Kimberley Primary Health Care
Sustainability Study
2008 – 2030

Kimberley Primary Health Care Sustainability Study 2008 – 2030

Prepared for Kimberley Division of General Practice Ltd

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1. Executive Summary.

Accessing appropriate and timely primary care has been an issue for much of the remote Kimberley population for many years. In recent times this has also been a significant problem in Broome, particularly during the tourist season.

Considerable changes to primary health care delivery are likely to occur in the Kimberley region over the next twenty years. It is clearly important therefore, for agencies working in the field of primary health care to plan collectively for the future as much as possible.

Community engagement in health service planning has been largely restricted to the ACCHO sector. For the wider community it is often seen as inaccessible and the province of governments remote from the area.

The region, like many others in remote / regional Australia, is serviced by a variety of different providers, many of which rely on a plethora of different funding sources to remain operational and viable. The separate evolution of these agencies has resulted in some awkward delineation of services and included development of seemingly incompatible records systems.

In recent years however, a number of agencies have begun to increasingly explore partnerships and other innovative ways of improving the overall health outcomes that they seek to promote. The co-location of the Nindilingarri Cultural Health Service with the new Fitzroy Crossing Hospital is one example of this.

Commonwealth government funding for primary care has been largely directed through the AMS's, with the state-funded hospitals taking up much of the slack through their emergency departments. Private practices in the region have until recently been essentially limited to Broome.

It is no surprise therefore that there has been interest in attracting funds from the Commonwealth's Super Clinic program for an integrated primary health care service. A general shortage of GPs Australia wide is evidenced in the Kimberley as acute, and only likely to get worse without significant change.

The separation of funding primary and secondary care between Commonwealth and state has also led to clear inequities in working conditions between the hospitals and AMS's. If anything this has created a sense of sometimes unfair competition between the providers in terms of attracting suitably qualified staff and other resources.

Health service funding models tend to discriminate against remote areas, with little apparent consideration of the special needs of much of the population or the time spent by health professionals in traveling vast distances to provide services.

Current formulas used to differentiate areas of need, do not vary greatly between outer suburban and regional areas. Some Kimberley towns, such as Fitzroy Crossing, do not qualify for the most remote status under the current classification regimes.

Agencies across the Kimberley report difficulties in filling many staff positions through lack of availability of basic infrastructure such as adequate housing. Many agencies are also plagued by high levels of turnover.

Private practice in the Kimberley can no longer be relied on as the basis for a system of provision of primary care. Those who are able to operate successful and sustainable private practice are likely to be few and far between. Where possible they should be supported.

Ongoing viability of private practices is not helped by the current Medicare system which does not appear to allow for the higher costs and difficulties of providing private GP services in the region.

The specific needs of the Indigenous population in the region have been well documented but all too often ignored by governments. A plethora of studies have been produced, often resulting in little or no action.

So, how might the primary health care needs of the regional population be addressed in future? Clearly, new and different models will be required.

These will require increased collaboration and partnerships between service providers, which will in turn require different approaches to health funding mixes by governments. A far greater emphasis on population health measures including prevention will also be required. This is beginning to be addressed in some allied health areas such as mental health, but still severely lacking in other important areas such as dental hygiene.

Much of the underlying health problems of the region are caused by inadequate infrastructure. Over time the shortage of housing must be addressed. Indigenous people of the region have never had their basic housing needs close to being fully met.

Infrastructure for health services will also require substantial investment. While most of the region's hospitals have been rebuilt in recent years, there is also a substantial need for further investment in staff housing for health service providers. Many remote clinics will also have to be rebuilt or enlarged to cater for the growing population.

Over time, social infrastructure should steadily improve through government, community and hopefully corporate investment, which will aid in retention of specialist providers.

Population growth in the Kimberley is expected to continue at a rapid rate, roughly doubling by 2030. This will add pressure to the existing shortfall of GPs available for primary health care in the region. Research presented in this study suggests that a minimum of 90 additional GPs will be required in the region by 2030.

While the current shortfalls are best known in Broome, due to media coverage, the least resourced areas in population terms are in fact the local government areas of Halls Creek and Derby-West Kimberley. There will not be any 'closing of the gap' unless the needs of the populations in these areas are addressed.

Money alone will not fix these problems. New ways of providing services must be explored and developed.

The health workforce in 2030 is likely to need to be somewhat different than it is today. Capacity is only likely to be met by greater use of nurse practitioners with increased levels of responsibility. This will in turn need to be supported by the development of career paths for Indigenous health workers.

Cooperative arrangements between health service providers must be increased. This should include increased use of funds pooling.

Ultimately we recommend that some kind of Primary Health Care organisation (PHCO) is established as a central coordinating and fund holding body. We conceive of a model where this supports existing services, allowing relatively autonomous local decisions to continue to be made, but with far better integration in the whole. This primary body should also be inclusive of all allied health areas where practical.

Access to common health databases must be further developed and improved in order to more effectively service a mobile population as well as providing a means for more accurate measurement of health outcomes and specific program needs.

Many of these initiatives will require a far greater commitment to the region by the Commonwealth. While there are little votes in this, the cost benefit returns over time will be worth the financial outlay.

In the meantime the high incidence of chronic disease in the region is likely to continue, although it may change over time in terms of typology.

Hopefully by 2030, the Kimberley region will have a more sustainable and vibrant primary health care service so that the generations that follow after that may experience far better health outcomes.

2. Summary of Recommendations

Recommendation 1: That a process to commence discussions regarding the nature of a regional health planning body with associated grants access and fund holding capacity be explored immediately. (Refer section 12.6)

Recommendation 2: That the proposed Kimberley Primary Health Care Organisation be consulted during planning for any major industrial development in the region. (Refer section 11.8)

Recommendation 3: That the Kimberley Managed Health Network patient information sharing and messaging system be further developed and implemented as soon as possible. (Refer section 12.6.5)

Recommendation 4: That forward projections of regional health workforce housing needs and associated medical infrastructure needs be developed and costed. (Refer sections 12.4.1 and 12.4.2)

Recommendation 5: That all Government agencies with responsibilities that impact on health service provision be required to report annually to their respective parliaments on progress towards 'closing the gap' on disparities in life expectancy and related health initiatives. (Refer section 12.9)

Recommendation 6: That the Medicare cost schedule be streamlined and that weighting for MBS item claiming for remote areas be reviewed and realigned to more appropriate regional cost indices. (Refer sections 12.8.1 and 12.8.2)

Recommendation 7: That a detailed survey be conducted of remuneration and benefits provided by Kimberley primary health care agencies. (Refer section 6.7)

Recommendation 8: That a regionally based Executive Search approach to recruitment for all health professional placements including locums, be developed. (Refer section 12.4)

Recommendation 9: That a mechanism be developed for formal liaison between Kimberley LGAs and a regional health planning body or bodies. (Refer section 6.2)

Recommendation 10: That an application be made for an NGO operated 'Super Clinic' for Broome. (Refer section 12.2.3)

Recommendation 11: That operation of a 'Super Clinic' in Broome occurs under a management structure that is inclusive of all relevant agencies. (Refer section 12.2.3)

Recommendation 12: That specific business commencement support be more readily available for private General Practitioners and allied health professionals. (Refer section 9.6)

Recommendation 13: That a public awareness campaign be conducted to advise visitors to the region of the medical facilities available and also to advise them to carry a current medications list and prescription repeats. (Refer section 3.5)

Recommendation 14: That the principles, objectives and major decisions made by regional health planning bodies be made available through broader forms of communication to the public. (Refer section 4.7)

Recommendation 15: That a regional pandemic response strategy be developed. (Refer section 11.2.1)

3. The community's current perception of the quality of primary care services and interest in accessing quality and timely primary care services.

3.1. General comments

Community perception of the quality and timeliness of primary health care does not appear to have been measured in the Kimberley in any real sense, however newspaper reporting of primary health issues during 2008 indicates that there is a perception of undersupply of GP services within Broome.

The closure of the privately owned Dakas Street Medical Centre in July 2008 was preceded by considerable publicity. This included dire warnings on the strain that this would put on access to other GP services in Broome. The three remaining non-hospital GP services all immediately placed restrictions on access by new clients.

Issues that have been reported as of concern are the closure of books to new patients at Dr. Jensen's clinic, temporary closure of books and fees to register as a new patient at Broome Medical clinic, and long waiting times at the emergency department of the Broome District Hospital. An indication from BRAMS that it would no longer accept non-Indigenous clients would also appear to have been somewhat controversially received by the public.

Community concerns appears to centre on waiting times for either GP appointments or the time it takes to be seen at a hospital emergency department or outpatient clinic, where there is one. It is difficult to ascertain whether community expectations are realistic in this regard. Waiting times for a GP appointment appear to be approximately 1 week in Broome and 1 or 2 days in Kununurra. This does not appear unreasonable when compared to other parts of Australia. However the closure of Dakas Street Clinic and the imminent closure of Dr Jensen's practice will add strain to the Broome Medical Clinic and it follows that the current waiting times to see a doctor of choice in Broome will be further stretched.

Other Kimberley towns appear to be better resourced per population at present, through the section 19.2 exemptions which allow the smaller hospitals to provide bulk billing GP services.

Bulk billing also appears to be a subject of some community concern. Current Medical Benefits Scheme arrangements would appear to severely limit the extent to which a privately operated GP based service can bulk bill its clients if it wants to stay in business, let alone provide a quality health service to those clients.

3.2. Current access to GPs in Broome

Broome currently has three GP service providers in addition to those provided through the Broome Hospital emergency department. They are the Broome Medical Centre operated by Dr. Harpreet Singh, Dr. Jensen's clinic and the Broome Aboriginal Medical Service (BRAMS). Only Dr. Jensen's service is a solo practice.

Most services that take appointments phone clients a day prior to the appointment to ensure that missed appointments are kept to a minimum. There is anecdotal evidence that some GP services may keep occasional appointment spaces for high priority needs.

Most non-Indigenous visitors to Broome would appear to use the hospital emergency department as a first contact for unplanned GP services while in the town. Indigenous visitors will either seek services at the hospital emergency department or at BRAMS.

It is clear that Broome needs a service now to replace the Dakas Street Clinic and will experience increased needs in the future.

3.3. Broome – Delays seeing a doctor

There may be genuine problems accessing GPs for workforce related consultations such as a certificate for time off work which is required by many employers, including police.

An effective triage system should be able to divert these health service clients to an accredited nurse practitioner, who could schedule a follow up if required.

3.4. Press coverage in Broome

Our initial impressions are that press coverage of the Dakas Street Clinic closure issues have not been entirely helpful:

- Some people may not even have tried to see a doctor when they should have because of the bleak picture painted by the media.
- Press coverage has possibly been linked too directly to the issue of supporting Dakas Street to stay in business rather than to increase knowledge of broader health issues.
- There does not appear to be a groundswell of community support for government funds to prop up private businesses, which is what some of the media coverage seemed to be projecting a call for.
- Press coverage appeared to target the wrong government with regards to the reported primary care crisis. The WA State Government is tasked with provision of hospital services which are meant to be either secondary or tertiary other than in emergency. A substantial building program has been undertaken with regard to Kimberley hospitals.

- The Australian Government's role in primary care was barely mentioned. Yet changes in MBS funding arrangements including bulk billing terms might have seen such a centre remain financially viable.
- No serious questions were directed at the Australian Government.

Positives:

- Many people might be more aware of what health services are available now, particularly through the KDGP's informative full-page notice regarding Broome primary health services which was printed in the Broome Advertiser on July 17, 2008.
- The scare regarding access to primary care GPs may have prompted some people to plan their GP visits a little more in advance. We have no evidence for this though.

3.5. Broome Hospital ED Patient Presentations

An interview with senior staff at Broome Hospital revealed a starkly different view to that provided by the local press.

Investigation of the conditions presented at the emergency department indicate that approximately 80% are not emergencies, typically being upper respiratory tract infections, feverish babies, skin infections and refilling of repeat prescriptions.

Older tourists (known locally as 'grey nomads') and international tourists are common sources of repeat prescription requests which might be better dealt with elsewhere. The majority of the patients at the emergency department are however non- indigenous Broome residents.

A large proportion of patients arrive with untreatable or minor conditions. Some present with conditions that could be treated with mild pain relief or over the counter medicines, or could have been prevented in the first instance with application of basic first aid wound dressing.

Patients with these conditions present assuming that they will not be able to see a GP at another clinic any faster, thus going to the emergency department. The majority have not sought GP appointments before attending the emergency department, as they assume that they will have to wait much longer, or won't be able to be bulk billed.

Many people may manage prescription repeats quite well, but will on occasion need a more urgent repeat. This would seem to be a service that would be better dealt with outside the emergency department.

The Broome hospital emergency department also suggests a portion of GP bookings be allocated to very brief consultations for the above mentioned minor ailments. It is

arguable that presentations of this type should be a low priority in assessing the performance and sustainability of primary health care. This may however alleviate bottlenecks and should be encouraged.

The Broome hospital emergency department has implemented a procedure whereby it calls Broome medical clinics in the morning to enquire about availability of vacancies and cancellations from their appointments list for that day so as to be able to refer patients directly to the GP clinic.

Broome Hospital also suggests a wider spread of GP opening hours so that access and waiting times are improved for those able to afford GP fees, or eligible for the services that GPs are prepared to bulk bill.

The hospital also suggests that a portion of GP bookings be allocated to addressing agreed areas of need that might be more suitably addressed by them. However, at the time of writing, the closure of Dakas Street and the height of the tourist season is not a good time to address this.

A summary of Triage statistics obtained from Broome Health Service show that the Emergency Department provides an efficient service to those patients most in need, which is its specific funded purpose.

Nonetheless, under the circumstances, it has also achieved excellent results in dealing with non- urgent presentations within a timely manner.

A table of the Triage Category Statistics Summary Report from 1/07/2007 to 30/06/2008 at the Broome Hospital is listed here. Total ED episodes during this period were 18250.

Table: Broome Health Service Triage Waiting Times.

Triage Category	Total Cases	Waiting Time	Cases	%
1. Resuscitation	52	Not seen within 2 minutes	1	1.9
2. Emergency	760	Not seen within 10 minutes	20	2.6
3. Urgent	4,337	Not seen within 30 minutes	161	3.7
4. Semi –Urgent	10,142	Not seen within 60 minutes	744	7.3
5. Non –Urgent	2,959	Not seen within 120 minutes	187	6.3

One senior BHS doctor expressed the view that they would like to see the private practitioners in town take more of an interest in the patients they refer to the hospital after admission, and for whom they could actually provide care on a private patient basis.

The hospital is keen to explore the capacity to offer a wider variety of services to those patients who do wish to use their private health insurance. The proportion of Broome residents who hold private health cover is unknown, although anecdotal evidence suggests it is low due to the perception of it being of limited use in the region.

Most admissions relate to infective illnesses where rest and IV antibiotic therapy work wonders. A proportion of these could be managed by their own GPs as private patients, with good clinical governance to ensure that routine clinical protocols are followed.

Recommendation: That a public awareness campaign be conducted to advise visitors to the region of the medical facilities available and also to advise them to carry a current medications list and prescription repeats.

3.6. Private Health Insurance

Kimberley residents who held private health insurance during 2001 comprised only 10.3% of the population, compared to 39.4% in Western Australia overall and 46% nationally.[1] Statistics for private health insurance cover by LGA do not appear to be readily available. However it appears reasonable to assume that the level of coverage is higher in the larger centres than in the more remote communities. Private health cover tends to be significantly less in more economically disadvantaged groups.

The very low level of private health insurance coverage in the Kimberley suggests that there is a lot of room for increasing coverage over the next twenty years.

3.7. Community concerns regarding Bulk Billing

There appears to be considerable community expectation that people should be able to have many services bulk billed. In the Kimberley this is possibly exacerbated by the fact that many locals may become used to accessing bulk billed GP services through hospitals and expect the same when they are in the main towns.

Patient income levels determine ability to pay full fees or to require access to bulk billing. There is a perception that this limits the service options for those people who may not be able to afford to pay. This lack of access to bulk billed services other than at the hospital emergency department is directly reflected in hospital emergency department queues.

The community appears to have a clear divide between those who can afford to pay the current Medicare gap for access to a GP, and those who can not.

[1] PHIDU, Population health profile of the Kimberley Division of General Practice: supplement (March 2007) p3.

The current Medicare Benefits Scheme and the restrictions on the Broome hospital with regard to bulk billing GP services appear to be major contributors to the current access issues with regard to primary care in Broome.

The region would also appear to have a significant need for access to allied health professionals including various mental health service providers such as psychologists if they could offer bulk billing.

3.8. Opening Hours

Current GP service opening hours are an issue for some sections of the public in several areas of the Kimberley.

There is clearly a need for increased opening hours for GP primary care service provision and access.

Broome Hospital would like to see a wider spread of GP opening hours so that access and waiting times are improved overall.

Extended GP opening hours, which particularly allowed for urgent, but not medical emergency consultations, would do much to alleviate current demands on both hospital emergency and GP clinics.

Opening hours tend to be based on external considerations that have little to do with the way people's working lives have evolved in recent years. Those AMS agencies not doing so yet, will find that they must soon make sure that they provide a broader spread of opening hours. This will also at least require Commonwealth assistance to fund current CDEP based positions fully. The AMS's are at a disadvantage here in that government decisions are made very remotely from the region.

3.9. Restrictions of Access to primary care GP services

There have been several notices of restrictions of access to primary health care in Broome over the 2008 tourist season, with Broome Medical Clinic temporarily closing its books to new patients during the height of the tourist season and recently BRAMS announced closure of its books to new non-Indigenous patients. It is uncertain as to how long this restriction will last.

3.10. Current access to GPs in other parts of the Kimberley

To date we have no recorded complaints regarding current waiting times at Wyndham, Derby, Fitzroy Crossing, or Halls Creek, for hospital or AMS GP access.

3.11. Reality of public expectations of appointment delays

It is possible that some of the expectations of patients regarding what should be available from their various health services are unrealistic.

A view has been expressed by some in the health sector that Broome in particular may have previously been 'spoiled' by a good level of access to primary GP services. While this is not apparent from the ratios presented in previous studies, it is possibly more expressive of comparisons with some areas of WA where access has been and still is very poor.

Concerns may be ameliorated by a community education program which promotes earlier lead times for less urgent conditions and requests. A community first aid program which promotes self help may also help alleviate demand for unnecessary GP visits.

3.12. Access to Allied Health Services

There is anecdotal evidence that suggests that the community would like to have improved access to allied health services, particularly mental health. This is reported generally in WA and would appear to be of particular concern in the Kimberley given the extremely high suicide rates per head of population.

At June 2008 the region had 25.5 Allied health professionals as follows:

- Occupational Therapy -3
- Physiotherapy – 6
- Radiographers – 2 (plus)
- Speech Therapy – 3
- Optometry – 1
- Audiology – 3
- Dietetics – 2
- Podiatry – 2
- Diabetes Education – 2.5
- Paediatric Nutrition - 1

Of these positions, twelve were based in Broome.[2]

3.13. Access to Dental Health Services

Broome and Kununurra currently each have one private dental practice. The Kununurra practice also provides a regular service to Wyndham. Services to the other major towns

[2] Source: KDGP June 2008

are generally provided through the hospitals. There are also some school based programs serving the larger communities. Staffing for the public dental clinics has proved difficult and the towns of Fitzroy Crossing and Halls Creek have both experienced lengthy periods without a locally based dental service in recent years.

The recent level of availability of dental services in the Kimberley is detailed in a submission by the Kimberley Regional Aboriginal Health Planning Forum, who have been seeking to have dental services added to the PATS system.

The submission noted that:

> 'Aboriginal people living in the Kimberley suffer high rates of rheumatic fever and rheumatic heart disease. Routine dental care is critically important in patients with a history of acute rheumatic fever and/or rheumatic heart disease.'[3]

In 2000 a substantial report on dental health services in the Kimberley was prepared for the WA Legislative Council.

Among a series of recommendations, the report recommended; 'That a survey be undertaken of dental health in the Kimberley and that a plan and program be established to address dental health needs.'[4] It is not clear which, if any, of the report's recommendations have been implemented.

The 2006 evaluation of the East Kimberley COAG Trial reported that 'utility of dental services in the region,' be included among ongoing indicators for the sustainability of the communities involved.[5]

In recent years the WA Government has commenced construction of public dental clinic facilities in several Kimberley towns including a new facility to be based at the Broome Hospital. However the region appears to suffer extremely limited access to the services of dental hygienists.

3.14. Comparison with access to urban GPs

There is a perception in the community that access to GPs is relatively poor in comparison with Perth.

This is supported by both historical and recently released GP to patient ratios. We include a table of recently released figures from the AGPN:[6]

[3] Kimberley Regional Aboriginal Health Planning Forum, Submission to the National Senate Inquiry into operation and effectiveness of Patient Assisted Travel Scheme (PATS), KAMSC, (2007)
[4] Western Australia Legislative Council Estimates and Financial Operations Committee, The Provision of Health Services in the Kimberley Region of Western Australia: Dental Health. Report No.33 Parliament of Western Australia, Perth, (2000)
[5] Nyaarla Projects, East Kimberley COAG Trial Formative Evaluation., OIPC (2006)

District	GP Ratio
Pilbara	2559
Kimberley	2202
Rockingham and Kwinana	1663
Armadale and Gosnells	1479
Joondalup, Osborne Park and Ocean Reef	1364
South Perth, Morley and Dianella	1336
Peppermint Grove, Subiaco and Leederville	1023

3.15. Public expectations of ongoing relationship with their GP

Given an ideal situation, many people would prefer to be able to access the same GP for purposes of continuity. High turnover of staff makes this difficult to achieve in many parts of the Kimberley region, and nigh impossible where patient / GP interaction is through a hospital emergency department.

It is widely accepted that a long term relationship with a GP produces better health outcomes and one of the major challenges of the Kimberley primary health sector is to develop an environment that allows this to occur.

3.16. Those not regularly attending a GP, who should do so

There is a perception that there may be a significant percentage of the Kimberley population who should be accessing GP services, but who are not doing so. This might be for a variety of reasons.

Early intervention in a range of conditions would reduce eventual requirements for secondary and tertiary care and therefore lessen the strain on hospitals. While there are often advertisements on Indigenous media encouraging people to have various types of health checks through the AMS, there does not appear to be the same level of encouragement to the broader population and it is doubtful if existing primary care services could cope if there were.

This is particularly important with regard to illness which might be treated more successfully and less expensively through earlier intervention.

[6] 'Doctor shortage worsens in WA,' Perth Now – http://www.news.com.au/perthnow/story/0,21598,24377574-5008620,00.html accessed 20/9/2008

3.17. Overseas Tourists

More research is required to determine the level of services being provided at primary care level to overseas tourists in the Kimberley region.

Most services would appear to have the right to charge significantly higher fees for provision of services to those visitors that are from countries without reciprocal health agreements, and who in many cases would have access to relevant travel insurance for medical purposes. Non-emergency cases should possibly be diverted to GP clinics where possible.

3.18. Suggested Improvements

Shared access to patient medical history would reduce some strain on the current services. It would also facilitate improved assessment of regional demand and supply. This would then enable accurate modeling of trends, threats, performance and resource allocation and enable a more effective population health approach to the region. The Managed Health Network (MHN) messaging system trialed during 2008 by KDGP appears to provide a way forward. This is discussed further in Section 4 of this paper.

Better use could also be made of the media in terms of informing people regarding services that are available and including advice for making best use of their access to those services.

Workplace requirements for medical certificates for days off work help only to clog the system, particularly in cases of common colds where rest and sleep are the most effective treatments and having to wait several hours for a GP consultation only adds to misery.

One improvement might be for nurses to be able to obtain accreditation to sign off on basic certificates for this purpose for those patients who only want the certificate and do not necessarily want to see a GP.

3.19. Implications for a Broome Super Clinic

Current perceptions and expectations regarding access to primary care have implications for any consideration to establish a community based GP Super clinic.

It may well be that a Community GP Super Clinic will need to initially charge fees for many services although the ideal might be to try to achieve bulk billing where possible.

This will require a level of service that allows effective triage, diverting apparent short contact patients to a faster turn-around service that might be provided for some conditions by a nurse practitioner.

Extended evening and weekend opening hours, particularly for certain types of services would alleviate pressure on other service providers and allow greater possibility of diversion from inappropriate presentations at hospital emergency departments.

