30 July 2009

Submission to the Education and Health Standing Committee

Review of WA's Current and Future Hospital and Community Health Care Services

1. Introduction

This inquiry offers an important opportunity, at what I believe to be a critical point, for the Education and Health Committee to build on its previous report into child health screening programs by conducting a thorough assessment of the health services available and needed for optimum child development, and to provide strong leadership on the necessary way forward. I am pleased to offer comment in my capacity as Western Australia's Commissioner for Children and Young People, and would be happy to provide further information as required.

In Western Australia community child health services[1] have been the 'poor relative' of the Department of Health for many years. Despite the increases in Western Australia's population and birth rate, community child health services have not received equivalent funding increases and are now significantly under-resourced. Consequently, most of these services are now stretched beyond capacity, a situation which is increasingly manifesting in poorer health and developmental outcomes for children and young people. Although the extent of the shortages in community child health is now widely known, budgets and resources continue to be cut further.

My submission focuses solely on the Inquiry's term of reference (b): *identifying any outstanding needs and gaps in health care services*. In this paper, I provide an overview of my primary concerns in the area of child health and propose that the way forward is for the State Government to:

- increase long overdue investment in community child health services;
- focus on increasing early childhood health services, including by aligning Western Australia's service provision with the COAG early childhood agenda.

2. Role of the Commissioner for Children and Young People

I was appointed as Western Australia's inaugural Commissioner for Children and Young People in December 2007 pursuant to the *Commissioner for Children and Young People Act 2006* (the Act). The role of the Western Australian Commissioner for Children and Young People is one of broad advocacy; I have responsibility for advocating for the half a million Western Australian citizens under the age of 18 and for promoting and monitoring their wellbeing. I must always observe and promote the right of children and young people to live in a caring and nurturing environment and to be protected from harm and exploitation.

In performing all functions under the Act, I am required to have regard to the United Nations Convention on the Rights of the Child, and the best interests of children and young people must be my paramount consideration. I must also give priority to, and have special regard

[1] In this submission 'community child health services' is used to mean community child and adolescent health and development services in both metropolitan and country areas.

for, the interests and needs of Aboriginal and Torres Strait Islander children and young people, and to children and young people who are vulnerable or disadvantaged for any reason.

3. Western Australia's population growth

Western Australia's population continues to grow faster than that of any other Australian state and territory, increasing by 2.3% (46,700 people) in 2006-07.[2] Children and young people comprise a large percentage of that population growth: in the year ended 30 June 2008, Western Australia recorded the largest percentage increase in Australia in the number of children aged 0-14 years (2.4%).[3] Further, the number of births per year in Western Australia has increased by more than 20% in the past 5 years, and since 2005 there has been a steady increase of 5% each year of children aged 0-4.[4]

This growth also looks set to continue, with the projected population of 0-8 year olds in Western Australia estimated to reach around 250,000 by 2011.[5]

4. Demands on community child health services

Running parallel to this substantial increase in population and births was Western Australia's resources boom and years of associated economic growth. Despite the State's recent comfortable fiscal status, however, there has been no significant investment in staffing or budget across community child health services for more than 20 years.

Professor Fiona Stanley argues that Australia's recent economic growth has in fact had adverse consequences on child development outcomes, and that "our very effective economic machine is taking us efficiently in the wrong direction." [6]

> *... many key health and other indicators of child and youth development are not improving in modern wealthy Australia. Many are actually getting worse... The impact on health, mental health, child protection, education and juvenile justice services have been enormous and all of them are in crisis. In response, those providing the services pour money and energy into the ends of the pathways rather than asking "Why is this happening?" and "Can we prevent these problems?"...*[7]

The compounded effects of more children and fewer staff and resources has slowly eroded the operating environment of community child health services which, for decades now, have been required to do more with less.

