Australian Government
Department of Health

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# Joint Regional Health Needs Assessment

## November 2024

PHN Name: Western Queensland PHN
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WQPHN gratefully acknowledges the valued input of numerous people, partners and organisations that have contributed insights to inform this Health Needs Assessment.

In particular, WQPHN extends its heartfelt gratitude to the following stakeholders:

- The North Western Hospital and Health Service, the Central Western Hospital and Health Service and the South Western Hospital and Health Service
- Members of the Western Queensland Health Services Integration Committee
- Members of the Nukal Murra Alliance
- Members of the WQPHN Care Governance Committee
- Members of the WQPHN Community Advisory Committee
- Members of the WQPHN Service Provider Network, and
- WQPHN staff.

Each of these stakeholders has provided invaluable input that has shaped and enriched this Health Needs Assessment. Through these contributions, the PHN has gained a deeper understanding of the strengths, needs and challenges impacting our various communities, and commits to using these insights to inform our future work.

**Australian Government Disclaimer**

# Acknowledgement 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. We recognise their cultural authority as First Nations people of Australia.

It is their strength and spirit that makes our work possible.

# Executive summary

This Report presents the key findings from a comprehensive, systematic and collaborative mixed-methods approach to identify the health and service needs impacting the various communities in the Western Queensland region.

In a first for the region, the four key providers and commissioners of health services – the Western Queensland Primary Health Network, the North Western Hospital and Health Service, the Central Western Hospital and Health Service and the South Western Hospital and Health Service – have worked collaboratively to undertake a Joint Regional Health Needs Assessment.

The resulting Report signifies a crucial milestone in our ongoing attempts to address the challenges that have arisen from previous independent assessments. More importantly though, it reflects our shared commitment to moving beyond traditional silos to embrace a more integrated approach to health care planning and service delivery that places the needs of our communities at the forefront. By coming together, we have set a strong foundation for ongoing collaboration aimed at addressing complex health challenges collectively. This Report marks not only the culmination of our current efforts but also the beginning of a future-focused partnership dedicated to improving health outcomes across our collective communities.

## Overview of process

The Western Queensland JRHNA Project Team was formed in early 2024. Collectively, this group designed a detailed approach to the joint work.

| Phase 1: Planning and determining the collaborative approach | Mar – Jun 2024 |
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- Establish appropriate governance mechanisms
- Define geographic regions
- Define and agree minimum dataset
- Define and agree responsibility for data collection, cleaning and management
- Discuss and agree stakeholder consultation approach
- Develop stakeholder engagement plan

| Phase 2: Analysis of health and service data | Jun – Sep 2024 |
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- Build repository for collaborative data sharing
- Source publicly available data and upload to shared repository
- Extract, clean, and manage PHN and HHS data and upload to shared repository
- Conduct stakeholder (sector and community) engagement
- Collate stakeholder data and upload to shared repository
- Review, analyse, and prepare visualisations of quantitative and qualitative data
- Extract all relevant insights from analysed data
- Undertake service mapping, workforce mapping and market analysis
- Host collaborative workshops to collate insights across sub-regions

| Phase 3: Validation and triangulation | Sep 2024 |
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- Conduct validation sessions with relevant stakeholders
- Triangulate health and service needs
- Finalise health and service needs in preparation for prioritisation

| Phase 4: Prioritisation | Sep 2024 |
|---|---|

- Discuss and agree prioritisation criteria and scoring methodology
- Coordinate prioritisation scoring
- Finalise prioritised health and service needs across sub-regions

| Phase 5: Report preparation, endorsement and submission | Sep – Nov 2024 |
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- Prepare draft JRHNA reports for each sub-region
- Prepare overarching whole-region report
- Gain endorsement from relevant governance entities
- Finalise and submit report to relevant entities
- Prepare public release version of reports
- Distribution to relevant stakeholders

# Prioritised health and service needs

The process outlined above provided extensive insights into a wide range of health and service needs – each one representing a valid and significant aspect of a community's wellbeing. As part of this process, we acknowledge that every identified need deserves attention and action, however not all needs can be addressed immediately, with the resources available.

A rigorous triangulation and prioritisation process was used to tier the health and service needs across the three sub-regions – North West, Central West and South West.

| Tier | Description | Intended action |
|---|---|---|
| 1 | **These needs emerged as top-tiered needs following prioritisation.** The need or issue aligns with the existing priorities of either the WQPHN or the relevant HHS. Resources are available to support activities to address the need, and activity is expected to occur within the next 12 months. In some cases, existing activities to address the need will already be underway, acknowledging some may require minor tailoring to best address the need. | Ensure these key needs are incorporated into relevant workplans for 2025. |
| 2 | **These needs emerged in-between the top and lower-tiered needs following prioritisation.** The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unlikely to be fully addressed within current resources. The partnering agencies will continue to advocate for resources to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 2-3 years. |
| 3 | **These needs emerged as lower-tier needs following prioritisation.** The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unable to be addressed within current resources. The partnering agencies will explore opportunities to partner with other relevant agencies to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 4+ years. |

The table below presents a summary of the prioritised needs across the region, split into the three key sub-regions – North West, Central West and South West.

Representatives of the PHN stakeholder groups participated in the prioritisation process endorsing this version of the regional wide priorities using the methodology outlined in Table1, Hospital and Health Services and their stakeholders used the methodology outlined in Table 2.

Each Hospital and Health Service presented versions as endorsed by their stakeholders detailed at:

Appendix 1 -North West Hospital and Health Service

Appendix 2- Central West Hospital and Health Service

Appendix3- South West Hospital and Health Service

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| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| Ageing | Long-term chronic conditions impacting independence of older people. | 2 | There is an aging population in the CWHHS region, which will require the expansion of health and aged care services, with a particular focus on long-term care and chronic disease management. | 2 | There is an aging population in the SWHHS region, which will require the expansion of health and aged care services, with a particular focus on long-term care and chronic disease management. | 1 |
| | There is limited availability of aged care facilities available for people in the NWHHS region, particularly home care services. | 2 | There is limited availability of aged care facilities available for people in the CWHHS region, particularly home care services. | 1 | There is limited availability of aged care facilities available for people in the SWHHS region, particularly home care services. | 2 |
| | There is a need for greater collaboration with aged care providers. | 2 | | | There is a need for greater access to aged care assessments and packages of care for older people in the SWHHS region, including CHSP support. | 1 |
| Audiology | | | | | Increase access to audiology services in the SWHHS region | 3 |
| Cancer Care | People across the NWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence. | 2 | People across the CWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence. | 3 | People across the SWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical and Breast). | 1 |
| | People across the NWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical, Colorectal, Lung) except Breast. | 3 | People across the CWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical and Breast). | 1 | People across the SWHHS region require increased access to cancer treatment services, including chemotherapy. | 2 |
| | | | People across the CWHHS region require increased awareness of sun-safe practices. | 3 | People across the SWHHS region require a dedicated community based service for routine skin checks, with effective onward referral pathways. | 3 |
| | | | | | People across the SWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence | 2 |
| Child and Maternal Health | There is a high rate of developmentally vulnerable children in more than one domain in the NWHHS region. | 3 | Pregnant women and new mothers in the CWHHS region require consistent access to culturally sensitive child and maternal health services in community, including screening and early intervention services. | 2 | Pregnant women and new mothers in the SWHHS region require consistent access to culturally appropriate child and maternal health services in community, including screening, health promotion and early intervention services. | 1 |
| | There are high rates of psychological distress in children in the NWHHS region. | 1 | Families in the CWHHS region require improved access to child development services. | 1 | Families in the SWHHS region require improved access to child development services. | 1 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | Pregnant women and new mothers in the NWHHS region require consistent access to culturally sensitive child and maternal health services in community, including screening and early intervention services. | 1 | | | | |
| | Families in the SWHHS region require improved access to child development services. | 1 | | | | |
| Chronic Disease | People in the NWHHS region experience high rates of all chronic diseases, in particular diabetes, chronic kidney disease, chronic heart disease and chronic obstructive pulmonary disease. | 1 | People within the CWHHS region require enhanced access to chronic disease screening, treatment and services, including testing for rheumatic heart disease and acute rheumatic fever. | 1 | People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of cardiovascular disease, including consideration of partnership arrangements to better address these needs. | 1 |
| | People in the NWHHS region experience higher rates of acute rheumatic fever and rheumatic heart disease when compared to other parts of the State. | 1 | The uptake of influenza vaccines is low for people with COPD in the CWHHS region. | 3 | People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of kidney disease, including consideration of partnership arrangements to better address these needs. | 1 |
| | People in the NWHHS region report limited access to dialysis services in community, and significant challenges in accessing transport to access services in other centres. | 1 | | | People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of respiratory disease, including consideration of partnership arrangements to better address these needs. | 1 |
| | The uptake of influenza vaccines is low for people with COPD in the NWHHS region. | 3 | | | People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of diabetes, including consideration of partnership arrangements to better address these needs. | 2 |
| | People within the NWHHS region require improved access to prevention programs, testing and treatment for rheumatic heart disease and acute rheumatic fever. | 3 | | | The uptake of influenza vaccines is low for people with COPD in the SWHHS region. | 3 |
| | People within the NWHHS region require enhanced access to chronic disease screening, treatment and services to support ongoing management. | 1 | | | | |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | There is a need for more consistent follow up for bicillin compliance for patients diagnosed with acute rheumatic fever and rheumatic heart disease. | 1 | | | | |
| Coordination, Integration and Continuity of Care | People in the NWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | People in the CWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | Services in the SWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 |
| | People in the NWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 | People in the CWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 | People in the SWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 |
| | Services in the NWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | Services in the CWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | People in the SWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 |
| | | | | | Upon return to home, people in the SWHHS region require improved coordination of follow-up care including having received following care received outside of catchment. | 2 |
| | | | | | Establishment of position(s) to communicate (outreach and eligibility) visiting services of the HHS and NGO providers. | 1 |
| | | | | | Communities in the SWHHS region require a commitment from services to more holistic models of care that recognise the physical, psychological, social and spiritual aspects of wellbeing | 1 |
| Domestic and Family Violence | People in the NWHHS region report high rates of domestic and family violence, and are in need of culturally sensitive 24/7 supports for victims and families. | 2 | People in the NWHHS region report high rates of domestic and family violence, and are in need of culturally sensitive 24/7 supports for victims and families. | 1 | Culturally safe, rapidly responsive, domestic and family violence supports are needed in communities. | 2 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | There is a need for clear and accessible information and pathways to community services for people vulnerable to and experiencing domestic and family violence. | 1 | | | | |
| | There is a need for greater training for staff to better support people experiencing domestic and family violence. | 1 | | | | |
| Digital Health | | | | | There is a need for enhanced access to digital technologies to support care closer to home for people living in the SWHHS region. | 3 |
| | | | | | There is a need for improved information sharing (where legislation allows) and consolidation of data analytics practices across service providers in the SWHHS region. | 2 |
| Disability | | | There is a lack of disability support services in the CWHHS region, including general supports, allied health services and accommodation services. | 1 | There is a lack of disability support services in the SWHHS region, including general supports, allied health services and accommodation services. | 2 |
| | | | There is a lack of respite services and supports in the CWHHS region, particularly for families of children with disabilities. | 3 | | |
| | | | There is a lack of support for families in the CWHHS region with children who are neurodivergent. | 3 | | |
| | | | There is need for enhanced training for practitioners supporting people with disabilities, including assessment training for the NDIS, as well as NDIS and aged care pathways literacy. | 3 | | |
| | | | There is a lack of support for people with disabilities and their families, to navigate the disability service system, including service literacy, navigation support, referral pathways and advocacy. | 3 | | |
| Aboriginal and Torres Strait Islander | Aboriginal and Torres Strait Islander peoples across the whole NWHHS region experience poorer health outcomes when compared with non-Indigenous communities. | 1 | Aboriginal and Torres Strait Islander communities in the CWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | Improved health outcomes and increase life expectancy of Aboriginal and Torres Strait Islander peoples. | 1 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | Aboriginal and Torres Strait Islander communities in the NWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the CWHHS region. | 3 | Increase Aboriginal and Torres Strait Islander peoples participation in health checks. | 1 |
| | There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the NWHHS region. | 1 | There is a decline in presentations by Aboriginal and Torres Strait Islander people in the CWHHS region to primary care for routine health checks. | 3 | There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the SWHHS region. | 2 |
| | There is a decline in presentations by Aboriginal and Torres Strait Islander people in the NWHHS region to primary care for routine health checks. | 2 | | | Aboriginal and Torres Strait Islander communities in the SWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 |
| Health literacy | People in the NWHHS region have variable levels of health literacy, which impacts their self-care and care for their families. | 1 | | | People across the SWHHS region require improved health literacy, prevention and health-promotion services tailored to their diverse needs to improve health and wellbeing. | 1 |
| Infrastructure, Facilities and Equipment | There is a lack of accessible imaging facilities in the NWHHS region, particularly in the more remote areas of the region. | 3 | There is a lack of accessible imaging facilities in the CWHHS region, particularly in the more remote areas of the region. | 1 | There is a lack of access to contemporary medical imaging facilities in the SWHHS region. Currently, there is one privately owned CT scanner at Roma for the entire district and no MRI service. | 1 |
| Mental Health | Communities in the NWHHS region experience a higher rate of ED presentations for mental health conditions when compared with the State average. This is particularly high for Burke, Carpentaria, Cloncurry, McKinlay, Mornington Island and Doomadgee. | 1 | Communities in the CWHHS region experience a higher rate of mental health admissions when compared with the State average. | 1 | People experiencing mental illness and psychological distress in the SWHHS region require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including early access, addressing suicidality and substance use issues. | 1 |
| | Communities in the NWHHS region experience a higher rate of mental health admissions when compared with the State average. This is particularly high for Burke, Cloncurry, Carpentaria, McKinlay, Mornington Island, Doomadgee and Mount Isa. | 1 | People experiencing acute mental health issues in the CWHHS region require more timely interventions and in some cases, retrieval services. | 3 | People experiencing higher acuity mental illness in the SWHHS region require ongoing support following intensive support provided out of catchment. | 2 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | People in more regional and remote communities within the NWHHS region require greater access to culturally sensitive mental health services and social and emotional wellbeing outreach services. | 1 | People experiencing mental illness and psychological distress in the CWHHS region require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including addressing suicidality and substance use issues. | 1 | No inpatient mental health beds / service provision in SWHHS | 1 |
| | People in the NWHHS region require improved access to specialised eating disorder services. | 3 | Young people experiencing mental illness and/or psychological distress in the CWHHS region require enhanced and more consistent access to targeted prevention and early intervention services. | 1 | People in the CWHHS region require improved access to specialised eating disorder services. | 3 |
| | Communities within the NWHHS region experience considerable wait times for mental health services. | 1 | People in the CWHHS region require improved access to specialised eating disorder services. | 3 | Communities within the SWHHS region require enhanced and timely access to early intervention mental health services and supports to improve outcomes. | 1 |
| | Services in the NWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities | 1 | Communities within the CWHHS region require reduced waiting times for mental health services to improve access and outcomes. | 2 | Services in the SWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities | 1 |
| | | | Services in the CWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities. | 1 | | |
| Obesity | | | | | Increase access to education and physical activity programs in the SWHHS region. | 1 |
| Optometry | | | | | Increase access to optometry services in the SWHHS region. | 3 |
| Oral Health | People in the CWHHS region have limited access to oral health services, resulting in poor oral health and potentially preventable emergency department presentations. | 1 | People in the CWHHS region have limited access to oral health services, resulting in potentially preventable oral health conditions. | 2 | | |
| Palliative Care | | | There is a need for palliative care providers to have a footprint in the region to facilitate stronger connections with other providers and better support to families. | 3 | People in the SWHHS region require a palliative care system that supports seamless integration of healthcare services in order to achieve person-centred end-of-life care. | 2 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | | | | | There is a need for service providers across sectors to have a stronger connection and better integration to ensure better support for patients at the end of life. | 2 |
| People Experiencing Homelessness | People experiencing homelessness have high numbers of undiagnosed and uncontrolled health needs. | 2 | There is a lack of support for people experiencing homelessness in the CWHHS region. | 2 | There is a lack of support for people experiencing homelessness in the region. | 3 |
| | There is a lack of support for people experiencing homelessness in the NWHHS region. | 2 | | | | |
| People from Multi-Cultural Communities | People from multicultural communities in the NWHHS region experience high rates of chronic disease. | 2 | | | | |
| | People from multicultural communities experience poorer health outcomes than their Australian-born counterparts. | 2 | | | | |
| | There is a need for services to be more welcoming and non-judgemental to ensure greater access for people from multicultural communities. | 2 | | | | |
| People from LGBTIQ+ Communities | People from LGBTIQ+ communities in the NWHHS region experience high rates of chronic disease. | 2 | | | | |
| | People from LGBTIQ+ communities experience poorer health outcomes than their heterosexual-born counterparts. | 2 | | | | |
| | There is a need for services to be more welcoming and non-judgemental to ensure greater access for people from LGBTIQ+ communities. | 2 | | | | |
| Physical Activity | | | There is a need for Increased access to physical activity programs / facilities in the CWHHS region. | 3 | | |
| Physical Rehabilitation | | | People in the CWHHS region require improved access to physical rehabilitation and occupational therapy services. | 3 | People in the SWHHS region require improved access to physical rehabilitation and occupational therapy services. | 3 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| Preventive Healthcare | There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 1 | There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 2 | There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 1 |
| Primary Care | People in the NWHHS region, including those in small remote communities (in particular Urandangi and Bidunggu communities), require access to sustainable and consistent primary and community care services. | 1 | Young families in the CWHHS region need enhanced access to comprehensive primary health care to support optimal health outcomes for children. | 1 | People in the SWHHS region, including those in small remote communities, require access to sustainable and consistent primary and community care services, including after hours | 1 |
| | There is a lack of after-hours GP services in the NWHHS region which contributes to high rates of low urgency ED presentations | 1 | There is a lack of after-hours GP services in the CWHHS region which contributes to high rates of low urgency ED presentations. | 3 | | |
| Respite Care | | | There is a lack of respite services and supports in the CWHHS region, particularly for people with dementia. | 2 | There is a lack of respite services and supports in the SWHHS region, irrespective of the type of care provided/needed. | 3 |
| Retrieval Services | | | People in the CWHHS region receiving care out of catchment require greater flexibility in retrieval services to optimise health outcomes following treatment. | 2 | People in the SWHHS region receiving care out of catchment require greater support following transfer by retrieval services to optimise health outcomes following treatment, including care at place of treatment that recognises being away from home, and dedicated support to ensure return to home in a supported manner. | 2 |
| Sexual Health | People in the NWHHS region require increased access to sexual health screening, testing, and treatment services at the community level (in community). | 1 | People in the CWHHS region require increased access to sexual health screening, testing, and treatment services at the community level (in community). | 3 | There is a lack of sexual and reproductive health service and support available in the SWHHS region. | 3 |
| Specialist Care | People in the NWHHS region require improved access to visiting specialist services to enhance integration and ensure seamless healthcare. | 2 | People in the CWHHS region require improved access to specialist services to increase diagnosis, treatment and ongoing management of health concerns. | 3 | People in the SWHHS region require improved access to specialist services to increase diagnosis, treatment and ongoing management of health concerns. | 1 |
| Stroke | | | | | There is a need for a dedicated service to support people in the SWHHS region who have experienced a stroke or stroke-like episode. | 3 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| Substance Use | People within the NWHHS region have a higher rate of alcohol consumption when compared with the State average, suggesting the need for alcohol harm reduction strategies. | 1 | People within the CWHHS region have a higher rate of alcohol consumption when compared with the State average, suggesting the need for alcohol harm reduction strategies. | 2 | People experiencing alcohol and substance use issues in the SWHHS region require increased education and access to support, treatment, detox and rehabilitation services. | 1 |
| | People experiencing substance use issues in the NWHHS region require increased access to support, detox and rehabilitation services. | 1 | There is need for increased awareness of the harms associated with substance misuse for people in the CWHHS region, including the association with domestic and family violence. | 2 | | |
| | There is a lack of community-based substance use support services for people experiencing substance use issues in the NWHHS region. | 1 | People experiencing substance use issues in the CWHHS region require increased access to support, detox and rehabilitation services. | 3 | | |
| | | | There is a lack of community-based substance use support services for people experiencing substance use issues in the CWHHS region. | 1 | | |
| Systems Issues | | | Current restrictions on MBS billing for Nurse Practitioners limits the ability to utilise an effective and available workforce in regional communities within the CWHHS region. | 1 | Support the further establishment of independent practitioner services, currently being piloted in SWHHS. | 2 |
| | | | There is a lack of community engagement to inform the design of health care services for people in the CWHHS region. | 2 | | |
| Transport | | | People in the CWHHS region require transport and accommodation support to facilitate access to necessary health services in other locations | 1 | People in the SWHHS region require transport and accommodation support to facilitate access to necessary health services in other locations. | 2 |
| | | | | | There is a need for greater awareness of, and access to, scheduled outreach services provided by the HHS / other NGO for smaller communities. | 1 |
| Workforce | There are significant challenges in recruiting and retaining qualified medical, nursing and allied health professionals in the NWHHS region. | 1 | There are significant challenges in recruiting and retaining qualified medical, nursing and allied health professionals in the CWHHS region. | 1 | There are significant challenges in attracting, recruiting and retaining qualified medical, nursing and allied health professionals in the SWHHS region. This might be alleviated by growing our own across all grades and professions in a sustainable manner. | 1 |

| | North West Region | Tier | Central West Region | Tier | South West Region | Tier |
|---|---|---|---|---|---|---|
| | There is a lack of available child care services which contributes to low attendance at healthcare appointments as well as the ability to retain skilled health workers. | 3 | Limited nursing staff available to support/administer chemotherapy. | 2 | The SWHHS region requires increased representation of First Nations' peoples within its health workforce to reflect legislative requirements. Through appropriate training, our wider staff and teams also need to ensure culturally competent care for the communities they serve. | 2 |
| | The NWHHS region requires increased representation of First Nations' peoples within its health workforce to better meet community needs. | 1 | The CWHHS region requires increased representation of First Nations' peoples within its health workforce to better meet community needs. | 1 | | |
| Young People | There is a high rate of developmentally vulnerable children in more than one domain in the NWHHS region. | 1 | Young people in the CWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 1 | Young people in the SWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 3 |
| | There are high rates of psychological distress in young people in the NWHHS region. | 1 | There is a lack of community engagement with young people in the CWHHS region to inform the design of culturally appropriate prevention and promotion activities. | 1 | | |
| | Young people in the NWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 3 | | | | |
| | There is a need for more consistent mental health services to support young people in the NWHHS region. | 1 | | | | |
| | There is a need for more consistent sexual health services to support young people in the NWHHS region. | 1 | | | | |

# Contents

# Acronyms used in this report

| | |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| AMS | Aboriginal Medical 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 |
| CHD | Coronary Heart Disease |
| CKD | Chronic Kidney Disease |
| CL | Commissioning Locality |
| COPD | Chronic Obstructive Pulmonary Disease |
| CWAATSICH | Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health |
| CWHHS | Central West Hospital and Health Service |
| DoHAC | Department of Health and Aged Care |
| ED | Emergency Department |
| FTE | Full Time Equivalent |
| GP | General Practitioner |
| HAO | Healthy Aging in the Outback (WQPHN Program) |
| HOC | Healthy Outback Communities |
| HOK | Healthy Outback Kids (WQPHN Program) |
| HHS | Hospital and Health Service |
| HNA | Health Needs Assessment |
| HWQ | Health Workforce Queensland |
| IRSD | Index of Relative Social-Economic Disadvantage |
| ITC | Integrated Team Care |
| JRHNA | Joint Regional Health Needs Assessment |
| LGA | Local Government Area |
| MBS | Medicare Benefits Scheme |
| MIHC | Mornington Island Health Council |
| NDIS | National Disability Insurance Scheme |
| NGO | Non-Government Organisation |
| NMA | Nukal Murra Alliance |
| NWHHS | North West Hospital and Health Service |
| PHIDU | Public Health Information Development Unit |

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| PHN | Primary Health Network |
| QAIHC | Queensland Aboriginal and Islander Health Council |
| QGSO | Queensland Government Statistics Office |
| QH | Queensland Health |
| RACF | Residential Aged Care Facility |
| RACH | Residential Aged Care Home |
| RFDS | Royal Flying Doctor Service |
| RHD | Rheumatic Heart Disease |
| RHF | Rheumatic Heart Fever |
| 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 |
| WQHSIC | Western Queensland Health Services Integration Committee |
| WQPHN | Western Queensland Primary Health Network |

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# 1 Introduction

## 1.1 Background

A Health Needs Assessment (HNA) is a process of determining the health and service needs of any given population or sub-group in an area. It serves as a foundational tool for guiding future health service planning and delivery across the broad Western Queensland region. It is a complex task requiring epidemiological expertise, the ability to work across organisational boundaries as well as an understanding of, and an ability to, engage effectively with all appropriate population groups. By systematically identifying and prioritising the health and service needs of the various communities, the HNA can shape strategies to ensure that health services are responding to identified needs, enhancing health outcomes and ultimately improving the wellbeing of our communities.

### 1.1.1 A history of independent assessments

Historically, the assessment of health needs and service needs across Queensland has been comprehensive, but uncoordinated. Primary Health Networks (PHNs) have prepared HNAs for their respective regions on a three-year cycle. These HNAs have entailed a detailed and systematic assessment of the region's population health needs, identification of the current service system capacity, alongside stakeholder and community consultation – to identify key issues and service gaps, which in-turn inform regional priorities. These regional priorities then inform the PHN's Annual Activity Work Plans.

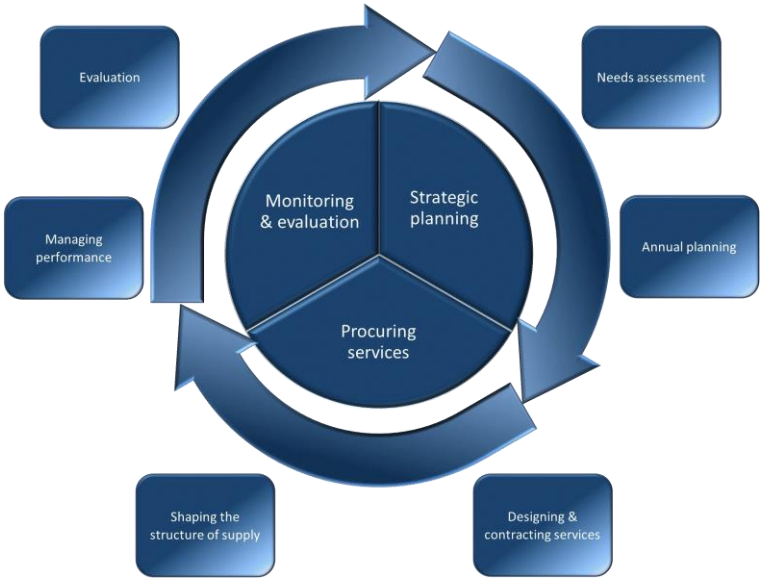


*Figure 1: PHN cycle of activities - starting with needs assessment*

Similarly, Hospital and Health Services (HHSs) across Queensland have prepared Local Area Needs Assessment (LANAs) for their respective regions, also on a three-year cycle. These LANAs, like the HNAs, provide a thorough and systematic evaluation of regional health needs. LANAs utilise six key domains to provide a comprehensive assessment of need, as well as stakeholder and community consultation. This process ensures that the planning and delivery of healthcare services across the State are informed by a robust evidence base.


*Figure 2: Queensland HHS LANA Framework*

While both PHNs and HHSs have engaged in rigorous health needs assessment processes, these efforts have largely been conducted independently of one another. As a result, the processes, though valuable, have often been disjointed, and by operating in parallel, may have inadvertently contributed to inefficiencies, misalignment of priorities, and confusion among stakeholders, while missing opportunities for greater collaboration.

At best, these independent efforts have been well-intentioned but uncoordinated, leading to inefficiencies and sometimes overlapping objectives. At worst, these siloed processes have resulted in conflicting priorities and suboptimal resource allocation, which have compounded an already fragmented healthcare system. This fragmentation has had direct consequences, contributing to inconsistent quality of care and, ultimately, poorer health outcomes.

### 1.1.2 Transition to Joint Regional Health Needs Assessments

Given the challenges outlined above, and in recognition of the need for greater coordination and alignment, the Western Queensland Primary Health Network (WQPHN), together with the North West Hospital and Health Service (NWHHS), the Central West Hospital and Health Service (CWHHS) and the South West Hospital and Health Service (SWHHS) are committed to working collaboratively to produce a Joint Regional Health Needs Assessment (JRHNA) for 2025 – 2028.

This JRHNA represents a crucial step forward in addressing the challenges that have arisen from past independent efforts. It builds on the strengths of previous assessments while ensuring that the process is more streamlined, coordinated, and responsive to the collective needs of the region's population. By bringing together PHNs, HHSs, and other key stakeholders, the JRHNA aims to reduce duplication of effort, clarify priorities, and facilitate more effective resource allocation.

This joint work is also supported by the Queensland – Commonwealth Partnership (QCP)[1], who have endorsed a Joint Regional Health Needs Assessment Framework[2] and associated Implementation Toolkit[3]. The QCP brings together partners from across Queensland's health system, including the Commonwealth Department of Health and Aged Care (DoHAC), Queensland Department of Health, PHNs, HHSs, Queensland Aboriginal and Islander Health Council (QAIHC), Health Consumers Queensland (HCQ) and health consumers. Partners are committed to working together to tackle health system challenges that cannot be overcome by any one organisation, and Joint Regional Health Needs Assessments are a key enabler to addressing these health system challenges.

[1] https://www.health.qld.gov.au/system-governance/health-system/managing/queensland-commonwealth-partnership
[2] https://www.health.qld.gov.au/__data/assets/pdf_file/0028/1351549/Joint-Regional-Needs-Assessment-Framework.pdf
[3] https://www.health.qld.gov.au/__data/assets/pdf_file/0027/1351548/Implementation-Toolkit_Joint-Regional-Needs-Assessment-Framework.pdf

## 1.2 Purpose

The Joint Regional Health Needs Assessment (JRHNA) for the Western Queensland region provides each of the partnering agencies (WQPHN, NWHHS, CWHHS and SWHHS) with a deep understanding of the health and service needs that exist across the communities in the Western Queensland region. All partnering agencies seek to deliver care in response to local communities' needs, and the needs identified through this JRHNA play a key role in informing policy, planning and resource allocation across the healthcare system.

For WQPHN, the health and service needs identified through this JRHNA will directly inform Activity Work Plans for 2025 and into the future. These Plans articulate the specific activities that PHNs will undertake to address the priority health and service needs identified in their respective regions. PHN Activity Work Plans are produced annually, and must be endorsed by the DoHAC prior to implementation. PHNs provide regular progress reports to the DoHAC against the activities outlined in these plans.

For NWHHS, CWHHS and SWHHS the HNA provides an opportunity to increase understanding of the health and service need ecosystem in the region, including identification of service gaps, which then inform ongoing negotiations and requests to the Queensland Department of Health regarding funding allocations, solution development and action plans.

## 1.3 Approach

The overarching approach to preparing the Western Queensland JRHNA is depicted in Figure 3.


*Figure 3: Overarching approach to preparation of the Western Queensland JRHNA*

### 1.3.1 Governance

The governance structure for the Western Queensland JRHNA is depicted in Figure 4.

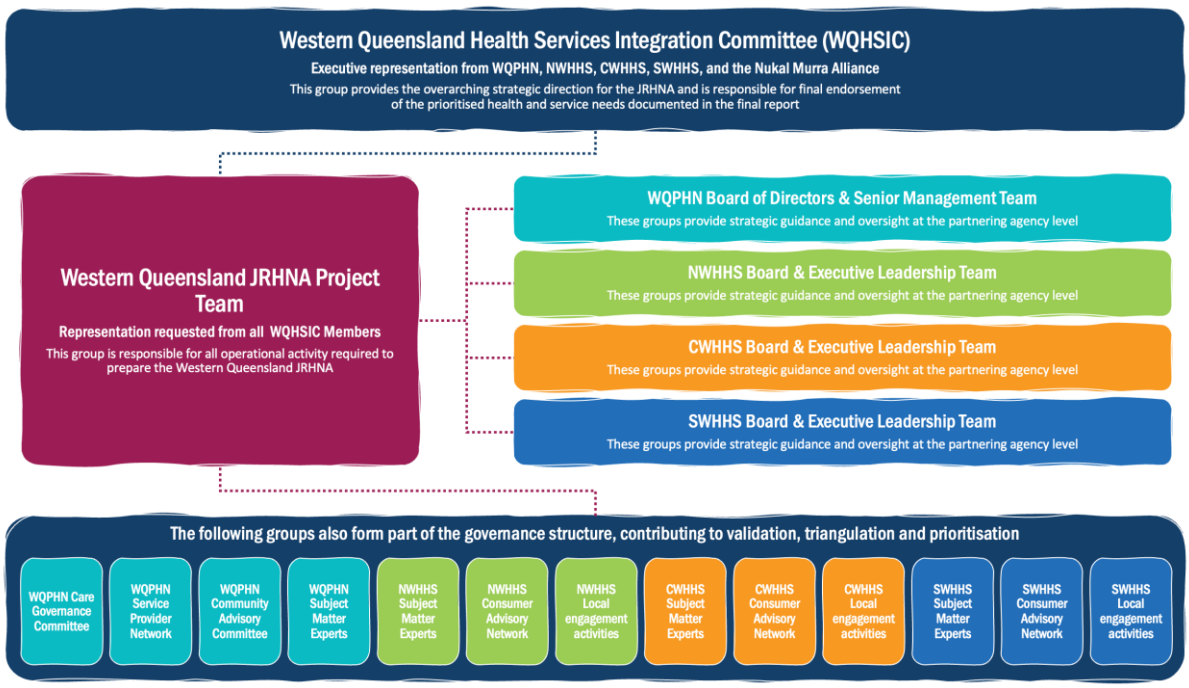


*Figure 4: Western Queensland JRHNA governance arrangements*

The Western Queensland Health Services Integration Committee (WQHSIC) has been identified as the overarching governance entity for development of the Western Queensland JRHNA. This existing Committee is comprised of executive representation from all the key healthcare stakeholders in the region (Figure 5 and Figure 6), and already functions to support collaborative efforts to improve integration of healthcare services across the region.

In early 2024, representatives of the WQHSIC were requested to nominate an appropriate person from their respective organisations to form the Western Queensland JRHNA Project Team. The Project Team would be responsible for all operational activity required to prepare the JRHNA.

The respective Executive Leadership Teams and Boards of each partnering agency also played a role in endorsing processes and outputs at various stages of development, before a final endorsement was sought from the WQHSIC.


*Figure 5: WQHSIC member organisations*

| Nukal Murra Alliance Members | | | |
|---|---|---|---|
| CWAATSICH – Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Limited | CACH – Cunnamulla Aboriginal Corporation for Health | Gidgee Healing Aboriginal Medical Services | Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services |

*Figure 6: Nukal Murra Alliance Members*

## 1.3.2 Methodology

### 1.3.2.1 Approach to collating quantitative data

Western Queensland PHN regularly monitor and analyse many quantitative data sources to maintain a comprehensive understanding of the health and service needs of the local region. This JRHNA includes analyses of complementary data elements recommended in the recently developed JRHNA Framework. The data domains include consideration of:

- Geography
- Demography
- Social determinants of health
- Lifestyle risk factors
- Health conditions and status
- Populations with particular needs
- Service mapping and utilisation
- Workforce

The above domains are considered and analysed using a variety of data sources and methodologies. Descriptive analytic methodologies were mostly employed to understand the population groups and geography most affected by the need. Where possible, time series analysis was used to investigate patterns of need over time. At all times, analyses considered the relativity of the needs, i.e., normalisation and comparison techniques were used to add depth to the absolute values retrieved from the data sources. Tools such as reference populations (Queensland figures), relative risks, and rates and proportions per population provided context and subjectivity to the analysis, while raw, crude numbers were used to understand the absolute size of an issue.

Examples of data sources used in this JRHNA include:

- Australian Bureau of Statistics Census
- Australian Institute of Health and Welfare data collections
- Queensland Health Planning Portal
- Queensland Government Statistician's Office data collections
- Public Health information Development Unit
- Australian Early Development Census
- GEN Aged Care
- Queensland Health data collections such as Hospital Admissions and Emergency Department presentations
- HeaDS UPP Workforce data collection
- WQPHN General Practice data collection

- Primary Mental Health Care Minimum Dataset

Utilising the subject matter expertise of the partner organisations, analysis and interpretation was delegated and conducted collaboratively where appropriate. For example, primary care data context and interpretation was provided by PHN team members, while hospitalisation data interpretations were supported by HHS team members for their respective regions. Understanding the interrelated service utilisation patterns of primary and secondary care, was assessed collaboratively with the partner SMEs.

WQPHN has clear principles to utilise secondary data analyses before considering data collection from stakeholders. Findings from secondary data analyses provides evidence or knowledge gaps and guides key lines of enquiry for stakeholder consultations. This ensures efficient and effective use of existing data assets to enable valuable and meaningful engagement of stakeholders.

#### 1.3.2.2 Approach to stakeholder consultation

Western Queensland JRHNA partnering agencies adopted a stakeholder engagement and collaboration strategy to plan and execute stakeholder engagement activity tailored to the unique context of the Western Queensland region.

The strategy prioritised collaboration and transparency to effectively leverage the group's diverse knowledge, capacity and networks, maximising resources and eliminating duplication of effort. Partnering agencies were mindful of recent engagement across the region to inform the 2022 Local Area Needs Assessments, and ensured these existing insights were considered and informed the lines of enquiry for this strategy.

A phased engagement approach, aligned to needs assessment phases, was undertaken from May to November 2024. Key activities during phases two and three included:

- An audit of information gathered through routine activities over the previous 12 months, such as insights gleaned from conversations with commissioned service providers, and insights shared by community members at regional Healthy Outback Community (HOC) events
- Stakeholder mapping
- A survey distributed to members and partners for distribution through their respective networks to gather qualitative perspectives on regional health needs and current engagement methods,
- An audit of existing engagement methods by partner agency and vulnerable stakeholder groups, with identified gaps informing future qualitative data collection,
- Collaborative planning workshops with partnering agencies, and
- Targeted engagement with existing regional working groups, forums and alliances such as the WQPHN Care Governance Committee, WQPHN Consumer Advisory Committee and WQHSIC to validate existing data and priorities.

Partnering agencies are committed to evaluating the engagement process and outcomes of this first joint regional assessment process for continual improvement over time. We will measure our success by how effectively we:

- Leverage collective capabilities and capacity across all partnering agencies,
- Plan and execute joint engagement activities,
- Ensure community voices are adequately represented,
- Identify and document knowledge gaps and key issues,
- Share existing data and gather sufficient evidence to support findings,
- Engage and involve collaborative working groups,
- Ensure priority/vulnerable stakeholder groups are engaged and represented, and
- Share draft reports with key stakeholder groups for acknowledgement and/or endorsement.

### 1.3.2.3 Approach to validation and triangulation

Triangulation is the process of gathering information across various sources to assess, verify and validate insights. Information from one source may corroborate information from another source, indicating the relative strength of an issue, or conversely, information may contrast information gathered from another source, warranting further investigations.

The Western Queensland JRHNA partnering agencies agreed to use a triangulation matrix similar to that depicted in Figure 7 to validate the health and service needs that emerged from the analysis of quantitative and qualitative data.

| Issue | Publicly available data | PHN data (GP and program data) | HHS data | Stakeholder insights – Sector | Stakeholder insights – Community | Triangulation score |
|---|---|---|---|---|---|---|
| Health Issues | | | | | | |
| Health Issue 1 | 0 | 2 | 3 | 2 | 2 | 1.8 |
| Health Issue 2 | 3 | 2 | 2 | 4 | 3 | 2.8 |
| Service Issues | | | | | | |
| Service Issue 1 | 4 | 3 | 3 | 3 | 3 | 3.2 |
| Service Issue 2 | N/A | 4 | 3 | 4 | 3 | 3.5 |

Scoring:

N/A – no data available
0 – Not raised / not evident in the data
1 – Rarely raised as an issue / somewhat evident in the data
2 – Raised as an issue / evident in the data
3 – Raised frequently as an issue / concern evident in the data
4 – Raised frequently as a high priority issue or concern needing action / significant concern evident in the data

*Figure 7: Triangulation Matrix*

### 1.3.2.4 Approach to prioritisation

The WQPHN identified six critical criteria to be used to support prioritisation of the health and service needs that emerged from the triangulation process (Table 1). **Error! Reference source not found.** provides further detail on how each criteria was scored.

*Table 1: WQPHN prioritisation criteria*

| WQPHN Prioritisation criteria | Definition | Scorers |
|---|---|---|
| Variation from benchmark | This criterion indicates the degree to which the health or service need varies (in an undesirable direction) from a reasonable and appropriate benchmark, such as a State or National average. | WQPHN Health Planning Team |
| Magnitude of the problem / need | This criterion aims to understand the scale and magnitude of the issue. This can be observed through the incidence or prevalence of an issue across the population of interest. | WQPHN Health Planning Team |
| Inequity | This criterion indicates the extent to which addressing the health or service need would reduce disparities between different population groups, especially vulnerable population groups. | WQPHN Health Planning Team |
| Clinical severity | This criterion indicates the clinical seriousness or severity of the health or service need, and the impacts of the need on health, quality of life and mortality. | WQPHN Care Governance Committee and Service Providers |

| | | |
|---|---|---|
| Community Seriousness | This criterion indicates the perceived seriousness of the health or service need in the community, and the impact of the need on people's quality of life. | WQPHN Community Advisory Council |
| Feasibility | This criterion indicates the feasibility for the PHN to address this health or service need, within current or anticipated future resources. | WQPHN Executive Leadership Team |

Given the differing requirements across WQPHN and the HHSs, the HHS partners adopted different prioritisation criteria (Table 2).

*Table 2: HHS prioritisation criteria*

| HHS Prioritisation criteria | Definition | Scorers |
|---|---|---|
| Scale / magnitude of the issue | This criterion aims to understand the scale and magnitude of the issue. This can be observed through the incidence or prevalence of an issue across the population of interest. | HHS Planning Teams |
| Impact of the issue | This criterion aims to understand the size and nature of the impact that the issue has on people affected by it. This can be thought of as the potential implications, costs or risks of inaction. | HHS Clinical, Operational and Planning Teams |
| Level of endorsement | This criterion aims to validate that the issue is genuinely an issue through the subjective endorsement (or dis-endorsement) of it, based on the professional expertise and wisdom of participants in the prioritisation process. | HHS Clinical, Operational and Planning Teams |
| Scope | This criterion aims to prioritise issues that relate to, or are likely to have, a response that falls within the remit of the partnering agencies. | HHS Clinical, Operational and Planning Teams |
| Effectiveness of the system response | This criterion aims to prioritise issues that are not likely to be adequately or effectively addressed through the current system response. | HHS Clinical, Operational and Planning Teams |

*Table 3: WQPHN Prioritisation Scoring Matrix*

| | Variation from benchmark | Magnitude of the problem/need | Inequity | Clinical severity | Community seriousness | Feasibility |
|---|---|---|---|---|---|---|
| | This score indicates the degree to which the health or service need varies (in an undesirable direction) from a reasonable and appropriate benchmark, such as a State or National average. | This is the number or proportion of the population affected by the health or service need. | This score indicates the extent to which addressing the health or service need would reduce disparities between different population groups, especially vulnerable population groups. | This score indicates the clinical seriousness or severity of the health or service need, and the impacts of the need on health, quality of life and mortality. | This score indicates the perceived seriousness of the health or service need in the community, and the impact of the need on people's quality of life. | This score indicates the feasibility for the PHN to address this health or service need, within current or anticipated future resources. It is also important to consider the PHN's willingness to act on this issue, as well as existing capacity and capability |
| 4 | Greater than or equal to 80% variation from benchmark | Greater than or equal to 25% of population | There are opportunities to prevent inequity from occurring by addressing the need | The need requires urgent attention due to significant impact on quality of life and/or clinically significant risk of premature mortality | There are significant recognised health inequities associated with the need or the need significantly impacts on people's quality of life and their ability to complete necessary tasks | Addressing the need is within the core scope of PHN activities and can clearly be achieved with the existing resources and partnerships. Addressing the need would be considered business-as-usual for the PHN |
| 3 | Between 50.0% - 79.9% variation from benchmark | Between 15.0% - 24.9% of population | There are opportunities to address existing inequity by addressing the need | The need leads to certain hospitalisation and/or significantly impacts on quality of life | The need causes disruption to a person's life such as ability to work, maintain relationships and complete important daily household tasks. | Addressing the need may be feasible if additional funding is sourced, and/or strategic partnerships developed or additional workforce and infrastructure is developed. |
| 2 | Between 20.0% - 49.9% variation from benchmark | Between 5.0% - 14.9% of population | Inequity has been evidenced, but limited opportunities exist to address inequity in the need | The need requires regular primary care management to minimise adverse impacts on people's quality of life. | The need has minor impact on people's quality of life | Addressing the need may be feasible if local health care system and broader systemic challenges and barriers are addressed. AND/OR Other Stakeholders are 1better placed to address the need, and the PHN can offer support. |
| 1 | Similar to, or up to 20.0% variation from benchmark | Between 1.0% - 4.9% of population | Inequity is suspected, but yet to be evidenced | The need has minimal impact on people's quality of life and risk of hospitalisation | People still live a positive quality of life with the issue present and has minimal impact on their day to day lives | Addressing the need is unlikely to be feasible due to existing barriers in the local health and social care system which are not likely to be resolved in the next 3-5 years. |
| 0 | Better than benchmark | Less than 1.0% of population | There are no equity considerations for the need | The need has no impact on quality of life or risk of hospitalisation | The need has no impact on people's day to day life | Addressing the need is not feasible, as it is outside the scope or remit of the PHN. |
| | Scored by PHN Health Planning Team | Scored by PHN Health Planning Team | Scored by PHN Health Planning Team | Scored by clinical representatives of the Care Governance Committee. | Scored by members of the Community Advisory Committee. | Scored by the PHN SMT. |

Whilst there is some overlap between the prioritisation criteria considered relevant by each partnering agency, the differing criteria have allowed each partnering agency to clearly identify the health and service needs that are within scope for each agency to feasibly address and/or are aligned with strategic commitments already resourced. This has assisted with identifying the lead agency for each prioritised need.

## 1.4 Limitations

### 1.4.1 Data Limitations

The partnering agencies have worked collaboratively and comprehensively to ensure a thorough understanding of the health and service needs in the Western Queensland region, however it is important to acknowledge a number of limitations will inevitably impact the outcomes. The most prominent limitations are included below, and are important to consider before using the information contained within this report.

**Inability to obtain data at localised levels**

Given the vast and significantly varied geographical area of the Western Queensland region, it is reasonable to expect challenges in accessing localised data for the health needs assessment. While State and regional-level data provides a useful overview, it can mask variations in health needs at smaller community levels. A number of datasets analysed for this JRHNA were at the PHN or HHS level. The aggregation of data at regional levels can sometimes mean that health disparities are overlooked, making it more challenging to design interventions that effectively address specific local health concerns.

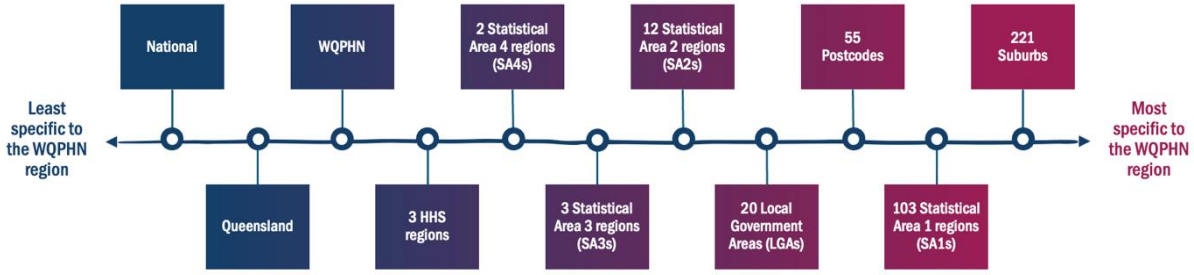


*Figure 8: Levels of data availability*

**Recency of data**

Outdated data is a frequent issue in health needs assessments and this JRHNA is not immune to this issue. Some datasets may be several years old, and therefore may fail to capture current trends or emerging health issues. This lag in data availability can lead to planning and decision-making that is not fully aligned with the population's present needs, limiting the assessment's relevance and effectiveness.

**Nature of data**

While this report aims to provide a comprehensive analysis, it is important to acknowledge the limitations regarding the nature of some data presented. In some cases, only absolute data was available, which can limit the ability to draw precise conclusions about trends or make direct comparisons across different groups or regions. The absence of rate-based data restricts capacity to account for population size differences, potentially influencing the interpretation of prevalence or service utilization.

Where rates were unavailable, absolute numbers have been used to illustrate trends and needs. While this approach offers valuable insights, it may not fully capture the relative impact on smaller or less represented groups.

**Unavailability of data for some population groups**

Health needs assessments often face challenges in accessing data for specific population groups, such as Indigenous communities, multicultural communities, queer communities or people with disabilities. This lack of disaggregated data can make it difficult to identify the unique health needs of these groups. Any activities that target vulnerable communities should be mindful of this limitation.

**Quality of data**

Data quality issues, such as inconsistencies, inaccuracies, or incomplete records, can compromise the reliability of health needs assessments. Poor data quality affects the ability to draw accurate conclusions about population health needs, potentially leading to misinformed resource allocation and program planning.

**Resource constraints**

Health needs assessments are inherently resource-intensive. This was especially true for the JRHNA, given the collaborative nature of the work spanning four distinct organizations, each with its own remit, strategic priorities, and boundaries of operation. These complexities inevitably influence the scope and depth of the analysis, as well as the ability to engage key stakeholder groups comprehensively.

As with any health needs assessment, the JRHNA should be seen as a snapshot in time, capturing the health landscape at a particular moment. While this provides valuable insights, it cannot fully account for evolving health needs, service delivery changes, or emerging population health challenges. Therefore, a commitment to ongoing review and regular augmentation of the JRHNA with additional data and insights is essential to ensure its continued relevance. This iterative process will allow the JRHNA to remain a living document, one that evolves with the changing health environment and continues to guide strategic planning and resource allocation effectively.

### 1.4.2 Stakeholder Engagement Limitations

**Broad Stakeholder Engagement Challenges**

Engaging stakeholders across the Western Queensland region presents significant challenges, with the primary obstacle being the vast distances involved. Covering 55% of Queensland, this region includes many remote communities, making in-person engagement logistically difficult. While engaging vulnerable or hard-to-reach communities can also present barriers, the sheer geographic spread and isolation of many communities pose the most critical challenges. These factors can limit participation, making it harder to gather comprehensive and representative input, which can ultimately affect the depth of the health needs assessment and its ability to capture the full spectrum of needs across the population.

**Aboriginal and Torres Strait Islander Engagement Challenges**

A notable limitation of this HNA is the insufficient engagement with Aboriginal and Torres Strait Islander communities. Due to the rapid pace at which this work was conducted, the PHN experienced challenges in fully align our approach with the needs and timelines of Aboriginal and Torres Strait Islander health services and communities in the region. We acknowledge that this approach did not allow for the depth of relationship-building and meaningful consultation necessary to truly reflect their perspectives and priorities.

While time constraints played a role in limiting our engagement, we recognise that this should not serve as an excuse. Genuine and respectful engagement with Aboriginal and Torres Strait Islander communities is essential for ensuring culturally safe and effective health planning. Our organisation is committed to improving our engagement practices, allowing sufficient time and flexibility in future work to improve this work.

### 1.4.3 Process Limitations

This Report represents an admirable collaborative effort by four large organisations working together for the first time to deliver a Joint Regional Health Needs Assessment. The commitment and dedication shown by each organisation in reaching a shared outcome are commendable and reflect a strong foundation for future collaboration.

However, as with any initial joint venture of this scale, certain challenges were inevitable. Differences in organisational processes, data sources, timelines, governance processes and reporting standards posed obstacles that affected various aspects of the Report's development. While these challenges highlight areas for improvement, they also underscore the valuable learning gained from this experience. The insights gleaned will serve as a basis for refining our collaborative approach and strengthening future joint efforts.

- With considerable work undertaken to develop previous HNAs and LANAs, partners found it challenging to adapt and pivot from familiar practices to an unfamiliar and loosely defined joint process.

- There were challenges in managing expectations within the collaborating partners due to inconsistent expectations from Queensland Health and the Commonwealth Department of Health and Aged Care, and the variable capacity and capability within each partnering organisation.
- Given the differing expectations from funders, high levels of collaboration were achievable for a large portion of the process, however each partner progressed their prioritisation processes independently, which has resulted in some minor variation in needs prioritisation.

## 1.5 Structure of this document

This JRHNA is essentially comprised of a standalone HNA for each of the three regions. Chapter 2 provides a high-level overview of the entire Western Queensland region, followed by three separate chapters for the North West Queensland region, the Central West Queensland region and the South West Queensland region. The communities that make up these regions vary significantly in their geography, populations and demography, and therefore the health and service needs experienced also differ. To facilitate comparison where relevant, each regional chapter follows a similar structure:

- Section 1: Population
- Section 2: Determinants of health
- Section 3: Vulnerable populations
- Section 4: Health needs
- Section 5: Service needs
- Section 6: Stakeholder consultation
- Section 7: Prioritised needs

In additional, this JRHNA also presents two shorter chapters summarizing the insights from two separate investigations into the health and service needs of multicultural communities, as well as the health and service needs of people experiencing homelessness. These are included as chapters 6 and 7.

# 2 An Overview of the Western Queensland Region

The Western Queensland PHN region borders the Northern Territory, South Australia and New South Wales, covering a land mass of 956,438 km$^2$, which is approximately 55% of Queensland. The region has a total of 63,678 residents, with approximately 20% identifying as Aboriginal and Torres Strait Islander (compared to a National average of 3.2%). There are 20 Local Government Areas (LGAs), and the PHN splits the region into seven Commissioning Localities – depicted below (Figure 9).

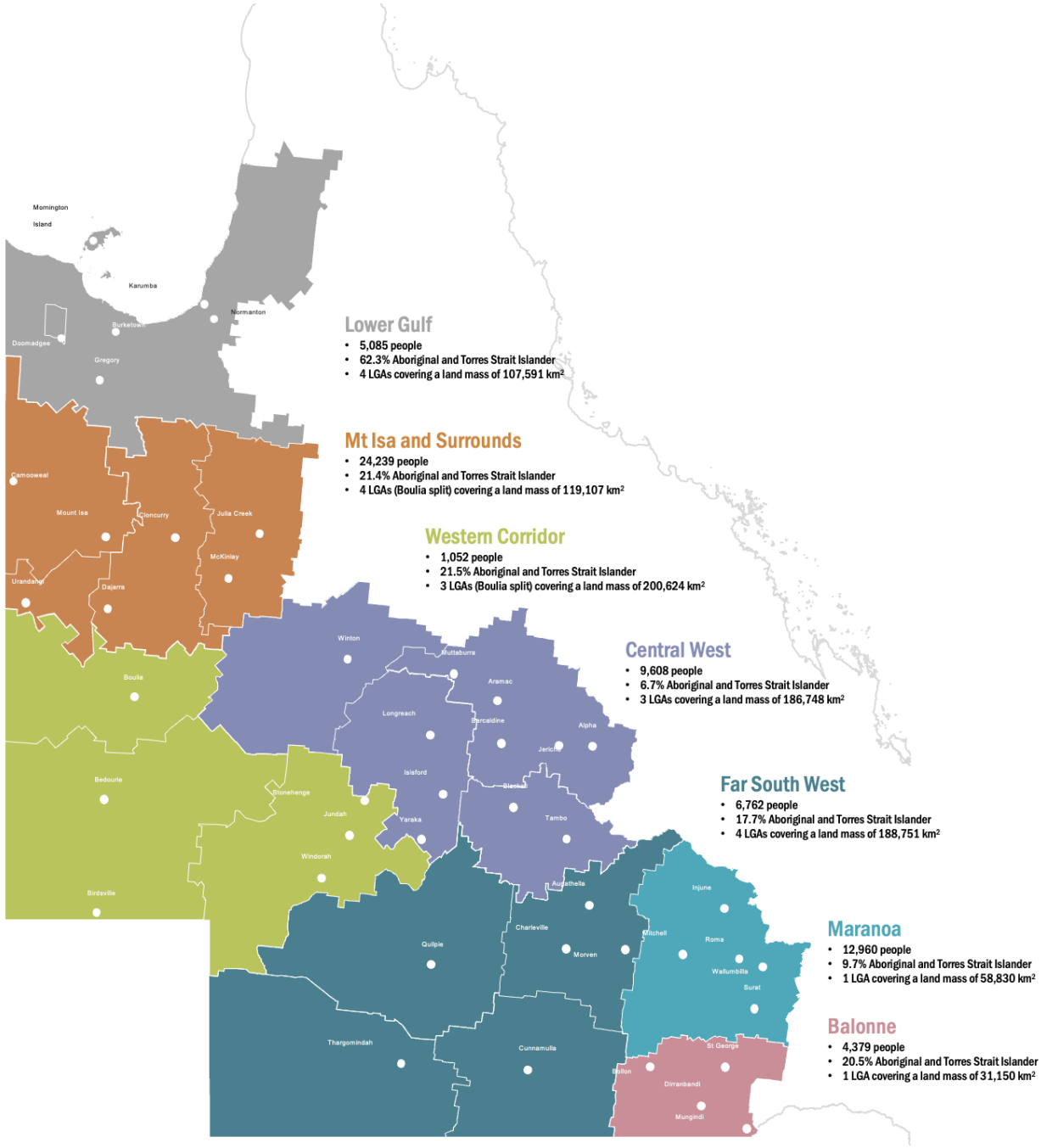


*Figure 9: Map of the Western Queensland PHN region, showing the seven Commissioning Localities*

The region is serviced by three local Hospital and Health Service (HHS) regions:

- North Western HHS – covering the Lower Gulf and Mount Isa and Surrounds areas
- Central Western HHS – covering the Western Corridor and Central West areas
- South Western HHS – covering the Far South West, Maranoa and Balonne areas.

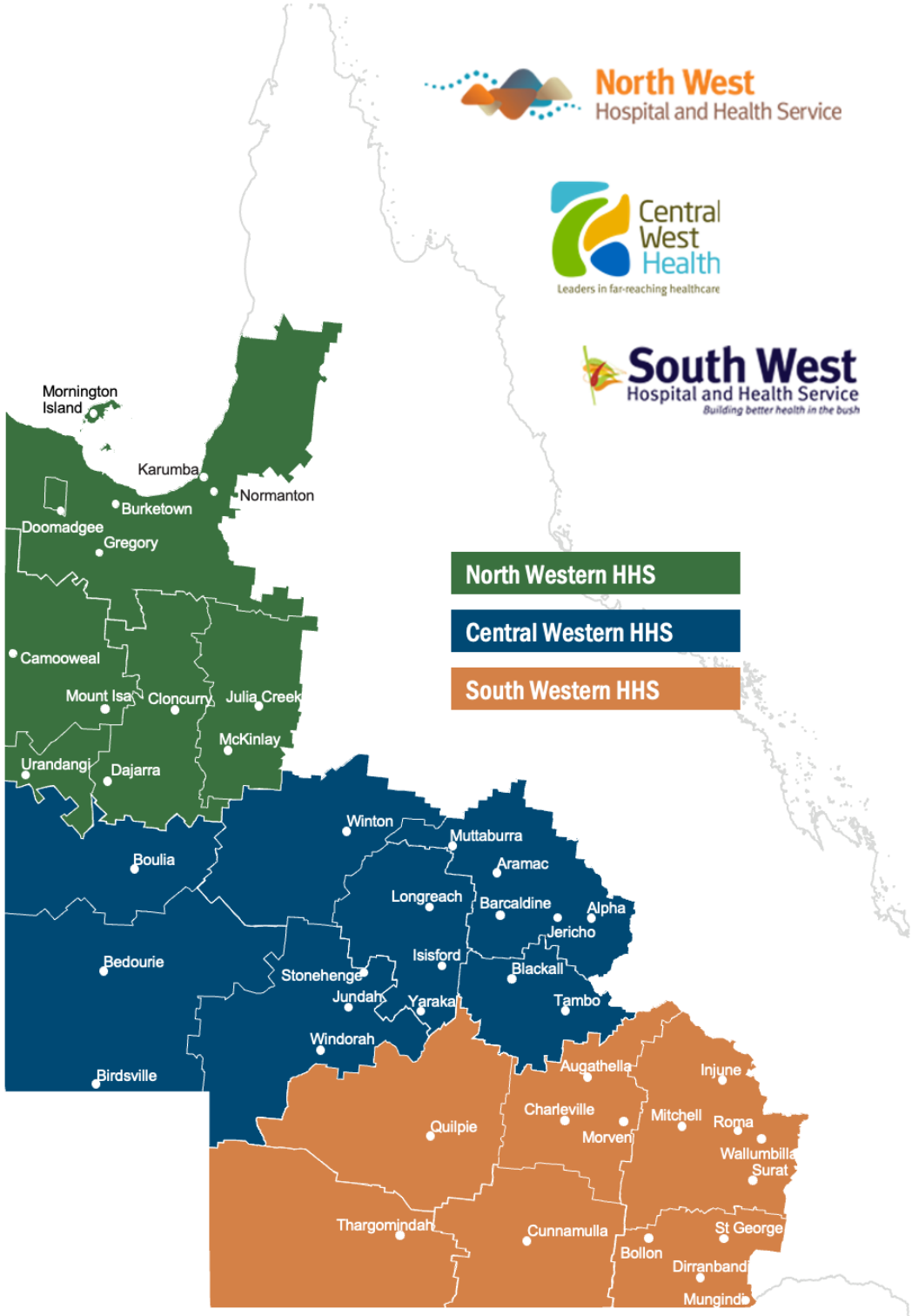


*Figure 10: Map of the Western Queensland region showing the North, Central and South Western HHSs*

Seventeen primary care organisations are operational across the region, comprised of:

- Eight private practices
- Four Aboriginal Community Controlled Health Services, operating from nine locations
- One Royal Flying Doctor Service with two bases operating from 17 locations, and
- Three Hospital and Health Services, operating from 41 locations.

Complimenting the primary care organisations are:

- 32 Pharmacies
- Eight Residential Aged Care Homes (permanent residencies), and
- 21 Home care providers

# 3 North West Queensland Region

## 3.1 Population

### 3.1.1 Geography

The North West Queensland region spans a large geographical area in the north west of Queensland, extending west to the Queensland – Northern Territory border, south beyond Dajarra, east beyond Julia Creek and North beyond Normanton, bordering Kowanyama (Figure 11).

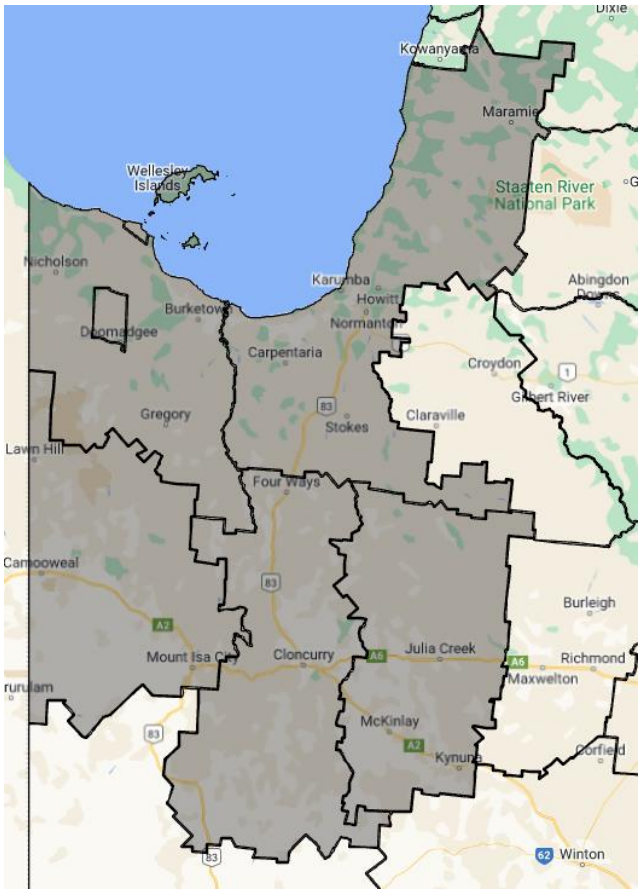


*Figure 11: Map of North West Queensland region*

Table 4 provides the concordance across statistical areas, local government areas and major towns across the North West Queensland region.

*Table 4: North West Queensland region statistical areas, local government areas, major towns and remoteness score*

| Statistical Area level 3 | Statistical Area level 2 | Local Government Areas | Major Towns | Remoteness |
|---|---|---|---|---|
| Outback - North | Mount Isa | Mount Isa City | Mount Isa | 100% Remote |
| | Mount Isa Surrounds | Cloncurry (S) | Cloncurry, Camooweal | 100% Very remote |
| | Carpentaria | Carpentaria (S)<br>Burke (S)<br>Mornington (S)<br>Doomadgee Aboriginal (S) | Karumba, Normanton, Doomadgee, Burketown, Gununa | 100% Very remote |
| | Northern Highlands | McKinlay (S) | Julia Creek | 100% very remote |

### 3.1.2 Demography

The North West Queensland region is home to 29,266 persons, with approximately two-thirds (64.7%) residing in Mount Isa (Figure 12), and close to a third (32.8%) of the population identifying as Aboriginal and Torres Strait Islander peoples (Figure 13). Doomadgee and Mornington LGAs are comprised of largely Aboriginal and Torres Strait Islander communities, with 93.8% and 87.5% of the population identifying as Aboriginal and Torres Strait Islander peoples respectively.

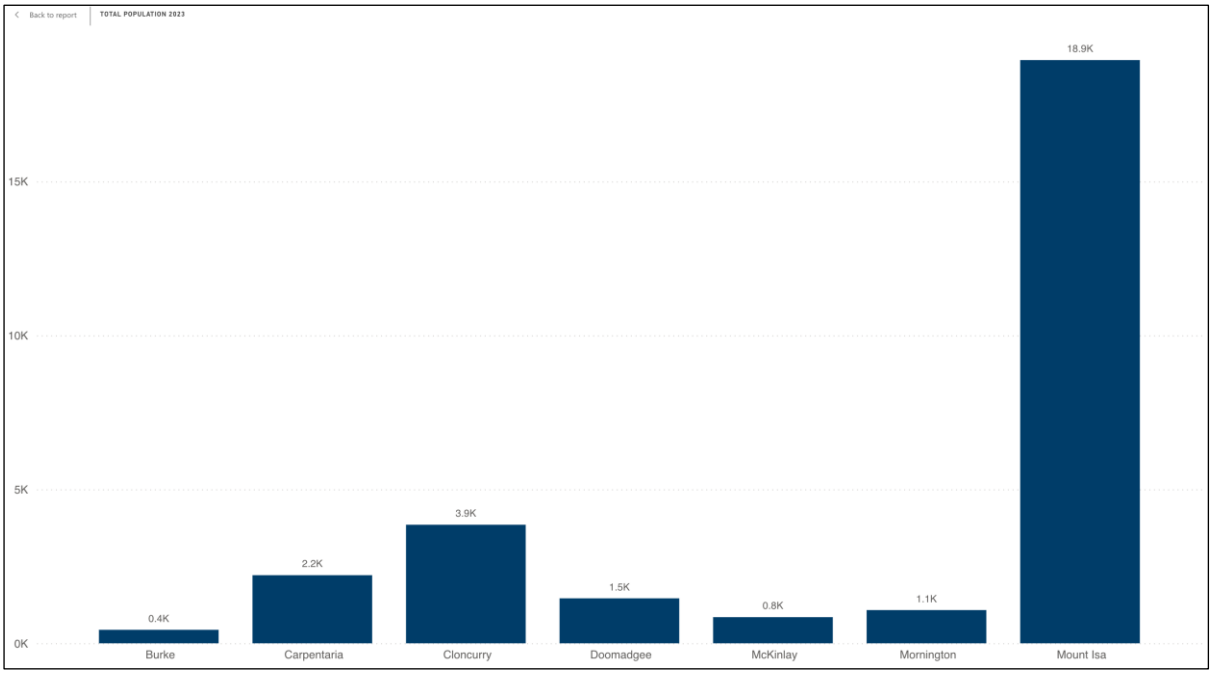


*Figure 12: North West Queensland population across LGAs*

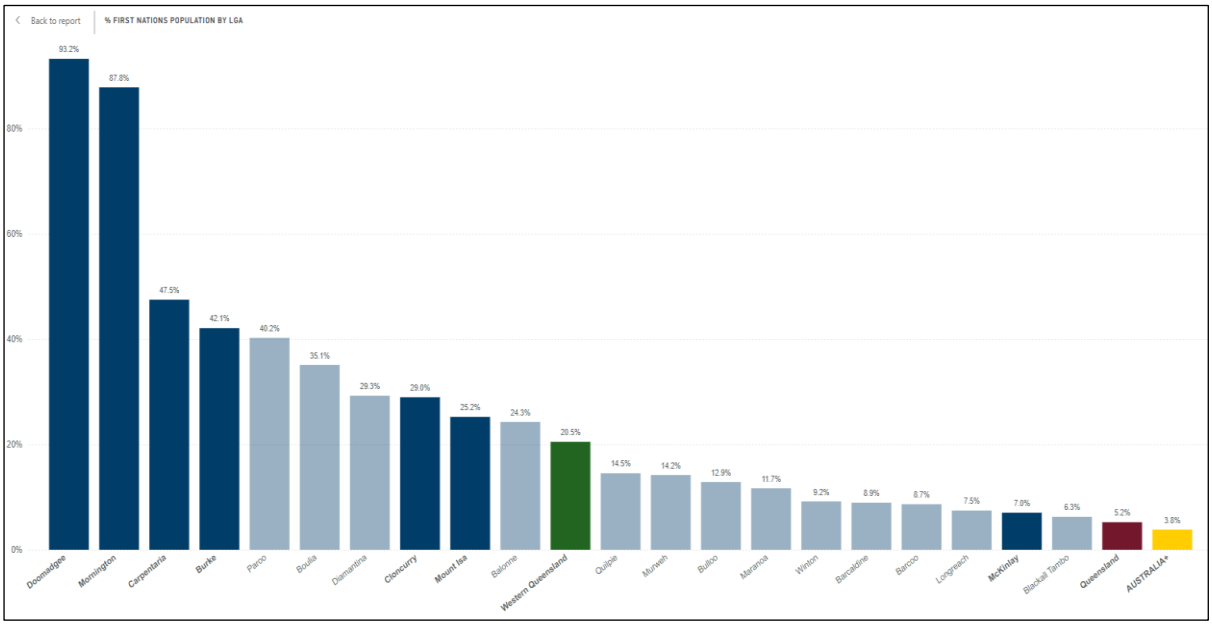


*Figure 13: Aboriginal and Torres Strait Islander population across the North West region*

The region has a considerably younger population compared to Queensland (Figure 14) with 68.4% of the population being aged under 45 years compared to 58.5% for Queensland, and over 90% of the population being aged under 65 years compared to 83% for Queensland (Figure 14).

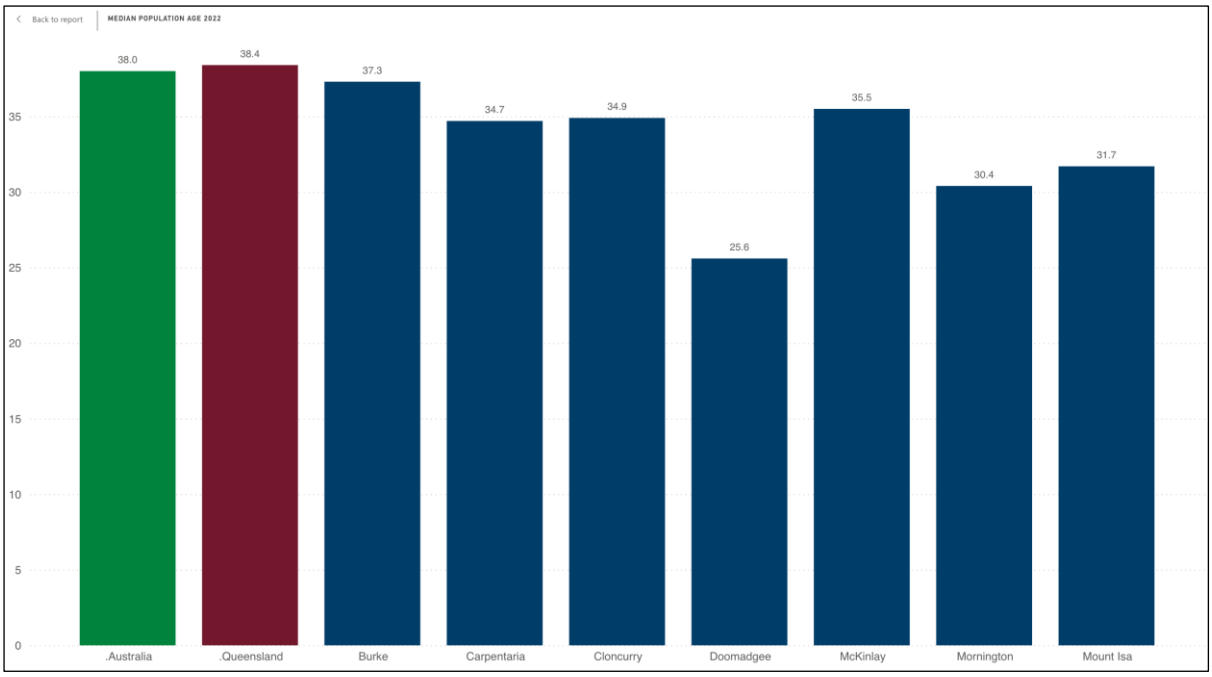


*Figure 14: Median age of the population in the North West region across LGAs*

More than one in five (21.7%) people are aged 0 to 14 years, which is higher than both the National and State levels (both 18.4%). Doomadgee (31.4%), Mount Isa (23.7%), Mornington (23.2%) and Carpentaria (21.9%) are the LGAs with the highest proportion of young people (Figure 15). All LGAs in the region have very low numbers of older people aged 65 years and over, with Doomadgee (3.9%), Mornington (7.5%), Mount Isa (8.0%) and Cloncurry (9.7%) all under 10%. The National and State average is 17.4% (Figure 16).

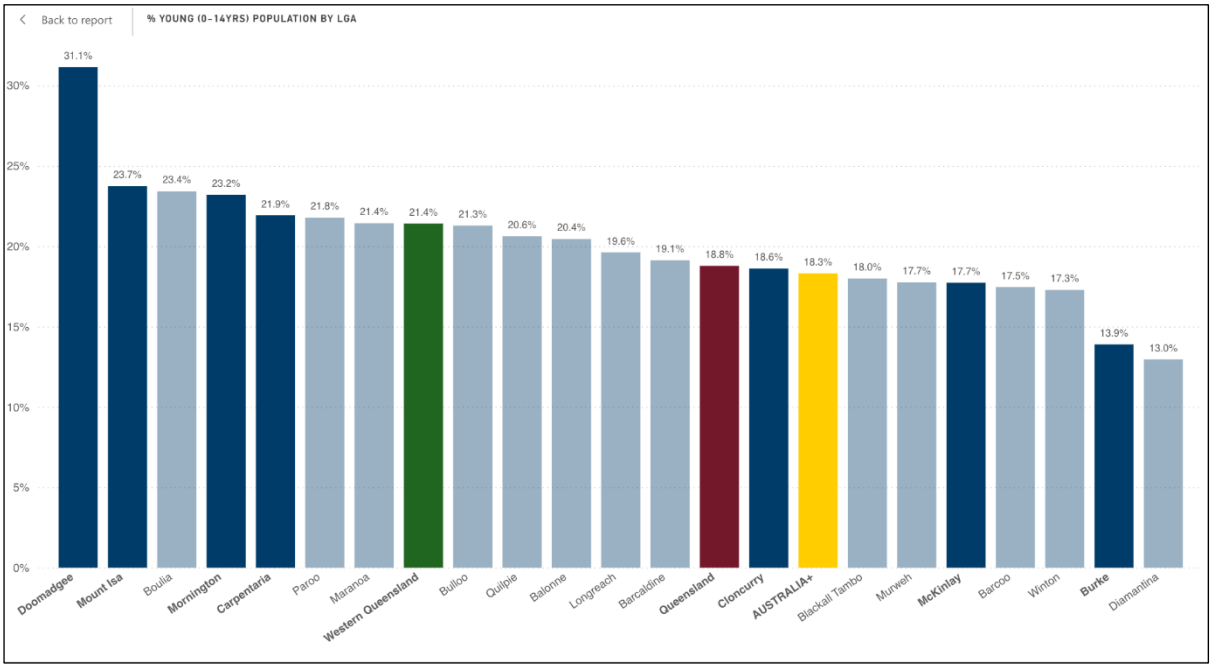


*Figure 15: Proportion of young people under 15 years across the North West region*

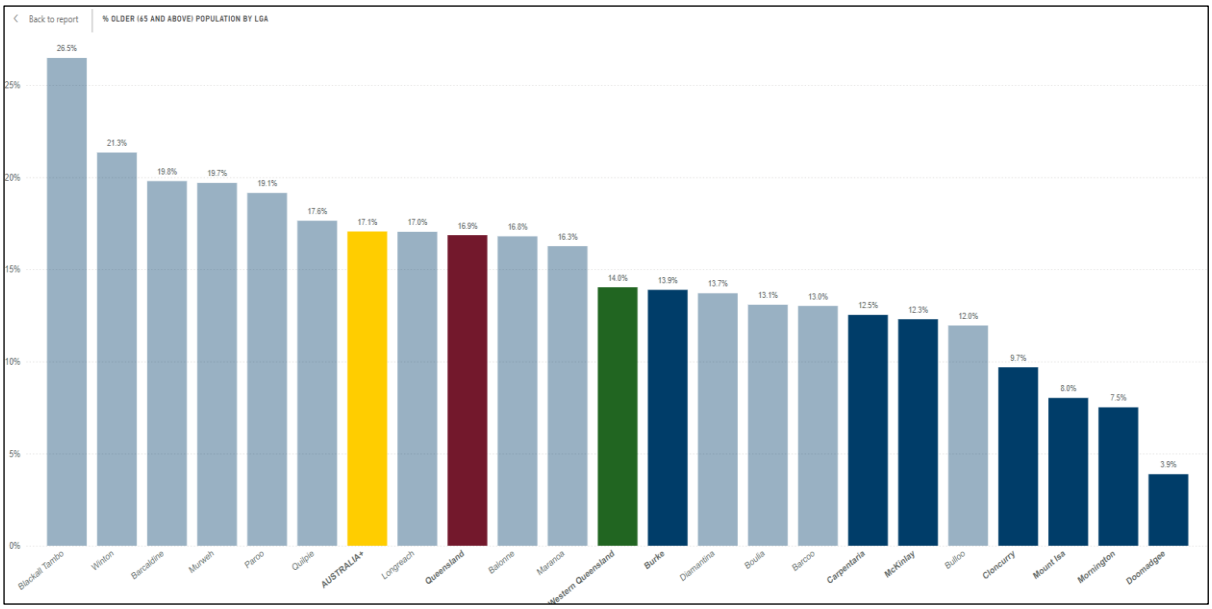


*Figure 16: Proportion of people aged 65 years and over in the North West region*

### 3.1.3 Population growth

Annual projected population growth in 2026-2046 period is -0.7%, compared to an expected +1.4% increase across Queensland, indicating there is an expectation that the population of the region will be decreasing in coming decades (Figure 17).

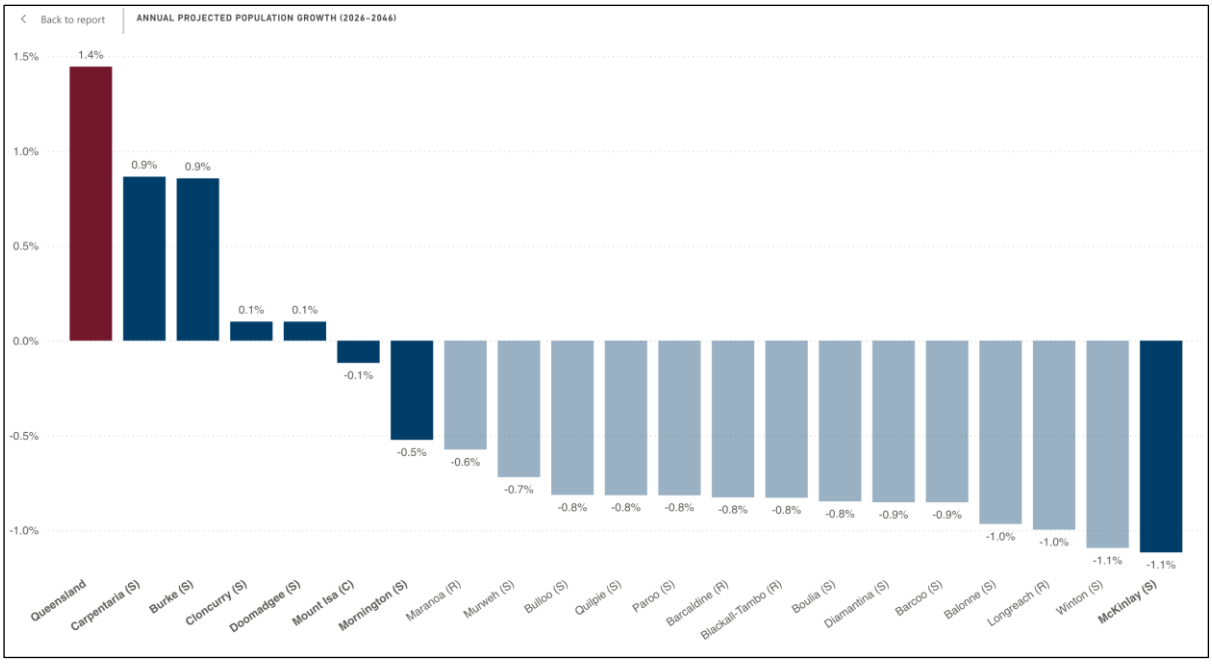


*Figure 17: Population projections for the North West region for 2026-2046*

## 3.2 Determinants of health

### 3.2.1 Relevance

**Why is exploring social determinants of health in the North West Queensland region important?**

The social determinants of health, including income, education, employment, housing, and access to nutritious food, fundamentally shape individual and community health outcomes. These factors are often more powerful than medical interventions in determining life expectancy and quality of life. Exploring social determinants is critical because they directly contribute to health disparities, particularly among vulnerable populations. Addressing these determinants through policy and systemic changes offers the most effective means of improving health equity and achieving sustainable health improvements across the region.

Lifestyle factors, including obesity, diet, exercise, smoking, and alcohol consumption, are major contributors to both chronic disease and preventable mortality. Poor dietary habits, physical inactivity, and substance use significantly increase the risk of conditions such as heart disease, diabetes, and certain cancers. These behaviours not only impact individual health outcomes but also place a considerable burden on healthcare systems. Understanding the prevalence of these factors and their role in shaping health is essential to designing effective health promotion and disease prevention strategies that can improve population-wide wellbeing and reduce healthcare costs.

### 3.2.2 Social determinants of health

#### 3.2.2.1 Socio-economic disadvantage

The Socio-Economic Indexes for Areas (SEIFA) consist of four indexes that rank regions across Australia based on socio-economic factors and disadvantage. There is a strong link between socio-economic status and health outcomes, where people from disadvantaged backgrounds tend to have poorer health, shorter life expectancy, and higher health risks compared to those from higher socio-economic backgrounds (Australian Institute of Health and Welfare, 2020). Additionally, research shows that individuals living in socio-economically disadvantaged areas are more likely to face challenges accessing healthcare services outside their local area[4].

Across the North West Queensland region, a significant proportion of the population sits in the lowest quintile (most disadvantaged), with close to half of the population in the Mount Isa region and more than 80% of Gulf residents in the most disadvantaged quintile.

Overall, approximately 61.3% of North West HHS population are in quintiles 1 and 2. Burke, Carpentaria, Doomadgee, Boulia, and Mornington have 100% of their population in quintiles 1 and 2, with Doomadgee ranked the 8$^{th}$ most disadvantaged area countrywide (Figure 18).