3.20. Summary of section

Community perception of the quality of primary care services varies across the region. In some areas there would appear to be confusion as to what might be reasonably expected from a primary care service.

The main concerns are waiting times and restrictions on access to services by either race or capacity to pay (ability to access a bulk billing service). These factors appear to be contributing to delays in Broome and Kununurra.

All health services report that many of their patients are presenting with conditions that they could self-manage better, even if that may require alternative forms of support.

Further qualitative data is required in order to establish why people in the hospital queues are seeking treatment there rather than at the local GP clinic or the AMS. This knowledge will be important for planning future primary care service delivery in the larger centres of Broome and Kununurra.

The wider perceptions of the community have not been sought through community engagement strategies. Until an effective consultation mechanism is in place or a wide-ranging survey is conducted, then gauging perceptions will rely on estimations and guesswork.

4. Current community engagement strategies in operation in the region with regard to health service planning and delivery.

4.1. General Comment

Analysis of the primary health care sector in the Kimberley has revealed a dedicated and talented workforce that is struggling within a fragmented financing and planning regime.

On the whole the sector is fragmented with duplication of services in towns and inconsistencies in structure, approach and levels of cooperation and collaboration.

This fragmentation appears to contribute to anecdotal examples of limited trust and respect at some levels between service providers, with added uncertainties regarding competition between some areas of health service provision. While in the main these observations are minor and not necessarily backed with facts, they appear to reinforce and entrench areas of planning that would be better shared and more broadly coordinated.

Virtually every agency consulted has developed some efficient models of co-operation and resource sharing which benefits the organisations and the community as a whole. However, the view from outside the health industry is that this has resulted in a patchwork of outcomes in the development of partnerships, collaboration, resource sharing and funds pooling.[7]

Community engagement levels overall appear to be very poor. The exception to this is the AMS structures which are community based, with governance and policy development overseen by boards elected from a community membership base. The Kimberley AMS's appear to have solid links into the Indigenous communities that they represent.

Virtually the only mainstream health advisory bodies that offer representation to the general public are the district health advisory bodies, which appear to offer a forum for feedback mainly to the regional or district hospitals.

There have been several examples of where government health policy objectives may appear to have been influenced by public outcry rather than through formal community engagement processes.

There certainly does not appear to be any community engagement with regard to overall health service planning for the region.

[7] Menadue, J., 'Obstacles to Health Reform,' Centre for Policy Development (2007)

4.2. General Health Planning and Delivery Forums

Health service providers are brought together in a number of forums that effectively bring the main parties together to plan and implement services.

The main groups include:

- Kimberley Aboriginal Health Planning Forum (KAHPF)
- Kimberley Medical Advisory Committee (KMAC)
- District Health Advisory Councils (DHACs)

Other relevant groups include:

- Kimberley Interagency Working Group (KWIG). This group is comprised mainly of government agencies.
- Kimberley Renal Advisory Group (KRAG).
- WA Human Services Regional Managers' Forum
- Kimberley Drug and Alcohol Working Committee (DAWC). This group reports to the WA Network of Alcohol and other Drug Agencies (WANADA).
- Liquor Accord Committees.

Of the above, only the District Health Advisory Councils appear to be open to application for membership by members of the general public.

It is questionable how these different health planning and service delivery groups provide an efficient regime for the co-ordination and cooperation of primary health organisations, in the absence of an overarching central coordination body.

4.2.1. Kimberley Aboriginal Health Planning Forum

The Kimberley Aboriginal Health Planning Forum is one of the area's major forums and includes a number of sub-committees.

Sub-committees include:

- Kimberley Regional Aboriginal Mental Health Planning Forum.
- Alcohol sub-committee.

Anecdotal evidence suggests that the Kimberley Aboriginal Health Planning Forum may be unwieldy due to the size of its constituent membership, and is reportedly plagued by high member turnover. This therefore requires constant education of new members before they can be productive. This forum is however not alone in this regard.

Concerns have been expressed that some of the sub-committees do not have an adequate focus on prevention strategies.

4.2.2. Kimberley Medical Advisory Committee

The Kimberley Medical Advisory Committee includes representation from hospital doctors, KAMSC, KDGP, and the Kimberley Population Health Unit.

4.2.3. District Health Advisory Councils

District Health Advisory Councils include membership based on ministerial appointment and are also open to public application to join. Appointments to the councils are generally made for a period of two to three years.

The Kimberley has five district health advisory councils. These are based in Broome, Derby, Fitzroy Crossing, Halls Creek and Wyndham/Kununurra.

DHACs were established by the WA Government 'to give country people a say in how their health services are delivered.'[8]

The Broome DHAC has apparently had a focus on 'mental health, dental health and bulk-billing issues' and claimed in 2006 to have 'made some great progress towards improving these areas.'[9]

4.3. AMS and other NGO Community Engagement Structures

The Aboriginal Medical Services and related services such as Nindilingarri Cultural Health are all managed by committees elected from their community membership base.

These are essentially based on a model that encourages community involvement and are generally comprised of people with non-medical backgrounds who are concerned about appropriate health service provision in their communities.

The governance of the Headspace service would appear to be in itself an inter-agency working group specific to youth health issues.

4.4. Role of Kimberley Division of General Practice

The Kimberley Division of General Practice Ltd (KDGP) had a membership base of 66 GPs as of June 2008. The Division provides a range of information and support services to its members and the public as well as providing advocacy for improvements to the quality of health care in the region. KDGP is also the region's major employer of Allied health professionals.

[8] Further information on the activities of DHACs can be found at: http://www.wacountry.health.wa.gov.au/default.asp?documentid=541
[9] http://www.health.wa.gov.au/press/view_press.cfm?id=556

KDGP has advocated for increased awareness of structural inefficiencies in health service delivery in the Kimberley, including specific problems associated with the shortfall of GPs and issues related to their recruitment and retention. As well as becoming a service provider in its own right it is also a driving force in regional primary health policy and reform.

4.5. Summary Private GP involvement in planning

Involvement of Kimberley private practice GPs in Kimberley health planning forums appears to be quite limited. It should be noted that even the board of the KDGP does not presently have a private GP as a director.

4.6. Other Community Forums

A series of community forums are being conducted during 2008 at eight locations across the Kimberley and Pilbara regarding the future use of the proposed 14 bed inpatient Mental Health Unit at the Broome Hospital.

4.7. Summary of section

Apart from the AMS and NGO organisations which rely on a community base, and to an apparently limited extent the WACHS District Health Advisory Councils, we have not found a great deal of evidence of wider community engagement in primary health care service planning and delivery.

Several forums exist for government and non-government agencies and would appear to contribute to areas of agreement on protocols and coordination of some health initiatives.

On the whole, primary health planning and service implementation is fragmented across a variety of bodies and this suggests the need for a single primary health coordinating body.

The high turnover of members experienced by some of the planning forums would appear to lengthen deliberation and possibly otherwise delay actions that might be undertaken by groups with greater continuity of membership. This would appear to create frustration amongst some longer term members.

There would appear to be a need for the major forums to set priorities and end goals both for their own deliberations and focus, as well as for the work of various sub-committees. Where these groups have established these principles it might be helpful if they are made more readily available.

Recommendation: That the principles, objectives and major decisions made by regional health planning bodies be made available through broader forms of communication to the public.

5. Models of health sector partnerships, including pooled funding arrangements (Health Service Agreement, Medicare, program, and discrete grant), government outsourcing, and community health 'Super Clinics.'

5.1. General Comment

The fragmented development of health services in the Kimberley over time has steadily led to the need for partnerships and other arrangements between the service delivery agencies.

One noticeable feature of the development of the region's health services has been an increasing trend towards development of GP based multi-disciplinary clinics. All of the region's AMS now have working relationships of varying degrees of efficiency with WACHS, while other agencies such as KDGP have emerged as key players particularly in the delivery of allied health services that might not yet be viable for many of the local clinics to operate separately.

Proposals to develop community 'Super Clinics' would appear to sit naturally within this context and may be interpreted as a Commonwealth commitment to devolve provision and management of primary health care services to community run organisations. It is possible that this is also is a reflection of research that shows not only improved financial efficiencies in the use of integrated multi-disciplinary teams, but also better community access and improved health outcomes.

Numerous researchers have identified aspects of remote disadvantage in terms of primary health. For example;

> 'In areas classified as "highly accessible", rates of GP use were significantly (10%) higher in disadvantaged SLAs after adjusting for GP availability. The reverse was found in "remote/very remote" areas, where rates of GP use were about 36% lower in disadvantaged SLAs. Also, the strength of the relationship between GP availability and GP use differed across the ARIA categories.
>
> In "highly accessible" areas, a unit increase in the number of FTE GPs per 10 000 population was associated with a 1% increase in GP use, whereas in "remote/very remote" areas it was associated with a 15% increase.
>
> This suggests that disadvantaged groups in rural and remote areas experience disproportionate difficulty accessing GP services. These areas are underserved by GPs, who charge more for their services and are less likely to bulk-bill.'[10]

[10] Turrell, G., Oldenburg, B., et al., 'Socioeconomic disadvantage and use of general practitioners in rural and remote Australia,' in MJA (2003) vol.179 no.6: pp325-326.

Primary health professionals will also be familiar with the following issues relating to primary health care in the Kimberley, which are in part responsible for lack of progress in improved health:[11]

- Lack of funding flexibility to address short tem and changing needs.
- A pre-occupation with fee for service provision rather than outcome based approaches to funding.
- A disease focus rather than preventative primary care focus; resources geared to dealing with crises rather that prevention.
- Poor co-ordination of the various strands of the services resulting in duplication and inefficiencies.
- Workforce issues, shortage of staff, lack of peer support and an inability to build and maintain capacity within rural communities and health services.

The Western Australian Country Health Service (WACHS) has been an active agent of change. It has embraced the concept of networked health provision, multi-disciplinary primary health care and partnership arrangements between health services.

WACHS have made some progress within the Kimberley, with some partnership agreements already reached, or currently being negotiated.

Historical distinctions between private general practice, AMS, allied health and hospitals are now being broken down with the introduction of new models of primary health care.

Community GP 'Super Clinics' and team based approaches to primary health care are a few examples of State and Commonwealth policy decisions reflecting a new approach to primary health care.

There is now an opportunity for a collaborative approach which will make better use of existing funds and provide a co-operative regional model which would be more likely to attract greater recurrent and project funding, as well as enabling the aggregation of funding and accumulation of discretionary funds.

Accumulation and regional prioritisation of discretionary funding should then enable implementation of programs which have a measured improvement of mortality and morbidity outcomes within the region.

Co-operation between service providers can enable the pooling of funds such as Medicare, MBS, PBS, HACC, grant monies and other funds.

[11] Refer: Harvey, P.W., 'Tantalus and the Tyranny of Territory: Pursuing the dream of parity in rural and metropolitan population health outcomes through primary health care programs,' in Australian Journal of Primary Health. Vol.10, no. 3 (2004)

Examples of funds pooling trials may be found in Enhanced Primary Care (EPC) for aged health assessment and care planning for patients with chronic conditions, as well as between local governments, industry and community organisations.

Larger scale funds pooling would almost certainly require the development of a Primary Health Care Organisation (PHCO). Clearly any PHCO model of organisational functions, structure and constitution would require agreement by the majority of Kimberley primary health organisations.[12]

Other initiatives that have successfully used funds pooling are:

- Care planning.
- Care coordination.
- After-hours care.
- Care for people with chronic and complex needs.
- Hospital admission prevention or improved discharge programs.
- Aboriginal community empowerment.
- Local government / industry / private practice.

Improved health and wellbeing of patients should be the end product of fund holding strategies.

Economic efficiencies gained from a collaborative approach should then be directed towards regional priorities and strategies, with measured health outcomes. If funding arrangements are transparent and outcome focused, with appropriate measurement tools, then the ability to quarantine some funds for discretionary purposes may be possible.

An organised, effective and cohesive regional primary health sector should then be capable of position itself to influence and access Commonwealth and State health and infrastructure expenditure. It may also be capable of attracting extraordinary funding.

There currently appears to be interest from the Commonwealth Government to fund primary health care initiatives and a cohesive regional approach is needed to engage with them.

[12] Refer: Wilson, R., McBride, T., and Woodruff, T., Strategic directions for a national primary health care policy. Centre for Policy Development. (2007). This article provides useful analysis of how Primary Health Care Organisation (PHCO) models may be developed and adapted to meet regional needs.

5.2. Health Sector Agreements

We are aware of the following health sector agreements:

5.2.1. NACCHO / AGPN Memorandum of Understanding

In November 2007 the peak bodies for Aboriginal community controlled health bodies, National Aboriginal Community Controlled Health Organisation (NACCHO) and the peak body for Divisions of General Practice, Australian General Practice Network (AGPN) signed a MOU listing a series of principles and terms of agreement which included twelve monthly work plans.

Four key areas were included in the initial work plan for 2007-2008 which included:

- Establishing and monitoring relationships across Networks.
- General Practice Accreditation.
- Child and Family Health.
- Chronic Disease Management.

The agreement sets out some basic principles under which Divisions of General Practice and Aboriginal community controlled health organisations might work together in future.

5.2.2. Kimberley Health Service (WACHS) Certified Agreement

WACHS have recently negotiated a Certified Agreement which allows for mobility of its medical staff, enabling them to be relocated, by agreement, for short periods for the purposes of locum relief, professional development and specific health initiatives.

It is possible that this potential flexibility in staffing would also be useful for Health Partnership Agreements. At the same time it may assist in reducing staff turnover within the hospital environment, by providing more varied and challenging work. It is also anticipated that the Certified Agreement might provide an environment for improved training opportunities for a variety of staff including Registrars.

While the Certified Agreement does encourage private practice provision and payment to the doctor for doing so, there is a relative reluctance among Broome hospital's highly trained proceduralists to go back into general practice. As a group, they are happier doing the high end procedural work like anaesthetics and obstetrics and the ICU type work in the resuscitation room and High Dependency Unit (HDU), rather than general practice.

All would appear to have left general practice to work in the secondary care setting and prefer this sort of work, although they still provide primary care through the emergency

department currently. There is often some continuity of primary care by asking patients to come back for review on known ED rostered days, or by offering palliative care home visits. One senior doctor at the hospital commented that; 'Once a good GP, it is hard to shake the training, however, most of the doctors have verbalised that they would not wish to be involved in urban general practice again.'

As a group, the Broome hospital doctors are relatively stable: being the longest serving medico group in Broome. Staff turnover within WACHS Kimberley is currently running at upwards of 30% while the turnover among Broome Hospital's medical staff is somewhat lower, at 10-20%, which is probably one of the lowest in the medical services in the Kimberley.

The Broome Hospital has been unable to access Health Insurance Act 1972, s19.2 exemptions to access Medicare. This effectively places limitations on stand alone services and associated capacity for additional finance.

If a 'Super Clinic' can be established in Broome and there is scope for staff to be shared or rotated through it in an appropriate manner, this would enable the hospital to generate more income and therefore fund new staff positions. Positions suggested have included a 50% clinician and a 50% physician. If a GP 'Super Clinic' were located at the current Broome Medical Centre premises that it could also mean the sharing of a pediatrician. This would improve primary health care outcomes in the region and therefore reduce strain on WACHS' secondary resources.

WACHS was also at pains to point out the difficulties faced in providing adequate housing for recruitment and retention purposes. The issue of remote classification anomalies (ARIA and RRMA) was also raised as a major issue which inhibits adequate funding and results in inequitable differences in salaries of remote nurses.

5.3. Health Service Agreements

There are several health service agreements in place in the Kimberley:

5.3.1. Derby Health Service (DHS), Derby Aboriginal Health Service (DAHS) and the Royal Flying Doctor Service (RFDS)

This agreement is currently under negotiation.

The relationship has already progressed to the point where all three services train together and they are heading towards a joint position across services, with a shared physiotherapist being the first objective.

The parties to the agreement also have reached agreement on patient record sharing, which is contained within a memorandum of understanding.

DHS was at pains to point out the seriousness of housing availability and quality within Derby. Although it owns a number of houses in Derby, they are of poor quality and this is a major disincentive to recruitment and retention.

The hospital has already commenced plans to take advantage of s19.2 exemptions to enable bulk billing. This will provide extra discretionary funding for the hospital and also enables the appointment of practice managers. Consulting rooms are already in place and it is envisaged that this would enable visiting specialists to bulk bill.

5.3.2. Fitzroy Valley Health Service / KPHU / Nindilingarri Agreements

The Fitzroy Valley Health Partnership began formally in 2000. It began as a partnership between the Fitzroy Valley Health Services (FVHS) and Nindilingarri Cultural Health Service (NCHS).

The Fitzroy Valley Health Service (FVHS) is part of the WA Country Health Service (WACHS) and includes services which come via Kimberley Health Region. This comprises a hospital, providing a wide range of inpatient and outpatient services, and Population Health Service.

Outpatient services include:

- appointment based General Practice,
- emergencies,
- specialist visits,
- allied health visits.

The Population Health Service includes:

- community clinics,
- child health,
- school health,
- community midwife,
- retinal photography,
- a diabetic educator.

Clinical management of Population Health is provided by the Kimberley Population Health Unit of WACHS (KPHU), based in Broome.

In 2004, the first partnership agreement was signed by the WACHS and NCHS. This agreement formalized the intention of both parties to work in partnership, so as to deliver, in a coordinated fashion, increasingly effective, efficient, and culturally appropriate health care to the population of the Fitzroy Valley region. The principal mechanism for the operation of the partnership agreement was the partnership forum. The partnership

forum membership included equal representation from each service and was chaired by the CEO of Nindilingarri. WACHS provided the secretariat support and it was agreed that the partnership forum would meet regularly (approximately monthly).

The partnership forum provided an environment that has allowed each organization to meet and discuss their roles, problems, plans and ideas. It continues to be the shared vision of the Fitzroy Valley health partnership to completely eliminate duplication and provide a continuum of care that is culturally appropriate, holistic and sustainable. In consultation, it was decided that each group would identify their core business functions and concentrate their activities in these areas.[13]

NCHS identified their core business as:

- Preventative Health/Health Promotion.
- Environmental Health.
- Aged Care services (Residential).
- HACC services.
- Alcohol Drug & Mental Health Services.

FVHS WACHS has identified their core business as:

- Acute Care Services.
- Hospital Services.
- S100 Medication.
- Population Health Services (through the Kimberley Population Health Unit).
- Allied Health Services (through Kimberley Division of General Practitioners).
- Mental Health Services (through North-West Mental Health).
- Ambulance Services.
- Kimberley Aged Care Services (community based).
- Specialist Services (visiting).
- Inpatient Palliative Care Services.

In order to facilitate the partnership, NCHS has agreed to withdraw from clinical service provision and transfer their clinical services, including all associated funding and on-costs to WACHS. To progress this process, new documents have been written that clearly define the parameters of an equal partnership between NCHS and WACHS, as the major health service providers in the Fitzroy Valley. The changes in service delivery commenced on July 1, 2006.

Negotiations are currently underway to totally integrate FVHS, Kimberley Population Health (KPH) and Nindilingarri service provision. This is envisaged to include a fully integrated primary health care model, with joint positions, joint services planning and joint out-reach / in- reach services.

[13] Source: http://www.kamsc.org.au/ as at 14/09/08

The WACHS Kimberley/ Nindilingarri model has developed a shared appointment system whereby the AMS pays WACHS for a position but the hospital is only nominally the employer, for the purposes of insurance cover etc.

5.3.3. Kimberley Aboriginal Medical Service Council (KAMSC) partnership agreements

KAMSC have a loose, historically based arrangement with WACHS Kimberley Population Health Unit (KPHU) which provides co-funding for 1 FTE GP to provide clinics to Beagle Bay, Lombadina and One Arm Point. The KPHU share is funded through the PHCAP via OATSIH.

There appears to be a need for monitoring of program and associated health outcomes, which may be more possible under a formal agreement.

KAMSC also runs clinics in Bidyadanga, and in other regions through BRAMS, DAHS, Jurrugk (servicing Gibb River Road communities), OVAHS, YYAMS, and in the Kutjungka region.

Originally established as a corporate support unit for the regional AMS services, KAMSC has become a primary care provider in its own right and also partners a range of organisations on shared training initiatives.
KAMSC is also keen to develop patient record sharing arrangements with Broome Health Service but believes that confidentiality concerns are delaying progress. It also sees opportunity in new primary health care models being able to provide GPs from other sectors to participate in Aboriginal health service delivery. This would in turn provide greater variety, more challenging medical experience and therefore greater job satisfaction.

5.3.4. KDGP Allied Health Service Arrangements

KDGP have arrangements with several health service providers in both the East and West Kimberley where allied health professional employed by the Division are able to provide consultations. These services are provided through both WACHS and AMS clinics as well as in other community settings such as Home and Community Care (HACC) locations.

Allied health staff employed directly by KDGP include: Dieticians, Diabetes Educators, Podiatrists, a Paediatric Nutritionist, and Mental health workers, including Psychologists.

5.4. Pooled Funding Agreements

KAMSC and KPHU provide shared funding for 1 FTE GP to service Dampier Peninsula Communities where some clinics are operated by WACHS and some by KAMSC. While both agencies contribute to funding the position, it is formally allocated to KAMSC.

A more advanced pooled funding model operates in the Fitzroy Valley, which is discussed above. Other examples of pooled funding arrangements outside the region may be found in the attached literature review.

5.5. Discrete Grants

There are many and varied grants available to not-for-profit health and community organisations. Navigating through the maze of grants provided by Australian and international organisations is, by itself, a daunting task. It appears that many smaller grants are not worth the time and effort to find, let alone apply for. Others are attractive but highly competitive.

A centralized, regional approach to grant application may provide some greater efficiency in this process.

5.6. Health Specific Grants

A range of health-specific grants are available through Australian and WA Government Health Departments, Healthways, NGO's, and agencies such as OATSIH. These include:

Australian Rotary Health Research Fund
- Rural Health: Evaluation of Service Provision
- Mental Health: Evaluation of Service Provision

DOHA
- Medical Rural Bonded (MRB) Scholarships
- Rural Australian Medical Undergraduate Scholarship
- Rural Private Access Program

Healthways
- Healthy Local Government Grants
- Aboriginal Health Project Grants
- Capacity Building Scheme
- Leadership Development in Health Promotion
- Health Promotion Research Project Grants and Research Starter Grants

National Health and Medical Research Council
- Independent Research Institutes Infrastructure Support Scheme (IRIISS)

- NHMRC Partnerships For Better Health: Creating effective collaboration between policy and research

Western Australian Government

- Regional Investment Fund
- Regional Infrastructure Funding Program (RIFP)
- Indigenous Regional Development Program (IRDP)
- Western Australian Regional Initiatives Scheme (WARIS)
- Regional Development Scheme (RDS)

Dept. Infrastructure, Transport, Regional Development and Local Government

- Rural Private Access Program

Australian National Commission for UNESCO Grant Scheme 2007-08

Mental Health Council of Australia (MHCA)

Pharmacy Guild of Australia

- Managing Mental Illness and Promoting and Sustaining Recovery: The Role of Community Pharmacy

GSK Australia Community Partnerships Program

These are just a small sample of the grants available. An exhaustive list of grants can be found at http://www.grantslink.gov.au/

5.7. Housing Funds

Funds available for the development of staff housing for WACHS and AMS / NGO services in the region have not kept pace with needs and cost escalations in recent years.

There are anecdotal reports of many possible health service positions that are not taken up by agencies or remain unfilled due to severe shortages of housing for staff.

It is unclear for instance, how the estimated increase in staff required for the present Broome Hospital redevelopment can be met, particularly in the lower paid positions for which accommodation is not provided.

Some agencies have used a capital loan mix to finance staff housing, for example through organisations such as the Country Housing Authority. It would appear likely in future that most agencies may have to seek financing for development of housing clusters or complexes in order to maximize the level of accommodation to be achieved versus cost.

5.8. Other Funds

The Australian Government has provided forward budget allocations for a Remote and Rural Infrastructure Fund which will commence during the 2009-2010 financial year. It is anticipated that some of this funding will be accessible in forms that might be targeted for health infrastructure needs in the Kimberley. Recent economic developments have also lead the Commonwealth to investigate increased "nation building" infrastructure investment, including accessing the Federal Future Fund. A costed regional plan would be the necessary first step in attempting to access these funds as they are unlocked.

