OUR PEOPLE
OUR PARTNERSHIPS
OUR HEALTH

2022–2025
Health Needs Assessment Summary

Western Queensland Primary Health Network

phn
WESTERN QUEENSLAND

An Australian Government Initiative

ACKNOWLEDGMENT OF COUNTRY

We wish to acknowledge the traditional custodians of the land on which we share our lives, care for our families, communities and country to create the best possible future for all our children for the generations to come. We acknowledge Elders both past and present and acknowledge Elders from the Stolen Generation. It is their strength and spirit that makes our work possible. It is to their memory we dedicate our efforts.

MESSAGE FROM THE CEO

Primary health care is the cornerstone of our health system where the majority of a person's health needs are met throughout their lifetime. This also includes broader public health issues and focusing on wider determinants of health, which are fundamental to improving health outcomes.

Countries with strong primary health care systems are more adaptable, flexible and better able to respond to population health and wellbeing. In Australia, access to health care is uneven, with people living in cities having more consistent service access when compared to people living in rural and remote areas.

All Western Queenslanders deserve the right care, right in their community. Urgent rural health reform is required, that supports place-based solutions for regional coordination, collaborative co-commissioning, interagency workforce development and funding reform. The key opportunities and priorities identified through out the consultative process of this Health Needs Assessment (HNA) are framed around the Recommendations from the Primary Health Reform Steering Group to inform the Australian Government's Primary Health Care 10 Year Plan.

As a rural and remote PHN, our key focus is on achieving health equality through the lens of the quadruple aim framework, that is more person-centred, efficient, professionally rewarding and whole of population focused health care. We continue to work towards integration of our health networks across primary care, secondary and tertiary sectors and other parts of the health system, aged care, disability care and social care system. A key role for WQPHN is to not only increase the efficiency and effectiveness of primary health care services, but to support continuity of care for individuals, particularly those at risk of poor health outcomes.

We continue to work with general practice, Aboriginal Community Controlled Health Organisations (ACCHOs), Hospital and Health Services (HHSs), community pharmacies, allied health services, mental health services, community health and nursing services, dental and oral health services and gather input and advice from the Clinical and Consumer Advisory Councils, MoU partners and communities across the region.

The purpose of the Western Queensland (WQ) HNA is not only as a planning and commissioning guide, but a catalyst for discussion about the health needs of the population within the WQPHN region. Used in conjunction with the WQPHN Outback Insights Health Intelligence Dashboard, the HNA has identified opportunities for early innovation and transformation to build greater primary health care capability, so that we can respond more directly to the significant health challenges that affect organisations and individuals alike across our vast catchment.

Sandy Gillies
CEO, Western Queensland Primary Health Network

WHAT ROLE DOES WQPHN PLAY IN PRIMARY HEALTH CARE?

A key role of WQPHN is to assess the health care needs of communities and commission health services to meet those needs, minimising gaps or duplication. This is achieved by supporting health services to connect with each other to improve people's care and strengthen the primary health care system. This is achieved through three main roles including:

- commission health services to meet the needs of people in their regions and address gaps in primary health care
- work closely with general practitioners (GPs) and other health professionals to build the capacity of the health workforce capacity to deliver high-quality care
- integrate health services at the local level to create a better experience for people, encourage better use of health resources, and eliminate service duplication.

ACKNOWLEDGEMENTS

WQPHN gratefully acknowledges the valued input of people, partners, organisations and the WQPHN staff for their valuable contributions and insights which have informed the Health Needs Assessment.

WQPHN commissioned KBC Australia to undertake the consultation, research, analysis and development of the 2022–2025 Health Needs Assessment. The KBC team – Dr Kristine Battye, Dr Hugh Burke, Sally Butler and Amy Gormly, appreciate and thank the many who willingly and thoughtfully participated including: community members; the North West, Central West and South West Clinical Chapters and Community Advisory Councils; the three Hospital and Health Services; GPs, allied health, Aboriginal Health Workers; the Nukal Murra Alliance representing the Aboriginal Community Controlled Health Organisations; aged care providers; Health Workforce Queensland; RFDS; CheckUP; James Cook University; local government and WQPHN staff and board members.

HEALING COUNTRY – YAPATJARRA MUU

WQPHN undertook an extensive search to find artwork created by local Traditional Owners which would reflect the unique nature of our Western Queensland Aboriginal and Torres Strait Islander heritage. Brooke Sutton's soulful piece called "Healing Country" was selected by the Working Group to be proudly featured in the WQPHN Reconciliation Action Plan. Brooke is a contemporary artist from the Kalkadoon Traditional Owner group and this painting is her personal interpretation of "Yapatjarra Muu" which means in the Kalkadoon language "Healing Country".

ACRONYMS

ABS – Australian Bureau of Statistics
ACCHO – Aboriginal Community Controlled Health Organisation
ACCHS – Aboriginal Community Controlled Health Service
AEDC – Australian Early Development Census
AIHW – Australian Institute of Health and Welfare
AHPRA – Australian Health Practitioner Regulation Agency
AHW – Aboriginal Health Worker
AODTS – Alcohol and Other Drug Treatment Services
APNA – Australian Primary Health Care Nurses Association
ASR – Age Standardised Rate
CACH – Cunnamulla Aboriginal Corporation for Health
CDM – Chronic Disease Management
CL – Commissioning Locality
COAG – Council of Australian Governments
COPD – Chronic Obstructive Pulmonary Disease
COVID-19 – Coronavirus Disease 2019
CPD – Continuing Professional Development
CRRH – Centre for Rural and Remote Health
CWAATSICH – Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health
CWHHS – Central West Hospital and Health Service
ED – Emergency Department
EMR – Electronic Medical Record
FTE – Full Time Equivalent
GP – General Practitioner
HHS – Hospital and Health Service
HNA – Health Needs Assessment
HWQ – Health Workforce Queensland
ICOP – Indigenous Cardiac Outreach Program
IROC – Indigenous Respiratory Outreach Care
IRSD – Index of Relative Social-Economic Disadvantage
ITC – Integrated Team Care
LGA – Local Government Area
MBS – Medicare Benefits Scheme
NDIS – National Disability Insurance Scheme
NGO – Non-Government Organisation
NMHSS – Nukal Murra Health Support Service
NWHHS – North West Hospital and Health Service
PHIDU – Public Health Information Development Unit
PHN – Primary Health Network
PP – Private Practice
QAIHC – Queensland Aboriginal and Islander Health Council
QGSO – Queensland Government Statistics Office
RACFs – Residential Aged Care Facility
RFDS – Royal Flying Doctor Service
RTO – Regional Training Organisation
SA – ABS geographical Statistical Area
SD – Statistical Division
SEIFA – Socio-Economic Indexes for Areas
SMO – Senior Medical Officer
SQRH – Southern Queensland Rural Health
SWHHS – South West Hospital and Health Service
WQ HCH – Western Queensland Health Care Home
WQPHN – Western Queensland Primary Health Network
QLD – Queensland

CONTENTS

SECTION 1: OUR PHN REGION

GEOGRAPHY

A beautiful landscape of contrasts spanning half of Queensland's land mass, Western Queensland is rich in culture with iconic landscapes and thriving farming and mining industries.

The Western Queensland Primary Health Network (WQPHN) is geographically the fourth largest Primary Health Network (PHN) in Australia, with a total land area of 956,438 km^2 – equating to 55% of the total land area of Queensland.

The region covers a vast landscape where long distances are required to access services. The demography is diverse with natural and environmental impacts major challenges, as both floods and droughts are common.

OUR POPULATION

Home to approximately 61,541 people (QGSO, 2021), 10,671 who are Aboriginal and Torres Strait Islander and 34 Aboriginal language groups. The population of the PHN has mixed health status with pockets of high advantage which are in direct contrast to large areas of extreme disadvantage.

COMMISSIONING LOCALITIES AND HOSPITAL AND HEALTH SERVICES

WQPHN have established seven (7) unique Commissioning Localities (CLs) in consideration of primary care flows, funding, demographic and cultural considerations.

The CLs provide a place-based regional framework to plan and provide a way for WQPHN and its partners to work together to tackle health inequality.

COMMISSIONING LOCALITIES AND HOSPITAL AND HEALTH SERVICES

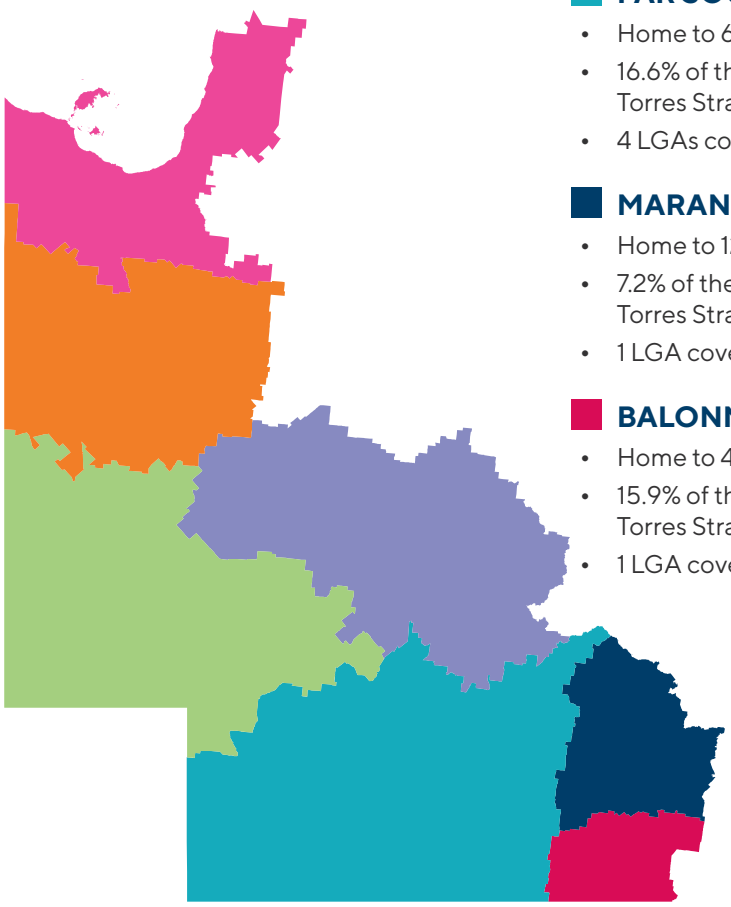
The region has three Hospital and Health Services (HHS) within the catchment including Central West HHS (CWHHS), North West HHS (NWHHS) and South West HHS (SWHHS). Mount Isa is the largest town in NWHHS, Roma is the largest town in SWHHS, and Longreach is the largest town in CWHHS.

LOWER GULF

- Home to 5,089 people
- 66.9% of the population are Aboriginal and Torres Strait Islander
- 4 LGAs covering a land mass of 107,591 km²

MOUNT ISA AND SURROUNDS

- Home to 22,613 people
- 17.4% of the population are Aboriginal and Torres Strait Islander
- 4 LGAs (Boulia LGA split) covering a land mass of 119,107 km²



WESTERN CORRIDOR

- Home to 757 people
- 19.4% of the population are Aboriginal and Torres Strait Islander
- 3 LGAs (Boulia LGA split) covering a land mass of 200,624 km²

CENTRAL WEST

- Home to 9,201 people
- 6% of the population are Aboriginal and Torres Strait Islander
- 4 LGAs covering a land mass of 186,748 km²

FAR SOUTH WEST

- Home to 6,872 people
- 16.6% of the population are Aboriginal and Torres Strait Islander
- 4 LGAs covering a land mass of 188,751km²

