

Interview Dr Lara Wieland.MP3

This submission is based on the transcript of an interview with the Queensland Productivity Commission on 23 October 2017.

I'm a medical doctor and I have at some point worked in pretty much every remote community in far north Queensland but mostly in Cape York. I worked there for 17 years on and off including four years during which I lived there as the resident doctor then I did nine years as a fly in fly out doctor and also for the last 13 years have been running help run a charity that works with children in Cape York.

Service delivery

Over the last two decades there's been a massive increase in investment in health in Cape York but not all the changes have been positive. In one community for example there was good access to a doctor who was resident 7 days a week but very, very limited access to other services, it was really under resourced lacking basic counselling, diabetic services etc.

So now there are lots of extra services but I believe things have gone backwards in terms of access and meeting needs of the patients.

Partly around service design, partly around funding.

Despite a massive increase in overall funding you've actually got poorer access to your basic quality primary health care – the core team of a GP, remote nurses and Aboriginal health workers, access to these is what makes the biggest difference in health outcomes along with the social determinants and the two need to work together. That has actually gone way backwards. So for example as a community of around twelve hundred it now only has a doctor in town two nights a week. A dr might fly in Tuesday around lunchtime and leave on a Thursday afternoon early afternoon. There are very few if any towns in Queensland including remote western Queensland towns that would tolerate that level of access to primary health care for that population let alone looking at the need.

Much of the money seems to go to duplicating organizational infrastructure, head offices, HR etc. and duplicated services from multiple organisations. It has also become very political and competitive with funding given out in lots of little buckets for organisations to fight over.

So rather than looking at funding a health service that meets the needs of the patient population it's divided up – “here's money for chronic disease here's money for antenatal care here's money for ... “ if you go to a GP in town or an AMS they get federal funding from Medicare and ideally then your GP works with the practice nurse, allied health, healthworkers etc to provide the complete coordinated package. Chronic disease and acute care is managed all in one and it's managed according to need whereas you go to a remote community all of a sudden there's conditions on using certain staff and funding streams only for certain conditions. Real people don't work like that.

In addition, different organisations competing for the same bucket of funding then adds a whole other layer of complexity to people's priorities and even to how they work together on the ground. And suddenly self-survival and contracts and maintaining programs become a priority over patient well-being. And then you have people funding similar things or sometimes even the same thing. I've heard lots of patients say that it's very confusing for them and it is difficult to know who is providing what or who they see for what and they get multiple invites for multiple services. They're not sure which one is most important and which one they should be going to and which one they shouldn't.

The other difficulty is then that if they want to go to the dr about their diabetes they have to be

there on the one day the 'chronic disease dr' fly in and if they miss that appointment because something else is going on in their life then they have to wait til the next visit. So it has become a crazily complicated system these days. And more complication only serves to further disadvantage disadvantaged communities. There's lots of duplication and multiple patient records in one community for one person which is a recipe for disaster in itself.

Community health plans

There has been several iterations of that process over the years. What gets done with that at the end of it depends on who is controlling what. There are multiple players that are holding the funds and have their own interests at heart - it's not necessarily really going to change a lot just to do a great community health plan.

Data and access to data

It's a problem in itself and it may be a bit of a chicken and egg thing too because you need data to design a system that addresses needs. But you also need a good system to actually get good data. I don't think there has ever been good data in the Cape. Sometimes I have suspected that there is no great incentive to have good data on how bad things are in the Cape. Your data is only as good as what goes in and when you've got paper charts along with a very dysfunctional and high turnover of agency staff who often don't have access to enter data it will be hard to rely on that data. Then there are the different organisations in community who don't have access to QH data systems and are using separate systems that others can't access.

The lack of good health service data is a major issue.

To get the good data you really need to have a good health service that's working with one system which we don't have.

There are multiple reports or 'solutions' that say let's integrate and communicate and have all these forums etc but in reality it's human nature of politics and at the end of the day I've never ever seen or heard of a health service that works well run like this. And the services that do work well are where it's one provider. And in particular where they've actually done some work on some funds pooling for example Katherine West Health Board model where they pooled state and federal funds and did a transition to a health board which then ran the services and was able to be flexible with their funding and respond to the needs on the ground.

And that's a model that was well known to government right down to Canberra.

Things are different at the remote level where you know in cities you've got a user driven service and that obviously cuts out the need for a lot of the bureaucracy which is why we moved to that sort of system.

I can see there being lots of problems with that in remote areas.

One is that just financially it wouldn't work. The cost of delivering health services in remote communities is so much greater. And Medicare barely covers the cost of health services for Aboriginal medical services even in rural and regional areas. And they have to rely on extra grant funding and so forth. Financially the model just wouldn't work. And then there's issues with land tenure which causes issues even now for service providers -who owns the land, you can't just buy land in Indigenous communities. And you certainly wouldn't get your money back on a private practice and then politically it's difficult too because you know there's philosophical things around community control vs private practice. I also think that even if it was financially viable there is a risk you wouldn't get people in there who are going to try and meet the needs of a very needy vulnerable population. And you know you've got an Aboriginal Health Board you know that is there that is nominally controlled by the community. So you know the politics of competing with that

would be difficult for anybody.

The report mentioned some of the evidence behind Aboriginal medical services in providing comprehensive primary healthcare which I absolutely agree with. I think it's a model in theory that works well. But I don't think it's correct to say that the current ACCHO is delivering comprehensive primary health care to eleven communities because of the way the funding is set up and it's so piecemeal. I don't think you can say if you're one of several providers flying people in and out that you're providing a comprehensive primary health care service so maybe there's one or two communities where they're doing that. I'm not saying that they couldn't do that but just the way it's set up and the politics behind it and what they've been allowed to take over or what they've been allowed to get funding for has not allowed them to provide comprehensive primary health care which is probably part of the problem.

