (along with aged-care and rehabilitation services) would place a significant demand on health care in the near future. The health system needed to be prepared for this contingency to ensure Western Australians were appropriately catered for. In response, the Health Reform Committee (HRC) proposed that Bentley Hospital, Osborne Park Hospital and a reconfigured Fremantle Hospital increase their mental health bed capacity. It proposed that Graylands Hospital remain as the State's premier provider of acute care. However, an expansion of services at these other 'specialist' hospitals would reduce the burden that Graylands was facing from the ever-increasing demand for mental health treatments. The four general hospitals placed on the periphery of Perth in Rockingham, Armadale, Midland and Joondalup would also increase their mental health care services.[419]

Clinical Services Framework 2005-15

The CSF 2005 conceded that the State's mental health services were struggling to cope with the increasing incidence of mental illness in the community. It reported on the $173 million spending commitment over three years as part of the *Mental Health Strategy 2004-2007* which proposed:

- 113 adult inpatient beds would be added to metropolitan hospitals and the Bunbury Hospital; and
- 420 beds would be established in 'community supported accommodation services' to assist those recovering from acute mental health episodes.

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417 Department of Health, 2004, *A Healthy Future for Western Australians,* Report of the Health Reform Committee, Perth, p16.

418 Department of Health, 2004, *A Healthy Future for Western Australians,* Report of the Health Reform Committee, Perth, pp33-34.

419 Department of Health, 2004, *A Healthy Future for Western Australians,* Report of the Health Reform Committee, Perth, pp46-47, 68. The Hawthorn Hospital has been converted to a 'step-down' facility for people at the post-acute stage of a mental illness.

The CSF 2005 service delineation matrix recommended that nearly 770 mental health beds should be operating by 2015-16. The overarching objective was to reduce the demand for acute mental health care, which was compromising general Emergency Department services through inappropriate admissions.[420]

Clinical Services Framework 2010-20

CSF 2010 was launched late in 2009 and now includes a level of care matrix for various 'non-hospital services' throughout the State, including public health and community mental health care. For 2015, the CSF 2010 lowers the number of mental health beds by 55 from the original projection of 769 contained in CSF 2005. This and other changes are driven by the Government's decision to retain RPH as a tertiary hospital. CSF 2010 also maintains adult Level 6 mental health inpatient services at RPH. This will take the number of such facilities to four by 2015 (Fiona Stanley, Sir Charles Gairdner and King Edward Memorial hospitals).

Osborne Park, Fremantle and Bentley hospitals are still scheduled in CSF 2010 to become specialist hospitals with a focus on mental health. Given the delay in completing capital works at other hospitals, such as Fiona Stanley, the date at which these specialist hospitals were to become operational at full capacity and offer mental health services has been extended from 2011 to 2014.[421]

Finding 101

The State's strategy to develop a broader range of acute inpatient mental health services closer to where patients live has been delayed by up to three years due to the retention of Royal Perth Hospital as a tertiary hospital and the delay in the construction of Fiona Stanley Hospital.

(c) National strategies

The first national Mental Health Strategy was endorsed in April 1992 by the Australian Health Ministers' Conference (AHMC) as a framework to guide mental health reform. It commenced on 1 January 1993. The strategy was intended to run for 10 years and address the needs of people with mental disorders and promoted the integration and coordination of specialised mental health services with community-based accommodation facilities and mainstream health providers.[422]

420 Department of Health, 2005, *Clinical Services Framework 2005-2015*, Department of Health, Perth, pp11,27-28.

421 Department of Health, 2009, *Clinical Services Framework 2010-2020*, Department of Health, Perth, p28.

422 Department of Health and Ageing, 'National Mental Health Strategy', 16 November 2009. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-strat. Accessed on 19 February 2010.

Australian health ministers have continued to support the strategy since its inception, with the Second National Mental Health Plan endorsed by all Australian health ministers in July 1998. This provided a five-year framework to consolidate the existing reforms and extend into additional areas of reform with a strong emphasis on population health issues and early interventions. Enhancements to mental health care contained in the second plan included initiatives such as providing $17.5 million of Commonwealth funding for *beyondblue*, the MindMatters national schools-based mental health promotion and prevention initiative, and a later $120.4 million for the *More Options Better Outcomes* initiative.[423]

COAG's 2006 *National Action Plan on Mental Health* committed a total of $4.1 billion to a wide range of new initiatives over 2006-11. A further $935 million was subsequently committed. These new funds, and the existing mental health budgets, will see a total of $19.9 billion of expenditure over the five years of the Action Plan. This represented the largest collective investment in mental health by Australian governments to that date. A review of progress published in 2008 showed "that the number of people accessing mental health services in 2006-07 (5% of population) is far less than the known rates of mental illness in the community, suggesting high levels of unmet need."[424] In November 2009 the AHMC launched the *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014*. This latest plan has five priority areas for government action in mental health:

(i) Social inclusion and recovery;

(ii) Prevention and early intervention;

(iii) Service access, coordination and continuity of care;

(iv) Quality improvement and innovation; and

(v) Accountability - measuring and reporting progress.

(d) New Victorian strategy

On 13 March 2009 the Victorian Minister for Mental Health released a whole of government ten-year plan for mental health titled *Because mental health matters – Victorian mental health reform strategy 2009-19*. This innovative strategy buttresses Victoria's reputation for progressive mental health policy. It was based on the findings of the earlier Boston Consulting Groups' report in 2006 and a government consultation paper in 2008. The strategy is centred on four core elements:

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423 Dr Grace Groom, Professor Ian Hickie and Ms Tracey Davenport, 'Out of Hospital Out of Mind: A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008', April 2003, Mental Health Council of Australia. Available at: www.mhca.org.au/Publications/documents/OutofHospitalOutofMindReport.pdf, p3. Accessed on 9 February 2010.

424 Council Of Australian Governments, 'National Action Plan for Mental Health 2006-2011: Progress Report 2006-07', February 2008. Available at: www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc. Accessed on 19 February 2010.

1 Prevention;

2 Early intervention;

3 Recovery; and

4 Social inclusion.[425]

The 2009-10 Victorian health budget included a total of $182 million over four years for new mental health initiatives such as:

- $13.8 million over four years for a dedicated response across a broader range of conditions for young people up to 25 years;
- $4.5 million over four years for new Schools Early Action teams in one metropolitan and one rural region to identify and treat children developing behavioural problems in the early primary school years; and
- $74 million in new capital projects in regional Victoria, including $8 million for two new Youth Prevention and Recovery Care services at Bendigo and Frankston and $66 million for a 120-bed mental health inpatient redevelopment at Dandenong Hospital and 30 new residential beds.[426]

The total mental health budget for Victoria in 2008-09 was $945 million, or 6.7% of the total health budget.[427] This proportion is just over 70% higher than Western Australia's allocation of 3.9% for mental health services in the 2009-10 health budget, as shown in Table 14.1 below.[428]

425 Mental Health & Drugs Division, Department of Health, Victoria, 'About the strategy', 1 March 2010. Available at: www.health.vic.gov.au/mentalhealth/reformstrategy/about.htm. Accessed on 19 March 2010.

426 Mental Health & Drugs Division, Department of Health, Victoria, '2009-10 State Budget fact sheet: mental health reform', 1 May 2009. Available at: www.health.vic.gov.au/mentalhealth/reformstrategy/documents/budget0910.pdf. Accessed on 19 March 2010.

427 Department of Treasury and Finance, Victoria, 'Department of Human Services', 1 May 2009. Available at: www.budget.vic.gov.au/CA25755B0004CE3B/WebObj/BP3Ch3DHS/$File/BP3Ch3DHS.pdf, p87. Accessed on 19 March 2010.

428 Department of Treasury and Finance, 'WA Health', May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p163. Accessed on 24 February 2010.

Table 14.1- Comparison of mental health budgets between Western Australia and Victoria, 2009-10

	Western Australia	Victoria	Comparison of WA budget to Victorian budget
Total health budget per capita	$2,155	$2,125	101%
Mental health budget per capita	$103.30	$184.21	56%

Finding 102

Despite its vibrant economy, Western Australian funding of mental health services lags well behind that of other Australian jurisdictions.

14.4 Western Australian mental health services

(a) Scope of services

The current approach to mental health care in Western Australia is primarily based on an acute care cycle where assessment precedes diagnosis, which is followed by treatment in a hospital that leads to discharge. However, the recently released National Mental Health Plan promotes a recovery-based model. This focuses on the whole person, including greater consideration for social and environmental factors which impact on mental illness, and seeks to avoid crisis for patients. DOH's Community Mental Health Team (CMHT) services in 2007-08 provided mainly acute care (84%) with limited availability for rehabilitation (6%) or emergency response and early intervention (10%) services. A recent review by the Auditor General found that the funding directed by DOH to non-government organisations for community activities in 2007-08 showed:

- 27% of funds directed at prevention and early intervention;
- 32% spent on rehabilitation services; and
- 41% of the funding was still directed at acute care services.[429]

The Auditor General found that CMHT services and funding allocation are not based on any analysis of community need. This leads to a variation in the service provided across the teams. Also, current processes for resource allocation by DOH do not explicitly consider community and consumer need, local demographics or socio-economic conditions despite research indicating that

429 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p22. Accessed on 18 February 2010.

there is a close relationship between the incidence of mental illness and socio-economic status. Neither DOH's Mental Health Division, the Area Health Services or individual CMHTs have undertaken a wide-ranging analysis on the needs of Western Australians with mental health problems. Without an understanding of community and consumer need and demand for services, it is not possible to determine whether the mix of services currently provided meets the needs of patients.[430]

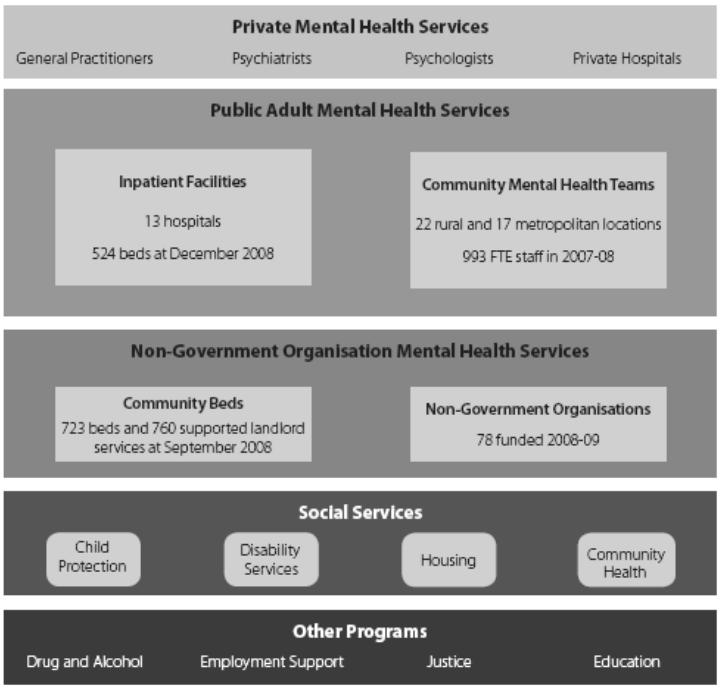
In 2007-08, about 28,500 Western Australian adults (or 2% of the adult population) had contact with Department of Health's CMHTs and 9,700 adults had an inpatient stay in hospital for a mental illness. CMHTs at 39 locations across the State deliver the majority of DOH's community mental health services. They provide services including initial assessment, treatment (clinical and therapeutic interventions and rehabilitation) and referral to other services (such as housing, education, training and employment). The majority of adults using CMHT's services live in the metropolitan area, while a quarter live in rural Western Australia. Around 16% of these patients moved between the three area health services for treatment.[431]

Figure 14.5 below describes the wide range of private, public and community-based mental health programs provided in Western Australia.

430 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p22. Accessed on 18 February 2010.

431 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p11. Accessed on 18 February 2010.

Figure 14.5- Western Australia's mental health service matrix[432]



The figure above shows that the State's mental health services include the important contribution of 78 non-government organisations (NGOs). Evidence was provided to the Committee that the Government relies on the NGOs to assist in the delivery of about 20% of community mental health care services.[433] Appendix Five includes data on NGOs who received government funding for their mental health services in 2008-09. Because of the disparity between the wages paid in the NGO and government sectors, the NGOs in the mental health sector are finding it harder to attract and retain staff.

Figure 14.6 below highlights the proportion of patients with various mental health complaints, and the mental health services they access. For example, about 13% of patients in Western Australia are diagnosed with schizophrenia but utilise over 30% of the State's mental health services. This data confirms a focus by the Department of Health on acute care over community care services.

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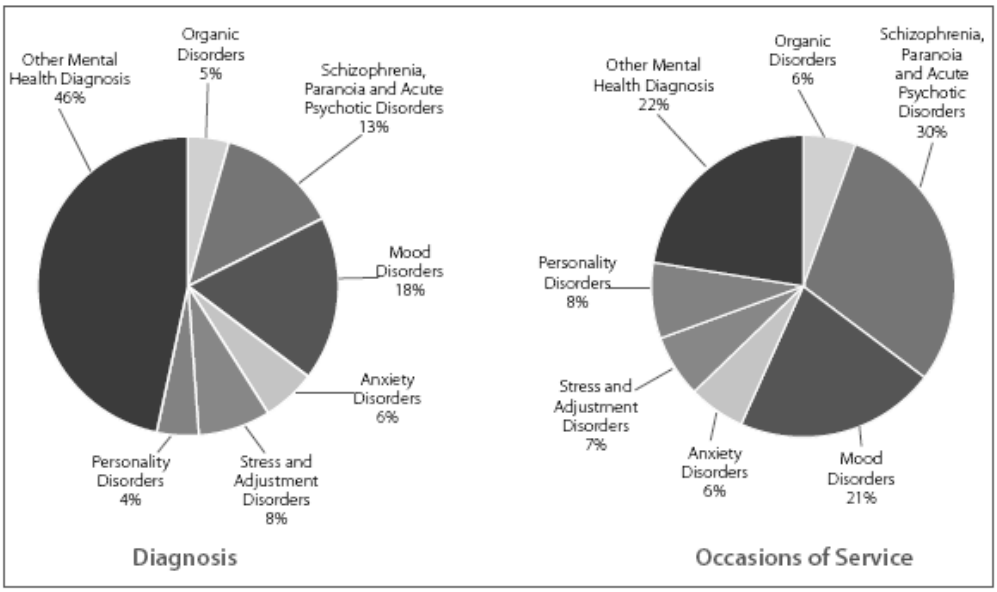
432 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p11. Accessed on 18 February 2010.

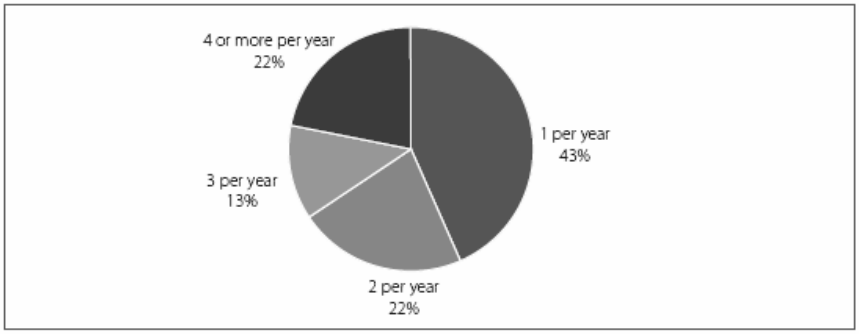
433 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p13. Accessed on 18 February 2010.

Figure 14.6- Diagnosis and service provision for mental health problems in Western Australia[434]



The Auditor General found that of the 9,669 mental health patients in the State who were hospitalised in 2007-08, the majority (65%) had only one or two inpatient episodes, and this was largely unchanged from 2006-07 (see Figure 14.7). The number of patients having an inpatient stay was also largely unchanged between 2006-07 and 2007-08.

Figure 14.7- Inpatient episodes for Western Australia mental health patients[435]



434 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p14. Accessed on 18 February 2010.

435 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p35. Accessed on 18 February 2010.

(b) Budget for the services

The Auditor General's report also summarised the broad scope of the resources allocated by Department of Health's three area health services to mental health programs (see Figure 14.8). Importantly, this data confirms that more needs to be allocated by the WA Country Health Service and the North Metropolitan Area Health Service for mental health care.

Figure 14.8- Mental health services and budgets of NMAHS, SMAHS and WACHS[436]

	NMAHS	SMAHS	WACHS	Total
Proportion of total CMHT consumers	51%	41%	24%	116%[1]
Proportion of Expenditure	39%	43%	18%	100%
Spend per Consumer	$3 456	$4 739	$3 217	$4 477
CMHT Staff (FTE) per 1 000 consumers	28	34	27	35

A fuller description of the recent and future budgets for mental health services is provided in the 2009-10 Budget for DOH. Table 14.2 contains budget figures for the period 2008-10 and it shows an increased emphasis (from a small base) for residential mental health programs. The data also emphasises DOH's continuing focus on acute programs.

Table 14.2- Department of Health mental health budgets, 2007-12[437]

	2007-08 Actual	2008-09 Estimated actual	2009-10 Budget	2010-11 Forward estimate	2011-12 Forward estimate	Increase over 2007-10
Specialised mental health	177,403	199,281	209,564	221,066	233,658	**5.2%**
Community mental health	161,253	176,142	184,694	194,832	205,929	**4.9%**
Residential mental health	8,319	11,453	14,603	15,404	16,282	**27.5%**
TOTAL	**346,975**	**386,876**	**408,861**	**431,302**	**455,869**	**5.7%**

The Budget also provides details of additional mental health expenditure such as:

436 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p20. Accessed on 18 February 2010.

437 Department of Treasury and Finance, 'WA Health', 14 May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p163. Accessed on 18 February 2010.

- $200,000 between 2008-10 for the review of mental health services;
- $13 million for the State suicide prevention strategy to be spent over 2008-11; and
- $273,000 per annum for the establishment of a Mental Health and Wellbeing Commissioner.[438]

This position remained vacant until the Premier and Minister for Mental Health announced on 4 February 2010 the establishment as from March 2010 of a Mental Health Commission. The Director of the Drugs and Alcohol Office, Mr Neal Guard, was appointed as acting Commissioner. The new Commission will assume and expand upon the current functions of DOH's Mental Health Division and at a later date "mental health would be separated from the Health portfolio."[439]

The Auditor General's report found that between 2005-06 and 2009-10 there was a 45% increase in community mental health service funding with the budget allocation increasing from $128 million to $185 million. This included funding for child and adolescent, adult and elderly services across government and non-government sectors. Based on data provided by Area Health Services in 2007-08, WA Health estimated that almost 80% ($128 million of the $161 million allocated as part of the State Budget) of community mental health service funding was spent on government CMHT services.[440] A further $40 million was allocated to about 80 non-government organisations (NGOs) for both community and inpatient care.[441] The proportion of funding spent on NGO programs is substantially lower in mental health than other areas of the State's health sector, according to the *Putting the Public First* Report by the Economic Audit Committee.[442] This report identified mental health as an area where there was considerable scope to do things differently to get better outcomes for Western Australians.[443] The NGOs who received funding from DOH in 2009 for mental health programs is included in Appendix Five. This data lists the NGOs by region.

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438 Department of Treasury and Finance, 'WA Health', date. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p161. Accessed on 9 February 2010.

439 Hon Dr Graham Jacobs, Minister for Mental Health, 'Mental health services revolutionised with Australian-first initiative', 4 February 2010. Available at: www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=133084&. Accessed on 18 February 2010.

440 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p31. Accessed on 18 February 2010.

441 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p6.

442 Economic Audit Committee, 'Putting the Public First: Partnering with the Community and Business to Deliver Outcomes', October 2009. Available at: www.dpc.wa.gov.au/Publications/Documents/eac_final_report.pdf. Accessed on 18 February 2010.

443 Hon Dr Graham Jacobs, Minister for Mental Health, 'Mental health services revolutionised with Australian-first initiative', 4 February 2010. Available at: www.mediastatements.wa.gov.au/Pages/default.aspx?ItemId=133084&. Accessed on 18 February 2010.

As part of the process of establishing a Mental Health Commission and increasing the funding to NGOs for community services, Dr Steven Patchett acknowledged:

> *We are currently identifying the mental health budget and then identifying a resource allocation model that takes into account the more sophisticated community care model. There is a kind of rough formula that the world is heading for. Whereas, 10 years ago 70% of State Government money on mental health was spent on inpatient facilities and 30% in the community, the ideal is probably the reverse: 30% to inpatients and 70% in the community. We are about 50-50 at the moment, so we are heading that way. The strategic plan will complete that story for us of how to invest in the community.*[444]

Budget cuts

The Minister for Mental Health announced in Parliament in late 2009 that mental health services have been asked to meet their budget (which includes a 3% efficiency dividend) without compromising 'front-line clinical services'. This was in response to claims by the Opposition that the South Metro Area Health Service was planning a 13% budget cut at the Fremantle Mental Health Service which would mean the loss of nearly 200 jobs across the SMAHS and that cuts were also planned at RPH.[445] The Minister said that "Department of Health staff have been asked to identify inefficiencies, duplication and priority areas where potential savings can be made" and that the memo tabled in Parliament was "middle management paperwork which is in the melting pot, and which has not come to the Director General, the area health manager or me for any decision."[446]

Finding 103

As in other major parts of Western Australia's health system, resources are skewed toward acute hospital-based services while other Australian jurisdictions have placed greater emphasis on community-based rehabilitation and accommodation services.

Recommendation 64

Given their past under-funding and the high level of unmet need, the State's mental health programs should be isolated from any further cuts flowing from the Government's 3% efficiency dividend.

444 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p5.

445 Ms Cathy O'Leary, 'Fears of mental health staff cuts', *The West Australian*, 10 October 2009, p16.

446 Hon Dr Graham Jacobs, Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 13 October 2009, p7821.

Recommendation 65

The State's mental health strategy should clearly outline a way to further boost the State's rehabilitation and accommodation mental health services in Perth and in regional Western Australia, especially for those services operated by non-government organisations.

(c) Mental health beds in Western Australia

The total number of mental health beds in Western Australia is 1,450. This is comprised of 689 inpatient beds and 761 community residential beds (see Tables 14.3 and 14.4 below).[447] The demand modelling undertaken for the *Clinical Services Framework 2010-20* estimated a requirement of 714 mental health inpatient beds (acute and non acute) for the whole metropolitan area by 2014-15, and 742 mental health inpatient beds by 2020-21. CSF 2010 does not provide any estimate for community residential beds for these later periods.

Table 14.3- Western Australian mental health inpatient beds by type, 2009

Bed type	Adult	Child & Adolescent	Older people	Forensic	TOTAL
Secure	155	4	110	30	**299**
Non-secure	318	24	24	8	**374**
Intermediate care	16				**16**
TOTAL	**489**	**28**	**134**	**38**	***689***

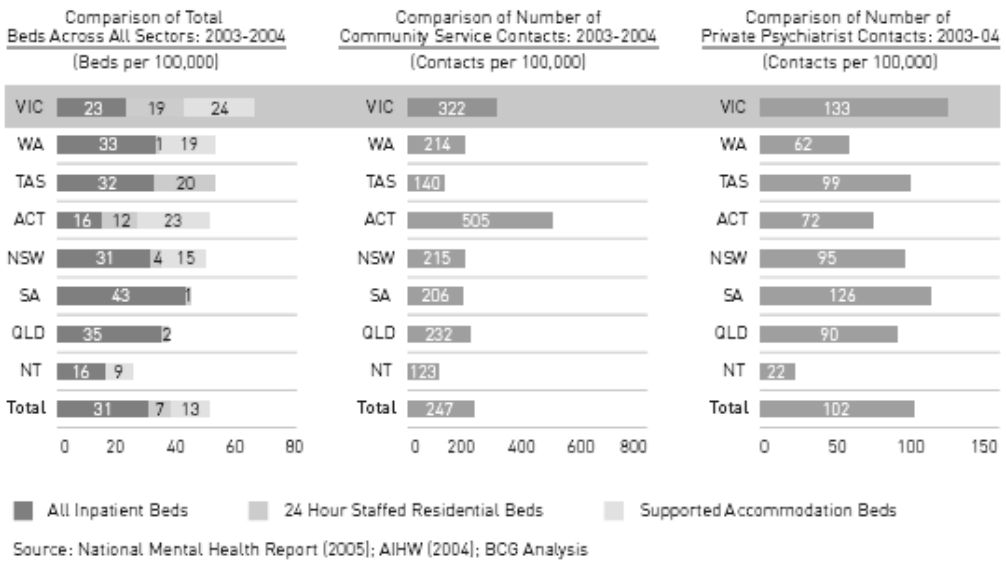
447 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Reply to Questions on Notice*, 23 September 2009, p4.

Table 14.4- Western Australian mental health community residential beds by type, 2009

Bed type	Adult	Child & Adolescent	Older people	Forensic
Publicly operated	31			
NGO operated	184			
Private psychiatric hostels	524			
Specialist residential			22	
TOTAL	**739**	**0**	**22**	**0**

Data contained in the Auditor General's report shows that in 2003-04 the number of acute mental health beds in Western Australia is similar to the average for other Australian jurisdictions, while the number of residential beds, community contacts and private services from psychiatrists is below the average (see Figure 14.9).

Figure 14.9- Mental health services in Western Australia compared to other jurisdictions, 2003-04[448]



448 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p21. Accessed on 9 February 2010.

The Department of Health's Executive Director of Mental Health described these mental health beds as the equivalent of intensive care beds in a tertiary hospital:

> *I prefer to talk about our beds as intensive care beds. People in hospital for a mental illness, require intensive care. People in that circumstance are seriously unwell. We should be aiming for as short a stay as possible, but then having the full range of step down and supported accommodation options or brief stay and quick resolution of psychosis back to original accommodation.*[449]

Under the 2004-07 Strategy, nearly 150 beds have been added in the metropolitan region and 50 in rural regions for intensive psychosocial support and stable accommodation provided in three or four-bed homestay-type accommodation. This program includes the expansion in-patient beds, such as that at the Joondalup Health Campus in early 2009.[450] Thirty beds of supported residential units are to replace the very long-stay beds in the Murchison ward at Graylands Hospital (where some patients might stay for a whole year) and surveys indicate that about 40% of patients could be discharged from Graylands if there was a stable community accommodation option for them.

Information provided to the Committee indicated a wide range of projected costs per bed-day, with the most expensive being for patients with mental illnesses in Princess Margaret and King Edward Memorial hospitals. It is not clear from this data why the average bed-day costs are half at Osborne Park Hospital compared to other hospitals, or 25% more expensive at Fremantle Hospital compared to other tertiary facilities. This data and length of stay for the metropolitan hospitals are included in Table 14.5 below.

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449 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p3.

450 'Mental health beds', *The West Australian*, 23 April 2009, p9.

