Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Network

Needs Assessment Reporting Template

Name of Primary Health Network

Western QLD

Section 1 – Narrative

Needs Assessment process and issues

WQPHN's approach to the updated HNA was influenced by a number of factors including:

- The HNA completed in June 2016 remains current with little changed in terms of new data to significantly impact on the 'Opportunities, priorities and options' section. As such the baseline HNA and the accompanying technical paper (*KBC Australia: WQPHN Technical Paper 2016 Health Needs assessment)* remain the primary source documents in terms of data analysis and data sources;
- The WQPHN has used the process of updating the HNA to better highlight and explain the unique health-related issues and health service challenges that the health system in Western Queensland faces, As such, the objective has been on producing a document in which the information is more easily read and understood;
- Since the completion of the baseline HNA, the WQPHN has produced its strategic plan, *Our People, Our Partnerships, Our Health: Western Queensland primary Health Network Strategic Plan 2016-2020.* As such, we have taken the opportunity to reconfigure the 'Opportunities, priorities and options' section of the updated HNA to better align with the strategies and enablers in the strategic plan;
- Also, since the completion of the baseline HNA, the WQPHN has produced the *Western Queensland Primary Health Network 2016 LGA Health Profiles,* which provide an epidemiological snapshot of people's in each Local Government Area in Western Queensland.

Additional Data Needs and Gaps

The WQPHN requires access to more nuanced health-related information to enable it to better define health and service needs, and commission and evaluate services and programs. This will require an ongoing commitment by the region's key health partners, and other authorities depending on the issue, to work in partnership to develop the required regional health intelligence capability to support both decision-makers and service providers.

There are significant limitations in the existing data including;

- The HNA has relied on national-level and state-level data with different timeframes, and extrapolation to the remote environment of Western Queensland;
- The smaller the population the greater the potential for variation. Given some of the information was based on small numbers, caution must be used in the interpretation of some findings;
- The geographical boundary of the WQPHN was defined by the geographical boundaries of the three HHSs. In turn the HHSs boundaries are defined by LGAs which enabled data in most instances to be grouped under each HHS and the PHN where appropriate. However the PHN and HHS boundaries are not as well aligned with SA2 and statistical division level boundaries which has impacted on some of the analyses;
- Some of the data could be regarded as being out of date and again caution should be used in the interpretation of the findings in these cases;
- While acknowledging disparities in relation to Medicare access, it should be noted that regional MBS data most likely underestimates usage of services because the RFDS and other non-Government are unable to access Medicare. Further, while some of the hospitals in the small towns have 19(2) exemption, there is variability in the rigor of their MBS billing systems.

Section 2 – Outcomes of the health needs analysis

Outcomes of the health needs analysis		
Priority Area	Key Issue	Description of Evidence
Geography	Geographic size	In terms of geography, Western Queensland (WQld) with approx. 937,000 square km is the 4th largest Primary Health Network (PHN) after country Western Australia (WA) at ~2,478,000, Northern Territory (NT) at ~1,346,000, and country South Australia (SA) at ~963,000. Northern Queensland (NQld) is the next largest PHN in Queensland at ~511,000, which is just over half the size of WQld
	Low population density	In terms of population density Western Queensland PHN (WQPHN) is the most sparsely populated in Australia, with only one person for every 13 square km. The next most sparingly populated PHN is the NT (1 person/5.5 sq km), followed by country WA (1 person/4.5 sq km) and country SA (1 person/2 sq km). By comparison, NQld's population density is 1 person per 0.75 square km, which equates to 17 times the population density of WQld.
	Remote setting	Based on the Australian Statistical Geography Standard – Remoteness Area (ASGS–RA) classification system of five remoteness categories, WQld and the NT are the most remote PHNs with approx. 99% of their respective regions categorised as either Very Remote (the majority) or Remote. However, in the case of the NT, its small Outer Regional component centres on the city of Darwin, while in WQld it concentrates on the much smaller town of Roma.
Demography	Small population	WQld is arguably the most unique of the 31 PHNs across Australia, and has by far the smallest population (about 72,000). The next least populated PHNs are Murrumbidgee in country New South Wales (NSW), NT and country Victoria's Gippsland but they all have a population base approximately 3.5 times (or around 250,000) that of WQld. The median PHN in terms of population size is 604,000 (Western Victoria), which is a massive 8.5 times the population of WQld. Smaller populations mean lower patient volumes which impact upon both the viability, and the quality and safety, of health services.
	Low population growth	There is low forecast population growth for the region compared to the rest of Queensland – about 11% by 2036 compared to the State's 50%. While two of WQld's three Hospital and Health Service (HHSs) – North West and South West – are predicted to have positive population growth, Central West will have negative growth.

