HEALTH IN THE KIMBERLEY

AN ABORIGINAL PERSPECTIVE

This submission was written by the Kimberley Aboriginal Health Planning Forum (KAHPF) at the request of the Kimberley Development Commission. It examines the issues determined by the Forums members to be the primary determinants of Aboriginal health outcomes in the Kimberley – September 2014

DRAFT FOR PUBLIC COMMENT

GOVERNMENT OF WESTERN AUSTRALIA

ROYALTIES FOR REGIONS

KIMBERLEY DEVELOPMENT COMMISSION

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1. EXECUTIVE SUMMARY

The Kimberley Aboriginal Health Planning Forum (KAHPF) is an inter-agency group of Kimberley health service providers focussed on improving the planning, coordination and delivery of primary health services to achieve better outcomes for Aboriginal people in the region. Membership includes the Kimberley Aboriginal Medical Services Council, Aboriginal Community Controlled Health Services from across the region, Alcohol and Drug Services from the region, the RFDS, WA Country Health Services, Boab Health Services, Kimberley Population Health and Kimberley Mental Health and Drug Service.

In 2012, all parties endorsed the Kimberley Aboriginal Primary Health Plan 2012-2015. This Plan was collated from existing planning and consultation documents and informed by Aboriginal health data produced by the Dept of Health. An updated version of this health data was produced in April 2012. We recommend reference both to the recommendations in the Aboriginal Health Plan and to current health data in the Blueprint.

1.1 RECOMMENDED AREAS FOR REGIONAL BLUEPRINT FOCUS

Aboriginal people in the Kimberley continue to have far worse health outcomes than both Aboriginal people in the rest of WA and their non-Aboriginal counterparts in the Kimberley.

For example:

- From 1997 to 2008, the mortality rates for diabetes, cardiovascular disease, respiratory disease, injury and poisoning, kidney failure, kidney disease, alcohol-related conditions and tobacco-related conditions were significantly higher for the Kimberley Aboriginal population compared to the Kimberley non-Aboriginal population.
- Between 2006 and 2010, all cause hospital separation rates were consistently at least 4 times higher for the Kimberley Aboriginal population compared with the Kimberly non-Aboriginal population.
- For 2001-2010, the all cause hospital separation rates for Kimberley Aboriginal children aged 0–4 years was 607 per 1,000 persons. This rate was 3.3 times and 1.4 times higher respectively compared with Kimberley non-Aboriginal children and State Aboriginal children.
- The leading causes of hospitalisation of Aboriginal people 2001-10 were dialysis, acute respiratory infections, skin and wound infections, influenza and pneumonia, and burns[1].

The region is experiencing what has been described as a tidal wave of chronic disease and mental health issues. Health service providers agree that continuing to do more of the same is likely to result in more of the same results. Instead, whilst maintaining the provision of services for people with diagnosed illnesses and servicing an increasing demand due to growth in the Aboriginal population (averaging 2% per year[2]), greater effort must be put into health promotion and early intervention activities which motivate people to take greater care of their own health.

[1] Aboriginal Health Profile 2012 (WACHS, Aboriginal Health Improvement Unit)

[2] Aboriginal Health Profile, Kimberley Health Region 2009 Dept of Health

There is a large volume of literature demonstrating how a child's early environment influences their health status in adulthood and whether that child is able to achieve its full potential in life – at school, in the work force and in society. Several smaller and/or more remote communities in the region still do not have access to safe drinking water or adequate sewerage disposal arrangements. Rubbish disposal, dust management and control of dogs are ongoing issues for many families, as are overcrowding and family violence.

Recommendations from KAHPF therefore revolve around 3 key areas:

1. Measures to address the social determinants of health, particularly the high levels of overcrowding and poor environmental health - in remote communities, reserves on the margins of towns and in the suburbs.
2. Measures to address the shortage of capital which is limiting expansion of health services – due to a lack of space in clinics and to a shortage of staff housing which exacerbates recruitment issues.
3. Ensuring greater equity in access to primary health services.

2. ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

The social, environmental and economic factors that play a significant role in shaping the health and wellbeing of individuals and populations are commonly referred to as the social determinants of health (SDH). Evidence documenting the contribution of the SDH to population health outcomes is well established and undisputed.