[4] Arpey, N. C., Gaglioti, A. H., & Rosenbaum, M. E. (2017). How socioeconomic status affects patient perceptions of health care: a qualitative study. *Journal of primary care & community health*, *8*(3), 169-175

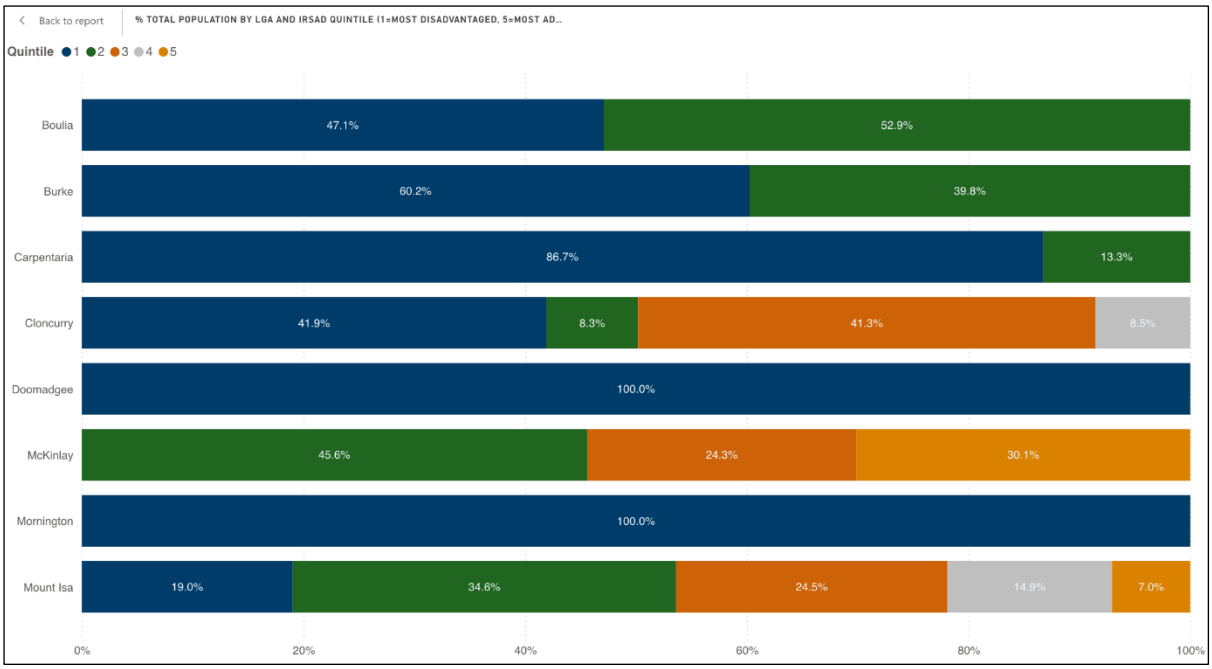


*Figure 18: Index of Relative Socio-economic Advantage and Disadvantage for the North West region*

*Table 5 SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) by Local Government Areas*[5]

| LGA | Burke | Carpentaria | Doomadgee | Mornington | Cloncurry | McKinlay | Mount Isa | Boulia |
|---|---|---|---|---|---|---|---|---|
| Population | 419 | 2,090 | 1,387 | 1,025 | 3,644 | 836 | 18,727 | 229 |
| SEIFA Score | 941 | 851 | 534 | 609 | 965 | 1,014 | 972 | 878 |
| SEIFA Quintile | 2 | 1 | 1 | 1 | 3 | 4 | 3 | 1 |

This disadvantage is influenced by a range of variables, including, for example, high rates of unemployment across the region, with all LGAs in the North West Queensland region having considerably higher rates than the broader Western Queensland region, as well as National and State levels (Figure 19).

[5] *Source: Council of Mayor website SEIFA by Local Government Area | South East Queensland | Community profile, accessed 4th November 2024.*

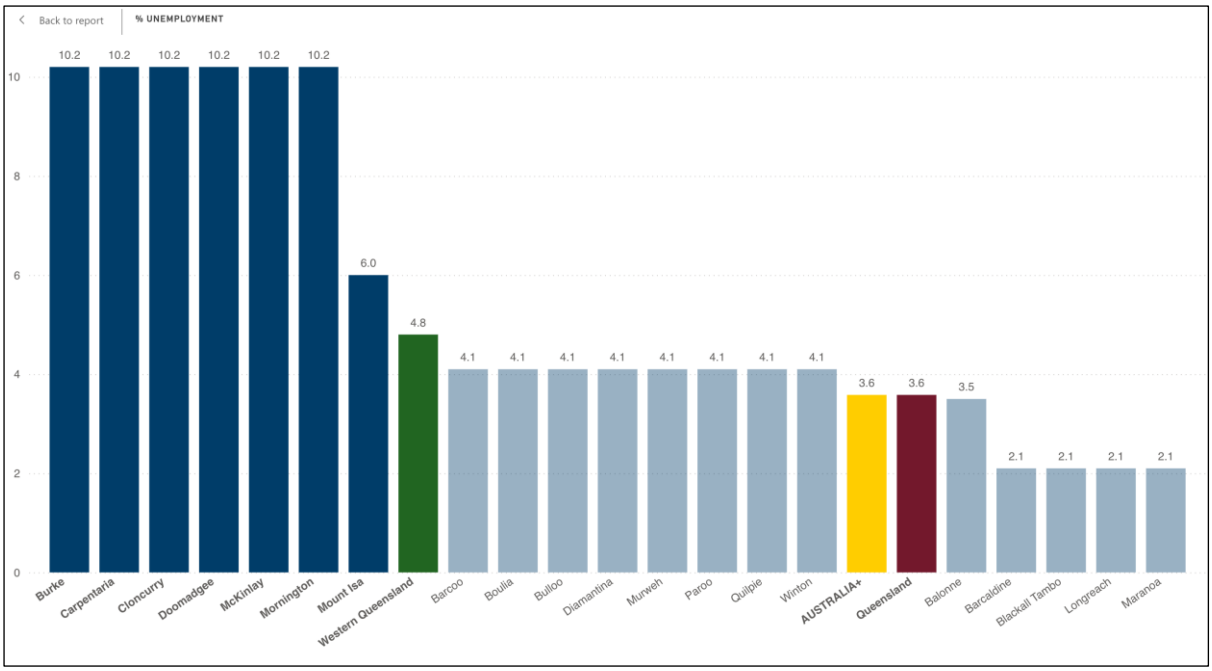


*Figure 19: High rates of unemployment across the North West region*

The proportion of private dwellings without access to the internet is considerably higher in the Western Queensland region (22.9%), compared with the National (14.1%) and State (13.6%), and the rates are even higher in the North West region, with 47.5% of dwellings in Mornington, 41.8% in Burke and 37.7% in Doomadgee not having access to the internet. This is up to 3.5 times higher than the State rate (Figure 20).

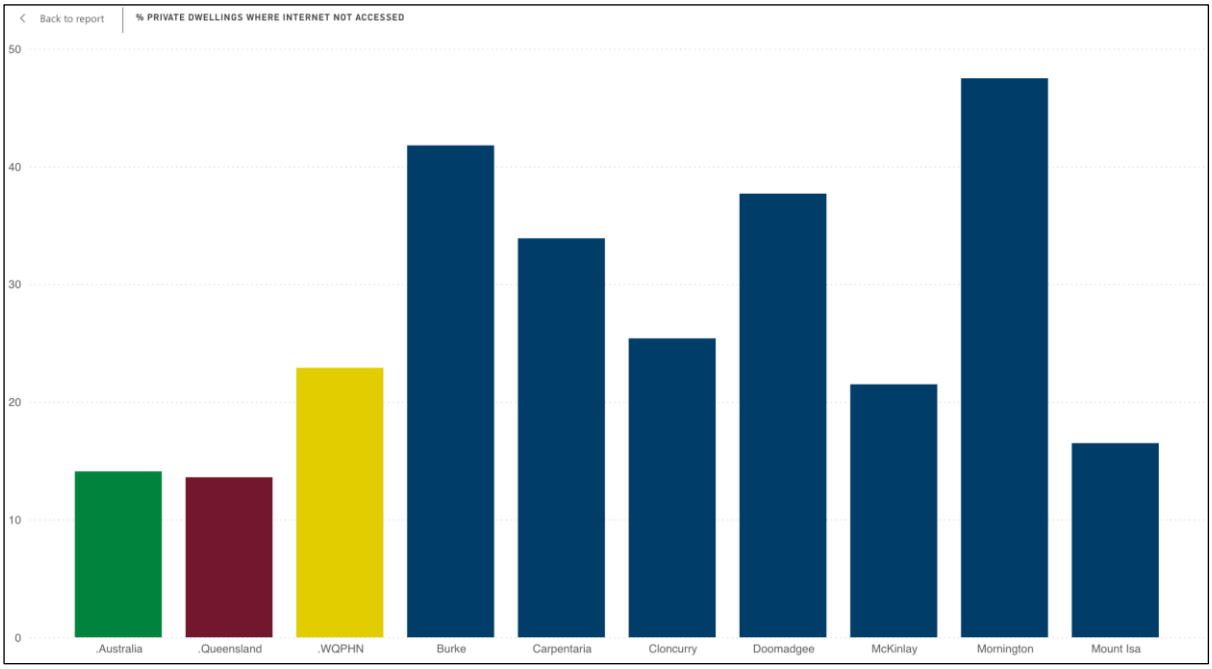


*Figure 20: Proportion of private dwellings without access to the internet in the North West region*

### 3.2.2.2 Income

Income varies considerably across the North West Queensland region, with the mean income in McKinlay ($83,417), Mount Isa ($83,249), and Cloncurry ($79,582) higher than the State mean ($63,718) and the mean income in Burke (57,422), Mornington ($54,767), and Doomadgee ($45,052) much lower than the State mean. Mount Isa's median income ($74,859) is more than double the mean income of people living in Doomadgee ($34,069). Note, income data is not available for Carpentaria.

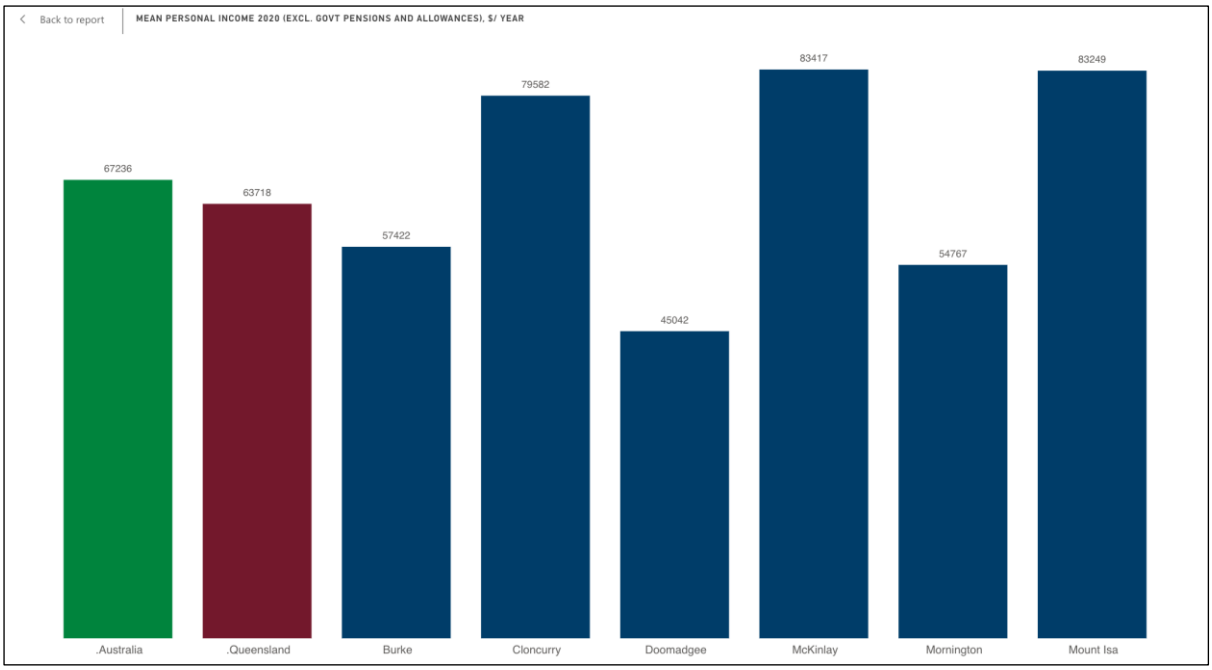


*Figure 21: Mean personal income across North West region LGAs, 2020*

The number of income earners has grown in every LGA across the region from 2016 to 2020, with the average annual growth rate varying across LGAs. Cloncurry (0.17%), Doomadgee (1.79%), and Mount Isa (1.92%) show very small growth rates (Table 6), whilst McKinlay (17.19%) and Mornington (16.09%) show very large increases in the number of income earners.

*Table 6: Number of income earners across the North West Queensland region*

| Region | # income earners 2016 | # income earners 2020 | Annual growth rate |
|---|---|---|---|
| Australia | 13,358,252 | 14,619,595 | 2.28% |
| Queensland | 2,623,526 | 2,921,819 | 2.73% |
| Burke | 128 | 151 | 4.22% |
| Boulia | 138 | 215 | 11.7% |
| Cloncurry | 1,597 | 1,608 | 0.17% |
| Doomadgee | 340 | 365 | 1.79% |
| McKinlay | 290 | 547 | 17.19% |
| Mornington | 174 | 316 | 16.09% |
| Mount Isa | 10,379 | 11,199 | 1.92% |

Figure 22 shows the median income for households adjusted to reflect household size and composition. In general, the region's median equivalised household income shows growth between 2011 and 2021, however at a lower rate when compared with the National and State growth rates. Weekly household income in Mount Isa ($1,436), Cloncurry ($1,230) and McKinlay ($1,166) was higher than the State ($1,032) and National ($1,070) median in 2021. Doomadgee ($473) and Mornington ($379) had considerably lower weekly incomes, with Mornington the only LGA to see a negligible increase across the past 10 years.

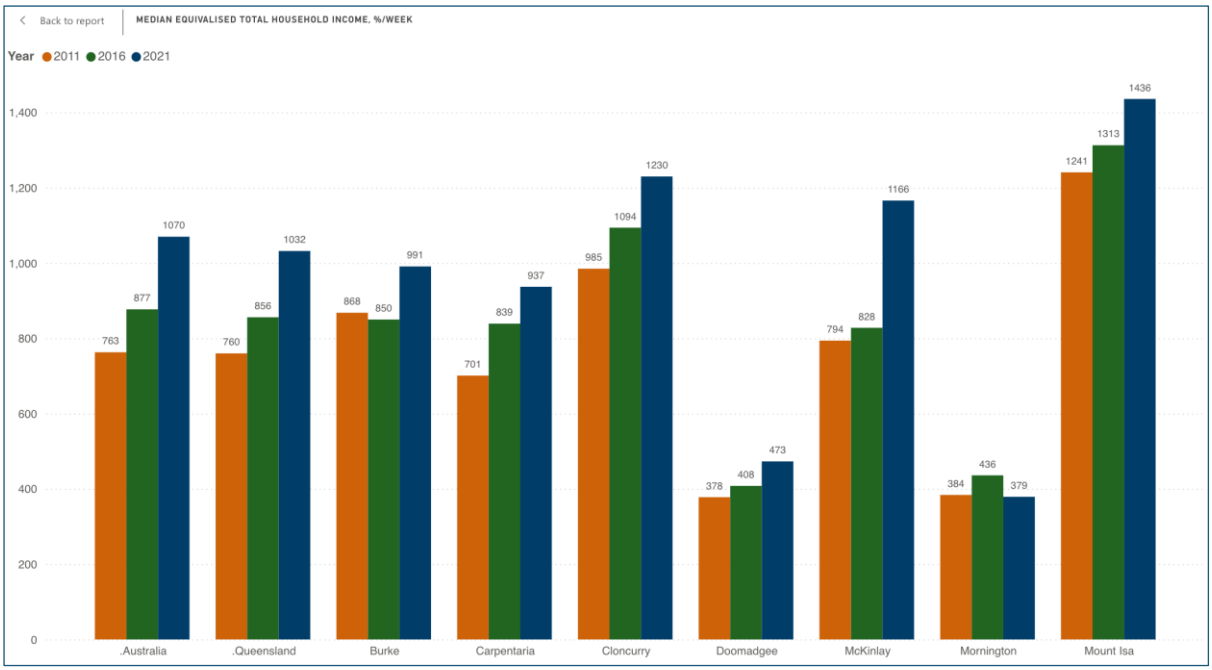


*Figure 22: Median equivalised total household income in North West region, 2011-2021*

Figure 23 presents Gini coefficients for each LGA in the North West Queensland region, providing an indication of the inequality of income distribution across the LGAs. A Gini coefficient of 0 reflects perfect equality, where all income or wealth values are the same, whereas a Gini coefficient of 1 reflects maximum inequality. Mount Isa has the best equality of income distribution across the region (0.38). Only Doomadgee (0.48) and McKinlay (0.55) had worse equality than the State as a whole (0.47).

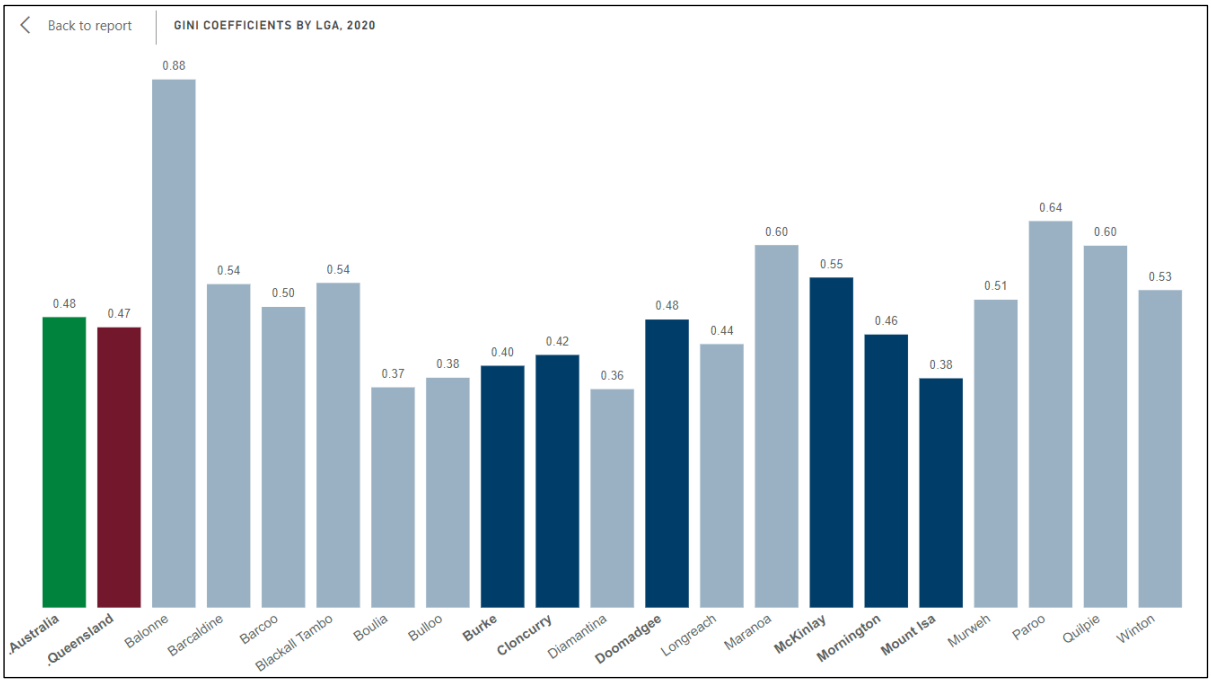


*Figure 23: Gini coefficients demonstrating income equity distribution in the North West region*

Low-income households, defined as those with income in the lowest 40% of households across Australia, make up nearly 74% in Doomadgee, 71% in Mornington, 46% in Carpentaria, and 39% in Burke (Figure 24). These four LGAs also have the highest rates of low income and welfare-dependent families with children (Figure 25).

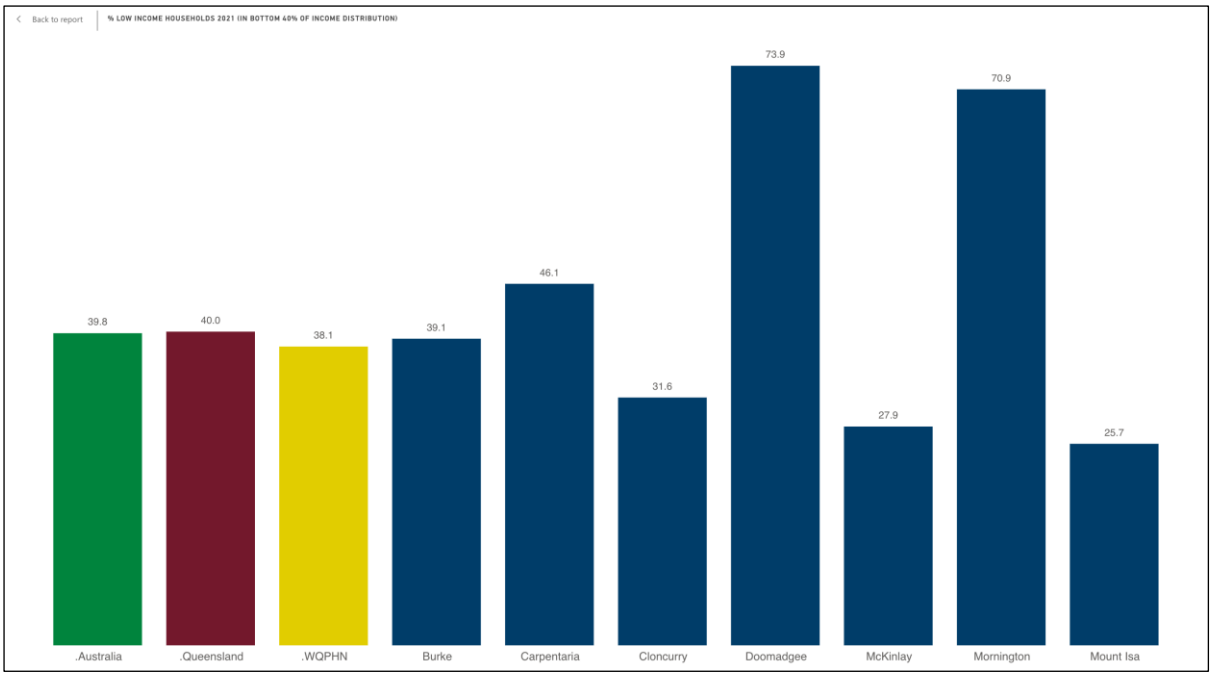


*Figure 24: Proportion of low income households across the North West region*

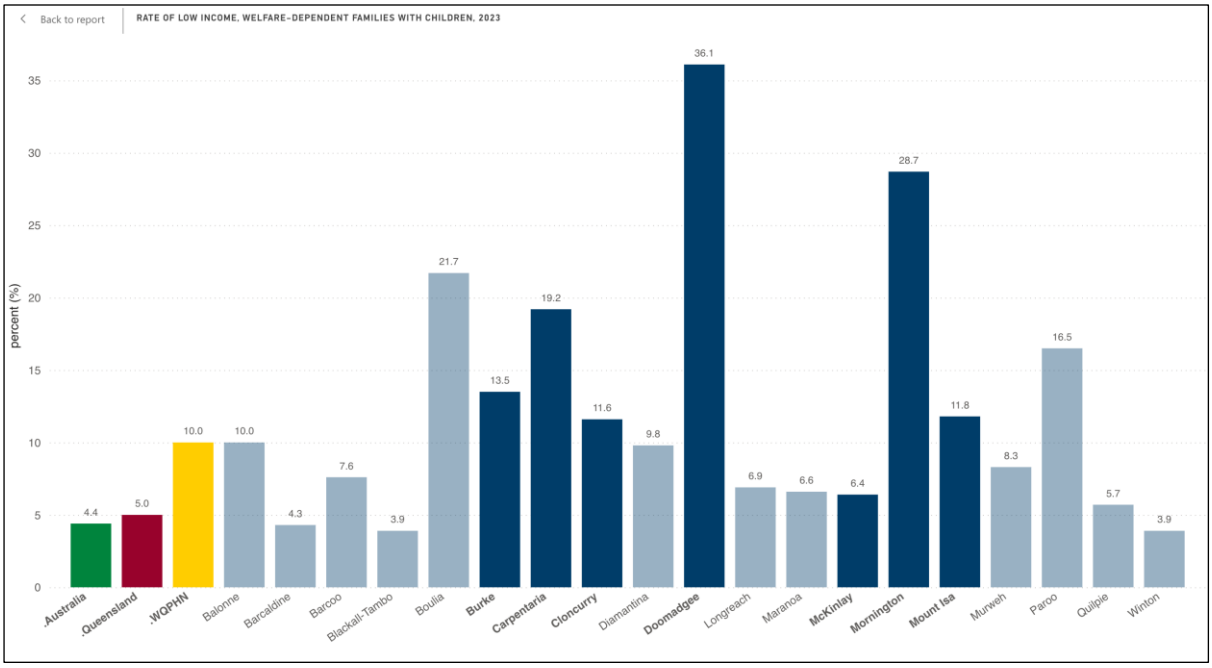


*Figure 25: Proportion of low income, welfare-dependent families with children across the North West region*

### 3.2.2.3 Education

Whilst actual numbers are very low in some LGAs, participation in early education is observed at relatively high rates across the North West Queensland region. In 2022, All LGAs had rates of children aged 4 or 5 years of age attending a preschool program higher than Queensland's average rate of 11.3% (Figure 26). Participation rates in secondary school at 16 years of age drop below the State average in all LGAs except McKinlay, with 92.5% of young people in Doomadgee and 67.1% of young people in Mornington having left school at year 10 or below (Figure 27). These rates are likely impacted by the lack of high schools in Burke and Doomadgee. Participation rates in higher education are extremely low across the region. This is likely attributed to there being no providers of higher education in the North West Queensland region, meaning any young person who wants to enroll, needs to leave their hometown and move into a major regional centre.

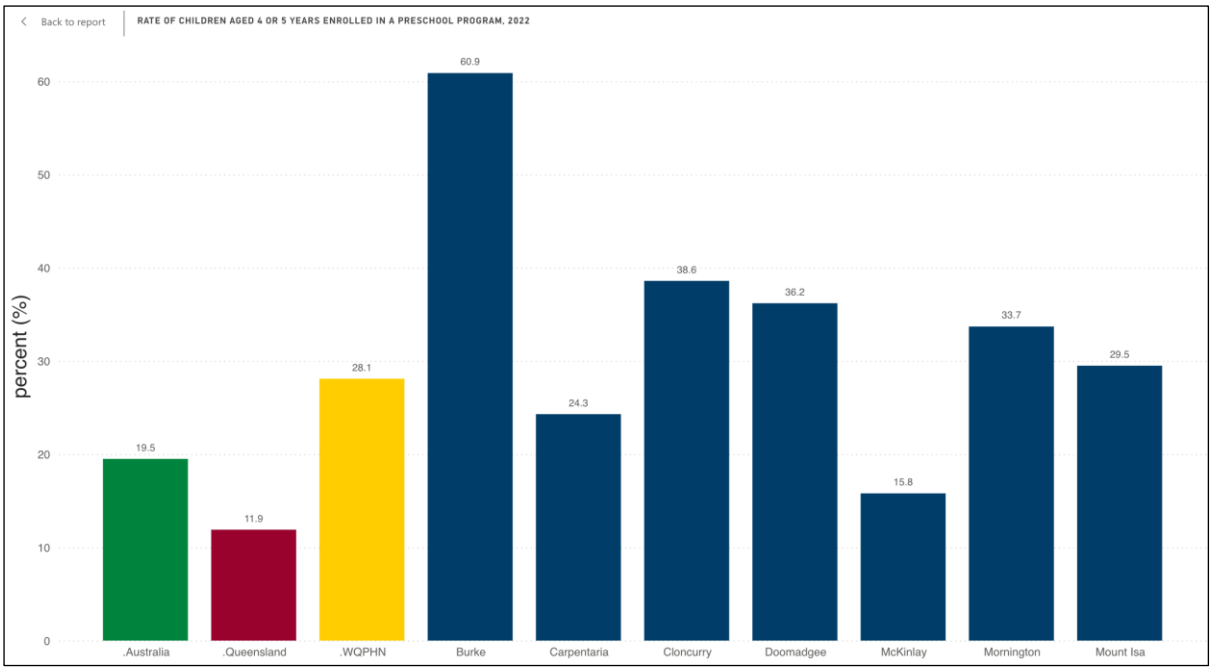


*Figure 26: Rates of children aged 4 or 5 years attending a pre-school program in the North West region, 2022*

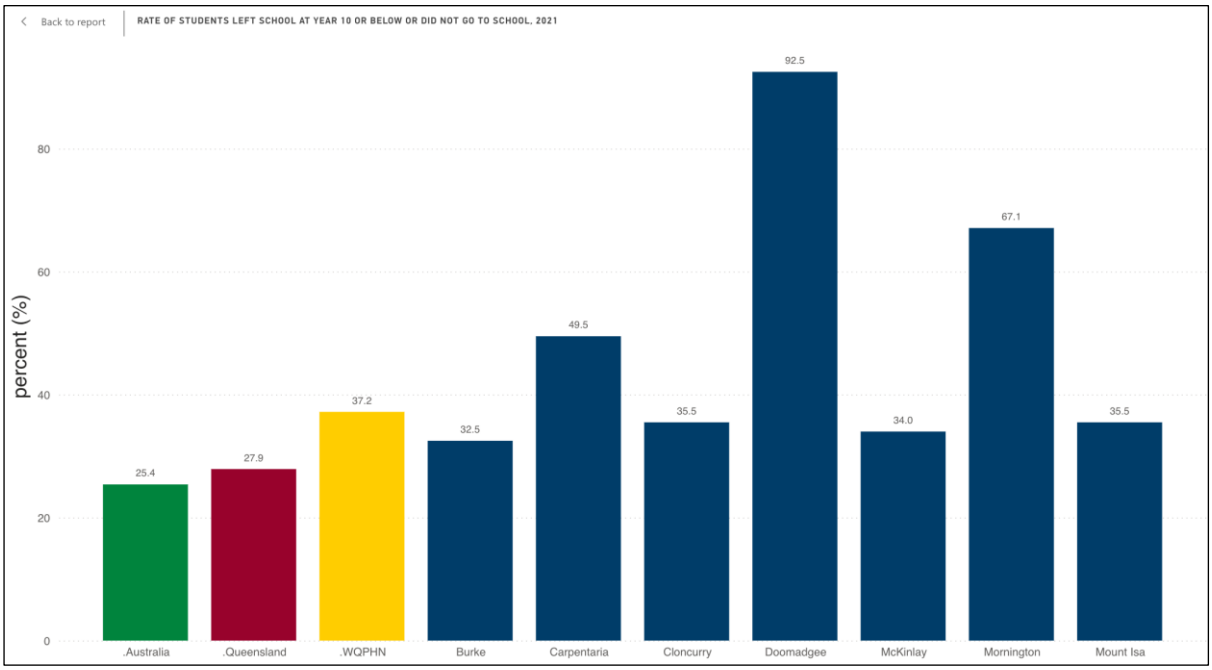


*Figure 27: Rates of students who left school at year 10 or below or did not go to school in the North West region*

Table 7 below shows the distribution of schools across the North West Queensland region.

*Table 7: Distribution of public schools across the North West Queensland region*

| | Burke | Carpentaria | Cloncurry | Doomadgee | McKinlay | Mornington | Mount Isa |
|---|---|---|---|---|---|---|---|
| Number and type of school | 1 Primary | 1 Primary<br>1 Combined | 1 Primary<br>1 Combined | 1 Primary | 1 Primary | 1 Combined | 7 Primary<br>1 High<br>1 Special<br>1 Distance |

Participation rates in vocational education and training are reasonable, with rates in Mount Isa (31.5%) and McKinlay (21.8) higher than the State average (18.3%) (Figure 28). Aboriginal and Torres Strait Islander participation rates are particularly high in McKinlay (84.2%) (Figure 29).

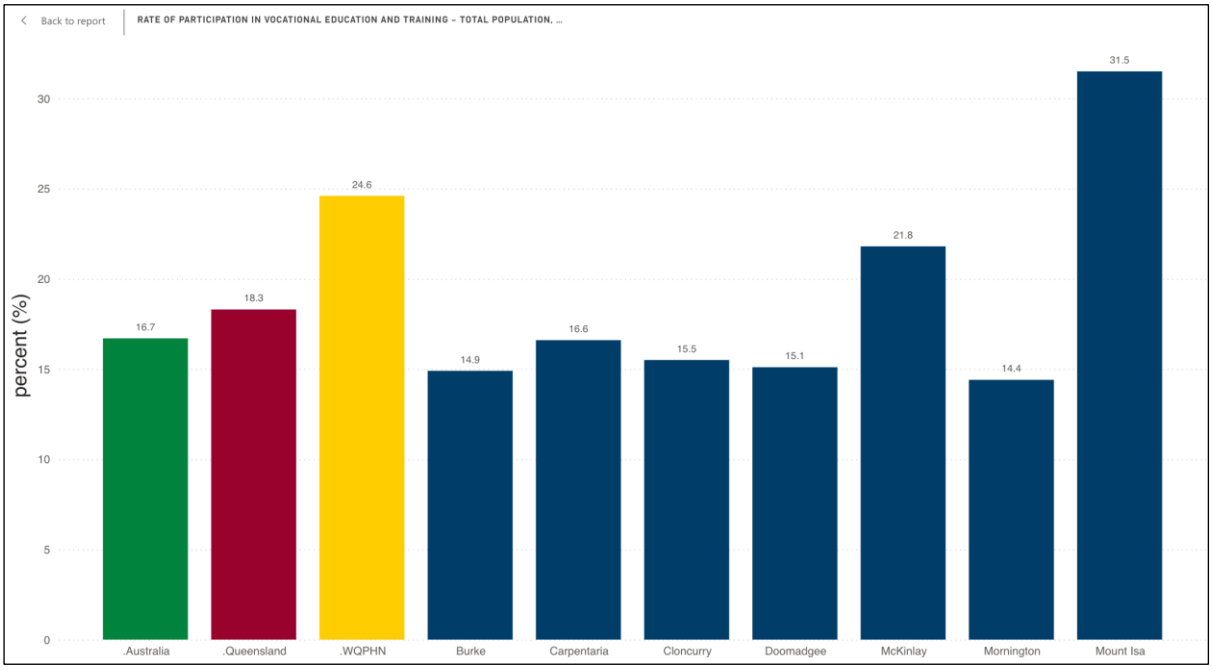


*Figure 28: Rates of participation in vocational education and training across the North West region*

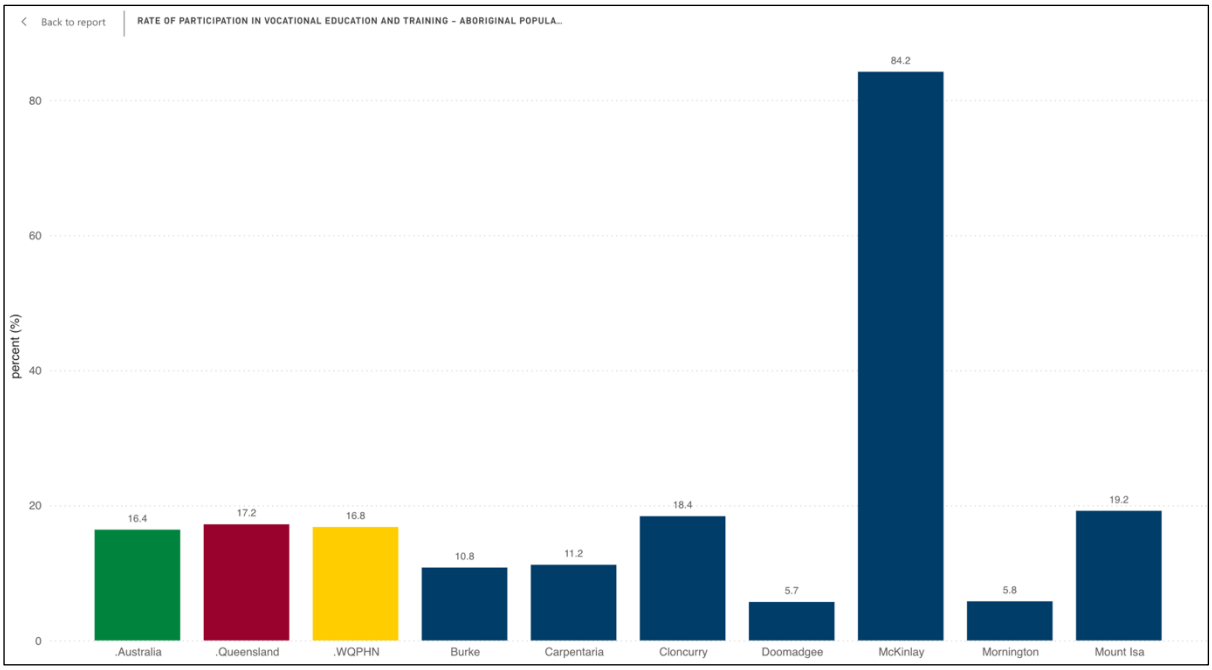


*Figure 29: Rate of participation in vocational education and training in the North West region - Aboriginal and Torres Strait Islander population*

### 3.2.2.4 Employment

In 2023, approximately 74% of the working-age population (aged 15 years and over) in Mount Isa participated in the labour force, while the remainder of North West region had an average participation rate of 64.8%. Figure 30 shows that in 2021, Doomadgee, and Mornington had very low rates of labour force participation, (both under 30%), while Mount Isa and McKinlay lead the region with 68.3% and 67.4%.

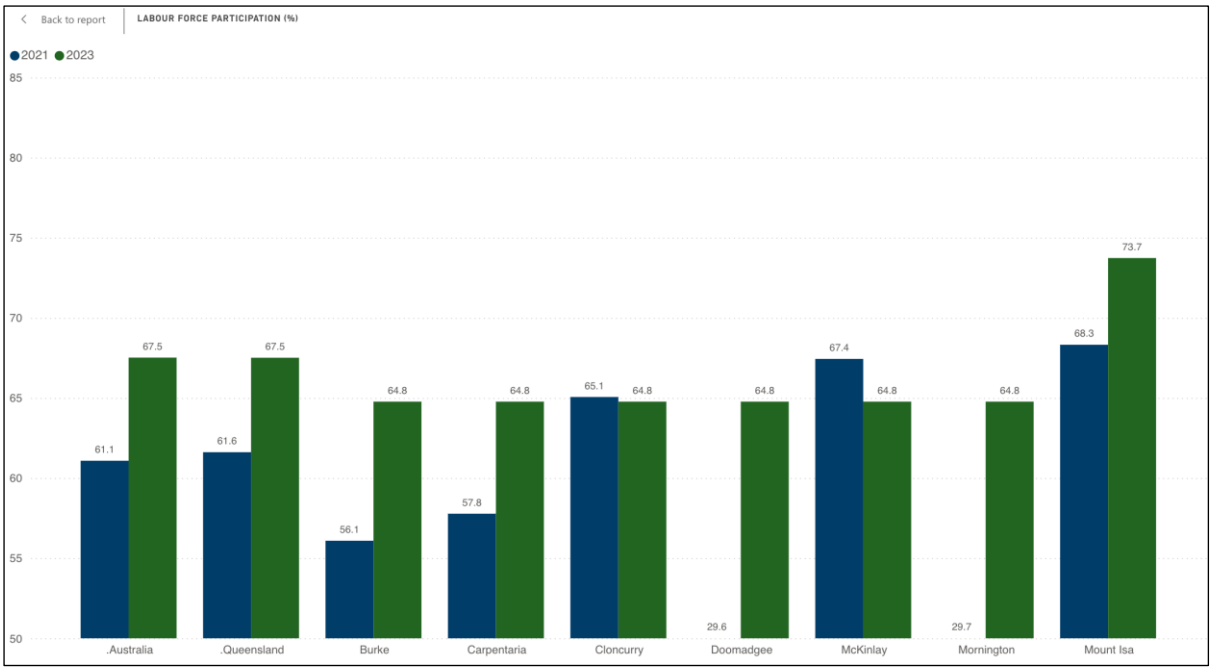


*Figure 30: Labour force participation across the North West region, 2021 – 2023*

Unemployment rates in the region are very high (Figure 19), with Mount Isa at 6%, and the remaining LGAs all higher than 10%, both of which are significantly higher than National (3.5%) and State (3.7%) rates.

Figure 31 shows the rate of young people aged 15 to 24 either earning or learning. The rates of all LGAs in the region are lower than the State rate of 83.7%, with the LGAs in the North of the region – Doomadgee (23.4%), Mornington (25.1%), and Carpentaria (53.9%) – considerably lower.

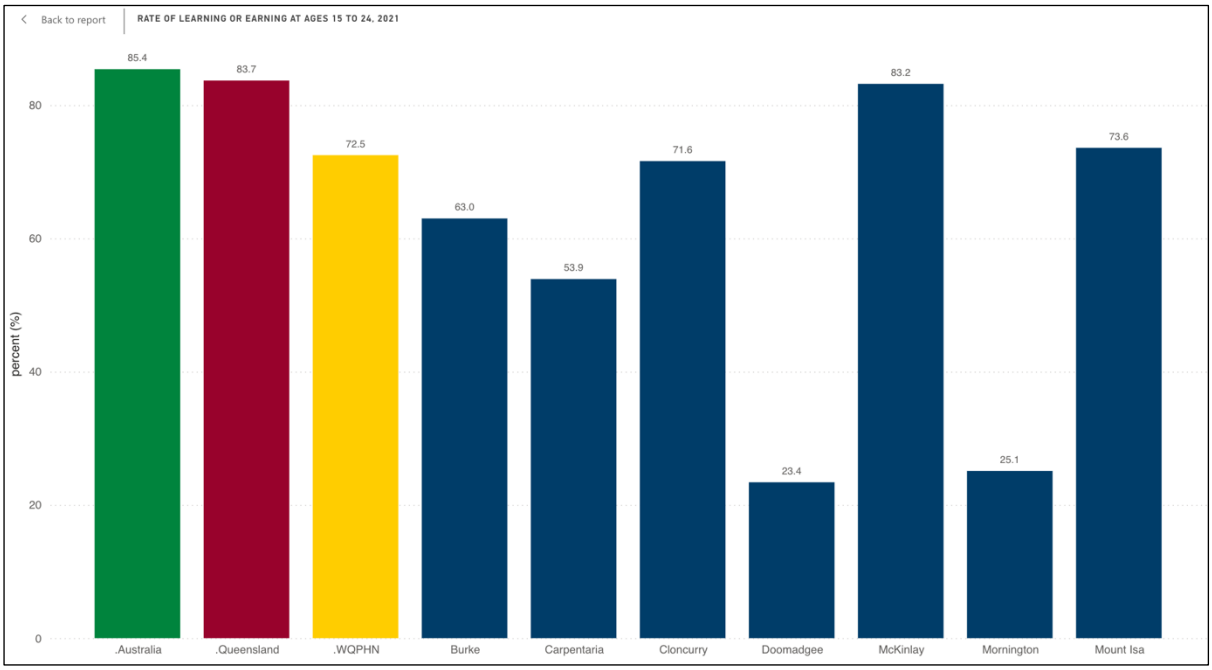


*Figure 31: Rates of young people aged 15 to 24 enrolled in either earning or learning in the North West region, 2021*

The rates of people receiving an unemployment benefit in 2023 are high across the region, with the exception of McKinlay (5.1%) which is lower than both the State (6.0%) and National (5.4%). Figure 32 shows the extremely high rates of people receiving an unemployment benefit in the LGAs in the North of the region (Doomadgee, 43.7%; Mornington, 36.0%; and Carpentaria, 21.3%).

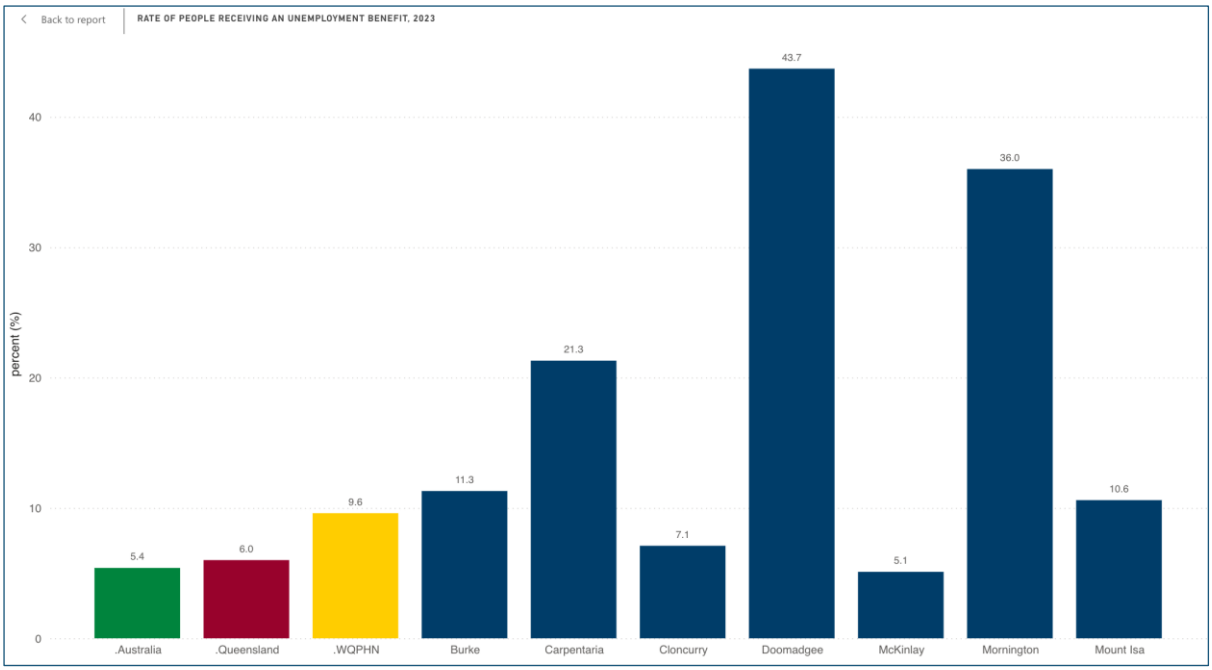


*Figure 32: Rates of people receiving an unemployment benefit across the North West region, 2023*

### 3.2.2.5 Housing

The rate of people living in crowded dwellings is considerably higher in some parts of the region, with Doomadgee (57.7%) more than 7 times the State average (8.2%) (Figure 33). Every LGA except McKinlay is higher than the State average. The rate of Aboriginal and Torres Strait Islander peoples living in crowded dwellings (Figure 34) and severely crowded dwellings (Figure 35) is higher than the rate for the whole population in every LGA except McKinlay.

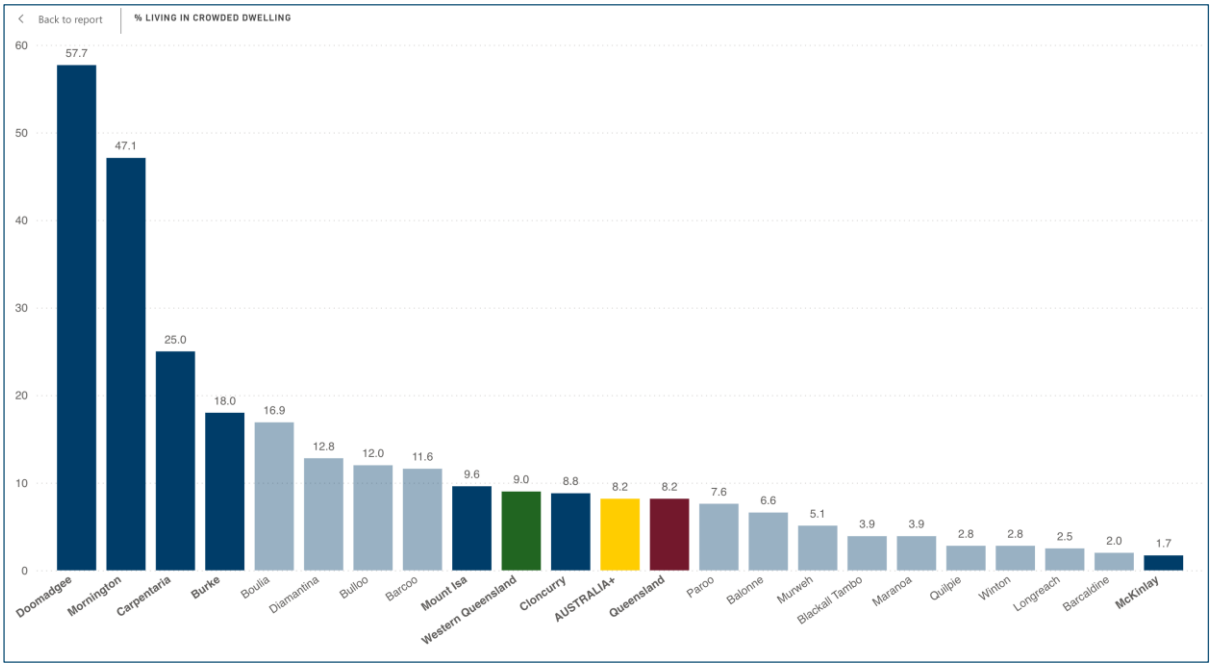


*Figure 33: Proportion of people living in crowded dwellings in the North West region*

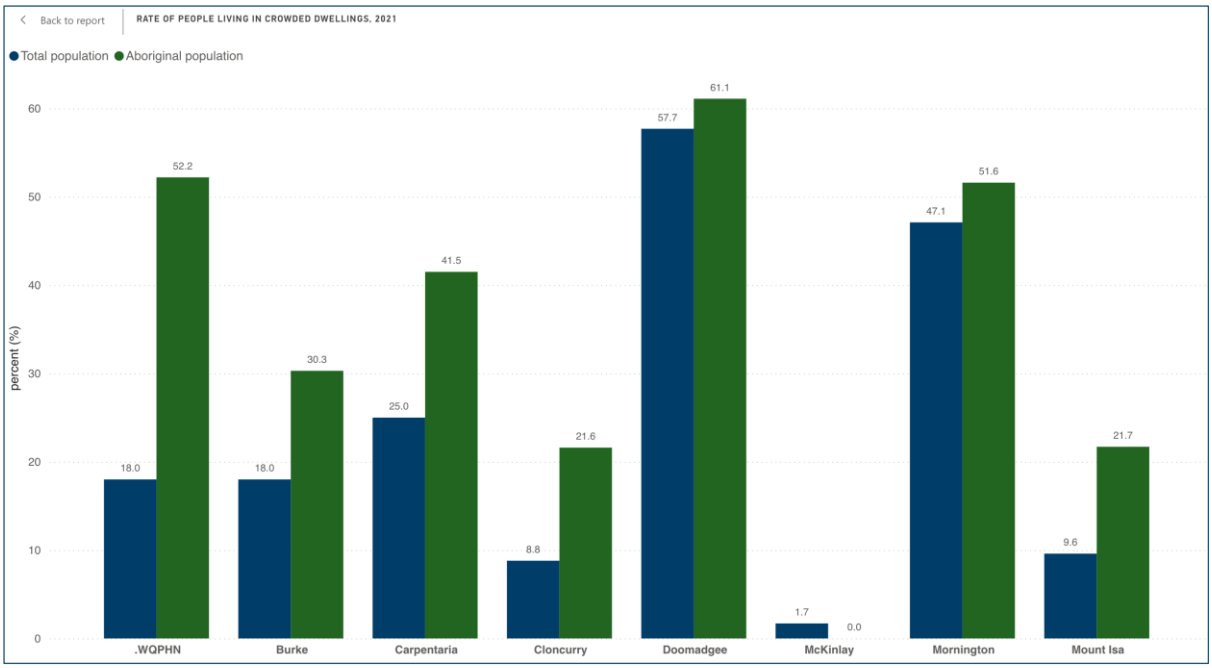


*Figure 34: Proportion of Aboriginal and Torres Strait Islander peoples living in crowded dwellings compared with the total population in the North West region*

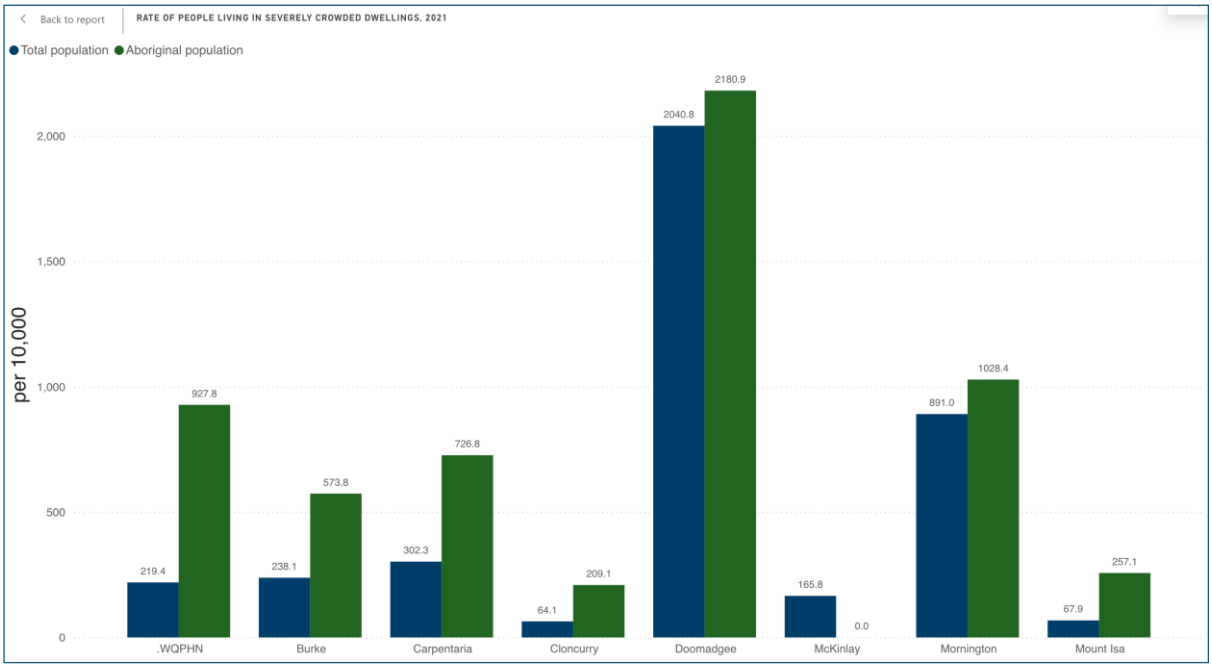


*Figure 35: Proportion of Aboriginal and Torres Strait Islander peoples living in severely crowded dwellings compared with the total population in the North West region*

Doomadgee (82.2%) and Mornington (68%) also register extremely high proportions of their population living in social housing, which is up to 8 times higher than the broader Western Queensland rate, and up to 32 times higher than the State average (Figure 36).

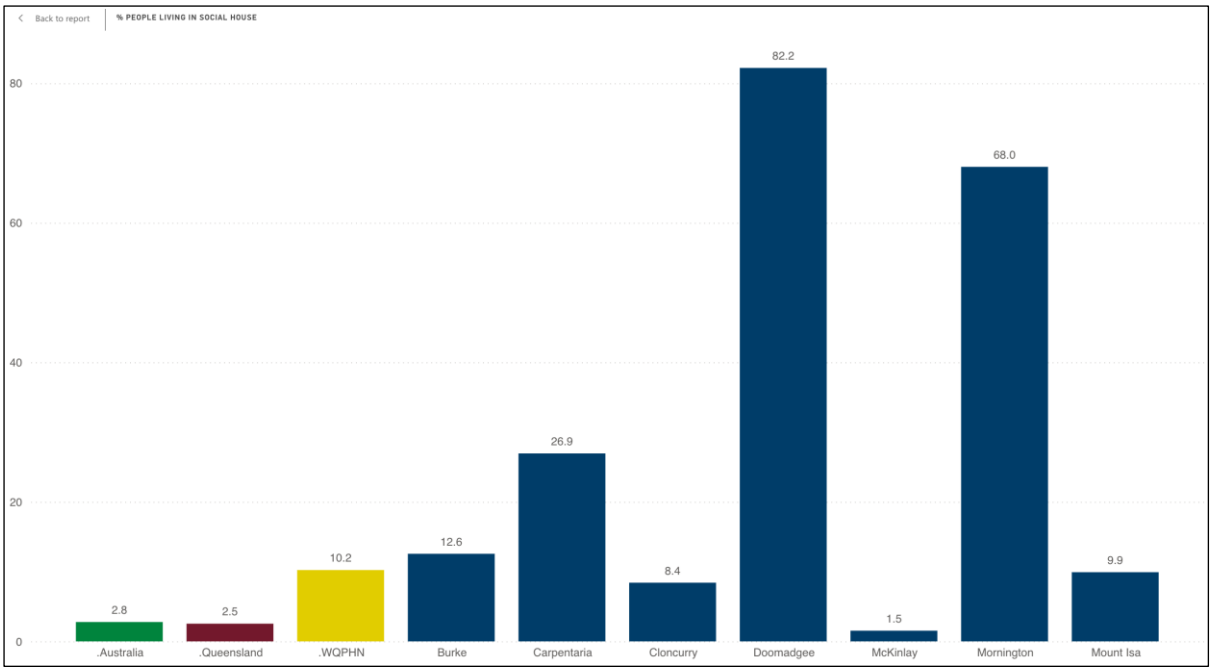


*Figure 36: Proportion of people living in social housing in the North West region*

### 3.2.2.6 Developmental vulnerability

Data about assessed developmental vulnerabilities in the North West Queensland region is available only for Carpentaria, Cloncurry and Mount Isa. Whilst actual numbers are low, the rate of children assessed as developmentally vulnerable on one or more domains is more than twice as high in Carpentaria (52.6%) when compared with the State average (24.7%) (Figure 37).

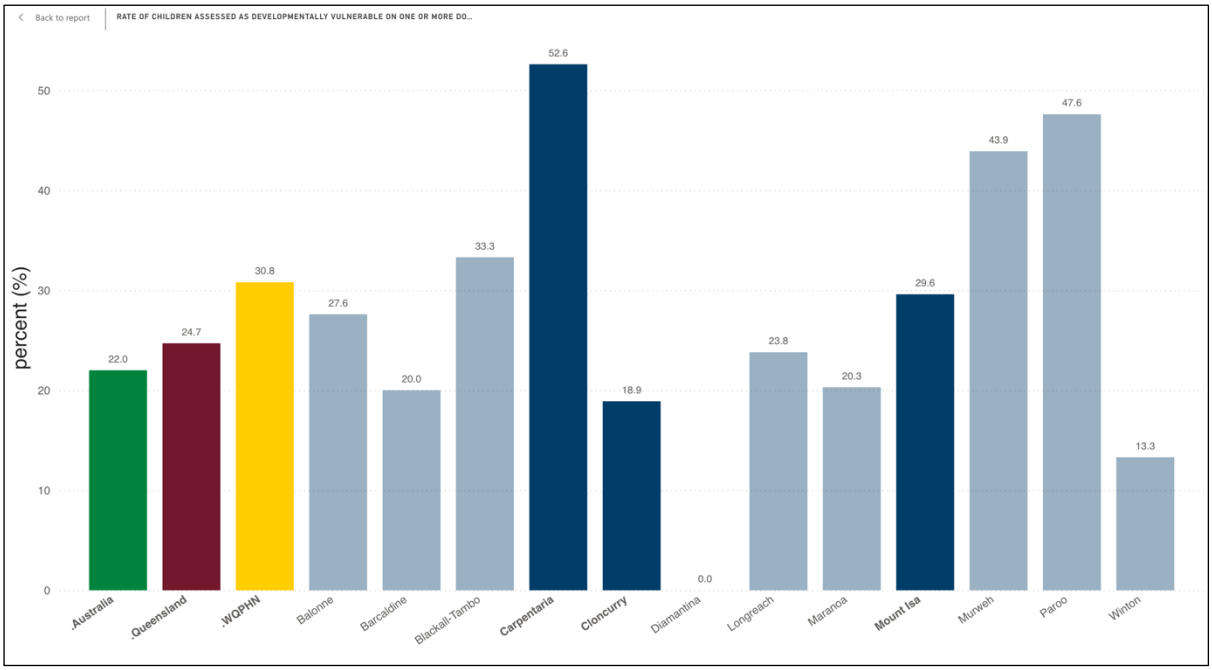


*Figure 37: Rate of children assessed as developmentally vulnerable on one or more domain in the North West region*

Table 8 depicts the rates of vulnerable children and child at risk of various vulnerabilities across the North West Queensland region, with the *vulnerable* and/or *at-risk* rates of children in Carpentaria typically higher across all developmental domains.

*Table 8: Rate of children assessed as developmentally vulnerable against each domain in North West Queensland*

| Developmental Domains | | Carpentaria | Cloncurry | Mount Isa | Queensland |
|---|---|---|---|---|---|
| Physical health and wellbeing | Vulnerable | 10.5% | 5.7% | 12.7% | 11.6% |
| | At risk | 26.3% | 5.7% | 9.8% | 11.9% |
| Physical readiness for school | Vulnerable | 21.1% | 18.9% | 18.9% | 12.9% |
| | At risk | N/A | 15.1% | 10.1% | 10.1% |
| Social competence | Vulnerable | 15.8% | 9.4% | 10.4% | 10.6% |
| | At risk | 26.3% | 11.3% | 17.3% | 15.4% |
| Emotional maturity | Vulnerable | 21.1% | 13.2% | 10.4% | 10.0% |
| | At risk | 15.8% | 7.5% | 18.9% | 15.9% |
| Language and cognitive skills | Vulnerable | 26.3% | 9.4% | 18.6% | 8.4% |
| | At risk | 5.3% | 7.5% | 15.6% | 10.9% |
| Communication skills and general knowledge | Vulnerable | 31.6% | 3.8% | 11.4% | 9.1% |
| | At risk | 26.3% | 3.8% | 13.7% | 14.8% |

## 3.2.3 Lifestyle factors

### 3.2.3.1 Self-assessed health

Data on self-assessed health in North West HHS region is available for Cloncurry and Mount Isa only. The rate of adults with fair or poor self-assessed health in Cloncurry (14.8%) and Mount Isa (16.2%) was lower than the State and the broader Western Queensland levels (Figure 38).

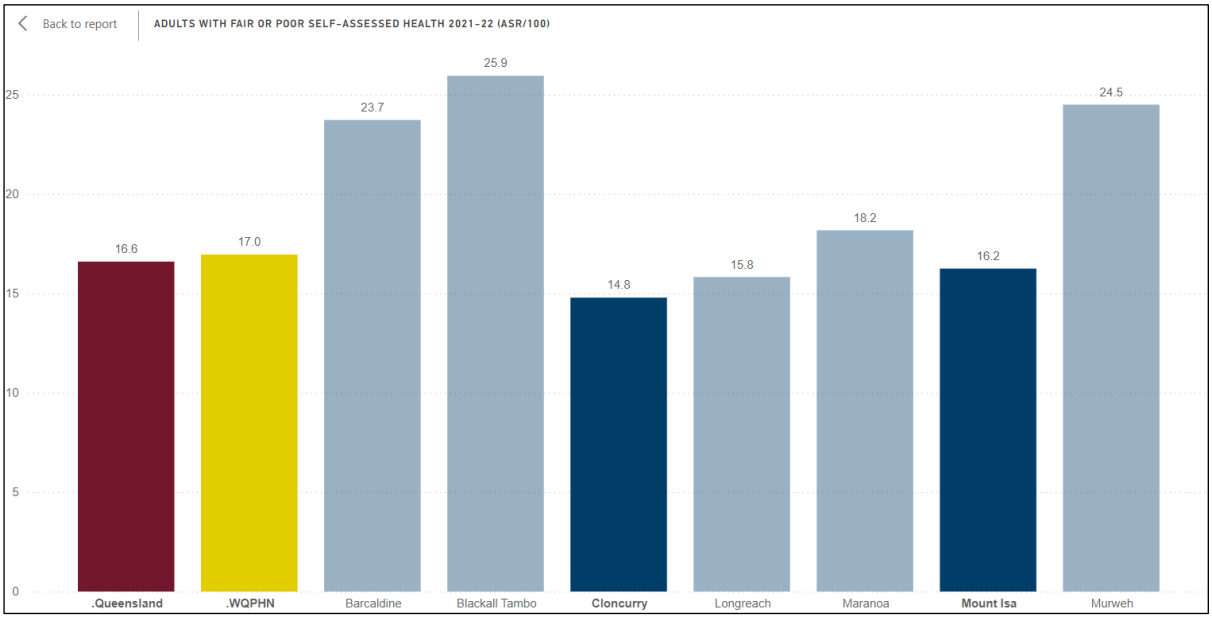


*Figure 38: Adults with fair or poor self-assessed health in the North West region, 2021-2022*

On average, each person from Cloncurry and Mount Isa reported a lower number of unhealthy days in the past 30 days, compared with the broader Western Queensland region, and the State average (Figure 39).

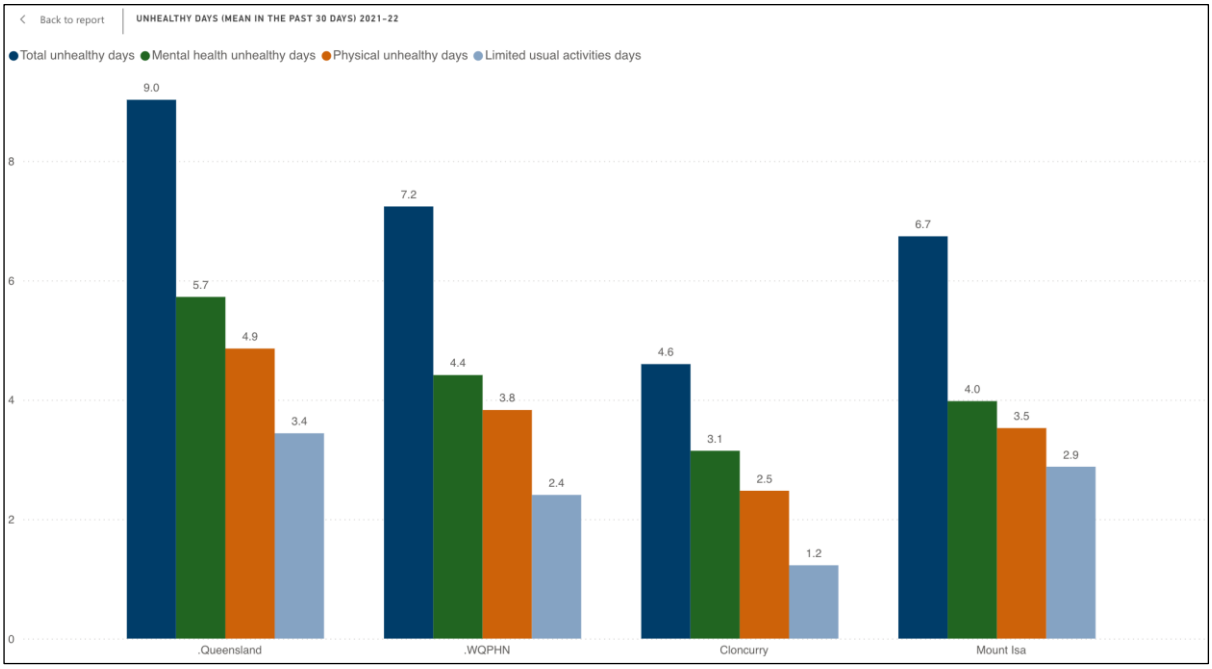


*Figure 39: Unhealthy days in the North West region, 2021-2022*

### 3.2.3.2 Overweight and obesity

Data on overweight and obesity rates in the North West region is available for Cloncurry and Mount Isa only. The rate of adults who are overweight (but not obese) in Cloncurry is estimated at 40%, which is higher than both Queensland and the broader Western Queensland levels. The rate for Mount Isa (31.3%) is slightly lower than the State average (Figure 40).

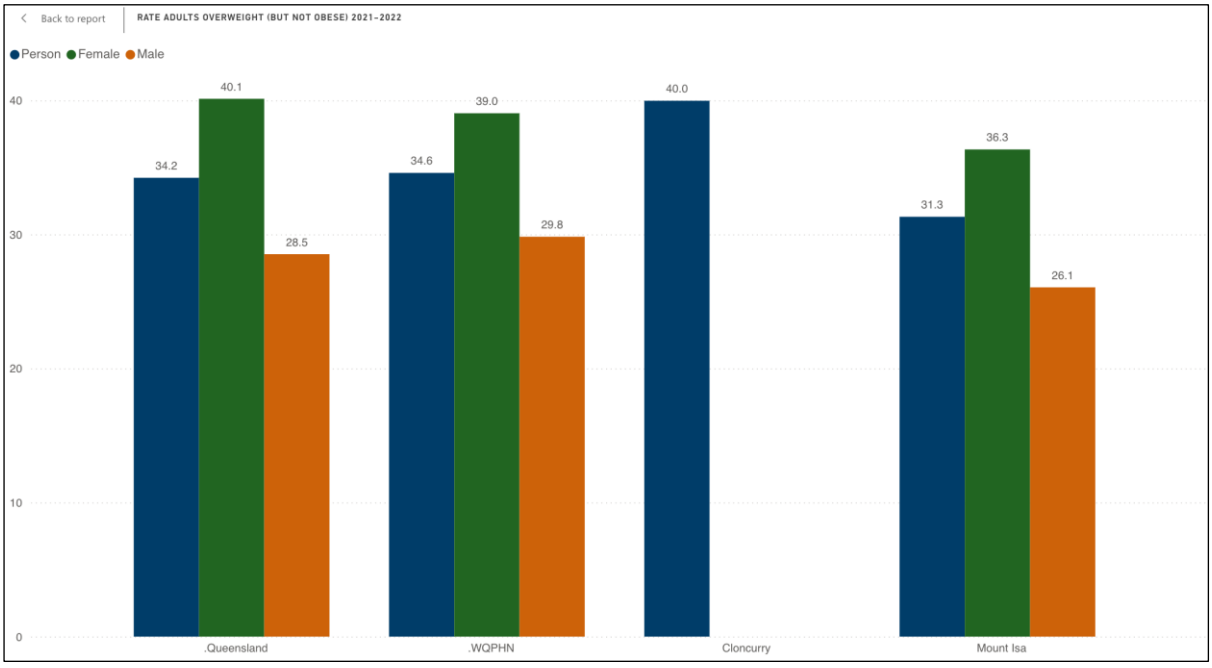


*Figure 40: Rate of adults with obesity (but not overweight)in the North West region, 2021-2022*

The rate of adults with obesity in Cloncurry is estimated at 31.7%, which is higher than the rate for Queensland but lower than broader Western Queensland levels. For Mount Isa (35.5%) rates are higher than both the State and broader regional averages.

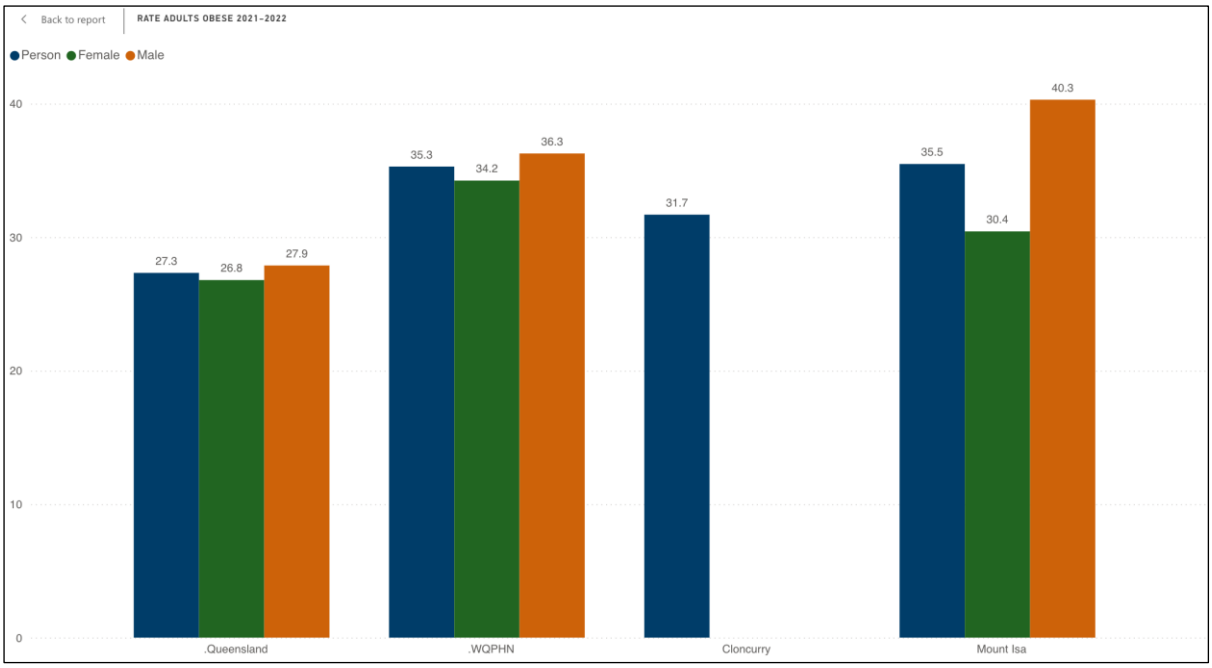


*Figure 41: Rate of adults with obesity in the North West region, 2021-2022*

The rate of people overweight or obese in the Western Queensland PHN region has consistently increased since 2009/10 through to 2021/22, and has remained consistently higher than the State rate (Figure 42).

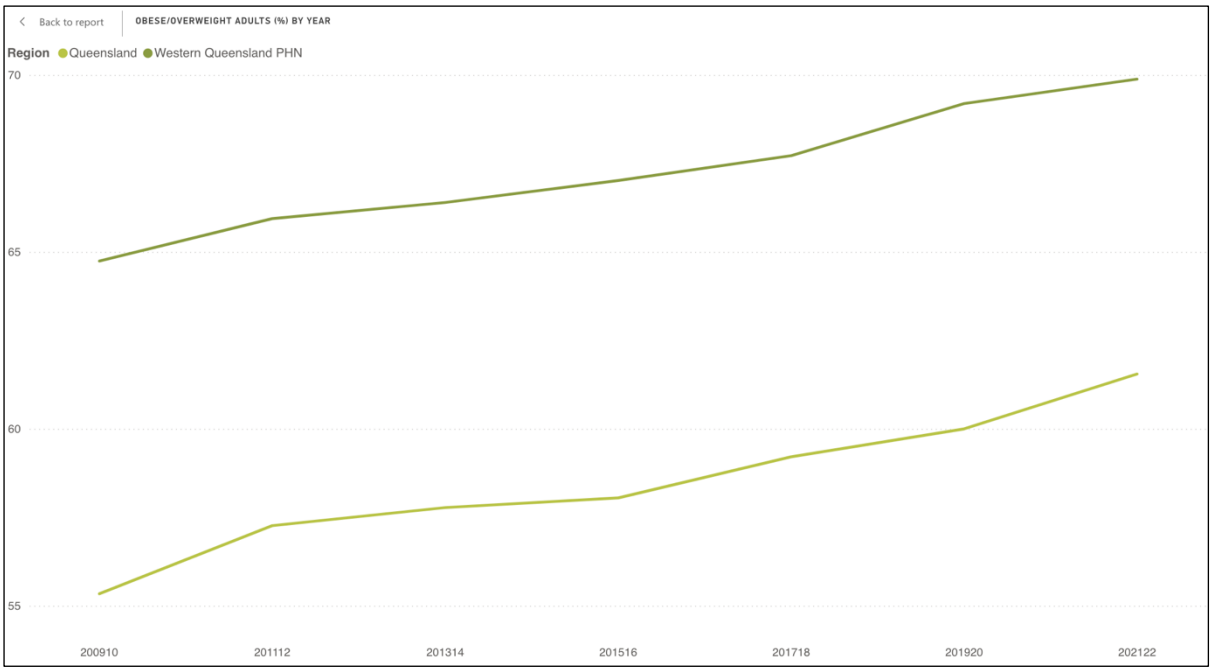


*Figure 42: The rate of adults overweight or obese across the Western region over time, compared to the Queensland rate*

### 3.2.3.3 Diet and physical activity

Data on fruit intake is available for Mount Isa only, and for vegetable intake for Mount Isa and Cloncurry only.

People in both Cloncurry and Mount Isa have lower proportions of population having adequate fruit and vegetable intakes in comparison to those in Queensland and WQPHN. In general, the population achieves an adequate fruit intake more than they do an adequate vegetable intake; also, more females achieve adequate fruit and vegetable intakes more often than males.

In Cloncurry, 48.7% of adults have an adequate fruit intake – for females, this rate is 63.1%. Although the data is missing, this discrepancy insinuates that males have a much lower rate of adequate fruit intake than

females. In Mount Isa, 42.3% of adults have an adequate fruit intake. In contrast to Cloncurry, the difference between adequate intakes for males and females was negligible, with females having only slightly higher rates (42.6%) than males (42.0%). Only 6.3% adults in Mount Isa have an adequate vegetable intake – for females, this rate is 8%. Again, the same interpolation for the male data can be made here.

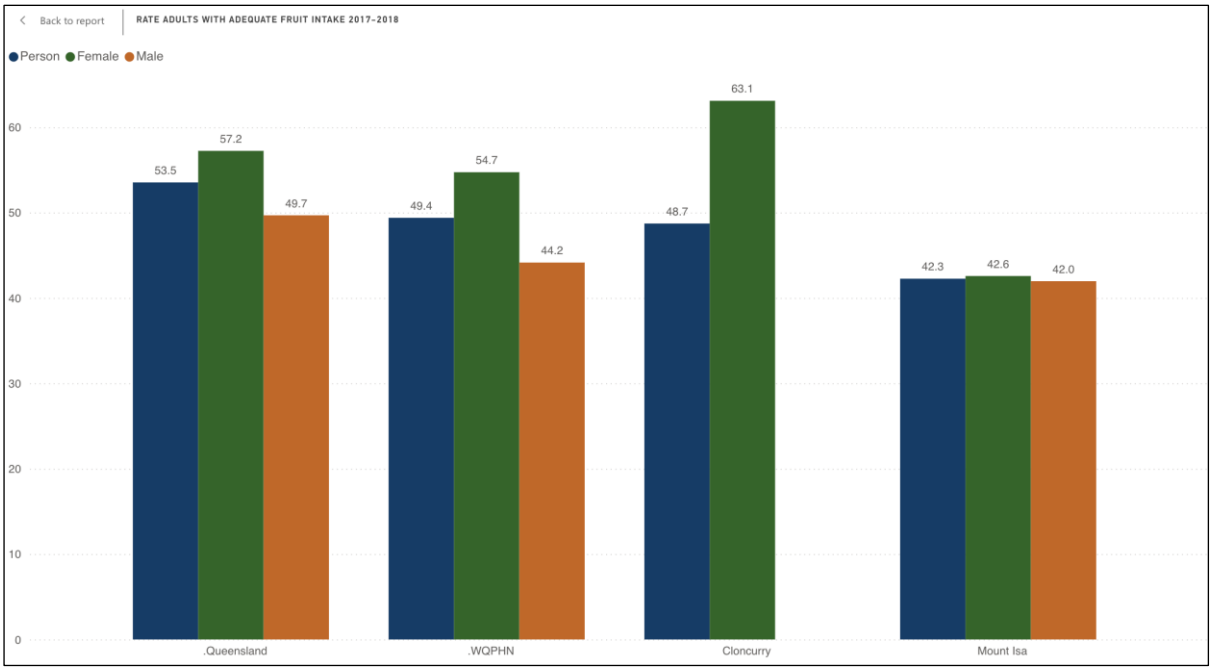


*Figure 43: Rate of adults with adequate fruit intake in the North West region, 2017-2018*

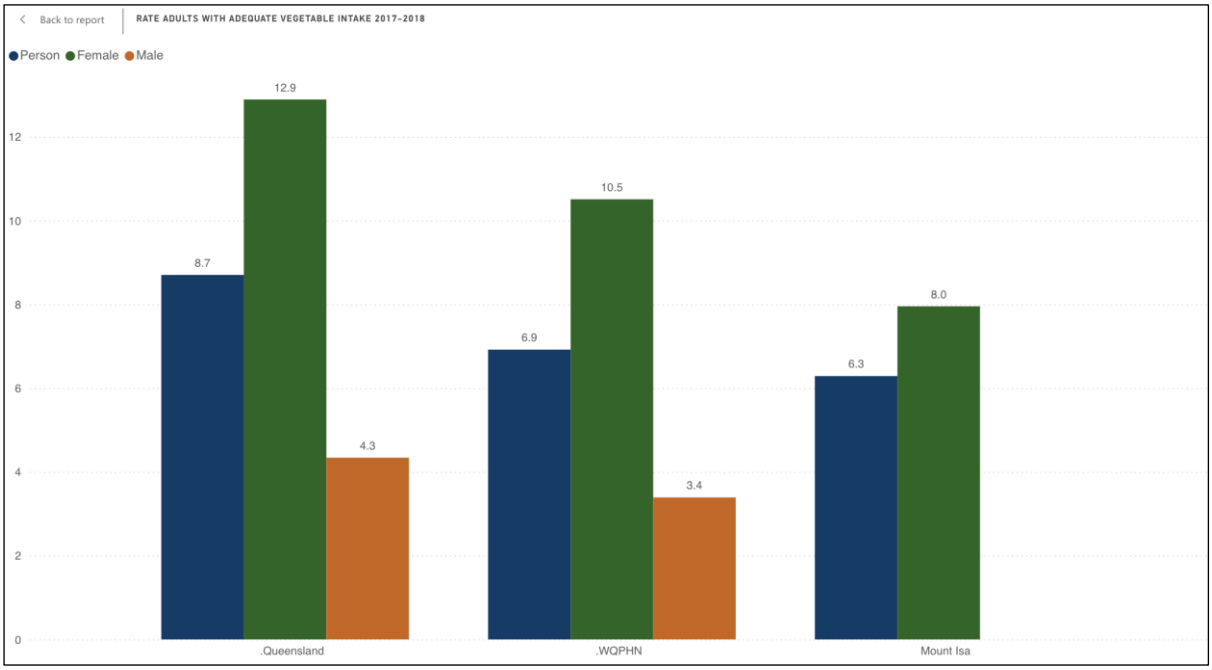


*Figure 44: Rate of adults with adequate vegetable intake in the North West region, 2017-2018*

Cloncurry and Mount Isa also have high rates of adults with low, very low, or no exercise in the previous week In Cloncurry, the rates are 47.4% for general adults – 39.7% for females. In Mount Isa, the rates are 44.3% for general adults – 49.8% for females and 39.3% for males. This discrepancy between male and female exercise rates is reflected in both the Queensland and WQPHN rates.

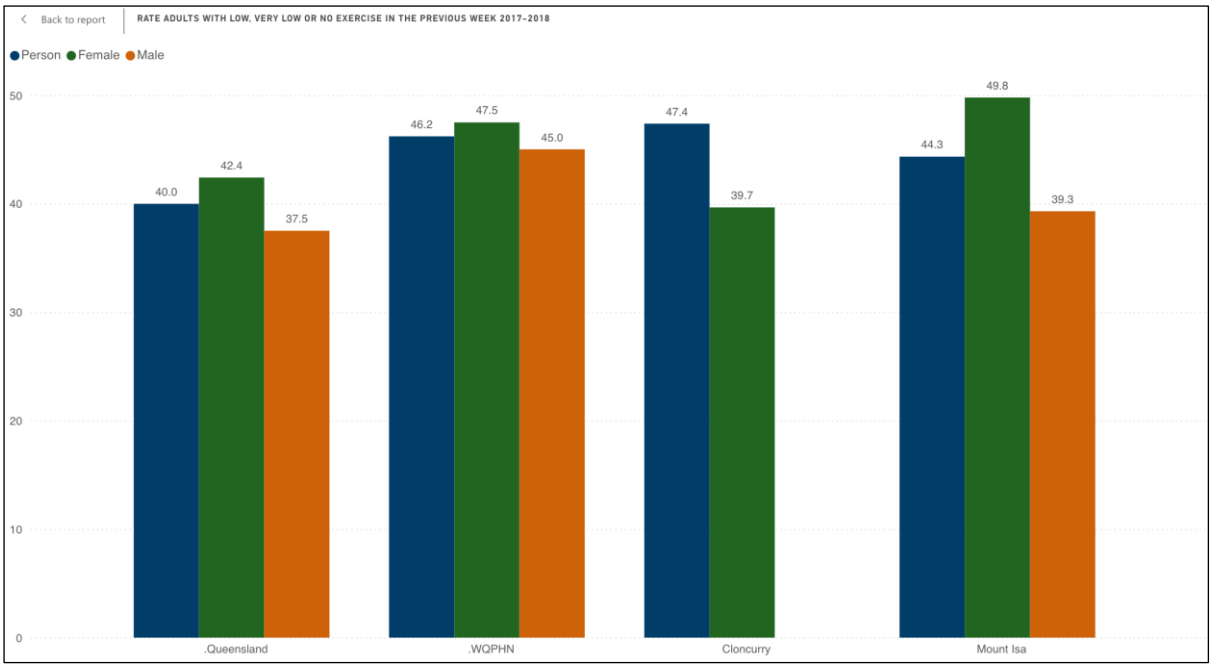


*Figure 45: Rate of adults with low, very low or no exercise in the previous week in the North West region, 2017-2018*

### 3.2.3.4 Smoking

Data for smoking in the North West region is available for Cloncurry and Mount Isa only. Rates of smoking adults in Cloncurry and Mount Isa are lower than in WQPHN but higher than in Queensland. In Cloncurry, 15.4% of adults currently smoke. In Mount Isa this rate is 17.5%, with smoking in males (21.2%) much more prevalent than in females (12.3%).

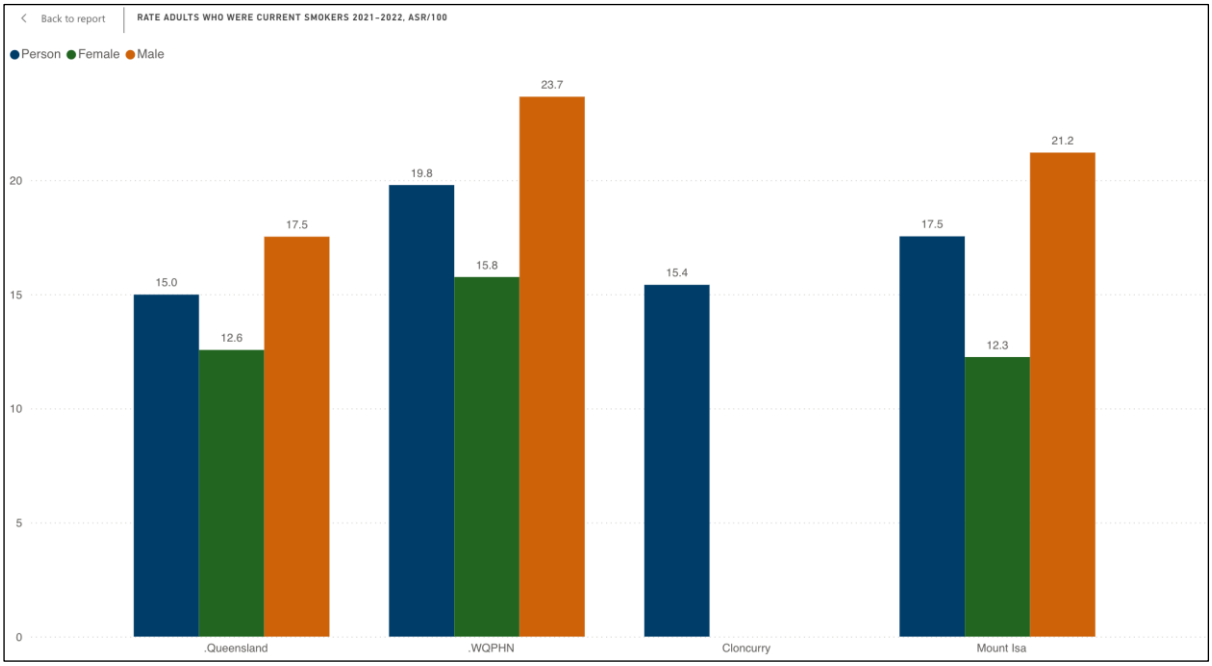


*Figure 46: Rate of adults who were currently smokers in the North West region, 2021-2022 (ASR/100)*

### 3.2.3.5 Alcohol consumption

Data for alcohol consumption in the North West region is available for Cloncurry and Mount Isa only. In Cloncurry, rates of adults drinking ten or more standard drinks per week is higher than Queensland's and WQPHN levels: 45.1%. The rate of adults who drank 10 or more standard drinks per week in Cloncurry (45.1%) was much higher than the rate in Queensland (30.2%) or WQPHN (35.7%).