Outcomes of the health needs analysis		
	Transient population	Official population estimates can be unreliable given the Fly-In/Fly-Out (FIFO) mining sector, seasonal workers and, in particular, the grey nomad invasion during the cooler months. Demand for health services at tourist hotspots skyrockets during the peak season: for example, the town of Karumba's resident population of about 600 triples during April to September. In 2013, visitors to outback Queensland numbered 378,000, more than five times the resident population.
Socio-economic status	Low socioeconomic status	The vast majority of the region is ranked as socio-economically disadvantaged compared to the rest of Australia – meaning low incomes, employment rates and educational attainment and few skilled occupations. There are even higher levels of socio-economic disadvantage within the region's Indigenous population, with such disadvantage driving poorer health outcomes, earlier deaths and greater service needs.
	Consumer issues	Consultations identified that many people's decision to seek assistance were influenced by a poor understanding of health issues and how to access health services, cultural and language barriers, and unpleasant past experiences of using the health system.
Health status	Poor health status	The health of Western Queenslanders is generally poorer than that of people living in the rest of the State. Within the region, those in North West HHS generally have poorer health than those in South West and Central West. Compared to the rest of the State, Western Queenslanders have: • Lower life expectancy with WQld residents living almost two years less than their Queensland counterparts • Lower median age of death resulting in all Western Queenslanders dying younger than other Queenslanders – this difference is most stark in the North West where the gap is 14 years • Higher rates of deaths that could have been avoided through timely and effective health care • Higher rates of hospitalisation due to cardiovascular disease, diabetes, respiratory disease, cancer and injuries • Higher cancer rates with worse outcomes • Higher rates of potentially preventable hospitalisations (PPHs), those conditions that should be manageable in the community without the need for admission to hospital, due to remoteness, lower socio-economic status and a high Indigenous population. While the inequitable health status is largely a reflection of the comparatively poorer health of the Indigenous population and the relatively large numbers of Indigenous people who live in the region, this does not entirely explain the gap. Living in a remote setting is itself a risk factor due to poorer access to services, worse lifestyle profiles, and unique environmental conditions, for instance, physically dangerous occupations such as mining and agriculture, and factors associated with motor vehicle accidents.

Outcomes of the health needs analysis		
Health determinants	Poor health behaviours	People living in WQld are more likely to engage in behaviours associated with poorer health compared to the rest of the State, such as: • be obese or overweight • drink alcohol in life-time risky quantities • smoke daily • have poorer dental health.
	Vagaries of rural economies	Many parts of WQld rely heavily on the agriculture industry, and economies reliant on the beneficence of the seasons are inherently less stable than others. The resultant income and employment insecurity has the potential for substantial negative impacts on health and illness.
	Worse biomedical determinants of health	Indigenous children in some communities in Western Queensland are more likely to be born with a low birthweight, and experience childhood growth failure and repeated childhood infections. The consequences of these can be to affect their health in adulthood adversely through higher rates of chronic disease.
Maternal and child health	Higher fertility rates	Higher number of babies born per woman than in Queensland overall with the difference most marked in the North West and South West HHSs. Some of this difference can be explained by the greater number of Aboriginal and Torres Strait Islander (Indigenous) mothers in the WQPHN given that Indigenous women have higher fertility rates than other Australian women.
	Younger population profile	Compared with the rest of Queensland, the region has a younger population profile with a greater proportion of children under the age of 15 years (23% compared to 20%).
	Poor maternal health outcomes	• Generally poorer antenatal and postnatal health. Non-Indigenous infants and mothers in the Central West had a greater number of perinatal risks (low maternal age, fewer antenatal visits, smoking during pregnancy and not breast feeding) relative to the rest of Queensland, as did Indigenous infants and mothers in the North West and South West • Higher proportion of low birth weight babies for Indigenous mothers in the North West.
	Poor child health outcomes	• Apparent higher rates of infant and child mortality most noticeable in the North West followed by the South West • Poorer early childhood development and wellbeing profile, as determined by the Australian Early Development Census,

