

KAHPF POSITION PAPER REFORMING THE DELIVERY OF HEALTH SERVICES IN/TO REMOTE COMMUNITIES July 2016

INTRODUCTION

As the draft Kimberley Development Commission document *2036 and beyond: a regional Blueprint for the Kimberley*¹ notes:

The health and wellbeing of the Kimberley population is a primary determinant of quality of life and a major determinant of productivity and participation in all areas. The Kimberley faces special challenges in the area of improving the health and wellbeing of its population, especially that of its Aboriginal people. The major drivers of poor health and wellbeing outcomes in the region are socio-economic disadvantage and associated lifestyle behaviours. Census data shows persuasive correlations between relative socio-economic disadvantage and low health and wellbeing outcomes. Addressing the health and wellbeing challenges in the region is therefore closely associated with enabling the region's economic and social development.

The Kimberley Aboriginal Health Planning Forum (KAHPF) is an inter-agency group of Kimberley health service providers focussed on improving the planning, coordination and delivery of primary health services to achieve better outcomes for Aboriginal people in the region. Membership includes the Kimberley Aboriginal Medical Services, Aboriginal Community Controlled Health Services from across the region, Alcohol and Drug Services from the region, WA Country Health Service including Kimberley Population Health Unit and Kimberley Mental Health and Drug Service, the RFDS and Boab Health. KAHPF has been meeting to coordinate health service delivery across the Kimberley for the past 20 years. In 2012, all members endorsed the Kimberley Aboriginal Primary Health Plan 2012-2015².

KAHPF welcomes the opportunity to support the WA Government's reform of the way health services are delivered to Aboriginal people living in remote communities in the Kimberley region. This paper, which has been endorsed by KAHPF, provides member's perspective on how better health outcomes can be achieved. It suggests some immediate and longer term measures the WA Government could take to address these matters.

The paper is based on the position that Aboriginal people in the Kimberley are entitled to an equivalent level of access to health and social care as non-Aboriginal residents of metropolitan Perth. To achieve this KAHPF argues strongly for an increased investment in:

- Health promotion, primary prevention, enhanced support for self-management and comprehensive primary health care that reduces the need for health care and unnecessary demand on hospitals and referrals outside the Kimberley.

¹ 2036 and beyond: a regional Blueprint for the Kimberley. Draft for public comment. Kimberley Development Commission 2015. Page 95.

² Available from <http://resources.kamsc.org.au/krahp.html>

- Actions which address the social determinants of health, particularly improving environmental health conditions, addressing food security and reducing overcrowding thereby contributing to better economic and social participation.
- Additional support to enable remote communities to address drug and alcohol issues.
- Increasing the involvement of Aboriginal families at all levels and at all stages in the planning, implementation and delivery of the health services affecting them.
- Measures to ensure external service providers engage with local Aboriginal health services to develop and implement strategies which ensure that services provided are culturally appropriate, effective and culturally safe.
- Developing stronger service delivery partnerships and new cross-sector linkages, avoiding duplication and discouraging inappropriate competition between regional and local health services, to strengthen care pathways and to deliver a more seamless continuum of Aboriginal patient care.
- Providing equitable access to health and medical services, in coordinated rather than siloed approaches across the region.

Recommendations that KAHFP believes would improve health outcomes for Aboriginal people living in remote communities in the Kimberley are detailed in pages 8-11 of this paper. For more information about any of these recommendations please contact the KAHFP Chair, Vicki O'Donnell on 0891 943 200.

THE CURRENT HEALTH STATUS OF THE KIMBERLEY POPULATION

Aboriginal people in the Kimberley continue to have significant health inequity and far worse health outcomes than both Aboriginal people in the rest of WA and their non-Aboriginal counterparts in the Kimberley. Data from the Kimberley Health Profile 2015³ demonstrates the region's specific health and wellbeing challenges:

- For 2007-11 the Kimberley mortality rate was almost double that of the WA rate. Just under half of the deaths for Kimberley residents under 75 years could potentially have been avoided. The leading causes of death were ischaemic heart disease, intentional self harm and diabetes/impaired glucose regulation.
- From 2008 – 2012 the hospitalisation rate of Kimberley residents was twice as high as the WA rate. Hospitalisation for potentially preventable conditions was also significantly higher than the WA rate.
- For 2007-2011, the notification rates for notifiable diseases for adults aged 15-64 years were significantly higher in the Kimberley compared with the State for all categories except zoonotic diseases. Of particular note, the rate of sexually transmitted infection (STI) notifications (4,217 per 100,000) was nearly six times the State rate.
- For 2008-2012, the rate of hospitalisation of older people for influenza/pneumonia (3,054 per 100,000) was three times higher than the State rate which was statistically significant.

