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Presenter: Darren J Armitage Population Health and Community Director KPML

Parliament of Australia
House of Representatives
Standing Committee on Health
KPML Opening Statement

Preface:

To open I would like to extend a sincere apology on behalf of the Kimberley Pilbara Medicare Local, Chief Executive Officer Mr Chris Pickett for his absentia today. Chris had a long standing commitment with the Regional Director of the Western Australia Country Health Service in Perth.

Opening Statement:

The Kimberley and Pilbara regions of North Western Australia are a majestical combination of natural and man-made phenomena's; a intertwining kaleidoscope of rich intoxicating beauty and raw unfathomable power; a land that is home to the oldest surviving culture and people on earth; and unfortunately a cosmopolitan delineation of the 'have's' and 'have nots'!

Population Demographic & Health Status:

Spatiality

The Kimberley (421, 457 sq km) and Pilbara (507, 896 sq km) regions are a vast area of almost 1 million square kilometres (929, 347 sq km) and occupy 40% of Western Australia's landmass or 12 % of the total Australian landscape.

The Kimberley region alone has an area of 0.42 million square kilometres meaning the entire State of Tasmania could snuggle in 4.5 times. The Pilbara region has an area of 0.51 million square kilometres allowing the State of Tasmania could fit in 5.6 times.

Shires

The KPML consists of 8 Local Government Areas (LGAs) or Shires; The Kimberley region encompasses the Shires of Broome, Derby–West Kimberley, Halls Creek and Wyndham- East Kimberley. The Pilbara region encapsulates the Shires of Roebourne, Exmouth, Ashburton and the Town of Port Headland.

Population

The total population of the Kimberley Pilbara regions is 94,688 (PHIDU 2013), inclusive of an identified Aboriginal and Torres Strait Islander population of 21, 126 which accounts for 22.3% of the overall population. The Kimberley region has a high Aboriginal and Torres Strait Islander (ATSI) population of 45% or 16,094 people in 2010, a much larger proportion than the 3% across all of Western Australia. The Aboriginal Kimberley population has a greater proportion of females than the non-Aboriginal population (50% compared with 45%) and a younger age structure.

The Kimberley region has the lowest population of all the regions in WA. The Estimated Resident Population (ERP) was 35,706 in 2010. It is projected to increase to 48,615 by 2021.

The area also has a large transient population (FIFO, Grey Nomads, Backpackers Families) usually in the dry season April-October, which greatly impacts on the region in terms of provision and utilisation of health services.

Remoteness

The Accessibility/Remoteness Index of Australia (ARIA) is a systematic approach to the classification of areas of Australia according to level of remoteness with 5 classes ranging from 'Major Cities to Very Remote'.

The Kimberley region is classified as 'Remote or Very Remote'. It is imperative to highlight that very remote is defined as locationally disadvantaged with very little accessibility to goods and services, including health services,

and very little opportunity for social interaction. The Australian Bureau of Statistics (ABS) census showed that half (47.8%) the Kimberley population lived in a very remote area and half (52.2%) lived in a remote area.

SEIFA (Socio-Economic Index for Areas)

SEIFA scores below 1000 are considered to be disadvantaged, and those above 1000 are considered to be less disadvantaged compared to the national average. The median SEIFA for the KPML region is 947 and for the Kimberley 795.

The Kimberley's four SLAs the Shires of Halls Creek, Derby-West Kimberley, Wyndham- East Kimberley and Broome SEIFA scores are 598, 746, 890 & 947 respectively representing high levels of disadvantage for all of the region.

Potential Needs Assessed in Each KPML Health Domain

The KPML region is compared to the other 60 MLs on a range of health domain indicators, by ranking within a quintile range. Almost without exception a snapshot for health conditions, care and service delivery by identified Medicare Locals Key Performance Indicators/Domains reveals; that the Kimberley and Pilbara regions consistently rank among those with the poorest health status of all Australians. Additionally this is compounded by a disproportionate highest ranking of needs associated with the social determinants of health by ML quintile and SLA range eg. Access, Affordability, Education, Housing, Transport etc.

Skin Cancer

For KPML non-melanoma skin cancer cancers accounted for 0.5% of all cancers between 2007 & 2011. Comparatively to the State and KPML the percentage of other and non-specific site non-melanoma skin cancers was lower being 5.5% and 2.4% respectively.

For KPML melanoma (skin) cancers accounted for 12.8% of all cancers between 2007 & 2011. Comparatively to the State and KPML region the percentage of other and non-site specific site melanoma (skin) cancers was higher being 67.1% and 68.6% respectively.

All Cancer Incidences

Relatively, therefore statistical significance of skin cancer is low compared with other incidences of all cancers. For example

Compared to the State rates, the rates of male cancer incidence due to pharynx; and tongue were significantly greater.

Compared to the State rates, the rates of female cancer incidence due to unknown primary site; vulva; and gallbladder & bile ducts were significantly greater.

Conclusion

The major identified need in the KPML region fundamentally relates to access to a range of efficacious health services and practitioners both at the primary and acute level to enhance the individual's and populations health status. The factors that contribute to this gap are seemingly simple in identification however complex to analyse and even more convoluted to redress. It is paramount to understand that for the Kimberley population each of these individual social determinants of health are intrinsically linked yet also arbitrarily to the next creating a meandering cyclical pattern of inaccessibility to improve health status.

In finishing I would like to quote Dr Peter Del Fante, the Director Health First who denotes:
"*The population of the Kimberley and Pilbara regions of North Western Australia experience's significant inequality and have some of the poorest health outcomes of all Australians. This requires urgent action by government and other key stakeholders in the region.*"

I concur and there are few that would disagree!

Thank you

Leading health conditions

Kimberley Pilbara Medicare Local Region

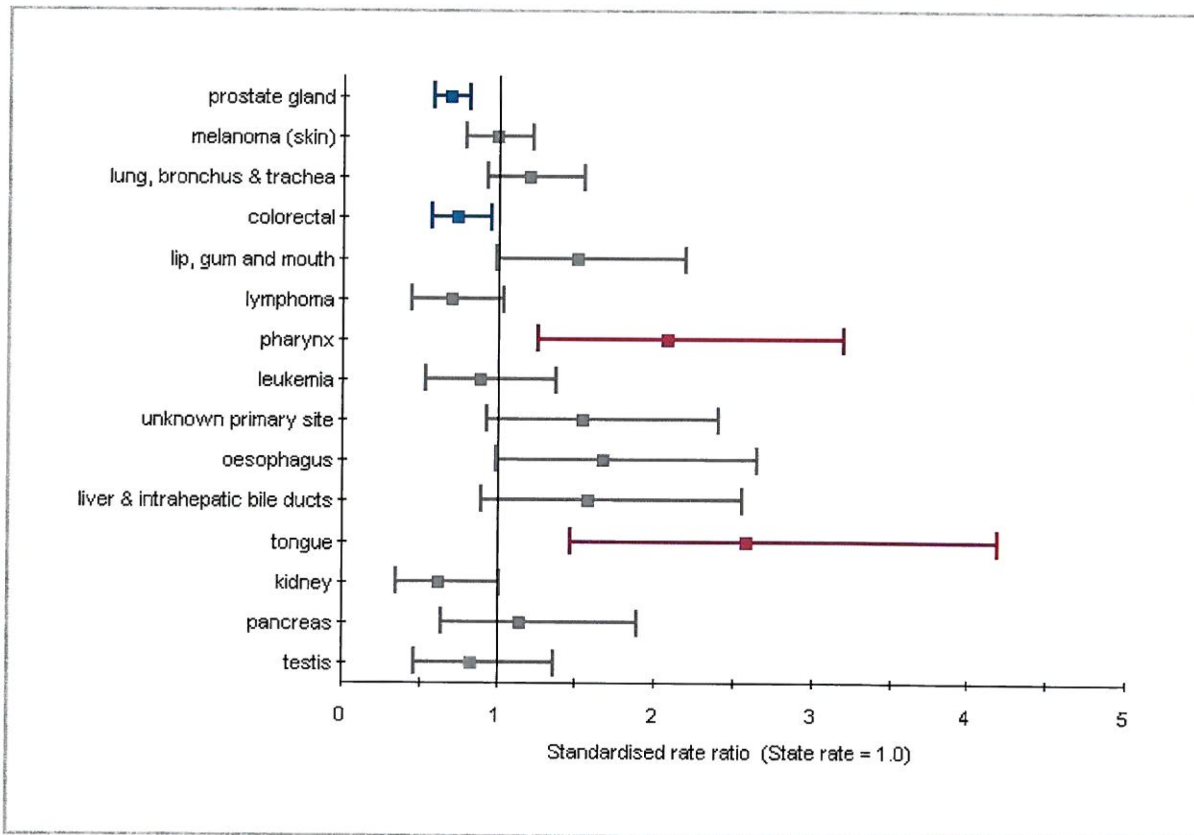
Cancer incidence

Citation: Top fifteen causes of cancer incidence for Kimberley Pilbara Medicare Local Region residents. Epidemiology Branch (PHI) in collaboration with the Cooperative Research Centre for Spatial Information (CRC-SI). Generated using data from the WA Cancer Registry. Accessed Thursday, 1 May 2014 by Laura Miller (Epidemiology Branch).

Visit **https://wsep256dev/healthtracks_reporting/pdf/Aids to interpretation - Cancer_Incidence data.pdf** for additional notes and aids to interpretation. If you wish to contact the Epidemiology Branch for further information or assistance please email **epi@health.wa.gov.au**.

What are the top fifteen causes of cancer incidence in Kimberley Pilbara Medicare Local Region residents?

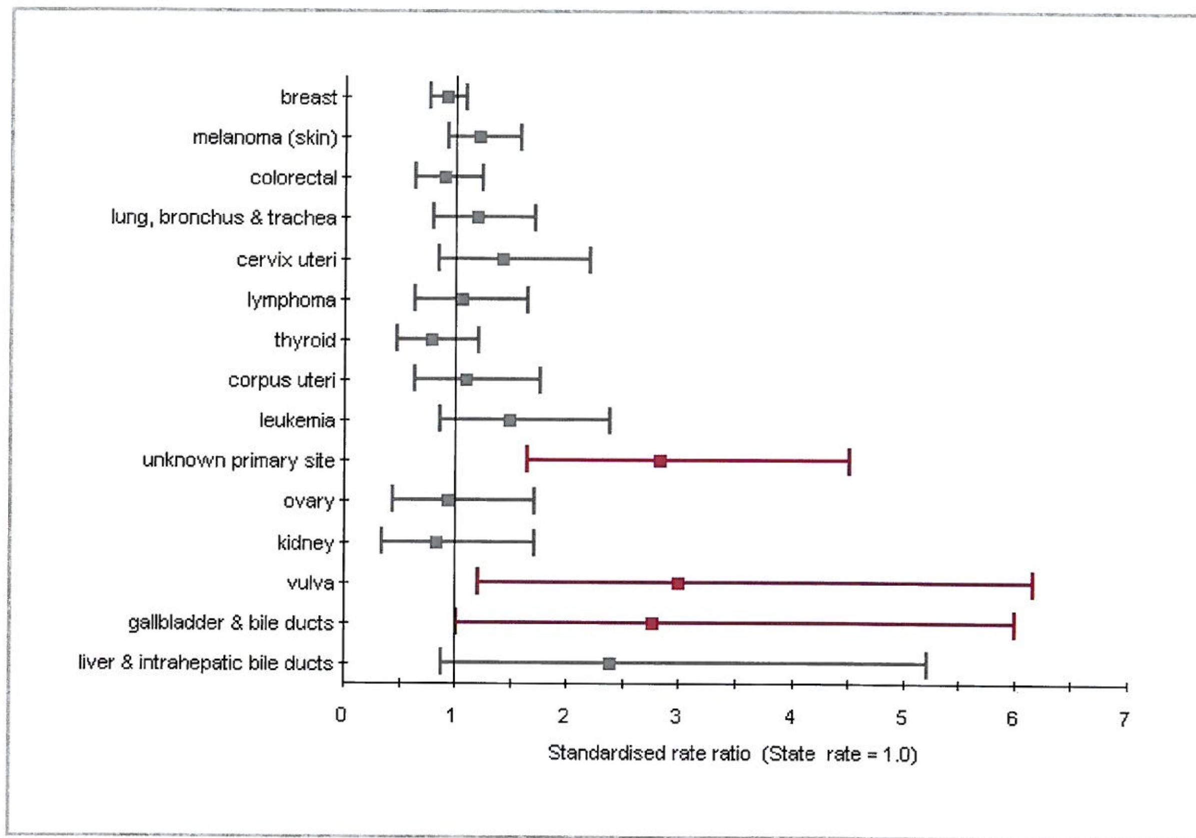
Figure 1: Male standardised cancer incidence rate ratios (top 15, ordered by number of cases) for Kimberley Pilbara Medicare Local Region residents (2007 - 2011).



Note: The error bars represent the 95% confidence intervals of the rate ratio. Red lines are significantly higher than the State rate while blue lines are significantly lower. **Note:** Data from Western Australian Cancer Registry, HIC, DOH.

- Compared to the State rates, the rates of male cancer incidence due to pharynx; and tongue were significantly greater.

Figure 2: Female standardised cancer incidence rate ratios (top 15, ordered by number of cases) for Kimberley Pilbara Medicare Local Region residents (2007 - 2011).



Note: The error bars represent the 95% confidence intervals of the rate ratio. Red lines are significantly higher than the State rate while blue lines are significantly lower. **Note:** Data from Western Australian Cancer Registry, HIC, DOH.

- Compared to the State rates, the rates of female cancer incidence due to unknown primary site; vulva; and gallbladder & bile ducts were significantly greater.

How many cases are affected by these top causes of cancer incidence and what are their rates?

Table 1: Total cancer incidence and rates for Kimberley Pilbara Medicare Local Region residents by condition (2007 - 2011).