Outcomes of the health needs analysis		
		with Carpentaria, Far South West and Roma areas displaying the worst results • Greater proportion of young children at risk with the North West and the communities of Aramac, Barcoo and Boulia having the highest numbers • Generally higher childhood immunisation rates than for the rest of Queensland. Much of this difference can be explained by the greater number of Indigenous mothers and children in the region, especially in the North West and South West.
Mental health and substance abuse	Limited regional health information	Data on the prevalence and treatment of mental health and substance abuse disorders in Western Queensland remains poor, particularly in relation to primary mental health care. The needs analysis for mental health and substance abuse from the first Health Needs Assessment completed in June 2016, which relied heavily on surrogate data and extrapolation, remains current.
	Remote environment	The large remote areas and very small population of WQPHN create particular challenges for delivering effective, good quality mental health care to a highly dispersed, mobile population.
	High-risk factors	As previously described, there is a high level of socio-economic disadvantage of WQld communities and the health status of Western Queenslanders is worse than both other Queenslanders and Australians as a whole. The high incidence of chronic diseases and co-morbidity that flows from these circumstances is associated with higher prevalence of mental health and substance abuse disorders. People with chronic physical conditions are more likely to experience high rates of mental health disorders such as anxiety and depression. People with low prevalence but serious mental health disorders, such as psychosis, have significantly higher rates of chronic diseases. Early childhood neglect and abuse is associated with addiction to alcohol in later years and, as previously mentioned, there is a greater proportion of young children at risk in Western Queensland. People aged 16–85 years living outside of Major Cities are 34% less likely to report very high levels of psychological distress.
	High need, low inpatient care	The rate of presentations to Emergency Departments for mental and behavioural disorders in WQPHN is 60% higher than for Queensland overall, and the rate for suicide and self-inflicted injury is 30% higher.

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		In contrast, the hospitalisation rate for mental and behavioural disorder for people living in WQPHN is 35% lower than for Queensland as a whole.
	High alcohol consumption and related mortality	The rate of risky life-time consumption of alcohol for adults in WQPHN is 40% higher than the Queensland average, with the consumption rate for females living in the Central West HHS twice the Queensland rate. The mortality rate associated with excess alcohol consumption for people living in WQPHN is 49% higher than for Queensland as a whole. On a more positive note, the rate for alcohol-related road traffic injuries for WQPHN residents is 42% lower than for the rest of Queensland.
Indigenous health	Large Indigenous population	WQld has large numbers of Indigenous peoples. While recognising that several PHNs have larger total Indigenous populations, WQld is second only to the NT in terms of the Indigenous population as a proportion of the total population (14% and 23% respectively). Within Queensland, Northern Queensland PHN is the next largest with a proportion of 9%. Within WQPHN, 62% (8083) of its Indigenous population resides in the North West, 30% (3897) in the South West and 8% (999) in the Central West.
	Younger age profile	Indigenous Queenslanders have a younger age profile than the non-Indigenous population. Within the WQPHN, more than half the Indigenous population is under the age of 24 years, compared to around one-third for the total population. There is also a sharp contrast in the proportion of residents aged 65 years plus – 4% in the Indigenous population compared with 11% in the total population. In WQPHN, 30% of all children are Indigenous and this increases to 40% in the North West HHS.
	Poorer health status	• The life expectancy of Indigenous Queenslanders decreases as remoteness increases (Queensland 61.2, Major cities 65.3, Regional 61.0 & Remote 57.8) • The median age of death for Indigenous Queenslanders in 2009–10 was 57 years, compared with 80 years for the non-Indigenous population – a 23-year age difference. While the median age of death for Indigenous people in the North West was lower than for Queensland as a whole (53 years), it was actually higher in the South West (60 years) and Central West (65 years) areas. • As remoteness increases, so too does the burden of disease and injury in Queensland's Indigenous population in terms of Disability-Adjusted Life Years (1.47 times higher in remote areas than in major cities). Cardiovascular diseases caused the largest burden followed by diabetes, mental disorders and chronic respiratory diseases. The burden of disease for