Rates of Chronic Disease are high in the Kimberley. For example, at least 420 people in the Kimberley have RHD (WA Dept. of Health 2014). There are at least 2,000 people diagnosed as having type 1 or type 2 diabetes in the Kimberley, with this figure projected to rise to over 2,300 by 2022 (WACHS 2014). In 2013 Princess Margaret Hospital reported a spike in the number of

³ http://wacountry.health.wa.gov.au/fileadmin/sections/publications/Kimberley_Profile_Sep_2015_FINAL.pdf

children with Acute Rheumatic Fever (ARF) and increased severity of the illness. The majority of sufferers were Aboriginal children from the Kimberley who will face long-term health consequences. Environmental factors such as substandard housing conditions, unreliable health hardware, inadequate maintenance and overcrowding were a major contributor to this spike, and to the increased prevalence of the Group A *Streptococcal* strain common to the outbreak.

Between November 2013 and December 2014 the Kimberley region experienced a dramatic outbreak of Acute Post Streptococcal Glomerulonephritis or APSGN. 100 cases of APSGN have been reported since the outbreak began, with children being hospitalised on average for 2-3 weeks under specialist care. Management of resultant severe hypertension was needed to prevent kidney and heart failure. Skin sores are thought to be the source of the group A streptococcal infection (GAS) that leads to APSGN. The underlying cause of the majority of skin sores is scabies, a condition that thrives where housing is inadequate for demand, environmental conditions are poor and access to essentials for health such as hot water, sanitation and organised waste disposal is suboptimal.

The social, environmental and economic factors that play a significant role in shaping the health and wellbeing of individuals and populations are commonly referred to as the social determinants of health (SDH). Evidence documenting the contribution of the SDH to population health outcomes is well established and undisputed. Addressing the shortage of housing, lack of environmental health services and services to fix health hardware (ensuring, for example, reliable and functioning stoves, fridges, sinks hot water, toilets), affordable fresh foods, food security, employment, education, cultural identity and hopelessness all lie outside the responsibility of the health sector yet, have a crucial impact on health outcomes. To date KAHPP advocacy for measures to address the social determinants of health has not resulted in the changes that are needed. Unless the reform process does, then the challenge of improving health outcomes will continue.

The size of the target Aboriginal population in the Kimberley is substantial. In 2011 the ABS Census reported an Aboriginal population in the region of 17,022, 46% of the region's population (KDC 2014). According to Kimberley Population Health Unit (KPHU) data there are at least 1600 Aboriginal children aged 0 – 4 years old in the region and, every year, at least another 300 Aboriginal babies are born. There are also nearly 1,700 Aboriginal children aged 5-9 years. In total, there are nearly 5,000 Aboriginal children aged up to 15 years across the Kimberley. This is the group that will benefit most from prevention and early intervention. Indeed, they will benefit for their entire lives.

CURRENT SERVICE DELIVERY TO REMOTE KIMBERLEY COMMUNITIES

Primary health care services to remote Kimberley communities are provided either by Kimberley Population Health Unit (KPHU) or one of the six⁴ Aboriginal Community Controlled Health Services (ACCHS) in the region. The exception to this is in the Fitzroy Valley where, under the auspices of the Fitzroy Valley Partnership, clinical services are provided by KPHU and the RFDS while Ningilingarri Cultural Health Services focusses on health promotion and prevention. This model of delivery, based on the Fitzroy Valley Health Partnership with WACHS / KPHU, was established after extensive community consultations. As a result, Nindilingarri Cultural Health Services hold the mandate as the Custodian for health in the Fitzroy Valley.

⁴ KAMS, BRAMS, DAHS, NCHS, YYMS, OVAHS.

A breakdown of primary health care providers for larger remote communities in the Kimberley is available at Appendix 1.