Males	Condition	N	% all cases	SRR	CI	ASR	CI
	prostate gland	148	22.6%	0.69	0.59-0.82	114.2	90.8-137.5
	melanoma (skin)	86	13.1%	0.99	0.80-1.23	54.9	39.0-70.9
	lung, bronchus & trachea	63	9.6%	1.20	0.93-1.55	66.0	46.1-86.0
	colorectal	59	9.0%	0.74	0.57-0.96	47.2	31.2-63.1
	lip, gum and mouth	27	4.1%	1.51	0.99-2.19	17.0	9.0-25.1
	lymphoma	24	3.7%	0.70	0.45-1.03	15.6	7.2-24.1
	pharynx	20	3.1%	2.07	1.27-3.20	15.8	6.9-24.8
	leukemia	19	2.9%	0.89	0.53-1.38	N/A	N/A
	unknown primary site	19	2.9%	1.54	0.93-2.41	N/A	N/A
	oesophagus	18	2.7%	1.67	0.99-2.65	N/A	N/A
	liver & intrahepatic bile ducts	16	2.4%	1.58	0.90-2.56	N/A	N/A
	tongue	16	2.4%	2.58	1.48-4.20	N/A	N/A
	kidney	15	2.3%	0.62	0.35-1.02	N/A	N/A
	pancreas	15	2.3%	1.15	0.64-1.89	N/A	N/A
	testis	15	2.3%	0.83	0.46-1.36	N/A	N/A
Females	**Condition**	**N**	**% all cases**	**SRR**	**CI**	**ASR**	**CI**
	breast	131	29.0%	0.92	0.77-1.10	113.2	89.4-137.1
	melanoma (skin)	56	12.4%	1.22	0.93-1.59	42.5	28.7-56.3

	colorectal	36	8.0%	0.90	0.63-1.25	31.7	19.4-43.9
	lung, bronchus & trachea	30	6.6%	1.20	0.81-1.71	40.6	23.2-57.9
	cervix uteri	19	4.2%	1.42	0.85-2.21	N/A	N/A
	lymphoma	19	4.2%	1.06	0.64-1.65	N/A	N/A
	thyroid	19	4.2%	0.78	0.47-1.22	N/A	N/A
	corpus uteri	17	3.8%	1.10	0.64-1.76	N/A	N/A
	leukemia	17	3.8%	1.49	0.87-2.39	N/A	N/A
	unknown primary site	17	3.8%	2.82	1.65-4.52	N/A	N/A
	ovary	10	2.2%	0.94	0.45-1.72	N/A	N/A
	kidney	7	1.5%	0.83	0.34-1.72	N/A	N/A
	vulva	7	1.5%	2.99	1.20-6.17	N/A	N/A
	gallbladder & bile ducts	6	1.3%	2.76	1.01-6.01	N/A	N/A
	liver & intrahepatic bile ducts	6	1.3%	2.39	0.88-5.21	N/A	N/A
Total	**Condition**	**N**	**% all cases**	**SRR**	**CI**	**ASR**	**CI**
	prostate gland	148	13.4%	0.84	0.71-0.98	66.7	53.7-79.8
	melanoma (skin)	142	12.8%	1.10	0.93-1.30	49.2	38.7-59.8
	breast	131	11.8%	0.76	0.63-0.90	47.3	36.9-57.7
	colorectal	95	8.6%	0.82	0.67-1.01	40.4	30.0-50.7
	lung, bronchus & trachea	93	8.4%	1.25	1.01-1.54	55.7	42.1-69.3
	lymphoma	43	3.9%	0.84	0.61-1.13	15.1	9.4-20.8
	leukemia	36	3.3%	1.13	0.79-1.56	13.0	7.4-18.6
	unknown primary site	36	3.3%	2.05	1.43-2.83	23.2	13.9-32.6
	lip, gum and mouth	32	2.9%	1.57	1.07-	11.6	6.7-16.6

				2.21		
pharynx	25	2.3%	2.55	1.65-3.76	10.5	5.2-15.8
thyroid	25	2.3%	0.67	0.43-0.99	6.5	3.1-9.9
kidney	22	2.0%	0.72	0.45-1.08	6.0	3.2-8.8
liver & intrahepatic bile ducts	22	2.0%	1.91	1.20-2.89	8.7	4.2-13.2
tongue	21	1.9%	2.83	1.75-4.33	6.9	3.1-10.6
pancreas	20	1.8%	1.04	0.63-1.60	8.4	3.7-13.1

Note: ASRs are standardised with the Australian 2001 population and expressed per 100,000 person years. **Note:** N/A indicates that the cell content has been suppressed due to privacy policies, or to withhold an unreliable rate derived from a low count. **Note:** Data geocoded to the SLA of residence has been used rather than postcode of residence.

- In addition to the standardised rate ratio, it is important to consider the magnitude of the age standardised rate and the total number of cases.

Skin cancer in Australia
Submission 39

Specific health condition analysis

Kimberley Pilbara Medicare Local Region

Melanoma (skin) cancers

Citation: Health status report on melanoma (skin) cancers for the Kimberley Pilbara Medicare Local Region. Epidemiology Branch (PHI) in collaboration with the Cooperative Research Centre for Spatial Information (CRC-SI). Generated using data from the WA Cancer Registry. Accessed Wednesday, 30 April 2014 by Colleen Koh (Epidemiology Branch).

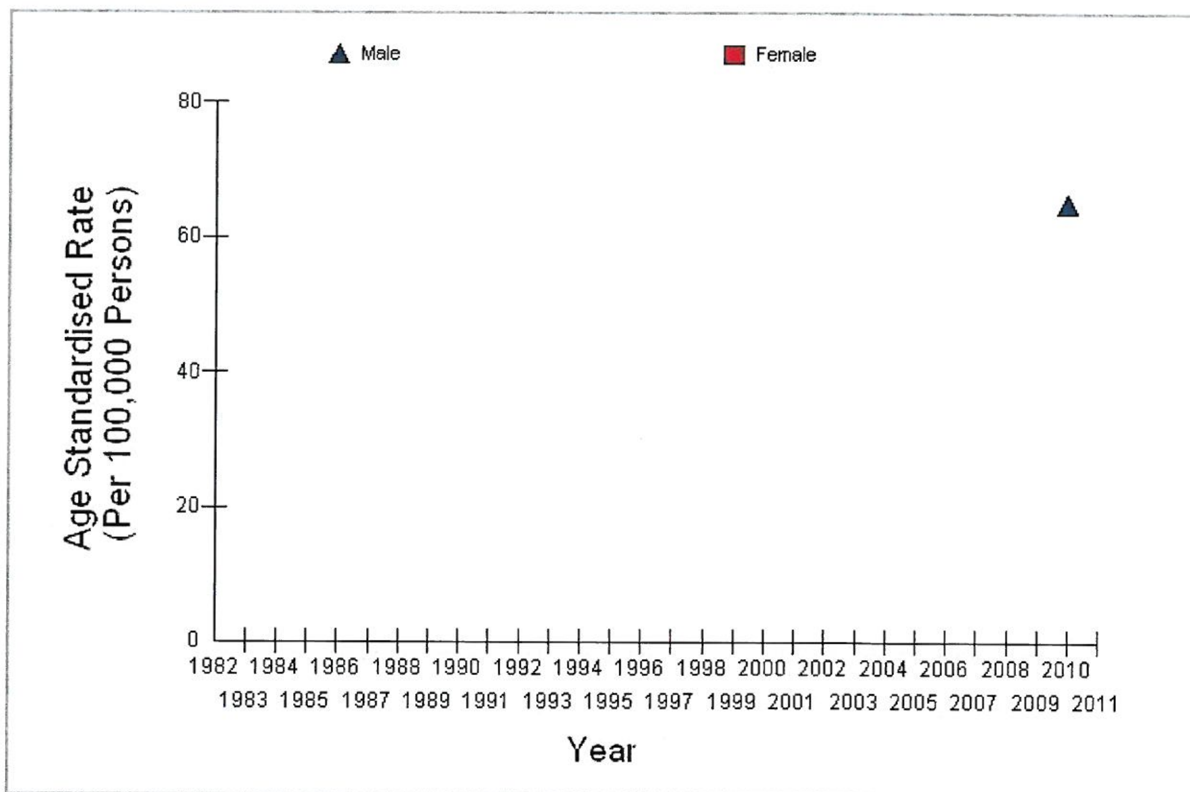
Visit **https://wsep256dev/healthtracks_reporting/pdf/Aids to interpretation - Cancer_Incidence data.pdf** for additional notes and aids to interpretation. If you wish to contact the Epidemiology Branch for further information or assistance please email **epi@health.wa.gov.au**.

How do melanoma (skin) cancers in this area compare to the State rate?

After allowing for any differences in the population age structure, the number of cancers for melanoma (skin) in the Kimberley Pilbara Medicare Local Region was similar for both males and females compared to the State rate (SMR = 0.990 and 1.217 for males and females respectively; based on cancers between 2007 and 2011 inclusive).

Has the situation changed over time?

Figure 1: Melanoma (skin) cancers age standardised rate (ASR) by sex and year.



Note: Where an age range has no corresponding data point, the number of cases within that age range is too small to generate a reliable rate.

Table 1: Number and rate of melanoma (skin) cancer in the Kimberley Pilbara Medicare Local Region.

Gender	Measures				
Male	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	17	N/A	N/A	N/A
	2008	12	N/A	N/A	N/A
	2009	19	N/A	N/A	N/A
	2010	21	65.11	27.15	103.06
	2011	17	N/A	N/A	N/A
Female	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	8	N/A	N/A	N/A
	2008	10	N/A	N/A	N/A
	2009	13	N/A	N/A	N/A
	2010	13	N/A	N/A	N/A
	2011	12	N/A	N/A	N/A
Combined	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	25	42.27	20.54	64.00
	2008	22	45.48	21.84	69.13

	2009	32	59.71	32.62	86.81
	2010	34	56.73	32.30	81.16
	2011	29	40.62	21.52	59.72

Note: 1. ASRs are standardised with the Australian 2001 population and expressed per 100,000 person years. 2. The 2011 data should be considered as preliminary. 3. As data may include cases with unknown gender, the number of persons could exceed the sum of males and females. 4. Data geocoded to the SLA of residence has been used rather than postcode of residence. **Note:** N/A indicates that the cell content has been suppressed due to privacy policies, or to withhold an unreliable rate derived from a low count.

- Since 2007 the total number of melanoma (skin) cancers increased from 25 to 29 by 2011.
- During the 5 year period, the male rate of melanoma (skin) cancer did not change significantly. The average annual percentage change in the rate was -2.4%.
- For females the rate of melanoma (skin) cancer also did not change significantly. The average annual percentage change in the rate was 4.9%.

How many people are involved and who is being affected?

Table 2: Number of melanoma (skin) cancers by Aboriginality and sex (2007 to 2011).

Race	Sex		Total
	Males	Females	
non-Aboriginals	73	48	**121**
Aboriginals	N/A	N/A	**N/A**
Combined	N/A	N/A	**N/A**

Note: As data includes cases with unknown gender and/or race, grand-total may exceed the sum of sub-totals. The number of cases with unknown race or gender represents 12.7% of the total record count. **Note:** N/A indicates that the cell content has been suppressed due to privacy policies, or to withhold an unreliable rate derived from a low count.

- The average number of melanoma (skin) related cancers in the Kimberley Pilbara Medicare Local Region was 28 persons per year between 2007 and 2011 inclusive.
- Of the cancers for the combined population, 60.6% were male.

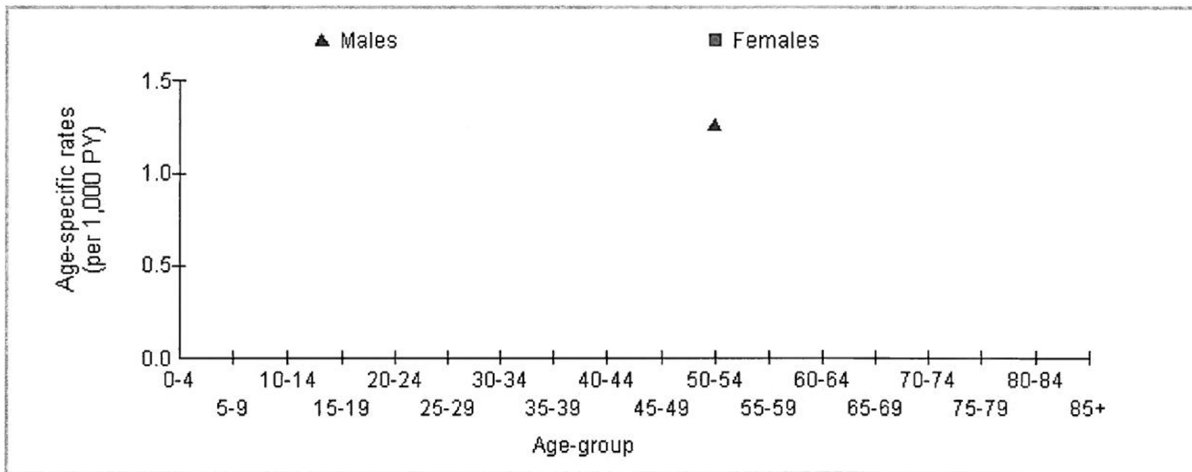
Table 3: Percentage of melanoma (skin) cancers by age and sex (Kimberley Pilbara Medicare Local Region: 2007 to 2011).

Sex	Age group					
	0-4	5-14	15-24	25-44	45-64	65+
Male	0.0%	0.0%	0.0%	24.4%	55.8%	19.8%
Female	0.0%	0.0%	5.4%	26.8%	55.4%	12.5%

- The age group most affected by melanoma (skin) is the 45-64 year olds.
- Although the total number of melanoma (skin) cancers in males was greater than the number of female cancers, the percentage of males aged 45-64 years affected was similar than that seen for females who live in the Kimberley Pilbara Medicare Local Region.

A graph of the age profile of those people most commonly affected by melanoma (skin) is shown below.

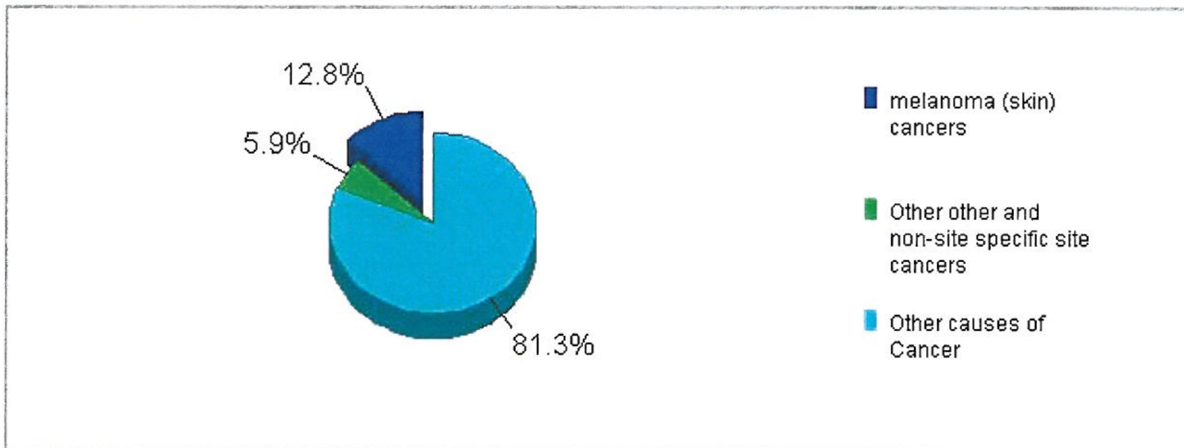
Figure 2: Age specific melanoma (skin) cancers rates (Kimberley Pilbara Medicare Local Region: 2007 to 2011).