5.9. Patient Records Sharing Issues

The multiplicity of patient records systems and their lack of coordination between the large numbers of service agencies in the Kimberley is striking for anyone investigating health service provision in the Kimberley. Many Kimberley people will present at different health service providers at different times. This lack of coordination regarding their records wastes precious resources and works against the capacity of the services to respond appropriately in instances where a patient may have recorded medical history that is relevant but not immediately apparent to the treating service provider.

This issue has been treated separately in a business case developed by the Kimberley Division of General Practice in collaboration with UWA. During 2008 a trial of a managed health network secure messaging system has been undertaken across a range of different service providers utilizing a system funded by the Department of Health and Ageing in the Great Southern of Western Australia. This trial has helped to inform the need for additional functional requirements and the need for related training and improved coordination.[14]

Development of such a shared system would produce efficiencies in a range of areas beyond better servicing of individual patients. It would for example assist in significantly improved monitoring of health outcomes and associated service delivery planning. It would appear that issues of patient confidentiality can be addressed in the further development of this system.

5.10. Workforce Training Partnerships

Several organisations are involved in health workforce training in the Kimberley. These include joint University of Western Australia (UWA) / KAMSC program for GP training, Nurse training provided at the University of Notre Dame's Broome campus, and Indigenous health worker training, also provided through KAMSC.

[14] Burrows, M. and Glance, D., KDGP – Managed Health Network Business Planning Project Business Case (KDGP working paper – June 2008)

KAMSC has been a registered training organisation (RTO) since 1998, and is accredited to offer six qualifications ranging from a Certificate III to an Advanced Diploma of ATSI Primary Health Care.

There appear to be numerous opportunities for further development of health workforce training that might be provided in the region in future.

5.11. Medicare

The beginnings of Medicare are found in the Health Insurance Act 1973. The introduction of a taxpayer funded universal health care system included a system of bulk billing. This enabled private GP's to receive compensation from the Commonwealth, rather than the patient, and provided free hospitalisation.

Over time the public health systems became a political football, with successive attempts to either reform or undermine it. Some aspects remain. Treatment in a public hospital as a public patient is fully subsidised by Medicare. Regardless of means, every Australian is entitled to attend a public hospital and receive medical treatment free of charge. However, there may be a considerable waiting list for elective surgery. Treatment and hospital accommodation is free to the patient. This is funded through the Commonwealth-State Health Care Agreements.

For private patients in public or private hospitals, Medicare will cover 75 per cent of the Medicare Schedule fee for medical procedures. Private patients still need private hospital coverage to help with accommodation costs and other hospital charges.

The major issues with Medicare are:

- For medical professionals – the rate at which the scheduled fees are set and how accurately they reflect running costs/support profit margins.
- For patients – the availability of a bulk-billing (free) doctor, particularly in rural and remote areas.

The 'bulk-billing rate' is the percentage of doctors providing a free service. The Department of Health and Ageing monitors bulk billing rates. Some doctors may only bulk-bill patients who can not afford to pay their medical fees out-of-pocket. Some doctors will not bulk-bill at all.

A decline in bulk billing in the region can be linked to the low level of the scheduled fees and doctors' desires to maintain their financial viability. It is strongly arguable that the intent of Medicare be revived in remote regions, with a meaningful rate of compensation.

Some improvements have been made to Medicare; however the impact that these changes will have to the retention of Kimberley private practitioners is likely to be minimal.

Previously the Health Insurance Act 1973 specifically prohibited public hospitals from charging fees or bulk billing. There has now been recognition of the role played by hospitals in towns with 5000 or less residents. Towns of this size, especially in remote regions, have relied on public hospitals to provide primary health care. This has been conducted outside their funding priorities and has been done so out of good will and necessity in the absence of private practioners.

The Health Insurance Act 1973 has now been amended (s19.2) to allow hospitals to swipe Medicare cards and thus bulk bill primary care patients. The funding they receive from this reform now allows them to accumulate discretionary funding which is then used to target service and delivery priorities that have been *identified locally***.**

Aboriginal Medical Services may also swipe Medicare cards, and this is also a useful means of accumulating discretionary funding.

5.12. Future Changes to Medicare / MBS

The topicality of Medicare in health service provision discussions suggests that there will be further changes to Medicare in Australia over coming years.

Services for Australian Rural and Remote Allied Health Inc (SARRAH) have recently made submissions to DOHA in the review of Medicare.

SARRAH suggests: [15]

- Establishing a process to assist in identifying health needs and services in rural and remote communities.
- Replicating the Medical Specialist Outreach Assistance program to provide enhanced Allied Health services to rural and remote communities.
- Extending access to Medicare to ensure that Allied Health professionals in remote Australia have direct payment without the requirement of a referral from a General Practitioner.

5.13. Health Insurance Act 1973 Section 19.2

The Health Insurance Act 1973 prohibits hospital emergency departments from charging fees for Australian residents who present to emergency departments (ED) or inpatient services with primary health care needs.

15

http://www.sarrah.org.au/site/index.cfm?page_id=110903&pageMode=indiv&FromSearch=true&module=MEDIA&leca=283

An exemption is allowable under s19.2 of the Act. It invites health services in smaller towns to apply for exemptions. Once granted an exemption, these services can then swipe Medicare cards and bulk bill the Commonwealth for inpatients and ED patients.

Derby and Fitzroy Crossing hospitals are currently setting themselves up to do this as means of increasing their discretionary funding, while a working party is also progressing a similar arrangement for Kununurra.

One of the questions yet to be answered is the extent to which this may affect their line funding or be open to be used for discretionary spending on specific local needs.

Due to its population levels, Broome Hospital does not qualify for this exemption, despite a significant Indigenous population and current shortage of GP services.

5.14. Government Outsourcing

5.14.1. Kimberley Satellite Dialysis Centre

The KSDC provides 10 dialysis chairs using Fresenius S&H machines. The initiative is a joint venture between BRAMS, the Health Department of WA and Royal Perth Hospital.[16]

5.14.2. St. John Ambulance Services

Ambulance services in Broome, Kununurra and Wyndham are provided by St. John Ambulance WA.

The Broome service is staffed by a paid manager and two paid qualified paramedics with heavy reliance on volunteers, who undertake all the night work. If there were no volunteers in Broome, the service would need to employ eight paramedics, which is clearly unaffordable.

The services in Kununurra and Wyndham are generally staffed only by volunteers. St. John Ambulance recently stationed a paramedic in Kununurra for a year on a pilot program to recruit, train and retain volunteers for the town and the neighbouring community of Wyndham. This followed a period where the Police had to drive the ambulances on several occasions because the town's existing eight volunteers could 'not cope with the workload.'[17]

St. John's is notionally fee-for-service but can't fully fund from receipts and reportedly carries a significant level of bad debts in the region.

[16] http://www.kamsc.org.au/dialysis_centre.html
[17] http://www.abc.net.au/news/stories/2007/09/03/2022173.htm

In the smaller towns (Derby, Fitzroy Crossing and Halls Creek), ambulance services are generally provided as a free service through the hospitals, staffed by orderlies, nurses and volunteers.

The Bidyadanga and Beagle Bay clinics have their own ambulances, but reportedly have regular difficulties finding drivers. Bidyadanga rarely sends its ambulance all the way into Broome, instead organizing a "halfway meet" with the Broome ambulance thus further taxing the already stretched Broome town service.

It has been suggested that ambulance transport in the region be recognised under Medicare given the inability of significant numbers of the population to pay for the service.

5.15. Community integrated primary health 'Super Clinics'

General examination of models for GP based multidisciplinary services including 'Super Clinics' is attached to this document in the form of a literature review.

As part of its election promises during 2007, the Rudd Government promised that a series of 'Super Clinics' would be established at upwards of thirty specific sites around Australia.

Difficulties in maintaining private GP based multi-disciplinary clinics in the Kimberley have led to discussions regarding the 'Super Clinic' model as a possible partial solution to present difficulties.

The closure of the privately operated Dakas Street Clinic in Broome in July 2008 has resulted in a proposal by KDGP to canvas the possibilities of establishing a 'Super Clinic' in Broome. Although Broome was not on the list of sites for the initial rounds of super clinic funding, it is considered that the town may well be in consideration for funding for such a service, given slower than anticipated uptake of the program in some other regions.

Several of the region's AMS organisations have expressed the view that some of them are already multi-disciplinary clinics and that a 'Super Clinic' innovation might as well be done through them. It is likely that there will be considerable debate regarding how this might work, not just in Broome, but potentially with a service that might partner other agencies across the region.

5.15.1. Immediate priorities for Broome General Practices maintenance

Maintenance and extension of basic GP services in Broome is an immediate priority. The demise of the Dakas Street Medical Centre, imminent closure of Dr Jensen's clinic and suggestions that the Broome Medical Centre might not be sustainable as a private practice beyond its current owner's commitment, threaten the provision of dedicated primary health care services to the town.

Establishment of a community based GP 'Super Clinic' funded by the Commonwealth appears to be the only means by which GP and Allied Health services can be maintained for non- Indigenous residents, particularly those who require access to bulk billing.

A funded multi disciplinary model would enable team based approaches to primary health care delivery and management. Literature suggests that this will result in both better primary health outcomes, economies of scale and other organisational efficiencies.

If a 'Super Clinic' is established it could provide an added resource for assistance to Aboriginal Medical Services by possibly providing GP resources on an outreach / in reach basis.

It would also provide a challenging, worker friendly and professionally interesting environment, which would assist in recruitment and retention of GPs and Allied Health professionals.

The Community GP 'Super Clinic' model would also provide a platform for vocational training components of a GP School as well as Allied Health training and professional development.

It could also provide a platform for the development of research and development initiatives which are both locally developed and focused.

5.15.2. KDGP Super Clinic Discussion Paper

A discussion paper released by KDGP during August 2008 canvasses the possibility of a 'Super Clinic' for Broome.

This initial paper raised the possibility of the purchase of existing privately owned clinics to create a multi-campus site, with core services likely to be located at a redeveloped Broome Medical Centre, which is conveniently sited adjacent to the Broome Hospital.[18]

It is understood that conversion of the current Broome Medical Centre site is particularly favored by WACHS, given its close proximity to the hospital, and the opportunities for resource sharing, training diversity and increased efficiency of referrals through triage that it might bring.

5.15.3. Alternative Service Provision Models and Suggestions

There are many ways in which a Kimberley 'Super Clinic' might be established and operated.

[18] KDGP Discussion Paper: 'Collaborative Primary Care in Broome,' August 2008

Discussions with stakeholders suggest that while initial investigation might be best confined to the establishment of a clinic in Broome, it is possible that through partnerships, some of the clinic's services could be provided to other centres across the region. Such arrangements could take many forms.

It is generally assumed that an NGO operated 'Super Clinic' would be able to source funds and achieve levels of financial assistance that a privately operated centre simply cannot under present MBS and tax regimes.

While the establishment of a 'Super Clinic' has been put forward by KDGP, who would appear to be well capable of developing such a service, there seems to be no obvious reason why such a venture could not be developed in partnership with the AMS sector. It is anticipated that a future feasibility study for the establishment of a 'Super Clinic' to be based in Broome will look carefully at all possible ownership structures.

It would appear to be preferable for a range of service providers to be represented on the board of this new service, in order to ensure not only a shared sense of ownership of the facility, but also to maximise potential for integration and collaboration with existing services and limit any unnecessary duplications.

5.16. Summary of section

It is clear that most Kimberley primary health service providers are already either in partnerships of one sort or another, or actively investigating their possibilities. There is still however, a long way to go in achieving efficiencies and overall better health outcomes for the population through increased sharing of resources, communication and partnered approaches to both service delivery and the planning and coordination behind them.

Regional health forums such as the Kimberley Aboriginal Health Planning Forum (KAHPF) appear to have the potential to encourage these further if sufficiently resourced to do so. Several agencies such as KDGP and KAMSC already have working relationships with a range of agencies.

WACHS may be able to increase its flexibility in this area through its EBA initiatives and has already shown through the relationships developed in Derby and the Fitzroy Valley that it can be a lead player in the development of partnerships premised on allocation of appropriateness of service delivery options.

A proposal for a 'Super Clinic' to be established and based in Broome should be embraced for further discussion and development by all interested parties. A range of models for GP based multi-disciplinary services are referred to in the attached literature review.

6. Opportunities for accessing government programs, corporate sponsorship and business partnerships, to enhance health services to the community.

6.1. Government Programs

There appear to be a large number of government programs that are accessible by health services in the region. Indeed one of the problems may be that there are so many. This presents challenges for administrators to prepare the appropriate cases to access the programs and it is suspected that their uptake may not be fully maximised for that reason.

These include:

6.1.1. National Remote and Rural Medical Infrastructure Fund

This is a recent reincarnation of the previous Rural and Remote Medical Infrastructure Fund. A point to note is the transposition of Rural and Remote. We would hope that this is an indication of Commonwealth recognition of the greater needs of remote regions. However the funding limits are by no means large.[19]

6.1.2. Practice Incentives Program (PIP)

The Practice Incentives Program provides financial incentives to general practices that provide comprehensive quality care and that are working towards meeting the Royal Australian College of General Practitioners Standards for General Practices.[20]

6.1.3. GPII Service Incentive Payments (SIP)

This program provides additional MBS payments for providers who immunize target groups.[21]

6.1.4. Primary Health Care Access Program (PHCAP)

This provides funding for the expansion of comprehensive primary health care services in Aboriginal and Torres Strait Islander communities that have been identified as being at highest need and have the capacity to receive and manage funding.[22]

[19] NRRMIF details are available at http://www.health.gov.au/internet/main/publishing.nsf/Content/nrrhip-lp
[20] PIP details are available at: http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp
[21] SIP details are available at: https://www.medicareaustralia.gov.au/provider/incentives/gpii/service-payments.shtml

6.1.5. Aged Care Access Initiative (ACAI)

The ACAI provides incentives for improved access to primary care (GP and allied health services) for residents of aged care facilities.[23]

6.1.6. General Practice After Hours Program (GPAHP)

The GPAHP provides grants to extend opening hours of practices. Grants are limited to a maximum of $100,000 over two years. Grant funding is available to assist with operating costs or recurrent expenses, of after hours services.[24]

6.1.7. Rural Women's General Practitioner Service (RWGPS)

The RWGPS funds improved access to primary and secondary health services for women in Rural and Remote Australia where there is little or no access to a female doctor. The service is managed by the Royal Flying Doctor Service Australia.[25]

6.1.8. Australian Primary Care Collaborative Program (APCCP)

Australian Primary Care Collaborative Program funding objectives are the improvement of clinical health outcomes, reduction of lifestyle risk factors, and maintenance of health for chronic and complex conditions and improve access to Australian general practice. The program management has been outsourced to the Improvement Foundation.[26]

6.1.9. More Allied Health Services (MAHS) Program

The MAHS program funds the provision of allied health workers to areas of need. It is managed in the Kimberley by KDGP.[27]

6.1.10. Mental Health Nurse Incentive Program

This program provides a non-MBS incentive payment to community based general practices, private psychiatrist services and other appropriate organisations who engage

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[22] PHCAP program details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/Primary+Health+Care+Access+Program-1
[23] ACAI program details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/aged_care_access
[24] GPAHP details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+After+Hours+Program
[25] Further information on RWGPS may be found at: http://rwgps.rfdsse.org.au/
[26] APCCP details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-apccp-index.htm
[27] MAHS program details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-mahs

mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.[28]

6.1.11. Nursing in General Practice

This program provide incentives for general practice to employ more practice nurses in order to improve patient access to integrated primary health care, prevention and management of chronic disease and to reduce workforce pressure.[29]

6.1.12. HECS Reimbursement Scheme

The scheme applies to Australian medical graduates who choose to undertake postgraduate training, or provide medical services in designated rural and remote areas.[30] (RRMA classifications 3-7)

This scheme could easily be extended to other categories of health professionals in high demand within remote regions.

6.2. Local Government

Local Governments have been placed under increasing pressure to assist where they can with development or maintenance of primary health services in recent years.

Several have opted to play a key role in capital development, land allocations, joint funding applications, or through offering rebates on rates or exemptions on costs for access to shire services. These have been useful in some areas as incentives to maintain services and to attract and retain GPs and other health services staff.

In the Kimberley, the four LGAs have long been coping with the fact that many of their constituents live in third world conditions. Given the range of pressures faced, it is understandable that LGAs in the region have been either unable or unwilling to set precedents on assisting the funding of local health services or businesses directly.

However it would appear likely that a forecast changed role of Local Government as a conduit for allocation of future Australian Government infrastructure funding will

[28] MHNIP details are available at: http://www.medicareaustralia.gov.au/provider/incentives/mental-health.jsp
[29] Nursing in General Practice program details are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-nigp
[30] HEC Reimbursement Scheme details are available at: http://www.health.gov.au/hecs-reimbursement-scheme

completely change this dynamic. The role of LGAs with regard to assisting health infrastructure funding into the Kimberley could become very important in coming years.

It would therefore be prudent for LGAs and a regional primary health organisation to develop a formal, productive, organisational relationship with each other. Joint agreement on regional health infrastructure priorities would assist in strategic funding approaches.

Recommendation: That a mechanism be developed for formal liaison between Kimberley LGAs and a regional health planning body or bodies.

6.3. Corporate Sponsorship

There would appear to be a variety of current and potential future opportunities for development of corporate sponsorship of primary care services in the Kimberley. These will not happen however by themselves and may require some sophisticated preparation and consultation. Businesses will generally want to see a tangible benefit to them from sponsorships.

6.3.1. Pilbara Example

An agreement was reached between private GP's, Rio Tinto and the Shire of Roebourne, which provides a practice subsidy in return for a service commitment to the company health needs, including licensing, testing and industrial medicine. The council contributes a support worker who endeavours to assist and meet the needs of GP's and families by providing a co-ordination role and facilitation of their involvement in the community.

6.3.2. Rio Tinto

Rio Tinto has recently sponsored the purchase of a new jet for the RFDS. The jet will carry corporate branding but will be otherwise free to operate at the discretion of the RFDS doctors. This would appear to be the largest single contribution to regional health services yet made by a corporate.

In Kununurra, Rio Tinto's relationship with the Kununurra Medical Centre is essentially a business one now, but involved some modest sponsorship assistance in the set-up phase.

6.3.3. Other Mining Companies

Regional mining companies generally have arrangements of one sort or another with private GP's if they are sufficiently large enough. All require pre-employment and other occasional medical checks to be undertaken for their staff.

Health providers should be in the position to reach agreement with mining companies to service their needs on a fee for service basis, provided there is some support with achieving necessary infrastructure.

Dual promotion activities could also be negotiated. The relationship between the two, and the benefits to employees and families could be used in recruitment advertising to benefit the company. A separate fee could be charged for health provider co-operation and usage of corporate logos and employees.

6.3.4. Tourism and Hospitality Industries

Tourism is a significant industry in the Kimberley, particularly in terms of the employment flow-on that it creates. The activities of the industry have a direct causal relationship with the increase in demand on many health services during the height of the tourist season. The huge burden that this places on Broome in particular, where the population at least doubles, and may even triple during the tourist season, creates significant problems for health planning in an area where there is still so much need.

Only a small number of businesses would appear however, to have the potential to contribute to any substantial extent. On that basis approaches to industry groups are unlikely to be successful other than as a minor adjunct to one or two major contributions by the wealthiest businesses.

6.3.5. Pearling Industry

Smaller industries are also a possible source of funds, either directly in particular from the largest companies, or through industry associations. The pearling industry should be a prime target for regional health funding support, and others may yet be identified.

6.3.6. Future Industry Development

Future sources of funding may be available from the partners in the Browse Basin Gas Hub, if it is selected for construction in the region. The Kimberley Land Council, in its negotiations with its member groups has advocated a policy for royalties and shared equity arrangements to be used to fund a range of social infrastructure that would certainly include addressing health needs.

6.3.7. Pastoralists

There are a small number of pastoral companies that own substantial property in the Kimberley. Under the type of model that operates in the USA, the families that own these holdings would almost be expected to contribute to significant infrastructure spending in their towns or regions.

6.4. Business partnerships

Several large companies have arrangements for their staff to attend particular clinics at agreed fees and terms. Potential business arrangements with corporates or universities through research and development could also be further explored.

6.5. Subsidies, Rebates and Exemptions

There are subsidies for GPs who are prepared to stay in remote areas. These are accessible on a sliding scale. There are also subsidies for other health positions in the most remote areas. The classifications for these do not necessarily reflect the true situation in the Kimberley.

Area tax rebates available are now worth very little compared to when they were first introduced and are unlikely to be increased unless as part of a wider package of Commonwealth incentives for regional or remote development.

Existing incentives include HECS rebates in certain cases.

In the previous section we referred to the exemptions being sought under section 19.2. of the Health Act 1972.

It is known that at least one private medical clinic requested an exemption from paying rates as a contribution from its LGA. This was declined.

6.6. Remote classification anomalies that need to be fixed

The issue of remote area classification anomalies (ARIA and RRMA) appears to be a major issue for the Kimberley, which inhibits adequate funding and results in inequitable differences in salaries, particularly of remote nurses.

6.7. Consolidation of Workforce Incentives and Allowances

One approach that may be worth investigation is the consolidation of workforce incentives and allowances, into a regional remote employment package.

Rather than it being incumbent on individual health professionals to navigate and apply to the various funding bodies and agencies, a remote employment package, which is applied automatically to a regional workforce, would enable workforce attraction and retention to be improved. It would also be both easier and more economic for government to administer.

Clearly some room would need to be kept for flexibility in allowances and compensation for more remote and disadvantaged sites.

Rolling these incentives into a single package, which is treated as salary, may also have a marked effect upon superannuation accumulation, as well as increased remuneration packaging benefits.

While some measurement of remuneration does occur, there is empirical evidence that there are disparities. These disparities appear to be largely caused by higher State government funding and lower Australian government funding in the areas for which they are responsible. A survey of remuneration would be useful for highlighting the disparities to the responsible governments.

Recommendation: That a detailed survey be conducted of remuneration and benefits provided by Kimberley primary health care agencies.

6.8. Summary of section

Health organisations in the Kimberley should make themselves ready to put cases for funding to the Commonwealth's new capital infrastructure funds as soon as they become available.

Corporate funding opportunities will, due to the nature of the region, be limited due to the small number of large employers or very wealthy individuals. It is important however to recognize that the health needs of the regions' corporations are a valid inclusion within any regional health planning focus and also a funding resource that should be developed with the appropriate level of support that it will require.

Many people in the Kimberley have long given up hope that the Commonwealth will review and substantially increase the zone tax rebate to its former comparative levels. It is to be hoped that recent efforts to highlight the plight of remote Australia through forums such as Desert Knowledge will impact on future policy in this area. The standards for area classification used as the basis for funding formulas also clearly require revision.

There are a variety of government programs that can be accessed. However the best way to maximize the amount of dollars into the region would be through a coordinated approach.

7. The main providers of primary care in each town and major community in the Kimberley region and their funding purpose.

In this section we provide a brief overview of each service and the extent to which they appear to be adhering to their primary funding purpose.

7.1. Broome Hospital

Broome Hospital is essentially funded for secondary and tertiary care. Its range of services includes geriatric, hyperbaric medicine, maternity, paediatrics and surgery. There are also pathology, pharmacy, physiotherapy and radiology services.

The hospital also operates a busy emergency department which includes the provision of services more appropriate to a primary care clinic. During September 2008, 12 Broome Hospital GPs were members of KDGP.

Broome Hospital's primary care activities in its emergency department have been discussed in Section 2 of this paper.

7.2. Kununurra Hospital

Kununurra Hospital is essentially funded for secondary, tertiary and acute care. Its services include maternity, paediatrics and surgery. There are also pathology, physiotherapy, speech therapy and radiology services.

Kununurra Hospital also provides primary health services through its emergency department, with a wait generally, of 3-4 hours. It has 8 doctors on staff, all GPs, some with procedural qualifications in obstetrics, anaesthetics and emergency medicine

The hospital also provides a GP service within consulting rooms which takes appointments, with at least a one week lead time if patients wish to see the doctor of their choice.

The hospital charges overseas visitors $140 and is shortly to start bulk billing once the 19(2) exemption has been obtained.