The rate in Mount Isa (32%) is considerably lower than in Cloncurry and similar to the State and broader Western Queensland rates. The rate in males (44.5%) is more than double the rate in females (19.2%).

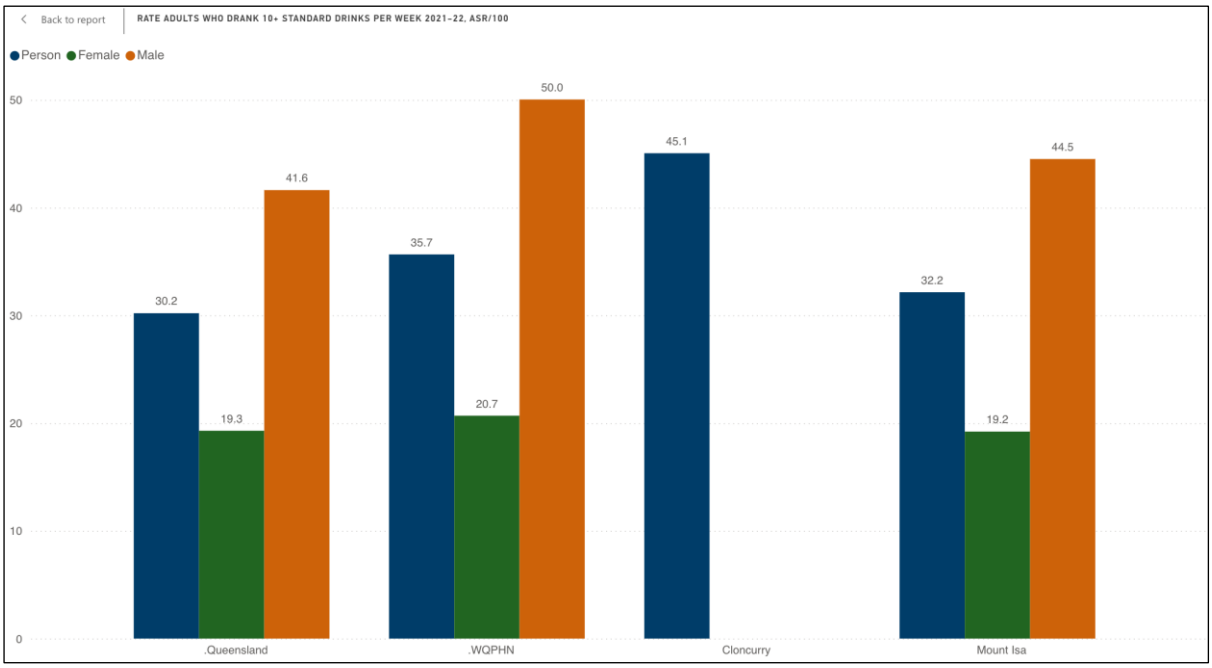


*Figure 47: Rate of adults who drank 10+ standard drinks per week in the North West region, 2021-2022, ASR/100*

## 3.2.4 Screening

### 3.2.4.1 Cancer Screening

The North West region has a low rate of participation in National cancer screening programs including bowel cancer screening with only 19.6% of invited people taking the test, much lower than the state and National average of 37.5% and 40.9% (in 2020-21). The participation rate is extremely low in Doomadgee (6.7%) and Mornington (7.4%)[6].

For cervical screening program, the uptake was 42.8% (in 2020-21), lower than the State and National average of 47.2% and 47.5%. Mornington (21.4%) and Burke (30.8%) have the lowest cervical cancer screening participation rate[7].

With regards to breast cancer screening, the region is doing well (54.4%), with rates higher than both State (52.3%) and National levels (49.9%).

There is no available data regarding skin cancer checks in the region but given there is no dedicated skin cancer clinic operating in the region, the proportion of people seeking skin checks is likely to be very low.

### 3.2.4.2 Screening for chronic conditions

There is a low number of regular patients having chronic conditions screening in the North West region. Only 41% of regular GP patients aged 45-74 years old (or 35-74 years for Aboriginal and Torres Strait Islander peoples) have CVD risk assessment, less than the WQPHN rate of 54.5%. The percentage is higher amongst Aboriginal and Torres Strait Islander patients (47.6%) compared to non-Indigenous patients (37.2%)[8].

For diabetes, 63.6% of regular GP patients who are diagnosed with Type 2 diabetes have HbA1c tested in the past 12 months, raising issues about the timely and appropriate preventative actions required for these patients.

[6] PHIDU, Social Health Atlas of Australia, Data by Primary Health Network, September 2024 release
[7] PHIDU, Social Health Atlas of Australia, Data by Primary Health Network, September 2024 release
[8] WQPHN, GP data, June 2024 submission

#### 3.2.4.3 Sexual health screening

There is an increase in the number of sexually transmitted infections (STI) reported in the region, suggesting an increased in sexual health screening. During 2019-2023 period, the number of STI notifications increased significantly from 466 cases to 577 cases[9]. Gonorrhoea cases largely contributed to the growth of STI notifications (up 65%) whereas the number of chlamydia only increased 29% and syphilis dropped 62%.

### 3.2.5 Vaccine-Preventable conditions

#### 3.2.5.1 Immunisations

There are lower percentages of fully vaccinated children at 1 year (89.1%), 2 years (87.8%) and 5 years (90.7%) compared to the State averages (92%, 90.6%, and 92.7%), well below the State target of 95%. The rates are low for Aboriginal and Torres Strait Islander population in the first two years (85.2% and 83.2%) but higher when children are at 5 years (91.2%)[10].

#### 3.2.5.2 Vaccine-preventable hospitalisations

The number of vaccine preventable hospitalisations in the North West region increased from 39 in 2020-21 to 162 in 2022-23, accounting for 66.4% of hospitalisations in Western Queensland. 75.3% of vaccine preventable hospitalisations were for Aboriginal and Torres Strait Islander peoples in 2022-2023.

[9] Queensland Health, Notifiable conditions annual reporting, October 2024
[10] Queensland Health, Hospital and Health Service (HHS) performance, June 2024

# 3.3 Vulnerable populations

## 3.3.1 Key insights from this section

**Why is exploring the needs of vulnerable populations in the North West Queensland region important?**

Vulnerable populations often experience compounded disadvantages that significantly impact their health outcomes. In this region, most communities are in remote or very remote areas of the State, making them inherently vulnerable due to challenges such as limited access to healthcare, social isolation, and reduced service availability. These vulnerabilities are further amplified among specific groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, people living with disabilities, people experiencing mental illness, people experiencing homelessness, people from LGBTIQ+ communities, as well as older and younger populations.

Understanding the unique needs of these populations is critical for developing equitable and inclusive health services. By better understanding the impact of compounded vulnerabilities, health interventions can be tailored to improve health equity and ensure that no group is left behind in achieving better health outcomes.

## 3.3.2 Aboriginal and Torres Strait Islander communities (NWHHS region)

The North West Queensland region (32.8%) has a very high proportion of Aboriginal and Torres Strait Islander peoples, higher than the State average of 5.2% and the National of 3.8%. Doomadgee (93.2%), Mornington (87.8%), and Carpentaria (47.5%) have the highest proportion of Aboriginal and Torres Strait Islander peoples in the region (Figure 48).

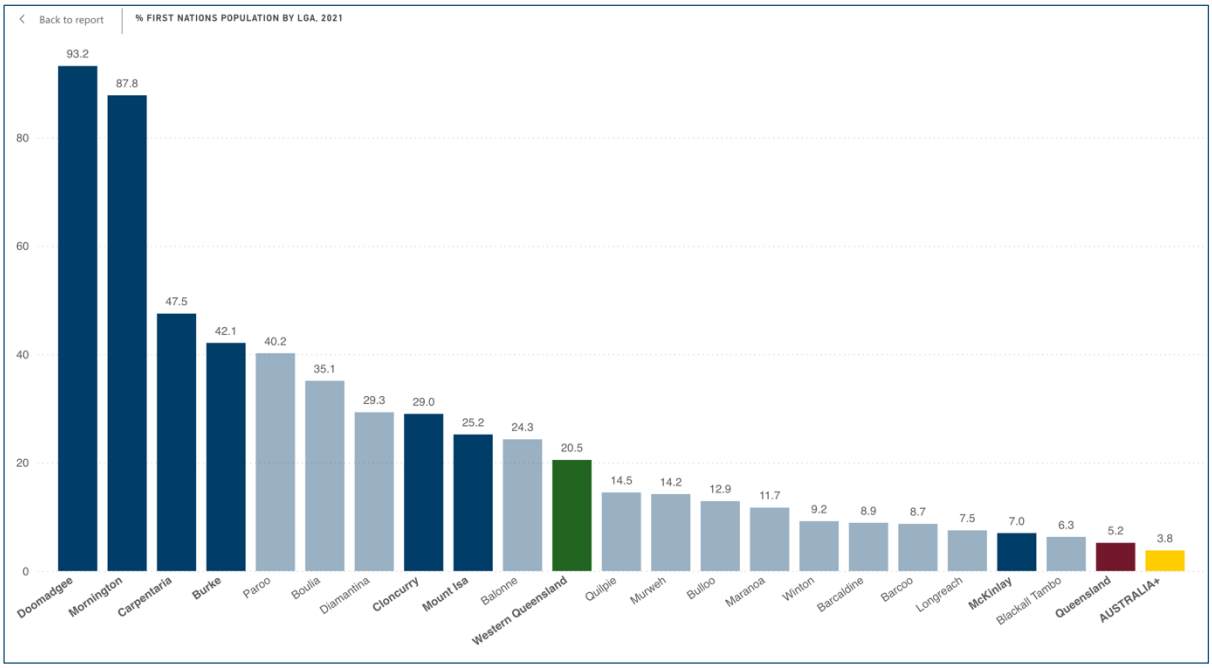


*Figure 48: Aboriginal and Torres Strait Islander population across the North West region*

Mount Isa (2.5%), Cloncurry (2.3%), Carpentaria (1.5%) and Doomadgee (0.5%) all experienced positive growth in the Aboriginal and Torres Strait Islander population between 2011 and 2021, with Bourke (-0.3%), McKinlay (-0.4%), and Mornington (-1.8%) all experiencing negative growth (Figure 49).

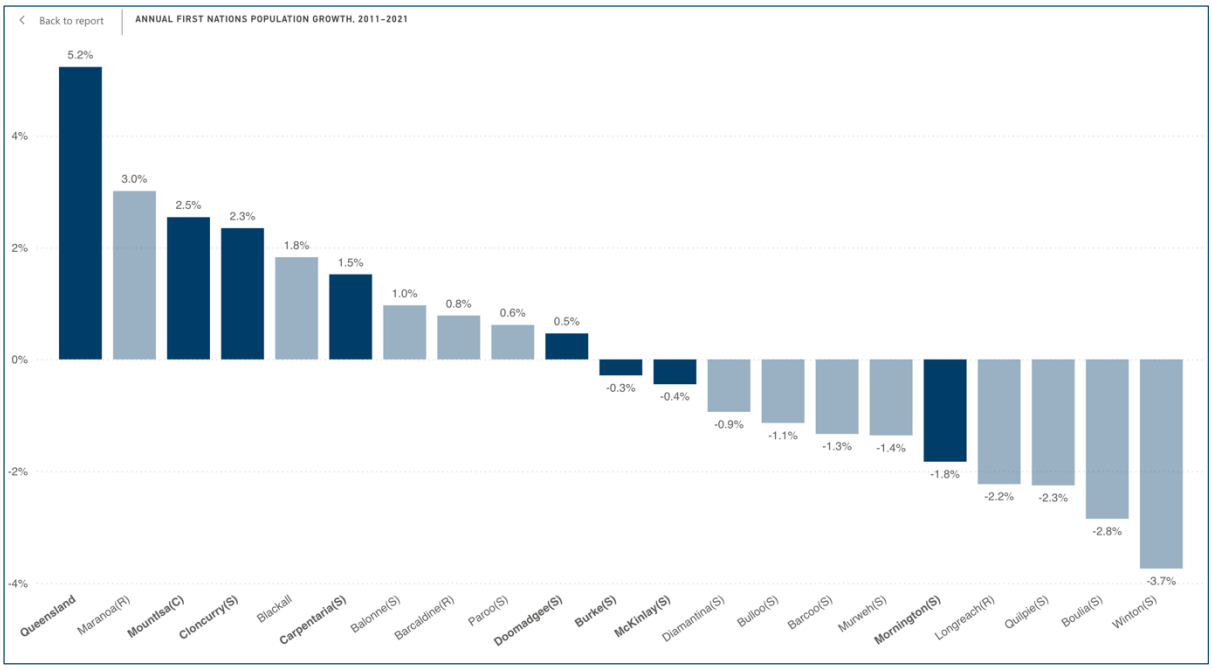


*Figure 49: Aboriginal and Torres Strait Islander population growth in the North West region*

**Lower life expectancy**

Life expectancy at birth (age-adjusted) of Aboriginal and Torres Strait Islander people living in remote and very remote areas, which cover majority of Western Queensland, was 67.3 years for males and 71.3 years for females (2020-2022), 12.4 years lower than non-Indigenous Australians (79.9 years for males and 83.7 years for females in remote and very remote areas)[11]

**Lower level of education**

2.3% of Aboriginal and Torres Strait Islander peoples do not go to school, which is three times the rate for WQPHN (0.7%), and significantly higher than the rate for Queensland (0.9%). Doomadgee (4.2%) has the highest proportion of Aboriginal and Torres Strait Islander peoples not going to school, followed by Mornington (3.8%), Boulia (3.5%), Balonne (2.7%), and Mount Isa (2.5%).

**Higher level of unemployment**

Unemployment rates are high in most locations within the region. 26.1% of Aboriginal and Torres Strait Islander peoples in Doomadgee are unemployed, significantly higher than the Queensland rate (13%). Carpentaria (17.4%), Mount Isa (16.0%) and Mornington (13.5%) have the highest unemployment rates in Aboriginal and Torres Strait Islander peoples.

**Decreasing health check uptake**

The health check uptake in Aboriginal and Torres Strait Islander peoples in Mount Isa in 2023 (29.2%) was slightly lower than the average in WQPHN (30.4%), but higher than the Australian average (27.9%). There are significant fluctuations in the rate year by year, with the current rate (29.2%) higher than the previous year (22.2%), but lower than in 2020 (34.1%).

In 2022, 49.6% of Aboriginal and Torres Strait Islander peoples attended their follow-up health check, which was lower than in 2018 (58.9%) but higher than the Australian average (45.1%).

**Lower percentage of Western Queensland Aboriginal and Torres Strait Islander mothers have recommended antenatal visits during pregnancy period**

[11] Australia Bureau of Statistics, 2023, Aboriginal and Torres Strait Islander life expectancy https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release

52.2% of Western Queensland Aboriginal and Torres Strait Islander mothers living in North West region attended 8 or more antenatal visits (2019/20-2022/23), which was significantly lower than the non-Indigenous attendance (85.6%) and slightly lower than Western Queensland (57.7%). Carpentaria (51.2%), Mount Isa (51.9%), and Mount Isa and surround (57.7%) are those SA2 with the lowest percentage in the region.

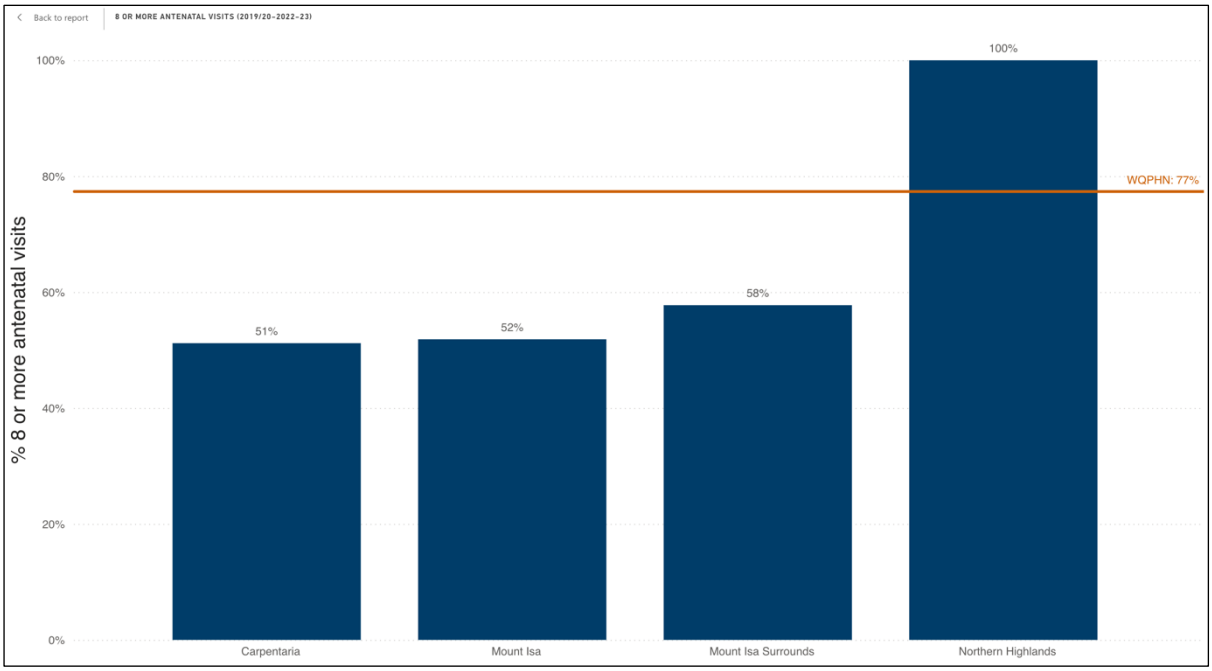


*Figure 50: Proportion of Aboriginal and Torres Strait Islander women who present for 8 or more antenatal visits in the North West region*

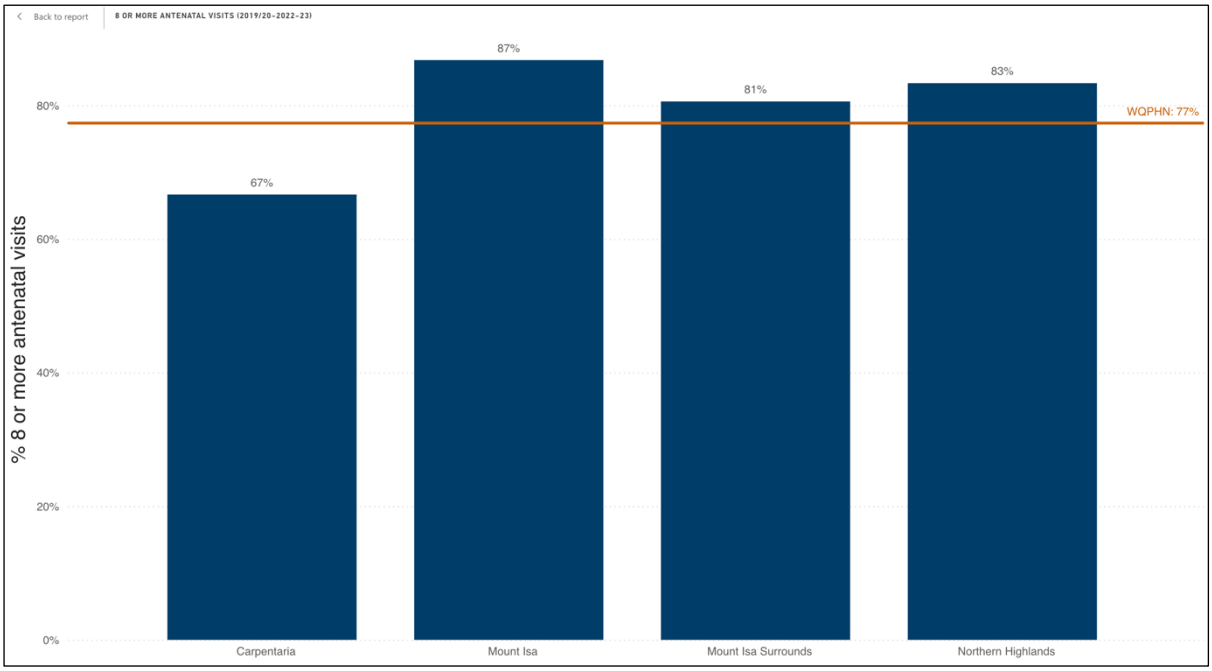


*Figure 51: Proportion of non-Indigenous women who present for 8 or more antenatal visits in the North West region*

**High rates of smoking during pregnancy**

55.4% of Western Queensland Aboriginal and Torres Strait Islander mothers living in the North West region smoke during their pregnancy (2019/20-2022/23), compared to only 10.2% of non-Indigenous mothers. 74.5% of mothers in Carpentaria smoke during their pregnancy, followed by Mount Isa (45.5%), and Mount Isa surrounds (43.7%).

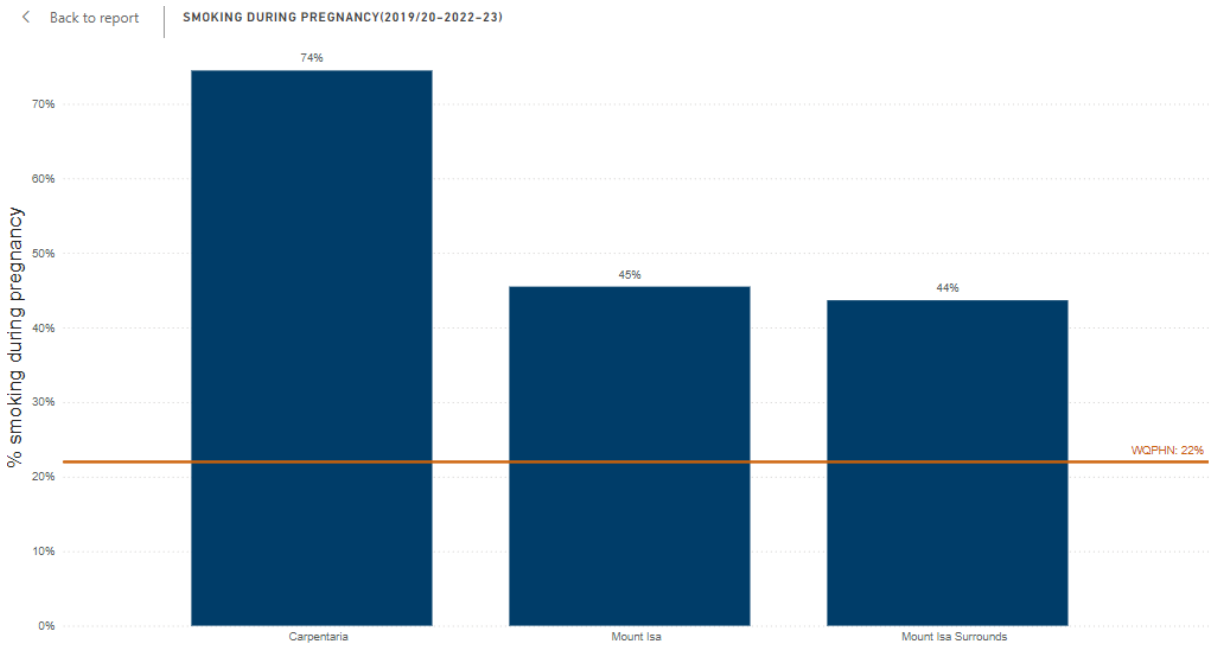


*Figure 52: Proportion of Aboriginal and Torres Strait Islander women who smoke during pregnancy in the North West region*

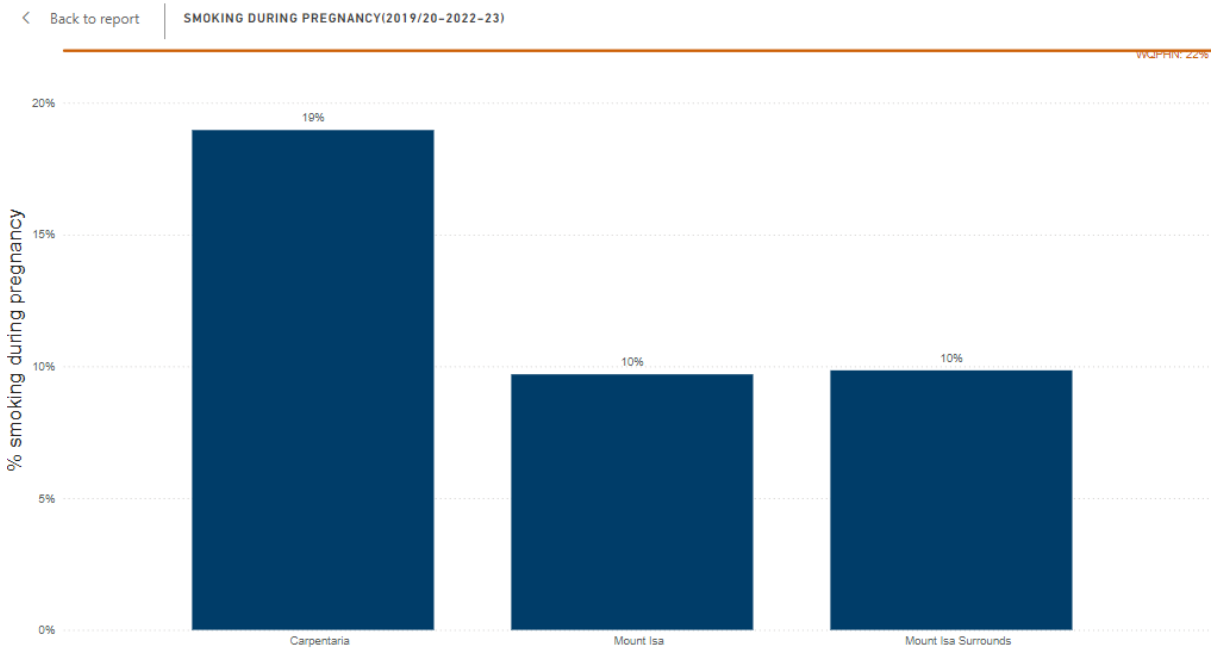


*Figure 53: Proportion of non-Indigenous women who smoke during pregnancy in the North West region*

**High percentage of obese mothers**

24.1% of Western Queensland Aboriginal and Torres Strait Islander mothers living in the North West region are obese during their pregnancy (2019/20-2022/23), lower than non-Indigenous mothers (29.2%). One third (33.8%) of mothers in Mount Isa surrounds are obese during their pregnancy, followed by Mount Isa (23.9%), and Carpentaria (21.7%).

**High rate of low birthweight babies**

14.8% of North West Aboriginal and Torres Strait Islander livebirths are low birthweight babies (<2500gram) (2019/20-2022/23), which was significantly higher than the rate for non-Indigenous babies (6.7%). Mount Isa surrounds (16.9%), Carpentaria (15.0%) and Mount Isa (14.3%) are all higher than the PHN level of 13.4%.

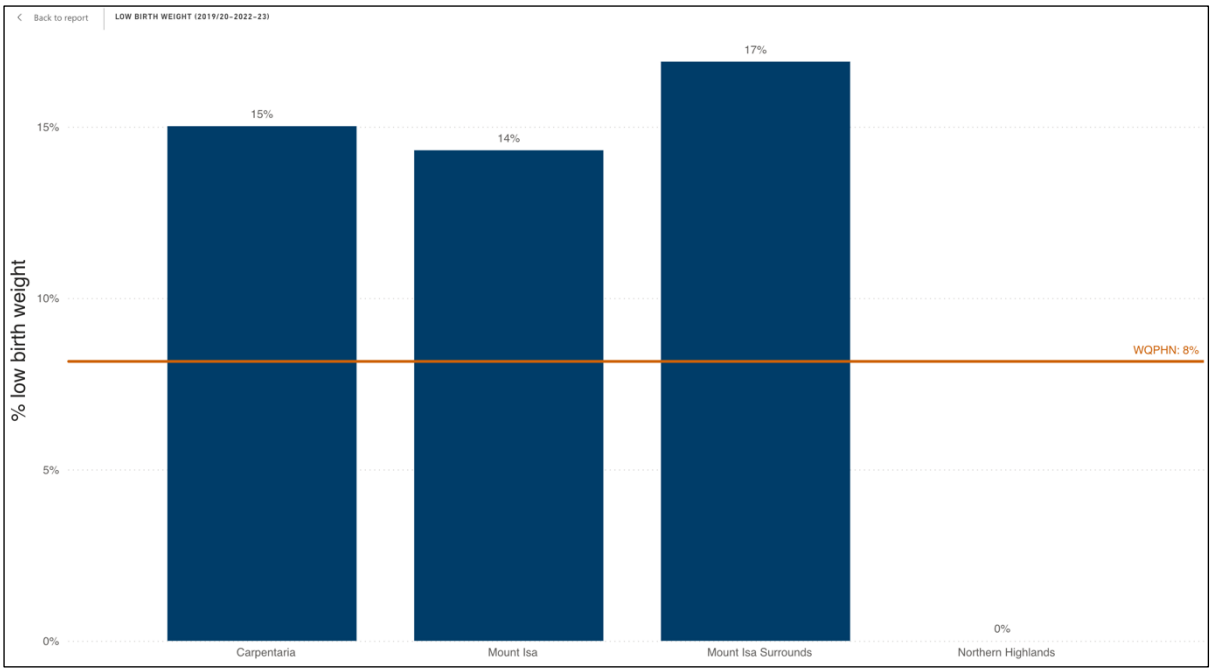


*Figure 54: Proportion of Aboriginal and Torres Strait Islander women with low birth weight babies in the North West region*

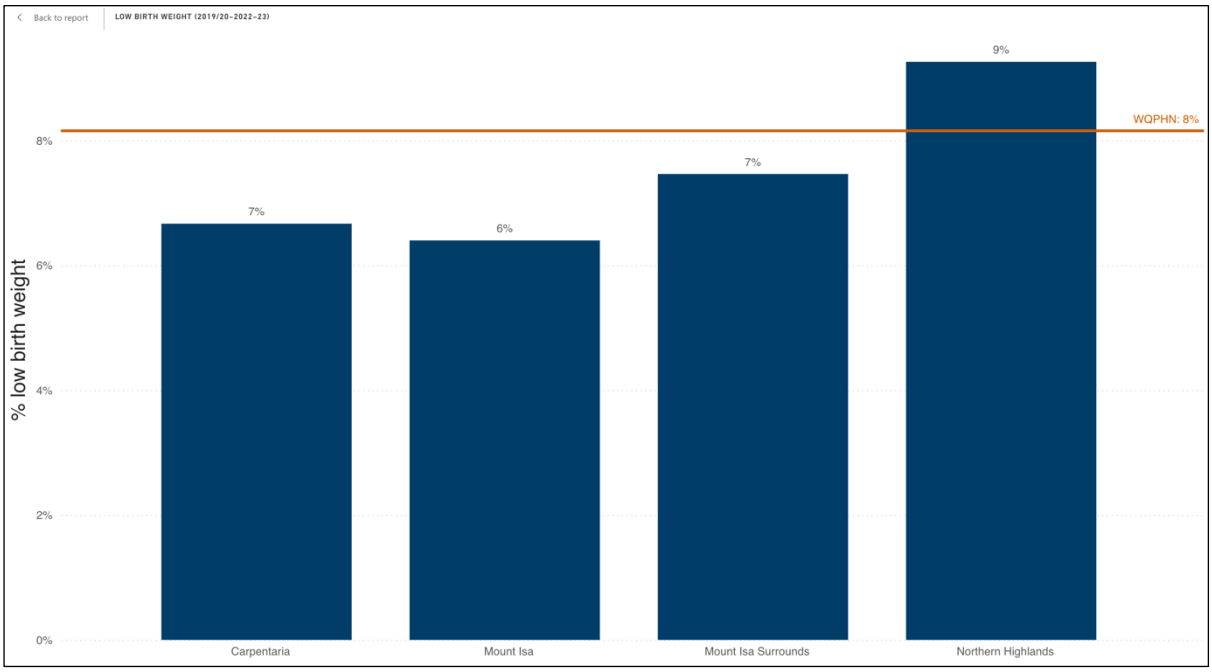


*Figure 55: Proportion of non-Indigenous women with low birth weight babies in the North West region*

**High rate diagnosed with chronic conditions**

The proportion of Aboriginal and Torres Strait Islander peoples in WQPHN diagnosed with at least one chronic condition is 27.1%. Boulia (37.3%), Mornington (27.7%), and Cloncurry (27.4%) have the highest proportions of Aboriginal and Torres Strait Islander peoples with chronic conditions.

### 3.3.3 Culturally, Linguistically Diverse communities (NWHHS region)

The North West region has a significant population born overseas (12.7%). Mount Isa had the largest percentage of people born overseas (16.3%) in the region.

The non-English speaking countries with highest proportions in Western Queensland are The Philippines (1.9%), India (0.7%), Fiji (0.4%), Papua New Guinea (0.4%), and Zimbabwe (0.3%).

9.2% of the population in Western Queensland spoke a language other than English at home. Mornington is the LGA with the highest proportion of people speaking other language at home (34.0%). Australian Indigenous Languages (1.8%), Southeast Asian Austronesian Languages (1.6%), Indo Aryan Languages (0.8%), Afrikaans (0.5%), and Chinese Languages (0.4%) are top 5 non-English spoken languages [12].

Available public data show that there were only a handful of people coming to the North West region under the offshore humanitarian program (0.1% of total population), and the majority chose to settle in Mount Isa area.

Please see Chapter 5 for a summary of insights focused on the health and service needs of multicultural communities in the region.

### 3.3.4 People with disabilities (NWHHS region)

3.0% of the population have a need for assistance with a profound or severe disability, half the State average of 6.0%, with 70.3% of these people living in Mount Isa. 3.5% of people aged 16 to 64 years receive a Disability Support Pension, less than the State and National averages of 5.0% and 4.7%. Carpentaria (5.0%) has the highest proportion of people receiving Disability Support Pension in the region.

### 3.3.5 People living with mental illness (NWHHS region)

**Substantial mental health issues and illnesses**

One in 10 regular GP patients (10.3%) are diagnosed with a mental health condition. Depression and anxiety are the two most prevalent mental illnesses in the North West region.

**Higher rates of non-intentional and intentional injuries**

The region is experiencing a high rate of intentional injuries, especially in Mount Isa (426.0 per 100,000), Cloncurry (463.9), and Doomadgee (299.8). These are all significantly higher than the National rate (125.1 per 100,000).

**High rates of suicide**

The high intentional injuries rate is associated with a high rate of suicide. In the North West region, the suicide rate is 20.0 per 100,000 population, higher than the PHN rate of 18.7, State of 15.5 and National of 12.6.

### 3.3.6 People experiencing domestic and family violence (NWHHS region)

**Increasing domestic and family violence issue**

There is an increasing number of DVO applications in the region. In 2019-20, there were 483 applications in Mount Isa, which increased to 588 in 2022-23. There was a slight decrease to 523 in 2023-24

The number of contravene DVO charges lodged increased dramatically from 526 in 2019-20 to 1,363 in 2023-24. The number of DFF offences also increased across the region. In Mount Isa, the number of DFV offence charges lodged increased from 365 in 2019-20 to 934 in 2023-24. DFV offences in Mornington Island and Doomadgee saw a very significant increase from 90 to 251 and 81 to 217 respectively during this period.

### 3.3.7 People experiencing homelessness (NWHHS region)

There are 266.2 homeless persons per 10,000 population, much higher than the State average of 43.2 per 10,000. The rates are highest in Doomadgee (1865.6) and Mornington (759.2).

Please see Chapter 6 for a summary of insights focused on the health and service needs of people experiencing homelessness in the region.

### 3.3.8 People from LGBTIQ+ communities (NWHHS region)

No data was available for this cohort.

[12] Queensland General Statistics Office, Regional profile, September 2024

### 3.3.9 Older people (NWHHS region)

**High rates of lifestyle-related risk factors**

70.3% of older Australians living in Western Queensland are overweight or obese (2021/22), 4.6% higher than the State average (65.7%).

### 3.3.10 Young people (NWHHS region)

**Large proportion of young population**

Young people account for 36.9% of the total population in the North West region, much higher than the State average of 31.2%, of which 23.1% were 0-14 years old and 13.8% were 15-24 years old.

**Less proportion of earning or learning young population**

66.6% of people aged 15 to 24 in the North West region are learning or earning, less than the PHN (72.5%), State (83.7%), and National (85.4%) proportions. The lowest rate of learning or earning young people are in Doomadgee (23.4%) and Mornington (25.1%).

**High percentage of children aged less than 15 years living in family where the mother has low educational attainment**

The rate of children less than 15 years old living in families in which the female carer had an education level of grade 10 or lower was 24.1%. This was higher than the proportion in WQPHN (20.8%), and much higher than in Queensland (14.8%) and Australia as a whole (14.1%). The highest rates are in Doomadgee (67.7%), Mornington (37.9%), and Carpentaria (28.0%).

## 3.4 Health needs

### 3.4.1 Relevance

| Why is exploring the health needs of the North West Queensland region important? |
| --- |
| The health needs of a population are influenced by a complex interplay of biological, environmental, and social factors. This section explores a broad range of critical health issues, from alcohol and drug use to the health needs in the antenatal and palliative periods. Chronic diseases such as diabetes, cardiovascular conditions, and cancers continue to drive morbidity and mortality, while communicable diseases remain a significant concern, particularly in vulnerable populations. Mental illness and suicide pose ongoing challenges, requiring a holistic approach to care that integrates physical and psychological health. Oral health, often overlooked, is also crucial, given its link to overall well-being. By comprehensively examining these diverse health needs, we gain a greater understanding of their burden on communities in the region. |

### 3.4.2 Alcohol and other Drug use (NWHHS region)

The prevalence of alcohol consumption is higher in the North West than on average for Queensland, with 68% of the adult population partaking in risky drinking, as opposed to 52% in Queensland.

The proportion of adults with lifetime risky drinking (28.4%) is higher than the State total (21.6%). The proportion of the population that participate in at least a single occasion of risky drinking behaviour each month is 40.1%, while for the State, the proportion is 30%. In Mount Isa, the age-standardised-rate for risky alcohol intake is 22.8 per 100 compared to the State total of 18.2 per 100.

The drug and alcohol ASRs separations have been increasing from 2017-18 to 2019-20. The drug and alcohol ASRs separation rate for Aboriginal and Torres Strait Islander people is 2.9 times higher than for non-Indigenous people in Mount Isa, and 1.7 times higher in the North West as a whole in 2019-20. The drug and alcohol hospitalisation separation rate are between 2.5 and 3 times higher than the State rate.

### 3.4.3 Antenatal care (NWHHS region)

Neonatal outcomes in the North West Queensland region are significantly poorer than the State average with higher rates of preterm birth, low birth weight and infant mortality. There is also significant disparity in outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous people. Suppression of the Aboriginal birth data prevents further triangulation of Aboriginal and Torres Strait Islander needs.

Outcomes appear to be poorest in the Gulf, with high rates of pre-term birth and low birthweight. The Mount Isa region is characterised by high rates of mothers aged 35+. The region also has high rates of diabetes, smoking during pregnancy and low rates of antenatal care, particularly for Aboriginal and Torres Strait Islander mothers. Mothers aged 35+ are concentrated in Lower Gulf and Mount Isa. 69% were non-Indigenous. 48.2% of Aboriginal and Torres Strait Islander mothers and 83.9% of non-Indigenous mothers have 8 or more antenatal visits compared to the State average of 67.8% and 81.7% respectively. The poor outcomes in Mount Isa may be related to patients needing to travel from the regions to Mount Isa Hospital for birthing.

The proportion of women who do not attend antenatal visits within the first 10 weeks of gestation is significantly higher in the Western Queensland region (67.0%) compared to the National and State rates (41.0% and 38.0%). The rates in Mount Isa (82.0%), Mornington (69.0%), Doomadgee (69.0%), Burke (69.0%), Carpentaria (69.0%) and Cloncurry (67.0%) are all higher than the already high regional rate.

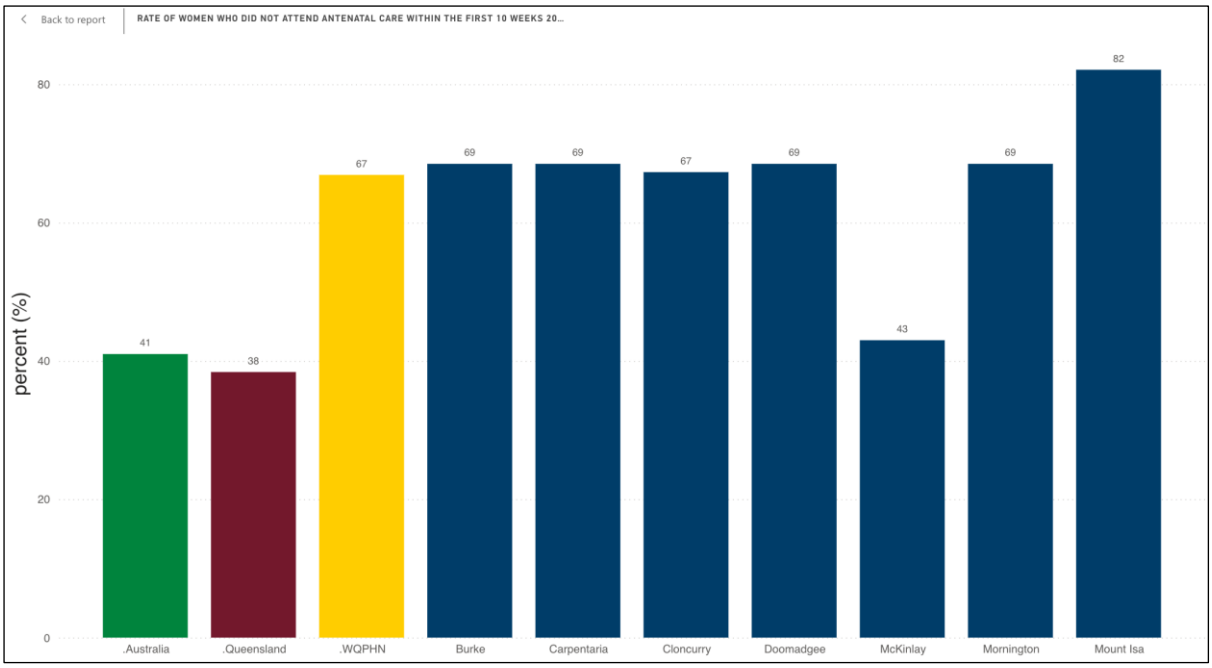


*Figure 56: Proportion of women who did not attend antenatal care in first 10 weeks in North West region, 2019-2021*

### 3.4.4 Cancer (NWHHS region)

The cancer incidence rate and cancer mortality rate for North West Queensland the same as the Queensland average, although certain types are slightly higher (such as lung cancer with an ASR of 26 compared to 22).

The incidence of cancer is highest in Mount Isa and has the lowest mortality compared to the Gulf and Lower Gulf.

The incidence (ASR per 100k) of breast cancer in females is highest in Mount Isa. These incidences are below the State incidence rate. The incidence of colorectal cancer is highest in Mount Isa (90.4 ASR). Lung cancer across the North West is higher than the State incidence rate of 51.7 ASR. The incidence of lymphoma, and ovarian, thyroid, and pancreatic cancers is minimal. The incidence of prostate cancer is below the State rate. The incidence of uterine cancer is highest in Mount Isa (33.4), much higher than the State incidence rate (21.5). The total number of participants in breast screening (2018-2019) was 1663.

The breast screening participation rate is the same as the State as a whole (57.0%). Across the HHS screening for cervical cancer was 38%. Across the HHS bowel cancer screening rate was 26.0% compared to the State participation rate of 42.0%.

**Causes of premature mortality**

In 2014-2018 there were 509 premature deaths in the region, with cancer being the leading cause of premature death (150 deaths). The most common causes of premature death in North West Queensland (by ASR per 100,000) were Cancer, Circulatory System Diseases, and Ischaemic Heart Disease – all were well above the Queensland average.

The cancer death rate for these regions is 1.5x the State death rate for cancer, when comparing age-standardised rates, with colorectal and lung cancer contributing to these premature mortality rates. From 2010-14, Mount Isa has the highest cancer incidence rate for colorectal (90.4 ASR) and lung cancer (83.1 ASR) compared to the other LGAs, with higher age-standardised rate compared to the State rates (68.9 ASR for colorectal cancer and 51.7 ASR for lung cancer). The region also has one of the highest rates of premature deaths from suicide and self-inflicted injuries compared to the State rate.

Potential years of life lost in Aboriginal and Torres Strait Islander people is highest due to external causes (suicide) and circulatory system disease. Premature deaths for Aboriginal and Torres Strait Islander people are highest due to circulatory system disease and cancer followed by external causes (suicide). Premature deaths

ASR per 100k for Aboriginal and Torres Strait Islander people is higher than State rate across cancer, circulatory system diseases, respiratory system diseases, external causes, and diabetes.

### 3.4.5 Chronic disease (NWHHS region)

In 2017-18, diseases with high prevalence are: mental and behavioural problems, asthma, and arthritis. The Mount Isa region had an age standardised diabetes prevalence rate of almost double the State rate. Since many of the complex chronic disease services are available in Mount Isa, the data captured for the North West region will mostly be reflected in the Mount Isa region. Additionally, 31.7% of people who visited a general practice in the North West region had 1 or more chronic health conditions. Mental health and diabetes were the leading chronic conditions (14.8% and 13.1%, respectively) the North West region, followed by respiratory and Cardiovascular disease (9.7% and 6.8%, respectively).

The prevalence of arthritis is 11.4 per 100 compared with the State prevalence of 13.9 per 100. Asthma has a prevalence of 11.9 per 100 compared with the State total of 11.8 per 100. There is a higher prevalence of COPD (4.3 per 100) compared to the State total of 3.5 per 100. The prevalence of diabetes mellitus is 8.9 per 100 compared with the State total of 4.7 per 100. There has been a significant increase in the need for renal services resulting from the high prevalence of diabetes and other chronic diseases in the region. This has a significant impact on the quality of life for people living with chronic disease. The prevalence of heart, stroke, and vascular disease is 5.6 per 100 compared to 4.7 per 100 for the State. The prevalence of mental health and behavioural problems is reported at 16.4 per 100 compared to the State total of 22.7. This may be due to under-reporting or consumers not willing or able to access services. The prevalence of osteoporosis is 2.3 per 100 compared to 3.8 per 100 for the State. The prevalence of blood pressure is significantly higher at 23.9 per 100 compared to the State total at 13.0 per hundred. The prevalence of Acute rheumatic fever/Rheumatic heart disease is greater amongst females than males. The prevalence rate increases from 15–24-year-old to 35–44-year-old. The prevalence rate is significantly higher in Aboriginal and Torres Strait Islander peoples at 10.4 per 100 compared to the rate of 0.35 per 100 in non-Indigenous patients. In some instances, the uncontrolled and undiagnosed nature of chronic disease has resulted in the need for additional resultant service needs, for example, renal services from uncontrolled/ undiagnosed diabetes and other chronic diseases.

There is a large chronic disease burden in North West Queensland, arising from mental and behavioural problems, arthritis, asthma, diabetes, cancer, circulatory system, and respiratory system diseases, leading to significantly higher premature mortality rates caused by these conditions compared to the State. The prevalence and burden of chronic disease is consistent across all geographical areas, with disproportionately poor health outcomes. In particular, the region of the Gulf, Lower Gulf and Mount Isa had a rate of premature mortality from diabetes that is significantly higher than the State rate. This suggests a relationship between low socioeconomic factors (SEIFA, unemployment rates) and increased incidence, prevalence and mortality of chronic diseases. There are opportunities to increase bowel and cervical cancer screening in these regions.

Chronic disease management plans are developed by GPs for the coordination and management of patients with a chronic disease. These plans can include patients who require a multidisciplinary approach to their chronic disease management and can provide access to Medicare rebates for certain allied health services that are required to manage their disease (Australian Government Department of Health, 2014).

Within the MBS data, the GP management plans are listed as Multidisciplinary Care Plans. The number of management plans in the North West region is very high compared to the Queensland average (15%), but the level of chronic disease in the region is also very high. the chronic disease management plans by region were 28.3% for the Gulf, 28.8% for Mount Isa and 20% for the Lower Gulf. These figures are significantly under-reported due to lack of GP consultations available across the region.

The Aboriginal and Torres Strait Islander population are eligible for a free annual health check-up which includes biometric testing of blood pressure, blood sugar levels, height and weight, routine blood and urine tests, and discussion of health priorities and goals (Australian Government Department of Health, 2021).

In 2022-23, the number of check-ups in the NWHHS region was 32.2% of the Aboriginal and Torres Strait Islander population, compared to 38% of the Queensland Aboriginal and Torres Strait Islander population. This included 21.4% in the Gulf, 42.8% in Mount Isa, and 22.3% in the Lower Gulf.

Data extracted from general practice indicates high rates of renal impairment across Mornington (17.0%) and Doomadgee (14.6%). The rates in the remaining areas of the North West region are considerably lower (Figure 57).

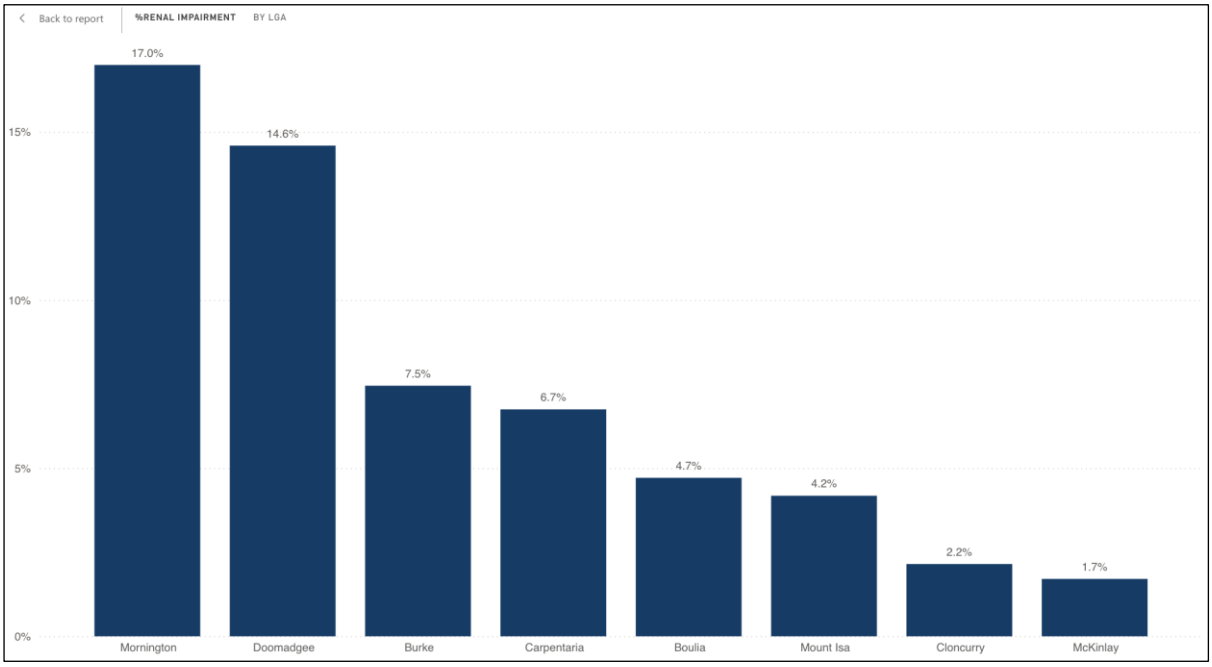


*Figure 57: Rates of renal impairment across the North West region*

## 3.4.6 Communicable disease (NWHHS region)

### 3.4.6.1 Sexually transmitted infections (NWHHS region)

The number of individuals in North West Queensland with a sexually transmitted infection (STI) has increased slightly since 2019. There were 466 people affected in 2019, 537 people in 2022, and 577 in 2023. The incidence of STIs reported are affected by service access and availability, and the health-seeking behaviours related to stigma associated with communicable diseases.

## 3.4.7 Mental illness and psychological distress (NWHHS region)

Mental health problems and suicide in North West Queensland are poorer than the State average and suicide is a leading cause of death. Mental and behavioural problems are the condition with the highest prevalence, based on PHIDU data. Drug and Alcohol use is the 4th highest relative SRG utilisation and the rates of lifetime risky drinking were higher than the State average. The relative utilisation of mental health services is only 51%. In the context of high prevalence of mental and behavioural problems, this suggests underservicing/under-utilisation of mental health services. However, the rate of mental health admissions for Aboriginal and Torres Strait Islander people is higher than the population rate. In particular, the rate of Aboriginal and Torres Strait Islander mental health hospitalisations is 2.1x the rate in North West Queensland. The mental health hospitalisation age-standardised rates have increased from 2017-18 to 2019-20. When comparing the mental health hospitalisation rate between Aboriginal and Torres Strait Islander peoples and non-Indigenous peoples, the Aboriginal and Torres Strait Islander rate is more than twice the non-Indigenous rate. Across all categories, the most mental health related hospitalisation in ED were at Mount Isa, Cloncurry, Doomadgee, and Normanton. The North West region has a self-sufficiency rate of 61% for adults and 20% for children for mental health services with acute transfers to Townsville HHS.

A good indicator of the response to mental health care needs and requirement is the mental health services activity. In 2019-20 2,254 people presented to the Emergency Department (ED) for mental health related services within the HHS. Of these presentations, 14% were admitted overnight, equating to 1,673 bed days. The average length of stay (5.2 days) was slightly shorter than the Queensland average (5.6 days).

GPs are often involved in the diagnosis and treatment of mental illnesses, including the development of mental health treatment plans and referrals to specialised mental health service providers. Any mental health related interaction with a GP, including the development of a mental health treatment plan, is billed to a specific mental health care consultation code under the Medical Benefits Scheme, and thus can be tracked separately to other GP consultations. In 2022-23, only 4.25% of people living in the region (Outback North SA3) had GP Mental Health services, half the National level of 8.3%, and 1.3% had Allied Health Mental Health Care, a quarter of the National average (4.95%). When considering only people diagnosed with a mental condition, data from GPs (in September 2024) shows that only 10.3% of these mental health regular patients access to GP Mental Health Treatment plan in the last 12 months, suggesting the availability of GPs and allied health, as well as access to their services. The need is significantly higher in the Gulf and Lower Gulf communities.

### 3.4.8 Oral health (NWHHS region)

Utilisation of public oral health services can be an indication of dental hygiene practices as well as access to private dental services and ability to pay. Not all the population are eligible for public oral health services – eligibility criteria are based on whether a person holds a concession card (adults) or in the case of children, a child's age and / or whether they are the dependent of a concession card holder.

In 2020, 34% of children and 19% of adults accessed public oral health services. Mount Isa had the highest participation amongst children and the Gulf region had the highest participation amongst adults.

The percentage of the population accessing oral health services has declined across North West Queensland. The areas of significant decrease include Gulf where only 16% of eligible children and 21% of adults accessed services. Service utilisation has declined due to workforce and staffing issues in providing a consistent oral health service. 48% of dental services provided to Aboriginal and Torres Strait Islander people was emergency services. 96% of dental services on Mornington Island and 89% at Doomadgee were emergency services. This highlights the significant need for preventative care and health literacy. At Mount Isa Dental Clinic, 39% of services provided are emergency services.

### 3.4.9 Palliative care (NWHHS region)

The need for palliative care has grown significantly across the region. The average length of stay is 8.7 days with a relative utilisation of adult palliative services at 225%. This demonstrates the need for additional palliative care services. The self-sufficiency rate for adult palliative care services is 94% with North West region at the appropriate levels of capacity and capability to provide comprehensive palliative care.

### 3.4.10 Potentially Preventable hospitalisations (NWHHS region)

In 2020, there were 2,222 PPHs for residents of the HHS. The main preventable hospitalisations were:

- Diabetes Complications – 44.1% of total PPH
- COPD – 14.1% of total PPH
- Congestive Cardiac Failure – 12.4% of total PPH
- Iron Deficiency Anaemia – 11.3% of total PPH
- Angina – 6.8% of total PPH
- Asthma – 5.2% of total PPH

PPH were higher and more common amongst the Aboriginal and Torres Strait Islander residents although the non-Indigenous residents also had PPH rates higher than the Queensland average.

The rate of PPHs is much higher in North West Queensland (10.9 per 100) compared to Queensland (7.9 per 100). PPHs are higher in the Aboriginal and Torres Strait Islander population (19.4 per 100) when compared to Queensland (13.9 per 100). The PPH admissions for chronic disease were higher than for acute episodes. The total admitted separations for PPH dental-related conditions across the HHS is significantly high due to poor access to services in the Gulf and Lower Gulf.

### 3.4.11 Premature births and birthweight (NWHHS region)

The North West Queensland region saw higher rates of high birthweight (8-9%) than the State average (6%). Rates for low birthweight were also significantly higher (14%) than they were in Queensland (4%). Noteworthy is that in Queensland, low birthweight had a lower prevalence percentage than high birthweight, but in the North West region, low birthweight consistently had a much higher prevalence percentage than high birthweight. Low birthweight was significantly higher in the Gulf (22%) than it was in Mount Isa (12%) or the Lower Gulf (14%). Similarly, preterm birth rates were much higher in North West Queensland (14%) than they were in Queensland (6%). In Queensland, preterm birth rates were similar to high birthweight rates, but in the North West region, preterm birth rates were much higher. The gulf had the highest rate of preterm births (20%), while the Lower Gulf had the lowest (9%).

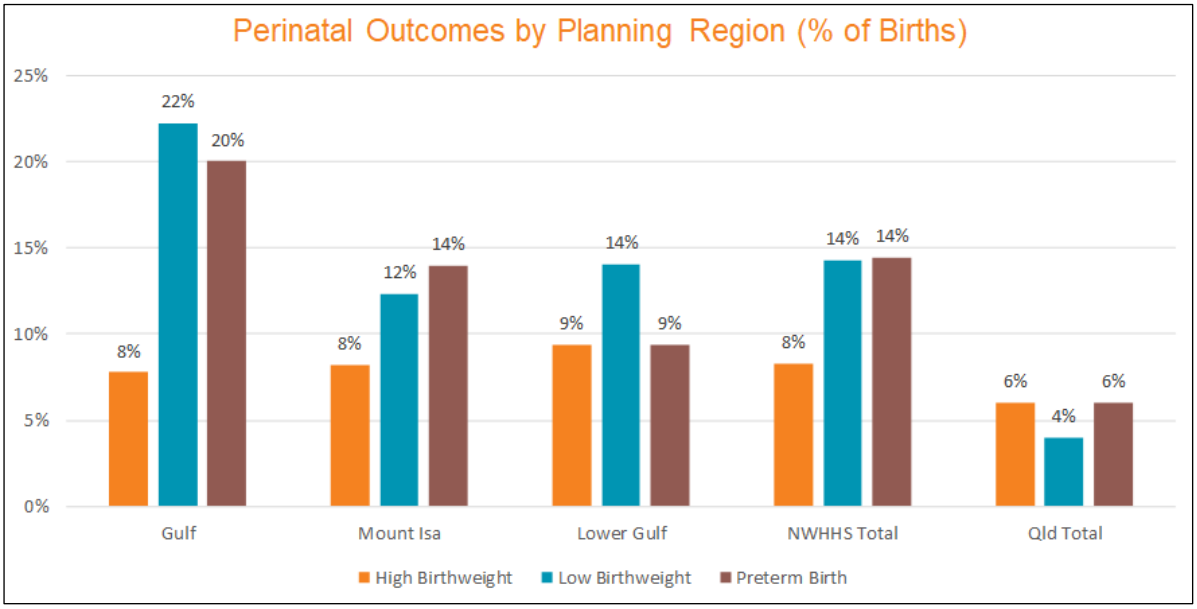


*Figure 58: Birthweight outcomes across the North West region*

### 3.4.12 Suicide (NWHHS region)

One of the leading causes of death in North West Queensland is suicide. The suicide rate (26.8%) is 1.7 times higher than State average (15.4%). Suicide is one of the highest contributors to potential years of life lost, premature mortality potentially avoidable deaths. The extent of the burden of disease in the Aboriginal and Torres Strait Islander population indicates significant inequity of access and under-provision of health services, particularly in relation to mental health and suicide services. The relative utilisation of drug and alcohol services was 362%, however only 51% for mental health services, which demonstrates extremely high demand for drug and alcohol services. This may be related to the stigma attached to seek help for mental health challenges and the provision of culturally appropriate services. The self-sufficiency for mental health admissions was 61% for adults and 20% for children. Self-sufficiency refers to the local accessibility of services, or whether the HHS refers the person onto another HHS, such as Townsville HHS.

# 3.5 Service needs

## 3.5.1 Relevance

| Why is exploring the service needs of the North West Queensland region important? |
|---|
| Effective health services are essential for meeting the diverse needs of a population, yet service gaps, inefficiencies, and workforce challenges persist. This section assesses the service landscape, including service mapping, workforce capacity, and utilisation patterns, to identify areas of need and potential service gaps. Understanding the efficiency and effectiveness of services is crucial for ensuring that resources are allocated where they are most needed. Coordination and integration of services, across primary care, social and community care, and hospitals, is key to delivering seamless care. After-hours care and hospital capacity are also explored, as they are often the pressure points within the system. By analysing these service needs, this section aims to inform strategies that enhance service delivery, improve patient outcomes, and optimise healthcare system performance. |

## 3.5.2 Service mapping (NWHHS region)

### 3.5.2.1 PHN commissioned services

Western Queensland PHN funds a wide range of commissioned services:  aged care, mental health, allied health, AOD, ITC, and Outback Kids in the North West region through 24 commissioning services providers. Aged care services are commissioned to Lower Guff residents whereas other areas can access multiple PHN funded services including AOD, Mental Health, Health Pathways, and NPS. ITC program is targeted to localities with high proportion of Aboriginal and Torres Strait Islander people in Doomadgee, Mornington Island, Normanton, and Mount Isa.

### 3.5.2.2 North West HHS

The NWHHS was established on 1 July 2012 under the *Hospital and Health Boards Act 2011*, with a vision to deliver trusted, connected, quality healthcare for all.

NWHHS delivers health services to the communities across North West Queensland, serving a resident population of around 30,000 people that significantly increases with visitors and tourists annually, with one regional hospital, two multi-purpose health services, four primary health clinics, and five community health centres. Mount Isa Hospital, as the regional hospital, is the primary referral centre within NWHHS. With one of the highest proportions of Aboriginal and Torres Strait Islander populations in Queensland, NWHHS is committed to improving health outcomes for Aboriginal and Torres Strait Islander people with the *Making Tracks Program,* which focuses on chronic diseases, sexual health, discharge against medical advice, and maternal and infant health. The NWHHS region's population is slowly declining with an increasing proportion of aged community members and an overall lower socio-economic population where high levels of acute and chronic disease are evident. These demographics place an increasing demand on public health services delivered across a geographical area of 300,000 kilometres stretching across North West Queensland and the Gulf of Carpentaria.

A list of NWHHS facilities in the region is included at Table 9 and depicted in Figure 59.

*Table 9:  NWHHS facilities*

| | |
|---|---|
| **Hospitals** | Mount Isa Hospital |
| | Cloncurry Multipurpose Health Service (MPHS) |
| | Normanton Hospital |
| | Julia Creek MPHS |
| | Doomadgee Hospital |
| | Mornington Island Hospital |

| | |
|---|---|
| **Primary Health Services[13]** | Burketown Primary Health Clinic (PHC)<br>Camooweal PHC<br>Dajarra PHC<br>Karumba PHC<br>McKinlay PHC<br>Urandangi PHC |

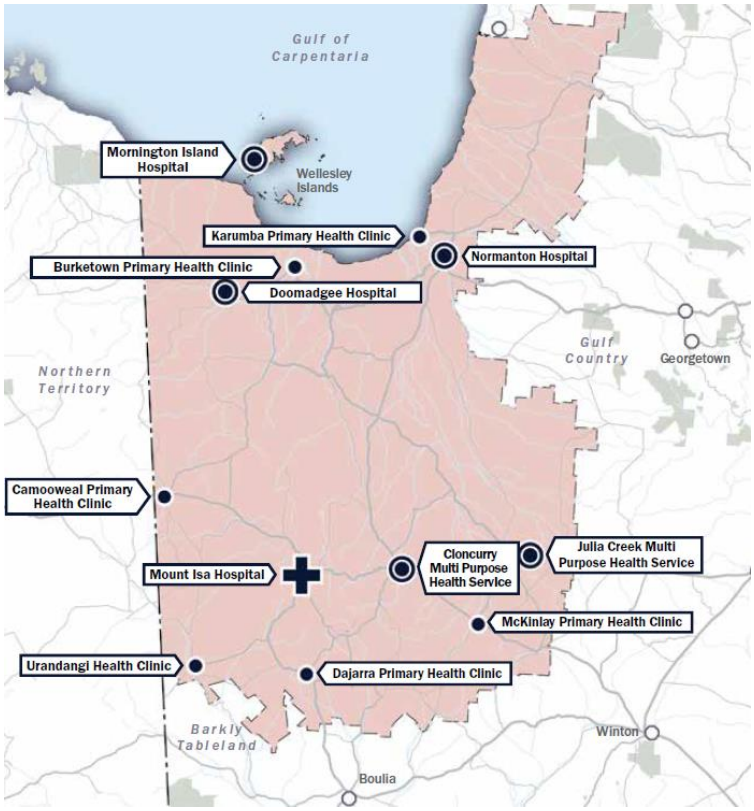


*Figure 59: North West HHS catchment*

**Mt Isa Hospital**

Mount Isa Hospital is a Level 4 facility under the Queensland Health Clinical Services Capability Framework (CSCF) that provides accident and emergency, ambulatory and inpatient medical, surgical, maternity and paediatric services, with 90 overnight beds, two operating theatres, one endoscopy suite, and three birthing suites. There is a critical care unit and a neonatal special care nursery. Subacute services include community rehabilitation in partnership with the Centre for Rural and Remote Health and North West Remote Health.

Mount Isa Hospital is the main referral centre within NWHHS and is the most remote Level 4 CSCF facility in Australia. Patients from other facilities across the North West region who require specialist treatment and care are predominantly referred to the Mount Isa Hospital unless more complex care is required at other major hospitals within Queensland, including at Townsville, Cairns, and Brisbane.

Specialist services are provided on a general surgery and general medicine model with visiting subspecialty services such as orthopaedics, ophthalmology, and gastroenterology services provided on an outreach basis predominantly from Townsville University Hospital (TUH).

Ambulatory services include renal dialysis, oral health, and allied heath (dietetics, occupational therapy, podiatry, social work, physiotherapy, clinical measurements, and speech and hearing). Chemotherapy is

[13] Note – this list does not include the other primary health services non run by NWHHS

provided with support from the Townsville Cancer Service. Mental health and alcohol and drug services are provided on an ambulatory basis with patients requiring admission to a specialist unit being transferred to Townsville or Brisbane.

Specialist outreach patient services are managed from the hospital, which is the hub for telehealth services across the North West service area, with the five primary health care clinics and six hospital sites having access to 24/7 medical and nursing and midwifery support for the advice and management of lower risk emergency department presentations and other outpatient care.

The Mount Isa Hospital radiology diagnostic service is provided by iMED Radiology through a private outsourcing agreement. The radiology department is co-located within the Mount Isa Hospital providing:

- General computerised radiography
- Magnetic resonance imaging
- Echocardiograms
- Ultrasound fluoroscopy, and mobile trauma services through a digitalised picture communication system supporting outlying facilities.

**Cloncurry**

Cloncurry MPHS is a Level 2 CSCF facility that provides rural and remote hospital services with a 15-bed inpatient facility, a ten-bed residential aged care facility, an emergency department, a small ambulatory area, and two renal dialysis chairs.

The inpatient service admits medically unwell babies, children, and adults who can be managed on a general ward under the care of the local medical staff. Patients requiring surgical and diagnostic procedures such as endoscopy are all transferred to Mount Isa. The Midwifery Group Practice from Mount Isa visits to provide antenatal and postnatal care.

Community health services are provided from a building offsite and include aged care assessment, sexual health, chronic disease management, diabetes education, mental health, alcohol and drug service, school health, child and youth health, women's health, palliative care, physiotherapy, dietician, and optometry services.

Community based primary care allied health services are provided by North West Remote Health. A private general practice, the Flinders Medical Centre, is located in Ramsay St. There is currently limited timely availability for appointments which has resulted in increasing ED presentations at the hospital.

**Doomadgee**

Doomadgee Hospital is a Level 2 CSCF facility that provides rural and remote hospital services with a 7-bed inpatient facility, an emergency department, a small ambulatory area, and four renal dialysis chairs (two chairs operating).

Culturally appropriate care is provided by Aboriginal and Torres Strait Islander health workers, nursing, medical, administration, and operational staff.

Main conditions treated include diabetes, sepsis, respiratory, renal, and social and emotional wellbeing admissions including alcohol intoxication.

Primary care and community health services are provided by Gidgee Healing. Selectability now operates the 10-bed residential aged care facility at Doomadgee which transitioned from Gidgee Healing.

The Doomadgee Community Health Centre is staffed by nurses and Aboriginal and Torres Strait Islander health workers who work in partnership with hospital staff and other agencies to provide health assessments, chronic disease management, and coordination of visiting services. The model of care includes clinical review, health education and promotion programs.

There are a wide range of visiting outreach programs with varying frequency of visits, including:

- Deadly Ears
- Indigenous Respiratory Outreach Care Program
- Women's health and child health
- Allied health
- Oral health services
- Diabetes education
- Medical physician outreach clinic
- Gynaecology

- Cardiac and respiratory services
- Sexual health
- Alcohol and other drugs counselling
- Maternal health
- Mental health
- Dermatology
- Hearing screening and services
- Optometrist
- Paediatric cardiologist
- Rheumatic heart disease program, and
- Renal services.

**Julia Creek**

Julia Creek MPHS is a Level 2 CSCF facility that provides rural and remote hospital services with a 2-bed inpatient facility, a 4-bed residential aged care facility, an emergency department, and a separate GP clinic.

The facility provides low-risk ambulatory care clinical services predominantly delivered by registered nurses and health workers. There is a permanent GP service that operates from the health facility. Patients requiring a higher level of care can be managed for short periods before transfer to a higher-level service.

The facility predominantly provides aged care and is the only residential aged care facility in Julia Creek. In addition to the MPHS, there are independent living units which are supported by a community nurse (50% funded by the Council and 50% by the NWHHS).

The Queensland Ambulance Services (QAS) is staffed by one full-time equivalent (FTE) paramedic position. Nursing staff from Julia Creek MPHS assist QAS with patient transfers to Cloncurry when required, including after-hours. There is currently an X-ray service provided from the facility and if more extensive diagnostic testing is required patients are transferred to Mount Isa.

**Mornington Island**

Mornington Island Hospital is a Level 2 CSCF facility that provides rural and remote hospital services with a 11-bed inpatient facility, an emergency department, a small ambulatory area, and six renal dialysis chairs.

Clinical staffing consists of a medical officer and registered nurses on each shift 24 hours a day.

Following transition to community control, Gidgee Healing provides primary and community health care from the community health building. The construction of a new primary health building is underway and will be completed by early 2025. Selectability operates a 15-bed residential aged care facility.

The model of care includes clinical review, health education, and promotion programs. Examples of programs are Deadly Ears; child and adult respiratory (lung health) care, provided by the Indigenous Respiratory Outreach Care Program; women's health and child health; allied health services; cardiac and respiratory services; sexual health; alcohol and other drugs counselling; maternal health; mental health; dental; diabetes education; and renal services.

Several other outreach services are also provided including social and emotional wellbeing counselling, child and maternal wellbeing, mental health, dental, diabetic education, nurse practitioner, Mobile Women's Health Services, and sexual health.

**Normanton**

Normanton Hospital is a Level 2 CSCF facility that provides rural and remote hospital services with a 14-bed inpatient facility, an emergency department, and an outpatient department.

An extensive range of visiting services from Mount Isa, Townsville and Cairns are delivered from the hospital. Outreach clinics include dental, cardiology, respiratory, paediatrics, obstetrics and gynaecology, women's health, general medicine, and mental health. Community Health services are also provided from Normanton Primary Health Clinic.

Gidgee Healing provides primary health care, allied health, optometry, hearing, aged care, family wellbeing and alcohol, tobacco and other drug services recovery services in Normanton. Selectability operates a 15-bed residential aged care facility.

The delivery of the new Normanton Hospital is scheduled for early 2025.

**Karumba**

Karumba Primary Health Care Clinic is a Level 1 CSCF nurse led Primary Health Care facility that provides a range of primary health care, emergency stabilisation and pathology collection. The clinic is staffed by a Director of Nursing (DON) and a Registered Nurse.

A visiting medical officer from Townsville holds a General Practitioner clinic 12 hours per week.

The clinic also provides the coordination of a range of other visiting specialist services including the Mobile Women's health nurse, chest physician, cardiologist, dermatologist, dietician, physiotherapist, podiatrist, and mental health services.

The population of Karumba increases by 2,000-3,000 people during the tourist season, many of whom stay for up to six months and place additional demand on services. Access to acute and ambulatory services are provided from Normanton which is around 50 minutes from Karumba by road.

**McKinlay**

McKinlay Primary Health Clinic is a Level 1 CSCF nurse led Primary Health Care facility that provides low-risk ambulatory, acute, and preventative care, including an emergency on-call service. The single-person nurse led clinic also offers pharmacy services, immunisation, dressings, station and home visits, outreach to Kynuna and visiting North West Remote Health podiatry, occupational therapy, and dietetics services.

The town population is very small, and few people attend the clinic in person. Those people still able to drive tend to go to Julia Creek or Cloncurry for health and other services.

The clinic services a largely ageing resident population over a large geographic area. The service model is predominantly outreach community nursing provided in people's homes similar to the original Bush Nursing Clinic service. There is a strong focus on keeping older people independent in their homes. The Commonwealth Home Support Program is supported by the clinic.

Telehealth is used extensively by most residents including for GP appointments.

**Burketown**

Burketown Primary Health Clinic is a Level 1 CSCF Primary Health Care facility that provides low-risk ambulatory care based on a nurse led and visiting medical officer model of care. The clinic provides a nurse-led acute and emergency service with a hospital-based ambulance, coordination and care for specialist services, chronic disease management and stabilisation of acute care patients prior to transfer to a higher-level facility, pharmacy services, antenatal and postnatal care, and community home visits.

Visiting services include allied health services, Mobile Women's Health, Indigenous Cardiac Outreach Program, endocrinology, diabetes nurse practitioner, ophthalmology, and breast screening.

The RFDS provides a weekly General Practitioner clinic and fortnightly child health clinic. There have been challenges with consistency of service provision in recent times, however, this continues to improve. Both North West Remote Health and Gidgee Healing provide services to Burketown but are also experiencing workforce issues.

The DON also provides an outreach service to the Bidunggu Aboriginal community outstation. RFDS have recently allocated a child health nurse to also participate in these outreach visits and now provides consistent weekly GP services from Gregory. However, there is a significant need for consistent primary care services at Bidunggu. There is no residential aged care facility in town.

**Camooweal, Dajarra, and Urandanji**

The Camooweal Primary Health Clinic and the Dajarra Primary Health Clinic are both nurse-led Level 1 CSCF Primary Health Care facilities that provide 24-hour acute and emergency on-call and ambulance services in addition to chronic disease management, preventative health, health promotion, and health education. Services include pharmacy services, sexual and women's health services, antenatal and post-natal care, child health, immunisation, school-based wellness health checks, and community home visits.

Visiting services include the RFDS weekly primary health care clinic, endocrinology, cardiology, mental health, child health nurse, women's health nurse, dentistry, diabetes nurse practitioner, and the North West Remote

Health team which consists of a diabetes nurse educator, podiatrist, occupational therapist, and exercise physiologist.

The clinics largely service the local Aboriginal and Torres Strait Islander populations, however there is also a large tourist population who seek services from the clinics for basic primary care, including medication supplies and treatment of minor illnesses and injuries. Services at Urandangi have not been resumed since the flood. Hence there is a significant need for primary care and GP services at Urandanji.

The construction of the new Camooweal facility is underway and due to be completed before the end of 2024.

#### 3.5.2.3 Aboriginal Community Controlled Health Organisations

There are four Aboriginal and Torres Strait Islander community-controlled health facilities in the North West region located in Mount Isa, Normanton, Doomadgee and Mornington Island. These facilities offer a range of culturally safe primary health care, social and emotional wellbeing, and allied health services. They also provide supporting service aims to improve outcomes for Aboriginal and Torres Strait Islander people accessing culturally appropriate mainstream services and care for Chronic Diseases through Nukal Murra ITC program. The ACCHO in the region – Gidgee Healing – also provides free health service for young people ages 12 – 25, including mental, physical and sexual health, vocational support, drug and alcohol information, and educational support through their affiliated Headspace Mount Isa.

### 3.5.3 Workforce mapping (NWHHS region)

The North West region is defined as a district of workforce shortage, where people have limited access to specialist medical practitioners. The ratio of specialists to residents is less than the National average for anaesthetics, cardiology, diagnostic radiology, general surgery, medical oncology, obstetrics and gynaecology, ophthalmology, and psychiatry.

Most communities are classified as distributed priority areas, where services for the population do not meet the National service standard. The workforce has been evolving to enhance the models of care for sustainable service provision. The practitioner workforce (per 1,000 estimated population) includes medical practitioners (3.99), dental practitioners (0.54), psychologists (0.70), pharmacists (0.80), registered nurses (18.51), other allied health (5.27), and Aboriginal and Torres Strait Islander practitioners (0.17). Medical and dental practitioners, psychologists, and pharmacists are well below the average for Queensland (per 1,000 estimated population), whereas registered nurses, other allied health, and Aboriginal and Torres Strait Islander workforce are greater than the State average.

The proportion of workforce that identify as Aboriginal and Torres Strait Islander is 9.5%, 14.6% are culturally and linguistically diverse (non-English speaking background), 2.2% have a disability, and 1.9% are LGBTIQA+. More than 56% of the workforce fall into the categories of Generation Y (born 1980-1994) and Generation Z (born 1995-2009). 43% fall into the categories of Baby Boomers (1946-1964) and Generation X (born 1965-1979). This demographic trend poses a potential retirement risk and the need for strategic workforce planning to ensure continuity and sustainability. This could include medical leadership, operational, administrative, and some specialised services.

### 3.5.4 Service utilisation (NWHHS region)

**Decreasing number of GP services per capita**

The number of GP services per capita is decreasing in NW region, down from 4.1 in 2018-19 to 3.0 in 2022-23, much lower than the PHN and National averages of 4.3 and 6.6 respectively. GP services per capita are particularly low in McKinlay (2.7), Mount Isa (2.9), Cloncurry (2.9). There are no GP services in Boulia and Burke.

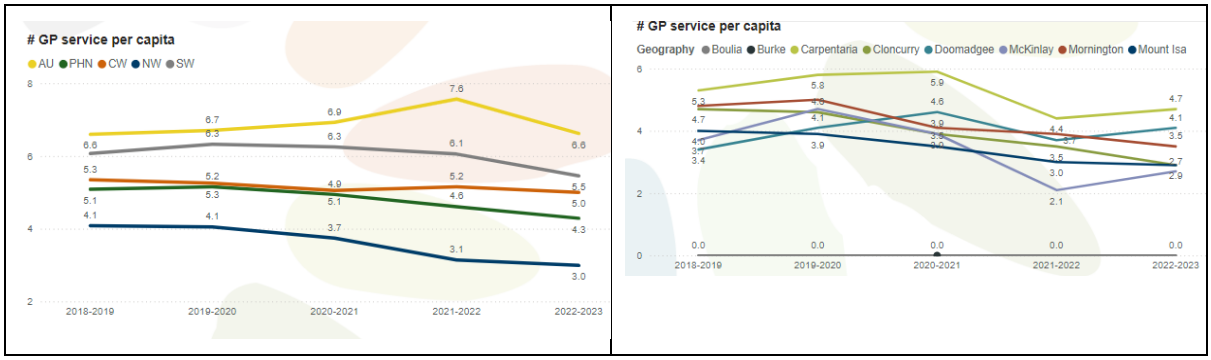


*Figure 60: GP services per capita across the North West region*

### High level of After-hours GP services

After-hours GP services accounted for 7.3% of total GP services across the region in 2022-23, higher than the National and PHN averages of 4.6% and 4.0% respectively. The proportion of after-hours GP services is high in Doomadgee (19.0%) and Mornington (17.8%), but low in Mount Isa (5.5%) and Carpentaria (6.4%).

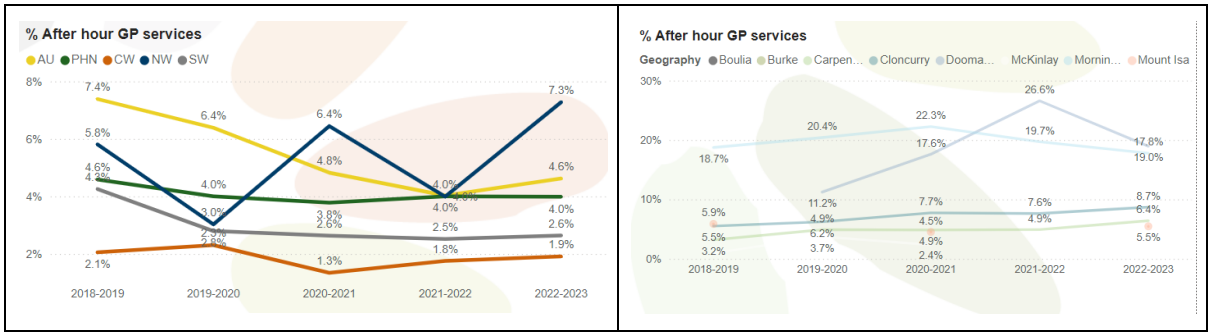


*Figure 61: After-hours GP services across the North West region*

### Increasing use of Telehealth GP services but still far beyond the National

7.3% of GP services in the North West region were telehealth and phone consultations, much lower than the National and PHN proportions of 18.8% and 13.0% respectively. Telehealth services are more commonly used in Mount Isa (10.3%) and are much less frequently used in Carpentaria (6.9%) or Mornington (2.0%).

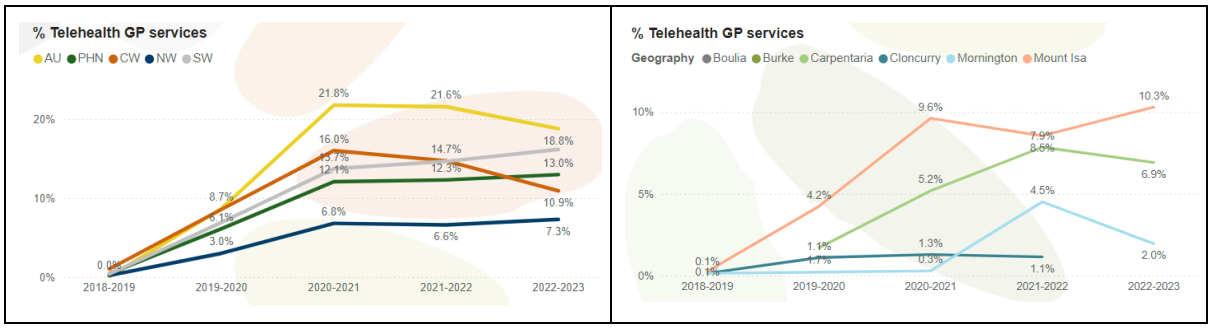


*Figure 62: GP telehealth services across the North West region*

### Increasing number and proportion of Mental health related GP services

2.2% of GP services are mental health related care, higher than the National and PHN averages of 2.0% and 1.6%. Mount Isa has the highest proportion of mental health related care (3.3%), while the rest of the region is much lower, with Cloncurry (0.7%), Carpentaria (0.6%), and Mornington (0.3%) the lowest.

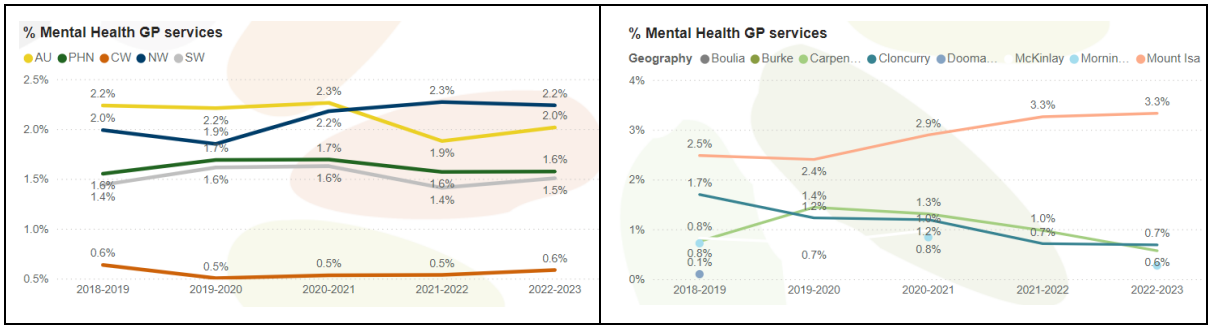


*Figure 63: GP mental health services across the North West region*

**Decreasing number of GP services at RACF**

There were 1,495 GP services delivered at RACF in 2022-23, which is a decrease from 2,167 in 2020-21, mainly due to a significant drop in Mount Isa's GP services – from 1,598 to 1,102 services.