Note: Where an age range has no corresponding data point, the number of cases within that age range is too small to generate a reliable rate.

What proportion of all melanoma (skin) cancers do those in Kimberley Pilbara represent and how does this compare to the State?

Figure 3: Percentage of cancers in Kimberley Pilbara Medicare Local Region by cause (2007 to 2011)



- For the Kimberley Pilbara Medicare Local Region, melanoma (skin) cancers accounted for 12.8% of all cancers between 2007 and 2011.
- Compared to the State, the percentage of other and non-site specific site melanoma (skin) cancers was higher in the Kimberley Pilbara Medicare Local Region (67.1% and 68.6% in State and Kimberley Pilbara Medicare Local Region respectively).

Specific health condition analysis

Kimberley Pilbara Medicare Local Region

Non-melanoma skin cancer (exc. scc/bcc) cancers

Citation: Health status report on non-melanoma skin cancer (exc. scc/bcc) cancers for the Kimberley Pilbara Medicare Local Region. Epidemiology Branch (PHI) in collaboration with the Cooperative Research Centre for Spatial Information (CRC-SI). Generated using data from the WA Cancer Registry. Accessed Wednesday, 30 April 2014 by Colleen Koh (Epidemiology Branch).

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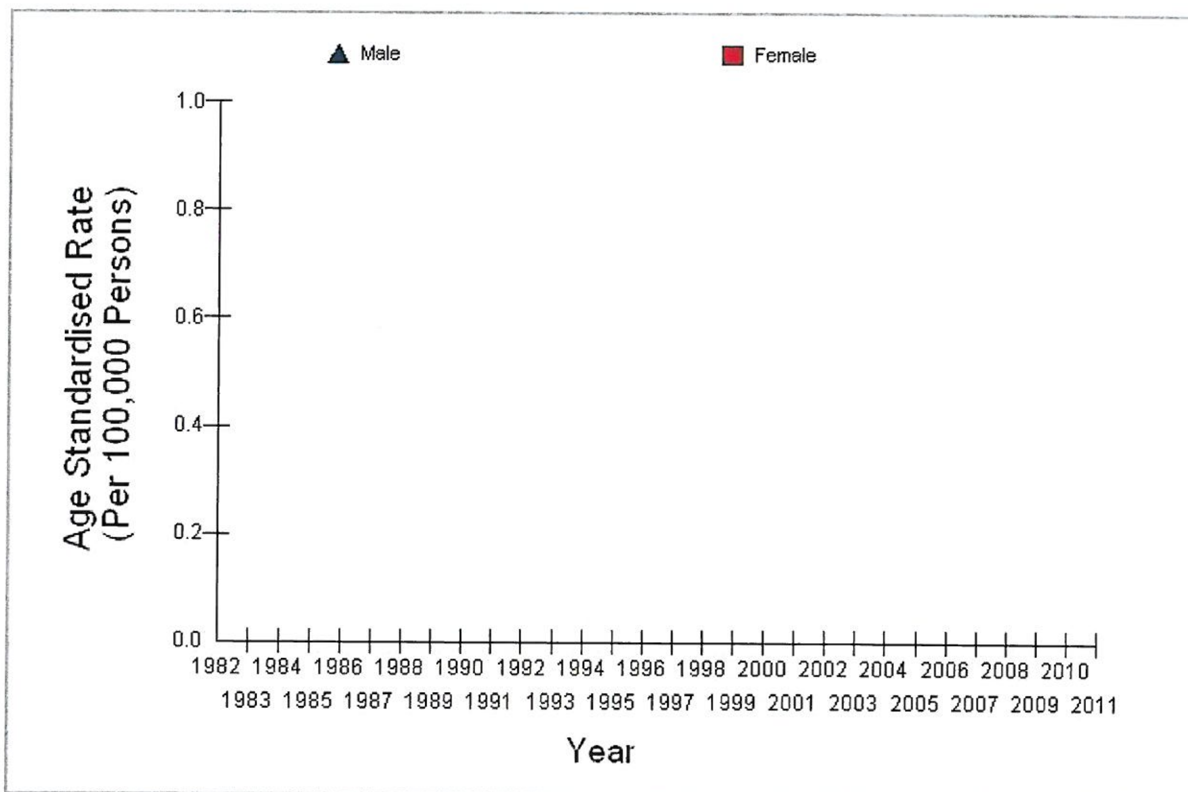
How do non-melanoma skin cancer (exc. scc/bcc) cancers in this area compare to the State rate?

After allowing for any differences in the population age structure, the number of cancers for non-melanoma skin cancer (exc. scc/bcc) in the Kimberley Pilbara Medicare Local Region was similar for both males and females compared to the State rate (SMR = 0.706 and 0.496 for males and females respectively; based on cancers between 2007 and 2011 inclusive).

Has the situation changed over time?

Figure 1: Non-melanoma skin cancer (exc. scc/bcc) cancers age standardised rate (ASR) by sex and year.



Note: Where an age range has no corresponding data point, the number of cases within that age range is too small to generate a reliable rate.

Table 1: Number and rate of non-melanoma skin cancer (exc. scc/bcc) cancer in the Kimberley Pilbara Medicare Local Region.

Gender	Measures				
Male	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	0	N/A	N/A	N/A
	2008	N/A	N/A	N/A	N/A
	2009	0	N/A	N/A	N/A
	2010	N/A	N/A	N/A	N/A
	2011	N/A	N/A	N/A	N/A
Female	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	0	N/A	N/A	N/A
	2008	N/A	N/A	N/A	N/A
	2009	0	N/A	N/A	N/A
	2010	N/A	N/A	N/A	N/A
	2011	N/A	N/A	N/A	N/A
Combined	**Year**	**n**	**ASR**	**Lower C.I.**	**Upper C.I.**
	2007	0	N/A	N/A	N/A

	2008	N/A	N/A	N/A	N/A
	2009	0	N/A	N/A	N/A
	2010	N/A	N/A	N/A	N/A
	2011	N/A	N/A	N/A	N/A

Note: 1. ASRs are standardised with the Australian 2001 population and expressed per 100,000 person years. 2. The 2011 data should be considered as preliminary. 3. As data may include cases with unknown gender, the number of persons could exceed the sum of males and females. 4. Data geocoded to the SLA of residence has been used rather than postcode of residence. **Note:** N/A indicates that the cell content has been suppressed due to privacy policies, or to withhold an unreliable rate derived from a low count.

- During the 5 year period, the male rate of non-melanoma skin cancer (exc. scc/bcc) cancer did not change significantly. The average annual percentage change in the rate was -7.1%.
- For females the rate of non-melanoma skin cancer (exc. scc/bcc) cancer also did not change significantly. The average annual percentage change in the rate was -41.9%.

How many people are involved and who is being affected?

Table 2: Number of non-melanoma skin cancer (exc. scc/bcc) cancers by Aboriginality and sex (2007 to 2011).

Race	Sex		Total
	Males	**Females**	
non-Aboriginals	N/A	N/A	**N/A**
Aboriginals	0	0	**0**
Combined	N/A	N/A	**N/A**

Note: As data includes cases with unknown gender and/or race, grand-total may exceed the sum of sub-totals. The number of cases with unknown race or gender represents 40.0% of the total record count. **Note:** N/A indicates that the cell content has been suppressed due to privacy policies, or to withhold an unreliable rate derived from a low count.

- Of the cancers for the combined population, 80.0% were male.

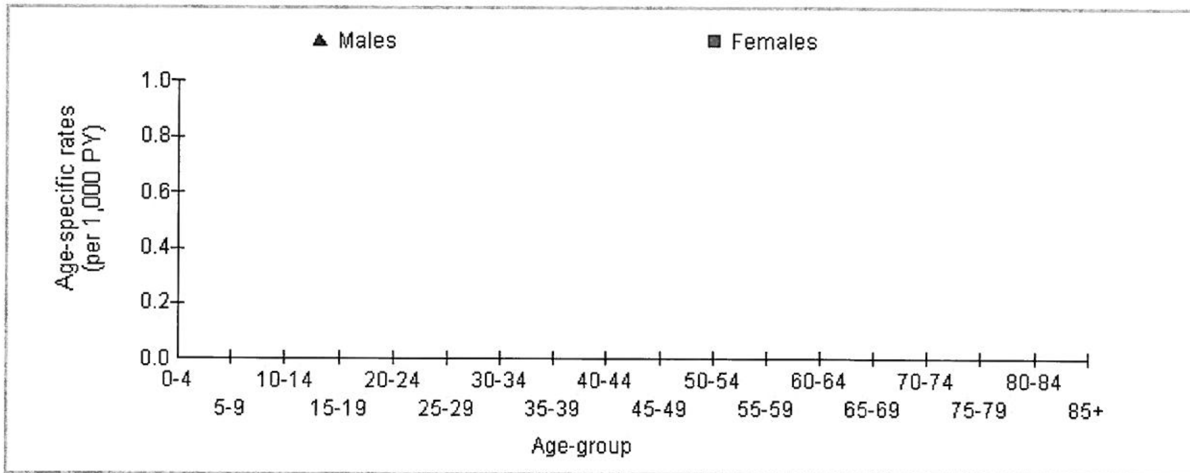
Table 3: Percentage of non-melanoma skin cancer (exc. scc/bcc) cancers by age and sex (Kimberley Pilbara Medicare Local Region: 2007 to 2011).

Sex	Age group					
	0-4	**5-14**	**15-24**	**25-44**	**45-64**	**65+**
Male	0.0%	0.0%	0.0%	25.0%	50.0%	25.0%
Female	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%

- The age group most affected by non-melanoma skin cancer (exc. scc/bcc) is the 45-64 year olds.
- Although the total number of non-melanoma skin cancer (exc. scc/bcc) cancers in males was greater than the number of female cancers, the percentage of males aged 45-64 years affected was lower than that seen for females who live in the Kimberley Pilbara Medicare Local Region.

A graph of the age profile of those people most commonly affected by non-melanoma skin cancer (exc. scc/bcc) is shown below.

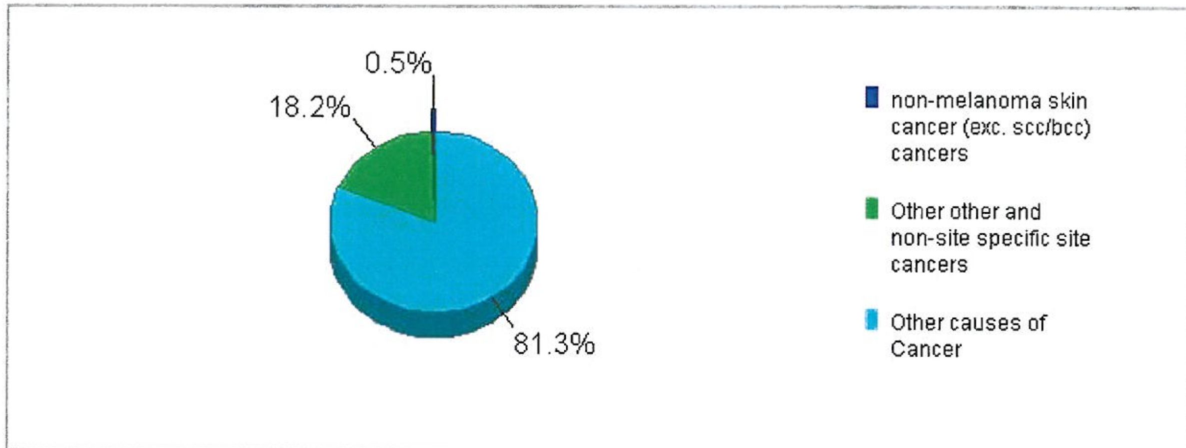
Figure 2: Age specific non-melanoma skin cancer (exc. scc/bcc) cancers rates (Kimberley Pilbara Medicare Local Region: 2007 to 2011).



Note: Where an age range has no corresponding data point, the number of cases within that age range is too small to generate a reliable rate.

What proportion of all non-melanoma skin cancer (exc. scc/bcc) cancers do those in Kimberley Pilbara represent and how does this compare to the State?

Figure 3: Percentage of cancers in Kimberley Pilbara Medicare Local Region by cause (2007 to 2011)



- For the Kimberley Pilbara Medicare Local Region, non-melanoma skin cancer (exc. scc/bcc) cancers accounted for 0.5% of all cancers between 2007 and 2011.
- Compared to the State, the percentage of other and non-site specific site non-melanoma skin cancer (exc. scc/bcc) cancers was lower in the Kimberley Pilbara Medicare Local Region (5.5% and 2.4% in State and Kimberley Pilbara Medicare Local Region respectively).

Medicare Locals Needs Assessment Report Template 2013

Medicare Locals must complete this template. The information provided in the template should reflect a concise summary of the information requested. Where appropriate, further information, tables, evidence, graphics etc. that you wish to provide, should form an attachment to this template.

Medicare Local information

Needs Assessment Report of:

Kimberley Pilbara Medicare Local

(Name of Medicare Local)

Contact Person

Darren Armitage – Population Health and Community Director

(Name of contact person at the Medicare Local)

Contact Details

phcd@kpml.org.au or 0417 734 068

(How can we contact you if we require additional information?)

CERTIFICATION

I, the undersigned, certify that the information provided in this Needs Assessment Report is correct and has been approved by the Medicare Local's Board of Directors. I acknowledge that it is an offence under Section 137 of the *Criminal Code Act* 1995 to provide false or misleading information or documents to the Commonwealth.

Signed: Darren Armitage Date: 16/05/2013

Name: Darren Armitage Position: Population Health & Community Director

1. How have you progressed your understanding of the health care needs of your population?

Your response should demonstrate that you have performed activities to obtain a better understanding of your population and that you are working collaboratively with local stakeholders.

This template should be completed with reference to the *Guide for completing the Template for Medicare Locals Needs Assessment Report* (the Guide).

1.1 Describe how you have progressed your understanding of the health care needs of your population?

(Please refer to items 2.1, 2.2, 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 4.1 and 4.2 of the Guide)

- *Outline the activities you have undertaken to understand the heath care needs of your population. For example, include details here of any formal processes you have implemented, focus groups held and specific data accessed.*
- *What challenges have you have faced?*

Response:

"The population of the Kimberley and Pilbara regions of North Western Australia experience's significant inequality and have some of the poorest health outcomes of all Australians. This requires urgent action by government and other key stakeholders in the region"

'Health First Network' – Learn Innovate Care
Dr Peter Del Fante,, Clinical & eHealth Director May 2013

A Snapshot: Kimberley Pilbara Region

The Kimberley and Pilbara regions of North Western Australia are a majestical combination of natural and man-made phenomena's; a intertwining kaleidoscope of intoxicating beauty and raw power; a land that is home to some of the oldest surviving peoples on earth; and unfortunately a cosmopolitan delineation of the 'have's' and 'have nots'!

