# SELECT COMMITTEE INTO CHILD DEVELOPMENT SERVICES

## INQUIRY INTO CHILD DEVELOPMENT SERVICES

**TRANSCRIPT OF EVIDENCE**
**TAKEN AT PERTH**
**WEDNESDAY, 17 MAY 2023**

**SESSION ONE**

**Members**

**Hon Dr Sally Talbot (Chair)**
**Hon Donna Faragher (Deputy Chair)**
**Hon Samantha Rowe**

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**Hearing commenced at 10.01 am**

**Professor NITIN KAPUR**
**President, Paediatrics and Child Health Division, Royal Australasian College of Physicians, sworn and examined:**

**The CHAIR**: I am going to formally open the hearing, Dr Kapur. You have only two out of the three committee members here. I am Sally Talbot; I am the chair of the select committee. My colleague Hon Donna Faragher is the deputy chair. We have one missing member this morning who has had to give and apology because she is in another meeting, Hon Samantha Rowe—so you have two out of three. We also have in the room with us our adviser, an assistant adviser, a committee clerk and Hansard doing the recording. It is like a cast of thousands over here. That is just so you know who you are talking to.

I will start the hearing now and welcome you on behalf of the committee. I start as we always do by acknowledging the traditional owners of the land on which we meet today and paying our respects and tributes to their elders, both past and present.

[Witness took the oath.]

**The CHAIR**: You have signed a document called "Information for Witnesses". Can I just check that you read and understand that document?

**Prof KAPUR**: Yes, I have read it and I understand it.

**The CHAIR**: Excellent. As I said earlier, Hansard are recording the proceedings and you will get a transcript of your evidence after the hearing. We are not broadcasting today, so there is actually no recording of this hearing. If you look at our website, you will see that most of our hearings are recorded so people can go back and watch the hearing. We are not able to record in this particular room.

**Prof KAPUR**: Yes. I have seen a few and I saw others prepare a statement and, hence, I prepared a statement as well.

**The CHAIR**: That is excellent. I will invite you to make an opening statement, but there are two things before you commence. If you could give us the full title of any document that you refer to during the course of the hearing for the record, and just know that if you make adverse allegations during this hearing, the committee might release that information to the other party to allow them to respond. I will give you some advice about what to do with your transcript when we close the hearing, but just know today that this is a public hearing. If you want to make a confidential statement, you can ask the committee if you can give your evidence in private. If the committee agrees with your request, we will move into private session and any members of the public or media in attendance will be asked to leave.

Finally, you should just know that when you get your transcript of the public evidence, you should not make it public. You should not publish or disclose the uncorrected transcript of the evidence because it may constitute a contempt of Parliament, which means you are not protected by parliamentary privilege.

Let us move now straight to your opening statement, which you have already indicated you have prepared.

**Prof KAPUR**: Thanks, Dr Talbot and the team, for giving me the opportunity to appear before the committee and its inquiry into child development services in Western Australia. The Royal Australasian College of Physicians—RACP—welcomes the establishment and ongoing work of this inquiry by the Western Australian government and the Western Australian Parliament. I want to start by acknowledging the Turrbal and Jagera peoples as the traditional owners of the land on which I am speaking today, and pay my respect to elders past, present and emerging. I recognise their connection to country and role in caring for and maintaining the country for thousands of years.

My appearance today will pertain to the following terms of reference of the select committee: the role of specialist medical colleges, universities and other training bodies in establishing sufficient workforce pathways. Before I go into any detail, I want to get you familiarised with the role of the Royal Australasian College of Physicians. We connect, train and represent over 28 000 medical specialists and trainee specialists from around 33 different specialties across Australia and Aotearoa, New Zealand. The Royal Australasian College of Physicians has a paediatric and child health division, which I am the president of. That is the only training body responsible for physician training in paediatrics in Australia and New Zealand. Community and child health—CCH—is a subspecialty within the paediatrics and child health division of the RACP. The speciality focuses on three broad aspects: development and behaviour, child protection and child population health. While general paediatricians will complete some aspect of community and child health during their training and will have some knowledge, most developmental paediatricians tend to do a standalone three-year CCH training program. In terms of numbers, while we have around 7 000 paediatric trainees or fellows in Australia and New Zealand, at least 600 of them are in Western Australia. As noted in our submission, if you look at the 100 000 paediatric population, the number of paediatric specialists who have an interest in developmental paediatrics in Western Australia is 39.4 compared with 39.8 for the entire country and 41.6 for New South Wales. One more figure that I want to bring to your notice is that there are 30 community and child health trainees in Western Australia, and 78 general paediatrics advanced trainees. There are roughly 210 community and child health trainees in Australia.

