Marella Health Consulting

Growth planning for Broome: through the lens of health and wellness

Prepared for Creating Communities
August 2016

Contents

Key Messages

Aboriginal advancement

There is interest in new approaches and most importantly aspirations to shift well away from racism and 'old think' paternalistic policies and attitudes to dealing with prevailing problems – like poverty, welfare dependency, social stresses, violence, substance abuse, higher burden of disease and shorter life expectancy.

Solutions to the prevailing barriers associated with land/living 'reserves' in town and communities would be a major breakthrough and something everybody wants to see happen.

To reduce the number of lives dependent on welfare and support, Aboriginal people will need to be:

1. Healthy throughout childhood and school years; protected from harm, diseases and disabilities detrimental to their education and job/advanced education readiness – the strategy for a school based and primary health partnership has the potential to be a cycle breaker for the future generation of workers, professionals, partners and parents;
2. Well equipped with effective personal strategies to avoid lifestyle/chronic diseases – prevention strategies will keep young people protected from lifelong medications, inevitable disability; and reliance on welfare/support services;
3. Aspiring to and reaching for better lives - motivated by tangible job, career and personal/family economic possibilities – strategies for a more diverse economy with a range of industry and professional trades, careers, jobs and business enterprise; and access to local training, advanced education and academic research endeavour;
4. Entitled to achievable personal/cultural and material ambitions – strategies to further leverage personal, family and cultural strength and especially those derived through the direct and indirect benefits of Native Title, land ownership, Indigenous enterprise and equal power and authority in planning and decision making;
5. Content with their family, community, cultural and modern day lives as measures of wellness – strategies to improve housing and living conditions which enshrine family and community connectedness; remove imposed barriers/take care not to impose future barriers to the freedoms to access and enjoy cultural places and pursuits;
6. Very competent consumers and independent custodians of their own/family health, lifestyle and economic choices – education which skills up young consumers about the marketing game; navigating conflicting/confusing health and dietary advice, financial advice/coaching for younger people designed to help them set and work to goals (tools to acquire knowledge, social and financial/property assets and equity; how to use credit to advantage and how to avoid debt traps).

Structural changes – to services and funding

State government is looking for more effective funding/service consolidation solutions for town and community client groups in the Kimberley and Pilbara. They have identified a high degree of inefficiency; myriad programs and funding streams

and chronically plateaued outcomes when considered in context with the allocated resources.

The Office of Prime Minister and Cabinet are supporting the Empowered Communities development. This is also about looking for ways of getting resources to communities of consumers in ways that enable better outcomes and value for money.

Specialist medical, diagnostic and secondary treatment services

The range of services can only grow well beyond the status quo if there is a much greater and sustainable population growth than already factored into forward demand/supply planning assumptions.

Higher demand from more people usually creates a supply response if market conditions are right. Broome presents some barriers to entry by private sector operators into the service mix. Strategies designed to lower barriers to private sector entry will be needed if/when the population and economic growth gain momentum.

Bigger, younger populations expect modern health technologies

In small towns, people are usually content to settle for a basic range of services. As the population grows in response to economic/industry diversity and expansion, people will expect more contemporary service models. Examples are:

- Cancer/chemotherapy;
- Diagnostics – including MRI and breast screening;
- End of life – palliation for a range of conditions (not just cancer);
- Ambulatory/in-home hospital treatment;
- Midwife managed low risk family birthing;
- Mental health and social, emotional wellbeing and healing services.

Healthy ageing and aged care needs attention

This was discussed through two lenses and the report suggests there is a need for planning to address both aspects:

1. The increased demand for aged care services and infrastructure – as people suffer from earlier age onset of disabilities related to the current epidemic of chronic diseases; and
2. Measures to attract/retain more productive retirement aged people to continue living in Broome – it will be necessary to consider a range of residential solutions (designed to meet the unique lifestyles of different consumers) community and social facilities, amenities and services; and opportunities to participate in a self-determined mix of affordable pleasure/leisure pursuits and part time employment or volunteering work.

Health and schools working together

A primary health service built through health and school collaboration which leverages the constant and enduring relationship children and their families have with schools from a very young age should be further explored – starting with the proposal put forward by Broome schools and also taking into account the model used for ear health at the East Kalgoorlie Primary School in the Goldfields.

Synergies between industry and education and training

Re-energising workforce education and training in Broome needs to be stimulated by a workforce hungry sector of industry and service employers whose job and career offerings are sufficiently motivating to prospective course entrants.

Another aspect of education is growth, nurturing and economic potential of advanced and applied research knowledge aligned to industry solutions.

It was suggested an academic research and development centre be considered for Broome, based on a contemporary redesign of the Combined University Centre for Rural Health which was established in Geraldton many years ago. The underpinning model for this is that all of the universities in WA collaborate so that a rich array of courses, programs, areas of academic and applied research can be sourced, brokered and supported for students and employers.

Advocating for a new agenda – transformation and deriving economic benefits

A health and wellness agenda emerged – with no limitations placed on scope – and encompassed the need for measures which:

1. Increase employment, business and material prosperity prospects so people can afford a comfortable and satisfying lifestyle in a modern day world – and resulting in greater economic participation, independence, less reliance on welfare incomes and social support services;
2. Create and leverage intellectual and technical knowledge and industry know-how;
3. Help to advance community cohesion, deeper mutual respect and quality of living – improving sporting and leisure amenities; social and artistic activities; and very importantly a reality of friendly and safe neighborhoods;
4. Enable a celebration of the culture of the Indigenous people as well as that of Broome's own history - able to be shared with others; create greater inclusion of locals; offer enjoyment by/enrichment of visitors; and underpinning greater enterprise growth;
5. Enable freedom to enjoy access to traditional and contemporary places, lifestyles, pleasures and cultural practices;
6. Leverage the potential of Native Title settlements – the people, ideas, aspirations and possibilities; their ideas for land development; their influence; and their financial, intellectual and cultural resources;
7. Make Broome an attractive and affordable place for people to live as they grow older;
8. Cater for people's care needs as advanced age and/or related disabilities influence their decisions to stay in Broome or return to larger centres or cities;
9. Cater for people's physical, mental, family/birthing, community and end of life care needs through an adequate range of general and specialist medical, diagnostic and therapy technologies and services;
10. Reduce public health hazards; early onset preventable diseases and the high cost/low productivity consequences of the associated disability burden.

Addressing health concerns which will detract from economic participation and benefits

A transformation agenda aimed at improving health – in the prevailing environment where most of the most debilitating ill health is associated with chronic/lifestyle diseases – must encompass measures for prevention that actually work.

Prevention at a population level remains elusive in the prevailing public health policy settings.

Therefore, poor health and disability will continue to limit the scope for participatory benefits of economic growth for many in the community to the extent a great many people are not well informed and able to make good consumer choices.

Engage with and leverage Native Title

There are new avenues for transformative strategies being driven by the Yawuru and possibly other Native Title groups in Broome. Yawuru is actively participating in growth planning for Broome and the scope for economic benefits is significant given the land they own and the range of business and property development interests they have.

They are keen to explore leveraging opportunities for themselves and to benefit Broome as a community. There should be equal interest from the BGP group to explore how plans can be similarly leveraged to drive community wellness/advancement and economic benefits.

The much anticipated thesis by doctoral student –Yawuru women Many Yap – on the 'Economics of Liyan' may help to make ideas more tangible.

Leverage government reforms

There could be opportunities for different structures and government funding models through the reform space, although how these might be aligned with economic and/or health and wellness advancements in Broome has yet to crystallise.

Neither agenda is seeking out links with growth planning for Broome specifically.

The Broome development oversight/stewardship group suggested in this report might be a productive way to gain engagement in exploring beneficial interests and ideas central to or linked with the BGP.

Food is powerful on many levels

Food production, enterprise and export is on the agenda for Broome and Kimberley development. Prospective enterprise benefits (in addition to wage/salary jobs) for locals – including for Aboriginal people - should also be in focus as part of the future food production industry growth.

Rather than being seen exclusively as a vehicle for corporate enrichment and local jobs; the evolving food story in Broome and the wider region could be fully exploited for its capacity to better feed local people right throughout the region – at prices able to be managed by a great many people on low incomes.

Community action on health and better prevention measures

Community focus on better food quality and affordability solutions to prevent and reverse chronic diseases could be a powerful way to bring community, local industry and government stakeholders together.

Solutions involving local/regional food basics production, distribution, marketing, preparation, eateries and retailing infrastructure, systems and enterprise would be beneficial.

There could be enterprise opportunity in the traditional indigenous food and medicinal products, cooking (skills teaching) and meals/eatery models.

Schools and health collaboration

Engagement of the education system and the network of schools in Broome to leverage their potential for health advancement with a strong generational 'legacy' is a very exciting prospect to envisage.

Other than in tiny pockets, neither the school or health systems 'have their heads around this' and in reality, there is probably a mind field of territorial warfare ahead. Health are generally not very good at sharing their space with others; and many schools don't see themselves as responsible for health.

However, the power, leverage and legacy prospects from a school based and long range student and family health model is compelling and should be fully explored and developed.

In Broome, the schools have already begun applying themselves to the potential for health measures to become built around their relationship over years with students, their siblings and their families. This should be further explored and supported once a workable model is agreed – even on a pilot basis.

Private sector involvement in an expanded range of specialist medical, diagnostic and allied health services

This is not envisaged as a likely option for viability reasons (high entry and operating costs as well as marginal consumer volumes) in current forward capacity planning assumptions for the next decade.

If the Kimberley Blue Print and BGP do cause a paradigm shift in growth with sustained momentum, the planning assumptions will need to be adjusted and it may present an opportunity to explore greater private/public mix of services in health.

This would be a big change from the status quo where government is the only operator of diagnostic and secondary treatment services. A greater proportion of private sector providers would add another dimension of economic productivity related to health.

Growing a healthy and productive older population

Older people – retired and semi-retired – are valuable within a growing local economy and at the present time, this aged group is relatively small in number for non-Aboriginal people.

They can continue to participate in employment and they are consumers of a wide range of products and services.

Healthy ageing is the ideal of course, however, as age advances people's residential and care/service needs being to change. Being closer to services and supports and being able to access the right type of residential solutions are factors believed to be influencing older people to leave Broome.

So changing from this status quo would require some worthwhile investigation and planning as part of the growth plan. The planning would be an excellent opportunity to explore the unique aspirations and models suited to the Indigenous aged people and their families as well as the standard/westernised models we typically think about – nursing homes, retirement villages.

Building awareness, optimism and motivation

Promoting the growth plan in ways that encourage thinking and innovation through a range of measures – for example, talking to high school and advanced education and training students, talking in the media and encouraging discussion in corporate, business and public forum settings.

An ability for people to access planning/advisory services to explore opportunities for small enterprise development could be an advantage – as well as some capacity for 'incubating' small enterprise and innovations.

Enhancing Broome's 'brand' as a welcoming and accommodative regional services and visitor destination centre.

It wasn't too many years ago when Derby was the regional centre for the Kimberley and most government services had their regional offices and accommodations in that town. Progressively many regional operations and corporate offices have relocated to Broome and some divide between Broome/Derby and Kununurra.

Being designated as a Regional Resource Centre, the hospital in Broome has undergone redevelopment and expansion from its former role as a small district hospital servicing the needs of the Broome community to being the central operation base for the highest level/capacity clinical services for patients from all over the Kimberley.

This dictates that many more people from around the region need to come to Broome for health care; and indeed for other government services. The ability to 'digest' the knock on consequences of this has taken some time and is still a work in progress to some extent. It will be exponentially a greater effect if and as populations in Broome and indeed right across the Kimberley grow as envisaged in the next two decades.

Tourists are the market most typically catered for by businesses in Broome. There are and will continue to be a greater number of health tourists from around the region; as well as intra-regional people who go to Broome for holiday breaks and to access goods and services only available in this larger centre.

A variety of hospitality and leisure solutions are needed; and public transport is another aspect needing some attention – both creating potential for enterprise responses.

Introduction

The context for this piece of work is the work being done to articulate a comprehensive growth plan for Broome as one component the Regional Centres Development Plan (RCDP) being driven by the WA Department of Regional Development (DRD).

The aims of the RCDP are to help designated regional centres such as Broome to realise their economic potential and create a flourishing community that is highly attractive to external investors[1].

Serving as a platform for developing the BGP are key documents published by the Kimberley Development Commission:

- The Kimberley Regional Investment Blue Print;
- The 2013-18 Strategic Plan; and
- Kimberley: a region in profile (published by DRD).