As revealed by this Committee's recent report *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australia is in need of 105 community child health nurses, 135 school nurses and 126 child development service staff[8]—

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[2]Australian Bureau of Statistics 'Population Change States and Territories' http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3218.0
[3]Australian Bureau of Statistics 'Population by Age and Sex, Australian States and Territories', http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3201.0.
[4] Advice received from Dr Peter Flett, Director General, Department of Health, Correspondence to Commissioner for Children and Young People, 12 March 2009.
[5]Cameron, J., (Editor) *Integration of Early Childhood Education and Care: Meeting the Needs of Western Australia's Children, Families and Communities in the 21st Century*, National Investment for the Early Years, 2009, p57.
[6]Stanley, F., et al, cited in 'The Challenge of Change: Why services for young children and their families need to change, and how early childhood interventionists can help', presentation given by Dr Tim Moore to Gippsland Early Childhood Intervention Advisory Network's 2006 Conference *Managing Change*, October 2006.
[7]Stanley, F., 'Australia's Wealth Harms Our Children's Health', blog published on WA Today, 14 October 2008. (http://blogs.watoday.com.au/fionastanley/2008/10/headline_here.html)
[8]Education and Health Standing Committee, *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australian Parliament, 2009.

not to provide an enhanced service, but simply to keep pace with the State's population growth.

In the 2006 census, children and young people under the age of 18 years comprised almost 25% of the Western Australian population.[9] On the basis of this population figure alone, community child health services should be adequately resourced to provide effective and comprehensive services to the quarter of the population it is assigned to.

The recent report by the National Health and Hospitals Reform Commission reinforced the importance of embedding prevention and early intervention into every aspect of our health system, and particularly into child health:

> *Our recommendations related to prevention and early intervention focus on children and young people. The evidence is overwhelming. If we act early, we can prevent or reduce the magnitude of many disabilities, developmental delays, behavioural problems and physical and mental health conditions. Our recommendations for a healthy start to life involve ensuring that children and parents – and potential parents – get access to the right mix of universal and targeted services to keep healthy and to address individual health and social needs.*[10]

4.1 Child Health Nurses

Box 1: Role of Community Child Health Nurses[11]

Community child health nurses:

- assess baby and child health and development after discharge from hospital and at scheduled stages during the first 3 years of life.
- provide ongoing support for families and can offer information about many aspects of parenting, maternal and family health and healthy lifestyles.
- provide information about immunisation and locations of free clinics in community health centres.
- act as a link between hospitals and the community, working with family GPs and other health professionals when necessary.
- work as part of a broader health team and can refer to Aboriginal and ethnic health workers, audiologists, dieticians, medical officers, occupational therapists, paediatricians, physiotherapists, podiatrists, psychologists, speech therapists, social workers and specialised health educators.

Community child health nurses offer a universal service, including making contact with every newborn in the state, and are under extraordinary pressure with the ratio of community child health nurse (FTE) to birth notification now at least 1:167, and up to as high as 1:420[12] (in most other jurisdictions this ratio ranges from 1:78 to 1:98).[13]

In addition to providing an essential universal health service, community child health nurses act as a critical 'gateway' to the health system. Through regular contact with families they provide trusted, non-judgemental support in areas such as infant feeding, child development, injury prevention and child safety and protection. They also provide

[9] Australian Bureau of Statistics, 2006 Census of Population and Housing Cat. No. 2068.0: Age by Sex. 2007. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/productsbytitle/A6D6129396973B5ACA257306000D4DB9?OpenDocument.
[10] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Australian Government, 2009, p5.
[11] Department of Health, *All About Community Child Health Nurses*, (Brochure) Child and Adolescent Health Service 2009.
[12] Community Health Nurses Western Australia, *Submission to the Inquiry into the Adequacy of Services to Meet the Developmental Needs of Children*, 2009, p2.
[13] Information provided to the Commissioner for Children and Young People from Department of Health, correspondence received 20 August 2008.

networks; linking new parents together and encouraging the development of social supports, as well as referring to specialist services where more support or intervention is required.

However, the increased demand on the existing child health nurses is placing limitations on their ability to fulfil the potential of their role; there is much less capacity for nurses to build relationships with families or to provide an appropriate level of support, advice or intervention. This lack of professional support can be difficult for all parents but poses particular challenges for parents who are vulnerable, disadvantaged, or do not have other support networks around them.

Unfortunately, Western Australia is falling behind its state counterparts in providing this early support (see Boxes 2 and 3). It is a disappointing reality that a child born in Victoria is likely to be given a better start than a child born in Western Australia, and that parents will be better supported and informed.

Box 2: Schedule of visits with child health nurses - comparisons[14]

A Western Australian child will have seen a child health nurse 5 times at 18 months old.
A Victorian child will have seen a child health nurse 5 times at 4 months old.