The model of primary health service delivery used in the region reflects the model described in the Kimberley Aboriginal Health Plan 2012-15, specifically primary health care is:

- *Freely available and accessible.*
- *Provided locally and managed locally or regionally, with significant Aboriginal community 'buy in'.*
- *Cultural health practices are valued and cultural beliefs about health are preserved.*
- *A holistic approach to health issues is adopted, encompassing medical, psychological, family, social and cultural dimensions which may require an inter-agency or team-based approach. This approach requires local leadership by services who hold local and cultural knowledge and history.*
- *Generalist health staff provide most care for conditions which are common in the region, even if in urban settings these conditions are mainly managed by specialised services. In the Kimberley this includes conditions such as diabetes including foot care, chronic kidney disease, growth faltering in children, acute and chronic lung conditions, sexually transmitted infections and cardiovascular risk factors.*
- *Rather than a focus on clinical service provision, local specialised services (regional medical specialists, regional allied health staff, regional specialised nursing staff etc) provide a greater amount of education and support for local staff than they might provide in an urban setting to support generalist provision of care (eg podiatrists support PHC staff to provide routine foot care for diabetics without significant foot problems). Direct clinical services are primarily only provided to patients with high/complex care needs.*
- *Provision of medical specialist services involves substantial regional input and management of waiting lists to maximise productivity.*
- *Collaborative partnerships exist with other community and government bodies involved in Aboriginal health.*

Evidence of the effectiveness of this type of service delivery model was provided by the WA government's review of services and the publication of the Holman Report. Professor Holman examined the effectiveness of funded services' *Closing the Gap* programmes and endorsed the quality and impact of Kimberley-based services.

Many more Aboriginal people in remote communities are able to access health care since the establishment of Aboriginal Community Controlled Health Services (ACCHS). Barriers to access focus on factors of availability, affordability, acceptability and appropriateness. Accessibility is the cornerstone of the ACCHS success regarding the extent to which the traditional barriers to health care access have been successfully broken down.

However, resourcing levels for individual health providers compared to the high demand for their services means that the focus has been on treating symptoms rather than preventing future occurrences. Due to the high burden of ill health in the Kimberley there is a necessary clinical focus to most primary health care in remote communities - either delivering health treatments (eg treating sores, injuries and STIs) and/or identifying and managing chronic diseases (eg diabetes, rheumatic heart disease) or children at risk. Few resources are available for primary prevention activities which stop people becoming sick in the first place or early intervention programmes to

motivate people showing the potential to acquire a chronic disease to take the steps necessary to avoid from doing so.

Health service providers agree that continuing to do more of the same is likely to result in more of the same results. Instead, whilst maintaining the provision of services for people with diagnosed illnesses and servicing an increasing demand due to growth in the Aboriginal population (averaging 2% per year⁵), greater effort must be put into health promotion and early intervention activities which motivate people to take greater care of their own health.

KAHPF advocates that there is a need to expand service delivery to remote communities to a true primary health care model which includes permanent employment of community-based health workers/community service workers who have a focus on community development, prevention and early intervention. This may necessitate additional resources up front, particularly to address the provision of housing for Aboriginal Health/Community Workers, but the offset is a predictable reduction in the downstream demand on hospitals in the Kimberley and Perth, transfers and evacuations by the RFDS, rehabilitation services etc. and reduced long term costs. For example, taking the steps required to enable people to eat a healthy diet and exercise will both prevent and delay the onset of diabetes and reduce the demand on health serviced for regular monitoring, eye surgery, amputations and/or renal dialysis affecting people with severe diabetes. The cost saved by avoiding the need for dialysis is in excess \$100,000 per person per year in the Kimberley⁶.

SERVICE DELIVERY CHALLENGES

The Accessibility/Remoteness Index of Australia (ARIA) classification system contains 5 categories ranging from Major Cities to Very Remote. Almost the entire Kimberley health region (97%) is classified by the ABS as Very Remote. The other 3% (areas around Broome and Kununurra) is Remote.

The impacts of remoteness are manifold and include:

- Higher costs of goods and services delivery
- High turnover of staff
- A reliance on employer provision of housing to accommodate staff, adding to employment costs
- Stringent attention to clinical governance
- A PATS budget able to address the need to travel to receive appropriate levels of care.