As I said earlier, I am here in the capacity of the president of the paediatric and child health division of the RACP. I want to clarify that my clinical work is limited to being a paediatric respiratory and sleep specialist at the Queensland Children's Hospital. I am also the director of paediatric education at the Queensland Children's Hospital, looking after all the basic trainees and the advanced trainees. I have no clinical work in child development services or community child health services in the state of Queensland or anywhere else in Australia or New Zealand.

I also want to quickly tell you how the paediatric training program works. It is overall a six to seven-year training program. All paediatric trainees do the first three years as basic training; that is common to all. Out of this, there is no mandatory developmental or psychosocial exposure required for that. They may choose to do it, but is it not mandated. Once they pass their clinical and written exam, then they do what is called advanced training, which is another three years of training, of which only six months are mandated to be in developmental and psychosocial. I just wanted to clarify that. But many advanced trainees can choose to do the training in community and child health, which is a standalone robust three-year training program. I am happy to answer questions about that if need be.

[10.10 am]

There are a few points that I want to clarify. The college has no role—when I say "college" I pertain to RACP. The RACP has no role in funding training positions in states, as state health departments

remain responsible for funding the number of registrar training positions. The RACP does approve training position locations according to set criteria that reflect any requirement. The RACP does not limit the number of positions or the number of paediatric or paediatric registrar entering the chapter of community and child health or in fact general paediatrics either. Our college accredits these settings, and these criteria are clearly outlined on our website. In anticipation of this meeting, I did take some feedback from some of my CCH colleagues who say that these criteria are not considered particularly onerous.

One thing that I want to highlight is the specialist training program. This is a funding initiative of the Australian government, of health, and the program wants to encourage a specialist workforce in regional areas and in private practice and in non-hospital settings. But because most of the community and child health settings have some linkage to a hospital and health setting, the STP funding does not cover these positions of development and psychosocial paediatrics. In terms of numbers, RACP manages 20 CCH positions in Australia and New Zealand, but only one such position in Western Australia. RACP manages 56 general paediatric positions in Australia and New Zealand, of which only eight are in Western Australia.

We have a council at PCHD that constitutes 20 members and I wanted their feedback on what should I bring to the table if I am called for this inquiry. I had requested more solution-focus. I will quickly summarise what is in the letter that I have already submitted, so we can go to the submission at the end of this. I want to clearly say that development and behavioural assessment of children is a very complex pathway. It involves overlapping clinical conditions as well as environmental, genetic and social determinants that impact the clinical spectrum. A single setting assessment may not be sufficient and paediatricians may have to bring the child back for further assessment to come to a diagnosis, and may even require a certain period of intervention before the diagnosis is made. The point I am trying to make is that the diagnosis is not as straightforward as ticking some boxes.

It is very clear to us that there is significant workforce shortage in developmental paediatrics. We have tried to figure out the reasons, and the reasons are many and complex, including the need for part-time work, inadequate Medicare reimbursement and an insufficient number of training positions in this paediatric specialty of community and child health. Close to 90 per cent of our CCH trainees are females and most of them work part time. This requires greater flexibility of training options as well as part-time options, which sometimes rural, remote and STP funding is unable to navigate. This need for flexibility also sometimes limits movement and relocation of trainees outside the outer metropolitan area.

We definitely want to advocate for an increase in specialist training program funding positions in community and child health. As I suggested, the current STP funding structure makes it hard for such community and child health trainee positions to be within a specialist service. We want to highlight that children in rural areas need a priority focus. Some developmental and diagnostic assessments cannot be suitable and appropriately carried out via telehealth.

I have seen the submissions of others, who have already discussed a multi-tiered integrated healthcare model of community and child health paediatricians, general paediatricians, child and adolescent psychiatrists, general practitioners and allied health staff working in a multi-tiered model. I know that you are seeing the representative from the GP college next, so that is something to be discussed. As the peak and only specialist education and training provider for paediatricians in Australia, we are internally assessing our own training programs so that we can improve developmental exposure to general paediatrics, because once the general paediatricians finish their practice and if they go into private practice, nearly 70 to 80 per cent of the practice is developmental paediatrics. We also feel that we need to engage with the Royal Australasian and New Zealand

College of Psychiatrists' faculty of child and adolescent psychiatry to seek their expertise in some of these difficult behavioural assessments. Thank you.