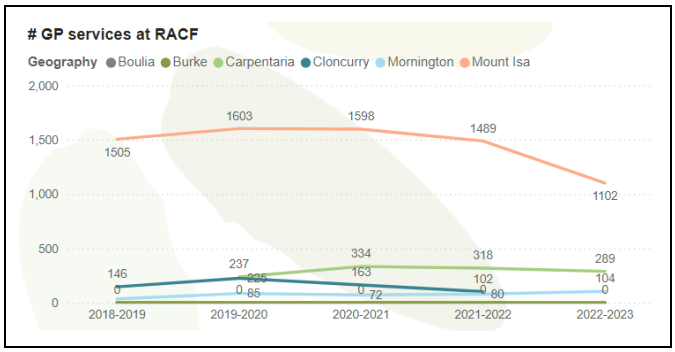


*Figure 64: GP RACF services across the North West region*

### 3.5.4.1 NDIS participation (NWHHS region)

NDIS participants choose and pay for their supports and services out of an individually allocated budget based on their goals. Available supports fall into 15 categories and include things like assistance with daily life, transport, assistance with social and community participation, and home modifications (Australian Institute of Health and Welfare, 2020).

In March 2021, 395 residents (1.4 % of the population) were active participants in the NDIS and were in receipt of an individual support package. This figure is slightly lower than the Queensland average (1.7%). The highest percentage of NDIS participants was in the Gulf planning region, however despite having the highest volume of registered NDIS participants with a support package in the North West, the Gulf Planning region community feedback indicates unmet need with in the region.

### 3.5.4.2 Hospital attendance (NWHHS region)

In 2020-21, the average length of stay (ALOS) for North West Queensland residents (1.8 days) is lower than the Queensland average (2.5 days). Table 10 presents a number of the Service-Related Groups (SRG) that contribute to lowering this average.

*Table 10: Average length of stay across a range of service related groups in the North West region*

| Indicators | North West Region ALOS | Queensland ALOS |
|---|---|---|
| Cardiology | 1.6 | 2.3 |
| Drug & Alcohol | 1.3 | 1.9 |
| Endocrinology | 2.3 | 2.5 |
| Haematology | 1.3 | 1.7 |
| Immunology and Infections | 3.2 | 4.1 |
| Mental Health | 1.4 | 5.6 |
| Neurology | 2.1 | 2.6 |
| Respiratory Medicine | 2.4 | 3.2 |

Most admissions to hospitals were for renal dialysis, obstetrics, cardiology, and respiratory medicine. For Aboriginal and Torres Strait Islander peoples, most admissions were for renal dialysis, respiratory medicine, cardiology, drug, alcohol, immunology, and infections. The relative utilisation by SRG includes drug and alcohol, immunology and infections, endocrinology, and cardiology. The mental health hospitalisation rate for Aboriginal and Torres Strait Islander peoples was more than twice non-Indigenous people in Mount Isa and higher than the State rate. Drug and alcohol ASR separation rate for Aboriginal and Torres Strait Islander peoples was 2.9 times higher than for non-Indigenous people in Mount Isa. In 2020-21, self-sufficiency in North West Queensland was 75% for adults and 73% for children. Due to location and remoteness, many SRGs have quite low self-sufficiency rates, especially for the more specialised services.

The self-sufficiency of hospitals is highest for palliative care, dermatology, drug and alcohol, immunology and infections, cardiology, and gastroenterology. It is lowest for prolonged ventilation, thoracic surgery, maxilla-facial surgery, cardiac surgery, and geriatric management. Low self-sufficiency is appropriate where demand for services is low and specialised services are provided by the surround regions.

### 3.5.4.3 Emergency department presentations (NWHHS region)

**Increasing number of categories 4 and 5 ED presentations**

There were 40,226 category 4 and 5 Emergency Department (ED) presentations in 2023-2024, accounting for 69.7% of total presentations, which was slightly higher than the 2021-22 value of 67.9%. The percentage of category 4 and 5 after-hours presentations increased from 26.6% to 39.1% in two years.

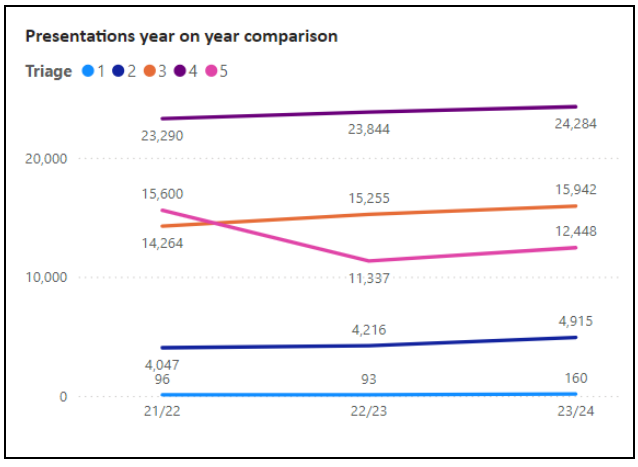


*Figure 65: ED presentations across the North West region*

**Increasing number of Mental health related ED presentations**

There were 2,733 mental health related ED presentations in 2023-24, up from 2,290 in 2021-22.

**High proportion of presentations using walk-in or public or private transport**

90.73% of ED presentations in 2023-24 were walked in /public or private transport, slightly less than 2021-22 rates (91.02%). Ambulance presentations have increased slightly (from 7.32% to 7.45%).

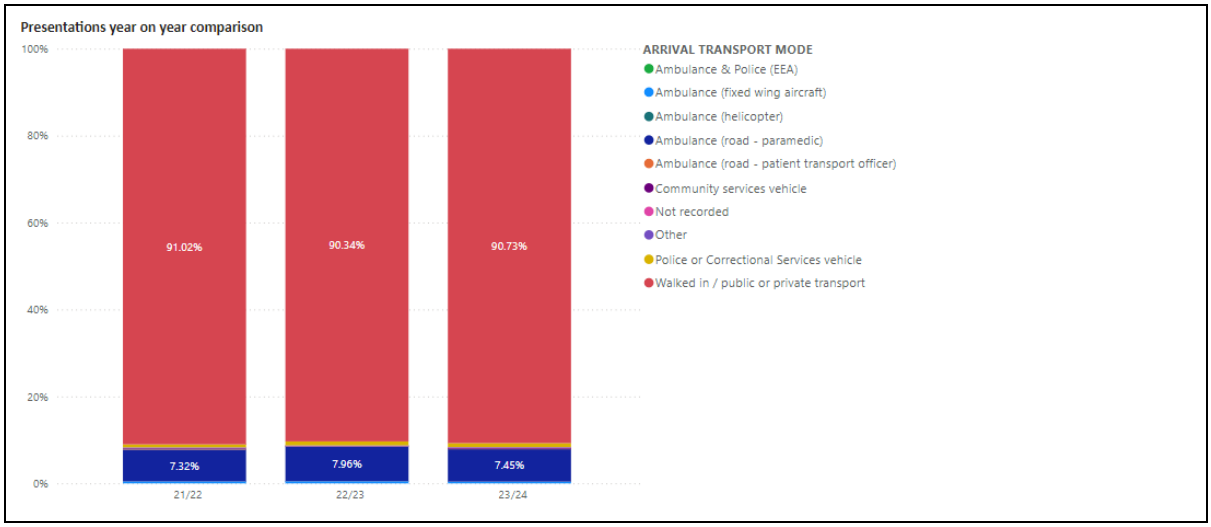


*Figure 66: ED presentation modality across the North West region*

### 3.5.4.4 Oral health presentations (NWHHS region)

In 2020, 34% of children and 19% of adults accessed public oral health services. Mount Isa had the highest participation amongst children and the Gulf region had the highest participation amongst adults. The proportion of children and adults accessing public oral health services has declined. There were 193 PPHs related to dental care with the most hospitalisations in Mount Isa and the Gulf.

## 3.5.5 Efficiency and effectiveness of health services (NWHHS region)

Elective surgery wait times are a policy priority in many health care systems, with long wait times for surgery associated with adverse outcomes, including higher risk of death and complications for patients[14].

In June 2023, the North West region had a total of 132 patients on the elective surgery waitlist. Three of these were classified as long waits (waiting longer than the clinically recommended time according to triage category). This is less than the Queensland average for long waits. In the 2022-23 financial year, the proportion of patients treated in time was slightly lower than the Queensland average for category 1 patients but higher for category 2 and 3 patients.

In June 2023 there were 1361 patients on the specialist outpatients waitlist. Of these, 647 were long waits. A large number of the specialist outpatients long waitlists are worse than the Queensland average, with Ophthalmology, Orthopaedic, and Cardiology having the largest long wait lists.

Year to date operating position is -$1.4M (SPR August 2024). Mental health service episodes with a documented care plan are at 82.2% and improving in performance. There were 885 staff employed by the NWHHS (MOHRI August 2024). More than 60% of capital funding has been spent to sustain infrastructure. Telehealth utilisation is at 120% of target and oral health access target is at 100%. The oral health preventative is at 19%. The year-to-date Capital Expenditure is 66%.

To ensure equitable care, the level of Aboriginal and Torres Strait Islander workforce has increased to 10% and general oral health for Aboriginal and Torres Strait Islander peoples has increased to 68.4% more than last financial year to date. Low birth weight is at 6% overall and has decreased to 11.6% for Aboriginal and Torres Strait Islander babies. Antenatal visits for Aboriginal and Torres Strait Islander mothers have improved from

[14] Rathnayake, D., Clarke, M., & Jayasinghe, V. (2021). Patient prioritisation methods to shorten waiting times for elective surgery: a systematic review of how to improve access to surgery. *PLoS One*, *16*(8), e0256578.

last financial year. PPHs for diabetes have increased for Aboriginal and Torres Strait Islander patients and decreased for non-Indigenous patients.

### 3.5.6 Coordination and integration of health services (NWHHS region)

At present, NWHHS operates as a central hub and spoke model (Figure 68). Mount Isa Hospital is at the centre to support the regional hospitals and primary health services. This is causing extended wait times and generating increased pressure on transfer services such as Royal Flying Doctor Service (RFDS) and Queensland Ambulance Service (QAS). The current central hub and spoke model will not address the ongoing issues that exist and the impacts on clinical service delivery, including:

- inequity of access for Aboriginal and Torres Strait Islander populations
- high levels of service fragmentation
- inconsistent delivery of services to full scope of clinical services capability
- ongoing market failure in the private and non-government aged and disability sectors

Due to the age and design of Mount Isa Hospital, efficiencies are lost and there are limitations on services that can be delivered to a modern standard. In order for NWHHS to unlock the potential of the service delivery, Mount Isa Hospital first needs to operate as a centre of excellence for rural and remote health with an increase in digital health capabilities, stronger partnership agreements, and an agile workforce.

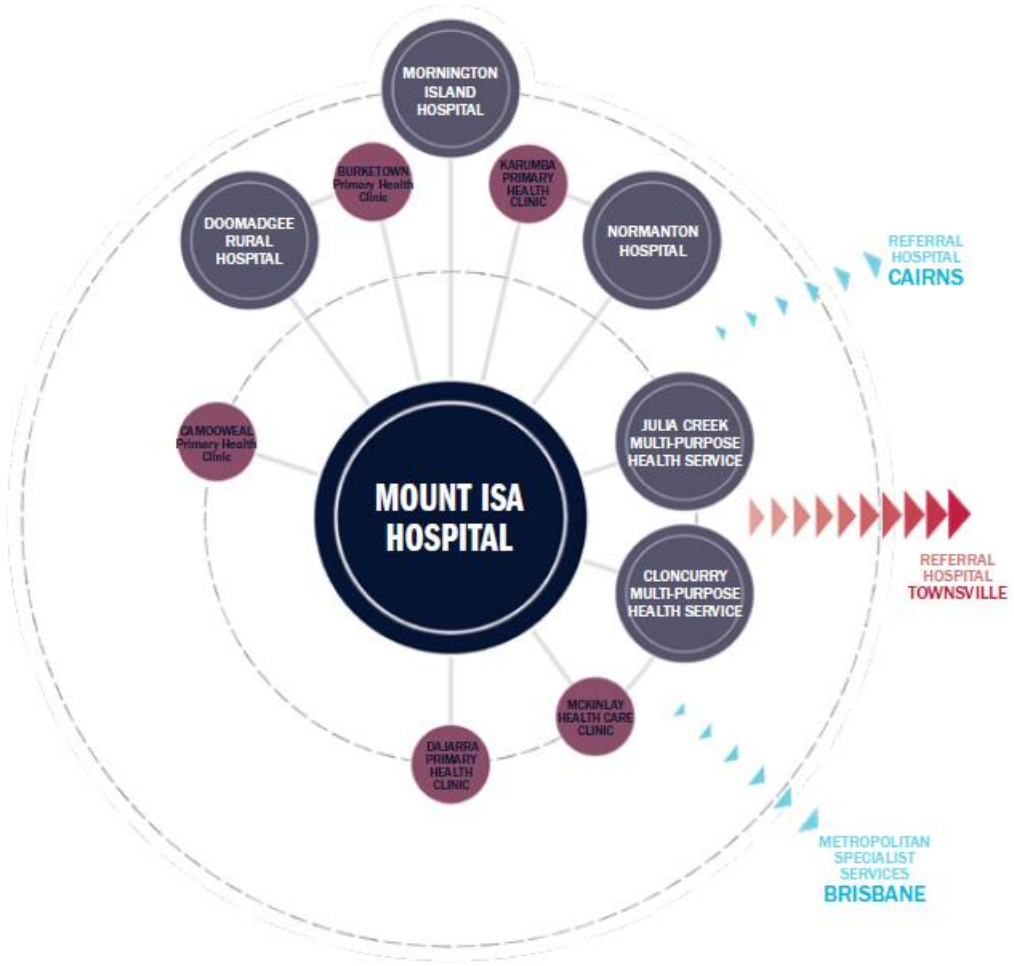


*Figure 67: Mount Isa Hospital service design*

Coordination and integration of services are important to ensure seamless service provision as patients transition across departments and across service providers within the community. There have been some significant strides taken to ensure that services are coordinated with visiting services and when patients are transferred for care to other HHSs. The Outpatient Coordinator ensures that visiting services are

communicated and published for communities to access. Within community, service providers support patients to arrive at appointments for visiting services. Data sharing poses a significant challenge as patients transition from primary to tertiary care and back. Local communication between service providers is essential to overcome these challenges. Nurse navigators have supported patients in navigating and coordinating care.

### 3.5.7 After-hours care (NWHHS region)

Due to the lack of GP after hours care across the region, there has been a concerted effort to implement virtual care and Hospital in the Home (HITH). In 2020, the unit was just being created and so the data is limited. By 2022/23 the number of patients looked after by the HITH unit had risen to:

- ED Patients – 407
- Gynaecology Patients – 23
- Medical ward Patients – 192
- Surgical Ward Patients – 372

The region is also supported by QAS and Retrieval Services Queensland for emergency services.

### 3.5.8 Primary care (NWHHS region)

There is a significant need for sustainable primary care services within communities to build resilience, health literacy, and prevention for better health outcomes. The HHS is prioritising working with Gidgee Healing, HHS maternity services, GPs, visiting specialists and other stakeholders to implement the Growing Deadly Families initiative across the north west region including: a focus on health promotion, early identification and targeted support for reducing risk factors in pregnancy, and Integration and/or co-location of delivery of primary maternity health services with social and emotional wellbeing services, allied health services, and child health and early childhood services in a culturally safe environment. Social and emotional wellbeing/mental health (including alcohol and other drugs services) services are provided by general practitioners, Headspace, Gidgee Healing. and Queensland Health. The core role of the HHS is to support people who have severe and complex needs or are in crisis. A place-based co-design approach needs to be taken to improve coordination between providers and better integrate psychosocial services with specialist clinical services. The goal is to ensure access to a stepped care approach to mental health treatment that offers flexible options at every step of an individual's recovery journey, allowing clients to 'step through' different levels of care as their needs change. The stepped care model also needs to include strengthening the capacity of local community members to respond and support the wellbeing of individuals and/or families affected by mental health issues in times of need i.e., Aboriginal and Torres Strait Islander peoples' mental health first aid, conflict resolution, suicide prevention awareness etc. A new co-designed model of care for a step-up step-down mental health service has been developed, which will support patients closer to home and to remain well in community.

The frequency of oral health services needs to be increased. This will include oral health visiting services to remote sites to support enhanced referral pathways, and further develop sustainable oral health promotion and prevention programs.

Rheumatic Heart Disease is a significant issue in North West Queensland. Improving the assessment and treatment of skin and throat infections to prevent Acute Rheumatic Fever (ARF) in people at high risk of the disease will help address this – as will, preventing progression of ARF to RHD. This can be achieved with early and accurate diagnosis of ARF. Additionally, delivery of secondary prophylaxis by ensuring timely referral to tertiary care for high-quality medical and surgical management for people with existing RHD will prevent complications and improve quality of life.

Sexual health services need to support the training of Aboriginal and Torres Strait Islander health workers and registered nurses to provide sexual and reproductive health screening and contraception, as well as incorporating 'point of care' testing to ensure access to immediate treatment when required. To better integrate and coordinate NWHHS Services there needs to be:

- Improvement in communication and discharge planning with Mount Isa Hospital. This will enable both a reduction in unnecessary patient transfers for post-discharge follow up or step-down care prior to discharge home or placement.

- Investment in a strong primary health service infrastructure through collaborative partnerships and consistent access to care. This may keep residents healthier in the community and decrease reliance on tertiary hospital services.
- Addressal of issues regarding coordination and communication of outreach services.
- Development of a case management approach for aged care.
- Usage of consistent referral pathways which also optimise the use of allied health and nursing for high volume specialties such as orthopaedics, ENT, ophthalmology, gastroenterology and urogynaecology.

#### 3.5.8.1 GP attendances (NWHHS region)

There is a low proportion of people living in the North West region who attended GP services. The data from MBS showed that in 2022-23 only 68.27% of the regional residents attended GP services – much lower than the National average of 85.99%. The percentage is particularly low in people aged less than 44 years old: 63.27% for 0-24 and 62.43% for 25-44 years.

There is a high proportion of GP long and prolong consults. These types of consultation account for 19.3% of the total GP attendance in the region, which is much higher than the National average of 12.6%, suggesting a high complexity of conditions that need to be addressed each visit. It also indicates the lack of GP services in the region, as residents need to discuss multiple conditions/issues with their GPs when they visit.

#### 3.5.8.2 GP services to Residential Aged Care Homes (NWHHS region)

There is a decrease in GP services provided to residential aged care homes in the region. For instance, in Mount Isa, there were 1,603 services in 2019-20 and only 1,102 in 2022-23. In Carpentaria, GP services in RACF also reduced from 334 to 289 services during this period. Mornington Island was the only area to see an increase in GP services, with 85 in 2019-20 and 104 in 2022-23 – possibly due to the dedicated age care facility (15 beds) on the island.

#### 3.5.8.3 GP Mental Health Treatment Plans (NWHHS region)

The proportion of services provided by GPs that were dedicated to mental health saw a slight increase over the last three years (1.9% in 2019-20 and 2.2% in 2022-23), pushing it higher than the National average (2.0%). However, the access to the service is not geographically equal. Areas other than Mount Isa have very low proportions of GP services dedicated to mental health (less than 1%), and these proportions are declining over time. In Cloncurry, the proportion was 1.7% in 2018-19 and has since dropped to 0.7% in 2022-23.

#### 3.5.8.4 Telehealth services (NWHHS region)

Telehealth usage in the North West region is steadily increasing, but is still significantly below the National level. In 2022-23, telehealth services in the region accounted for 7.3% total GP services, up from 3.0% in 2019-20 and 6.8% in 2020-21 (National level was 18.8% in 2022-23).

Telehealth services are less popular in very remote areas like Mornington Island (2.0% in 2022-23), Carpentaria (6.9% in 2022-23), Cloncurry (1.1% in 2021-22), which put pressures on traditional face to face GP services in these areas.

#### 3.5.8.5 Allied health services (NWHHS region)

One in five (22.92%) of people living in the North West regions are able to access allied health services in 2022-23, less than the National average of 38.86%. All services within allied health services also see lower access in the North West region than in Australia: 19.76% for Optometry and 1.64% for Physical Health Care (31.56% and 5.08% for National level).

### 3.5.9 Social and community care (NWHHS region)

There were 109,316 outpatients occasions of service in 2020-21. These related to maternity, medical, primary health care, surgical, and other services (excluding COVID-19). Tier 2 clinics focused on general imaging, primary health care, maternity and midwifery, and general practice. Community health services were

predominantly for sexual health, wound management, and chronic disease. Health checks were conducted on 32.2% of the Aboriginal and Torres Strait Islander population in the North West region. Chronic disease management services, maternity visits, sexual health related services, prevention and literacy programs in schools, oral health services, some homelessness services, and follow-up care are provided in the North West region.

There was an average of 795 13HEALTH calls annually in North West Queensland. The major issues these calls related to was digestive system, issues of health status and injuries, and the toxic effects of drugs and trauma. Only 30% of callers were asked to present to ED, 60% were asked to consult a GP, and 10% were asked to self-care.

### 3.5.10 Hospital capacity (NWHHS region)

The NWHHS has 139 beds (NWHHS Clinical Services Plan 2023-37). This equates to 4.81 beds per 1,000 population. This is significantly higher than the State average of 2.07 beds per 1,000 population. However, this does not account for the significant distance between facilities and access to services.

Promoting the role of Mount Isa Hospital in collaboration with the JCU Centre for Rural and Remote Health as a leading provider of rural and remote services is a propriety to improve the hospital capacity in the North West region. This is a fundamental driver of improved workforce recruitment and retention and is essential for sustainability of networked Level 1 and 2 facilities. There are opportunities to grow gastroenterology, ENT, ophthalmology, urology, and some low complexity elective and emergency orthopaedics including fracture reductions. Provision of Level 4 surgical services is currently limited by theatre availability, surgeon availability, inpatient bed block, equipment, availability of appropriately skilled nursing staff, and issues related to theatre utilisation. Increasing day procedure capacity to address the unmet need in the Aboriginal and Torres Strait Islander population for diagnostic procedures, ENT, dental, ophthalmology, and gynaecology day procedures is a priority. As is creating a dedicated ambulatory service which integrates specialist outpatients, community health, sexual health, chronic disease, child health, allied health, renal dialysis, mental health, and dental health. There is significant potential for major expansion of telehealth services to underpin the integrated model. The existing physical infrastructure is a major constraint to implementation of an integrated ambulatory model of care.

There are plans to establish a six-bed acute/subacute mental health inpatient unit in accordance with priorities identified in Better Care Together: a plan for Queensland's State funded mental health and alcohol and drug services to 2027. There are currently no inpatient mental health beds at Mount Isa and any person requiring admission must be transferred to Townsville. Delays in these transfers due to transport issues are a major issue for the Emergency Department. People with behavioural issues from alcohol and drugs, delirium, and dementia are admitted to the medical ward which is not fit for purpose for care of these types of patients. A mental health inpatient unit would reduce the number of patient transfers to Townsville University Hospital (TUH) and provide a suitable space for patients awaiting transfer.

Development of a purpose-built subacute unit for inpatient and outpatient rehabilitation, and nonacute patients, is a service need. There are currently no dedicated subacute beds at Mount Isa Hospital, with major gaps in service provision relating to allied health and geriatrician input. A dedicated unit in Mount Isa with strong linkages with Townsville (including telehealth) would reduce the number of patient transfers to TUH and enable a shortened length of stay at TUH by facilitating step down care. Stakeholders report that there are consistently between six and ten medical ward beds occupied by people waiting for community-based and residential aged and disability care as a result of ongoing market failure of the private and non-government aged and disability sectors in NWHHS. As a result, patient flow within the hospital is impacted with medical patients being routinely admitted to surgical beds, reducing elective surgery capacity and limiting access to medical beds for acute medical patients. Projections indicate a need for at least 11 overnight subacute beds, however, a 16-bed subacute unit has been recommended to inform master planning.

North West Queensland would benefit from a Virtual Health Hub and Virtual Ward, which uses a mixed model of standard HiTH services for Mount Isa residents as well as a process for formal specialist medical oversight of patients in remote facilities. A Virtual Health Hub in Mount Isa, supported by digitally enabled diagnostic hubs in the Level 2 facilities, could enable several medical patients from any location to be admitted under a specialist in the Virtual Ward, depending on risk assessment and avoiding transfer. Further work is required to determine the exact number of virtual treatment spaces and supporting infrastructure, however, given the

nature of this model, virtual treatment spaces will not offset (i.e., will be in addition to) the physical overnight beds projected/required at Mount Isa Hospital.

Expanding the emergency department and emergency department short stay unit capacity would improve patient flow. The lack of access to GPs in Mount Isa is reflected in the increasing numbers of patients with Triage Category 4 and 5 presenting to ED. Introduction of a nurse-led rapid access model is needed in addition to the existing fast track service. There is also a need to expand the emergency department short stay unit adjacent to the ED to provide an appropriate setting for the assessment and management of people presenting with acute or behavioural issues.

The cultural, social, economic, and mental health needs of women and families are not being met by the current maternity service model. The need to address these issues, particularly in the first 1,000 days of a child's life, is a priority for contemporary models of care such as Growing Deadly Families. A review of the current maternity model is underway to assess the feasibility of an expanded Midwifery Group Practice model. It is noted that the model is currently not sustainable within midwifery resources from an overtime and fatigue perspective. In addition, the current maternity unit does not meet contemporary design standards, such as access to outdoor spaces, family support areas, etc., which impacts on the provision of a culturally safe service.

### 3.5.11 Hospital capability (NWHHS region)

Mount Isa Hospital is the main Level 4 hospital in the region. It provides level 4 services for adults, children, medical oncology, maternity, neonatal, medication, medical imaging and pathology. The proposed mental health services for adults and older persons (2026) are to provide level 4 services. The hospital is still able to leverage the full scope of a Level 4 facility particularly for a range of surgical services, including orthopaedics, neurology, rehabilitation, and geriatric medicine services. Effective provision of Level 4 services at Mount Isa Hospital is essential to ensuring sustainability of all Level 2 and Level 1 facilities in NWHHS, particularly in terms of clinical governance, workforce support, and risk management. Maintaining the capability of clinical services requires addressal of issues of workforce availability and culture, the quality of the physical infrastructure and existing processes, and relationships between providers. The current subacute services for palliative care are level 5 and level 3 for rehabilitation services. The proposed levels for palliative care and rehabilitation are level 4 and 5 from 2026. Currently, emergency geriatric and geriatric acute inpatient services are at level 4. Normanton and Cloncurry Hospitals provide level 2 emergency, medical, medication, surgical, and pathology services. These facilities provide level 1 medical imaging, adult mental health, palliative care, and renal services. Normanton Hospital also provides a level 2 children's surgical service. Doomadgee, Julia Creek, and Mornington Island facilities provide level 2 adult emergency, medical, medication, and pathology services. Level 2 mental health adult services are provided at Doomadgee and Mornington Island, but only level 1 mental health services are provided at Julia Creek. Julia Creek does not provide any surgical services for children. Level 1 services at these facilities include maternity, medical imaging, palliative care and renal services. Camooweal, Dajarra, Karumba and Burketown provide level 1 adult emergency, maternity, medical, medication, mental health adult ambulatory and pathology services.

The current CSCF Levels are under review as the HHS has increased the capability especially with renal services and ICU beds. With the planned new mental health service and infrastructure, there will also be an uplift for mental health services.

## 3.6 Stakeholder consultation

### 3.6.1 Relevance

| Why is gathering stakeholder insights from the North West Queensland region important? |
| --- |
| Incorporating stakeholder perspectives is essential in the development of a robust health needs assessment. While quantitative data provides valuable insights into measurable health trends and service gaps, it alone cannot fully capture the nuanced needs and experiences of regional communities. Qualitative insights, drawn from the lived experiences of community members and the expertise of service providers, add depth and context that enrich the analysis. These perspectives illuminate the unique challenges, cultural values, and local strengths that shape health outcomes in these regions. Engaging with stakeholders not only ensures that the assessment reflects real-world conditions but also fosters a sense of ownership and trust within the community, ultimately leading to more targeted, effective, and sustainable health interventions. |

### 3.6.2 Insights from sector consultation

Consultation with the sector included incorporated insights from four key sources:

- Sector survey – administered in August 2024
- A review of insights gathered by WQPHN staff at community events over the past 12 months
- A review of insights gathered by NWHHS staff as part of their most recent Local Area Needs Assessment
- A survey and focus groups with staff from Gidgee Healing Aboriginal Medical Service in early 2024.

The JRHNA Working Group wish to specifically acknowledge the work of Gidgee Healing for the comprehensive work undertaken to explore the health and wellbeing needs of Aboriginal and Torres Strait Islander communities in the North West Queensland region. These insights, gathered from the sector supporting the Aboriginal and Torres Strait Islander communities in Mount Isa, Doomadgee, Normanton, and Mornington Island, as well as from community members directly, has enabled a strong focus on identifying the particular needs impacting these communities.

#### 3.6.2.1 Stakeholder insights – Aboriginal and Torres Strait Islander communities in North West Queensland region

Drug and alcohol misuse, diabetes, mental health issues, chronic kidney disease, oral health, and cardiovascular disease – Rheumatic heart disease in particular – were all raised as prominent concerns for Aboriginal and Torres Strait Islander communities in the North West Queensland region (Figure 68).

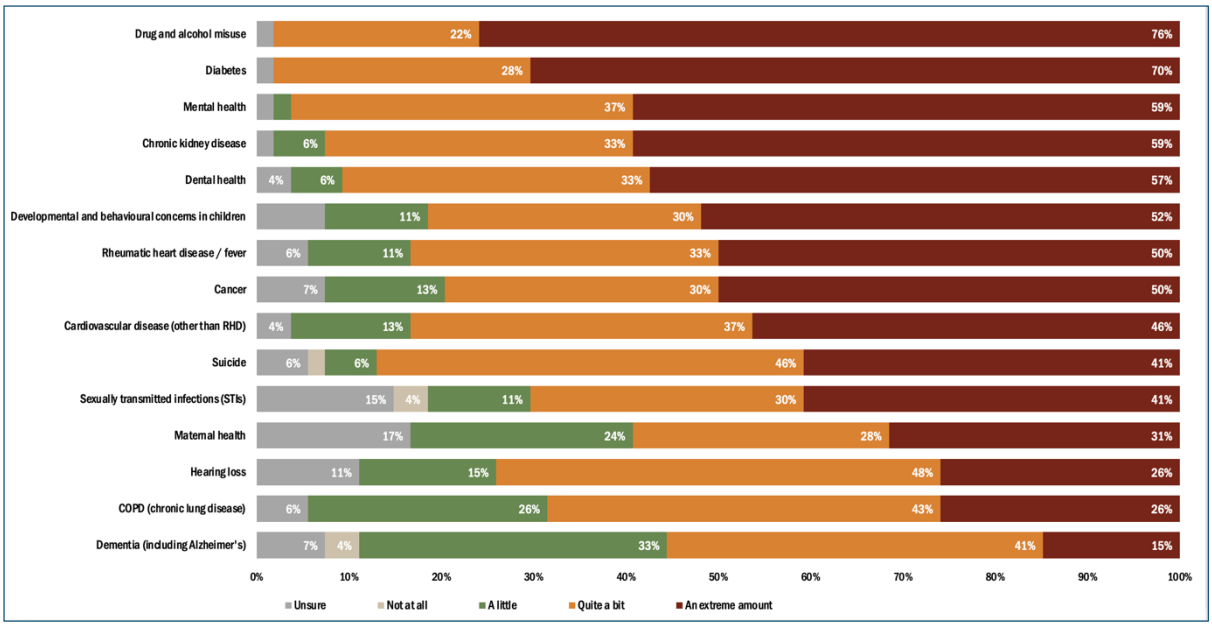


*Figure 68: Health and wellbeing issues of most concern for Aboriginal and Torres Strait Islander communities in the North West region.*[15]

Long wait times, lack of coordination across services, workforce shortages, limited services available in the region, as well as health literacy issues were identified as the main barriers that make it challenging for Aboriginal and Torres Strait Islander communities to access the care they need (Figure 69).

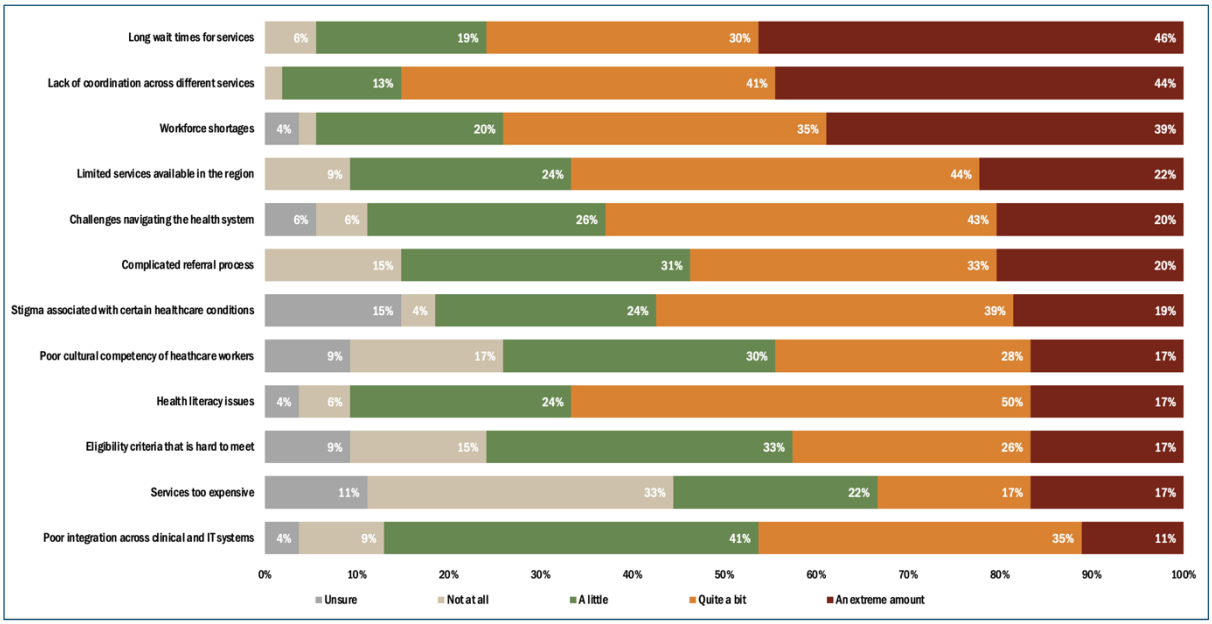


*Figure 69: Barriers to accessing health care for Aboriginal and Torres Strait Islander peoples in the North West region* [16]

Potential solutions to address barriers were focused on three key areas:

- improved access to transport to support accessing care outside the region,
- improved awareness of the visiting services within each community, and
- improved relationships and coordination between health care providers across clinics, hospitals, and visiting services.

[15] Source: Gidgee Healing staff consultation
[16] Source: Gidgee Healing staff consultation

#### 3.6.2.2 Stakeholder insights – General communities in the North West Queensland region

The health and wellbeing issues raised as most concerning more generally (not specific to Aboriginal and Torres Strait Islander populations) were similar to those raised for Aboriginal and Torres Strait Islander communities, but also identified the need to better support people with chronic and complex needs and to provide better preventive healthcare. In addition, both older people and younger people were identified as of particular concern with regard to their health outcomes.

Suggested improvements included the following:

- Working harder to form stronger partnerships with clients and to improve health literacy.
- Ensure culturally appropriate services are delivered consistently.
- Ensure information about available services is accessible, including advertising on community and council websites.
- Better support for clients, their families, and the broader sector on gaining access to the National Disability Insurance Scheme, and
- Increased funding and incentives to attract and retain a skilled workforce in the region.

### 3.6.3 Insights from community consultation

In an effort to more comprehensively understand the health and wellbeing issues impacting communities, Gidgee Healing Aboriginal Medical Service designed and administered a survey with community members across Mount Isa, Doomadgee, Normanton, and Mornington Island. In total, 118 community members completed the survey. All 118 survey respondents identified as Aboriginal and/or Torres Strait Islander.

A high-level summary of the health and service issues identified by community members, listed in order of priority, is included below.

*Table 11: Health and service issues from Aboriginal and Torres Strait Island community members across the North West region*

| | Mount Isa | Doomadgee | Normanton | Mornington Island |
|---|---|---|---|---|
| Health issues | Rheumatic heart disease<br>Mental health<br>Diabetes<br>Chronic heart disease<br>Chronic kidney disease<br>Substance use<br>Asthma<br>Cancer<br>High blood pressure / hypertension / dyslipidaemia<br>Chronic lung disease<br>Skin conditions<br>Developmental disorders in children | Rheumatic heart disease<br>Diabetes<br>Chronic heart disease<br>Chronic kidney disease<br>High blood pressure / hypertension / dyslipidaemia<br>Asthma<br>Developmental disorders in children | Diabetes<br>Substance use<br>Chronic heart disease<br>Chronic kidney disease<br>Mental health<br>High blood pressure / hypertension / dyslipidaemia<br>Asthma<br>Cancer<br>Poor diet<br>Mobility issues / Musculoskeletal<br>Developmental disorders in children<br>Dental health | Diabetes<br>Rheumatic heart disease<br>Chronic kidney disease<br>Chronic heart disease<br>Sexually transmitted infections<br>Mental health<br>Substance use<br>Domestic and family violence<br>Dental health |
| Service Issues | Clinic to check in with people / more reliable follow-up<br>A commitment for health care providers | Better transport options<br>A commitment for health care providers to work better together | More mental health services available<br>Promotion of what services are available and when services are coming to town | People need to use the services that are available<br>Clinic to check in with people / more reliable follow-up |

| | | | | |
|---|---|---|---|---|
| | to work better together<br>Improved relationship between health care providers and the community<br>Better transport options<br>More GP services available<br>Being able to see a consistent GP<br>Promotion of what services are available and when services are coming to town | More local community workers<br>Increased community engagement to inform health care design<br>Phone calls to remind people about appointments<br>Promotion of what services are available and when services are coming to town<br>Home visits to people in community | Increased community engagement to inform health care design<br>More dental services available<br>Clinic needs to be open longer hours<br>More local dialysis services available | A commitment for health care providers to work better together<br>Improved health literacy across community<br>More community gatherings to inform health care services<br>Better transport options<br>Home visits<br>Clinic needs to be open longer hours |

## 3.7 Prioritised needs – North West Queensland region

| Tier | Description | Intended action |
|---|---|---|
| 1 | **These needs emerged as top-tiered needs following prioritisation.**<br>The need or issue aligns with the existing priorities of either the WQPHN or the relevant HHS. Resources are available to support activities to address the need, and activity is expected to occur within the next 12 months. In some cases, existing activities to address the need will already be underway, acknowledging some may require minor tailoring to best address the need. | Ensure these key needs are incorporated into relevant workplans for 2025. |
| 2 | **These needs emerged in-between the top and lower-tiered needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unlikely to be fully addressed within current resources. The partnering agencies will continue to advocate for resources to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 2-3 years. |
| 3 | **These needs emerged as lower-tier needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unable to be addressed within current resources. The partnering agencies will explore opportunities to partner with other relevant agencies to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 4+ years. |

| Need Area | Health and Service Needs (NW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Ageing | • Long-term chronic conditions impacting independence of older people. | 2 | WQPHN | WQPHN Care Finders (CF), My Aged Care (MAC) community services, Gidgee Healing, SEWB providers, NWRH, Rhealth |
| | • There is limited availability of aged care facilities available for people in the NWHHS region, particularly home care services. | 2 | WQPHN | Selectability, NWHHS, MAC, |
| | • There is a need for greater collaboration with aged care providers. | 2 | WQPHN | WQPHN CFs, MAC, |
| Cancers | • People across the NWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence. | 2 | WQPHN | WQPHN Practice supports HSS, AMS, RFDS and private primary care services. |
| | • People across the NWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical, Colorectal, Lung) except Breast. | 3 | NWHHS | WQPHN Practice supports, HSS, AMS, RFDS and private primary care services (NBCSP, NCCSP, NLCSP). |
| Child and material health | • There is a high rate of developmentally vulnerable children in more than one domain in the NWHHS region. | 3 | NWHHS | Healthy Outback Kids (HOK) Alliance, NDIS, NWHHS – SOP ears, eye |
| | • There are high rates of psychological distress in children in the NWHHS region. | 1 | WQPHN | NWHHS |
| | • Pregnant women and new mothers in the NWHHS region require consistent access to culturally sensitive child and maternal health services in community, including screening and early intervention services. | 1 | Nukal Murra Alliance | NWHHS, CheckUP, Mornington Island Health Council (MIHC), RFDS |
| | • Families in the SWHHS region require improved access to child development services. | 1 | WQPHN | MIHC |
| Chronic disease | • People in the NWHHS region experience high rates of all chronic diseases, in particular diabetes, chronic kidney disease, chronic heart disease and chronic obstructive pulmonary disease. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing, RFDS, Foundations |
| | • People in the NWHHS region experience higher rates of acute rheumatic fever and rheumatic heart disease when compared to other parts of the State. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • People in the NWHHS region report limited access to dialysis services in community, and significant challenges in accessing transport to access services in other centres. | 1 | NWHHS | Nukal Murra Alliance (ITC), PTSS, MIHC, Gidgee Healing |

| Need Area | Health and Service Needs (NW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • The uptake of influenza vaccines is low for people with COPD in the NWHHS region. | 3 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • People within the NWHHS region require improved access to prevention programs, testing and treatment for rheumatic heart disease and acute rheumatic fever. | 3 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • People within the NWHHS region require enhanced access to chronic disease screening, treatment and services to support ongoing management. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing, RFDS, Foundations |
| | • There is a need for more consistent follow up for bicillin compliance for patients diagnosed with acute rheumatic fever and rheumatic heart disease. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing, RFDS, Foundations |
| Coordination, integration and continuity of care | • People in the NWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing, RFDS, Foundations |
| | • People in the NWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 | WQPHN | NWHHS, WQPHN – Primary Care, MIHC, Gidgee Healing, RFDS, Foundations |
| | • Services in the NWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | WQPHN | NWHHS, WQPHN – CSP and Primary Care, RFDS, CheckUP, QAS, QPS, Rhealth |
| Domestic and family violence | • People in the NWHHS region report high rates of domestic and family violence, and are in need of culturally sensitive 24/7 supports for victims and families. | 2 | WQPHN | QAS, QPS, DV Connect, Gidgee, MIHC |
| | • There is a need for clear and accessible information and pathways to community services for people vulnerable to and experiencing domestic and family violence. | 1 | WQPHN | Mount Isa – NQ Domestic Violence Resource Centre |
| | • There is a need for greater training for staff to better support people experiencing domestic and family violence. | 1 | WQPHN | QH Hotline, Anglicare, DV connect |
| Aboriginal and Torres Strait Islander | • Aboriginal and Torres Strait Islander peoples across the whole NWHHS region experience poorer health outcomes when compared with non-Indigenous communities. | 1 | Nukal Murra Alliance | WQPHN – Primary Care, NWHHS, MIHC, Gidgee Healing, RFDS, CheckUP, QAIHC |
| | • Aboriginal and Torres Strait Islander peoples communities in the NWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | Nukal Murra Alliance | WQPHN, NWHHS, CheckUP, HCQ, |

| Need Area | Health and Service Needs (NW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the NWHHS region. | 1 | Nukal Murra Alliance | WQPHN – Primary Care, NWHHS, MIHC, Gidgee Healing, RFDS, CheckUP, QAIHC |
| | • There is a decline in presentations by Aboriginal and Torres Strait Islander people in the NWHHS region to primary care for routine health checks. | 2 | Nukal Murra Alliance | WQPHN – Primary Care, NWHHS, MIHC, Gidgee Healing, RFDS, CheckUP, QAIHC |
| Health literacy | • People in the NWHHS region have variable levels of health literacy, which impacts their self-care and care for their families. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| Infrastructure, facilities and equipment | • There is a lack of accessible imaging facilities in the NWHHS region, particularly in the more remote areas of the region. | 3 | NWHHS | IMED and private providers |
| Mental health | • Communities in the NWHHS region experience a higher rate of ED presentations for mental health conditions when compared with the State average. This is particularly high for Burke, Carpentaria, Cloncurry, McKinlay, Mornington Island and Doomadgee. | 1 | NWHHS | WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • Communities in the NWHHS region experience a higher rate of mental health admissions when compared with the State average. This is particularly high for Burke, Cloncurry, Carpentaria, McKinlay, Mornington Island, Doomadgee and Mount Isa. | 1 | NWHHS | WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • People in more regional and remote communities within the NWHHS region require greater access to culturally sensitive mental health services and social and emotional wellbeing outreach services. | 1 | NWHHS | WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • People in the NWHHS region require improved access to specialised eating disorder services. | 3 | WQPHN | NWHHS – QH entry point. |
| | • Communities within the NWHHS region experience considerable wait times for mental health services. | 1 | NWHHS | WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • Services in the NWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities | 1 | WQPHN | NWHHS |
| Oral health | • People in the CWHHS region have limited access to oral health services, resulting in poor oral health and potentially preventable emergency department presentations. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |

| Need Area | Health and Service Needs (NW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| People experiencing homelessness | • People experiencing homelessness have high numbers of undiagnosed and uncontrolled health needs. | 2 | WQPHN | H2H, Rhealth, Gidgee, MIHC, |
| | • There is a lack of support for people experiencing homelessness in the NWHHS region. | 2 | WQPHN | H2H, Rhealth, Gidgee, MIHC, |
| People from multicultural communities | • People from multicultural communities in the NWHHS region experience high rates of chronic disease. | 2 | WQPHN | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • People from multicultural communities experience poorer health outcomes than their Australian-born counterparts. | 2 | WQPHN and NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • There is a need for services to be more welcoming and non-judgemental to ensure greater access for people from multicultural communities. | 2 | WQPHN and NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| People from LGBTIQ+ communities | • People from LGBTIQ+ communities in the NWHHS region experience high rates of chronic disease. | 2 | WQPHN | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • People from LGBTIQ+ communities experience poorer health outcomes than their heterosexual-born counterparts. | 2 | WQPHN and NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| | • There is a need for services to be more welcoming and non-judgemental to ensure greater access for people from LGBTIQ+ communities. | 2 | WQPHN and NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| Preventive healthcare | • There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 1 | NWHHS | WQPHN – Primary Care, MIHC, Gidgee Healing |
| Primary care | • People in the NWHHS region, including those in small remote communities (in particular Urandangi and Bidunggu communities), require access to sustainable and consistent primary and community care services. | 1 | NWHHS | WQPHN – Primary Care, Gidgee Healing, RFDS |
| | • There is a lack of after-hours GP services in the NWHHS region which contributes to high rates of low urgency ED presentations | 1 | WQPHN | NWHHS |
| Sexual health | • People in the NWHHS region require increased access to sexual health screening, testing, and treatment services at the community level (in community). | 1 | NWHHS | WQPHN – Primary Care, Gidgee Healing, RFDS |
| Specialist care | • People in the NWHHS region require improved access to visiting specialist services to enhance integration and ensure seamless healthcare. | 2 | NWHHS | Checkup, WQPHN HOK, HOC expansion |

| Need Area | Health and Service Needs (NW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Substance use | • People within the NWHHS region have a higher rate of alcohol consumption when compared with the State average, suggesting the need for alcohol harm reduction strategies. | 1 | NWHHS | Gidgee Healing, MIHC, WQPHN – Primary Care |
| | • People experiencing substance use issues in the NWHHS region require increased access to support, detox and rehabilitation services. | 1 | PHN | TBC |
| | • There is a lack of community-based substance use support services for people experiencing substance use issues in the NWHHS region. | 1 | PHN | TBC |
| Workforce | • There are significant challenges in recruiting and retaining qualified medical, nursing and allied health professionals in the NWHHS region. | 1 | NWHHS | HWQ, WQPHN – WPP |
| | • There is a lack of available child care services which contributes to low attendance at healthcare appointments as well as the ability to retain skilled health workers. | 3 | Local Govt | WQPHN, WPP, NWHHS, HWQ |
| | • The NWHHS region requires increased representation of Aboriginal and Torres Strait Islander peoples within its health workforce to better meet community needs. | 1 | Nukal Murra Alliance | WQPHN – Primary Care, NWHHS, MIHC, Gidgee Healing, RFDS, CheckUP, QAIHC |
| Young people | • There is a high rate of developmentally vulnerable children in more than one domain in the NWHHS region. | 1 | NWHHS | Gidgee Healing, MIHC, WQPHN – Primary Care, |
| | • There are high rates of psychological distress in young people in the NWHHS region. | 1 | NWHHS | NWHHS acute, WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • Young people in the NWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 3 | NWHHS | WQPHN – Primary Care,, MIHC, Gidgee Healing |
| | • There is a need for more consistent mental health services to support young people in the NWHHS region. | 1 | WQPHN | NWHHS acute, WQPHN – H2H, Rhealth, Gidgee Healing, MIHC, QAS |
| | • There is a need for more consistent sexual health services to support young people in the NWHHS region. | 1 | NWHHS | MIHC, Gidgee Healing, WQPHN – Primary Care, |

# 4 Central West Queensland Region

## 4.1 Population

### 4.1.1 Geography

The Central West Queensland region covers an area of 382,800 square kilometres, representing 22% of Queensland's landmass. It stretches 950km west to east, and approximately 500km south to north (Figure 70).

The region includes the local government areas (LGA) of Barcaldine, Blackall-Tambo, Barcoo, Boulia, Diamantina, Winton, and Longreach. All areas within the region are classified as 'Very Remote Australia' according to the Australian Statistical Geography Standard Remoteness Areas Structure. Figure 71 depicts the vast distances between each of the major towns, and the major centre at Longreach.


*Figure 70: Central West Queensland region*

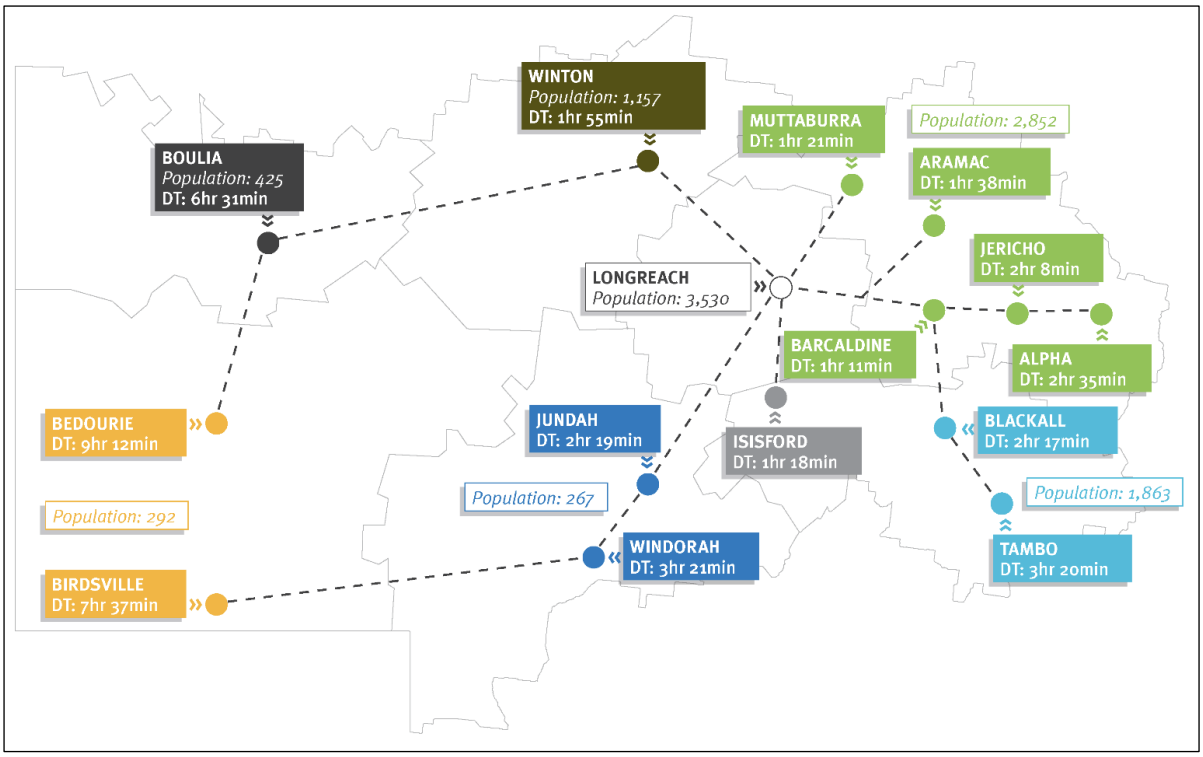


*Figure 71: Central West Queensland region - distances from Longreach to major towns*

Table 12 provides the concordance across statistical areas, local government areas, and major towns across the region.

*Table 12: Central West Queensland geographic region statistical areas, local government areas and major towns*

| Statistical Area level 3 | Statistical Area level 2 | Local Government Areas | Major Towns |
|---|---|---|---|
| Outback - South | Barcaldine – Blackall | Barcaldine (R)<br>Blackall-Tambo (R) | Barcaldine, Alpha, Jericho, Aramac, Muttaburra, Blackall and Tambo |
| | Far Central West | Barcoo (S)<br>Boulia (S)<br>Diamantina (S)<br>Winton (S) | Stonehenge, Jundah, Windorah, Boulia, Bedourie, Birdsville and Winton |
| | Longreach | Longreach (R) | Longreach, Ilfracombe, Isisford and Yaraka |

### 4.1.2 Demography

Central West Queensland region is home to 10,713 persons, with 15.0% identifying as Aboriginal and/or Torres Strait Islander. Boulia (35.1%) and Diamantina (29.3%) are the LGAs with the highest proportion of Aboriginal and/or Torres Strait Islander population.

18.3% of the population are less than 15 years old, which is a lower proportion than that of the entire Western Queensland region (21.4%), but is that same as the National and State level (18.4%). Across LGAs within the region, Boulia (23.4%) and Longreach (19.6%) have the highest proportion of young population, Boulia by a significant margin.

17.8% of the population is aged 65 and over, which is a larger proportion than that of Western Queensland (14.0%), Queensland (17.4%), and Australia (17.4%). Blackall (26.5%), Winton (21.3%), and Barcaldine (19.8%) have the highest proportion of older Australians.

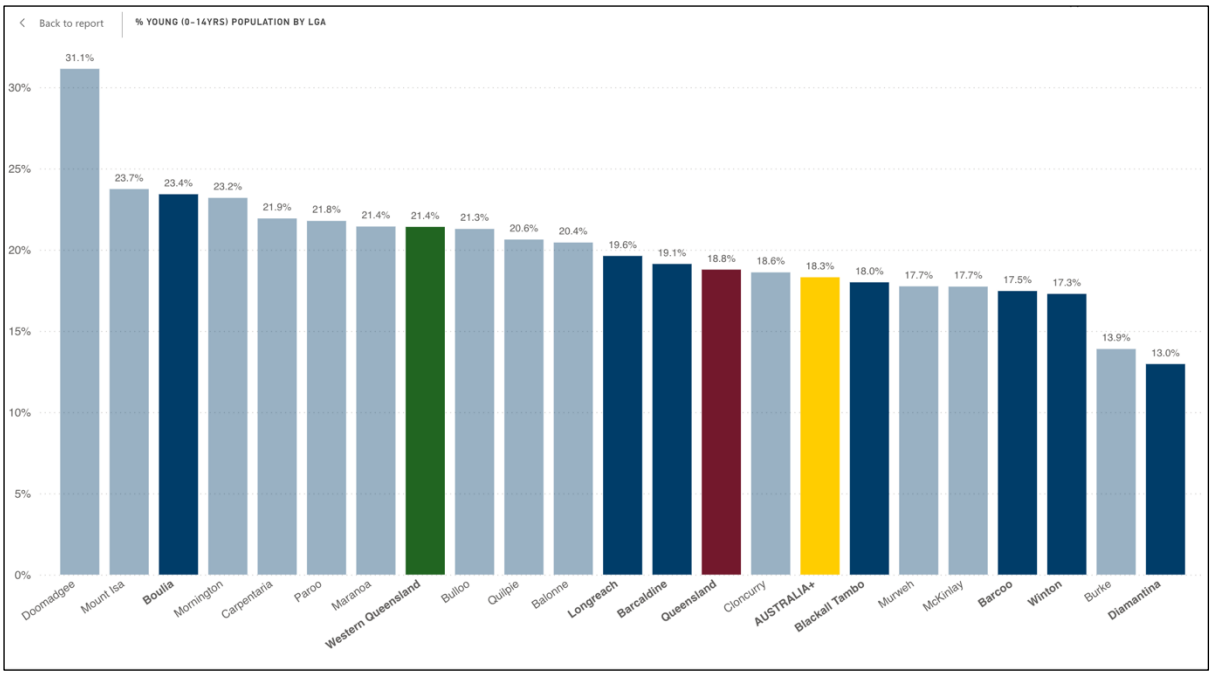


*Figure 72: Proportion of young people aged 0 - 14 years in the Central West region*

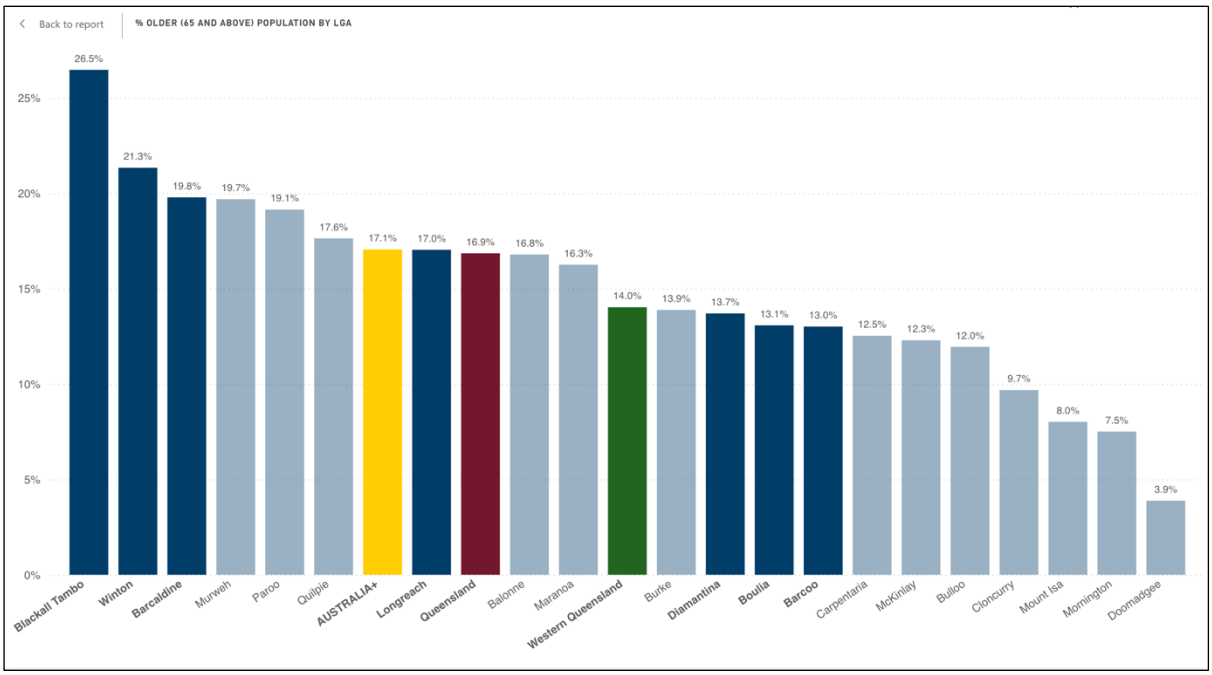


*Figure 73: Proportion of older people aged 65 years and over in the Central West region*

### 4.1.3 Population growth

The Central West region is projected to see a population decline by 2031/32, with the total expected to fall to 9,848, reflecting a decrease of 0.86% from current levels. However, the aging population presents significant implications for healthcare and social services.

The 65-84 age group is anticipated to grow by 13.6%, while the 85+ age group is expected to increase by 24.16%. These shifts indicate a rising demand for health and aged care services, including long-term care and chronic disease management.

Conversely, the 0-14 age group is projected to decline by 27.24%, suggesting a decreasing younger population. This demographic transition may reduce the demand for paediatric and educational services, while increasing

the focus on services for older adults. Overall, this population change underscores the importance of planning to address the specific healthcare and support needs of an aging population.

### 4.1.4 About the Central West Hospital and Health Service

The Central West Hospital and Health Service (Central West HHS) spans the entire 382,800 square kilometres across the Central West Queensland region, making it Queensland's largest HHS region by area.

Central West HHS offers a comprehensive network of community, primary, and hospital-based services, ensuring that diverse communities can access safe and appropriate healthcare close to home.

Longreach Hospital, the largest facility in the region, provides inpatient and emergency services, along with the only maternity and CT radiology services available locally. Additional inpatient and emergency care is available in Barcaldine, Blackall, Alpha, and Winton, supported by nurse-led primary healthcare centers. Barcaldine, Winton, and Alpha also serve as Multi-Purpose Health Services (MPHS), offering residential aged care in the absence of alternative facilities.

Central West HHS delivers coordinated outreach services, including allied health, oral health, mental health, pharmacy, and maternal and child health, to ensure quality care is accessible to residents. General practices operated by Central West HHS are located in Longreach, Barcaldine, Blackall, and Winton, with outreach visits to smaller communities.

In the western part of the health service area, medical and oral health services are provided by the Royal Flying Doctor Service, while allied health services are supplemented by North and West Remote Health. In many of the seventeen communities served, Central West HHS is the sole provider of community and primary care.

# 4.2 Determinants of health

## 4.2.1 Relevance

**Why is exploring social determinants of health in the Central West Queensland region important?**

The social determinants of health, including income, education, employment, housing, and access to nutritious food, fundamentally shape individual and community health outcomes. These factors are often more powerful than medical interventions in determining life expectancy and quality of life. Exploring social determinants is critical because they directly contribute to health disparities, particularly among vulnerable populations. Addressing these determinants through policy and systemic changes offers the most effective means of improving health equity and achieving sustainable health improvements across the region.

Lifestyle factors, including obesity, diet, exercise, smoking, and alcohol consumption, are major contributors to both chronic disease and preventable mortality. Poor dietary habits, physical inactivity, and substance use significantly increase the risk of conditions such as heart disease, diabetes, and certain cancers. These behaviours not only impact individual health outcomes but also place a considerable burden on healthcare systems. Understanding the prevalence of these factors and their role in shaping health is essential to designing effective health promotion and disease prevention strategies that can improve population-wide wellbeing and reduce healthcare costs.

## 4.2.2 Social determinants of health

### 4.2.2.1 Socio-economic disadvantage

Overall, Central West HHS has 51.1% of its population in the two most disadvantaged SEIFA quintiles (1 and 2). In Boulia, Baroo, and Diamantina, 100% of the population are in the two most disadvantaged areas (Quintiles 1 and 2) whereas in Barcaldine, Longreach, and Winton more people are living in better conditions.

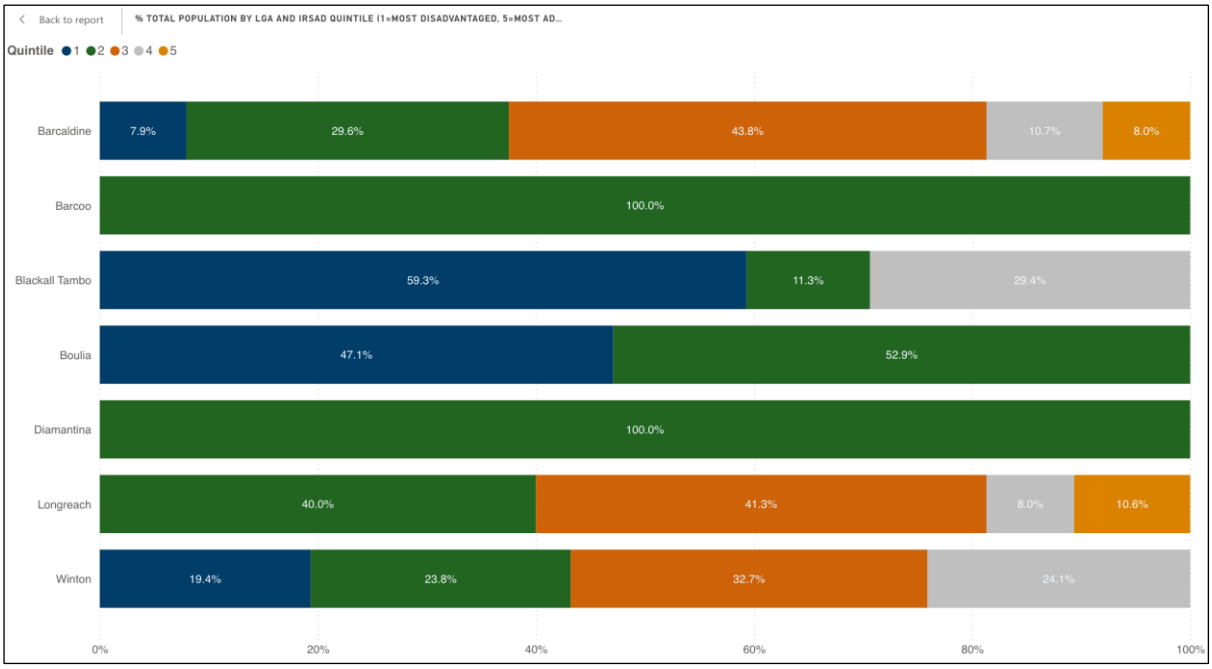


*Figure 74: Index of Relative Socio-economic Advantage and Disadvantage for the Central West region*

*Table 13: SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) by LGA in Central West Queensland Region*

| CWHHS | Barcaldine | Blackall-Tambo | Longreach | Winton | Diamantina | Barcoo | Boulia |
|---|---|---|---|---|---|---|---|
| Population | 2,849 | 1,905 | 3,647 | 1,129 | 266 | 308 | 229 |
| SEIFA Score | 1,002 | 961 | 1,003 | 993 | 952 | 988 | 878 |
| SEIFA Quintile | 4 | 2 | 4 | 4 | 2 | 3 | 1 |

The higher level of socio-economic advantage of communities in the Central West region is partially attributed to the relatively low rate of children in jobless families and a relatively low unemployment rate in the labour force (2.1% in Barcaldine, Blackall-Tambo, and Longreach) among other factors (Figure 75).

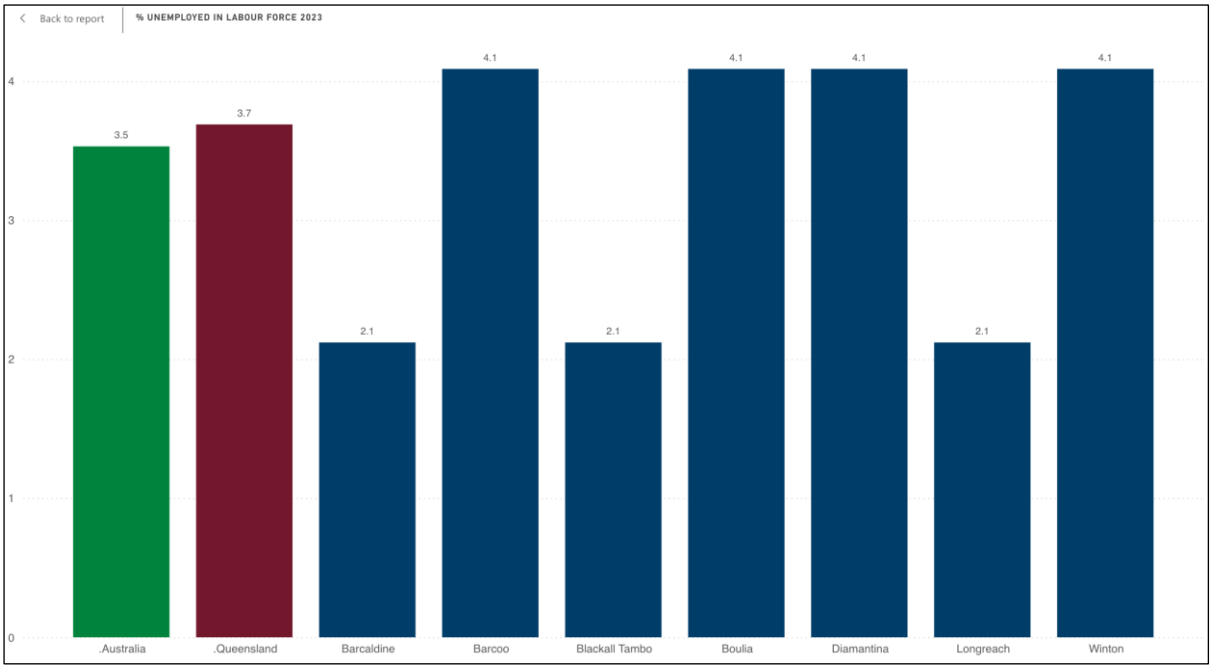


*Figure 75: Unemployment rate in the Central West region, 2023*

The proportion of private dwellings without access to the internet is considerably higher in Western Queensland (22.9%) than it is in Queensland (13.6%) and Australia (14.1%). In the Central West region, the proportion is even higher, with 32.7% of dwellings in Barcoo and 29.6% of dwellings in Boulia without access to the internet (Figure 76).

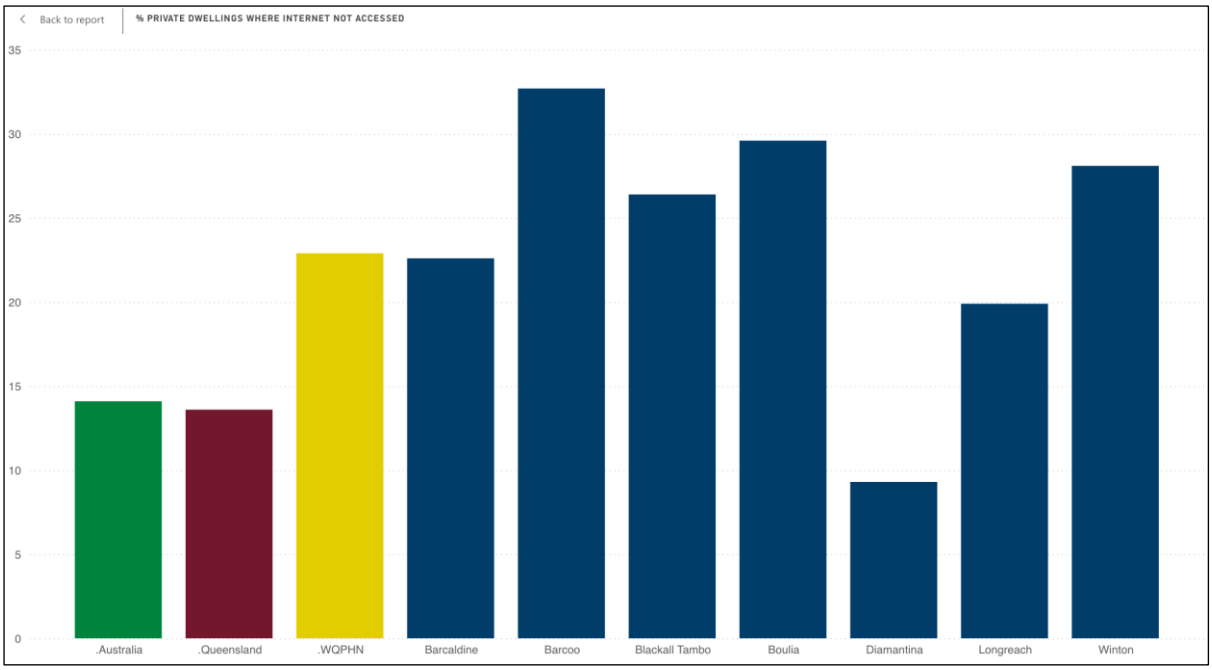


*Figure 76: Proportion of private dwellings without access to the internet in the Central West region*

### 4.2.2.2 Income

Mean personal incomes across the Central West region range from $71,272 in Barcoo to $57,138 in Blackall-Tambo. The average personal income for the State and nation are $63,718 and $67,236 respectively (Figure 77).

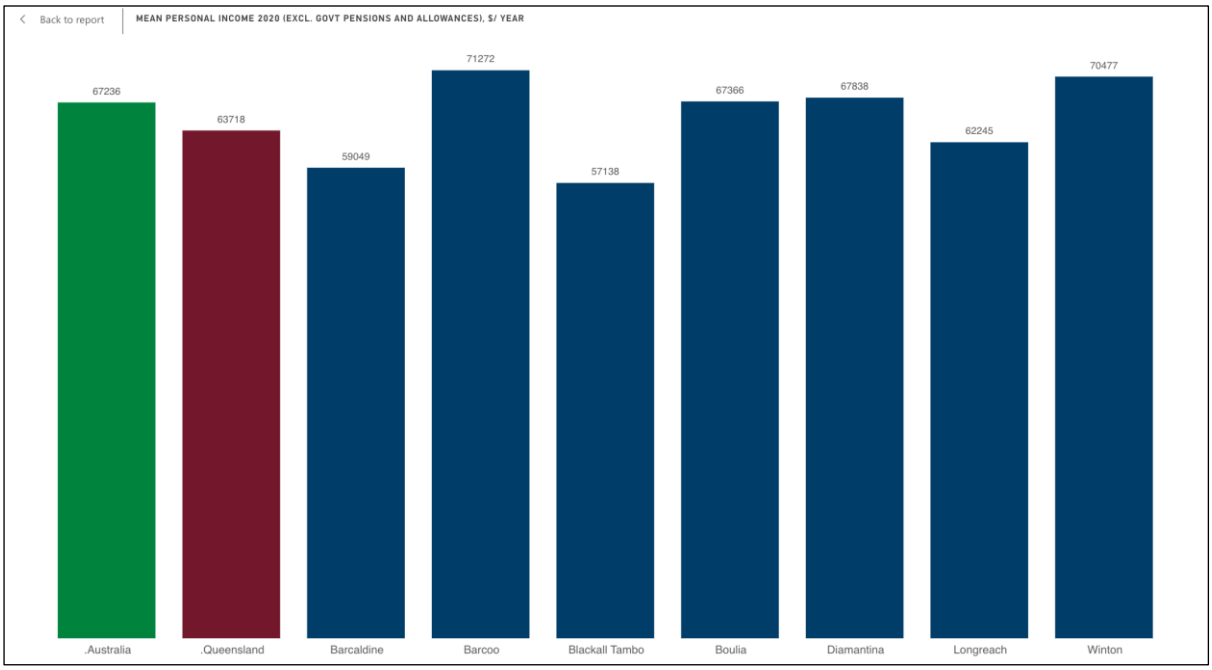


*Figure 77: Mean personal income in the Central west region, 2020 (excluding pensions and allowances)*

The region has experienced strong growth in median equivalized household income over the ten-year period between 2011 and 2021, with an annual average increase of 4.1%, while National and State growth rates in the same period are 3.4% and 3.1% respectively (Figure 78).

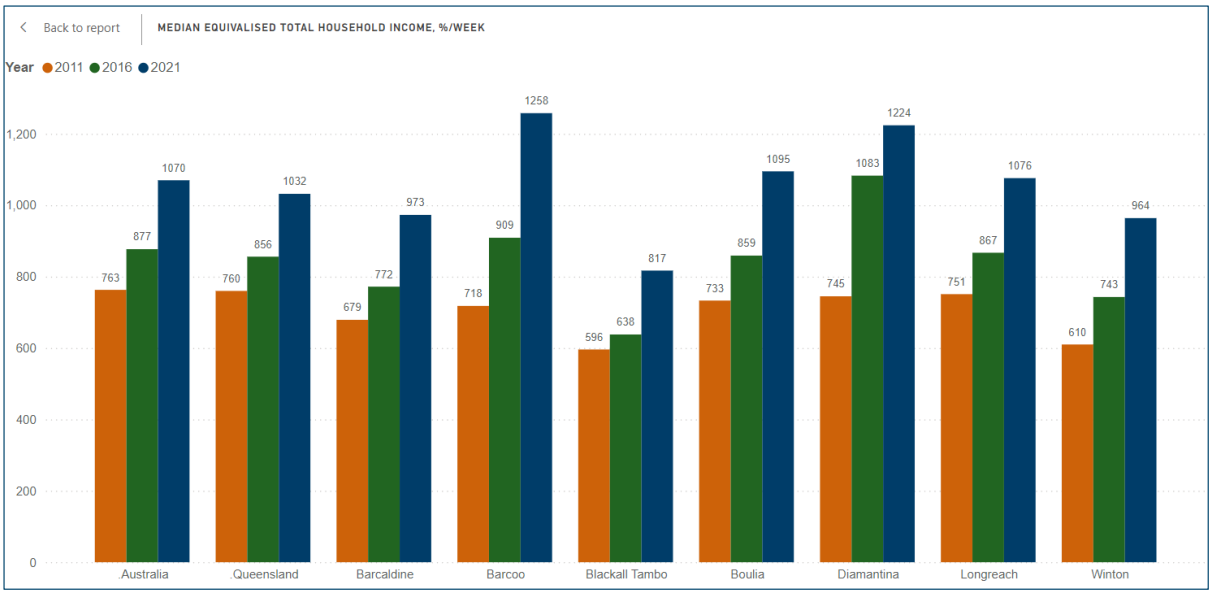


*Figure 78: Median equivalised total household income in Central West region, 2001-2021*

Total number of income earners in Central West region increased by 2.9% per year between 2016-2020, slightly higher than National (2.3%) and State (2.7%). Income earners rapidly increased in areas with small population such as Diamantina (12.3%), Boulia (11.7%) and Winton (8.2%), adding about 40%-60% to existing income earners in those areas in 4 years. In areas with larger population like Barcaldine (3.4%), Barcoo (3.1%), and Blackall-Tambo (2.2%), the growth rates are much lower. Longreach – the area with the largest population – had only a 0.3% growth rate.

*Table 14 Total income earners across the Central West region, 2016-2020*

| Region | # income earners 2016 | # income earners 2020 | Annual growth rate |
|---|---|---|---|
| Australia | 13,358,252 | 14,619,595 | 2.3% |
| Queensland | 2,623,526 | 2,921,819 | 2.7% |
| Barcaldine | 1,467 | 1,674 | 3.4% |
| Barcoo | 169 | 191 | 3.1% |
| Blackall-Tambo | 976 | 1,066 | 2.2% |
| Boulia | 138 | 215 | 11.7% |
| Diamantina | 112 | 178 | 12.3% |
| Longreach | 2,207 | 2,231 | 0.3% |
| Winton | 508 | 696 | 8.2% |

Figure 79 presents Gini coefficients in Central West. A lower Gini coefficient represents more equality in income. Compared with National and State levels, Boulia, Diamantina, and Longreach have higher income equality while Barcaldine, Barcoo, Blackall-Tambo, and Winton have lower income equality.

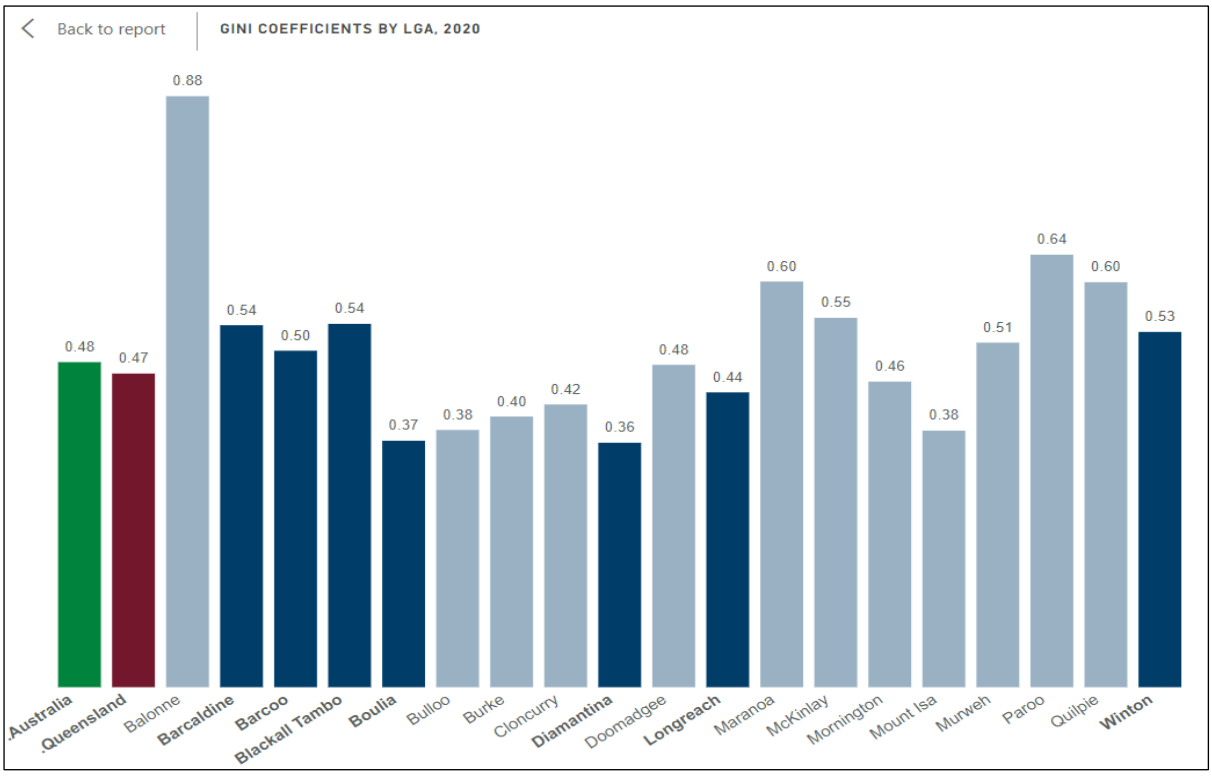


*Figure 79: Gini coefficients demonstrating income equity distribution in the Central West region*

Low-income households, defined as those with income in the lowest 40% of the population, make up 51.2% of the households in Blackall-Tambo, 43.4% in Barcaldine, 43.3% in Winton, 38.2% in Longreach, 36.6% in Boulia, 31.6% in Barcoo, and only 16.9% in Diamantina.

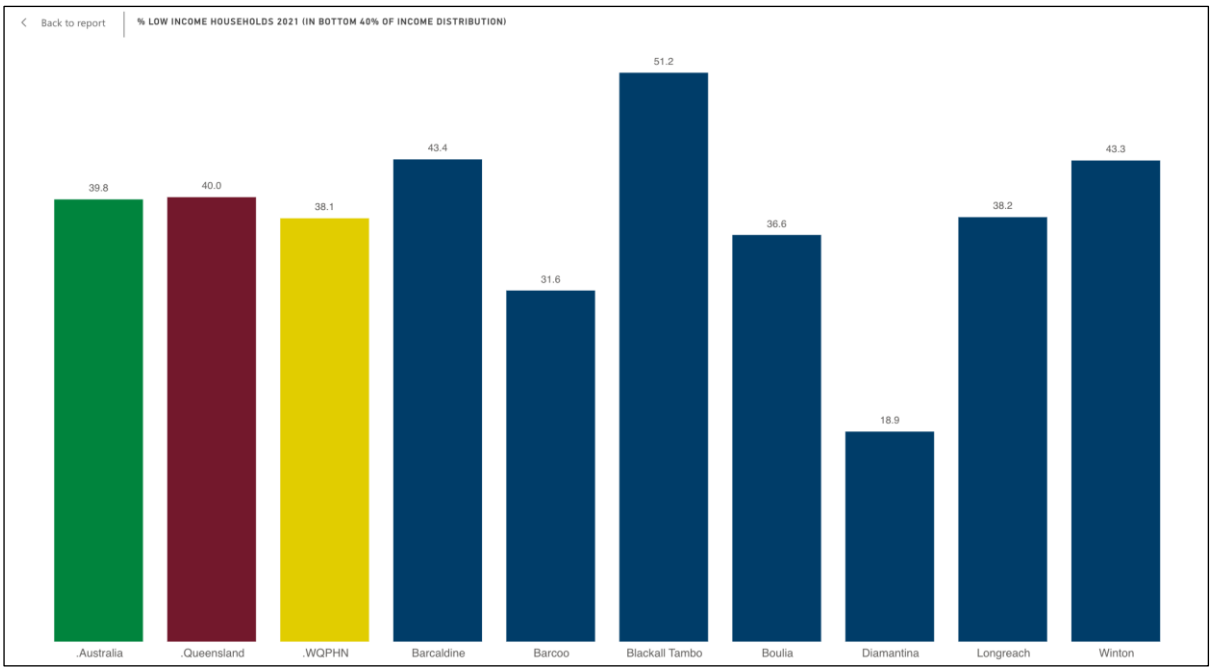


*Figure 80: Proportion of low income households in the Central West region, 2021*

In the Central West region, LGA-level rates of low income and welfare-dependent families with children are lower than National, State, and WQPHN average levels, except for Boulia which has a rate of 21.7%. There is no coincidence between this rate and the rate of low-income households across the region. However, the combination of these two rates can give hints about the structure of households/ families in each area. For example, more than half of the households in Blackall-Tambo are classified as low-income households, but

only 3.9% of its low-income and welfare-dependent families have children, suggesting that Blackall-Tambo has a demographic structure where single or couple families are a large proportion of the population.