KAHPF recommends that urgent work is required in 3 key areas:

2.1 Housing

The links between overcrowding and infectious diseases such as scabies, hookworm and trachoma and life-threatening diseases such as pneumonia and rheumatic heart disease (RHD) are well established. KAHPF is concerned to note the recent spike in the incidence of RHD in children in the region.

KAHPF has been lobbying for more housing to be built in the region for the past 10 years. We strongly support the inclusion of funding for housing as a priority in the Blueprint for Investment.

2.2 Environmental Health

Environmental health programmes are designed to prevent the transmission of communicable diseases and reduce the impact of environmental conditions on community health. Despite the best efforts of organisations that provide services, due to limited funding many people in the Kimberley live in an environment that is not conducive to health and wellbeing. Management of rubbish, dogs, pests, dust and maintenance of community infrastructure has largely been neglected as each level of government has refused to take responsibility for addressing the obvious need.

Immediate priorities include:

- The need to 'Bind the Crown' - A change the WA Health Act to require publicly funded buildings and infrastructure on Aboriginal Lands Trust land to comply with local government regulations. (This has been discussed since 2006 but as far as we are aware, not yet implemented - probably because of debate over the next point).

- Funding to bring existing municipal services and government-funded buildings in remote communities on Aboriginal Lands Trust land up to a standard where they comply with Local Government standards.
- Finalisation of arrangements for provision of the appropriate level of environmental health and municipal services in remote communities. This necessitates resolving the standoff which has occurred since 2006 when a Bilateral Agreement on Indigenous Affairs was signed regarding Local Government taking over responsibility for providing local government services including waste management, roads, recreation facilities, air strip maintenance, street lighting, dog control, town planning, building control and emergency management. Shires in the Kimberley have refused to accept this responsibility unless they are provided with realistic and ongoing funding.
- Sufficient funding to deliver best practice environmental health programmes across the region, including community greening.

2.3 Improved Food Security

Eating good food is an essential part of bearing healthy babies and the management of chronic diseases. Although access to adequate food for a nutritious diet is a basic human right, many Aboriginal people in the Kimberley do not have the same access to safe, healthy food as non-indigenous people. Issues relate to the cost and quality of food, especially perishable food for sale in community stores, transport of the food to the community, health hardware in homes to store food purchased, and income to purchase food. Recent experience by KAHPF members (EON and UFPA) suggest it is difficult to effect sustainable change through community stores, or to influence customers to choose healthy food options even if the food is cheap without cooking and nutrition education which is linked to health messages.

Priorities for funding therefore include:

- Investigation and implementation of mechanisms to subsidise healthy food in community stores including ways to reduce freight costs and subsidise the cost of food storage
- Establishment of a standardised system for monitoring and evaluating the availability and cost of food in remote communities
- Funding to support the production of healthy foods within and by community through edible gardens and agriculture, along with capacity building and education to enable sustainability of the gardens and agriculture and to promote healthy food choices.
- Support for initiatives that give the children access to healthy meals and nutrition education on a regular and consistent basis.

3. ADDRESSING CAPITAL WORKS NEEDS

Kimberley primary health services are under critical pressure from unprecedented rates of chronic disease, learning difficulties including FASD and mental health issues including depression. In this context, suboptimal access to well-qualified health professionals from the necessary disciplines including GPs, dentists, community nurses, allied health professionals (including dieticians and community nutritionists, audiologists and speech pathologists) is no longer acceptable.

Due to a welcome increase in community outreach by health service providers (including allied health, mental health, specialists, aged care etc) and the increased demand for services from growing community populations and increasing ill health, clinics in remote communities and smaller

towns are unable to meet the demand for consulting rooms, treatment areas or group work spaces. Some clinics are old and in need of refurbishment to meet current best practice work practices and accreditation requirements e.g. for client confidentiality or pharmaceuticals storage. Few have group work areas which can support the health promotion and group work activities that are required to reduce chronic disease rates. In a competitive recruitment environment for health professionals, sub-optimal work environments serve only to reduce retention rates.