Table 14.5- Information on mental health bed-day costs and length of stay[451]

Mental health facility	2009-10 Cost per bed-day	2008-09 Episodes of care	2008-09 Median stay (days)	2008-09 Maximum stay (days)
Tertiary facility				
Graylands	$891	3,589	7	365
Princess Margaret	$1,764	185	6	62
KEMH	$1,328	143	15	365
RPH	$735	480	10	158
Fremantle Hospital	$1,070	1,090	12	365
SCGH	$824	943	7	134
Other facility				
Armadale Hospital	$979	626	8	365
Bentley Hospital	$838	1,266	11	365
Osborne Park Hospital	$476	139	33	305
Selby Older Adult	$1,033	167	42	293
Swan Districts Hospital	$1,096	527	10	365

When questioned about patients being released early from mental health institutions such as Graylands, Dr Steven Patchett said "It is mostly about bed pressure. The beds that we have—between 600 and 700 beds—are filled all the time to 98% capacity. It is about bed pressure. You can prevent that."[452] Further, Dr Patchett viewed this pressure on beds was due to a long-term lack of effort to build resources in the community and in his view "we probably have, in terms of hospital beds, too many, but we need them because we do not have those community services. … That ultimately will see far fewer inpatient beds".[453]

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451 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Questions on Notice*, 22 March 2010, Appendix A, pp1-2.

452 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p4.

453 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p10.

While DOH is more focused on community facilities in Perth, it is working closely with WACHS to improve the number of mental health beds in regional areas:

> *In terms of regional areas …there is an inpatient unit in Albany; there is one in Kalgoorlie, a large inpatient unit in Bunbury, and there is soon to be—it has been delayed—the 14-bed inpatient unit at Broome; and Geraldton is obviously the next. But we need to provide the range of services throughout the rural and remote areas as well through the Western Australian Country Health Service, as it exists at the moment. There is a disparity between the amount of mental health funding that goes into the metropolitan region and the amount that goes into regional and remote regions.*[454]

Dr Patchett told the Committee that "the metropolitan region is pretty well covered. Maybe you could say that that kind of north eastern corridor out to Ellenbrook may require particular investment in inpatient beds at a later stage" but he viewed the real need was for in-patients beds in regional areas north of Perth, where none presently exist.[455]

Finding 104

Western Australia's current focus on acute in-patient mental health facilities has led to higher costs for the mental health sector and poorer health outcomes for mental health patients who require community residential accommodation (step-down) facilities.

Recommendation 66

A key thrust of the new Western Australian mental health strategy should be for the rapid development of new community residential accommodation (step-down) facilities in both metropolitan Perth and in regional communities to the north of Perth.

(d) Staff

Figure 14.10 provides the services and Table 14.6 outlines the number of staff employed by DOH to provide mental health services across the State in the three area health services.[456] This data

454 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p6.

455 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p13.

456 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p19. Accessed on 18 February 2010.

indicates that the WA Country Health Service provides a disproportionate amount of mental health services relative to the two metropolitan AHS while using a smaller proportion of its staff.

Figure 14.10- Department of Health mental health services by area health service

Service Type		NMAHS	SMAHS	WACHS	Total
Early Intervention	Early Intervention Services	1	3	0	4
	Community Emergency Response Teams	5	6	0	11
Acute Care	Assessment Services	12	21	20	53
	Acute General Services	14	15	29	58
	Acute Specialist Services	3	5	0	8
Rehabilitation	Rehabilitation Services	2	4	2	8
Total		37	54	51	142

Table 14.6- Department of Health mental health staff by area health service, 2009

DOH Service	Mental Health FTE	Mental Health Headcount	Proportion of Total Headcount
Mental Health Division	43.1	46	**1.3%**
Child and Adolescent Health Service	109.7	138	**3.8%**
North Metro AHS	1,500.4	1,741	**47.8%**
South Metro AHS	1157.4	1,355	**37.1%**
WA Country Health Service	328.7	366	**10.0%**
TOTAL	**3,139.3**	**3,646**	

Tables 14.7 and 14.8 (below) provide the same data on DOH mental health staff, but by the type of service they are employed to deliver.

Table 14.7- Department of Health mental health staff (FTE) by occupation, 2009

	Nursing	Medical	Medical support	Admin & clerical	Hotel services	Site services
Mental Health Division		1.1		42.0		
Child and Adolescent Health Service	36.4	11.4	32.0	27.0	2.1	0.8
North Metro AHS	698.8	123.6	315.3	195.4	128.0	39.3
South Metro AHS	616.5	125.0	214.4	162.3	34.6	4.6
WA Country Health Service	134.3	22.9	91.9	60.5	6.3	12.8
TOTAL FTE	**1,486.0**	**284.0**	**653.6**	**487.2**	**171.0**	**57.5**

Table 14.8- Department of Health mental health staff (headcount) by occupation, 2009

	Nursing	Medical	Medical support	Admin & clerical	Hotel services	Site services
Mental Health Division		1	45			
Child and Adolescent Health Service	49	16	41	29	2	1
North Metro AHS	794	143	395	243	136	40
South Metro AHS	702	124	266	188	69	6
WA Country Health Service	150	26	108	59	10	13
TOTAL	**1,695**	**310**	**855**	**519**	**217**	**60**
PROP. OF HEADCOUNT	**46.4%**	**8.5%**	**23.4%**	**14.2%**	**5.9%**	**1.6%**

The Committee heard that mental health workforce issues had been a major priority for Dr Flett, then-Director General of DOH.[457] New initiatives included the Assistants in Nursing program and providing scholarships for registered nurses to complete their studies and work in mental health. Other workforce initiatives included an overseas recruitment drive in June 2007 and 34 postgraduate Diploma of Mental Health scholarships.[458] Dr Patchett noted that "the registered nursing level, we find it hard to attract graduate nurses into mental health."[459] However, the Committee understands that mental health staff were among the services mooted to be cut to allow the Department of Health to meet its 3% efficiency dividend to the Government. It was reported in late-2009 that RPH's psychiatry department had plans to reduce its number of doctors and to cut after-hours support to save funds.[460]

Regional staff

Some of the difficulties for mental health staff were presented to the Committee as evidence, especially in smaller regional centres where lower numbers of staff operate over vast distances. For example, the Great Southern Mental Health Service provides a specialist treatment service for people with mental illness from birth through to old age for 71,000 people in the southern Wheatbelt and Great Southern regions (about 75,000 square kilometres). Patients in this region with severe illness can be transferred to G ward at the Albany Hospital, to Perth or Bunbury, or to Bentley Hospital if the patient is under 18 years of age.[461]

The impact of dealing with patients with a severe mental illness can be hard for nurses:

> *with a smaller population and smaller hospitals you do not want to burn out the nursing staff that can actually get rattled when you have someone who is psychotic coming in for services—they are better to be transported and treated elsewhere.*[462]

Difficulties also extend to the Police:

> *Apart from the fact that we have taken somebody who has a problem into the hospital, which does not have instantly the facilities to secure them, means that, yes, we will leave police with those people until everybody is safe. At the end of the day, we still have a duty*

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457 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p7.

458 Council Of Australian Government, 'National Action Plan for Mental Health 2006-2011: Progress Report 2006-07', February 2008. Available at: www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.doc, p41. Accessed on 19 February 2010.

459 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p7.

460 Ms Cathy O'Leary, 'Fears of mental health staff cuts', *The West Australian*, 10 October 2009, p16.

461 Ms Marcelle Cannon, Regional Manager, Great Southern Mental Health Service, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p2.

462 Mr Eric Nordberg, Regional Manager, Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions, Wheatbelt Community Drug Service Team, *Transcript of Evidence*, 7 September 2009, p14.

> *of care even to the nursing staff there; we cannot expose them to a risk or a danger that they do not have the facilities to deal with.*[463]

The Committee heard that there is a difficulty providing 24-hour mental health services in some smaller regional hospitals:

> *In some of the smaller sites in country health, and G ward at Albany is no different, we run a 2, 2 and 2 roster, so we have only two nurses on any shift. If one is a new graduate and there is one other nurse working with them, that puts a lot of responsibility on that one person to not only support the new graduate but also provide care for the patients in the new unit. I have to say that those mental health nurses are supported by others such as psychologists, OTs and other people in the department.*[464]

There is anecdotal evidence that country services are starting to see presentations that are more complex and more acute for numerous reasons:

> *one of which might be an increase in drug availability and drug use, but there are also other issues such as the more transient nature of families generally in modern society. The feedback from the CAMHS team is that they are actually seeing far more acute presentations. Also, I hate to use the word 'chronicity' in relation to children and adolescents, but we are seeing also more chronic issues, such as the emergence in increasingly younger people of what might in an adult be diagnosed as a personality disorder. … We would receive referrals for children as young as one year or 18 months on occasion.*[465]

Regional mental health staff liaise closely with NGOs, but find that "we definitely have more referrals and more client needs than the NGO capacity can match."[466] Some of the difficulty is that NGOs might be able to offer some services for DOH clients, but not others.

Other issues which impact on the ability of DOH to attract mental health staff include resources:

> *it is the lack of support when people go in for clinical placements. Because the care is so complex, we cannot send a graduate out to a home to case manage somebody because they just do not have the experience. It is intensive resourcing initially to build up their skills.*[467]

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463 Sgt Michael Daley, Acting Officer in Charge, WA Police, Merredin, *Transcript of Evidence*, 7 September 2009, p14.

464 Ms Suzanne Seeley, Nurse Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p5.

465 Ms Melinda Misson, Team Manager, Great Southern Mental Health Service, WA Country Health Service-Great Southern, *Transcript of Evidence*, 11 September 2009, p3.

466 Ms Melinda Misson, Team Manager, Great Southern Mental Health Service, WA Country Health Service-Great Southern, *Transcript of Evidence*, 11 September 2009, p3.

467 Ms Suzanne Seeley, Nurse Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, pp5-6.

Security in older hospitals is also an important factor. Staff preferred good electronic systems, such as CCTV, proximity cards, and zoning the hospital to minimise security hazards with single-entry and exit points from wards. The Committee's view is that this is preferable to having ill-equipped security staff who are not trained to respond to aggressive situations.

Finally, DOH staff highlighted the lack of graduate staff education in the mental health area:

> *we do not have any dedicated graduate mental health programs. I think if we are going to develop a sustainable and robust mental health workforce, we need to have funded graduate mental health programs. They are an absolute essential for the future.*[468]

Finding 105

The Department of Health has continuing difficulty filling mental health nursing places, especially in regional locations.

Recommendation 67

The Department of Health should give an urgent priority in its regional workforce strategy to employing mental health staff, particularly graduate nurses, and seek ways in which to ensure staff in regional areas are encouraged to stay in those communities.

(e) Service performance

The performance of the community services within Western Australia's mental health system was analysed by the Auditor General[469] who reported to Parliament in October 2009 that "failings in community mental health services are putting patients at risk and forcing many to have a crisis before they can get treatment."[470] The report found that the main objective of community mental health care was to enable patients to receive care in their own community rather than at a hospital, and to provide care that helps consumers stay and participate in their communities. This is a demanding objective given the wide range of illnesses patients might have and because some conditions are often chronic with little prospect of a full recovery. The shift to community-based care across Australian jurisdictions over the past decade is reflected in the allocation of funding in

468 Ms Suzanne Seeley, Nurse Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p5.

469 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p19. Accessed on 18 February 2010.

470 Ms Amanda Banks, 'Mental health gets grim report card', *The West Australian*, 15 October 2009, p4.

Western Australia. Based on the budget allocation for 2009-10, community mental health funding will have increased by 45% since 2005-06.

For mental health clinical treatment in the community to be effective, it often has to be supported by non-clinical services such as accommodation and help with employment, social and personal skills. This involves a whole-of-government effort to coordinate the services from other agencies and non-government organisations with those provided by DOH's Community Mental Health Teams (CMHTs). The Auditor General's key findings on the performance of the CMHTs include:

- DOH does not have the planning and resourcing mechanisms in place to ensure that CMHT services consistently reflect community needs, leading to gaps in the availability of services;
- The range of services available in each CMHT has developed in an ad hoc way in each location rather than being planned to make the right mix of services available;
- WA Health does not know if funding is being targeted to the most efficient and effective CMHT services;
- A comprehensive set of CMHT objectives that link to broader WA Mental Health objectives, is not in place;
- Independent reviews and complaints about CMHTs do not consistently prompt operational change and improvement;
- The services that a CMHT provides and its resourcing are not based on analysis of community need, leading to variation in service availability;
- Over 80% of services provided by CMHTs focus on acute care and only 6% on rehabilitation, so care is often crisis-driven;
- For consumers, gaps in the availability of services mean that their care is often driven more by where they live than their assessed needs;
- Almost half of mental health consumers do not receive good information and find it difficult to get the services they need;
- Access criteria are inconsistent across CMHTs so consumers with the same needs are likely to receive different treatment, depending on where they live;
- The time it takes consumers to access services puts them at risk of deteriorating into crisis before they get the care they need;
- WA Health is not ensuring consumers get timely access to services after discharge from hospital. They have not met their target for contacting 70% of consumers within 14 days after their discharge from hospital; and

- Care planning is not yet consistent for all consumers reducing the likelihood they will get the right care – 22% did not have a care plan.[471]

The Auditor General's report also found that access criteria for Community Emergency Response Teams also vary. In metropolitan areas 11 Community Emergency Response Teams are available to visit individuals in their home but there are no consistent agreed guidelines or protocols for their despatch. This variance in protocols might explain why the North Metropolitan Area Health Service accounted for 65% of home visits in 2008, despite having only 56% of metropolitan patients.[472]

Communication with patients

Importantly in terms of the link between suicide and mental illness, the Auditor General found that WA Health had not met its targets for contacting consumers within either seven or 14 days of discharge from specialist inpatient units. Timely contact after discharge helps consumers access the services they need in the period immediately after hospitalisation and research indicates that consumers are at their highest risk of suicide up to two weeks after discharge from hospital, and without timely contact, their risk increases. DOH's targets for contacting patients are lower than the good practice targets from the National Mental Health Benchmarking Project (2008) and the Key Performance Indicators for Australian Public Mental Health Services (2005). Both recommended that consumers should be contacted within seven days of discharge. The National Benchmarking Project recommends that 90% of patients be contacted within seven days. The Auditor General said "It is not clear why the WA Health target has not been updated to reflect these national good practice benchmarks."[473]

Patient care plans

DOH's policy states that all patients should have a care plan, but research by the Auditor General found over 20% did not have one. Where care plans existed, their content varies between, and sometimes within, CMHTs. In 77% of cases, essential information such as what to do and who to contact in an emergency, was not recorded. Although 86% of patients with a care plan had received a comprehensive assessment, including an assessment of risk, there is no agreed and standardised clinical risk assessment tool. This means that risk is not uniformly assessed so some patients may not receive appropriate care. Of the 57 care plans reviewed for the report, only 23%

471 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, pp7-8. Accessed on 18 February 2010.

472 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p26. Accessed on 18 February 2010.

473 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, pp27-28. Accessed on 18 February 2010.

had evidence of consumer involvement or consent to their plan. Only three of 57 consumers received a copy of their care plan.[474]

Finding 106

The Auditor General has highlighted severe shortcomings in the practices of Department of Health's community mental health services, including inconsistent care programs that do not meet the needs of patients.

Recommendation 68

Before any of the Department of Health's mental health services are transferred to the Mental Health Commission, the Department needs to introduce a standard approach to providing and evaluating mental health programs that meet the needs of its patients in a transparent fashion.

14.5 Urgent mental health challenges

(a) Children and youth services

The number of children with mental illness currently being treated in Western Australia is dramatically lower than in the past. Historically about 5-7% of children with a mental illness were being treated, but that rate has declined to just 0.9%. This situation was recently acknowledged in an announcement from Western Australian psychiatrists that "child mental health services are being hit hard by budget cutbacks, with fewer staff treating only a quarter of the children thought to be at risk of potentially serious conditions, such as suicidal thoughts."[475]

474 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, pp30-33. Accessed on 18 February 2010.

475 Ms Cathy O'Leary, 'Child mental health 'critically underfunded'', *The West Australian*, 16 September 2009, Available at: http://au.news.yahoo.com/thewest/a/-/newshome/6037669/child-mental-health-critically-underfunded. Accessed on 9 February 2010.

Dr Caroline Goossens, of the Royal Australian and New Zealand College of Psychiatrists' faculty of child psychiatry in Western Australia, said government-funded services had been 'hideously' under-resourced for some time but were now at a critical level due to a freeze on hiring staff, noting:

> *We're supposed to be seeing about 4% of the population from infancy to 18* [years old] *with quite severe mental health difficulties and we're probably currently resourced to see less than 1%.*[476]

The Committee heard critical evidence about the need for the Department of Health to focus more of its mental health services on children and youth, especially infants:

> *there is very good evidence that we are intervening in mental illness at the wrong stage in life. There is really good evidence now that we should be concentrating mostly on infants—not even children; on infants. The kinds of traumas they may suffer—broken families, and sexual, physical and emotional abuse—leave a very deep mark on the psyche at an early stage. Increasingly, the world is heading that way. Now in mental health services, instead of talking about child and adolescent, we are talking about infant, child, adolescent and youth. We are also focusing very heavily on youth, because there is this sudden ridiculous cut-off at the age of 18 where the child one side of that is an adult and on the other side is a youth. It is recognised that that is the most dangerous time for mental illnesses, the severe ones—15, 16 and 17, through to the early twenties.*[477]

The Committee heard evidence from the Great Southern region that in 2006-07 they had nearly 500 patients under the age of 15:

- 15 children in the zero to four age group;
- 128 children in the five to nine age group; and
- 272 children in the 10 to 15 age group.[478]

Residential facilities in rural areas for young people is another gap in the current mental health system. The Committee heard that:

> *We need suitable programs and suitable facilities for the younger disabled with challenging behaviours; they always seem to manage to get either left in a hospital system*

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476 Ms Cathy O'Leary, 'Child mental health 'critically underfunded'', *The West Australian*, 16 September 2009, Available at: http://au.news.yahoo.com/thewest/a/-/newshome/6037669/child-mental-health-critically-underfunded. Accessed on 9 February 2010.

477 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p8.

478 Ms Melinda Misson, Team Manager, Great Southern Mental Health Service, WA Country Health Service-Great Southern, *Transcript of Evidence*, 11 September 2009, p4.

> *in an acute setting or they try to push it onto aged-care to have them admitted into a residential facility, which is not suitable for the other residents.*[479]

To be successful in addressing the mental health needs of children and young people, DOH needs to collaborate and work very closely with other government agencies such as the Department for Child Protection and the Department for Communities. In regional areas DOH staff need to work closely with school staff, such as the psychologist and the child health nurses. The Department already has some experience with this type of whole-of-government collaboration and has established a program called PECN (people with exceptionally complex needs) that involves working with the Department of Corrective Services, the Disability Services Commission, the Police, mental health services and Drug and Alcohol services.[480]

Finding 107

Historically about 5-7% of children with a mental illness were being treated in Western Australia, but that rate has declined to under 1%. The State's mental health services for young people, particularly in regional areas, need a dramatic funding boost. A significant proportion of these funds need to be spent on providing suitable community residential accommodation facilities.

Recommendation 69

Like other child health services in Western Australia, the State's mental health services for young people, particularly in regional areas, need a dramatic funding boost.

(b) Suicide

Rates of suicide

Every 15 minutes someone in Australia attempts suicide. Every four hours someone dies as a result. Suicide is the leading cause of death in people under 30. It causes more deaths than road accidents, yet government efforts to reduce suicide are comparatively smaller than attempts to reduce the road toll. Suicide accounts for 1.3% of all deaths in Australia, which means that there are between 5 and 6 suicide deaths every day. The most recent data revealed that there were 1,881 suicides in Australia during 2007. For men aged 20–25 years, 1 in 5 deaths are due to

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479 Ms Suzanne Millar, Regional Manager, Aged-Care, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p8.

480 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p8.

suicide.[481] Australia is recognised as a nation with one of the highest ratios of male to female suicides (approximately 4:1). Similar to other countries, for every suicide completed there are between 10 — 20 occasions where an attempt to suicide was made.[482]

In the late 1980s, Western Australia was confronted with a rapid increase in suicide and suicidal behaviour among young people. As a result of this disturbing trend, and in recognition of the seriousness of the issue, the State Government developed a youth suicide prevention strategy. The Coroner found that between 1982-2006, a total of 4,787 deaths in Western Australia occurred as a result of suicide. Of this number, 3,840 were men and 947 were women. The Coroner's database of deaths illustrates that while the overall occurrence of suicide extends across all socioeconomic groupings, rates are higher for disadvantaged socio-economic groups and for women in the highest 20% socio-economic quintile.[483]

There were 257 people who suicided in WA in 2007, nearly 80% (196) were men. The chief method of self-harm was hanging and strangulation.[484] Of this State total, 15 were Indigenous Western Australians (12 men). In 2007, suicide accounted for 3% of all Indigenous deaths, compared to just 2% for non-Indigenous deaths.[485]

The Committee was told that increased alcohol and other drug use frequently occur in the period leading to a suicide. The proportion of Western Australian men and women who had a substance abuse problem at the time of taking their lives has increased substantially from 36% in 2002, to 45% in 2006. Between 1986 and 2006, 32% of men and 25% of women had experienced substance use within the three months before their death. Alcohol and cannabis were the most commonly used substances among men who had substance misuse issues at the time of their death. For women, the most commonly used substances were alcohol and amphetamines. In the period between 1986 and 2006, positive blood alcohol readings were present in 41% of men and

481 Australian Bureau of Statistics. '3303.0- Causes of Death, Australia, 2007'. 18 March 2009. Available at: www.abs.gov.au/ausstats/abs@.nsf/cat/3303.0. Accessed on 9 February 2010.

482 Professor Patrick McGorry, 'Mental health needs early care', *The Australian*, 6 February 2010. Available at: www.theaustralian.com.au/news/health-science/mental-health-needs-early-care-health-system/story-e6frg8y6-1225826908208. Accessed on 9 February 2010.

483 Department of Health, 'Western Australian Suicide Prevention Strategy 2009-13', 2009. Available at: www.health.wa.gov.au/mentalhealth/docs/WA_Suicide_Prevention_Strategy.pdf, pp19-25. Accessed on 9 February 2010.

484 Australian Bureau of Statistics. '3303.0- Causes of Death, Australia, 2007'. 18 March 2009. Available at: http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D372DADC3BC75355CA25757C00135393/$File/3303.0_6%20Underlying%20cause%20of%20death%20(Western%20Australia).xls. Accessed on 9 February 2010.

485 Australian Bureau of Statistics. '3303.0- Causes of Death, Australia, 2007'. 18 March 2009. Available at: http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/D06DD427F61E8922CA25757C00135F8E/$File/3303.0_12%20Deaths%20of%20Aboriginal%20and%20Torres%20Strait%20Islander%20Australians.xls#'12.5'!A1. Accessed on 9 February 2010.

27% of women who suicided. In over 70% of these cases, the reading was equal to or greater than the 0.05 blood alcohol reading allowed for drivers in WA.[486]

The Committee heard that many DOH and NGOs services are not available after hours, particularly in regional areas. For example, in Kalgoorlie:

> *there are very few GPs who will take on any form of drying out. The hospital will not really book the clients in. There are limited services for those clients if they want to withdraw from substances anyway. If they suffer an acute crisis during that withdrawal period and they are not in the hospital and it is after hours or on a weekend, community mental health is not available.*[487]

Suicide and mental health

A distinguishing feature of the link between suicide and mental illness is social isolation. It is common in Western Australia for a person to be discharged from a mental health service following an attempted suicide and disappear into the community, without any arrangements for follow-up care, as was reported by the recent Auditor General's report. This represents a fundamental breakdown in our mental health services and is a breach of its duty of care to a patient. The various national mental health plans have recognised that there is an urgent need to construct a new and more effective community-based model of care specifically in relation to suicide. This model would be open-ended and, in essence, create a 'no wrong door' approach to reducing suicide attempts, especially amongst high-risk groups. The current system is best characterised as almost universally fragmented. A feature of a new approach to community care must include synchronised whole-of-government services incorporating community development, youth outreach, community nursing and General Practice.[488]

In Western Australia over the past two decades, 35% of men and 60% of women who suicided had suffered from a diagnosed psychiatric disorder in the preceding 12 months. These disorders included depressive disorders, schizophrenia, substance misuse and personality and other adjustment disorders. The observations of family and friends of those who suicided indicate that 57% of men and 66% of women exhibited symptoms of depression in the three months preceding their deaths. Over a third of Western Australian men who suicided between 1986 and 2005 had been admitted to either a psychiatric hospital or a public hospital for psychiatric treatment at some time in their lives. Of these men, 15% suicided on the day of discharge from their last admission.

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486 Department of Health, 'Western Australian Suicide Prevention Strategy 2009-13', 2009. Available at: www.health.wa.gov.au/mentalhealth/docs/WA_Suicide_Prevention_Strategy.pdf, p25. Accessed on 9 February 2010.

487 Ms Rosemary Hunt, Executive Manager, Centrecare, *Transcript of Evidence*, 15 Septe5ber 2009, p5.

488 Western Australian Auditor General, 'Report 10- Adult Community Mental Health Teams: Availability, Accessibility and Effectiveness of Services', October 2009. Available at: www.audit.wa.gov.au/reports/pdfreports/report2009_10.pdf, p12. Accessed on 18 February 2010.

Similarly, 20% of Western Australian women completed suicide on the day of discharge from mental treatment, and another 33% within a month of discharge.[489]

Finding 108

The Auditor General has found that the Department of Health is not currently meeting national guidelines such as those contained in the National Mental Health Benchmarking Project (2008) and the Key Performance Indicators for Australian Public Mental Health Services (2005) and needs to do more for patients leaving institutions, especially in the first month, to ensure that they are discouraged from attempting suicide.

Recommendation 70

The Department of Health needs to put in place measures to counter the alarmingly high rate of suicides occuring within seven days of discharge from treatment facilities. These measures should follow nationally recognised benchmarks guidelines, such as those contained in the *National Mental Health Benchmarking Project* (2008) and the *Key Performance Indicators for Australian Public Mental Health Services* (2005), which require 90% of patients to be contacted by mental health staff within seven days of leaving a mental health facility.

State suicide strategy

World Suicide Prevention Day in 2009 was used by the Western Australian Government to launch a new $13 million strategy. The *Suicide Prevention Strategy 2009-2013* is a State-wide approach to suicide prevention and Minister Jacobs said that it "will support the work of individuals, communities and agencies to reduce suicide and set the framework for the development and delivery of future Western Australian suicide prevention initiatives."[490] The Minister said the strategy placed an emphasis on young people (particularly young men) and those living in rural and regional areas, especially those living in Aboriginal communities. He also said "suicide rates

489 Department of Health, 'Western Australian Suicide Prevention Strategy 2009-13', 2009. Available at: www.health.wa.gov.au/mentalhealth/docs/WA_Suicide_Prevention_Strategy.pdf, p24. Accessed on 9 February 2010.