**The CHAIR**: Thank you. That is very comprehensive and much appreciated. I want to go straight to the point you made in your second submission where you talked about the concern that the college has with, for example, GPs getting involved with the treatment and management of children generally with complex neurodevelopmental problems. You are very strongly advocating against that. This is the particular reason we wanted to talk to you. You will be aware that in relation to, for example, ADHD, nationally Australia is looking at a way of involving GPs in co-prescribing. You seem to be very firmly against that. While you are framing your answer, I will develop my question a little bit more. I do not know that we have heard a single witness, even by implication, say that paediatric physicians are not required in the system, but what we have heard is an enormous amount of frustration about specialist paediatricians not being able to work at scope of practice because they are having to do so much of the work that in fact could have been done by other health professionals, including GPs, nurse practitioners and, in some cases, schools, for example, that need to produce reports. Can I ask you that very important question? I will leave that as a broad question and then we can keep unpicking it as we go.

**Prof KAPUR**: As the college position states, that for diagnosis and initial assessment of children with developmental needs that needs to stay with the paediatricians because we think that is complex, requires multiple levels of assessment and requires a lot of training, which I have shown over the few years that paediatricians who have trained for six to seven years have that experience. We are actually not against co-prescribing once the diagnosis is made at a later stage. I have had discussions with Dr Brad Jongeling, who has appeared in your hearings as well, and overall we are supportive of this pathway forward. It is not only general paediatrics. We see there needs to be a triage system where there are some simple cases, which after the initial diagnosis can certainly be managed by general practitioners. In fact, we also see an upward trend in the very complex cases when even a general paediatrician, while it will be a very small minority, may need help and seek assistance from a developmental paediatrician to co-manage this as well. We certainly feel that there is a role for not only general practitioners, but also nurse practitioners as well in the years to come who have trained specifically in this area.

**The CHAIR**: Is the college prepared to get involved in that training or has the college been invited to be involved? What is the status currently?

**Prof KAPUR**: The college per se is not involved in that training. In saying that, once we get our own house in order, we will absolutely be happy to help other colleges to do that. We have had contact from the academy of paediatrics in the psychiatry division to work together on some of these hub-and-spoke models as well, and we absolutely are keen to educate our colleagues if possible. We first though need to get our own training program robust enough so that our general paediatricians who, at the end of that six years of training, have more exposure than we are currently providing in developmental and psychosocial paediatrics.

[10.20 am]

**The CHAIR**: Thank you, that is a very helpful piece of information for us. May I just turn now to unpick some of those very interesting numbers that you gave us in your opening statement. You talked about the fact that Western Australia is actually quite well serviced per head of population. Then you talked about 210 trainees in WA. This is not the first time we have heard that. We certainly have not heard a figure in the hundreds, but we have had other evidence about quite a significant number of trainees being in the system. One witness I think even suggested to us that we might

have a glut in the future. Of those 210 trainees that are currently in the system, how many of those are doing a stream of study that will bring them into the CDS realm?

**Prof KAPUR**: Let me break it down a little bit more. The 210 trainees are the overall number of trainees, which includes basic trainees as well. This is over six years. Once they complete their basic training, then they can choose between a sub-speciality training, like I did respiratory and sleep. They could choose to do general paediatrics or they could choose to do community and child health. Community and child health trainees are at the top. They have had three to four years of focused training in community and child health and development paediatrics, and that number in Western Australia is only 30 full-time equivalent positions roughly.

**The CHAIR**: That is 30 trainees of the 210?

**Prof KAPUR**: Yes, 30 trainees; that is right. I actually do not know how many FTE positions they are doing, sorry. But there are 30 trainees doing that. Then there are 78 paediatric advanced trainees, which are going to become a paediatrician in the next one to three years, and they should be equipped to manage most children with developmental and psychosocial needs. So 30 plus 78. I do not know what FTE the 78 are doing, but a lot of them might be part-time workers.

**The CHAIR**: So that is 78 as a head count.

**Prof KAPUR**: That is 108 by the head count.

**The CHAIR**: Yes, okay, thank you. During that six years, do your trainees have to do work placements?

**Prof KAPUR**: Yes. These are all in-hospital training positions—all of them.

**The CHAIR**: That is really what I am asking. Where do they do their practical element of their education? Is it in hospitals?