It also provides an after hours clinic, which would appear to be more associated with primary care.

7.3. Derby Hospital

Derby Hospital provides a range of services from primary to tertiary. These include:

- Aboriginal Health and Liaison.
- Emergency and General Surgery.
- Maternity, Midwifery and Ante / Post Natal Care.

Allied Health Services include:

- Diabetes Management and Education
- Occupational Therapy
- Paediatrics
- Physiotherapy
- Speech Therapy

The hospital also provides general practice services.[31]

The Derby hospital has commenced plans to take advantage of s19.2 exemptions to enable bulk billing. This will provide extra discretionary funding for the hospital and also enables the appointment of practice managers. Consulting rooms are already in place and it is envisaged that this would enable visiting specialists to bulk bill.

7.4. Wyndham Hospital

Wyndham Hospital has been steadily downgraded over the past twenty years as the town has declined as the regional centre for the East Kimberley.

It presently provides a limited impatient / outpatient facility, with its former geriatric ward having been moved to Kununurra. The hospital is staffed by 2 GPs.

The hospital has been the subject of regular political debate over recent years, with several attempts to downgrade it having been resisted through political pressure. It serves as a base for WACHS GPs to provide visiting services to the major East Kimberley communities of Kalumburu and Oombulgurri.

Of all the major WACHS facilities, Wyndham Hospital is the most controversial in terms of what its future role might become. The building remains substantial and many local people are hopeful that services may eventually be restored if and when the town experiences a significant economic upturn.

[31] http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=91

7.5. Halls Creek Hospital

Halls Creek Hospital was almost entirely rebuilt during 2006-7. The hospital operates as both a primary and secondary care facility and includes paediatrics and radiology. It operates an outpatient clinic which doubles as an emergency department. The hospital does not have a birthing facility. The hospital generally has 2 GPs on staff, with assistance from time to time of GPs employed by the YYAMS.

Nursing staff, orderlies and volunteers support the town ambulance service.

7.6. Fitzroy Crossing Hospital

Fitzroy Crossing Hospital provides primary, secondary, tertiary and acute services. Its primary services include Population Health Services provide through the Kimberley Population Health Unit, Allied Health Services provided through KDGP, Mental Health Services provided through NWMH, and an outpatient clinic.

The hospital also provides a base for visiting specialist services, ambulance services and inpatient Palliative Care Services.

The hospital is co-located and coordinated with Nindilingarri Cultural Health whose focus is premised on culturally appropriate health promotion.

7.7. Nindilingarri Cultural Health Service

NCHS have a primary focus on preventative health and health promotion activities in the Fitzroy Valley. Their activities include environmental health, Aged Care services (Residential), HACC services and Alcohol Drug & Mental Health Services

Nindilingarri is funded to provide services which are separated into two streams. Their health promotion team provides services in First Aid, Nutrition & Physical Activity, Sexual Health, Skin Health and Hygiene, Spiritual Health and Child Health. The Environmental Health Team provides services in Environmental Health Services as well as supporting community services that include a Frail Aged Hostel, HACC and Alcohol Drug and Mental Health Services. Services are all provided within a culturally appropriate context.

A developed agreement between the Fitzroy Valley Health Service and NCHS suggests that service delivery has been clearly delineated and that functions are as funded.

7.8. Broome Regional Aboriginal Medical Service (BRAMS)

BRAMS is funded as an AMS with a primary care and health education focus and also operates a separate arm which provides dialysis treatment. The service employs 8 GPs on average. It was the first AMS to be established in the Kimberley, commencing in 1978.

BRAMS operates both a clinic and, 'field orientated public health programs (women's health, sexual health, chronic disease, under five, men's health, aged care, prison health),' manages patient transport needs and specialist appointment notification. It does not use an appointment system, and advises that; 'People are seen as they come in and waiting times to see a doctor are about an hour or less to see clinic Aboriginal health workers and nurses. Very sick people are always seen first.' There is no after hours clinic but a Saturday morning clinic.[32] There is a general evening clinic once a week and a men's evening clinic once a week.

BRAMS assisted in the establishment of EKAMSC (now OVAHS) and then collaborated with that AMS to establish KAMSC. BRAMS and KAMSC are essentially co-located in a precinct which includes the BRAMS-operated Kimberley Satellite Dialysis Centre.

The service is the largest AMS in the Kimberley region and had a turnover of over $6.7M in 2006-7. Of this amount, only $2.1M was sourced from Department of Health and Ageing recurrent grants. Approximately $2.5M was sourced from dialysis treatment receipts. Income from Medicare in 2006-7 was $1.07M.

BRAMS' operations correlate with its funded purposes. The development of its dialysis centre developed as a response to the needs of the core patient group to receive treatment within a culturally appropriate setting. It would appear likely that the range of health services offered by BRAMS will continue to be added to over time.

7.9. Derby Aboriginal Health Service (DAHS)

The DAHS is essentially funded as an AMS with a primary care focus. During September 2008, five DAHS GPs were members of the Kimberley Division.

It has partnering arrangements with both the Derby Hospital and the Royal Flying Doctor Service which are currently being formalised. DAHS is also the funds holder for the Jurrugk Health Service which provides primary care services to the Gibb River Road communities.

DAHS's income during 2006-7 was approximately $4.9M (excluding grants brought forward). Of this approximately $1.85M was sourced from OATSIH for DAHS operations with a further $598,093 from OATSIH for the Jurrugk Health Service.

[32] http://www.kamsc.org.au/brams_practice.html

The other major grant source to DAHS's operations was $668,552 from the PHCAP. Income from Medicare was $497,239 during the 2006-7 financial year.

7.10. Yura Yungi Aboriginal Medical Service (YYAMS)

Yura Yungi (YYAMS) is funded as an AMS with a focus on primary care and health promotion activities. These include a specific focus on maternal, women's health, child health (including child nutrition issues) and sexual health. The service was established in 1987 and is provided with corporate services outsourced to KAMSC.

The service is generally staffed by 2 GPs with support from nurses and health workers. YYAMS doctors share an after-hours and weekend roster with the hospital doctor. A doctor is contactable through the hospital. GPs at YYAMS can apply for hospital admitting rights.

The clinic is open weekdays 8.00 am to 4.30 pm. Doctors are not available from 1.00pm to 2.00 pm or on Wednesdays. There is no appointment system at Yura Yungi. People are seen as they come in and waiting times to see a doctor are about an hour, or less to see the clinic Aboriginal health workers and nurses. Very sick people are always seen first.[33]

YYAMS's turnover during 2006-7 was approximately $2.04M. Over 80% of this income was through various grants from the Department of Health and Ageing. In that financial year income from Medicare sources was $213,760. The only other income of any significance in 2006-7 was $95,330 from GP services provided to the Halls Creek Hospital. YYAMS appears to be operating in line with its stated funded purposes.

7.11. Ord Valley Aboriginal Health Service (OVAHS)

OVAHS was originally established as the East Kimberley Aboriginal Medical Service (EKAMSC) before changing its name in 2001. As EKAMSC, it collaborated with BRAMS to establish the Kimberley Aboriginal Medical Services Counsel (KAMSC) in 1986. It is primarily funded as an AMS.

OVAHS provides a multi disciplinary practice employing 3 FTE doctors. It treats 80-120 people a day and has also noticed an increase in non-indigenous patients from 11% in July 2007 up to 20% in August 2008.

The organisation was recently granted Commonwealth funding for a mental health nurse ($130,000) and a psychologist ($230,000) but was unable to accept either, due to an inability to house them. It has bought 12 houses for staff and used a $1,000,000

[33] http://www.kamsc.org.au/ as at 14/09/08

overdraft. Currently house rental prices for a 3 bedroom house in Kununurra are $600.00 per week.

The service is considering a partnership arrangement with Wyndham MPS to act as a satellite clinic with thoughts of a GP service for three days per week, allied health perhaps two days a week and a permanent nurse/health worker. OVAHS also have a partnership arrangement with WACHS for mental health service delivery in Kalumburu and Oombulgurri

OVAHS expressed the view that they have a need for an after hours clinic. One is already provided by Kununurra Hospital. It questions whether the Commonwealth after Hours GP program is sufficient to adequately fund this activity as it provides only $100,000 over two years. It does not, in their view, provide sufficient compensation to supply power, nurses, receptionists and doctors. OVAHS suggest that the funding needs to be $100,000 per annum. This suggests that a partnership arrangement with the hospital to share after hours clinics is an option which should be explored.

OVAHS state that; 'As much as possible, regular OVAHS patients are seen by OVAHS doctors in the [Kununurra] hospital. The hospital doctors look after general emergencies during the week and there is a shared roster with OVAHS doctors on the weekends. Outside clinic opening times, OVAHS patients must go to the Kununurra District hospital…'[34]

Recurrent funding for OVAHS is approximately $ 2.7M per annum, from a mix of sources. Total turnover during 2006-7 was just under $4M. The majority of this income was sourced from the Department of Health and Ageing through OATSIH. OVAHS' OATSIH funding was recently reduced by 17% resulting in staff reductions. The centre has developed a variety of income sources which included $606,641 in Medicare income in 2006-7. In that year it also earned $105,135 from GP services to the Kununurra hospital and a further $187,385 from unspecified fees for service.

OVAHS appears to be operating in line with its funded objectives and appears keen to be able to fund expanded operations in the future.

7.12. Kimberley Population Health Unit (KPHU) - WACHS

KPHU is funded to provide population health services in the Kimberley through WACHS.

The service provides a Public Health Physician multiple Public Health Nurses and shares the cost of one GP servicing the Northern end of the Dampier Peninsula. The GP is paid 0.5 by KAMSC and 0.5 by KPHU. The position appears within the establishment structure at KAMSC. The KPHU share is funded through the PHCAP via OATSIH.

[34] http://www.kamsc.org.au/ovahs_practice.html

This relationship has developed on a more or less ad hoc basis and is not the result of a formal partnership.

KPHU plays a major role in providing immunization. However it is unable to access the full funds available under Service Incentive Programs (SIP). A private GP will receive $24 from SIP whereas KPHU receives only $8 per immunization.

If a GP performs more than 10 immunizations under certain circumstances they are able to access Practice Incentive Payments (PIP), whereas KPHU is ineligible.

The KPHU is currently trying to gain access to s19.2 exemptions in the East Kimberley. It currently operates services in Oombulgurri, Kalumburu, Warmun, Looma, One Arm Point, and Lombadina.

KPHU has a statutory function with regard to chronic disease and also shares sexual health and audiology workers with KAMSC. It is interesting to note that KAMSC also runs a Population Health Unit, and the two agencies appear to operate in parallel in some areas.

7.13. Kimberley Division of General Practice

Divisions of General Practice are non-government organisations (NGO's) that were originally devised as means of supporting GPs through education, professional development, integration, access, chronic disease management, workforce issues and consumer needs.

Divisions are primarily funded to provide advocacy and support roles. They are operated by a Board, generally but not exclusively comprised of GP's. The Divisions work with GPs and allied health providers to improve the quality and accessibility of health care, at the local level. They can also serve as an avenue for the support and delivery of Government programs. Examples of this are the abilities to apply for both Community GP Super Clinic funding and NRRHIF.

Divisions of General Practice are really Primary Health Care Organisations by another name, and this is demonstrated in the Kimberley, with the provision by KDGP of allied health services across the region. This is furthered by KDGP's commitment to facilitating improvements in regional health service integration, co-operation and resource sharing.

KDGP has obtained funding from various sources for 17 Allied Health positions. These include dieticians, diabetes educators, podiatrists, a paediatric nutritionist, psychologists, a mental health nurse, social worker and two mental health professionals allocated to the Headspace initiative. Staff are allocated across the East and West Kimberley.

Total funding for KDGP in 2007-08 was $4.1M although unspent funds were very high due to the lag in recruitment for some of the newer positions. It is expected KDGP will operate a budget between $4M and $5M for at least the next three years, with a staffing compliment of 25 of which 80% will be allied and mental health clinicians.

7.14. Kimberley Aboriginal Medical Services Council (KAMSC)

KAMSC was originally established as a cooperative venture between BRAMS and the former East Kimberley Aboriginal Medical Service, now known as OVAHS. Its services gradually expanded to provide centralised corporate services for four other AMS in the Kimberley including YYAMS, DAHS, JAHS and PMHC. The organisational structure was changed from a registered Aboriginal Corporation to a WA state-registered incorporated association in 2000/2001.

KAMSC has evolved to provide direct services in primary health care in six communities across the region. These are Beagle Bay and Bidyadanga in the Broome LGA and Ringer Soak, Balgo, Mulan and Billiluna in the least serviced Halls Creek LGA.

KAMSC operates a Population Health Unit, sharing two Allied health staff with KPHU. In addition it shares one FTE GP with KPHU to consolidate primary health service in the Dampier Peninsula communities.

KAMSC provides training to the region's Aboriginal health workers. It has been a registered training organisation (RTO) since 1998 and is currently qualified to offer training in:

- HLT33207 – Cert III in ATSI Primary Health Care
- HLT43907 – Cert IV in ATSI Primary Health Care (Practice)
- HLT44007 – Cert IV in ATSI Primary Health Care (Community Care)
- HLT52107 – Diploma of ATSI Primary Health Care (Practice)
- HLT52207 – Diploma of ATSI Primary Health (Community Care)
- HLT61207 – Advanced Diploma of ATSI Primary Health Care (Practice)

KAMSC also assists in providing advanced GP training in cooperation with the Rural Clinical School of WA, through the University of Western Australia (UWA).

The organisation has arguably changed considerably since its establishment in 1986 and provides advocacy for issues relevant to the ATSI health sector in the region as well as playing an active role in supporting the activities of the Kimberley Aboriginal Health Planning Forum. The changes within KAMSC over time appear to have been in direct response to the identification of gaps in the health service provision needs of the region's Aboriginal population.

7.15. AMS funding

Consultations have indicated that AMS funding has not kept pace with the hospital system, leading to inequities in wages. There is some evidence that AMS's are diverting Medicare income sourced from their GP consultations to provide funding for their Allied Health services and for other staff positions.

Further work is required to determine whether these positions might be funded through other sources or whether those other sources are already fully subscribed.

7.16. Table of Basic Funding Correlation

Location	Provider	Primary	Secondary	Funding priority
Broome	Broome Hospital / Broome Health Service	yes	yes	secondary
Derby	Derby Hospital / Derby Health Service	yes	yes	secondary
Fitzroy Crossing	Fitzroy Crossing Hospital / Fitzroy Valley Health Service	yes	yes	secondary
Fitzroy Crossing	Nindilingarri Cultural Health Service	yes	no	primary
Wyndham	Wyndham Hospital	yes	no	primary* and secondary
Kununurra	Kununurra Hospital	yes	yes	secondary
Halls Creek	Halls Creek Hospital / Halls Creek Health Service	yes	yes	secondary
Halls Creek	Yura Yungi AMS	yes	no	primary
Broome District	BRAMS	yes	yes	primary & secondary (KSDC)
Kimberley	KAMSC	yes	no	primary
Kimberley	KDGP	yes	no	primary
Kimberley	RFDS	yes	no	primary
Broome	Broome Medical Clinic	yes	no	primary
Broome	Neil Jensen Clinic	yes	no	primary
Kununurra	Kununurra Medical Clinic	yes	no	primary
Kununurra	Ord Valley Aboriginal Health Service	yes	no	primary

* Wyndham Hospital essentially operates now as a clinic with reduced inpatient use.

Note: hospitals in Derby and Kununurra are planning to introduce bulk billing of ED patients who present with primary health needs. This is through an s19 (2) exemption.

7.17. Specialist Allied Health Services

Several agencies provide a range of Allied health services. The most prolific of these are WACHS and KDGP. Some AMS also directly employ Allied health workers.

The region also has a limited number of private Allied health providers such as physiotherapists. During June 2008, there were 25.5 Allied health professionals working in the Kimberley.

7.18. Summary of section

It would appear that all services are providing the core functions for which they are primarily funded. Many however have expanded into the provision of additional services.

Several of the hospitals are effectively providing primary health care on a (possibly) ad hoc basis – possibly outside their originally intended funding purposes. Some of these variations have been formalised or are about to be formalised through section 19.2 exemptions.

Variations from original core funding activities appear to have arisen as a direct response to need. In some cases, for example in Fitzroy Crossing, they appear to be complimentary to other services and have not resulted in unnecessary duplication.

Some of the variations appear to be indicative of problems with primary health care service supply. This would appear to be the case in both Broome and Kununurra where there have been no bulk billing primary care services other than the AMS. The special focus of the AMS on Aboriginal health issues appears to be more strictly applied in some towns than others; however most appear to be open to providing more services to the broader public if able to obtain sufficient resources.

8. Health service provision which is not attracting the "normal" remuneration (e.g. bulk billing practices, Medicare item claiming, primary care at hospital ED).

There are several areas of health service provision in the Kimberley which may not be attracting 'normal' Medicare / MBS remuneration funds into the region.

The most obvious of these would appear to be the WACHS hospitals that do not as yet have the s.19.2 exemption or are ineligible for it. There is anecdotal evidence to suggest that many patients are seen at hospital emergency departments for what are essentially remunerable primary care services, and that these are often not charged.

8.1. Bulk billing practices

8.1.1. AMS

Bulk billing is possible at all AMS through the s19.2 exemption. A portion of each AMS's income is derived from Medicare; however this appears to vary between the different services.

8.1.2. Private GPs

The three remaining private practices in the Kimberley either do not bulk bill at all, or do so only with certain classes of patients. For example both Broome Medical and Kununurra Medical will tend to offer bulk billing for minors, particularly where the GP believes that this is essential for maintenance of care.

Kununurra Medical will also bulk bill for various concession card holders including veterans.

The three practices all tend to charge fees that appear to be somewhat in excess of comparative metropolitan services, but are still very reasonable once the Medicare rebate is claimed.

One former private practice GP advised that in order to maintain a private practice on bulk billing on local costs, consultations would have to be reduced to nine minutes or less. This would be dysfunctional in terms of patient needs and result in a level of service that would be unlikely to attract most GPs.

8.1.3. Hospitals

Several of the region's hospitals are eligible to bulk bill under the s.19.2 exemption, with Kununurra likely to follow shortly. There is strong anecdotal evidence that in spite of this many patients are seen gratis – with no Medicare bulk billing, particularly when seen through emergency departments.

Anecdotal evidence also suggests that failure to bulk bill may be more prevalent out of normal hours, when there may tend to be fewer administrative staff on hand to monitor this.

8.2. Medicare Item claiming

8.2.1. AMS

AMS's in the region generally rely on Medicare for a significant proportion of their income. This includes item claiming where possible.

8.2.2. Private GPs

All private GP practitioners who have been consulted during this study indicated that Medicare item claiming is an important part of maintaining their private practice viability.

8.2.3. Hospitals

There is anecdotal evidence to suggest that Medicare item claiming occurs at least occasionally in some hospitals, but may not as yet be the norm.

Hospital GPs are salaried and therefore receive remuneration for their services independently from Medicare. The increased spread of section 19.2 exemptions across the region's hospitals may result in a change in this regard.

8.2.4. KPHU

Kimberley Population Health provides vaccination services that would normally be eligible for Medicare remuneration if provided by a regular GP, but is yet to achieve a section 19.2 exemption. It is currently investigating obtaining this in the East Kimberley

8.3. Allied Health Services

Allied health services would appear to be one of the main areas that are not attracting sufficient support through Medicare.

8.4. Summary of section

Private practices by nature encourage their GPs to identify all relevant charges where possible.

Primary care at hospitals, particularly those services provided through emergency departments, would appear to be an area of particular concern regarding not attracting the 'normal' remuneration.

Broome Health Service is a case in point, as it is funded to provide emergency service, 24 hours per day. At the same time it is attempting to cope with an influx of non-urgent primary care patients, which is outside its funding purpose. Waits for non- emergency primary patients, due to triage, is therefore clearly acceptable in the circumstances.

The lack of access to appropriate and timely primary care within a dedicated primary health care framework is however not acceptable and providing this resource is one of the major challenges of the region.

9. The viability of private (fee-for-service) general practice models of primary care delivery in Broome, Kununurra and Derby.

9.1. General Comment

The viability of private (fee-for-service) general practice in the Kimberley varies naturally according to the population levels and socio-economic mix.

Discussion of the issue begs the question of how viability may be determined. This tends to relate strongly to the business model and structure of private practices.

High costs of operating in the Kimberley, along with a range of workforce limitations and constraints suggest that solo private practices may remain a path of choice for some GPs who are happy to work to a level of income that suits them through personal choice. The issue becomes more problematic where the service employs multiple practitioners and other support staff.

Recent experiences indicate that private medical practices operated as a business investment by non-medical people may not achieve the returns that they might expect from a similar level of investment in different fields. It is possible however that this may change once the population reaches a higher level.

Viability would also appear to be strongly linked to the level of capital investment or outlay required to establish and maintain the practice.

Private General Practices, like most private small businesses, are generally dependant on one or two key individuals. These businesses may be quite viable while those individuals are involved, but may not necessarily be sustainable if sold to others who may lack the same business skills and drive.

9.2. Broome

Broome currently has two private GP clinics; Broome Medical Clinic, which is owned and operated by Dr. Harpreet Singh, and a solo practice operated by Dr. Neil Jensen. A third clinic, the Dakas Street Medical Centre, which was owned and operated by a business consortium, closed in July 2008.

9.2.1. Broome Medical Clinic

Situated next to the Broome Hospital this is a reportedly profitable clinic; however is beset with staff turnover problems.

The owner reports that it only remains profitable through charging full fees. This naturally discourages many potential patients on lower incomes.

Broome Medical Clinic takes an open approach to the disclosure of its fees structures and this is to be commended. Its fees however are almost twice the rate of a sample of Australian urban GP practices taken from an internet search.

The Broome Medical Clinic places emphasis on encouraging its GP staff to meet performance objectives as part of their salary agreements. It employs extra staff during the tourist season high demand period although this is often at considerable costs as accommodation is also at its premium then.

The Broome Medical Clinic is ideally located; literally next door to the main entrance of the Broome Hospital. The premises are owned by the proprietor.

9.2.2. Dr. Neil Jensen's Clinic

This is a solo GP practice which has apparently been profitable enough to sustain Dr. Jensen. The clinic operates in rented rooms. The practice is currently (September 2008) up for sale with an asking price of $35,000 which includes a surgical bed and a range of equipment. The owners of the premises are seeking a three year lease.

At present there have been no offers to purchase and it is possible that the practice will close. This will add strain on the remaining providers of GP services.

9.2.3. Dakas Street Medical Centre

The Dakas Street Medical Centre was a privately owned GP based multidisciplinary clinic which closed its doors in July 2008.

Despite being very popular with local residents, the clinic was unable to attract sufficient business to fully staff its 8 consulting rooms and continued with two to three GPs and some allied health provision until it closed due to its inability to deliver sufficient returns to its owners.

There was considerable community concern regarding its closure. It appears that this practice was possibly over capitalized, with a purpose built clinic and an inability to attract sufficient medical staff. Since its closure, the issue of patient records transfer has been managed by KDGP.

It is unclear at this stage as to how many ex-patients are now in the marketplace for GP services. KDGP's analysis of the records shows 4,800 patients who have presented in the past year and 6,600 who have presented in the prior two years.

Clearly this will add to the demand for services provided by the Broome Medical Centre and the Broome Health Service emergency department.

9.3. Kununurra

9.3.1. Kununurra Medical

Kununurra Medical is a private medical clinic operated by Dr. Andrew Marsden in a custom built transportable building situated at the rear of the private dental clinic operated by Dr. Lars Moir.

Dr. Moir's practice is multi-disciplinary, with consulting rooms for visiting podiatry, massage therapy, optometry, physiotherapy and naturopathy services.

Dr. Marsden was encouraged to come to Kununurra by Argyle Diamond Mine (ADM) who assisted in the provision of a house and paid removal costs for his clinical equipment. His wife works 0.8 as a GP at Kununurra Hospital, which contributed use of a vehicle and removal of household effects.

Dr. Marsden provides medical services to the mine on a fee for service basis. He works two days a month at the ADM and is on call by phone 24 hours a day. He makes use of internet and digital camera where possible so that he can consult remotely.