MARANOA

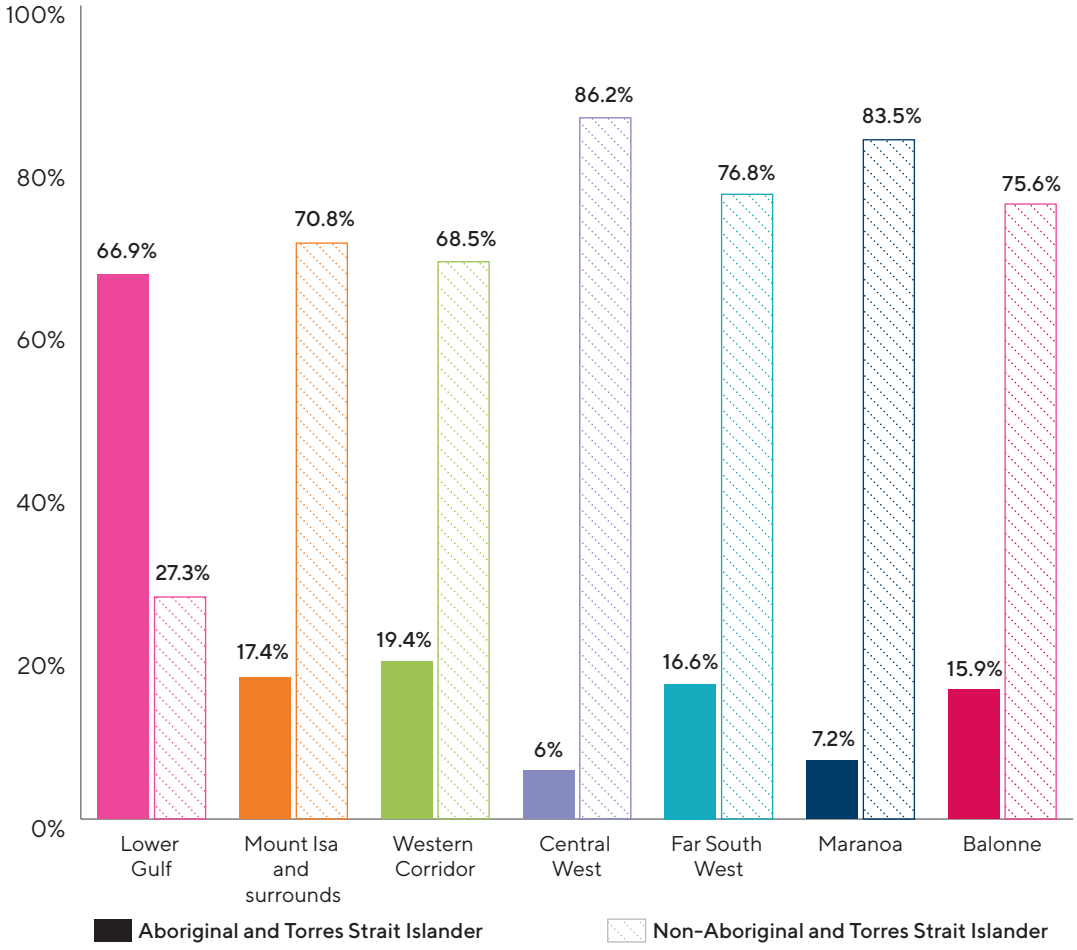
- Home to 12,688 people
- 7.2% of the population are Aboriginal and Torres Strait Islander
- 1 LGA covering a land mass of 58,830 km²

BALONNE

- Home to 4,321 people
- 15.9% of the population are Aboriginal and Torres Strait Islander
- 1 LGA covering a land mass of 31,150 km²

Figure 1. Commissioning Localities

Figure 2. Population by Commissioning Localities



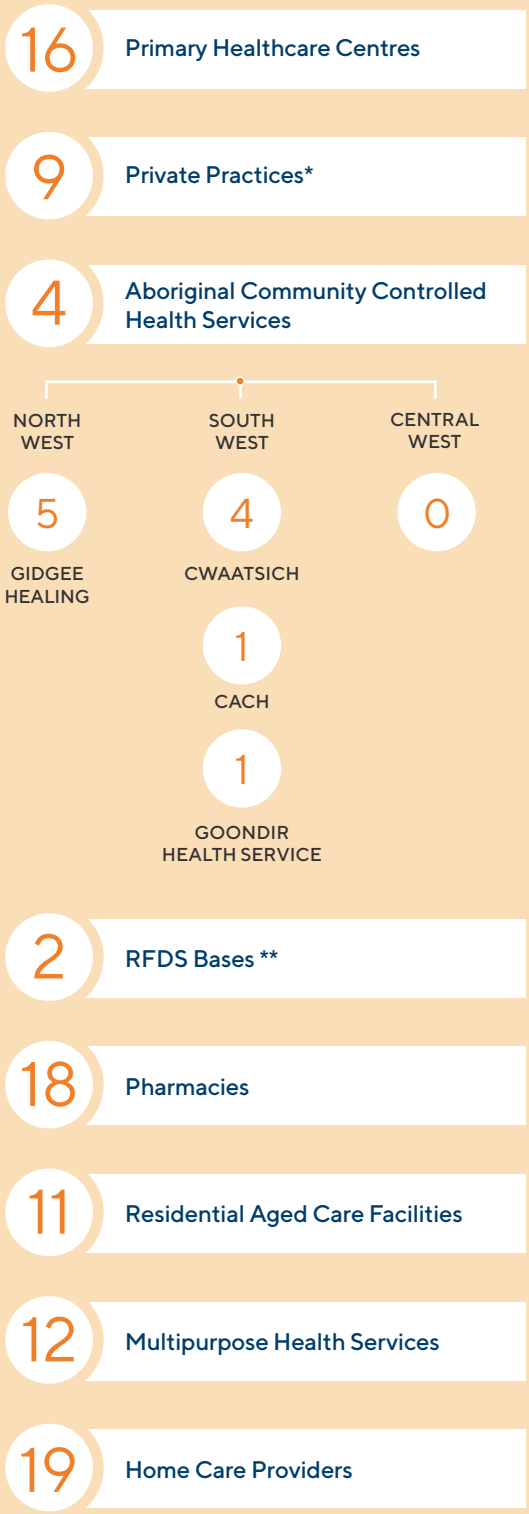
88% of the population live in remote and very remote areas.

CONSIDERATIONS

Remoteness has implications for users of health services, in terms of a general reduction in access to necessary services. The people living in WQPHN face a unique set of challenges in maintaining and accessing good health care with long distances to services, poor regional public transport, limited patient and family accommodation, telecommunication constraints and impacts of extreme weather events.

Health and community services in remote and very remote areas tend to experience difficulty in attracting and retaining the necessary health care staff to service the needs of the population. Hence, as one of the most remote PHNs in the country, WQPHN faces unique challenges in meeting the health needs of its people.

Figure 3. The types and number of service organisations operating in Western Queensland



* Breakdown of Private Practices (3 x Mount Isa, 1 x Cloncurry, 1 x Barcaldine, 1 x Longreach, 2 x Roma, 1 x St George)

** Breakdown of RFDS bases: South West, Charleville (1) North West, Mount Isa (1)

REMOTENESS

The remoteness of the region is an important factor in assessing the health needs of its population. Based on the Modified Monash Model, Western Queensland, along with the Northern Territory, are the most remote PHNs.

- 88% of the population live in remote and very remote areas.
- 4 CLs have people living mostly in very remote areas.
- 2 CLs have people living mostly in remote areas.
- 1 CL has half the people living in outer regional areas, with the other half in remote and very remote areas.

HEALTH SERVICE PROFILE

Due largely to the remoteness of the region, and the population profile of the people in the region, WQPHN has a unique health service structure set up to address the needs of the people it serves. The health service system is funded through multiple Commonwealth and State sources resulting in a very complex service system. HHSs deliver acute care, procedural services, community health, mental health and alcohol and other drug services, visiting medical specialist services, as well as aged care services in Multipurpose Health Services.

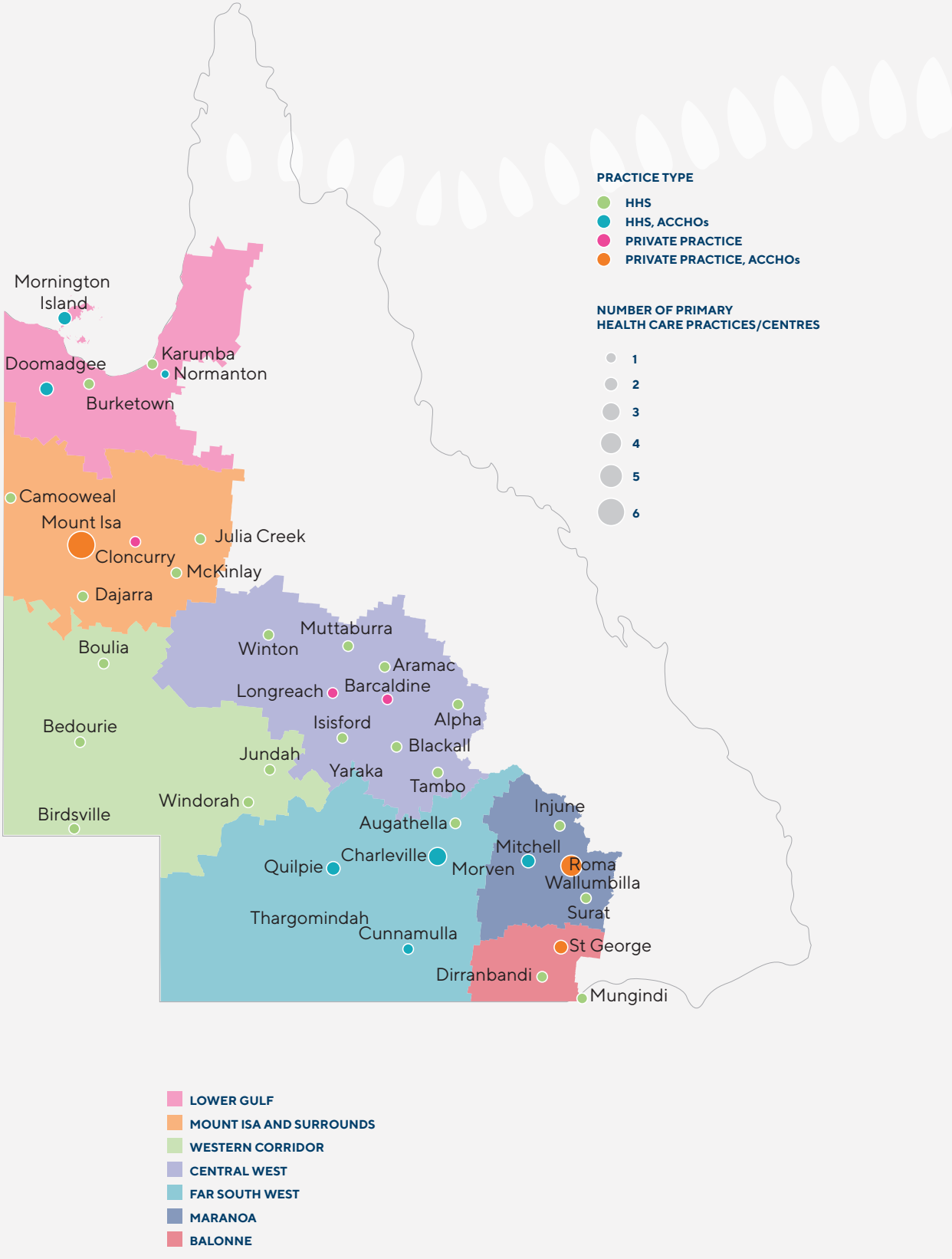
In addition to medical retrieval services, the RFDS provides GP services to primary health clinics in small communities in the region.

Domiciliary nursing services and Home and Community Care services are provided by NGOs, local government as well as HHSs in some locations.

Residential aged care facilities are operated by a range of providers including local government, NGOs, and for-profit providers, in addition to Multipurpose Health Services operated by Hospital and Health Services in some regions. Home and Aged Care providers include local government, HHSs and NGOs.

There is an array of visiting medical specialist, allied health and specialist nursing services across the PHN catchment. Some services are based in the main centres of Mount Isa, Roma and to a lesser extent Longreach and provide outreach services from these hubs to smaller towns and communities. In addition, there are visiting services to the region from larger metropolitan and regional cities.

Figure 4. WQPHN – Primary Health Care Practice Type and Practice Numbers Map



SECTION 2: OPPORTUNITIES AND PRIORITIES

The WQ HNA was conducted between June and November 2021. The methodology included: a review of previous health and workforce needs assessments; program evaluation reports, service activity reports; analysis of population data; service mapping; surveys of service providers, community and WQPHN staff to identify priority issues using a life-course approach; and consultation with key stakeholder groups.

The qualitative information and data was synthesised to identify key themes and priorities, and opportunities to progress activity to address these. The priorities and opportunities are aligned with the draft recommendations from the Primary Health Reform Steering Group to inform the Australian Government's Primary Health Care 10 Year Plan. These priorities and opportunities were tested with the WQPHN Executive Management Team and Board before being submitted to the Commonwealth Department of Health.

OPPORTUNITIES AND PRIORITIES

Reshape the primary health care system to create meaningful sharing of resources and reduced service duplication and fragmentation

Deliver funding reform to support integration and a one system focus

Provide ongoing support and development of existing WQPHN partnership arrangements to enable flexibility for local solutions to meet community needs and a tangible demonstration of investment and redirection of funding towards primary health care.

Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice

Enable a culture of innovation to improve care at the individual/population level, build 'systems' thinking and ensure application of cutting edge knowledge and evidence.

Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them.

Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support.

- Provide ongoing support and further development of the WQ Health Care Home (WQ HCH) program to enable quality patient care and adoption of practice-based systems to support team-based care.
- Through the WQ HCH identify mature sites and trial patient activation measure ideally using practice staff trained in coaching or motivational interviewing.
- Provide ongoing advice and support to general practices to help enhance their viability and sustainability.

Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islanders through structural reform of the primary health care system

- Provide ongoing support and development of The Nukal Murra Alliance.
- Continue to invest in the Western Queensland ACCHOs as the preferred providers of primary health care services to Aboriginal and Torres Strait Islanders.
- Support Gidgee Healing, NWHHS and other key stakeholders to undertake a review of the community control pathway and health service model for the Lower Gulf including the communities of Mornington Island and Doomadgee, with an aim of developing the most appropriate community control governance option, GP workforce solution and integrated primary care system for the region.
- Maintain support for the Nukal Murra Integrated Team Care (ITC) Health Support Services.
- Support Nukal Murra Alliance, CWHHS and other key stakeholders to examine the transitioning of government-run Aboriginal health services in the region to community-control where this will better meet the needs of communities and improve outcomes.
- Work with Nukal Murra Alliance and other key stakeholders to develop an Aboriginal and Torres Strait Islander health training and workforce strategy with an aim of developing and supporting Aboriginal and Torres Strait Islander workforce to work to top of scope in delivering primary health, mental health, aged care, disability and family support services.
- Trial the implementation of some place-focused interventions within a geographical area, be it a town or community, to identify likely causes of the health system failures and develop solutions to bring down potentially preventable hospitalisations over time.

Prioritise structural reform in rural and remote communities

- Trial the implementation of some place-focused solutions and partnerships within a geographical area, be it a town or community, as a means of supporting better integration and cooperation across local providers within a 'whole-of-population' focus in order to reduce risks that contribute to fragmented and poorly coordinated services.
- Work with HHSs, GP providers and other key stakeholders to review existing GP service models in Western Queensland and explore new models, with an aim of developing a joint plan that supports a mixture of general practice models in the region in order to support a sustainable and quality supply of GPs in general practice and deliver viable remote and rural general practice services across all the towns in the region.
- As part of the general practice review, explore the adaptation of the Rural Area Community Controlled Health Organisation (RACCHO) proposed service model to suit local community circumstances and needs, and state jurisdictional health system conditions, in the region. Assuming strong local support in one or more towns for the RACCHO service model lobby Commonwealth and state jurisdictions to trial its development and implementation in the region.
- Continue to support existing local private general practices, including ACCHOs, so as to maintain ongoing community access to these established services.
- Continue to support the RFDS as a discernible general practice in Western Queensland and support the development of chronic disease management (CDM) and business models that builds general practice capacity.
- Support NWHHS and Mount Isa general practice providers to revisit and review the Emergency Department Avoidance Strategy addressing the high number of low acuity presentations to the Mount Isa Hospital Emergency Department.

Support people to access equitable, sustainable and coordinated care that meets their needs

- Work with CheckUP, GP service providers and other key stakeholders to review the Western Queensland CheckUP visiting specialist and allied health schedule with an aim to supporting greater medical specialist led multidisciplinary team based care.
- Work with CheckUP and other key stakeholders to jointly develop and implement a collaborative commissioning program for Western Queensland that initially focuses on community paediatric and child health services, child and adolescent mental health services, community geriatrician and older persons services.
- Work with CheckUP and other key stakeholders to commission more region-wide visiting medical specialist led health services (similar to IROC, ICOP & Deadly Ears) through 'metropolitan-remote medical specialist partnerships' with metropolitan-based institutions such as HHSs, hospitals, hospital departments and universities (relying less on opportunistic ad hoc individual specialist service providers) and integration of service provision with health services research, to build an evidence base of what works to deliver improved outcomes, and training opportunities to promote succession planning.
- Undertake a review of services for people living with a disability and their carers, with an aim of developing a more appropriate disability service model for Western Queensland.
- Review and refine the mental health stepped care model to:
  - » promote optimal utilisation of low intensity services and ensure clinical services are directed to those patients with higher care needs
  - » maximise use of available resources including Better Access and PHN funding to improve reach of commissioned services to communities with small populations
  - » embed mental health stepped care into the WQ HCH model.
- Implement the Western Queensland five-year Mental Health, Suicide Prevention and Alcohol and Other Drug Treatment Services Plan (2021 – 2026).
- Given the expanding role of PHNs in aged care (flagged in the 2021-2022 Federal Budget in response to the Royal Commission into Aged Care Quality and Safety), the WQPHN works with and support others (e.g., RACFs, HHSs, visiting geriatrician and aged care services, GP providers, allied health providers) to undertake more detailed review of aged care issues including gaps and challenges in system navigation, delivery of coordinated care, and provision of high-quality clinical care to older people in the aged care system and develop a road map that identifies opportunities/priorities to improve Western Queensland aged care system.

Foster cultural change by supporting ongoing leadership development in primary health care

- Provide ongoing support to the region-wide Clinical Council and HHS level Clinical Chapters.
- Provide ongoing support to the region-wide Consumer Advisory Council.

Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce

Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care.

Support the role of nursing and midwifery in an integrated Australian primary health care system.

Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system.

Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce

- work with HWQ to develop an accurate annual report card of the health workforce working in the primary care environment (distinct from the hospital environment) in Western Queensland to inform and stimulate health workforce and health services planning
- continue to support existing private general practices to provide sustainable and quality GP services through WQPHN's GP locum support program.
- Support private general practice, including ACCHOs, to create a 'sister remote and rural practice program' that links metropolitan practices and/or individual GPs with Western Queensland practices to employ metropolitan based GPs who would regularly visit providing face to face services, and also virtually connected form their home base between visits, providing remote telehealth consultations and other practice support functions, lead and coordinated by the remote and rural practice.
- Support the efforts of individual GP providers to attract and retain a skilled primary care workforce including:
  - » developing strategies to support hospital nurses to undertake APNA training in primary care e.g., accessing HWQ heath workforce scholarship program
  - » training and CPD for practice managers
  - » HR support.
- Support local and visiting primary health care providers to identify opportunities to trial new or expanded roles to support an integrated multidisciplinary team (e.g., local Allied Health Assistants working under the direct or indirect supervision and delegation of an allied health professional to assist with clinical and program related activities, Nurse Practitioner delivering some of the GP services traditionally provided by a GP).
- Support HWQ, Queensland Health and other key stakeholders to progress the allied health workforce development scoping work done in SWHHS (2021) and NWHHS (2020) and the recommendation to develop and implement a regional, inter-agency, collaborative allied health workforce strategy based on the Allied Health Rural Generalist Pathway.
- Using an inter-agency approach, develop and implement a training and employment pathway for allied health assistants, assistants in nursing, Aboriginal and Torres Strait islander Health Workers, aged care and disability workers. Key agencies include employing organisations (i.e., HHSs, ACCHOs, local government, aged care providers and NGOs), SQRH and CRRH with clinical educator capability, CheckUP (delivering the Gateway to Industry Program) and RTO with capacity and flexibility to deliver training in the regions.
- Initiate a proof of concept in the Central West where there are identified AHW vacancies.

Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care

- WQPHN continues to engage with the Rural and Remote Digital Healthcare Committee as the Queensland Digital Strategy for Rural and Remote Health Care roadmap is implemented to progress improvements in sharing patient record data such as EMRs, My Health Record and improved access to The Viewer between multi-speciality and inter-disciplinary teams.
- The PHN also investigates opportunities to share patient consented health records across the continuum of care drawing on learnings from South West Sydney PHN (Integrated Real-time Active Data) (iRAD) interoperability project.
- Identify and promote opportunities to build workforce and consumer digital readiness to expand telehealth use and confidence to embrace technology and digital modes as an adjunct to face-to-face services.

The following sections (3,4 and 5) of this report further detail the findings and show through the data the health needs analysis by social determinant, stages of lifecycle and health conditions and health service and systems. The gaps and issues have informed the opportunities and priorities.

SECTION 3: SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people are born, grow, live, work and age. An individual's socio-economic status is shaped by their personal circumstances and can strengthen or undermine the health of individuals and communities.

In general, people from poorer social or economic circumstances are at greater risk of poor health than people who are more advantaged (AIHW, 2020). The links between the social determinants of health and the development of disease such as chronic disease are complex, although the evidence is clear that health and illness are not distributed equally within the Australian population. Differences in health status tend to follow a gradient, with overall health improvement associated with access to opportunities and resources linked to improved socioeconomic position.

AREAS OF DISADVANTAGE

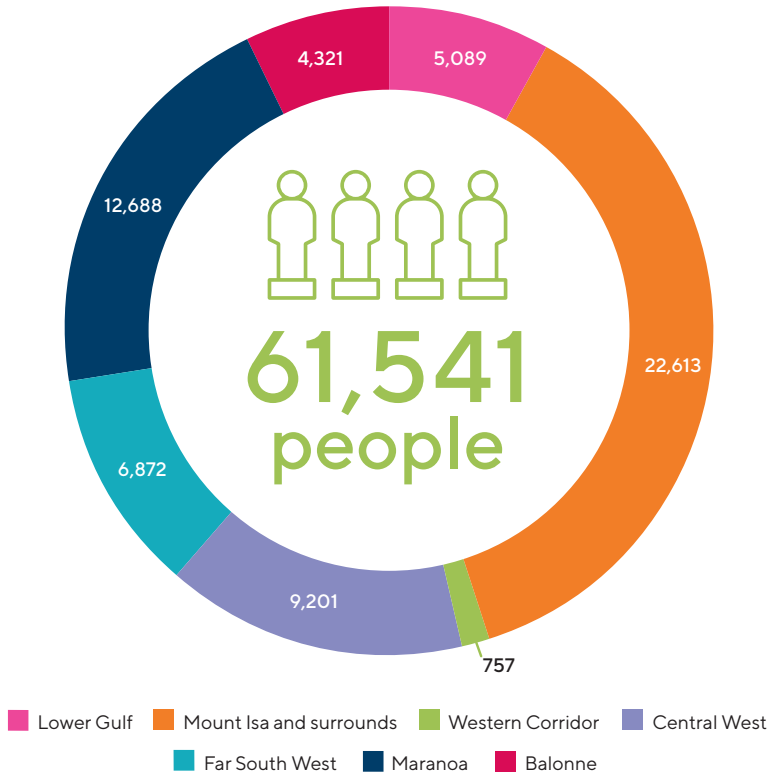
The Socio-Economic Indexes for Areas (SEIFA) Index of Relative Disadvantage ranks geographical areas in terms of their relative socio-economic disadvantage in Australia. WQPHN experiences high socio-economic deprivation.

- 53% of the region's population are in the two most disadvantaged SEIFA quintiles.
- 100% of Lower Gulf CL population are in the two most disadvantaged SEIFA quintiles.
- 70% of Western Corridor CL and Far South West CL population are in the two most disadvantaged SEIFA quintiles.

POPULATION CHARACTERISTICS

- People – 61,541
- The population has mixed health status with small pockets of high advantage contrasted with areas of extreme disadvantage.
- Aboriginal and Torres Strait Islander people – 10,671, equating to 17.2% of the population (compared to QLD average of 4%).

Figure 5. Population by Commissioning Locality in WQPHN



Source: ABS, 30 June 2020

From 2016 to 2041, the population in Western Queensland is projected to decrease from 63,719 persons to 57,516 persons, equating to a decrease of 0.4% per year.

Paroo LGA is projected to have the fastest decrease in population from 2016 to 2041 with an average annual rate of -1.8% per year.