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		Indigenous people in the North West was 2.1 times that of non-Indigenous Queenslanders.
Geographical hotspots	Health inequity	The Grattan Institute's recent analysis of PPH rates identified a number of geographical 'hotspots of health inequity' in WQld. These included the Lower Gulf (Carpentaria), Cloncurry (Mt Isa Region) and the Charleville Cluster (Charleville and Far South West). The report's findings added to the existing body of evidence, and substantiate similar conclusions by the WQPHN, the region's three HHSs and the Aboriginal Community Controlled Sector (ACCHS) about the priority areas in WQld (with the one addition of the Western Corridor). Furthermore, the report's recommended future actions reinforce the strategic approach for which the region's health partners have been advocating over the last 12 months – that is, jointly led, transformational, 3–5 year geographical trials, with tailored solutions, focusing on comprehensive and integrated care.

Section 3 – Outcomes of the service needs analysis

Outcomes of the service needs analysis		
Priority Area	Key Issue	Description of Evidence
Poor access to health services	Poor regional self-sufficiency	People living in WQld cannot access the range of health care services closer to home that are available for people in urban parts of Queensland. Large numbers of residents have to travel out of the region for acute and specialist care (North West HHS 57% outflows, Central West HHS 48%, South West HHS n/a). The region has a heavy reliance on FIFO specialist and other health services, which is dependent on a well-functioning local primary care service.
	Tyranny of distance	Costs of travel and lack of transport are regularly cited as major impediments to accessing health care by WQld residents. Increasing centralisation of health services in major regional centres and Brisbane has resulted in longer journeys for patients that often disrupt home life, increased costs in accessing health services, and a greater reliance on private and community transport providers for residents without private transport.
	Limited uptake in telehealth services	The slow adoption of telehealth services in WQld, especially in general practice, was identified as an issue given its proven usefulness in improving access to health services.
Lack of health system integration	Fractured service delivery	The health service system analysis clearly demonstrates a fractured service delivery environment that potentially results in gaps and duplication in care, poor coordination of care, and leads to an adverse impact on patient experiences and outcomes. The lack of integration in WQld can be seen at three levels: organisational, service and clinical. At an *organisational level*, there is a poorly articulated common frame of reference (i.e. shared mission, vision, values) between key health organisations servicing WQld. There are also limited inter-organisational relationships in place (e.g. strategic alliance, joint commissioning, select contracting), including common governance mechanisms to deliver comprehensive services. Previous planning exercises and funding initiatives have promoted siloed services, and there are perceived trust and turf war issues among some service providers. At a *service level*, needs are structured and organised around the services, not the patients. There is limited coordinated care across local primary health care (PHC), visiting specialist, hospital and tertiary services (vertical integration), and between health services, social services and other care providers (horizontal integration). As with the organisational level, there are perceived

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		professional tribalism and turf war issues. At a *clinical level* there are a lack of coherent processes within and/or across professions to support coordinated care (e.g. shared treatment guidelines, clinical pathways, disease registers, recall systems). Joint multi-professional care planning and case management are both limited, and there are no shared clinical records across the multi-professional team. Clinical leadership is also missing, and clinical governance arrangements unclear.
	Integrating care delivery	Integrated care development can be positioned on a continuum from informal *linkages* between health service providers (e.g. improved communication), to more formal *coordination* between providers (e.g. shared health information, clinical pathways), through to *full integration* of services within a single organisation (e.g. pooling resources, creating new organisation). The intensity with which organisations and services need to integrate with each other depends on the needs of the patient. The literature tells us that full integration approaches work best when aimed at people with little self-direction who have severe, complex, long-term and broad needs – which appears to describe many people living in WQld.
Limited general practice capacity	Marginal viability and sustainability of general practice	A challenging characteristic of WQld's health care environment is the borderline viability and continued decline of general practice in the region over the past 20 plus years. Traditional models of independent general practice, as characterised by private ownership and the rural general practitioner (GP) with hospital and after-hours responsibilities, have become less attractive for many younger doctors. This has seen the emergence of other general practice models such as those run by the Queensland Health (QH) Rural Generalist Pathway, the Aboriginal Community Controlled Health Sector and the RFDS. As such the current general practice environment in the region is distinguished by marginal sustainability, notable diversity and limited primary care capacity. While many of these alternative general practice models have been crucial in maintaining essential services in the region's communities, the driver for these new models has understandably meant that the focus has been on a GP's acute skills in dealing with accidents and emergencies, and clinical procedures such as general surgery, anaesthesia and operative obstetrics. The challenges now facing some of these new general practice models will be the need to recruit and retain a stable, appropriately skilled medical workforce, to deliver more comprehensive primary care services, to enable strong clinical leadership, and to create a more robust business model with a greater emphasis on care coordination and GP-led, team-based outcomes.
	Disconnect between general practice	In addition to the decline in general practice over the past few decades, and the growing difficulty of recruiting and retaining a stable medical workforce, has been the lack of integration of other primary care and specialist services with general practice, resulting in