Overview - Progression Processes & Plans

The Kimberley Pilbara Medicare Local (KPML) since its inception in July of 2012 has already progressed significant substantive achievements and outcomes in this relatively short time frame. One of these key milestones is the undertaking and completion of the mandated Medicare Local 'Needs Assessment Report' (NAR). The incipient strategy in ensuring this outcome was to generate a pragmatic, dynamic working document that would identify and comprehend the health needs of the people in its population. To this effect the KPML NAR employed a semi-structured investigative research model that engaged both formal and informal relationships with Government, non-government bodies, tertiary/academic institutions, Aboriginal controlled/owned community organisations, key external stakeholders and individuals. Numerous audit mechanisms were undertaken that underpinned and informed the body and recommendations of this report.

Existing Knowledge and Experience Synthesis

It is of paramount importance to acknowledge that the majority of KPML employees have been entrenched in the health service needs and landscape of this region for many years through a diversity of organisations and local experiences. Moreover the additional collegial staff members bring extensive health delivery experience from rural and remote Australia inclusive of working in Aboriginal and Torres Strait Islander Communities. Commensurately KPML engenders a very efficacious and intimate knowledge of local communities, their cultural, social, political and economic structures in their geographical boundaries. This 'rich' resource of professional and personal knowledge and experience contributed invaluably to the identification, assessment, analysis, interpretation and planning to most appropriately meet the health needs of the KPML population. As ultimately at the core of all health planning are the knowledge and the experiences of individuals, families and communities whom shape the context for health. Thus prior to submission for ratification this document will be peer reviewed and where possible by those whom it will potentially impact upon.

Historically there is no paucity of documentation that outlines and focuses on the health status and delivery of primary health service to the population of the Kimberley and Pilbara regions. However the integrity of the data sources and subsequent well-intentioned interventions are vulnerable to arguably subjective interpretations, primarily by groups and individuals with vested interests. Nonetheless this report unashamedly draws upon some of the findings of previous population health profiles, needs assessments, and community analyses, to assist and inform KPML's current needs assessment and outsourcing service capacity to address the needs of its population. This data is both quantitative and qualitative in nature and substance.

KPML Population Health Commissioning Atlas

An integral component of the NAR is the utilisation of the innovative and reputable 'Health First Network' to generate KPML's Population Health Commissioning Atlas (PHCA). The PHCA incorporates best practice epidemiological and statistical evidence informed by local, state and national policy reports and research. This robust tool proffers evidence that is tailored for the local population trends, service delivery/access, prevalence and burden of disease to inform health planning.

The concept is to produce an active document that not only profiles health status and variation in the KPML population, but also identifies areas of need and recommendations for future planning and commissioning. The proposed National Performance Indicators for Medicare Locals (ML) are used as a starting point for analysis and supplemented by other local population health considerations and stakeholder input. Information rich graphs and maps are generated to summarise key epidemiological and health services/workforce data. Additionally PHCA uses the latest Global Information Systems technology to precisely plot coordinates of communities in the regions. The KPML data is compared where possible to the other 61 ML's. For each indicator, the data is compared to the total range of ML data, then ranked and assigned a position in a quintile range – the highest ranked position having the greatest health need. The PHCA is comprised of four components. The first is an introduction and map of the region showing areas of disadvantage based on Socio-Economic Index for Areas (SEIFA). The second is the visual presentation of population health and services data. The third is an analytical matrix comparing KPML with other ML's and between the (Statistical Local Areas) SLAs within the ML's. A summary needs assessment is generated for each domain and subsequently created for each of the seven domains of population health, as well as a needs

requirement for any specific populations at risk. The final component is a description of the approach to commissioning and prioritising needs, culminating in a summary of commissioning recommendations, prescriptive but not mandated for the KPML NAR outcomes. The completed KPML 'PHCA' may be used as a stand-alone document for health planning however caution is issued and it is highly recommended that the Atlas be engaged with other health planning tools for optimum value. The PHCA will be as an addendum of this NAR document.

As previously reiterated existing reports of the region's population health needs have been considered with the visioning for planning by KPML. This involved consistently revisiting and reflecting on these reports and studies from state and federal bodies, such as the Australian Government and State Territory Governments, Department of Health and Ageing, Australian Institute of Health and Welfare, Western Australian Country Health Service and other population health data sources and then superimposing with the PHCA data so as to determine if the patterns and trends coalesced.

Examples of organisations that documentation, reports and data has been extrapolated from to inform the NAR includes but is not limited to:

- The Australian Government and State Territory Governments (Australian Early Development Index)
- Australian Bureau of Statistics
- Department of Health and Ageing (Commonwealth)
- Department of Health Western Australia
- Western Australian Country Health Service (WACHS)
- WACHS Population Health
- Kimberley Aboriginal Health Planning Forum
- Pilbara Health Network
- Mawarnkarra Health Services
- Boab Health Services
- Aboriginal Health Council WA
- Puntukurnu Aboriginal Health Service
- Derby Aboriginal Health Service
- Centre for Research Excellence in Aboriginal Health & Wellbeing
- University of Western Australia
- Telethon Institute for Child Health Research
- Australian General Practice Network
- Royal Flying Doctors Service WA
- St Johns Ambulance Service
- Medicare Australia
- Kimberley Development Commission;
- Australian Institute of Health and Welfare
- Australian Bureau of Statistics
- Western Australian Planning Commission
- Tourism Western Australia
- Department of Regional Development
- Pilbara Development Commission
- Rural Health West
- Town of Port Hedland
- Health Outcomes Assessment Unit, Department of Health WA
- National Health Workforce Taskforce

Stakeholder & Community Consultation

The Combined Universities Centre for Rural Health Research (CUCRH) were engaged by KPML to undertake additional activities to qualitatively assess and analyse the health service needs of the population with an supplementary after-hours caveat. This objective research was compartmentalised into four phases and all research tools were developed and informed by guidelines proffered by DoHA in consultation with KPML.

1. Desktop analysis: This incorporated sourcing demographic data in the KPML sub-regions of the Kimberley and Pilbara. Specific health data was obtained and subsequently distilled using the headings of the After-Hours Program template as a guide to the information required. The analysis included health service providers but not limited to: Hospital separations, GP surgeries, Community health centres, Aboriginal Medical Services, WA Country Health Service sites, Nursing posts, The Royal Flying Doctor Service, St John Ambulance Service, Pharmacies, Aged Care Facilities, Palliative care services, Allied Health, Radiology, Pathology and Mental Health.
2. Anecdotal Information: Telephone contact was established and discussion/consultation with key service providers from both regions to obtain anecdotal information required assisting in informing the health needs of the population. Interviews were completed over the telephone or by the service provider completing the questionnaire vis-a-vis email. Examples include but not limited to are: Kimberley & Pilbara Development Commission's; Western Australian Planning Commission; Department of Regional Development; Rural Health West; National Health Workforce Taskforce and Tourism Western Australia.
3. Field visits: Randomly identified service providers in the regions of the Kimberley and the Pilbara were contacted to arrange a convenient time for the completion of a questionnaire on health services provided including the provision of any after-hours services offered or the intention to do so in the future. The questionnaire was interviewer administered.
4. Community Questionnaire: A questionnaire using the on-line tool 'Survey Monkey' was constructed and distributed to numerous KPML communities. This enabled community members the opportunity and capacity to comment on the health services in their area. The KPML 'Survey Monkey' access link was sent out on-line via email to local organisations such as tourism centres, libraries, small store owners, WACHS sites, AMS's and GP clinics in both regions. A flyer was attached with information about the questionnaire outlining aims, highlighting confidentiality and noting date required for completion. The community questionnaire was also disseminated to personal contacts of KPML and CUCRH staff.

Summary

Although the above research, activities and mechanisms has been comprehensive and exhaustive in its collation and analysis, given the tight time-frame; the information surmised proffers a relatively accurate broad spectrum and perspective of the health service and care needs of the Kimberley and Pilbara population. In the first instance it must be noted to state that 'the challenges confronted in sourcing, compiling and analysing an area and population the size and diversity of the KPML catchment was formidable'; is an understatement. However acknowledging, utilising and incorporating the 'rich' pre-existing resource of professional and personal knowledge and intuitive experiences of the KPML team ensured that the NAR 'hit the

ground running'. Additionally as the 'Medicare Local' brand becomes better known and in particular the Kimberley Pilbara hub the increased access and information is shared by organisations and communities. Overall this has assisted invaluably for collaboration with the aim of improving the health of the KPML population.

Fusing the intrinsic learned knowledge and experiences of the KPML team; the bio-statistical and epidemiological data of the PHCA with the mandate given to CUCRH for qualitative research into actual organisation health services and perceived community health service delivery and care was instrumental in developing, implementing and evaluating mechanisms by which to measure the 'rhetoric vs the reality'. Desktop analysis, anecdotally shared information, organisation and community consultations constructed the essence of responses and subsequently the data that outlined the theoretical and practical commitments for health services and utilisation.

Finally the capacity to acquire and access the combination of qualitative and quantitative data whilst both efficacious and meritorious is problematic and remains an important caveat, as it is laborious, time-consuming, oft-dated and open to subjective interpretation. The statistical data specifically has proven to be challenging as the validity is habitually variable and at times incompatible for comparative analysis. Moreover the status of the raw data available and documented needs to be cogitated and considered very carefully for the planning of any potential future services of the Kimberley Pilbara population. Paradoxically the opportunity around collecting further information about the health care needs and services for the KPML population is tremendously exciting factoring into the equation the employment of the KPML's 'Population Health Commissioning Atlas' the scope and size of which has not been undertaken in the region previously.

Through this rigorous three-tiered configurative process, engaging the duality of qualitative and quantitative data on the health service delivery and needs of the Kimberley and Pilbara population; ensures KPML is in a robust position moving forward to highlight and facilitate the addressing of health strengths, priorities, inequities and gaps of the catchment area.

1.2 Provide details of your relationships with stakeholders in your catchment area

(Please refer to items 4.2 and 4.3 of the Guide)

- *Detail the stakeholders you have worked with to develop your understanding of health care needs?*
- *Which stakeholders do you need to build relationships with?*
- *What barriers or issues have you encountered in working with stakeholders?*

Response:

Historical Stakeholder Context

Prior to commencing any commentary on relationships with KPML stakeholders it is of paramount importance to echo the foundations of the historical liaisons of 'Medicare Local' predecessor organisations and employees (eg. Divisions/Networks of GP's). Including the solicitation for carry-over of their alliances with numerous stakeholders for health service delivery and care in the Kimberley Pilbara population. It should also be noted that with all relationships both professional and personal there are intellectual, social, emotional, material, fiscal caveats and constraints, however currently none of these have been prohibitive for KPML in maintaining high degrees of integrity and trust with its stakeholders.

Correspondingly given the relatively brief operational status of KPML, it has continued to sustain, develop, nurture and build stakeholder relationships across the spectrum of health service agencies including government, non-government, community organisations, groups and individuals.

Pre-existing and Existing Stakeholder Engagement

KPML is an establishment member of the Pilbara and Kimberley District Health Advisory Committees convened by the WA Country Health Service comprising of consumer/client representation, key community agencies and health service providers across the regions. These committees work to ensure connectivity between the acute and primary health care sectors and provide access for community input to health plans for the regions. KPML will continue to advise these committees on developing and strengthening the linkages between the primary and acute sector to ensure the best possible health outcomes for community consumers.

Of real significance that needs to not be understated is that KPML has been accepted and welcomed into membership for both the Pilbara and Kimberley Aboriginal Health Planning Forums as a key partner. These forums are the peak primary health care forums for Aboriginal primary health care in the regions and membership includes all Aboriginal Medical Services, the Western Australian Country Health Service, Royal Flying Doctor Service, the Divisions/Networks of General Practice and valued community based primary health care organisations. The forums are instrumental in the development of health care planning for Aboriginal people in the regions and have been utilised by the WA Government as the key advisors on COAG CTG programs and funding arrangements. KPML will continue to work with the forums on community engagement and population health planning.

KPML is an establishment member of the inaugural National Rural Health Alliance – a network of individuals and organisations supporting best evidence and practice health outcomes in regional and remote areas of Australia. Additionally KPML as its own entity has actively engaged across the region with Aboriginal Medical Services, the Divisions, General Practices, Hospitals Government and non-Government organisations. Initially for the development of the stakeholder consultation but also to inform and recruit for national programs including Personal Controlled Electronic Health Records (PCEHR), After Hours Services, Partners in Recovery, Mental Health and Workforce Issues. Moreover relationships have been developed and enhanced with agencies such as WA General Practice Education and Training, Rural Health West, Aboriginal Health Council of WA, ARAFMI, Carers WA, SARRAH the WA ML Group, the State-wide Aboriginal Planning Forum and the WA Country Health Forum. Numerous and diverse interagency meetings are attended by KPML staff on a regular basis.

KPML has played an integral role in the coordination of Ehealth initiatives across the region and is convening workshops of clinicians and Ehealth representatives from service agencies and is developing agreements on standards, protocols and procedures relating to Ehealth governance, privacy and consent, data security and information exchange. The Ehealth team uses a web based solution called Basecamp which has proved highly successful in maintaining communication with its Ehealth constituency and also as a peer networking tool.

Complimenting these initiatives is the evolving KPML website which will embed a community access portal that will advise on health plans and priorities and provide information on service availability throughout the regions. A comprehensive service map coupled with contact information and service delivery timetable will be available for health agencies and consumers.

Formative Stakeholder Engagement & Challenges

Sustained efforts to continue to build relationships along the social paradigm continuum will progress in the immediate future. KPML will explore symbiotic connections with State Departments of Education, Community Services, Police, Emergency Services and Ageing and Disability with a distinctive local capacity to further enhance the health of all people in the Kimberley and Pilbara regions. Strengthening previous associations with Local Government agencies, such as the eight SLA's (shires/councils) within the KPML boundaries are a priority. As are those related to large non-government organisations such as but not limited to the Heart Foundation, Cancer Council, Diabetes Australia, the Pharmacy Guild, Anglicare, and other Benevolent/Philanthropic Societies as is required.

The challenges for KPML in sustaining, rejuvenating past and forging new relationships have been relatively few, largely due to the tireless and committed efforts of a small, passionate and rigorous employee base. Nonetheless perhaps the greatest barrier has been that of the generic brand 'Medicare Local'. Currently the brand and identity of 'Medicare Local' is not easily recognised nor understood by service providers and consumers alike. In the most rudimentary of observation it is this lack of 'validation' which impacts upon the potential of health service planning for the future. The continuing advocacy by staff as a 'voice' and 'visibility' of the brand in the Kimberley Pilbara regions is incrementally but significantly alleviating this anomaly. However it is with great anticipation and expectation that the Commonwealth, State and Regional mass media campaigns will provide much needed identity and creditability to the brand 'Medicare Local'.