Some contemporary profiling, planning and survey work undertaken by the Shire of Broome have also been briefly examined:

- Broome Economic Profile
- Broome Community Profile
- Community Survey.

This particular exercise undertaken for Creating Communities was intended to explore prospective economic development and population growth (as envisaged for the BGP) from health and wellness perspectives.

The scope of inquiry, research and analysis is pitched at a high level as the timeframe for this work was short.

Situational Analysis

A few general observations are offered:

Not surprising was that the agencies and individuals able to be engaged during this exercise are all concerned that economic, industry and population growth in a future Broome is balanced enough to underpin material progress and improvement for the community and all of its people.

Some people were sceptical and even cynical – they see growth based on industry (especially resource and agricultural industry with environmental impacts) would enrich big corporates and a small number of 'local fat cats'. In the same vein, they talked about 'token' initiatives for community wellbeing as having little value unless they are genuinely and adequately targeted to improve inclusion, cohesion and broader enjoyment of the benefits over the long term.
The dimension of wellness as distinct from health care/illness was overwhelmingly what people wanted to talk about. This included the health service providers as much as the agencies and individuals whose interests sit more within the community development and advancement domains.

[1] www.drd.wa.gov.au Regional Centres Development Plan

It was virtually impossible for discussions of health and wellness not to be predominantly focussed on the needs of the Aboriginal people of the community; Prevailing themes in wellness were:

- Greater inclusion, participation sharing of benefits;
- Changes in the power and intellectual dynamics post Native Title and the potential for this as a 'game changer';
- Various assumptions and views on 'community closures' and service /funding reforms;
- Looking beyond government's ability to design and execute effective solutions at national and state levels;
- Prevention of a wide range of diseases through regional/local foods.

Broadly considering wellness as being happiness and a state of satisfaction with measures of quality of life, many people talked about things like:

- Opportunity for paid work in a chosen field that pays well;
- Good living conditions and a manageable cost of living;
- Financial security;
- Employment security and career satisfaction;
- A good state of mental, emotional and physical health;
- Good municipal services;
- Justice, fairness and equity;
- A living environment and lifestyle that supports good general health – good quality foods and food security, community amenities for leisure, activity; sports and social groups/clubs;
- Harmonious and peaceful community and neighbourhood dynamics with good social behaviour standards;
- Safety and security;
- Freedoms and choices – self-determination, self-agency, sufficient influence and control over own life and wellbeing of self and family;
- Access to the things they need most – housing, income, mobility, communications, social contacts, family support, entertainment, recreation, services and advice;
- A community where there is fairness for all people; and where there are cohesive, inclusive and respectful relationships between the different cultural groups.

It is stated[2] that western measures of wellness are not sufficient for Indigenous people, albeit they might serve as statistical measures of use to governments and their programs.

A research paper[3] published in August 2016 by Mandy Yap and Eunice Yu – both Yawuru women – reports in great detail on qualitative and quantitative research on concepts and definitions of wellness undertaken by and amongst a sample of Yawuru Indigenous people in and from Broome.

These concepts of wellness from an Indigenous perspective – are defined for the first time with academic rigour by people who are centred within the status quo of health and wellness in Broome right now. Importantly, people are considering not

[2] Operationalising the Capability Approach: Developing culturally relevant indicators of Indigenous Wellbeing – An Australian example. Mandy Yap and Eunice Yu

[3] http://www.curtin.edu.au/local/docs/bcec-community-wellbeing-from-the-ground-up-a-yawuru-example.pdf

only the multi-dimensional frame of wellness from an exclusively cultural perspective; they are also clearly seeing wellness in a contemporary, modern world view and there is some thinking as so how material essentials for a good life and good health are fitting in alongside the cultural frame.

Wellness was defined by study subjects as a mixture of measures essential to 'mabu liyan' or health and wellbeing of the spirit/soul and inner self. These are shown below:

- Family wellbeing – the strength of connectedness to one's family;
- Community wellbeing – it is necessary for one's community to also have wellbeing;
- Strong culture, country and identity – knowledge of culture and stories, about flora and fauna on country, about fishing and hunting, about eating traditional foods and knowing how to prepare them, and about knowing the language;
- Self-determination, rights and autonomy – this mean more than just an ability to 'have a say'. It is about feeling one's rights are genuinely respected and that people are free to exercise decisions and rights;
- Health and wellbeing – the necessities to live a healthy life and have help when needed for physical health;
- Material wellbeing – having an education, good employment, steady income and being able to afford the basic things that make modern life comfortable, satisfying and safe such as housing and transport for mobility;
- Subjective wellbeing – a person's overall rating of their feelings about their state of wellbeing – how good and satisfying personal, family community, modern world and cultural life balance is.

The report quotes a number of statements by study subjects which illustrate how overall wellness is challenging for some contemporary Indigenous people and they reflect the mix and balance of 'normal and basic' material essentials (like income, housing, financial and lifestyle resources) together with the essential cultural measures. For example:

- One person spoke of needed to redefine the contemporary settings of our sense of wellbeing – it has to have the normal material kind of issues like health, income and housing.
- Another observed that there needs to be room for economic and cultural and social wellbeing.
- One individual expressed this as feeling under pressure to sustain both culture and work – having to live in two worlds where surviving financially means working fourty hours a week and cultural activities having to be fitted in on weekends. They observed that this was hard.
- A couple of quotes from younger study subjects were clear about measures of a good life – such as having all the necessities like clothes, money, a car and probably my own house. Another statement reflected on ambitions and dreams – ticking the milestones, finishing school and going to university.

The Current State – A broad description of the health service and wellbeing provision system/s

State government hospital and health services

The region itself influences health care provision decisions by governments and the private sectors.

The WA Country Health Service (WACHS) operates all government hospital services in the region in addition to population health, community, school, child and mental health services in towns and several remote communities.

Their planning and operating model is based on a 'hub and spoke' network. In each of their seven WA regions with the exception of the Wheatbelt, one of their hospitals in the largest regional centre (Broome in the Kimberley context) is designated as the 'Regional Resource Centre' (RRC).

The RRCs deliver the highest range and level of service and support the hospitals and other health services and teams in other regional places.

Typically, the specialist medical, diagnostic, allied health and population health services are based in the regional centre.

The hospitals and health services around the regions are then accorded specific designations which prescribe their range and level and capacity in some detail.

The entire WA Department of Health (metropolitan and regional service systems) now plan and develop services aligned to a comprehensive Clinical Services Framework (CSF). The prescribed services range and levels are projected forward based on combinations of modelled population and consumption patterns.

The prevailing CSF 2015-25 documents the services provided by the Broome Hospital and other WACHS services working in and from Broome.

> A growth plan which realised faster and more material population growth within the Broome Shire and wider region would likely necessitate earlier re-modelling of the CSF – assuming also that lowered barriers to entry of advanced level services and a stronger private sector may also be positive factors to enable material service expansions.

All of the Kimberley's major townships as well as the regional centre in Broome are a long way from Perth where the major publicly funded and private sector diagnostic, treatment and therapy systems are based.

As in other WA regions, the health care/referral system relationships are exclusively between each region and Perth providers. There are very few service linkages with referral and transfer/transport pathways between WA regions (for example between Broome and Port Hedland). Outside of WA, the Royal Darwin Hospital is used as a referral destination mainly for East Kimberley inpatients due to its relative proximity and depending upon its capacity at the time of requests.

Off all WA regions, the Kimberley is somewhat unique in health system planning because:

- The total population is relatively small and Broome as the regional 'hub' is also a much smaller population (15,000-17,000 estimated) than Geraldton, Kalgoorlie, Bunbury and Albany which have more than 30,000;
- The small population combined with serious cost and clinical viability detractors are constant barriers to advancing hospital services in Broome beyond current range and levels;
- The commercial viability of private sector health services is limited by big barriers to entry for general practice, routine medical specialties, advanced diagnostics, advanced secondary hospital clinical care systems like intensive and coronary care units, private hospital services and a full range of allied health/therapy services;
- The absence of a good range of private health sector options expresses itself through low levels of private health insurance, the cost of which is generally well beyond the means of many of the highest need/consumer group;
- Aboriginal Community Controlled Health Services (ACCHS) are major players throughout the region in provision of culturally aligned primary health and GP services;
- In the absence of private or ACCHS GPs who bulk bill, WACHS (mainly through their hospital emergency departments and also in their remote community clinic services) continue to provide 'default' free primary medical services;
- There are a huge number of remote communities throughout the region of varying population sizes and infrastructure/services capability and servicing arrangements;
- The population is uniquely 'young' in structure;
- Community and residential aged care provision is geared mostly (but not exclusively) to Aboriginal consumers;
- Many non-Aboriginal people leave the region (and Broome) when they begin to age to a point their residential, care and family support needs begin to manifest;
- Other than standard model residential and in-home aged care/service solutions, 'retirement aged' living facilities, amenities/attractions and services best suited for older Aboriginal people and their families have not been well conceptualised or materialised;
- Solutions for an older (but not yet requiring care) non-Aboriginal population are generally not a priority due to the younger age structure and relatively low numbers of non-Aboriginal people who chose to 'age in place';
- The greater proportion of WA's Aboriginal population live in the Kimberley and the proportion of Aboriginality in the major townships range from upward of 80% in Halls Creek and Fitzroy Crossing to an estimated 35% in Broome.

Primary health services – NGOs, state government and private sectors

Community Controlled Aboriginal Health Services

These operate from clinics based in Broome, Derby, Halls Creek and Kununurra. They are each independent with their own constitution and board of directors and they all service a number of outlying communities in their district.

The Kimberley Aboriginal Medical Service (KAMS) is based in Broome and functions as an umbrella/support organisation for its members (who control the organisation via the governance board). KAMS also delivers direct primary health services to the remote Kutjunka region (Balgo, Bililuna and Mulan) and to the Dampier Peninsular and Bidyadanga. They deliver renal dialysis services in Broome, Derby, Fitzroy Crossing and Kununurra under contract to WACHS; operate a population team; and provide the Head Space (mental health) service. They also operate their own Registered Training Organisation; and host the UWA's Rural Clinical School.

Other NGO primary care services

Boab Health Service is an established provider of non-medical primary health services for patients with one or more chronic diseases and who wish to have a supported program to help them manage their conditions and lifestyle modifications.

They operate from and in Broome and are also active in the East Kimberley.

Allied Health

In Broome, private physiotherapy services are quite commercially viable thanks to the demand from a significant young professional, sporting and industrial market.

There is one private podiatrist in Broome. Other than these therapy services, there are no private allied health services in Broome or other parts of the region.

Pharmacy

Broome currently sustains four private pharmacies in a very viable retail market. Kununurra and Derby are also able to sustain private pharmacy businesses.

Private medical services

There are four private GP practices in Broome; much less in Kununurra; and as yet none in any of the other towns (Derby, Fitzroy Crossing, Halls Creek and Wyndham).

Specialist medical consultants

There are no region based specialist consultant and diagnostic providers outside of the public system.

Regional based specialists cover the basics of:

- Generalist physicians;
- Obstetrics and gynaecology;
- Surgical;
- Paediatrics;
- Psychiatry.

Otherwise, specialist services are supplemented by visiting specialist arrangements funded by WACHS and/or with funding support from Rural Health West in Perth (a commonwealth funded rural health service workforce 'commissioning' body.

Diagnostic services

The region is well enough served for clinical pathology although this would need to expand in range if there was a paradigm shift in population and demand growth

followed by a significant expansion of level and range of hospital services in Broome and other parts of the region.

Medical imaging is well covered for XRay but not for MRI which has become a clinical necessity in diagnosis in many specialty areas.

A Broome MRI service (public and/or private) cannot be supported for the Kimberley with current population levels or even at projected population levels encompassed with the CSF to 2025 based on current growth/consumption patterns.

The absence of MRI diagnostics in the region dictates a range of other specialist medical services are also not very viable; and that patients requiring this type of imaging will continue to be referred/transferred to Perth for their diagnostics and quite probably also for their medical/procedural treatment.

Primary health care financing and investment – national government reforms

In Australia, state governments are responsible to finance and operate public hospitals and a range of other non-hospital programs (community health for example).

Primary general and specialist medical care outside of the public/hospital system is the responsibility of the for-profit private sector funded/reimbursed through Medicare (financed by the Australian Government).

Private medical services are not 'regulated' in terms of where business owners choose to operate. This has resulted in medical business/workforce and service distributions consolidated in places where market forces prevail.