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	and other providers	poorly coordinated and often duplicated care. While there has been an increased investment in allied health and specialist services in the region in the past 10 years, the design of these services has, to some extent, been disconnected from general practice and evolved in parallel. The WQPHN recognises the central role of the GP in the design of health services, and views general practice as the gateway to other primary care and specialist providers via referral pathways. To this end, primary care services need to be developed in a manner that supports GP-centred, multidisciplinary, team-based care.
	High general practice-type presentations at Mt Isa Hospital	Nearly half (48%) of Emergency Department (ED) presentations to hospitals in the WQPHN are accounted for by Mt Isa Hospital. This large number of presentations is believed to reflect unmet general practice needs in the town and/or the need for better management and referral of patients presenting to the ED after hours.
Poorly developed primary health care	Multidisciplinary team based care	The WQPHN Strategic Plan defines PHC as incorporating primary care, but having a broader focus through a comprehensive range of generalist services by multidisciplinary teams that include not only GPs and practice nurses, but also allied health professionals and other specialists working in Indigenous health, health education/promotion and community development. The experience from other similar service delivery environments tells us that multidisciplinary teams with good clinical governance are essential in the delivery of effective primary clinical care. The complementary roles of GPs, nurses and Aboriginal Health Workers (AHWs), supported by medical and allied health specialists, are critical in addressing the broad needs of many patients. This PHC model reflects that adopted by the ACCHS, and has parallels with the concept of the extended general practice used in other jurisdictions.
	Building a strong PHC base	In remote areas across Australia, similar to those in WQld, PHC services form the only stable access points to the health system in environments marked by fragile or non-existent service infrastructure. Critical services may be difficult to access for physical (e.g. distance, lack of transport, poor roads), economic (e.g. costs of getting to the specialist service and of treatment/medicines), cultural (e.g. cultural safety of services) or social (e.g. historical experience of Indigenous people with health services, competing social pressures) reasons. In these circumstances, PHC services play a key role in nurturing long-term patient relationships with health professionals and the health system, facilitating patient access across critical transition points (e.g. community to hospital or to larger regional centre), integrating services from outside the community (e.g. visiting specialist), mobilising around GPs, community-based, multi-

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		professional teams that include generalists working alongside specialists, providing continuity of care over time and over episodes, and so on. The findings of this analysis clearly show a poorly developed local PHC base in WQld, including: • Community-based PHC services limited in terms of size and scope • Inadequate staffing levels and/or disconnected team members to undertake both the clinical and non-clinical work to deliver quality outcomes • Local primary care services and support systems more oriented towards acute sector and treating sickness and episodic care (e.g. more GPs based in hospital than in the community) • An ad hoc approach to PHC service development and delivery, largely dependent on the ideas of individuals and individual organisations at the time • A service environment that appears largely specialist driven as opposed to primary care driven • Health care that appears poorly organised with a lack of contemporary systems to support service delivery.
Indigenous health	Pathway to community control	The health needs analysis highlights the large proportion of Indigenous people living in WQld. Also, it demonstrates that Indigenous people living in the region face more health challenges and experience more illness, disability and injury than other Western Queenslanders. Indigenous participation in, and control of, PHC services has been identified at both a State and national level as an effective action to improve health outcomes for Indigenous people and contribute to 'closing the gap'. Potential benefits include a more responsive health system, better access to and cultural security of services, and improved levels of family and community functioning – all of which contribute to improvements in health and wellbeing. The policy reform known as 'Transition to Community Control' implies that as communities' aspirations and capabilities expand, governments should be ready to engage with them to realise these aspirations in a manner consistent with ensuring a functioning health system.
	Low Indigenous workforce	Despite the high proportion of Indigenous peoples who live in WQld, they are significantly under-represented in the region's health workforce. The literature tells us that a strong Indigenous Australian workforce is integral to ensuring that the health system has the capacity to address the needs of Indigenous peoples. Indigenous health professionals can align their unique technical and socio-cultural skills to improve patient care and access to services, and ensure culturally appropriate care in the services in which they and