By 2041, Mount Isa LGA is projected to have the largest population in the region with 18,677 persons. (Source: 2016 Census data)

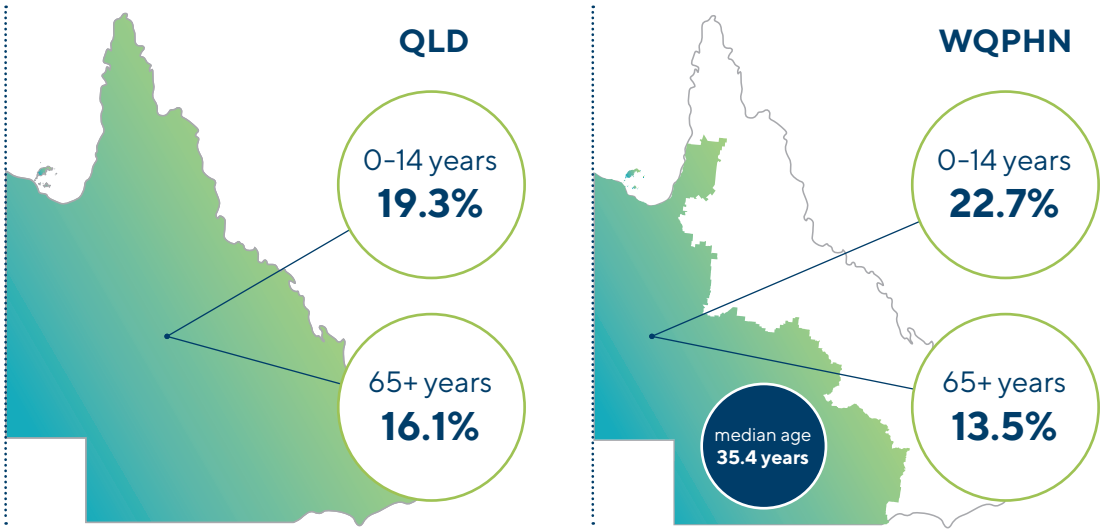
The negative population growth across 16 of the 20 LGAs in Western Queensland will further decrease the population density of Western Queensland and impact on the feasibility and viability of local service delivery.

1,076,000 people visited the outback region of Queensland in 2019.

In 2020, visitor numbers dropped nearly 20% to 823,000, due to travel restrictions from COVID-19. The transient population ('grey nomads' in particular) and their demand for services is seasonal and not reflected in official population estimates.

AGE STRUCTURES

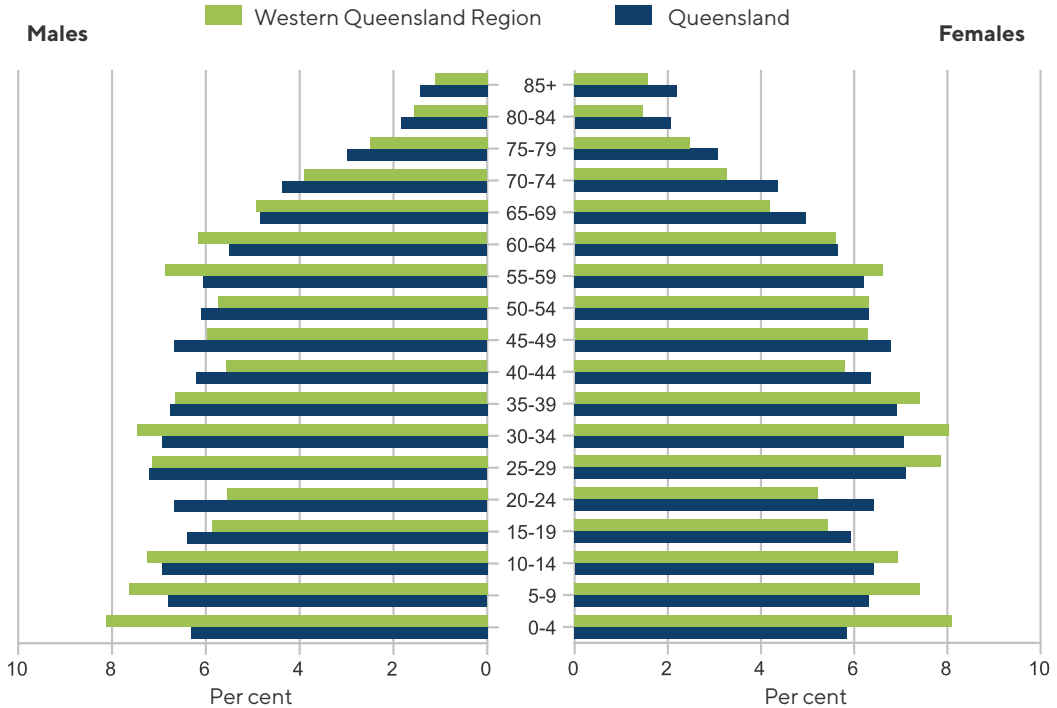
The age distribution of a population can have a major impact on the demand for health services. Health needs of different age groups vary with many diseases and illnesses only prevalent at certain ages. Whilst nationally there is a growing proportion of elderly people, WQPHN has a younger population when compared to Queensland.



This younger population profile is largely due to the influence of the north-west part of the region and its large Aboriginal and Torres Strait Islander population.

The Lower Gulf CL has a considerably younger population profile compared to other CLs in the region, with 28% of the population aged less than 15 years, and 8.8% aged 65 years and over.

Figure 6. Estimated resident population by age and sex, Western Queensland region and Queensland, 30 June 2020p



Source: ABS 3235.0, Population by Age and Sex, Regions of Australia

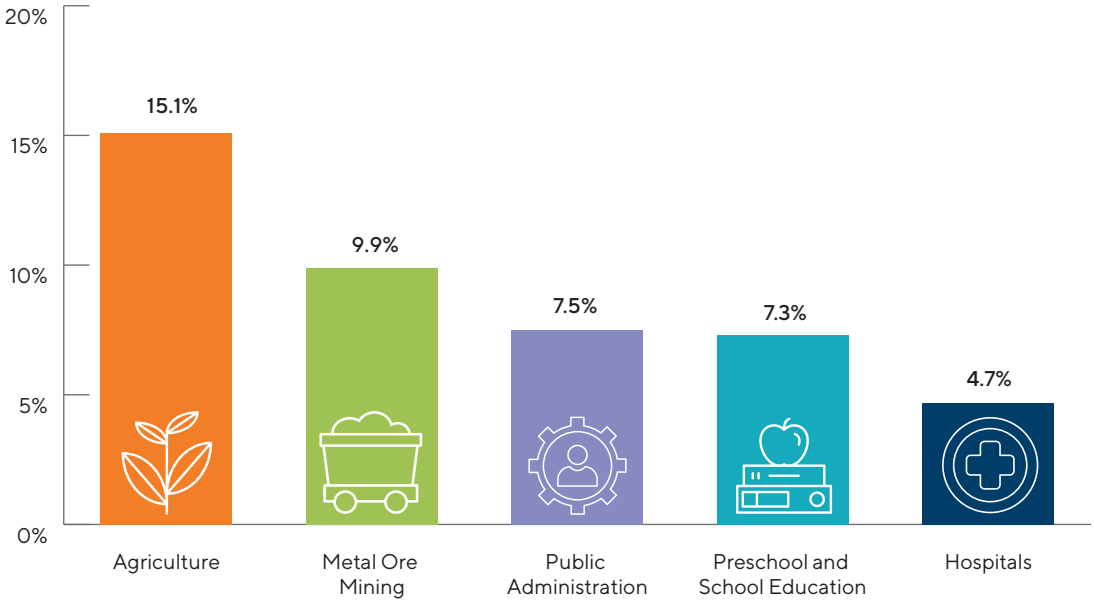
ECONOMY AND INDUSTRY

This is a two-way process, in which the health of the population impacts the economy, and the economy impacts the health of the population. Strengthening the productive capacity of all sectors of WQPHN will have positive impacts on the economy and health of the region.

EMPLOYMENT BY INDUSTRY

The top five industry subdivisions of employment for the region are:

Figure 7. Top five industry subdivisions of employment



QGSO (2021)

INCOME

NUMBER OF LOW-INCOME FAMILIES* – 1,586

Persistent socio-economic disadvantage has a negative impact on the life outcomes of individuals, particularly a lack of occupation and income. Low-income workers are less likely to access health care simply because they cannot afford it. Low income is also associated with increased stress, low self-esteem, and a greater tendency to engage in unhealthy behaviours like smoking.

* 'low income' defined as less than $650 per week or less than $33,800 per year.

MEDIAN TOTAL FAMILY INCOME – $92,862/year

Mount Isa LGA had the highest median total family income with $123,864 per year. Mount Isa LGA had the highest median weekly family income with $2,382 per week.

Doomadgee LGA had the lowest median total family income with $38,740 per year. Doomadgee had the lowest median weekly family income with $745 per week, followed closely by Mornington Island with $762 per week.

QGSO (2021)

EDUCATION AND EMPLOYMENT

Education increases opportunities for choice of occupation and for income and job security and equips people with the skills and ability to control many aspects of their lives. These are key factors that influence wellbeing throughout the life course.

Level of schooling	47.3%	highest level of schooling of Year 11 or 12 (or equivalent). Diamantina LGA had the largest percentage (53.8%) of people whose highest level of schooling was Year 11 or 12 (or equivalent). Barcoo LGA had the largest percentage (16.7%) whose highest level of schooling was Year 8 or below (or did not go to school).
Childhood education development	18%	of children developmentally vulnerable on 2 or more domains of the Australian Early Development Census (AEDC) (vs QLD 14%). Carpentaria, Far Central West/ Far South West and Charleville showed the worst results in WQPHN.
Earning and learning	74%	of young people aged 15-24 years are learning or earning (vs QLD 82%). However, in contrast only 44% are learning or earning in the Lower Gulf CL.
Unemployment	7.4%	of people are unemployed in WQPHN, on par with the Queensland rate. Burke LGA had the highest unemployment rate of 27.9%. Barcoo LGA and Winton LGA had the lowest unemployment rate of 3.3%

Source: PHIDU (2021)

FAMILY AND COMMUNITY

Family and community strength provides an indicator of how people feel about aspects of their life and community in which they live, and their participation in opportunities to shape their community.

Families	42.2%	of families in WQPHN were couples with children.
	23.6%	are single parent families with children under the age of 15 in WQPHN. Carpentaria/Mount Isa region had the highest proportion of one parent families with 30%.
Housing	31.1%	of occupied private dwellings in WQPHN were rented.
Overcrowding	10.5%	of households with Aboriginal and Torres Strait Islander peoples were overcrowded.
Jobless families	14%	of families with children under 15 years of age in WQPHN.
Homelessness	849	people are homeless. Doomadgee LGA had the highest rate of homelessness (1,273.8 persons per 10,000 persons).
Access to Internet	22.9%	nearly a quarter of private dwellings have no Internet access and more than a third (38%) in the Lower Gulf region were without Internet access.
Disability	3.6%	of people in need of assistance with a profound or severe disability (QLD 5.2%).

Source: PHIDU (2021)

SECTION 4: OUR HEALTH

The presence of lifestyle risk factors, high incidence of chronic disease and lower life expectancy and high Aboriginal and Torres Strait Islander population, create health challenges which are compounded by extreme disadvantage of some communities, rurality and remoteness.

LIFE EXPECTANCY

The region has a lower estimated life expectancy (76.2 years for males and 81.7 years for females) when compared to Queensland (80.9 years for males and 85.0 years for females) (AIHW 2019).

On average, males in the WQPHN region live

4.7 YEARS LESS

than their counterparts elsewhere in Queensland

On average, females in the WQPHN region live

3.3 YEARS LESS

than their counterparts elsewhere in Queensland

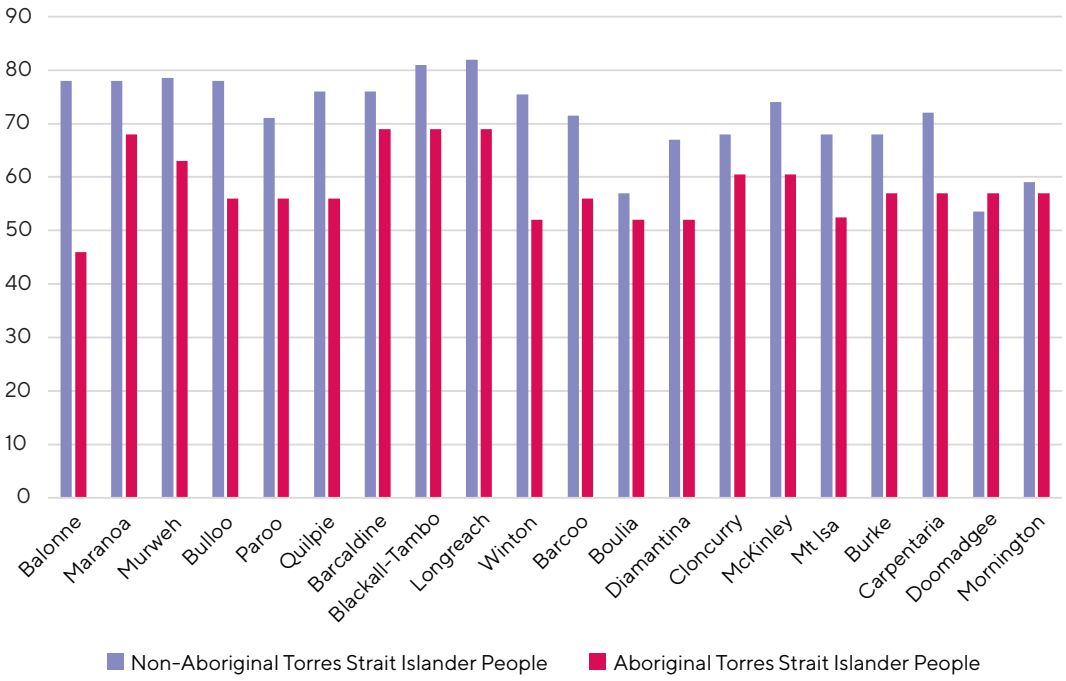
Queensland's Aboriginal and Torres Strait Islander population experience worse health and poorer life expectancy than non-Aboriginal and Torres Strait Islander Queenslanders. While there have been some improvements in the gap in life expectancy when compared to non-Aboriginal and Torres Strait Islander Queenslanders.