The more remote places with lower numbers of more complex patients in the market (higher cost and lower profit margin); where the barriers to entry (operating and living costs) are high; and living conditions not so attractive to professionals and their families are typically underserved.

The Kimberley demonstrates this 'maldistribution' system better than most places in WA; although the gaps have been significantly lessened with the establishment of Medicare bulk billing and supplementary block and grant funded ACCHS (through salaried GPs) throughout the region.

Various governments have been collaborating on major health system reforms for several years and most especially (although not exclusively) in the primary medical sector to try and better engage and focus the GP services.

The most recent/current approach is Primary Health Networks (established in 2015). These are exclusively commissioning bodies and don't deliver services.

There are much higher expectations for preparation for and execution of commissioning functions for primary health services and in the Kimberley region, what they do will be critical to strengthening the secondary prevention/disease management effort.

In WA, a new organisation called the WA Primary Health Alliance (WAPHA) has been established. It is a NGO sector incorporated enterprise. They are Perth based but operate an extensive country arm and have a small office in each region and for the Kimberley, this office is based in Broome.

Other significant national health reforms

Significant funding reforms for hospital services nationally are underpinned by the introduction of Activity Based Funding/Management (ABF/ABM). This is essentially a financing model where volumes of certain types of services are purchased/funded to state governments based on need/consumption patterns and best practice; and also valued on a Nationally Efficient Price (NEP) benchmark.

This presents WACHS with challenges as the actual costs in the WA regional system, most especially in the Kimberley, are so much greater (and probably always will be) than the NEP benchmark.

Finally and perhaps most importantly in terms of the national reforms are the intended synergies between primary and hospital systems. The two systems are intended to function collaboratively – ensuring reduced demand for hospital admissions for preventable conditions. Hospitals for their part must ensure there are much better transition to primary care systems in place.

Wellness and services aligned to wellness

Primary health service providers in the ACCHS, other NGO, government and private sector would lay claim to a wellness agenda and service profile.

This would also include the population health service units in WACHS and KAMS which operate from Broome.

Similarly, environmental health services would see themselves in this space also.

Mental health and drug and alcohol services deal with complex cases therapeutically but a good measure of their models of care embrace general wellness at the person and household/family levels.

Collectively, the grounds for this are that they are concerned to prevent disease and in so doing, promote a state where wellness is created or at least made more possible. They do this by way of:

- Influencing prevention of disease and illness through their actions in educating and promoting good personal, domestic, community and lifestyle knowledge and applied behaviours;
- Screening of health markers and to identify possible and/or existing health hazards and risks;
- Provision of early interventions designed to protect and restore good health and limit exposures to future risks and decline;
- Acting early and systematically on communicable and non-communicable diseases and outbreaks;
- Respond to community concerns about health issues and risks – for example, in the areas of substance abuse (crystal meth being a very contemporary matter) and outbreaks of suicide including in young children outside of the mental illness domain;
- Influence plans, strategies, actions and health policy designed to promote and improve wellness;
- Considering the impact/s of growth and development strategies on public health.

Community sector services and wellness

Outside of the health service system itself, there is a much broader sector engaged in various aspects of community wellness.

There are some emerging developments – such as surveys, research work, new models and engagement in business and planning which have been empowered consequent to the Yawuru Native Title determination. There are now powerful forces for good at work on several fronts examining questions from a uniquely Yawuru (and more broadly local Indigenous) perspective.

Apart from Yawuru, there are a number of community service styled organisations – mostly Aboriginal owned and controlled but some not – operating in the general wellness space and targeting social problem amelioration (such as meals, counselling, pre-post custodial release support and the like); enterprise creation; training and employment; and other means of advancement of interests.

This exercise has of necessity been only superficial in this domain. Indeed it would require a rather more extensive study to map and examine all the organisations, funding streams and initiatives in process at the present time.

For now though, the most impressive endeavour was observed to be the models and initiatives being developed by some very key agencies and what appears to be a 'thought and action leadership collaborative'. The intellectual capacity (which has been around for a very long time) is emerging and becoming increasingly influential and empowered due to contemporary developments.

Whilst there was that 'vein of dissent' about prospects for major economic and population growth (for fear that the Aboriginal community, the environment and the local community other than the 'fat cats' would get very little benefit); there was surprisingly a very strong thought and action front from contemporary Indigenous leaders to join in and help design and guide the solutions.

They appeared to have a strong conviction that there is a far better way to do things other than to wait for government programs to sort things out; and that there are huge benefits to be had for Indigenous people generally, Yawuru in particular and the general community of Broome in taking a place around the tables in the BGP development.

Clearly, the thinking is that wellness – and indeed health itself – will be greatly enhanced if there are equal opportunities for Aboriginal enterprise and inclusion in future developments in mainstream industries; and also in a range of enterprises being nurtured within the Aboriginal land holding and organisational domain.

Aged care services

The aged care services available are structured as they are in other places – governed by the commonwealth government's aged care services resource allocation policies and the provider industry funded to provide various types of care.

A long standing goal in aged care is to keep elderly people living at home for as long as possible and provide in-home and community based care and supports to enable people/families achieve this goal.

Residential nursing home care is available in mixtures of low and high care formats and for people caring for elderly at home, the residential sector usually accommodates some respite care availability.

There are significant planning challenges to addressing aged care:

- Aged care cannot be dealt with in isolation from the chronic disease burden and its impact on premature ageing and disability;
- Disability will continue to drive non-Aboriginal older/retired people away from Broome as their care needs transcend the range and level of services available locally;
- Aboriginal people will continue to succumb to these diseases at a higher rate and with greater early age onset in the absence of more effective prevention;
- New medical and surgical breakthroughs may keep people alive longer, but the burden of disability and demand for care will grow;
- A significant driver of demand for aged care services will be the upward trends in earlier age onset dementias and Alzheimer's Disease; loss of limbs due to diabetes, partial paralysis following strokes, loss of vision, autoimmune and neurological conditions resulting in severe physical disabilities.

To the extent the issue of ageing was raised at all during the consultations for this exploration, the interest was not about 'aged care services' but rather about exploring measures to encourage people to keep living in Broome as they begin to age.

At the present time, there is a trend for many people who have lived for several years in Broome to return to live in cities or other places closer to service and family contacts as or before they begin to age. Elders in the Aboriginal context have enormous cultural value. Older –retirement aged but well and generally productive – people generally have great value within families.

Senior people often have time to contribute to community endeavour through volunteering and/or part time work and many have a great deal of knowledge, skills and wisdom to impart to others. This suggests that a future planning agenda is emerging around the aging population and may need to be addressed through two specific dimensions:

3. The increased demand for aged care services and infrastructure – as people suffer from earlier age onset of disabilities related to the current epidemic of chronic disease; and
4. Measures to attract/retain more productive retirement aged people to continue living in Broome – it will be necessary to consider a range of residential solutions (designed to meet the lifestyles of different consumer markets) community and social facilities, amenities and services; and opportunities to participate in a self-determined mix of affordable pleasure/leisure pursuits and employment or volunteering

Overview of current health and wellbeing/ statistics and outcomes for Shire of Broome

The scope of this exercise has not allowed for a thorough going gathering, analysis and presentation of health and wellbeing statistics.

Most of the health outcome statistics gathered during the project relate to the Kimberley as a whole. However, they can reasonably be assumed to reflect outcomes for Broome as well, especially for the Indigenous population.

For Broome itself, very little has been obtained which is exclusive to the area other than Indigenous population enumeration (done in 2011 through the Knowing Your Community (KYC) household survey[4]); some numbers on homelessness and social meals provision; and community perceptions[5].

A 'potpourri' of statistics and estimates of health and wellbeing for the Kimberley (reflective of Broome generally) and Broome in particular is summarised in this table.

Table 1: Some Kimberley and Broome health and wellness statistics to consider

Category	Summary detail
Population and growth outlook	Projections vary in different reports: – Living in the Regions 2013 (DRD publication) said Broome's population was 17,251, with 35% Indigenous and had grown 2.2% over the previous 10 years; and projected that by 2023 the population would be 44,0000 for the Kimberley region; – The Kimberley Blueprint (KDC) projects a Broome population of 48,500 by 2036 and a total Kimberley population of 93,173 is possible if the type and scale of envisaged economic growth occurs. The Blueprint also estimated the impact on new jobs creation in this projects at about 34,000; – The Knowing Your Community (KYC) household survey to better enumerate Broome's population of Yawuru/Indigenous people and households reported in 2011 there were 3712 people in 997 households. Even allowing for some growth over the 5 years since the ABS 2006 census, the population count was 61% higher. There was a big difference in the number of households as well – 686 in ABS 2006 versus 997 in KYC survey 2011. Importantly, the 'service population' of Indigenous people in Broome (8763) was very similar in both ABS Census and the KYC survey.
Stolen Generation Legacy	– In 1958, 25% of Indigenous Kimberley adults and 45% of the children were living in mission settings following removal policy through to the 1970s[6]; – 96% of Kimberley Aboriginal people belong to a family were members were removed[7].

[4] Statistics for Community Governance: The Yawuru Indigenous Population Survey of Broome, J Taylor, B Doran, M Parriman, E Yu. Centre for Aboriginal Economic Policy Research, ANU College of Arts and Social Sciences (CAEPR Working Paper 82/2012)

[5] Shire of Broome, Community Perceptions, 2015

[6] Kimberley Stolen Generation Aboriginal Corporation website

[7] Kimberley Aboriginal Health Planning Forum: Suicide Position Paper 20 May 2016

Suicide	– 71% of the people who suicided 2004-2014 did not have a mental illness and had no contact with mental health services; – Determinants of suicide[8] are violence, dysfunction, homelessness and poverty (data not sourced but prevalence is known to be high); – A 2013 spike in Acute Rhematic Fever followed by a spike in post streptococcal kidney infection are outcomes of overcrowding in housing, very poor domestic/environmental conditions and the potential for "menacing impact on young people living in these conditions".[9] – 75% of completed suicides in the Kimberley occurred amongst Aboriginal men; – Aboriginal children regularly attend funerals of relatives who die prematurely and frequently from suicide and violence (statistics not known); – The 'Feed the Little Children' service are providing around 300 meals to hungry young people on Friday and Saturday nights in Broome and crime statistics by youth are lower as a result.
Homelessness	– Centacare in Broome[10] reported over 1400 homeless and at risk adults and children are on their books; – They provide meals for 50 individuals per sitting; – There are around 87 new people turning up each month in need of food and help; – 8 out of 10 of the murder victims in Broome in the last 3.5 years have been alcohol related and in people who don't usually reside in Broome; – 'Rough Sleepers' are more likely to die prematurely; – Regionalisation of services (like health care) stated to be contributing to homelessness and need for meals and social assistance – placing stress onto the community and needing better hospitality solutions.
Health	In their Kimberley Health Profile[11] WACHS provides a broad overview of health statistics and outcomes: – Low SEIFA scores indicate high exposures to the determinants of health; – Heart and vascular diseases and cancers caused two out of three of all deaths; – Mortality from alcohol and tobacco was higher for the Kimberley than for WA as a whole; – Around 66% of deaths in the Kimberley in the decade 1997-2007 were due to potentially preventable conditions – ie, prevented from occurring in the first place (primary prevention); – More than half of the deaths could have been avoided through better primary health care management of diagnosed conditions (secondary prevention including lifestyle/diet modifications); – Crude rates for notifiable diseases (particularly STIs) were higher in the Kimberley than WA as a whole (2009/10); – In 2008, one in four Kimberley Aboriginal women who gave birth were aged under 20 years and three in five smoked during pregnancy; – In 2009, the proportion of Broome children rated as developmentally vulnerable was 31.4% (compared to 56.3% in Halls Creek); – In Fitzroy Crossing, 1 in 5 children have FASD[12] - this is a particularly bad area for FASD but reflects also that the problem is region wide.