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		their non-Indigenous colleagues work. Given the challenges non-Indigenous service providers face in WQld in providing technical and culturally competent services, it will be essential to focus effort on building the capability and capacity of the resident Indigenous health workforce.
	Low rates of Indigenous annual health checks	In 2013/14 WQPHN had the lowest uptake of Indigenous annual health checks (MBS 715) of all Queensland PHNs (21.3% compared with the next best of 32% in NQPHN).
Mental health and substance abuse	Primary care's role in mental health and substance abuse	As part of their overall focus on a person's health and wellbeing, primary care services in WQld play an increasingly important role in identifying and managing mental health and substance abuse issues. The World Health Organization has called integrating mental health services into primary care the most viable way of closing the treatment gap for untreated mental illnesses, characterising primary care for mental health as affordable and an investment that can bring important benefits. One way to support primary care providers in delivering this holistic health care is to integrate and co-locate mental health services with physical health care. There is considerable evidence that this is highly effective. Where primary care and mental health providers are not co-located, coordination is more difficult but no less important. As such, all the features of the general health service needs analysis also apply to mental health and substance abuse services.
	Limited, fragile and poorly coordinated services	There are no designated inpatient mental health beds in WQPHN hospitals, and medical detoxification is generally unavailable. Residential rehabilitation services are provided at two locations in the North West, with limited support for people with complex conditions. GP undersupply is reaching critical levels and the non-medical mental health workforce is well below Australian and Queensland rates for all professions, apart from nurses and occupational therapists. Psychologists are particularly scarce with a population ratio one-third that of the rest of Queensland. The majority of mental health staff in the WQPHN region work from HHS community teams, nearly all of which are challenged by recruitment and retention to remote settings and prone to regular disruption and failure. The exception is Mt Isa where a larger critical mass has been built and a relatively stable team established. Access to Allied Psychological Services (ATAPS) and Mental Health Services in Rural and Remote Areas (MHSRRA) are provided

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		through a small pool of individual private practitioners, and a major provider in the former Medicare Local in the North West. Through both limited availability of GP primary care and the proliferation of self-referral arrangements, many ATAPS and MHSRRA services operate in isolation and have become focused on low-intensity interventions. For both patients travelling away and specialists visiting communities, stakeholder consultations consistently reported difficulties in the sharing of patient information and in linking specialist support for the planning and delivery of primary mental health care. In this environment, the care, enthusiasm and innovation shown by many service providers has dissipated.
	Integrated regional planning	Historically, there has been little opportunity to plan primary mental health services or configure the necessary workforce for WQld as a whole. The bulk of planning has been focused within individual organisations, locations and professions. The current service environment has evolved over many years. WQPHN recognises that commissioning and development activities will need to balance the need for new services with supporting and reorienting current contracted services towards a PHC model. WQPHN has also received strong support from providers within the region and from the Queensland Aboriginal and Islander Health Council (QAIHC) and QH for co-design of an integrated regional mental health and suicide prevention plan. This will be the priority activity for 2016–2017 and will include developing a new model for primary mental health care in WQld within the plan development. At the same time WQPHN has the opportunity to continue to build projects and activities to bolster general practice capacity at the centre of the primary mental health care model and to implement a number of new services at pilot sites. Commissioning tools are also being developed that will promote the connection of allied health providers to general practice services, and ensure that contracts and governance arrangements reflect the common vision and objectives being developed between the major funders of services in the region. These developments will mirror the general PHC model and systems for managing chronic disease. The alignment of mental health within the overall system for delivering PHC will be critical for the small, widely dispersed and high-needs population of WQld.
Health intelligence	Timely and good quality health data	Health intelligence is one of the underpinning enablers for quality, integrated care. However, obtaining a comprehensive 'health data story' for WQld has been an ongoing challenge for health service providers, government agencies and the community. The reasons for this include: • Lack of access to complete Medical Benefits Scheme (MBS) statistics due to the ineligibility of existing medical practitioners to claim (e.g. Royal Flying Doctor Service (RFDS), North and West Remote Health)