KAHPF'S ACHIEVEMENTS, ONGOING CHALLENGES and OPPORTUNITIES

In 1999 health services worked competitively and in isolation. The Kimberley Aboriginal Health Planning Forum (KAHPF) was formed in 2000 and has met regularly since that time. In 2016, joint

⁵ WA Planning Commission on the Kimberley Development Commission website <http://kdc.wa.gov.au/economic-activity/demographics/>

⁶ Western Australian Aboriginal Community Controlled Health Sector (AHCWA). Executive Summary to the November 2014 Position Paper profiling our sector in Western Australia.

planning, collaborative inter-agency activity and partnership approaches underpinned by MOUs and Letters of Agreement are the norm. Achievements of KAHPF include:

- The formation of ten sub-committees and working groups operating under the auspices of KAHPF.
- A Kimberley Standard drug list used to guide the dispensing of medications by all health services which is regularly reviewed.
- Collaborative development and review of Kimberley therapeutic treatments protocols that have been endorsed and adopted for use by all Kimberley service providers. These include:

Chronic Disease	Maternal and Child Health
Rheumatic Health Disease	Anaemia in children
Coronary Artery Disease	Diabetes in pregnancy
Diabetes Type II	Ear Health
Chronic Kidney disease	Failure to thrive
Hypertension	Perinatal depression
Dyslipidaemia	Child sexual abuse
Heart Failure	Type II diabetes in children
Proteinuria & normal eGFR	Respiratory disease in children

- All WACHS-operated remote clinics provide drugs at no cost to patients under Section 100 of the Pharmaceutical Benefits Scheme.
- Increased numbers of GP Registrars from the collaboration between KAMSC and WAGPET have increased GP capacity in the region.
- The provision of 19.2 exemptions in WACHS remote clinics and some hospitals has facilitated the generation of revenue for the purpose of primary health service enhancement in each community.
- Kimberley services have successfully lobbied for increased funding to address renal issues in the region.

KAHPF is currently working on a number of initiatives that will enhance regional effectiveness, for example:

- Identifying mechanisms and processes to share data better – eg. via the development of a diabetes audit tool that will be used by service providers
- Developing a framework for sharing KPI information across the region.
- Embedding strong governance in clinical protocols, standardised drug lists and environmental health referral processes.

The Australian Government’s Health Care Home initiative⁷ offers the opportunity to improve coordination of the provision of holistic support and comprehensive care to people with chronic and complex conditions. In remote communities the community clinic can be regarded as the patient’s ‘home base’. New payment models and measures which facilitate the sharing of information and flexible service delivery provide opportunities for re-envisaging service delivery models.

⁷ Better Outcomes for People with Chronic and Complex Health Conditions report. Available from http://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/%24File/Primary-Health-Care-Advisory-Group_Final-Report.pdf

RECOMMENDATIONS RE GUIDING PRINCIPLES FOR REMOTE SERVICE DELIVERY

The objective of the KAHPF is:

To improve health outcomes for Aboriginal and Torres Strait Islander peoples in the Kimberley region of Western Australia through a co-ordinated approach to the planning and delivery of comprehensive primary health care services.

KAHPF recognises that improved coordination can enhance the quality of services and benefit service providers and service recipients via the efficient use of resources and improved working relationships.

KAHPF members support the findings of the Closing the Gap Clearing House⁸ which found evidence from process evaluations and documented practice experience that service delivery coordination initiatives designed with, and for, Indigenous populations must:

- focus on outcomes
- be culturally appropriate
- invest time and resources into community consultations
- apply a strengths-based approach
- support Indigenous and non-Indigenous staff.

KAHPF members also concur with the factors the Closing the Gap paper identified that do not support coordinated service delivery, particularly:

- Lack of time and resources (human, capital and financial) to negotiate coordination and partnership arrangements
- Inflexible organisational structures or service delivery models, including 'silo'-based frameworks
- 'One-size-fits-all' approaches that ignore local diversity
- Programme partners that lack clearly defined roles or responsibilities.

Sustainable, long-term measures that are driven at the community level have long been recognised as the most appropriate for the diverse cultural and health needs of Indigenous Australians.

KAHPF advocates that any reforms of regional service delivery must:

- support the coordination strategies advised by the Closing the Gap report
- replace the silo approach with better integration, collaboration and coordination of services founded on local service design, local governance, local delivery and local accountability
- acknowledge the need for a holistic approach which includes the spiritual and cultural dimensions of health
- respect the role of Aboriginal people as central to all decision making
- ensure that external service providers work in partnership with local services.