Where ADM refer work to him as an Occupational Physician, it is at an agreed commercial rate. Work for the ADM includes providing medicals for the company HRM section. Dr. Marsden also holds the GP poisons permit for RIO Tinto / Pilbara Iron at 19 of their nine sites, but plans to relinquish this in the near future to concentrate on development of his practice in Kununurra. His present relationship with ADM is in part related to his previous experience in industrial and occupational medicine.
Should he leave the region there is no guarantee that this relationship would continue if he were able to sell his practice, although ADM had been trying to encourage a private practice doctor in the area for some time.

Dr Andrew Marsden charges the following:

- $ 60 basic consultation (locals and tourists)
- Bulk billing for small children.
- Bulk billing and Medicare Plus regional / rural #10991 MBS top up plus $14 fee for Health Care Card holders.
- Bulk billing for Department of Veterans Affairs Card holders (repat $9.60)
- He does not charge a joining fee.

Dr Marsden does not receive any government grants. He did attempt to access the former Rural Medical Infrastructure Fund during the period in which it was placed on hold earlier in 2008.

Dr Moir is understood to be interested in further developing his multi-disciplinary practice and has room for expansion on the present site. The venture would appear to be viable although his dental clinic may experience some competition from a new government dental service at the Kununurra Hospital.

9.4. Derby

Derby would appear on the surface to have a sufficient level of population to sustain a small private practice. Anecdotal evidence suggests however that DAHS is a reasonably popular service within the town, so any new private service would need to offer some competitive advantages.

Growth in the town's population has increased in recent years particularly as Broome has become increasingly unaffordable for many of the region's trades people. The development of a substantial new regional prison will further swell the population with an increased workforce.

A possible private practice in Derby would be assisted in viability if it could negotiate regular arrangements with regional mining or exploration companies or other industry. Derby has had significant land releases in recent times and there are also several commercial blocks available for development in the town. Viability might in part depend on what terms premises could be obtained.

9.5. Common Factors Affecting Viability

9.5.1. Medicare Remuneration

Medicare remuneration in the region does not vary significantly enough from outer metropolitan levels to cover increased costs. All of the region's private practices charge at least $60 for a minimal consultation.

9.5.2. Recruitment and Retention Issues

Health Workforce Queensland identified the following reasons for the medical workforce shortage in rural and remote Queensland, which may be equally applied to the Kimberley:

- An ageing workforce
- The increased participation of women in the GP workforce

- Changes in participation
- Lifestyle factors
- Changing attitudes to owning and managing a general practice
- The poor image of general practice and rural / remote practice.

The Rural Doctors Network reports that remote practice fails to address the themes that are common to all rural and remote locations:

- Regular holidays, structured time off and reduced (safe) working hours.
- Predictable and reasonable income.
- The difficulties in running own business, including unpaid administrative and practice management burdens.
- The ability to concentrate on quality practice of medicine.
- Third party provision of real estate infrastructure e.g. quality domestic housing, surgery premises.
- Not feeling they are deserting their community when they finally decide to leave.

The Rural Doctors Association of Australia (RDAA) surveyed rural and remote region GPs in order to develop an understanding of the issues contributing to the levels of viability of these practices.[35]

A detailed definition of viability was then developed along with a benchmark system for ensuring minimum standards for viable practice.

The survey was extensive, with all remote and rural GPs surveyed and achieved a high response rate of 34%, being 1498 GP's. This represented 53% of all practices.

It found that GPs are an ageing workforce, with 40% over the age of 50. It further found that doctors in towns of 10,000-20,000 people need between two to three extra FTE GPs and towns with less than 10,000 people need an extra four to five GPs.

The study developed a number of benchmarks for providing an environment which would provide sustainability and enable, at least, the ability to attract employee GPs.

Key dimensions of viability that were identified as amenable to systemic intervention are as follows:

- Remuneration that reflects rural GP's skills, workload and commitment.

- Enough doctors to provide locum relief for annual leave and professional development, as well as reducing on-call loads.

[35] Rural Doctors Association of Australia, Viable Models of Rural and Remote Practice: Stage 1 and Stage 2 Report. RDAA (2003)

- Procedural opportunities through VMO access to appropriate facilities. Smaller hospitals have been closed or downgraded, which degrades procedural skills and reduces income streams.

It is however, in the absence of major changes to health financing, unlikely then to expect a change in the aspirations of younger GPs regarding employment, purchase or establishment of remote GP practices.

The cost of providing adequate housing for additional GP staff would appear to be a major disincentive to private practice in the Kimberley.

This has been echoed by senior Kimberley WACHS staff members who were at pains to point out the difficulties faced in providing adequate housing for recruitment and retention purposes.

9.6. Summary of section

The apparent decline in provision of private general practice within remote regions relates largely to two main factors:

- Difficulty in attracting and retaining qualified GPs to accept positions within established practices.

- Reluctance of younger GPs to buy into, purchase or establish GP clinics.

A third of all rural and remote GPs indicated their intention to leave their practice within the next five years, with 31% of these in larger towns and 66% in smaller towns.

It is not overstating the case to suggest that the Kimberley private ‘fee for service’ practice model is facing the difficulties of many other remote practices. Younger GPs are all too aware of this and are reluctant to risk investment in remote clinics, combined with the long hours and administrative burdens, with no real guarantee that they will eventually be able to sell their practice.

There will however be individual GPs who from time to time decide that they would prefer to operate a private practice, possibly for a range of quite personal reasons, or because there is a pre-existing enabling relationship that makes it particularly attractive to them.

Future Kimberley GP workforce planning should ensure that it can encourage private practice where possible, but not rely on it as a necessarily enduring vehicle for primary health care.

The State government and the Australian government currently have programs that are intended to assist the development of new businesses. Development of further programs

that assist GPs and other allied health professionals to set up their own businesses would be a worthwhile investment.

Agencies currently responsible for delivering business start-up facilitation or advisory services should ensure that they have access to expertise in the specific needs of the establishment of these businesses and that such support is more readily available.

Primary health care service provision now needs to take note and meet the new aspirations and expectations of health professionals. It is clear that workforce initiatives alone have failed to deliver sustainable and consistent workforce to the region.

A creative approach to regional health delivery and financing is therefore required to provide a framework which enables recruitment and retention of workforce in sufficient numbers to meet existing needs, and those of an increased population.

Recommendation: That specific business commencement support be more readily available for private General Practitioners and allied health professionals.

10. A Kimberley Primary Care Sustainability Plan 2008 to 2030

10.1. Future Changes to Kimberley Health Service Delivery

There are likely to be some significant changes to the way in which primary health care is required to be delivered in the Kimberley over the next twenty years. Many of these changes may well be universal, reflecting adjustments in primary care across Australia.

In the Kimberley, we would anticipate that there will be some evolution in the nature of the main organisations that deliver primary care, and in particular how they are organised and work together. We foresee that there will be roles for the descendants of most if not all of the current services although their structure and make up may change quite considerably in some areas.

One thing that seems quite clear is that there will need to be a different workforce mix, with less reliance on GPs and increased roles for Nurse Practitioners. The nature of the region's population also suggests that there should be some evolution of the roles and career paths of Indigenous health workers. Ideally this might include several levels of qualifications which would offer much better career paths for these workers than exist now.

Health service delivery in the Kimberley appears to be currently trending more and more towards a mix of government and NGO service delivery, with the latter provided mainly, but not exclusively through the AMS's. We would envisage that there will still be opportunities for entrepreneurialism through both private practices, research entities, or through an increased business focus among the NGO service providers.

It is anticipated that the region will continue to manifest high levels of chronic disease and the difficulties associated with their management. However the mix of these may well change.

10.2. Infrastructure Requirements

10.2.1. Social Infrastructure Requirements

Our study indicates that a range of both capital and service investments will need to occur in order to meet the primary health care needs of the Kimberley population and projected visitors in 2030. These will include significantly increased investment in capital infrastructure and further investment in service delivery. The capital needs tend to be a little easier to project.

There is no question that health service delivery will require significant funding increases to meet first world standards of care in the region. However some movement towards

more centralized coordination of these may produce efficiencies and thus limit some of the potential cost.

10.2.2. Capital Infrastructure Requirements

Several of the region's hospitals have been rebuilt during recent years and may well remain functional for another twenty years. Some facilities, such as the Wyndham Hospital may well evolve into a different mix of use and require substantial renovation.

Anecdotal advice suggests that many of the region's remote clinics already require re-building, as is happening currently with the new clinic at Kalumburu. Where these occur will depend on which of the current communities prove their viability and are able to flourish.

Business cases may be developed for significant training facilities or research centres. These may well develop in locations that are not presently considered either likely or suitable.

The political and economic situation will dictate the extent to which there is increased investment in resource extraction from the region. This may well result in significant future investment in health facilities by corporates.

Housing for health staff over the next twenty years will require considerable expenditure by their employer agencies. The relative costs of construction in the region might reasonably be expected to fall somewhat over time as the level of relevant trade skills increase among the resident population. This should also be helped by improved roads and innovations in building design and materials.

10.3. Capacity Constraints and Social Infrastructure Impacts on Health Service Needs

There are currently a range of capacity constraints affecting:

- attraction and retention of GPs
- levels of GPs being trained and the time that it will take for them to be workforce ready
- levels of available nurses
- levels of allied health professionals
- availability of administrators and other staff

Many primary health centres are physically not big enough to provide space for the range of services that they should ideally be offering. Anecdotal reports tell of several professionals currently sharing single offices in a number of AMS's.

Current levels of social infrastructure are also working against attracting the appropriate levels of skilled staff or acting to reduce the time in which they are willing to remain in the region. Quality of schools, availability of other services including entertainment, indeed a broad range of social factors are all impediments to the achievement of a stable workforce.

Several of the larger communities presently have reputations for varying degrees of lawlessness and general social dysfunction, which are major disincentives to the recruitment of predominately city-trained professionals. Some of these communities are well on the way to achieving levels of population that will require full time practitioners, whether they are GPs or Nurse Practitioners in the future.

While governments have expressed varying degrees of concern regarding the longer term viability of some smaller communities, and may choose to de-fund some of them in future, this is still likely to increase concentrations of population in the larger remote communities.

The larger Kimberley towns of Broome and Kununurra are likely to grow considerably, particularly as issues of Native Title are gradually resolved and land use is opened up through Indigenous land use agreements (ILUAs). Derby has in recent years appeared to reverse a previous long term decline and Wyndham may well do the same. The latter still has some significant infrastructure and its port is likely to see increased use as Kununurra develops through likely expansion of the Ord Irrigation area.

The projected future growth of these towns will result in generally improved facilities and increased service provision. This will in turn make them more attractive places for recruitment of skilled professionals.

10.3.1. Housing

Housing availability and standards in many parts of the Kimberley are widely regarded as a national disgrace. It is no small wonder that a community such as Balgo experiences dysfunction on the levels that it does, where 400 people reportedly have access to 30 fit houses.[36]

A recent investment of new housing in Halls Creek has done little to alleviate the chronic shortage of housing in that town, with a net gain of only 3 to 4 houses as many older stocks have been demolished. The high growth rate among a predominately young Indigenous population means that many can have no prospect of having their own home.

The current inadequacy of housing in the region is a major contributor to the relatively poor health of the community and the high prevalence of alcoholism and other chronic

[36] Parliament of Australia, Senate daily summary updates, No. 50/2008 Tuesday, 2 September 2008

disease. Adequate staff housing is also a major capacity restraint to delivery of primary health services in communities.

10.3.2. Environmental Health / Social Health Factors

The Kimberley region is still very much a frontier area in terms of social and community infrastructure.

Provision of adequate social resources for much of the Indigenous community has really only begun to be commenced in the last thirty years and has generally not been treated as a high priority by governments.

Environmental health services provided by Local Governments are only just beginning to impact some communities despite the development of a bilateral agreement on provision of municipal services several years ago.

Levels of education, basic knowledge of health issues, transport, communications, and employment are still very poor in many parts of the Kimberley. In many areas quality of food available in stores is poor, of poor nutritional value or simply unavailable at times. These factors all contribute significantly to prevalence of ill health and chronic disease.

Over the next twenty years it is reasonable to expect that the region will become considerably less 'isolated' than it has been and the effects of some of these factors will very slowly but surely be improved. The changes however, are unlikely to have an effect on general levels of health for at least another generation.

10.4. Caveats Regarding Population and GP Workforce Needs Projections

We have included population projections for Kimberley LGAs based on recent DPI projections of the population of the region to 2030. These have then been extrapolated against formulas developed in the Kimberley Workforce Analysis 2006, for WACRRM,[37] to provide an indicative number of GPs likely to be required in the region by 2030. The study undertaken by WACRRM was evidence based. Our extrapolation is arbitrary by comparison, but in our view represents a reasonable projection of future GP needs.

[37] Roach, S., Waters, A., Atkinson, D., Jefferies, F., Kimberley Workforce Analysis. WACRRM. (2006)

11. Shortfalls and excesses in current service delivery and changes required to meet the needs of an increased resident population as well as an increased visitor demand to the year 2030.

11.1. General Comment

Significant shortfalls in current primary health service capacity have been treated by several studies, including most specifically, the WACRRM Kimberley Workforce Analysis 2006, which used sophisticated population modelling and provided a break down of the actual time spent on primary care by the region's GPs.[38] That data clearly showed that the Kimberley had a shortage of 20.6 GPs at that time. The area of most need was the Halls Creek LGA, followed by the Derby-West Kimberley LGA. These figures still appear to be largely accurate in 2008.

This section includes projections of population growth to 2030 and borrows the formulas used by the WACRRM report to project notional GP needs based on the projected figures. Projecting Allied Health (including Mental Health) needs is a little more problematical.

Forward projections in a region where population levels could be altered significantly by any one of several possible industry developments is fraught with variables, so only those figures that might reasonably be estimated on current projections are included here.

Service delivery needs are presently and will continue to be complicated by the large amount of visitor numbers through the region during the tourist season which broadly operates from April to September each year, with a peak in July.

11.2. Shortfalls and Excesses in Current Service Delivery

11.2.1. Current Shortfalls

As stated above the region has in recent times had a primary care GP shortfall of 20.6 FTE positions. This number is exacerbated by high turnover which means that at any one time several notionally funded positions are vacant. Workforce shortfalls affect regional ability to provide extended clinic hours of operation and the number and frequency of clinical services conducted within remote communities, which contribute to remote inequities of access.

There are current GP vacancies in the region which have been brought to public attention in recent times by the closure of the Dakas Street Medical Centre in Broome. The worst

[38] Roach, S., Waters, A., Atkinson, D., Jefferies, F., Kimberley Workforce Analysis. WACRRM. (2006)

region however in terms of servicing versus need by far and away is the Halls Creek LGA. High turnover is further evidenced by the regularity of advertisements for all range of health positions in the Kimberley.

Allied health shortfalls have been identified by KDGP, which has to an extent, addressed some of these through service provision across the region. Central employment by KDGP of these positions on a largely mobile basis would appear to be to the benefit of the various regional AMS's who may not have been able to fully employ these professionals in their own right.

Adequate housing of staff within towns and remote communities appears to be one of the major contributing factors which can be dealt with in relation to shortfalls in staffing, both in terms of attraction and retention.

There would also appear to be shortfalls in inter-organisational communication, co-ordination, co-operation and resource sharing.

It appears also that the fragmented nature of health service within the region has left it unprepared, in an organisational sense, to deal with a pandemic.[39]

Recommendation: That a regional pandemic response strategy be developed.

11.2.2. Current Excesses

The effect of substantial and ongoing workforce shortfalls makes it unlikely that there are any excesses in primary health care delivery within the region.

Demand and need within the region, along with discussions with health providers, has not identified any excesses in delivery and capacity.

During the consultation process we encountered several instances of inferred perception of excesses in other agencies, however we could find no real evidence of this and suggest that it may be more a case of 'relativity of shortfalls,' with some agencies experiencing a greater burden.

A designated primary care service would be beneficial for Wyndham. In this regard it was interesting that the main East Kimberley detox unit operated by Ngnowar Aerwah outside Wyndham complained that they would like increased access to GP services. The situation at Wyndham may turn around in any case, as projected expansion of the Ord River Irrigation Area (ORIA II) will almost certainly result in increased traffic through the port there, with likely associated population increase.

[39] Collins N., et al., 'General Practice: Professional Preparation for a Pandemic' in Medical Journal of Australia. (2006) vol.185 No.10 SS66-69.

Mild excess capacity to deliver certain services should be an aim of any remote regional health plan, considering the volatility of workforce supply and health service demands.

11.2.3. Duplications and how to resolve them

Duplication of services does occur, however it is difficult for this to be categorised as excess, without in depth statistical analysis of community and patient demand and needs. Examples of this include AMS population health activities and KPHU, who both appear however to be providing important services in areas of high need.

It is however likely that a single, region wide approach to population health is preferable and this would need to be dealt with through coordinated regional primary health planning and service delivery.

Some communities, such as Bidyadanga, may receive duplication of services from a range of providers (KPHU, BRAMS, KAMSC, and KDGP) however, rather than oversupply it could also be categorized as choice between providers.

Greater efficiencies in service delivery are however likely to be achieved through central co-ordination of clinic scheduling, joint operations and resource sharing. Increased delineation of services within partnership agreements has been an initial step towards achieving efficiency and focus.

Duplication has however also occurred, in some instances, as a means of filling gaps in service delivery and geographic coverage. Adequate funding and organisational structure to resolve these service gaps are a necessary precursor to reduction in duplication and inefficiencies.

An agreed future overriding Primary Health Care organisation or body can and should play a major role in identifying duplications, brokering solutions and reallocation of resources as part of its role in reforming regional primary health care and delivery.

11.3. Population growth assumptions

Kimberley population notes and projections are as follows:

11.3.1. Kimberley Overall

Population projections for the Kimberley as a whole are problematic. The most recent census conducted in 2006 is not generally held to be a reliable guide to the overall population numbers at the time and has been the subject of some critical review. It is generally accepted that a significant undercount of the Indigenous population occurred in 2006.[40]

The 2006 census counted 29,298 usual residents in the Kimberley as against an Estimated Resident Population (ERP) of 35,748 in 2005 by the Kimberley Development Commission based on WA Planning Commission projections at that time.[41]

We note that the Kimberley Development Commission has revised its current figures down in line with the census, but is at the time of writing continuing to use WA Planning Commission resident population projections for forward estimates to 2031.[42]

We have chosen to use the current WA Planning Commission forecast resident population figures, which are based on the current age spread of the population and historical patterns of growth. A number of potential developments will impact on the accuracy of these over time. For example, at the time of writing there is speculation regarding the location of a large processing hub for processing of gas sourced from the Browse Basin north west of Broome. There are also numerous other sites for potential resource development and given the relatively small population base, one or two major developments will significantly alter the projections.

The WA Planning Commission projects the Kimberley population in 2030 at 69,200 residents.

[40] Morphy, F., (ed.) Agency, contingency and census process: Observations of the 2006 Indigenous Enumeration Strategy in remote Aboriginal Australia. CAEPR Research Monograph No. 28, ANU, Canberra (2007)
[41] Australian Bureau of Statistics, 2006 Census; and KDC: http://www.kdc.wa.gov.au/kimberley/tk_demo.asp accessed 04122007
[42] Western Australian Planning Commission, Western Australia Tomorrow: Population projections for planning regions 2004 to 2031 and local government areas 2004 to 2021. Population Report No.6., WAPC, Perth (2005)

11.3.2. Kimberley Local Government Areas

The Commission's projected population for the each of the four Local Government areas is only projected to 2021. We have applied a uniform increase per LGA from the 2021 projections to 2030 as per the total Kimberley population projection, so these figures should only be treated as generally indicative. Historical patterns suggest that Broome's growth may be under-projected here. The 2006 census suggests an undercount of up to 27% across the region.

Table: Population Projections by LGA[43]

LGA	Census 2001	WAPC ERP 2005	Census 2006	WAPC 2016	WAPC 2021	WAPC 2030 * =Estimate
Broome	13196	-	13059	20700	23800	28445*
Derby / West Kimberley	8287	-	6507	13700	15100	18047*
Halls Creek	3937	-	3136	6200	7200	8605*
Wyndham / East Kimberley	7211	-	6596	10800	11800	14103*
Total Kimberley	32631	35748	29298	51400	57900	69200

(*Note that LGA projections for 2030 are an estimate).

11.3.3. Indigenous Population

The 2006 Census counted 12325 people in the Kimberley who identified themselves as Indigenous. This represented 42.1% of the total resident population. This is in itself suggestive of an undercount, as the 2001 Census estimated 47.3% of the population as Indigenous and the Indigenous population is generally considered to be growing.[44]

11.3.4. Population in the larger centres

Population growth in future will almost certainly be greatest in the existing larger population centres. Broome has experienced the most growth in recent years and would reasonably be expected to continue in that regard.

[43] Extrapolated from: WA Western Australian Planning Commission, Western Australia Tomorrow: Population projections for planning regions 2004 to 2031 and local government areas 2004 to 2021. Population Report No.6., WAPC, Perth (2005); ABS Census 2001; ABS Census 2006
[44] ABS Census 2001 and 2006

Population growth in Kununurra and Derby will likely be influenced by further migration to these centres from outside the region, as facilities and opportunities for employment expand. Wyndham, as mentioned earlier in this section, may well experience some renewed population growth through expansion of the ORIA II.

The central Kimberley towns of Fitzroy Crossing and Halls Creek have experienced growth through a predominately young Indigenous population demonstrating high birth rates. Changes that might reduce the high incidence of fly-in fly-out mining activities near these centres could significantly affect their populations.

The Kimberley region has many small to medium Aboriginal communities, including several that may grow significantly over the next twenty years. Those with already significant populations include Bidyadanga and the Balgo area where the overall area population (Kutjungka region) is already well over 1000 people. The population at Kalumburu has recently been estimated at 450 people. There are several other substantial communities that may out-pace these in growth over the next twenty years.

Developments in these communities will gradually result in increased need for further full time primary health care GPs and related staff positions.

11.4. Projected Primary Care General Practitioners in 2030

Given the limited scope and duration of this study we have relied on the formulas used in WACRRM's Kimberley Workforce Analysis 2006 to factor standardised population numbers.[45] This is in the absence of any evidence to suggest that the level of relative disadvantage is likely to change significantly in the region over the period to 2030.

Following considerable consultation and modelling, the authors of the 2006 study factored age and gender, Index of Relative Socioeconomic Disadvantage (IRSD) and Indigenous Population needs into their standardisation weightings.

We do not have enough forward data on the population mix to re-calculate these ratios, but note that the standardisations per local government area, with the highest ratio for Halls Creek, and only the most minimal weighting for Broome would appear to be realistic for 2030:

Table: Standardised Population at 2030

LGA	Projected Population at 2030	Standardisation Ratio (WACRRM 2006)	Standardised population at 2030
Wyndham-East Kimberley	14103	1.082923	15272
Halls Creek	8605	3.682913	31691
Derby-West Kimberley	18047	1.622510	29281
Broome	28445	1.035346	29450
Totals	69200		105694

WACRRM use a ratio of 1:900 GP to standardised population. The required number of GPs based on the standardisation model used by WACRRM (assuming the figures remain relative), are as follows:

Table: Numbers of FTE Equivalent GPs Required at 2030 by LGA

LGA	Standardised Population (adjusted to reflect need)	Number of FTE GPs required to meet estimated primary care needs
Wyndham-East Kimberley	15272	17
Halls Creek	31691	35.2
Derby-West Kimberley	29281	32.5
Broome	29450	32.7
Totals	105694	117.4

[45] Roach, S., Waters, A., Atkinson, D., Jefferies, F., Kimberley Workforce Analysis. WACRRM. (2006)

The 2006 WACRRM study showed that of 64 GP positions, only 62% or 38.3 effective FTE positions were engaged in primary care.

It is too far in the future to predict what that effective percentage of FTE GPs servicing primary health care might be by 2030. Even if for example it increased to 75%, the overall GP workforce would need to be approximately 156.5 based on the above population mix. This would represent an increase of some 90 plus GPs into the region over the next twenty years.

If the effective percentage of GP work on primary care remains at 62% then the overall Kimberley GP workforce required would be approximately 189.4.

11.5. Allied Health needs to 2030

It is beyond the scope of this work to assess and accurately project all Allied health needs to 2030, although these may be inferred from the population projections. At the least it is suggested that the current numbers of professionals (25.5 at June 2008) will need to be doubled.