490 Hon Dr Graham Jacobs, Minister for Mental Health, 'New $13million State-wide strategy for suicide prevention delivered', 10 September 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=132464. Accessed on 9 February 2010.

are often higher in rural and remote areas and the recent alarming increase in WA Aboriginal suicides demands that more work be done."[491]

Recommendation 71

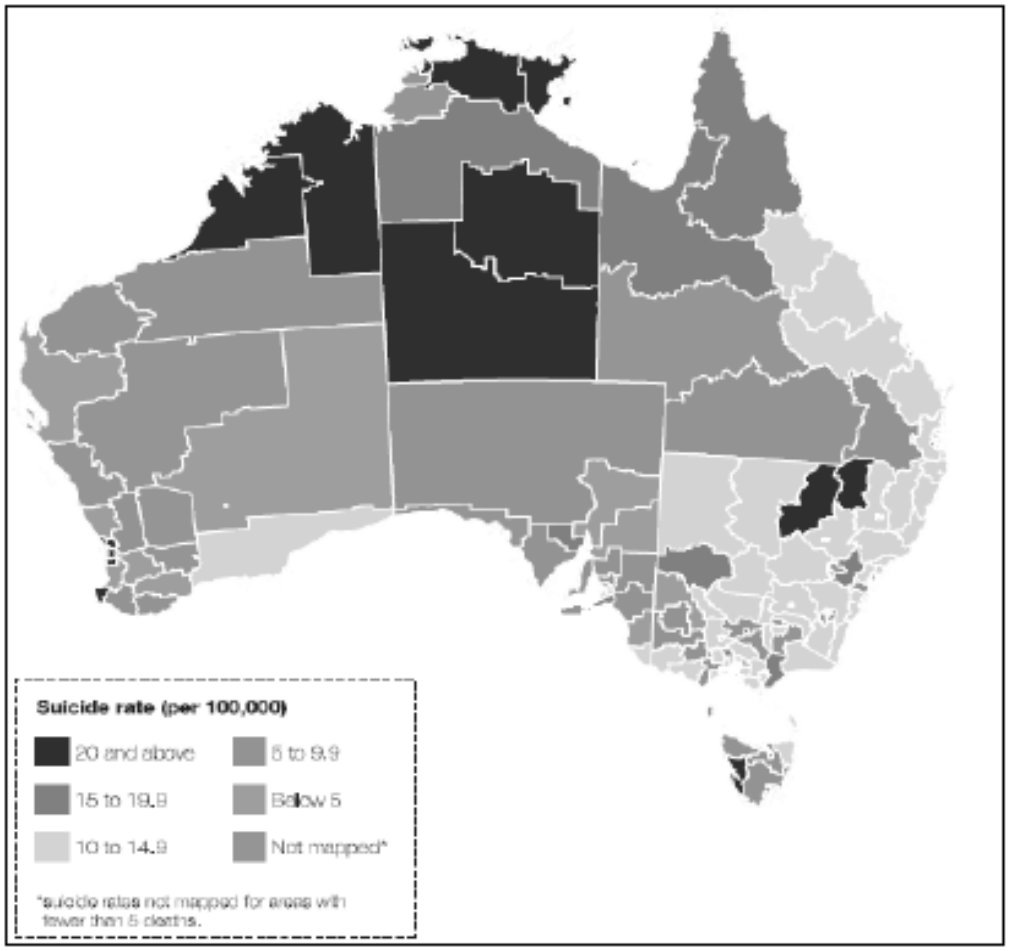
The Mental Health Commission should report annually on its evaluation of the success of the State's *Suicide Prevention Strategy 2009-2013.*

Regional factors

These higher regional rates of suicide are shown in Figure 14.11 below which includes data provided for a Senate Inquiry into suicide.

491 Hon Dr Graham Jacobs, Minister for Mental Health, 'New $13million State-wide strategy for suicide prevention delivered', 10 September 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=132464. Accessed on 9 February 2010.

Figure 14.11- Age-standardised suicide rate per 100,000 population by statistical subdivisions (2001-2004)[492]



The North West has some of the highest suicide rates in the State and suffers from a dire lack of mental health services. The Committee heard that:

> *people wait up to a week for the Royal Flying Doctor Service to pick them up, because there is not one secure mental health bed north of Perth. The RFDS gets to those people when it can. They are sedated, and normally have a guard with them. They get significant respiratory complications because of their sedated state.*[493]

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492 Mental Health Council of Australia, 'Submission to the Senate Community Affairs Committee Inquiry into Suicide in Australia', 11 December 2009. Available at: www.aph.gov.au/senate/committee/clac_ctte/suicide/submissions/sub212.pdf. Accessed on 9 February 2010.

493 Hon Ms Helen Morton MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 13 September 2006, p5801.

In 2006, Hon Helen Morton reported to Parliament that there was just one psychiatrist who services the whole of the Kimberley and the Pilbara and:

> *There is a fantastically designed and built respite centre for people with mental illness in Kununurra. However, it is empty because the Department of Health cannot get any staff to work in it. Remote communities are suffering an epidemic of permanent mental health damage caused by the combined use of alcohol and marijuana.*[494]

Finding 109

Despite the plans of the current and past Governments, there is not one secure mental health bed north of metropolitan Perth.

(c) Indigenous suicides and mental health needs

In their research into Indigenous depression, a project funded by *beyondblue* found

> *people from the mainstream mental health sector had little involvement in the various initiatives that occurred as a part of the Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan (1996-2000), with the result that there was limited impact on State and Territory activities and on mainstream services.*

The *beyondblue* organisation report a greater awareness exists among non-Indigenous policy makers in recent developments, particularly the attention directed to Indigenous mental health needs in the *National Mental Health Plan (2003-08)* and the *Social and Emotional Well Being Framework: a national strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being, 2004-09.*[495]

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494 Hon Ms Helen Morton MLC, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 13 September 2006, p5802.

495 Australian Indigenous HealthInfoNet, 'A scoping study of depression among Indigenous peoples', November 2005. Available at: www.google.com.au/url?sa=t&source=web&ct=res&cd=16&ved=0CBwQFjAFOAo&url=http%3A%2F%2Fwww.beyondblue.org.au%2Findex.aspx%3Flink_id%3D85.436%26tmp%3DFileStream%26fid%3D281&rct=j&q=National+Forensic+Mental+Health+Scoping+Study&ei=1UV-S7vgFISqtgOQ7PT7Cw&usg=AFQjCNGMOP-tWF53Y3qyaruFAWee-VqkKA. Accessed on 19 February 2010.

Between 1986 to 2006, there were 304 suicides by Indigenous people in Western Australia.[496] Of these, 261 were men and 43 were women. Almost two thirds (62%) of Indigenous men who suicided were under the age of 30, compared to 32% for non-Aboriginal men. During the same period, the suicide rate among Indigenous men aged 20-29 years was 108 per 100,000, more than three times the comparable rate for non-Aboriginal men. The rate of suicide among Aboriginal men increased dramatically in the decade from 1986 (4.7 per 100,000) to 1999 (78.8 per 100,000) and then declined to a rate of 68.4 per 100,000 in 2006.[497] This reduction coincided with an increase in State and Federal resources to assist Indigenous communities in tackling the issue.

One factor behind these high levels of mental illness and suicide is unemployment, particularly where multiple generations of unemployed live in the same accommodation. The Committee heard from DOH staff who "have worked in some communities where there are three, four and five generations unemployed. Those particular groups in our community are extremely vulnerable to mental health issues."[498] DOH staff in regional areas are reportedly keen to do more in terms of mental health promotion with Indigenous communities, but the Committee heard that there was just one staff member in the Great Southern undertaking these preventative programs:

> *I think there is still more opportunity for the hospitals to link better with Aboriginal health. That is something we are actually working on. Possibly a gap in the service, particularly from a mental health point of view, is early intervention mental health promotion. We do have mental health promotion in public health but it is one person.*[499]

In 2007 and 2008, the State Coroner inquired into the high number of Indigenous deaths in the Kimberley and reports of increased suicides in Perth and the South West. The Coroner reported that suicide in the Kimberley has grown into what has been described as a 'behaviour culture'. In this culture, suicide is an automatic response to psychological distress brought about by life events that in other populations would normally not lead to this outcome. There is a lack of resilience and alternative coping mechanisms for people in the Kimberley who experience multiples of acute and extended traumas. In this context, suicide is seen as the preferred way out.[500]

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496 Tatz reports that prior to the 1960s there were no references to the phenomenon of Indigenous suicide in Australia in the writings and records of missionaries, government officials, in anthropological and medical journals, fiction, memoirs, in Aboriginal languages or artistic depictions; and little before the mid-1980s. Colin Tatz, 'Aborigines, Sport And Suicide', Paper given to Pathways to Reconciliation Summit, Amman, Jordan, 15 December 2009, to be published in *Indigenous People, Race Relations and Australian Sport*, editors Chris Hallinan and Barry Judd, special edition of *Sport in Society*, 2011.

497 Department of Health, 'Western Australian Suicide Prevention Strategy 2009-13', 2009. Available at: www.health.wa.gov.au/mentalhealth/docs/WA_Suicide_Prevention_Strategy.pdf, p21. Accessed on 9 February 2010.

498 Ms Suzanne Seeley, Nurse Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, pp6-7.

499 Ms Sandra Crowe, Population Health Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p9.

500 Department of Health, 'Western Australian Suicide Prevention Strategy 2009-13', 2009. Available at: www.health.wa.gov.au/mentalhealth/docs/WA_Suicide_Prevention_Strategy.pdf, p21. Accessed on 9 February 2010.

The emergence of suicide clusters in Aboriginal communities such as the Kimberley is very concerning and the need for more State health investment in this area was reinforced by evidence from Dr Patchett:

> *I think the other thing that I probably have not stressed enough is Indigenous mental health and the importance of that and how really we are under- investing in mental health generally but we are far under-investing in Indigenous mental health.*[501]

(d) Mental health in prisons

Almost one quarter of the 332,000 people on the Department of Health's Mental Health Register have a record of arrest.[502] The Committee heard that the State's "prisons are our largest psychiatric hospital…. If you look at really serious mental illness, and I mean psychosis, it is 10% of prisoners at any one time".[503] With a prison roster of over 5,055 this means about 505 prisoners have a serious mental illness. Given the data from the 2003 *National Forensic Mental Health Scoping Study*,[504] the indicative number of Western Australian prisoners with a mental illness is over 1,600.

In a similar fashion, recently published data on the mental status of newly remanded prisoners in Victoria showed that 28% of newly remanded criminals suffer from some level of mental illness, with about 8% suffering from schizophrenia or bipolar disorder. The prevalence of depression in prisoners was at least 50% higher than that in the general population, and the prevalence of schizophrenia and bipolar disorder is almost 10-times greater.[505]

In June 2006, Professor Richard Harding, the Inspector of Custodial Services, released a report entitled *Thematic Review of Offender Health Services* which recommended that the Department of Health assume responsibility for providing health services to the prison population. Responsibility for the delivery of health care services for prisoners lies with Prison Health Services (PHS), within the Department of Corrective Services (DCS), with specialist hospital care and in-patient services delivered by DOH. PHS comprises over 200 staff delivering a range of programs in 15 health centres, five remote regional work camps, a 21-bed infirmary and a central Pharmacy.

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501 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p15.

502 Department of Health, *Response to Question on Notice*, Submission to the Expenditure Review Committee: Business Case for Improved Mental Health Services for Offenders, February 2006, p4.

503 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p13.

504 Australian Institute of Criminology, 'The identification of mental disorders in the criminal justice system', 24 August 2009. Available at: www.aic.gov.au/publications/current%20series/tandi/321-340/tandi334/view%20paper.aspx. Accessed on 19 February 2010.

505 Boston Consulting Group, 'Governments Working Together: Improving Mental Health Outcomes in Victoria- The Next Wave of Reform', July 2006. Available at: www.dpc.vic.gov.au/CA256D800027B102/Lookup/ImprovingMentalHealthOutcomesinVictoria/$file/FINAL%20report%20060706.pdf, p14. Accessed on 9 February 2010.

A 2007 census of Western Australian adult prisoners showed 3,747 people in custody, of which 1,547 (41%) were Indigenous. Of the total custodial population in 2008, 3,441 (92%) were male, of which 1,381 (40%) were Aboriginal. In the case of females, of the 306 women in custody, 166 (54%) were Aboriginal.[506] Statistics for 2010 show a total of 4,887 Western Australians in custody (193 juveniles) of which 1,947 were Indigenous prisoners (139 juveniles). This is nearly 40% of the State's prisoners and over 70% of its juvenile prisoners.[507] The State's rate for incarcerating Indigenous people in 2010 is 2,483 per 100,000 people, nearly 50% higher than the national rate of 1,720 per 100,000 people.[508]

Recommendation 72

The Government should report to Parliament by the end of 2010 on new and existing strategies aimed at lowering the rate of criminal activity among Indigenous youth.

The Committee heard that following the report by Professor Harding, "There was a review chaired by Greg Joyce the year before last that revisited the possibility of health services here and the Department of Health taking over the health of prisoners. That has been placed on hold."[509] In the United Kingdom, the National Health Service took over prison health services in 2006, after a 1999 report recommending this course of action.[510] Mr Joyce's report stated that the health systems in the State's prisons weren't in crisis, but they:

> *have serious shortcomings in respect of Mental Health Care, Aboriginal Health and Dental Health. Blood Borne Viruses and Drug and Alcohol services also need attention. For many inmates prison is the first opportunity for structured and preventative health care. It is an opportunity to improve the long term health of disadvantaged people and*

506 Mr Greg Joyce, 2008, *Prison Health Services*, Department of Health, Perth, p10.

507 Department of Corrective Services, 'Weekly Offender Statistics', 8 April 2010. Available at: www.correctiveservices.wa.gov.au/_files/about-us/statistics-publications/statistics/2010/cnt100408.pdf. Accessed on 12 April 2010.

508 Steering Committee for the Review of Government Service Provision, 'Report on Government Services 2009, Chapter 8- Corrective Services',
22 December 2009. Available at: www.pc.gov.au/gsp/reports/rogs/2009. Accessed on 12 April 2010.

509 Dr Steven Patchett, Executive Director, Mental Health, Department of Health, *Transcript of Evidence*, 25 August 2009, p13.

510 Joint Prison Service and National Health Service Executive, Working Group, 'The future organisation of prison health care', 1999. Available at:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006944. Accessed on 19 February 2010.

> *hopefully, over time, impact on recidivism rates and ultimately the overall cost of running the prison system in this State.*[511]

A 2003 Victorian health study states that "what is striking about the prisoner population is that it constitutes a cohort that is exposed to or susceptible to those diseases and lifestyle factors that contribute most significantly to the burden of disease [and] …the prisoner population is an extraordinarily needy, unhealthy and life-damaged cohort."[512]

Finding 110

The health of prisoners in Western Australia is worse than that of the general public, and the Committee was told that the State's prisons are our largest 'psychiatric hospital'.

Joyce reported that Western Australia was one of the last jurisdictions with prison health services run by Corrective Services. Queensland and the Northern Territory recently transferred their services to their health departments while inmate health in South Australia has been delivered by the SA Department of Health since 1986. In New South Wales, prison health services have been provided by Justice Health, a statutory health corporation, since 1997. Mental health services provided by DCS to Western Australian prisoners currently costs about 20% of its annual recurrent budget.[513]

Finding 111

Western Australia is one of the last jurisdictions in Australia to transfer the responsibility for the health of its prisoners to the Department of Health.

While the association between suicide and mental health has been addressed above, it is also the leading cause of death in Australia's correctional institutions, and accounts for almost half of all prison deaths. From 1986 to 2006, 66 suicides—of which 65 were men—were recorded in Western Australian prisons, with a higher rate for Indigenous people than for non-Aboriginal prisoners. People on remand have higher suicide rates than sentenced prisoners, and this is consistent with studies that show higher levels of emotional distress among people in the early stages of custody and in the first few weeks of their incarceration. The Minister for Mental Health acknowledged the seriousness of the problem of the mental health of prisoners and told Parliament

511 Mr Greg Joyce, 2008, *Prison Health Services*, Department of Health, Perth, p1.

512 Mr Greg Joyce, 2008, *Prison Health Services*, Department of Health, Perth, p13.

513 Mr Greg Joyce, 2008, *Prison Health Services*, Department of Health, Perth, p6.

the Government "will address those issues in the WA mental health strategy for reform in Western Australia."[514]

Recent business case

To date, the Committee could locate no comprehensive State strategy for addressing the needs of offenders with a mental illness. It appears the Departments of Corrective Services (DCS) and DOH, together with other service providers such as the Disability Services Commission (DSC), have attempted to provide basic services and have developed a business case for government to do more. Current services have not been strategically planned, formally coordinated or well linked between departments. In most areas of health, service capacity is also inadequate to meet demand. The business case proposed additional resources for:

- court services;
- offenders in the community (metropolitan and regional);
- prisoners and offenders requiring inpatient treatment;
- the needs of adult, juvenile, regional, Indigenous offenders and offenders with an intellectual disability or acquired brain injury;
- a new inpatient facility including a Dangerous and Severe Personality Disorder (DSPD) Unit; and
- residential assessment/rehabilitation units and day hospital and therapy facilities within prisons.

The proposal was based on the 'phasing-in' of prison-based services over three years and community services over four years, and would have required a capital investment of about $103 million and total recurrent funds of $113 million over the period 2009-10.

Finding 112

Substantial planning work has been completed by departments to improve mental health facilities in Western Australian prisons, but the proposals remain unfunded by the Western Australian Government.

514 Hon Dr Graham Jacobs, Minister for Mental Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 15 September 2009, p8.

Recommendation 73

The Government should urgently fund existing departmental proposals to upgrade mental health facilities in Western Australian prisons over the next four years.

CHAPTER 15 ALCOHOL AND ILLICIT DRUGS

15.1 Alcohol is the main drug problem

The Committee is currently conducting a separate inquiry into the *Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*. A report will be tabled later in 2010 but the Committee took initial evidence of the scope of the State's alcohol and drug problem to include in this Report. Every witness who gave evidence to the Committee on this topic reported alcohol as the major 'drug' issue facing the Western Australian community.

Alcohol is the most widely used psychoactive, or mood-changing, recreational drug, with the majority of adults (about 62%) consuming alcohol on a weekly basis.[515] The Drug and Alcohol Office Alcohol (DAO) said that alcohol is "the most prevalent drug in use and causes most drug related harm (excluding tobacco) in the Western Australian community", and that 86% of Western Australians over 14 years of age can be classed as recent drinkers (consumed alcohol in the past 12 months).[516]

DAO also submitted evidence that levels of risky drinking in Western Australia are marginally higher than those reported nationally and that "the social cost of alcohol and drug use in Australia in 2004-05 was estimated at around $55.1 billion. Of that, alcohol contributed to around $15.3 billion [about 28%] and illicit drugs around $8.2 billion [about 15%]."[517] These costs can be broken down by the most serious impact areas:

Crime:

- Alcohol attributable - $1.7 billion
- Illicit drugs - $4.0 billion
- Both alcohol and drugs - $1.4 billion

Health:

- Alcohol – about $2 billion
- Illicit drugs – $202 million

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515 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p14.

516 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pv.

517 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p2.

Productivity loss:

- Alcohol $3.5 billion
- Illicit drugs $1.6 billion

Road accidents:

- Alcohol - $3.1 billion
- Illicit drugs - $702 million[518]

DAO reported "regular drinking above the recommended health limits is having a significant impact on the WA health system."[519] They estimate that the annual cost to the health system alone was about $33 million in 2006. The cost of alcohol-related hospitalisations increased significantly over the period between 2002 and 2006. In 2005-06, the cost associated with alcohol-related Emergency Department (ED) attendances for injury and assault alone was conservatively estimated at $7.15 million. Additionally, in 2006 the service provision costs of attendances for conditions such as alcohol intoxication and withdrawal in all metropolitan EDs were over $1.15 million.

Data from DAO is included in Table 15.1 below on alcohol consumption behaviour. More broadly, DAO said that alcohol and drug problems impact on many different parts of life in this State, and are comorbidly associated with a range of other issues including mental health problems, substance use conditions such as blood borne viruses, road accidents, crime and violence, community protection concerns, suicide and homelessness. In Western Australia about 80% of clients in alcohol and drug treatment have a co-occurring mental health condition and these patients are more likely to develop chronic and disabling conditions that lead to greater health service use in the longer term.[520] Importantly, many people who have problematic drug and alcohol issues have dependent children in their care. In some cases the quality of parenting is impaired by an adult's alcoholism, putting their children at risk of harm or neglect.[521]

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518 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p14.

519 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pp14-15.

520 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p3.

521 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p24.

Table 15.1- Alcohol consumption behaviour in the State's population over 14 years, 2001-07[522]

Alcohol use	2001	2004	2007
Use within past 12 months	86.0%	86.8%	86.2%
Short-term risky drinking	37.6%	39.1%	37.1%
Long-term risky drinking	10.8%	11.4%	11.5%

The age-standardised rate (ASR) of alcohol-related deaths from chronic health conditions increased significantly over the period 1997-2005 for both men and women. Five conditions (suicide, alcoholic liver cirrhosis, stroke, road injuries and oesophageal cancer) were responsible for 59% of all alcohol-related deaths over this period.[523]

A comparison of alcohol-related death rates among the State's nine health regions showed that male's rates were significantly higher in the Goldfields, Kimberley and Pilbara, and female's rates significantly higher for the Kimberley and the Pilbara. Among the Indigenous population, alcohol-related death rates were highest in the Pilbara, and lowest in the South West. For the non-Indigenous population, the alcohol-related death rate was significantly higher for the Goldfields while the rate for North Metropolitan region was significantly lower compared with the rest of the State.[524]

Suggested policy interventions that DAO identified as having significant quantifiable benefits include:

- higher alcohol taxation, including differential tax rates on forms of alcohol which are particularly subject to abuse;
- partial or complete bans on the advertising and promotion of alcohol;
- measures to reduce drink driving, including more intensive enforcement of random breath testing and lowering the legal blood alcohol concentration (BAC) level; and

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522 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p4.

523 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p16.

524 Table 15.3 lists these regions. Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p16.

- brief interventions by primary care physicians to reduce hazardous alcohol consumption.

Further policy interventions identified as being effective by DAO, but whose benefits could not be quantified, included:

- control of drinking environments;
- alcohol ignition locks on vehicles driven by convicted drink-driving offenders;
- guidelines for low risk drinking; and
- standard drinks labelling and health warnings on drinks containers.

DAO submitted that such interventions would make it possible, over a period of time, to reduce the social costs of alcohol abuse in Western Australia by half.[525]

Finding 113

Alcohol is the main, and most serious, drug problem in Western Australia.

(a) Illicit drug consumption

Illicit drug use has been declining in Western Australia since 1988. Cannabis remains the most widely-used illicit drug in the State, while the prevalence of heroin use is relatively low and stable and methamphetamine use is declining, but still above the national level (see Table 15.2 below). Ecstasy use has remained relatively stable in Western Australia since 2001 with 4% of people reporting that they have used it, down from a peak of over 5% in 1998.[526] While most DAO services are out-patient based, in 2001 there was a total of 4,605 other drug-related hospital admissions (i.e. other than tobacco and alcohol) in Western Australia, resulting in about 20,394 bed days of inpatient treatment at a cost of around $10 million.[527]

525 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p15.

526 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p10.

527 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p2.

Table 15.2- Proportion of population using illicit drugs in Western Australia in the past 12 months, 2001-07[528]

Illicit drug	2001	2004	2007
Cannabis	17.5%	13.7%	10.8%
Meth/amphetamine	5.8%	4.5%	4.2%
Ecstasy	4.0%	4.1%	4.1%
Analgesics	3.9%	2.7%	2.5%
Cocaine	1.5%	1.2%	1.8%
Tranquillisers	1.7%	1.3%	1.6%
Hallucinogens	2.0%	0.6%	1.0%
Inhalants	0.6%	0.5%	0.3%
Heroin	0.3%	0.2%	0.2%
Methadone/buprenorphine	0.1%	0.1%	0.1%

DAO data from 2004 show that residents in the Kimberley and Goldfields regions were the most likely to have recently used an illicit drug (see Table 15.3 below).

528 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p5.

Table 15.3- Proportion of regional population using illicit drugs, 2004[529]

Region	Cannabis	Amphetamines	Ecstasy	Any illicit drug
Kimberley	30.2%	7.8%	3.8%	35.9%
Pilbara-Gascoyne	14.9%	2.5%	-	16.7%
Midwest-Murchison	14.0%	3.6%	4.1%	18.4%
Goldfields- south east coastal	22.5%	5.3%	7.7%	25.3%
North Metropolitan	14.4%	5.2%	4.9%	18.3%
South Metropolitan	12.4%	4.0%	4.1%	16.1%
Wheatbelt	4.7%	-	-	11.4%
South West	13.1%	5.7%	3.2%	14.8%
Great Southern	11.3%	2.4%	0.5%	11.5%
TOTAL	**13.7%**	**4.5%**	**4.1%**	**17.3%**

Finding 114

Illicit drug use has been declining in Western Australia since 1988 but cannabis remains the most widely used illicit drug. The problems flowing from the use of illegal drugs is greater in more remote regions containing large numbers of miners and Indigenous people.

15.2 Impact on Indigenous communities

Indigenous people in Western Australia experience a disproportionate burden of the harm and disease relating to drug and alcohol use.[530] The harmful use of drugs and alcohol can be seen in part as a result of the long-term disadvantage they experienced, such as poverty, poor health, lack

529 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, p10.

530 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pp11-12.

of employment opportunities and disconnection from country. Their marginalisation within Western Australian society has impacted on their physical, mental, social, and cultural wellbeing. In some communities, the remoteness and isolation that limits access to infrastructure and services also increases the impact of drug and alcohol use on communities that are already stressed and have limited resources and capacity.

The Committee heard that Indigenous people also often experience barriers to effective treatment and support due to a lack of culturally secure service delivery, distance from services, workforce issues, absence of effective partnerships and lack of community capacity to address drug and alcohol use. Some of the drugs of concern within Indigenous communities include alcohol, cannabis, amphetamines and volatile substances such as petrol.