Aboriginal Community Controlled Health Organisations (ACCHOs) and other non government organisations e.g. Alcohol and Drug service providers cannot access GROH housing (a programme that has seen some expansion in the region) and are constrained from accessing private rentals for staff due to the limited/non-existent rental market outside major towns in the region. For example, the lack of housing for staff is a major limitation on programme expansion in Fitzroy Crossing, Halls Creek and most remote communities, and has already prevented services from effectively utilising funding they have received because of their inability to house staff or attract staff if housing is not offered.

There are numerous research articles detailing how staff recruitment and retention is significantly related to housing and appropriate working conditions.

The immediate priorities for funding are:

- Capital funding for the purchase/building of additional staff housing in Fitzroy Crossing, Halls Creek and the Dampier Peninsula
- Additional office space and counselling rooms for Kimberley Mental Health and Drug Service in Broome, Kununurra and Derby
- Major extension of the Bidyadanga clinic
- Replacement of the clinics at One Arm Point and Djarindjin
- New premises for Derby Community Health
- Extension for Fitzroy Valley Community Health
- Additional clinic space at Looma
- Renovation and redesign of Balgo clinic

In addition, the increased ill health and growth in the Aboriginal population in the region impact on the need for evacuations and inter-hospital transfers. Increased investment in the RFDS's transport infrastructure is required to meet this need.

4. ENSURING GREATER EQUITY IN ACCESS TO HEALTH SERVICES

4.1 Services distributed and allocated by need

The distribution of health services and health programmes in the Kimberley resembles a patchwork rather than a consistent pattern. While there are historical reasons why this has occurred, continuation of the inequity is not acceptable. As a basic principle, remote communities of a similar size and distance from town-based services should have equivalent levels of service. Recommendations regarding what these services should be are identified in the Kimberley Aboriginal Primary Health Plan 2012-15 (pg 19).

The immediate priorities for funding are:

- Operational funding for 3 Remote Area Nurses to provide an onsite health service with on-call capacity at Noonkanbah
- Capital and operational funding to create on onsite health service with on-call capacity at Wangkatjungka.

4.2 Dental Services

The need to address the overwhelming burden of dental disease among Aboriginal people in the Kimberley is urgent and continuing. A child who cannot sleep or eat due to toothache cannot be fit to attend school or be ready to learn. An adult with decayed or disfigured teeth does not create a good first impression at a job interview. The need for people with chronic diseases such as diabetes to have good oral health is well known – the lack of dental services is a significant limiting constraint on the effective management of chronic diseases in the region.

Evidence of the poor levels of oral health in the region is provided by Dental Health Services data (Figure 1). It shows, for example, that twice as many children in the East Kimberley examined by the dentist have tooth decay compared to the WA average.