⁸ Australian Institute for Health & Welfare, and Australian Institute for Family Studies. Effective practices for service delivery coordination in Indigenous communities *Resource sheet no. 8* produced by the Closing the Gap Clearinghouse. Jacqui Stewart, Shaun Lohoar and Daryl Higgins. December 2011

RECOMMENDATIONS: IMMEDIATE CHANGES THAT COULD BE MADE BY THE WA GOVERNMENT TO IMPROVE HEALTH OUTCOMES IN REMOTE COMMUNITIES

KAHPF has identified a number of changes that Government could make that would have an immediate impact on the health status of remote communities:

- **Amend the regulation of minor plumbing work** via the introduction of a Restricted Plumbing License for Aboriginal Environmental Health Workers. Currently remote communities are at a disadvantage, with health risks compounded by reduced access to plumbing services. Reinstating the ability of qualified Aboriginal Environmental Health Workers to undertake minor plumbing repairs (e.g. leaking taps) will immediately reduce the presenting environmental health disease risk and potential disease burden.
- **Pass the new Public Health Bill (WA)** to ensure an equitable level of health protection is available to Aboriginal communities. To effect this, it is essential that the provisions for binding the Crown are preserved and commenced. This would ensure there is a standard level of Authority available to protect basic health standards, including housing standards, public buildings, food premises, waste water disposal, drinking water quality and waste disposal.
- **Provide realistic levels of funding for the provision of the appropriate level of environmental health and municipal services in remote communities.**
A current example is the need for regular i.e. weekly testing of the drinking water supply in all communities, and access to funding for infrastructure upgrades when testing results indicate the need for improvements to meet safe drinking water standards.
- **Improve Food Security:** Eating good food is an essential part of bearing healthy babies and the prevention and control of chronic diseases. Although access to affordable, healthy food to ensure a nutritious diet is a basic human right, many Aboriginal people living in remote Kimberley communities do not have the same access to safe, healthy food as non-indigenous people. For example, a 2010 study⁹ reported:
 - the mean cost per fortnight for a healthy food basket in metro WA in August/September 2010 was \$542.19 to \$627.11. This was compared with the average basket cost of \$709.04 in very remote areas i.e. 23.5% more expensive.
 - the range and quality of foods that were available decreased with distance from Perth.

The 2015 Regional Price Index¹⁰ (an index of 500 goods and services) shows that the overall prices in the Kimberley have risen since 2014 by 0.7% and that, on average, the Kimberley as a whole is 15.4% more expensive than Perth, with prices highest in Derby and Halls Creek.

For people in remote communities food security issues relate to the cost and quality of food, especially perishable food for sale in community stores, transport of the food to the community, health hardware in homes to prepare and store food purchased, and income to purchase food. Recent experience by KAHPF members (EON and UFPA) also suggest it is

⁹ Landrigan & Pollard. Food Access and Cost Survey (FACS), Western Australia, 2010 cited in Pereira R (2015) APSGN Look-back report. KPHU.

¹⁰ Available on KDC website <http://kdc.wa.gov.au/economic-activity/cost-of-living/>

difficult to effect sustainable change through community stores, or to influence customers to choose healthy food options even if the food is cheap without cooking and nutrition education which is linked to health messages.

What is needed therefore includes:

- Investigation and implementation of mechanisms to subsidise healthy food in community stores, including ways to reduce freight costs and subsidise the cost of food storage are urgently required.
 - Capacity building for store managers re looking after fresh food/store layout to promote healthy food choices
 - Cold chain management training for transport workers.
 - Price gradients to facilitate healthy choice (for example, bottled water vs soft drink and short shelf life healthy foods vs highly processed, energy dense long shelf-life foods)
- **Address inequity in access to health services.**

The Kimberley Aboriginal Health Plan¹¹ identifies, as a basic principle, that remote communities of a similar size and distance from town-based services should have equivalent levels of service, regardless of who their preferred service provider is. Further, the Plan identifies that ‘at a minimum’:

- Communities with regular populations of over 250 should have an onsite health service with an on call capacity.
- Communities with a regular population of between 100 and 250 should have an onsite health clinic staffed by 2 health professionals, either Senior Aboriginal Health Workers (SAHW) or Registered Nurses (RN).
- Communities with a regular population of 50-100, which are not within easy access of a community or town clinic should have a fortnightly visit by a health team.
- Communities with regular populations of less than 50 should be serviced on an as-needed basis

These ratios are in line with national standards for remote service delivery.