I include this comparison not to spark debate about what an appropriate schedule of visits is, but rather to highlight the differing value—and associated resources—the two states give to early childhood. I commend Western Australia's community child health staff for the important work they do and for performing under increasing pressure, and point to the desperate need for these staff to receive high-level departmental, Government and political support. We must increase the value we place on investment in early childhood.

The current push from all governments through the Council of Australian Governments (COAG) to 'close the gap' between outcomes for Aboriginal and non-Aboriginal people should logically lead to an increased focus on universal, preventative health and supports. The role of community child health nurses, particularly in home visiting schemes, is a proven effective measure to make gains in healthy child development and improved outcomes. It is also an appropriate place to start in a complex policy area such as this where such substantial transformations are required: to begin "with the little children"[15] and their parents.

For example the recent *Overcoming Indigenous Disadvantage* report shows that Aboriginal women who participate in antenatal sessions are far less likely to have low birth-weight babies than Aboriginal mothers who do not. This improvement is by a significant margin (41.6% versus 8.5%) and other positive outcomes then tend to flow on from this improvement (for example, a reduction in pre-term babies and perinatal death).[16]

The prevalence of Foetal Alcohol Spectrum Disorder (FASD), which some estimates have as affecting one in four Aboriginal children in some parts of the Kimberley region,[17] must also

[14] Victorian Department of Education and Early Childhood Development, Maternal and child health service information sheet, 2007; and Western Australian Department of Health, 'Child Health Services Birth to School Entry – Universal Contact Schedule', 2006.
[15] Prime Minister Kevin Rudd's Apology to Australia's Indigenous Peoples, http://www.aph.gov.au/house/Rudd_Speech.pdf , 13 February 2008.
[16] *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commission, 2009, p5.8.
[17] *Report into the deaths of 22 Aboriginal people in the Kimberley*, Western Australian Coroner, 2008, p14.

become a priority for policy and service delivery. Importantly it must be recognised that this is not an issue for Aboriginal children exclusively. There is currently no screening process for the disorder, little research, and a lack of data.[18] Services are required to assess, diagnose and provide the appropriate developmental intervention needed for these children. Again, this is an issue where early identification and intervention provides a significant benefit in improving the future positive outcomes for these children.

Box 3: South Australia Family Home Visiting Service[19]

The South Australian Family Home Visiting Service offers intensive care and support for parents who are considered to be more at-risk, for example where the mother is less than 20 years of age or where the infant is identified as being of Aboriginal or Torres Strait Islander descent. These parents are then offered **34 home visits over the first 2 years of the child's life**. This model is based on the building of a relationship between the nurse home visitor and the family, and on the development of the infant and the parent-infant relationship. Flexibility is embedded in the program so that it suits the family and follows the parent's lead, addressing the issues they raise. It is highly likely that this program has contributed to South Australia's delivering a "significant" increase in the proportion of Aboriginal mothers who are attending antenatal sessions.[20]

The evidence shows that where investment in child health has occurred and community health services have been boosted, positive outcomes follow. Despite knowing all this, however, the state of the community child health nurse sector in Western Australia is, as this Committee concluded, "dire", "under-resourced" and "dispirited".[21]

4.2 Child Development Services

Box 4: Role of the Child Development Service[22]

Child development services deal with the prevention, assessment and management of children's developmental disorder and delay. Child development services also play a key role in health prevention and promotion through the delivery of community education, professional development and the delivery of universal prevention programs. Child development services in WA are important referral points from universal and specialist health service providers. In the metropolitan Child and Adolescent Community Health Service and the WA Country Health Service the following occupational groups are employed in child development services: audiology; psychology; social work; physiotherapy; occupational therapy; speech pathology; podiatrist; dietician; clinical specialist early intervention; play and learning program therapist; senior child care; therapy assistant; paediatrics; medical officer; community health nurse.