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		• Multiple health service providers, both resident and FIFO, each with their own patient health record system (both electronic and paper-based) • Lack of access to disaggregated population health information due to the region's small populations, making the availability of locally relevant data difficult to obtain and assess • Need for a shared 'health intelligence presence' to ensure the collection and interpretation of locally relevant information to better support service providers.
	General practice support to improve data quality	There is a need to develop better general practice systems to improve the identification, recording, reporting, analysis, interpretation, sharing and application of health data. Improved health information is essential for responsive and responsible service planning, developing local population lists and disease registers for planning and delivering clinical care, and monitoring and evaluating the effectiveness of care.
Attracting and retaining a skilled health workforce	Low number of GPs	Health Workforce Queensland reports the region has 92 GPs, which equates to 1 GP per 780 persons and aligns with the 1:750 benchmark for a rural GP with after-hours/hospital responsibilities. However, the WQPHN figure is artificially high, and leads to a false conclusion given it is a simple head count and not a full-time equivalent (FTE) number. It also includes acute-focused medical practitioners like the RFDS and hospitalists who work in a GP setting 1–2 sessions per week, as well as 'regular' locums sharing a position to service a town. Best guess estimate would be 60 FTE, which equates to 1:1200 ratio. Furthermore, it could be easily argued that the region needs a GP:population ratio of around 1:600, double the current FTE GP number, given the underlying need for more PHC due to the region's poorer health status, the broader scope of practice for GPs and the need for them to spend time travelling between different worksites. GP supply has reached a critical level in many parts of WQld with consultations signalling a heavy reliance on locums, which has been having an impact on service capacity and continuity. National data ranked WQPHN as last for the proportion of adults who had a preferred GP in the past 12 months, although the NT was excluded from analysis (44%, next best PHN was 72%). The successful recruitment and retention of an adequate GP workforce in WQld should involve active partnerships with the WQPHN, the HHSs in the region, the Generalist Medical Training Unit, Health Workforce Queensland, QAIHC, the tertiary education sector, professional colleges, and so on.
	Workforce development	Workforce development in WQld has tended to focus on medical practitioners, however, the entire health workforce needs to be developed in keeping with cross-disciplinary and generalist requirements. There is a critical need to expand existing scopes of

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		practice and create new roles to optimise workforce capacity and to meet health care needs. The development of more advanced roles needs to be progressed over a wide range of remote health workers including GPs, nurses, allied health workers and AHWs.
Tackling agreed health priorities	Preventable chronic diseases	The health service needs analysis shows that WQld has disproportionately high numbers of people with chronic and complex conditions such as heart disease, diabetes, cancers, respiratory diseases and mental illness. Furthermore, these conditions are the leading causes of illness, disability and death in the region. Lastly, the region's health system is not set up to prevent and manage these chronic diseases effectively.
	Child and maternal health	The analysis identifies that WQld has a higher number of babies born per woman and a younger population profile than Queensland overall. It highlights proportionally more low birthweight babies, early years illnesses, and poor child development and wellbeing. The origins of many chronic diseases are set in utero and early childhood. As such, deficits in the early years (including before birth) can predispose people to a lifetime of ill health. In addition, early childhood is a time of rapid growth and development and establishes the foundations for a child's future development, health, learning and social wellbeing. These early experiences set the stage for later success in adolescence and adulthood. There is good evidence that investment in promoting child development and wellbeing in the early years is more cost effective than addressing ill health, poor social outcomes and educational deficits later in life.
	Mental health and substance abuse	The analysis presents a sobering critique of mental health and drug and alcohol services that have been: • diluted by low population numbers and dispersed over a large region to the point of ineffective or uncertain coverage • impeded by the absence of a primary care foundation and the institutionalised structural separation between State- and Commonwealth-funded services • dealing with some of the highest mental illness and substance abuse morbidity and mortality rates in Australia.
	Joint planning strategies	The bulk of planning has been focused within individual organisations, locations and professions and there is a critical need for more joint planning. Clearly, preventable chronic disease, maternal and child health, and mental illness are critical issues for action, and regional strategies will be required to provide frameworks for the development and implementation of initiatives in these areas.