Of 17 communities that had a confirmed, probable or possible case of APSGN from September 2013 to November 2014, 14 communities had primary health care service arrangements that met the minimum KAHPF criteria relevant to their size while 3 communities did not¹². Of these communities, one is very close to the town of Fitzroy Crossing, the other two, Wangatjunga and Noonkanbah, are distant with Wangatjunga being accessed by road including a 15 km unsealed section and Noonkanbah having health staff flown in by charter. At present, due to the lack of staff housing, nursing and clinical support staff travel out to these sites from Fitzroy Crossing 4 days a week. Each day almost 3 hours of the working day is spent driving rather than addressing health needs. This is both unsustainable and inefficient.

Similar inequities exist in the delivery of allied health¹³, mental health and oral health¹⁴ services to remote communities.

¹¹ Kimberley Aboriginal Health Plan 2012-15 produced by the Kimberley Aboriginal Health Planning Forum 2012.

¹² Pereira, Rushanthi (2015) APSGN Look-back report. Kimberley Public Health Unit.

¹³ See data available from KPHU and Boab Health re Allied Health service delivery to remote communities

¹⁴ See the Oral Health Technical paper developed by KAHPF in June 2016

- **Address the backlog in capital works funding required to address clinic and staff housing shortfalls:**

A number of clinics require expansion if they are to move away from the 1:1 provision of clinical care and into primary prevention and early intervention – where a larger room for group work may be required if there is no other meeting space in the community.

Although the value of an holistic approach is acknowledged and discussions are underway about the value of team visits e.g. by the regional physician, allied health providers and Chronic disease or Renal Support nurses, the reality is that few if any remote clinics have the capacity to provide appropriate space for so many providers.

Similarly, several remote clinic sites, in particular Wangkatjunga and Noonkanbah, require new or additional staff housing.

A detailed long term plan which addresses the capital works requirements for health facilities and staff housing needs to be developed in conjunction with KAHPF. This must budget appropriately for the need to work with stakeholders in remote communities including Councils and Traditional Owners to identify available housing or land.

- **Amend the PATS regulations to enable the transport costs for an individual who has been accepted for AOD rehabilitation to be covered:**

At present the transport costs of getting an individual who has secured a place at a AOD rehabilitation service to that service are only covered if they are discharged from hospital to rehab, for example after detoxification. The lack of funding for transport is a significant disincentive preventing or delaying many people taking up their rehab place.

RECOMMENDATIONS: INITIATIVES WHICH WOULD GENERATE IMPROVED HEALTH OUTCOMES IN THE SHORT-MEDIUM TERM

- **Additional measures to improve food security:**

Priorities which should be addressed include:

- Establishment of a standardised system for monitoring and evaluating the availability and cost of food in remote communities
- Funding to support the production of healthy foods within and by community through edible gardens and agriculture, along with capacity building and education to enable sustainability of the gardens and agriculture and to promote healthy food choices.
- Support for initiatives that give the children access to healthy meals and familiarise them with nutrition for good health on a regular and consistent basis.

- **Additional funding for AOD prevention and early intervention in remote communities:**

The capacity of AOD services in the region to provide prevention and early intervention services to remote communities is extremely limited in most of the Kimberley. Priorities which require additional funding to enable them to be addressed include:

- Prevention and early intervention strategies for remote communities (important with the emerging issue of methyl amphetamine (ICE)), including increasing the capacity of communities to respond to AOD related harm.
- Increased programs/interventions to respond to youth AOD issues.

- Family-based AOD interventions.
- Improved access to culturally secure AOD treatment and support.
- Increasing the availability of a range of holistic and culturally secure AOD interventions.

- **Additional funding to support and mentor clients leaving AOD rehabilitation**

At present service providers have very limited capacity to provide the ongoing support and mentoring that is required by clients leaving rehab and returning to their previous home environment. Additional resources are needed to enable greater coverage across the Kimberley.