[8] Suicide 2020: Mental Health Commission 2015
[9] KAHF Suicide Position Paper
[10] Fr Matthew Digges: Article on Homelessness (website)
[11] WA Country Health Service (website) regional profiles
[12] June Oscar, Fitzroy Crossing

	Chronic diseases These are metabolic dysfunction, weight gain and diabetes; micro/macro vascular diseases; and cancers. They are a global epidemic and public health crisis affecting a lot more Aboriginal people due to the poorer foods and lifestyle risks but also non-Aboriginal people in ever growing numbers. These conditions will be massive drivers of demand for health, disability services and service for people who have aged prematurely. Renal disease[13] is a metaphor: – For underlying exposure to chronic diseases with high morbidity and premature mortality and outcome gaps; – As at February 2016 there were over 2000 cases of diagnosed renal disease in various stages; a vast quantum of undetected disease was a certainty including in children; – There were 108 people having regular dialysis treatments in the Kimberley and around 70 late disease stage patients expecting to transition to dialysis in the next 6 to 18 months; – It costs around $100,000 per patient per year for dialysis treatments in the Kimberley units. BRAMS activity – The health service has 7,500 active enrolled clients on their books; – They do 40,000 episodes of care each year; – They have 2,737 chronic disease cases under active management and this is 30% of their client load.
Food costs	Food cost survey – Food across the Kimberley costs 26.1% more than in Perth[14]; – The increase in food costs in 2010/2013 was mostly in fresh vegetables and fruit; – Welfare recipients need to spend a higher proportion of their disposable incomes on food than others – food cost stress is a factor once >25% of income is required for food; – All single parent families on welfare are at risk of food cost stress Food generally – Poor quality, poor access, high cost and poor consumer knowledge and skills) is a major contributor to chronic disease.
Community perceptions	– Lifestyle and happiness were rated highest for the Kimberley (78-80%) and safety, education and training were rated the lowest (57-70%)[15] – Community survey[16] of people living in Broome and the surrounding rural areas rated the town high as a place to live (85%) and visit (82%) but very low on measures of community governance (48%). Much of the dissatisfaction related to anti-social behaviour – In the remote communities of Broome, the survey of those people rated the communities very high as places to live (91%) and visit (94%) but again very low (44%) on community governance.

[13] KAMS and WACHS renal data reports
[14] Food Access Survey 2013
[15] Living in the Regions (Kimberley) Department of Regional Development 2013 social survey
[16] Shire of Broome: Community Perceptions 2015

Key Stakeholder Mapping and Network Analysis

In the short timeframe set for this piece of work, it has not been possible to develop a comprehensive picture which adequately depicts the network of organisations currently operating in the health and wellbeing space in the Shire of Broome and how they interact.

A fairly simple approach is offered in the table below to enable at least a beginning examination of organised/structural health and wellness business in Broome. The list of organisation in each category is not exhaustive, most especially in the domain of general wellness and community support where there are a very large number of NGOs and locally based Aboriginal owned and controlled entities.

Table 2: Summary of health and wellness related organisations and their services

Hierarchy	Organisations	Service offerings
Providers, lead operators and decision makers	WACHS regional executive group	– Resourcing and operations management
	Broome Health Service	– Hospital inpatient including psychiatric and obstetric, emergency department, medical specialists, community mental health and drug service, community health and allied health (various in therapy and diagnostics)
	Kimberley Population Health Unit (Broome Based)	– Communicable disease and outbreak management, remote community services management; health promotion and education; public health program s for non-communicable and preventable diseases
	Kimberley Satellite Dialysis Centre (KAMS)	– Dialysis treatment for Broome people and some remote community people
	Broome Regional Aboriginal Medical Service (BRAMS)	– Primary medical and health services for Broome
	KAMS (regional focussed member support organisation for ACCHS but also provides some services)	– Remote primary medical and health services for Bidyadanga and Dampier Peninsular communities; – Population Health; – Renal services; – Head Space services; – Health leadership, planning and advocacy.
	WA Primary Health Alliance (Broome team)	– Primary health planning and commissioning (resource allocation)
	Kimberley Aboriginal Health Planning Forum	– Planning, leadership, governance and coordination (all providers and related agencies)
	Rural Health West (Perth based)	– Commonwealth workforce support agency

		– Finances various medical, allied health and multidisciplinary teams visits to the region and remote areas
	Private GP services (4) Broome Medical Clinic; Broome Doctor's Practice; Kimberley Medical Group; Roebuck Bay Medical Services	— Private fee payment and limited bulk billing medical services in Broome
	Boab Health Services	– Primary health care financed as a not-for-profit by the WAPHA. – Supports longer term chronic disease management for referred patients through organised programs
	Private pharmacies	— Full dispensing services
	Physiotherapy (several)	– Fee paying and some Medicare rebateable private operators
	Royal Flying Doctor Service (new Broome regional base)	– Primary emergency medical evacuations; – Inter-hospital patient transfers; – Some primary medical services to remote communities; – Emergency medical chests in remote settings
Providers of wellness services	Nirrumbuk	– Environmental health; – Training and work experience
	Shire of Broome	– Municipal and public health services
	Aged care providers (various)	– Community and residential care services
	Centacare	– Homelessness and meals support; – Social care programs.
	Feed the Little Children	– Delivered meals for young people to age 18 years Friday and Saturday nights
	Milly Rumara	– Alcohol detox and rehabilitation
	Anglicare	– Counselling support and other
	Mamabalunjin	– Night patrol (Kularri)and other initiatives – RJCP – Regional Jobs and Community Projects (Kularri CDEP)
	Broome Circle	– Social support for women, children, financial advice and community development support interests
	Men's Outreach	– Engagement and involvement for men
	Head Space	– National youth mental health – prevention/early intervention
Community support and	Goolarri Radio Enterprises(Broome Media Association)	– Community engagement and advancement agenda;

development agencies	Kimberley Institute	– Innovative models and collaborations
	Nyamba Buru Yawuru (NBY)	– Not-for-profit corporate arm of the Yawuru Native Title Prescribed Body Corporate; – Land development – sales and lease; – Conservation; – Culture and language; – Planning and needs; – Housing – rental relief and purchase support; – Community development; – Legal services/acts; – Funeral fund.
	Nangala Jarndu	– Women's Resource Centre – arts, crafts, textiles
	Broome Recovery Centre	– Men's Shed
	Burdekin Youth Broome	– Youth Drop In Centre
	T.H.E. (Traditional Homelands Enterprise) and Kakadu Plumb Company	– Food production enterprise
	Argunya	– Housing
	Red Cross	– Social support
	Jaylgurr Guwan	– Dampier Peninsular Child Care for working mothers and families when taking up training and employment.

Opportunities and Constraints

The next table considers the key opportunities and constraints for a health and wellness advancement agenda in context with prospective economic growth aspirations.

Table 3: A summary of key opportunities and constraints in the health, wellness and growth sphere

Opportunities	Constraints
A shared commitment and forward looking ideas for 'transformational growth' for the Kimberley as a whole and for Broome through the BGP	Translation of aspirations into reality – belief and optimism haven't filtered to the greater community and focus is on every day issues: constrained services, overcrowding, visitor pressure, anti-social behaviour, neighbourhood troubles; Poor understanding and community support for the major drivers and developments; Community opposition and negativity to growth – low trust, some cynicism and environment issues.
Economic growth means more jobs and more employment – especially for young regional people and the local Aboriginal people – addresses one or more of the determinants of health deficits	Job readiness amongst young Aboriginal people will need a big boost; Education and training motivation is low when job opportunities are limited and confined to low level/skill and pay jobs; Literacy and numeracy are problems – health, social problems, hearing deficits and truancy rates.

More prospects for enterprise – entrepreneurial business, ownership, control and autonomy for local people in response to local, regional and further afield consumer markets	Education, training and business acumen not sufficient at this stage – will need to be developed in alignment with materialising opportunities.
Greater critical mass in the local and broader regional population brings with it prospects for material expansion of the types of health services currently not economically or clinically viable in Broome; Material Kimberley population growth (for example as envisaged in the KDC Blueprint) will generate a paradigm shift in demand for higher level services from the Regional Resource Centre in Broome – this could conceivably open up consideration for more private sector involvement in services than is currently the case.	Government's ability to finance the infrastructure and recurrent cost profile of expanding range and volumes of health services; Current hospital campus in Broome is small – adequate for now and next decade but if the population growth tracks close to aspirational projections, a re-think of its location and a green field development may be necessary; Private sector involvement (if population and demand growth makes it a possibility) would also depend upon other market conditions, such as the proportion of the consumer population with private health insurance, which at the present time is quite low.
A new era of Aboriginal affairs leadership and community advancement; and the emergence of strong, intellectually advanced and innovative thought leadership in Broome. There is a clear intent to break some cycles - shake of shackles of old (paternalism underpinning dependence on government and welfare); and to move away from the status quo.	There is a 'transitioning' underway from the early era of activism and self-determination to a contemporary post Native Title universe of more sophisticated and legitimate legal power over land and resource development; There may be mutually beneficial growth and development opportunities that could be leveraged for improved community wellbeing.
A more varied array of underpinning economic industries with synergies – reducing over reliance on government funded services making up almost half of the Broome economy/GPD.	There is a very strong mindset – amongst the community and within the health professional and governance leadership – that government funding and programs are essential in order to meet needs and make a difference in health and wellbeing outcomes (somewhat regardless of cost); There is some thought leadership wanting to challenge the tendency for government and NGOs to 'overreach' and provide basic services as a compensation for failure of parental and personal accountability. For example, feeding programs for children with homes and parents – there are polarised views.
Workforce development – home grown careers in health and a professional/clinical health workforce comprised of a more equally balanced proportion of Kimberley Aboriginal people (doctors, nurses and nurse practitioners, midwives, allied health practitioners and corporate business, accounting and IT professionals).	Most jobs for Aboriginal people in the health sector are in lower paid positions – Aboriginal Health Workers, Indigenous Outreach, Tobacco Worker, various liaison and program jobs associated with fixed term government funding initiatives; and in hotel/domestic services and transport/orderly roles. To get young people into meaningful health careers across the full health workforce spectrum and balancing the Kimberley health workforce such that Aboriginal participation is balanced commensurate with the makeup of the population – a very significant investment in creating a healthy, robust and training/job ready market is necessary; As well, the education (trades and tertiary), training and job practice is going to need to be within the Kimberley.
Leadership in achievement of primary prevention of chronic and infectious diseases – especially via the	Food is a major problem but could equally be a major solution provided local food production of

prospects of higher quality local food production; intra-regional distribution of the produce (rather than shipping it all off to Perth or Asia); with availability through retail food shops at affordable prices. The KAHPF has begun the process of monitoring health research and findings; More recently, KAMS and others have been developing a more formal governance solution for stimulating and monitoring research activities and outcomes.	richly nutritious and fresh meat and produce makes its way into the realm of everyday people who need it the most. Unlike the NT, WA health leaders have little organised participation and governance authority over academic research and where it interfaces with health delivery, best practice, clinical governance, planning and service design, or the acquisition and dissemination of learnings and knowledge;
Using schools for high risk children/family health and education outcomes improvement – the combined schools model from Broome could examine & develop this concept based on experience elsewhere. The concept of building primary health improvement – early intervention and better longer term case management for children and troubled families – around their 'multi-year and every day' association with their schools is not well developed in either health or education systems. But there is a development in action to examine - an ear health service for students (and their associated families) of the East Kalgoorlie Primary School. It is a virtual 'prototype' and whilst the focus in this instance is ear health (chronic otitis media and hearing loss prevention) the model lends itself to a more comprehensive approach to dealing with the full gamut of health and wellness issues afflicting school kids (and their pre-school and infant siblings via contact with their families). It is designed to change hard and measurable outcomes for kids – attendance and good learning; Good achievements/performance at school; good hearing. It appears to have a compelling 'legacy' benefit built in – changing knowledge and self-agency capacity in schooling children will make them more effective adults, parents and community participants. This could help the younger generation make a break from the current cycle.	Health providers see themselves/their systems as the preferred solution for health care and outcomes – hence they build their strategies around getting people in front of them, at their clinics etc. For children (who rely on parents to be proactive about their health and care needs), they are mostly only seen opportunistically and/or episodically. They might be 'oft screened' but the alibility for well- orchestrated and highly sustainable follow through and long term case management from health providers is not always very robust or reliable. It depends on programs being funded. These are typically short term and the targeting is built around health services able to put up successful bids for funds and therefore geographically 'patchy'. For those children with problems, their ongoing interactions with the health system for their conditions depends upon them being bought back into the health services on a scheduled basis and outside of school (or instead of school). There may be some resistance to having school systems as the 'lead agency' in a health outcomes improvement strategy; and there is not as yet very much momentum within the education system to positions schools as health/wellness leaders for their student populations (and by extension their families as well). It would take some 'work' to convince enough of the most influential and authorised leaders in health and education to develop a schools based health solution where health providers work as 'technical' partners to a largely school driven system of case management.
Prospects for local 'liveability' improvements shared by all of the community	Most people consider that the Broome Aboriginal community have been chronically excluded from the real benefits of growth and development and see this is the foundation of social and health issues including anti-social behaviour which is on display in public and neighbourhoods; A more 'liveable' Broome means that the local people – especially the Aboriginal people – get a fairer go and that developments pay a lot more attention to the things they need;

	An example talked about was the case for modern hospitality amenities for Aboriginal visitors to the town – not rough camps 'out of sight' but pleasant places where they are made to feel as welcome and important to the town as any other visitor.
Improved community cohesion through inclusion and well balanced attention to real community needs and solutions	Racism was said to be alive and well in Broome; Some said "Old Broome wasn't perfect but it was better than this"; If economic growth builds upon and keeps the status quo going, some people said they see no value for the general community in growth and really would prefer it not happen at all.