2. What are the health care needs of your population?

Provide a snapshot of the health care needs of your population. Your response should demonstrate that you understand differences in health care needs across your population and that you have identified and considered a range of opportunities to improve health outcomes through primary health care initiatives/services.

NOTE: If you have identified other health care initiatives/services to improve health outcomes which you intend to pursue please provide details of these here.

2.1 Provide a snap shot of the health care needs of your catchment population

(Please refer to items 4.3 and 4.4 of the Guide)

Your snapshot should:

- *Describe the health care needs of your population.*
- *Describe the health service system in your catchment area, identifying what works well, what doesn't work well and what gaps exist.*
- *Discuss opportunities to improve the health outcomes of your population through primary health care services/interventions.*
- *Discuss the levers available to your Medicare Local to implement primary health care*

initiatives or services changes.

NOTE: You are not required to provide comprehensive details on the health care needs of your population. You should highlight what you consider to be the ***major*** *(primary) health care needs in your catchment.*

Response:

Health Care Needs – not just a health issue!

Almost without exception a snapshot for health conditions, care and service delivery by identified Medicare Locals Key Performance Indicators/Domains reveals; that the Kimberley and Pilbara regions consistently rank among those with the poorest health status of all Australians. Additionally this is compounded by a disproportionate highest ranking of needs associated with the social determinants of health by ML quintile and SLA range eg. Access, Affordability, Education, Housing, etc.

It must be reiterated that the Kimberley and Pilbara are vast regions of almost 1 million square kilometres combined that occupy 40% of Western Australia's landmass and 12 % of the total Australian landscape. Moreover there are over 250 identified towns and communities from large local hubs to very small remote isolated camps with little or no infrastructure and services. Accessibility to and from these towns and communities is often only possible with all-terrain 4WD vehicles, light aircraft and/or helicopter; and this too is often subject to the volatile extreme weather conditions particularly during the wet season (October to March). There are 8 SLA's in the catchment population of 94,688 inclusive of an identified Aboriginal and Torres Strait Islander population of 21,126 which accounts for 22.3% of the overall population. The other significant population demographic to highlight is the particularly high numbers of fly-in-fly-out (FIFO) workers, long term and visiting tourists that accounts for a large transient sub-population.

The health service needs of the KPML population are as varied and complex as any population when considering the uniqueness of communities which make up the large catchment area. In terms of health status of the population living in and around these areas, it is widely documented in the literature and accepted that those from rural and remote areas are generally not as healthy as their city counterparts. This picture of poorer health is formed by numerous elements including the socio-economic disadvantages of many rural/remote communities (lower levels of education, income and employment, occupational risks from farming or industry). Additionally the depiction of rural/remote health is also affected by the many health disadvantages suffered by ATSI Australians as they contribute to a considerable proportion of the population and their health problems are severely disproportionate to that of the general population.

Compounding the problem although somewhat paradoxically (due to very high-end scale wages) is that the data indicates that there is a significant 'fly- in fly-out' workforce in the Kimberley Pilbara region at any one given time. The Beyond Blue submission to the House of Representatives House Standing Committee on Regional Australia Inquiry into the use of FIFO workforce practices in regional Australia potentially impacts on health and wellbeing of workers, their families and host communities:

- Increased numbers of fatigue-related injuries and accidents
- Mental health problems
- Crime and violence associated with excessive alcohol intake and other drug use
- Family-related problems, including violence, break-ups and parenting problems

• Low levels of community cohesion and connectedness

To a lesser degree is that of the significant influx of the transient sub-populations (Grey Nomads/Backpackers) that move through and reside in the region during the 'dry season' and the pressure placed on already widely straining health service.

Whilst regional, rural and remote areas of Australia will always struggle with the geographical constraints of distance to some degree which directly effects access to services; other factors such as socioeconomic status as mentioned above have compounding detrimental impacts. It is in recognising these and other social determinants of health that we have gained a better understanding of the health care needs of the region. Therefore the key local social health determinants of influence that impact on health status, care and service delivery, that are particularly exacerbated in the KPML catchment area include in no chronological order:

- Lack of education
- Poor environmental health
- High levels alcohol and drug misuse
- Unemployment
- High cost of living
- Poor law and order
- Family violence
- Poor quality food and food access
- Unwillingness to take care of own health
- Poor health literacy

Whilst it is recognised that there will be greater potential in the future to tackle identified gaps as further relationships are made; and secured based more substantially on the social determinants of health. A realistic and pragmatic approach is required for the 2013-2014 period. Hence reporting of findings ultimately aims to offer significant scope and opportunities to improve health outcomes through primary health care initiatives and services facilitated and assisted by KPML.

The major identified need in the KPML region fundamentally relates to access to a range of efficacious health care services and practitioners both at the primary and acute level to enhance the individual's and populations health status. The factors that contribute to this gap are seemingly simple in identification but complex to analyse and even more convoluted to redress. It is important to understand that for the KPML population each of these factors is linked intrinsically yet also arbitrarily to the next creating a meandering cyclical pattern of inaccessibility. To summarise:

Access to health services and health opportunities for the catchment region is impeded by;

- Geographical distance and isolation
- Access to and affordability of transport
- Service availability or perceived availability.
- Workforce shortages
- Prohibitive costs - associated with all of the above
- Limited knowledge of the service availability or how to access information on services

provided in the region

• Severe levels of disadvantage

Acknowledging and incorporating these elements for planning to enhance, expand and develop health service systems is paramount for success. Further discussion of access related barriers to health service, care and health opportunities specific to the population of the KPML region will be delineated later in this report.

Health Service System – State of Affairs

The rhetoric of the health service system and the organisations, groups and individuals that serve in the Kimberley Pilbara is laudable in its aims, achievements and outcomes. However the reality of the health service paradigm is that of a piecemeal, fragmented, and often divisive collaboration. The pre-dominant organisations that provide the acute and primary health service for the catchment area are: WACHS, AMSs, GPs, RFDS, private practices and to lesser degree smaller benevolent providers to rural and remote communities. That being stated the individuals, groups and organisations that provide health services in the KPML region are genuinely dedicated, and tirelessly committed to improving the health of this population. Medicare Local Kimberley Pilbara goal is to assist, foster and forge actual change and action that will enable the capacity of health services to make that difference.

Workforce Issues

The health service workforce in the Kimberley Pilbara is no different to that of the rest-of-the-world phenomena being the shortages of health professionals nominally doctors and nurses for acute health treatment and care. Nonetheless if real gains are to be made on the health status of the target and overall population then certainly the paucity of preventative, health promotion and allied health professionals in the region needs also to be addressed. Factors influencing the ongoing challenge for recruitment and retention of a suitably qualified workforce include remuneration, housing, education, transport and the overall liability of the environmental conditions.

As such the key local health system challenges comprise:

- Linkages with WA Country Health Services for Hospitals, Community Health, Population Health and ED
- Clinical staff retention, and high turn-over of locums and agency nurses
- Adoption of shared integrated electronic health records, access and privacy
- State systems still paper based
- Data gaps, variability and quality
- Service and medication management across departments
- Lack of coordination between providers: primary/allied/mental health/ health promotion

Challenges create opportunities! As such KPML has a platform to influence and underpin workforce practice change in recruitment and retention strategies. Maintaining the existing health workforce and improving the capacity for attracting new skilled practitioners to the catchment area is an integral focus in the visioning for KPML given the impact a poorly resourced workforce has on the overall health status of the population. Proposed prospects to build on existing and previous efforts in the region must be utilised. To this effect KPML in consultation with service providers and community will aim to;

- Facilitate wider professional networks for the varied health professionals by expanding membership opportunities to the KPML and developing enhanced information systems.
- Provide opportunities for health professional gatherings such as Continuing Professional Development forums which may also consider a wider more integrated approach than

previously available.

- Enhance and extend the organisational support services to a wider scope of health provider groups to assist in Ehealth & PECHR initiatives and effective delivery of service.
- Expand 'Health Recruitment and Retention Strategy' which works in partnership with key community and health organisations which have a vested interest in attracting professionals to the region.
- Collaborate coordination for activities with locally based universities and GP training organisations to promote rural workforce participation and research endeavours.
- Engage commissioned or subcontracted services to assist in meeting demand placed on workforce as an interim measure.

WA Country Health Services (WACHS)

The region is serviced by regional hospitals located at South Hedland and Broome, integrating hospitals located at Derby, Fitzroy Crossing , Halls Creek, Kununurra, Newman and Nickol Bay (Karratha). Smaller centres are serviced by clinical settings that primarily focus upon emergency response, resuscitation and stabilisation for transport. Most gazetted towns have a hospital and a community health centre where visiting specialist and GP services are either based or offer visiting services.

Aboriginal Medical Services

The region is home to eight Aboriginal Medical Services. Ord Valley Aboriginal Medical Service (Kununurra), Yura Yungi Medical Service (Halls Creek), Derby Aboriginal Health Service(Derby & Gibb River Road), Broome Regional Aboriginal Medical Service (Broome) Kimberley Aboriginal Medical Service Council (Bidyadanga, Beagle Bay, Balgo & surrounding communities), Wirraka Maya Aboriginal Health Service (Hedland), Puntukurnu Aboriginal Medical Service (Western Desert), Mawarnkarra Health Service (Roebourne).

General Practitioner Services

There are 4 categories of GPs in the Kimberley Pilbara region: GPs working in hospitals, GPs in Aboriginal Medical Services, GPs in corporate practices and GPs in private practices Information purports that GPs working in hospitals only have limited opportunities to provide primary care services, Corporate GP Services have a focus towards occupational health (worker medicals) and while well-staffed overall Aboriginal Medical Services can be impacted by mobile non-Aboriginal populations in the region seeking medical care.

Numbers listed below are for General Practitioners as at April 2013 designated by practice type, number and actual Full Time Equivalent (FTE); figures are not divided by gender. The GP's must have a local provider number to practice. These figures are subject to change at short notice and do not reflect if the GP's from practices also perform services in the hospital. It is of note to highlight that GP's do not have admitting rights to the Hospitals. The Numbers include private practice GPs, GP Registrars, RFDS GPs based in the KPML, AMS GPs, DMOs, SMOs and FIFO GPs who have a regular long term placement. The FTE is based on self-reported hours or session numbers provided by either the GP or the practice, and thus may be subject to interpretation or comprehension of term FTE.

Broome	#	FTE	**Derby**	#	FTE	**Hedland** #	FTE

AMS	22	20.6	AMS	2	1.5	AMS	5	5
WACHS	17	15.5	RFDS	6	6	WACHS	11	11
Private	10	9.5	WACHS	10	9.5	RFDS	5	5
	49	**45.6**		**18**	**17**	Private	7	7
							28	**28**

Karratha	#	FTE
WACHS	14	12.6
Private	9	7.6
	23	**20.2**

Kununurra	#	FTE
AMS	2	2
WACHS	11	8.7
Private	1	1
	14	**11.7**

NUMBER = 132
FTE = 122.5

There are conceivable opportunities for building GP primary care capacity in KPML region such as:

1. Building a more collaborative approach among providers in the region - System improvements such as Telehealth, PCEHR, standardised discharge summaries, secure messaging and e-discharge.

2. Joint education opportunities and orientation of all GPs and Medical Graduates coming to the region; around 1) Medicare & practice systems 2) best practice clinical management specific to population health issues and 3) culturally appropriate practice

3. Maximising operability between private GPs and hospitals (i.e. admitting rights)

4. Consideration to region specific funding formulas rather than more generic national formulas are combined with localised innovations to build resources (refocus programs such as ATAPS to populations of need or local partnerships with industry for localised solutions)

5. Addressing workforce challenges of recruitment and retention can be compounded in areas experiencing economic growth resulting in high costs of housing GPs or retaining dedicated

GP service where these are in competition with employment opportunities with higher remuneration, for example mining companies/hospitals.

However at the core of all GP focused primary care is a presence and applicability. For example of the all GPs working in the Pilbara almost half work in either the hospital or RFDS system and do not work in primary care. Therefore in surmising the major health workforce challenges for primary care medical services is securing sufficient funds to adequately service the region, attracting staff to positions and retaining them to ensure some level of stability in service delivery.

<u>Specialist Services – or rather lack-there-of!</u>

Specialist services within the KPML region are in enormous demand with current waiting lists in excess of anywhere from 3 - 24 months to secure an appointment. The region relies heavily, if not dependent on visiting specialist services which are provided to communities in the major Towns of the region by WACHS and may be either public and/or private consultant services. Few Outreach Assistance Programs are available however are subject to funding changes from one financial year to the next. The dependence on Visiting Medical Officer's (VMO) and the fragile instability of the outreach programs causes great anxiety for resident health providers and the community in the region. The majority of the KPML resident specialist services are geographically limited to Hedland and Broome making access difficult for those who are not close to these two major towns. The following list outlines the current resident Specialists in the catchment area as at time of writing.

Resident Specialists of the KPML Region are listed below, unfortunately at the time of writing the Pilbara region was unable to advise of such figures:

#	Kimberley	
#	nil	Anaesthetists
#	nil	Endocrinologist
#	nil	Palliative Care
#	nil	Surgeon – ENT
#	1.6	Gyn/Obstetrician
#	nil	Orthopaedic Surgeons
#	nil	Dermatologist
#	nil	Rheumatologist
#	nil	Radiologists
#	nil	Physician – Cardiologist
#	nil	Gastroenterologist
#	nil	Physician – Gastroenterologist
#	nil	Surgeon – Urology
#	2	Surgeon – General
#	2.5	Paediatrician
#	nil	Ophthalmologist
#	3	Psychiatrist

#	nil	Neurologist
#	nil	Rehabilitation Medicine
#	0.4	Nephrologist
#	1	Haematologist (also a general physician)
#	nil	Medical Oncologist
#	1	Physician
#	nil	Radiologists
#	nil	Consultant Neurosurgeon
#	nil	Cardiothoracic Surgeon
#	nil	Surgeon – Plastic and Cosmetic
#	nil	Surgeon – Oral/Maxillofacial
#	nil	Surgeon – Ear/Nose/Throat
#	nil	Paediatric Dental

Related but separate to general gaps in specialist service provision it is has been recognised that health needs and people requiring access to specialist services for children are severely disadvantaged and will most likely have to leave the region. This impact on the parents and wider family unit is traumatic; and often emotionally, socially and financially crippling.

In addition to specialist services, the majority of primary health care needs of the region are currently managed by a limited workforce of General Practitioners either vis-à-vis AMS's or private practices. Many GPs across the other regional areas whilst working for AMS's or private practice also provide Visiting Medical Officer (VMO), anaesthetic, and procedural obstetric services in the district health facilities and community hospitals, often in the after-hours period. However no such paradigm currently exists in the KPML region and the evolvement of such would be more conducive to specialised training; a capacity for the GPs in to participate in after-hours on-call arrangements with either their own practice or in agreement with other practices within larger towns and reciprocal admitting rights. This would greatly enhance the health care service in the region.