- **A commitment to stop short term project funding and to providing appropriate funding for prevention/health promotion and early intervention.**

This approach was proposed by Prof Holman. Aboriginal communities will welcome a pledge to long-term health service funding. Health services in metropolitan settings for non-Aboriginal people are typically recurrently funded. However in the remote Kimberley, short-term project funding has been the only way to secure growth funding. In a situation where relationship building and trust are crucial to effective health service delivery, the uncertainty of future contracts constrains staff to commitment to communities.

In essence, the majority of key positions in primary health care including but not restricted to community midwives, sexual health nurses, Aboriginal liaison officers, GPs, Aboriginal ear health workers, community cultural carers and generalist remote area nurses should be established positions unaffected by staff freezes or end-of-funding.

- **Support for the recruitment and retention of Kimberley residents in the health industry**

Health is a major employer in the Kimberley. WACHS employs 1250+ people in the Kimberley, the ACCHO sector approximately 500. WACHS have evaluated their recruitment and identified a need for entry-level workers. A pilot programme that prepares entry-level workers for employment in WACHS has been successfully trialled in Broome. Due to the high turnover of staff, such programmes require annual funding to generate real change.

Similarly KAHPF has identified the crucial need to recruit more Aboriginal men into the health sector. Anecdotal evidence from across the Kimberley supports research findings from elsewhere which emphasise that:

- Men are not comfortable presenting at health services
- Men are not comfortable talking about their personal situation or feelings until a good deal of time has been spent on trust-building activities
- Men are unlikely to follow up on referrals without a good deal of support and encouragement to do so
- Men do not respond well to interventions by female workers.

There is therefore a need for much greater investment in providing services and programmes which operate in ways that men respond positively to and the development of a strategy to employ more Aboriginal males in health services.

- **Embark upon fundamental regional housing policy reform.**

Overcrowding in remote communities has a significant impact on health and wellbeing outcomes. In consultation with local communities, measures need to be explored that will address the issues of land supply, housing design and maintenance, affordable housing and housing support.

Appendix 1: Primary Health Care Service Provider for Remote Kimberley Communities

EAST KIMBERLEY				CENTRAL KIMBERLEY				WEST KIMBERLEY		
Community	Provider	Resident (R) Visiting (V)		Community	Provider	Resident (R) Visiting (V)		Community	Provider	Resident (R) Visiting (V)
Kalumburu	KPHU	R		Yiyili	KPHU	V		Mowanjum	KPHU	V
Doon Doon	OVAHS	V		Moongardi	KPHU	V		Bidyadanga	KAMS	R
Glen Hill	OVAHS	V		Wangatjunka	KPHU	V		Beagle Bay	KAMS	R
Warmun	KPHU	R		Yakananara	RFDS	V		One Arm Point	KPHU	R
Duncan Hwy communities	OVAHS	V		Milligidee/ Kajina	RFDS	V		Djarindjin/ Lombardina	KPHU	R
Keep River communities	OVAHS	V		Noonkanbah/ Yungnora	KPHU/RFDS	V		Pandanus Park	DAHS	V
Crocodile Hole	KPHU	V		Muludja	KPHU	V		Looma	KPHU	R
Balgo	KAMS	R		Djugerari	RFDS	V		Jarlmadangah	DAHS	R
Mulan (Mindibungu)	KAMS	R		Koorabaye/ Ngalapita	RFDS	V		Imintji	DAHS	V
Ringers Soak	YYMS	R		Bayulu	KPHU	V		Ngallagunda	DAHS	R
Billiluna	KAMS	R						Dodnun	DAHS	V
								Kupungarri	DAHS	R
								Other Gibb River Rd. communities	DAHS	V

Points to note:

- The frequency of visiting services varies widely from intermittent or monthly eg. RFDS to Djugerari or Kadjina to several times a week eg. Wangatjungka (4 days /week) or Mowanjum.
- Additional visits by Child Health, School Health and/or Allied Health clinicians and GPs may occur at all sites
- There are 45 communities in the Fitzroy Valley. Some communities receive no visiting services.

KAMS Kimberley Aboriginal Medical Services

KPHU Kimberley Population Health Unit, WACHS

OVAHS Ord Valley Aboriginal Medical Service

DAHS

RFDS

YYMS

Derby Aboriginal Health Service

Royal Flying Doctor Service

Yura Yungi Aboriginal Medical Service