Existing and Future Plans

The following tables set out a high level overview of the current/forward going plans for governments, key institutions and some of the key local organisations. It is not comprehensive. It is drawn from prior knowledge (of the consultant) together with what has been able to be learned from talking/meeting with people over the course of the work.

Table 4: Government plans

Governments	Key plans and strategies
Federal	– Closing the Gap agenda through the COAG continues; – Monitoring KPIs from recipients of health funds for Closing the Gap/COAG initiatives and publishing regular annual reports (for each individual service as part of a Continuous Quality Improvement process; and for the sector at each state and national level; and a report is tabled in the federal Parliament by the Prime Minister each year in February); – A number of programs consolidated and administered as the Indigenous Advancement Strategy (IAS) via the Office of the Prime Minister and Cabinet; – Hospitals funding reforms – paying on volume and efficient price benchmarks nationally; – Primary health system reforms – phased out the Medicare Locals and setting up not-for-profit incorporated entities (PHNs) as planning, commissioning and resource allocation and performance monitoring bodies around the nation; – Health technology – electronic patient held health records; – New focus on Empowered Communities approach; – Sourcing Indigenous strategic advice from outside the traditional community controlled health sector from other leaders – including Andrew Forrest; – Empowered Communities developments – a new and evolving leadership and energy/intellectual source in Aboriginal affairs improvement driven by the Office of Prime Minister and Cabinet; – Welfare reforms – income management; – Medicare items review; – Review of the National Aboriginal Community Controlled Health Organisation (NACCHO) and State Affiliates (for WA, this is the Aboriginal Health Council of WA (AHCWA).
State	– New Public Health Act – Local Governments are also major players;

	– New Health Act recently enacted introduces a new system of governance of health services into the WA publicly funded health system; – New board chairs were appointed several months ago and most recently following the enactment of the new Health Act, each of the new boards (WA Country Health and the North, East and South Metropolitan Health Service) has been populated with a full set of members; – The new boards are currently setting up their sub-committees and getting about regular governance business; – In the new governance system, the department of health (in Royal Street East Perth) is presided over by the Director General of Health and its function is now described as 'system manager'. Importantly, the chairs of each health service are now fully accountable for their health service performance to the Minister for Health and the chief executives report directly to their respective chairman. This is a significant departure from the health governance arrangements in place since early 2001 where the Director General of Health has doubled up as the head of the department and as the board chairman for each health service; – A regime of tight cost controls and savings measures continues – the system has just (1 July) come off a whole of system and Treasury/Cabinet imposed staffing freeze lasting six months; – The WA Country Health Service continues as it has for the past fifteen years (albeit now under the direct governance of an appointment board) and is accountable for planning, reforms and operations management, resource allocation and management and performance of all publicly funded health services (including services outsourced to other providers via procurement contracts) in the seven WA regions outside of the metropolitan area; – The Mental Health Commission was established by the current state government in recent years and operates under its own Minister and Commissioner. Funding for mental health was separated out of the Health budget allocation and reallocated to the MHC which has been established on a model of planning, solutions development, commissioning and procurement and performance management and reporting to government; – The overall department of health service sector continues to be the majority provider of mental health treatment services (including in the regions) and continues to do this with funds provided by the MHC; – Since the introduction of the Royalties for Regions scheme from the outset of the first term of the current Liberal government in WA, there has been an evolving regional development agenda – underpinned by extensive planning and investments in infrastructure, capacity building and longer term sustainability; – A great deal of the Royalties funds have found their way into the Health domain through investment programs such as the Southern Inland Health Initiative and others, including in the north west; – In the mid 2005's the Health Networks section of the department was established and there were several years of collaborative clinical services plans and frameworks developed. The system is still working on building around the models and plans for primary health, chronic disease management and most notably for the Kimberley, the development and investments in renal dialysis services and statewide governance of renal services; – Announcement by the Barnett Government following the Bilateral Agreement with the federal government on funding for remote community utility services (articulated and/or interpreted to mean closure of a large number of small communities);

	– Undertaking given that the state government would not close any communities – but would be consulting with communities to develop a plan on which particular communities should continue to be supported; – Subsequently two Ministers (Regional Development and Mental Health/Family Services) appointed Mr Grahame Searle (Director General of the Department for Housing) to set up a special unit (called the Regional Services Reform Unit) to undertake examination of how government organisations and funding streams might be better organised and targeted to helping communities achieve much better outcomes in the future.
Local	– The Shire of Broome has been responding to the prospects of community, economic and industry growth for some time. Most recently, the James Price Point development and also the planning work developed through the KDC; – For this work planning documents on the Shire of Broome website were examined- Community Profile and a Broome Economic Profile; – A body of work based on a 2015 Community Survey was also obtained; – The Shire of Broome are a key partner in the BGP process; – Their planning work is focussed on: o Measures for servicing the entire population – having regard to the significant differences between the resident and service populations and the peak/off peak dynamics; o Future population demand in the context of material growth – infrastructure, services, amenities for recreation; o Pockets of disadvantage – promoting more cohesion and equality; o Housing affordability; o Indigenous population engagement in economic growth benefits. – Planning now must be done with due regard to the ramifications and legal technicalities of post Native Title; – The issue of municipal services to remote communities in the future is an as yet unresolved matter. A funding solution for Local Government is necessary for this to be achieved. – The future of the Town Reserves is also an outstanding matter needing to be planned and negotiated with the Native Title owners.

Table 5: Major Institutions

Major Institutions	Key plans and strategies
Broome Hospital and Health Service	– Range, volume of services and bed numbers for medical, surgical, obstetric, psychiatric and high dependency are prescribed and compliant with the 2015-2025 Clinical Services Framework (CSF); – Whether or not some of the prescribed services can be expanded when scheduled in the CSF will depend upon contemporary assessment of the actual situation, clinical viability prospects and affordability to the state government; – Broome Hospital has been redeveloped and is currently operating very well and meeting over 85% of local and regional need. This is a very high retention rate and reflects the fact that the greater majority of health care demand is within the scope of the hospital in Broome;

	– The linkage of service areas (for example the medical/nursing high dependency unit) to tertiary support and advice via Telehealth in Perth is a major enabling factor.
Royal Flying Doctor Service	– The organisation has recently established a major operating base in Broome.
Notre Dame	– The university has been on the Broome scene for some time. It was able to offer tertiary nursing education but is currently offering Enrolled Nurse level training.
Broome Primary Schools	– Proposal to develop health/wellness responses within and around the school system where children and their families attend virtually every day of the school year and where the relationship between child/family/school spans many years (4 to 17).
KAMS	– This is a regionally focussed umbrella/member support organisation governed by directors from each of the ACCHS around the Kimberley (including BRAMS); – They operate full medical and health primary services in Dampier Peninsular, Bidyadanga and Kutjunka inland remote communities and also provide the renal dialysis services throughout the Kimberley including in Broome; – KAMS runs a number of functional units and programs and has diverse roles and responsibilities; – They are influential health planning and policy leaders in the region and within the universe of the WA ACCHS sector in WA and nationally; – They (along with AHCWA and many other ACCHS in WA) are currently developing their strategic thinking in a new and different future; – They have a very good understanding of 'the changing nature of the game' and the need to be a lot more businesslike (pursuing diverse streams of income and avenues for building equity, balance sheet strength and an ability to be a lot more self-determining; – KAMS recently relocated into new purpose built premises which they own; – They continue to expand into land/facilities more recently acquired.
Churches	– This dimension was not explored in this project.
BRAMS	– BRAMS are a robust primary health service servicing the population of Broome and offering bulk billed medical care though a team of salaried doctors and other health staff in their clinics and community programs; – They recently took possession of the land and buildings on their wider campus in Anne/Dora Streets once KAMS (who leased premises from them) vacated; – This has given BRAMS a great deal more scope to fully utilise and progressively redevelop their campus; – The first step (other than relocating some offices to create more space in their clinic building) has been to establish a Family Health Service in the building adjacent to their medical clinic; – This will enable them to undertake more 'slow stream' and multidisciplinary work with individuals at the family level and helping them a lot more with education and lifestyle modifications – these sorts of measures are in fact very difficult (if not impossible) to follow through properly in an acute medical clinic where the patient demands are high every day, the needs are more acute, and the consultations with the GPs and the other health staff are – of necessity- very time constrained. – BRAMS are very excited about this new model – enabled because they have more space and amenity available to them; – They will require additional resources to fully actualise this new service model to its fullest extent. This adds up to around $2.7 million/annum.

	Part of their financing model is to 'drive' the medical consulting business harder and produce more Medicare income to be invested into the 'slower stream' Family Health model.
WA Primary Health Alliance	– Currently established stakeholder advisory groups, governance and Clinical Commissioning Committees; – Have done needs assessments (partnered with Curtin University); – Developing 'machinery' for formal health commission procedures including various mechanisms for market engagement and procurement; – Until this is full developed they are continuing with prevailing funding arrangements and relationships with all of the providers who receive funds and deliver services (these were initiated by the former Medicare Locals and there is a significant business continuity requirement pro-tem).

A thorough study of all of the local organisations involved in the broader health and wellness domain and their existing plans was not able to be done during this short exercise.

However, there were some key organisations able to be engaged directly or examined briefly through the content on their websites and other sources which are of particular interest in the context of the BGP and the dimension of wellness. These are very briefly identified in the next table.

Table 6: Local organisations

Local organisations	Current plans and strategies
Nyamba Buru Yawuru (NBY)	– Community census styled survey – improved understanding of their own community; – Transitional housing; – Funeral assistance; – Land use and development; – Creating wealth/prosperity for the land owners; – Working with and influencing future growth, land development and economic plans in Broome in ways which leverage their constituent's direct interest.
Kimberley Institute	– A 'think tank' function for contemporary thought and innovation leaders; – Developed and promulgating 'The Broome Model' – a way of moving away from slavish dependence on government programs designed nationally and at a whole of state level based on one-size-fits-all thinking and associated reliance on government funding everything; – A different – shared – approach to funding: proposing that hard outcomes are bought and paid for (rather than price/volume specified outputs) by those who get the best value from them: governments, corporates, philanthropists; – Gathering support for this amongst the universe of Broome Aboriginal organisations and others; – Partners with other organisations and provides project management and consultancy support.
Mamabalunjin	– Transitioned successfully from a former CDEP administration hub (former ATSIC days) to a community development and employment support agency with a number irons in the fire; – Sponsor the Kularri Night Patrol service.

Goolarri Media Enterprise	– A big and active supporter of Indigenous community advancement through entertainment, talent creation and educating and connecting people; – A powerful vehicle for community knowledge and information sharing and to enhance inclusion and participation.
Centacare	– A Catholic Church agency – social support and caring for people at risk and in need.
Broome Circle	– Aiming to build a stronger more inclusive community through connecting people, encouraging collaboration, supporting initiatives and exchanging skills; – Focus is on sustainable future growth; responsive programs; inclusion and participation and strengthening the community through their activities.
Aarnja	– Developing a range of activities and income sources for self-sustainability; – Initially funded by the state government to help develop the Indigenous community's interests which were intended to evolve following the James Price Point development; – Continue to be funded and have taken on administrative facilitation of the West Kimberley Empowered Communities Developments; – Empowered Community leadership - the driving force is mostly from the East/Kununurra. In the West Kimberley, the participants are still finding their feet.
Nirrumbuk	– Significant pre-employment and employment based training; – Strong involvement in Environmental Health service delivery.
Traditional Homeland Enterprises	– Kakadu Plumb Company is a community owned venture seeking to create prosperity, skills and employment through Indigenous enterprise through scaled up unique foods production.

Strategies

The next table gives a summary of ideas and strategies discovered during the consultation. A brief and very high level assessment is offered for each one.