Life expectancy gap for Aboriginal and Torres Strait Islander peoples in WQPHN is

14.5 YEARS

Median age and death

Figure 8. Median age of death by LGA



MEDIAN AGE AT DEATH

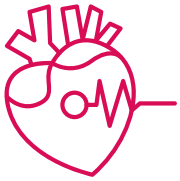
74.5 YEARS

188 potentially avoidable deaths per 100,000 people in Western Queensland in 2014-2018 compared with 106 per 100,000 nationally.

47% of all deaths were classified as premature and 55.5% of these were potentially avoidable (AIHW MORT Books 2014-2018).

Aboriginal and Torres Strait Islander people are still dying prematurely and living with more disease and injury from an earlier age.

Leading cause of death

1 

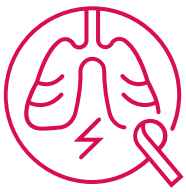
CHD

Coronary Heart Disease was the leading cause of death for WQPHN males and females.

2 

COPD

Chronic Obstructive Pulmonary Disease was the second leading cause of death amongst WQPHN males and fifth amongst females.

3 

Lung cancer

was the leading cancer death in Western Queensland and the third leading cause of all deaths.

AIHW MORT Books 2014-2018

MATERNAL, CHILD AND YOUTH HEALTH

Maternal, child and youth health and wellbeing outcomes are dependent on individual factors such as biological (e.g. genes) and environmental (e.g. family, housing, community). These factors influence a child both in positive ways that can enhance their development and in negative ways that can compromise developmental outcomes. Pregnancy, birth, childhood and adolescence are important life stages that set the foundation for adulthood. Different health issues may be more relevant to people's lives at varying life stages and are opportunities to target interventions and health promotion to support healthy behaviours.

Higher proportion of the population are children (0-14 years)

WQPHN: 22.7% (13,996)
LOWER GULF CL: 27% (nearly 1 in 3)
QLD: 19.3%

Infant mortality has been trending down since 2011

WQPHN: 3.8 deaths per 1,000 live births
QLD: 4.1 deaths per 1,000 live births
NATIONAL: 3.3 deaths per 1,000 live births

Infant mortality in WQPHN has been trending down since 2011 when the crude rate was 10.8 per 1,000 live births.

Higher fertility rates

WQPHN: 2.49 children per woman
QLD: 1.76 children per woman

Higher percentage of developmentally vulnerable children

(two or more domains)

WQPHN: 18%
QLD: 14%

Higher percentage of Aboriginal and Torres Strait Islander women smoke during pregnancy

WQPHN: 49.5%
QLD: 42.7%

Photo courtesy Gidgee Healing

Fertility rate

WQPHN women have higher fertility rates (2.49) compared to Queensland (1.76). In 2019 the Mount Isa and Surrounds CL had the highest rate of births within Western Queensland (21.0 per 1,000 persons), followed by the Lower Gulf CL (18.9 per 1,000 persons).

Approximately 57% of Western Queensland mothers who gave birth in 2019 were under the age of 30 years compared to 45% of mothers in Queensland.

Within Western Queensland 15% of births by Aboriginal and Torres Strait Islander mothers occur in the under 20 age group compared to 3% of non-Aboriginal and Torres Strait Islander mothers.

Antenatal visits

Research shows the health, wellbeing and nutrition of a mother prior to conception and during pregnancy not only can have an impact on the birthweight, growth and health of the newborn, but also has a major impact on the lifelong health of the child. A person's susceptibility to many chronic diseases in adult life is determined during pregnancy and are a response to maternal risk factors and behaviours. The primary risk factors include poor maternal nutrition and substance use in pregnancy.

For Aboriginal and Torres Strait Islander women, timely access to antenatal care is particularly important as they are at higher risk of giving birth to babies of low birthweight and have greater exposure to other risk factors such as anaemia, poor nutrition, hypertension, diabetes, genital and urinary tract infections and smoking.

In 2018, females having an antenatal visit during the first trimester was lower for WQPHN compared to Australia (61.4% v 74.3%) and has remained unchanged since 2012.

Smoking in pregnancy

20.3% of mothers smoked during pregnancy in Western Queensland (2016-2018). In Balonne and the Lower Gulf specifically, smoking rates during pregnancy exceeded 60%.

Aboriginal and Torres Strait Islander mothers had much higher rates of smoking during pregnancy in both Queensland (42.7%) and Western Queensland (49.5%).

Amongst non-Aboriginal and Torres Strait Islander mothers, the proportion of low birth-weight babies and mothers who smoked during pregnancy in the WQ HHSs was similar to Queensland rates (9.1%).

Low birth-weight babies

8.3% of babies born in Western Queensland were classified low birth-weight (2016-2018).

Aboriginal and Torres Strait Islander mothers in the Central West HHS had the highest rate (33.3%) of low birth-weight babies, compared to 6.3% in non-Aboriginal and Torres Strait Islander mothers.

HEALTH ISSUES – CHILDREN

The importance of the early years is now well known. These years are a time when the brain develops and much of its 'wiring' is laid down. The experiences and relationships a child has, plus nutrition and health, can actually affect this enormously. Positive experiences help the brain to develop in healthy ways. Seriously negative experiences such as neglect and abuse, on the other hand, affect brain development in more harmful ways, and contribute to emotional and behavioural problems later in life. So, the experiences a child has in the early years can either support learning or interfere with it.

Fewer children enrolled in preschool programs

WQPHN: 78.0% (2018)
QLD: 89.4% (2018)

Aboriginal and Torres Strait Islander children live away from home at 10x the rate

ABORIGINAL & TORRES STRAIT ISLANDER CHILDREN: 51.4 PER 1,000
NON-ABORIGINAL & TORRES STRAIT ISLANDER CHILDREN: 5.9 PER 1,000

High prevalence of mental health disorders

WQPHN 4-11 YEAR OLDS: 17%
WQPHN 12-17 YEAR OLDS: 16.6%

High prevalence of ear conditions in young children in the Carpentaria -Burke-Mornington Indigenous Area*

*Queensland Deadly Ears Program

0-4 YEAR OLDS: 24%
5-9 YEAR OLDS: 37%

In 2019/20, dental conditions were the most common potentially preventable hospitalisation

WQPHN 5-9 YEARS: (n=119 separations)
WQPHN 10-14 YEARS (n=23 separations)

Overall, potentially preventable dental admissions accounted for 32% (n=195) of the total hospital admissions in Western Queensland children aged 0 to 14 years.

Early childhood development

The proportion of children in their first year of full time school who were developmentally vulnerable in one or more of the five Australian Early Development Census (AEDC) domains was higher for Western Queensland children compared with Queensland and Australian children. Carpentaria, Far Central West/Far South West and Charleville statistical areas showed the worst results across the five domains.

In 2018, 78% of children aged four years were enrolled in a preschool program compared to 89.4% of four year olds in Queensland.

Living away from home

Children and young people living away from home are a highly vulnerable group with increased physical, mental and social health needs. Living away from home refers to children in out-of-home care (foster care, approved kinship care, provisionally approved care and residential care services) and other locations such as hospitals, Queensland youth detention centres, and those in independent living.

In Queensland, the rate of Aboriginal and Torres Strait Islander children living away from home is ten times higher compared to non-Aboriginal and Torres Strait Islander children (51.4 per 1,000 children vs 5.9).

Hearing health

Hearing loss in childhood can lead to a lifetime of disadvantage, initially through a detrimental impact on a child's learning and language development, which may lead to behavioural problems, early school leaving and limited job options.

Data from Queensland Deadly Ears Program estimates that the minimum prevalence of ear conditions in the Carpentaria-Burke-Mornington Indigenous Area to be 24% for 0-4 year olds and 37% for 5-9 year olds. These prevalence rates are some of the highest of all Deadly Ear Program locations.

Furthermore, 2019/20 hospitalisation data shows that ear, nose and throat conditions were the most common potentially preventable hospitalisation for children aged 0-4 years in all three Western Queensland HHSs. Potentially preventable ear, nose and throat admissions accounted for 9.4% (n=117) of the total hospital admissions in Western Queensland children aged 0 to 4 years.

Oral hygiene

Poor oral hygiene as well as limited access to dental services contributes to poor oral health.

In 2019/20, dental conditions were the most common potentially preventable hospitalisation for Western Queensland children aged 5-9 years (n=119 separations) and 10-14 years (n=23 separations). Overall, potentially preventable dental admissions accounted for 32% (n=195) of the total hospital admissions in Western Queensland children aged 0 to 14 years.

Childhood overweight and obesity

Childhood obesity is associated with a higher chance of premature death and disability in adulthood. Worldwide the prevalence of overweight and obesity amongst children has dramatically risen.

Queensland Preventative Health Survey estimates for children (aged 5-17 years) show the percentage of overweight and obese children is higher in Western Queensland compared to Queensland (38% – all WQ children vs 26% – all QLD children).

Mental health

17% of 4-11 year olds and 16.6% of 12-17 year olds in the Western Queensland PHN experienced a mental health disorder.

4-11 year olds in Outback-North SA3 (which aligns with the Lower Gulf and Mount Isa & Surrounds CLs) had a noticeably higher prevalence of mental health disorders, 19.9% compared to the other regions average of 14.5%.

In 2021, an evaluation of the Queensland Deadly Ears Program by the AIHW reported 68% of children from North West Queensland (which includes Mornington Island, Normanton, Doomadgee and Mount Isa) between 2015 to 2019 had at least one ear condition at their first service, among which 59% had conductive hearing loss.

Photo courtesy Gidgee Healing

HEALTH ISSUES – ADOLESCENTS AND YOUNG ADULTS

Employment, education and training opportunities will help young people to gain the skills and knowledge to enable them to gain employment, reach their full potential, lead healthier lives and make positive contributions to their communities.

Lower percentage of 15-24 year olds involved in learning or earning

QLD: 82%
WQPHN: 74%
LOWER GULF CL: 44%

80% of long term smokers begin before the age of 20 years

Over the last decade, the percentage of 18-29 year olds that smoke daily in Western Queensland appears to be decreasing (21% to 11%).

North West HHS – highest rate of rheumatic heart disease in QLD

NW HHS RATE: 145.6 PER 100,000

Since 2016, GP mental health services provided increased 70%

The number of patients increased 48%.

Rheumatic heart disease

Rheumatic heart disease is preventable and occurs as a result of damage to the heart following acute rheumatic fever. Healthy housing, sanitation, reduced household crowding, cultural safety, access to quality education and employment and access to health services are some measures known to reduce the rates of acute rheumatic fever and rheumatic heart disease.

The North West HHS has the highest rate of rheumatic heart disease in Queensland (rate 145.6 per 100,000).

In 2016-17, rheumatic heart disease was the most common PPH for young people aged 10-14 years in the NWHHS. (AIHW 2019)

Sexually transmitted infections

Disproportionately high rates of blood borne viruses and sexually transmissible infections in remote and rural Aboriginal and Torres Strait Islander communities.

In the NWHHS the number of notifications of infectious syphilis has been trending down in the five year period 2016 to 2020 (from 44 in 2016 to 22 in 2020), as has chlamydia, while gonorrhoea notifications increased (83 notifications in 2016 to 111 in 2020). Low numbers of notifications for syphilis and gonorrhoea (usually <4 per year) have been reported in the SWHHS and CWHHS in each year of the five year period.