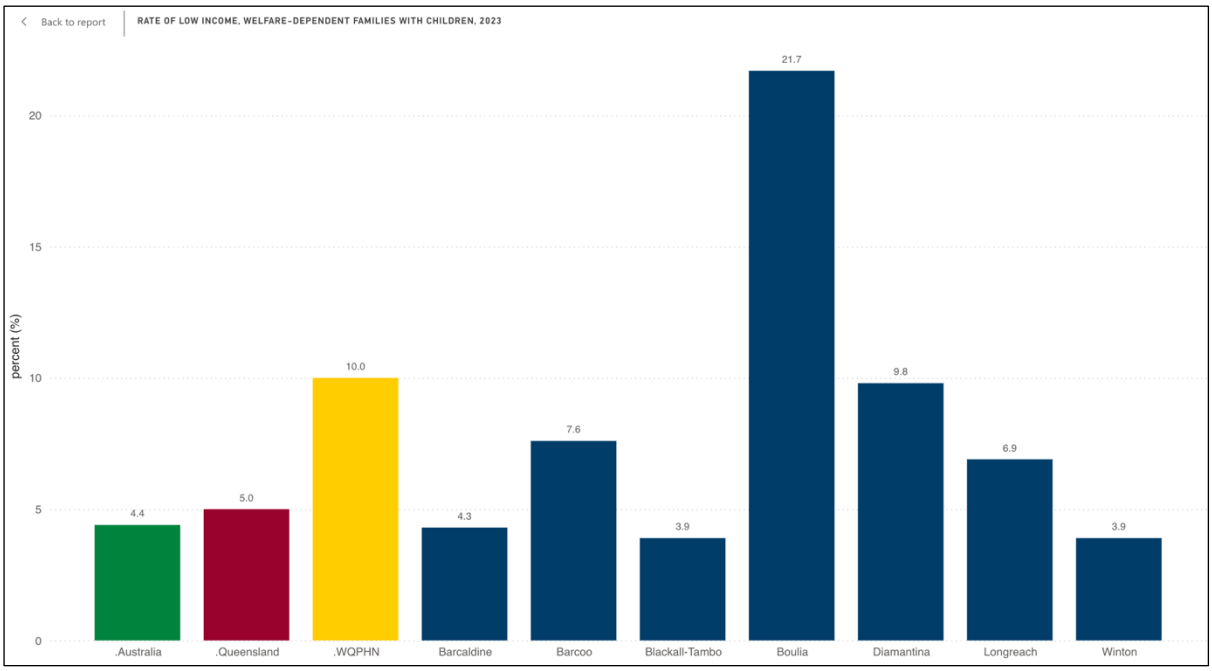


*Figure 81: Proportion of low income, welfare-dependent families with children across the Central West region*

### 4.2.2.3 Education

Participation rates in early education are high in Central West Queensland. In 2022, the proportion of children aged 4 or 5 years attending a preschool program was higher in all LGAs than it was in Western Queensland, Queensland, and Australia, except for Barcoo for which data is not available. The rates vary from 26.5% in Longreach to 58.2% in Blackall-Tambo.

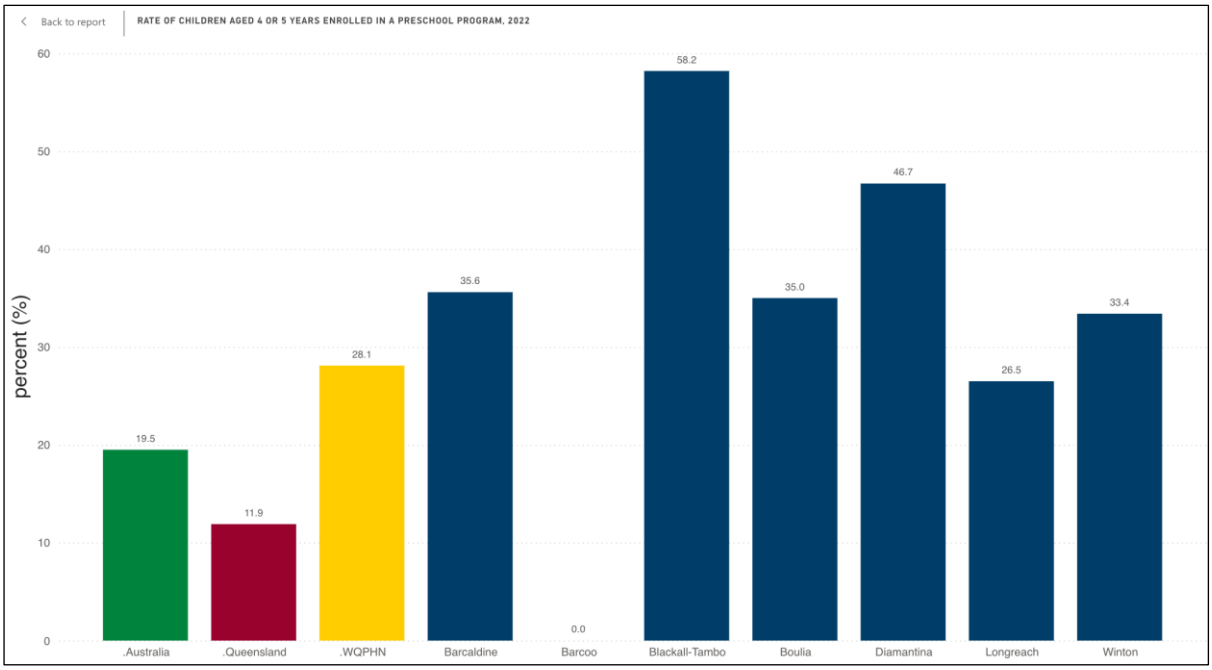


*Figure 82: Rate of children aged 4 or 5 years attending a pre-school program in the Central West region, 2022*

The proportions of students that left school at or below grade 10 or didn't to school in Central West's LGAs are all considerably higher than National (25.4%) and State (27.9%) levels, varying between 30-50%. Boulia

(48.5%), Barcoo (43.0%), and Blackall-Tambo (39.2%) have higher proportions than WQPHN (37.2%). There is no data available for proportions of students participating in higher education.

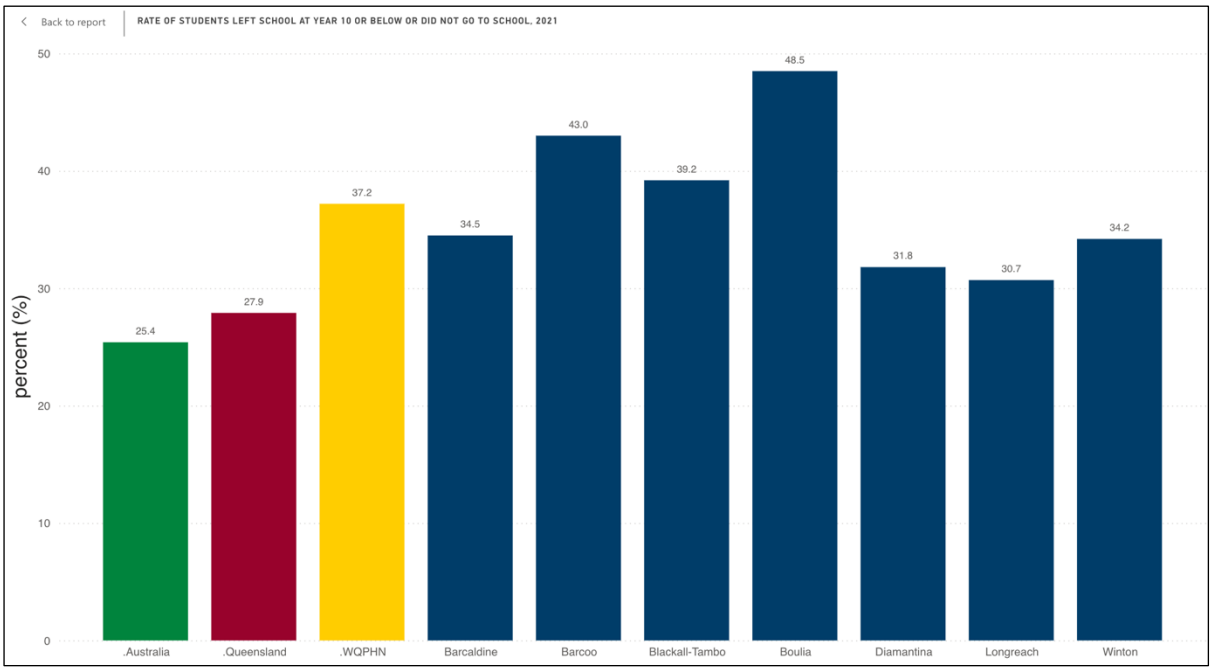


*Figure 83: Rate of students who left school at year 10 or below or did not go to school in the Central West region*

Table 15 below shows the availability of public schools across the Central West region.

*Table 15: Distribution of public schools across the Central West region*[17]

| | Barcaldine | Barcoo | Blackall-Tambo | Boulia | Diamantina | Longreach | Winton |
|---|---|---|---|---|---|---|---|
| Number and type of schools | 2 Primary<br>3 Combined | 3 Primary | 2 Combined | 2 Primary | 2 Primary | 3 Primary<br>1 High<br>1 Distance | 1 Combined |

The participation rates in vocational education and training in Central West's LGAs vary between 20-30% and are all above the National level (16.7%) and State level (18.3%). Winton (29.5%) and Boulia (27.3%) are the only LGAs with higher participation rates than WQPHN (24.6%).

In Boulia and Diamantina (both 11%), the participation rates in vocational education and training in the Aboriginal and Torres Strait Islander population are much lower than those in the entire population (27.3% and 24.3% respectively). In Barcaldine, Blackall-Tambo, and Longreach, the Aboriginal and Torres Strait Islander participation is only marginally lower than for the entire population. Barcoo has high rates of participation in the Aboriginal and Torres Strait Islander population (43.3%) than in the entire population (24.4%).

[17] *Source: Queensland Government, 2024*

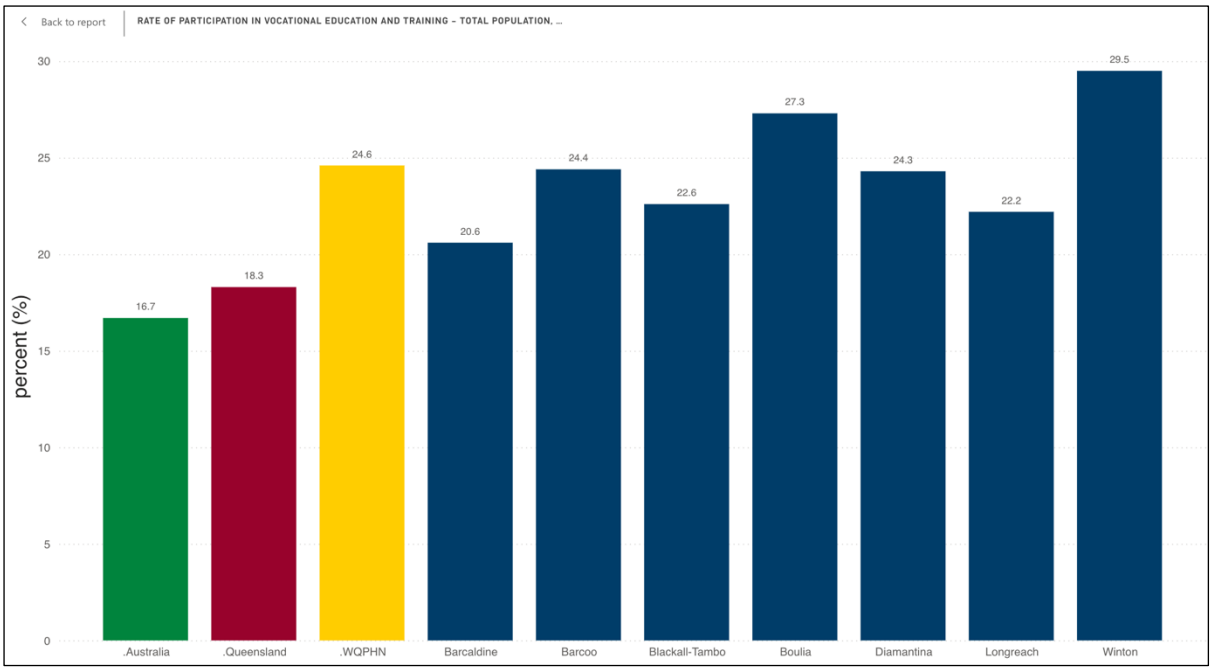


*Figure 84: Rate of participation in vocational education and training in the Central West region, 2022*

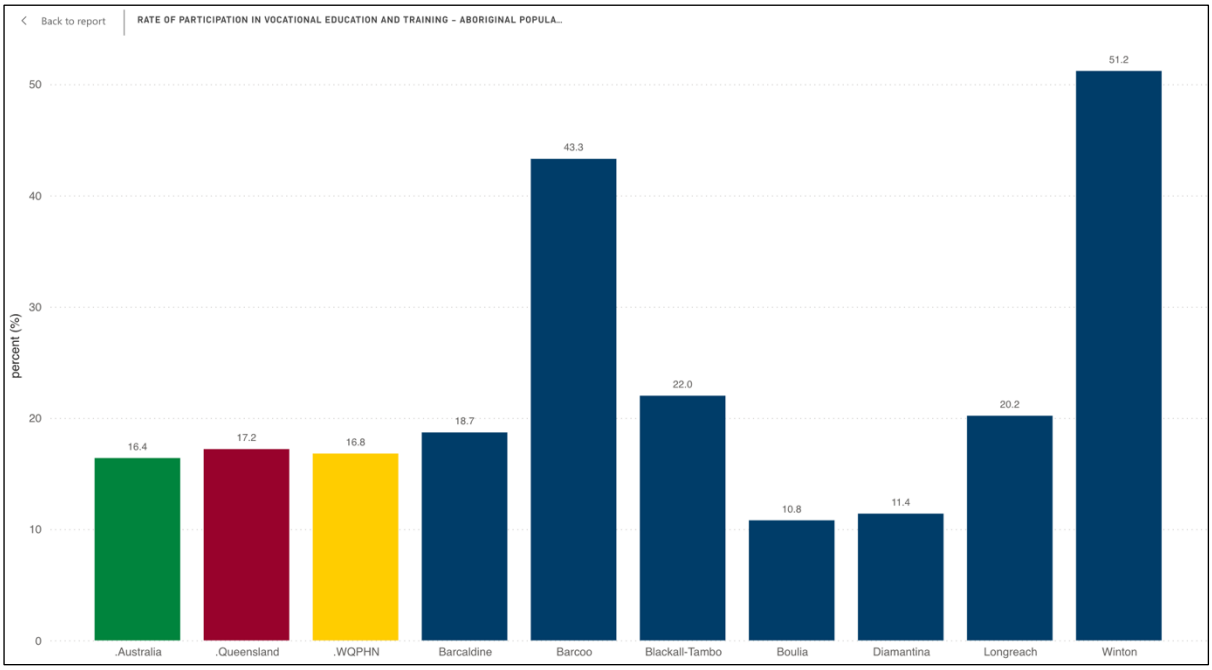


*Figure 85: Rate of participation in vocational education and training in the Central West region - Aboriginal and Torres Strait Islander population*

#### 4.2.2.4 Employment

In 2023, about 67% of the working-age population (aged 15 years and over) in Central West Queensland participated in the labour force. There was very little variance in labour force participation between LGAs (the highest was 67.5% while the lowest was 67.0%). Barcaldine, Longreach, and Winton saw in increase participation between 2021 and 2023, while Diamantina and Barcoo observed a decrease.

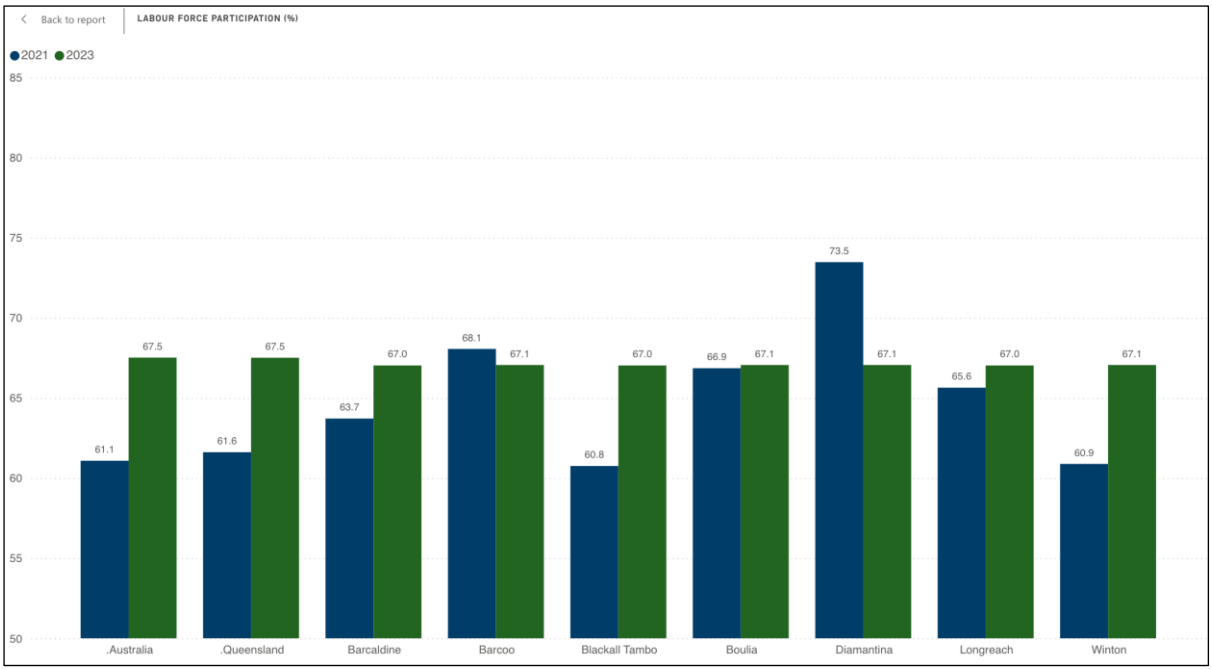


*Figure 86: Labour force participation across Central West Queensland, 2021 – 2023*

For those participating in the labour force, the unemployment rate is 4.1% in Barcoo, Boulia, Diamantina, and Winton – slightly lower than in Western Queensland (4.8%), but higher than Queensland (3.7%) and Australia (3.5%). In Barcaldine, Blackall Tembo, and Longreach, the unemployment rate was 2.1%, which was significantly lower than the National, State, and WQPHN rate.

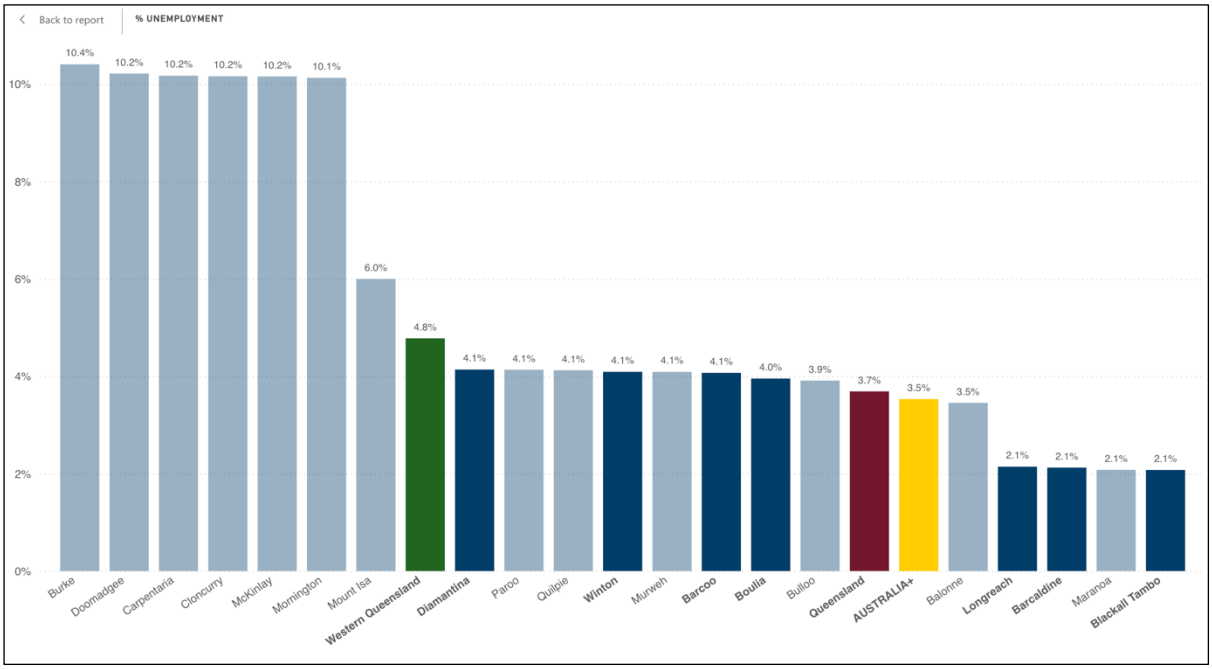


*Figure 87: Unemployment rate in Central West region, 2003 (%)*

Figure 88 shows the rate of people aged 15-24 who are learning or earning. Barcaldine (85.7%) is the only LGA with a rate higher than Australia (85.4%), Queensland (83.7%), and WQPHN (72.5%). Barcoo (65.1%) is the only LGA with a learning or earning rate lower than WQPHN (72.5%). All other LGA's have rates lower than Australia and Queensland, but higher than WQPHN.

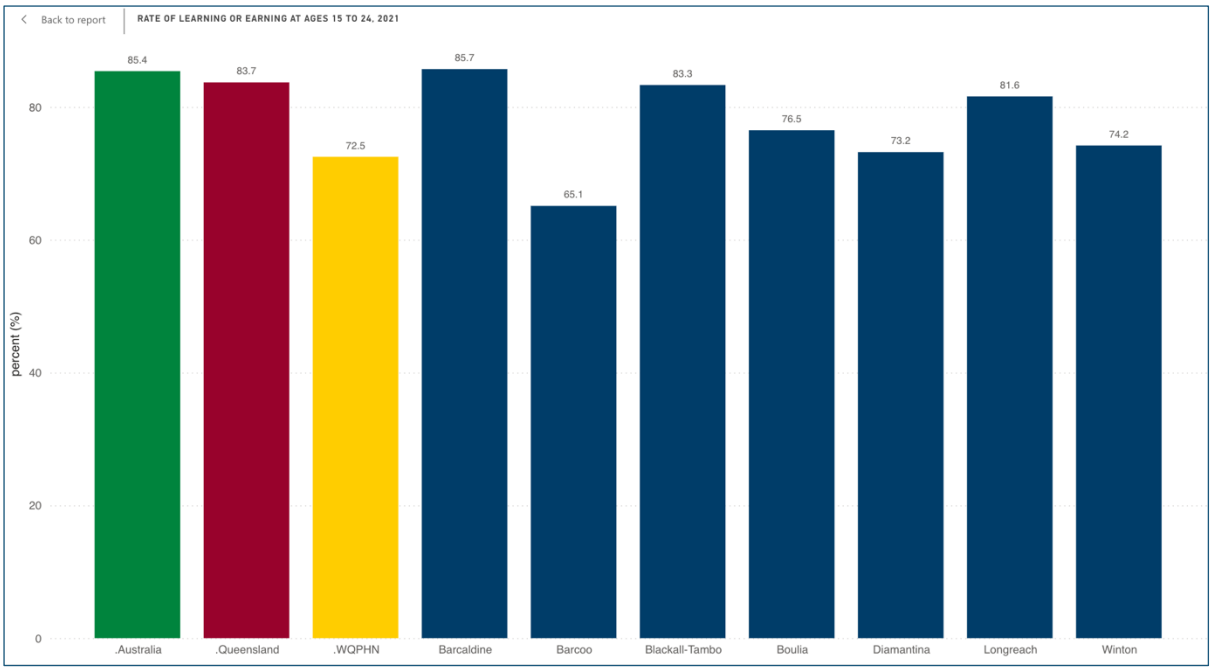


*Figure 88: Rates of learning or earning at ages 15 to 24 in the Central West region, 2021*

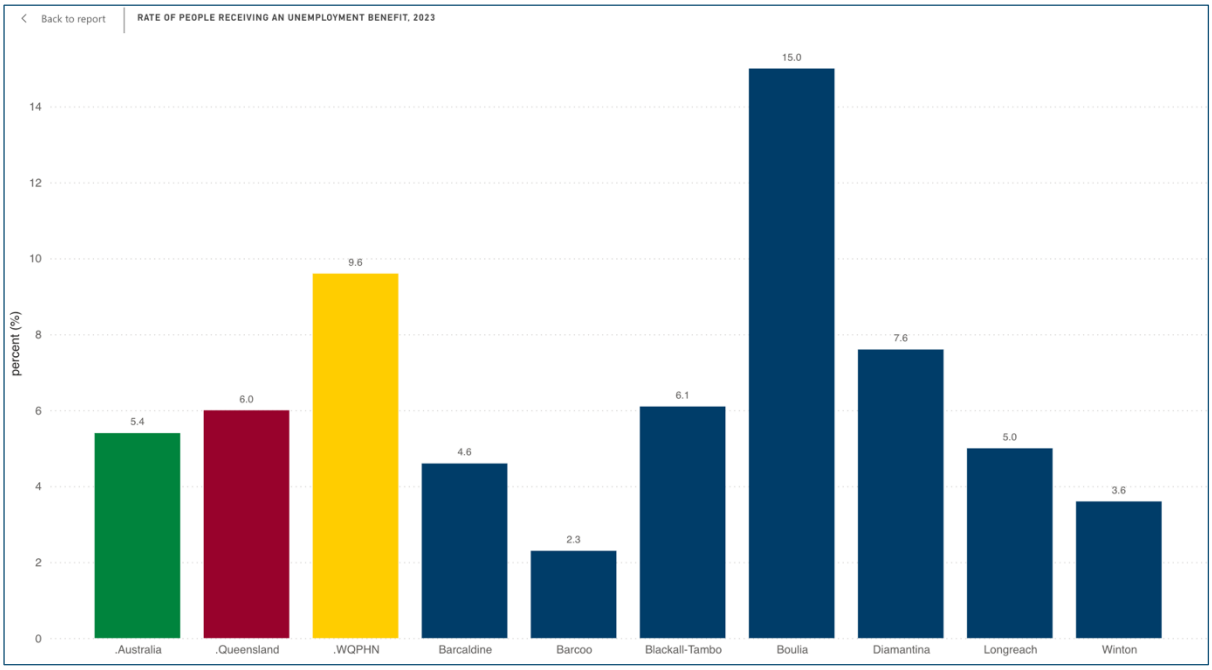


*Figure 89: Rate of people receiving an unemployment benefit in the Central West region, 2023*

### 4.2.2.5 Housing

In Central West Queensland, all LGAs have rates of people living in crowded dwellings lower than the WQPHN average level. Boulia (16.9%), Diamantina (12.8%), and Barcoo (11.6%) are the only LGAs with a proportion higher than that of WQPHN (9%). Other LGAs have extremely low rates, with Barcaldine at 2%, Blackall-Tambo at 3.9%, Longreach at 2.5%, and Winton at 2.8%.

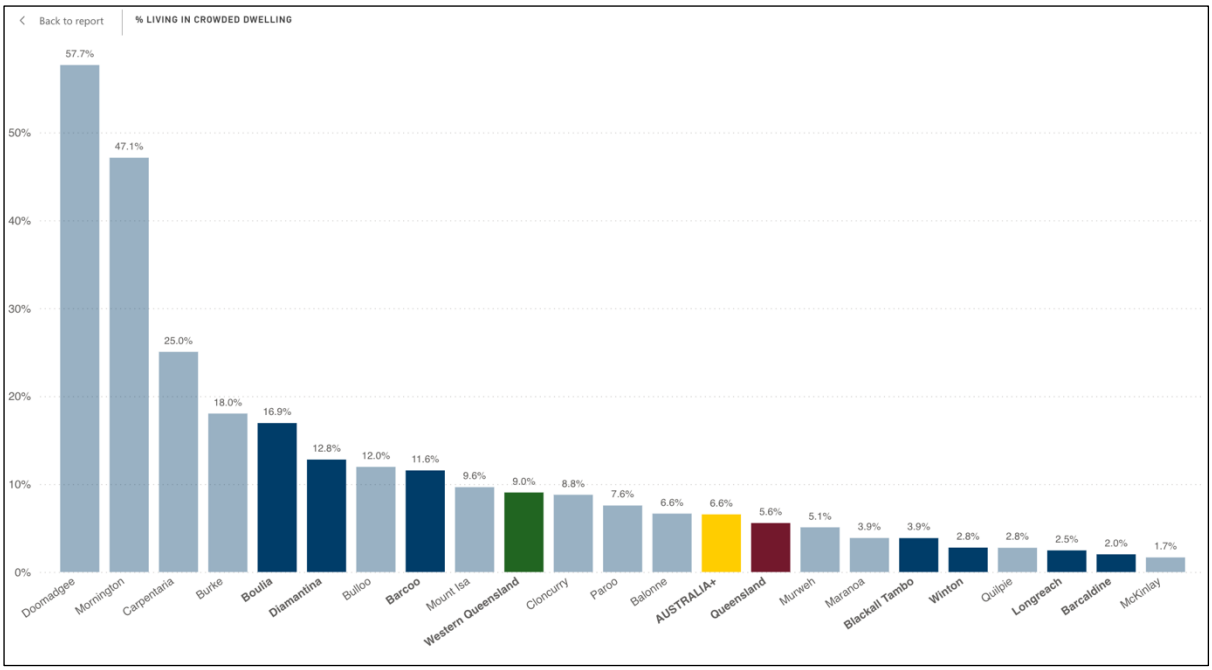


*Figure 90: Proportion of people living in crowded dwellings in the Central West region*

When comparing the Aboriginal and Torres Strait Islander population to the total population for the metric above, Blackall-Tambo (3.3%) is the only area that had lower rate of Aboriginal and Torres Strait Islander residents living in crowded dwellings compared to the general rate of 3.9%. In other areas, where data are available, the proportions of Aboriginal and Torres Strait Islander residents living in crowded dwellings are higher than those of the total population, though the discrepancy between these values is much larger for WQPHN than it is for these LGAs.

Data of severely crowded dwellings is not available for this region.

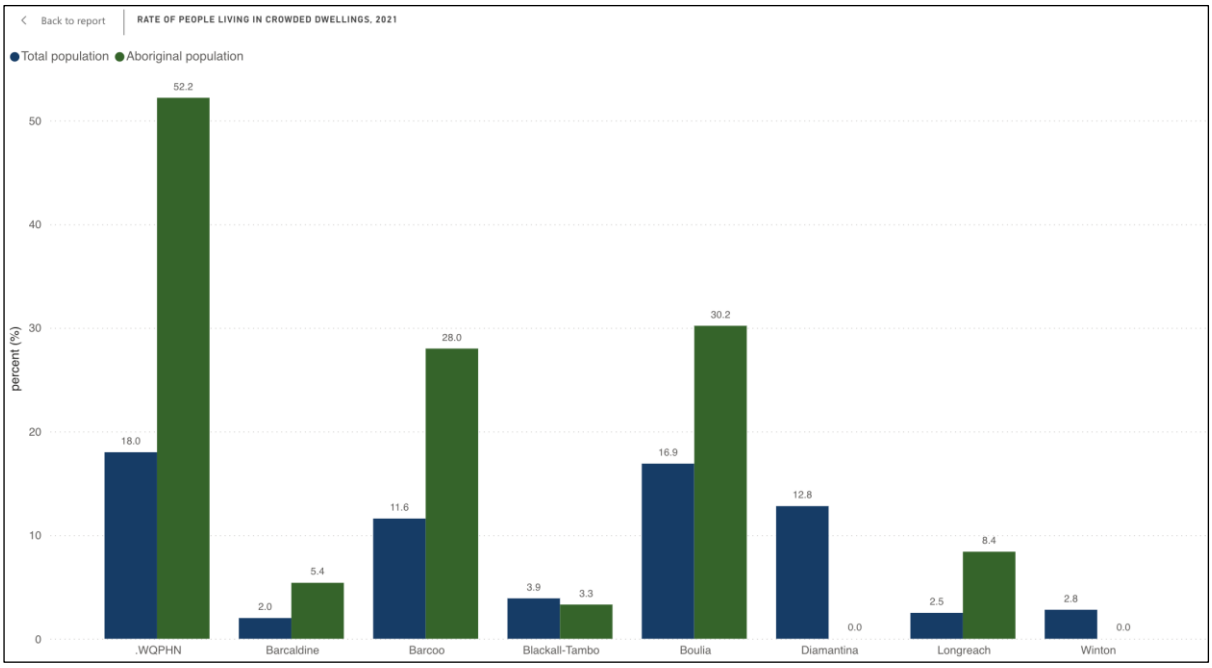


*Figure 91: Proportion of Aboriginal and Torres Strait Islander peoples living in severely crowded dwellings compared with the total population in Central West region*

Boulia (16.9%) is the LGA with the highest proportion of the population living in social houses – approximately 1.5x higher than the WQPHN level (10.2%) and 6x higher than National (2.8%) and State (2.5%) levels. Diamantina (8.8%) had a slightly lower proportion than WQPHN but was still almost 3x higher than National

and State levels. Other LGAs, including Barcaldine, Barcoo, Blackall-Tambo, Longreach, and Winton, have relatively low rates, ranging from 3.2% to 4.9%.

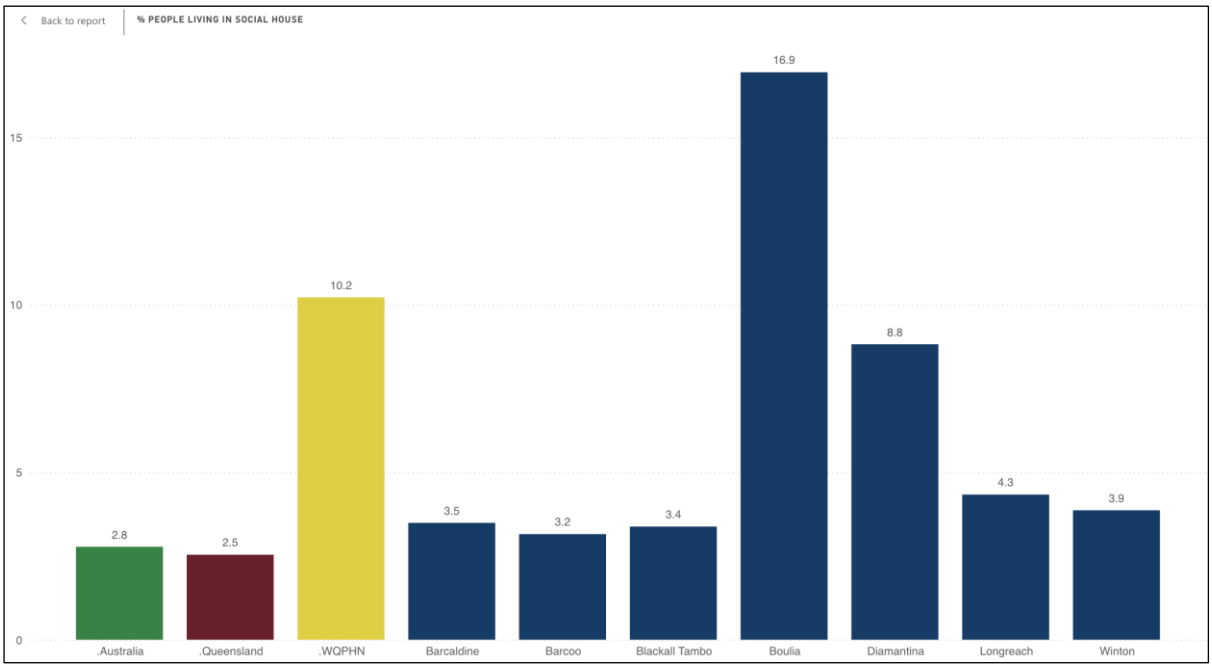


*Figure 92: Proportion of people living in social houses across the Central West region*

#### 4.2.2.6 Developmental vulnerability

Data regarding assessed developmental vulnerabilities in the Central West region is partially available for Barcaldine, Blackall-Tambo, Longreach, and Winton.

Children in Blackall-Tambo are associated with more developmental vulnerabilities, with 33.3% vulnerable on one or more domains, 26.7% in physical health, 20% in physical readiness to school day, and 20% in languages and cognitive skills.

Longreach's assessment rates are lower than Blackall-Tambo, and approximate to WQPHN rates.

Barcaldine had the lowest rates among the four LGAs in emotional maturity domain (5.7%), language and cognitive (2.9%), and communication skills and general knowledge (2.9%), while Winton had the lowest rates in physical health (6.3%) and physical readiness for school day (6.3%). Winton also had the lowest rates in general for children vulnerable on one or more domains (13.3%) or on two or more domains (6.3%).

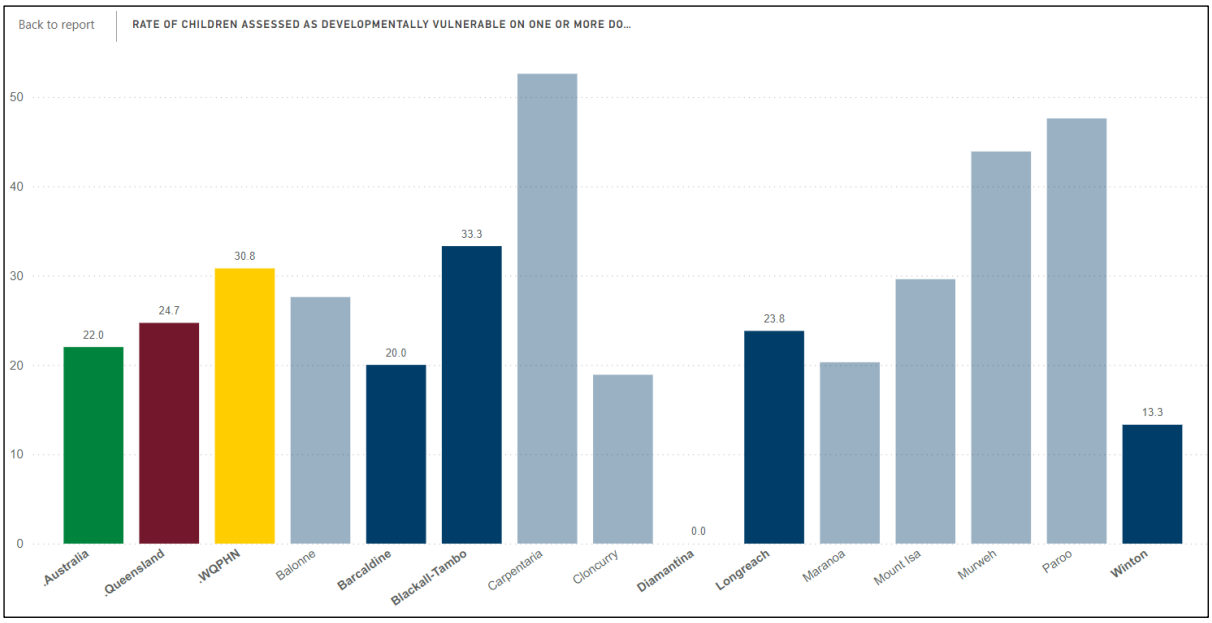


*Figure 93: Rate of children assessed as developmentally vulnerable on one or more domains in the Central West region*

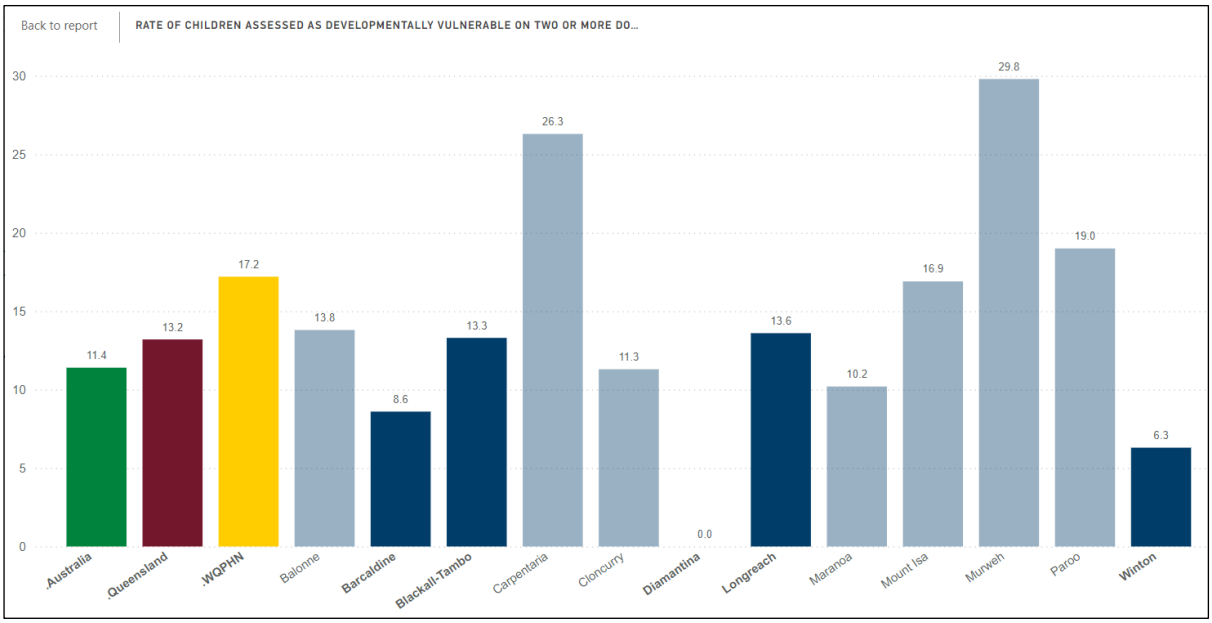


*Figure 94: Rate of children assessed as developmentally vulnerable on one or more domains in the Central West region*

*Table 16: Rate of children assessed as developmentally vulnerable against each domain in the Central West region*

| Developmental Domains | | Barcaldine | Blackall-Tambo | Longreach | Winton | Queensland |
|---|---|---|---|---|---|---|
| Physical health and wellbeing | Vulnerable | 14.3% | 26.7% | 11.4% | 6.3% | 11.6% |
| | At risk | 0% | 6.7% | 9.1% | 6.3% | 11.9% |
| Social competence | Vulnerable | 8.6% | 0% | 9.1% | 0% | 10.6% |
| | At risk | 11.4% | 13.3% | 20.5% | 6.3% | 15.4% |
| Emotional maturity | Vulnerable | 5.7% | 0% | 9.5% | 0% | 10% |
| | At risk | 8.6% | 13.3% | 26.2% | 6.7% | 15.9% |
| Language and cognitive skills | Vulnerable | 2.9% | 20% | 9.1% | 12.5% | 8.4% |
| | At risk | 11.4% | 13.3% | 18.2% | 37.5% | 10.9% |
| Communication skills and general knowledge | Vulnerable | 2.9% | 0% | 11.4% | 6.3% | 9.1% |
| | At risk | 2.9% | 6.7% | 13.6% | 0% | 14.8% |

## 4.2.3 Lifestyle factors

### 4.2.3.1 Self-assessed health

Data on self-assessed health in Central West Queensland is available for Barcaldine, Blackall-Tambo, and Longreach.

In Barcaldine and Blackall-Tambo, 24% and 26% of adults indicated they have fair or poor health, in comparison with 17% in Queensland and also 17% in WQPHN. Longreach (16%) had similar results as Queensland and WQPHN.

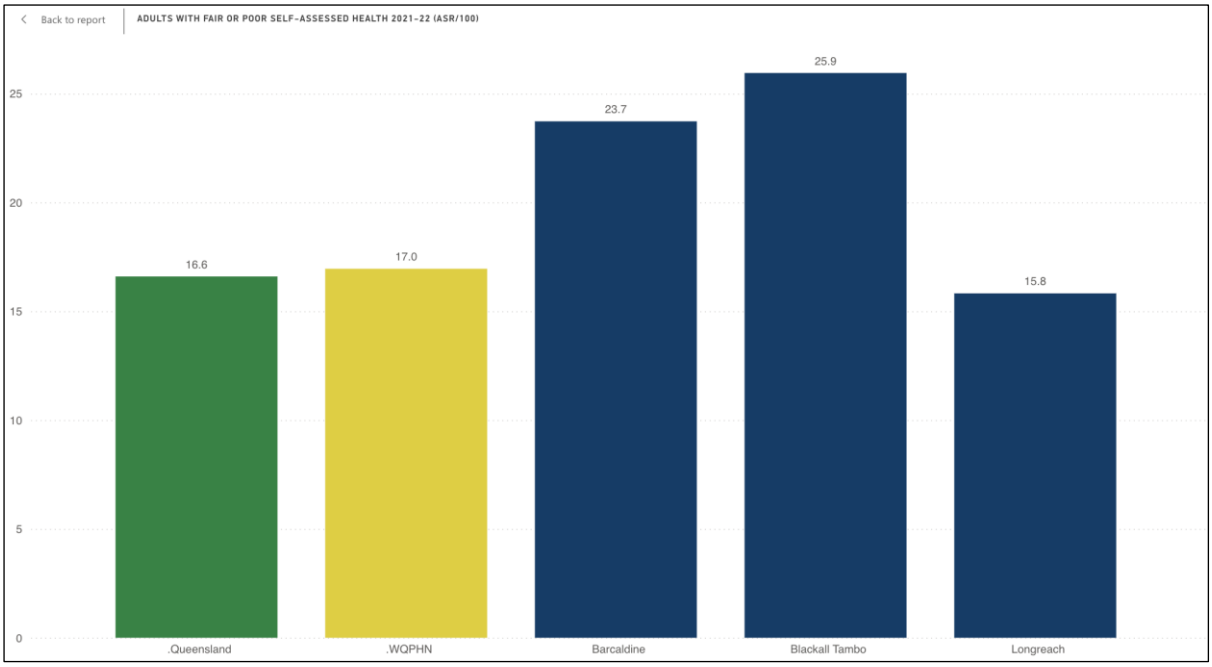


*Figure 95: Proportion of adults with fair or poor self-assessed health in the Central West region, 2021-2022*

The self-assessed total number of unhealthy days in the past 30 days in Barcaldine (9.0 days) and Blackall-Tambo (9.3 days) was the same as in Queensland (9.0 days), but much higher than in WQPHN (7.2 days). Longreach (7.5 days) was the LGA with the lowest number of unhealthy days (of the LGAs with data). Barcaldine and Longreach observed a similar pattern to Queensland and WQPHN where 'mental health unhealthy days' was greater than 'physical unhealthy days', which was greater than 'limited usual activities

days'. Blackall-Tambo did not reflect this pattern in its data, with 'physical unhealthy days' greater than 'mental health unhealthy days'.

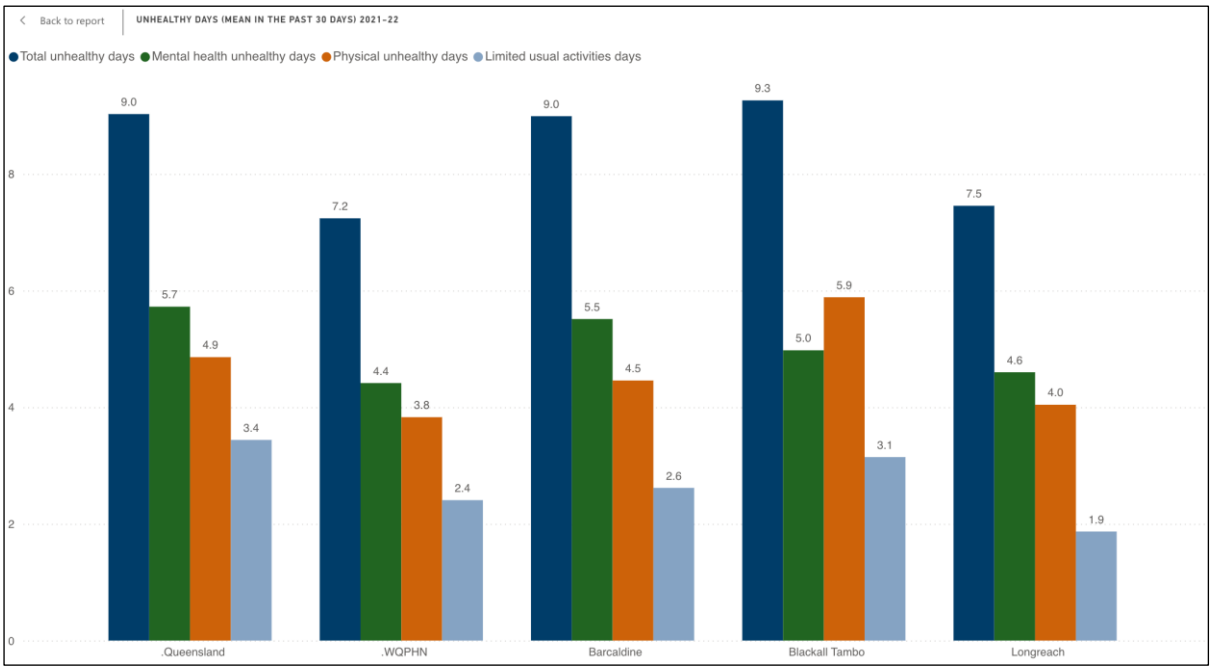


*Figure 96: Number of unhealthy days in Central West region, 2021-2022*

### 4.2.3.2 Overweight and obesity

Central West Queensland has a significantly higher obesity rate (52.1%) compared to the State average (45.4%), with 60.9% of the population classified as overweight or obese (vs 58.7% in Queensland). Excess weight is linked to chronic diseases like diabetes and heart disease, and during pregnancy, it increases the risk of complications such as gestational diabetes and hypertension. Weight management programs and healthy lifestyle promotion are crucial to addressing these concerns.

Rates of adults who are overweight (but not obese) in Barcaldine and Black Tambo are lower than are in WQPHN and Queensland, while those rates in Longreach are higher.

In Barcaldine, 28.4% of adults are overweight, and in Blackall-Tambo, 31.8% of adults are overweight. In Barcaldine, there is little difference between the rates of males and females who are overweight. There is no data split by gender for Blackall-Tambo. In Longreach, 39% adults are overweight, with 46.4% of females and 31.6% of males overweight. This trend, with female overweight rates higher than male's, is reflected in Queensland and WQPHN.

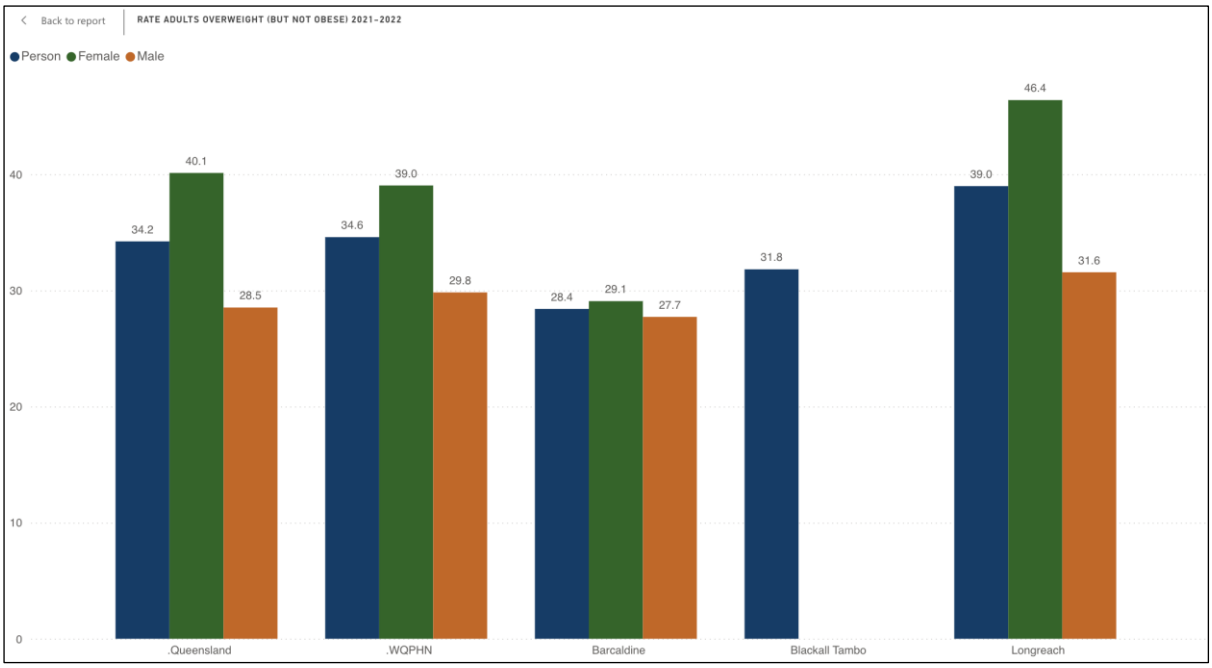


*Figure 97: Proportion of adults overweight (but not obese) in the Central West region, 2021-2022*

Barcaldine (34.5%) and Longreach (31.7%) have lower obesity rates than WQPHN (35.2%), but higher obesity rates than Queensland (27.2%). Blackall-Tambo (41.5%) has significantly higher obesity rates than WQPHN. In Queensland, WQPHN, and Longreach, females have lower obesity rates than males. However, in Barcaldine, this trend is reversed.

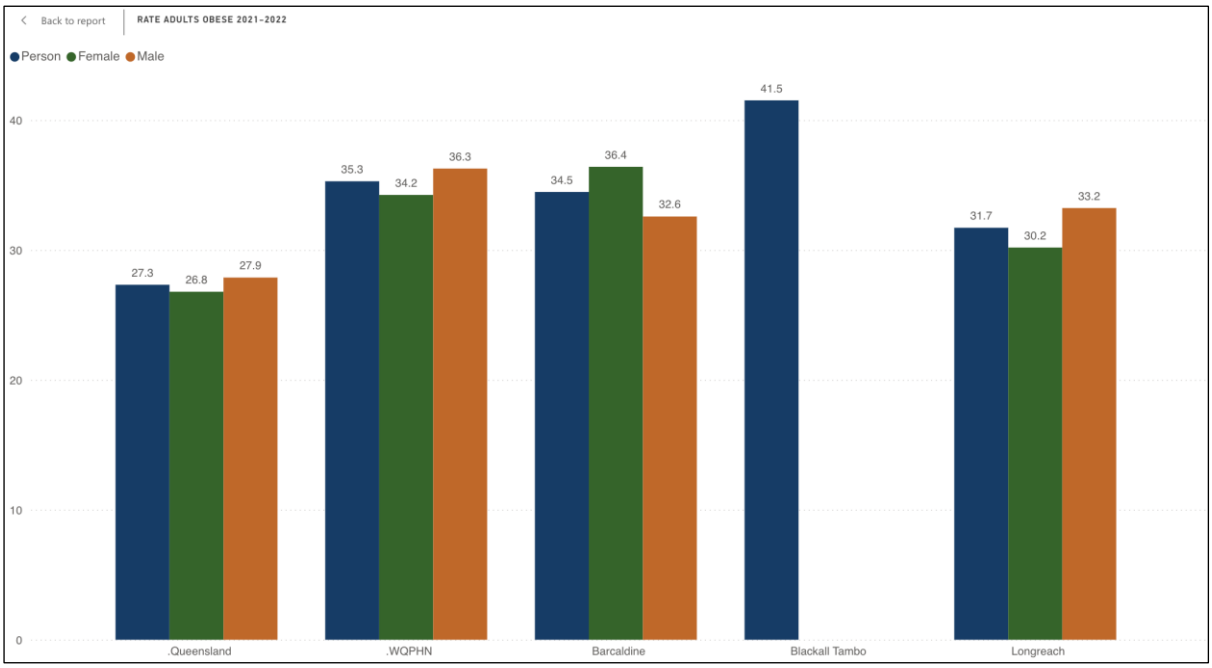


*Figure 98: Proportion of adults with obesity in the Central West region, 2021-2022*

The rate of people overweight or obese in the Western Queensland PHN region has consistently increased since 2009/10 through to 2021/22 and has remained consistently higher than the State rate (Figure 99).

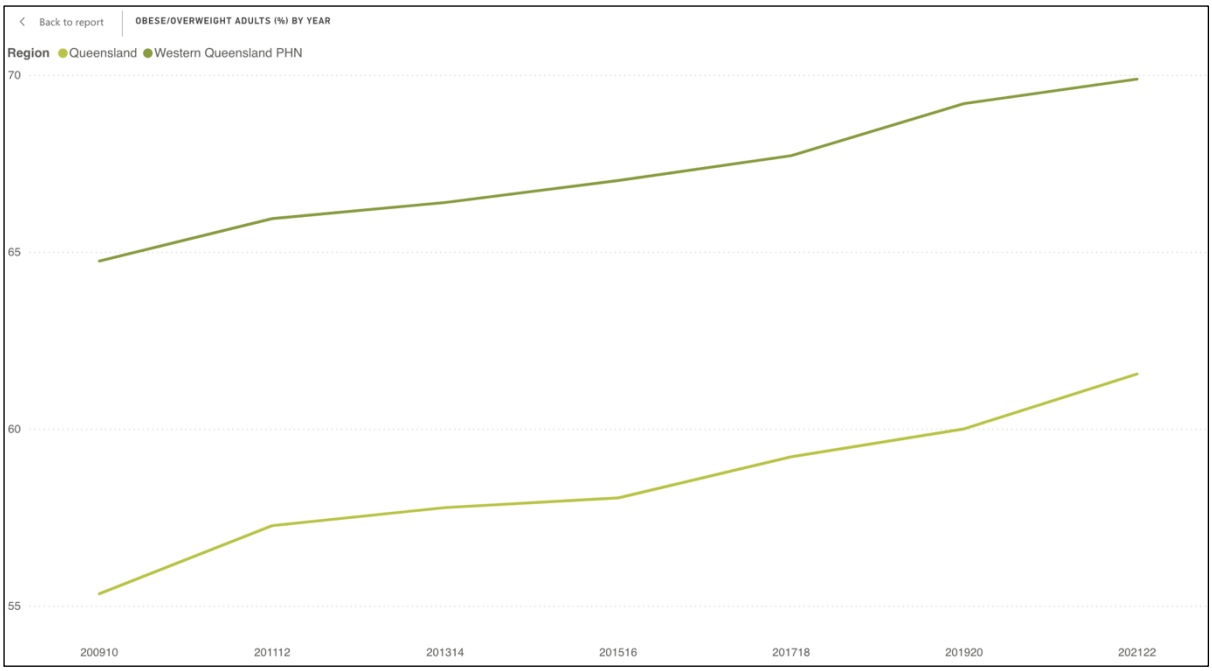


*Figure 99: The rate of adults overweight or obese across the Western Queensland region over time, compared to the Queensland rate*

#### 4.2.3.3 Diet and physical activity

Data on fruit intake in the Central West region is available for Barcaldine, Blackall-Tambo and Longreach only. Data on vegetable intake is available for Longreach only.

All three areas with data available have rates of adults consuming adequate fruit intake similar to the broader Western Queensland levels (49.4%), slightly below Queensland levels (53.5). For Barcaldine, 50.4% of adults consume adequate fruit, with rates higher for males (56.6%). For Longreach, 49.8%% of adults consume adequate fruit, with rates markedly lower for males (33.0%). For Blackall-Tambo, 45.4% of adults consume adequate fruit. (Figure 100).

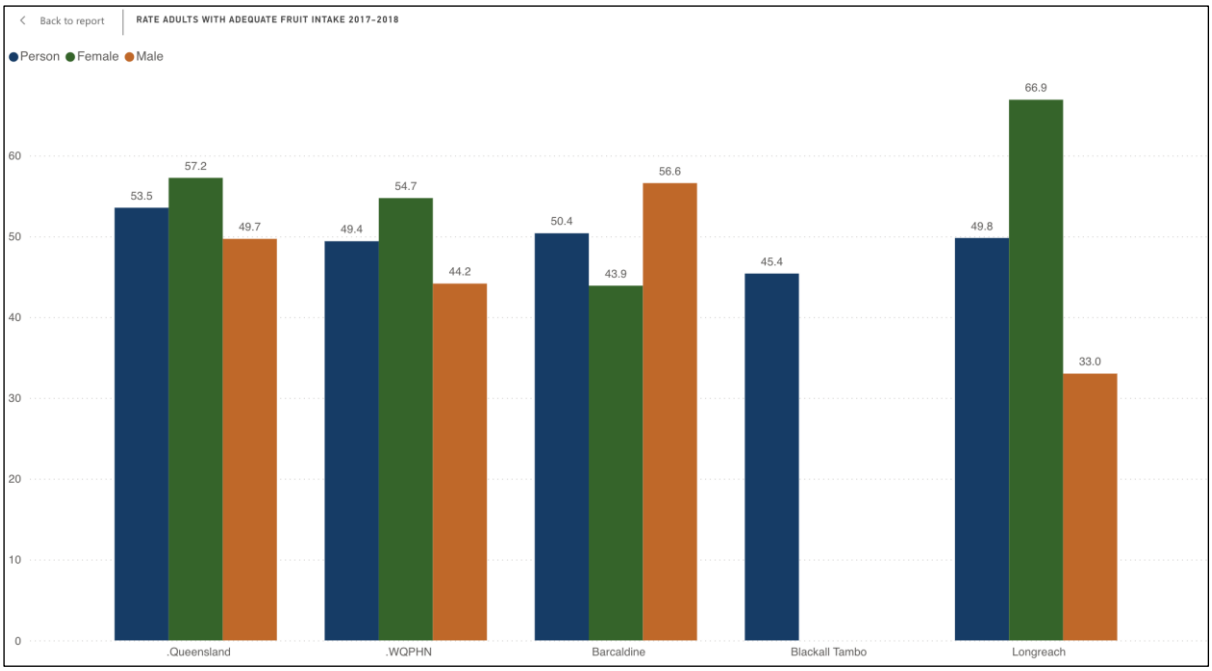


*Figure 100: Proportion of adults with adequate fruit intake in the Central West region, 2021-2022*

In general, the rate of adults with adequate vegetable consumption is much lower than that for fruit consumption. The rate of adults consuming adequate vegetables in Longreach is 9.4%, which is higher than both the regional (6.9%) and State (8.7%) average.

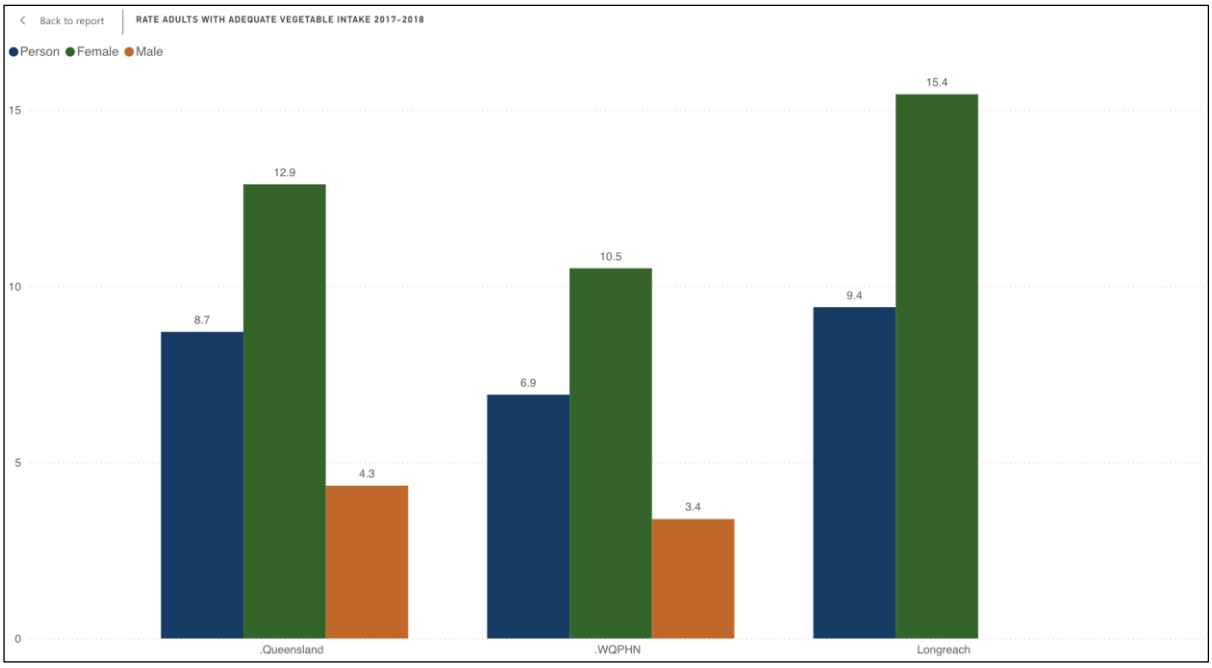


*Figure 101: Proportion of adults with adequate vegetable intake in the Central West region, 2021-2022*

Rates of physical inactivity in the Central West region (46.2%) are higher than the State average (40.0%). Rates of physical inactivity in Barcaldine are the highest in the region at 43.0%, with 35.9% of adults inactive in both Blackall-Tambo and Longreach. Data is not available for the other areas.

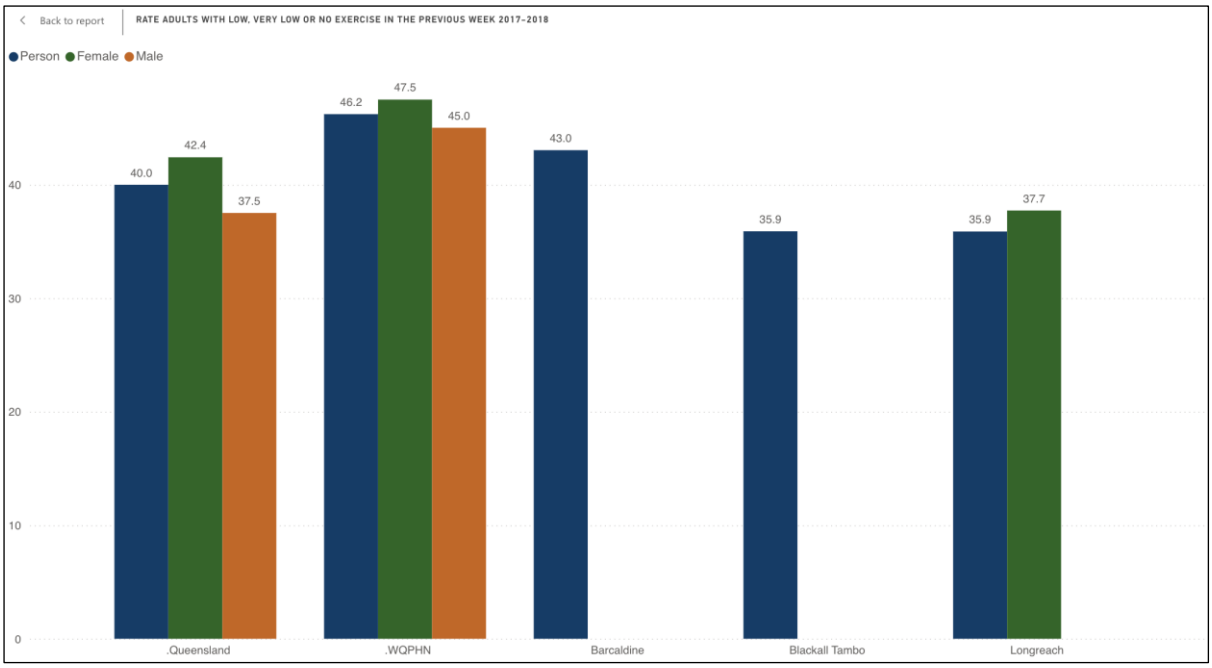


*Figure 102: Proportion of adults with low, very low or no exercise in the Central West region, 2021-2022*

### 4.2.3.4 Smoking

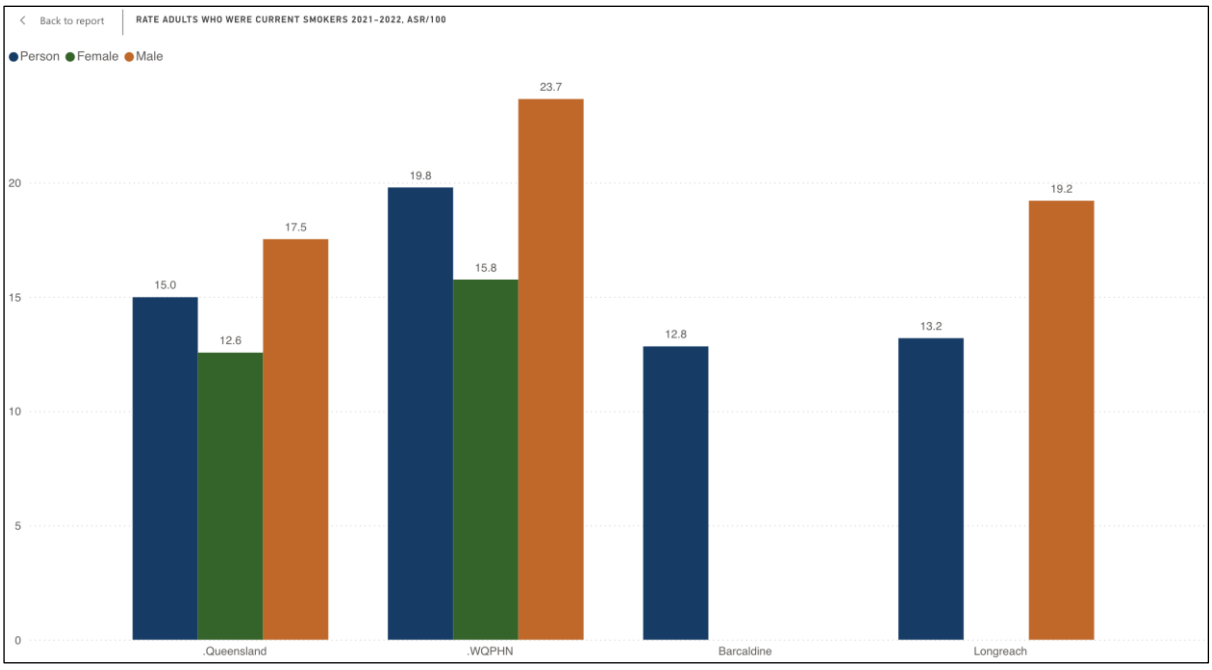


*Figure 103: Proportion of adults smoking in the Central West region, 2021-2022*

Adult smoking rates in the Central West region seem to be lower than the broader Western Queensland rate (19.8%) and the State rate (15.0%). 12.8% of adults reporting smoking in Barcaldine, and 13.2% in Longreach. Data is not available for the other regions.

#### 4.2.3.5 Alcohol consumption

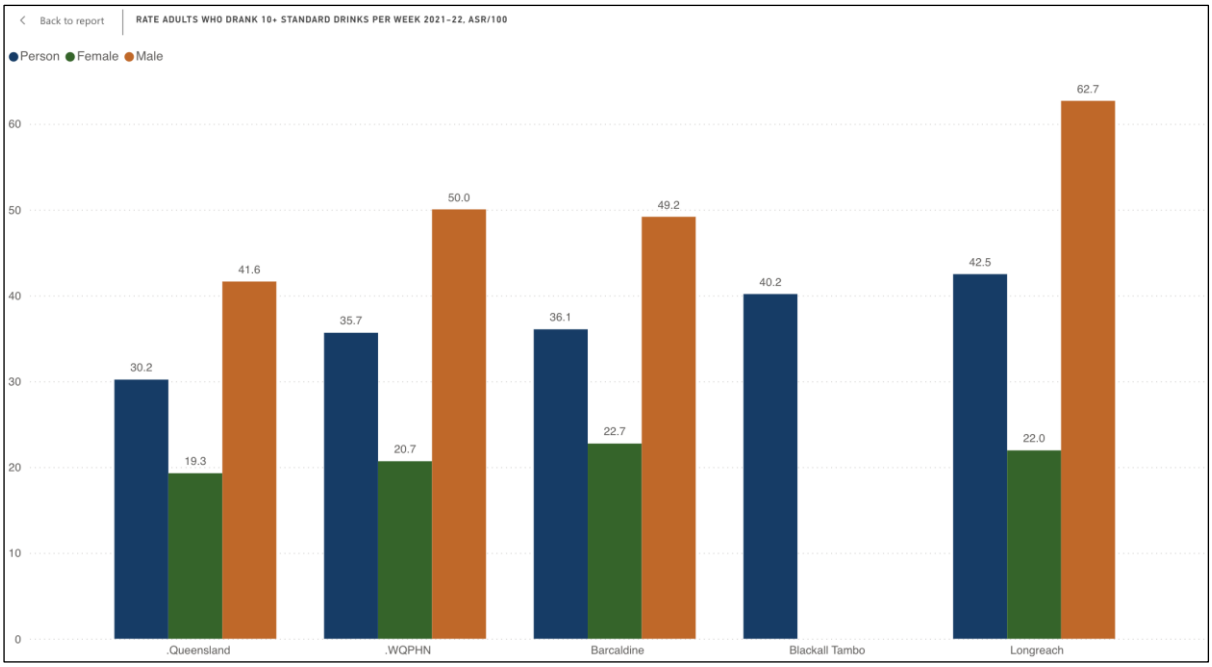


*Figure 104: Proportion of adults who drank 10 or more standard drinks per week in Central West, 2021-2022*

In Central West Queensland, the rates of lifetime risky drinking (30.3%) and single-occasion risky drinking (34.9%) are slightly below the Queensland averages (31.4% and 35.6%, respectively). While these figures are promising, a substantial portion of the population still engages in risky drinking, which can negatively impact maternal and infant health. Continued efforts to reduce alcohol consumption are needed.

For the LGAs with data available, rates of adults who have ten or more standard drinks per week are all higher than the rates in WQPHN (35.7%) and Queensland (30.2%), with rates consistently higher for males. In Longreach, 42.5% of adults reported drinking 10+ standard drinks per week, with rates slightly lower in Blackall-Tambo(40.2%) and Barcaldine (36.1%).

## 4.2.4 Screening

### 4.2.4.1 Cancer Screening

Cancer screening efforts in the Central West region, although not detailed here, remain a key component of preventive health, focusing on early detection to improve treatment outcomes. Breast, cervical, and bowel cancer screening programs are essential in detecting cases early and reducing cancer-related mortality rates.

### 4.2.4.2 Screening for chronic conditions

82.2% of regular GP patients diagnosed with Type 2 diabetes have HbA1c tested in the past 12 months

There is a low number of regular patients having screening for chronic conditions in the Central West region. Only 62.8% of regular GP patients aged 45-74 years old (or 35-74 years for Aboriginal and Torres Strait Islander peoples) have CVD risk assessment. The percentage is lower amongst Aboriginal and Torres Strait Islander people (55.9%) compared to non-Indigenous (63.7%)[18].

### 4.2.4.3 Sexual health screening

There is an increase in the number of sexually transmitted infections (STI) in the region, indicating the increasing uptake of sexual health screening. During 2019-2023 period, the number of STI notifications

[18] WQPHN, GP data, June 2024 submission

increased significantly from 40 cases to 77 cases[19]. Chlamydia is still the major concern of the region (84.4% of total cases).

### 4.2.5 Vaccine-preventable conditions

#### 4.2.5.1 Immunisations

Immunisation rates for Aboriginal and Torres Strait Islander children within Central West Queensland are significantly lower than those of non-Indigenous children. This gap increases the vulnerability of Aboriginal and Torres Strait Islander children to vaccine-preventable diseases, placing them at higher risk of hospitalisation. In 2023/24, there were 20 potentially preventable hospitalisations (PPH) related to vaccine-preventable diseases, with 16 attributed to pneumonia and influenza. These cases accounted for 132 PPH bed days, underscoring the need to improve immunisation coverage, particularly among Aboriginal and Torres Strait Islander populations. Closing this gap is crucial to reducing preventable illnesses and alleviating the strain on healthcare resources.

#### 4.2.5.2 Vaccine-preventable hospitalisations

The number of vaccine preventable hospitalisations increased during the past couple of years in the Central West HHS region. In 2020-21, only 2 vaccine PPHs were recorded. In 2021-22, there were 7, and in 2022-23 there were 18. Majority of vaccine PPHs were mainly amongst non-Indigenous people and/or aged 65 years and above.

[19] Queensland Health, Notifiable conditions annual reporting, October 2024

## 4.3 Vulnerable populations

### 4.3.1 Relevance

| Why is exploring the needs of vulnerable populations in the Central West Queensland region important? |
|---|
| Vulnerable populations often experience compounded disadvantages that significantly impact their health outcomes. In this region, most communities are in remote or very remote areas of the State, making them inherently vulnerable due to challenges such as limited access to healthcare, social isolation, and reduced service availability. These vulnerabilities are further amplified among specific groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, people living with disabilities, people experiencing mental illness, people experiencing homelessness, people from LGBTIQ+ communities, as well as older and younger populations.<br><br>Understanding the unique needs of these populations is critical for developing equitable and inclusive health services. By better understanding the impact of compounded vulnerabilities, health interventions can be tailored to improve health equity and ensure that no group is left behind in achieving better health outcomes. |

### 4.3.2 Aboriginal and Torres Strait Islander communities (CWHHS region)

The Aboriginal and Torres Strait Islander community in the Central West region has seen consistent growth, increasing from 901 individuals in 2017 (out of a population of 10,656) to 972 in 2022 (out of 10,649). This rise in population highlights the growing representation of Indigenous people in the region, underscoring the importance of culturally appropriate health services to address their specific needs.

The Barcaldine-Blackall area holds the largest concentration of Aboriginal and Torres Strait Islander people within the Central West region. This demographic trend emphasises the need for enhanced support services, healthcare programs, and community engagement initiatives tailored to the Aboriginal and Torres Strait Islander population. As this community continues to expand, addressing health inequities and ensuring access to culturally sensitive care will be key priorities moving forward.

### 4.3.3 Culturally and Linguistically Diverse communities (CWHHS region)

In Central West Queensland, 81.8% of the population is born in Australia, with 6.0% of the population born overseas and remaining not recorded. Among the overseas-born population, 3.6% come from English-speaking backgrounds, while 2.2% are from non-English-speaking backgrounds.

In terms of language, 85.9% of the population speak English only at home. The top five countries of birth, excluding Australia, include New Zealand, the United Kingdom (including the Channel Islands and the Isle of Man), the Philippines, South Africa, and Germany. Common languages spoken at home, apart from English, include German, Australian Indigenous languages, Afrikaans, Spanish, and Southeast Asian Austronesian languages.

This linguistic and cultural diversity, although relatively small, underscores the importance of inclusive communication strategies and culturally sensitive healthcare services to effectively meet the needs of non-English speaking residents and ensure equitable access to care.

Please see Chapter 5 for a summary of insights focused on the health and service needs of multicultural communities in the region.

### 4.3.4 People with disabilities (CWHHS region)

Approximately 4.69% of the population, or 470 out of 10,700 people, require assistance due to disability, including individuals residing in long-term accommodation. This statistic highlights a significant portion of the community that depends on ongoing support services. Examples of these are household chores, self-care, property maintenance, and assistance with personal activities.

The inclusion of individuals in long-term care within this group highlights the need for tailored healthcare services and resources aimed at addressing their unique challenges. Ensuring that these individuals have access to appropriate and continuous support is crucial for improving their quality of life.

Addressing the needs of this population requires a multi-faceted approach. This should include improving accessibility to health services, expanding disability support programs, and enhancing infrastructure to ensure comprehensive care. Such a coordinated effort would significantly contribute to better outcomes for individuals requiring disability assistance in the region.

Effective service delivery to this group will also rely on ongoing collaboration between healthcare providers, community organisations, and disability advocacy groups to ensure resources are allocated where they are most needed.

### 4.3.5 People living with mental illness (CWHHS region)

In the Central West region, 167 consumers are being provided care in a community-based service, with 19% identifying as Aboriginal and Torres Strait Islander and 49.5% identifying as female. This diverse demographic highlights the need for culturally sensitive care, as nearly one-fifth of the consumers come from Aboriginal and Torres Strait Islander backgrounds. The near-equal gender distribution indicates a balanced representation of male and female consumers, emphasizing the importance of gender-inclusive care. These statistics demonstrate the necessity for tailored healthcare services that meet the specific cultural and gender-related needs of the population.

The facility operates without inpatient beds, instead leveraging telehealth in collaboration with CQHHS to provide specialist care remotely. This model enhances access to healthcare for consumers in rural settings, ensuring they receive timely medical consultations without needing to travel long distances. For consumers requiring inpatient admission, transfers are managed through the Royal Flying Doctor Service (RFDS) or Retrieval Services Queensland (RSQ). This streamlined transfer process ensures that critical patients are moved efficiently to higher-level care, maintaining continuity and ensuring that acute needs are met.

In terms of mental health (MH) and Alcohol and Other Drugs (AOD) services, the Central West region mainly employs a community-centered approach. There are no inpatient mental health beds, with care focused on outpatient services for individuals with mental health needs. Similarly, there are no inpatient AOD beds provided in the region, but a wide range of services including Alcohol and Other Drugs Services (AODS), police and court diversion programs, and consultation liaison services are offered. These community-based programs provide comprehensive support and intervention, focusing on outpatient care to manage mental health and substance use challenges. This approach ensures that consumers receive consistent support while reducing the need for inpatient admissions.

### 4.3.6 People experiencing domestic and family violence (CWHHS region)

There has been a significant increase in the number of domestic and family violence related offences from 2018 to 2022. Numbers increased from 31 offences in 2018, to 75 offences in 2020, which is close to a 2.5 times increase in just two years, with numbers continuing to rise.

### 4.3.7 People experiencing homelessness (CWHHS region)

Data from 2016 indicates that the homelessness rate stands at 32.0 per 10,000 people. There was an increase in the utilisation of homelessness services compared to previous years. This rise may be linked to the escalating cost of living, which is impacting many individuals and families within the community. As economic pressures grow, addressing homelessness and ensuring access to support services becomes increasingly crucial in Central West Queensland.

Please see Chapter 6 for a summary of insights focused on the health and service needs of people experiencing homelessness in the region.

### 4.3.8 People from LGBTIQ+ communities (CWHHS region)

No data was available for this cohort.

### 4.3.9 Older people (CWHHS region)

Data projections to 2041 highlight a significant trend: the rapid growth in the 85+ age group, signalling a shift towards an aging population, with a larger proportion of individuals reaching this age bracket by 2041/2042. In comparison, the 65 to 84 age group is experiencing slower but steady growth. While both age groups are expanding, the much steeper increase in the 85+ population underscores the need for targeted support, resources, and services to meet the demands of this older demographic.

Possible Implications:

- Healthcare and Elderly Care Services: The sharp rise in the 85+ population will likely increase the demand for healthcare and elderly care services, as this age group typically requires more intensive medical and support care.
- Social Services and Policy Adjustments: Social systems, including pensions and social security, will need adjustments to accommodate the growing number of elderly citizens.
- Housing and Assisted Living: There will be a growing need for elderly-specific housing solutions, such as assisted living facilities and age-friendly homes, to meet the increased demand from the aging population.

### 4.3.10 Young people (CWHHS region)

There is a clear demographic shift towards an aging population, with significant declines in the younger and working-age groups. This trend is expected to have broad social, economic, and policy implications, particularly around workforce sustainability, healthcare, and eldercare needs. The most notable trend is the projected decline in the younger population. The 0 to 14 years age group is expected to shrink by 37.66%, signalling a significant reduction in the number of children in the coming years. This decline could affect future demand for early childhood services, schools, and paediatric healthcare. Similarly, the 15 to 24 years age group is projected to decrease by 25.48%, which could impact post-secondary education and the job market, leading to fewer young workers entering the workforce and creating challenges for industries that rely on youth labour.

# 4.4 Health needs

## 4.4.1 Relevance

Why is exploring the health needs of the Central West Queensland region important?

The health needs of a population are influenced by a complex interplay of biological, environmental, and social factors. This section explores a broad range of critical health issues, from alcohol and drug use to the health needs in the antenatal and palliative periods. Chronic diseases such as diabetes, cardiovascular conditions, and cancers continue to drive morbidity and mortality, while communicable diseases remain a significant concern, particularly in vulnerable populations. Mental illness and suicide pose ongoing challenges, requiring a holistic approach to care that integrates physical and psychological health. Oral health, which is often overlooked, is also crucial, given its link to overall well-being. By comprehensively examining these diverse health needs, we gain a greater understanding of their burden on communities in the region.

## 4.4.2 Alcohol and other drug use (CWHHS region)

Alcohol and other drugs (AOD) usage in Central West Queensland is not well reported due to the region's small population and the limitations of available data sources. These sources do not clearly identify usage numbers or trends, making it difficult to accurately assess the scale or patterns of AOD use within the community.

## 4.4.3 Antenatal care (CWHHS region)

In the Central West region, data sources highlight several key aspects of antenatal care and its impact on maternal and infant wellbeing. Maternal health in the Central West region provides several key insights. Antenatal care engagement is strong, with 383 mothers attending eight or more antenatal visits, meeting the recommended guidelines for optimal care. This reflects a positive level of access to healthcare services during pregnancy, which is crucial for monitoring both maternal and infant health and for the early detection and management of any potential complications.

However, the data also highlights several maternal health risk factors. Among the mothers, 117 were classified as obese, and 48 smoked during pregnancy. Both obesity and smoking are associated with a higher likelihood of pregnancy complications, such as preterm birth and low birthweight, and often require more intensive antenatal care. These risk factors underscore the need for targeted health interventions to address and reduce these risks. These could include educational programs on the risks associated with smoking and obesity, as well as additional support for high-risk groups, such as older mothers and those with more complex health needs. Addressing these risk factors could improve maternal and infant health outcomes across the region.

In terms of maternal age, the region recorded a relatively low number of young mothers (aged 19 or under), with only 13 cases. On the other hand, 64 mothers were aged 35 or older, a group that typically requires closer antenatal management due to the increased risk of complications associated with pregnancies in older women.