Child development services across the state are suffering from inadequate resourcing and lengthy waitlists—and the situation is worsening. The metropolitan Child Development Service (CDS), for example, has waitlists of 12-18 months with some children, especially

[18] *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commissioner, 2009, p5.10.
[19] South Australian Children, Youth and Women's Health Service, *Family Home Visiting: Service Outline*, 2005, pp15-19.
[20] *Overcoming Indigenous Disadvantage: Key Indicators 2009*, Productivity Commissioner, 2009, p32.
[21] Education and Health Standing Committee, *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australian Parliament, 2009, pxxi.
[22] *Future Directions for Western Australian Child Development Services*, Report of the Review by the Health Reform Implementation Taskforce, 2006, p5; http://www.pmh.health.wa.gov.au/general/CACH/services.htm#cds; and advice received from Department of Health, 24 July 2009.

those over eight years of age, not receiving treatment at all.[23] The shrunken capacity of child development services to meet increasing demand means, inevitably, that the often already extreme disadvantage of the children requiring treatment is compounded:

> *…there is a severe deficit in resources [within CDS] for targeted programs. The most significantly underserved 0-3 year olds are:*
> - *Indigenous children*
> - *Culturally and linguistically diverse children*
> - *children with severe disorders of language development,*
> - *children of substance abusing parents*
> - *children of intellectually handicapped parents*
> - *children of mentally unwell parents*
> - *children of lower socioeconomic areas*
> - *children with other risk factors (such as early fire lighting, aggression, violence, cruelty to animals).*[24]

Any delays in receiving treatment in the metropolitan region can generally be multiplied in the regional and remote parts of the State. These waiting lists are so long as to practically render the service obsolete in some cases—an 18 month old child with a speech delay might have to wait until he/she is three before they can receive professional treatment. Children cannot afford to wait half their lives for treatment; their window for intervention is small and their growth is rapid. Conversely, health issues identified early and treated early magnify positive outcomes into later life.

It is increasingly common to hear that if a child is identified as having a developmental issue, the parents are told that because of the waitlists for child development services their only option is to seek assistance from a private practice. For many parents, the cost of seeking private assistance is prohibitive and, once again, the cycle of disadvantage is perpetuated because of underfunded public health services.

> *For the most disadvantaged families, a healthy start to life is equivalent to providing a lifeline to help lift children out of generational cycles of poverty and unhealthy environments and give them the best health and life opportunities.*[25]

With all that we know about the benefits of early intervention, the situation within the child development service is untenable. The evidence showing the benefits of investing early in child health is conclusive, and there is increasing urgency for resources in this area.

4.3 School Health Nurses

Box 5: Role of school health nurses[26]

School health services aim to promote improved health outcomes for school aged children and young people through universal and targeted prevention, health promotion, early identification and intervention. Services are provided on site and in collaboration with public and private schools. The Department of Education and Training is a joint funder of the program. Universal health assessments at school entry, support to children in school with particular health needs, access to health care for adolescents and health promotion for all students are key elements of the program.

[23] Education and Health Standing Committee, *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australian Parliament, 2009, p52.
[24] Wray, J., *Submission to the Inquiry into the Adequacy of Services to Meet the Developmental Needs of Children*, 2009, p3.
[25] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Australian Government, 2009, p98.
[26] Department of Health website at http://www.pmh.health.wa.gov.au/general/CACH/services.htm#shs

As a result of the increasing population and birth rate, the number of school students in Western Australia continues to increase. According to the Department of Education, the number of full-time pre-compulsory, primary and secondary students in the public school system will increase by 12% between 2007 and 2017.[27] This projected growth comes on the back of the already substantial growth that has occurred over the past 10 years.

As with other community child health services, the growth in numbers has not been matched by a growth in staffing, and services are diluted and folding under the pressure. According to this Committee's inquiry into child health screening programs: "[t]he ratio of School Health Nurses to students in metropolitan primary schools is one-third of the government target that is required to provide appropriate services."[28]

The National Health and Hospitals Reform Commission also strongly supported the important prevention and intervention role of school health nurses and recommended that:

> *…all primary schools have access to a child and family health nurse for promoting and monitoring children's health, development and wellbeing, particularly through the important transition to primary school.*[29]

4.4 Mental Health Services

I am aware that the Western Australian Government is developing a new State Mental Health Policy and Strategic Plan. I have participated in this process but have outlined key points below as mental health issues are consistently raised with me by children and young people, families and communities.

Across the State, there is concern about the gaps in services to meet the mental health needs of children and young people including: the high need for services, difficulty in accessing services, and that the services that do exist are limited, under resourced and poorly coordinated.