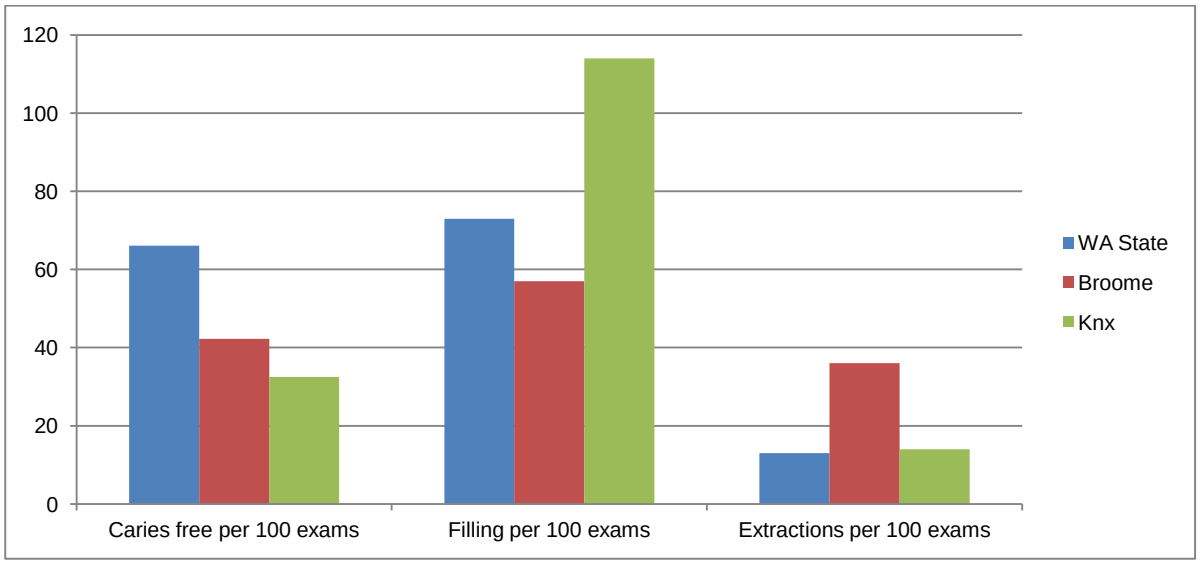

Figure 1: Dental treatment comparison of east and west Kimberley SDS January to June 2011 Source: Dental Health Services January 2012.

Current service delivery patterns are highly inequitous. For example, communities on the Dampier Peninsula are visited by Dental Health Service teams for 4 weeks a year. Similar-sized communities in the Fitzroy Valley receive no visits at all and Kutjunkga communities receive a very limited service. Whilst a voluntary group has addressed some of this shortfall in the past few years, their future presence should not be relied on as an alternative to government service provision.

While the data from 2011 (Figure 2) has been improved by the recruitment of dentists to the long-vacant positions in Fitzroy Crossing, the reality is that more FTE is needed to service Aboriginal

people in the region adequately. At present no children at schools in remote communities apart from Warmun have access to school dential services.

The immediate priorities for funding are:

- Employment of a dentist and dental therapist in Halls Creek to service the town and surrounding communities
- Additional staff resources to implement an extensive outreach programme to Fitroy Valley communities
- Provision of regular screening and free government dental care for all children aged 0-17

Community/ population size Yellow >500 Green>250 Blue 100-250 White <100	**No. Dental Health Service visits by dentists**	**No. visits School Dental Service (SHS)**	**No. visits Kimberley Dental Team (volunteers)**	**Army Aboriginal Community Assistance programme (AACAP)**	**Comments**
Kalumburu	4 days in June		2 days in May		
Bidyadanga	5 weeks				
Beagle Bay	4 weeks				
Lombardina/ Djarindjin	4 weeks)				
One Arm Point	4 weeks				
Looma	I day by visiting team ex Derby				
Jarlmadangah					
Dodnun			1 day in June		
Mt Barnett					
Noonkanbah					
Wangkatjungka	3 days at school Nov-Dec			2 months June/July	several communities
Bayulu				3 days	12 km to Fitzroy Crossing
Yiyili			I day in May		Children screened in 2010 by KDT
Ringers Soak			3 days May & June		School x 1 day; Clinic x 3 days
3 Kutjunkga communities	3 days in Nov		8 days May & June		Volunteers worked in clinic and school
Warmun	Patients travel to Kununurra Dental clinic on a regular basis	6 – 7 weeks Term 3	6 days (3 days Feb & Aug)		SDS visit included Frog Hollow students

Figure 2: Dental services to Kimberley communities in 2011 (adapted from Kimberley Aboriginal Primary Care Plan 2012-15 Page 87)

4.3 Population Based Funding Models

One of the major difficulties in planning services for the Kimberley region is obtaining realistic and consistent population figures for the Aboriginal population. ABS admitted to an undercount of Aboriginal people by as much as 24% in the 2006 Census. This is not a major issue AS LONG AS POPULATION –BASED FUNDING FORMULAE ARE NOT ADOPTED BY GOVERNMENTS. A recent paper produced in April 2013 by the Centre for Aboriginal Economic Policy Research (CAEPR) suggests that service populations should be estimated on a service-by-service basis.

We recommend therefore that:

- The Blueprint for Investment does not include any recommendation for population-based funding models.
- If the CAEPR recommendation is accepted, KAHPF recommends that the necessary data analytic expertise be located in the Kimberley.

References:

- Kimberley Aboriginal Health Planning Forum (2012) *Kimberley Aboriginal Primary Health Plan 2012-2015.*
- CAEPR (2013) New *directions in indigenous service population estimation*. WP 88/2013.

WACHS Planning Team (2012) *Kimberley Aboriginal Health profile*.