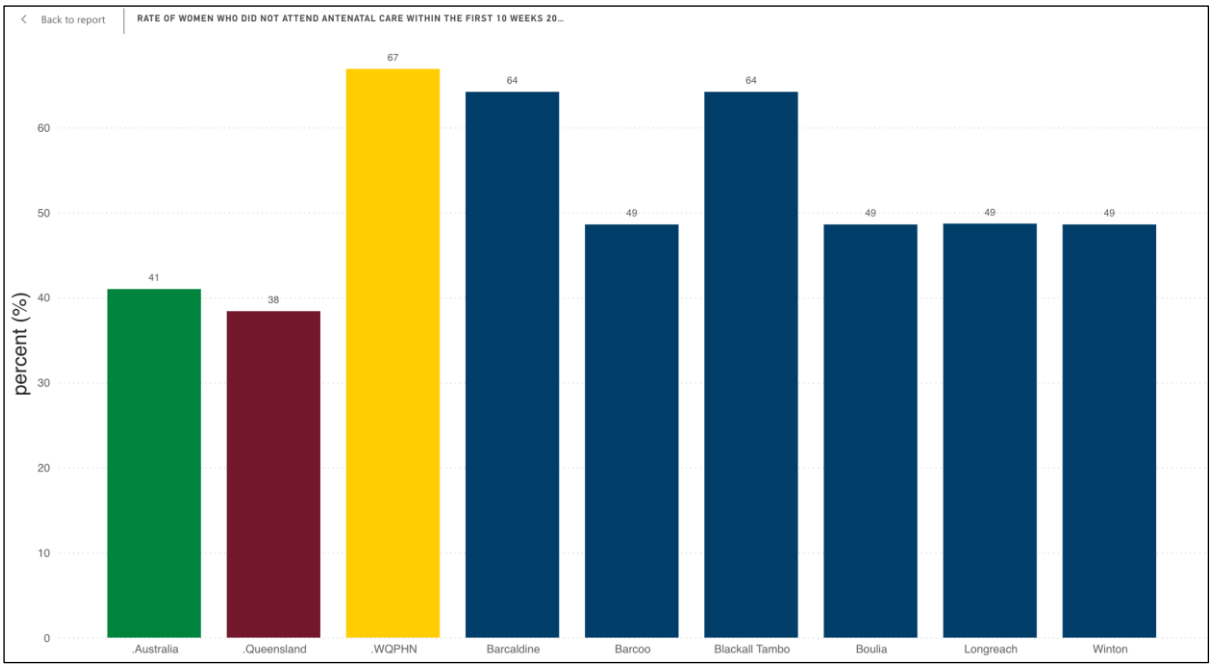


*Figure 105: Proportion of women who did not attend antenatal care in first 10 weeks in Central West region, 2019-2021*

The proportion of women who do not attend antenatal visits within the first 10 weeks of gestation is significantly higher in the Western Queensland region (67.0%) compared to the National and State rates (41.0% and 38.0%). The rates across the Central West LGAs are all lower than the regional rate, but higher than National and State rates (Figure 105).

### 4.4.4 Cancer (CWHHS region)

Cancer incidence projections to 2041 indicate a stable trend, with rates expected to remain at approximately 80 cases per 100,000 people. Males are projected to account for 53.75% of the total. This steady rate highlights the ongoing need for targeted cancer prevention, screening, and treatment programs, particularly for male populations, to ensure early detection and improved outcomes.

### 4.4.5 Chronic disease (CWHHS region)

Data from 2020-21 highlights diabetes complications as the leading chronic disease in Central West Queensland, accounting for 50.3% of cases. This is followed by congestive cardiac failure, which represents 18.4% of chronic disease cases. The prevalence of diabetes-related complications underscores the need for enhanced management strategies, early intervention, and community education to better control and prevent the progression of this condition. Similarly, the significant presence of congestive cardiac failure points to a growing demand for cardiac care services, emphasising the importance of integrated chronic disease management in the Central West region.

In general practices, more than a third of people experience 1 or more chronic health conditions (41%). This is similar to the Western QLD population prevalence (36.8%). Musculoskeletal conditions and Mental Health are the most prevalent chronic conditions in Central West general practices (20% and 18.4%, respectively). Respiratory and Diabetes are the following most prevalent conditions in general practices (13.4% and 11.9%, respectively).

There are variations seen in the chronic diseases presenting to hospital services compared to those recorded in general practice. For example, diabetes prevalence is slightly lower than Western Queensland region (12.1%), however diabetes complications are the leading hospital presentations in the Central West. This highlights the opportunity to improve early detection and management of diabetes in primary care to reduce the risk of diabetes microvascular and macrovascular complications.

Data extracted from general practice indicates high rates of renal impairment in Winton (9.7%), with lower rates across Barcoo (6.6%), Longreach (5.9%), Blackall-Tambo (5.8%), Boulia (4.7%), Barcaldine (3.3%) and Diamantina (2.3%) (Figure 106).

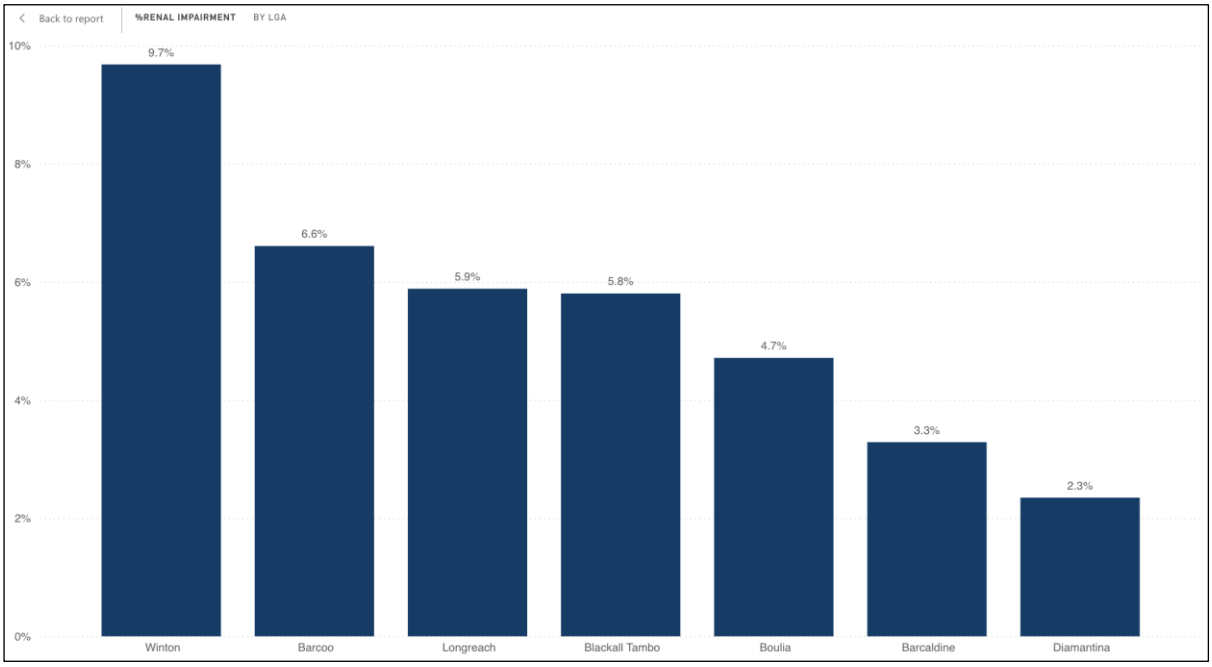


*Figure 106: Renal impairment across the Central West region*

## 4.4.6 Communicable disease (CWHHS region)

### 4.4.6.1 Sexually transmitted infections (CWHHS region)

The data indicates that Chlamydia is the most prevalent Sexually Transmitted Infection (STI) within the assessed period, with 29 reported cases, significantly exceeding the number of cases for other STIs. In comparison, Gonorrhoea recorded 3 cases, while both infectious syphilis and late syphilis had only 1 case each. These findings establish Chlamydia as a critical public health concern, necessitating a targeted approach to enhance sexual health education, prevention efforts, and testing campaigns to effectively reduce the spread of STIs in the community.

Furthermore, it is essential to address syphilis, despite its lower incidence, due to the potential for serious long-term health consequences if left untreated. These insights underline the need for a comprehensive needs assessment to identify gaps in education and healthcare resources related to STI prevention and management within the community.

### 4.4.6.2 Other (CWHHS region)

The disease surveillance data for Queensland reveals stability across several disease categories between 2019 and 2023, though there are some areas of concern. Gastrointestinal diseases, such as Salmonellosis, have seen a slight increase, while Campylobacter infections have declined. In the area of acute respiratory diseases, influenza has surged significantly, with nearly twice as many cases compared to the historical average, highlighting a concerning rise in flu activity. Additionally, Respiratory Syncytial Virus (RSV) shows notable prevalence, though no historical data is available for comparison.

The data on vaccine-preventable diseases indicates a resurgence of pertussis (whooping cough), with 10 year-to-date (YTD) cases compared to zero in previous years, suggesting the need for renewed vaccination efforts. In contrast, varicella (chickenpox) cases have remained stable. Mosquito-borne diseases, such as Barmah Forest Virus and Ross River Virus, continue to exhibit stable but persistent transmission rates.

There has been a notable increase in zoonotic diseases, particularly Q fever, with cases nearly tripling the historic mean. Meanwhile, rare diseases like cholera, tuberculosis, and anthrax remain at zero cases, reflecting successful prevention efforts. The overall analysis highlights the importance of ongoing public health

interventions to manage rising flu and Q fever cases, address the resurgence of vaccine-preventable diseases like pertussis, and maintain vigilance in monitoring respiratory and mosquito-borne diseases to protect public health in Queensland.

### 4.4.7 Mental illness and psychological distress (CWHHS region)

In the Central West region, 167 consumers are being provided care in a community-based service, with 19% identifying as Aboriginal and Torres Strait Islander and 49.5% identifying as female. This diverse demographic highlights the need for culturally sensitive care, as nearly one-fifth of the consumers come from Aboriginal and Torres Strait Islander backgrounds. The near-equal gender distribution indicates a balanced representation of male and female consumers, emphasizing the importance of gender-inclusive care.

The Central West region employs a telehealth model, ensuring access to specialist mental health care remotely. This approach is especially valuable in rural settings, where patients may otherwise need to travel long distances for consultations. When inpatient care is required, transfers are handled efficiently through the Royal Flying Doctor Service (RFDS) or Retrieval Services Queensland (RSQ), guaranteeing timely access to higher-level care for those in critical need.

There are no inpatient mental health or Alcohol and Other Drugs (AOD) beds provided, with the region focusing instead on outpatient services. Extensive support is available through community-based programs such as Alcohol and Other Drugs Services (AODS), police and court diversion programs, and consultation liaison services. This community-centered approach aims to manage mental health and substance use challenges outside the hospital setting, reducing reliance on inpatient admissions and promoting consistent outpatient care.

Additionally, there are four GP clinics in Central West Queensland that provide both mental health and Alcohol and Other Drugs (AOD) services. As part of these services, GP Mental Health Treatment Plans (MBS 2700-2717) have been developed for a total of 1,279 patients with diagnosed mental health conditions. This distribution highlights the extensive provision of mental health care across diverse demographic groups within the primary care settings.

### 4.4.8 Oral health (CWHHS region)

The oral health needs in the region are multifaceted and reflect the challenges of providing care in a remote and geographically dispersed area. Key oral health needs include:

**Improved Access to Services**

Many areas, particularly more remote locations like Alpha, have minimal or no recorded dental services, highlighting significant gaps in both preventive and general dental care. Access to routine dental services is limited, particularly for children and older adults, which increases reliance on emergency services and reactive care. Expanding access to both emergency and non-emergency dental services is essential to meet these needs.

**Preventive Care**

The limited access to preventive dental services, especially in rural and remote areas, points to a need for targeted preventive care initiatives. There is a need to educate and engage populations, particularly children and older adults, in maintaining good oral hygiene and receiving regular dental check-ups to avoid more serious dental issues later on. This includes improving access to regular cleanings, examinations, and fluoride treatments.

**Consideration of Vulnerable Populations**

Certain populations, such as Aboriginal and Torres Strait Islander communities and socio-economically disadvantaged groups, face additional barriers to accessing dental care. Culturally sensitive services and outreach programs aimed at these vulnerable groups are necessary to ensure they receive appropriate care. Improving access and engagement for these populations will help address inequities in oral health outcomes.

**Workforce and Service Integration**

A shortage of dental professionals in the region, combined with geographic barriers, limits the availability of regular dental care. This highlights the need to improve service integration, particularly through partnerships with private dental providers and the expansion of mobile and telehealth dental services. These steps would help address workforce shortages and provide more consistent care across the area.

These needs underline the importance of a more coordinated approach to oral health care that prioritises access, prevention, and targeted support for vulnerable groups.

### 4.4.9 Palliative care (CWHHS region)

In Central West Queensland, a Palliative Care Coordinator is employed within the Primary Health Care team to develop strategies and advance care planning, focusing on delivering effective end-of-life care. This role is integral to defining the health strategies for Central West, ensuring that patients receive compassionate and appropriate support during their final stages of life. Additionally, the Specialist Palliative Care Rural Telehealth (SPaRTa) program enhances access to specialist palliative care services for individuals in rural and remote areas.

### 4.4.10 Potentially Preventable Hospitalisations (CWHHS region)

Data sources reveal notable variations in Potentially Preventable Hospitalisations (PPH) related to a range of conditions. Chronic conditions, particularly diabetes complications (166 separations, 3.6% of total) and congestive cardiac failure (53 separations, 1.1%), are the leading contributors to PPH separations. In particular, diabetes complications contribute disproportionately to hospital bed days, accounting for 6.1% of total bed days. This highlights the critical need for targeted interventions to better manage diabetes and prevent complications that result in hospitalisation.

Potentially preventable hospitalisations due to acute conditions such as cellulitis (65 separations, 1.4%) and urinary tract infections (49 separations, 1.1%) are also prominent. These conditions, while not as prevalent as chronic illnesses, still represent a significant burden on hospital resources. The relatively high number of separations for these conditions suggests a potential gap in early intervention or outpatient treatment that, if addressed, could reduce hospital admissions.

Vaccine-preventable conditions, including pneumonia and influenza, show lower rates of separations (0.3% of total PPH), but they still had a measurable impact on hospital bed utilisation (0.9% of total bed days). These findings highlight the need for increased vaccination efforts and public health initiatives aimed at reducing hospitalisations for preventable diseases, particularly among vulnerable populations.

Overall, the data emphasises the importance of comprehensive prevention strategies, particularly for chronic conditions like diabetes and congestive cardiac failure. Improving early intervention and vaccination coverage could help to reduce PPH rates, thereby relieving pressure on hospital services and improving patient outcomes across the health system.

### 4.4.11 Premature births and birthweight (CWHHS region)

Between 2019/20 and 2022/23, 9.3% of births in the Central West region were classified as preterm, presenting a significant maternal and child health challenge. Premature births are a critical indicator of maternal health, and this elevated rate calls for targeted interventions. Improving prenatal care and early intervention programs could help reduce preterm birth rates, ultimately improving neonatal outcomes and long-term health for affected infants.

In 2023/24, the incidence of low birthweight was relatively low, with only 2 out of 91 babies (2.2%) born underweight. This positive figure reflects well on maternal health efforts but requires ongoing monitoring to ensure sustained progress. Continued access to comprehensive antenatal care will be crucial to maintaining and improving these outcomes, ensuring early detection and management of maternal health issues that may contribute to low birthweight.

### 4.4.12 Suicide (CWHHS region)

From 2016 to 2020, data reveals that local suicide rates are 35% higher than the Queensland average per 100,000 people, highlighting a critical public health challenge that requires immediate attention. This alarming figure underscores the urgent need for targeted mental health interventions and suicide prevention strategies tailored to the specific needs of the local population. Addressing this issue demands a multi-faceted approach, including improving access to mental health services, enhancing early intervention, raising community awareness, and strengthening crisis support. Through targeted strategies and coordinated efforts, health services can make meaningful progress in reducing suicide rates and improving mental health outcomes for the region.

# 4.5 Service needs

## 4.5.1 Relevance

Why is exploring the service needs of the Central West Queensland region important?

Effective health services are essential for meeting the diverse needs of a population, yet service gaps, inefficiencies, and workforce challenges persist. This section assesses the service landscape, including service mapping, workforce capacity, and utilisation patterns, to identify areas of need and potential service gaps. Understanding the efficiency and effectiveness of services is crucial for ensuring that resources are allocated where they are most needed. Coordination and integration of services, across primary care, social and community care, and hospitals, is key to delivering seamless care. After-hours care and hospital capacity are also explored, as they are often the pressure points within the system. By analysing these service needs, this section aims to inform strategies that enhance service delivery, improve patient outcomes, and optimise healthcare system performance.

## 4.5.2 Service mapping (CWHHS region)

### 4.5.2.1 PHN commissioned services

Western Queensland PHN funds a wide range of commissioned services, including aged care, mental health, allied health, substance use, integrated team care, and Outback Kids in the Central West region through 21 commissioning service providers. These services are provided not only for residents living in main hubs in the region like Longreach, Barcaldine, and Charleville, but also to very remote areas like Stonehenge, Yaraka, and especially those in Western Corridors (Boulia, Birdsville, Bedourie, and Windorah), where residents are experiencing lack of access to GP services.

### 4.5.2.2 Central West HHS

Central West HHS offers a comprehensive network of community, primary, and hospital-based services designed to provide our diverse communities with safe and appropriate healthcare options as close to home as possible.

Longreach Hospital, the largest facility operated by Central West HHS, serves the town of Longreach and surrounding areas with inpatient and emergency services. It is the only provider of maternity and Computed Tomography (CT) radiology services in the region. Additionally, local inpatient and emergency care services are available in Barcaldine, Blackall, Alpha, and Winton, complemented by several nurse-led primary healthcare centres. The inpatient facilities in Barcaldine, Winton, and Alpha function as Multi-Purpose Health Services (MPHS), delivering residential aged care in the absence of alternative options.

Central West HHS owns and operates four General Practice clinics, further supporting healthcare delivery in the region. These clinics, in conjunction with existing services, play a key role in expanding access to both general and specialised care, including Mental Health and AOD services.

To ensure that residents receive safe and quality care close to home, coordinated outreach services in allied health, oral health, mental health, pharmacy, maternal and child health, and general medical services are provided across the region. Central West HHS operates general practices in Longreach, Barcaldine, Blackall, and Winton, with outreach visits by General Practitioners to smaller communities.

In the western regions of Central West Queensland, medical care is supported by the Royal Flying Doctor Service, while allied health services are further supplemented by North and West Remote Health. Oral health care is provided by both Central West HHS and the Royal Flying Doctor Service.

In many areas within Central West Queensland, Central West HHS is the sole provider of community and primary care services. Several sites also operate clinic-based ambulance services to ensure emergency response capabilities.

The corporate headquarters of Central West HHS is located in Longreach and encompasses the Executive Leadership, Building Engineering and Maintenance Services, Clinical Governance, Finance, Strategy and Governance, and project teams.

Central West HHS fosters strong collaborative relationships with various organisations, including the Royal Flying Doctor Service, Western Queensland Primary Health Network, North and West Remote Health, Metro North Hospital and Health Service, South West Hospital and Health Service, Queensland Ambulance Service, and local government councils. These partnerships are essential for ensuring timely and coordinated access to appropriate healthcare services.

### 4.5.3 Workforce mapping (CWHHS region)

As of June 2024, the Central West HHS health workforce consists of 431.44 Full-Time Equivalents (FTE), equating to 40.3 FTE per 1,000 people. The workforce distribution shows a strong focus on nursing, with 182.62 FTE, or 17.0 FTE per 1,000 people, underscoring the critical role nurses play in the healthcare system. By contrast, the medical workforce comprises 31.34 FTE, equating to 2.9 FTE per 1,000 people. Additionally, health professionals and technical staff represent 38.37 FTE, or 3.6 FTE per 1,000 people, while operational, managerial, and clerical staff collectively make up 181.11 FTE, or 16.7 FTE per 1,000 people.

Aboriginal and Torres Strait Islander health workers are notably underrepresented, with only 2 FTE, translating to 0.19 FTE per 1,000 people. This limited presence highlights a significant gap in Indigenous workforce participation, which is critical given the cultural needs of the region. The percentage of the workforce identifying as Aboriginal and Torres Strait Islander stands at 6.75% for 2023-2024, demonstrating some diversity but indicating further opportunities to grow representation in alignment with the region's demographics.

Mental health practitioners total approximately 14 FTE, marking a vital part of the workforce. However, the density of mental health professionals remains relatively low compared to the high demand for these services, signaling a need for further recruitment and resource allocation. Addressing shortages in the district’s mental health services, alongside targeted recruitment of Aboriginal and Torres Strait Islander health workers, will be essential for ensuring comprehensive care across the region.

Workforce shortages across all disciplines remain a significant concern for the community and the health service, highlighting the difficulty in recruiting and retaining clinical and non-clinical staff.

### 4.5.4 Market analysis (CWHHS region)

The Central West region encompasses diverse rural populations, presenting unique healthcare challenges and opportunities. There is an increasing demand for services related to chronic diseases, mental health, and preventive care, driven by demographic trends. Additionally, the rising cost of delivering services in rural and remote areas exacerbates these challenges. Funding constraints, including limited State and federal support, significantly impact provider operations and the expansion of services.

Key weaknesses include resource limitations in rural areas and disparities in healthcare access. To address these issues, strategies such as enhancing telehealth services, promoting collaboration among providers, and advocating for increased funding are essential.

Recent market failures in aged care, NDIS providers, private services, and GP services highlight sustainability challenges in the region. The limited population restricts market viability, causing reluctance among private providers to enter the market.

### 4.5.5 Service utilisation (CWHHS region)

#### 4.5.5.1 NDIS participation (CWHHS region)

In 2021, data shows that there were 113 participants enrolled in the National Disability Insurance Scheme (NDIS). This highlights the region's utilisation of the NDIS, providing critical support and services to individuals with disabilities, ensuring they have access to necessary resources and opportunities to improve their quality of life. The NDIS plays a vital role in addressing the unique needs of participants within the catchment, offering tailored services and support mechanisms.

### 4.5.5.2 Hospital attendance (CWHHS region)

In 2021, the relative utilisation of public and private hospitals was 53%, with public hospitals significantly higher at 129%. Demand across various health service areas is pronounced, especially in categories exceeding 120%. Notably, Other Non-Acute services led at 313%, highlighting a reliance on non-acute care, like rehabilitation and chronic condition management. Other areas of high demand include Immunology and Infections at 178%, driven by infectious diseases, and Prolonged Ventilation at 159%, indicating the intensive support needed for critical respiratory care. Additionally, Neurosurgery and Cardiology are at 153% and 148%, respectively, underscoring the need for advanced surgical and cardiovascular interventions. High demand for Gastroenterology (141%) and Medical Oncology (116%) also reflects the ongoing need for chronic and cancer care.

In the moderate utilisation bracket (100-120%), Respiratory Medicine and Orthopaedics are both at 115%, indicative of consistent demand related to common health issues in the ageing population. Endocrinology at 109% and Gynaecology at 107% further demonstrate significant ongoing needs for endocrine and reproductive health management. On the other hand, some areas show lower utilisation rates (below 80%), suggesting gaps in service delivery or a need for specialisation. Mental Health at 40% and Haematology at 41% indicate low engagement, potentially due to under-diagnosis or under-referral. Specialties such as Palliative Care at 69% and Rehabilitation at 46% may also require enhanced outreach or resources to better serve community needs. These findings stress the urgent demands in high utilisation areas and the need to address underutilised services for comprehensive healthcare access.

Mental Health Hospitalisations

Data for 2022-2023 reveals fewer than five admissions for mental health (MH) patients, indicating stable admission rates. Typically, mental health or Alcohol and Other Drug (AOD) patients are not directly; instead, these individuals are transported to tertiary facilities for inpatient care, highlighting the reliance on external services for comprehensive mental health treatment.

Self-Sufficiency Rates and Service Separations

The self-sufficiency rate for admitted patients across various Service Related Group (SRG) classifications is 50.33%, indicating that just over half of the patients can access care locally without external providers. Central Queensland contributes an additional 11.13% to this figure, showcasing the region's capacity to address a substantial portion of its healthcare needs internally. These statistics emphasise the critical role of local healthcare services in providing comprehensive care and highlight opportunities to enhance local capabilities and resources to meet population needs.

There were 2,796 inpatient separations and 11,848 emergency presentations across the five acute facilities in Central West Queensland for the 2023-2024 period. Importantly, re-admission rates remain low, with an overall downward trend since 2018-19, further reflecting the effectiveness of local healthcare initiatives.

### 4.5.5.3 Emergency department presentations (CWHHS region)

**Increasing number of category 4 and 5 ED presentations**

There were 8,701 category 4 or 5 Emergency Department (ED) presentations in 2023-24, accounting for 73.5% of total presentations, which was slightly higher than the proportion in 2021-22 (71%). The number of category 4 and 5 after-hours presentations increased from 2,099 to 2,533 in two years.

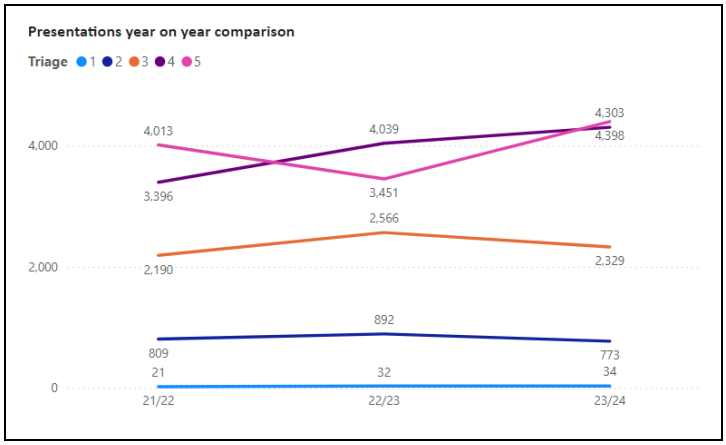


*Figure 107: ED presentations across the Central West region*

**Increasing number of mental health related ED presentations**

There were 368 mental health related ED presentations in 2023-24, which was nearly double the amount recorded in 2021-22 (198).

**Increasing proportion of presentations using walk-in or public or private transport**

In 2023-24, 94.92% of ED presentations were walk-in, or public or private transport, up from 92.81% in 2021-22. The proportion of presentations using an ambulance as their transport mode declined in the past two years (from 5.06% to 4.62%).

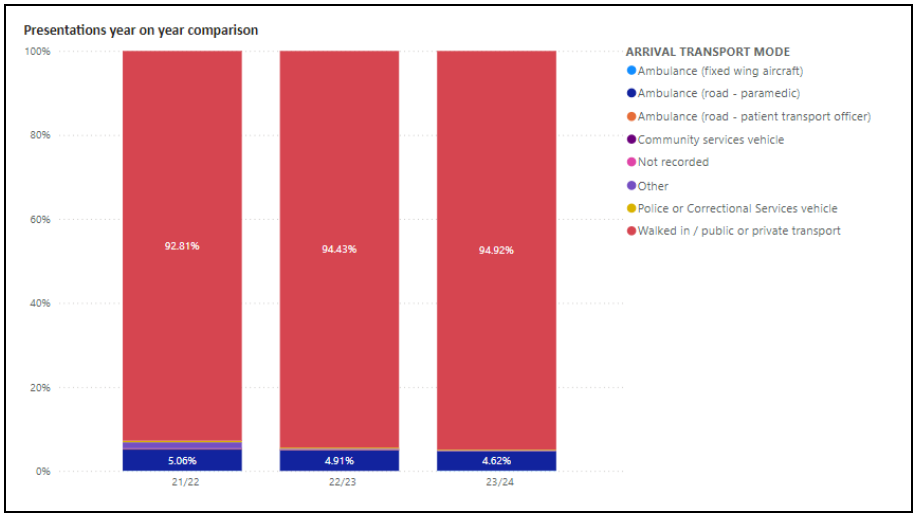


*Figure 108: ED presentations arrival model across the Central West region*

In the last 12-month period, a total of 11,848 ED presentations were recorded across five acute facilities (Alpha, Barcaldine, Blackall, Longreach, and Winton). Among these, 300 presentations were related to mental health, indicating a notable demand for mental health services within emergency care settings. This highlights the importance of continuing to prioritise mental health resources and support within EDs to manage this specific patient group effectively.

The ED performance in meeting triage targets was commendable, with Category 1 presentations (the most urgent cases) achieving a 100% on-time response rate. Category 2 through Category 5 presentations also demonstrated strong performance, with 94.6% to 99.2% of patients being seen within the recommended timeframes. Notably, Categories 4 and 5 achieved particularly high success rates, with over 97% of patients seen on time. These metrics reflect efficient handling of patient flow and timely responses across various urgency levels.

Regarding inpatient admissions, 2,796 separations were reported, with an average length of stay of 4.6 days. The gender distribution among admitted patients was relatively balanced, with 51.3% female and 48.6% male separations. These statistics suggest a consistent inpatient care performance and balanced utilisation of services by both male and female patients. The overall findings underscore the efficiency of ED operations, while highlighting mental health as a growing area of focus within emergency care.

#### 4.5.5.4 Oral health presentations (CWHHS)

In the 2023/24 period, the healthcare system in the Central West region recorded 11,401 Weighted Occasions of Service (WOOS), reflecting consistent and comprehensive healthcare provision across the catchment. This high volume of service delivery demonstrates that healthcare facilities are maintaining effective operations in addressing the population's needs.

In dental care, the region is served by two full-time equivalent (FTE) dental officers, representing 0.19 FTE per 1,000 people for a population of 10,700. Despite this limited staffing, the delivery of services has been efficient. As of July 2024, 96% of adult patients had been waiting less than two years for dental services, surpassing the target of 85%. This indicates exceptional performance in managing wait times and maintaining patient care standards within the dental sector.

Overall, the findings highlight strong efficiency in both general and dental services, with dental care outcomes significantly exceeding expectations despite staffing limitations. The consistent healthcare provision and reduced wait times reflect positively on service management and patient care quality within the region.

### 4.5.6 Efficiency and effectiveness of health services (CWHHS region)

Efficiency and effectiveness of healthcare delivery in Central West Queensland is achieved, in spite of the challenges posed by its vast and remote service area, through a strategic focus on resource optimisation, streamlined operations, and continuous improvement in patient outcomes.

**Efficiency Initiatives**

Partnerships with key health organisations such as the Royal Flying Doctor Service (RFDS), Western Queensland Primary Health Network (WQPHN), and North and West Remote Health, maximise shared resources and minimise duplication of services. These collaborations enable the health service to provide specialised care without the need for excessive infrastructure expansion. The use of telehealth services further enhances efficiency, allowing patients to receive specialist consultations and follow-up care remotely, reducing unnecessary travel and associated costs.

The Multi-Purpose Health Services (MPHS) model adopted in facilities like Barcaldine, Winton, and Alpha combines hospital and aged care services under one roof, effectively streamlining operations and optimising staffing and resources. This integrated approach allows the service to adapt to the fluctuating demands of smaller communities, ensuring that both acute care and long-term care needs are met efficiently.

**Effectiveness Strategies**

A strong emphasis on the effectiveness of its care through coordinated outreach services ensures that patients receive timely, appropriate care, whether in primary, emergency, or specialised settings. The focus on preventative health and early intervention through community health programs further enhances care effectiveness, addressing health issues before they escalate.

The health service actively monitors performance indicators, including patient outcomes, service accessibility, and wait times, to continuously assess and improve the quality of care. For example, the centralised management of services at Longreach Hospital, the largest facility in the region, ensures that patients have access to essential services like emergency care, maternity, and radiology, while more complex cases are efficiently referred to higher-level care providers through established networks.

**Integration and Data-Driven Decision Making**

Effectiveness of health services has been enhanced by integrating data-driven decision-making into service operations. Continuous monitoring of patient care metrics allows the service to make informed decisions about resource allocation, ensuring that services are both effective and aligned with community needs. This

approach enables timely responses to emerging healthcare demands and helps to scale services in a cost-effective manner.

By fostering close coordination between its various health services and partners, both efficiency and effectiveness can be balanced, ensuring that quality healthcare is accessible, sustainable, and tailored to the specific needs of the diverse and geographically dispersed population.

### 4.5.7 Coordination and integration of health services (CWHHS region)

The coordination and integration of healthcare services across the diverse and remote communities in Central West Queensland ensure seamless and comprehensive care delivery. The health service collaborates closely with key organisations, such as the Royal Flying Doctor Service, Western Queensland Primary Health Network, North and West Remote Health, Metro North Hospital and Health Service, South West Hospital and Health Service (with the flying surgeon), Queensland Ambulance Service, CheckUp, Health Workforce Queensland, and regional councils. These partnerships enable a well-coordinated approach, providing timely access to a broad range of services across the region.

At the heart of this integrated network is Longreach Hospital, the largest facility in the region, offering inpatient, emergency, maternity, and CT radiology services. Additional inpatient and emergency care services are integrated locally within the communities of Barcaldine, Blackall, Alpha, and Winton, supported by nurse-led primary healthcare centres. Barcaldine, Winton, and Alpha also operate as Multi-Purpose Health Services (MPHS), providing residential aged care services in areas where alternative facilities are unavailable.

Coordinated outreach services are delivered throughout the Central West region, including allied health, oral health, mental health, pharmacy, maternal and child health, and medical services, ensuring that residents can access safe, quality care as close to home as possible. General practices owned by Central West HHS in Longreach, Barcaldine, Blackall, and Winton, along with outreach General Practitioner services, enhance access to care in smaller communities. In more remote areas, the Royal Flying Doctor Service provides essential medical care, supplemented by allied health services from North and West Remote Health.

### 4.5.8 After-hours care (CWHHS region)

**Low level of After-hours GP services**

After-hours GP services account for 1.9% of total GP services across the region in 2022-23, much less than the National and WQPHN average of 4.6% and 4.0%. This indicates the need for more promotion or resource allocation to after-hours GP services.

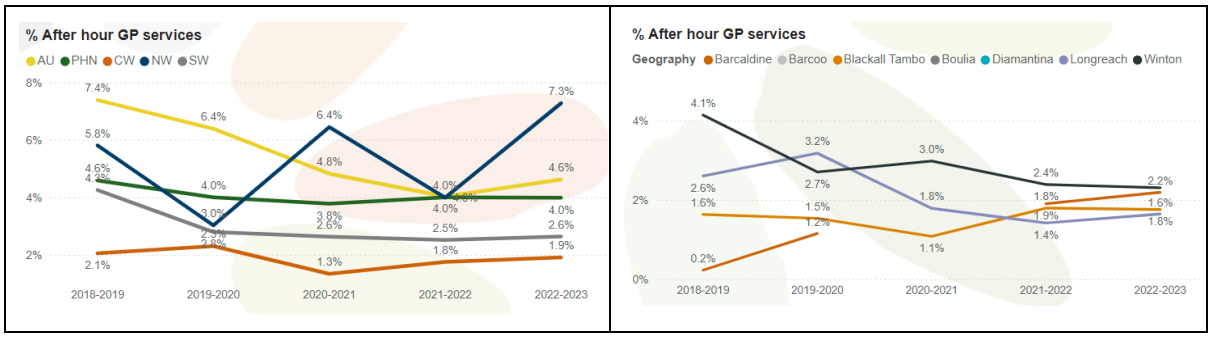


*Figure 109: GP after-hours services across the Central West region*

### 4.5.9 Primary care (CWHHS region)

#### 4.5.9.1 GP attendances (CWHHS region)

**Low number of GP services per capita**

The number of GP services per capita is 5.5 in 2022-23, much lower than the National average of 6.6 but higher than the State of 4.3. There are no GP services in Boulia and Diamantina.

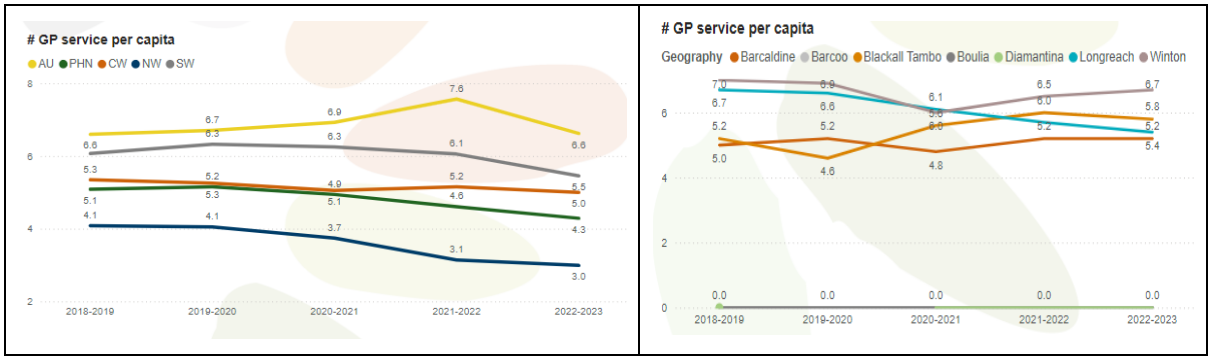


*Figure 110: GP services per capita across the Central West region*

### 4.5.9.2 Primary care delivered by CWHHS (CWHHS region)

Central West HHS plays a key role in managing healthcare delivery across the region, owning and operating four General Practice clinics. These clinics are pivotal in providing primary care services, including mental health support, to the diverse populations within the HHS catchment area. Their presence significantly enhances healthcare accessibility and ensures ongoing care for mental health conditions.

The Primary Health Services division, led by the General Manager of Primary Health Services, plays a pivotal role in delivering comprehensive care across multiple areas, ensuring accessible, high-quality healthcare for communities in Central West Queensland

**Primary Health Care**

Critical for promoting overall health and well-being, primary health care services focus on prevention, early intervention, and managing ongoing health conditions. The four General Practice clinics managed by Central West HHS serve as the first point of contact for a range of health issues, from routine check-ups to mental health support.

**Community Health**

This service aims to engage the community through health education, preventive programs, and outreach initiatives. Community health teams work closely with individuals and families to manage chronic diseases, improve health literacy, and support healthier lifestyles.

**Specialist Outpatients**

Specialist outpatient services provide critical follow-up and specialist consultations for patients who need ongoing care after an acute hospital stay or are referred for specialised treatment. These services help manage more complex health issues while reducing the need for hospitalisation.

**Telehealth**

Telehealth services are integral in improving access to specialist care in remote and rural areas. By offering consultations and follow-up appointments virtually, telehealth reduces the need for travel and ensures timely access to medical expertise across a wide range of specialties.

**Primary Healthcare Centres**

There are several Primary Healthcare Centres providing comprehensive primary care services to rural and remote communities. These centres offer essential health services, including emergency care, chronic disease management, and preventive health programs, bridging gaps in healthcare access.

**Chronic Disease Management**

Chronic disease care is a key focus, particularly given the rising prevalence of conditions such as diabetes and congestive heart failure. The HHS provides integrated care pathways for managing chronic diseases, ensuring that patients receive coordinated and ongoing support through primary care, specialist services, and community health programs.

The General Manager of Primary Health Services oversees these critical areas, ensuring that primary health services are delivered efficiently, equitably, and in line with the community's needs. The focus on telehealth

and community health initiatives continues to improve access, particularly in rural and remote locations, ensuring comprehensive and connected care for all populations in Central West Queensland.

### 4.5.9.3 GP services to Residential Aged Care Homes (CWHHS region)

**Increasing number of GP services at RACF**

There were 1,810 GP services delivered at RACF in 2022-23, which was an increase from 1,318 in 2020-21, mainly due to a significant increase in Blackall-Tambo: from 442 to 727 services.

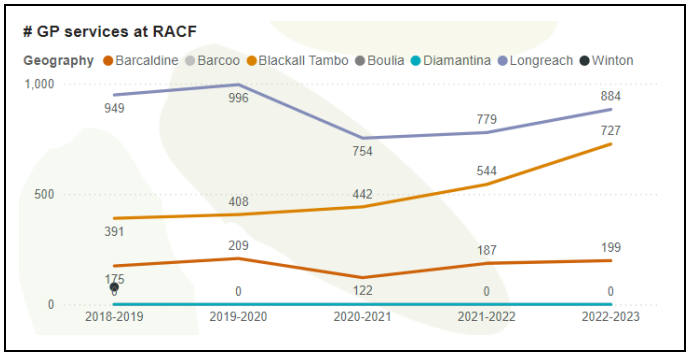


*Figure 111: GP RACF services across the Central West region*

### 4.5.9.4 GP Mental Health Treatment Plans (CWHHS region)

**Very low proportion of Mental health related GP services**

0.6% of GP services are mental health related care, much lower than National and WQPHN average of 2.0% and 1.6%. The figures are low across the region: 0.7% in Longreach, 0.6% in Barcaldine, 0.5% in Blackall-Tambo, and 0.3% in Winton.

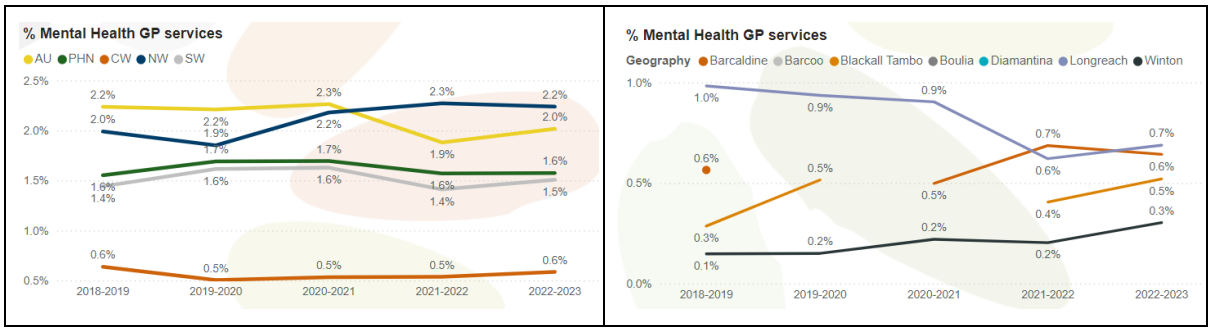


*Figure 112: GP mental health services across the Central West region*

A total of 1,279 patients were diagnosed with mental health conditions. Of these, 125 identified as Aboriginal and Torres Strait Islander, 1,125 as non-Indigenous, and ethnicity was not recorded for 29 patients. This data reflects significant mental health diagnoses among both Aboriginal and Torres Strait Islander and Non-Indigenous populations, with the majority of cases being non-Indigenous. A total of 121 GP Mental Health Treatment Plans (MBS 2700-2717) were initiated. This included 16 plans for Aboriginal and Torres Strait Islander patients, 100 for non-Indigenous patients, and 5 for whom ethnicity was not recorded.

### 4.5.9.5 Telehealth services (CWHHS region)

**Decreasing use of Telehealth GP services**

Usage of telehealth services dropped from 16.0% in 2020-21 to 10.9% in 2022-23, below the National (18.8%) and PHN (13.0%) usage. The proportion of telehealth usage significantly decreased in Blackall-Tambo, from the peak at 25.9% in 2020-21 to only 6.3% in 2022-23.

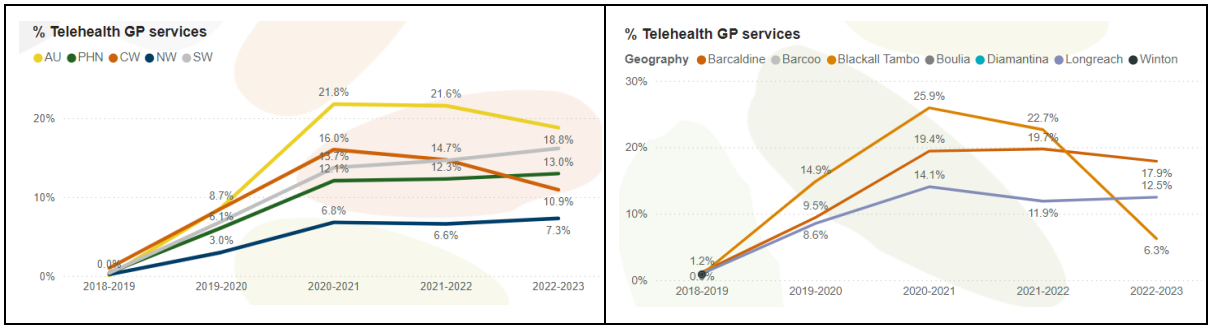


*Figure 113: GP telehealth services across the Central West region*

### 4.5.9.6 Allied health services (CWHHS region)

13Health utilisation rates have remained stable over the years, averaging 200 calls per period across 2018-19, 2019-20, and 2020-21. This consistently usage of telehealth highlights its importance in maintaining access to care in geographically challenging regions.

## 4.5.10 Social and community care (CWHHS region)

There is a comprehensive range of social and community care services to meet the diverse needs of the community. This includes 24/7 healthcare at the five primary CWHHS facilities, where inpatient wards and emergency departments are fully staffed to ensure continuous care for admitted patients and those requiring urgent medical attention. In more remote areas, there are 24/7 emergency response capabilities, including nursing-led ambulance care, ensuring timely and effective care even in isolated communities.

Chronic disease management and preventative care is also a focus in the Central West region, with programs on offer that help patients manage conditions such as hypertension and asthma. These programs provide education, management plans, and preventive care to improve long-term health outcomes. Additionally, aged care services are supported by the presence of both residential care and in-home support, meeting the needs of older adults in our community.

Mental health and social support are integral to the service offerings of Central West Queensland. Mental health services are integrated with social care, providing access to counselling, case management, and specialist referrals. Through community health initiatives, the public is engaged with health education, outreach programs, and partnerships with local organisations, ensuring the well-being of all age groups. This holistic approach addresses both social care and healthcare needs, fostering a healthier, more supported community.

## 4.5.11 Hospital capacity (CWHHS region)

The Central West region, with a population of 10,700, maintains 51 overnight hospital beds, translating to 4.77 beds per 1,000 people. This ratio provides a satisfactory bed capacity for the region, ensuring adequate inpatient care resources for the population size. While bed availability seems sufficient, elective surgery and procedure wait times are key indicators of overall system efficiency.

Elective surgery wait times show moderate performance. Category 1 surgeries have an average wait time of 14 days, while Category 2 and 3 surgeries face longer delays, with average waits of 63 days and 154 days respectively. Additionally, the elective surgery waiting list completion rate is 96%, though there is a discrepancy between WQPHN data and Health SPR data, indicating possible variations in reporting.

For gastrointestinal endoscopy procedures, performance across elective procedure Categories 4, 5, and 6 is strong, with 87.5% of patients treated on time overall. The average wait times are 30 days for Category 4, 91 days for Category 5, and 162 days for Category 6, with higher categories (5 and 6) achieving 93.9% and 100% on-time treatment, respectively. These findings suggest efficient management of endoscopy procedures, particularly for more complex cases, contributing to improved patient outcomes in elective care.

### 4.5.12 Hospital capability (CWHHS region)

The Central West HHS delivers a comprehensive range of public health services across remote central western Queensland, extending from Tambo in the southeast to Boulia in the northwest. Accident and emergency care is offered at all times, with emergency responses available around the clock via the Triple Zero (000) system. The service also provides acute inpatient care, pharmacy, physiotherapy, radiology services, and outpatient clinics.

Longreach serves as the hub for the district's maternity and visiting surgical services, as well as mental health and community health services. Hospital activities encompass both admitted patient services, for those formally admitted to a hospital bed, and non-admitted patient services, which include outpatient clinics, specialist appointments, allied health services, and certain clinical procedures such as clinical measurements.

## 4.6 Stakeholder consultation

### 4.6.1 Relevance

| Why is gathering stakeholder insights from the Central West Queensland region important? |
| --- |
| Incorporating stakeholder perspectives is essential in the development of a robust health needs assessment. While quantitative data provides valuable insights into measurable health trends and service gaps, it alone cannot fully capture the nuanced needs and experiences of regional communities. Qualitative insights, drawn from the lived experiences of community members and the expertise of service providers, add depth and context that enrich the analysis. These perspectives illuminate the unique challenges, cultural values, and local strengths that shape health outcomes in these regions. Engaging with stakeholders not only ensures that the assessment reflects real-world conditions but also fosters a sense of ownership and trust within the community, ultimately leading to more targeted, effective, and sustainable health interventions. |

### 4.6.2 Insights from sector consultation

Consultation with the sector included incorporated insights from three key sources:

- Sector survey – administered in August 2024
- A review of insights gathered by WQPHN staff as part of ongoing liaison with commissioned service providers over the past 12 months, and
- A review of insights gathered by CWHHS staff as part of their most recent Local Area Needs Assessment.

**The most prominent healthcare issues identified included:**

- Supporting people with chronic and complex healthcare issues
- Earlier intervention, including preventive healthcare
- Supporting people's mental health and wellbeing
- Bowel cancer
- Dementia
- Disability services, and
- Respite care.

**A number of solutions were suggested to address these issues:**

- Redesigned models of care to ensure clear pathways that are easy to navigate for both clinicians and consumers. This would include identifying the necessary disciplines required to deliver care in remote and very remote communities, rethinking the best way to combine face-to-face services with telehealth, and collaborating better together, so that a range of visiting services provide services together.
- Identifying strategies to improve workforce recruitment and retention, such as redesigning workforce initiatives for Aboriginal Health Workers in remote locations, and thinking creatively about recruiting couples, friends, and family who may bring multiple disciplines (e.g., teacher and healthcare worker).
- Enhancing transport options, including redesigning travel and accommodation supports for when people from remote communities need to travel out of community for their healthcare.
- Ensuring relevant cultural protocols are documented for each community to support visiting services to deliver culturally safe services in an appropriate location, with appropriate staff at an appropriate time.
- Improved collaboration between Governments and communities to minimise gaps and duplication of services.

### 4.6.3 Insights from community consultation

Consultation with community took the form of a review of insights gathered by WQPHN staff at community events over the past 12 months, in particular the insights shared by community members at regional Healthy Outback Community (HOC) events in the Far West Queensland regions.

Specific issues raised in the Barcoo, Boulia, and Diamantina regions included:

- Considerable challenges accessing general practice and allied health services in a timely manner, particularly in the after-hours period.
- Significant gaps across a range of service areas, including rehabilitation services, imaging services, aged care, palliative care, women's health, and disability services, often requiring residents to leave their communities for care.
- High rates of mental illness and suicide, with limited diversionary activities to support improvements in mental health.
- High rates of chronic disease, with a considerable need for improved chronic disease management.
- The need for staff in regional areas to be appropriately trained to deliver culturally safe and responsive healthcare services.
- Inadequate primary health care facilities, with limited consultation rooms, impacting patient privacy and effective service delivery.
- The need for service providers to communicate with each other, and work better together, to ensure a more coordinated effort to help improve health outcomes.

## 4.7 Prioritised needs

| Tier | Description | Intended action |
|---|---|---|
| 1 | **These needs emerged as top-tiered needs following prioritisation.**<br>The need or issue aligns with the existing priorities of either the WQPHN or the relevant HHS. Resources are available to support activities to address the need, and activity is expected to occur within the next 12 months. In some cases, existing activities to address the need will already be underway, acknowledging some may require minor tailoring to best address the need. | Ensure these key needs are incorporated into relevant workplans for 2025. |
| 2 | **These needs emerged in-between the top and lower-tiered needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unlikely to be fully addressed within current resources. The partnering agencies will continue to advocate for resources to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 2-3 years. |
| 3 | **These needs emerged as lower-tier needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unable to be addressed within current resources. The partnering agencies will explore opportunities to partner with other relevant agencies to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 4+ years. |

| Need Area | Health and Service Needs (CW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Ageing | • There is an aging population in the CWHHS region, which will require the expansion of health and aged care services, with a particular focus on long-term care and chronic disease management. | 2 | WQPHN | WQPHN – Care Finders, CWHHS HAO program, |
| | • There is limited availability of aged care facilities available for people in the CWHHS region, particularly home care services. | 1 | WQPHN | WQPHN – Care Finders, MAC, Advocacy |
| Cancers | • People across the CWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence. | 3 | CWHHS | WQPHN Practice supports, HSS, AMS, RFDS and private primary care services. |
| | • People across the CWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical and Breast). | 1 | WQPHN | CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| | • People across the CWHHS region require increased awareness of sun-safe practices. | 3 | CWHHS | CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| Child and Maternal Health | • Pregnant women and new mothers in the CWHHS region require consistent access to culturally sensitive child and maternal health services in community, including screening and early intervention services. | 2 | CWHHS | WQPHN – HOK, BK, WQPHN – Practice Support, CWAATSICH, Paediatric Outreach Services, |
| | • Families in the CWHHS region require improved access to child development services. | 1 | CWHHS | CWHHS WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| Chronic Disease | • People within the CWHHS region require enhanced access to chronic disease screening, treatment and services, including testing for rheumatic heart disease and acute rheumatic fever. | 1 | CWHHS | WQPHN Practice supports HSS, CWAATSICH RFDS and private primary care services. PHASES. Heart of Australia, Heart Foundation, QH |
| | • The uptake of influenza vaccines is low for people with COPD in the CWHHS region. | 3 | CWHHS | CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| Coordination, integration and continuity of care | • People in the CWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | CWHHS | WQPHN – Primary Care, CWAATSICH, RFDS, Foundations, Check up |
| | • People in the CWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 | WQPHN | HPW, Digital health, HOC, CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |

| Need Area | Health and Service Needs (CW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • Services in the CWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | WQPHN | HPW, Digital Health, CWHHS WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| Domestic and family violence | • People in the NWHHS region report high rates of domestic and family violence, and are in need of culturally sensitive 24/7 supports for victims and families. | 1 | WQPHN | QAS, QPS, DVConnect, CWAATSICH |
| Disability | • There is a lack of disability support services in the CWHHS region, including general supports, allied health services and accommodation services. | 1 | TBA | MAC team, WQPHN, NDIS services |
| | • There is a lack of respite services and supports in the CWHHS region, particularly for families of children with disabilities. | 3 | TBA | CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| | • There is a lack of support for families in the CWHHS region with children who are neurodivergent. | 3 | WQPHN | CWHHS, NDIS (advocacy) |
| | • There is need for enhanced training for practitioners supporting people with disabilities, including assessment training for the NDIS, as well as NDIS and aged care pathways literacy. | 3 | WQPHN | CWHHS, NDIS (advocacy) |
| | • There is a lack of support for people with disabilities and their families, to navigate the disability service system, including service literacy, navigation support, referral pathways and advocacy. | 3 | WQPHN | CWHHS, NDIS (advocacy) |
| Aboriginal and Torres Strait Islander | • Aboriginal and Torres Strait Islander communities in the CWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | Nukal Murra Alliance | CWHHS, CWAATSICH Other WQPHN – CSPs, Primary Care services |
| | • There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the CWHHS region. | 3 | Nukal Murra Alliance | WQPHN – H2H, RHealth, CSPs, |
| | • There is a decline in presentations by Aboriginal and Torres Strait Islander people in the CWHHS region to primary care for routine health checks. | 3 | Nukal Murra Alliance | CWHHS, WQPHN-primary care sites, CWAATSICH, RFDS, Foundations |
| Infrastructure, facilities and equipment | • There is a lack of accessible imaging facilities in the CWHHS region, particularly in the more remote areas of the region. | 1 | SWHHS | Private and travelling providers |
| Mental Health | • Communities in the CWHHS region experience a higher rate of mental health admissions when compared with the State average. | 1 | CWHHS | WQPHN – H2H, RHealth, QAS, Primary Care |

| Need Area | Health and Service Needs (CW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • People experiencing acute mental health issues in the CWHHS region require more timely interventions and in some cases, retrieval services. | 3 | CWHHS | WQPHN – H2H, RHealth, CSPs, |
| | • People experiencing mental illness and psychological distress in the CWHHS region require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including addressing suicidality and substance use issues. | 1 | WQPHN | WQPHN – H2H, RHealth, CSPs, |
| | • Young people experiencing mental illness and/or psychological distress in the CWHHS region require enhanced and more consistent access to targeted prevention and early intervention services. | 1 | WQPHN | WQPHN – H2H, RHealth, CSPs, |
| | • People in the CWHHS region require improved access to specialised eating disorder services. | 3 | WQPHN | CWHHS entry pathway via QH, |
| | • Communities within the CWHHS region require reduced waiting times for mental health services to improve access and outcomes. | 2 | WQPHN | WQPHN – H2H, RHealth WQPHN CSPs |
| | • Services in the CWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities. | 1 | WQPHN | HOC Alliance partners |
| Oral health | • People in the CWHHS region have limited access to oral health services, resulting in potentially preventable oral health conditions. | 2 | CWHHS | RFDS, Checkup |
| Palliative care | • There is a need for palliative care providers to have a footprint in the region to facilitate stronger connections with other providers and better support to families. | 3 | WQPHN | Cmwth NGO providers, CQHHS unit |
| People experiencing homelessness | • There is a lack of support for people experiencing homelessness in the CWHHS region. | 2 | WQPHN | WQPHN – H2H, RHealth, CWAATSICH, |
| Physical activity | • There is a need for Increased access to physical activity programs / facilities in the CWHHS region. | 3 | WQPHN | HOC Alliance |
| Physical rehabilitation | • People in the CWHHS region require improved access to physical rehabilitation and occupational therapy services. | 3 | CWHHS | WQPHN – CSPs |
| Preventive healthcare | • There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 2 | CWHHS | WQPHN – Primary Care and CSPs, CWAATSICH, RFDS |

| Need Area | Health and Service Needs (CW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Primary Care | • Young families in the CWHHS region need enhanced access to comprehensive primary health care to support optimal health outcomes for children. | 1 | CWHHS | WQPHN – Primary Care and CSPs, CWAATSICH, RFDS |
| | • There is a lack of after-hours GP services in the CWHHS region which contributes to high rates of low urgency ED presentations. | 3 | WQPHN | CWHHS, WQPHN – Primary Care, CWAATSICH, RFDS, Foundations |
| Respite | • There is a lack of respite services and supports in the CWHHS region, particularly for people with dementia. | 2 | CWHHS | NDIS, MAC, WQPHN – CF, HAO (Advocacy) |
| Retrieval services | • People in the CWHHS region receiving care out of catchment require greater flexibility in retrieval services to optimise health outcomes following treatment. | 2 | CWHHS | WQPHN – Primary Care and CSPs, CWAATSICH, RFDS, HOC Alliance |
| Sexual health | • People in the CWHHS region require increased access to sexual health screening, testing, and treatment services at the community level (in community). | 3 | CWHHS | WQPHN – Primary Care, CWAATSICH, RFDS, HOC Alliance |
| Specialist care | • People in the CWHHS region require improved access to specialist services to increase diagnosis, treatment and ongoing management of health concerns. | 3 | CWHHS | WQPHN – Primary Care, CWAATSICH, RFDS, |
| Substance Use | • People within the CWHHS region have a higher rate of alcohol consumption when compared with the State average, suggesting the need for alcohol harm reduction strategies. | 2 | WQPHN | CWHHS, WQPHN – CSPs, RFDS, CWAATSICH |
| | • There is need for increased awareness of the harms associated with substance misuse for people in the CWHHS region, including the association with domestic and family violence. | 2 | WQPHN | TBC |
| | • People experiencing substance use issues in the CWHHS region require increased access to support, detox and rehabilitation services. | 3 | WQPHN | TBC |
| | • There is a lack of community-based substance use support services for people experiencing substance use issues in the CWHHS region. | 1 | WQPHN | TBC, clean slate |
| Suicide prevention | • The suicide rates for communities in the CWHHS region are high when compared with the State average. | 1 | CWHHS | Crisis- CWHHS, Lifeline, Early supports, WQPHN – H2H, RHealth |
| System Issues | • Current restrictions on MBS billing for Nurse Practitioners limits the ability to utilise an effective and available workforce in regional communities within the CWHHS region. | 1 | WQPHN | WQPHN – Primary Care and CSPs, CWAATSICH, RFDS, HOC Alliance |
| | • There is a lack of community engagement to inform the design of health care services for people in the CWHHS region. | 2 | WQPHN | CWHHS, CheckUP, HCQ, HOC Alliance, CACs |

| Need Area | Health and Service Needs (CW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Transport | • People in the CWHHS region require transport and accommodation support to facilitate access to necessary health services in other locations | 1 | PTSS-CWHHS | NMA, CWAATSICH, Primary care |
| Workforce | • There are significant challenges in recruiting and retaining qualified medical, nursing and allied health professionals in the CWHHS region. | 1 | CWHHS | HWQ, WQPHN – WPP |
| | • Limited nursing staff available to support/administer chemotherapy. | 2 | CWHHS | WQPHN – WPP, Advocacy |
| | • The CWHHS region requires increased representation of Aboriginal and Torres Strait Islander peoples within its health workforce to better meet community needs. | 1 | Nukal Murra Alliance | WQPHN, CWHHS |
| Young People | • Young people in the CWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 1 | CWHHS | WQPHN Practice Supports HSS, CWAATSICH, RFDS and private primary care services<br>QLD HEALTH<br>CW Alliance |
| | • There is a lack of community engagement with young people in the CWHHS region to inform the design of culturally appropriate prevention and promotion activities. | 1 | Nukal Murra Alliance | WQPHN, CWHHS |

# 5 South West Queensland Region

## 5.1 Population

### 5.1.1 Geography

The South West Queensland region spans a large geographical area in the south west of Queensland, bordering New South Wales, South Australia and the Northern Territory. The region covers a large catchment of 319,000 km$^2$, or 17% of the State, and incorporates six LGAs – Bulloo, Quilpie, Murweh, Paroo, Maranoa and Balonne.

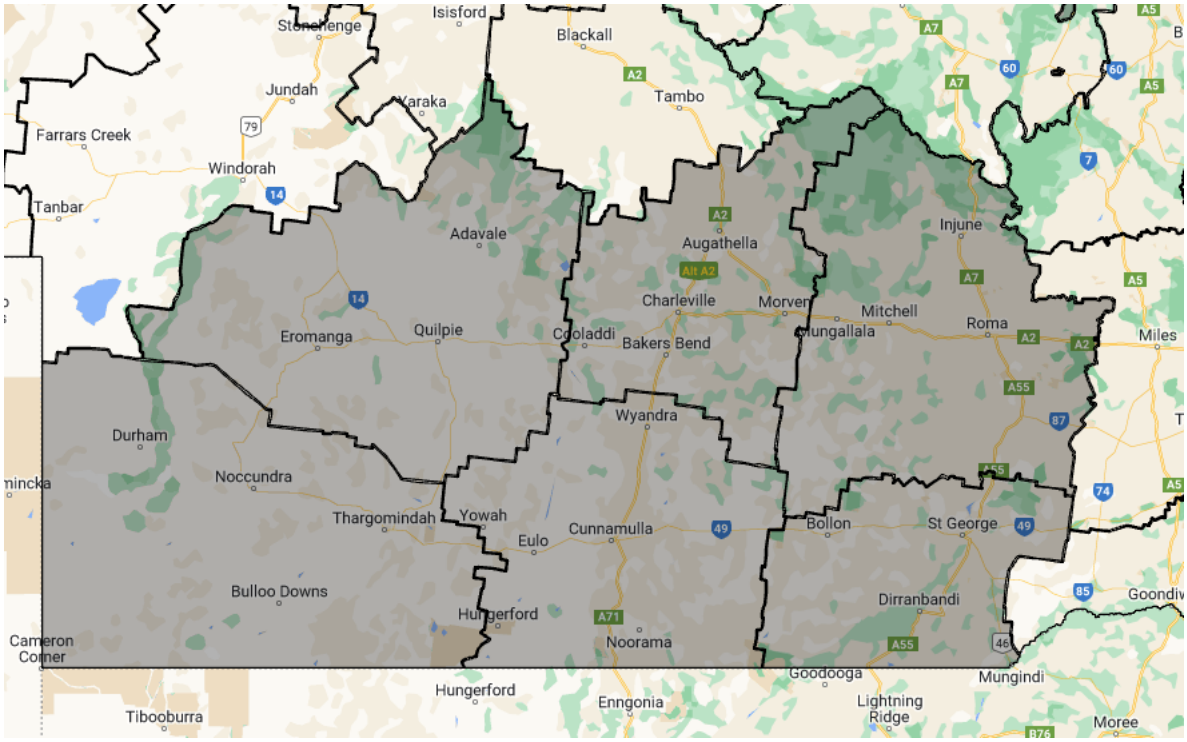


*Figure 114: South West Queensland region*

The table below provides the concordance across statistical areas, local government areas and major towns across the South West Queensland region.

*Table 17: South West Queensland region statistical areas, local government areas, major towns and remoteness score*

| Statistical Area level 3 | Statistical Area level 2 | Local Government Areas | Major Towns | Remoteness |
|---|---|---|---|---|
| Darling Downs | Roma and Roma Region | Maranoa (R) | Roma, Injune, Mitchell, Surat, Wallumbilla | Remote |
| | Balonne | Balonne (S) | St George, Bollon, Dirranbandi, Mungindi | Remote |
| Outback South | Far South West | Quilpie (S) | Quilpie | Very remote |
| | | Bullo (S) | Thargomindah | Very remote |
| | | Paroo (S) | Cunnamulla | Very remote |
| | Charleville | Murweh (S) | Charleville, Augathella, Morven | Very remote |

### 5.1.2 Demography

South West Queensland region is home to 24,173 persons, with more than half (54.8%) the population residing in Maranoa, (Figure 118) and approximately one fifth (19.6%) of the population identifying Aboriginal or Torres Strait Islander peoples. Paroo and Balonne LGA have the largest proportion of people identifying as Aboriginal or Torres Strait Islander peoples, with 36.7% and 20.0% respectively (Figure 118Figure 115).

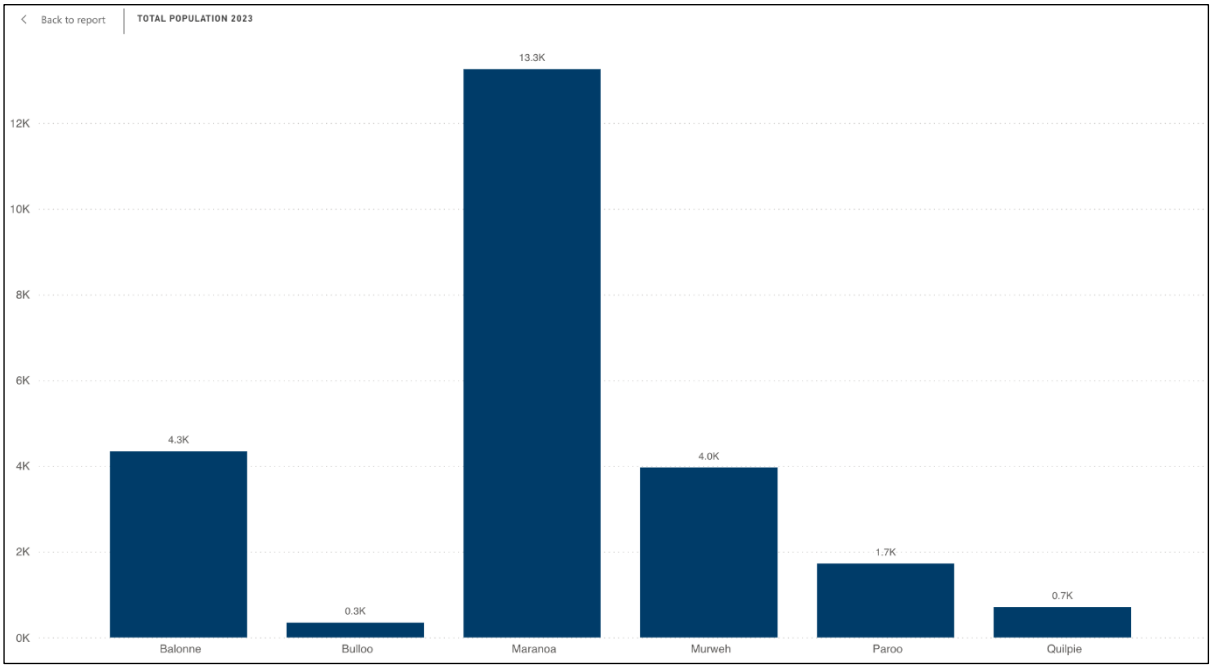


*Figure 115: South West Queensland population across LGAs*

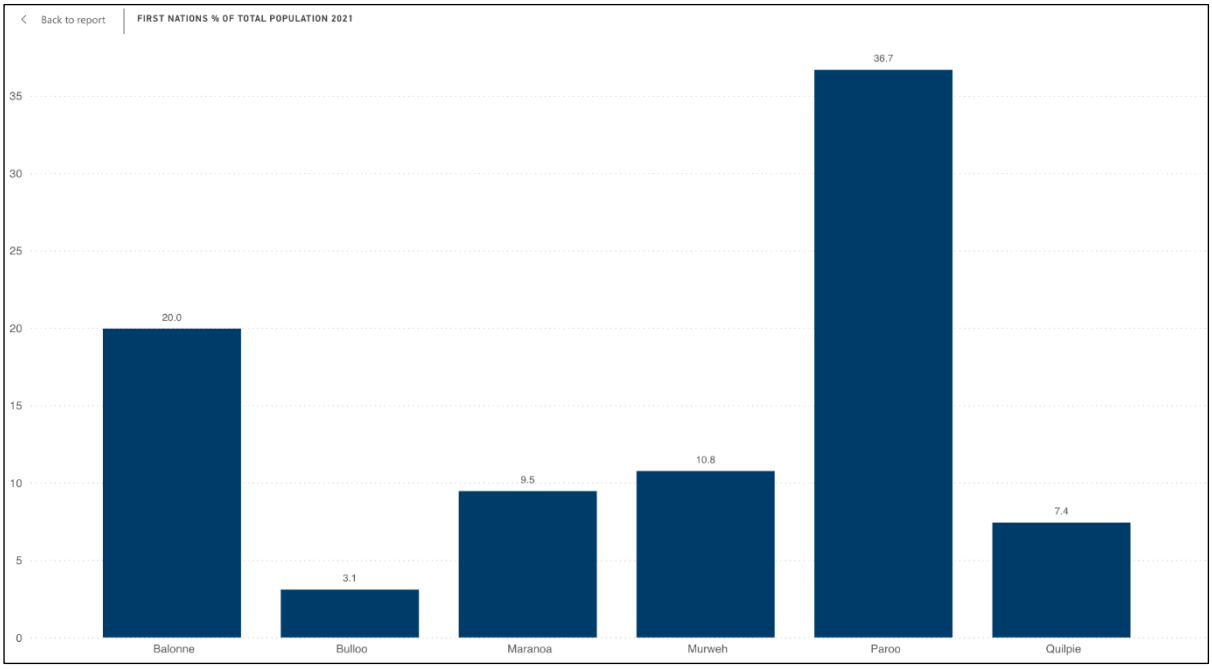


*Figure 116: Aboriginal and Torres Strait Islander population across South West Queensland*

The region has a slightly older median age when compared with Australia (38.8 years) and the State (38.4 years), with five of the six LGAs with higher median ages. Murweh (43.5 years), Paroo (42.3 years) and Quilpie (41.7 years) all have a median age of 40 or higher (Figure 120).

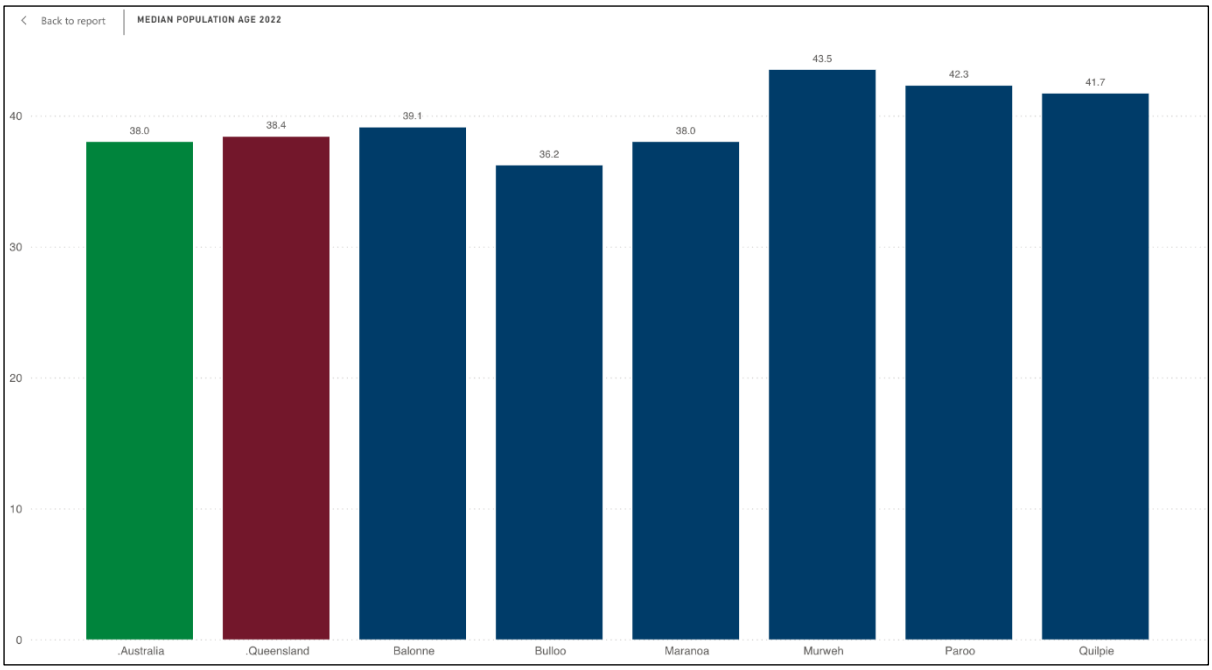


*Figure 117: Median age of the population in South West Queensland across LGAs*

20.6% of the population are less than 15 years old, which is similar to the broader Western Queensland region (21.4%) but higher than the National and State levels (18.3% and 18.8 respectively). Paroo (21.8%) and Maranoa (21.4%) Bulloo (21.3%) and Quilpie (20.6%) have the highest proportion of young people (Figure 121).

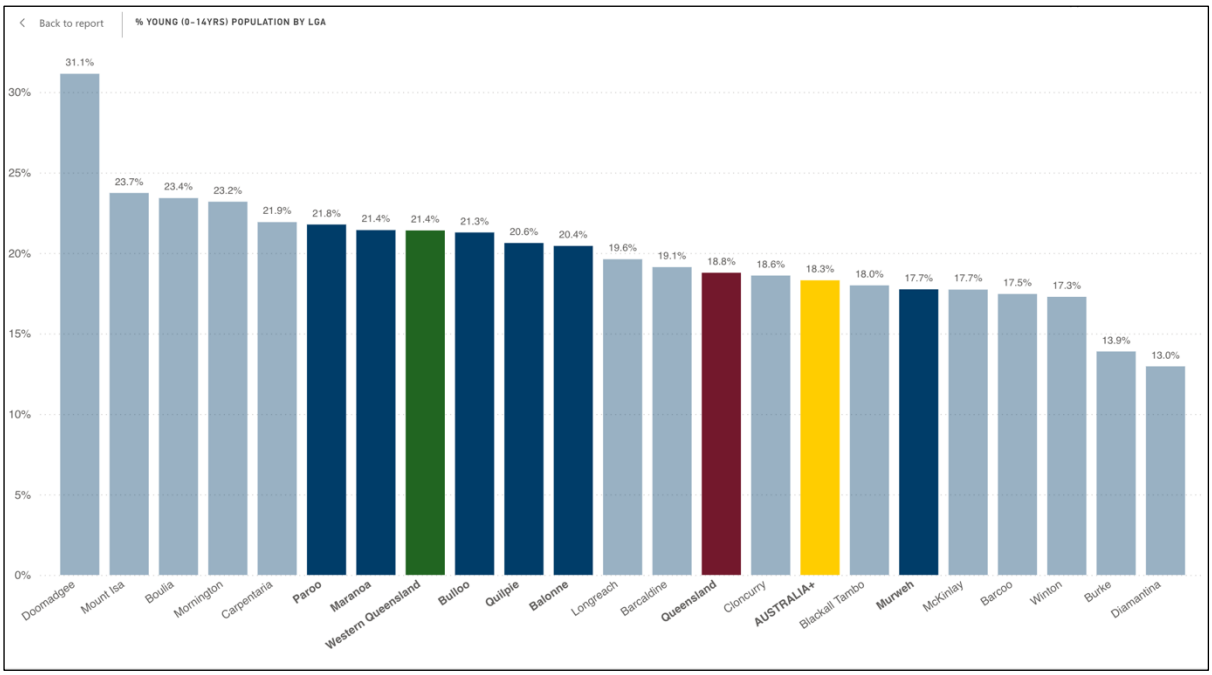


*Figure 118: Proportion of young people aged 0 - 14 years in the South West region*

The South West Queensland region has a higher proportion of people aged 65 and over (16.9%) compared to the broader Western Queensland region (14.0%) but lower than the National (17.4%) and State (17.4%) levels. Murweh (19.7%), Paroo (19.1%) and Quilpie (17.6%) have the highest proportion of older Australians in the region (Figure 122).

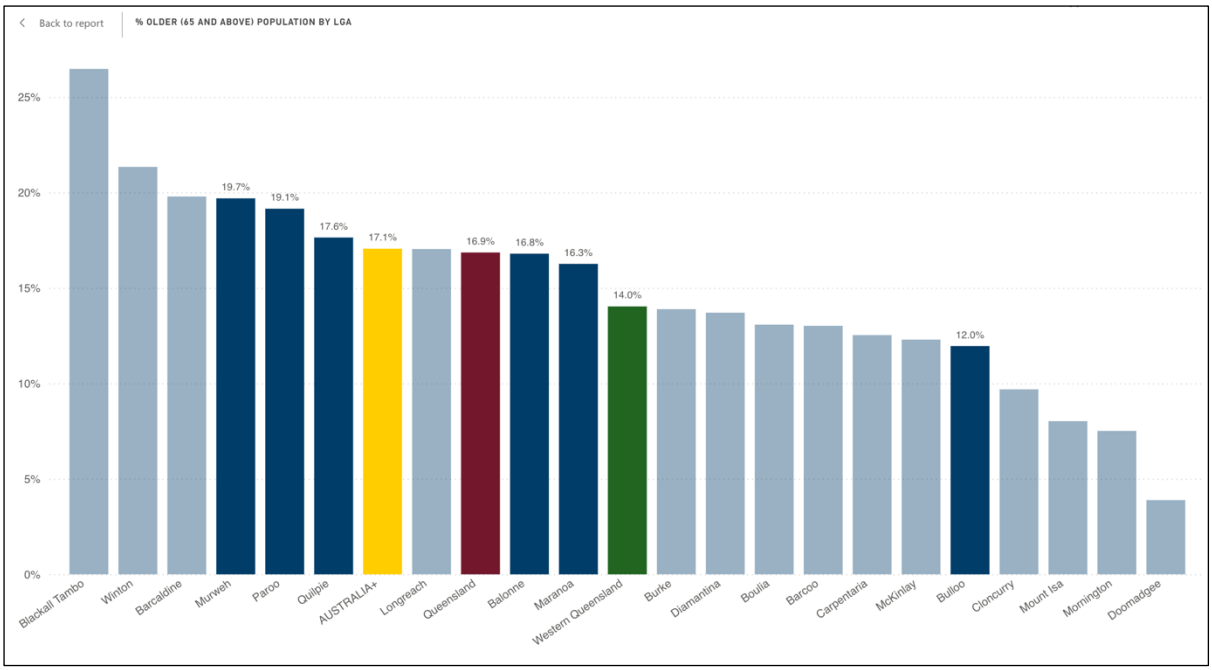


*Figure 119: Proportion of older people aged 65 years and over in the South West region*

## 5.1.3 Population growth

Annual projected population growth in 2026-2046 period is -4.7%, compared to an expected +1.4% increase across Queensland, indicating there is an expectation that the population of the region will be significantly decreasing in coming decades.

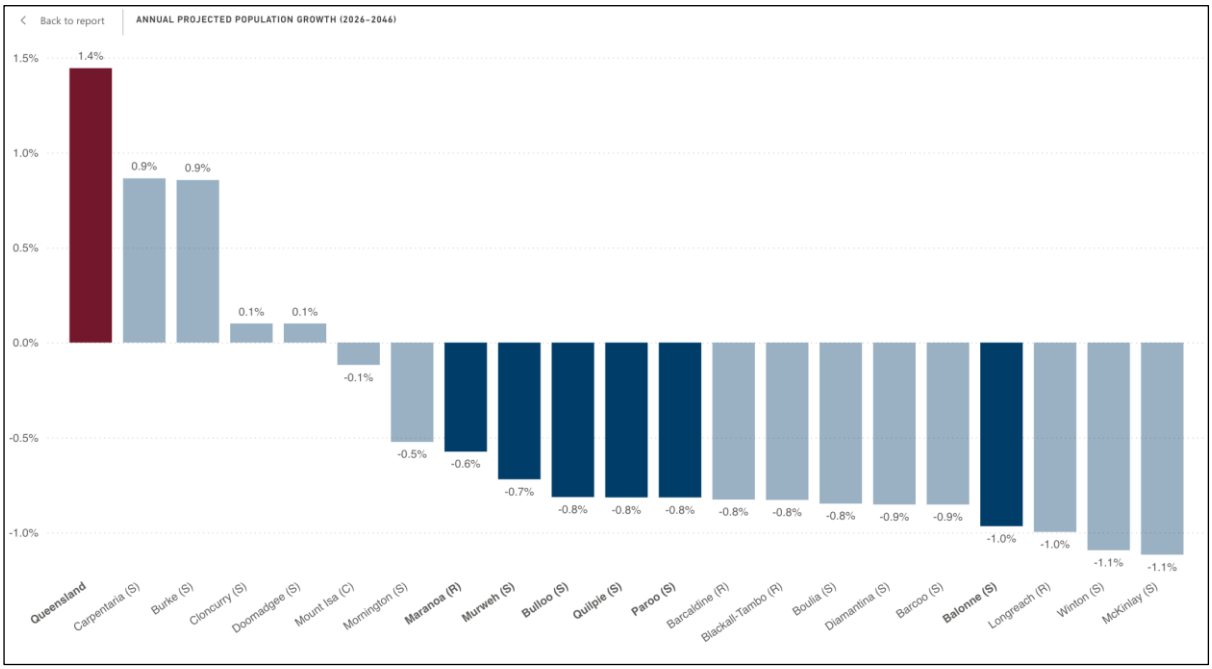


*Figure 120: Population projections for the South West region for 2026-2046*

## 5.2 Determinants of health

### 5.2.1 Relevance

**Why is exploring social determinants of health in the South West Queensland region important?**

The social determinants of health, including income, education, employment, housing, and access to nutritious food, fundamentally shape individual and community health outcomes. These factors are often more powerful than medical interventions in determining life expectancy and quality of life. Exploring social determinants is critical because they directly contribute to health disparities, particularly among vulnerable populations. Addressing these determinants through policy and systemic changes offers the most effective means of improving health equity and achieving sustainable health improvements across the region.

Lifestyle factors, including obesity, diet, exercise, smoking, and alcohol consumption, are major contributors to both chronic disease and preventable mortality. Poor dietary habits, physical inactivity, and substance use significantly increase the risk of conditions such as heart disease, diabetes, and certain cancers. These behaviours not only impact individual health outcomes but also place a considerable burden on healthcare systems. Understanding the prevalence of these factors and their role in shaping health is essential to designing effective health promotion and disease prevention strategies that can improve population-wide wellbeing and reduce healthcare costs.

### 5.2.2 Social determinants of health

#### 5.2.2.1 Socio-economic disadvantage

The Socio-Economic Indexes for Areas (SEIFA) consist of four indexes that rank regions across Australia based on socio-economic factors and disadvantage. There is a strong link between socio-economic status and health outcomes, where people from disadvantaged backgrounds tend to have poorer health, shorter life expectancy, and higher health risks compared to those from higher socio-economic backgrounds (Australian Institute of Health and Welfare, 2020). Additionally, research shows that individuals living in socio-economically disadvantaged areas are more likely to face challenges accessing healthcare services outside their local area (Arpey, Gaglioti, and Rosenbaum, 2017).

Across the South West region, 49.0% of the population sit in the two most disadvantaged SEIFA quintiles (1 and 2). Paroo has 84.0% of its population in quintile 1. Balonne and Murweh have 79.9% and 75.5% of their populations respectively in the most and second most disadvantaged quintiles. The least disadvantaged areas include Maranoa and Quilpie with 36.7% and 35.0% of the population living in quintile 4 and 5 areas (Figure 121124).

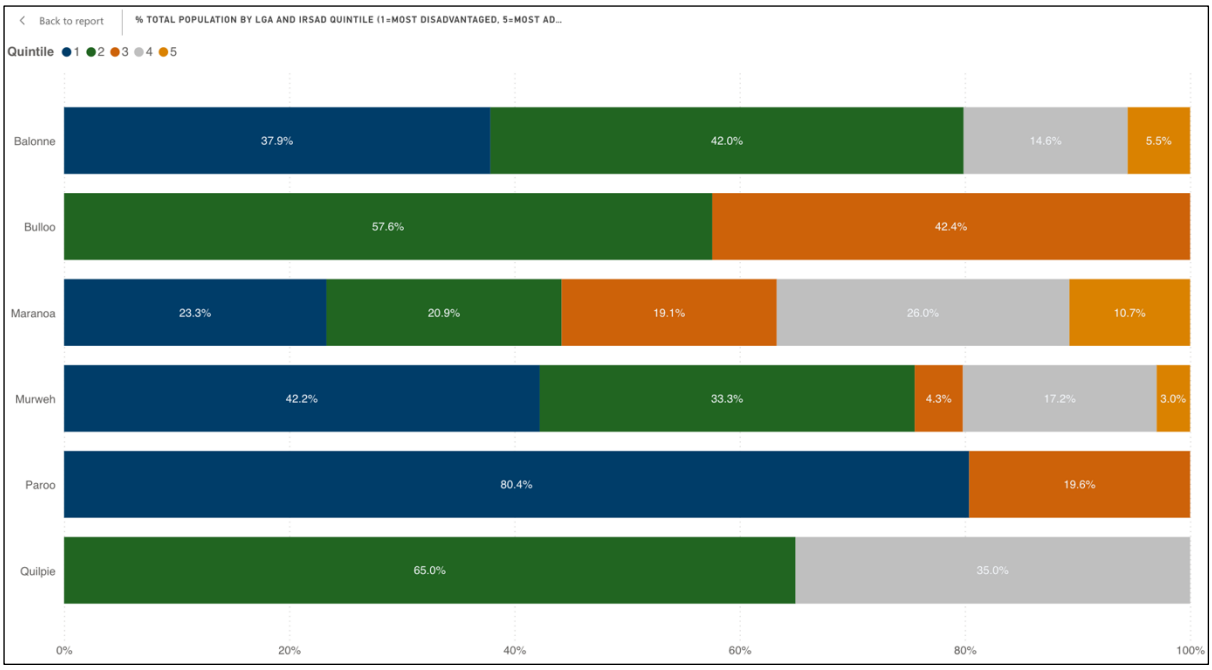


*Figure 121: Index of Relative Socio-economic Advantage and Disadvantage for the South West region*

Table 18 shows the IRSD profile of each LGA in the region. Paroo, Murweh and Balonne belong to the most disadvantage quintiles (1 and 2), while Buloo, Maranoa and Quilpie are categorized into the less disadvantage quintiles (3 and 4).