**Prof KAPUR**: Because I said I am the director of paediatric education in Queensland, some of my examples will be Queensland-based. They start basic training—we call it BPT 1, 2 and 3. They do 18 months of the core basic training requirement and 18 months of non-core. At least nine months of that three years has to be in a tertiary paediatrics centre. This has now been reduced to six months, so that only six months can be in a tertiary paediatric centre and the rest of the three years can be either at a level 2 hospital or a secondment hospital. That is how it is spread out. Out of this, you need to do at least three months of a sub-speciality, and that sub-speciality could be D&P, but it does not have to be. Sub-specialities are oncology, respiratory, sleep, rehab etc. That is one. You have to do three months of neonatology and three months of emergency medicine, wherever it is accredited. That is, nine months out of the 18 months of core work has to be general paediatrics. These are all done in various hospitals. In Queensland, there are 17 sites that we locate our trainees to. I do not know in Western Australia what that number is, but I can take it on notice and get back to you about how it is spread out in Western Australia.

**The CHAIR**: Yes, I think that would be very useful. We will make that question on notice 1, which is: where are the trainees doing their placements?

**Prof KAPUR**: In that period of training, they have to pass a written and a clinical exam. Once they have passed that, they become advanced trainees and then they can choose to do advanced training in whatever field they choose. There are various accredited sites of various CCH positions, and I have a PDF of all 210 CCH positions available in Australia and New Zealand and I am happy to share that with you. That is available on the RACP website as well. These are accredited positions where CCH trainees can train and then there is similar accredited training. Almost all of them for general paediatrics are in a hospital setting.

**The CHAIR**: Thank you. Dr Kapur, correct me if I am wrong, but I understand your first submission is saying that there are dwindling numbers of trainees in three specific sub-specialities: neurodevelopmental, mental health and adolescent paediatrics. Have I understood that correctly?

**Prof KAPUR**: I am not aware of that. I do not know where that figure comes from.

**The CHAIR**: I might make it question on notice 2: what explains —

**Prof KAPUR**: That is not my experience in Queensland, Dr Talbot. While we do have certain unfilled positions, it is mostly because of part-time work or leave. We are still having lots of applicants at least in Queensland for all these positions. I am not sure what the numbers are in Western Australia.

**The CHAIR**: Perhaps you can take that one on notice. This information I think comes from your *National medical workforce strategy* and it suggests that there are dwindling numbers of trainee paediatricians in the sub-specialities of neurodevelopmental, mental health and adolescent paediatrics in WA. Question on notice 2 is: what explains those dwindling numbers; and, does the *National medical workforce strategy* have anything to say about redressing that imbalance, about encouraging people into those three particular areas? If you are happy to take that as question on notice 2?

**Prof KAPUR**: Yes, definitely. Do I need to know these questions or is someone else —

**The CHAIR**: No, I will tell you at the end. You will get them all in writing.

Can we move now to some questions about workforce. We have got slightly more paediatricians per head of population than other states, yet we have still got very long waiting lists to access services. Are you able to say in relation to WA, perhaps with reference to some advice you have received from your WA colleagues, how many general paediatricians and community child health paediatricians would need to be employed by the Department of Health to meet the current demand?

**Prof KAPUR**: I will have to take that question on notice.

**The CHAIR**: We will make that question on notice 3. The second part of that question is: can you give us an idea about what would be the cost of one new full-time general paediatrician and one from the 26 paediatric sub-specialities? Would you like to take that on notice as well?

**Prof KAPUR**: I will definitely take that question on notice.

**The CHAIR**: We will make that two parts of question 3.

You might have the same reaction to my next question which is about your suggestion that WA Health should resource —

> paediatric registrar positions to begin the process of increasing paediatrician workforce in the state.

That is a quote from your submission. Do you know how many paediatric registrar positions would be needed to meet current demand?

**Prof KAPUR**: Is that for developmental needs or overall statewide services?

**The CHAIR**: That would be within child development services.

**Prof KAPUR**: I will definitely take that on notice.

[10.30 am]

**The CHAIR**: That is question on notice 4. Thank you. I have just a couple more questions then I think we can draw to a close; I will ask my colleague if she has any questions to explore with you.

You have suggested that WA Health should explore, and I quote again, "accrediting private settings for training … in collaboration with the RACP and other stakeholders." Can you explain what you mean by that? What does that look like in practice?