There are many areas of the Kimberley that currently have little access to these services. Those communities that achieve significant growth rates over time will most likely require the introduction of regular visits from a variety of allied health staff.

As communities grow it is possible that there may be a greater shift towards local employment of allied health staff, particularly through the AMS's, although there would appear to be clear advantages at present of the current practice whereby many are employed directly by KDGP and operate through the region's clinics on a rotational basis. The establishment of a super clinic in Broome could also result in further resourcing of outreach allied health services.

11.6. Mental Health needs to 2030

Mental Health services are an area of health service delivery that has experienced regular criticism in recent years for being chronically under-resourced in the region. Reported high public concern regarding this appears to be beginning to be reflected in increased allocations of government funding.

The recent WA Government initiative to build a 14 bed inpatient facility at the renovated Broome Hospital signals a move towards catering locally for the needs of those Kimberley mental health sufferers experiencing severe episodes rather than being sent to Graylands Hospital in Perth.

Numerous government reports in recent years have highlighted a continued need for increased and improved mental health services of various kinds in the region, including concentrating where possible on early intervention. Existing services have generally been severely constrained in this regard through both capacity issues and policy restrictions.

The inability of the Graylands facility to effectively treat Indigenous patients sent there from the Kimberley has been compounded by under resourcing of the Kimberley Mental Health and Drug Service arm of WACHS (KMHDS). This service has had to share the services of one psychiatrist with the Pilbara, and only then with occasional visits to Broome.

Longer term supported residential accommodation is already clearly needed and will be further highlighted as a need to support patients discharged from the new Broome Mental Health Unit. This can be particularly difficult for Indigenous mental health sufferers. Inadequacies in services have meant that patients have had to fend for themselves, seek accommodation in one of the few backpackers that will accept Indigenous people, or sleep in the bush on the edges of the town.

There is still a long way to go in tackling Indigenous mental health issues. Services currently have little capacity for intervention unless a patient presents on site. Carers dealing with episodic cases are routinely referred to the police as there is little that the services can do.

Of the many recent Indigenous suicides in the Kimberley investigated by the WA Coroner, only a small percentage of the people concerned were reportedly previously known to KMHDS.

Early intervention is regarded as critical. This needs to take account of the circumstances of young people in communities and provide access to a range of services, including access to life skills training. Recent attempts to establish a more holistic service in Fitzroy Crossing, for example, were supported by the WA Government but not the Commonwealth, which meant that it was unsustainable so the project collapsed. Such services need to be fully supported by both the state and Commonwealth and made available in all the major Kimberley towns.

The new MBS mental health referral program introduced in 2007 suffers from a lack of coordination with other agencies and relies on a limited number of available psychologists for support. These specialists are only available in the smaller towns on an occasional basis. This program should be better tailored to suit the needs of Indigenous people.

One recent innovation has been the introduction of the Headspace youth program in Broome. This type of service should be expanded into other Kimberley towns and integrated with a mix of vocational and / or life skills training. Locally developed programs such as Yiriman have appeared to be relatively effective and should receive

considerably greater funding than they do at the present time, or the situation will not improve.

11.7. Visitor Numbers

11.7.1. Visitor numbers in Broome

The Kimberley is a popular tourism destination for intrastate, interstate and international visitors. It is claimed that the total population in Broome can reach 45,000 during the months of July and August each year at the height of the tourist season. This places an enormous burden on health services in the town.[46]

Broome had 237,200 average visitors per annum during 2005-2007 with an average stay of 6.9 nights per person.[47]

Broome Medical Clinic and the Dakas Street Medical Centre, before its closure, coped with the extra demand created during the tourist season by employing extra GPs on short term placements. This is extremely expensive due to the need to house these staff in suitable short term accommodation at the time when the prices for such accommodation are at a premium.

Growth in visitor numbers during the tourist season is expected to continue to grow significantly and will present increased demand in future in areas that until now have been to some extent quarantined from these effects, such as the Dampier Peninsula to the north.

11.7.2. Visitor numbers in other areas of the Kimberley

Visitor numbers have steadily increased in all parts of the Kimberley often constrained during the peak periods only by existing capacity of accommodation. The high percentage of 'grey nomads' among these travelers, i.e. retirees, is likely to continue for at least the next decade.

11.8. Projected Regional Industry Developments

The Kimberley is rich with minerals, fuel and other resources, including potential for large scale agricultural development. Development of any one of these areas to any significant extent will affect projections of population growth and therefore the projected primary health service needs of the region.

[46] http://www.broomevisitorcentre.com.au/pages/population-statistics/ - sourced 11/09/08
[47] Tourism WA. Local Government Area Fact Sheet, Shire of Broome, 2007.

The region is likely to experience continued exploration and mining activities in various areas regardless of more broadly proposed environmental restrictions.

Large scale industrial activity generally requires dedicated access to medical services. In the Kimberley these have tended to be catered for through service agreements between private GPs and the companies involved. However the capability for the region's services to provide paramedic response to a remote industrial emergency, without compromising regular services is an area which would appear to require significant further planning. The costs for this should be considered and borne in large part by the relevant companies.

As discussed previously, a regional overarching health planning body should provide advocacy on the effects that planning in other sectors will have on health service provision, so that this can be factored in associated social infrastructure costing. This may enable reaching agreement with industrial developers to provide funding and other investments, as an offset to increased demand being placed on the regional health and social infrastructure.

Recommendation: That the proposed Kimberley Primary Health Care Organisation be consulted during planning for any major industrial development in the region.

11.9. Access to Land for Services Development or Expansion

Access to land for construction of both resident population and staff accommodation has been restricted around most Kimberley towns for many years for various reasons among which protracted court battles over Native Title have been significant.

As the process of claims and appeals is gradually settled, governments and Native Title bodies corporate are beginning to negotiate terms for long term leases of this land under Indigenous Land Use agreements (ILUAs). Such arrangements provide capacity for the parties to enter into long term agreements to build housing and other important facilities.

As common understanding of this area increases, it should result in the freeing up of land for construction of facilities that in particular benefit the resident population, of which health facilities are a primary concern.

11.10. Risk Management Factors to consider in Kimberley health planning

There are many factors which might completely alter any forward projection of primary health care planning for the Kimberley. A significant change in circumstances affecting any one of these areas could have consequences for future health service delivery:

- Climate change & water & temperature issues

- Natural disaster – e.g. tsunami and cyclones
- Epidemics and pandemics
- Significant changes in Indigenous Affairs policy (e.g. NT Intervention type activities).
- Housing
- Communications
- Education
- Major industry developments

11.11. Summary of section

It is clear that on current projected population growth the Kimberley region will require a very significant increase in primary health care services that will make present difficulties of resourcing appear modest.

The greatest gaps between present and future projected needs are clearly in those areas where the disparity between Indigenous and non-Indigenous health outcomes are currently the worst. The major regional centres will all require planning for significant increases in health infrastructure including recruitment, retention and staff accommodation.

All services should plan for at least a doubling of population by 2030. This need will be further increased by any significant industrial or resource development.

12. Strategies to achieve structural and procedural efficiencies through collaboration and partnership, possible enhancements to primary care and changes required in health financing, planning and/or delivery.

12.1. General Comment

In this section we list a series of strategies to develop collaboration and partnerships between agencies that may assist structural and procedural efficiencies and enhancements to primary care. We include several recommended reforms in health financing, planning and coordination of regional primary care health activities.

Reforms will require commitment in principle from relevant agencies where they are agreed, and support from governments to action the processes required to bring them to fruition.

Time and resources are needed to work through various delineation processes. Central planning and coordination roles will need to be improved to cope with the expected population growth in the region, let alone dealing with the huge disparities in health status of sections of the region's population.

A regional network model with funds pooling and central co-ordination should also improve the efficiency and efficacy of primary health expenditure, logically leading to better health outcomes.

Strategies will be required to reduce anomalies in services provision, and will include dealing with barriers to collaboration and co-operation, as well as legal and practical barriers to sharing of staff.

Some of the arguments put in this section call for reforms in health planning at the regional level, as well as some proposed changes in health services delivery. This includes changes needed in overall coordination of primary health care efforts and also projected changes to the future primary care workforce mix.

12.2. Enhancements to Primary Care

12.2.1. Need for Greatly Increased Focus on Prevention

An increased allocation of resources to disease prevention programs is needed in order to contain cost blow-outs in secondary and acute health care.

Nearly 10 percent of GDP is currently spent on health and as a result of the combined pressures of the ageing population, increasing costs and the burden of chronic diseases, such as diabetes, it is expected to rise to 20 percent by the year 2025.

The largest single area of health expenditure by state and territory governments is in public hospital services. In 2005-06, state and territory governments spent $12,374 million or 66.8% of their total recurrent health expenditure on public hospital services. In addition, a large part of these governments' $1,898 million capital expenditure and $1,234 million capital consumption related to public hospital services.[48]

The seven disease groups that accounted for the greatest health expenditure in Australia in 2000-01 were:

- Cardiovascular diseases - $5.5 billion (10.9% of total allocated health expenditure)
- Nervous system disorders - $4.9 billion (9.9%)
- Musculoskeletal diseases - $4.6 billion (9.2%)
- Injuries - $4.0 billion (8.0%)
- Respiratory diseases - $3.7 billion (7.5%)
- Mental disorders - $3.7 billion (7.5%)
- Oral health - $3.4 billion (6.7%)

Clearly this level of expenditure is unsustainable and a population health approach to prevention and management of chronic disease is vital.

In human terms a coordinated regional approach to health should create the conditions necessary for closing the gap between Indigenous and non-Indigenous people within the region.

12.2.2. Population health approach

We suggest that establishing a central coordinating body (PHCO) is a necessary precursor to the application of a population health approach to the Kimberley.

A network approach would enable the standardising of reporting and data collection to enable an effective population health approach to the region as well as development of programs and services which are appropriate to the regions needs.

[48] Ring, I., and O'Brien, J., 'Our Hearts and Minds - What would it take to become the healthiest country in the world?' in Medical Journal of Australia. (2007) vol.187 No.8; pp447-451; Harvey, P.W., 'Tantalus and the Tyranny of Territory: Pursuing the dream of parity in rural and metropolitan population health outcomes through primary health care programs,' in Australian Journal of Primary Health. Vol.10, no. 3 (2004)

12.2.3. Establishment of a Community based GP 'Super Clinic'

As noted earlier in this paper, there are compelling arguments in favour of the establishment of a GP based multi-disciplinary 'Super Clinic' in Broome.

We recommend that consultations commence regarding the potential 'ownership' mix, but see considerable benefits in it being operated by either a single NGO or several relevant NGO's under an agreed joint management structure. In going forward, partnerships across the health sector are likely to become increasingly important in terms of maximising efficiencies, funding and workforce resources, as well as assisting capability to target areas of greatest need.

Development of a 'Super Clinic' should consider the extent to which it might be linked to regional outreach service provision and future workforce training roles. We also suggest that consideration be given to investigation of the role that it could play in assisting rotation of staff to areas of need on a locum basis. If this is possible it would distribute benefits of the 'Super Clinic' to the wider region.

Recommendation: That an application be made for an NGO operated 'Super Clinic' for Broome.

Recommendation: That operation of a 'Super Clinic' in Broome occurs under a management structure that is inclusive of all relevant agencies.

12.3. Workforce Planning and Training

12.3.1. Changes needed in future workforce mix

Despite indications that increased numbers of GPs will enter the workforce in coming years, these will take time to develop appropriate skills and experience. There appears to be some consensus that the provision of primary health care services will have to adapt to a somewhat different workforce mix over the years to 2030.

An increase in capacity to provide health workforce training in the Kimberley will be an essential ingredient towards achieving long term sustainability of services. This is an area where there are already some initiatives that can be built on.

The more that nurses and health workers can be locally recruited and trained, the more stable the underlying workforce will be.

12.3.2. Changed roles of GPs

The Australian Government has recently signaled that it expects gradual change and devolution in some of the primary care roles that have historically been exclusively the

province of GPs. This is likely to remain an area of controversy within the profession, particularly over details of what roles might be devolved and under what kind of safeguards and protocols. However there appears to be broad agreement that services in the Kimberley will require some of these changes to occur if they are to be able to provide a sustainable level of primary care.

12.3.3. Nurse Practitioners

We anticipate that future delivery of primary care in remote areas will necessarily include increased numbers of Nurse Practitioners.

12.3.4. Indigenous Health Workers

Indigenous health workers in the Kimberley are likely to be increasingly required to be trained to levels where they are able to cover more aspects of primary care.

KAMSC currently offer six qualifications in ATSI health from Certificate III level to an Advanced Diploma. Over time this should evolve into increased capacity for career paths for the region's Indigenous health workers, with potential for steadily increased levels of responsibility for delivery of primary health care services.

12.3.5. Regional GP training School

Regionally based GP training initiatives by KAMSC, UWA and WACHS should be built upon with establishment of a Regional GP training School as a medium term objective.

This should include multi placement training and increased links with universities and specialist medical schools from around Australia.

12.4. Recruitment and Retention

Issues relating to recruitment and retention of GPs and other health professionals, particularly in remote areas such as the Kimberley are well known and have been widely documented.

Wage disparities and housing issues can and must be dealt with. Issues relating to the general attractiveness of the region as a workplace of choice are more difficult.

Several suggestions have been made regarding targeting of GPs with specific interests that are relevant to the region. An executive search approach to attracting staff with the appropriate skills, interest and temperament may be the most effective means of attracting professionals that are likely to stay for a longer period of time. Such an

approach might also be useful in targeting locums who may be prepared to assist in the regional on a regular basis over a long term.

The Community GP 'Super Clinic' model appears to be structured in such a way that it will improve attraction and retention of health professionals.

Aboriginal Medical Services may also, with sufficient funding, be able to restructure their organisations, employment practices and conditions in such a way as to improve recruitment and retention outcomes.

Development of local training capacity, research and development, workplace flexibility, and capacity to input to health policy development are all worth considering.

Recommendation: That a regionally based Executive Search approach to recruitment for all health professional placements including locums, be developed.

12.4.1. Workforce housing

There is no question that quality and availability of housing is a major issue affecting recruitment and retention of medical staff in the Kimberley. Reports of this appear to be widespread and affect the capacities of both AMS's and government to be able to fill positions.

This is one area where expenditure must be increased in the short to medium term. If design and construction of new staff housing is undertaken with sufficient foresight and planning, it might be anticipated to gradually reduce over time.

It is quite likely that there will be an increasing mid-term need for staff housing cluster developments.

Consideration might also be given to the purchase of high quality mobile accommodation for targeted remote clinical activity in the short to medium term. Allied health and dental services should be included in these considerations.

Recommendation: That forward projections of regional health workforce housing needs and associated medical infrastructure needs be developed and costed.

12.4.2. Improved regional clinic conditions

Recent programs to rebuild the region's hospitals now have to be accompanied by a program of rebuilding the region's remote clinics, particularly in the larger communities. The new clinic at Kalumburu provides an example for this.

Several of the region's AMS clinics appear to have well and truly outgrown their original intended capacity and in some cases this will require substantially increased buildings.

Facilities for some allied health services remain limited in even the larger centres. For example, audiology tests in Broome are currently undertaken at Lotteries House. These needs and the future needs for other community health needs, such as services specifically for children, need to be projected into forward planning.

12.4.3. Increased capacity for placement rotations and locums

Workforce planning must address capacity for increased flexibility in use of placement rotations and availability of locums to cover temporary shortfalls, absence or periods of increased needs, as well as to provide professionals with a variety of work experiences

Centralised regional workforce planning would also assist in delivering the flexibility of working hours and balance between work and home life that has been identified as a crucial determinant of recruitment and retention.

12.4.4. Remuneration and Employment Inequities

There are significant inequities in levels of remuneration between various Kimberley primary care services. This creates a class system of employment which seriously disadvantages the agencies with less capacity to pay. The result of that of course places those staff willing to work under those conditions at a comparative disadvantage, despite being in many cases at the coal face of areas of most need.

It would appear that these issues can only be addressed through a more cooperative relationship between the Commonwealth and WA governments, including more realistic funding provision by the former.

12.5. Centre of Excellence

There has been some discussion of the possible benefits of establishing a centre for excellence in the region devoted to health research and development and associated training. Suggestions have included that it might focus on tropical health issues, Indigenous health, and incorporate further development of mental health service development.

Possible research and development links with universities and even commercial interests would appear to be worth exploring. We note that there has been some discussion about this among the AMS's in the past and suspect that it is time that this area is revisited.

It is possible that some aspects of the development of such a centre could be commercially sponsored or funded.

12.6. Centralised Regional Planning: The PHCO Model

The Kimberley region has several key health committees in place, but no universally recognised central planning body in a formal sense. Development of a central regional health planning body with associated funds holding capacity appears to be a priority need.

A recent innovation in primary health planning, financing and delivery is the PHCO model. It provides the appropriate structure and resources to plan and coordinate a regional network of primary health organisations. These are linked through partnership agreements and are represented through the PHCO board structure and associated committees.[49]

Some agencies might be understandably nervous at the suggestion of formalising a central planning body. However investigation and consultation as to ways in which it might be acceptable to the current range of service delivery organisations should resolve these concerns.

A PHCO would provide an agreed central planning, finance and co-ordination organisation that is representative of the region's primary health needs to state governments, the Commonwealth and other funding bodies. This would provide the framework to direct funds towards locally identified priorities and source additional funding, some of which may become discretionary.

It also provides the organisational model to devise and implement reforms which will be create a more sustainable health care model in the long term with a focus towards improvement in regional morbidity and mortality outcomes.

Agreement to conduct health service planning and committee secretariats within the organisational structure of the PHCO might be considered either as a vehicle for a central coordinating role or an adjunct to one. Central coordination, resourcing and consolidation of the work of specialist committees should also be considered.

It is possible that the current Kimberley Aboriginal Regional Planning Forum might evolve into this, given its broad spread of membership at present, however a PHCO would need a neutral organisational framework that would be acceptable to all parties. It may be decided that a new organisation could be formed, or an existing organisation could create a separate entity that meets the needs of the region.

A Kimberley PHCO would need to have effective community engagement strategies in place through board membership and through other means such as rotation of meetings across the region, allowing local public input.

[49] Note that this model is further discussed in the attached literature review.

The PHCO would also provide the structure to enable significant input to establishment of state and federal budget priorities, including advice to government .as well as being the natural organisation to act as funds holder for any regional pooling arrangements. It could also provide the basis for oversight of standards in recruitment, including potential for provision of executive search and workforce training functions.

Recommendation: That a process to commence discussions regarding the nature of a regional health planning body with associated grants access and fund holding capacity be explored immediately.

Other Benefits arising from a PHCO would include an agreed level of uniform organisational standards and protocols such as:

12.6.1. Performance Measurement Innovations and Improvements

Several innovations have been suggested:

- Patient / client satisfaction surveys and complaint investigation / management processes.
- Quality and performance management mechanisms.
- Self assessment of organisational performance against objectives.
- Access to increased assistance in organisational capacity building.
- Standardised regional position descriptors and competencies which allow job mobility and career progression.

12.6.2. Organisational analysis of core business and business opportunities

Organisational reforms should be not be implemented at the cost of focus upon core business. Organisations should however investigate opportunities for business opportunities - either through partnerships or establishment of commercial arms of locally controlled health services.

12.6.3. Vertical Integration

Commitment and action from primary health service providers to either vertically integrate service provision or establish clear and effective partnerships.

A regional approach to planning and service delivery should provide both resources and the will to accelerate progress towards integration of primary health care services.

12.6.4. Commonwealth funding for a regional Certified Agreement

A regional health plan may also incorporate a vision for a regional set of employment standards, improved career paths and organisational restructure. If the plan is able to relate these reforms to improved health outcomes it could also attract Commonwealth funding.

Some examples of legislative instruments to enable this are found within the Workplace Relations Act 1996, including *s329 Union greenfields agreement*s and *s331 Multiple-business agreements.*

If adequate funds were made available for collective bargaining, as part of a Regional-Commonwealth funding arrangement, then it is likely that collective negotiations of this kind would progress smoothly.

12.6.5. Records and Data Uniformity and Sharing Mechanisms

It is essential that a process is devised and appropriately resourced by government to facilitate agreement and implementation of a single records sharing platform across the region. In the interim, further development of the Kimberley Managed Health Network (KMHN) based on the Great Southern Managed Health Network messaging system should be rigorously pursued. This system should be made available as soon as it is developed sufficiently and it is practical to do so.

Recommendation: That the Kimberley Managed Health Network patient information sharing and messaging system be further developed and implemented as soon as possible.

12.6.6. Effective Community Engagement

Future planning functions must include increased capacity for effective community engagement.

Formalised mechanisms which link to major community stakeholder groups including industry should be developed, so that health planning is both informed by and aligned to broader community aspirations.

12.6.7. Performance Reviews

Centralised regional health planning should include increased capacity to review overall performance against long term targets and recommend resource allocations across the region as necessary.

12.7. Regional Consolidation of Health Funding

12.7.1. Funds Pooling

There have been a number of suggestions regarding the need to consider central funds pooling for specific areas of need within the region.

The recent Commonwealth intervention into the Northern Territory Indigenous communities has injected substantial Commonwealth funding into primary health and housing. Clearly the Kimberley will not be subject to a Commonwealth intervention in the same manner, notwithstanding the Constitutional arguments.

Regional health bodies may however, wish to consider agitating for direct Federal funding, based on its recent expenditure patterns within the Northern Territory, to support regionally devised solutions to primary health determinants and outcomes.

Primary health focused agencies within the region should position themselves for the possibility of major changes to health financing levels in the future, as well as the increasing challenges of maximizing improvements to primary health outcomes.

A well governed and representative regional PHCO would most likely, within the current political environment, be considered by the Commonwealth as the appropriate conduit for direct funding of regional primary health initiatives and associated infrastructure requirements.

This should in turn allow a primary health care organisation to exercise greater flexibility and targeting of expenditure, so as to achieve measured improvements in mortality and mortality.

The window of opportunity to make this happen is now open. The Commonwealth Government appears, through its actions, to accept that the Commonwealth / State health agreements do not provide an adequate model for delivery of health funding. It is also abundantly clear to many in Kimberley primary health that centralised policy and expenditure decision making do not serve remote regions well.

Regional and community models are now being recognised in policy as a more effective means by which to deliver health services, as well as prioritise infrastructure needs. Development of this model within the Kimberley would be an important first step in fostering the environment and initial discussions for a direct funding agreement with the Commonwealth. It may also be enough to seek Commonwealth assistance in progressing development of a PHCO with its associated regional primary health care planning capability.

It is suggested that the key parties within the Kimberley primary health sector meet to discuss this approach to regional co-ordination and representation with a view to implementing an agreement within the near future.

12.7.2. Improved Local and Regional Capacity to maximize access to funding

There appears to be some need for an increase in dedicated roles for maximizing access to funding by regional and by area and service providers.

Locally based service providers may be missing out on eligible funding through inability to physically handle all possible funding applications available to them.

This might include a central grant search and application resource, which would also have responsibility for sourcing funds from the corporate sector and from Australian and International philanthropic sources.

12.7.3. Access to Discretionary Funding

There have been numerous recommendations for access to some form of discretionary funding available within the region in order to be able to target locally recognized needs in a timely manner.

Further work may need to be undertaken to identify broader sources of funding that might be held for discretionary use. This might include investigation and establishment of a community benevolent primary health care fund which attracts charitable or tax deductible status.

12.8. Changes Required in Government Health Financing

The need for governments to fund on the basis of relative levels of need has been argued previously, and it is clear that the current Commonwealth / State funding model is an inefficient means by which regional primary health services are funded.

Some critics of the current system have even called for establishment of a Royal Commission into public health, as well as creation of a central agency to progress health reform.[50]

The remoteFocus prospectus of Desert Knowledge Australia also points to issues of inadequate governance within remote regions. It promotes what it describes as, 'a new paradigm,' of governance for remote Australia:

> 'A reformed governance system for Remote Australia based on the principle of networked governance and decentralisation, in order to provide regional resilience

[50] Menadue, J., 'Obstacles to Health Reform,' Centre for Policy Development (2007)

> in the face of inevitable variations in levels of attention by central governments. Network governance and decentralisation is based on global trends of delegating authority away from centres of power to local levels…'[51]

It is however imperative that regional health organisations do not wait until reforms are in place. Instead it is advised to commit to discussions regarding regional reform *immediately*, so that the Kimberley is enabled to partially bypass the Commonwealth / State funding model and the morass of disconnected grants and program monies currently available.