Table 7: Assessment of identified ideas/strategies

Idea/strategies	Assessment
Family birthing centre – midwife led & enabling interagency maternity care in Broome	This is a contemporary and very popular approach to normal low risk birthing and designed around an enjoyable, non-clinical style of care highly supportive of families; Broome will increasingly provide for many more births and this is the experience most women and families aspire to.
More inpatient psychiatric beds and mental health infrastructure and services development	The growth in morbidity in mental illness and more generally in social and emotional wellbeing is huge; Facilities and service models will need to keep pace with this and have a strong bias to contemporary approaches; prevention and early intervention; and the cultural and existential underpinnings of the unique client population being served.
Cancer services (chemotherapy) A 4 chair/1bed unit	A growing morbidity sector along with chronic diseases generally. New research suggests many cancers are caused by the same diet, inflammatory conditions and chronic exposure to stress and anxiety as metabolic, vascular and mental illnesses;

	Arguably a contemporary regional health hub in growth mode and serving a high demand population ought to cater for cancer diagnoses and treatment services – this should include quality palliation services (noting that palliation should not be confined exclusively or mostly around a cancer model – for example, there are a growing number of people who chose a palliation route instead of renal dialysis and they have very special needs for symptom management which is quite different to those for cancer patients); Increasing use of Advanced Health Directives also empowers patients with a range of other debilitating conditions to opt out of treatment and to receive only symptom and comfort care through a more palliative approach.
Local/regional breast screening service	A growing population and bringing with it high expectations for local/regional access to what is now considered a 'basic women's health screening service' will make this an increasing necessity for the future; The technology for breast screening might align well to other medical imaging technologies of use in a much expanded range and volume of diagnostic services.
Orthopaedic surgery	Trauma management, sporting injuries and joint replacement surgery; The case for this will grow – the determinant will be cost, viability, demand and value for money compared to other priority areas. Needs some examination of market potential (and it is understood a group of orthopods are looking at this right now).
Resident nephrologist	Identified by regional renal providers – as the number and clinical complexity of existing and prospective renal failure cases increases, so will the need for a region based nephrology service. Ideally, a resident nephrologist should be able to have some capacity for admitting patients to the Broome Hospital and have the necessary nursing and other support available to care for more of these types of patients in Broome; At the present time, any patient beyond the scope of renal nurses and advanced skill GPs must go to Perth if their clinical status is a concern. Most of these problems do get quickly sorted out at RPH and in hindsight, it was not really necessary to transfer the patient to Perth.
Ambulatory care – in the home	Palliative, dressings service, post discharge and ancillary services; Ambulatory care (out of hospital and often instead of hospital) is a very contemporary but as yet under developed model; In a growing Broome and regional population, it is very likely that a vast volume and range of services could be provided to patients by an ambulatory patient work team and would reduce the demand for much more costly admitted patient services with long lengths of stay; Often the longer length of stay for Kimberley patients is simply due to there being no ambulatory care system organised.
Palliative care	End of life care is becoming an increasing need as more people suffer from chronic conditions including cancers. Increasingly, older and sick people these days are taking advantage of Advanced Health Directives through which they can dictate their wishes relating to continuing with specific treatments, being resuscitated or choosing conservative and palliative styled care for symptom control and comfort only. As population, demand and expectations grow, the need for palliative in home and hospice styled respite and final care solutions suited to Aboriginal and non-Aboriginal cultures will manifest and demand a solution. This was identified by WACHS as a priority/evolving issue they currently only have a minimalist solution for.
More Men's Health models	Reduce domestic violence by men – these are highly regarded mechanism to engage and work with men to improve connections, inclusion and reduced harming behaviours and violent harm to partners/others; A big part of the poor outcomes in chronic disease screening and early intervention is that adult men will not engage very well and consistently with health services;

	The same applies for young men – once out of school, they tend to access health care infrequently and episodically. For example for STIs or accidental injuries. They are often into substance abuse, very poor nutrition and neglect of personal and oral health.
Improving prospects for ageing and retaining senior citizens in Broome	Regional Development Australia (the Broome office) are keen to develop strategies to entice older people to remain in Broome. There are factors influencing people's decisions and ability to stay in Broome in the ageing years: need for a range of service, affordability once on retirement incomes, community and neighbourhood stress, loss of connections and isolation. The Wheatbelt RDA team developed some strategies for ageing and the Broome office are keen to do some work in this area too – this would be good to do in context with a future growth plan and would need to be focused on the unique issues in Broome life/community.
New campus for expansion	The prediction is that the current campus, whilst small and tight will continue to be adequate for the next 10 to 15 years. Once and if time comes for material expansion – especially if there is rapid and much higher growth than locked into current planning assumptions; and also if there is a desire and the wherewithal to opt for very contemporary 'best practice' models for things like: o Public/private colocation partnership; o Family birthing; o Ambulatory in-home hospital care; o Oncology – chemotherapy; o Mental health and social and emotional wellbeing; o Palliation care options and end of life care. This may trigger a need and an opportunity to re-consider prospects for a green field development site and a very exciting health and wellness precinct development. However, the current campus may be suitable if 'building upward and outward' solutions are possible.
Health workforce education and training	Essential but no clear strategies were observed. Employment in health has been constrained with financing and efficiency drives by funding governments. Local training and education is static at the present time.
Better ear health outcomes	Hearing impairment and impact on school attendance and outcomes Microbe load causes other serious mischief (heart value and kidney disease for example) The suggested school/health concept is already maturing in the East Kalgoorlie Primary School.
Research governance	Better ability for industry leaders to set the research agenda, target the areas of interest, set the rules, monitor results and have the opportunity to use the learnings for outcomes improvement and economic advancement.
Combined Universities model in Broome – research careers and learning	Several years ago (mid 1990's) the department of health in collaboration with all WA universities established an entity called the Combined Universities Centre for Rural Health (CUCRH). It was intended to generate a research and learning agenda, sponsor and support academic/clinical careers and deliver benefits for heath leaders and communities from the research work; It is based in Geraldton and was intended to be state wide. However, it is 'mostly Midwest focussed'. There is still a lot of merit and attraction to the model however and quite a bit of interest in establishing a re-vamped and modern 're-minted' model into Broome.
Better structure, capital allocation and outcomes from government agencies	Brokerage/case management model to concentrate and coordinate resources and effort around families in trouble

Expenditure reviews	Recently done by RSR in Roebourne and in Youth Services. Clearly mapped 'the mish mash' – shows there is scope for structural reform and makes it all very visible
Place and location based solutions which are co-designed	Agreed – externally designed and imposed ideas often don't work that well; The alternative is just more slow-stream – it takes patience and time and often these are not available commodities for governments and their departments working on specific time horizons, deadlines, reporting frameworks and politically imposed expectations; This is where more locally guided, place based and unhurried solutions might be better 'brewed'.
Investment pilots of innovations (and evaluations)	Agreed and again – patience and time is of the essence.
Kimberley Schools Proposals	I would want to see this idea developed as a more cohesive and joined up partnership between schools, primary health services and population health; Great opportunity to change outcomes for children at a young age and possibly families if done right. The model (based on ear health) maturing at the East Kalgoorlie Primary School in partnership with Earbus Foundation) is well worth examination in the context of developing a school/health partnership model in Broome.
Joined up approach to maternal and child health outcomes	As above – opportunities abound but not helpful if specific organisations and sectors plan and act in isolation.
Mutual obligations	Much discussed – sense a keenness to get people off the dependency wheels; Problem is that there may be some 'lost causes' not able to be helped and in the process, things might even (need to) get a little worse before they get any better; Difficult issues to discuss, very hard for government agencies to act on, rife with politics and strongly polarised views; Something like this as a general framework for the future would need to be strongly owned and supported by community leaders who don't run for cover the minute fingers start pointing.
Bring back 'Home Maker'	Another 'round' of intensive domestic skills development for the current generation is needed urgently and should include contemporary food and consumer knowledge and skill building. Consumers have the ultimate power to force suppliers to change what produce and products are available
Hospitality industry comprehensive careers	It was said by several people to be difficult to attract young Aboriginal people into working in the hospitality industry in Broome and yet it is currently and in the future a big industry and on a growth trend. To not have employment for locals seems a missed opportunity; Partly the reason given was cultural related to history – not wanting to 'wait on' white people doing menial work; Another view is that a lot of young people these days want to start at the top – management and senior positions in their sights and not interested in starting at the bottom and working their way up (like in 'the old days'). Careers in hospitality might be a solution – start at the bottom as part of a tangible career pathway leading to higher paid and skilled work in the industry and also being prepared if/as opportunities for developing businesses.
Old style growth policies reinforce exclusion – do it differently this time	People mean that there is a lot of learning and listening and genuine inclusion in solution design needed if things are ever going to done to produce different outcomes.
Want the Shire to 'own and address'	People are looking to the Shire to pick up and get solutions into place to deal with some of the community problems more effectively in the future as especially as part of the BGP.

social problems more	However, many of the community and social problems are beyond the scope and powers for the Shire to address.
Alternative power	A big concern – environmental wellbeing and cost of living.
Cultural tourism	A great opportunity if community people can get prepared for it so they don't miss out (due to lack of health, motivation, acumen, ability to get good backing)
Food enterprises	Community Gardens – not at project/volunteer level but as a serious and systematic approach to improving access to affordable in season fresh produce from multiple gardens around the community. Affordable fresh food widely available has more potential to improve health than expensive medicine (subsidised extra virgin olive oil to go with it would increase the impact significantly)
Build a knowledge economy – northern knowledge and know-how, links to SE Asia	Sounds good – not sure on the detail.
Cooking and traditional foods, adapted recipes and techniques	Big role for traditional foods, cooking techniques and medicinal foods to be developed and re-entered into contemporary knowledge and practice; Has enterprise/market potential and well as health benefits.
Living Library - stories	Real people with real stories to share and tell and show; Could be part of cultural tourism experiences.
Indigenous small business – fleet cleaning	Ideas like this abound – need the right people, support and backing; Someone prepared to take some risks.
Integrated BGP stewardship group	Have a modern day go at getting the stakeholders together as equals in power and decision making to steer community development;
Redevelop the social housing area in the older urban part of the town	A major problem most people said they would like fixed; There was a perception that the Shire of Broome have somehow blocked solutions; when in fact they have pushed for and supported the Broome Urban Renewal Project; A distributive public housing model is better regarded than the consolidated 'ghetto/projects' style of residential settings (according to the Housing Authority); This policy seems a logical approach to breaking down social problems. But there are some challenges for decision makers in Broome. For example, things like public transport needs; and possibly the desire by Aboriginal people to live close to family groups and their own/unique concepts about 'community'; The work commenced to better define and understand wellness (By the Yawuru Native Title Group) is a good basis for exploring this in more depth locally with the people most affected by the outcomes.
Economics of Liyan	Mandy Yap (local Yawuru woman) will soon complete her PhD thesis on the 'Economics of Liyan'; Not available for examination as yet, but it sounds encouraging. It is highly anticipated and talked about in the 'think tank' circles of Broome Indigenous leadership. This may offer ideas for the future aimed at getting things right on the next leg of the Broome growth journey.
ALT reserve system 19th century and paternalistic	Land ownership for people, rateability and proper municipal services; This needs to be dealt with – it would be a massive relief to the entire community if done correctly and Broome could become a role model for other areas needing this stuff fixed; This will require appropriate and significant resourcing.