DAO provided evidence that the average age at death from alcohol-attributable causes among Indigenous people is about 35 years of age. While there are fewer current drinkers in the Indigenous population and while they drink less frequently, a greater percentage of Indigenous people who do drink, consume alcohol at levels that pose both short-term and long-term risks for their health. The 2007 National Drug Strategy Household Survey (NDSHS) showed that Indigenous people were almost twice as likely to have used illicit drugs in the past 12 months as other Australians (24.2% compared with 13.0%). Cannabis was the most commonly reported illicit substance used by Indigenous people in 2004-05 (23% compared to 11% across all Australians). The rates of amphetamine use in the past 12 months among Indigenous people are more than twice that of the non-Indigenous population. Seven percent of Indigenous people had used amphetamines in the previous 12 months compared to 3.2% of total national population.[531]

Harmful alcohol and drug use and wellbeing issues are also closely linked to Indigenous violence, offending and incarceration. The seriousness of this link between alcohol and incarceration is provided by prisoner data. In Western Australia in 2008, the total prison population was 3,766 with Indigenous prisoners representing over 41% of this number but only about 3% of the State's population.[532]

15.3 Treatment approaches

The preferred treatment approach used by DAO in Western Australia seeks to provide the appropriate supports and responses to health issues where they arise, which is generally in the community, through local and accessible services. DAO reports the primary benefits of this approach include reducing pressure on the tertiary hospital system by allowing people to receive community-based treatment and support or care in the most appropriate setting. This was one of the Reid Report's key tenets. DAO stresses that this approach needs to be supported with

531 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pp11-12.

532 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pp11-12.

sustained prevention and promotion programs that lower the demand for, and the harmful use of, alcohol and other drugs. This would reduce the number of people entering the State's hospital system.

The DAO treatment services consist of:

- 7 community drug services teams operating in regional and remote areas;
- 4 community drug services teams in the Perth metropolitan area;
- the Next Step specialist medical drug and alcohol service;
- outpatient clinics across the Perth metropolitan area;
- an inpatient withdrawal service; and
- a 24 hours, seven days a week clinical advisory service for pharmacy support.[533]

The number of treatment episodes (not including data from Sober-Up centres) for alcohol and illicit drugs has been increasing since 2005-06, particularly for alcohol, cannabis and amphetamines. The DAO data for 2008-09 (see Table 15.4) indicates about 21,500 current or completed treatment episodes. In terms of DAO's success rates, around about 71% of those episodes were completed successfully or the person was still engaged in their treatment program.[534]

Table 15.4- Alcohol treatment episodes, 2008-09

Episodes	Number
Sobering Up Centre treatments completed as planned	19,416
Non-*Sobering Up Centre* treatments commenced	21,493
Non-*Sobering Up Centre* treatments completed	10,642
Non-*Sobering Up Centre* treatments continuing	4,579
Unplanned exits from treatment	6,129

533 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p15.

534 Ms Myra Browne, Drug and Alcohol Office, Electronic Mail, 13 January 2010, p1. Note: There is a 143 difference in the DAO figures. This is due to cases where the client's status is not stated or inadequately described, and these have been excluded from the analysis.

15.4 Budget allocations

While it is a statutory authority within the Department of Health, DAO works and engages with a wide range of agencies, including the Department for Child Protection, WA Police, the Department of Racing, Gaming and Liquor, divisions of general practice and community groups at a range of different levels. The DAO community drug service teams located in the Kimberley, Pilbara and Midwest-Gascoyne are operated by the WA Country Health Service.[535] In 2008-09 approximately $51 million was provided by DAO to treatment agencies, with about $31.5 million provided by the State and about $19.8 million provided by the Federal Government.[536] Of its budget, DAO spends around $6 million in the prevention area and about $44 million in the treatment and support area. About 80% of the treatment funds are directed to community-based treatment and prevention initiatives, and a significant proportion of that (around 70%) is directed to non-government organisations.[537]

15.5 Awareness campaigns

DAO reported on the success of some of its recent awareness campaigns. Surveys show that the awareness levels around the *rethinkdrink* campaign on alcohol use were 75%, with 63% of respondents aware of the campaign able to recall its key messages. In the *drug aware* campaign on amphetamines, there is a 48% awareness rate. This is a lower rate compared to the *rethinkdrink* campaign as it does not use television, but uses radio and other interactive media to engage younger people. Of the group aware of the *drug aware* campaign, 99% were able to correctly recall its key messages.[538]

DAO believes that the following interventions make a real difference to alcohol and drug usage rates in Western Australia:

- prevention and education campaigns;
- school drug education;
- local drug action groups;
- DAO information and support services;
- referral pathways for high risk individuals;
- illicit drug diversion;

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535 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p3.

536 Mr Eric Dillon, Director- Client Services, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p5.

537 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p7.

538 Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p8.

- alcohol accords; and
- supporting community action.[539]

In terms of community action, the DAO is working closely with the communities in Fitzroy Crossing, Halls Creek and Oombulgurri in the Kimberley to implement new programs such as restrictions on the sale of take-away alcohol. DAO reported after 12 months of community and government action in Fitzroy Crossing:

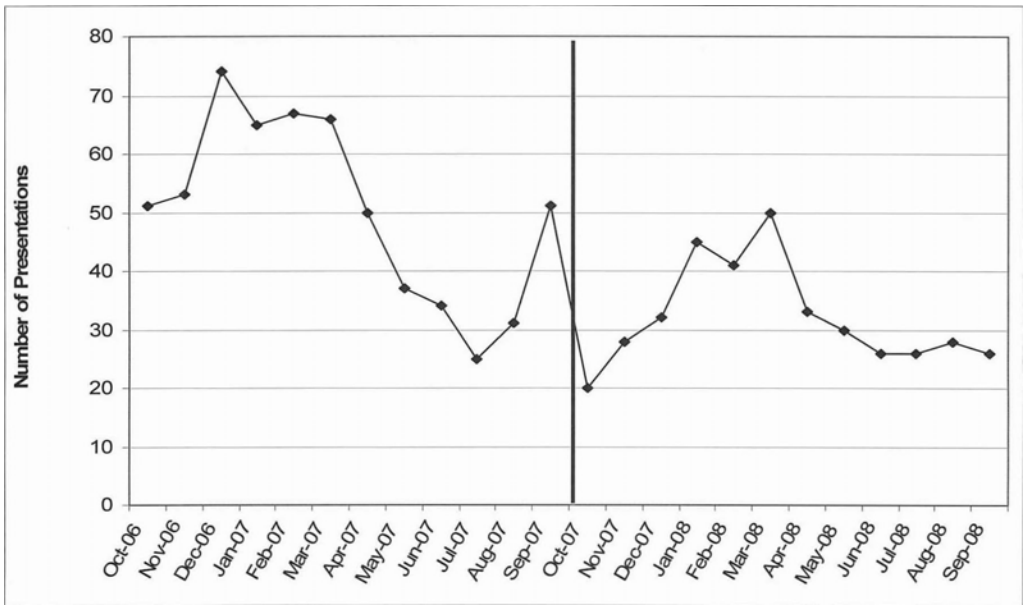
- 36% reduction in the average number of alcohol-related ED presentations;
- 34% reduction in the number of Fitzroy Crossing residents reporting to EDs in Broome, Derby, and Halls Creek;
- 25% reduction in women seeking support through the Women's Refuge;
- reduction in suicides, ambulance call-outs, violence and abuse towards staff, cases of attempted self harm, after-hours presentations, and overall trauma due to alcohol abuse;
- community health staff note fewer drunk teenagers, and healthier newborns; and
- AOD services noted a recent increase in demand for treatment services- now a waiting list.[540]

The dramatic impact of this campaign over the past two years is shown in Figure 15.1 which tracks presentations by Fitzroy Crossing residents to the Fitzroy Crossing 8-bed acute care hospital ED section before and after the implementation of restrictions on the sale of take-away alcohol in October 2007.

539 Submission No. 37 (Part A), Drug and Alcohol Office, *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*, 20 August 2009, pp46-50.

540 Drug and Alcohol Office, 'Fitzroy Crossing Liquor Restriction- October 2007 to September 2008 Twelve Month Report', March 2009. Available at: www.dao.health.wa.gov.au/IntheMedia/tabid/105/DMXModule/443/default.aspx?EntryID=1078&Command=Core.Download, pp3-5. Accessed on 29 March 2010.

Figure 15.1- Presentations by Fitzroy Crossing residents to the Fitzroy Crossing hospital ED[541]



Finding 115

The initial government actions at limiting alcohol use in Indigenous communities in the Kimberley have shown additional benefits such as a reduction in violence and injuries requiring attention at medical facilities.

15.6 Future challenges

The *WA Drug and Alcohol Strategy 2009-13* developed by the Drug and Alcohol Office contains a number of key priorities for the State:

- focusing on prevention;
- intervening before problems become entrenched;
- effective treatment and support services; and
- strategic co-ordination and capacity building.

541 Drug and Alcohol Office, 'Fitzroy Crossing Liquor Restriction- October 2007 to September 2008 Twelve Month Report', March 2009. Available at: www.dao.health.wa.gov.au/IntheMedia/tabid/105/DMXModule/443/default.aspx?EntryID=1078&Command=Core.Download, p12. Accessed on 29 March 2010.

DAO gave evidence to the Committee that their five top challenges for future activities were:

(i) a need for increased and sustained prevention activity at a broad, population-based level, with additional targeted interventions for the at-risk populations;

(ii) more needs to be done in the area of developing and prioritising early and brief intervention strategies, particularly for younger people;

(iii) continue to build the capacity of treatment options, including in regional and remote areas;

(iv) building the capacity of specialist staff working closely with primary health care providers and Indigenous health workers in regional areas to appropriately respond to drug issues; and

(v) building on the work DAO has been doing with the Department of Health Mental Health Division to improve the case management of people with co-occurring mental health and alcohol and drug issues.[542]

[542] Mr Neil Guard, Executive Director, Drug and Alcohol Office, *Transcript of Evidence*, 26 August 2009, p16.

CHAPTER 16 DENTAL HEALTH

16.1 Introduction

Oral disease is a marker for ill-health and can begin the process of early identification, prevention and treatment, while reducing the burden of disease for individuals and the health system. Over the last 30 years, the collective oral health of Western Australians has improved dramatically, particularly amongst children. Despite this overall improvement, the State's country residents continue to lag behind their city counterparts, a situation that has arisen partly as a result of reduced access to services. In general, when dental services are adequate, and people are receiving the dental care they need, good oral health will be maintained through regular check-ups and routine restorative procedures.

When people do not receive routine treatments (such as check-ups) dental disease will often progress to a stage where the extraction of teeth is required. Recent research indicates that dental health's importance as a preventative measure may extend to lowering rates of cardiovascular disease. Coronary heart disease was found to be closely related to the number of teeth a person had.[543]

Section 51 (xxiiiA) of the Constitution empowers the Commonwealth to make laws with respect to the provision of dental services. However, the section imposes no responsibility to make such laws. The Commonwealth is also empowered to support publicly funded dental services through section 96 of the Constitution, and section 81, the 'Appropriations' power, also allows funding of dental services. The Commonwealth has had some involvement in the provision of dental services in the past. For example, the Australian School Dental Program was initially funded by specific purpose Commonwealth grants to the States, and was eventually subsumed into general-purpose grants.

The Commonwealth Dental Health Program (CDHP), which operated between 1993-97, provided a total of $245 million to the States. It was abolished by the Howard Government in 1996, following which the States resumed full responsibility for public dentistry.

This had a profound impact on low-income earners in Western Australia, including:

- a large reduction in the number of people who are eligible for public dental treatment;
- a significant increase in waiting times; and
- a shift from preventive to emergency dental treatment patterns.

543 *The West Australian,* 'Teeth linked to heart disease', 13 April 2010. Available at: http://au.news.yahoo.com/thewest/a/-/mp/7053715/teeth-linked-to-heart-disease/. Accessed on 13 April 2010.

The Dental Bill 2005 was passed in 2006 following a review by the Western Australian Government of competition policy guidelines and provides for the regulation of the practice of dentistry and dental prosthetics and the registration of dentists, dental hygienists, dental prosthetists, dental therapists and school dental therapists. The competition policy guidelines required all organisations, such as the Dental Board of Western Australia, to review their structure with a view to forming a new structure for regulating the management of various professions. This Bill replaced two acts - the *Dental Act 1939* and the *Dental Prosthetists Act 1985*.[544]

16.2 Overview of dental services in WA

The Department of Health's Dental Health Services (DHS) directly serviced about 105,000 adult and 245,000 children's visits in 2009. Additionally, some 41,000 visits to private clinics were funded by Dental Health Services. The State Budget for 2009-10 provides $73.1 million for dental health services, or about 1.4% of the estimated total DOH service costs of $5.1 billion for the year. This figure is about 9.8% higher than the estimated actual cost for the 2008-09 year. The Budget also includes annual growth estimates of between 5-6% for the out-years.[545] Programs funded by this allocation include:

- the School Dental Services;
- subsidised general dental care programs via public dental clinics and private practitioners;
- general dental services to geographically isolated communities including Aboriginal communities;
- specialised subsidised dental care through participating private practitioners;
- provision of oral health services to residents of aged-care facilities; and
- oral health education.[546]

The DOH also funds:

- public programs managed by the Dental Health Services (DHS) unit within the Public Health and Ambulatory Care directorate, North Metropolitan Area Health Service;
- the Centre for Rural and Remote Oral Health (CRROH) to provide dental services to six Aboriginal Medical Centres and the Esperance Hospital, via a contract with WACHS; and

544 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 23 November 2005, p7646.

545 Government of Western Australia, 'WA Health', 14 May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p163. Accessed on 25 January 2010.

546 Department of Health, 'Dental health services', 4 February 2004. Available at: www.health.wa.gov.au/services/detail.cfm?Unit_ID=39. Accessed on 25 January 2010.

- the Oral Health Centre of WA (OHCWA), which is contracted to provide surgical services to metropolitan residents and specialist care to WACHS residents.[547]

DHS provides 26 public adult dental clinics and 5 mobile adult public clinics servicing the State. The adult clinics include 11 metropolitan clinics, six in the regional towns of Albany, Bunbury, Geraldton, Kalgoorlie, Ravensthorpe and Busselton, and nine remote clinics. DHS employed 168 dentists in 2005, from a State total of 999 (or about 17%).[548] Additionally, a School Dental Service (SDS) is provided from 106 clinics and 40 mobile services that visit 300 different locations across Western Australia.[549]

(a) School dental services

There has been a dramatic decline in the number of dental caries in Western Australian children over the past four decades. In 1968 more than 95% of Western Australian 12-year-olds had dental decay. By the year 2000, this figure had fallen to 37%. The mean 'decayed, missing and filled teeth' rate (DMFT) for 12-year-olds in 1977 was almost 4.0 teeth. By 2000 this figure had fallen below 1.0 tooth. This rate may have risen in the past decade with the greater consumption of unfluoridated water and heavily sweetened drinks consumed by children. The improvement in Western Australian child dental health between 1970 and 2000 compares favourably with children in other jurisdictions.[550]

The dramatic improvement in child dental health has been attributed to two important public health initiatives: water fluoridation and the SDS. Through regular check-ups and routine maintenance, children enrolled in the SDS benefit from early intervention, which minimises the risk of dental disease. Oral health education and promotion are also important preventive strategies employed by the SDS to ensure the continued good oral health of school children. The SDS provides all children in Western Australia from pre-primary to Year 11 high school, and Year 12 in some remote areas, with free general and preventative dental care. It also provides referrals to specialist dental care, if required.

Recommendation 74

The School Dental Service should provide dental services for students from Kindergarten to Year 12 in high school.

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547 The Oral Health Centre of WA replaced the Perth Dental Hospital in 2002.

548 Australian Institute of Health and Welfare, 'Dental labour force in Australia, 2005', July 2008. Available at: www.aihw.gov.au/publications/den/dlfia05/dlfia05.pdf, p3. Accessed on 25 January 2010.

549 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Reply to Questions on Notice*, 21 September 2009, p6.

550 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

DHS employed about 630 staff in 2009 and Table 16.1 shows the school dental staff employed over the past three years.

Table 16.1- School dental health staff employed by Dental Health Service, 2007-09

	2007	2008	2009
Dentists (FTE)	22.6	22.3	23.1
Dental therapists (FTE)	120.6	122.6	124.0
Dental assistants (FTE)	118.4	117.3	120.0

The School Dental Service does not have a waiting list. Children are placed on a recall roster which reflects their dental disease status. Those who are decay-free are seen on a 24 month recall; those with no active caries (but a history of some disease) are on a 15 month recall; and those with active deacy are recalled as required, some are recalled at 3 months, others at 6 months. The average recall period in 2008 was 19 months.[551] The latest DOH data for 2009 shows that there were 276,900 visits to SDS school clinics in 2009, a rise of 8.6% from the 2008 bookings.[552]

A key challenge for the SDS is in the area of IT. The Committee heard that all of the more than 276,000 bookings per year are done using a card system. Therefore "They work manually. They do not have electronic appointments."[553] This is a similar situation to that found in DOH's Child Development Services by the Committee's *Healthy Child- Healthy State* report in 2009[554] and it needs to be urgently addressed. The Minister for Health reported that a business case (Clinical Information Systems Infrastructure in the School Dental Service) was developed in June 2009 to transfer this card system to a computer-based one but it has yet to be funded by the Government.[555]

551 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Reply to Questions on Notice*, 21 September 2009, p148.

552 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p24. Accessed on 13 April 2010.

553 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

554 Education and Health Standing Committee, 2009, *Healthy Child-Healthy State*, Parliament of WA, Perth, p59.

555 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 13 October 2009, p7963.

Finding 116

The manual booking process used by the Dental Health Service is a key factor limiting its further improvement.

Recommendation 75

The Government should fund the Clinical Information Systems Infrastructure in the School Dental Service business case developed in June 2009 by the Department of Health to transfer the existing card booking system to a computer-based one.

(b) Adult dental health

Whilst there has also been an improvement in adult oral health during the past three decades, the improvement is more moderate than that seen in children. The most notable improvement has been a decline in the prevalence of edentulism (complete tooth loss). In 1979, more than 80% of Australians over the age of 65 were edentulous, compared with only 40% by 1994. In Western Australia in 2004, the prevalence of edentulism was strongly associated with age, being negligible among 15–34-year-olds but affecting 17.5% of the State's adults aged 55 years or older. This aspect of dental health is also affected by the socio-economic status (SES) of the patient, with 23.5% of lowest SES adults missing all their teeth, while the rate was nearly half this (11.9%) for the highest SES cohort.[556]

More recent data on the oral health of Western Australian adults showed:

- 60.3% of people surveyed had visited a dentist within the preceding 12 months, and 56.1% said they usually did so. Dental attendance varied according to socio-economic status and dental insurance status;
- 75.7% of people surveyed had a dentist that they usually attended, although 30.9% said that they avoided or delayed dental care due to its cost. Barriers to dental care were most strongly associated with low socio-economic status and a lack of dental insurance;
- 5.6% of people surveyed had no natural teeth and among dentate people, an average of 5.0 teeth per person were missing. These and two other indicators of tooth loss were more frequent among government health cardholders compared with non-cardholders, and among people with no dental insurance compared with the insured;

556 Australian Institute of Health and Welfare, 'The National Survey of Adult Oral Health 2004–06: Western Australia', 2008. Available at: www.aihw.gov.au/publications/index.cfm/title/10623, p1. Accessed on 25 January 2010.

- 19.6% of people surveyed had untreated dental decay and an average of 13.1 teeth per person were decayed, missing or filled. There was little variation among socio-demographic groups in indicators of dental decay experience; and
- 10.0% of people surveyed had inflamed gums and 12.6% had moderate or severe gum disease. Rates of gum disease displayed little variation among socio-demographic groups.[557]

The other impact of SES status is on a patient's insurance coverage. While the survey suggests an average of 60.3% of Western Australian adults visited a dentist in the past 12 months, it also suggests 93.2% of over 55 year olds with private insurance visited a private dentist in the past 12 months, compared to 67.0% of those without insurance.[558]

Evidence gathered by the Committee showed extensive waiting lists in some areas (see Table 16.2 below). In the metropolitan area, waiting times varied between 1.4 months in the Mt Henry dental clinic to 19.7 months in the Morley dental clinic. Similarly, waiting times in regional WA varied between none (Derby and the Goldfields) to 21.4 months in Busselton. The average waiting time across all clinics in June 2009 was 11 months for general dental care, and the Committee heard that emergency dental care, "on most occasions, can be had on the day."[559]

557 Australian Institute of Health and Welfare, 'The National Survey of Adult Oral Health 2004–06: Western Australia', 2008. Available at: www.aihw.gov.au/publications/index.cfm/title/10623, p1. Accessed on 25 January 2010.

558 Australian Institute of Health and Welfare, 'The National Survey of Adult Oral Health 2004–06: Western Australia', 2008. Available at: www.aihw.gov.au/publications/index.cfm/title/10623, p43. Accessed on 25 January 2010.

559 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

Table 16.2- Waiting times for dental appointments in Western Australia, 2009*

Clinic	Waiting time (months)
Albany	6.1
Armadale	6.5
Bunbury	10.0
Busselton	21.4
Cockburn	9.8
Derby	0
Fremantle	7.8
Geraldton	13.7
Goldfields	0
Joondalup	5.1
Liddell	10.5
Morley	19.7
Mt Henry	1.4
Newman	0
Ravensthorpe	0
Rockingham	12.4
South Hedland	0
Swan	14.9
Warwick	9.2

* Clinics at Kununurra, Fitzroy Crossing, Exmouth, Wyndham, Halls Creek, Broome and Meekatharra have intermittent services and don't have waiting lists.

In 2005 the then-Minister for Health reported that the metropolitan public dental clinics' waiting list was 6,763 for general dental work and 1,692 for dentures.[560] The latest DOH figures for

[560] Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Question on Notice* (Hansard), 10 November 2005, p7189.

December 2009 show a substantial rise from this 2005 figure to 15,159 patients on the waiting list, a 45% increase over the previous December quarter figure.[561]

Finding 117

There has been a substantial rise in patients on the metropolitan dental clinic waiting list with a 45% increase over the December 2008 quarter figure.

Recommendation 76

The Government report by the end of 2010 on strategies it has adopted to reduce the metropolitan dental clinic waiting list and provide an update on current waiting list numbers.

(c) Country services

The general health of people living in regional, rural and remote communities is generally worse than that of people living in capital cities. Oral health is no exception, with people in non-urban areas having poorer oral health than their metropolitan counterparts. A report into rural dental services by the Committee in 2002 found that:

> *Several Western Australian country regions have some of the lowest rates of practising dentists in the nation. The average rate of practising dentists in Western Australia is 48.5 per 100,000 people. The rate in Perth is 55.6, and throughout the rest of the State the rate averages 29.0 dentists per 100,000 people. Of the eight non-metropolitan statistical divisions in Western Australia, five have rates below 20. The rates of practising dental auxiliaries (therapists, hygienists and prosthetists) are also significantly lower in country regions than in the Perth metropolitan area.*[562]

Access to DHS depends on whether a town has a public dental service or, if it does not, if it has a private dentist who is participating in the Country Patients Dental Subsidy Scheme (CPDSS). If the town has a private dentist who is in this scheme, then patients are able to attend with the same subsidisation as applies to public dentists. Under this scheme, participating dentists agree to utilise the Department of Veterans' Affairs fee schedule, and patients are required to contribute a co-payment amounting to either 25% or 50% of the total fee. The total treatment value limit is $640

561 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p25. Accessed on 13 April 2010.

562 Education and Health Standing Committee, 2002, *Adequacy and Availability of Dental Services in Regional, Rural and Remote Western Australia*, Parliament of WA, Perth, pxviii.

per patient, per year.[563] In 2005, the then-Minister for Health reported that there were 655 people on the CPDSS waiting list.[564] There had been a long-standing unhappiness by country patients with the CPDSS. The 2002 report by the EHSC found faults with the service included:

- the lengthy waiting time for processing of authorisation for commencement of treatment;
- the restricted range of dental procedures that it covers;
- the difficulties dentists encounter in recovering patient contributions; and
- the large disparity between the fees paid by the CPDSS and the fees that private practitioners would normally charge.[565]

As part of a new commitment to reducing dental health waiting lists, and to address the shortage of country dentists participating in the CPDSS, the Gallop Government in 2004 planned on utilising the services of the OHCWA for the majority of country dental patients, "These patients would receive a travel subsidy, covering the cost of their train or bus fares to Perth, and an overnight accommodation allowance of $70 per night."[566]

Indigenous people are at risk of poor long-term dental health simply by virtue of the fact that they are more likely than non-Indigenous people to live in rural or remote communities that have less access to public dental services. Also, many facets of modern Indigenous lifestyle, particularly their diet, further increase the risk of poor long-term dental health. WACHS has contracted the Centre for Rural and Remote Oral Health (CRROH) at UWA to provide dental services to six Aboriginal Medical Centres and at the Esperance Hospital.[567] The location of these CRROH clinics are shown in Table 16.3 below.

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563 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 22 June 2006, p4189.

564 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Questions on Notice*, (Hansard), 10 November 2005, p7190.

565 Education and Health Standing Committee, 2002, *Adequacy and Availability of Dental Services in Regional, Rural and Remote Western Australia*, Parliament of WA, Perth, pxx.

566 Dr Geoff Gallop, Premier, '$2million plan to provide treatment to long wait public dental patients', 18 February 2004. Available at: www.mediastatements.wa.gov.au/ArchivedStatements/Pages/GallopLaborGovernmentSearch.aspx?ItemId=124009&minister=Gallop&admin=Gallop&page=3. Accessed on 25 January 2010.

567 See www.sparhc.uwa.edu.au/crroh.

Table 16.3- Centre for Rural and Remote Oral Health clinics in WA Country Health Service regions

WACHS region	CRROH Clinic
Goldfields	Bega-Garnbirringu health service Warburton health service Esperance hospital dental unit
Great Southern	None
Kimberley	None
Midwest	Carnarvon Aboriginal medical service Geraldton Aboriginal medical service Ngangganawili Aboriginal medical service
Pilbara	Mawarnkarra medical service
South West	None
Wheatbelt	None

The latest DOH data for 2009 shows that there were 29,260 visits to SDS rural clinics in 2009, a rise of 13.3% from 2008.[568] In 2009 there were 106 private dental practitioners operating in the WACHS regions, with about a third in the South West (see Table 16.4). These figures can be deceiving as many major centres only have one private dentist. For example, all but one of the dentists in the Midwest region operate in Geraldton. Similarly, Port Hedland only has one dentist and there are none in any Kimberley towns other than Broome and Kununurra.

Table 16.4- Private dentists in each WA Country Health Service region, 2009

WACHS region	Number of private dentists
Goldfields	10
Great Southern	18
Kimberley	4
Midwest	15
Pilbara	5
South West	36
Wheatbelt	18

568 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', 26 March 2010. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p24. Accessed on 13 April 2010.

Workforce issues have been one of the key reasons for the inadequate supply of dental health services to regional and rural regions, both in this State and in other jurisdictions.[569] In 2006 the then-Minister for Health outlined two actions the Government had taken to fill vacant dentist positions in rural areas:

> *A recruitment and retention allowance was made available to improve the salaries of public dental officers in Western Australia. From memory it was about a 10 per cent allowance that I approved about a year and a half ago. The rural dentists scheme has broadened the number of overseas countries from which dentists can be recruited. Recruitment to country areas remains a priority. To compound this, there is also a national shortage of dentists.*[570]

(d) Future challenges

While rural staffing issues remain an ongoing challenge for the Dental Health Service, one of the important tasks it is currently undertaking is a population-based needs assessment to see if the programs it has traditionally delivered continue to meet the needs of the State's population. The Committee heard:

> *One of the processes we are undergoing is to look at that epidemiology and the areas of need, and look at the extent of the scope of the current service and make a determination about where that service is required to be delivered, and then carry out an analysis that will allow us to completely acknowledge all the various areas that at the moment are maybe struggling to receive dental intervention, and to readjust our current service delivery.*[571]

The Committee was told this review would be completed by January 2010 but it has yet to receive a copy of the review.