Photo courtesy Gidgee Healing

MENTAL HEALTH IN ADOLESCENTS AND YOUNG ADULTS IN WQPHN

Youth mental health problems are increasing. The teens and early 20s are the most common time for the onset of mental illness and as young people grow up the prevalence continues to rise. There's also evidence that for 50% of people the first episode occurs before the age of 14 years.

19.2% **14.3%**

16.6% of 12-17 year olds in Western Queensland PHN experienced a mental health disorder. Males had a higher prevalence of mental disorder than females.

1 in 5 (21%) 15-24 year olds living in Western Queensland are diagnosed with a mental health and behavioural disorder.

The South West HHS had a higher prevalence of mental health and behavioural disorders compared to the Central and North West HHS.

Nearly 1 in 5 15-24 year olds in WQPHN were admitted to hospital for mental health and behavioural disorders in 2019-2020.

1,015 **70%**

GP Mental Health services

provided to 593 Western Queensland young people (15-24 years).

In the past five years, the number of GP mental health services provided increased 70%, whilst the number of patients increased 48%.

The occasions of service being delivered by Headspace in Mount Isa continues to increase (except during COVID). The majority (71%) of the attendees were in the 15-24 years age group.

ADULT HEALTH

LIFESTYLE CHOICES

Our lifestyle choices, including the amount of exercise we undertake and food we eat, along with the extent to which we smoke, all impact on our health. These modifiable risk factors can increase the likelihood of developing chronic diseases and impact on the management of existing chronic conditions.

Highest proportion of overweight and obese adults among all Queensland PHNs

Much higher rates for those in the 45-64 years age category for all persons.

Significantly higher co-morbidity rates in 65+ year olds

South West region:
86% > 1 chronic condition
62% > 2 chronic conditions
(WQPHN PATBI, 2021)

Overall smoking rates across Western Queensland are decreasing

CHRONIC DISEASE

Chronic diseases are the leading cause of illness, disability and death in Australia and are defined as any condition which is long lasting and with persistent effects. The chronic diseases which affect the greatest proportion of the population and have the greatest impacts on quality of life are the ones most often considered high priorities for monitoring and intervention in the general practice and primary care settings.

Highest age standardised mortality rate of all PHNs in Australia

WQPHN (HIGHEST):
712.3 deaths per 100,000 people
NORTHERN SYDNEY (LOWEST):
398.3 deaths per 100,000 people

Age standardised mortality rates for Western Queenslanders

MALES: 767.4 deaths per 100,000 people
FEMALES: 584.2 deaths per 100,000 people

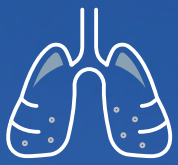
High rates of premature deaths and potentially avoidable deaths

47% of all deaths were classified as premature (aged under 75).
55.5% of these premature deaths were potentially avoidable.

Coronary Heart Disease

leading cause of death in Western Queensland with an age-standardised rate of 89.2 per 100,000. This equates to 13.2% of all deaths.

Chronic Obstructive Pulmonary Disease



(COPD) was the 2nd leading cause of death amongst WQPHN males and 5th amongst females.

Lung Cancer

was the leading cancer death in Western Queensland and the 3rd leading cause of all deaths. Survey findings and stakeholder consultations noted the considerably higher cancer mortality was due in part to the limited access to services in WQPHN for timely screening, diagnosis and treatment.

Musculoskeletal

prevalence rates in 65+ adults were on par with the national rates, but the North West had significantly lower rates of Osteoporosis and Osteoarthritis (12% and 21% respectively compared to national rates of 15.6% and 32.7%), while the South West had higher rates of both diseases compared to the national rate (19% and 37% respectively).

Diabetes

is most prevalent in the North West region, at 26% of the 65+ population, however all regions had higher prevalence rates than the national rate.

Diabetes complications form ¼ of all potentially preventable hospitalisations in Western Queensland. Diabetes related deaths are 2 x higher in Western Queensland compared to nationally.

Potentially Preventable Hospitalisations

Diabetes is the largest contributor to chronic disease-related potentially preventable hospitalisations in the WQPHN's Aboriginal and Torres Strait Islander population (North West 47.4%, Central West 52.4%, South West 59.1%).

Significantly lower rates of cardiovascular-related chronic disease potentially preventable hospitalisations in the South West Aboriginal and Torres Strait Islander population compared to other Western Queensland regions (South West 9.8%, Central West 19.0%, North West 19.9%).

There appears to be significantly lower COPD-related chronic disease potentially preventable hospitalisations in the Central West Aboriginal and Torres Strait Islander population (Central West 9.5%, North West 15%, South West 23.2%).

Hypertension and Hyperlipidaemia

are biological risk factors to chronic vascular disease.

1 in 5 Western Queensland adults (25-64 years) are diagnosed with hypertension and/or hyperlipidaemia.

The rate of hypertension is about 1.5 times higher in WQPHN in the 65+ population compared with the rest of the nation.

MENTAL HEALTH

We know, 1 in 5 Australian adults experiences a mental health disorder every year and almost half of all Australians will experience a mental health disorder at some point during their lifetime.

Although people living in rural areas score better on indicators of life satisfaction and feelings of wellbeing, and report higher levels of civic participation, social cohesion, social capital, volunteering and informal support from friends, neighbours and the community, they experience unique circumstances that may impact on their wellbeing, including, for example, flood, fire, drought and economic variability, and these increase with increasing remoteness.

Furthermore, we know Aboriginal and Torres Strait Islander people are almost three times as likely as non-Aboriginal and Torres Strait Islander people to report high levels of psychological distress.

High rates of mental health and/or behavioural disorder diagnoses

SOUTH WEST HHS: 1 in 3 (33%)
WQPHN: 1 in 5 (20%)

Depression is the most common diagnosis

DEPRESSION: 15%
ANXIETY: 9%

Psychiatrists provide 4.8 services to every one patient

2020-21 Rates of mental health emergency department presentations

NORTH WEST HHS: 64.1 presentations per 1000 population
SOUTH WEST HHS: 25.0 presentations per 1000 population
CENTRAL HHS: 18.2 presentations per 1000 population

Admissions to hospital for mental and behavioural disorders (2019-20)

WQPHN: 1,046 admissions
NORTH WEST HHS: 675 admissions

SUICIDE

While the prevalence of people experiencing mental illness is similar across Australia: around 20%, rates of suicide and self-harm are higher in remote and rural areas, and increase with increasing remoteness. Farmers, young men, older people and Aboriginal and Torres Strait Islander peoples in remote and rural areas are at greatest risk of completing suicide. A range of remote and rural circumstances contributes to broad socio-cultural, mental health, economic and service-related barriers which in turn place individuals in these areas at greater risk of self-harm. The increasing rates of suicide with remoteness evince there are significant mental health issues that need to be addressed in these remote and rural areas.

WQPHN has the highest rate of intentional self-harm hospitalisations of all PHNs (2019-20)

WQPHN: 317 per 100,000 population.

The age-standardised suicide rates for Western Queensland SA3s were much higher compared to Queensland and Australia.

Suicide is the 4th highest cause of death amongst Western Queensland males

Males had the highest rate of death from suicide compared to all PHNs (2.18 times the rate compared to Australia-wide).

640 suicide specific presentations to Emergency Departments within Western Queensland

Both males and females of Queensland-Outback SA4 have higher rates of suicide compared to their respective metropolitan counterparts. But males of Queensland-Outback SA4 have nearly three times the age-standardised suicide rate compared to females residing in Queensland-Outback SA4 (34.7 vs 13.0 per 100,000).

Of these presentations, 60% identified as Aboriginal and Torres Strait Islander. In 20/21 this increased to 640 suicide specific ED presentations, of which 66% identified as Aboriginal and or Torres Strait Islander. NWHHS had the highest number (480) compared to SWHHS (124) and CWHHS (36).

ALCOHOL AND OTHER DRUGS

People living in regional and remote areas are more likely to drink frequently or at levels that are harmful to their health. Various factors contribute to higher alcohol consumption within regional and remote areas including the social acceptability of alcohol and its role in community and social events. Overall use of illicit drugs in regional and remote areas is similar to that in cities, however the type and frequency of drug use varies considerably. For example, people in remote and very remote areas are 2.5 times more likely to use methamphetamines as those in cities. Cannabis use is also more widespread and frequent in remote and very remote settings. Men, FIFO workers, farmers and Aboriginal and Torres Strait Islander peoples in remote and rural areas are at greatest risk of harm from alcohol and other drugs.

Higher rate of risky alcohol consumption

WESTERN QLD: 28%
QLD: 22%

North West HHS males had the highest rate of risky alcohol consumption (43%) as did young males aged 18-29 years (52%). Data also showed that over the past 10 years there has been minimal change to the rate of risky alcohol consumption among age groups across Western Queensland.

Presentation to emergency departments for mental and behavioural disorders due to alcohol or drug use in 2020-21 was very high in the North West HHS in comparison to the Central HHS and South West HHS (32.5 per 1,000 in North West vs 4.1 in Central West and 5.9 in South West).

Nearly double the rate of alcohol-related road traffic deaths compared to Queensland

Highest rate of mental health hospitalisations due to alcohol or drug use compared to other PHNs

Double the rate of alcohol and drug treatment episodes compared to Queensland

1 in 4 people in WQPHN access alcohol and drug treatment services outside the PHN region

Reasons for AODTS episodes across WQPHN

Alcohol is the greatest reason for Alcohol and Other Drug Treatment Services (AODTS) episodes in NWHHS and CWHHS, however Cannabis type is slightly higher in SWHHS.

INJURY

Those living in remote and rural areas sustain higher non-intentional (e.g. road transport injuries, injuries associated with agricultural production, drownings, poisonings, falls, thermal-related injuries) and intentional injury (e.g. self-harm, assaults) rates than those living in major cities.

Hospitalisation for injuries was significantly higher for remote and rural residents compared with people living in major cities.

The age-standardised death rate for transport injury deaths amongst remote (19.0 per 100,000 population) and very remote (20.4 per 100,000 population) residents was four times higher than the age-standardised death rate for residents of major cities (4.6 per 100,000 population).

Age-standardised injury deaths from self-harm in remote (15.9 per 100,000 population) and very remote areas (16.5 per 100,000 population) of Australia were 1.7 and 1.8 times (respectively) higher than in major cities (9.3 per 100,000 populations).

Residents in very remote and remote areas were respectively around 14 and 7 times more likely to be hospitalised for assault than residents in major cities.

WQPHN average annual ASR per 100,000 of 10.5 for deaths from road traffic injuries, 0 to 74 years. This was the third highest rate for all PHNs after NT (15.1) and Country WA (14.2). It was over twice as high as the national rate of 4.4.

WQPHN had an average annual ASR per 100,000 of 25.2 for deaths from suicide and self-inflicted injuries, 0 to 74 years. This was the highest rate for all PHNs and it was over twice as high as the national rate of 12.7.

PEOPLE WITH A DISABILITY

People living in rural and remote Australia don't have the same opportunities to access disability support services as people living in big cities. There simply isn't the population base to support the range of specialist services that some people with disabilities need to access.

1,055 PEOPLE

in Western Queensland were in need of assistance with a profound or severe disability in 2021. However, only 775 accessed NDIS.

Within the region, Blackall-Tambo LGA had the highest percentage (5.9%) of people in need of assistance with a profound or severe disability.

