E01 Sub 20

Notes for Parliamentary Standing Committee on Education and Health.

Summary of submission made by Professor John Boulton to the WA Legislative Assembly Education and Health Standing Committee. 14th March 2012.

1. Introductory remarks.

I noted that I was presenting material to the committee at the invitation of the CEO of Nindilingarri, Ms Maureen Carter.

I introduced my remarks by paying respects to the groundbreaking and brave work done by women leaders in achieving the alcohol restrictions at Fitzroy Valley.

I noted that there was a profound lack of awareness of the significance of alcohol on the unborn child, particularly in such remote areas as Fitzroy Crossing, and that my submission of advocacy in 2006 which was published in the press caused a change in people's awareness of the consequences, as reported to me by the Bunaba leader Mr. Jo Ross.

I stated that the Marulu program of Prevention of Early Life Trauma and FASD was a model of partnership between government agencies including Education and Health, and Aboriginal NGOs.

2. The aims of my submission were to highlight

The need for the recognition of the extent of morbidity amongst children in the Fitzroy Valley;

The recognition of the extent of damage to children's future potential for health, wellbeing and economic independence from FASD;

The need for formal cooperation between government agencies and within agencies, especially Health, to achieve a properly integrated family-focused service to provide support and medical intervention for children with chronic serious illness

3. Historical barriers to the provision of services to children with chronic disease.

These have their origins in the historical situation of the Kimberley with respect to medical services being based on the need for a robust acute response to serious illness by medical staff, and the gap between those and the equally essential Population Health model which is based on a programmatic approach for immunisation, trachoma screening etc. These two historical models cannot provide a family-focused approach, let alone a focus on the whole of the child's needs within the family.

I noted the relevance of this deficit to sources of funding, and therefore to service delivery, from the parallel and competing strand delivered by Commonwealth-funded Aboriginal medical services. I drew a comparison between the insignificant effect of the funding for the Daruk AMS general practice service in Mt Druitt in western Sydney which served a population of 5000 Aboriginal people within a total population for that area health service of 1.5 million people, with the substantial proportion of total regional funding provided for general practice services by the Commonwealth through the AMS in the Kimberley. Overlap and duplication are sources of waste of resources.

I noted that the Kimberley Aboriginal Medical Service Council had a formal relation only with Derby Aboriginal Health Service, Ord Valley Aboriginal Health Service, Yura Yungi Medical Service in Halls Creek, and provided a direct GP service to the Kutjunka, as well as providing some primary health services to the Dampier Peninsula communities which ran in parallel with those provided by Kimberley Health, but not with Broome AMS nor with Fitzroy Crossing Nindilingarri Cultural Health. I also noted the lack of family doctor (GP) continuity throughout the region, apart from in the Broome Aboriginal Medical Service (BRAMS) which provided an office-hours GP service.

4. Contemporary tensions acting as barriers to health services to children:

I stated that my analysis of the barriers to the efficacy of current services towards children with chronic serious illness, including behavioural abnormalities and developmental disabilities from FASD, was an outcome of the tension between:

4.1 The evidence from the Lililwans Survey of the Marulu program that up to half the children in the Fitzroy Valley had chronic illness:

4.2 The consequent increased expectations from the local Aboriginal NGOs and local people for a substantial increase in services to support and care for affected children;

4.3 The trajectory of the increasingly sophisticated services provided by the Kimberley Paediatrics and Child Health Team which is moving beyond that of an acute curative response and General Paediatric outreach consultation to a formal Community Child Health program focussed on Behavioural and Developmental Paediatrics, through to working in partnership with Indigenous organisations such as the Yawuru Corporation in Broome and Marulu program in Fitzroy Crossing.

These factors create a tension with:

4.4 The historical model of provision of health care which has no focus on case identification, management, let alone family management of the child within the family.

(I contrasted this to the situation in the Apunapima Aboriginal Medical Service for Cape York which has a household focus with family nurse practitioners delivering comprehensive health care to the family within each small community)

4.5 The logistic barriers to the provision of housing etc for community nursing and Allied Health staff.

5. Recommendation for an external review

My recommendation was for an external review of the way resources are used for child health across all agencies. I advocate integration between agencies, and disciplines within agencies, so that a professional focus is achieved by age group by location. In practice this would mean Fitzroy Crossing having a specialist Community Child Health team comprising Community Child Health and School Health nurses, Paediatric Nurse Practitioner, a fractional contribution by the Regional Paediatrician, and locally based Allied Health professionals.

I advocate a matrix management model so that the focus of the team is the case management of the individual patient with chronic disease or disability within the family group. The professional responsibility of each staff regardless of discipline would therefore be to the child within the family, with health care being provided by one or more member of the Kimberley Paediatrics and Child Health Team. Line management would be to the respective discipline managers. This would complement the existing Under-5s, the trachoma screening, and other population-focussed programmes run by KPHU.

I described the role of the Paediatric Nurse Practitioner within the Kimberley Paediatrics and Child Health Team: that she is responsible to the Senior Regional Paediatrician but her line management is to the Regional Director of Nursing. Further, that we were recruiting potential Paediatric Nurse Practitioners to create an innovative model relevant for delivery of comprehensive family-focused health care within this remote region.

I concluded by stating that there was an opportunity provided by the strength of the Marulu program to trial a locality-based Community Paediatric Child Health Team in Fitzroy Crossing. Further that the stated need for a cost benefit analysis of family support and intervention for a child with FASD could be done within the context of Professor Elizabeth Elliott's NH&MRC three-year project which had as its primary focus health service research.