*Table 18: SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) by LGA in South West region, 2021*[20]

| LGA | Balonne | Bulloo | Maranoa | Murweh | Paroo | Quilpie |
|---|---|---|---|---|---|---|
| Population | 2,849 | 337 | 12,825 | 3,971 | 1,679 | 698 |
| SEIFA Score | 943 | 990 | 995 | 948 | 866 | 998 |
| SEIFA Quintile | 2 | 3 | 4 | 2 | 1 | 4 |

The proportion of private dwellings without access to the internet is considerably higher in the Western Queensland region (22.9%), compared with the National (14.1%) and State (13.6%), and the rates are even higher in the South West region, with 35.2% of dwellings in Paroo not having access to the internet, more than 2.5 times the State rate (Figure 125).

[20] *Source: ABS, Socio-Economic Indexes for Areas (SEIFA), Australia, 2021 | Australian Bureau of Statistics*

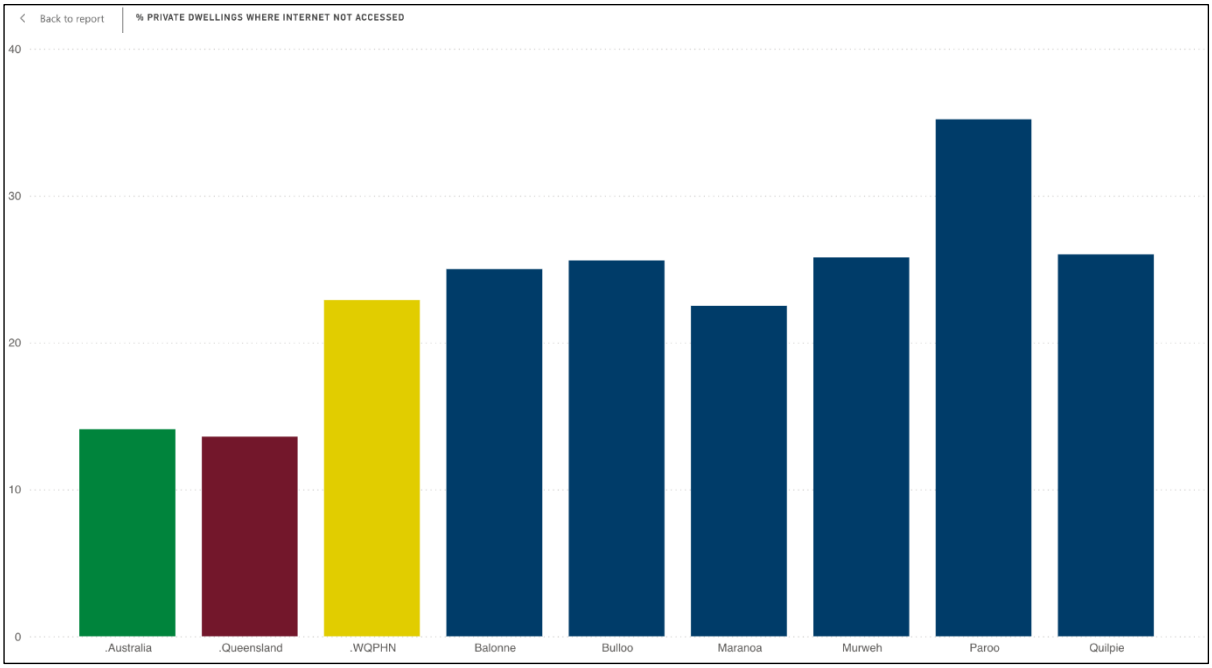


*Figure 122: Proportion of private dwellings not accessed to the internet in South West region*

### 5.2.2.2 Income

The mean personal income across the South West Queensland region tends to be lower than both the National ($67,236) and State ($63,718) means. The highest mean income is in Bulloo ($64,875) ranging down to $40,543 in Balonne.

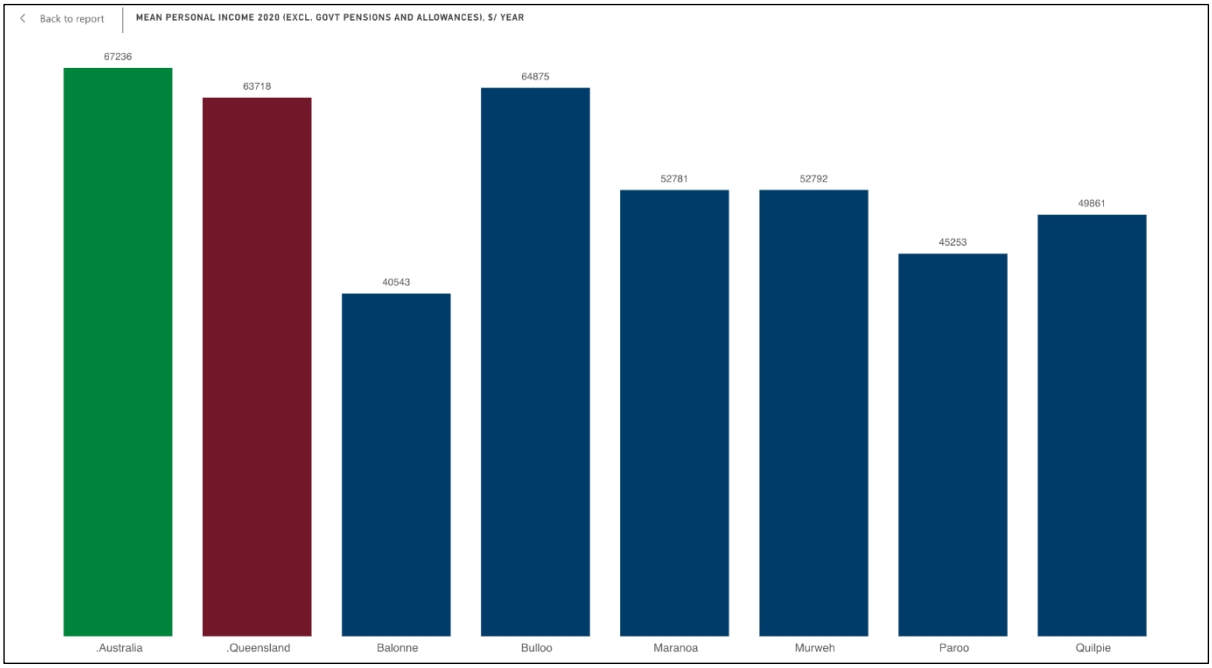


*Figure 123: Mean personal income across the South West region, 2020*

The growth in income earners from 2016 to 2020 is variable across the South West region, with a negative growth rate in all LGAs except Bulloo and Maranoa, where small positive growth rates are observed (Table 19: Number of income earners across the South West region).

*Table 19: Number of income earners across the South West region*

| Region | # income earners 2016 | # income earners 2020 | Annual growth rate |
|---|---|---|---|
| Australia | 13,358,252 | 14,619,595 | 2.28% |
| Queensland | 2,623,526 | 2,921,819 | 2.73% |
| Balonne | 2529 | 2443 | -0.86% |
| Bulloo | 151 | 175 | 3.76% |
| Maranoa | 7255 | 7678 | 1.43% |
| Murweh | 2454 | 2409 | -0.46% |
| Paroo | 763 | 751 | -0.40% |
| Quilpie | 522 | 510 | -0.58% |

Figure 127 **Error! Not a valid bookmark self-reference.**shows the median weekly income for households adjusted to reflect household size and composition across the 10-year period 2011 to 2021. In general, the region's median equivalised income has increased between 2011 and 2021, with the exception of Paroo, where the median rate has dropped. The median household income in Bulloo in 2020 ($1,156) was higher than both the National ($1,070) and State ($1,032) medians. All the remaining LGAs has a median equivalised household income lower than the National value.

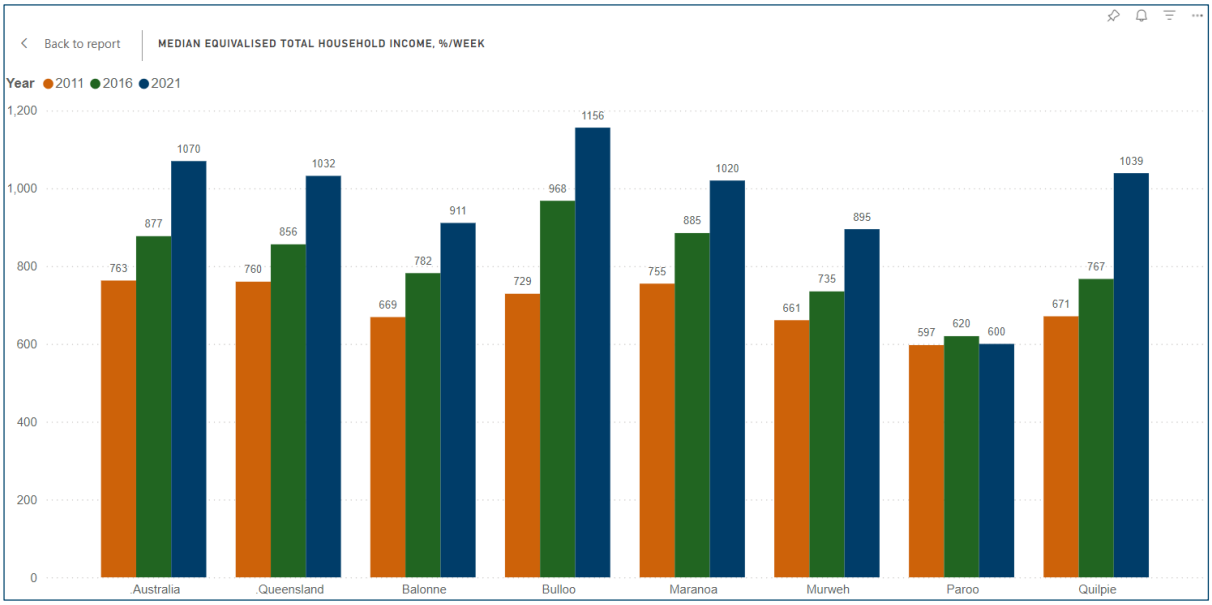


*Figure 124: Median equivalised household income in the South West region, 2001-2021*

Figure 128 presents Gini coefficients for each LGA in the South West Queensland region, providing an indication of the inequality of income distribution across the LGAs. A Gini coefficient of 0 reflects perfect equality, where all income or wealth values are the same, whereas a Gini coefficient of 1 reflects maximum inequality. Balonne has the greatest income inequality (0.88), with Paroo (0.64), Maranoa (0.60), Quilpie (0.60) and Murweh (0.51) all above the National (0.48) and State (0.47) averages.

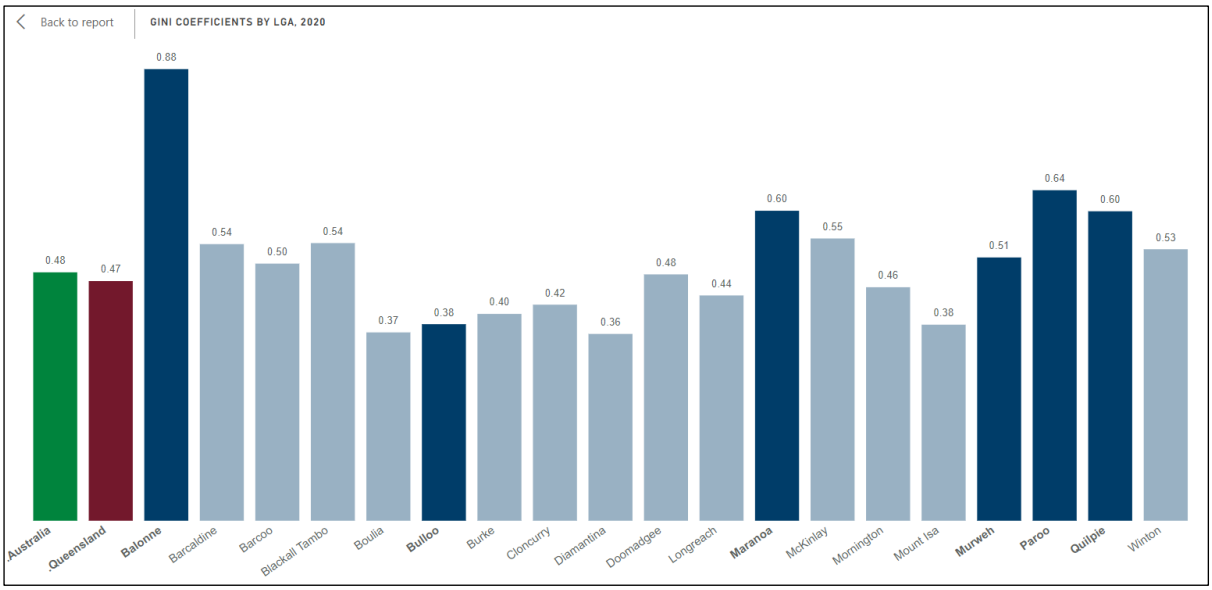


*Figure 125: Gini coefficients by LGA in South West region, 2020*

Low-income households, defined as those with income in the lowest 40% of households across Australia, make up 61.6% of all households in Paroo, 47.2% in Murweh and 45.9% in Balonne. Conversely, only 25.2% of households in Bulloo are classified as low income households (Figure 126129). Similarly, these three LGAs also have the highest rates of low income and welfare-dependent families with children (Figure 127).

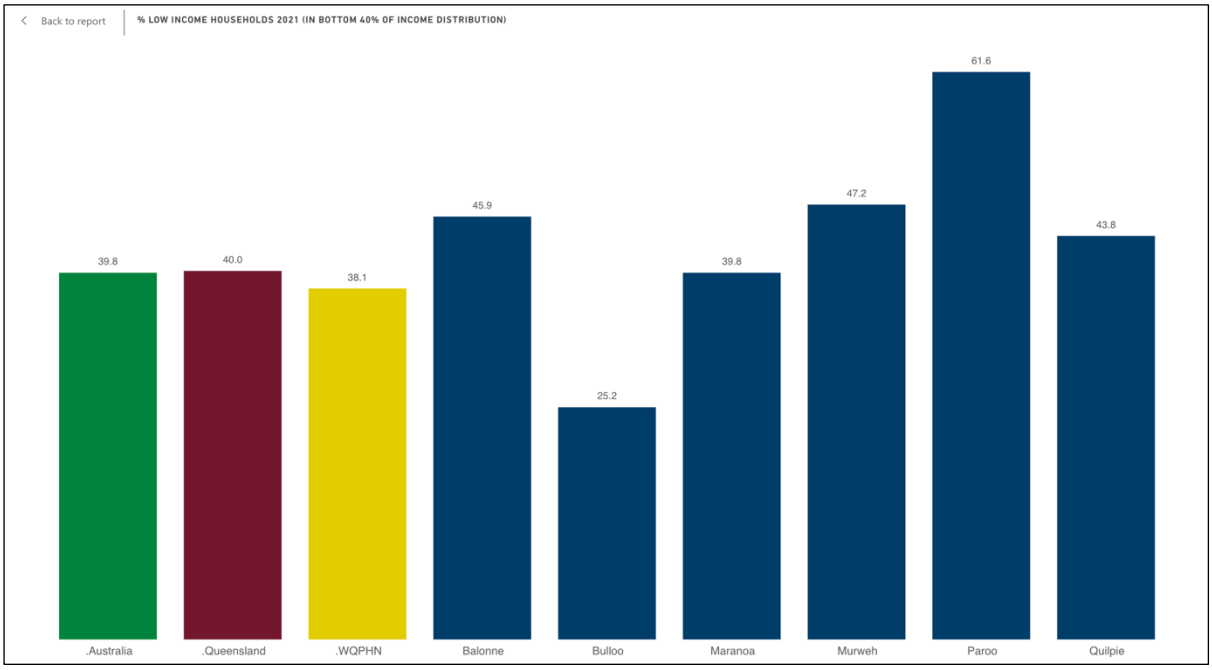


*Figure 126: Proportion of low income households in the South West region*

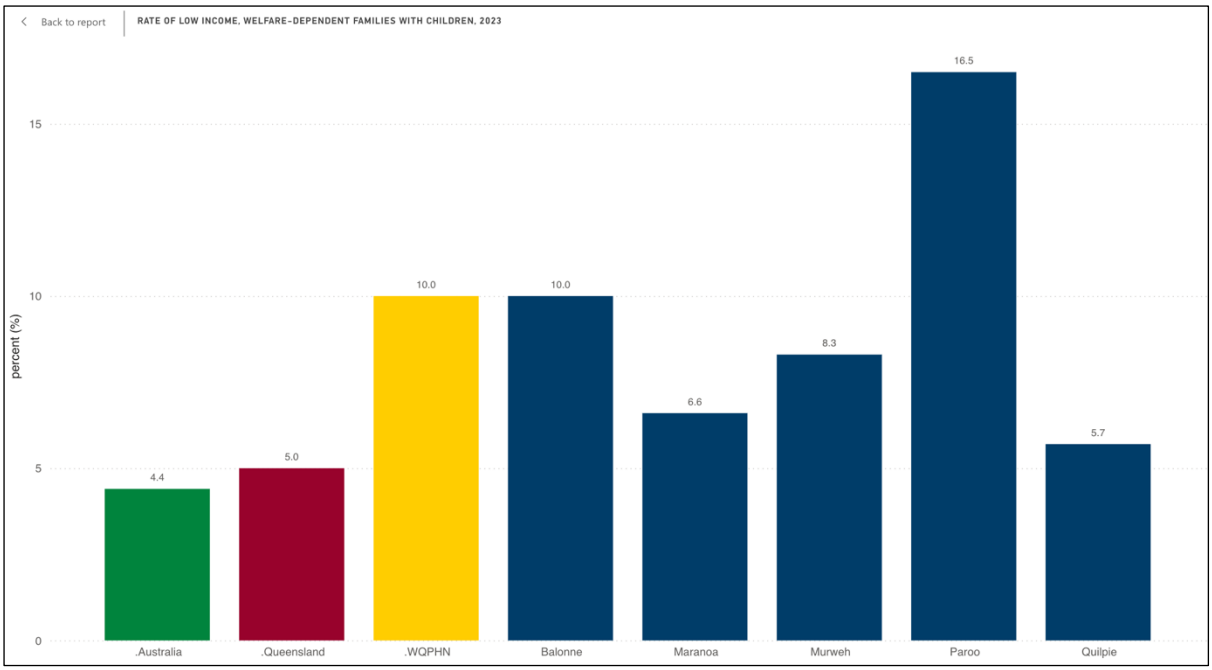


*Figure 127: Proportion of low income, welfare-dependent families with children in the South West region*

### 5.2.2.3 Education

In 2022, the rates of children aged 4 or 5 in the South West region attending a preschool program are variable across the LGAs. Balonne (38.5%), Maranoa (29.5%) and Murweh (24.8%) have rates higher than the National (19.5%) and State (11.9%) rates. No data is available for Bulloo, but rates for Paroo (12.0%) and Quilpie (10.3%) are both low (Figure 131).

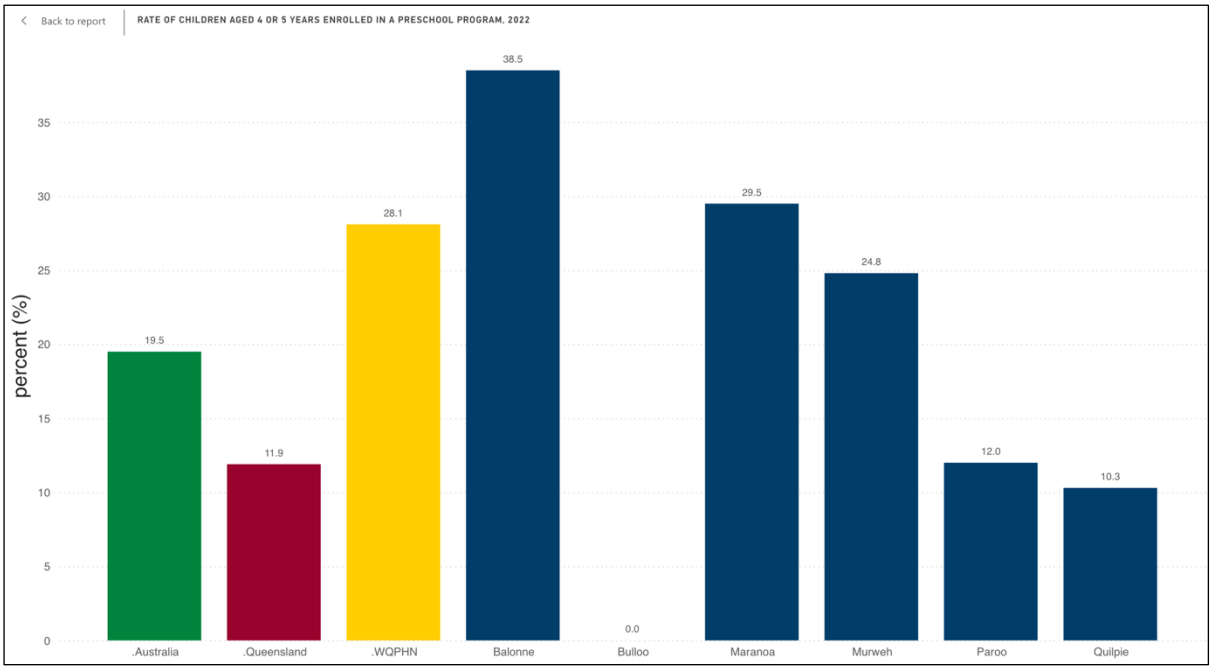


*Figure 128: Proportion of children aged 4 or 5 years enrolled in a preschool program in the South West region, 2022*

Rates of full time participation in secondary schools at age 16 are high (100%) in Bulloo, but are lower than the National (85.3%) and State (83.1%) rates in all other LGAs. Balonne has the lowest full time participation rate at 50.8%.

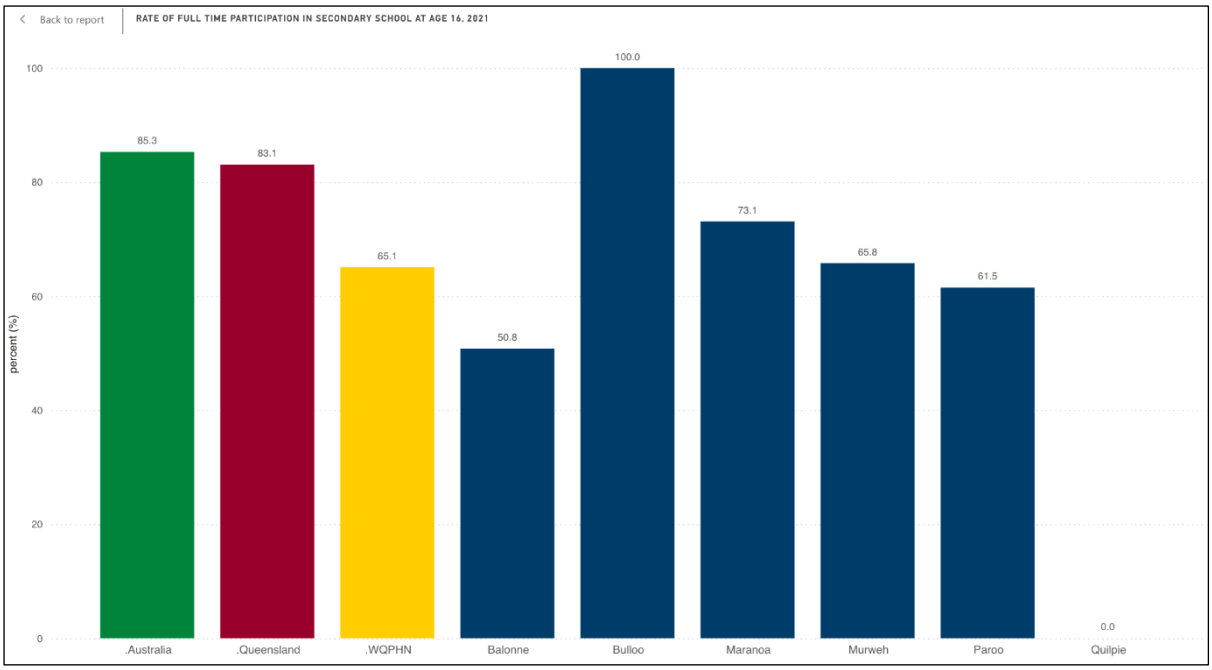


*Figure 129: Rate of full time participation in secondary school at age 16 across the South West region, 2021*

By grade 10, rates of students leaving school or not going to school in South West's LGAs are all considerably higher than National (25.4%) and State (27.9%) levels. Bulloo (47.9%) and Paroo (41.8%) have the greatest proportion of students having left school, with the remaining LGAs similar to the broader Western Queensland regional level (37.2%) (Figure 133).

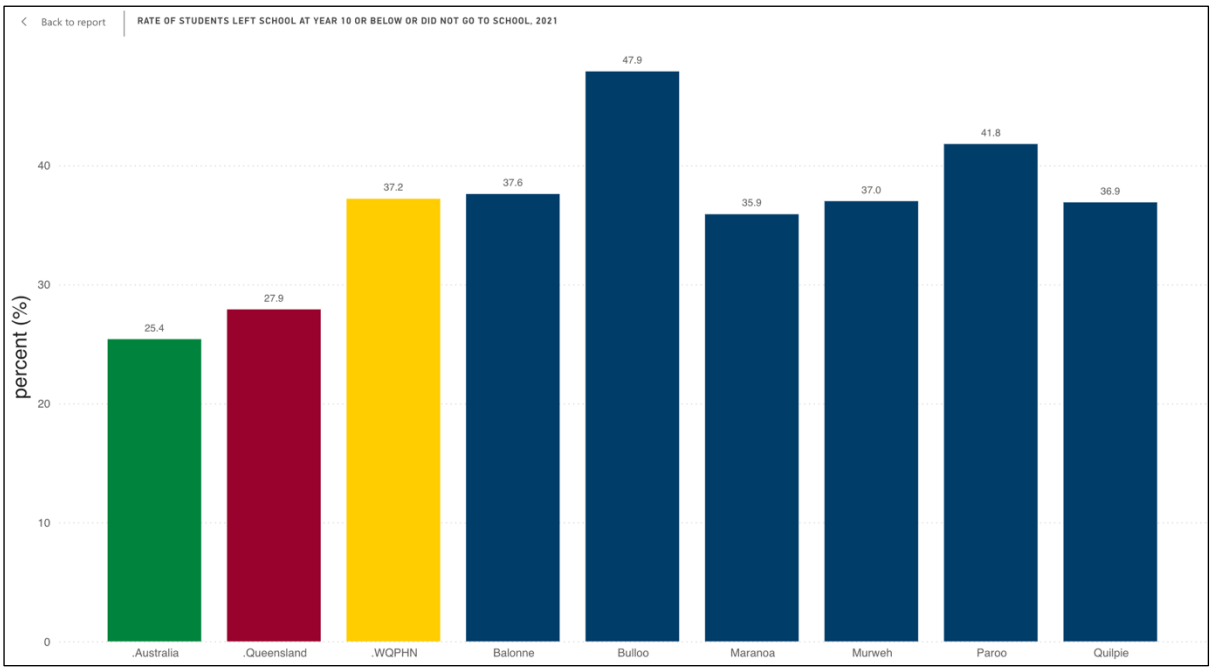


*Figure 130: Rate of students who left school at year 10 or below or did not go to school in the South West region*

Table 20 shows the distribution of public schools across the region. Data for the rate of students enrolling in higher education is not available.

*Table 20: Distribution of public schools across the South West region*

| | Balonne | Bulloo | Maranoa | Murweh | Paroo | Quilpie |
|---|---|---|---|---|---|---|
| Number and type of schools | 4 Primary<br>1 High<br>1 Combined | 1 Primary | 6 Primary<br>5 Combined | 3 Primary<br>1 High<br>1 Distance | 2 Primary<br>1 Combined | 1 Primary<br>1 Combined |

Participation rates in vocational education and training are reasonably high, when compared with National (16.7%) and State (18.3%) rates, with all LGAs except Balonne above the National and State rates. Paroo (25.8%), Quilpie (25.6%) and Murweh (23.7%) have the greatest participation in vocational education and training (Figure 134).

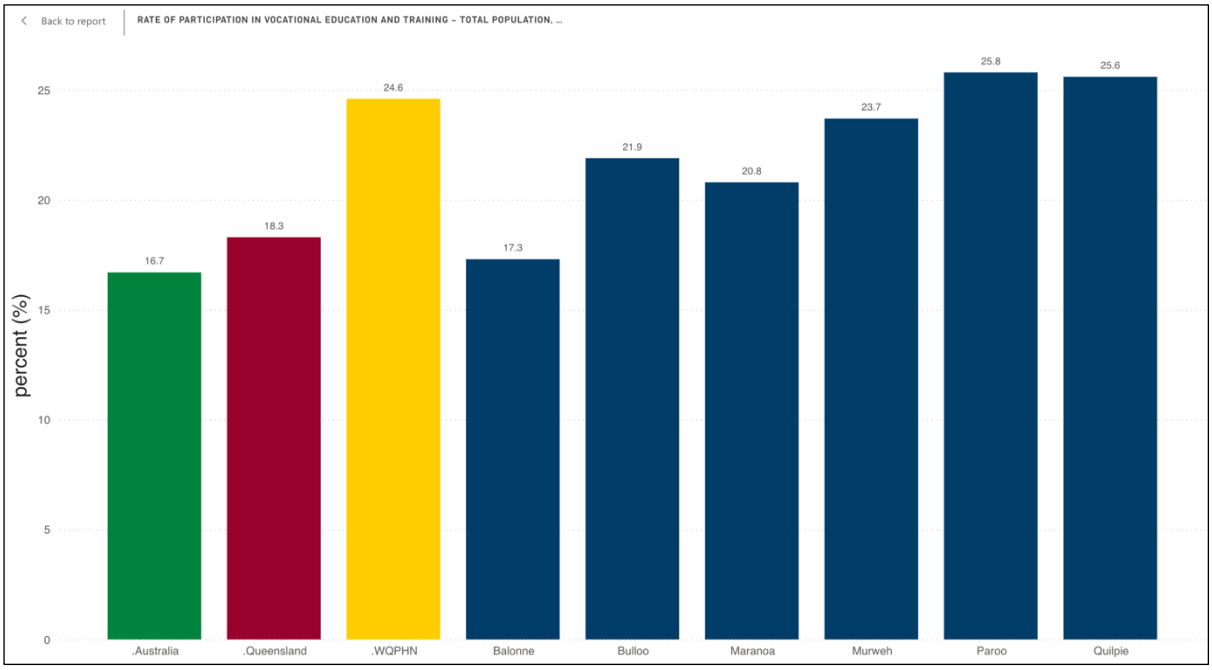


*Figure 131: Rate of participation in vocational education and training in the South West region*

The rates of participation in vocational education and training for Aboriginal and Torres Strait Islander peoples vary significantly across the LGAs, with Quilpie (37.0%), Bulloo (29.8%) and Murweh (27.1%) all well above National and State rates, and Maranoa (13.7%), Paroo (9.1%) and Balonne (7.7%) all well below (Figure 135).

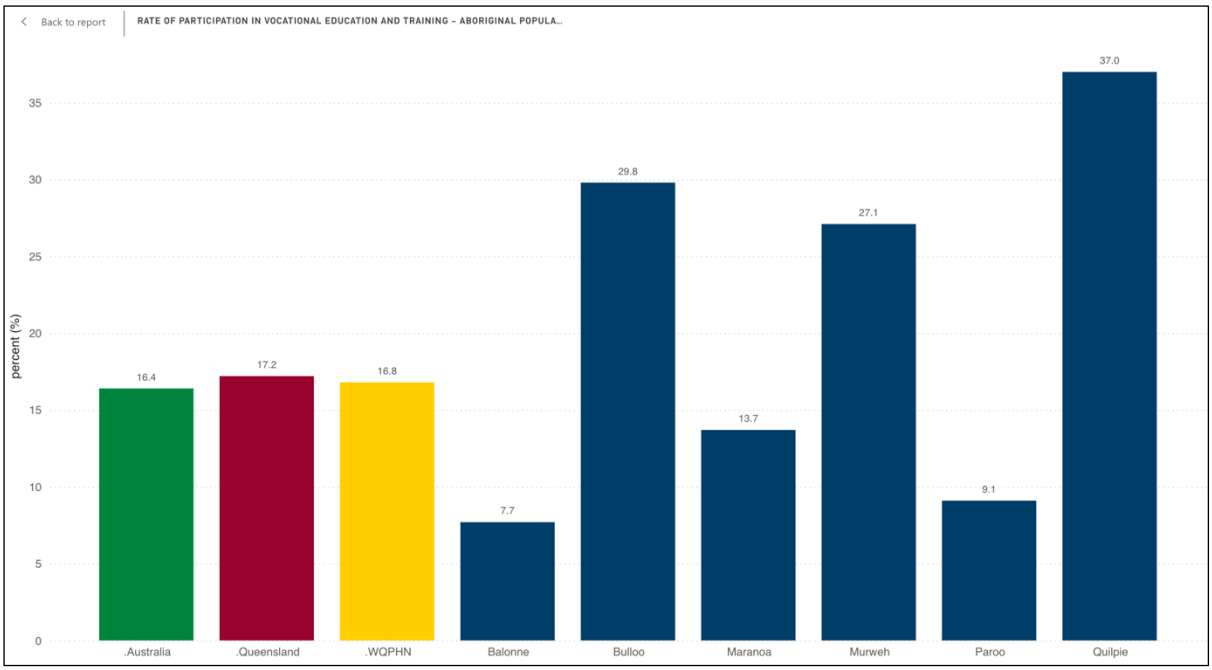


*Figure 132: Rate of participation in vocational education and training in the South West region - Aboriginal and Torres Strait Islander population*

### 5.2.2.4 Employment

In 2023, approximately 67% of the working-age population (aged 15 years and over) in the South West region participated in the labour force. Labour force participation has increased across the region over the period 2021 to 2023, with the exception of Bulloo and Quilpie, where participation has dropped.

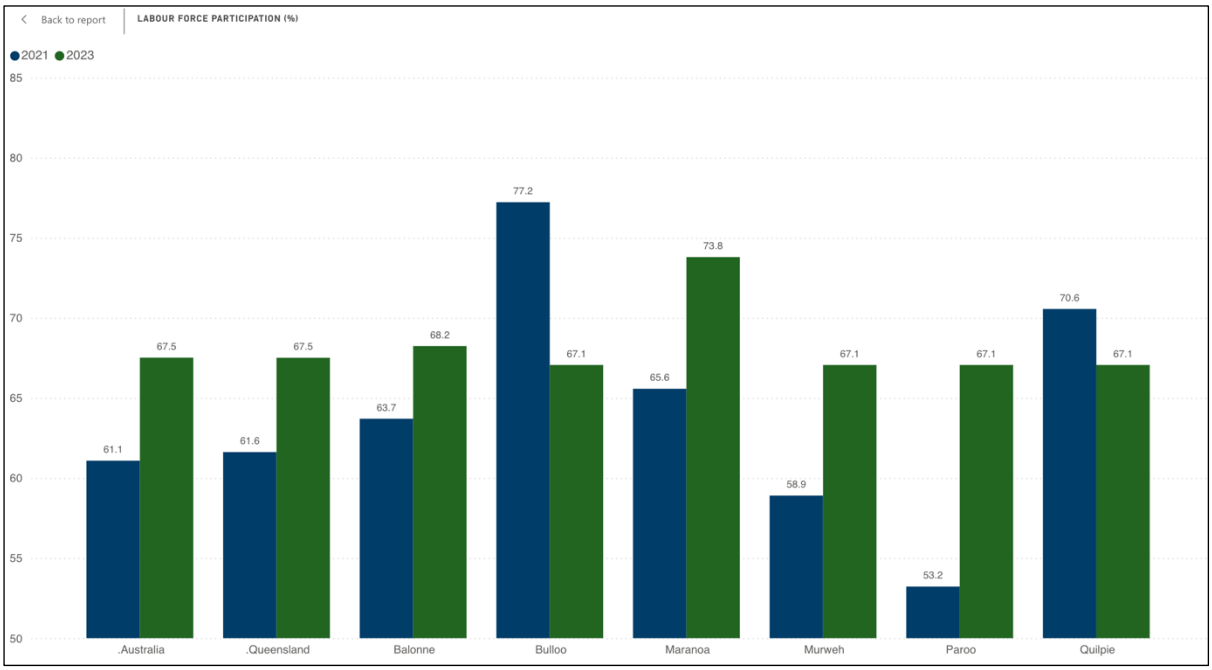


*Figure 133: Labour force participation across South West Queensland, 2021 - 2023*

For those participating in the labour force, the unemployed rates are aggregately 4.1% in Boulia, Bulloo, Murweh, Paroo and Quilpie which is higher than National (3.5%) and State (3.7%) levels; 2.1% in Maranoa and 3.5% in Balonne. Unemployment rates across the LGAs are slightly higher than National (3.5%) and State (3.7%) averages, with the exception of Balonne at 3.5% and Maranoa at 2.1%.

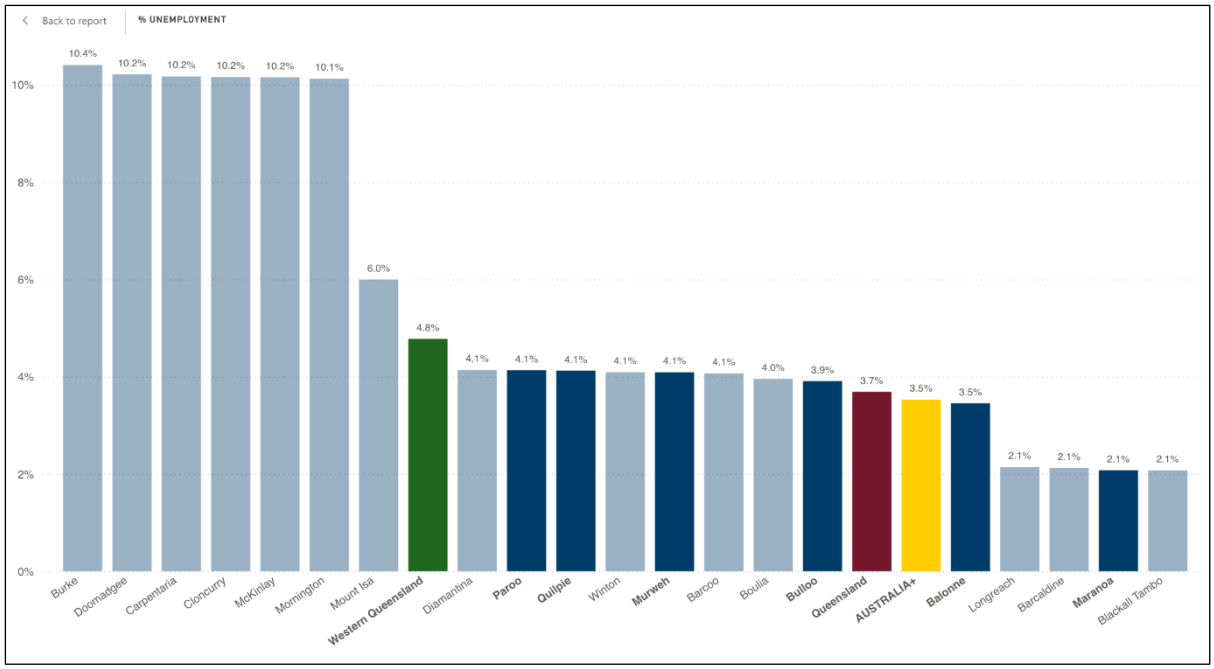


*Figure 134: Unemployment rates across the South West region*

Figure 135128 shows the rate of young people aged 15-24 either earning or learning, across each LGA. In general, South West's LGAs achievement is close to the three benchmarks (National at 85.4%, State at 83.7% and the broader Western Queensland region at 72.5%). Apart from Paroo with the lowest rate of 64.6% and Bulloo with the absolute rate of 100%, other LGAs have higher rates than the broader PHN level and slightly lower than National and State levels.

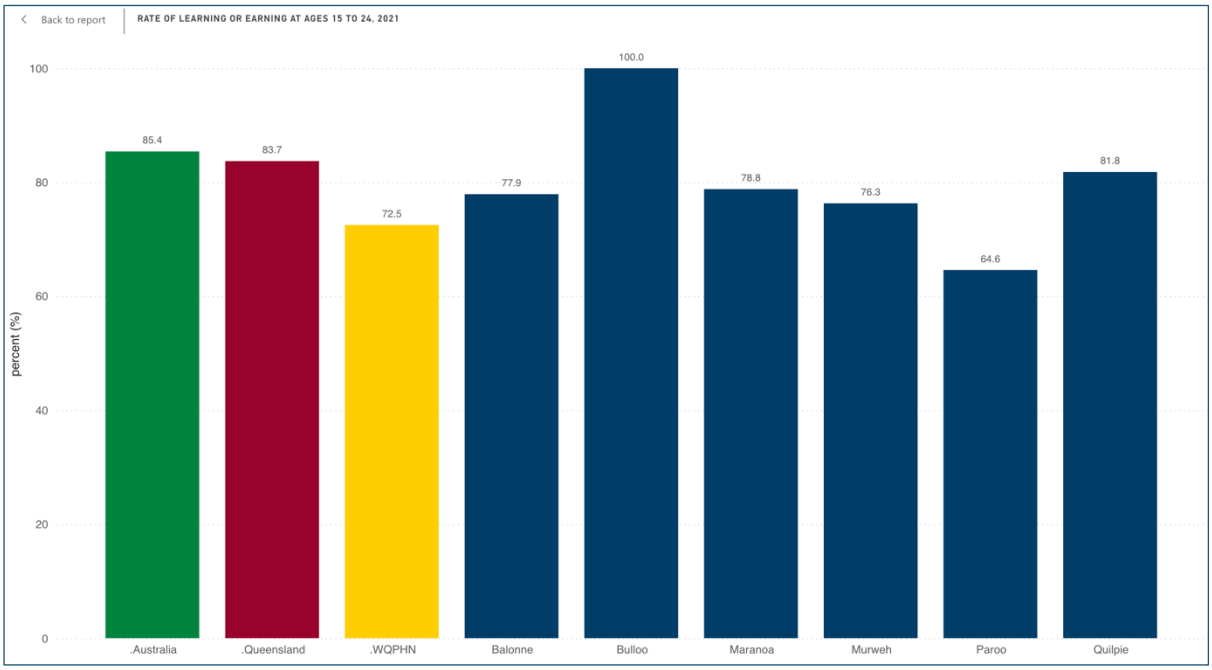


*Figure 135: Rates of earning or learning in the South West region, 2021*

The rates of people receiving an unemployment benefit in 2023 are higher than the National (5.4%) and State (6.0%) rates. Paroo (16.1%) has the highest rate in the region, with the remaining LGAs all sitting below the broader Western Queensland regional rate (Figure 136139).

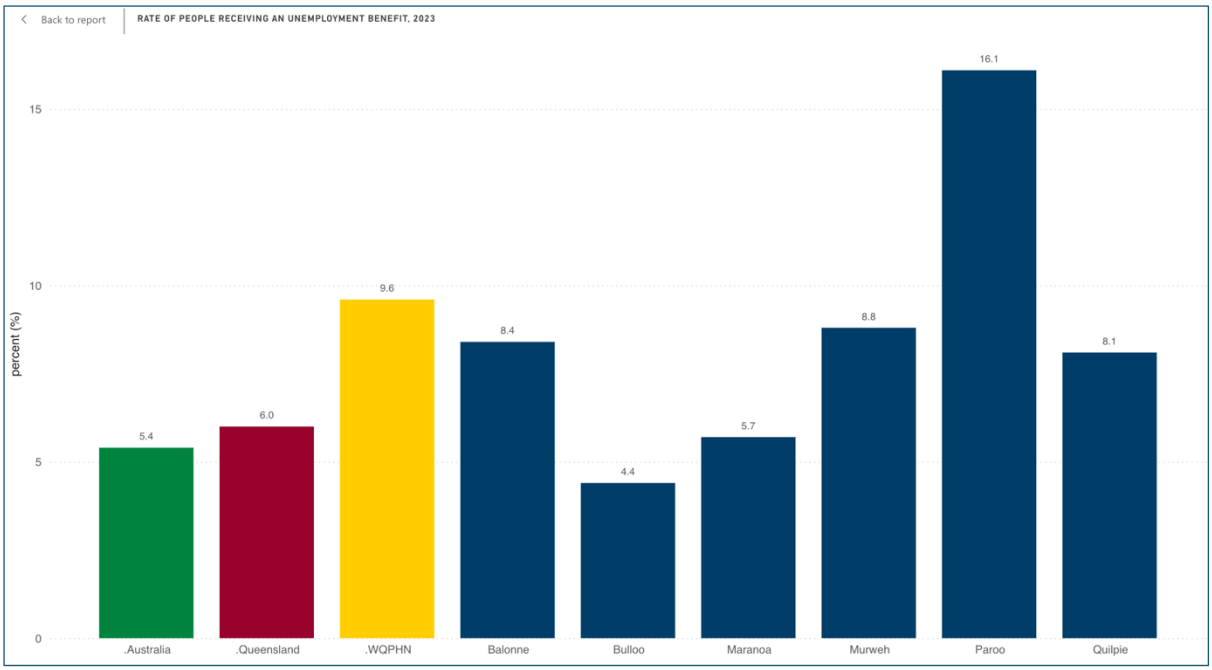


*Figure 136: Rate of people receiving an unemployment benefit in the South West region, 2023*

### 5.2.2.5 Housing

In the South West region, the rates of people living in crowded dwellings varies across LGAs. Bulloo has the highest rate at 12.0%. Murweh (5.1%), Maranoa (3.9%) and Quilpie (2.8%) all have rates lower than the National (6.6%) and State (5.6%) averages (Figure 137).

When reviewing the rates Aboriginal and Torres Strait Islander peoples, the rates are higher across all LGAs (Figure 138140).

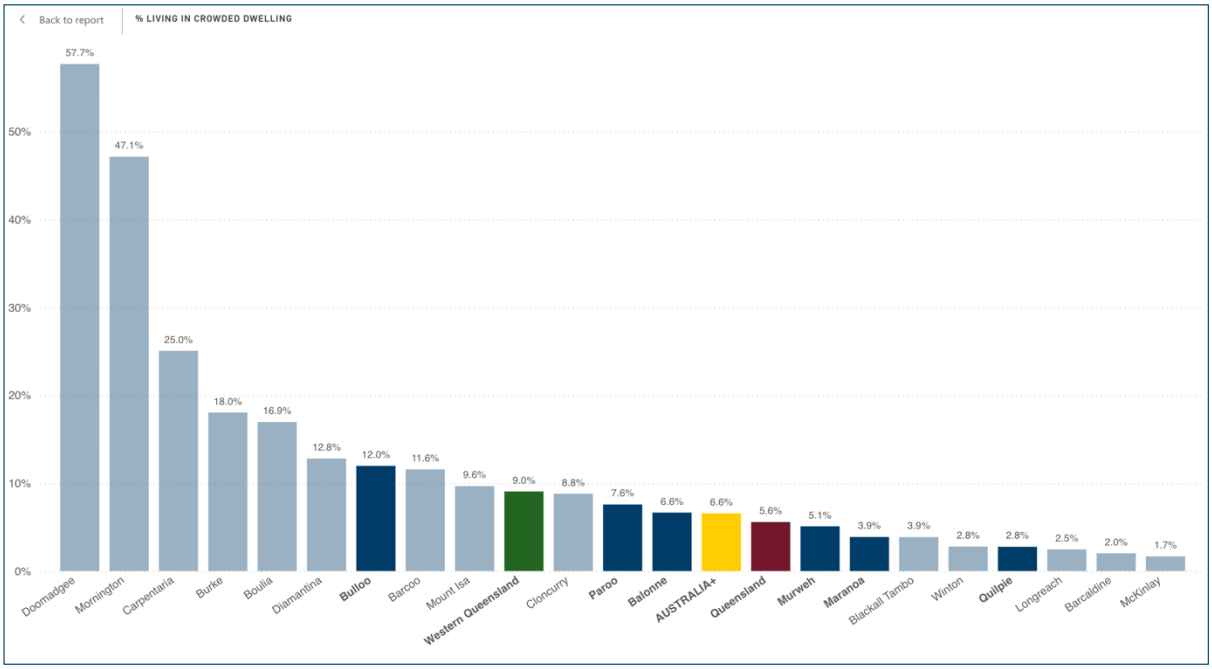


*Figure 137: Proportion of people living in crowded dwellings in the South West Queensland region*

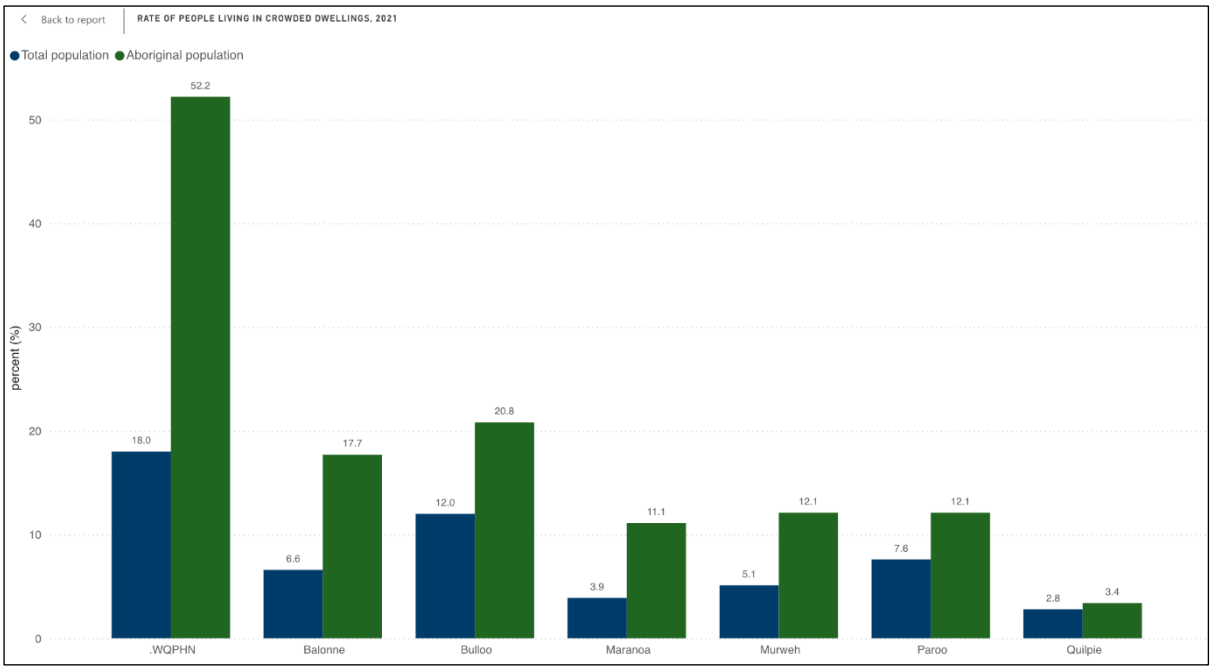


*Figure 138: Proportion of Aboriginal people living in crowded dwellings in the South West Queensland region, 2021*

Data on severely crowded dwellings is available only for Bulloo and Balonne (Figure 142). The rates in Balonne are considerably lower than the broader Western Queensland region, while the rates in Bulloo are considerably higher. Similar patterns are noted as for people living in crowded dwellings, with higher rates for Aboriginal and Torres Strait Islander peoples.

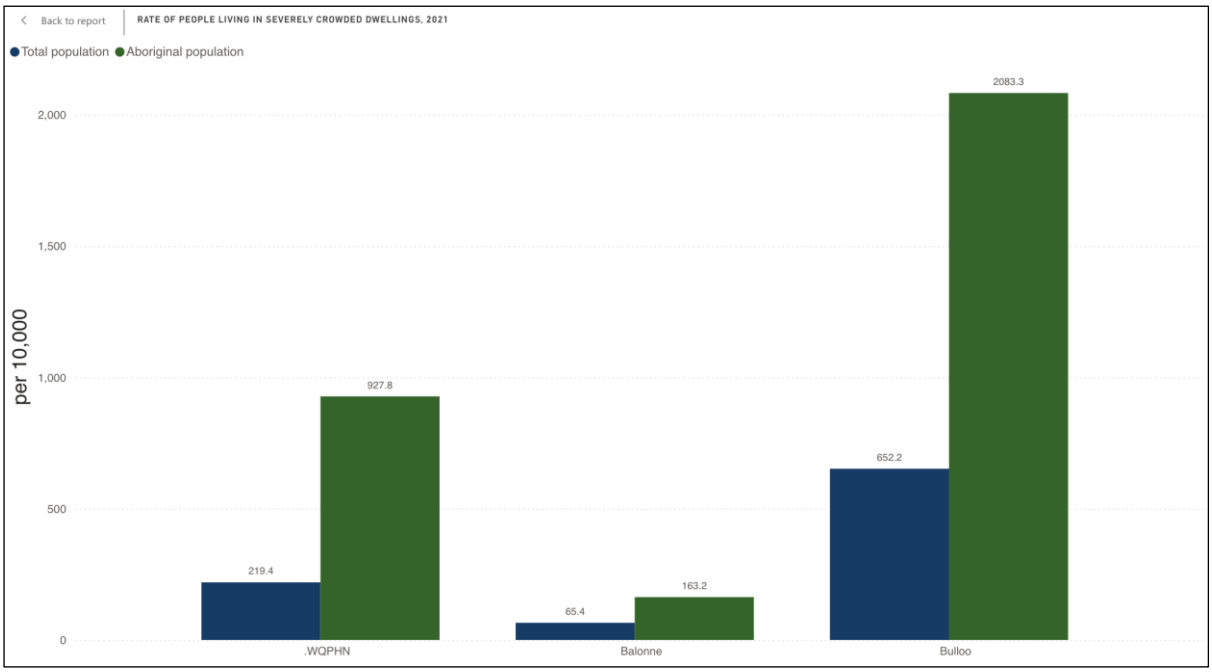


*Figure 139: Proportion of people living in severely crowded dwellings in the South West region, 2021*

The proportion of people living in social housing is high across the region, with all LGAs higher than the National (2.8%) and State (2.5%) rates. Paroo has the highest proportion at 13.2%, followed by Balonne (8.0%) and Bulloo (5.2%) (Figure 143).

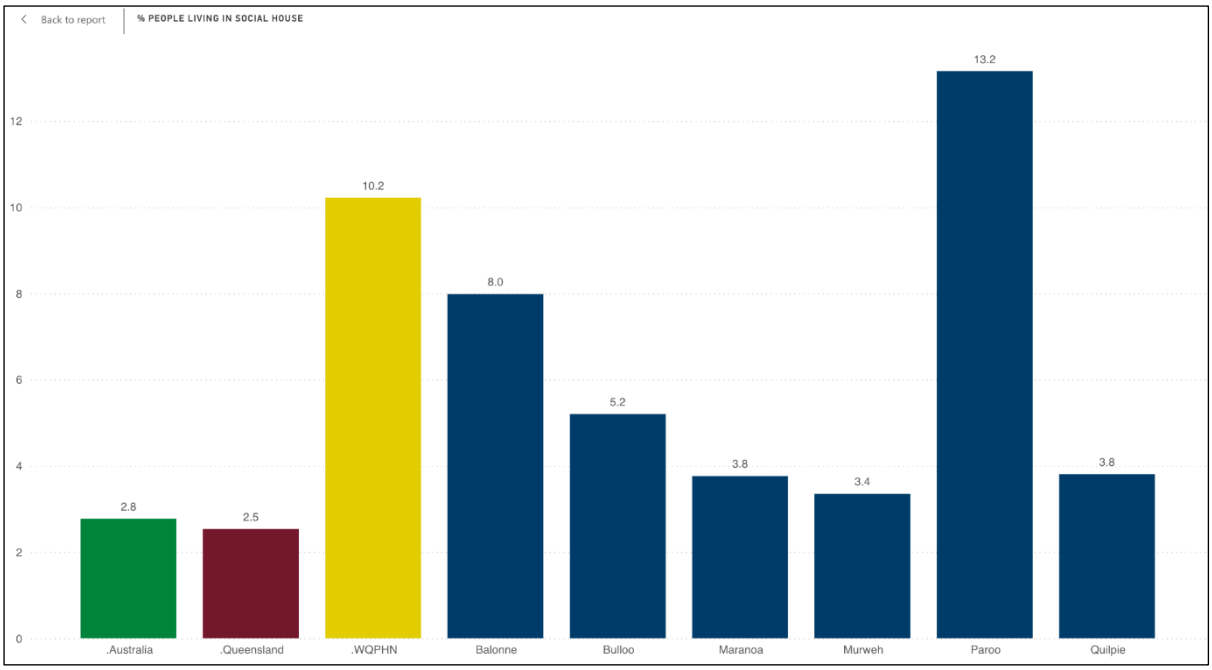


*Figure 140: Proportion of people living in social housing across the South West region*

### 5.2.2.6 Developmental vulnerability

Data about assessed developmental vulnerabilities in the South West region is only available for Balonne, Maranoa, Murweh and Paroo. Data indicates there is a greater proportion of children in Paroo (47.6%) and Murweh (43.9) who are developmentally vulnerable on one or more domain, compared with the other LGAs (Figure 144).

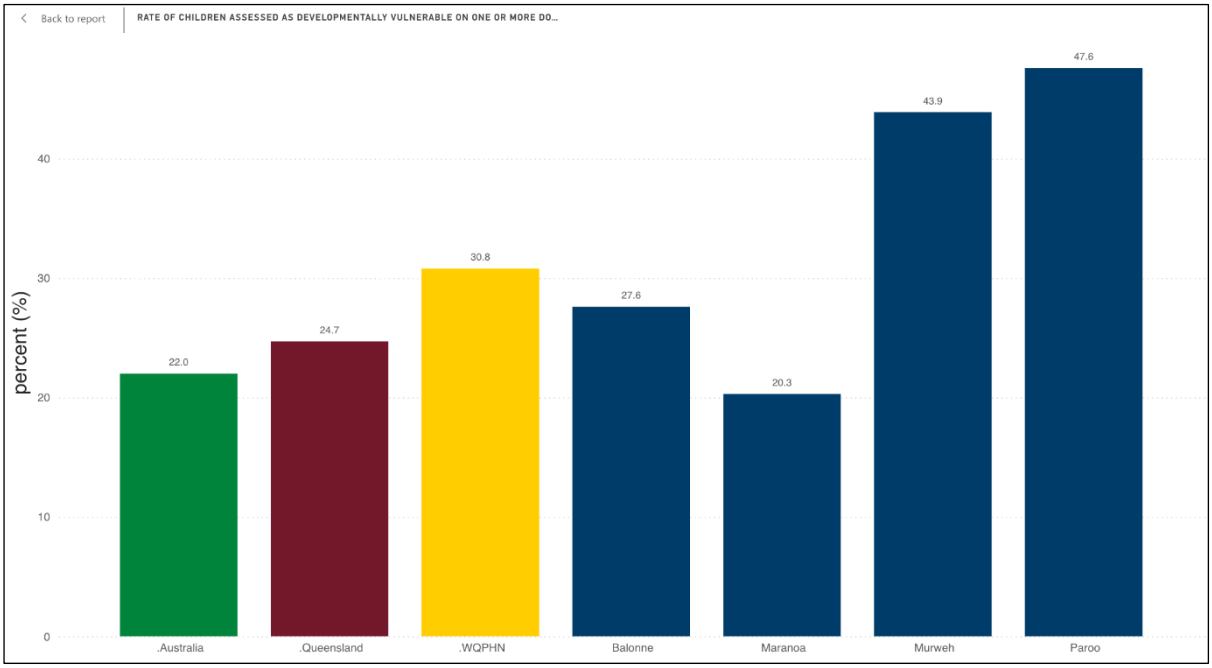


*Figure 141 : Rate of children assessed as developmentally vulnerable on one or more domains in the South West region*

Paroo has 47.6% children vulnerable on one or more domains, 19% on two or more domains, 28.6% in physical health and wellbeing, 14.3% in social competence, 14.3% in emotional maturity, 28.6% in language and cognitive skills, and 19% in communication skills and general knowledge.

Murweh has 43.9% children vulnerable on one or more domains, 29.8% on two or more domains, 24.6% in physical health and wellbeing, 21.1% in social competence, 26.3% in emotional maturity, 15.8% in language and cognitive skills, and 15.8% in communication skills and general knowledge.

Balonne and Maranoa's rates are similar to both National and State rates.

*Table 21: Rate of children assessed as developmentally vulnerable against each domain in South West Queensland*

| Developmental Domains | | Balonne | Maranoa | Murweh | Paroo | Queensland |
|---|---|---|---|---|---|---|
| Physical health and wellbeing | Vulnerable | 12.1% | 9.1% | 24.6% | 28.6% | 11.6% |
| | At risk | 5.2% | 8.6% | 24.6% | 19% | 11.9% |
| Physical readiness for school | Vulnerable | 17.2% | 12.3% | 26.3% | 47.6% | 12.9% |
| | At risk | 8.6% | 12.8% | 17.5% | 28.6% | 10.1% |
| Social competence | Vulnerable | 10.3% | 7% | 21.1% | 14.3% | 10.6% |
| | At risk | 8.6% | 15.5% | 21.1% | 23.8% | 15.4% |
| Emotional maturity | Vulnerable | 5.2% | 8% | 26.3% | 14.3% | 10% |
| | At risk | 13.8% | 9.6% | 22.8% | 33.3% | 15.9% |
| Language and cognitive skills | Vulnerable | 19% | 5.3% | 15.8% | 28.6% | 8.4% |
| | At risk | 10.3% | 11.8% | 12.3% | 4.8% | 10.9% |
| Communication skills and general knowledge | Vulnerable | 11.9% | 8% | 15.8 | 19% | 9.1% |
| | At risk | 11.9% | 9.1% | 33.3 | 14.3% | 14.8% |

## 5.2.3 Lifestyle factors

### 5.2.3.1 Self-assessed health

Data on self-assessed health in South West region is only available for Maranoa and Murweh.

18.2% of adults in Maranoa and 24.5% in Murweh indicated they have fair or poor health, both of which are higher than State and broader Western Queensland levels (16.6% and 17.0% respectively) (Figure 145).

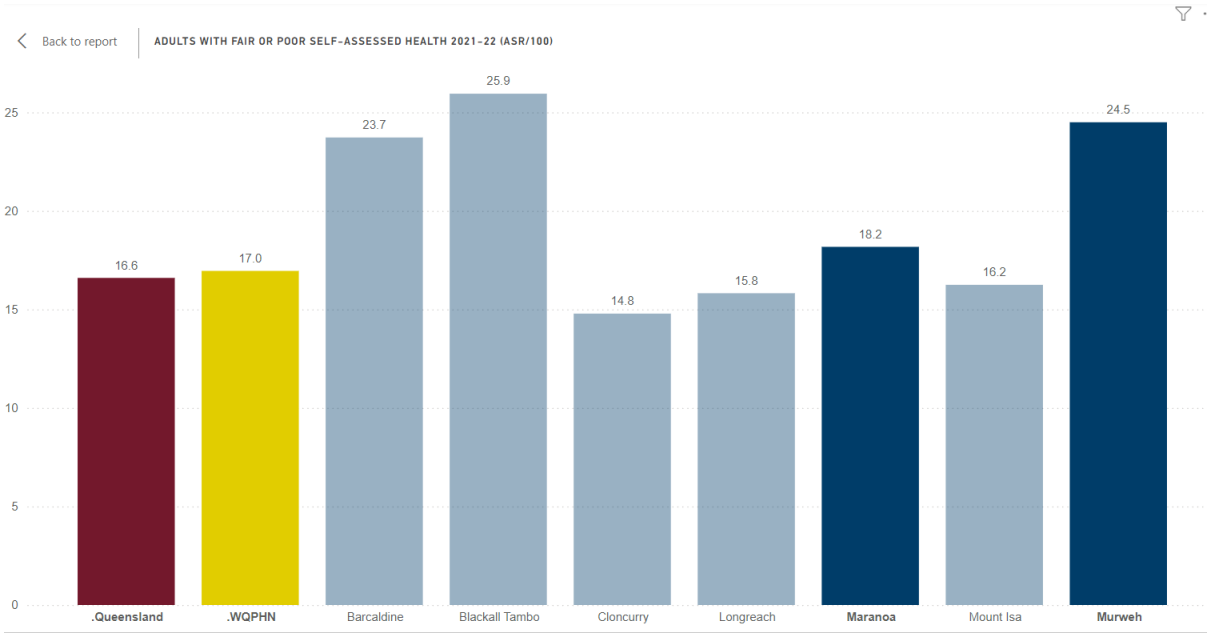


*Figure 142: Proportion of adults with fair or poor self-assessed health 2021-22 (ASR/100)*

Data on unhealthy days is available for Balonne, Maranoa and Murweh LGAs only.

In general, people from Balonne have the lowest number of unhealthy days, across mental health, physical health and limited usual activities. People from Maranoa tend to have a comparatively higher number of unhealthy days, however these numbers are still below the State levels (Figure 146).

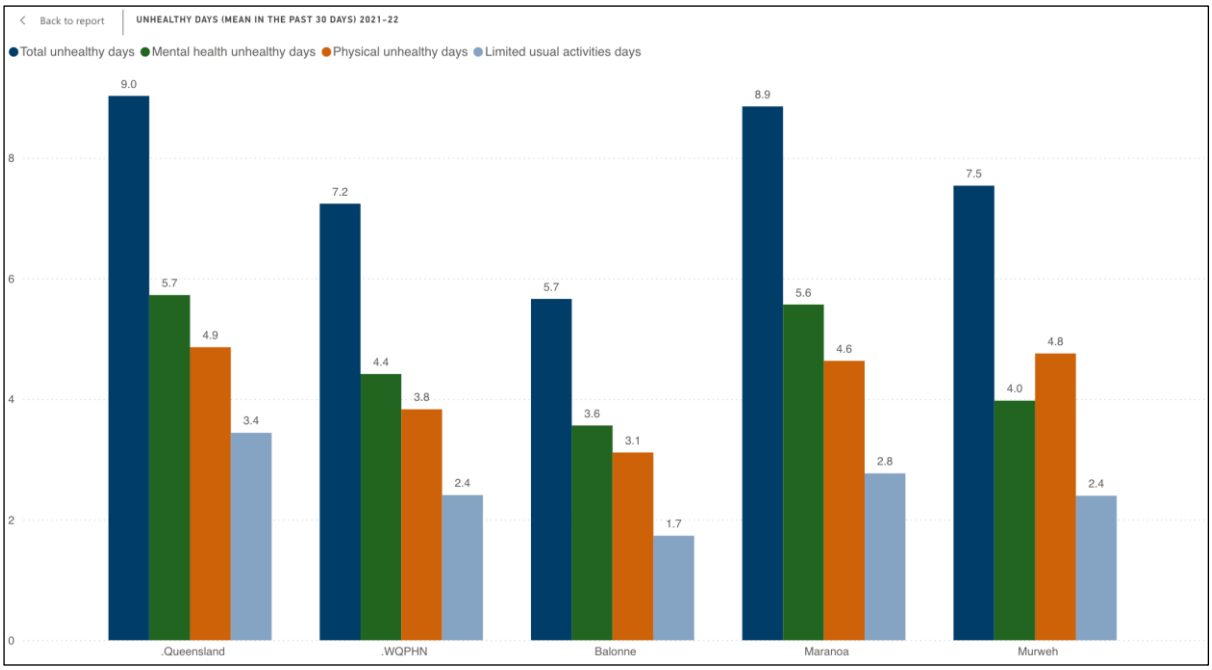


*Figure 143: Mean self-assessed unhealthy days in the past 30 days in South West region, 2021-2022*

### 5.2.3.2 Overweight and obesity

Data for rates of adults who are overweight and obese is the South West region is available for Balonne, Maranoa and Murweh LGAs only. Rates of adults who are overweight (but not obese) are highest in Maranoa (37.0%), which is higher than both the National (34.6%) and State (34.2%) averages. In general, across all regions, more females tend to be overweight than males.

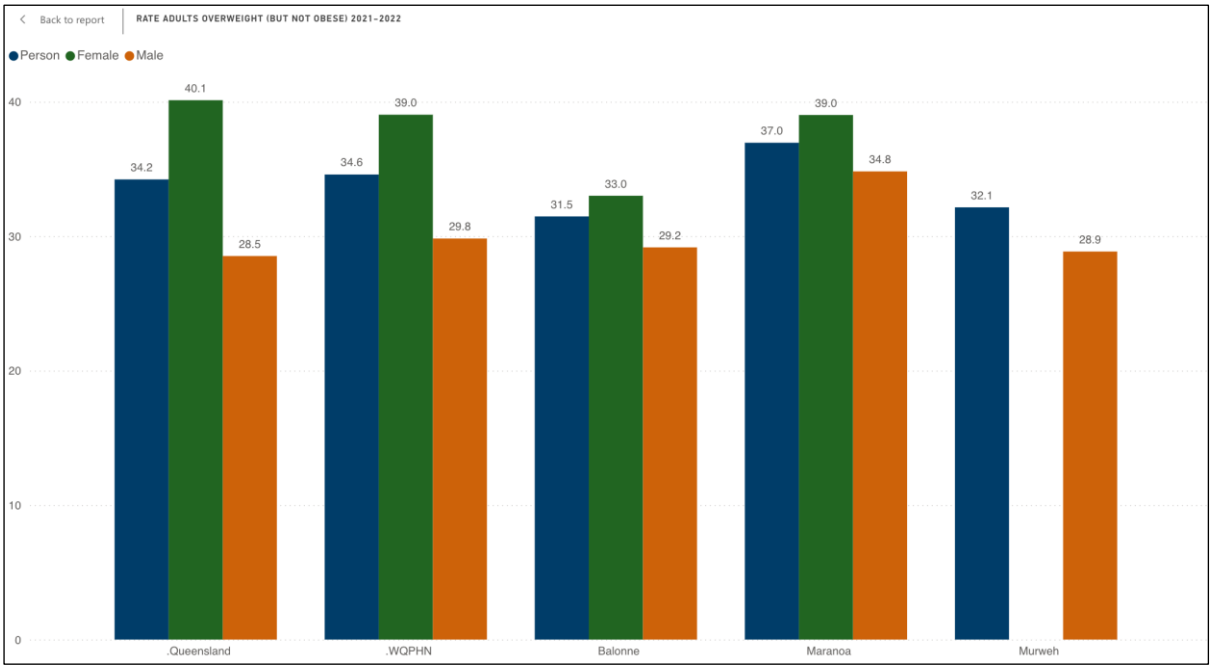


*Figure 144: Proportion of adults overweight (but not obese) in the South West region, 2021-2022*

Regarding obesity, both Maranoa (40.9%) and Murweh (42.8%) have very high rates of adults who are obese, both significantly higher than the State (27.3%) average. In contrast to being overweight, the rates of obesity are not always consistently higher for females.

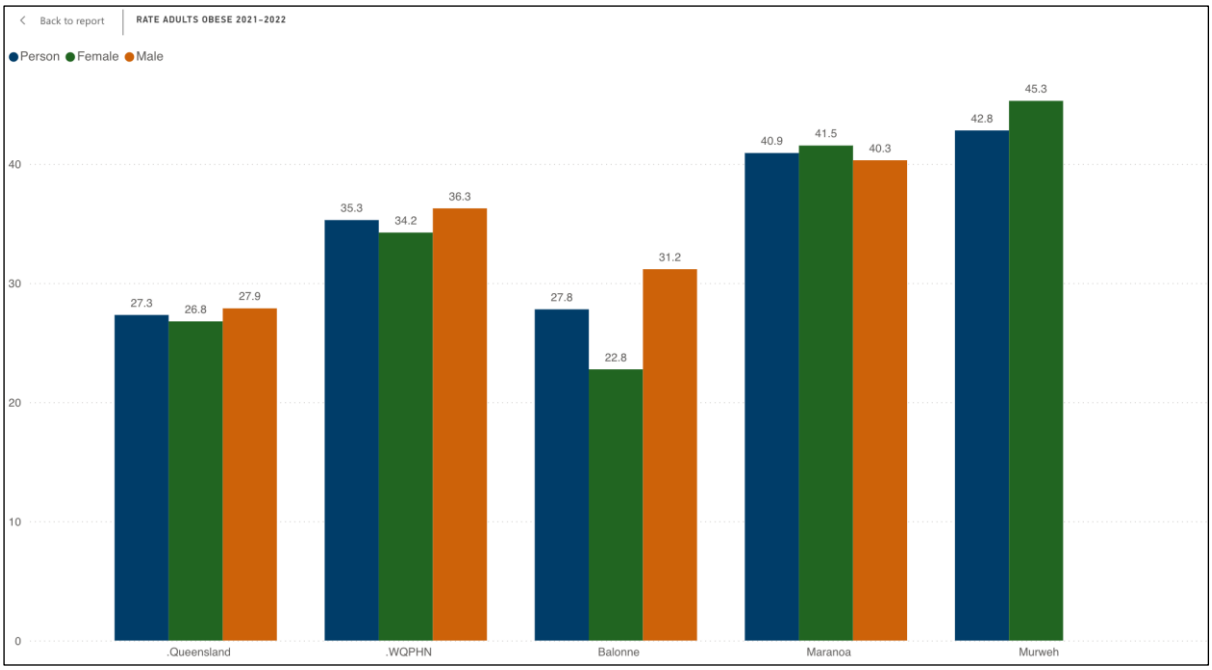


*Figure 145: Proportion of adults with obesity in the Central West region, 2021-2022*

The rate of people overweight or obese in the Western Queensland PHN region has consistently increased since 2009/10 through to 2021/22, and has remained consistently higher than the State rate (Figure 149).

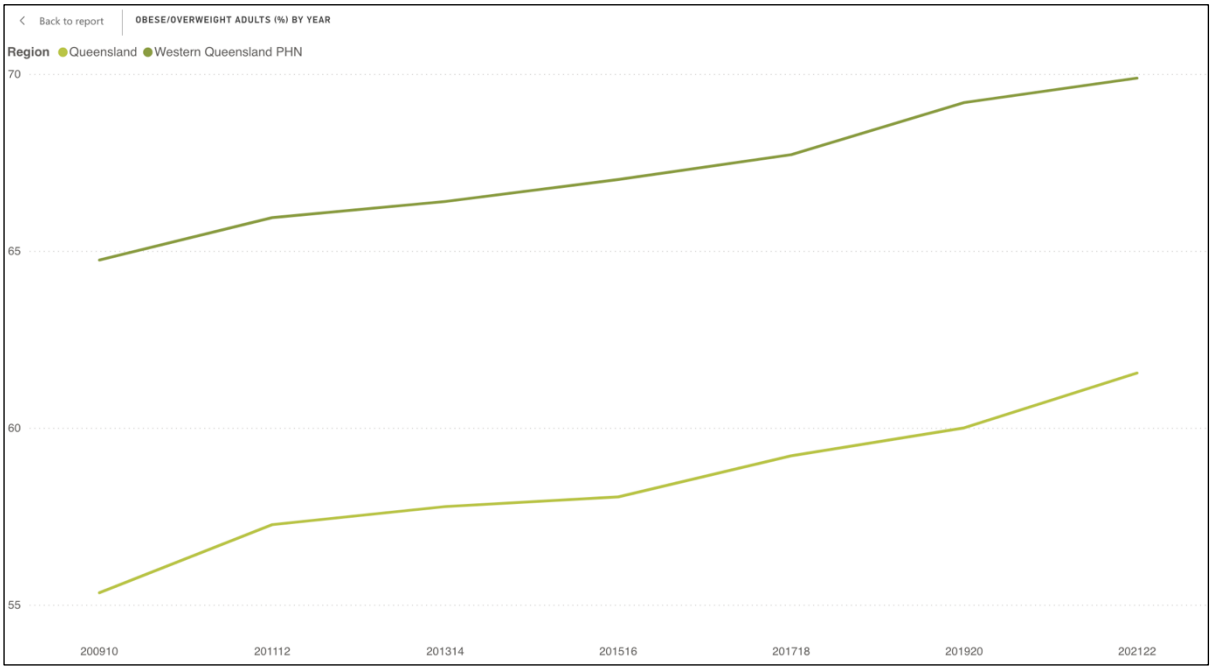


*Figure 146: The rate of adults overweight or obese across the Western Queensland region over time, compared to the Queensland rate*

### 5.2.3.3 Diet and physical activity

Data on fruit and vegetable intake in the South West region is only available for Balonne, Maranoa and Murweh LGAs.

All three areas with data available have rates of adults consuming adequate fruit intake similar to Queensland levels. For Balonne, 53.2% of adults consume adequate fruit, with rates slightly higher for males (54.6%). For Maranoa, 55.9% of adults consume adequate fruit, with lower rates for males (51.5%). For Murweh, 50.7% of adults consume adequate fruit, with the rate significantly higher for females (57.9%) (Figure 150).

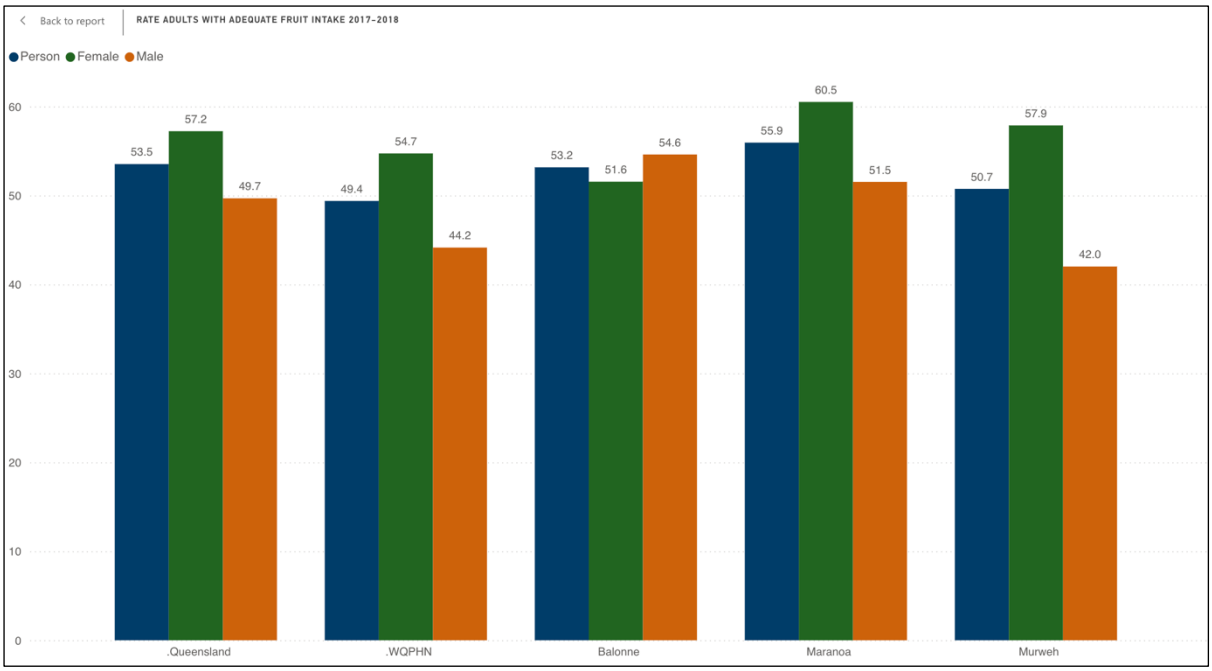


*Figure 147: Proportion of adults with adequate fruit intake in the South West region, 2017-2018*

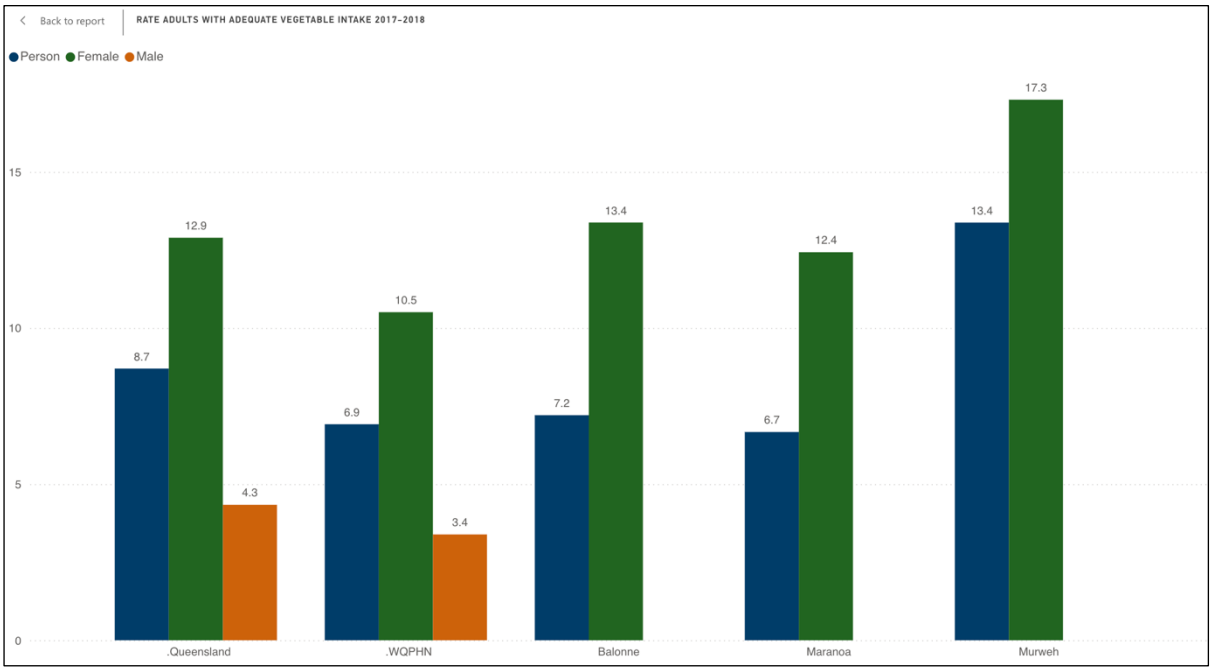


*Figure 148: Proportion of adults with adequate vegetable intake in the South West region, 2017-2018*

In general, the rate of adults with adequate vegetable consumption is lower than that for fruit consumption. The rate of adults consuming adequate vegetables in Murweh (13.4%) is considerably higher than the State (8.7%) average. Rates in Balonne (7.2%) and Maranoa (6.7%) are lower than the State average.

The proportion of adults with low, very low or no exercise in the South West region is slightly higher than the Queensland rate (40.0%). Balonne (46.2%) has the greatest proportion of adults who report little to no exercise, followed by Maranoa (42.2%) and Murweh (40.7%) (Figure 152). Data are not available for the other LGAs in the region.

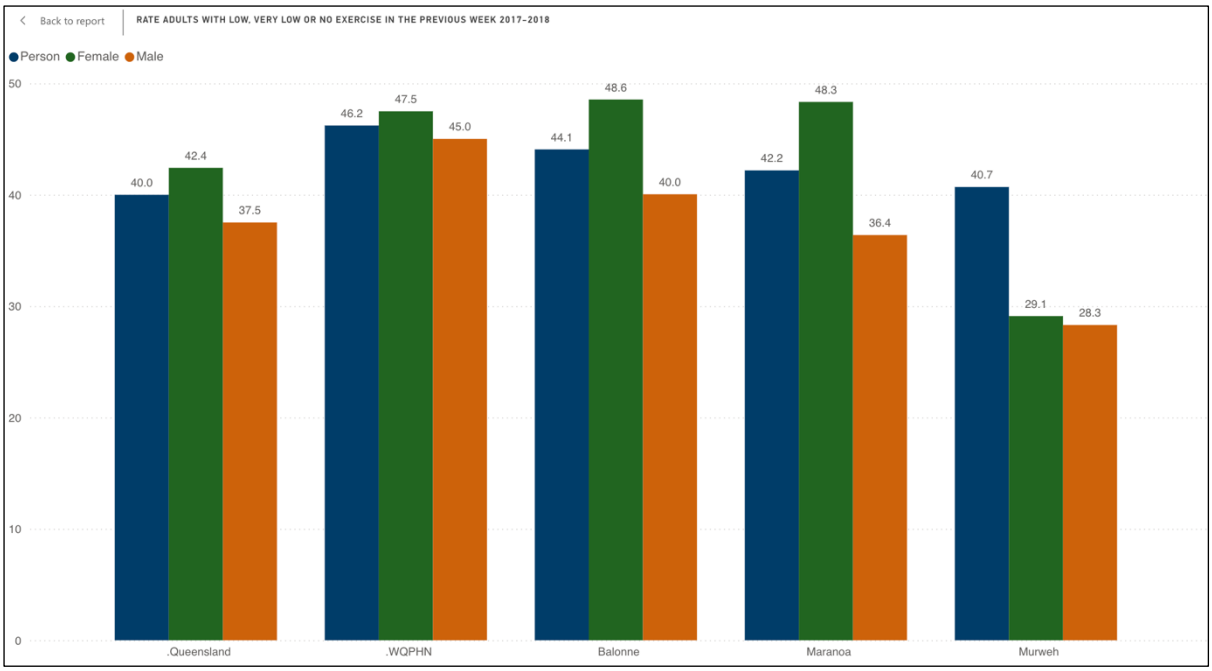


*Figure 149: Proportion of adults with low, very low or no exercise across the South West region, 2017-2018*

### 5.2.3.4 Smoking

Data on smoking in the South West region is only available for Balonne, Maranoa and Murweh LGAs.