I know some argue that there are problems with Apunipima around their governance and so forth, but I know people always use that as the reason why you shouldn't have them running services. But having been involved in some of the politics from the beginning of this whole process, I also believe that some of the organizations really did get set up to fail and they don't get given the resources they need to do the job properly or you know there isn't the investment in capacity building or the governance structures and staff needed to get a good service going. It's not like the organisations who have been there for years have done a great job despite having good people working hard trying their best, so clearly something needs to be done differently. Past and current providers have not been held to account either.

I think that if it was allowed to proceed properly and with the appropriate support and investment behind governance capacity building etc that transition to community control would be something that would work well as it did in Katherine West. But I don't think the process has been done well and partly because it has been this long drawn out process where it's basically a big fight between organisations over little buckets of money and they just crawl you know two steps forward one step back with little regard for the patients.

With regards to transition to community control it is interesting to look at what's actually happening in reality because the deed of agreement for that was actually signed in 2006. And it only really started to transition in the last year or two. So it's been really drawn out there's been a lot of resistance and there are really differing views. If you ask somebody from Queensland government versus someone from Apunipima versus someone from RFDS what they think that end result is going to look like or what that process entails, each of them would give you a different answer which would again add to the problem.

There appears to have been some major issues with transition.

It would be obviously a good starting point if everyone actually agreed on what it was but there doesn't seem to be that agreement and certainly no one on the ground knows what the actual transition plan is. I mean one of the recommendations way back when was that there is actually a formal negotiated transition plan that includes the nuts and bolts of how it is going to work and keep patients safe.

Rather having a competitive process seems to have bred a certain amount of paranoia with no one being able to talk about anything in case you let something slip to 'the others' when we are supposed to be all working towards one thing.

And then the way they are doing the funding is also causing problems in the sense that because they partition funding into chronic disease, child health etc rather than block funding for providing

health care, there's no incentive to take on the broader parts of the service because you can get maximum Medicare money from just doing Chronic disease care planning which is actually not that costly to provide but you get the bigger Medicare dollars and no incentive to then provide after hours cover because there's little Medicare money in that and it can be quite costly to provide. That seems to raise all kinds of issues that people are struggling to work through.

How on earth can you separate out acute and chronic care in small remote places like Aurukun or Kowanyama.

You tell a doctor they are employed to just do primary care in the clinic and not to do any emergency work. They are there with a couple of nurses and healthworkers and that's it. There's no ambulance. No hospital... A two hour flight from help. And somewhat...an accident happens or someone coming in having a heart attack and you are just going to sit there and say sorry I'm not trained for that I'm sorry I don't have experience in that, sorry I'm not employed to do that.... And just watch a patient die or a nurse struggle with something beyond their experience. Those details do not seem to be being worked out well.

It just seems ridiculous to go to one service for your sore toe and say while I'm here I need my diabetes checked and be told you have to go to another service in another building when you're in such a small community.

I don't know what the barriers are. Is it money? Is it politics and the fear that if it fails bureaucracy will be blamed for having let it be handed over because people expect that to fail? Perhaps that is the level where the blockages are? Who knows?

There seems to be no overall level of accountability for outcomes. There are reports to funders for various buckets of money but a very vague overall picture of whether outcomes are improving or getting worse. And even if we had that data – who is responsible with so many players?

Maybe there should be a scan of the needs of the community.... then we say 'are they being met?' or 'this is a community of 1200 people...it should as a minimum have access to this, this and this' ...based on the ground reaching people who need it the most. I think there needs to be some kind of benchmarking based on population and need but also looking at the access because you can say a community of this size needs a minimum of nine nurses on the ground doing on call etc for example and then someone turns around and goes oh well Apunipima sends in a nurse who is antenatal, and someone else sends in a child health nurse and someone else sends something else in but they are not really carrying the full load of the community's needs or the nursing on call burden so it's false representation of how needs are being addressed.

That modelling might be based on having nine remote area nurses working across all areas based in town being part of the on call roster and not someone who just flies in for two days a week, sees five patients and flies out again. So on paper it might look good but not in reality.

Having seen some Western Qld non-indigenous towns and the services they have, they are not flash but in terms of basic GP and nursing services it far surpasses what is on offer in the Cape and yet we are trying to close the gap??

There's a couple a couple of issues here. One is to solve the fragmentation of funding. One is to make sure we've got some mechanism for cooperation across all health providers and then to make sure that if we're going to have community control that it actually covers the entirety of healthcare not just components of it is that. Get rid of the fragmentation of funding and services.

But do it well and make sure that they have a way of measuring that the needs are being met... and access to those services so they are being delivered in a way that is acceptable and not just meeting

the needs of the reporters, the funders and the people writing the report to maintain their program.

What is new? We haven't tried pooling funds and pooling services into one provider. Or properly have not been tried for that those two things are new. But I think that perhaps the measurement by valuation and accountability can be done differently. As well as delivering the funding and the services differently. There needs to be meaningful accountability measures and performance indicators.

I also believe that when you talk about vulnerable disadvantaged population with low levels of education and reduced ability to advocate for themselves effectively as a group then you need to reduce the number of commercial interests in health or organisations who rely on these places to survive financially but their wellbeing is not their core purpose for existence. Contractors always end up acting as contractors.