Allied Health & Nursing

The region has a diverse range of Allied Health Professionals who work either through WACHS, the AMS's or in private practice and are in huge demand. A number of communities benefit from visiting Allied Health services as supported by funding from local organisations and WACHS. Demand for Speech Pathology and other child associated services is very high as is the demand for mental health services. Community awareness of service availability and the networking of health organisations to appropriate Allied Health Professionals in the region requires attention as does further investigation of the barriers associated with accessing these services, particularly prohibitive fiscal concerns. Local anecdotal evidence strongly indicates that the region has seen more demand and use of preventative health and health promotion services than ever reported previously which is extremely positive but paradoxically disenfranchising as practitioners across the region are extremely limited.

The nursing workforce in the region has generally also experienced a shortage with many health facilities experiencing difficulties in rostering skilled and qualified staff to hospitals and health care facilities. Recruiting and retaining appropriately qualified nurses to the catchment area are at best problematic and at worst nigh on impossible. The Nurses and the nursing

profession/union though are highly valued and extremely credible from the community's perspective. This was most recently highlighted by the targeted tiered off work 'strike' by WA nurses prior to the WA State election for an increase in pay; the caretaker government incipiently refused the union's demands, but eventually relented and agreed to the demands. This was primarily due to community and consumer pressure. Very few professions have the political clout and robustness to achieve such an outcome; the transport and prison bodies/unions attempted to dovetail off the nurses success, however these actions fizzled and passed through apathy and attrition. Nurses simply as a metaphor are the face and frontline personnel of WACHS. They are held in highest esteem by the community particularly given the perceived constraints of resources available. The region employs, across its many health organisations and facilities significant numbers of Aboriginal Health Workers, other health workers such as Aged Care Assistant/workers, Assistants in Nursing, Disability Support workers and Home Care workers which support the nursing workforce. It should be also be highlighted that there are many unheralded auxiliary staff that enable the health workforce to function operationally to the best of its capacity such as PSA's orderlies, cleaners, maintenance, and catering etc. Without these 'blue collar' staff the health system would suffer immeasurably.

Access, Transport, Telemedicine, & a fistful of Dollar$ - interlocking cables for health!

Access, Transport and Telemedicine are all innately bound for the provision of health services and even more so in rural and remote areas. All communities and organisations raise access to services in a timely manner as a concern, obviously with a clear correlation to workforce shortages. Although intrinsically related to access, transport issues are frequently identified as an issue on its own. Anecdotal community examples noted included long waits to access health care, closed books, the infrequency of visiting health professionals, the special needs of disadvantaged groups and the need to travel to access services eg. Patient Admission Travel Scheme (PATS). PATS as a consequence and conduit of transport in the health care access with siloed funding is constantly revered and pilloried at the same time as an integral part of the rural/remote health care system. The less reliant on PATS as form of health care and more self-sufficient the localised health system can become the greater the incremental improvement in the health of the population will be both perceived and actual.

An important codicil to the access/transport issue is the emerging role of telehealth medicine, particularly for non-metropolitan areas. The KPML catchment region is planning for the footprint of the current optic fibre and fixed wireless rollout (negotiations are ongoing with telecommunication providers) in communities with the aim of provision for quality telehealth consultations and an impetus for health providers to embrace and utilise. There is a strong correlation that exists between after-hours access, workforce capacity and work/life balance for GPs and their practice teams. In many communities in-hours access is such a pressing issue that after-hours access is considered to be a low priority, and solutions are considered almost unachievable. Both the socio-economic disadvantages described above and the geographical remoteness and isolation of the population, may contribute to a significantly greater burden of disease with an increased need for after-hours services. The proportion of Aboriginal and Torres Strait Islander people living in the catchment area are very high and may have an impact on after-hours and Aboriginal people have a significantly greater burden of chronic diseases, such as diabetes, cardiovascular disease and kidney disease and their associated co-morbidities, compared to non-Aboriginal people.

A further possible impact on after-hours needs is the seasonal increase in the population from tourism. As tourists do not have access to their regular medical care, they may access care as casual clients of the local medical services, including after-hours services. Fly in/fly out workers from the mining industry may also access local medical services (if unavailable at the industry site), particularly for injuries. KPML has consulted widely with providers to map the

after-hours services provided with a view increasing and improving access. Addressing this issue requires effective and timely engagement of regional program staff and contractors and this has been initiated, linking into existing networks to engage with clinicians and other service providers. Additionally working relationships are being established with GP Connections and Ehealth including divisions and networks that continue operation in the region, representing the interests of GPs and practices. It is expected this will assist to decrease the disconcerted, disconnected experience for those located on the 'edge' of health, who have expressed the frustration of 'missing out'!

Emergency After Hours Services

The services available to the people of the KPML in the after-hours periods are severely limited to a number of factors, but largely due to geographical distances and economic viability. There are no pharmacies across the region open until after 8.00pm at night, there are no 24 hour GP clinics, and there are no dentists open after hours. The only stand-alone after-hours service accessible to the catchment area is the Accident and Emergency Departments of the WACHS which is limited to large towns. Smaller communities may only have access to a rural/remote clinical post with no Doctor, and/or Ambulance Service. Furthermore due to the lack of resources available at a number of the WACHS facilities, people requiring treatment that is not life-threatening are often required to drive many hours to access appropriate care. Utilising resources effectively is a constant dilemma due to the vast area needs service, including the major towns pooling of resources to cope with large scale incidents (cyclone/storm fronts, motor vehicle and farm accidents) including incoming patients from the RFDS or Rescue Helicopter.

Locally developed interventions to assist in managing the after-hours periods for those very small rural and remote communities are being investigated. KPML's future planning for expansion and enhancement of new initiatives across the region may assist in easing the burden of service delivery. Additional opportunities to tackle the barriers for accessing health care and health opportunities are being explored. The extended utilisation of technology in terms of telehealth and Ehealth (as discussed previously) is an alternative option specifically factoring in further roll-out of the National Broadband Network into the region. A successful example of such initiatives was recently highlighted when a major motor vehicle trauma incident occurred in the Great Southern region WA. The patients were able to triaged, stabilised and rudimentally treated via a telehealth link at a small rural health facility with surgeons based in Perth before being evacuated to a major metropolitan hospital for surgery and post-operative care and rehabilitation.

Both acute and primary health service initiatives and programs currently being offered and utilised around the region would benefit immensely from the inclusion, or further advances of technologies for health. KPML vision is that of collaborative planning to identify solutions to gaps in After-Hours service provision for the catchment area. The scope for these interventions is wide-ranging and a number of programs and initiatives currently delivered within the KPML potentially have the capacity to include telehealth to enhance the impact that services have on communities. The Rural Outreach Services (RHOS) – Medical Specialist Outreach Assistance Program (MSOAP) is a program which could see great success at lower costs than an actual visiting specialist, specifically in the designated disciplines. Programs linked with mental health, such as the Early Years Outreach Assistance Program and others would also be suitable. Promoting telehealth to service providers around the region and forming links with appropriate specialists or facilities would require a sustained, focussed and financially supportive commitment.

The caveat to fostering and facilitating such a paradigm shift in service delivery, however requires a sensitive 'tread softly' approach to address community concerns of being 'ignored' and remote technology will not nor ever 'replace' the real need for a physical resident medical presence. Consulting, engaging and planning with communities will be the key in the first instance to alleviating these concerns. This 'future' may actualise the restructuring of the traditional health care delivery team and creating 'virtual' teams as has been proposed recently by the Australian Health Workforce Institute. This 'health system model' development is aimed to support and service those rural and remote areas where there is a paucity of GPs and other health professionals, to meet the health needs of the community.

Transport

In a catchment area of almost one million square kilometres it almost goes without saying 'Transport' is a constantly identified challenge to health services by the workforce; but further reinforced by consultation with the population. This barrier to accessing health care and health opportunities like many determinants is often outside the realm of the health portfolio. The inherent difficulty in improving transportation and access for all communities is embedded in the prohibitive nature of cost and inter-sectoral collaboration. In a catchment area of KPML this is exacerbated immeasurably. Regional Development Australia – Northern WA identify that the transport arrangements for the Kimberly Pilbara region are of concern considering the following factors;

• The 8 Local Governments require at least in excess of ½ billion in investment to bring the roads across the entire catchment region to a satisfactory standard.

• There is no rail link to major centres in the northern area of the region.

• Air services are increasingly important for the region to allow for better access to a range of services. Cessation of services to sizable towns due to costs impacts these communities negatively and concerns about further deterioration of services remain constant as costs to upgrade safety and security measures increase incrementally.

• Public transport is variable among the dispersed larger towns of the region with the majority of services being provided by private bus and taxi services which are relatively costly and often limited due to timetabling. The bus direct links between metropolitan areas and Broome and Hedland have recently ceased. In smaller rural/remote towns and communities there are no public transport options. It is well documented in the literature that limited transport options have the potential for enormous detrimental effects on the health status of communities. Travel opportunities and independence for the young, elderly, disadvantaged and disabled are further restricted. Commensurately health employment and training opportunities are effectively reduced and curtailed.

Current transport arrangements across the catchment area are linked with PATS for patients requiring access to services such as renal dialysis or chemotherapy are present but limited and are often bolstered by community transport initiatives, volunteer services or private arrangements with either family, friends and in some cases private nursing or home-care agencies. Those requiring health services outside of the current infrastructure capacity for the region require PATS transport to Perth at exorbitant fiscal resources. Additionally it is of paramount importance to note that the ambulance services participate in a booked patient transfer agreement between health facilities, in a non-emergency capacity, when all other options have been exhausted. Consequently this often leaves communities without an ambulance service for that interim duration. Emergency transport throughout the region is assisted by RFDS & emergency search and rescue helicopters.

Opportunities to enhance access to health services and health opportunities through transport as means are multitudinous and through KPML facilitation agencies are collaboratively

investigating the feasibility of addressing the deficiencies in this area. Current activities undertaken by service providers (eg. WACHS, AMS) for transport specifically focussing on the Aboriginal and Torres Strait Islander population to and from health appointments may be expanded conditional to the sourcing of additional funding from external bodies. The potential impact would be easily quantifiable, utilised to enhance capacity, and actualise improved health care outcomes. Moreover additional and more robust auditing of the current physical transport arrangements across the region is required to identify service gap or duplication provision for in the KPML catchment region. This is to be achieved through continued collaboration and fostering stronger relationships with the eight Local Government Councils/Shires across the region and further interaction with WACHS, AMS's and other non-government agencies.

Cost

The inevitable discussion of cost for accessing health services, care and opportunities, looms large and ominous over the entire health landscape. That is the cost of GP's and Medical specialists of which there are comparatively few in the catchment area or other health professionals, the cost of transport to health facilities and the cost of associated therapies including medications and health equipment. The gap in health care equity and equality is of course as previously and consistently outlined in this report is widened in the Kimberley Pilbara region; and those who experience lower socio-economic circumstances such as the Aboriginal and Torres Strait Islander and other marginalised populations.

For health, more money is never enough! Health is and always will be a growing industry, simply put advances in technology and an aging population will largely dictate the future resource allocation to address the health needs of the population. However the 'subjective wants' of the community should not be ridden roughshod over by the cold 'objective statistics' of the 'bean counters'. Developing, advocating and promoting efficacious paradigms that ultimately recognise the needs of health sub-populations outside of the mainstream metropolitan GP driven service model is essential for addressing the health of rural and remote communities. A failure to do so will see an already disproportionate health status gap widen even further. KPML in facilitating, consulting and engaging the diverse and vested interests health of this region will aim to assist in overcoming the prohibitive cost barrier to health care and health opportunities.

Ensuring effective communication and marketing strategies to communities and health professionals of the extent of services available through the development of a large-scale, region-wide 'Pathways to Health' reference document would progress the potential to decrease expenses experienced by consumers. Additionally as outlined previously, the benefits of telehealth should be considered here as a possible solution to alleviating costs as should further understanding of the challenges faced by other regional organisations which may lead to collaborative efforts in eroding this obstacle.

Further educating and providing informational support to those who provide services in the Primary Health Care field about available initiatives to assist consumers with costs, may assuage a number of the burdens associated with fiscal constraints. For example the National Diabetes Services Scheme which can assist with subsidised products, Continence Foundation of Australia schemes to assist in costs in managing conditions, various Medicare Australia services and schemes such as the Teen Dental and other broad based health Schemes. Establishing improved links between allied health professionals and preventative health and health promotion officers and their organisations in the region is also an area that requires further exploration and action.

Health Service Navigation & Hospital Avoidance

Hospital avoidance and health service navigation is a major contributor to poor experiences and reflections of communities health concepts ie: Those from disadvantaged groups experiencing poorer health status overall indicate that interventions that assist in preventing further illness and injury, and promoting healthy lifestyles and better management of chronic conditions, is lucid in the expectations of being a significant way forward for achieving better health outcomes. Accessing services in the KPML catchment region is fraught with challenges cogitating on the multi-layered gamut of health issues. The physical, social and emotional wellbeing of the population is dependent on the tools and mechanisms that are engaged and utilised to maintain health or striving for better health outcomes. The KPML qualitative research indicated that 'service availability' is the biggest barrier to accessing health care in the region. Notations indicated that people struggle to navigate the health care services. This has also been the experience of many health care providers who aim to locate services for clients and patients closer to home. This lack of service knowledge has even seen service duplication within small communities which has caused frustration and friction between providers and those they service. Compounding the problem is that after-hours health services are severely limited and poorly resourced.

Hospital avoidance and health improvement programs currently utilised within the KPML, such as the Connecting Care program in association with WACHS, and the Care Co-ordination and Supplementary Services (CCSS) for Aboriginal and Torres Strait Islanders with chronic disease, COAG sponsored Aboriginal Health Workers/Liaison Officers are well positioned to create change and thus better health outcomes. Further investment in these programs may engage communities who have not been serviced well previously. Replicating programs and priority areas under the Australian Better Health Initiatives as from other like ML's regionally may also form a solid platform for additional concerted time and efforts.

Disadvantaged Population Groups within the KPML

Barriers to accessing health care and health opportunities in the KPML region are more significant when compared with other ML regions. The previous barriers to access as described above are amplified for those who have poor incomes, low levels of education and employment, are Aboriginal/Torres Strait Islander or experience disability. The two most prominent groups experiencing disadvantage throughout the region are those from lower socioeconomic groups and Aboriginal Australians, and often these are one in the same. The KPML catchment area has significantly higher proportion of both these groups than that of mainstream Australia.

The majority of these findings are based on the Index of Relative Socio-Economic Disadvantage (IRSD) which demonstrates that KPML area is generally more socio-economically disadvantaged than the state and certainly the nation as a whole. Additionally KPML also falls well below the average for country Western Australia. Factoring this into the equation it is extremely important to note that burden of disease studies indicate greater burden among people who are relatively disadvantaged in society and that those with lower levels of socioeconomic status (SES) have markedly higher rates of diabetes, injuries and mental disorders than those with the highest SES. Furthermore, understanding that Aboriginal Australians typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health has a great impact on effectively planning for health service, care and health opportunities.