5.9%

Source: *NDIS; **PHIDU. (2021. Derived from 2016 ABS census data)

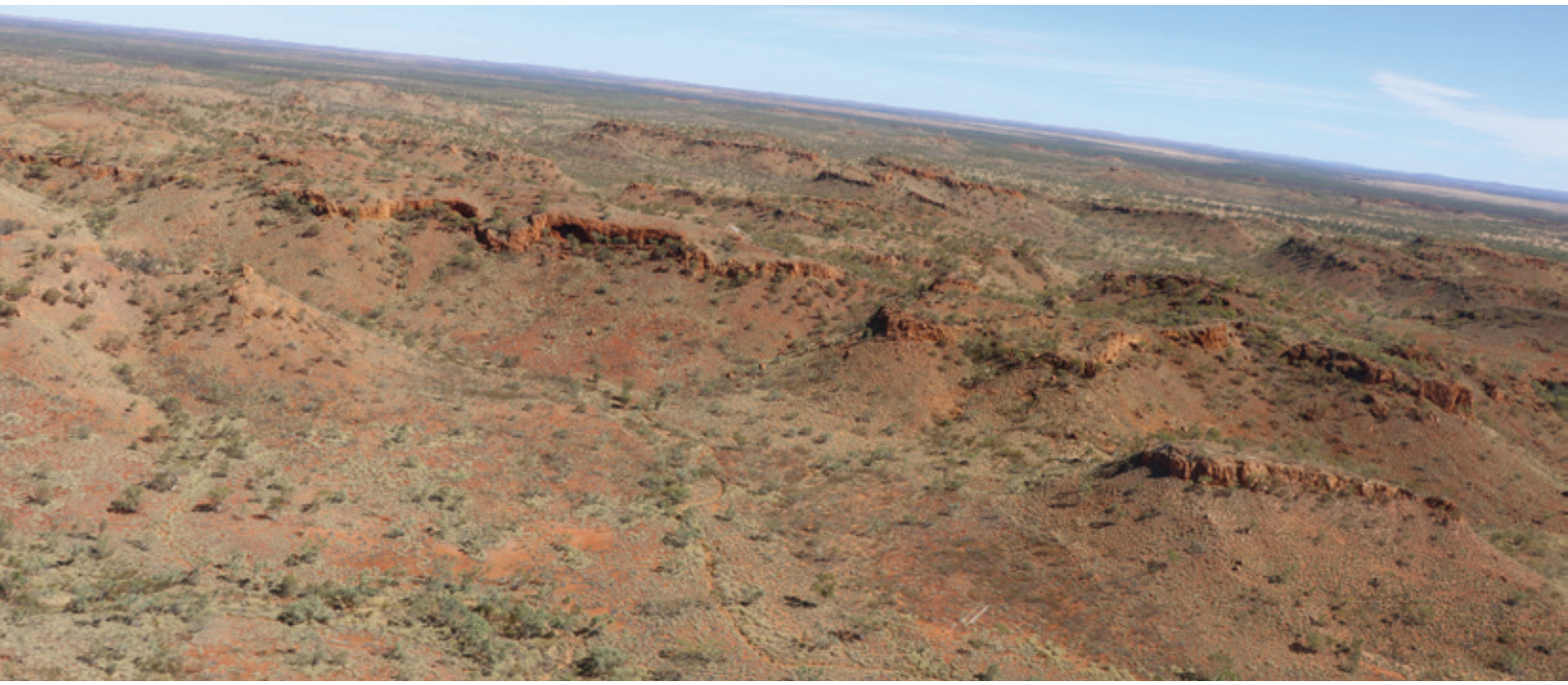
SECTION 5: HEALTH SERVICE AND SYSTEM ISSUES

OVERVIEW

Since its establishment in 2015, WQPHN has been intent on building the capacity and sustainability of general practice providers so that people living in Western Queensland have access to an agreed set of essential primary health care services close to home. This has been the focus of the Western Queensland Health Care Home (WQ HCH). Retaining and attracting key clinical and management personnel presents an ongoing challenge impacting on the viability of services, continuity of care for patients and maximisation of potential benefits of the model.

There are an array of health services and programs operating in the WQPHN geographic footprint funded through Commonwealth, state and HHS sources in addition to those commissioned by the PHN. While their purpose is to improve access to health care for the residents of the region, the wicked problem of fragmentation of services with subsequent challenges continuity of care and service system navigation for patients and clinicians arises.

This section draws together health service and workforce data and the views of community, clinicians and health service provider organisations to provide a detailed description of the service and system issues to be considered by the WQPHN and its partners in planning and commissioning for a sound platform of local primary health care in Western Queensland.



ACCESS TO SERVICE

Medical Services

GPs and other community-based health professionals provide the majority of care to people with chronic conditions such as respiratory disease, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.

Caring for people with chronic and complex healthcare needs can require:

a higher or more specialised level of care

the support of several healthcare professionals, including medical specialists

care for multiple conditions associated with the person's illness.

Specialist support in general practice and community settings can provide:

access to specialist care, sooner and closer to home

a stronger focus on a whole of specialism team based clinical governance model

healthcare at a lower cost to the health system

a stronger focus on patients' multidisciplinary health needs for an individual specialism

equal or better health outcomes as people spend less time in hospital

fewer avoidable hospital stays.

NATIONALLY BOTTOM 4 – PHN GP attendances

NATIONALLY BOTTOM 2 – PHN Medical Specialist attendances

However, for the four year period 2013/14 to 2016/17 WQPHN ranked:

- **in the bottom four** PHNs for GP attendances along with Country WA, the Northern Territory and the ACT
- **in the bottom two** for medical specialist attendances compared with other PHNs, with only the Northern Territory below it.

Table 1. MBS Specialist attendances and MBS expenditure per person by PHN (2013-14 to 2016-17)

Year	Specialist attendance / person WQPHN	Range for PHNs	MBS expenditure WQPHN	Range for PHNs
2013/14	0.41	0.37–1.19	$33.77	$29.39-$109.15
2014/15	0.45	0.38–1.20	$36.29	$31.14-$108.56
2015/16	0.46	0.41–1.21	$38.48	$28.50-$109.41
2016/17	0.48	0.38–1.20	$40.23	$27.74-$107.99

Source: AIHW 2021

Table 2. MBS GP attendances and MBS expenditure per person by PHN

Year	GP Specialist attendance / person WQPHN	Ranking	Range for PHNs	MBS expenditure WQPHN	Range for PHNs
2013/14	4.1	2nd last	4–7.6	$205.42	$208.48-$340.02
2014/15	4.4	3rd last	4.3–7.7	$231.44	$214.85-$354.16
2015/16	4.6	2nd last	4.4–7.7	$245.15	$223.70-$359.90
2016/17	5.1	equal 4th last	4–7.6	$279.62	$242.98-$363.10

Source: AIHW 2021

General Practitioner workforce capacity is decreasing

The number of GPs working in the general practice and primary care environment and hence adequacy of supply is difficult to determine in WQPHN due to complicated work arrangements across the HHS and general practice particularly in the Central West and South West, visiting GP services provided by the RFDS, implementation of the COAG Section 19(2) Initiative and other factors such as:

- underlying need for greater quantities of primary care given the poorer health status of the region
- need for remote and rural GPs to have a broader scope of practice
- need for many remote and rural GPs to spend time travelling between different worksites and patients, and therefore having less time to spend with patients
- the increased chronic disease complexity and comorbidity in the region means longer consults and fewer patients being seen in a ‘standard’ work day
- the average number of hours worked per week by a GP is declining meaning fewer patients are seen in a ‘standard’ work day

While the yearly headcounts for the overall number of medical practitioners in Western Queensland increased between 2018 and 2020, the rise has been minimal for general practice.

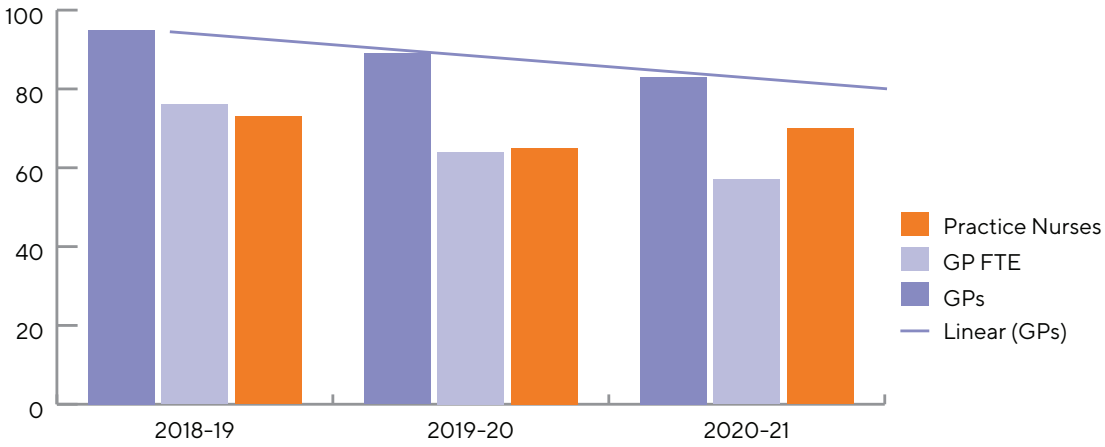
Table 3. Number of GPs 2018-2020 by employment type and HHS region

Year and HHS	Total	General Practice	HHS	RFDS	ACCHO
2020 Total	**124**	**55**	**53**	**19**	**6**
Central West	21	11	10	0	0
North West	36	16	11	<10	<10
South West	67	28	32	11	<10
2019 Total	**110**	**52**	**33**	**16**	**9**
Central West	20	13	<10	0	0
North West	34	16	<10	<10	<10
South West	56	23	18	<10	<10
2018 Total	**101**	**51**	**29**	**10**	**11**
Central West	21	13	<10	0	0
North West	30	17	<10	<10	<10
South West	50	21	16	<10	<10

Source: HWQ 2021

The WQPHN's own general practice census shows that in the three year period from 2018/19 to 2020/21 general practitioners working in general practices (private and HHS managed) has declined. In 2020-21 the GP FTE per 1,000 residents is 0.9. This figure is equal to that of the Northern Territory but less than Western Australia (1.1) and the national average (1.2).

Figure 9. Number/FTE of General Practitioners and Practice Nurses in General Practice 2018-19 to 2020-2021



Fragile and marginal viability of general practice environment in Western Queensland is evidenced by:

Decline in the number of private general practices operating in the region from **11 in 2017** to **7 in 2021.**

Management of **nine** general practices shifted to the SWHHSs since 2015.

All GPs in Central West are employed as Senior Medical Officers.

Complex array of services challenges navigation of care for patients and providers

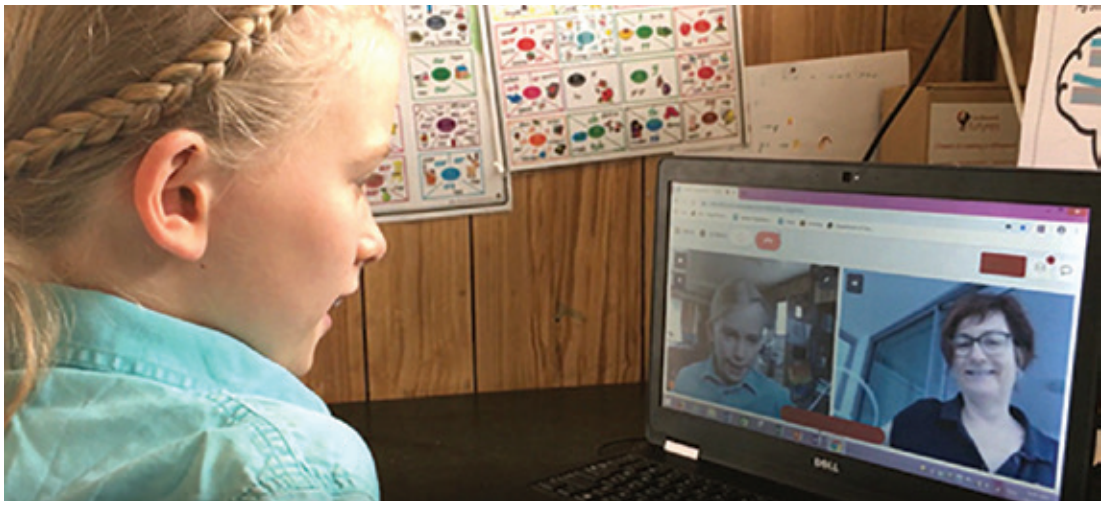
The health service system in WQPHN is complex and includes locally resident providers, outreach services from a local hub and visiting services from locations external to the WQPHN region. For example, in 2021-22 CheckUP provides funding to support 47 visiting providers across Western Queensland, through the various streams of the Commonwealth Government's Medical Specialist Outreach Assistance Program, delivering health services to 76 locations, the majority of which are allied health services.

CRITICAL CONSIDERATION

Numerous funding programs support multiple service providers under an array of contracts for services with different target groups and eligibility criteria. This is confusing for community people, referring clinicians and service providers alike, and contribute to poor value, perceived and real duplication, reduced patient engagement, and inferior clinical outcomes. Planned models of team-based care are required to maximise the effectiveness and efficiency of health care inputs, provide continuity of care and improve health outcomes.

Telehealth has an important role in complementing face-to-face service

The community survey identified that where people had used telehealth the majority (58% – telephone, 62%– video) were satisfied with services accessed by telephone or video. Health professionals surveyed in the HWQ 2021 Health Workforce Needs Assessment for the Western Queensland region reported telehealth had a positive impact on their capacity to provide services but saw it as complementing face-to-face consults. However, limitations in internet access for households, digital infrastructure and computer literacy challenges wider application.