**Prof KAPUR**: The college currently does not even have information on who is working in the private sector. We are trying to make our own system robust so that we have clear sight of who is working what hours in the private sector. The second thing is that while a lot of trainees cannot move to a rural setting and miss out on STP funding, STP funding does cover at least 50 per cent of the time if it is done in the private sector. A great limiting step is the training program and supervisors. If we can identify supervisors who work a considerable time in the private sector and then like it to an STP funding position, I think it will be a win-win for all the trainees as well the community.

**Hon DONNA FARAGHER**: For clarification, when you refer to STP, can you elaborate on that further?

**Prof KAPUR**: Basically, the federal government has this pool of money that they want to invest in specialist training programs that pertain to Indigenous health in either rural settings or private settings. There are roughly around 700 STP-funded positions out of which 318 positions are being governed and managed by RACP. Because there is a shortage of specialist paediatricians in the developmental sphere, we want STP, which is a specialist training position initiative of the federal government, to fund some of these positions in the non-rural setting as well. The developmental paediatricians who, because of various reasons—90 per cent being female; an inability to move—are unable to go to a remote setting, can then stay in the metropolitan position, work in the private sector and attract that funding so that there can be more developmental positions created in the private sector. I can give you many more details about the STP funding if need be.

**The CHAIR**: Now you have reminded us, I think we did have some fairly extensive evidence from Professor Adrian North at Curtin University in Western Australia, who is one of the deliverers of those programs with commonwealth money. We might come back to you on that one, Dr Kapur.

**Prof KAPUR**: It is surprising and sad that Western Australia has only one STP-funded CCH position. I need to investigate why that is the case. I suspect that a lot of the child development services sit in a hospital setting here and, hence, miss out on the STP funding.

**Hon DONNA FARAGHER**: You mentioned that the RACP manages around 300; is that right? I presume that is across —

**Prof KAPUR**: It is 380.

**Hon DONNA FARAGHER**: Is that across Australia?

**Prof KAPUR**: That is across Australia; that is right.

**Hon DONNA FARAGHER**: In the context of WA, there is only one, and that is —

**Prof KAPUR**: No. In Western Australia, there are eight general paediatric STP-funded positions and one CCH-funded position by STP. It is a total of nine. In paediatrics, sorry; there might be some in rehab and others. I am not aware of that, but in paediatrics, there are a total of nine: eight in general paeds and one in CCH.

**Hon DONNA FARAGHER**: Thank you for clarifying that.

**The CHAIR**: Dr Kapur, you said you could provide the committee with further information about those STP-funded positions, particularly in relation to Western Australia, and what the college's position is on extending those into non-regional settings. Perhaps you could take that as question on notice 5.

**Prof KAPUR**: Yes, definitely.

**The CHAIR**: Thank you. One last question, and it segues quite well from your previous comments: Has the college looked to reducing the training period down from between six or seven years of post-university training? Has the college looked at reducing that training time?

**Prof KAPUR**: Yes. This does come into discussion multiple times. I can go back and look at when the most recent formal discussion on this happened and I can take that on notice and get back to you. This does get discussed—is six years or eight years is too long—but when it was formally discussed I can look up.

**The CHAIR**: What was it formally discussed and what conclusions have been drawn from those discussions—that is question on notice 6.

That brings me to the end of the questions. Hon Donna Faragher does not have anything. That is the end of the questions we prepared. You have certainly given us quite a lot to think about. If you do not mind, Dr Kapur, we might come back to you at some stage in the next few weeks with some follow-up questions, particularly once we have had a look at your responses to the questions you have taken on notice. Is that all right with you?

**Prof KAPUR**: Most definitely, and I am very happy to send the statement that I wrote this morning for this. I can email that to you.

**The CHAIR**: That would be very helpful. Thank you very much. Unless you have anything else to add, I have to close the session formally, but I want to double check that there is not an area that we have not discussed that you are keen to talk about. Have we covered everything that you had anticipated?

**Prof KAPUR**: All good.

**The CHAIR**: Excellent. A transcript of the hearing will be sent to you for correction. If you find typographical or transcription errors in the transcript, you can correct them on the transcript, but if you find errors of fact or substance, you will need to correct those in a separate communication to the committee. You have taken several questions on notice. When you get your transcript of evidence, that document will also clearly indicate the precise questions that you have taken on notice and we will also let you know when the committee would like the responses to arrive back with us. If you want to provide additional information or elaborate on particular points, you can provide supplementary evidence for the committee's consideration when you return your corrected transcript. Of course, our staff are here if you have any further queries. May I thank you very sincerely for appearing before us today. It has been very helpful. Thank you.

**Hearing concluded at 10.38 am**