Early Years 0-5

The AEDI is a population measure of children's development in communities across Australia. AEDI information is gathered by a teacher-completed checklist for all children in their first year of full-time school. The AEDI gives us a national picture of children's health and development – a first for Australia. The results pinpoint strengths in the community as well as what can be improved. The AEDI is a population measure.

1) It gathers information about every child
2) It sorts the information according to where the children live, then
3) It reports the information for each community.

The AEDI measures five areas, or domains, of early child development. These are important areas of child development and are also good predictors of adult health, education and social outcomes. The early years of children's lives have a significant impact on their later development. Many of the health and wellbeing problems seen in adults – obesity and its associations such as diabetes and heart disease, mental health problems, family violence, poor literacy and unemployment – have their origins in pathways that begin much earlier in life.

As such of the eight shires in the KPML catchment region on average anywhere between 11% and 68% of children have been identified as developmentally vulnerable in at least one or more domains of the Australian Early Development Index Indicator 2012 data and results. Clearly this is unacceptable. There is a direct and timely need for interventions to address the population of the early years and their immediate parents and/or carers to impact on health status for the future in the KPML region.

Single parent families particularly those with children aged 0-5 years are important to take note of in any region as planning for health care needs to focus on affordable and accessible services as it is identified that in lone parent households there is poorer health among children and young people, which is often attributed to material disadvantage. Similarly, the percentage of welfare dependant and other low income families is significantly higher for the KPML area then that of the state or national averages. The entire KPML catchment area also has the highest percentage of Aboriginal and Torres Strait Islanders per population These elements coupled within the geographical locations are concerning as they generally create a cyclical picture of poor health status.

The recent AIHW report, Australia's Health 2010, identifies that disadvantaged individuals are more likely to have come from disadvantaged families and that family factors and experiences of lower income and fewer opportunities for education and employment may all affect a person's health adversely. Essentially this means less satisfactory early development before and after birth, less opportunity for health literacy, and a greater influence of family and friends towards unhealthy behaviours such as smoking, heavy alcohol use and a poor diet.

As identified, the recurrent nature and causal effects of disadvantage (both socio-economic and cultural) makes this barrier extremely difficult to overcome without generational change and community shifts in consciousness. Congruently KPML envisions accelerating levers of social change as identified and proposed by AMLA to assist in effecting political and policy reform to improve elements of access to primary health service, care and health opportunities progressive to current endeavours.

Mental Health – The elephant in the region

Mental Health is consistently identified throughout the data thematically as an ongoing, ever-burdening emerging priority. Access to mental health services is growing in scope, frequency, and demand. Any narrative on Mental Health is of course underpinned by the previously

outlined social determinants of health, but none more so than the pivotal role of the issue of problematic use of Alcohol and other drugs. Considering that the KPML demographics and due to the numerous factors highlighted earlier the population at large are more likely to experience mental health disorders then that of the average of the State and Nation. Thus literally any initiatives that improve access and creates services must be supported in its entirety. Further funding is required to support and expand current KPML programs such as the Access to Allied Psychological Services (ATAPS) program and the Early Years Outreach Program, which focuses on early intervention and the projects under the Mental Health Services Rural and Remote Areas (MHSRRAs), which aids service provision. All have the potential to assist in filling significant existing gaps. Additionally a greater and further collaboration between WACHS, AMS's and other mental health services is essential to achieve cohesive care outcomes for the population. Resources historically have been limited, but as the need grows exponentially, thus also will the human, material and fiscal resources needed to address this health high priority.

GP Mental Health Care Plans are a requirement for patient referrals to short-term psychological interventions (i.e. CBT) under the Medicare funded ATAPS Programs. However preparation of GP Mental Health Plans in the Kimberley-Pilbara ML is well below the Australian rate (340.76 per 100,000 people). The completed suicide rate highlights a great need for mental health services in the region. The suicide rate at 80% above the national average is clearly demonstrating a gap in mental health services within the region. The impact of isolation, remoteness and having a large workforce that is transient (FIFO/Tourists) is likely to result in reduced social networks and social support, which are known to be protective factors for maintaining positive mental health.

Additionally the gaps seen in accessing AMS's, GPs, Specialists and Allied Health Professionals, has been identified that access specifically to Mental Health services in the region across the lifespan of the population has been difficult. The percentages of male and females with mental or behavioural problems are higher in the region than in both the state as a whole and the nation. These figures follow evidence that suggests that the 'higher prevalence' of mental health problems in rural/remote communities is due to socioeconomic disadvantage, a harsher natural environment and social environment, loneliness and isolation, and fewer available health services. These figures also represent mental health problems which may stem from increased rates of substance abuse, including risky levels alcohol consumption and illicit drug use. The health consumers of the region consistently reported anecdotally that mental health is either the 'most important' issue or the 'very important' issue for KPML to be concentrating on when asked to prioritise health focus areas.

Chronic Obstructive Pulmonary Disease

COPD is a serious long term lung disease with a high level of disability. The principle risk factor for COPD is smoking with the amount and length of time smoking increasing the risk. Smoking rates for Kimberley-Pilbara Medicare Local is 27.2 (for 18 years and over (PHIDU, 2013) compared with the national rate of 20.3. This matches information from the W.A. Health and Wellbeing Surveillance System (HWSS) based on 2011 data that 1 in 3 adults (16 years and over) in the Kimberley (29.6%) and 1 in 4 adults in the Pilbara (23.7%) smoke a higher prevalence rate compared with W.A. (14.5%)

In 2008, nearly half (45%) of Indigenous Australians over the age of 15 smoked cigarettes daily. 46% of Indigenous men and 43% of Indigenous women smoke daily. This is twice the rate of Non-Indigenous Australians (Centre of Excellence Indigenous Tobacco Control 2013). Similarly higher states of smoking are likely to exist within the ATSI population of the KPML.

Ischemic Heart Disease

In 2009, the leading underlying cause of mortality for KPML was cardiovascular disease (9.4%) (HWSS). Patients with IHD need close monitoring by primary care teams, risk factor management and exercise programs. Areas of concern are clusters of SLAs in the Halls Creek, Derby-West Kimberley and Ashburton regions. Reducing the impact of IHD and Diabetes within the KPML requires a focus on prevention, detection and treatment and coordination across providers and systems is required (i.e. collaborative planning, service delivery, information sharing such as patient records). Actions targeting a wide range of risk factors including smoking, diet and physical activity are also necessary.

Sexual Health

The number and trend of notifiable diseases, particularly sexually transmitted infections points to unsafe sexual behaviour that places the individual and local populations at risk of increasing rates of STI infections. Of particular note is the 44% increase in the crude rate of gonorrhoea notifications between 2008/09 and 2009/10 in the Pilbara. While the rate is declining it still remains 17 times higher than the state rate in the Kimberley. As the notifications for STIs are higher in younger people and the Aboriginal population these groups may need to be the focus of health promotion and screening programs.

Alcohol Misuse and Injury

The alcohol use/abuse rate for KPML is 6.2 per 100 (for 18 years and over) compared to the national rate of 5.4. The alcohol use data is likely to be understated as data was only available from the coastal areas of the region. Information from HWSS (2011) indicates 2/3 of people in both the Kimberley and the Pilbara, drank alcohol to levels that put them at risk for long term harm (2 standard drinks per day) and this was well above W.A. as a whole (just under 50%). Further data from the W.A. Department of Health found that assaults and injury associated with alcohol consumption was significantly higher for the Kimberley Pilbara region when compared with W.A.

Health Autonomy and Responsibility

Finally healthy lifestyles are inextricably linked with healthy lifestyle choices. However these are largely governed and influenced by the social determinants of health. The preventative health/health promotion type programs currently available across the KPML catchment region are extremely limited but have the potential to expand given the opportunity for supportive environments. Revisiting the basic tenants of the 1986 Ottawa Charter for Health Promotion and the its five broad action areas for health needs to be undertaken and a commitment to the philosophy integrated to the population based health interventions. There are significant opportunities for health gain through the use of health promotion approaches. Risk reduction or prevention approaches can reduce the risk of injury or disease, prevent or delay the development of disease among those at higher risk, minimise complications and improve health outcomes associated with both disease and injury. A population based approach must be taken to ensure that appropriate prevention activities occur across the continuum from wellness to ill health, for the overall population, specific sub groups and individuals at greater risk of harm. This whole-of-system approach shares the responsibility for health promotion across the health system.

The literature identifies the early childhood years as those having the most impact on health status hence linkages with community groups and even schools and childcare centres/playgroups will address the health message needed to homes. Furthermore implementing programs to the general community and the health professionals that may provide referrals into them is a constant struggle which may be somewhat alleviated by investing efforts in to developing and maintaining a region-wide Health Services Directory.

Health promotion supports people to have control over their health. This coupled with community awareness campaign activities may see consumer participation in programs grow and health outcomes improve.

Where to From Here?

As documented previously the capacity of the current health service system resources to meet the health needs of the community varies according to location and distances from other services. The effectiveness of this system for individual communities may be positive, if access to a range of services is available. The subjective experience of effective health service and care in communities for this region is influenced by the age and life circumstances of individuals. These individuals appear to begrudgingly accept that their access to health and health opportunities are perhaps limited but also appear to understand that the benefits associated with regional living sometimes means living with the negatives as well. This level of acceptance and stoicism skews any anecdotal data which contains an assessment of the level of expectation that the community has for its needs to be met. Others in the same communities are not at all satisfied with service provision and have expectations of the health service and other providers that are just not necessarily realistic in economic terms. The challenge with this section of the population and their perceptions of access is to find ways to enhance access through new interventions and also to assist the community to better utilise the existing services.

Health service issues for the population of the KPML catchment region can therefore be surmised as typically the result of;

- Geographical Isolation
- Workforce shortages
- Economic viability of maintaining a service
- Cost to the consumer

Making services more available to a region which has significant gaps is certainly challenging but small changes to a number of elements may have wide arching effects for the manner that current services are utilised. A constant theme as mentioned above is that lack of local knowledge of services is often its own barrier to access. Making stronger links with like organisations within the social determinants of health arena and devoting efforts to gathering information about the regions services (service capacity mapping) will, through developing a diverse and region-wide KPML-specific 'Pathways to Health' reference document will make this barrier less obstructive. The further opportunities surrounding this Health Service Directory – as already realised by state and national governments are even clearer to see if technology is used appropriately and innovatively to support such initiatives. KPML will identify and implement effective means of disseminating service information to the communities in a format that has the greatest impact will be explored and implemented.

Furthermore creating pathways to improve community awareness regarding services and how consumers may most effectively utilise is equally important. This is particularly true of the after-hours periods where admissions have consistently presented at Emergency Departments for treatment of minor illnesses or injuries because of a gap-knowledge or have been unaware of additional support services offered locally. Bridging the gap in service availability may be assisted by extending current well utilised and successful programs to support and service more consumers. Opportunities which focus on more 'connectedness' within the health systems should also be considered. The benefits of 'secure messaging' between health professionals are numerous effectively reducing time and efforts associated with usual referral processes. Additionally, the advent of the Personally Controlled Electronic Health Record,

support in primary care organisations with the facilitation and assistance of KPML also has the potential to improve the patient experience and health provider efficacious.

Opportunities to be involved with strategic planning with other major organisations such as WACHS, AMS's, GP's already occurs and is paramount in reducing the effects of poor service availability. At a local community level, working with service providers in auditing their own accessibility levels and investigating quality improvement activities collaboratively may prove beneficial. Access to health care and health opportunities for people within the KPML are directly impacted by a shortage of an appropriately qualified and skilled workforce. Historically the region has always experienced such shortages and the acceptance of this has sometimes seen effective recruitment strategies by a number of organisations fall in the 'too-hard basket'. The health workforce in the region undertake a meritorious role but are largely understaffed, underfunded, and under-resourced and thus inherently may burn-out with demand and little professional support due to isolation created by professional and geographical tyranny.

To continue assisting in re-dressing these concerns a robust and continuous community consultation process has commenced and will be dynamic to generate individual and community ownership of proposed programs and initiatives. In addition, the Kimberley Pilbara Medicare Local is developing a comprehensive regional online and hard copy services directory generic and by discipline that will support to identify available service providers in a timely manner, and is working to engage organisations (including regional councils, WA Health, training organisations and technology suppliers) to improve the potential uptake. Ultimately it is envisioned these strategies and activities will assist to improve the health status of the entire catchment area and population.

3. What priority activities will you pursue in 2013-14?

Provide details of how you identified your priorities for 2013-14. Your response should illustrate the processes you used to determine priorities and provide details on each priority.

NOTE: The information on priorities provided here should align with the priorities detailed in your Annual Plan

3.1 Provide details of the process you used to identify priorities for 2013-14 (Please refer to items 5.1 of the Guide)

- *Outline any processes you used to identify your priorities for 2013-14. Include details of the information considered to identify priorities and who was involved in making decisions.*

Response:

KPML is yet to celebrate its first year anniversary as an organisation, however since inception a clear mandate was directed to deliver a sustained committed effort to engage and consult with health services, communities and stakeholders to identify priorities and key activities for 2013 and beyond. The findings of this process lucidly delineated numerous priorities to be addressed but also highlighted that further community and stakeholder consultation engagement processes need to be undertaken, specifically in the more rural and remote areas of the KPML region. This mechanism for the elicitation of information has now been embedded into Annual/Strategic Planning documents and will be an ongoing dynamic process for the monitoring of the health needs and priorities of the population.

A plethora of data collection using a diversity of conduits commenced at the inception of KPML in July 2012 and has been ongoing. Data collection has included collating, analysing interpreting and prioritising the intelligence and findings from National, State and Local sources including:

- Local Community & Stakeholder engagement
- KPML consultation with Board of Directors, member organisations and staff
- ABS
- MBS
- PBS
- PIP
- AEDI
- WA Epidemiological Branch
- Health Atlas
- NHSD - SiteID

The sources of data has included quantitative and qualitative; gleaned from a myriad of instruments namely literature reviews, statistical data set/matrixes, Focus groups, Key Informant Interviews, and anecdotal observations and information.

The report outlines that the research mechanisms, activities and outputs have been as comprehensive and exhaustive in collation and analysis as was possible given the tight time-frames (from beginnings of KPML July 2012 to present); the information surmised does however proffer a relatively accurate broad spectrum and perspective of the health service, care and health needs of the Kimberley and Pilbara population. The directive to undertake the

challenge confronted in sourcing, compiling and analysing an area and population the size and diversity of the KPML catchment was daunting. However acknowledging, utilising and incorporating the 'rich' pre-existing resource of professional and personal knowledge and intuitive experiences of the KPML team ensured that the NAR 'hit the ground running'. Additionally as the 'Medicare Local' brand strengthens and becomes part of the health vernacular and in particular the Kimberley Pilbara hub (KPML) the greater the increased access and information is shared by organisations and communities. Overall this has assisted invaluably for collaboration with aim of improving the health of the KPML population.