Key deficiencies are seen by DHS in the services available for children younger than five years, and the growing number of people in residential aged-care facilities in the metropolitan area. DHS provides publicly-funded visiting dentists who visit residential aged facilities and undertake work for people who are immobile. Also, DHS trains about five staff a month from these facilities to undertake oral assessments to determine whether patients need to see a practitioner, such as a dentist, or whether the carers and the person need to be taught better oral hygiene. The Federal

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569 A NSW parliamentary standing committee reported in 2006 on "difficulties in accessing treatment, particularly in rural and remote areas, and a shortage of dental practitioners working in public dentistry" Standing Committee on Social Issues, NSW Council, 'Inquiry Into Dental Services- Report Tabled', 31 March 2006. Available at: www.parliament.nsw.gov.au/prod/PARLMENT/committee.nsf/0/09224d0fbea7169dca257142000f7530/$FILE/060331%20Media%20Release.pdf. Accessed on 25 January 2010.

570 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 15 June 2006, p3833.

571 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Transcript of Evidence*, 26 August 2009, p4.

Government announced in March 2009 that it would ensure that every residential aged-care facility had a similar training program.[572]

The final challenge for the DHS in providing services to regional areas remains workforce issues. The Centre for Rural and Remote Oral Health developed an undergraduate rural placement program to provide dental students from the University of Western Australia with opportunities for direct experience of rural and remote practice during the final year of their undergraduate course. The Rural, Remote and Indigenous Placement program started in 2002 and by 2005 had placed 78 final-year students in supervised clinical practice in rural and remote regions.[573]

16.3 Future direction for the State's dental health program

Dental health services have already been recommended in the Final Report of the National Health and Hospitals Reform Commission as being a sector that should be managed by the Federal Government. The Australian Dental Association indicated their support for this proposal along with other proposals such as the creation of one-year internships for all dental graduates, to be served primarily in public dental services.[574] However, they oppose the NHHRC's proposal for the establishment of Denticare Australia at an estimated annual cost at $5.5 billion, funded by a new personal income tax of 0.75%. Instead they have proposed their own scheme modelled on the Commonwealth Dental Program abandoned by the Howard Government in 1996, and funded through a new tax on sugar, sweets and soft drinks.[575]

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572 Mrs Roslyn Elmes, Executive Director, Public Health and Ambulatory Care, Department of Health, *Transcript of Evidence*, 26 August 2009, p9.

573 Rural and Remote Health, 'An innovation in Australian dental education: rural, remote and Indigenous pre-graduation placements', 2007. Available at: www.rrh.org.au/publishedarticles/article_print_703.pdf, p1. Accessed on 25 January 2010.

574 Mr Neil Hewson, 'Dental scheme must target the needy', 16 January 2010, *The Australian Online*. Available at: www.theaustralian.com.au/news/health-science/dental-scheme-must-target-the-needy/story-e6frg8y6-1225819469535. Accessed on 20 January 2010.

575 Mr Adam Creswell, 'Dentists favour focus on poor over a universal scheme', 7 December 2009, *The Australian Online*. Available at: www.theaustralian.com.au/news/nation/dentists-favour-focus-on-poor-over-a-universal-scheme/story-e6frg6nf-1225807511228. Accessed on 20 January 2010.

CHAPTER 17 END OF LIFE CARE: PALLIATIVE AND AGED-CARE SERVICES

17.1 Introduction

This chapter incorporates two major aspects of the end-of-life experience for Western Australians that also impact on the demand for acute hospital beds, aged-care and palliative care. These two aspects of the State's health care system are considered jointly in this chapter given:

(i) the increased impact of Western Australia's ageing population from the higher proportion of the 'baby boomer' generation turning 65 years of age and older;[576]

(ii) both sectors face similar workforce issues in attracting enough specialist and nursing staff to provide adequate services; and

(iii) that Federal government policies and funding interact with State health policies in these areas.

Both of these areas of the health system deserve their own separate inquiry, given their importance to Western Australians and their impact on the health system. These sectors will need to receive continuing policy focus from government as data from the OECD shows that Australia has the third-highest life expectancy of 81.4 years for Australians born in 2007 (83.7 years for women), an increase of nearly 12 years since 1960.[577] This chapter outlines the chief issues affecting these sectors impacted by the ageing population. Also, as both sectors receive substantial funding from the Australian Government, it is likely that both will be impacted by any change to the role of the Federal Government in the delivery of health services in WA later in 2010. For instance, the Federal Government announced in early April a new $740 million four-year aged-care funding package that will increase aged-care places by 5,000, but only if State governments agree at COAG to the proposed new Federal plan.[578]

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576 Professor Aoun predicts that the number of people aged over 60 years in Perth in 2015 will be 50% higher than the figure for 2005- up from about 258,000 to 384,000. Dr Samar Aoun, 2005, *Palliative Care In Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p26.

577 OECD, 'Health at a Glance 2009: OECD Indicators- 1.1. Life expectancy at birth', 2009. Available at: www.oecdilibrary.org/oecd/sites/health_glance-2009-en/01/01/index.html;jsessionid=2bsfei1pcgp4j.delta?contentType=&itemId=/content/serial/19991312. Accessed on 17 December 2009.

578 AAP, 'Ageing Australia: PM's $739m boost', 12 April 2010. Available at: www.smh.com.au/national/ageing-australia-pms-739m-boost-20100412-s207.html. Accessed on 12 April 2010.

17.2 Aged-care

The Western Australian population is ageing rapidly. The Reid Report projected that by 2016 13.9% of the population would be aged 65 years and over, with an increased proportion aged 75 years and over. It reported that 72% of all public hospital bed days are presently used by just 22% of the population and that one-third of these 'frequent users' are aged 75 years and over. The cost of patients remaining in acute hospital beds rather than in residential care was estimated by Reid at $32 million per annum. The Reid Report recognised the importance of moving older people from hospitals (Recommendations 10 and 11) as one way in which to provide more appropriate care for these patients, and to reduce hospital expenditure.[579]

The Council on the Ageing summarised the statistics for the State's ageing population:

- 53% of seniors are female - a woman aged 55 in 2006 has a 10% probability of living to 103;[580]
- 39% of seniors were born overseas, with 16% born in a non-English speaking country;
- in 1971, seniors over the age of 80 represented 10% of the seniors' population of 12,000, but by 2031 they will represent 24% of the larger seniors' population of 185,000;
- the number of people reaching 100 years of age has tripled since 1988, with nearly four-times as many females reaching this age as men; and
- 54% of people with a disability are aged 65 years and older.[581]

While the State Government grapples with the policy issues flowing from the 'greying' population, the provision of aged-care services for Western Australians is primarily funded by the Australian Government under the *Aged-care Act 1997*.[582] The difficulty this provides for the State Government is to ensure that the Australian Government provides sufficient aged-care places in Western Australia so that people don't end up in hospital beds instead. In 2009 the Australian Government spent almost $10 billion to provide approximately 210,000 people with subsidised permanent residential aged-care, with an average of around 160,000 people receiving care each night in one of Australia's 2,800 aged-care homes. Around half this budget is provided by the Aged-care Funding Instrument (ACFI), which was introduced in March 2008 to replace the Resident Classification Scale as the means of allocating Australian Government care subsidies to

579 Department of Health, 2004, *A Healthy Future for Western Australian*, Report of the Health Reform Committee, Department of Health, Perth, pp30-31.

580 Mr Ken Marston, Executive Director, Council on the Ageing WA Inc, *Transcript of Evidence*, 26 August 2009, p11.

581 Submission No. 20 from Council on the Ageing WA Inc, 28 July 2009, pp2-5.

582 Department of Health and Ageing, 'Legislation- Aged-care Act 1997', 27 July 2009. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/ageing-legislat-aca1997-acaindex.htm. Accessed on 17 December 2009.

residential aged-care facilities. ACFI was designed to have funding more accurately matched to the care needs of residents and to allow aged-care workers to spend less time on administrative matters. In November 2009 the Minister for Ageing, Hon Ms Justine Elliot, released terms of reference for a review of the Aged-care Funding Instrument.[583]

A recent Senate Inquiry found that approximately 40% of older Australians aged 70 years and over are accessing some aged-care services and that a third of all men and half of all women aged over 65 years will go into permanent residential care at some time later in their lives. The majority of the funding for residential care is provided by the Department of Health and Ageing, but specific residential aged-care funding is also provided through the Department of Veterans' Affairs for aged veterans and from permanent residents in aged-care facilities paying accommodation and daily living charges. On average, care recipient fees account for about 26% of the costs of high-level care and about 53% of the cost of low-level residential care.

Table 17.1- Types of care aged-care provided[584]

Type of Care	Residential aged-care	Community care programs
High	24 hour nursing	Extended Aged-care at Home (EACH)
	Accommodation	Extended Aged-care at Home – Dementia (EACH–D) package
Low	Personal care	Home and Community Care (HACC) (with States and Territories)
	Accommodation	Community Aged-care Package (CACP)
	Support and allied health services	FINE (State funding for assistance with bathing, cooking, cleaning, etc)

(a) Residential programs

According to the Australian Greens, Western Australia faces an imminent crisis in residential aged-care because centre operators cannot afford the cost of providing services. Evidence was

583 Hon Ms Justine Elliot, Minister for Ageing, 'Review of the Aged-care Funding Instrument – Release of Terms of Reference', 6 November 2009. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je126.htm?OpenDocument&yr=2009&mth=11. Accessed on 24 November 2009.

584 Senate Standing Committee on Finance and Public Administration, 'Chapter 2- Overview of residential and community care in Australia', 29 April 2009. Available at: www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/report/c02.htm#anc1. Accessed on 16 December 2009.

given to the Senate Inquiry into Residential and Community Aged-care that in 2008-09, aged-care providers only applied for 538 of the 1,208 beds allocated by the Federal Government to Western Australia. In 2007-08 providers failed to apply for 362 of the beds allocated by the Government.[585] Aged-care operators have complained that the level of subsidy attached to the residential places made it unviable to build new beds, with some boycotting the process.[586] A Western Australian aged-care operator said that the Federal Government provided a subsidy of $110,000 per bed while it cost organisations $245,000 per bed to build facilities.[587] This was cited as the main reason why these organisations were not only not taking up new options, but returned 283 licenses for places in Western Australia to the Federal Government between December 2007 and March 2009.[588]

The costs associated with building aged-care facilities are more of a problem in Western Australia due to higher building costs associated with the construction industry being impacted by the State's resources 'boom'. The national average bed costs were $170,000 per bed with finance servicing costs of around $10,000 per bed.[589] The State Government's own submission to the Senate Finance and Public Administration Committee's Inquiry into residential and community aged-care in Australia confirmed these high construction costs in Western Australia. This submission also highlighted that the Federal Government's *Securing the Future* funding package assumed a 20% rate of increase for capital contributions between 2008-11, but the figure was more likely to average 40-50% in Western Australia.

Table 17.2- Federal aged-care funding for Western Australia, 2007-09[590]

Year	Funding ($ mill)	Places	Occupancy rate	Client numbers
2007-08	$426.6	14,252	94.8%	17,396
2008-09	$463.2	14,423	94.2%	17,657

As shown in Table 17. 2, in mid-2009 there were 17,657 clients using residential aged-care beds in Western Australia. The Aged-care Association Australia believes that the difficulties in funding new residential aged-care beds will lead to a severe shortage of 4-5,000 beds in the next few years,

585 Australian Greens, 'Western Australia leads looming aged-care crisis', 30 January 2009. Available at: http://rachel-siewert.greensmps.org.au/content/media-release/western-australia-leads-looming-aged-care-crisis. Accessed on 16 December 2009.

586 Ms Siobhain Ryan, 'Aged shun nursing homes and stay put', *The Australian*, 30 January 2009. Available at: www.theaustralian.news.com.au/story/0,25197,24981623-5006790,00.html. Accessed on 16 December 2009.

587 Mr David Fenwick, 'Aged-care crisis will worsen', *The West Australian*, 4 November 2009, p22.

588 Mr Joseph Catanzaro, 'Aged-care funding 'too low' for new beds', *The West Australian*, 7 January 2010, p6.

589 Government of Western Australia, 'Submission 111', 17 November 2008. Available at: www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub111.pdf, p3. Accessed on 16 December 2009.

590 Dr Peter Flett, Director General, Department of Health, *Response to Questions on Notice*, 10 November 2009, p2.

placing new pressures on hospital beds or voluntary caring by family members in patient's homes.[591]

In financial terms, the need for the State Government to rectify these shortages can be seen in the costs of $200 per day given to residential facilities to provide a comprehensive range of services, accommodation, nursing, 24-hour care and products for high-care residents, compared to the average cost of about $1,100 per day for patients in a tertiary hospital bed.[592] The Health Minister, Dr Kim Hames, said that the State spent $60 million a year on providing hospital care for patients who needed a nursing home bed, and estimated that there were about 370 people in State-funded care that could be discharged if they had suitable residential accommodation. Of these people, about 70 were being cared for in hospital beds.[593]

The aged-care sector is an incredibly complex one, especially for families trying to navigate it to find care for their loved ones. The Committee heard that "overall about 70% of people who are in residential care are classified as high-care. The residents arrive as low-care residents but over time they become high-care residents."[594] However, given the Federal funding requirements, aged-care providers often can't use the same facility, or same bed, for high-care and low-care residents and patients have to move as their needs change:

> *The buildings themselves have certain classifications regarding their capability. A low-care building is classified in one way and a high-care building is classified in another way. That has quite a bearing on what happens inside the building. The commonwealth is very keen on ageing-in-place. If a person comes in as a low-care resident, the service provider has the ability for that person to stay in that room until that person's last day, regardless of the resident's changing care needs. If the building was built as a high-care facility, even though it was providing low care, the internal staffing arrangements can be restructured to meet the ageing-in-place. Quite a lot of flexibility can be created in that type of building. If that cannot physically be done, it is quite limited and the provider must continue to provide low care. If a resident leaves the facility to go to hospital and comes back as a high-care resident, it might be that the person's needs cannot be met in that type of building.*[595]

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591 Mr Ken Marston, Executive Director, Council on the Ageing WA Inc, *Transcript of Evidence*, 26 August 2009, pp7-8.

592 Mr Vaughan Harding, Chief Executive Officer, Uniting Church Homes, *Transcript of Evidence*, 1 September 2009, p4.

593 Ms Angela Pownall, 'Aged-care bed shortage hits hospitals', *The West Australian*, 9 April 2010, p9.

594 Mr Vaughan Harding, Chief Executive Officer, Uniting Church Homes, *Transcript of Evidence*, 1 September 2009, p10.

595 Mr Vaughan Harding, Chief Executive Officer, Uniting Church Homes, *Transcript of Evidence*, 1 September 2009, pp9-10.

Finding 118

Providing residential aged-care to Western Australians is costly, but not as expensive to the State as having them receive care in an acute hospital setting.

Recommendation 77

The Department of Health should urgently improve the information it provides to Western Australian families on access to non-hospital based residential aged-care.

Recommendation 78

As a matter of urgency, the State Government should immediately undertake negotiations with the Federal Government aimed at overcoming the boycott by providers in building new aged-care facilities in Western Australia.

Recommendation 79

In its annual report to Parliament, the Department of Health should include data on the number of patients who are admitted to the State's tertiary and secondary hospitals when they could receive more appropriate care in a residential aged-care setting.

Recommendation 80

The State Government should ensure that there is ongoing education and support for aged-care staff employed in residential facilities to assist them to provide a high level of care to their residents and thereby prevent unnecessary hospital admissions.

(b) Funding to stay at home

Federal programs

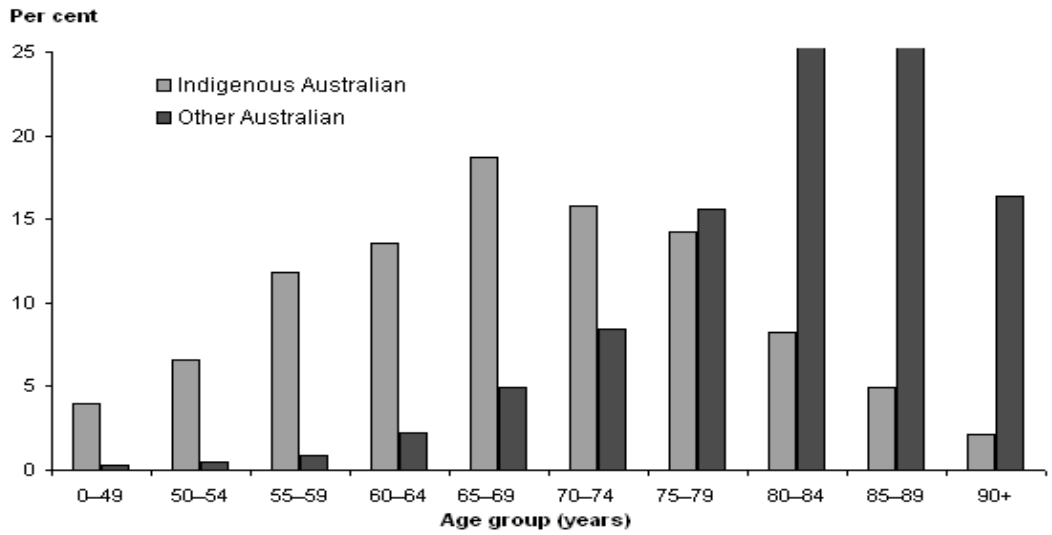
Community care has been a growing element of aged-care for the past two decades, as a response to the preference of most people who need support to live at home in the community rather than

moving to some form of institutional setting. The Australian Government provides community care packages to help people who are eligible for entry into residential aged-care to stay in their own homes. There are three types of packages: Community Aged-care Packages (CACPs) for people with low-care needs (first introduced in 1992), Extended Aged-care at Home (EACH) packages for people with high-care needs (introduced in 2002) and EACH Dementia packages for people with behavioural problems or psychological symptoms associated with dementia (introduced in 2006).

As at 30 June 2008, almost 37,000 people were receiving help from a CACP, almost 3,900 people were getting help from an EACH package and around 1,600 people from an EACH Dementia package. There were over 3,000 Western Australians receiving help from the CACP program, including 176 Indigenous people. Western Australia was entitled to 3,630 CACP packages, 406 EACH packages and 174 EACH dementia packages.

While the availability of high-care packages is more limited in remote and very remote regions, the usage by Indigenous people aged 65–74 years was 44.2 per 1,000 and 95.0 per 1,000 for those aged 75 and older. Overall, Indigenous people aged over 50 years used community aged-care packages at over 3 times the rate of other Australians. Figure 17.1 below shows the uptake of these packages for Indigenous and non-Indigenous Australians.[596]

Figure 17.1- Combined packages per 1,000 people



State programs

The Hospital in the Home (HitH) program delivers short-term acute services in a patient's home for conditions that traditionally required hospital admission and in-patient treatment. All

596 Australian Institute of Health and Welfare, 'Aged-care packages in the community 2007-08: a statistical overview', 15 October 2009. Available at: www.aihw.gov.au/publications/index.cfm/title/10750. Accessed on 16 December 2009.

Australian jurisdictions have developed HitH programs since the late 1990s as important ambulatory health projects. These services are based on daily home visits by nurses provided by organisations such as Silver Chain, with medical governance usually provided by a hospital-based doctor. These patients remain hospital inpatients. They include patients who can be cared for safely without constant monitoring, such as those who may require regular intravenous drug treatments or wound dressings.

The program has been supported by governments from both sides of Parliament and has grown from about 30 HitH beds in 2005 to over 250 in 2007 when the Government provided a budget of $26.3 million for this program.[597] Forward estimates show the HitH budget (including Rehabilitation in the Home and Mental Health in the Home) doubling to over $53 million in 2011-12.[598]

Currently, HitH services are provided in Western Australia at tertiary hospitals in Perth — Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Princess Margaret Hospital for Children. While the HitH program provides support to patients of all ages, it is an important program for older people to keep them out of hospitals and residential facilities.

Recommendation 81

The Department of Health should transfer, if appropriate, the management of Hospital in the Home (HiTH) patients from the existing tertiary hospitals to secondary hospitals to ensure that patients are being serviced closer to their homes.

The State Government introduced in its 2009-10 Budget a new scheme to complement the HitH program to support people who preferred to receive treatment in their homes. The Friend in Need - Emergency (FINE) program is designed to help the elderly and chronically ill stay out of hospital and remain in their homes at a cost of $84 million over four years. FINE will relieve pressure on the public hospital system by reducing the demand on EDs and on hospital in-patient services and will fund community-based health providers, such as Silver Chain, to work with ED doctors and general practitioners. Hospital Emergency Department care co-ordination teams will be strengthened and will identify patients who do not need to be hospitalised, but who require care and home support and will be referred to FINE.[599] The $27 million budget for FINE in the 2009-10 Budget will provide funds for:

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597 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), 24 May 2006, pE337.

598 Department of Treasury and Finance, 'WA Health', 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p163. Accessed on 19 March 2010.

599 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 18 March 2009, p2041.

- Silver Chain Nursing Association- $16,932,500;
- Other Community Care programs- $2,567,500;
- Community Flexible Care Packages- $800,000;
- Emergency Department Care Coordination Teams- $1,657,720;
- Complex Care Coordination- $4,342,280;
- Training, Education- $200,000;
- Quality and Evaluation- $300,000; and
- Administration- $200,000.[600]

The Western Australian 2009 Mid Year Economic Review reduced the FINE program funds in the 2009-10 Budget by $7.6 million and transferred them to the following year.[601]

Finding 119

Programs such as Hospital in the Home and Friend in Need - Emergency are excellent examples of low cost ways of providing appropriate non-hospital based care to aged Western Australians.

Recommendation 82

Programs such as Hospital in the Home and Friend in Need - Emergency need to be isolated from any further cuts to the Western Australian health Budget.

600 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), 28 May 2009, p593.

601 Department of Treasury and Finance, '2009-10 Government Mid-year Financial Projections Statement', December 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/_Treasury/State_finances/myr_200910.pdf?n=3157, p99. Accessed on 3 February 2010.

Recommendation 83

In its annual report to Parliament, the Department of Health should include data on the number of beds in the State's tertiary and secondary hospitals freed up by patients participating in the Home and Friend in Need - Emergency programs.

While the State Government has recognised the benefits of providing health care for elderly people in their own homes, the Committee heard that problems existed in the transition from hospitals to patient's homes:

> *However, in the context of hospitals, the issues that we often hear about are the need for effective transition from acute care into community care, the need for discharge planning, and the need for people to receive support services when they leave hospital—particularly if they have experienced procedures, including anaesthetics which leave them a bit dazed or not quite as steady on their feet as they may normally be. In particular, people who live alone and who return alone to an empty house on a Friday afternoon, find it difficult to get services, for example the fridge may be empty, and they are not feeling too good.*[602]

The Home and Community Care (HACC) Program in Western Australia provides care, support and services to the frail, the aged, the chronically ill, people with a disability and their carers. It provides personal care to help over 64,000 people shower and prepare their food for the day and is jointly funded by the State and Federal governments. Silver Chain provides about a third of the State's HACC services, operating in 28 towns from Albany to Eucla to Carnarvon, and is required to provide seven hours of personal care a week to their clients.[603]

In late December 2009, the Western Australian Government announced a further $13.6 million for 158 new or extended HACC projects across the State, with $5.3 million in funding from the State Government and $8.3 million from the Federal Government. Total investment in HACC services in Western Australia grew by almost 9% from 2008, to over $196 million.[604] The DOH Budget reports that in 2009-10 this program reaches about 342 patients per 1,000 target population, down from a proposed rate of 352 in the 2008-09 Budget.[605]

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602 Mr Ken Marston, Executive Director, Council on the Ageing WA Inc, *Transcript of Evidence*, 26 August 2009, p2.

603 Mr Christopher McGowan, Chief Executive Officer, Silver Chain, *Transcript of Evidence*, 1 September 2009, p9.

604 Hon Dr Kim Hames, Minister for Health, '$13.6million boost for Home and Community Care services in WA', 22 December 2009. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=132971. Accessed on 5 January 2010.

605 Department of Treasury and Finance, 'WA Health', 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p169. Accessed on 19 March 2010.

The ageing of the State's population has placed pressure on programs such as HACC, especially in regional areas. The Committee heard that in the Great Southern the proportion of the population over 65 years of age "In the past 10 years it has increased by 9.5%. We are looking at 52,500 people over the age of 65-plus in the region. There are 6,651 over 65s in the HACC target group. Out of that number we have only 2,462 receiving HACC services."[606]

Finding 120

The ageing of the Western Australian population has had a greater impact on regional communities given their isolation from many of the State's health programs which are based in Perth.

Recommendation 84

The Government should give priority to further Royalties to Regions funding to supplement existing State and Federal funds to boost effective regional health care programs, such as the Home and Community Care program.

The State Government has also used the HACC program to address issues around the discharge of elderly people from hospitals, both in Perth and regional areas. The Government's strategy is centred on the discharge coordinators and aged-care assessment teams (ACAT) in hospitals:

> *We have actually funded service providers, particularly in the HACC arena… to be able to facilitate a timely discharge from hospital. I think it was in 2005, through the HACC program utilising some strategic thinking with Silver Chain, that we put in place a process whereby now a discharge coordinator on the ward, be it a social worker or a nurse, can ring up and, providing the client or the patient is HACC eligible, get a service within 24 hours. So far in WA, we have put $3 million into that particular program. We have rolled it out into Albany and Geraldton as well, because the complaint was … that often an agency, by the time they go in and do their assessment, it might be a week later, whereas the person was vulnerable on going home.*[607]

One area of concern in the aged-care sector remains the decision of the State Government to remove its funding from the Care Awaiting Placement (CAP) program. The CAP program was an additional $25 million per annum of State funds provided to address the shortage of aged-care beds in Western Australia. The Government decided to close the program's 272 beds by

606 Ms Suzanne Millar, Regional Manager, Aged-care, WA Country Health Service, Great Southern, *Transcript of Evidence*, 11 September 2009, p6.