Sort housing	Solutions needed – homelessness, visitors from other towns, overcrowding and better styling of housing suited to Aboriginal extended family way of living.
Quality hospitality facilities and services for Indigenous visitors	Another major social concern for want of a decent solution; The short stay accommodation facility in Derby is helping a lot and very appreciated by the community; A short stay accommodation facility is due to be operational in Broome in 2017.
Food production – locals first	If quality and nutritious food production is trucked and shipped out of the Kimberley for the benefit of other markets and sellers but does not make its way in adequate quantities as a food solution for local people who desperately need it, it will be a massive missed opportunity to move the needle on primary prevention of chronic diseases including many cancers, mental illness and general health and wellbeing.
The Broome Model	Developed by the Kimberley Institute and collaborating interests. A good sign of 'new think' on how to allocated resources, quantify, price and measure outcomes. May/should have some appeal to the RSR and E/Community groups seeking better solutions.
BRAMS Family Health Centre	An excellent and much needed approach to differentiating the service model in the ACCHS and it may contribute materially to developing best practice; Relying on rapid throughput GP consult models in busy clinics has reached the end point of utility as the predominant prevention and outcomes improvement tool, especially at a population level. A different approach is badly needed and the thinking behind this effort by BRAMS is good; They will need more support – they will most probably not be able to generate enough funding to fully realise the potential of the model; It is worth being supported as a pilot over a very decent (more than 3 years) timeframe and should be evaluated academically.
Development, conservation, ranger services & food production enterprises	Happening now and a bit under the 'radar'.
Integrated primary health and family support centre (for multi-agency use in: mental health, chronic conditions, drug and alcohol problems; co-morbid illness; social, emotional and wellbeing issues; family and domestic violence	Great idea – more contemporary and enabling infrastructure and service models go hand in hand with restructured departments and funds targeting systems; Co-location, collaboration and coordinated action should ideally be supported by enabling (rather than detracting) service design and technologies; In integrating, a great deal of duplication can be weeded out – shared IT infrastructure, telecommunications hub, fleet management, meeting and function rooms, staff and community amenities, storage areas, catering and corporate bureau services are possible and overall the savings could be substantial. At the present time, every individual organisation, group and agency are duplicating most of this stuff; Improved access and amenity for consumers is also enhanced in 'precinct' models.
Cultural centre – art, stories, commerce, food, learning, entertainment, performance, showcasing	No argument at all why something like this shouldn't be as big a draw card in Broome as the camel rides and staircase to the moon attractions; Other than for tourists, major potential benefits for community pride, development, and inclusion abound.
Reduce cost of living	Is this possible? This is what makes it virtually impossible to get private sector health and wellness services into Broome;

	And it is partly why older people don't stay; There are much cheaper holiday destinations for people who want as much as possible for their dollar – Broome is very costly.
Private sector operators need inducement	Apart from cost of living, access to the essential infrastructure at affordable rates is crucial; It was reported that a dollar in Broome only has spending power of 75c; and that it costs 500.00 rent for half a day for a medical consulting facility; Built medical specialist and diagnostic/treatment and therapy program infrastructure is needed as people will never come if they have to put their own capital into facilities and fit out.
Asset and enterprise acquisition by KAMS	A very logical next step – the community, including the other leading local Aboriginal owned organisations need a health leader to have some financial power and capacity to decide what to do and with whom; In the prevailing economics of the global world, Australia and the state government, it is very wise to start thinking and planning around ways to acquire assets, equity and profitable businesses and reduce to exclusive reliance for your very existence on government's capacity and will to fund.
Renal best practice leadership	Renal health is big business in the Kimberley with a great deal (financial cost penalty) at stake for governments if the system does not manage to change the current trends. To do this requires some serious work in primary prevention as well as screening, early treatment, quality management long term and excellent management of end stage renal failure, transition to dialysis and care from that point on (including end of life care for a growing number of people with very special and unique palliation needs); Getting a clear and balanced strategy and getting all the right leaders and experts together in collaborative governance of future developments in renal is an opportunity for national and world leadership.
Environmental health a very powerful game changer	Infectious and inflammatory diseases are caused by poor environments either at the community and/or domestic household level; A new generation of householders with poor skills and knowledge require education and assistance through organised programs of monitoring, vigilance and fast mediative action; Environmental health is an important knowledge and skill base and in well structured (and financed) programs there are significant job and career opportunities possible; The cost of not doing environment health aggressively is hearing loss, lifelong damage to heart values, irreversible and severe kidney damage and early age renal failure, poor pregnancy outcomes.
Create avenues for the environmentalists to come up with alternative ideas for economic growth	There is a very vocal anti-development lobby based on concerns for loss of environment; loss of amenity for locals to the places they want to go; stresses on the town services and local community; and concerns that social problems will be put out of sight and out of mind by developers; There is considerable intellect amongst this group of people and their energy could be very productively channelled into some legitimate processes to explore tangible and possibly actionable strategies.
Must have a local public transport solution all year round	A growing and spread out community will need a reliable public transport system designed with at least equal attention to the needs of the resident local and transient Indigenous community; The current system is private, goes mostly to popular visitor points of interest and winds back in the off-peak season.

Strategies for Moving Beyond the Status Quo

Health services – secondary care/hospital

Hospital services are adequate to cope with most secondary care needs in terms of bed capacity and the range of clinical services on offer. These are well aligned to current and forecast population projections and about 85% of all inpatients Broome Hospital deal with are retained for treatment in Broome.

As and if the population in Broome (and the region as a whole) grows by 2036 as suggested in the Kimberley Blue Print, there will be a need along the way for additional capacity to cater for bigger demand volumes. Some of this is already documented in the CSF 2015-25 but it may need revising.

The case to also consider expanding clinical and diagnostic capability as well as just volume may present.

With this in mind, the Robinson Street hospital campus will need to be critically examined.

In the meantime, contemporary capital solutions would be welcomed for innovations like:

- Midwife managed low risk family birthing and multi-provider maternity services;
- Chemotherapy;
- Better integrated mental illness and social and emotional wellbeing services and programs;
- Ambulatory care (cancer, palliation, home hospital and longer term therapies);
- Contemporary residential solutions for older people and facilities and amenities to support healthy ageing and access to care when it is needed.

Given the amount of capital already invested into the current campus, it would be ideal if a campus plan could be developed for capacity and capability growth as well as inclusion of some very contemporary infrastructure models on or very near the campus.

It may be that the next hospital expansionary stages go skyward and a little outside the campus boundary.

There are significant barriers to entry to private health operators such as low population and episode/procedural volumes; poor commercial viability prospects coupled with high operating and living costs; low levels of private health insurance (and a population accustomed to free 'point of care' services); and prohibitive costs for capital set up.

If some of these barriers can be lowered, it might alter feasibility prospects.

Realistically:

- Population and volume/demand potential could improve if sustained growth occurs as is currently being envisaged and planned for;
- Operating and living costs are probably always going to be a factor;
- Investment in lease- ready medical infrastructure might change the prospects and would almost certainly be necessary as a means to attracting private sector interests to set up and operate in and from Broome.

Health services – primary care and keeping people out of hospital

At the present time, primary medical and health services are faced with growing demand for episodic medical and clinic treatment services.

Their program styled services – especially for chronic disease and lifestyle intervention education, counselling and support are at capacity with very high numbers of cases on their books needing follow up checks and tests and fine tuning of medications for symptom control.

It is not uncommon for program staff to get 'pulled off' their jobs to work in the clinics just to get through the daily patient load.

Within this typical picture, there is little practical scope for establishing and supporting innovative models designed to work in a more 'slow-stream' way with individuals and their families including in their own home and community environs to tackle what is often an extremely complex set of factors acting as compliance barriers; and neutralising their prospects for effectively managing their conditions.

The Family Health Centre model being developed by new management in BRAMS is quite a breakthrough (at least conceptually) in innovation. With support, collaboration from others and clear focus on outcome measures and their value this model could 'move the needle' on outcomes.

Wellness – disease prevention

There is an epidemic of diet and lifestyle diseases worldwide. Diabetes, obesity and the metabolic syndrome are starting to overtake communicable diseases as major threats to health worldwide. The prevalence rates of diabetes and obesity are rising sharply[17]

Younger adults and even children are gaining weight, some are already obese or heading that way and many have or are on their way to full blown diabetes and the other chronic disease complications and disabilities that go with it.

This affects Aboriginal people – and the younger ones too - extremely badly because of the generally poor quality and very metabolically damaging foods they are doomed to consume on low incomes. But it also affects non Aboriginal people increasingly and worldwide.

Medicine has developed means to diagnose, monitor and medicate to bring markers like LDL cholesterol, blood glucose and blood pressure into clinically acceptable ranges.

However, unless something changes the causes of these conditions, Broome's much bigger population looks well on the way to being prematurely old, disabled and sick a lot of the time – and this is in spite of regular medical checks and medicines.

Hardly the stuff of a robust and successful growth plan with good health and wellness outcomes and participatory benefits for the community.

Good nutrition (from quality, fresh, affordable and ideally locally produced seasonal vegetables, fish, meat, fruit) before and after birth and for life positively supports

[17] The Lancet, July 2015

good health and generally protects the body's inherent ability (through its own immune and healing systems) to keep itself healthy and strong and even deal better with infections and other occasional insults.

It would be hard to argue against a case for doing whatever it takes to improve food quality, availability and affordability and that to some extent, doing so would be a game changer in future population wellbeing and economic participation.

Developments in the food production domain – large and small scale, community enterprise and a system of well supported community gardens – should be exploited for enterprise, economic and health and wellness outcomes.

Wellness – a general state of happiness, wellbeing and freedom from disease

Broome is stuck deep into the groove of the 'haves and have-nots' profile of the community. A place so lovely and with so much to offer and yet troubled by a significant pocket of poverty, neglect and regular displays of anti-social behaviour and tragic violence and death.

As the community grows and strengthens, this aspect of community life in Broome is probably getting generationally worse. It stands as a big concern for most people – either because they just don't want to see it; or for many, because it is genuinely concerning to the point where they don't even want economic growth if it means they have to see all this get any worse. Either way, it is quite a detractor.

Endless attempts to meet needs and improve the situation by governments through funding programs, by departments through their various efforts and strategies and by community organisations and the church and charitable sectors have not materially changed the situation.

This is a piece of the status quo that people don't want 'dragged' forward into a new Broome future. A new approach is needed and in this post Native Title Broome world, there appears to be a groundswell of thinking people willing to step forward and take some of this on in new ways.

At the same time, governments are looking at ways they can change and work with change agents. At the federal government level the Empowered Communities movement is evolving. At the state level, the Regional Services Reform exercise has got underway.

If these interests could align, the potential to set and steer a different course for Broome and improve life and prospects for traditional owners would position Broome as a national leader.

Community amenity

This is a big theme in peoples' minds with the prospect of expansion and growth. This encompasses dimensions of:

- Cultural celebration and ways of living;
- Hospitality;
- Arts and performance;
- Community media;
- Cost of living – especially food, housing affordability and power;
- Public transport;

- Integrated health, wellness and culture precinct;
- Retaining seniors in Broome;
- Land – Aboriginal Lands Trust 'reserve' solutions and municipal services for surrounding communities.

Investments in a cultural centre; housing solutions; a pleasant and welcoming hospitality solution for visiting Aboriginal people from other towns and communities and year-round public transport will be needed.

As well as a cultural centre, a very modern and well integrated primary health and family support services precinct development would enable and align very well to new departmental/agency service and government financing models.

A massive show of faith and perhaps a way to open up new possibilities right now would be to address the reserve land and community municipal services issues. This needs ownership and leadership by the Shire of Broome, state government and land owners together.

Structural reform

The number of funded organisations, agencies and programs providing an enormous range of health, human and social service support programs funded by governments is immense and confusing.

There is considerable interest – at community leadership and government levels to explore ways to restructure service models and fund allocations.

There is a lot of shared frustration at the intractability of problems and the relatively low impact on outcomes from the myriad streams of funding and complex corporate structures and programs.

New models of funding and service are needed – it seems most people think these should be:

- Place based;
- Co-designed;
- Given sufficient time; and
- Integrated, collaborative and somehow really well logistically and financially better coordinated than they presently are.

Through the vehicles of innovative new models/structures and funding arrangements, schools and health providers could become powerful collaborators in proactive health and wellness intervention, changing outcomes and improving learning.

The model put forward by the combined schools has merit and should be further developed. Schools have substantial under exploited leverage on outcomes by way of the very enduring relationship they have with children and their families over many years.

A well leadership group to help guide the BGP developments was suggested where Native Title Holders and other community leaders and key stakeholder could work as equal partners to steer future developments aligned to economic and industry growth through the BGP.

Enterprise

Low levels of participation in employment, career pathways and locally owned business in the hospitality and other economic sectors could be improved.

A market of educated and training/job ready people is needed – and for this they need to be healthy and ready to take on new beginnings, training and education, gaining qualifications through study.

Having a significant proportion of the Aboriginal and non-Aboriginal youth and young adult population overweight, reliant on medications, frequent doctor visits and endless specialist referrals, illiterate and not numerate will ensure the status quo.

Tourism is a staple industry for Broome but the participation rates by young Aboriginal people is low. The industry relies on 457 Visa and backpacker visitors for its seasonal workforce.

There is genuine enterprise in culture – living people have much to share by way of stories and experiences and many visitors place high value on this.

Homemaker and consumer skills

There is at least one generation of people who are poorly prepared for home making and raising families. The skills and knowledge are low across most areas of household and family management.

There is a component of public health policy and political action driven by the community and consumers which will be essential to advance the health and wellness agenda. And there is no reason why this cannot be driven by Broome's community leaders.

Food knowledge is very poor and consumer skill levels are generally low. Consumers have considerable power and it would be useful for a lot more of them to be better educated so they can leverage their power on retailers and food producers more than they currently do.

Broome as a knowledge economy

A health workforce in a Broome and regional population scenario around three times bigger than it is now in twenty years will mean a lot more jobs.