Fusing the intrinsic learned knowledge and experiences of the KPML team with the mandate given to CUCRH for qualitative research into actual organisation health services and perceived community health service delivery and care was instrumental in developing, implementing and evaluating mechanisms by which to measure the 'rhetoric vs the reality'. Desktop analysis, anecdotal shared information, organisation and community consultations constructed the essence of responses subsequently the data that outlined the theoretical and practical commitments for health services and utilisation.

Finally the capacity to acquire and access the combination of qualitative and quantitative data whilst both efficacious and meritorious is problematic because it is laborious, time-consuming, dated and open to subjective interpretation. The statistical data specifically has proven to be challenging as the validity is habitually variable and at times incompatible for comparative analysis. Moreover the status of the raw data available and documented needs to be cogitated and considered very carefully for the planning of any potential future services of the Kimberley Pilbara population. Paradoxically the opportunity around collecting further information about the health care needs and services for the KPML population is tremendously exciting factoring into the equation the employment of the KPML's 'Population Health Commissioning Atlas' the scope and size of which has not been undertake in the region previously.

This rigorous three-tiered configurative process, engaging the duality of qualitative and quantitative data on the health service delivery and needs of the Kimberley and Pilbara population; ensures KPML is in a prime robust position moving forward to highlight and facilitate the addressing of health strengths, priorities, inequities and gaps. Subsequently the combination of the latest available epidemiological data and the 'professed' needs of community and stakeholders have reflected and indelibly shaped the following health and organisational priorities for the KPML population catchment area in 2013-2014 in the immediate future and for beyond.

The ensuring priorities outlined in 3.2 of this report are in no chronological order of importance or systematic attention for redressing, however are intrinsically ratcheted up to Strategic Objective 3 of the KPML Annual Plan.

3.2 Provide details of your priorities
(Please refer to item 5.1 of the Guide)

For each priority included in the Annual Plan provide:

Priority name:	*Immunisation*
Brief description of why the	*KPML catchment area has a history of low vaccination*

priority was selected:	*rates generally across all identified (child) targets with goal being 90% coverage.*
Brief description of activities to deliver the priority:	*General Practice, AMS & WACHS Hospital, Population Health/Communicable Disease support. Advocacy and advice on immunisation systems, cold-chain management catch-up strategy through inter-personal, phone, email etc.* *Targeted interventions in cooperation with regional Population Health teams.* *Provide professional development training and updates.* *Collaborate with rural/remote clinics on vaccination programs.* *Collaborate and assist with facilitation of advocacy for vaccination programs in pre-school and school based programs, CTG, and community organisations.* *Provision of quarterly feedback to GP's, AMS for immunisation performance.* *Investigation for feedback to all primary health care immunisers.*
What are the expected impacts and/or outcomes?	*Vaccination rates across all areas do not dip below 85% which is considered at risk of potential Epidemic level.* *Increased collaboration across all immunisation service providers and targeted programs.*
How will the success of the priority be measured?	*90% vaccination rates across all age specific immunisations in the catchment area.* *Documentation of collaboration for providers and programs, including training and information dissemination.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Child Health Early Years (0-5)*
Brief description of why the priority was selected:	*Of the eight shires in the KPML catchment region between 11% and 68% children on average have been identified as developmentally vulnerable in at least one or more domains of the Australian Early Development Index Indicator 2012 data and results.*
Brief description of activities to deliver the priority:	*Two Tiered Approach:* • *Place specific population 'hotspot' intervention – communities of greatest developmental need, focusing on 0-5.*

	• *Population-region base coordination, advocacy and support intervention.*
What are the expected impacts and/or outcomes?	*Identified targeted health specialist service provision increase to 'hotspot' communities.* *Improved linkage, collaboration and service delivery accessibility to children 0-5 parents and carers.*
How will the success of the priority be measured?	*Overall and community specific decrease in the percentage of children considered 'developmentally' vulnerable by 2015 (next AEDI).*
(optional) Indicative Budget for 2013-14	

Priority name:	*GP Access Utilisation*
Brief description of why the priority was selected:	*Medicare figures report that GP/AMS attendances per person are the lowest in the country at 2.4 consults per year per person.* *Low levels of bulkbilling across the region including for the most disadvantaged populations.*
Brief description of activities to deliver the priority:	*Increased advocacy and negotiation for funding and recruitment of GP's/AMS resident and locums for region.* *Increased advocacy and negotiation for increased bulkbilling capacity for GP's/AMS resident and locums for region.* *Negotiation and collaboration with WAGPET to provide for increased opportunities as GP trainee positions from Medical Graduates.*
What are the expected impacts and/or outcomes?	*Increased number of GP's and locums working and living in the region.* *Increased access of the % of the population/consumer that utilise GP/AMS services.* *Increased bulkbilling across practices in the region.*
How will the success of the priority be measured?	*Increased number in the catchment area of resident and locum GP's/AMS; Graduate Placements.* *% of patients bulkbilled in the region.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Specialist Medical Services Access*
Brief description of why the priority was selected:	*Medicare figures report that Specialist attendances and resulting care management per person are the lowest in the country at less than 1 consults per year per person.*
Brief description of activities to deliver the priority:	*Increased advocacy and negotiation for funding and recruitment of Specialist resident and locum for region.* *Increased efforts to establish further Telehealth capacity and services at points of health access.*
What are the expected impacts and/or outcomes?	*Increased access of the % of the population/consumer that utilise Specialist Medical Services.* *Increased number of Telehealth facilities in the region.*
How will the success of the priority be measured?	*Increased number in the catchment area of resident and locum Services.* *Number of Telehealth consultations undertaken in the region.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Lifestyle – Chronic Disease Primary Prevention*
Brief description of why the priority was selected:	*Smoking & Alcohol prevalence is at significant problematic usage with both significantly higher than that of the National Average.* *Nutrition & Physical Activity; Overweight and Obesity are serious concerns and paradoxically as to is under-nourishment. Physical activity reported does not meet the Nationally recommended level required for good health.*
Brief description of activities to deliver the priority:	*Three tiered approach:* • *Environmental – Coordination of advocacy aimed at National, State and Shire level for improvement of policy and environmental conditions conducive to healthy behaviours.* • *Organisational – Continued liaison and support at Lifestyle/Chronic Disease prevention programs inclusive of organisations & groups.* • *Social – Identify and increase behavioural access support for development of personal skills.*
What are the expected	*Reduction in the uptake of smoking in individuals*

impacts and/or outcomes?	*Reduction in the level of harmful drinking of individuals.* *Increase in access to good nutrition and recommended levels of physical activity.* *Increased harm minimisation strategies implemented in communities.* *Identification, development and promotion of lifestyle community intervention programs.* *Access funding for increased development of and promotion of lifestyle community intervention programs.*
How will the success of the priority be measured?	*Policy/legislation development and implementation for smoking & alcohol restricting potential uptake.* *Increased funding and lifestyle community intervention programs for smoking, alcohol, nutrition and obesity.* *Reduction in the prevalence of tobacco and alcohol related illnesses (longitudinal).*
(optional) Indicative Budget for 2013-14	

Priority name:	*Chronic Disease 2- Secondary Prevention*
Brief description of why the priority was selected:	*Ischemic Heart Disease – rates are the worst in the Country;* *Diabetes Type 2 – highest rate of all Medicare locals;* *Chronic Obstructive Pulmonary Disease; Deaths are the second highest of all Medicare Locals.*
Brief description of activities to deliver the priority:	*Increase the rigour for diagnosis of these conditions with clinical providers.* *Coordinate CPD2 training/education for clinical providers to ensure diagnosis data is accurately identified, recorded and collated (focus on new Locums).* *Instigate discussion for a vision of a model of improved coordinated pathway of care for patients with the all service providers.*
What are the expected impacts and/or outcomes?	*Decreased missing 'data sets' from the KPML region.* *Increased early identification, and diagnosis of CD2 secondary conditions by service providers.* *Improved access and 'journey' for patients diagnosed with*

	a secondary CD2.
How will the success of the priority be measured?	*Systematic process for identification and diagnosis CD2 by ED's GP's AMS's and other service providers.* *Gaps in data sets recording decreased for CD2.* *Number of education information disseminated delivered to service providers on CD2 identification and diagnosis (focus on new Locums).* *¼ review for service providers of the pathway for care of CD2 patients.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Data Deficits*
Brief description of why the priority was selected:	*Missing, incomplete and inconclusive health data is a serious anomaly in the KPML region.*
Brief description of activities to deliver the priority:	*Facilitate discussion between providers (eg. ED, GP's AMS etc) for agreed protocols on data recording, collation and exchange.*
What are the expected impacts and/or outcomes?	*Increased interfacing between providers to record and access rigorous data sets.*
How will the success of the priority be measured?	*Improved capacity to assess and plan for the health needs/priorities of the population in Kimberley and Pilbara.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Screening*
Brief description of why the priority was selected:	*KPML ranks 2nd lowest on screening participation rates for breast, cervical and bowel (BCB) screening data of ML's that record such data (42 of 61). Amongst worst Australia wide for general screening of health afflictions.*
Brief description of activities to deliver the priority:	*Revise treatment protocols/education for screening BCB and others as required and disseminate to ED's, GP's and AMS's.*

	Promote/Encourage opportunistic screening particularly BCB from providers at point of health access for patients.
What are the expected impacts and/or outcomes?	*Increased appropriate screening for target populations and health conditions by ED's, GP's AMS's.*
How will the success of the priority be measured?	*Number of participation rates increased for screenings for breast, cervical and bowel cancer.* *Number of general screenings increased for preventable health conditions.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Mental Health – Suicide ideation, attempt, completion. End point.*
Brief description of why the priority was selected:	*Completed suicide rate is 80% higher than the national average. Paradoxically rates for prevalence of depression are low.*
Brief description of activities to deliver the priority:	*Identification of 'why' the disparity between high suicide rates and low levels of prevalence for depression and other mental health issues.* *Mapping of mental health provider organisations and levels service in Kimberley and Pilbara.* *Identification of barriers to accessing mental health services.* *Development of a generic 'pathway' to enable easier access to mental health services.* *Identification and promotion of 'crisis response' for population vulnerable to end point mental health issue – suicide.*
What are the expected impacts and/or outcomes?	*Highlighted 'data gap' for accessing and recording of people seeking mental health assistance eg. Ed's, AMS, CHS. Particularly outside of high population areas & FIFO.* *Generation and promotion of 'service directory' outlining mental health services in the Kimberley Pilbara.* *Consumer pathway for mental health priorities/services especially 'suicide ideation' appropriately promoted and accessible.*
How will the success of the	*Improved data interface between all service providers*

priority be measured?	*particularly primary care.* *Increased register of 'mental health plans' implemented via all service providers for mental health.* *Mental Health Service Directory completed and disseminated.* *Increased rate, utilisation and recording of 'crisis response' to suicide ideation.* *Decreased rate of completed suicides (longitudinal).*
(optional) Indicative Budget for 2013-14	

Priority name:	*Sexual Health*
Brief description of why the priority was selected:	*Rates of STI's are unacceptably high including the potential for transmission of HIV.* *High 'unwanted' pregnancy rates of under age of consent.*
Brief description of activities to deliver the priority:	*Identification and mapping of services that provide sexual health counsel and promote healthy sexual behaviour, inclusive of free or substantively reduced cost prohibitive prophylactics.* *De-stigmatisation of accessing these services.* *Increase promotion of access to free or substantively reduced cost prohibitive prophylactics, conducive healthy sexual behaviour.* *Advocacy for GP & associations involvement in school and community for positive sexual health/family planning programs.*
What are the expected impacts and/or outcomes?	*Sexual Health Services directory widely disseminated and promoted.* *Sexual health/family planning program activity in schools and community.* *Increased accessing of Sexual Health Services particularly by young people and FIFO.* *Increased uptake of utilisation of prophylactics in sexual activity.*
How will the success of the priority be measured?	*Sexual Health Services directory generated and disseminated to agencies and priority 'hotspots'.* *Number of people accessing Sexual Health Services and reporting of use of prophylactics for sexual activity.*

	Decreased STI prevalence (including HIV) (longitudinal). *Decreased 'unwanted' pregnancies, (inclusive of age under consent) (longitudinal).*
(optional) Indicative Budget for 2013-14	

Priority name:	*Aged Care / Roaming Grey Nomads*
Brief description of why the priority was selected:	*Primarily for 3-6 months of the year (Dry) there are a significant number of aging people 55+ that are a transient population in the Kimberley Pilbara region.* *Research indicates that they travel without necessary care plans and/or without information for extended stays.*
Brief description of activities to deliver the priority:	*Promotion of key alternative primary health access points and messages for targeted aging/transient population eg. Pharmacies etc.* *Encouragement of utilisation of emergency health services for emergencies only.* *Promotion of Ehealth record uptake.*
What are the expected impacts and/or outcomes?	*Increased awareness of the importance of keeping and carrying health care management plans.* *Provision of information disseminated for accessing alternative primary health services rather than ED, and GP's.* *Uptake of Ehealth record utilisation.*
How will the success of the priority be measured?	*Number of aging transient population registered with Ehealth.* *Number of point of access outlets providing alternative primary health services rather than ED, and GP's eg. Visitors Centre, Tourist info etc.* *Number of aging transient population having and carrying care plans.* *Decrease of aging transient population accessing Ed's and GP's for non-emergency health needs.*
(optional) Indicative Budget for 2013-14	

Priority name:	*Youth Tourist/Backpacker*
Brief description of why the priority was selected:	*Primarily for 3-6 months of the year (Dry) there are a significant number of young people 18-30 yrs (Australian & International) that are a transient population in the Kimberley Pilbara region.* *Research indicates that they travel without necessary health education and/or without information for extended stays.*
Brief description of activities to deliver the priority:	*Promotion of key alternative primary health access points and messages for targeted aging/transient population eg. Pharmacies etc.* *Encouragement of utilisation of emergency health services for emergencies only.* *Promotion of Ehealth record uptake (Australian Citizens).*
What are the expected impacts and/or outcomes?	*Increased awareness of the importance of keeping and carrying health care management plans.* *Provision of information disseminated for accessing alternative primary health services rather than ED, and GP's.* *Uptake of Ehealth record utilisation (Australian Citizens).*
How will the success of the priority be measured?	*Number of young people transient population (Australian Citizens) registered with Ehealth.* *Number of point of access outlets providing alternative primary health services rather than ED, and GP's eg. Visitors Centre, Tourist info etc.* *Decrease of young people accessing Ed's and GP's for non-emergency health needs.*
(optional) Indicative Budget for 2013-14	

END OF TEMPLATE