607 Ms Gail Milner, Operational Director- Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 26 August 2009, pp3-4.

31 December 2009. The decision was made in light of the Federal Government's commitment to open an additional 2,000 transition care services (either a bed or a place) and the provision of an additional 394 residential aged-care beds in the metropolitan area. The average length of stay in these CAP beds was 49 days in 2008 with 1,173 patients transferred from acute hospital beds during 2006-07.[608] The CAP program had halved the number of patients in the State's hospitals waiting for placement into an aged-care facility from about 120 per week to about 60.[609]

While inquiring into this aspect of the State health system, the Committee was concerned to hear that the State Government does not know how many beds are being funded in Western Australia by the Australian Government, and has no means of establishing this figure. The only data that is provided to it is the ratio of high-care beds, low-care beds and community aged-care packages for every 1,000 people aged 70-plus:

> *They* [the Federal Government] *will not tell us how many beds short we are. They will only ever give us a ratio. That was a decision Bronwyn Bishop made however many years ago and no jurisdiction has been able to get that information. Even at the federal Senate hearing on aged-care in February this year, we could not provide that information. That information has to come from the commonwealth. I do not have it. I do not have the means to have it.*[610]

The Committee received evidence that "We are well below the ratio. We are the second lowest nationally."[611] As at 30 June 2007, Western Australia had a combined aged-care service ratio of 103.5 places per 1,000 people aged over 70 and Indigenous people aged 50-69 years of age, compared to a national average of 107, and a figure of 109.6 in Victoria.[612]

Programs to support the elderly and frail keep out of hospitals have been the subject of recent budget cuts associated with the Government's 3% efficiency dividend. The Health Minister confirmed in December 2009 that the patient transport service at Sir Charles Gairdner Hospital would lose three of its 13 vehicles. Many patients who use it to access the outpatient services at SCGH are unable to drive.[613]

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608 Government of Western Australia, 'Submission 111', 17 November 2008. Available at: www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub111.pdf, pp5-6. Accessed on 16 December 2009.

609 Ms Gail Milner, Operational Director- Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 26 August 2009, p10.

610 Ms Gail Milner, Operational Director- Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

611 Ms Gail Milner, Operational Director- Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

612 Government of Western Australia, 'Submission 111', 17 November 2008. Available at: www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub111.pdf, p6. Accessed on 16 December 2009.

613 Mr Paul Lampathakis, 'Cuts to target elderly', *Sunday Times*, 20 December 2009, p40.

(c) Regional aged-care

The Committee heard evidence that the situation for the provision of aged-care in regional Western Australia is qualitatively different to metropolitan Perth as:

- people who can't gain access to residential care leave the town;
- there are less volunteers to provide in-home support;
- it is harder to employ qualified carers; and
- community organisations such as Silver Chain do not operate in all towns.

As an example, the Merredin Hospital is the 'hub' hospital facility for the Wheatbelt region of about 12,600 people in 10 shires spread over 67,000 square kilometres. The Merredin Hospital has 10 high-care aged beds and 10 low care aged beds, with a total of 56 high care aged beds and 39 low-care aged beds in the eight hospitals in the Wheatbelt. Aged-care services now make up about 85% of the operations of the Merredin Hospital and the aged-care beds are usually fully-occupied.[614] The largest residential facility in Merredin is the community-run Merrittville Retirement Village with 26 beds and a waiting list of about 20. This facility is jointly managed with HomesWest and residents have to meet a strict asset limit of $80,000 to be able to access a place, but the average cost of a house in Merredin of about $130,000 means that most residents are unable to meet this test.[615] Dementia patients who have been in the nursing home or residential village have to go to Northam as there is no facility to care for them in Merredin, although there is enough demand for a 25-bed unit.[616]

Finding 121

One of the major impacts on regional communities of the ageing of the Western Australian population is the difficulty communities have in providing and staffing cost-effective aged-care facilities.

614 Ms Elizabeth Marmion, Acting Operations Manager- Eastern Wheatbelt, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, pp2-3.

615 Councillor Julie Townrow, Shire Councillor, Shire of Merredin, *Transcript of Evidence*, 7 September 2009, p6.

616 Mrs Gearing, Liaison Officer, Merrittville Retirement Village, *Transcript of Evidence*, 7 September 2009, p7.

Recommendation 85

As an urgent priority the Government should provide Royalties for Regions funds to regional communities to assist them develop residential aged-care and dementia facilities.

Finding staff to deliver aged-care services over large distances in regional areas (where staff might be required to travel two hours to provide a half-hour service) is very difficult. The Committee heard:

> *We have found that in our hospitals that although the recruitment of nurses has been uplifted, the retention probably is not what it should be. But we are finding now that recruitment and retention of certificate III, IV, and then aged-care diplomas are very, very hard. We suspect that is probably because aged-care and particularly community care has been undervalued for a long, long time.*[617]

The low pay given to care workers is an obvious reason why it is hard to recruit these staff, but another reason why they might be undervalued is confusion over their role:

> *When we send a care worker into the home, often the community see them as the cleaner and then they identify themselves as the cleaner, which is a long way from the truth. We are sending that person in to enable and to promote independence in a whole range of things that are vital for the client. …One of the ways we have addressed that is to send out two workers together so that they are feeling a little more supported. More broadly, it needs to have better education so that not only the community but the care workers have a greater appreciation of the role of the care worker.*[618]

A new initiative to improve community care in regional Western Australia was established by the previous State Government. It established multipurpose service centres (MPS) where, with the agreement of the Federal Government, funds from various programs can be 'cashed in'. This State has the largest number of MPSs in regional areas of any Australian jurisdiction, mostly located at a town hospital. The Committee heard that:

> *Regional WA took up an initiative very aggressively and very successfully which involves the cashing in of residential, community and acute-care services within a local hospital. Western Australia has 31 MPSs. It has been a very successful initiative in WA.*[619]

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617 Mrs Jeanette Fegan, District Community Care Coordinator- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p4.

618 Mrs Jeanette Fegan, District Community Care Coordinator- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p9.

619 Ms Gail Milner, Operational Director- Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 26 August 2009, p9.

The MPS system allows health staff in each town to determine their own priorities and provide the care services they think are the most needed.

17.3 Palliative care

Palliative care is the specialised care provided to a patient who has an advanced terminal illness and is near the end of their life. Mr William Hallahan, CEO of Palliative Care WA, defines this as "the longer period when people are living perhaps for several months or even years with increasing disability and a range of conditions, one or more of which will eventually lead to their death."[620] Each year more than 20,000 Australians receive specialist palliative care and more than 500,000 patients, carers, family members and friends provide approximately 1.2 billion hours of care annually. Estimates suggest carers provide 76% of all palliative services to people needing this care and support. The demand for palliative services near the end-of-life is substantial and will increase with the expected rise in the proportion of the population aged over 65 years. While the majority of people die at home, residential aged-care facilities are increasingly the place of death for people with terminal health conditions, unless they are transferred to acute care facilities in hospitals.[621] The CEO of Silver Chain believes that Western Australia has the best palliative care service of any Australian jurisdiction.[622]

Palliative care is provided to people of all ages who are dying. Organisations such as Palliative Care Australia (PCA) believe that requirements for palliative care should not depend on any specific medical diagnosis, but on a person's needs. PCA claim that between 30-50% of people with a terminal illness will experience physical pain that is under-treated.[623] Some of the common medical conditions requiring palliative care include: cancer, HIV/AIDS, motor neurone disease, muscular dystrophy, multiple sclerosis and end-stage dementia. A 'palliative approach' aims to improve the quality of life for people with a life-limiting illness (and their families) by reducing their suffering through the early identification, assessment and treatment of their pain and addressing their physical, cultural, psychological, social, and spiritual needs. Underlying this approach should be a positive and open attitude towards death and dying by health staff.[624]

The current number of people living in Western Australia with cancer is 70,000 and about 3,500 people die from it each year. About 1 in 2 men and 1 in 3 women will get cancer by the time they reach 85 years old. With an ageing population this number will increase by 50% to 15,000 people

620 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p2. Mr Hallahan suggests that "between 60 and 75% of people die of a condition they have and know about".

621 Palliative Care Australia, 'Position Statements'. Available at: http://www.palliativecare.org.au/Default.aspx?tabid=1942. Accessed 11 December 2009.

622 Mr Christopher McGowan, Chief Executive Officer, Silver Chain, *Transcript of Evidence*, 1 September 2009, p2.

623 Palliative Care Australia, 'EoL – Towards quality care at the end of life', 2009. Available at: www.palliativecare.org.au/Portals/46/EoL%20-%20Winter%202009.pdf. Accessed on 16 December 2009.

624 Dr Samar Aoun, 2005, *Palliative Care In Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p13.

in Western Australia being diagnosed with cancer each year by 2020. Figures 17.2 and 17.3 below provide a summary of the most common cancers treated in Western Australia, and indicate how rates increase dramatically as men and women age. The need for more services and support for people suffering from cancer will be discussed later in this Chapter.

Figure 17.2- Cancer mortality rates in Western Australia, 2007[625]

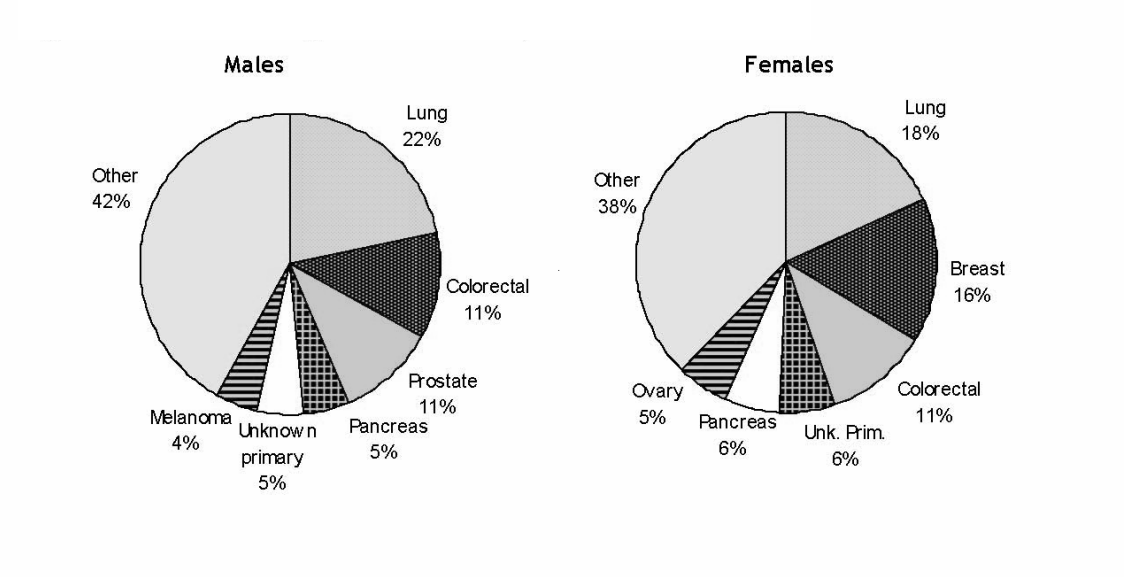
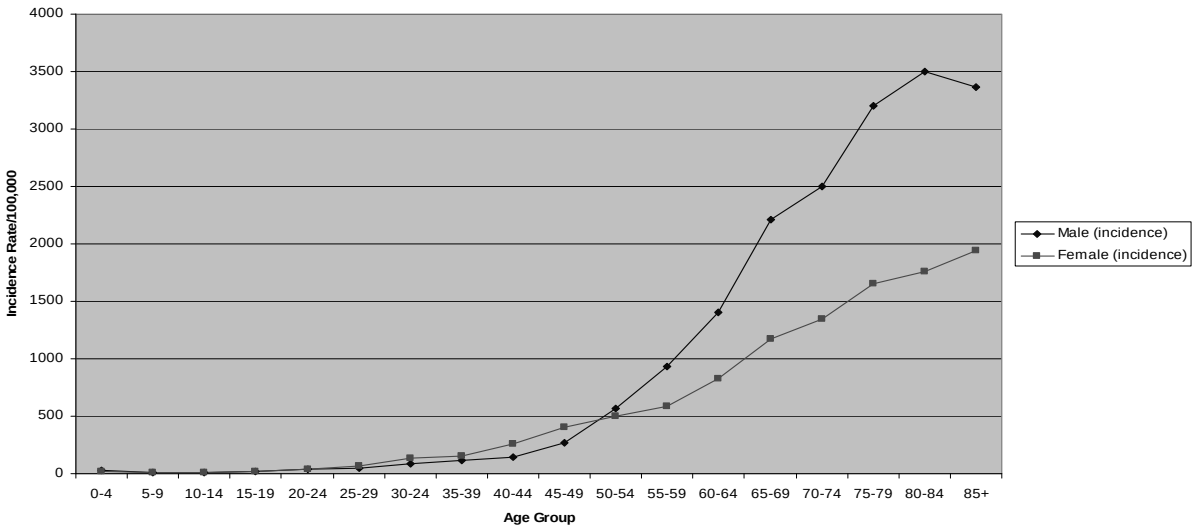


Figure 17.3- Age-specific cancer incidence rates, 2007[626]



625 Submission No. 46 from Cancer Council of WA, 10 March 2010, pp1-2.

626 Submission No. 46 from Cancer Council of WA, 10 March 2010, pp1-2.

Finding 122

Every Western Australian has a fundamental right to a palliative approach to their health care. To enable this right to be met, issues regarding the equity, access and affordability of palliative care need to be considered for both current and future populations.

In late 2009, the Minister for Transport (representing the Minister for Health) reported to the Parliament that from 1 January to 31 December 2008 the total number of West Australian patients admitted into hospital beds who received palliative care from specialist palliative care services was 8,125. Importantly, the Minister reported that "the information system within the Department of Health only captures palliative care 'care type' which reflects patients admitted into hospital beds. This does not give a true reflection of the scope of specialist palliative care provided throughout the State."[627]

The Minister also reported to Parliament that accurate data on patients who sought palliative care is unavailable from the Department of Health (DOH) and that the "Average length of time from referral to receiving care is not available within the public system data collection for Western Australia".[628] This deficiency in DOH's systems increases the difficulty in planning for providing proper palliative care in the future. For instance, the *Clinical Services Framework 2005-2015* reported that 15 palliative care patients had been to Sir Charles Gairdner Hospital (SCGH) in 2004. However, an extensive analysis by Professor Samar Aoun found that there were actually 540 patients treated at SCGH for that period.[629]

Finding 123

The Department of Health's information systems do not capture the complete range of data on the experience of Western Australian's requiring and receiving palliative care.

627 Hon Mr Simon O'Brien, Minister for Transport representing the Minister for Health, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 24 November 2009, p60.

628 Hon Mr Simon O'Brien, Minister for Transport representing the Minister for Health, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 24 November 2009, p60.

629 Professor Samar Aoun, Director of the WA Centre for Cancer for Cancer and Palliative Care, Curtin University, *Transcript of Evidence*, 25 August 2009, p5.

Recommendation 86

The Department of Health's information systems should be improved to allow the better collection of data on the experience of people requiring and receiving palliative care in the State's public and private health system.

National palliative care data (including key Western Australian palliative care services) shows that 87% of inpatients are seen within 48 hours, and for community patients 62.9% are seen in that period. Silver Chain's Hospice Home Care contact all of their patients within 24 hours of referral. In Western Australia, 90% of the community-based service is supplied by the Silver Chain Nursing Association.[630] Evidence was given to the Committee that about 530 Western Australians are being supported in their homes by Silver Chain at any one time, at an annual cost of about $23 million. This equates to about $250 per day, although services usually are delivered for a cost of $80 per hour.[631] This community service is critical as the State has, at 50%, the highest death rate at home of all Australian jurisdictions.[632] Table 17.3 below shows the total number of patients receiving palliative care from specialist palliative care services in Western Australia during 2008.[633]

630 Professor Lorna Rosenwax, & Professor Beverley McNamara, 2006, 'Who receives specialist palliative care in Western Australia- and who misses out', *Palliative Medicine*, vol. 20, p440.

631 Mr Christopher McGowan, Chief Executive Officer, Silver Chain, *Transcript of Evidence*, 1 September 2009, pp2-8.

632 Professor Samar Aoun, Director of the WA Centre for Cancer for Cancer and Palliative Care, Curtin University, *Transcript of Evidence*, 25 August 2009, p6.

633 Hon Mr Simon O'Brien, Minister for Transport representing the Minister for Health, Western Australia, Legislative Council, *Parliamentary Debates* (Hansard), 24 November 2009, p60.

Table 17.3- The number of Western Australian patients receiving palliative care from specialist palliative care services- 2008*

Facility	Patients
PUBLIC	
Royal Perth Palliative Care Team (PCT)	1,084
Sir Charles Gairdner Hospital PCT	896
Fremantle Hospital PCT	573
Peel Community Palliative Care Service	229
Albany Palliative Care	190
Geraldton Palliative Care	119
Kalamunda Hospital Palliative Care Unit (PCU)	78
Busselton Hospice	65
Avon Hospice Service — Northam	57
Joondalup Health Campus	53
Princess Margaret Hospital	42
PRIVATE/COMMUNITY	
Silver Chain Hospice Home Care	2,709
Hollywood Private Hospital PCU	479
St John of God Subiaco	444
Murdoch Community Hospice	441
Bethesda Hospital PCU	336
Glengarry Private Hospital	174
Bunbury St John of God	156

* In light of the evidence above, this list may be incomplete.

(a) Palliative care beds

There are currently only 88 specialist palliative care beds in the State, of which 51 are publicly-funded beds. Professor Aoun is Director of the WA Centre for Cancer and Palliative Care at

Curtin University and her report on palliative care in Western Australia considered the issue of appropriate bed numbers. Of her 48 recommendations, the first three were:

1 a total of 148 palliative care beds in the metropolitan area would meet the projected future needs of the significant ageing population, anticipated by the year 2015-16.

2 the minimum recommended number of publicly-funded palliative care beds is 32 beds in North Metropolitan Area Health Service (NMAHS) and 36 beds in South Metropolitan Area Health Service (SMAHS), based on the current PCA benchmark of 6.7 beds per 100,000 population.

3 Palliative Care Units (PCUs) should be established at Joondalup, Swan Districts, Rockingham and Armadale to ensure equitable access to palliative care and care that is provided closer to patient's homes.[634]

In 2004 the Reid Report recommended (Recommendation 41) that there should be integrated palliative care services at designated secondary hospitals, but they do not yet exist other than at the Joondalup Hospital.[635] The Clinical Services Framework 2010-20 plans for the establishment of PCUs in the general hospitals at Rockingham, Armadale and Swan Districts by 2014-15. However, in this period it only plans an additional 6 public palliative care beds across the State, with one in the SMAHS and five in the NMAHS.[636] This plan will still leave the SMAHS short of the PCA benchmark by 16 beds and the NMAHS short by 17 beds. Professor Aoun gave evidence to the Committee that another 19.6 private beds and 36 public beds are needed in the south metropolitan area health service. Both area health services serve similar population levels but the SMAHS has only 29.1 palliative beds compared to 63.4 in the NMAHS.[637]

The Cancer Council supported the view of Professor Aoun that there are not enough beds in Western Australia for palliative patients, many of whom then occupy acute beds in the State's tertiary or general hospitals. A Cancer Council report on bed numbers for cancer patients found that:

> *the level of services for cancer patients will not be adequate, even when Fiona Stanley Hospital is built. There will not be enough beds to treat patients. Most cancer ancillary treatment is out-patient based. The report identified that there are not beds. When the cancer centre at Fiona Stanley Hospital opens, it will be full.*[638]

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634 Professor Samar Aoun, 2005, *Palliative Care in Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p2.

635 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pxv.

636 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p21.

637 Professor Samar Aoun, 2005, *Palliative Care in Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p22.

638 Ms Susan Rooney, Chief Executive Officer, Cancer Council WA, *Transcript of Evidence*, 31 August 2009, p4.

The importance of building new palliative care units is illustrated by the current impact of these patients on the State's main tertiary hospitals. Professor Aoun found that:

- in 2003-04, approximately 55% of separations for palliative care services were from tertiary hospitals, 30% for public patients from hospices/private palliative care units and 15% from non-tertiary hospitals; and
- between 2001-02 and 2003-04, palliative care separation activity has increased for both hospices and non-tertiary hospitals by about 5%, with the highest increase in the tertiary hospitals at about 17%. Overall, there was an increase of 11% in three years.

Finding 124

The Western Australian health system will continue to have insufficient public palliative care beds to meet the demand for these services, even at the end of the *Clinical Services Framework 2010-20* planning period in 2021.

Recommendation 87

The Government should increase the funding at the four general hospitals in the metropolitan area to provide at least an additional 35 palliative care beds.

(b) State programs

Surveys of patients with advanced illnesses consistently report that up to 80% of patients with cancer would prefer to die at home supported by family and friends, if given the choice.[639] Given the wide scope of palliative services offered across various parts of the health system, it is critical to ensure efficient linkages exist amongst disability services, community-based palliative care, hospital-based palliative care, and other health care providers. This would enable those receiving palliative care and their families to move freely between these places in response to their medical care and support needs. PCA suggests that "Quality care at the end of life is realised when strong networks exist between specialist palliative care providers, primary generalist, primary specialist and support care providers and the community."[640] For example, while Professor Aoun found that the community is the preferred place of care for most patients she also found that admission to a

639 Professor Samar Aoun, 2005, *Palliative Care In Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p14.

640 Palliative Care Australia, 'Strategic Plan 2008-2011'. Available at: www.palliativecare.org.au/Portals/46/docs/PCA%20strategic%20plan%20-%202008-2011.pdf. Accessed on 11 December 2009.

specialised palliative care inpatient facility may only occur during brief episodes of care (i.e. respite, symptom management, terminal phase of illness).[641]

Professor Aoun believes that patients who have suffered heart or kidney failure, or have neuro-degenerative disorders such as MND (motor neurone disease) and MS (multiple sclerosis) miss out on good palliative care because the State's health resources are stretched with dealing with cancer patients. She reports that specialists in general palliative care say "We have so much to do with the cancer population that we cannot possibly stretch our resources to cover the non-cancer care".[642] The key difference between the two cohorts is that the prognosis for cancer patients and how long they have to live is generally better understood. However, other neurodegenerative diseases have different, longer, pathways to death. Evidence was given to the Committee that this bias was beginning to change. About 15 years ago 95% of patients in a palliative care service had cancer while now "depending on where you are, that could be as low as 75% as other people with other conditions start to be referred and admitted."[643]

One major challenge still to be faced is to ensure that palliative care providers operate on a prognosis-based, not a needs-based, service provision. Silver Chain, for example, are reported as saying that they do not have the resources under their public contract to provide care for people with MND, which could endure for years or months, so they will only provide services to people in the last 60 days of their life.[644]

(c) Western Australians missing out on palliative care

A recent report on palliative care reinforced the cultural aspects hindering medical staff directing certain patients to this type of care, rather than to acute hospital beds, including intensive care units. Professor Ken Hillman told *Four Corners* that modern medicine is too focused on keeping patients alive, when palliative care services are less expensive and better able to meet a dying patient's needs, "we do it for what we consider are the best interests of patients. We want to look after them. We want to cure them. And in doing so we've set up a situation where it's very difficult to die peacefully."[645]

Professor Hillman reinforced the inappropriateness of continuing to try to keep patients alive in an ICU, "Most of us who work in Intensive Care, doctors and nurses, when we see elderly patients,

641 Professor Samar Aoun, 2005, *Palliative Care In Western Australia*, WA Centre for Cancer and Palliative Care, Bentley WA, p5.

642 Professor Samar Aoun, Director of the WA Centre for Cancer for Cancer and Palliative Care, Curtin University, *Transcript of Evidence*, 25 August 2009, p3.

643 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p8.

644 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p8.

645 Australian Broadcasting Corporation- Four Corners, 'A Good Death', 8 February 2010. Available at: www.abc.net.au/4corners/content/2010/s2813530.htm. Accessed on 9 February 2010.

serious illness, about to die, then we all say to each other please don't let this happen to us."[646] This program also highlighted the cost differential between the two approaches to patient care: $3,000-4,000 per day for an ICU bed versus $600-$1,600 per day for a palliative care bed.

Recent research of people who died in Western Australia during the period 1 July 2000 to 31 December 2002 has given an insight into those who miss out on palliative care. Two-thirds of the people who died of cancer received specialist palliative care (SPC) - either community-based, hospital-based, or both. However, less than 10% of those who died of non-cancer conditions received SPC (see Table 14.4 below). Those who died of cancer were significantly less likely to receive SPC services if they were:

- single;
- widowed;
- aged over 85 years; or
- lived in a region other than a major city.

Although numbers were small when compared with non-Indigenous deaths, Indigenous people were more likely to have been provided specialist palliative care (SPC). Of those who died of non-cancer conditions, most patients (other than those who were married) were significantly less-likely to have accessed SPC than cancer sufferers (see Table 17.4 below).[647]

646 Australian Broadcasting Corporation- Four Corners, 'A Good Death', 8 February 2010. Available at: www.abc.net.au/4corners/content/2010/s2813530.htm. Accessed on 9 February 2010.

647 Professor Lorna Rosenwax, & Professor Beverley McNamara, 2006, 'Who receives specialist palliative care in Western Australia- and who misses out', *Palliative Medicine*, vol. 20, p441.

Table 17.4- Western Australian patients who received specialist palliative care during the last 12 months of their life, 2000-03[648]

Diagnosis	Proportion of patients	Received only community-based SPC	Received only hospital-based SPC	Received community and hospital-based SPC	Did not receive SPC
Cancer	55.0%	24%	19%	25%	32%
Both cancer and non-cancer conditions	4.5%	20%	13%	15%	52%
Non-cancer conditions amenable to palliative care	40.5%	3%	4%	1%	92%

The lack of uptake of palliative care for those aged over 85 years is of particular concern. Compared with those aged between 75 and 84 years of age, this group is proportionally less likely to have accessed SPC in both hospital and community settings for either cancer or non-cancer conditions.

Professors Rosenwax and McNamara report that:

> *Although this older group may be more likely to reside in an aged-care facility, it cannot be assumed that symptoms and psychosocial support are of less concern to these people and their families, or that adequate palliative care standards are being met in these facilities. As the proportion of deaths from malignancy decreases after 75 years, SPC focused upon care of cancer patients discriminates against older people.*[649]

Evidence to the Committee suggested that any new palliative care units (PCUs), especially in regional areas, need to be incorporated into a hospital. The Cancer Council of WA said there are real benefits for PCUs being located on a hospital ground, otherwise patients would need to be transported for X-rays and for pain relief. The Cancer Council also endorsed the views of Professor Aoun that these units needed a minimum of 10 beds, "The base number is 10 beds. It is more to do with nursing levels. A certain number of beds are needed for the number of nurses there are. It is also about physically making it viable."[650]

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648 Professor Lorna Rosenwax, & Professor Beverley McNamara, 2006, 'Who receives specialist palliative care in Western Australia- and who misses out', *Palliative Medicine*, vol. 20, p442.

649 Professor Lorna Rosenwax, & Professor Beverley McNamara, 2006, 'Who receives specialist palliative care in Western Australia- and who misses out', *Palliative Medicine*, vol. 20, p442.