The role of governments in the purchase and construction of appropriate housing for current and future staff across the region is also vital to future capacity to resource effective services and reduce strain on hospitals and contain associated costs.

There will be a need within the region to reach agreements with governments to ensure funds pooling and discretionary funding activities may proceed without adverse effects on recurrent, program or grant funding. Certainly, within this context there also appears to be a need for review and realignment of areas where funding is historically based rather than needs based. This is an area in which a central planning body would be the most appropriate facilitator for change.

12.8.1. Area Classification Weightings

ARIA and RRMA inequities should be realigned to allow direction of resources to areas of greatest need. Examples of inequities within the Region include the inequitable classification of Fitzroy Crossing, which has hampered efforts by WACHS to deploy nursing staff.

This will be essential component of any attempts to develop appropriate levels of remuneration and associated benefits to attract staff to areas where they are hardest to recruit and most needed.

Once again, the problems caused by current inequities in area weightings might be bypassed by the establishment of a PHCO with capacity to negotiate more appropriate remote area weightings within the region.

[51] Desert Knowledge Australia. remoteFocus: Revitalising Remote Australia. Desert Knowledge Australia (2008)

12.8.2. Medicare

Current inequitable and unfair eligibility restraints must be addressed.

There is clearly a need for increases to Medicare bulk billing compensation for remote regions. There is also clearly a need for more equitable weightings in MBS item claiming for remote regions.

Streamlining the Medicare cost schedule should be done in a way that minimizes current uncertainties regarding which categories should be used.

Recommendation: That the Medicare cost schedule be streamlined and that weighting for MBS item claiming for remote areas be reviewed and realigned to more appropriate regional cost indices.

12.8.3. Taxation Reform

Reform of the area zone rebate rate may be one way in which the taxation system may be put to use. It appears to have lost favor with successive governments, however might be revived in a targeted manner.

12.8.4. Salary Packaging and Fringe Benefits Taxation

Improvements to salary packaging and FBT treatment within remote regions are another means to possibly further assist pay inequities within remote regions.

Certainly this would be another a cost-effective means by which the Commonwealth can support the efforts of remote regions in attracting, housing and retention of health professionals.

12.8.5. Primary health care contribution deductibility

Some regional health agencies such as KAMSC already have DGR status. A Kimberley Primary Health Care Organisation should also be structured in such a way that it is eligible for deductible gift recipient (DGR) status.

The application of the taxation deduction system in this manner has over the years been widely used to foster research and development (R&D) investment and it would be easily applied to primary health.

The R&D taxation deduction rate has previously reached 150% in some areas and is now currently set at 125%. Considering the huge cost of secondary health care to the

Commonwealth it would not be too ambitious to lobby for 150% deductibility. It would be surprising if this was not sufficient to attract some major corporate investment.

If taxation incentives of this kind could be linked to evidenced improvements in primary health outcomes, it would result in a reduction of Commonwealth exposure to costs within the secondary health system.

Clearly this level of funding assistance would need to be met by a cohesive and representative body, with clear plans and agreed objectives as well as the appropriate organisation to receive such funds.

12.9. Need to Develop Improved Measurements of Health Outcomes

One reform which would assist greater overall accountability would be requirements on government health agencies to report to their respective Parliaments on progress towards agreed health outcomes. In the Kimberley this should have specific regard to issues associated to 'closing the gap' on disparities in life expectancy between the Indigenous and non-Indigenous population.

Regional reporting and data analysis methodologies, which enable tracking and measurement of health initiatives, should also be introduced.

Primary health programs, projects and services also need to align expenditure with targeted health outcomes to ensure efficacy of activities and value for money. It is clear that an evidence based system of measurement is crucial for both developing both a mature regional based funding relationship with governments, as well as effective regional management of health resources and activities.

This requirement should be extended to all agencies whose policies impact on health service provision, not simply those with primary responsibility for health.

Recommendation: That all Government agencies with responsibilities that impact on health service provision be required to report annually to their respective parliaments on progress towards 'closing the gap' on disparities in life expectancy and related health initiatives.

13. Literature Review of Health Sector Models in Rural and Remote Areas

13.1. Introduction

Primary health care delivery models in rural and remote areas have been researched and discussed, in various levels of detail, by a wide range of government, medical and local government organizations. Literature ranges from academic papers to promotional or information style booklets.

A common thread to the literature is broad agreement on the difficulties in attracting and retaining GPs and other health professionals to rural and remote areas.

Previous government policy, at a state and federal level, has focused on workforce strategies to recruit and retain general medical staff.

In recent years the focus of research appears to have shifted from concentration on issues relating to attraction and retention of GPs to a more inclusive appraisal of primary care options.

The Commonwealth has now recognised the value of collaborative, multi disciplinary community based primary health care, which is a recurring theme within the reviewed literature. This is evidenced by the roll out of Community GP Super Clinic funding to 20 communities across Australia, which is now well underway.

In this review we list some of the regularly recurring factors and themes that appear in the literature and offer a brief appraisal of the contribution of some of the more relevant studies with particular regard to models of primary health care in rural or remote areas.

13.2. Common Issues in the Literature

13.2.1. Definition of Primary Health Care

In defining primary health care, we accept the following definition of primary health care by the World Health Organization (WHO):

> 'Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination.
>
> It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.'[52]

13.2.2. Improving regional health outcomes

Improving health outcomes should be the principal concern of primary health care models. In Australia in recent years this has required focus on ways in which communities can maintain basic primary health care services. In some areas, Local Government authorities have had to step outside their core roles to assist the maintenance of GP practices in their communities. Where possible this has included efforts to incorporate allied health care.

13.2.3. A Sustainable Health System

The sustainability of the current Australian health system is frequently questioned in current literature. A sustainable system is not only about attracting and retaining GPs, though that has proved difficult enough, but it is also one that should deliver continuous improvements to regional mortality and morbidity rates. In short it should be a system that reduces the incidences of chronic disease and morbidity, and therefore reduces stresses on provision of acute care.

[52] WHO: Alma-Ata Declaration.1978

A system cannot deliver sustainable improvements to health outcomes if it cannot sustain itself. Proof of systemic, program and project improvements to health outcomes cannot be achieved without accurate measurement tools that assess the performance of health strategies. It is difficult to find evidence of strategies that have worked to this level of effect in regional Australia.

13.2.4. Viability of Private Practice GPs

Australia has had a long standing 'tradition' of primary health care being accessible through a local private practice GP.

In recent years there has been a steadily increasing focus on new models of delivery including multi-disciplinary approaches. Research has overwhelmingly indicated that the discrete model is rarely viable in remote communities today. Its long term sustainability, other than in isolated cases, should no longer be relied on as the basis for primary care in these areas.

This is not to say that private practice is no longer viable *per se*. It is simply that the free market can no longer be relied upon to produce enough of these types of businesses, and that in many cases they can only exist through increasingly costly incentives from governments or through collaboration or partnership with industry.

13.2.5. Patient / GP Relationship

It is widely accepted that a patient benefits from developing a long term relationship with individuals providing primary health care.

Stimulating retention of GPs and other health professionals is critical for this to occur. However in apparently increasing numbers of regions, access to any form of primary care has become the more critical issue. This has ramifications in particular for people suffering chronic ill health and the many Indigenous people living in the most remote areas of Australia.

Improving access to primary health care is the important factor in allowing this relationship to commence in the first instance.

13.2.6. Recruitment and Retention

One of the most pressing needs for remote health is the attraction and retention of GPs, both salaried and self employed, within private practice, Aboriginal medical services and government health services.

It is clear from wider research that the issue of attraction and retention also applies to allied health professionals.

A considerable amount of research has been undertaken and documented to establish the factors which contribute to more successful recruitment and retention strategies. Broadly speaking, the following issues are repeated in many studies:

- Capacity to generate employee wages and sufficient income for practice principals.
- Administrative requirements.
- Hours of work including percentage of time on call.
- Capacity to maintain procedural skills and certification.
- Leave cover.
- Family friendly policies such as flexible hours and childcare - particularly for female GPs.
- Spousal employment.
- Housing and other infrastructure, including social infrastructure.
- Continuing professional development.

13.2.7. Workforce Initiatives

Workforce initiatives that are currently in place to assist maintenance of the GP workforce include:

- Rural Workforce Agencies (RWAs)
- Rural Retention Program for GPs
- Medical Indemnity Insurance Subsidies
- Procedural Training Grants
- Rural Practice Incentive Program (PIP)
- Rural Medical Infrastructure Fund
- The Five Year Overseas Trained Doctors Scheme (OTD)
- Rural Locum Relief Program
- Rural Other Medical Practitioner (ROMPS) Program
- Division of General Practice (DGPP)
- Australian General Practice Training Program

It is broadly agreed that these programs, by themselves, have been unable to arrest the decline in primary health care delivery within rural and remote communities.

13.2.8. Medicare Benefits Scheme

The literature suggests that the MBS is clearly inadequate for sustainable primary health care in remote Australia.

This is well put by the Rural Doctor's Association, who offer the view that, 'the structure of the Medicare Benefits Schedule (and particularly consultation items) has not kept pace with changes to general practice and cost structures. The economic viability of rural practices is dependent on alternative sources of income, such as hospital income or other packages.'[53]

The literature points to this also being linked to structurally inaccurate and inequitable measurements and ratings of need. The definitions of remoteness currently in use (ARIA and RRMA) contribute to this under funding of remote general practice, and broader health funding.

13.2.9. Increased roles for Practice Nurses

Much of the literature reviewed indicated that there was broad agreement within the wider community regarding the need to develop ways to make primary health care more sustainable. This is for example evidenced by a joint ten-point policy statement released in 2004 by the Australian Local Government Association, Rural Doctors Association of Australia, National Farmers Federation, Country Women's Association of Australia and Health Consumers of Rural & Remote Australia. Among their joint recommendations were to extend the roles of practice nurses and Aboriginal Health Workers in providing Medicare funded services.[54]

Indications are that increased roles for practice nurses are more likely to be considered in models proposed for regional and remote Australia than they might be in the cities, as a practical solution to shortages of GPs where appropriate.

13.2.10. Indigenous Health Issues

The Kimberley Workforce Analysis and the Kimberley Regional Aboriginal Health Plan provide a rigorous and detailed assessment of Aboriginal health and the primary health care services provided to Aboriginal people in the Kimberley region.

The latter plan now needs to be updated but still provides a range of material, and is a valuable resource for understanding the underlying issues and factors associated with Indigenous health in the region.

[53] RDAA, Viable Models, p.xvii.
[54] ALGA, Good Health to Rural Communities, p8

13.2.11. Mental Health and Other Allied Health

Some of the more recent models of Primary Health Care are including co-location of a variety of allied health services together with GPs and practice nurses to improve overall quality of services as well as economic sustainability.

This suggests that momentum is growing, particularly among primary health care professionals for better integration of services that address mental health and other allied health issues as part of a more comprehensive response to patients' needs.

13.3. Regional Health Planning and Research specifically relevant to the Kimberley

13.3.1. Kimberley Workforce Analysis

Roach, S., Waters, A., Atkinson, D., Jefferies, F., Kimberley Workforce Analysis. WACRRM. (2006)

This study investigated the actual amount of time spent by Kimberley based GPs in the provision of primary health care, when considered against the amount of time required for travel and other tasks.

It showed that the current methodology for calculating numbers of full time equivalent (FTE) GP positions is flawed and that the known shortage of GPs, particularly in the areas of most need, is much worse than generally accepted.

This study takes this a step further, by weighting the needs of the population in terms of the proportion of indigenous population, prevalence of chronic illness and socio-economic factors.

It argues that the planning process substantially underestimates the real need for GPs in the region. When traveling time and other factors are taken into account, then only 62% of available GP time is used in patient care.

Recommendations include:

- New funded GP positions.
- Infrastructure investment.
- Mapping exercise of remote primary health care, with a single coordinating body.
- Retention strategies including housing, remuneration, etc.
- A multi disciplinary primary health care approach.

13.3.2. Kimberley Regional Aboriginal Health Plan

Atkinson, D., Bridge, C., Gray, D., Kimberley Regional Aboriginal Health Plan. AAD & UWA (1999)

Written in 1999, the Kimberley Regional Aboriginal Health Plan provides a comprehensive analysis of Aboriginal health issues in the Kimberley that is still largely relevant. It also provides a description of the Aboriginal community controlled health services at that time. The plan includes a series of recommendations addressing underlying issues and the provision of appropriate health care services.

Interestingly, it flagged the need for the development and implementation of performance indicators for both underlying issues and health care service provision for Indigenous people.

13.3.3. Snowball Report 2007

Snowball, K. Maintaining an Effective Procedural Workforce in Rural Western Australia. WAGPET (2007)

This report provides evidence of the shortages of procedural GPs, with indications of future shortfalls, by region. It also points to their role in reducing requirements for patients to be sent to tertiary hospitals.

Recommendations include:

- An agreed target of 10 GP proceduralist graduates by 2008/09.
- Contacting and encouraging lapsed proceduralists to recommence.
- Assessing qualifications and expertise with a view to allowing overseas trained GP proceduralists to practice.

Current numbers of GP proceduralists are identified within the Kimberley, as well as current and projected shortfalls up to 2021.

The report indicates that at present there are few if any workforce planning initiative for procedural GPs.

13.3.4. WA Health Clinical Services Framework 2005-2015

Western Australian Department of Health, WA Health Clinical Services Framework 2005-2015. WA Department of Health (2005)

This plan is heavily geared towards metropolitan health service delivery and does not have a strong remote focus. However it does refer to many issues that are of relevance to the regions.

Relevant points include:

- Delineation of WACHS health services and care.
- Outlines new metro hospitals and building up of general hospitals.
- Introduction of new education and research initiatives.
- Health policy and clinical reform will bring together stakeholders, including public sector, private sector, academics and communities.

- Refers to adoption of the Reid Report recommendations and detailed planning *in the future*. Appears that the report has only been partly adopted.
- Points to increase in medical graduates over next 5 years.
- Suggests that administration time will be reduced for medical staff through increased admin support.
- More nurse practitioners will be introduced.
- Improved reporting relationships and methodology.
- Refers to public / private partnerships.
- Excludes reference to regional GP residents.
- Provides a very simplistic view of remote primary health care issues.
- No rationale or methodology for service delineation between remote regions and the rest of the state, or any definitions of varying remoteness and its role in service planning and funding.
- This document is a precursor to the WA Health Strategy.

13.3.5. Country Health Services Review 2003

Western Australian Department of Health, Country Health Services Review: Vision-Goals-Directions for Developing WA Country Health Services. WA Department of Health (2003)

This review argues for sufficient flexibility to allow different priorities and approaches between regions. The report identifies and proposes the following:

- Scope for developing strengthened and well integrated regional health delivery systems.
- Efforts need to be made to enhance service sustainability.
- Regional network model for each region, featuring a single service delivery, with potential for new or revised terms of funding.
- Recognition of inequitable population resource allocation and suggests health services based on an area management or regional network model.
- An agenda for State and Commonwealth governments to negotiate flexible new approaches to overcome policy and funding barriers.
- A whole of community approach to developing service models, alliances, joint funding, and service collaboration.
- Moves towards integrated multi disciplinary approach to primary health care.
- That a framework is needed through which appropriate service planning may be undertaken. It suggests a legislative amendment may be required.
- Population projections to 2011.

13.3.6. Comment on Kimberley Population Issues

The extreme remoteness of the Kimberley, its high proportion of Indigenous people and high levels of poverty are not accurately reflected in health planning statistics, strategies or funding.

Support and development of existing and new model primary health care delivery is generally only considered in recent studies, however review of the adoption of the Reid report may go some way to addressing this.

Our readings indicate that little research has been conducted into allied health care workers in regional primary health care. This suggests a need for mapping all Kimberley primary health care providers and services across the region in order to adequately:

- Assess resources and gaps across organizations.
- Analyze demographics.
- Assess the effectiveness of programs.
- Develop an integrated regional PHC plan.

A broadly accepted regional strategic plan or coordinated effort to address these factors is not in place, although in recent years there have been some moves to address this through the Kimberley Aboriginal Health Planning Forum.

13.4. Reviews of Specific Models

13.4.1. Wakerman Report

Wakerman, J., et al., A Systemic Review of Primary Health Care Delivery Models in Rural and Remote Australia 1993-2006. Australian Primary Health Care Research Institute (2006)

This report investigated the range of primary health care models in use in Australia and produced a typology of models in use in rural and remote Australia.

An abridged version of the arrangement as categorized in the study is shown here: [55]

Table: Abridged version of the typology of rural and remote models

CATEGORY	HEALTH SERVICE MODELS	RATIONALE / SENTINEL ISSUE
Discrete services	• Walk-in / Walk-out (RARMS) • Viable models / sustainable models • University Clinics	***Sustainable*** medical ***workforce*** (getting GP's into rural and remote services)
Integrated Services	• Shared Care • Co-ordinated Care Trials (CCTs – mainstream) • PHC teams (Multidisciplinary) • Multi-Purpose Services Program	***Co-ordination*** between and ***access*** to services otherwise not available locally or not sufficient.
Comprehensive PHC Services	• Aboriginal Controlled Community Health Services (including Aboriginal CCTs)	Primary focus on improved ***access*** to services
Outreach Services	• Hub-and spoke • Visiting / periodic services • Fly-in, fly-out	***Access*** to service for communities too small to support discrete rural service. A secondary driver relates to sustainable workforce.
Virtual Outreach Services (IT/Telehealth)	• Virtual amalgamation • Virtual clinics – video pharmacy / assessment & monitoring • Telehealth / telemedicine	Use of IT to increase ***access*** to and ***sustain*** service for communities too small to support discrete rural service

The report characterizes the various categories of models with examples currently in use. Interestingly, the authors note that, 'economic evaluation of health service innovations is all but non-existent. This is consistent with a policy environment that has funded many trials and pilots, and focused on workforce issues rather than the systemic development of comprehensive models of PHC service delivery.'[56]

[55] Wakerman, et al, A Systemic Review, p20
[56] Ibid, p41

13.4.2. WA CCI Discussion Paper

Western Australian Chamber of Commerce and Industry, Health: A Discussion Paper. Chamber of Commerce and Industry WA (2007)

This paper takes a broad economic view of primary health care sustainability. Compiled from existing literature it does not attempt to introduce empirical research of its own. It identifies the unsustainable nature of the current health system as being due to:

- Increased and unsustainable budgetary expenditure.
- Ageing population and chronic health issues increasing pressure on the health system.
- Fragmented and complex health management and funding structures.
- Blame shifting between State and Commonwealth governments.

The paper recommends the transfer of all health management and funding to the Commonwealth. It also recommends that funding should occur in the form of regional health allocations, to provide the flexibility for localized regional health needs and to purchase services and manage resources more efficiently. The paper argues that this would simplify and focus funding into targeted funding areas, which should be accompanied by research, evaluation and benchmarking.

The document recommends the establishment of nationally consistent benchmarks, standards, planning, workforce and statistics/evaluations. It also suggests linking funding to measured primary health care outcomes.

More competition in provision of health care services is advocated but the document is unclear as to what is envisaged and how this would assist in the improvement of services and sustainability.

The discussion paper also advocates integrated service delivery as a more effective means by which primary health care can have an affect on reducing hospitalization, particularly for the old and frail. It argues that the current system is largely geared towards treatments of episodic illness and that there is limited investment in preventing ill health. Upstream investment in primary health care is argued as a cost effective means of improving health outcomes.

Linking up of separate services is also recommended, for the purposes of funds pooling, co-operation and co-ordination of efforts.

The paper suggests macro and micro reforms to the health system, many of which appear valid and correlate with other critical analyses of the health sector's structure, financing, and co-ordination, as well as health outcomes.

A rational economic argument is given for the role in primary and community health care in reducing strain on the taxation system, morbidity and mortality, the upward pressure on health expenditure and also increasing productivity and workforce participation.

The WA CCI paper argues for:

- Provision of a multidisciplinary team of health professionals, including GPs, nurses, dentists and other allied health professionals.
- Strengthening linkages across primary and community health, residential aged care and community support sectors.
- Proactively managing health risk by investing in upstream interventions such as education, health promotion, early detection / treatment and patient self management to minimize downstream costs.
- Increase in the flexibility of funding arrangements, to ensure that services are provided by the most appropriate provider, in the most appropriate setting. Regional fund holding is argued as the most efficient and flexible means by which health expenditure can be managed by the community.
- Significantly increasing the capacity of the community support sector to assist people in maintaining independence and quality of life within the community.

The macro nature of the paper restricts it to broad structural, economic, and social issues relating to the health sector generally. It makes some specific recommendations in relation to increasing the efficiency of, and investment within the primary health care sector as the most cost effective means by which illness can be prevented and the system can become sustainable.

The paper mentions remote areas only in passing and refers to the maldistribution of GPs and other health professionals, however it does not focus upon alternative primary health practice models, other than integrated service delivery models. Examples of organizational structures, funding examples and financial statements are not included.

13.4.3. Shire of Roebourne Operating Plan

Kadmos Group. Attracting and Retaining Private Practice Medical General Practitioners in the Shire of Roebourne. Kadmos Group, Shire of Roebourne, Woodside & Pilbara Iron. (2006)

This document is based upon commonly agreed factors in the retention and attraction of medical GP's to rural and remote areas and proposes solutions specifically for the Roebourne area.

It provides a detailed checklist on how a community can attract and retain medical GPs, from issues of remuneration, housing, professional development and maintaining procedural qualifications, spouse employment, family education, community involvement

and appreciation. It neglects however to deal with the issue of unpaid hours devoted to practice management, hours of work in a general sense and amounts of on-call work.

The Shire of Roebourne approach is aimed at maintaining discrete private GP practice by adopting a coordinated partnership approach to recruitment and retention. It recognizes that various government incentives and grants to supplement income and satisfaction of GPs have failed to have a positive effect in remote regions. It also places emphasis on the high turnover of mining staff due to insufficient primary health care, with implied costs for business. It also suggests that *annual salary reviews* be conducted against national remuneration surveys, to ensure maintenance of market linked remuneration.

Entering into a partnership agreement with Pilbara Iron, the Shire of Roebourne plan provides a top up of $50,000 to the Rural Retention Funds received by remote GPs after five years service. This is linked to an agreement by the GPs to provide a defined level of service based on hours and billing.

The practicalities of the housing needs of GPs are directly addressed with eleven houses to be provided in Dampier, Wickham and Karratha by Woodside and Pilbara Iron, with the Shire of Roebourne to contribute two additional homes by 2008.

The funding arrangement also provides for a coordinator whose role is to ensure that all of the items in the checklist have been complied with and that the GPs are making use of the services provided to them. The coordinator is also responsible for maintaining contact with GPs and monitoring their levels of happiness and satisfaction.

Survey data from other sources has shown that the burden of practice management and unpaid hours, along with generally long hours and unsociable amounts of on call are major deterrents to attraction, retention and practice sustainability. No indication is given to whether these issues were considered and if so how they are to be dealt with in this model, other than through the support of the service coordinator.

Anecdotal advice indicates that the service levels required by Pilbara Iron and other companies are such that, when benchmarked, hours of work and call outs are at a level which may still threaten retention of existing GPs.

Structured locum relief and professional development leave appear not to be allowed for in this model. These have been clearly identified by other studies as major aggravating factors in attraction, retention and practice sustainability.

The paper outlines consultation which appears to be limited to organisation and corporate stakeholders rather than providing evidence of any more developed primary health care objectives in improving public health, other than to reduce staff turnover in the interested companies. Sustainability is also questionable in this model, as the funding partners reserve the right to withdraw annual funding support at any time.

The Roebourne model also does not attempt to deal with sustainability of the wider allied and mental health sectors, nor issues relating to aged and mental health care. The model does include a mechanism for maintaining continuous improvement and it would be useful to know to what extent it has evolved since its inception.

13.4.4. RDAA Viable Models

Rural Doctors Association of Australia, Viable Models of Rural and Remote Practice: Stage 1 and Stage 2 Report. RDAA (2003)

This report emphasizes the need for an integrated approach to solving the problem of medical workforce shortages in rural and remote Australia. It highlights the roles played by practice organization and infrastructure, professional issues and practice economics, in maintaining practice viability.