ACCESS TO CULTURALLY SECURE PRIMARY CARE

NUKAL MURRA HEATLH SUPPORT SERVICE

Aboriginal and Islander Community Controlled Health Services (AICCHS) offer holistic models of care provided by GPs, nurses, Aboriginal Health Workers and allied health professionals. Nukal Murra Health Support Service (NMHSS) is an alliance of six bodies established in 2017 including:

1. Western Queensland Primary Health Network (WQPHN)
2. Queensland Aboriginal and Islander Health Council (QAIHC)
3. Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health (CWAATSICH)
4. Cunnamulla Aboriginal Corporation for Health (CACH)
5. Goondir Health Services (Goondir) and
6. Mount Isa Aboriginal and Islander Community Controlled Health Services Limited trading as Gidgee Healing.

Nukal Murra Health Support Service (NMHSS) is responsible for:

- delivering Integrated Team Care (ITC) services throughout Western Queensland
- overseeing the NMHSS
- contributing to greater clinical and cultural leadership by the Western Queensland Aboriginal and Islander Community Controlled Health Service (AICCHS) sector to enable greater quality and capability in services for Aboriginal and Torres Strait Islander people of the catchment
- maximising the pool of funds available to support supplementary services for Aboriginal and Torres Strait Islander peoples with complex chronic conditions. Allied health and mental health services are delivered by private providers, NGOs, AICCHS and the HHSs, often provided under hub and spoke arrangements.

Evaluation of the Nukal Murra Health Support Services in 2021 noted that the NMHSS is

- making a positive contribution on the uptake of chronic disease management MBS items
- contributing to improving patient navigation of the health system and
- reducing many of the barriers to accessing services and health aids for Aboriginal and Torres Strait Islander peoples.

The NMHSS offers a positive return on investment with $1 invested in the service estimated to save $3.48 in avoided hospital costs. Maintaining the NMHSS is warranted.

Completion of cycles of care for Aboriginal and Torres Strait Islander patients

All Aboriginal and Torres Strait Islander people are eligible for an annual health check (MBS item 715). Nationally, WQPHN had the highest rate of annual health checks compared with all PHNs in both 2018-19 (41.2% of population) and 2019-20 (39.2% of population). This has increased from 3,504 health checks in 2015-16 to 5,263 conducted in 2018-19. However, only 51% of health checks (2,697 persons) had a follow up service within 12 months in 2018-19. (AIHW 2021)

While WQPHN is performing well in conducting annual health checks, only half of health checks have a follow up service within 12 months.

Progressing a pathway to Community Controlled Health Services in the Lower Gulf

In the last five years Gidgee Healing has grown to become a major provider and partner in the delivery of health care to Aboriginal communities of Mount Isa and the Lower Gulf. However, expansion of operations to the Lower Gulf is an immense organisational challenge to develop clinical service capacity AND transition to a community controlled model that is consistent with the aspiration of residents in the Lower Gulf. WQPHN can support Gidgee Healing and its partners to review the community control pathway and service model for the Lower Gulf drawing on learnings from the Northern Territory and Apunipima in Cape York.

PRIMARY CARE WORKFORCE SUPPLY AND SUSTAINABILITY

Improved workforce data is required to inform service planning and workforce development strategies

Comprehensive, high quality health workforce data for rural and remote environments such as WQPHN is essential for workforce planning, service planning, development of training plans and pathways, and to inform health policy. In Western Queensland, an accurate picture of the health workforce working in primary care is complex and limited by:

- Conflation with the hospital workforce, particularly where HHS employed SMOs and Other Medical Practitioners (OMPs) work across the hospital and HHS managed general practice, with the quantum of work in primary care difficult to determine
- The Section 19(2) exemptions operating in most locations in Western Queensland result in provider numbers issued for locums, junior doctors, SMOs and OMPs that work only or predominantly in rural hospitals providing an inaccurate and over-estimated measure of medical workforce capacity in primary care
- Using MBS billing generated through the Section 19(2) exemption is an inaccurate assessment of the provision of comprehensive primary care (and general practice capacity) as MBS billing under Section 19(2) is predominantly non-referred Emergency Department presentations
- The limited number of allied health professions registered with AHPRA further complicated by the relationship of their registered address and where they may work (i.e., resident or visiting basis from outside the region)
- The visiting service models operating in the region particularly for allied health, challenge the development of an estimate of the quantum of work undertaken in the region, a town, in the primary care setting or hospital setting
- Turnover and delays in recruitment hindering assessment of capacity for all workforces.

Strategies to attract, retain and replenish practitioners across the career continuum and develop local training and employment pathways required

11 workforce shortages across the WQPHN with difference between HHSs.

Gaps common to two or more HHSs were psychology, dentistry and audiology. Aboriginal Health Workers were identified as a gap in the Central West and there is no ACCHO. (HWQ, 2021)

Two thirds (66%) of allied health professionals were resident in the South West < 2 years indicative of high turnover. (HWQ 2021)

Limited allied health assistant workforce in the WQPHN.

Developing the assistant workforce can enhance access to and capacity of child development, chronic disease management, aged care and disability services. Availability of a Registered Training Organisation with a focus on health careers and flexible delivery model is needed to progress local training and career pathways.

Early career practitioners are a feature of the WQPHN health workforce.

37% of allied health professionals in the South West had 1-2 years professional experience. Geographic isolation, complex and culturally diverse client base and turnover of senior clinical and management staff impacts recruitment and retention. (HWQ 2021)

Recruitment of practice nurses and mental health nurses with long-term vacancies is an ongoing challenge for general practices and ACCHOs, limiting potential benefit of the WQ HCH for patients and services

MENTAL HEALTH

Refining the Stepped Care Model and improve equity of access to residents of small communities

There has been significant growth and in investment in mental health services by PHNs in response to Commonwealth policy direction and funding. The WQPHN in partnership with the HHSs and other key industry stakeholders have developed *The Western Queensland five-year Mental Health, Suicide Prevention, Alcohol and Other Drug Treatment Services Plane (2021-2026)*.

While the findings of the consultations to inform this HNA align with the focus areas of Five Year Plan, further work is required to refine the stepped care model to promote and better utilise Better Access where indicated, increase referrals to low intensity services, improve equity of access to communities with small populations and expand reach of mental health services and social supports to older people living in the community.

Dementia Care Services in the North West are an emergent gap

'Dementia in Australia 2021' AIHW Summary Report noted rates of dementia and cognitive impairment not dementia (CIND) in older Aboriginal and Torres Strait Islanders are 3-5 times higher than the rest of the population. Cited small studies found that rates of dementia for older Aboriginal and Torres Strait Islander peoples in rural and remote communities are among the highest in the world, and prevalence of dementia for Aboriginal and Torres Strait Islanders aged over 60 living in urban and regional areas was 21% compared with 6.8% for all Australians over 60.

Gidgee Healing is participating in the Let's Chat research study led by the University of Melbourne to improve detection of cognitive impairment and dementia as well as dementia care and brain health in the primary care context. Given the high Aboriginal population in the North West the demand for behavioural dementia care services is likely to increase with the introduction of more culturally appropriate screening tools.

ALCOHOL AND OTHER DRUGS

Prioritising support for GPs and other front-line providers in evidence based assessment, brief and early interventions was identified by Alcohol and Other Drug service providers. Access to addiction withdrawal, treatment and rehabilitation services were priorities identified in the community survey and stakeholder consultations particularly in the South West.

OLDER PEOPLE AND AGED CARE

The Federal Government has indicated a role for PHNs as part of the aged care reform package announced in the 2021-22 Federal Budget response to the Royal Commission into Aged Care Quality and Safety. *The Draft White Paper, Supporting Healthy Ageing: The Role of PHNs*, prepared by the PHN Cooperative flags the increasing role PHNs will play in aged care and the intersection with primary health care services.

The community survey and consultations identified the need for:

- Increased focus and supports for older people to age in place inclusive of: support to navigate My Aged Care; strategies to facilitate community connection; improved mental health support services; strengthening home care services; healthy ageing initiatives and other social supports; community transport options; and better access to home modification assessments and services.
- Timely access to geriatric assessments and coordination of care to enable living in the community for longer
- Recruitment and retention of aged care workers and nurses
- Increased GP attendance to Residential Aged Care Facilities. In 2018-2019, GP attendances to RACFs in WQPHN was 13.9 attendances per RACF patient compared with 19.1 for metropolitan and 17.8 nationally (AIHW 2021).

CRITICAL CONSIDERATION

Sustainable delivery of services to older people in remote communities is challenged by low client density and 'thin market' in a market-based environment. This is similar for people with a disability to access carer and support services. Strategies to develop innovative service models, workforce development and employment strategies to span aged care and disability in remote communities in a market-based environment is likely to be an emergent priority for WQPHN, the aged and disability sectors.

PALLIATIVE CARE

In Australia, and many other parts of the world, the demand for palliative care services is increasing due to the ageing of the population and increasing prevalence of cancer and other chronic diseases that accompany ageing. In Western Queensland, renal disease as a complication of diabetes is a specific issue where people may choose not to progress dialysis treatment rather than leave their community resulting in a prolonged palliation.

While Palliative care services were identified as an area for service improvement through the community survey and South West Clinical Chapter consultation, there is limited data to determine demand or capacity to meet demand at local and regional levels. This is also the case at a national level (Palliative care services in Australia, Overview of palliative care in Australia – Australian Institute of Health and Welfare, 2021).

CRITICAL CONSIDERATION

Determining a service and system response for palliative care requires tailoring for a dispersed population, local and regional demographics, with consideration of medical specialist, generalist and nursing capability and capacity.

INTEGRATED HEALTH CARE REFORM

Over the last 5 years WQPHN has established a strong foundation in the region and progressed multiple high-level strategic health partnerships. It has focused on promoting primary health care reform to enable person-centred health and care journey through the WQ HCH. The PHN's list of achievements are impressive: supporting regional governance endeavours, engaging with key regional health care providers including the HHSs, brokering Aboriginal-led solutions by supporting ACCHOs to play a stronger role, facilitating clinical and community leadership, utilising and promoting data to enable local and regional analysis, to name a few.

However, as indicated in the preceding sections, local level benefits are still to materialise in relation to addressing long-standing 'wicked' remote health issues such as general practice vulnerability, hotspots of inequality, global health workforce shortages and challenges in recruiting and retaining health care professionals, closer to home access to medical specialist services, and stronger ACCHO service role in order to close the gap.

Progressing healthcare reform requires:

More tangible outcomes from current WQPHN partnership arrangements	Ongoing support and development of existing WQPHN partnership arrangements (e.g., Maranoa Accord 2020; Nukal Murra Health Alliance; Strategic MoUs with CheckUP, HWQ, RFDS & RHealth) to create meaningful opportunities for sharing of resources between key partners (e.g., joint planning, pooled funding, shared workforce, co-commissioning services) to achieve a more integrated and coordinated care system.
Less competitive, more collaborative service arrangements	Commissioning framework goes beyond the simple funding and contracting of services to trialling more collaborative commissioning and co-design of services with key partners to achieve a more integrated and coordinated care system.
Place-based solutions and partnerships within a geographic area, be it a town or community	Implement place-based approaches that enable flexibility for local solutions and partnerships to tailor service providers, workforce and funding options to achieve a more integrated and coordinated care system.
Brokering Aboriginal and Torres Strait Islander-led solutions by supporting ACCHOs, both individually and collectively through the Nukal Murra Health Alliance, to play a stronger role in the regional integration of services	Consistent with the new National Agreement on Closing the Gap, appropriately fund and resource ACCHOs as the preferred providers of primary health care services to Aboriginal and Torres Strait Islander peoples so that they are accessible across all of Western Queensland.
Innovation in virtual integrated care models	Lack of funding and planned approach to supporting expansion of digital health
Interconnected health information so that clinicians and support services can access and share information and data to make timely and informed decisions	Lack of interoperability of patient information systems continues to impede service integration

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TABLES & FIGURES

TABLES

FIGURES

Limitations The HNA has relied on national and state-level data, HHS, LGA, some community level data which have been drawn from multiple data sources, which can vary from source to source. This can generate differences between data sets, which can result in slight variations in data outcomes. 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 CLs, 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. Care has been taken in the WQPHN Outback Insights portal to concord each data source across the geographic area for which it was recorded. Data is published in line with WQPHN Data Governance Framework, which is underpinned by the Australian Privacy Principles.

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