650 Ms Susan Rooney, Chief Executive Officer, Cancer Council WA, *Transcript of Evidence*, 31 August 2009, p4.

Given the small budget for palliative patients in the State's health budget (compared to capital items such as hospitals) the chief limitation to expanding these services is workforce issues. While the number of people in Western Australia with cancer is growing, the Cancer Council gave evidence that:

> *WA has the lowest number of oncologists per population in Australia, we have a shortage of radiation oncologists, and there are shortages in various other workforce areas that are consistent in radiotherapy across the country and internationally.*[651]

Their view of the importance of workforce shortages was reinforced by the Prime Minister, who said "the future shortages of doctors, the future shortages of nurses, and other allied health professionals, is frankly very stark and very sobering."[652]

The total State budget for palliative care recurrent expenditure for 2009-10 totals $22.4 million, with the State Government providing $21.1 million and the Federal Government $1.3 million. The Federal component is comprised of:

- Department of Veterans Affairs - funds to treat veterans - $1.140 Million;
- Palliative Home Care Grant - Paediatric Palliative Care - $67,000; and
- Palliative Home Care Grant - Palliative Care Community Medications - $50,000.[653]

New policy initiatives in palliative care funded by the State Government in the 2009-10 Budget include:

- the development of the 'living wills' legislation by the Attorney General's Department and the Department of Health;[654]
- an additional $1 million to enhance the State-wide paediatric service at Princess Margaret Hospital to boost nursing to 1.4 FTE;[655] and
- a $14 million fund over four years to help properly manage patients with cancer, particularly in rural areas.

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651 Ms Susan Rooney, Chief Executive Officer, Cancer Council WA, *Transcript of Evidence*, 31 August 2009, p4.

652 Cited in Mr Dennis Shanahan, 'Health care should become the big battleline', 11 December 2009. Available at: www.theaustralian.com.au/news/opinion/health-care-should-become-the-big-battleline/story-e6frg75f-1225809216787. Accessed on 11 December 2009.

653 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), Supplementary Information No B27, 28 May 2009, p593b-595a.

654 Hon Dr Kim Hames, Minister for Health, WA, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), Supplementary Information No B27, 28 May 2009, p593b-595a.

655 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p8.

Health Minister, Dr Kim Hames, reported that the $14 million commitment for cancer patients will be spread over both metropolitan and country areas, with a particular focus on remote, rural and Indigenous communities. The program will establish teams that will help people manage the end stage of their cancer in their own homes, if that is their choice, and will be managed by the Western Australian Cancer and Palliative Care Network.[656] This program will also try to regularise the list of drugs used by palliative care services across the State and develop a network of community pharmacists who will stock drugs commonly used in palliative care. In country areas it is often difficult to access these drugs after hours and on a weekend in the quantities required.[657]

The Committee heard from the Cancer Council that Western Australia currently has only 65% of the radiation oncologists it needs to provide adequate cancer services and needs another nine of these specialists. Also, a shortage of medical physicists has delayed the introduction of new radiation therapy technologies. There is also a shortage of special equipment such as linear accelerators. Western Australia has only 10 in its private and public hospitals but needs 16, with an additional one being added every 2-3 years due to population growth.[658]

Palliative Care WA reported another area of concern, that is not a problem in other jurisdictions, is the end-of- life experience for people living in residential aged-care facilities. This is a system predominantly funded by the Federal government. Staff in these homes receive training to provide basic primary-level, end-of-life care. However, a proportion of their patients need specialist input. PCWA reported that "Silver Chain, which is the community palliative care provider in this State, does not have the resources to support those aged-care facilities and see those patients as much as we think they should."[659]

In other jurisdictions, the state-funded palliative care provider will provide services on a needs basis to whoever lives in their catchment, whether they live in a caravan, a prison or an aged-care facility. The Palliative Care Network is instituting a 'link nurse' project in Western Australia to identify a key nurse in an aged-care facility and link them with the local palliative care service so there is a proactive flow of information and training. This has been done in other jurisdictions and has been shown to be an effective method of improving the quality of patient care and reducing inappropriate admissions to hospitals.[660]

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656 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 May 2009, pp4458b-4458b.

657 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p11.

658 Submission No. 46 from Cancer Council of WA, 10 March 2010, pp30-38.

659 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p13.

660 Mr William Hallahan, Executive Officer, Palliative Care WA Inc, *Transcript of Evidence*, 25 August 2009, p13.

Finding 125

The use of 'link nurses' has proven beneficial to the end-of-life experience for palliative care patients in aged-care facilities in other jurisdictions.

Recommendation 88

The State Government should allocate additional funds to providers, such as Silver Chain, to allow the provision of comprehensive palliative care services to people living in aged-care facilities.

(d) Federal Government's National Palliative Care Program

The Federal Government's National Palliative Care Program consists of:

- *Palliative Care in the Community* – to improve the standard of palliative care in the community;
- *Palliative Care National* - $14 million over four years;
- *Rural Palliative Care Project*, managed by the Australian General Practice Network; and
- *Strengthening Palliative Care Services* (local palliative care grants) –to help health-related services provide better support to people needing palliative care, and their families.

In addition, the Federal Government has provided $500 million to all jurisdictions for the improvement of their sub-acute care services (including palliative care) under the Council of Australian Governments' National Partnership Agreement on Hospital and Health Workforce Reform.[661] Also, many medicines used in palliative care are available under the Pharmaceutical Benefits Scheme (PBS). Recent initiatives include the announcement in December 2009 by the Minister for Ageing, Hon Justine Elliot, that 187 palliative care services across Australia will share $2.6 million in funding to help them upgrade their syringe driver equipment.[662]

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661 Department of Health and Ageing, 'Palliative Care',. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-program.htm. Accessed on 11 December 2009.

662 These devices deliver measured doses of medications via a syringe at a constant and controlled rate. Hon Justine Elliot MP, Minister for Ageing, 'Better equipment to assist terminally ill patients', 10 December 2009. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-je-je137.htm?OpenDocument. Accessed on 11 December 2009.

(e) Carers

Carers who are friends and family of older people and those with terminal illnesses provide the majority of their care requirements. An Australian report on the needs of these carers found they need:

- to access adequate and flexible resources;
- fairer remuneration;
- more respite care;
- better training and equipment;
- counselling and bereavement support;
- personal and home help; and
- improved access to the paid workforce.[663]

The Federal Government provides a means-tested carer payment via Centrelink to around 500,000 people. The Carer Payment provides income support if carers are unable to support themselves through substantial paid employment because they are caring for someone aged 16 years or over on a daily basis "who has a severe disability, medical condition or who is frail aged".[664] In the 2009-10 Budget, the Federal Government announced an increase to the allowances paid to carers so that "A single carer who receives both full rate Carer Payment and Carer Allowance will get two supplement payments totalling $1200, plus an annual pension increase of $1689, bringing additional permanent increases in this Budget to $2,889 a year."[665]

The needs of special groups were also highlighted by Palliative Care Australia, in particular older and younger carers, those from an Indigenous or CALD background, those living in rural areas and those with chronic disabling conditions whose eligibility to access palliative care is restricted.[666] The Committee heard in evidence at a regional town of the difficulty some carers find when looking after their partners "Easily 60% of assessments that I do are being cared for by

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663 Palliative Care Australia, 2004, *The Hardest Thing We Have Ever Done- The Social Impact Of Caring For Terminally Ill People In Australia*, Palliative Care Australia, Deakin West ACT, p9.

664 Centrelink, 'Carer Payment (caring for a person 16 years or over)', 15 January 2010. Available at: www.centrelink.gov.au/internet/internet.nsf/payments/carer_adult.htm. Accessed on 4 February 2010.

665 The Hon Jenny Macklin MP, Minister for Families, Housing, Community Services and Indigenous Affairs, 'Secure and Sustainable Pension Reform: New payment for 500,000 carers across Australia', 12 May 2009. Available at: www.treasurer.gov.au/DisplayDocs.aspx?doc=pressreleases/2009/052.htm&pageID=&min=wms&Year=&DocType=0. Accessed on 4 February 2010.

666 Palliative Care Australia, 2004, *The Hardest Thing We Have Ever Done- The Social Impact Of Caring For Terminally Ill People In Australia*, Palliative Care Australia, Deakin West ACT, p9.

someone equally as frail, and sometimes the carer has dependencies that are as high as the person we are providing the care to."[667]

Finding 126

People with a terminal illnesses requiring palliative treatment receive a substantial proportion of their care from friends and family. This results in far less cost to the State's health system than if their treatment was provided in a hospital.

Recommendation 89

The Government develop a specialised strategy to address the needs of carers who are friends and family of those receiving palliative care, which particularly addresses the needs of special groups, such as younger and older carers, those from Indigenous and Culturally and Linguistically Diverse backgrounds, and those living in rural areas.

Recommendation 90

The Department of Health coordinate palliative care service funding and service provision across all levels of government (Federal, State and local) to ensure the equitable social and geographical distribution of services in Western Australia.

Recommendation 91

The Government should develop a strategy to meet the increased future demands for cancer services and palliative care, and incorporate it into the next version of the Clinical Services Framework.

667 Mrs Jeanette Fegan, District Community Care Coordinator- Merredin District Hospital, WA Country Health Service, *Transcript of Evidence*, 7 September 2009, p8.

APPENDIX ONE

SUBMISSIONS RECEIVED

List of Submissions received for the Inquiry.

Submission Number	Date	Name	Organisation
1	8 December 2008	Mr Brad Sebbes	Department of Health
2		Dr Philip Montgomery	Department of Health
3		Dr Peter Flett	Department of Health
4	7 July 2009	Ms Glenda Brown	
5	13 July 2009	Mr Nigel Baker	Cystic Fibrosis Western Australia
6	10 June 2009		Woodvale Private Hospital for Women
7	17 June 2009	Ms Yasmin Naglazas	Bethesda Hospital
8	25 June 2009	Dr Peter Flett	Department of Health
9	4 June 2009	Dr Shane Kelly	St John of God Hospital, Subiaco
10	27 May 2009	Ms Robyn Lewis	St John of God Hospital, Murdoch
11	28 May 2009	Ms Marcia Everett	South Perth Hospital
12	29 May 2009	Mr Justin Walter	Mount Hospital
13	14 July 2009	Mr Stephen Wisnewski-Smith	Peel Health Campus
14	16 July 2009	Mr Maurice Swanson	Heart Foundation
15	16 July 2009	Ms Michele Kosky	WA Advisory Committee on HIV/AIDS and STIs
16	29 July 2009	Ms Marlene Browne, Ms Eve Lucas and Ms Catherine Kapiteyn	Principal Gladys Newton, Sir David Brand and Burbridge schools

17	29 July 2009	Professor C. Brook	Department of Human Services, VIC
18	28 July 2009	Hon Dr Kim Hames	Minister for Health
19	3 August 2009	Dr Nigel Armstrong and Dr Kevin Warr	Clinical Service Executive, RPH
20	31 July 2009	Mr Ken Marston	Council on the Ageing Western Australia Inc
21	31 July 2009	Ms Susan Rooney	Cancer Council Western Australia
22	31 July 2009		Connect Groups-Support Groups Association of WA Inc
23	3 August 2009	Ms Maxine Drake	Health Consumers' Council
24	26 August 2009	Ms Michelle Scott	Commissioner for Children and Young People
25	3 August 2009	Assoc Prof Barby Singer	University of Western Australia
26	3 August 2009	Ms Gail Cutts	Shire of Manjimup
27	4 August 2009	Ms Pip Leedham	Department of Health and Human Services, TAS
28	6 August 2009	Hon Katy Gallagher, MLA	ACT Government
29	4 August 2009	Mr Will Hallahan	Palliative Care WA Inc
30	11 August 2009	Professor Peter Howat	Public Health Advocacy Institute of WA
31	12 August 2009	Mr Kim Snowball	WA Country Health Service
32	12 August 2009	Dr Ron Chalmers	Disability Services Commission
33	18 August 2009	Dr Peter Flett	Department of Health
34	24 August 2009	Hon John Della Bosca, MLC	Government of NSW

35	24 August 2009	Hon John Hill, MP	Government of SA
36	27 August 2009	Ms Rhonda Kerr	Recovery Inn
37	24 August 2009	Hon Maxine Morand, MP	Government of Victoria
38	30 August 2009	Dr John Wray	
39	14 September 2009	Professor Harvey Coates	
40	21 September 2009		Baptistcare (Great Southern)
41	18 September 2009		Community Health Nurses WA
42	20 September 2009	Professor Linda Shields	Curtin University of Technology
43	9 September 2009	Hon Kon Vatskalis, MLA	NT Government
44	20 September 2009		Combined Universities Centre for Rural Health for the Office of Aboriginal and Torres Strait Islander Health
45	25 February 2010	Ms Amanda Tilbury	
46	2 March 2010		Cancer Council of WA
47-50	10 March 2010	Mr Ernie Bridge	Unity of First People of Australia

APPENDIX TWO

HEARINGS HELD

List of Hearings held for the Inquiry.

Date	Name	Position	Organisation
8 December 2008	Dr Peter Flett	Director General	Department of Health
	Dr Philip Montgomery	Executive Director, Royal Perth Hospital	Department of Health
	Mr Bradley Sebbes	Executive Director, Fiona Stanley Hospital	Department of Health
18 March 2009	Dr Peter Flett	Director General	Department of Health
	Dr Robyn Lawrence	Executive Director, Innovation and Health System Reform	Department of Health
	Dr Philip Montgomery	Executive Director, Royal Perth Hospital	Department of Health
	Mr Bradley Sebbes	Executive Director, Fiona Stanley Hospital	Department of Health
	Ms Jodie South	Senior Project Manager, Infrastructure	Department of Health
19 August 2009	Mr Philip Aylward	Executive Director, Child and Adolescent Health Service	Department of Health
	Mr Mark Morrissey	Executive Director, Child and Adolescent Community Health	Department of Health
	Ms Jodie South	Senior Project Manager, Infrastructure	Department of Health
25 August 2009	Dr Nigel Armstrong	Psychiatrist, Royal Perth Hospital	Department of Health
	Dr Steven Patchett	Executive Director, Mental Health	Department of Health

	Professor Samar Aoun	Director of Research, WA Centre for Cancer and Palliative Care	Curtin University of Technology
	Mr William Hallahan	Executive Officer	Palliative Care WA Inc
	Professor Gary Geelhoed	President	Australian Medical Association (WA)
	Mr Peter Jennings	Deputy Executive Director	Australian Medical Association (WA)
26 August 2009	Ms Michelle Scott	Commissioner	Commissioner for Children and Young People (WA)
	Ms Amy Tait	Principal Policy Officer	Commissioner for Children and Young People (WA)
	Mr Kim Snowball	Chief Executive, WA Country Health Service	Department of Health
	Mr Kenneth Marston	Executive Director	Council on the Ageing WA Inc
	Ms Gail Milner	Operational Director, Innovation and Health System Reform	Department of Health
	Mr Neil Guard	Executive Director	Drug and Alcohol Office
	Mrs Myra Browne	Director, Policy, Strategy and Information	Drug and Alcohol Office
	Mr Eric Dillon	Director, Client Services	Drug and Alcohol Office
	Mrs Roslyn Elmes	Executive Director, Public Health and Ambulatory Care	Department of Health
	Dr Amanda Frazer	Executive Director, Women and Newborn Health Service, King Edward Memorial Hospital	Department of Health
	Professor D'Arcy Holman	Chair in Public Health	University of Western Australia
31 August 2009	Dr John Wray	Paediatrician	Department of Health

	Mr Tony Ahern	Chief Executive Officer	St John Ambulance WA
	Mr Stephen Wisnewski-Smith	Chief Executive Officer	Peel Health Campus
	Ms Gayle Hillen	Occupational Therapist	Kidz OT Essentials
	Ms Lynne Middleton	Speech Pathologist	
	Mr Maurice Swanson	Chief Executive Officer	National Heart Foundation (WA)
	Ms Susan Rooney	Chief Executive Officer	Cancer Council WA
	Ms Denise Sullivan	Director, Tobacco Programs	Cancer Council WA
1 September 2009	Mr David Kelly	Secretary	Liquor, Hospitality and Miscellaneous Union
	Mr John Thomas	Station Manager	St John Ambulance WA
	Dr Cori Williams	Speech Pathologist and Lecturer, School of Psychology and Speech Pathology	Curtin University of Technology
	Mr Justin Walter	General Manager	Mount Hospital
	Mr Christopher McGowan	Chief Executive Officer	Silver Chain
	Mr Kempton Cowan	Chief Executive Officer	Joondalup Health Campus
	Mr Kevin Cass-Ryall	State Manager, Operations, WA/SA	Ramsay Health Care, Hollywood Private Hospital
	Mr Vaughan Harding	Chief Executive Officer	Uniting Church Homes
	Mr Garry England	Chief Executive	Mercy Hospital, Mount Lawley
	Ms Michelle Kosky	Executive Director	Health Consumers' Council WA
	Ms Maxine Drake	Advocate	Health Consumers' Council WA

	Dr Lewis Marshall	Sexual Health Physician, Infectious Diseases Department, Fremantle Hospital	Department of Health
7 September 2009 MERREDIN	Ms Elizabeth Marmion	Acting Operations Manager, Eastern Wheatbelt, WACHS Merredin Hospital	Department of Health
	Mr Cecil Stones	Health Service Manager, WACHS Merredin Hospital	Department of Health
	Councillor Ken Hooper	Shire President	Shire of Merredin
	Mr Frank Ludovico	Chief Executive Officer	Shire of Merredin
	Councillor Julie Townrow	Shire Councillor	Shire of Merredin
	Mrs Wendy Jardine	Primary Health Manager, WACHS, Wheatbelt Population Health	Department of Health
	Mrs Shelley Lombardini	Project Coordinator	Eastern Wheatbelt Early Years Network
	Dr Gabriel Adeniyi	Medical Practitioner	Merredin Medical Clinic
	Mrs Beth Gearing	Liaison Officer	Merrittville Retirement Village
	Mrs Jeanette Fegan	District Community Care Coordinator, WACHS Merredin Hospital	Department of Health
	Mrs Bree Hetherington	Occupational Therapist, WACHS Merredin Hospital	Department of Health
	Ms Suzann Franklin	Clinical Nurse, Eastern Wheatbelt Aboriginal Health	Department of Health
	Mr Michael Hayden	Chairperson	Merredin Aboriginal Project
	Mr Eric Nordberg	Regional Manager, Wheatbelt Community Drug Service Team	Holyoake Australian Institute for Alcohol and Drug Addiction Resolutions

	Mr Luke Turner	Diversion Officer and Counsellor-Educator	Wheatbelt Community Drug Service Team
	Sgt Michael Daley	Acting Officer in Charge, Police Station, Merredin	WA Police
11 September 2009 ALBANY	Mr Garry Adams	Acting Regional Director, WACHS Great Southern	Department of Health
	Ms Suzanne Seeley	Nurse Director, WACHS Great Southern	Department of Health
	Dr Jonathon Mulligan	Medical Director, WACHS Great Southern	Department of Health
	Mr Mark Robinson	Acting Operations Manager, Albany Hospital, WACHS Great Southern	Department of Health
	Mr Bruce Manning	Chief Executive Officer	Great Southern Development Commission
	Mr Russell Pritchard	Regional Manager	Great Southern Development Commission
	Mr William Madigan	Executive Director	City of Albany
	Mr Peter King	Director	St John Ambulance Australia (WA) Inc
	Mr Ashley Wilson	Regional Manager	St John Ambulance Australia (WA) Inc
	Miss Stacey Abbott	Station Manager	St John Ambulance Australia (WA) Inc
	Mr Moray McSevich	District Director	Department for Child Protection, Great Southern
	Mr Juan Clark	Manager, Community Health, WACHS Great Southern	Department of Health
	Ms Suzanne Millar	Regional Manager, Aged-care, WACHS Great Southern	Department of Health

	Ms Natalie Galantino	Service Coordinator	Silver Chain, Great Southern
	Mr Andrew Markovs	Manager	Men's Resource Centre
	Mr Lester Coyne	Manager, Aboriginal Health, Great Southern Aboriginal Health Service	Department of Health
	Ms Sandra Crowe	Population Health Director, WACHS Great Southern	Department of Health
	Superintendent Dene Leekong	Great Southern District Office	WA Police
	Mr Bryan Taylor	Community Drug Service Team	Palmerston-Great Southern
	Ms Marcelle Cannon	Regional Manager, Mental Health Service, WACHS Great Southern	Department of Health
	Ms Melinda Misson	Team Manager, Mental Health Service, WACHS Great Southern	Department of Health
14 September 2009 KALGOORLIE	Ms Geraldine Ennis	Regional Director, Kalgoorlie Regional Hospital, WACHS Goldfields	Department of Health
	Dr Peter Barratt	Medical Practitioner, Kalgoorlie Regional Hospital, WACHS Goldfields	Department of Health
	Ms Karen De Bonde	Goldfields Regional Nurse Director, WACHS Goldfields	Department of Health
	Ms Lucy Murphy	Coordinator of Nursing, Kalgoorlie Regional Hospital, WACHS Goldfields	Department of Health
	Mr David Bowdidge	Operations Manager, WACHS Goldfields	Department of Health
	Mr Anthony Chisholm	Acting Chief Executive Officer	City of Kalgoorlie-Boulder

	Mr Robert Hicks	Chief Executive Officer	Goldfields-Esperance Development Commission
	Dr Charles Douglas	Public Health Physician, Goldfields Population Health, WACHS Goldfields	Department of Health
	Dr Anne Mahony	Director, Population Health, WACHS Goldfields	Department of Health
	Mrs Karine Miller	Regional Coordinator, Community Nursing, WACHS Goldfields	Department of Health
	Mrs Erin Bond	Allied Health Coordinator, Population Health, WACHS Goldfields	Department of Health
	Mrs Sharon Lenton	Regional Aged-care Manager, Aged-care Unit, WACHS Goldfields	Department of Health
	Ms Lisa O'Loughlin	Administration Officer	Eastern Goldfields Community Centre
	Ms Sherryl Wolfenden	Regional Manager, MPS and Aged-care, WACHS Goldfields	Department of Health
	Ms Sue Cristopoulos	Manager, Clinical Services	Bega Garnbirringu Health Service
	Miss Karen Kujawski	Manager, Social Support Unit	Bega Garnbirringu Health Service
	Associate Professor Christine Jeffries-Stokes	Paediatrician, Kalgoorlie Regional Hospital WACHS Goldfields	Department of Health
	Miss Deborah Clark	Chairperson	Kalgoorlie Local Drug Action Group
	Ms Rosemary Hunt	Executive Manager	Centrecare
16 September 2009	Mr Timothy Shackleton	Chief Executive Officer	Royal Flying Doctor Service (Western Operations)

	Professor Harvey Coates	Senior ENT Surgeon, Princess Margaret Hospital for Children	Department of Health
21 September 2009 KATANNING	Mrs Fiona Berger	Acting Director of Nursing—Health Service Manager, Katanning Health Service, WACHS Great Southern	Department of Health
	Dr Nicolas du Preez	General Practitioner, Katanning Health Service, WACHS Great Southern	Department of Health
	Ms Lynette Davey	Psychologist	
	Mr Robert Douglas	Executive Manager, Community Development	Baptistcare
	Ms Suzanne Millar	Manager Aged-care, WACHS Great Southern	Department of Health
	Ms Claire Heffernan	Manager, Community and Youth Justice	Department of Corrective Services
	Mr Gregory Crofts	Police Officer, Katanning Police Station	WA Police
	Mr Carl Beck	Deputy Chief Executive Officer and Manager of Community Services	Shire of Katanning
23 September 2009	Mr Philip Aylward	Executive Director, Child and Adolescent Health Service	Department of Health
	Mr Mark Morrissey	Executive Director, Child and Adolescent Community Health	Department of Health
	Mrs Margaret Abernethy	Senior Policy Officer, Child and Adolescent Community Health	Department of Health
	Mr Darryl Kickett	Former CEO and Spokesperson	Aboriginal Health Council of Western Australia
	Mr Peter Mott	Chief Executive Officer	St John of God Hospital Murdoch

14 October 2009	Professor Mike Daube	Professor of Health Policy	Curtin University of Technology
	Mr David Smith	Deputy Director General	Department of the Premier and Cabinet
10 November 2009	Dr Peter Flett	Director General	Department of Health
11 November 2009	Ms Carol Cheney	Principal Policy Officer	Department of Health
	Mr Mark Miller	Manager, Intergovernmental Relations	Department of Health
18 November 2009	Ms Susan Ash	Chief Executive Officer	WA Council of Social Service
	Mr Timothy Marney	Under Treasurer	Department of Treasury and Finance
12 February 2010	Ms Susan Oliver		
	Ms Brigitte Rodda		
	Ms Amanda Tilbury		
16 February 2010	Mr Kim Snowball	Acting Director General	Department of Health
	Dr Robyn Lawrence	Executive Director, Innovation and Health System Reform	Department of Health
	Ms Jodie South	Acting Director, Clinical Modelling and Infrastructure	Department of Health

APPENDIX THREE

BRIEFINGS HELD

List of Briefings held for the Inquiry.