Again, the effects of a dearth of services are felt keenly by Aboriginal young people. In 2005, the *Western Australian Aboriginal Child Health Survey* painted a distressing picture, revealing the large gap between Aboriginal (24%) and non-Aboriginal (15%) children and young people identified as at risk of emotional and behavioural problems.[30] The recent ARACY report card reinforced this, showing that Aboriginal young people's mental health is astoundingly poor, rating 23 out of 24 OECD countries.[31]

The particular difficulties facing Aboriginal children and young people in regional and remote parts of the state, particularly the Kimberley and Pilbara regions, have been well documented. For the Aboriginal children and young people who live with the significant impact of a wide range of trauma including grief, loss, abuse and neglect, improved services are a priority. In his investigation into the suicide of 22 Aboriginal people in the Kimberley, Coroner Alastair Hope described the desperate situation for young Aboriginal people in the region:

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[27] *WA Teacher Demand and Supply Projections*, Department of Education and Training, [not dated], p6.

[28] Education and Health Standing Committee, *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australian Parliament, 2009, pxxi.

[29] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Australian Government, 2009, p20.

[30] Zubrick S, et al., *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Curtin University of Technology and Telethon Institute for Child Health Research, 2005.

[31] *The Wellbeing of Young Australians: Report Card*, Australian Research Alliance for Children and Youth, 2008.

> *It was clear that the living conditions for many Aboriginal people in the Kimberley were appallingly bad. The plight of the little children was especially pathetic and for many of these the future appears bleak. Many already suffer from foetal alcohol syndrome and unless major changes occur most will fail to obtain a basic education, most will never be employed and, from a medical perspective, they are likely to suffer poorer health and die younger than other Western Australians. In this context the very high suicide rates for young Kimberley Aboriginal persons were readily explicable.*[32]

Given this reality, it is alarming that there are no child psychologists employed by the Department of Health in the Kimberley or Pilbara regions,[33] and that the new mental health facility in Broome is not being designed with the intent to provide dedicated child and adolescent services.

These are just some examples of where identified needs are being met by considerable gaps in mental health services.

Additionally I draw your attention to the tiered system of care described in the existing mental health policy for children and young people.[34] In this policy the importance of community health services and schools in providing primary mental health services for children and young people is very clearly articulated. This indicates the reliance that other health services place on community child health and school nurses to deliver their health messages (and supports) because of their universal role.

We cannot expect our community health professionals to perform all of these multiple tasks and deliver all of these primary health services without providing adequate resources.

5. COAG Early Childhood Policy Agenda

While community child health services across the board are requiring investment, there is a current – and necessary – focus on increased services for early childhood health services.

As mentioned above, COAG recently signed off on a wide-ranging package of reforms for early childhood, including a new national strategy for early childhood development titled: *Investing in the Early Years—A National Early Childhood Development Strategy* [35] (the COAG strategy). The COAG strategy is intended to guide consideration of investment in future reforms to support children aged 0-8, and their families, and refers to Australia's responsibilities under the United Nations Convention on the Rights of the Child to nurture and protect children in our society.

All State and Territory governments are in agreement that the area of early childhood is a critical area for attention and there is much work for Australia to do in order to elevate its international standing (Australia currently ranks 23rd out of 25 participating countries in meeting minimum standard benchmarks for childhood services).[36]

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[32] *Report into the deaths of 22 Aboriginal people in the Kimberley*, Western Australian Coroner, 2008.
[33] Hansard: Hon. Simon O'Brien representing the Minister for Health, Legislative Council, Tuesday 7 April 2009, p 2684.
[34] *Infancy to Young Adulthood: A Mental Health Policy for Western Australia*, Mental Health Division, Department of Health WA, 2001, p9.
[35] *Investing in the Early Years – A National Early Childhood Development Strategy*, Council of Australian Governments, 2009.
[36] UNICEF, *The child care transition: A league table of early childhood education and care in economically advanced countries, Innocenti Report Card 8*, Florence, UNICEF Innocenti Research Centre, 2008, p. 2-8.