To ensure that workforce comprises around a 40% Aboriginal mix means a lot of people will need to achieve entry standards into professional and clinical disciplines.

A move away from the status quo on health workforce means more Aboriginal medical, nursing, midwifery, allied health and pharmacy professionals and a range of corporate and technology professionals.

This will need a paradigm shift away from lower paid jobs in hotel and clerical services and also building upon the more traditional Aboriginal Health Work, liaison and outreach worker roles.

Outside of the health industry a growth in the economy will also create jobs and career opportunities on a broad spectrum.

The key to making this possible – apart from a wide range of jobs, careers and even academic researchers materialising – is access to education, qualifications, training

and mentored jobs in the Kimberley rather than needing to go to cities to study and seek opportunities.

In the Northern Territory, the health system is buffered by a robust community of academic research undertaken by people who also work in the system. As such, it is recognised as a 'knowledge' economy because it generates so much learning and evidence able to be applied in practice systematically.

A great deal of knowledge is generated by the NT system of health and academia and as a result, the Territory has a very high profile in Indigenous health leadership and enjoys substantially more attention, favour and funding benefits from the federal government.

Getting research funding, support and opportunity in the Kimberley is much less easy for prospective students and researchers. Hence, the current efforts are patchy at best.

It is time the region's leaders – in health, education, wellbeing and community development – were solidly positioned to develop and drive a highly relevant and productive research agenda. This would help them and their university partners and students access better research funding and could also be a much more welcoming environment for researchers to feel valued and have their work regarded critically and with great interest for its applicability regionally and beyond.

A re-imagined contemporary model based on the best attributes and achievements of the Combined Universities Centre for Rural Health was considered by many to be an ideal solution to Broome.

Broome currently has one private university satellite campus struggling to sustain its full potential in the current market.

A substantial and well-designed academic research and education sector with excellent industry linkages and utility needs investing into the Broome milieu.

Leaders in such a development should have a suitable degree of expectation and performance obligation placed upon them. They need to deliver specific outcomes aligned to and enabling Broome's economic, health and wellbeing advancement growth and development.

Strategies to Support a Growing Economy

This short study has identified some key requirements and ideas for a health and wellness agenda within a broader economic growth plan for Broome.

They are summarised very briefly here:

1. **Expansion of health care** - as population grows, both the need and the viability prospects for a greater range of secondary/acute hospital and maternity/obstetric services will emerge – the scope for this will depend upon the pace, quantum and sustainability of population growth, mix and health status/demand;
2. **Primary health innovation** – these are critical in the chronic disease prevention and management domain. Some scope and support for innovation to deal with harder to reach people and problems – like a more family centric and slow-stream model – is desperately needed, especially by the Aboriginal Community Controlled Health Services sector;
3. **Leverage schools** - health outcome systems designed around the uniquely strong and long relationships children, their siblings and family units have with schools looks to be one of the most

exciting prospective ideas emerged from this exercise. It is highly developmental but the potential for what is inherently offered through schools is under exploited. In an environment where the 'needle' is just not moving any more, this should be thoroughly explored and tested for the potential to change measurable hard outcomes in the short to medium term as well as a longer term legacy impact on the next generation of adults, parents and employees.

4. **Community and social amenity** - the community of Broome needs some of its amenity problems treated. Living conditions and exclusion policies have the power and do 'neutralise health treatments and advice/counselling'. What is needed for Broome are:
   - A precinct for culture;
   - A hospitality solution for visiting Aboriginal people;
   - Local housing – better neighbourhoods;
   - Solution to the long standing land problem – reserves and municipal services for the remote communities;
   - An all-year round public transport system geared as much to the needs of the local consumers as for tourist visitors.
5. **Education, training and on the job work experience** –infrastructure and systems are needed in Broome to nurture careers in health and other industries in a growth scenario.
6. **Knowledge and research** - the organisation and execution management of research and its learnings and applicability for the Kimberley could and should be driven out of Broome.
7. **Nutrition** – this is a huge and systematically overlooked problem most people wrongly assume can be:
   - Dealt with by doctors;
   - Educated away through mass media health promotion campaigns; and
   - Fixed with greater promotion of exercise.
8. **Structural changes** - are essential in order to change things. The way things are financed and managed, the way solutions are designed and how they are executed all need to be re-designed. This is currently being explored by both state and federal governments (Regional Services Reform and Empowered Communities) and also by local organisations and leaders (for example NBY and Kimberley Institute). In the context of the BGP, some alignment and leveraging of some of the ideas and measures which will emerge is an opportunity.

Consideration of this ideas framework from the perspective of 'tradability/export' suggests some – but at this stage a somewhat narrow scope – possibilities:

1. Expansion of secondary health care systems – potential for private sector economy in health operating in a Broome hub and leveraging the broader Kimberley market;
2. Primary health innovation – exportable as best practice region wide and beyond;
3. The schools/health model – enormous best practice exportability state/nationwide (noting that this idea was sourced from research into a program established by an education leader in Kalgoorlie. If it is adopted (or something like it) in Broome, it would be already proven to be 'exportable'). There are a few people within the education system also trying to drive this innovation;
4. Cultural tourism (including art and performance) – enormous potential;
5. Research – as in the NT: greater recognition, influence, leadership, benefits flowing into Broome and Kimberley from a knowledge and research economy;
6. Leadership on prevention (especially community/politically drive) influencing reforms to food and public health policies on diet and nutrition coming from a strong driving force in Broome;
7. A food economy – enormous health benefits as well as enterprise and economy benefits.

There are a number of requirements contextual to the suite of ideas and strategies identified through this brief exercise and the aim to shift from the status quo in health and wellbeing as part of the BGP evolving.

Most of the ideas and actions would need to be progressed incrementally; and some would be more or less dependent on actual achievements in enterprise, economy, population growth and supply and demand dynamics. On the other hand, some developments within the health and wellness domain could positively influence achievement of population and economic growth targets. For example, things that get more kids achieving school graduation and being training/job ready would go hand in hand with enterprise and jobs growth.

The health system is not generally very good at enterprise thinking. Of course, there are some pockets emerging strongly nationwide. Examples are mole scanning; corporatized general practice; cardiac catheter laboratories; radiology and medical imaging are highly profitable enterprises in somewhat 'cornered markets'.

As most health systems are publicly funded (in the Kimberley), the predominant 'appetite' is for more government funding and by that measure, there is usually always some degree of a real/perceived burden of hardship and lack.

In this segment, we are suggesting that at least some of the ideas could be developed with the underlying intent being to establish working systems, patent them; possibly even package and franchise them; and market them with all the ongoing support and business enterprise that goes with it.

There is no reason why a 'culture of innovation and enterprise' cannot be threaded into health and wellness advances in Broome. It just is an overall idea that would require a bit of 'work' and finding of champions and highly competent individuals whose skill sets are aligned well to each and different stage/s of developments.

The table below is a beginning attempt to envisage how the key ideas might be framed over the short, medium and longer term time frames.

Requirement	Short term - 2024	Medium term - 2031	Long term – 2036+
Expanded secondary/hospital services – both volume/capacity and range/level of clinical specialty and diagnostics	Capacity and range satisfactory for current population; Planning for expansion scenarios in the next few years – including for the next 'stage' of infrastructure and service initiatives; Planning and roll-out of new infrastructure for midwifery based birthing and maternity care; for chemotherapy; for mental health and social and emotional wellbeing services; and for ambulatory hospital at	Re-cast population growth and demand assumptions; Continue and complete roll-out of contemporary service infrastructure; Develop a longer term campus plan – explore upward and outward solutions on and from existing campus.	Consider any need/case for a green field hospital and health campus development for the future beyond the next 20 years.

	home and comprehensive palliation services; Start exploring feasibility prospects for a attracting private health sector suppliers into the service mix in Broome (& for the region); Critical assessment of private health insurance levels; Preparation of the consumer market for private services – need and benefits of PHI.		
Innovation in primary health care	Explore avenues to advance the Family Health Centre model being developed by BRAMS – as a pilot co-designed to test very specific parameters; Develop a business case and seek financing (the WAPHA might be interested); Look to the Broome Model (KI) for possibilities to assist by securing investment partners; Create some patent on the model if possible; Explore packaging with franchising and licensing (like the Head Space business)	Evaluate and build on primary health innovation model; Promulgate and market license; Develop franchise/license management and systems for the market (if successful as a patented and tradeable model).	Continue development of packaged models and systems for a national and international market.
Leveraging schools & their enduring and constant relationship with children, their siblings and families	Examine and engage with key players in education and health – with the Broome Combined Schools group; Explore and design a leading edge model for Broome; Prepare a business case and seek out funders and investment partners; Have some regard for 'franchising' to a broader market – perhaps good enterprise	Promulgate and market the model; Develop business enterprise; Plan for and implement system growth to accommodate the enterprise; Take great care to keep refining the local model.	Enterprise growth in national and international markets.

	for NGO health services and schools which operate as Independent Public Schools (IPS); Have some careful respect for the enormity of the potential here – nurture and safeguard it for its potential tradability within the Broome economy.		
Cultural enterprise	Consider the development of a well sighted and scoped cultural precinct in Broome.	Continue development of culture activities; community functions; entertainment; tourism and enterprises	Expansion and growth in range, depth and value of activities, offerings and community value.
Research and knowledge economy	Explore and plan for trades and undergraduate advanced training and education in Broome; Strong focus on a wider range of key health professional and corporate and business courses; Explore the CUCRH model and engage people in designing a model suited to Broome's BGP aspirations; Undertake feasibility and business case development.	Consolidation and sustainability of new initiatives in training, education and applied research linked to a variety of industries (including health); Expand investor and partner base; Look for trading opportunities.	Growth and expansion.
Preventing chronic diseases caused by poor quality food & malnutrition	Get community leadership together to expand & promulgate leading edge scientific evidence & knowledge; develop outcome measures; and plan executable actions for chronic disease and disability prevention in Broome; Develop political influence – align with leading thinkers, champions and advocates; Create and action an applied research agenda around the prevention	Publish and promote learnings and improvements using political and media vehicles (this will help establish a strong evidence base and push/pull effect on languid (and wrong) public health prevention policies and move them forward much faster; Leverage Broome's leading position in this space; Work on next stages of emergency possibilities;	Actualise next stages of development and growth.

	measures and outcomes measurement.		
A food economy in Broome	Identify and action existing opportunities to get local and/or regional produced food in all Broome food retail outlets or alternatives (farmer's markets, farm shop sales); Investigate ways to lower (or subsidise) prices on the most nutritionally dense and appetite satisfying foods; Scope out a robust 'community garden' business system for all year-round seasonal vegetables and fruits; Explore ways to expand food interest, knowledge & skills – build around traditional diet and medicinal foods template (modernised adaptable interpretations).	Evolve food business over a wide front; Infrastructure and systems in place to support (and be supported by) a robust mix of food related enterprises; Build traditional foods, cuisine, products and eatery businesses and link them into the cultural tourism experience and cultural precinct; Ensure every food product raised, caught and grown in the district (and region) feeds local people at very attractive prices – open up distribution and marketing systems region wide (health benefits and a growing local food economy); Leverage global interest in grass fed animal products (eg rendered fats & both broth); traditional healing herbs; organic herbal health and skin care products – for local economic enterprise and for export.	

Appendix 1: Summary of Stakeholder Engagement

Kimberley Development Commission – Jeff Gooding
Notre Dame University – Sandra Wooltorton
Professor Patrick Sullivan – NDU/ANU
Sandra Joffe
Dr Jeanette Ward – Kimberley Population Health
Andrew Waters and staff – Kimberley Population Health
Bec Smith – Regional Director, WACHS
Peter Yu and Howard Pederson – Nyamba Burra Yawuru
Eunice Yu and Paul Lane – Kimberley Institute
David Wirken – Aarnja, Empowered Communities
Chris Mitchell – Regional Development Australia and Shire of Broome
Aletta Nugent and Sam Mastrolembo – Shire of Broome
Vicki O'Donnell and Robert McPhee – KAMS
Bob Mahony – BRAMS
Jeff Moffet – WACHS
Graham Searle – Regional Services Reform
Tracey Gillett – Regional Services Reform
Neale Fong – WACHS
Margie Warne – Boab Health Service
Andrew McGraw – WAPHA
Jan Lewis – KAHPF Secretariat
Broome District Health Advisory Council
Broome Hospital Operations
Former Principal, East Kalgoorlie Primary School
Earbus Foundation team (associated with EKPS).