Date	Name	Position	Organisation
28 September 2009	Dr David Panter	Executive Director, State-wide Service Strategy	Department of Health, SA
	Ms Kerrie Bowering	Director, Child and Family Health Service	Children, Youth and Women's Health Service, Department of Health, SA
	Ms Sharyn Delahoy-Galwey	Clinical Services Coordinator	Children, Youth and Women's Health Service, Department of Health, SA
	Ms Joan Gilbert	Director, Education and Care	Children, Youth and Women's Health Service, Department of Health, SA
	Dr Peter Harvey	Senior Lecturer/Manager	Flinders University
30 September 2009	Dr Richard Matthews	Deputy Director General, Strategic Development	NSW Health
	Mr Todd Harper	Chief Executive Officer	VicHealth
	Mr Andrew Abbott	General Manager, Strategy and Coordination	Department of Education and Early Childhood Development, VIC
	Dr Sharon Goldfeld	Principal Medical Advisor	Department of Education and Early Childhood Development, VIC

9 December 2009	Ms Alice Burchill	Deputy Secretary, Care Reform	Department of Health and Human Services, TAS
	Ms Pip Leedham	Director, System Reform	Department of Health and Human Services, TAS
	Mr Michael Pervan	Chief Executive Officer, Southern Area Health Service	Department of Health and Human Services, TAS

APPENDIX FOUR

STATUS OF REID REPORT RECOMMENDATIONS[668]

Recommendation Number	HRC Recommendation	HRIT Final Project Name	Completed	In-progress	Not commenced
1	Health System Objectives	Health System Objectives	X		
2	Promotion and Prevention Programs	Integrated Lifestyle Program	X		
3	Promotion and Prevention Program - Falls	Promotion and Prevention Programs - Falls Prevention Program	X		
4	Primary Care Summit	Primary Care Practitioners Summit	X		
5	Health Call Centre - Interface GPs, Community & Hospitals, and monitoring	Strategy for Health Call Centre	X		
6	Health Call Centre - Integrate with National Call Centre	Strategy for Health Call Centre	X		
7A	Discharge Summaries - To GP within 12 hours	Standardised Hospital Discharge Summaries		X	
7B	Discharge Summaries - Standardised Electronic format	Standardised Hospital Discharge Summaries		X	
8	Early Discharge Programs	Healthy@Home Program - Chronic Disease Management Teams	X		

668 Mr Kim Snowball, Acting Director General, Department of Health, Reply to Questions on Notice, 16 February 2010, pp6-13

9	GP After Hours Services at or adjacent to metro hospital sites	General Practice Services at Metropolitan Emergency Departments	X		
10	Care for Older Persons - Non Hospital Based Care Options	Healthy@Home Program - Hospital in the Home	X		
11	Care for Older Persons - Care Packages	Pathways Home	X		
12	Mental Health - Whole Of Government Framework	Collaborative Whole of Government Framework for Mental Health (Mental Health Strategy)	X		
13	Mental Health - Promotion & Prevention Program	Prevention and Early Intervention Programs and Services for Mental Health	X		
14	Mental Health - Community Based Care	Improving Community Based Mental Health Care	X		
15	Aboriginal Health - Primary Care Strategy	Primary Care Strategy for Aboriginal People	X		
16	Child & Maternal Health - Approach	Women's and Children's Health Service	X		
17	Evidence Based Clinical Guidelines	Evidence Based Clinical Guidelines	X		
18	Develop a System-Wide Clinical Information System	Patient Focused System Wide Clinical Information System		X	
19	Country Health Services Review Endorsed	Monitor Implementation of the Country Health Services Review	X		

20	Development of Integrated, Multi-Purpose District Health Services	Range of Projects		**X**	
21	Regional Resource Centres	Range of Projects		**X**	
22	Expand Telehealth	Enhancement of Telehealth	**X**		
23	Integrated Models Of Care	Clinical Services Plan	**X**		
24	Expand General Hospitals	Range of Projects		**X**	
25	Conjoint Clinical Staff Appointments	Conjoint Clinical Staff Appointments	**X**		
26	Reconfigure Hospitals - Other Metro	Range of Projects - Other Metropolitan Hospitals		**X**	
27	Reconfigure Hospitals - Fiona Stanley	New Southern Tertiary Hospital		**X**	
28	Reconfigure Hospitals - Fremantle	Reconfigure Fremantle Hospital		**X**	
29	Reconfigure Hospitals - SCGH/RPH	Central Tertiary (formerly Northern Tertiary) - Sir Charles Gairdner Hospital	**X**		
30	Single Clinical Management Structure between RPH and SCGH	Single Management & Clinical Staffing Structure Across RPH & SCGH	**X**		
31	Reconfigure Hospitals - KEMH & PMH	Co-locate King Edward Memorial Hospital			**X**
32	Evaluate and Establish Medi Hotel	Medi Hotel - Establish & Evaluate	**X**		
33	Tertiary Trauma and Emergency Services	State Trauma Centre	**X**		

34	Cardiothoracic - Operate as a single integrated service	Integrated Cardiothoracic Service	X		
35	Neurosurgery - Operate as a single integrated service	Integrate Neurosurgical Services	X		
36	Haemodialysis services	One Tertiary Centre/Centre of Excellence	X		
37	Haemodialysis - Home & Community Based haemodialysis expanded	State-wide Plan for Haemodialysis	X		
38	Transplant - Renal - Operate as a single integrated service	Integrated Renal Transplant Services	X		
39	Transplant - Liver, Heart, Lung - To continue as at present	Maintain Status Quo in Transplant Services for Liver, Heart and Lung	X		
40	Cancer - Establish State Centre for Cancer Care	State Cancer Services and Centre	X		
41	Palliative - Purpose built facilities incorporated into the 4 general hospitals	Expand Palliative Care Services	X		
42	Obstetrics - "WA State-wide Obstetric Services Review" implemented	Implementation of the WA State-wide Obstetric Services Review - Women's and Newborn Health Service (WNHS). Establish King Edward Memorial as a State-wide Centre of Excellence	X		
43	ICU - Increase number of adult & paediatric ventilated ICU beds	Increase Intensive Care Beds	X		
44	Outpatient services	Reconfigure Outpatient Services Provided at Tertiary Hospitals	X		

45	Elective Surgery-to be accommodated in the 4 general hospitals	Enhance Clinical Links	X		
46	Reduce Average Length of Stay	Reduce Average Length of Stay	X		
47	Improve rates of DOSA and Day Surgery	Improve Rates of Day of Surgery Admission And Day Procedures	X		
48A	Pathology - Implement review recommendations	Implement Review of Pathology Services	X		
48B	Pharmacy - Implement review recommendations	Implement Review of Public Hospital Pharmacy Departments		X	
48C	Food Services - Implement review recommendations	Implement Review of Hospital Food Services	X		
49A	Pathology - Operate as a single integrated service	Single Pathology Service	X		
49B	Pharmacy - System wide drug formulary & bar coding implemented	Implement Review of Public Hospital Pharmacy Departments	X		
49C	Food Services - Computerised food service system introduced	Implement Review of Hospital Food Services	X		
50	Procurement - Dedicated group established to drive reform	Develop and Implement Procurement Reform	X		
51	Oncology & Sterile Manufacture	Review of Oncology & Sterile Manufacturing		X	
52	Staff contribute to the development of a State Health Strategic Plan	State Health Strategic Plan	X		

53	Innovation	Develop and Implement an Innovations and Continuous Improvement Strategy	X		
54	Workforce planning tools developed	Develop Workforce Planning Tools	X		
55	Workforce Strategic Plan developed	Healthy Workforce Planning Framework	X		
56	New approaches to under + post graduate medical training	Develop & Implement New Approaches to Undergraduate & Post-graduate Medical Training	X		
57	Senior Advisor on Allied Health appointed	Chief Health Professional Officer	X		
58	Increase number of Aboriginal health professionals	Increase the Number of Aboriginal Health Professionals	X		
59	Establish State Research Policy Council & Plan	Develop a Collaborative Medical Research Strategy	X		
60	Clinical leadership appropriately recognised and supported	Recognise and Support Clinical Leadership	X		
61	Better role definition between AHS's & Royal Street	Health System Role Delineation	X		
62	Role definition for Royal Street	Health System Role Delineation	X		
63	Transfer/devolve all service delivery from Royal Street to AHS	Health System Role Delineation	X		
64	AHS CE's focussed on improving & maintaining health of their populations	Enhance and Implement Performance Agreements	X		

65	Rename State Health Management Team	Rename State Health Management Team to State Health Executive Forum	X		
66	Formal links between country and metropolitan AHS established	Establish Formal Links Between Country and Metropolitan AHS	X		
67	Community Advisory Committees established	Establish Community Advisory Committees in NMAHS, SMAHS and SWAHS	X		
68	Health Consumers Council provides regular formal feedback	Engage Health Consumers' Council (WA) to Provide Regular Feedback	X		
69	Metropolitan AHS structure to include only 3 AHS - North, South and W&C	Reconfigure Metropolitan Area Health Services	X		
70	WCHS responsible for coordinating and integrating a State-Wide service	Women's and Children's Health Service	X		
71	Improve joint Federal/State planning and service provision	Improve Joint Australian and State Government Planning and Service Provision, Integrated Models of Care and Pooled Funding	X		
72	RAM - Adopt a population and output based funding model	Develop and Implement a Population and Output Based Funding Model	X		
73	Implement comprehensive Performance Agreements between DG & C.E.s	Enhance and Implement Performance Agreements	X		

74	Implement Clinical Governance Framework	Implement a State-wide Clinical Governance Framework	X		
75	Promote regular performance monitoring & benchmarking	Health System Performance Framework	X		
76	Improve Budget Outcome Statement & KPIs	Health System Performance Framework	X		
77	(Quarterly) Community Report Card developed	Health System Performance Framework	X		
78	Health System data	Construct a Central Data Repository		X	
79	Reduce growth in expenditure - Various clinical reforms	Measure & Report on the Reduction of Growth in Health Expenditure	X		
80	Analysis of hospital cost drivers	Analysis of hospital cost drivers	X		
81	Pursue revenue raising initiatives	Optimise Revenue	X		
82	Capital investments supported by robust business cases, service provision planned & managed to achieve a 2% reduction in cost growth	Develop Robust Capital Planning & Business Case Processes for Capital Investment	X		
83	Develop a Health Reform Action Plan and Communication Strategy	HRIT Work Plan	X		
84	External Reference Group	Health Reform Implementation Steering Committee	X		
85	Health Reform Implementation Unit	HRIT	X		

86	Clinical Senate to be the principal advisory group on clinical reform	Role of the Clinical Senate	X		

APPENDIX FIVE

NGOS WHO RECEIVE FUNDING FOR MENTAL HEALTH PROGRAMS, BY REGION[669]

669 As at 27 August 2009. Reply to Question on Notice from Department of Health, Mental Health Division, 23 September 2009, p5.

Area	Service Provider	Service Type
Goldfields/South E	Bay of Isles Community Outreach Incor	Independent living skills support Psychosocial support
	Centrecare Incorporated	Carer/family support - education/information and skill development Early intervention - general Independent living skills support Psychosocial support Supportive landlord services
Goldfields/South East Total		
Great Southern	Albany Halfway House Association Inco	Community supported residential units Independent living skills support Intermediate care accommodation Psychosocial support Recreation
	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development
	Baptistcare	Psychosocial support
	Great Southern Community Housing As	Supportive landlord services
	Samaritan Befrienders of Albany Incorp	Early intervention - telephone services
	Schizophrenia Fellowship Albany and D	Independent living skills support Psychosocial support Recreation
Great Southern Total		
Kimberley	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development
Kimberley Total		
Metrowide	Amana Living	Specialist residential services
	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development Mental health promotion
	Association for Services to Torture and	Early intervention - general
	Curtin University of Technology	Mental illness prevention
	Daughters of Charity Services (WA) Ltd	Carer/family support - education/information and skill development Psychosocial support
	Even Keel (Bipolar Disorder Support As	Psychosocial support
	Fremantle Multicultural Centre	Individual advocacy
	ISHAR Multicultural Centre for Women'	Carer/family support - education/information and skill development
	June O'Connor Centre Incorporated	Recreation
	Mental Illness Fellowship of Western Au	Carer/family support - education/information and skill development Independent living skills support Psychosocial support Recreation
	Mercy Hospital	Clinical treatment and care - admitted
	PDLE	Pre-vocational training
	Perth Home Care Services Incorporated	Carer/family support - non admitted respite Psychosocial support
	Perth Inner City Youth Service	Psychosocial support
	Richmond Fellowship of WA	Independent living skills support Intermediate care accommodation Long-term supported accommodation Psychosocial support
	Southern Cross Care (WA) Incorporated	Specialist residential services
	Women's Healthworks	Psychosocial support
	Youth Focus Inc	Early intervention - general
Metrowide Total		
Midwest/Murchisor	Baptistcare	Crisis/respite accommodation Psychosocial support Supportive landlord services
	Fusion (Aust) Ltd	Community supported residential units
	Midwest Community Living Association	Recreation
Midwest/Murchison Total		
North Metro	55 Central Incorporated	Independent living skills support Psychosocial support

	ARAFMI Mental Health Carers & Friend	Recreation
	Casson House	Personal care support
	Disability in the Arts, Disadvantage in th	Recreation
	Dudley House	Personal care support
	Foundation Housing Association Incorp	Supportive landlord services
	Hills Community Support Group	Mental health promotion Psychosocial support Supportive landlord services
	Home Health Pty Ltd (trading as Tende	Carer/family support - non admitted respite Independent living skills support Psychosocial support Recreation
	Honeybrook Lodge	Personal care support
	Midland Women's Health Care Place In	Perinatal mental health service
	Perth Primary Care Network	Clinical treatment and care - non admitted
	Private Clinics Australia	Clinical treatment and care - admitted
	Richmond Fellowship of WA	Crisis/respite accommodation
	Romily House	Personal care support
	Rosedale Lodge	Personal care support
	Salisbury Home	Personal care support
	Southern Cross Care (WA) Incorporate	Carer/family support - non admitted respite Community options Independent living skills support Psychosocial support
	St Jude's Hostel (Pu-Fam Pty Ltd)	Personal care support
	The Salvation Army (Western Australia)	Independent living skills support Psychosocial support
	UnitingCare West	Supportive landlord services
	Vincentcare	Personal care support Psychosocial support
	Women's Health Care Association Inco	Clinical treatment and care - non admitted Perinatal mental health service Psychosocial support
	Woodville House	Personal care support
North Metro Total		
Pilbara/Gascoyne	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development
	Pilbara & Kimberley Care Incorporated	Carer/family support - non admitted respite Independent living skills support Psychosocial support Recreation
Pilbara/Gascoyne Total		
South Metro	Access Housing Association Incorporat	Supportive landlord services
	Burswood Psychiatric Hostel	Personal care support
	Daughters of Charity Services (WA) Ltd	Psychosocial support
	Devenish Lodge	Personal care support
	Franciscan House	Personal care support
	Fremantle GP Network	Early intervention - general
	Fremantle Women's Health Centre Inco	Perinatal mental health service
	Gosnells Women's Health Service Inco	Perinatal mental health service
	Richmond Fellowship of WA	Community options
	South Coastal Women's Health Service	Perinatal mental health service
	South Metro Personnel	Psychosocial support
	Southern Cross Care (WA) Incorporate	Carer/family support - non admitted respite Independent living skills support Psychosocial support
	St Bartholomew's House Incorporated	Community supported residential units Crisis/respite accommodation Supportive landlord services
	Support In-Site Incorporated	Recreation
	Wanslea Family Services Incorporated	Carer/family support - education/information and skill development
South Metro Total		
South West	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development
	Bunbury Pathways '92 Incorporated	Carer/family support - admitted respite Carer/family support - education/information and skill development

		Independent living skills support Psychosocial support Supportive landlord services
	Collie Family Centre Incorporated	Early intervention - general
	Home Health Pty Ltd (trading as Tender	Carer/family support - non admitted respite Independent living skills support Psychosocial support Recreation
	LAMP Incorporated	Carer/family support - education/information and skill development Independent living skills support Psychosocial support Recreation
	Richmond Fellowship of WA	Community supported residential units
South West Total		
Statewide	ARAFMI Mental Health Carers & Friend	Carer/family support - education/information and skill development Individual advocacy
	Beyondblue	Mental illness prevention
	Carers Association of Western Australia	Systemic advocacy
	Curtin University of Technology	Mental health promotion
	GROW (WA)	Psychosocial support
	Mental Illness Fellowship of Western Au	Mental health promotion
	Richmond Fellowship of WA	Psychosocial support Workforce development
	Silver Chain Nursing Association Incorp	Carer/family support - education/information and skill development Workforce development
	Telethon Institute for Child Health Rese	Mental illness prevention Research and evaluation
	The Samaritans Incorporated	Early intervention - general Early intervention - telephone services
	University of Western Australia (School	Mental health promotion Research and evaluation Workforce development
	University of Western Australia (School	Mental health promotion Research and evaluation Workforce development
	University of Western Australia (School	Research and evaluation Workforce development
	WA AIDS Council Incorporated	Early intervention - general
	WA Association for Mental Health Incor	Mental health promotion Systemic advocacy Workforce development
Statewide Total		
Wheatbelt	Hills Community Support Group	Supportive landlord services
	Home Health Pty Ltd (trading as Tender	Carer/family support - non admitted respite Independent living skills support Psychosocial support Recreation
	Share and Care Community Services G	Carer/family support - non admitted respite Independent living skills support Psychosocial support Recreation
Wheatbelt Total		

APPENDIX SIX

SUCCESSFUL HEALTH-RELATED REGIONAL GRANTS PROJECTS APPROVED FOR FUNDING 2008-09

APPLICANT	PROJECT TITLE	FUNDS (Ex GST)	REGIONAL TOTAL	PROPORTION OF TOTAL
GASCOYNE REGION			***$78,189***	**2.2%**
Drug and Alcohol Office	Scoping exercise to assess the need for a residential alcohol and drug facility in Carnarvon WA	$70,000		
Ngala Community Services	Ngala Online	$8,189		
GOLDFIELDS-ESPERANCE REGION			***$765,759***	**21.3%**
Bay of Isles Community Outreach Inc.	Mental Health Capacity Building -Esperance, Norseman, Ravensthorpe and Hopetoun)	$139,710		
Rural Clinical School of WA - UWA and Notre Dame University	Western Desert Kidney Health Project	$280,049		
The Esperance CT Scanner Project Inc	Esperance CT Scanner	$246,000		
Wannan Community Aboriginal Corporation	Internal refit – Wanarn Healthy Store	$100,000		
GREAT SOUTHERN REGION			***$370,000***	**10.3%**
Shire of Gnowangerup	Gnowangerup Medical Centre Upgrade	$120,000		
Shire of Jerramung	Medical Practitioners Accommodation for the Shire of Jerramungup	$200,000		
Shire of Katanning	Katanning Aged Housing Feasibility	$50,000		
KIMBERLEY REGION			***$526,245***	**14.7%**
Broome Aged & Disabled Services	Breakfast Club: Bran Nue Dae Community Care Services	$50,000		
EON Foundation Inc	EON Edible Gardens	$67,345		
Kimberley Division of General Practice	SNAP into LIFE in the Kimberley	$65,000		
Leaping Joey Pty Ltd	Fitzroy Valley Men's Shed	$50,000		
Marnja Jarndu Womens Refuge Inc	Child Support Facility	$18,000		
Ngala Community Services	Ngala Online	$30,900		
Shire of Derby West Kimberly	Derby Memorial Swimming Pool Redevelopment	$145,000		
Warmun Community Inc	Gija Total Health Project	$100,000		

MID WEST REGION			***$433,403***	**12.1%**
Aidan's Place Inc	Service Development Project for Aidan's Place Inc (Autism Intervention Development and Networking)	$45,651		
Karalundi Aboriginal Education Centre	KOPE with Life (Karalundi Outdoor Personal Enrichment Program)	$86,855		
Ngala Community Services	Ngala Online	$25,897		
St John Ambulance Australia WA Inc	New Ambulance Sub-centre Kalbarri (Stage 1)	$250,000		
St John Ambulance Sub Centre, Yalgoo WA	Yalgoo Sub Centre	$25,000		
PEEL REGION				
Shire of Boddington	Boddington Retirement Village Development	$136,000	***$136,000***	**3.8%**
PILBARA REGION			***$517,630***	**14.4%**
Ngala Community Services	Ngala Online – web based services for parents	$10,714		
Onslow Occasional Child Care Association	Upgrade existing childcare centre	$8,955		
Pannawonica Playgroup	Pannawonica Playgroup Upgrade	$20,961		
Senses Foundation	Specialist Training for People in the Region Caring for People who are Deaf/Blind	$37,000		
Shire of East Pilbara	The Pilbara Indigenous Women's Gathering in Newman in 2009	$40,000		
The Young Men's Christian Association of Perth Inc	Construction of the Karratha Early Learning Centre	$300,000		
Town of Port Hedland	Murdoch Drive Fitness and Rest Nodes	$100,000		
SOUTH WEST REGION			***$411,648***	**11.5%**
Agencies for South West Accommodation Inc	Men's Emergency Accommodation Service	$22,590		
Bridgetown Family and Community Centre Inc	Maggie Dent Tour: Understanding and Preparing our Children for Life's Ups and Downs	$6,500		
Bunbury Rotary Club Inc	Leschenault and Districts Men's Shed	$30,000		
Bunbury Wellington Economic Alliance	South West Medical Attraction taskforce	$20,000		
Investing in Our Youth Inc	Development and Implement a Marketing Plan	$5,000		
Riding for the Disabled Association of Western Australia Collie Group In	Arena Fencing Project	$6,960		
Riverlinks Child Care and Communty Centre Inc	Outside Play Area Upgrade	$13,400		

Shire of Donnybrook-Balingup	Donnybrook Medical Centre	$85,000		
South West Women's Health and Information Centre Inc	Wellness Programme for Women	$75,000		
Val Lishman Health Research Foundation Inc	Systematic Discovery of Familial Hypercholesterolaemia (FH) in the South West of Western Australia	$147,198		
WHEATBELT REGION			***$349,850***	**9.7%**
Anglican Parish of Wongan Hills - Dalwallinu	Early Childhood and Family Expo	$5,000		
Child Inclusive Learning and Development Australia (Child Australia) Inc	Wheatbelt Regional Childcare Support (WRCS)	$125,000		
St John Ambulance Association (WA) Inc	Williams St John Ambulance New Training Facility and Ambulance Garage	$70,000		
WA Country Health Service - Wheatbelt Mental Health Service	Youth Mental Health and Drug/ Alcohol Misuse - Improving Treatment Access - 2 year Pilot	$149,850		
TOTAL			***$3,588,724***	

APPENDIX SEVEN

LIST OF THE DOH PROJECTS DEFERRED UNDER ADJUSTMENTS RESULTING FROM THE DEPARTMENT OF TREASURY AND FINANCE'S CAPITAL WORKS AUDIT[670]

(a) Projects *deleted* from the DOH Capital Works Program

- Sir Charles Gairdner Hospital Development Stage 1- a significant proportion of the Diagnostic and Treatment Centre Component of the SCGH redevelopment;
- Osborne Park Hospital Redevelopment Stage 1, phase 2- a range of projects including expansion of day therapies, upgrade to wards, additional beds for medical-type patients, and non-clinical support services; and
- Carnarvon Integrated District Health Service Redevelopment Stage 2- included small ED expansion, review of engineering services, relocation of community and population health.

(b) Projects where capital allocation was *reduced*

- Equipment replacement program- reduction in forward years capital allocation based on assumption of introducing a leasing strategy for the future;
- WACHS 12 Year various- a holding fund for WACHS to fund urgent works. Fund was reduced;
- PMH redevelopment/replacement- reduction of total allocation to reflect a change in proposed location on QEII site, removing the need to fund a relocation of LMN blocks; and
- RPH Redevelopment Fees- reduction in overall allocation, with a proportion of the remaining allocation brought forward by 1-2 years.

(c) Projects which were *deferred*

- New Midland Health Campus- deferred by 18 months;
- Esperance Integrated District Health Service Redevelopment - deferred by 12 months;
- Harvey Hospital Redevelopment- deferred by 24 months; and
- Busselton Integrated District Health Service Replacement- deferred by 24 months.

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670 Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p4.

APPENDIX EIGHT

WESTERN AUSTRALIA'S PRIVATE HOSPITAL BED NUMBERS - MAY 2009[671]

Facility	Location	Bed Numbers
Albany Community Hospice	Albany	4 (palliative)
Attadale Private Hospital	Attadale	38
Bethesda Hospital	Claremont	88
Busselton Hospice	Busselton	2 (palliative)
Glengarry Private Hospital	Duncraig	110
Hollywood Private Hospital	Nedlands	494
Joondalup Health Campus	Joondalup	70*
Mercy Hospital	Mount Lawley	212
Mount Hospital	Perth	220
Mount Lawley Private Hospital	Mount Lawley	24
Ngala Family Resource Centre	Kensington	30 (parenting)
Niola Private Hospital	West Leederville	18 (psychiatric)
Peel Health Campus	Mandurah	181
Perth Clinic	Perth	98 (psychiatric)
South Perth Hospital	South Perth	48
St John of God Hospital - Bunbury	Bunbury	155
St John of God Hospital - Geraldton	Geraldton	60
St John of God Hospital - Murdoch	Murdoch	382#
St John of God Hospital - Subiaco	Subiaco	623

671 Submission No. 8 from Department of Health, 25 June 2009, pp6-7. A full list of services provided at these facilities is contained in the DOH submission available on the Committee's web site.

The Marian Centre	Wembley	31 (psychiatric)
Waikiki Private Hospital	Waikiki	45

* Dedicated private beds located in the joint public/private Joondalup Health Campus. A new private hospital containing 85 beds in Stage 1 (with 150 by the end of Stage 2) is being constructed.
# St John of God Murdoch operates 20 public palliative care beds under contract to the Department of Health.

APPENDIX NINE

2009-10 BUDGET REPORTING OF PREVENTATIVE HEALTH PROGRAMS

The Department of Health provided the following information to the Committee on the new reporting structure of the State's preventative and protection health programs contained in the 2009-10 Budget.[672]

Combined Services 8 & 9	2007-08 Budget	2007-08 Actual
DOH – Health Promotion Prevention and Protection	$44,628,392	$48,999,177
Area Health Service – Population Health	$141,601,209	$169,429,043
BreastScreen WA	$8,922,900	$9,115,811
DOH – Health Protection	$59,100,499	$97,101,886
TOTAL	**$254,253,000**	**$324,645,917**

The Department of Health uses its best endeavours to classify expenditure among services for the purposes of the Budget process. The timing of budget setting versus actual allocation of expenses accounts for movements in a number of settings. There are realignments of services within WA Health all the time. Such realignments result in the reallocation of costs determined by service profile. Classification of services and costs within services is also subject to variation.

For example, the variance for Area Health Service – Population Health, is understood to relate to a realignment of population health related expenditure in the South and North Metropolitan Area Health Services to the Child and Adolescent Health Service-based state-wide population health program. It is understood that much of this realigned expenditure was previously reported under other services.

The 2007-08 Actual figures also include state-wide corporate overheads, previously only apportioned to Department of Health indicators across all Services. With respect to variation in Full Time Employee (FTE) numbers, the following table contains information extracted from the 2007-08, 2008-09 and 2009-10 Budget Statements, Budget Papers No. 2.

672 Ms Patsy Turner, Acting Director, Director General's Division, Department of Health , Electronic Mail, 30 April 2010, p1.

Budget	Service 8 (FTE(	Service 9 (FTE)	Combined Service 8 & 9 (FTE)
2008-09 (2006-07 Actual FTE)	1,007	863	1,870
2007-08 (2007-08 Target FTE)	262	835	1,097
2008-09 (2007-08 Budget FTE)	262	835	1,097
2008-09 (2007-08 Estimated FTE)	1,113	887	2,000
2009-10 (2007-08 Actual FTE)			2,045

The second and third rows of this table [above] show an obvious anomaly in the number of target FTE for Service 8 (262) in the 2007-08 Target. This was perpetuated as the prior year's target became the next year's budget for Service 8 in the 2008-09 Budget Statements. The 2007-08 Budget Statements for Health reported FTE at service level. The 2006-07 Budget Statements did not. The 2005-06 Budget Statements for Health reported FTE at service level, but the number of services at that time was three and there was substantial change to the service structure between the 2005-06 Budget Statements and 2006-07 Budget Statements to improve the transparency of allocation of resources, both financial and FTE, to the various service activities. No supporting documentation for the FTE numbers which appear in the 2007-08 Budget can be located.

There is consistency between 2006-07 Actual FTE, 2007-08 Estimated FTE and 2007-08 Actual FTE.

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