The COAG strategy (and broader agenda) has brought with it tremendous momentum, and a great deal of alignment of Federal and State priorities—particularly in the area of early childhood health, and a shared commitment to achieve the 'closing the gap' targets. The strategy:

> *... seeks to achieve positive early childhood development outcomes and address concerns about individual children's development early to reduce and minimise the impact of risk factors before problems become entrenched. The aim is to improve outcomes for all children and importantly, reduce inequalities in outcomes between groups of children. This is especially important for some Indigenous children who, on average, have significantly poorer outcomes than non-Indigenous children.*[37]

Three of the six areas identified for further action in the COAG strategy relate to community child health services, and plans for their implementation are to be considered by COAG in 2010. These areas are:

1. *Strengthen maternal, child and family health service delivery as a key plank of a strong universal service platform.*
2. *Improve support for vulnerable children and their families through improved service response and accessibility.*
3. *Improve early childhood development infrastructure to support maternal, child and family health service delivery, increased access to quality early childhood education and care, and improved service response for vulnerable children.*[38]

I believe this COAG strategy has accurately identified the most pressing priorities and I am supportive of its focus on early childhood. There is an urgent need now for the Western Australian Government to turn this strategy into action. Clear leadership is required to support community child health services (and the education and care sectors) to achieve these commendable goals and make a real difference in outcomes, particularly for our Aboriginal children.

However, despite agreeing to the COAG strategy, as yet there has been no indication from the Western Australian Government, or the Department of Health, that these areas will receive increased funding, focus or resources. In fact, as mentioned above, I continue to receive reports that community health services are in fact being cut further.

Western Australia needs to work hard to establish a strategic plan of investment and implementation for community child health, in <u>all</u> the areas I have outlined above, so it can move at the pace required by COAG. This is imperative if we are to avoid the high risk that these COAG goals will dissipate into nothing or—worse—require that community child health spread its services even thinner without further resources.

If this rare opportunity presented by COAG is not taken, and if community child health continues to be cut, there is no question that Western Australia will be guilty of 'widening the gap' and will suffer later the significant social and financial consequences of not investing in children. As this Committee stated in its most recent inquiry:

> *...delayed interventions end up being more costly for government, as it extracts a greater demand on future health services to provide therapy and treatment requirements. In addition, many of these delays may exacerbate a child's behavioural conditions and social*

[37] Ibid, p4.
[38] Ibid, p27.

dysfunction, which ultimately places added pressures on other public agencies, such as the education and justice departments.[39]

To address many of these issues, it is my view that Western Australia needs an Office of Early Childhood to become a central office for all early childhood matters. I have proposed that a Western Australian Office of Early Childhood would be a central office, bringing together the key elements of:

- Early childhood health services;
- Childcare; and
- Early childhood education.

By pulling early childhood health services out of the Department of Health and into a separate Office, it would no longer be competing for budget with the resource intensive tertiary health services (such as hospitals) but would independently represent the universal and developmental health needs of children and young families. This model has been implemented in Victoria and is proving to be effective in creating well integrated early childhood services from the policy level through to service delivery.

Recently I published an 'Issues Paper' providing more detail on this proposal. It is attached for the Committee's information.

6. Conclusion

Investment in community child health through screening, prevention and early intervention is critical to ensuring the best possible outcomes for all children, and will also be the key to addressing many of the appalling disparities in health, education and employment experienced by Aboriginal people. We know that investment in childhood also saves money in the long term, and that investing earlier is more effective than investing later.

Yet unfortunately, neither this knowledge nor the recent years of wealth in Western Australia have delivered results for our children. The State's population and birth rate have increased significantly over past decades, but investment and planning in community child health services have not occurred concurrently. As a consequence, service delivery has thinned, become less effective, less universal, and it is becoming apparent that the children and families who are being most disadvantaged are the ones who are in need of the most support.

Now, in the more restricted economic environment in which we currently find ourselves, it will become increasingly important to invest wisely. The need to be more strategic and prudent with the State's finances in fact provides an opportunity to concentrate funding in areas that will have the most effect, be the most sustainable and contribute to a future society that can handle the environmental, social and economic challenges that will need to be faced.

I am strongly of the view that investment in community child health services meets these criteria. Western Australia now has a brief but invaluable opportunity to harness the momentum of COAG, and invest wisely by enhancing the entire system of community child health generally, with early childhood health as a priority.

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[39] *Future Directions for Western Australian Child Development Services*, Report of the Review by the Health Reform Implementation Taskforce, 2006 cited in: Education and Health Standing Committee, *Healthy Child – Healthy State: Improving Western Australia's Child Health Screening Programs*, Western Australian Parliament, 2009, pxx.

Investing in our children is important for their health and development now, and will reap rewards for the whole of society by ensuring decision-makers of the future have been given the best opportunity to be physically, mentally and emotionally equipped.