Its key findings regarding practice viability indicated that the following factors are instrumental:

- Workforce supply
- Practitioner recruitment strategies
- Retention strategies
- Training
- Workload
- Practice economics
- Incentives
- Hospitals

Detailed analysis of practice operations, structures, systems and running costs are used to develop a framework for viability and benchmarks. The methodology used in this study, its associated survey and consultations with participants is both statistically sound and rigorous.

A detailed survey of rural and remote practitioners compared practices against benchmarks that were considered to set the minimum requirements for economic, professional and organizational viability of practices.

The report outlines the context of rural and remote practice, including low population densities and distances between rural and remote centres. Differentials between city and rural / remote areas in terms of morbidity and mortality underpin the need for improved access to primary health care, as well as the affect poor health has on productivity and other economic indicators.

Aggregation of remote and rural population is also seen as an effective means by which health planning and delivery may be more effectively managed.

The paper also investigates the definition of appropriate service levels within rural and remote communities and points to ***community managed integrated practices*** as the most likely sustainable model in remote communities.

The document outlines practice viability characteristics and definitions for viable and at risk practices and this is a useful framework against which Kimberley primary health care can be assessed and alternative practice models can be explored.

The viability framework is extended into professional, organizational, economic, service delivery, family / social and environmental dimensions and provides corresponding indicators or measures which address these.

The study examines the minimum benchmarks for viable practice in detail and proposes a model for their application based on the viability framework. It provides a methodological assessment tool based on an integrated viability framework that it suggests if met by practice structures and incentives, would deliver, 'all that could possibly achieved'.[57]

This paper is a useful resource in developing elements of a regional survey, as well as providing evidence based frameworks of both benchmarks and sustainability. Used in conjunction with data from alternative practice models as well as existing GP practices this framework provides a useful tool in undertaking an assessment of regional primary health care and an evidenced argument by which to improve sustainability.

The study uses CCH benchmarking which has proven difficult to extrapolate to the Kimberley region in other fields, particularly in the smaller towns.

At the time of this study the only public ownership models surveyed were 'an Aboriginal Medical Service and a Primary Health care centre in remote northern Australia.'[58]

The study concludes that, 'there is no one ownership style that can cover all circumstances but clearly in very remote regions public ownership has generally proven to be a more sustainable option.'[59]

13.4.5. Finding the Best Medicine

Western Australian Local Government Association, Finding the Best Medicine: Information for Local Government on GP recruitment and retention. WALGA and WACCRM (2005)

This paper appears to have been written primarily as a guide to local government in the recruitment and retention of GPs. It explains the various workforce factors that influence

[57] RDAA, Viable Models, Chapter 7.
[58] Ibid, p78.
[59] Ibid, p179.

recruitment and retention as well as detailing state and federal government initiatives in grant, subsidies, infrastructure funding and bursaries.

It provides an informative introduction to the issues faced by rural communities in recruiting to towns, but has little focus upon the extra difficulties faced by remote regions. Although it provides descriptions of alternative models for GP practice it appears to favour the discrete private model, assisted by local government and community assistance and subsidies.

The paper includes a very brief description of 'future practice' models of medical and allied health teams. It also suggests doctor sharing between towns that are proximate, sharing GPs across a region and also canvasses the potential for LGAs assuming management of practices.

The only paper to include 'real world' financial data in the form of a budget projection, it demonstrates the onerous nature of unpaid practice management, on both billable hours and overall profitability.

This paper does not offer any detailed comparisons between various service delivery models. It is a distillation of the issues faced by rural and remote practice and means by which the traditional discrete model is endeavored to be sustained through workforce initiatives and funds pooling arrangements with local governments.

13.4.6. Mid West of WA

Francis, N., A model to deliver sustainable general practice services to the Mid West of W.A. Midwest GP Network & WACRRM (2006)

This document is based upon interviews with GPs, WACHS staff, local governments, AMS, RFDS, Mid-West Development Commission, Combined Universities Centre for Rural Health, Area Consultative Committee, Chamber of Minerals and Energy, Department of Health and Ageing, and rural clinical schools. It reports general consensus that there needs to be more social and professional incentives to attract and retain GPs in remote areas.

The report points to evidence of the reluctance of younger GPs to invest in and manage their own practices, with the attendant unpaid work and hours issues. The result is that many practices close without sale.

The rationale for the model proposed in this paper is that 'stand alone' or discrete private GP practices are either dead or dying in remote communities; certainly that they cannot be relied upon as models to address primary care needs in the future. In this context it looks towards aggregating resources to enable at least a preservation of existing services and perhaps an increase.

The paper proposes the formation of a coordination unit which will assess needs of communities, assess existing practices and expressions of interest. Successful providers would then reach agreement for a set level of service over a set period for a set reward.

The coordination unit would then manage the practice, freeing up GPs for more consultation time and community health work. The paper argues that this model provides professional and financial opportunity, security and sustainability.

The paper does not go into detail regarding quantification and prioritization of the stakeholders' needs or the financial and legal issues affecting a proposed coordination unit. It therefore appears insufficient, on its own, to attract recurrent funding from relevant organizations. It is however another useful example of a different model that might be worth exploring.

13.4.7. GP Super Clinics: National Program Guide

Australian Government, Department of Health and Ageing, GP Super Clinics: National Program Guide. Department of Health and Ageing (2008)

The Australian Government has in 2008 unveiled a new policy for funding Super Clinics. The Super Clinics program guide provides a new service delivery model and includes information regarding funding arrangements and application requirements and processes. The Commonwealth is currently funding a first year roll out of 20 multi-disciplinary primary health clinic projects across Australia.

13.4.8. Primary Health Care Organisation Model (PHCO)

Wilson, R., McBride, T., and Woodruff, T., Strategic directions for a national primary health care policy. Centre for Policy Development. (2007)

A recent innovation in primary health planning, financing and delivery is the PHCO model. The PHCO model is based on linkage of primary health providers through partnership agreements, and these organisations are also represented through the PHCO board structure and associated committees.

A PHCO organisation provides an agreed central planning, finance and co-ordination organisation. It also enables pooling of funds for reallocation to agreed priority health needs. The PHCO structure also provides an avenue for effective community engagement.

Various forms of Primary Health Care Organisations have been implemented in both New Zealand and the United Kingdom.

The final structure and functions of a PHCO should be customized to regional needs, resources and environment. This would be a necessary precursor to successful implementation.

It may be decided that a new organisation could be formed, or an existing organisation could create a separate entity that meets the needs of the region.

13.4.9. New Zealand Primary Health Organisation (PHO) Model

Malcolm, L., 'How General Practice is funded in New Zealand' in Medical Journal of Australia (2004) vol.181 No.2 pp106-107.

It is generally accepted that primary health care and associated financing in New Zealand is ahead of Australia in terms of:

- Innovation.
- Integration.
- Multidisciplinary team approaches.
- Community engagement.
- Relative power balance between primary and secondary care.

In 2000 the NZ Government decentralised health service provision and established population based district health boards (DHBS). These are providing public hospital services and managing government funding of all health and disability services, including primary health care.

This approach should have some resonance with those providers in remote regions dependent on grants and program funding that have been devised on the other side of the Australian continent.

The New Zealand approach enables regional prioritisation of health needs and the local channeling of funding to projects and programs which meet the needs of the provider and community. This has included the launch in 2001 of primary health organisations (PHOs).

New Zealand PHOs are needs funded and serve defined populations enrolled in member GP practices. They provide population healthcare as well as treatment services, involve communities in their governance, and are multi disciplinary. Responsibility has also been assumed for management of equitably funded budgets for pharmaceutical and pathology services.

13.4.10. Equal is not Equitable: Medicare in the Bush

Stratigos, S., EQUAL IS NOT EQUITABLE: Medicare in the Bush. Rural Doctors Association of Australia (2002)

This document provides a detailed analysis of the Medicare rebate, in relation to remote and rural areas.

The paper argues that the standard Medicare rebate is based on urban cost structures and consultation content. These are insufficient to cover the higher costs of rural practice and thus act as a disincentive to recruiting and retaining rural doctors.

Rates of bulk billing are falling in country areas where patients whose health needs may be greater have to pay more for the services they need. The equal Medicare rebate no longer reflects the principles upon which Medicare was formed.

This study presents a strong case for a revised Medicare payment schedule, which takes into account rural, and remote health factors, as well as the economics of general practice.

The study points to long hours and worsening economics of rural practice and its ultimate effect on reducing access to general practice and bulk billing.

13.5. Examples of Further Relevant Studies

There is an enormous amount of available health policy literature available. Included here are some further brief reviews of studies loosely relevant to the Kimberley region.

13.5.1. General Practice: Professional Preparation for a Pandemic

Collins N., et al., 'General Practice: Professional Preparation for a Pandemic' in Medical Journal of Australia. (2006) vol.185 No.10 SS66-69.

This document states that General practice will play a key role in both prevention and management of an influenza pandemic. Australian pandemic plans acknowledge a role for general practice, but there are few published data addressing the issues that general practitioners and their practices will face in dealing with such a crisis.

The capability and structure of GP organisations is questioned in terms of readiness for a pandemic. The paper suggests that a local or regional program of training and communication protocols be established to map any pandemic as well as educating the public through information dissemination. It also suggests central funding of pandemic preparation with local or regional resource provision and allocation.

The paper observes that general practice will play a key role in both prevention and management of an influenza pandemic. Australian pandemic plans acknowledge a role for general practice, but there are few published data addressing the issues that general practitioners and their practices will face in dealing with such a crisis.

The document is included on the basis that a comprehensive pandemic management plan for the Kimberley should be developed. The current fragmented nature of the primary health care sector would appear to limit appropriate and timely response.

13.5.2. Tantalus and the Tyranny of Territory

Harvey, P.W., 'Tantalus and the Tyranny of Territory: Pursuing the dream of parity in rural and metropolitan population health outcomes through primary health care programs,' in Australian Journal of Primary Health. Vol.10, no. 3 (2004)

This article points to the inequity in health outcomes between urban and rural / remote people. It provides examples of collaborative care arrangements and makes suggestions for improvements to funding arrangements.

13.5.3. Long Term Trends in Indigenous Deaths from Chronic Diseases in the Northern Territory

Thomas D., Condon, J., et al., 'Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: A foot on the brake, a foot on the accelerator,' in Medical Journal of Australia. (2006) vol.185 no.3: pp145-149.

This paper examines trends in Northern Territory Indigenous mortality from chronic diseases other than cancer. These include six chronic diseases (ischaemic heart disease [IHD], chronic obstructive pulmonary disease [COPD], cerebrovascular disease [CVD], diabetes mellitus [DM], renal failure [RF] and rheumatic heart disease [RHD]) in the NT Indigenous population.

The paper found that mortality rates from IHD and DM in the NT Indigenous population have been increasing since 1977, but there is evidence of a slower rise (or even a fall) in death rates in the 1990s. These early small changes give reason to hope that some improvements (possibly in medical care) have been putting the brakes on chronic disease mortality among Aboriginal and Torres Strait Islander peoples.

This paper however is unable to clearly identify what measures, if any, have been responsible for improvements in health. This adds to our view that reporting and performance measurement of health interventions within the Kimberley are also currently inadequate for health planning purposes.

13.5.4. A New Approach to Primary Care for Australia

Doggett, J., A New Approach to Primary Care in Australia. Centre for Policy Development Occasional Paper No.1. (2007)

This document appears to be a major policy influence on the Community GP Super Clinic model now being implemented by the Commonwealth. It proposes 'one stop shop' multi-disciplinary clinics, with a preventative focus and consolidated patient records.

13.5.5. Our Hearts and Minds

Ring, I., and O'Brien, J., 'Our Hearts and Minds - What would it take to become the healthiest country in the world?' in Medical Journal of Australia. (2007) vol.187 No.8; pp447-451.

This paper proposes that Australia should aim to become the country with the lowest mortality rate in the world. The writers suggest that this could be achieved by benchmarking performance nationally and internationally, applying current knowledge

and available interventions, matching policies with funding, and implementing systemic national programs and activities to promote health.

It follows that the greatest impact upon the national health status would be achieved by focusing resources on preventative primary health care policies, with a focus upon Indigenous health.

13.5.6. Time to Talk to Australians about a Sustainable and Fair Health System

McBride, T., Time to talk to Australians about a sustainable and fair health system. Centre for Policy Development. (2007)

This paper calls for more engagement of community and consumers in health care issues. The writer makes a statement which should resonate within the Kimberley;

> "As well-meaning as the professions, health services, and government bureaucracies are, they are inevitably driven by their own professional, governmental or commercial paradigms and, in some cases, self-interest."[60]

13.5.7. AusAid Model

AUSAID, *Evaluation of Australian Government Funded NGO Projects in Africa.* Quality Assurance Series No.25, AUSAID (2000)

This paper details and evaluates the steps taken by AUSAID to introduce procedural and reporting standards into African aid projects, along with capacity building exercises.

We include this article as an example of how provision of primary health care in the Kimberley might be treated differently if it was a foreign aid initiative.

13.5.8. Increased Access to Evidence Based Mental Health Care

Hickey, I., and McGorry, P., 'Increased Access to Evidence Based Primary Mental Health Care: Will the Implementation match the Rhetoric?' in Medical Journal of Australia. (2007) vol.187 No.2: pp100-103.

This article points to strong evidence that coordinated systems of medical and psychological care (collaborative care) are superior to single-provider-based treatment regimes.

[60] McBride, T., Time to Talk, accessed at http://cpd.org.au/article/health-reform-time-to-talk-to-Australians

The writers suggest that the MBS payment system reverts largely to individual-provider service and fee for service rebates. They suspect that this will most likely result in high out-of pocket expenses and poor geographical and socioeconomic distribution of specialist services. It is also argued that primary health service delivery has not placed enough emphasis on systematically adopting evidence-based forms of collaborative care.

13.6. Conclusion

The review of recent literature suggests that there is a current shift away from reliance on GP based primary health care through private practice towards a more integrated and holistic approach to service delivery. This certainly appears to be the case with examinations of rural and remote service delivery capacity.

Papers specific to the needs of the Kimberley are fairly few, and the comprehensive Kimberley Regional Aboriginal Health Plan is now in need of being brought up to date.

The Kimberley Workforce Analysis published by WACRRM in 2006 details the dire situation in terms of provision of primary health care in the Kimberley through applying some reality tests to the percentage of time that GPs have available for this work. It is of considerable concern that governments do not appear to have acknowledged these issues, especially considering that this document highlighted the effect that this has on the most poorly resourced areas of the region.

The RDAA Viable models of rural and remote practice used detailed survey data to develop a set of benchmarks for sustainable rural and remote practice. It also, in addition to broadly accepted factors such as remuneration, indicates the high importance of hours of work, annual leave / locum relief and the amount of unpaid hours devoted to administration and professional satisfaction as being major determinants of sustainable practice.

If, as the evidence suggests, traditional stand alone practice structures are unviable in the region, or at best not to be relied on, then any alternative model of service provision would need to consider application of these benchmarks.

Multi disciplinary practice models would also require a set of benchmarks that deal with the conditions of allied health professionals.

Review of the literature indicates that detailed financial and infrastructure modeling of 'future practice' have not been undertaken, nor has there been any comprehensive review of introduced models in terms of performance and sustainability.

Alternative funding streams and regional health coordinating bodies are also generally absent from the literature and a strategic approach to their sourcing and make up would be worthy of investigation.

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15. Glossary of commonly used Non-Medical Acronyms

Table provided by KDGP:

A	
AAOT	Australian Association of Occupational Therapists
AAPM	Australian Association of Practice Managers
AASW	Australian Association of Social Workers
ABHI	Australian Better Health Initiative
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACHS	Australian Council on Healthcare Standards
ACHSE	Australian Council for Health Service Executives
ACIR	Australian Childhood Immunisation Register
ACRRM	Australian Council for Rural and Remote Medicine
ADA	Australian Dental Association
AERF	Alcohol Education and Rehabilitation Foundation
AFS	Audited Financial Statements
AGM	Annual General Meeting
AGPAL	Australian General Practice Accreditation Limited
AGPN	Australian General Practice Network
AHCWA	Aboriginal Health Council of Western Australia
AHHA	Australian Healthcare and Hospitals Association
AHW	Aboriginal Health Worker
AIATSIS	Australian Institute for Aboriginal and Torres Strait Islander Studies
AICD	Australian Institute of Company Directors
AIDA	Australian Indigenous Doctors' Association
AIM	Australian Institute of Management
AKMC	Annual Kimberley Medical Conference
AMA	Australian Medical Association
AMHW	Aboriginal Mental Health Worker
AMS	Aboriginal Medical Service
ANF	Australian Nursing Federation
AoD	Alcohol and other Drugs
APA	Australian Physiotherapy Association
APCCP	Australian Primary Care Collaboratives Program
APNA	Australian Practice Nurses Association
APodA	Australian Podiatry Association
APodC	Australasian Podiatry Council
APS	Australian Psychological Society (also Australian Public Service)
ARHEN	Australian Rural Health Education Network
ARIA	Accessibility/Remoteness Index of Australia
ASIC	Australian Securities and Investments Commission
ASX	Australian Securities Exchange

ATAPS	Access to Allied Psychological Services
ATO	Australian Taxation Office
ATSI	Aboriginal and Torres Strait Islander
B	
BAS	Business Activity Statement
BDP	Broome Doctors' Practice
BHS	Boab Health Services (also Broome Health Services)
BMC	Broome Medical Clinic
BOiMHC	Better Outcomes in Mental Health Care
BRAMS	Broome Regional Aboriginal Medical Service
BEP	Break Even Point
C	
CA	Corporations Act 2001 (C'wlth)
CACP	Community Aged Care Place
CAEP	Community Aids and Equipment Program
CAEPR	Centre for Aboriginal Economic Policy Research
CAT	Centre for Appropriate Technology
CCI WA	Chamber of Commerce and Industry of Western Australia
CDM	Chronic Disease Management
CDSM	Chronic Disease Self Management
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHSM	Clinical Health Service Manager
COAG	Council of Australian Governments
COTRB	Council of Occupational Therapists' Registration Boards of Australia and New Zealand
CPD	Continuing Professional Development
CRANA	Council of Remote Area Nurses of Australia
CRH	Centre for Remote Health
CSA	Chartered Secretaries Australia
CSP	Centre for Software Practice
CUCRH	Combined Universities Centre for Rural Health
CWA	Country Women's Association
CWP	Capital Works Program
D	
DAA	Dietitians Association of Australia
DAHS	Derby Aboriginal Health Service
DAWC	Drug and Alcohol Working Committee
DCP	Department of Child Protection (WA)
DGPP	Divisions of General Practice Program
DHAC	District Health Advisory Committee
DIS	Division Information System
DMO	District Medical Officer
DoHA	Department of Health and Ageing (C'wlth)
DoHWA	Department of Health Western Australia (WA)

DoN	Director of Nursing
DPI	Department of Planning and Infrastructure (WA)
E	
EAP	Employee Assistance Program
EFY	End of Financial Year
EPC	Enhanced Primary Care
EQuIP	Evaluation and Quality Improvement Program
F	
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs (C'wlth)
FBT	Fringe Benefits Tax
FHHS	Fremantle Hospital and Health Service
FS	Frontier Services
FTE	Full-time Equivalent
FVHS	Fitzroy Valley Health Service
FWE	Full-time Workload Equivalent
G	
GP	General Practice (or General Practitioner)
GPII	General Practice Immunisation Incentive
GPMP	General Practice Management Plan
GSMHN	Great Southern Managed Health Network
GST	Goods and Services Tax
H	
HACC	Home and Community Care
HMR	Home Medicines Review
HP	Health Promotion
I	
IAS	Instalment Activity Statement
ICC	Indigenous Coordination Centre
IHCAC	Institute for Healthy Communities Australia Corporation
ISO	International Organisation for Standardisation
IT/IM	Information Technology / Information Management
J	
JAS-ANZ	Joint Accreditation Standards of Australia and New Zealand
K	
KACS	Kimberley Aged and Community Services
KAHF	Kimberley Allied Health Forum
KAHPF	Kimberley Aboriginal Health Planning Forum
KAMSC	Kimberley Aboriginal Medical Services Council
KDC	Kimberley Development Commission
KDGP	Kimberley Division of General Practice
KEMH	King Edward Memorial Hospital
KIWG	Kimberley Interagency Working Group
KM	Kununurra Medical
KMHDST	Kimberley Mental Health and Drug Services Team

KPHU	Kimberley Population Health Unit
KRAG	Kimberley Renal Advisory Group
KRAMHPF	Kimberley Regional Aboriginal Mental Health Planning Forum
KSDC	Kimberley Satellite Dialysis Centre
L	
LGA	Local Government Area
LPI	Local Performance Indicator
M	
MAC	Medical Advisory Committee
MAHS	More Allied Health Services
MBS	Medicare Benefits Schedule
MD	Medical Director (also Managing Director)
MHN	Managed Health Network
MJA	Medical Journal of Australia
MMEx	Medical Message Exchange
MMR	Medication Management Review
MoU	Memorandum of Understanding
MPA	Multi-Purpose Agreement
MRN	Medical Registration Number
MSHR	Menzies School of Health Research
MYOB	Mind Your Own Business (accounting software)
N	
NACCHO	National Aboriginal and Community Controlled Health Organisation
NATSINSAP	National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
NCHS	Nindillingarri Cultural Health Service
NFP	Not For Profit
NGO	Non-government Organisation
NiGP	Nursing in General Practice
NPI	National Performance Indicator
NPS	National Prescribing Service
NRHA	National Rural Health Alliance
NRHSN	National Rural Health Students' Network
NRRHIP	National Rural and Remote Health Infrastructure Program
O	
OAH	Office of Aboriginal Health (WA)
OATSIH	Office of Aboriginal and Torres Strait Islander Health (C'wlth)
OBF	Outcomes Based Funding
OES	Ord Enhancement Scheme
OIPC	Office of Indigenous Policy Coordination (C'wlth)
OVAHS	Ord Valley Aboriginal Health Service
P	
PATS	Patient Assisted Travel Scheme
PAYG	Pay As You Go
PBS	Pharmaceutical Benefit Scheme

PDA	Performance Development Agreement
PGA	Pharmacy Guild of Australia
PGPPP	Pre-vocational General Practice Placement Program
PHCAP	Primary Health Care Access Program
PIP	Practice Incentive Payment
PM	Practice Manager
PN	Practice Nurse
Q	
QIC	Quality Improvement Program
QIP	Quality in Practice
QM	Quality Management
QUM	Quality Use of Medicines
R	
RAC	Regional Advisory Committee
RACGP	Royal Australian College of General Practice
RCS	Rural Clinical School
RD	Regional Director
RDAWA	Rural Doctors' Association of Western Australia
RFDS	Royal Flying Doctor Service
RHS	Regional Health Services
RHW	Rural Health West
RMFN	Rural Family Medical Network
RPH	Royal Perth Hospital
RRMA	Rural Remote Metropolitan Area (classification)
RTO	Registered Training Organisation
RWGPS	Rural Women's General Practice Service
S	
SARRAH	Services for Australian Rural and Remote Allied Health
SBO	State Based Office
SCGH	Sir Charles Gairdner Hospital
SEWB	Social and Emotional Wellbeing
SGAA	Superannuation Guarantee (Administration) Act 1992
SIP	Service Incentive Payment
SJA	Saint John Ambulance
SJoG	Saint John of God
SLA	Statistical Local Area (or Service Level Agreement)
SMO	Senior Medical Officer
SSU	Social Support Unit
T	
TCA	Team Care Arrangement
ToR	Terms of Reference
U	
UFPA	Unity of First Peoples of Australia
VW	
WACHS	Western Australian Country Health Service

WAGPET	Western Australian General Practice Education and Training
WAGPN	Western Australian General Practice Network
WALGA	Western Australian Local Government Association
WANADA	Western Australian Network of Alcohol and other Drug Agencies
WC	Working Capital
WHO	World Health Organisation
WSRGP	Workforce Support for Rural General Practitioners
XYZ	
YMHI	Youth Mental Health Initiative
YYAMS	Yura Yungi Aboriginal Medical Service

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