The smoking rate for the broader Western Queensland region (19.8%) is higher than the State average (15.0%), with the rate for males considerably higher (23.7%). Rates across Balonne (14.1%), Maranoa (15.9%) and Murweh (16.1%) are closer to the State average.

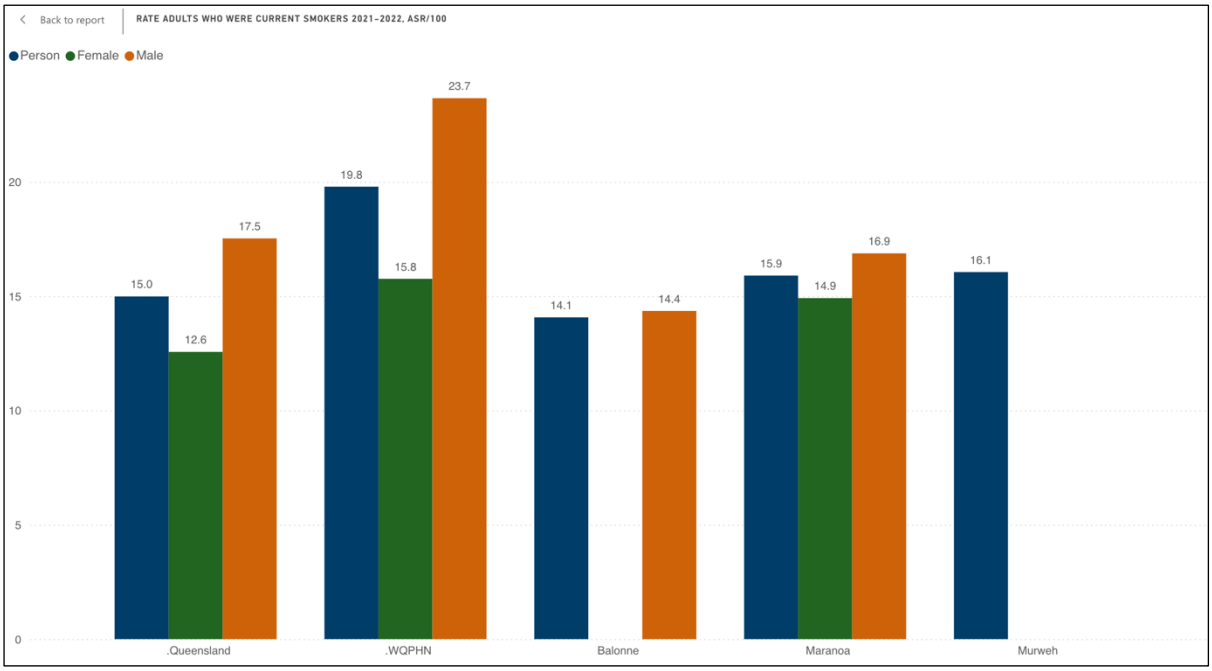


*Figure 150: Proportion of adults who smoke in the South West region, 2021-2022*

### 5.2.3.5 Alcohol consumption

Data on alcohol consumption in the South West region is available for Balonne, Maranoa and Murweh LGAs only.

The rate of adults who drink 10+ standard drinks per week is higher for the broader Western Queensland region (35.7%) is higher than the State average (30.2%), with the rate for males considerably higher (50.0%). Rates across Balonne (38.6%), Maranoa (34.2%) and Murweh (35.3%) are similar to the broader regional rate

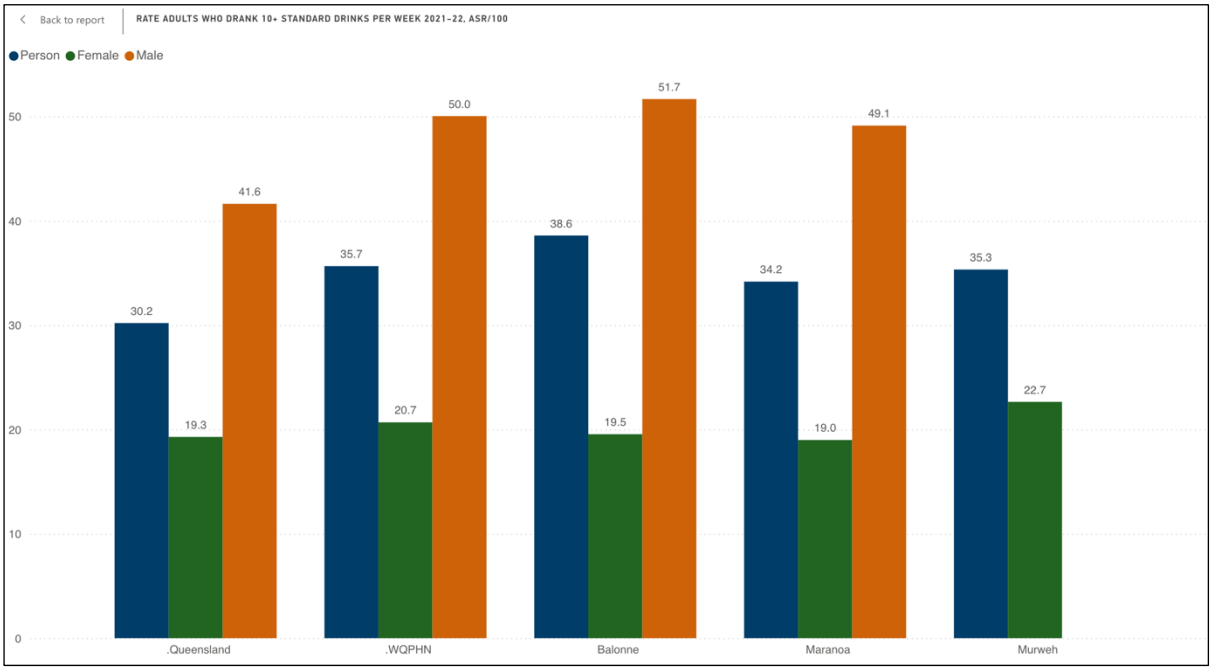


*Figure 151: Proportion of adults who drink 10+ standard drinker per week across the South West region, 2021-2022*

## 5.2.4 Screening

### 5.2.4.1 Cancer Screening

The South West region has a low rate of participation in National cancer screening programs. Only 33.5% of invited to participate in the bowel cancer screening program people took the test, lower than the State and National average of 37.5% and 40.9% (in 2020-21). The participation rate is lowest in Paroo (26.3%) and Quilpie (28.2%)[21].

For cervical screening program, the uptake was 46.8% (in 2020-21), slightly lower than the State and National average of 47.2% and 47.5%. Paroo (30.7%) has the lowest cervical cancer screening participation rate in the region[22].

For breast cancer screening, the region is doing quite well with a higher rate (55.8%) compared to the State and National levels (52.3% and 49.9%)[23], however there is still 44.2% of eligible women not participating.

There is no available data about skin cancer check in the region but as the fact that there is no skin cancer clinic operating in the catchment, the percentage of people having their skin check would be very limited.

### 5.2.4.2 Screening for chronic conditions

There is a considerably low number of regular patients having chronic conditions screening in the South West region. Only 68.9% of regular GP patients aged 45-74 years old (or 35-74 years for Aboriginal and Torres Strait Islander people) have had CVD risk assessment. The rate is lower for Aboriginal and Torres Strait Islander peoples (64.6%) compared to non-Indigenous (69.7%)[24].

[21] PHIDU, Social Health Atlas of Australia, Data by Primary Health Network, September 2024 release
[22] PHIDU, Social Health Atlas of Australia, Data by Primary Health Network, September 2024 release
[23] PHIDU, Social Health Atlas of Australia, Data by Primary Health Network, September 2024 release
[24] WQPHN, GP data, June 2024 submission

For diabetes, 84.2% of regular GP patients who are diagnosed with Type 2 diabetes have HbA1c tested in the past 12 months, indicating, 15.8% of these patients require the timely and appropriate preventative action.

#### 5.2.4.3 Sexual health screening

There is a sharp increase in the number of sexually transmitted infections (STI) in the region, indicating the increasing uptake of sexual health screening. During 2019-2023 period, the number of STI notifications doubled from 72 cases to 153 cases[25]. Chlamydia is still the major concern of the region (86.9% of total cases).

### 5.2.5 Vaccine-preventable conditions

#### 5.2.5.1 Immunisations

There are considerably high percentages of fully vaccinated children at 1 year (92.0%), 2 years (93.8%) and 5 years (95.0%) compared to the State averages (92%, 90.6%, and 92.7%), but still below the State target of 95%. The rates are low for Aboriginal and Torres Strait Islander populations in the first year (91.7%) but higher when children are at 2 and 5 years (94.6% and 96.6%).

#### 5.2.5.2 Vaccine-preventable hospitalisations

The number of vaccine preventable hospitalisations in the South West region increased from 17 in 2020-21 to 61 in 2022-23, accounting for 25.0% of hospitalisations in Western Queensland. 23% of vaccine preventable PPH are for Aboriginal and Torres Strait Islander peoples (2022-23).

[25] Queensland Health, Notifiable conditions annual reporting, October 2024

## 5.3 Vulnerable populations

### 5.3.1 Relevance

Why is exploring the needs of vulnerable populations in the South West Queensland region important?

Vulnerable populations often experience compounded disadvantages that significantly impact their health outcomes. In this region, most communities are in remote or very remote areas of the State, making them inherently vulnerable due to challenges such as limited access to healthcare, social isolation, and reduced service availability. These vulnerabilities are further amplified among specific groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, people living with disabilities, people experiencing mental illness, people experiencing homelessness, people from LGBTIQ+ communities, as well as older and younger populations.

Understanding the unique needs of these populations is critical for developing equitable and inclusive health services. By better understanding the impact of compounded vulnerabilities, health interventions can be tailored to improve health equity and ensure that no group is left behind in achieving better health outcomes.

### 5.3.2 Aboriginal and Torres Strait Islander communities (SWHHS region)

Although this HNA report highlights patterns and trends specific to Aboriginal and Torres Strait Islander peoples in various sections, (where data is available, and where it is relevant to do so), it is also essential to include a dedicated summary of the health and service needs of Aboriginal and Torres Strait Islander peoples in this section. Indigenous communities face unique and intersecting vulnerabilities due to historical, social, and economic factors that often compound health disparities. Collating these insights in one section enables a more cohesive understanding of the challenges Aboriginal and Torres Strait Islander peoples encounter and the specific supports that may be needed to address these challenges effectively.

**Considerably large numbers of Aboriginal and Torres Strait Islander peoples**

Aboriginal and Torres Strait Islander people account for 16.5% of total population in the South West region, higher than the State average of 5.2% and the National of 3.8%. Paroo (40.2%), Balonne (24.3%), and Quilpie (14.5%) are three LGAs with the highest proportion of Aboriginal and Torres Strait Islander people.

Maranoa (3.0%), Balonne (1.0%) and Paroo (0.6%) have positive annual growth of Aboriginal and Torres Strait Islander population, whereas Bullo (-1.1%), Murweh (1.4%) and Quilpie (-2.3%) experienced negative growth in 2011-2021 period

**Low life expectancy**

Life expectancy at birth (age - adjusted) of Aboriginal and Torres Strait Islander males living in remote and very remote areas which cover majority of Wester Queensland was 67.3 years and females was 71.3 years (2020-2022), 12.4 years lower than non-Indigenous Australians (79.9 years for males and 83.7 years for females in remote and very remote areas)[26]

**High rate of Aboriginal and Torres Strait Islander population living in crowded dwellings**

Relatively large proportion of Aboriginal and Torres Strait Islander population living in crowded dwellings in Barcoo (18.2%), Bulloo (16.7%), which are much higher than the State level of 9.3%.

**Lower level of education**

2.3% of Western Queensland Aboriginal and Torres Strait Islander people in the South West do not go to school, tripled the value for the whole region (0.7%) and higher than Queenslander Aboriginal and Torres

[26] Australia Bureau of Statistics, 2023, Aboriginal and Torres Strait Islander life expectancy https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release

Strait Islander peoples (0.9%). Balonne (2.7%), and Murweh (2.5%) have the highest proportion of Aboriginal and Torres Strait Islander children not going to school.

**Higher level of unemployment**

Unemployment rates are high in many locations across the region. 16.1% of Aboriginal and Torres Strait Islander peoples in Paroo are unemployed, higher than the State level of 13%. Balonne (11.9%), Murweh (9.7%) and Maranoa (8.7%) are those areas with high unemployment rates.

**Considerably good level of health check uptakes**

31.4% or Aboriginal and Torres Strait Islander peoples living in Outback South have had health check, higher than the PHN level of 30.4%, and the National average of 27.9% in 2023.

54.2% of Aboriginal and Torres Strait Islander people have a followed-up health check in 2022, increased from 51.4% in 2018, higher than the National average of 45.1%.

**High percentage of smoking during pregnancy**

44.9% of Western Queensland Aboriginal and Torres Strait Islander mothers living in the South West region smoke during their pregnancy (2019/20-2022/23), compared to only 7.6% of non-Indigenous mothers doing so. More than half of mothers in Roma (54.1%), and Balonne (50.8%) smoke during their pregnancy, followed by Far South West (43.8%), Roma Surrounds (32.4%) and Charleville (26.2%).

**High percentage of obese mothers**

35.4% of Western Queensland Aboriginal and Torres Strait Islander mothers living in the South West region are obese during their pregnancy (2019/20-2022/23), higher than non-Indigenous mothers (25.8%). 50% mothers in Charleville are obese during their pregnancy, followed by Far South West (43.8%), and Roma surrounds (35.3%).

**High rate of low birthweight babies**

10% of South West Aboriginal and Torres Strait Islander livebirths are low birthweight babies (<2500gram) (2019/20-2022/23), doubled non-Indigenous babies (5.7%). Far South West (18.4%) and Balonne (12.7%) are areas with higher rates of low birthweight babies.

**High rate diagnosed with chronic conditions**

27.1% of Aboriginal and Torres Strait Islander regular patients in Western Queensland diagnosed with at least one chronic condition. The rate is higher across the whole South West region: Paroo (37.4%), Bulloo (34.1%), Murweh (31.4%), Quilpie (30.2%), Maranoa (29.3%) and Balonne (28.3%).

### 5.3.3 Culturally and Linguistically Diverse communities (SWHHS region)

A lower proportion of the population in the South West region were born overseas (6.9%) compared to State average of 22.7%. Murweh had the largest percentage of persons born overseas (8.5%)

For those born overseas coming from non-English speaking countries, Philippines (1.0%), Vietnam (0.6%), India (0.3%), Papua New Guinea (0.1%) and Netherlands (0.1%) are top five in the region.

4.3% of population spoke a language other than English at home and Murweh is the LGA with the highest proportion of person speaking other language at home (5.7%). Southeast Asian Austronesian Languages (0.9%), Vietnamese (0.6%), Indo Aryan Languages (0.4%), Chinese Languages (0.3%), and Australian Indigenous Languages (0.3%) are top 5 non-English spoken languages.

Available public data show that there were only a handful of people coming to the South West region under the offshore humanitarian program (0.1% of total population), and the majority chose to settle in Maranoa area.

Please see Chapter 5 for a summary of insights focused on the health and service needs of multicultural communities in the region.

### 5.3.4 People with disabilities (SWHHS region)

A lower proportion of the population in the South West region are in need of assistance with a profound or severe disability (4.5%) when compared with the State (6.0%). Close to half (47.4%) of this population are located in Maranoa. This is in contrast to approximately 5.5% of people aged 16 to 64 years in the South West region receiving a Disability Support Pension, higher than the State and National averages of 5.0% and 4.7%. Paroo (10.1%) and Murweh (6.8%) have the highest proportion of people receiving disability support pension in the region.

### 5.3.5 People living with mental illness (SWHHS region)

**Substantial mental health issues in general practice**

There is a large proportion of regular GP patients diagnosed with a mental health condition (21%) in the South West region. Depression and anxiety are the two most common mental health disease within the region.

**Higher rates of intentional injuries**

The South West region has a relatively high rate of intentional injuries, for instance, Maranoa (249.2 per 100,000), Balonne (243.2) and Murweh (210.8) admissions for intentional self-harm in 2020/21, doubled the National average of 125.3 admissions per 100,000.

**Considerably high rate of suicide**

Murweh LGA has a very high rate of suicide, with 31.4 per 100,000, much higher than the PHN rate of 18.7 per 100,000, State of 15.5 per 100,000 and National of 12.6 100,000. In comparison, the suicide rate is low in Maranoa area (8.6 per 100,000).

### 5.3.6 People experiencing domestic and family violence (SWHHS region)

No data was available for this cohort.

### 5.3.7 People experiencing homelessness (SWHHS region)

**High rate of people experiencing homelessness**

There are 50.6 homeless persons per 10,000 population, higher than the State average of 43.2 per 10,000. The rates are significantly higher in Bulloo (369.7) and Balonne (88.1).

Please see Chapter 6 for a summary of insights focused on the health and service needs of people experiencing homelessness in the region.

### 5.3.8 People from LGBTIQ+ communities (SWHHS region)

No data was available for this cohort.

### 5.3.9 Older people (SWHHS region)

**High rates of lifestyle-related risk factors**

76.4% of older Australians living in the South West region are overweight or obese (2021/22), 10.7% higher than the State average (65.7%).

66.4% of older Australians living in the South West region did not have sufficient physical activities (2020/21), 15.1% higher than the State average (51.3%).

9.6% of older Australians living in the South West region are daily smokers (2021/22), 3.9% higher than the State average (5.7%).

33.3% of older Australians living in the South West region are risky drinkers (2021/22), 4.7% higher than the State average (28.6%).

**Low rate of excellent/very good/good self rated health condition**

66.8% of older Australians living in the South West region self rated their health as excellent/very good/good (2021/22), 7.6% lower than the State average (74.4%).

**High rate of admissions for potentially preventable conditions**

There is a high rate of admissions for potentially preventable conditions for people aged 65 years and over across the South West region, Balonne – 12,032, Bulloo – 35,792, Maranoa – 9,382, Murweh – 12,652, and Quilpie – 17,411, are all much higher than the National and State averages of 6,389 and 5,646 per 100,000.

### 5.3.10 Young people (SWHHS region)

Young people account for 32.1% of total population, which is similar to the State average of 31.2%.

**Less proportion of earning or learning young population**

77.8% of people aged 15 to 24 are learning or earning, less than the National and State averages of 85.4% and 83.7%. The lowest rate of learning or earning young people are in Paroo (64.6%) and Murweh (76.3%).

**High percentage of children aged less than 15 years living in family where the mother has low educational attainment**

18.8% of children aged less than 15 years living in families where the female parent's highest level of schooling was year 10 or below or female parent did not attend school, higher than State average of 14.8% and National average of 14.1%. The highest rates are in Bulloo (27.9%), Paroo (23.7%), and Balonne (20.0%).

# 5.4 Health needs

## 5.4.1 Relevance

| Why is exploring the health needs of the South West Queensland region important? |
|---|
| The health needs of a population are influenced by a complex interplay of biological, environmental, and social factors. This section explores a broad range of critical health issues, from alcohol and drug use to the health needs in the antenatal and palliative periods. Chronic diseases such as diabetes, cardiovascular conditions, and cancers continue to drive morbidity and mortality, while communicable diseases remain a significant concern, particularly in vulnerable populations. Mental illness and suicide pose ongoing challenges, requiring a holistic approach to care that integrates physical and psychological health. Oral health, often overlooked, is also crucial, given its link to overall well-being. By comprehensively examining these diverse health needs, we gain a greater understanding of their burden on communities in the region. |

## 5.4.2 Alcohol and other Drug use (SWHHS region)

The use and misuse of licit and illicit drugs, and associated health, social and economic harms to the community, is commonly recognised as a significant issue in remote communities, with the AIHW noting tobacco, risky alcohol and illicit drug use remaining stable or higher despite comparative decreased use in major cities and inner regional areas .

It is also likely, through rates of alcohol and other drugs consumption, that the availability of brief intervention services is likely to continue to be in high demand, either through the HHS or other NGO funded partners.

## 5.4.3 Antenatal care (SWHHS region)

Research suggests the health, wellbeing and nutrition of the mother prior to conception and during pregnancy not only can have an impact on the birth-weight, 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.

The proportion of women who do not attend antenatal visits within the first 10 weeks of gestation is significantly higher in the Western Queensland region (67.0%) compared to the National and State rates (41.0% and 38.0%). The rates in Bullo (71.0%), Paroo (71.0%), Quilipe (71.0%) and Murweh (68.0%) are all higher than the already high regional rate.

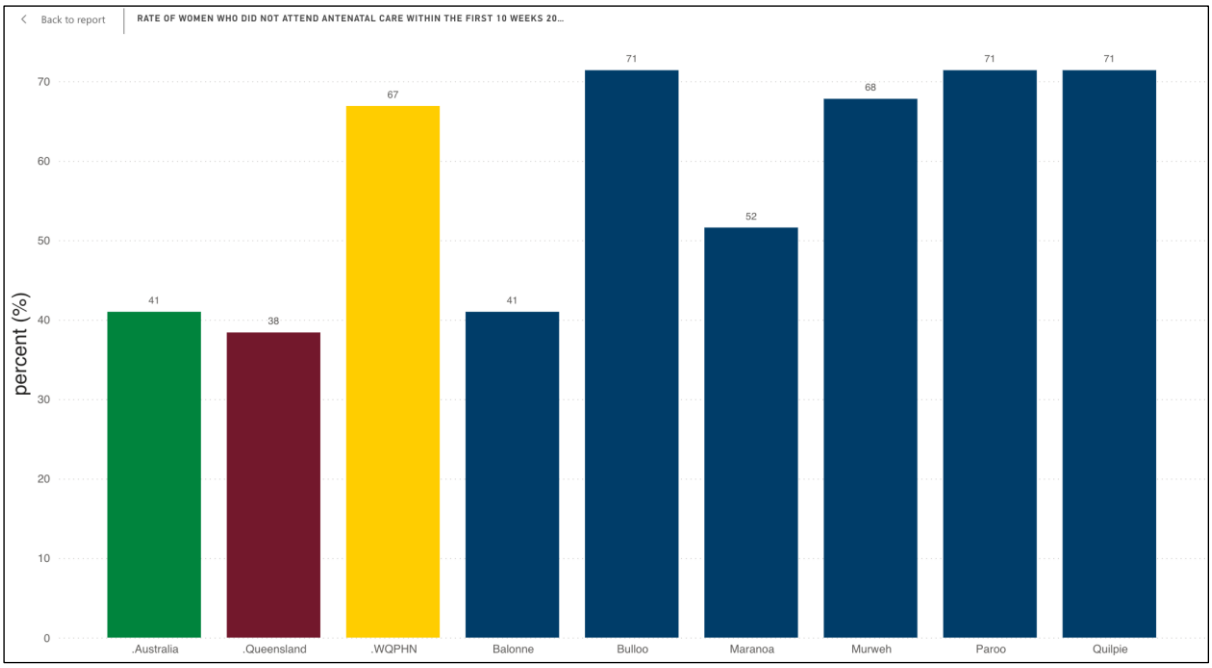


*Figure 152: Proportion of women who did not attend antenatal care in first 10 weeks in South West region, 2019-2021*

## 5.4.4 Cancer (SWHHS region)

The cancer incidence rates across the South West region are mixed, with some higher than the State rates (Colorectal, lung and melanoma), and some lower (prostate, breast, cervix and pancreas) (Table 22).

*Table 22: Cancer incidence rates across South West region (ASR/100,000 people)*

| Indicator | ASR/100,000 (Queensland) | ASR/100,000 (South West region) | Average incidence / year (South West region) |
|---|---|---|---|
| All cancers | 532.8 | 542.0 | 154 |
| Colorectal | 51.1 | 56.2 | 17 |
| Lung | 47.1 | 71.7 | 21 |
| Melanoma | 70.6 | 76.7 | 80 |
| Prostate | 157.1 | 144.3 | 23 |
| Breast | 124.0 | 85.3 | 13 |
| Cervix | 9.9 | 9.0 | 1 |
| Pancreas | 12.8 | 5.0 | 1 |

The cancer mortality rates across the South West region are also mixed, with many cancer types with a higher mortality in the South West region (colorectal, lung, melanoma and breast). Both prostate and pancreatic cancer have a lower mortality rate in the South West region (Table 23).

*Table 23: Cancer mortality rates across South West region (ASR/100,000 people)*

| Indicator | ASR/100,000 (Queensland) | ASR/100,000 (South West region) | Average incidence / year (South West region) |
|---|---|---|---|
| All cancers | 156.0 | 190.9 | 58 |
| Colorectal | 18.3 | 26.7 | 8 |
| Lung | 30.7 | 52.4 | 16 |
| Melanoma | 5.5 | 5.7 | 2 |
| Prostate | 27.2 | 14.2 | 2 |
| Breast | 18.7 | 21.0 | 3 |
| Cervix | 1.9 | N/A | N/A |
| Pancreas | 8.9 | 3.8 | 1 |

### 5.4.5 Chronic disease (SWHHS region)

Chronic Kidney Disease (CKD) is a group of disorders that gradually affect the structure and function of kidneys, leading to end-stage kidney failure, which is fatal without artificial filtering (dialysis) or a kidney transplant. Known risk factors including diabetes, high blood pressure, heart disease, smoking, obesity, frequent use of medications that can damage the kidneys and is also more prevalent in Aboriginal and Torres Strait Islander peoples.

Originally published in 2019, Queensland Health's *Advancing Kidney Care 2026 Plan*[27] emphasises kidney health as a key areas of focus to:

- Prevent chronic kidney disease.
- Detect chronic kidney disease earlier for better outcomes.
- Avoid or delay kidney failure from chronic kidney disease where possible.
- Constantly improve specialist kidney care to deliver the best access and outcomes for all Queenslanders.

The majority of chronic centre-based haemodialysis services are provided publicly in Queensland, with a small proportion provided privately. However, although provision exists for self-administration at Roma Hospital, South West HHS is currently the only HHS in Queensland that does not provide a dedicated nurse led renal service, with patient flows continuing to be allocated to Darling Downs HHS for treatment[28].

Patients are currently required to relocate to Toowoomba to learn self-dialysis which generally takes a minimum of six months to accomplish before being deemed competent and safe to return to self-dialyse in their own home.

The burden of travel on people with end stage kidney disease is significant with evidence supporting that the stress of travel and haemodialysis is related to poorer clinical outcomes and reduced quality of life. The financial burden for these individuals is also considerable. Some patients have subsequently not been able, or are deemed unsuitable, to perform self-dialysis which has left them no choice than to relocate away temporarily or permanently from family and friends.

It is also understood that, given the absence of a local service, that some Aboriginal and Torres Strait Islander peoples have decided not to continue with dialysis rather than being required to relocate.

Notwithstanding the significant support of the Darling Downs based service, establishment of a more locally based service is one of the most consistently advocated service requests from consumers and Aboriginal and Torres Strait Islander partner organisations to better support people managing chronic kidney disease within the community.

[27] https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/advancing-kidney-care-2026
[28] https://qheps.health.qld.gov.au/__data/assets/pdf_file/0036/2866275/Dialysis_Demand_Capacity_Oct_2022.pdf

The establishment of a locally based / satellite supported renal haemodialysis service is therefore imperative to providing long awaited local support to people within the South West community with kidney disease, enhanced equity of access to haemodialysis for rural consumers closer to home, and would also create further career pathway opportunities to sustain a skilled nursing workforce in rural health settings.

Data extracted from general practice indicates high rates of renal impairment across Paroo (11.4%), Quilpie (10.1%) and Murweh (9.6%). Rates are lower in the other LGAs in the region (Figure 153).

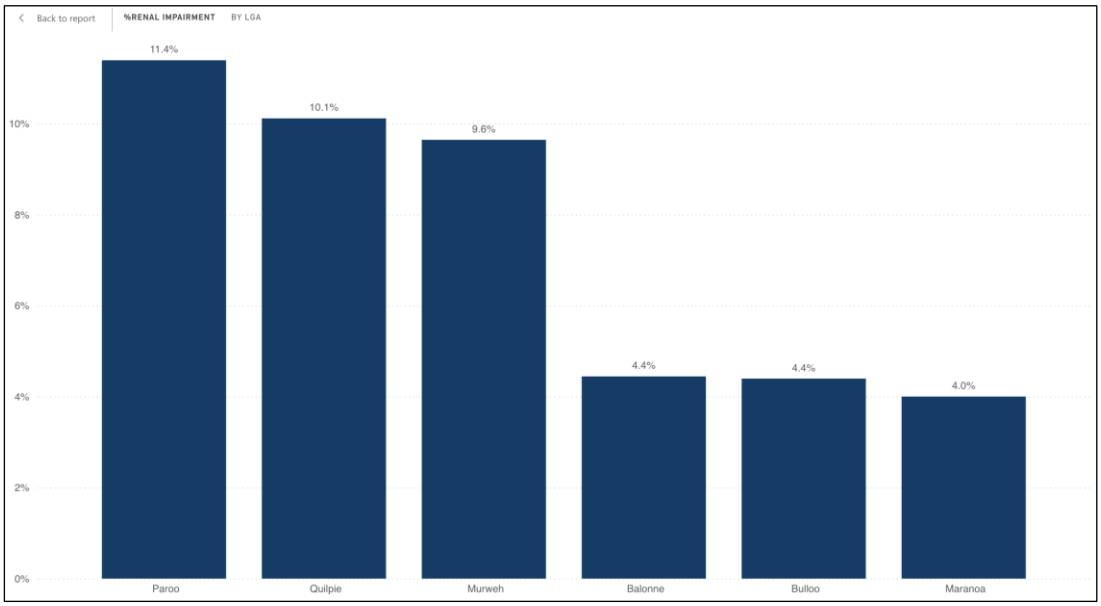


*Figure 153: Rates of renal impairment across the South West region*

General practices, in the South West region, recorded some of the highest prevalences of chronic conditions compared to the rest of Western Queensland. Of particular interest, is the leading prevalence of mental health conditions (25.4%) which is significantly higher than NW (14.8% but lower than CW 18.4%, respectively). Additionally, South West's older population may have influenced the highest prevalence of musculoskeletal conditions in Western Queensland (22.5%). Furthermore, Respiratory conditions presented in a greater proportion of people in general practices in South West than North and Central West regions (16.5% compared with 9.4% and 13.4% respectively).

Overall, 44% of people visiting general practices in the South West region were experiencing 1 or more chronic conditions, which equates to over 6900 people.

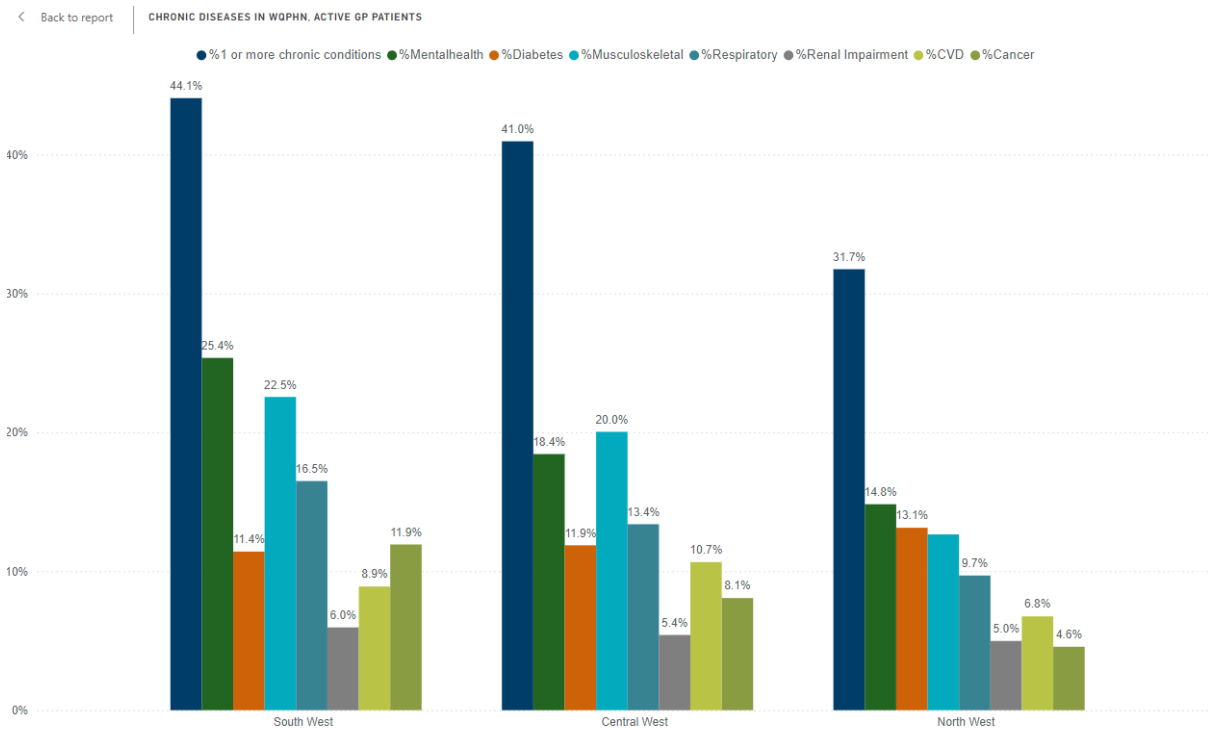


*Figure 154: Rates of chronic disease in WQPHN*

## 5.4.6 Communicable disease (SWHHS region)

### 5.4.6.1 Sexually transmitted infections (CWHHS region)

It is noted that there are currently no established Queensland Health sexual health clinics within South West Queensland, all of which are concentrated in Northern, Central and South-east Queensland[29].

There is also no community based testing sites within the region, with sexual health contact tracing support designated to the Princess Alexandra Sexual Health services (Metro South).

Access to syphilis surveillance, infectious disease units (including blood borne viruses and sexually transmissible infections) are provided at a Statewide level.

## 5.4.7 Mental illness and psychological distress (SWHHS region)

As with all locations linked to a harsh environment and outback way of life, the compounding impacts of droughts, floods and bushfire place a significant mental load upon our communities, which are often considered to have limitless reserves of resilience, optimism, and a capacity to rally and support each other over time.

Whilst these indications of stoicism and mate-ship are considered to be comparative strengths, relatively low numbers of hospitalisations are more likely to be due to the availability of services, and an unwillingness to seek support, rather than a marked difference in the prevalence or burden of disease.

In 2021, 1,700 South West residents reported having one or more long-term mental health conditions, equivalent to 7.2% of the population, which was slightly lower than the State average.

South West HHS District Mental Health and Alcohol and Other Drugs Services (MHAODS) provides a community based South West wide service for individuals experiencing severe mental illness and/or problematic alcohol and other drug use, and those experiencing mental health crisis including suicidality, and

[29] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/services/find-service

their families, carers, and significant others. Staff are situated permanently in Roma, St George, Cunnamulla, and Charleville with outreach provided to other locations on a regular basis by appointment.

South West HHS has no Acute Inpatient capacity, with out of hours support provided by Darling Downs HHS.

Two non-clinical community program areas are incorporated under the MHAOD Service with a focus on partnerships, collaboration, prevention, and early intervention:

- Tackling Regional Adversity through Connected Communities (TRACC): Enhancing the resilience and reducing the impact of adversity associated with drought and disaster by supporting suicide prevention, mental health promotion and prevention activities in communities impacted by disasters such as drought, floods, and fires.
- EdLinQ: Improving linkages and service integration between the education sector, primary care, community, and mental health sectors and supporting the early detection and collaborative care of school-aged children and young people at risk of, or experiencing, mental health problems or mental illness.

Both program areas have experienced higher activity levels than previous years – with self-harm, general behavior, anxiety, and trauma identified as the primary drivers for schools requesting EdLinQ liaison. TRACC staff are also routine supports in emergency responses to local fires and floods and active participants in local community and health promotions engagement activities.

### 5.4.8 Oral health (SWHHS region)

Queensland's Chief Health Officer observes[30] that untreated dental decay is the most common health condition worldwide. Oral diseases effect nutritional intake, the ability to socialise and work without pain or embarrassment, and are associated with several chronic diseases, including diabetes, stroke, cardiovascular and lung diseases and adverse pregnancy outcomes.

Although largely preventable, socioeconomic inequalities and inadequate prevention and treatment contribute to ongoing high levels of oral disease. Oral health outcomes improve with good oral hygiene and nutrition, regular dental visits with the first visit before two years of age, and access to fluoride through community water supplies and oral care products.

South West HHS provides oral health services to communities from fixed and mobile facilities and routinely undertakes extensive oral health promotion and eligibility awareness activities across the region. There are fixed, permanently operated, adult clinics based at Roma and Charleville Hospitals. Eight additional dental clinics are attended through an outreach schedule to St George, Mungindi, Dirranbandi, Surat, Injune, Mitchell, Cunnamulla, and Quilpie.

With South West Oral Health Services the preferred provider for all south west district schools, three mobile dental vans and a Drover predominately provides services to schools across the South West and areas with no fixed surgeries, including Augathella and Thargomindah.

Denture work is provided in conjunction with patient's dental care and includes both emergency / urgent work and the provision of new dentures - both part and full. Currently, and in the absence of a dedicated position, services are generally outsourced to a dual qualified Prosthetist / Dental Technician based in Roma.

With a service philosophy that completing courses of care ensures patients become dentally fit, the time spent in any area will vary depending on the needs of the local population. Services are delivered to patients in accordance with administrative waitlist processes, ensuring equity in care delivery and facilitating clinical prioritisation, with emergency appointments also available at permanent and outreach clinics.

All visiting services, including accessibility, are advertised by extensive prior community awareness via local facilities, Aboriginal and Torres Strait Islander Liaison officers, General Practitioner Services, the local CAN and other internal and external stakeholders.

South West HHS Oral Health Services has consistently delivered above target levels in terms of preventative health, smoking cessation and completion of courses of care for First Nations people as well as ensuring no

[30] https://www.choreport.health.qld.gov.au/our-health/dental-and-oral-health

long waits for dental services and increasing rates of child activity and is now using digital formats for all x-rays.

Services may also extend to community members who are having difficulties in accessing private dental care, dependent on clinical need, and workforce availability. Due to the closing and limited hours of practice in private dental clinics across the South West, the requirements of private patients seeking emergency care has increased other recent years. Potentially, increasing demands will continue where rates of private insurance decline.

The number of public patients waiting for South West services has also increased over time – with the overwhelming majority completing their course of care and requesting a further examination in twelve months and therefore being placed back on a waiting list – due in part to the positive impact of improvements in reaching patients and influencing communities to maintain good oral health care.

Service demand, compounded by workforce capacity and administrative support, will therefore continue to be key influences in the successful management and continuation of quality dental care for South West communities.

### 5.4.9 Palliative care (SWHHS region)

Compassionate end-of-life care includes support and treatment that is respectful of a person's physical, psychological, emotional, social, cultural and spiritual needs. This care is provided by a range of healthcare workers and includes support for families and carers.

With services co-ordinated through the three service hubs of Charleville, Roma and St George, palliative care goes beyond end-of-life-support. South West HHS's Palliative Care Team provide early interventions, including advice, support and education for all patients, their families and/or carers and our clinical teams, as well as crisis support.

With an overall end goal for consumers to receive care that aligns with their personal care goals and support all consumers who wish to die in the place of their choosing (including hospital) a multidisciplinary approach to culturally appropriate palliative care services – informed by consumer input and supported at a Statewide level by Specialist Palliative Rural Telehealth Service (SPaRTa) and Specialist Palliative Care in Aged Care (SPACE) colleagues – is vital to ensure the needs of our rural and remote communities are supported wherever possible.

During the 2023-2024 financial year, approximately 45 people accessed South West HHS palliative care services, with 10% of patients managed via St George and the remainder between Roma and Charleville.

Informed by consumer and broader partner co-design South West HHS has set a clear direction towards transitioning an existing palliative care service model that is largely supporting 'crisis' care when end of life is imminent, to facilitating early engagement in the consumer's journey to provide support which best optimises their quality of life and aligns their care goals for their palliative and end of life journey.

#### 5.4.9.1 Voluntary Assisted Dying

Voluntary assisted dying (VAD) is an additional end-of-life choice that gives eligible people who are suffering and dying the option of asking for medical assistance to end their lives.

Originally introduced on 1 January 2023, the initial 18 months of service has indicated[31] that approximately 25% of all people accessing VAD services lived in outer regional, remote or very remote areas (compared to around 2% of the QLD population being resident in these areas as a whole).

With data not available regarding access by South West residents, it is noted that approximately 75% of people accessing VAD services across Queensland since introduction had a cancer diagnosis.

Given Federal legislation, it is not currently possible to provide a telehealth enabled VAD service, which is therefore dependent on the availability of suitably qualified authorised practitioners who also provide an important role in terms of supporting process improvements.

[31] https://www.health.qld.gov.au/research-reports/reports/departmental/voluntary-assisted-dying-review-board-annual-report

To ensure equitable access and awareness of VAD and associated support services, and ensuring rural and remote considerations are fully represented, additional Statewide awareness of voluntary assisted dying processes and conversations – including support for clinicians wishing to voluntarily apply for authorised practitioner status – is required.

### 5.4.10 Potentially Preventable hospitalisations (SWHHS region)

Potentially Preventable Hospitalisations (PPH) are admissions to hospital that could have potentially been prevented through the provision of, and access to, appropriate primary and community health services. PPHs encompass 22 conditions grouped into three broad categories:

- vaccine-preventable conditions
- acute conditions and
- chronic conditions.

The Australian Institute of Health and Welfare (AIHW) advise the term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission. Rather, the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings.

In the period 2018-19 to 2020-21, the aged-standardised rate of hospitalisation in the South West region (45,898 per 100,000) was lower than the State rate (49,363 per 100,000), however the rate of potentially preventable hospitalisations (10%) and lifestyle related (6%) hospitalisations were higher that the Queensland rates (6% and 4% respectively).

Table 24 below presents the aged-standardised hospitalisation rates for a range of conditions. All conditions except Falls 65+ years and mental and behavioral disorders have a higher hospitalisation rate in the South West region, compared with the State.

*Table 24: Aged-standardised hospitalisation rates across the South West region, 2018/19 - 2020/21*

| Indicator | ASR Hospitalisations (Queensland) | ASR Hospitalisations (South West) | Average hospitalisations / year (South West |
|---|---|---|---|
| All cause | 49,362.7 | 45,897.8 | 11,755 |
| x7 chronic conditions | 1,722.3 | 2,962.8 | 662 |
| Asthma | 143.5 | 197.7 | 48 |
| COPD | 265.7 | 554.5 | 162 |
| Coronary Heart Disease | 421.0 | 664.1 | 188 |
| Dental conditions (0-9 years) | 695.9 | 1,275.6 | 45 |
| Diabetes | 224.9 | 341.3 | 89 |
| Falls 65+ years | 4,778.0 | 3,299.1 | 125 |
| Mental & behavioural disorder | 2,641.9 | 1,387.0 | 317 |
| Road traffic accidents | 324.5 | 717.8 | 158 |
| Stroke | 241.3 | 340.1 | 97 |
| Pneumonia and poisoning | 410.9 | 604.4 | 163 |
| PPH – vaccine preventable | 204.7 | 237.6 | 61 |
| PPH – acute | 1,610.1 | 2,251.8 | 549 |
| PPH – chronic | 1,336.4 | 1,953.5 | 533 |
| PPH – total | 3,128.6 | 4,420.6 | 1,137 |

### 5.4.11 Premature births and birthweight (SWHHS region)

A premature baby is one who is born too early, before 37 weeks. Premature babies may have more health problems and may need to stay in the hospital longer than babies born to full term.

Low birth weight has been defined by the World Health Organisation as weight at birth of less than 2500 grams (compared to an average birth of approximately 3600 grams) and is often caused by being born prematurely. Whilst some births may be healthy, low birth weight has been associated with an increased risk of illness and death in infancy and further complications into adulthood.

South West HHS maternity services at Charleville, Roma and St George are Level 3 CSCF which essentially support low-risk pregnancies. Therefore, mothers assessed as being at risk of a low weight birth are transferred to a higher CSCF rated facility to ensure the best possible outcomes for mum and bub, however this will result in a birth further away from home, family and potentially a prolonged stay away from community.

Potential factors influencing premature birth include smoking, alcohol or drug use during pregnancy, age (less than 17 or over 35), infection during pregnancy, not gaining enough weight during pregnancy or a previous low weight birth. Aside from lifestyle choices, access to timely and regular antenatal support may limit the risk of premature birth, and will also provide opportunities for further advice and guidance during the course of pregnancy and beyond.

*Table 25: Premature, birthweight and related factors in South West region*

| Indicator | Queensland rate | South West rate – Total population | South West rate – non-Indigenous population | South West – Aboriginal and Torres Strait Islander population |
|---|---|---|---|---|
| Premature | 6.6% | 5.8% | 5.0% | 9.0% |
| Low birth weight <37wks | 5.2% | 4.8% | 4.0% | 8.0% |
| Low birth weight 37wks+ | 2.0% | 1.9% | 1.5% | 3.2% |
| Smoked any stage | 11.4% | 16.4% | 9.1% | 46.1% |
| Smoking 20wks+ | 8.9% | 14.3% | 7.5% | 46.1% |
| 5+ antenatal visits | 96.2% | 96.7% | 97.8% | 92.2% |
| Antenatal visit 1st trimester | 81.1% | 68.0% | 71.5% | 53.5% |

### 5.4.12 Suicide (SWHHS region)

Between 2019 and 2021, there were 11 deaths attributed to suicide and self-inflicted injury, which equated to 0.5% of all Queensland suspected suicides during this period and making South West region the second lowest overall. However, when extrapolated to deaths per 100,000, the South West rate of 16.2 is slightly higher than the 15.5 Queensland rate and greater than the equivalent rate of the HHS with the highest number of attributed deaths (442 people / 12.2)[32].

[32] Suicide in Queensland: Annual Report 2022: www.griffith.edu.au/griffith-health/australian-institute-suicide-research-prevention/research/qsr/annual-report-2022

# 5.5 Service needs

## 5.5.1 Relevance

**Why is exploring the service needs of the South West Queensland region important?**

Effective health services are essential for meeting the diverse needs of a population, yet service gaps, inefficiencies, and workforce challenges persist. This section assesses the service landscape, including service mapping, workforce capacity, and utilisation patterns, to identify areas of need and potential service gaps. Understanding the efficiency and effectiveness of services is crucial for ensuring that resources are allocated where they are most needed. Coordination and integration of services, across primary care, social and community care, and hospitals, is key to delivering seamless care. After-hours care and hospital capacity are also explored, as they are often the pressure points within the system. By analysing these service needs, this section aims to inform strategies that enhance service delivery, improve patient outcomes, and optimise healthcare system performance.

## 5.5.2 Service mapping (SWHHS region)

### 5.5.2.1 PHN commissioned services

Western Queensland PHN funds a wide range of commissioned services:  Aged care, mental health, allied health, palliative care, Health Care Home and substance use services in the South West region through 15 commissioning services providers. Access to these services is equally spread across the region with the main hubs in Roma and St George. Other very remote areas (Thargomindah, Bullo, Eulo, etc) can access to these services via RFDS support and other virtual meas.

### 5.5.2.2 South West HHS

Commencing service on 1 July 2012, the South West Hospital and Health Service (South West HHS) is an independent statutory body overseen by a local Hospital and Health Board in accordance with the *Hospital and Health Boards Act 2011*.

South West HHS is the main provider of acute services, and the largest provider of aged care and primary healthcare services across the region which, alongside our partners and informed by community need and aspirations, provides significant scope and opportunities for integrated service provision.

Based around three core hospitals at Charleville, Roma and St George, services are delivered in line with our Service Agreement with Queensland Health[33] and include: medical; surgical; emergency; obstetrics; paediatric; specialist outpatient clinics; mental health; community and allied health; oral health; critical care; clinical support services; residential aged care and home and community care services.

Although strong collaborative ties are maintained with private providers established across the region, and the Western Queensland Primary Health Network (WQPHN), the traditional model of privately-owned General Practice is absent across many South West communities. This has resulted in South West HHS becoming a significant provider of bulk billed primary health care services through eight medical practices.

South West HHS also operates a network of eight Multipurpose Health Services (MPHS), and other community health facilities, which serve as the main care providers across our very remote communities who are also supported by the Royal Flying Doctors Service and our Aboriginal Community Controlled Health Organisation (ACCHO) partners, namely:

- Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Ltd
- Cunnamulla Aboriginal Corporation for Health and the Surat Aboriginal Corporation
- Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services

[33] https://www.publications.qld.gov.au/dataset/south-west-hhs-service-agreements

We strive to be a trusted and valued leader in the delivery of health services to rural and remote communities and also work closely with a wide range of valued partners to provide safe, effective, responsible and sustainable rural and remote health services. Additional partners include:

- The Surat Aboriginal Corporation
- The Western Queensland Primary Health Network, and the Nukal Murra Alliance
- Southern Queensland Rural Health, and other tertiary education partners including the University of Queensland and the University of Southern Queensland
- Our Community Advisory Networks
- The Darling Downs Public Health Unit
- Local government, education providers and Queensland Emergency Service colleagues (Ambulance, Police and Fire, in addition to State Emergency Service teams)
- State and Commonwealth departments of health and associated programs
- Neighbouring and Statewide HHSs
- Other Statewide entities, including Health and Wellbeing Queensland, Health Consumers Queensland and the Queensland Mental Health Commission.

**South West HHS Services**

Public health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services are delivered from three hospitals at Charleville, Roma and St George. Primary and Community Care services are also based in these locations and provide outreach. Eight multipurpose health services provide care from Augathella, Cunnamulla, Dirranbandi, Injune, Mitchell, Mungindi, Quilpie and Surat. The HHS also manages eight general practices, located within towns served by the MPHS, and two dedicated residential aged care facilities at Westhaven Residential Aged Care Facility in Roma, and Waroona Mulitpurpose Centre in Charleville.

In addition, four community clinics at Bollon, Morven, Thargomindah and Wallumbilla provide nurse led services and community care support. Commonwealth Home Support Program (CHSP) services, including various domestic assistance and other supports to assist people maintain independence at home, are also provided at selected locations.

Through contractual arrangements, Flying Specialist Services and Flying Obstetrician Services provide services to rural and remote locations in the South West, the western part of Darling Downs and Central and Western Queensland with further outreach services also provided in person / by telehealth by external partners, to supplement ACCHO and other service provision.

Queensland Ambulance Service stations are located at Charleville, Cunnamulla, Dirranbandi, Injune, Mitchell, Roma, St George and Surat, with hospital based stations (managed via South West HHS employee and / or voluntary Hospital Based Ambulance drivers) are located at Augathella, Bollon, Morven, Quilpie and Thargomindah.

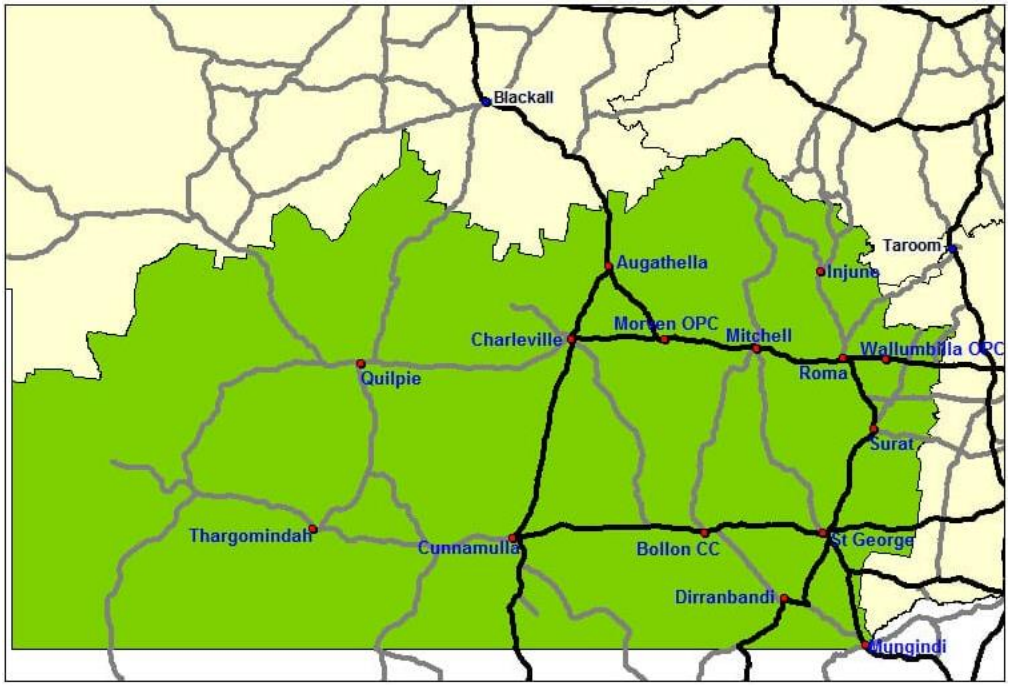


*Figure 155: South West HHS regional services*

## 5.5.3 Workforce mapping (SWHHS region)

As at 30 September 2024, the overall proportion of residents per workstream was broadly favourable for South West residents compared to the Queensland equivalent – with the exception of Medical (who are caring for an additional 96 persons per clinician) and Operational staff:

*Table 26: Workstream FTEs across South West HHS*

| Workstream | South West FTE | Residents per workstream | QLD equivalent |
|---|---|---|---|
| Aboriginal and Torres Strait Islander | 10 | 394 | 496 |
| Managerial and Clerical | 183 | 132 | 351 |
| Medical (including VMO) | 45 | 536 | 440 |
| Nursing | 389 | 62 | 136 |
| Operational | 156 | 154 | 623 |
| Professional and Technical | 97 | 248 | 407 |
| Trade and Artisans | 4 | 6,025 | 11,577 |
| **TOTAL:** | **884** | **27** | **60** |

As of October 2024, approximately 79% of South West HHS FTE were permanent staff, compared to 88% of Queensland HHS, which indicates a higher reliance on agency and / or unsustainable overtime working to meet local requirements, resulting in fatigue amongst existing staff filling gaps in the workforce and impacts the HHS's capacity to maintain a consistent workforce with appropriate skill mix.

Given the dispersed nature of South West communities, significant vacancy rates across professions and limited opportunities to support backfill or access other relief, pressures may be higher on permanent staff to maintain continuity of service in local communities given the more transient nature of agency and locum positions.

Of note, the higher relative caseload for medical staff may also provide additional challenges, with the overall proportion of Aboriginal and Torres Strait Islander people to Aboriginal and Torres Strait Islander Workforce also identified as an area where further development of local options to establish home grown pathways will be beneficial for local communities. Residential aged care staff are also in high demand, with community

representatives also noting a high need for the provision of additional at home care and support packages to support older residents maintain independence and dignity.

Whilst there is a nationwide shortage of all types and levels of medical staff, the most critical for South West HHS, and other rural and remote services, are appropriately trained and qualified Rural Generalists with special skills in Obstetrics, Anaesthetics and Emergency.

Secondary care (emergency departments, maternity care) also continues to mitigate for market failure in primary care (aged care, general practice, and Indigenous health), which in turn results in presentations to emergency departments and / or later detection, diagnosis and commencement of treatments for conditions that may result in potentially preventable hospitalisations and, ultimately, avoidable deaths.

The current mitigation for medical workforce shortages is to engage locum medical officers. However, vacancies have been exacerbated by the inability to source quality locums with availability and the appropriate qualifications and registrations. In addition, financially unviable rates have been requested by locum agencies to secure medical officer placements. Annual costs and average daily costs for locum medical officers have increased significantly between 2021 and 2024, placing a strain on labour budgets. These increases have generally been absorbed elsewhere within the budget or offset against periods of critical vacancies.

In response to primary care related shortages, alternative models of care, implemented in consultation with South West communities, have ensured service continuity by way of SMO/GP outreach models of care delivered by community based Nurse Practitioners working within the medical team with virtual GP appointment and Telehealth Emergency Medical Support Unit to assist with emergency presentations.

Overall, there has been a positive response to these models by staff and communities as team-based continuity of care is maintained. Further implementation of an Independent Practitioner model of service, supplemented where available additional recruitment and retention incentives, is intended to be further progressed by South West HHS.

Aging properties, lack of available and suitable family accommodation and overall limited availability of housing in rural and remote communities, is critically impacting attraction and retention rates – including where positions are filled pending the availability of housing within policy and reward requirements. These pressures are exacerbated by limited purchasing and rental markets across South West Queensland, the high cost of building, and legislative limitations on purchasing suitable properties. South West HHS is working to relieve these pressures through a combination of new builds, onboarding of Government Employee Housing leases and private leases and management of its internal portfolio, within a constrained and in-demand market.

### 5.5.4 Market analysis (SWHHS region)

**Market Share**

At a Statewide level, the balance of hospital market share across Queensland has progressively shifted over the past decade from the private to the public sector. As at 30 June 2021, and reflective of South West HHS's position as the principal provider of services across the region, average annual public hospital market share from 2014/15 was 78.0% – compared to 63.4% Statewide[34].

In relation to Aboriginal and Torres Strait Islander people, South West HHS's total market share was 96.8%, almost five percent higher than the equivalent Statewide rate.

**Private Health Insurance**

Considering remoteness, overall market share may also be due in part to limited availably of private medical insurance services or providers compared to cities and other regional areas – with the AIHW, informed by previous ABS data, noting people living in major cities, and those within the higher deciles of social advantage, continue to be most likely to hold, and utilise, private health insurance.

[34] Market Share – Planning Portal maintained by Queensland Health

More broadly, the ABS also observed people living in major cities were also more likely than those living in outer regional, remote, or very remote areas to see a dental / medical professional or access an out of hours GP service.

As at 2019-20, an average of 37.5% of South West adults held private health insurance, which was marginally less than the Statewide average of 38.8% [35].

Conversely, people living in outer regional, remote, or very remote areas were more likely to visit a hospital Emergency Department, or be admitted than those living in major cities or delay getting - or go without - prescription medication which suggests scope for earlier intervention and support in community settings to better manage their conditions and avoid people presenting to ED or requiring a hospital stay.

### 5.5.5 Service utilisation (SWHHS region)

**Decreasing number of GP services per capita**

The number of GP services per capita is decreasing in SW region, down from 6.6 in 2018-19 to 5.5 in 2022-23, much lower than National average of 6.6. The number is low at Paroo (4.2).

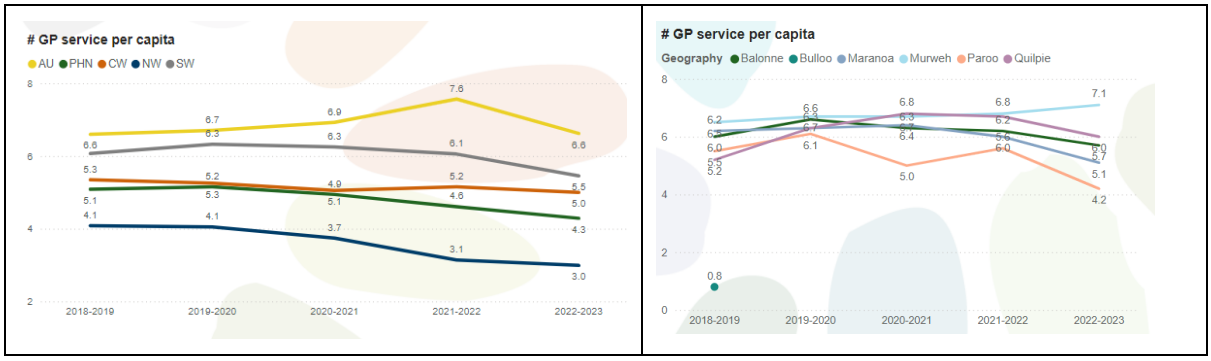


*Figure 156: GP services per capita across the South West region*

**Low level of After-hours GP services**

After-hours GP services account to 2.6% of total GP services across the region in 2022-23, much less than the National and PHN average of 4.6% and 4.0%. The proportion of after-hours GP services is only 1.6% in Paroo and Balonne, 2.4% in Quilpie.

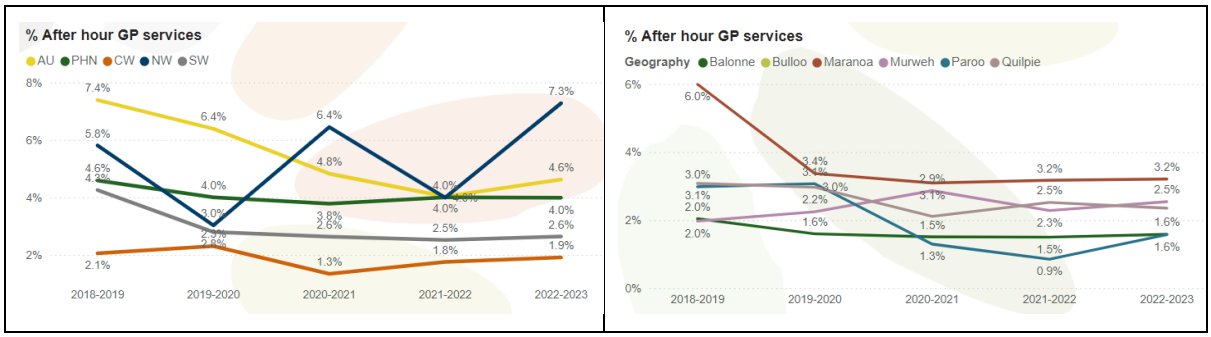


*Figure 157: GP after-hours services across the South West region*

**Increasing use of Telehealth GP services**

Telehealth services increased from 13.7% in 2020-21 to 16.2% in 2022-23, still below the National 18.8% but surpassed the PHN of 13.0%. The proportion of telehealth usage increase in all areas, for instance, Balonne from 10.6% (2020-21) to 15.4% (2022-23), Murweh from 15.7% (2020-21) to 21.3% (2022-23).

[35] PHIDU – Social Atlases of Australia: LGA (QLD) Private Health Insurance

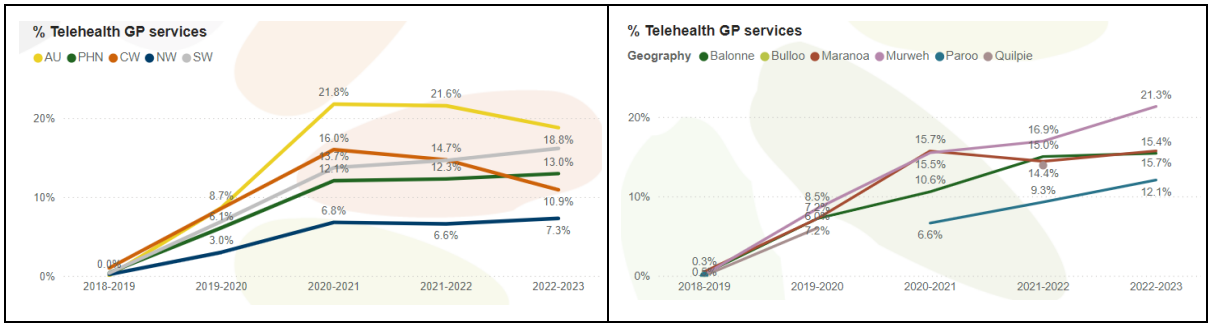


*Figure 158: GP telehealth services across the South West region*

**Low number proportion of Mental health related GP services**

1.5% of GP services are mental health related care, lower than the National average of 2.0% but not much different with the PHN average and 1.6%. The proportion of mental health related GP services is high in Maranoa (2.0%) but low in Murweh (0.6%) and Paroo (0.4%).

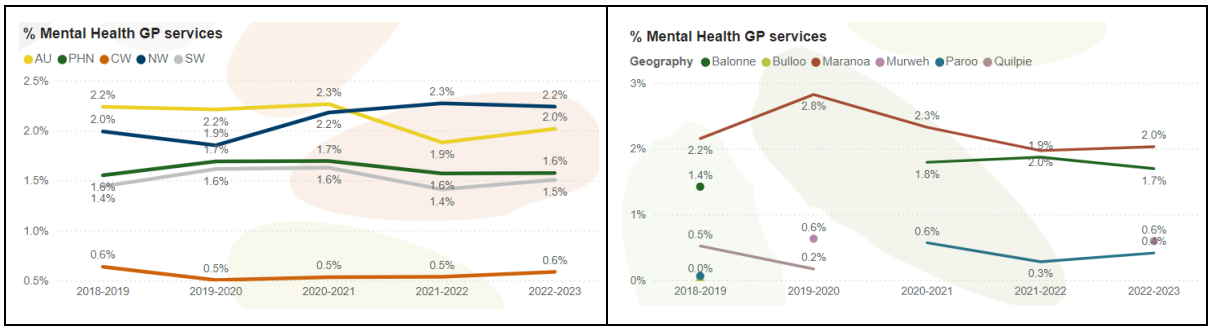


*Figure 159: GP mental health services across the South West region*

**Significant drop in number of GP services in RACF**

3,623 GP services in RACF in 2022-23, down from 4,337 services in 2020-21. The number of services significantly decreased in Balonne (1,267 down to 916 services) and Murweh (1,106 down to 740 services).

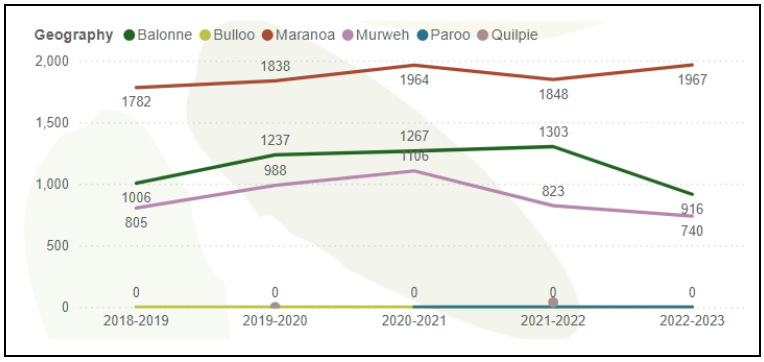


*Figure 160: GP RACF services across the South West region*

### 5.5.5.1 NDIS participation (SWHHS region)

In June 2024, around 570 residents (2.4 % of the population) were active participants in the NDIS and were in receipt of an individual support package. This figure is slightly lower than the Queensland average (2.6%). The highest percentage of NDIS participants was in Quilpie (3.8%), and Murweh (3.4%).

### 5.5.5.2 Hospital attendance (SWHHS region)

There is an increasing trend of inpatient hospitalisations in the South West region. In 2020-21, SWHHS provided treatment for 7,168 inpatient episodes and jumped to 7,643 in 2022-23. Ophthalmology, gastroenterology, respiratory, cardiology, neurology are top reasons for admissions in the region.

The number of patient days (for overnight stay) was also up to 14,834 days from 13,513 in 2020-21.

### 5.5.5.3 Emergency department presentations (SWHHS region)

**Decreasing number of categories 4 and 5 ED presentations**

19,017 categories 4 and 5 ED presentations in 2023-24, accounting for 66.6% of total presentations, less than 2021-22 value of 74.7%. The number of categories 4 and 5 after hours presentations dropped from 7,042 to 6,126 but the proportion went up from 27.4% to 32.2%.

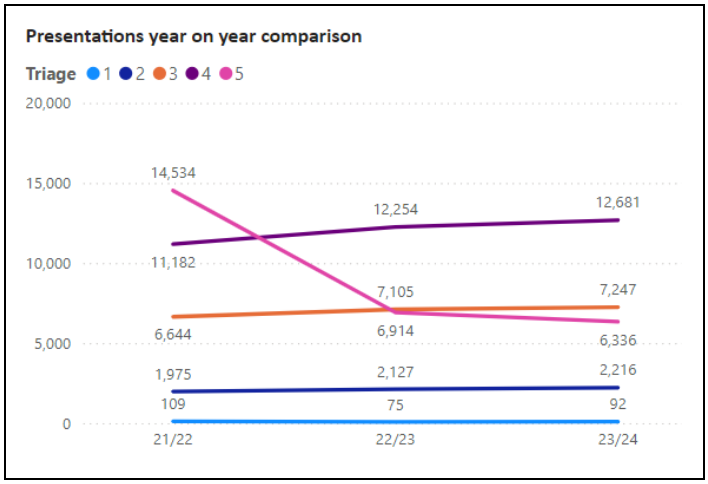


*Figure 161: ED presentations across the South West region*

**Increasing number of Mental health related ED presentations**

368 ED presentations in 2023-24, nearly doubled 2021-22 number (198 presentations).

**Reducing the proportion of presentations using walk-in or public or private transport**

94.21% of ED presentations in 2023-24 were walked in /public or private transport, down from 95.47% in 2021-22 whereas increasing in Ambulance (from 3.54% to 4.94%).

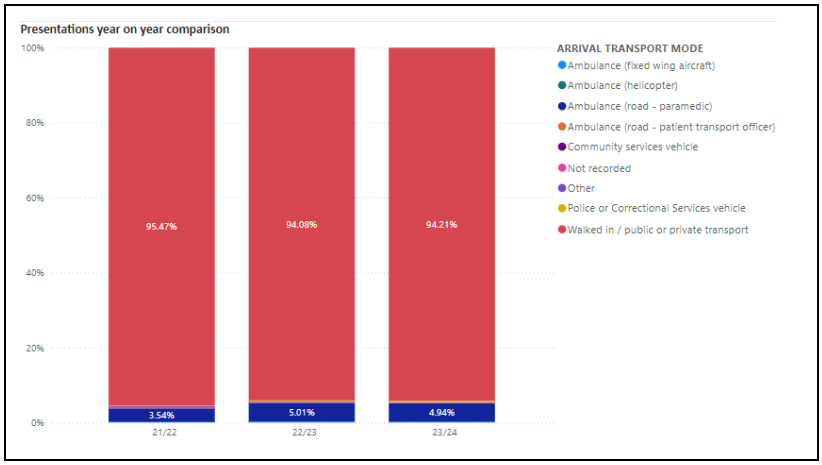


*Figure 162: ED presentations by modality across the South West region*

### 5.5.5.4 Oral health presentations (SWHHS region)

There is an increasing trend of inpatient hospitalisations in the South West region due to oral issues. In 2019-20, SWHHS provided treatment for 61 inpatient episodes and jumped to 94 in 2022-23.

There were 123 ED presentations in the region due to oral related incidents in 2022-23, 81% of these presentations were in categories 4 and 5 with less emergent status and 43% were presented after normal business hours.

### 5.5.6 Efficiency and effectiveness of health services (SWHHS region)

Through the dedication and commitment of our staff and teams across dispersed communities, South West HHS continued to ensure major services are provided in a safe, effective and sustainable manner in accordance with expectations of our Communities and aligned with our Service Agreement.

For instance, through HOPE, Healthy Communities, Tackling Regional Adversity through Connected Communities, Healthy Ageing and Domestic and Family Violence teams – and their extended partners – SWHHS continued to host and participate in a vast range of community focussed health promotion initiatives, effectively resulting in at least one event being held every 1.5 days during the reporting period across the South West. This demonstrates the SWHHS commitment to improving health outcomes through proactive prevention and health literacy programs.

South West HHS, through its active Safety and Quality Committee to oversees the safety, quality and effectiveness of health services and monitors compliance with plans and strategies. Overall the Average Length of Stay (ALOS) was 3.9 days, which in a rural and remote setting represent a sound achievement. At June 2024, the SWHHS had 6 Elective Surgery and 3 Endoscopy long wait patients. These figures represent a better than State average performance, however our goal was to have zero long wait patients, which we continue to work towards. Overall performance against the majority of key performance indicators and activity levels reached or exceeded the required target figure. Prevention and Primary WAU is 141.6% above target. All measures are reported in QWAU Phase Q26. The 2023–2024 Actual is based on data available on 19 August 2024.

During 2023-24 SWHHS employed a workforce of 886 FTE staff, with an increase in First Nations workforce representation to 6.5%. In an effort to continue to improve the culturally safe and appropriate care provided, we will continue to strive to our target of 16%.

Whilst Telehealth utilisation was at 81% of the 2023-2024 target this represents a total occasions of service figure of 4438, which was approximately 450 occasions of service higher than the previous five year average.

At end of financial year, SWHHS returned a surplus of approximately $4.4m, including adjustments for exceeding performance targets.

### 5.5.7 Coordination and integration of health services (SWHHS region)

Coordination and integration of services are important to ensure seamless service provision as patients transition across departments and across service providers within the community. Data sharing poses a significant challenge as patients transition from primary to tertiary care and back. Local communication between service providers is essential to overcome these challenges and the HHS continues to work collaboratively with our partner organisations to problem solve and support service improvements where needed.

SWHHS utilises ‘Access My Healthcare’ an externally based online calendar of local public / private health and community services available to the public. Details are maintained by registered providers of services that can be accessed by communities and / or host events, provide advocacy or other support services. An online calendar is also maintained online to enable people wishing to access services to schedule appointments. Further details regarding registered service providers are also maintained on the Queensland Community Directory.

Further work has been undertaken with the South West Primary Care Pilot commencing to further improve coordination and integration of care for our consumers within the South West region. This pilot represents a place-based approach to a consumer driven model, where needs drive services.

### 5.5.8 After-hours care (SWHHS region)

The percentage of after hours care provided at GP facilities declined over time from 4.3% in 2018-19 to 2.6% in 2022-23 over total GP visits, far below the national average of 4.6%. The percentage is low across the whole region with the lowest rate in Paroo and Balonne (1.6%), even in Maranoa (3.2%) areas where it is supposed to have higher availability and needs for after-hours services.

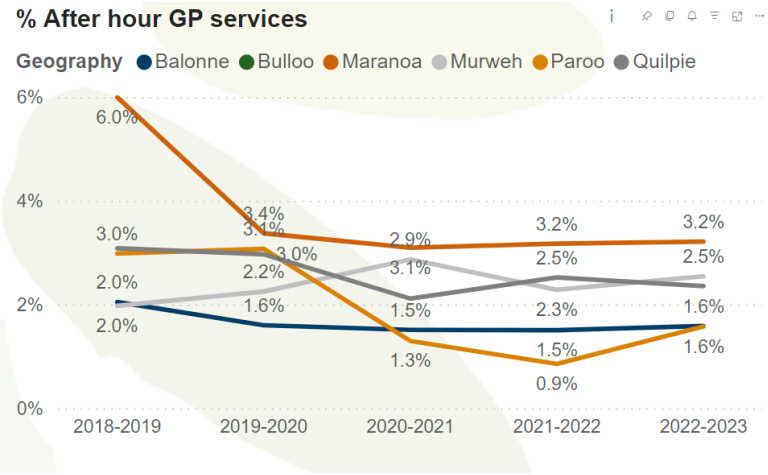


*Figure 163: After-hours GP services across the South West region*

Furthermore, only 9.15% of people living in Outback South SA3 – which covers the SWHHS region, had after-hours GP services in 2023-24, much less than the national level of 16.4%.

## 5.5.9 Primary care (SWHHS region)

### 5.5.9.1 GP attendances (SWHHS region)

There is a low proportion of people living in the North West region had GP services. The data from MBS showed that in 2022-23 81.81% of the regional residents attended GP, less than the National average of 85.99%. The percentage is particularly low in people aged 25- 44 years old (78.75%).

There is a high proportion of GP long and prolong consults. These types of consultation account to 16.2% of total GP attendance in the region, much higher than the National average of 12.6%, suggesting the complexity of conditions every time the South West residents had GP visits. It also indicates the lack of GP services in the region driving residents to discuss with GPs multiple conditions/issues for each visit.

### 5.5.9.2 GP services to Residential Aged Care Homes (SWHHS region)

There are not many changes in the number of GP services provided to residential aged care homes in the region during the past 5 years (3,593 services in 2018-19 and 3,625 services in 2022-23). However, there is a switch in the location of services provided as more services in Maranoa and less in other areas. In Maranoa area, the number jumped from 1,782 services in 2018-19 to 1,967 services in 2022-23. In Balonne and Murweh, the number dropped from 1,303 and 823 (2021-22) to 916 and 740 (2022-23)

### 5.5.9.3 GP Mental Health Treatment Plans (SWHHS region)

GP Mental Health services delivered to the South West residents is still below the National average. In 2022-23, GP mental health services only account to 1.5% of total GP services, compared to 2.0% for the nation. In addition, the access to the service is not geographically equal. People living in areas rather than Maranoa have very limited access (less than 1%). In Murweh and Paroo, only 0.6% and 0.4% GP services were for mental health.

### 5.5.9.4 Telehealth services (SWHHS region)

There is an increasing uptake of telehealth services in the South West region is still much below the National level. In 2022-23, telehealth services in the region account for 16.2% total GP services, up from 6.9% in 2019-20 (National level at 18.8% in 2022-23).

Telehealth services are less popular in very remote areas like Paroo (12.1% in 2022-23), Balonne (15.4% in 2022-23). However, in more developed areas like Maranoa, only 15.7% of GP services are done via phone or video, raising concerns about digital health literacy as well as the availability of the services in the region.

#### 5.5.9.5 Allied health services (SWHHS region)

One in four (27.92%) of people living in the South West regions are able to access to allied health services in 2022-23, less than National average of 38.86%. The limited access is across all allied health services: 26.09% for Optometry, 0.85% for Physical Health Care (31.56% and 5.08% for National level).

### 5.5.10 Social and community care (SWHHS region)

There were 111,058 outpatient occasions of service in 2022-23, These related to maternity, medical, primary health care, surgical, and other services (excluding COVID-19). Tier 2 clinics focused on general imaging, primary health care, maternity and midwifery, and general practice.

In addition to the range of services provided by South West HHS both on site and via outreach, *Access My Healthcare* provides an externally based online calendar of local public / private health and community services available to the public. Details are maintained by registered providers of services that can be accessed by communities and / or host events, provide advocacy or other support services. Services include: wound management, diabetes education clinics, exercise physiology cardiology sonography, women's health services, physiotherapy, occupational therapy, podiatry, social work, mental health and drug and alcohol services, Indigenous health, skin clinics, Home and Community Care, early intervention parenting program, RFDS clinics and other services provided by and ACCHO and other NGOs.

Services are designated as a 'fixed' (e.g. at a designated facility, clinic, pharmacy etc – and may not imply that these are available 24/7), or 'visiting' basis which potentially may also include virtual access. An online calendar is also maintained online to enable people wishing to access services to schedule appointments.

For indicative purposes, given the need for service providers to register with the directory, the following health and health related services provided by a range of service providers within a 50KM radius of each location's central postal code are provided for indicative purposes, noting that registration is voluntary in nature and that scheduled visiting appointments may change. Total numbers may also include South West HHS facilitated services. It is also acknowledged that there a range of other smaller communities and townships in surrounding areas, who may need to travel to attend services.

*Table 27: Total listed services (within 50KM of location) – November 2024*

| Locations: | Fixed | Visiting |
|---|---|---|
| **Charleville** | 76 | 63 (to 31 January 2025) |
| Augathella | 27 | 11 (to 21 November 2024) |
| Cunnamulla | 67 | 65 (to 16 January 2025) |
| Morven | 20 | 11 (to 20 November 2024) |
| Quilpie | 45 | 10 (to 19 December 2024) |
| Thargomindah | 21 | 65 (to 25 January 2025) |
| **Roma** | 111 | 53 (to 31 January 2025) |
| Injune | 28 | 7 (to 22 November 2024) |
| Mitchell | 38 | 10 (to 18 December 2024) |
| Surat | 38 | 23 (to 19 December 2024) |

| Locations: | Fixed | Visiting |
|---|---|---|
| Wallumbilla (25KM) | 21 | 5 (to 1 December 2024) |
| **Locations:** | **Fixed** | **Visiting** |
| **St George** | 66 | 44 (to 13 January 2025) |
| Bollon | 17 | 1 (to 25 November 2024) |
| Dirranbandi | 28 | 3 (to 24 November 2024) |
| Mungindi | 39 | 2 (to 6 November 2024) |
| **Toowoomba** | 268 | 8 (to 13 November 2024) |
| **Brisbane CBD** | 2,000+ | 44 (to 8 January 2025) |

## 5.5.11 Hospital capacity (SWHHS region)

The following table details total hospital and MPHS (aged care) bed / bed alternatives across South West HHS facilities as at 1 July 2024, and an indicative ratio based on local populations. Additional private provision (including retirement communities) is not incorporated into the calculations below. For the purposes of this calculation, the Community Clinics located at Wallumbilla (Roma and Surrounds SA2), Bollon (Balonne), Thargomindah (Far South West) and Morven (Charleville) do not have defined beds. It is also assumed that residents requiring higher CSCF level services would receive treatment at either the nearest South West hospital or be referred to alternate providers outside of catchment. It should also be noted South West HHS is an approved provider for two Residential Aged Care Facilities –the 45 bed Waroona facility, located in Charleville, and the 40 bed Westhaven facility located in Roma.

However, combining these additional bed numbers with available MPHS beds would equate to a revised allocation of one aged care bed per 15 people in the Charleville SA2 and 1 aged care bed per 31 people for the Roma and Surrounding area. These assumptions are also based on the full availability of MPHS and residential aged care beds, requiring sufficient staff to ensure required Daily Resident Care Hours and Skill Mix rations. It is also recognised that these additional beds are required to support the wider population rather than just the local SA2 areas. As such, any beds temporarily unavailable where these ratios cannot be maintained would result in an adjustment to the calculated indicative ratios.

Notwithstanding additional potential demand via fly-in, fly-out workforce, other transient populations / tourism and mass events, available hospital beds are significantly over subscribed in terms of potential local population need. Current and anticipated projected demand on aged care beds is also challenging, particularly within the context of an ageing population, which in turn increases service need upon CHSP and other in-home care supports to maintain independence and dignity of residents closer to home.

*Table 28: South Weste HHS hospital and MPHS beds at 1 July 2024*

| SA2 area | Hospital | MPHS | Baseline (2022/20223) | Ration beds / person |
|---|---|---|---|---|
| **Balonne** | **45** | **18** | **4,353** (731 aged 65+) | • 1 hospital bed per 97 people (all pop)<br>○ 1 MPHS bed per 41 people (65+) |
| St George | 35 | - | | |
| Dirranbandi | 7 | 6 | | |
| Mungindi | 3 | 12 | | |
| **Charleville** | **27** | **6** | **3,691** (780 aged 65+) | • 1 hospital bed per 137 people<br>○ 1 MPHS bed per 130 people |
| Charleville | 23 | - | | |
| Augathella | 4 | 6 | | |
| **Far South West** | **12** | **16** | **2,759** (493 aged 65+) | • 1 hospital bed per 230 people<br>○ 1 MPHS bed per 31 people |
| Cunnamulla | 8 | 10 | | |
| Quilpie | 4 | 6 | | |
| **Roma / Surrounds** | **72** | **29** | **7,011** (946 aged 65+) | • 1 hospital bed per 143 people<br>○ Nil MPHS beds |
| Roma | 49 | - | | |
| Injune | 7 | 7 | **6,089** (1,184 aged 65+) | • 1 hospital bed per 264 people<br>○ 1 MPHS bed per 41 people<br>(adjusted to 1:73 whole of Roma) |
| Mitchell | 12 | 18 | | |
| Surat | 4 | 4 | | |
| **TOTAL:** | **156** | **69** | **24,173** (4,134 aged 65+) | • 1 hospital bed per 155 people<br>○ 1 MPHS bed per 60 people<br>(adjusted to 1:27 aged care beds with the inclusion of Westhaven and Waroona) |

## 5.5.12 Hospital capability (SWHHS region)

All of our services provide the highest quality of care in accordance with applicable national accreditation schemes, ensuring a consistent standard of quality, safe and compassionate care for our communities.

The *Clinical Services Capability Framework* (CSCF11) for public and licensed private health facilities outlines clinical levels of service provided by health facilities. Current version 3.2 describes service level capabilities

rather than the overall capability of a health facility. As at 1 July 2024, South West HHS provided CSCF services as follows:

• Level 1 (low-complexity ambulatory care services) at its General Practices and Community Clinics

• Level 2 (low complexity inpatient and ambulatory care services) at its MPHS sites

• Level 3 (low to moderate complexity inpatient and ambulatory care services) at its three hospitals at Charleville, Roma and St George. Where clinically safe to do so, South West residents are supported to remain as close to home as possible.

However, given the imperative to ensure appropriate levels of safe and efficient care, patients are referred to their nearest hospital - or to a higher CSCF level facility located outside of the HHS - where a higher level of care is needed, for example in relation to birthing services.

Where required, the most commonly used hospitals by South West residents outside of the service area include Toowoomba Hospital (Darling Downs HHS), and hospitals in Brisbane (Metro North / Metro South / Children's Health Queensland / Mater).

## 5.6 Stakeholder consultation

### 5.6.1 Relevance

| Why is gathering stakeholder insights from the South West Queensland region important? |
| --- |
| Incorporating stakeholder perspectives is essential in the development of a robust health needs assessment. While quantitative data provides valuable insights into measurable health trends and service gaps, it alone cannot fully capture the nuanced needs and experiences of regional communities. Qualitative insights, drawn from the lived experiences of community members and the expertise of service providers, add depth and context that enrich the analysis. These perspectives illuminate the unique challenges, cultural values, and local strengths that shape health outcomes in these regions. Engaging with stakeholders not only ensures that the assessment reflects real-world conditions but also fosters a sense of ownership and trust within the community, ultimately leading to more targeted, effective, and sustainable health interventions. |

### 5.6.2 Insights from sector consultation

Consultation with the sector included incorporated insights from three key sources:

- Sector survey – administered in August 2024
- A review of insights gathered by WQPHN staff as part of ongoing liaison with commissioned service providers over the past 12 months, and
- A review of insights gathered by SWHHS staff as part of their most recent Local Area Needs Assessment.

**The most prominent healthcare issues identified included:**

- Supporting people with chronic and complex healthcare issues
- Earlier intervention, including preventive healthcare
- Supporting people's mental health and wellbeing
- Chronic kidney disease
- Oral healthcare
- Mental healthcare
- Skin diseases
- Maternity services, and
- Homecare services.

**A number of solutions were suggested to address these issues:**

- There is a need to increase the number of healthcare positions in the region in general, as well as enhance workforce distribution across the region. One specific area identified was domestic and family violence, including sexual assault counsellors.
- Ongoing advocacy is needed to ensure improved imaging facilities in the region. A CT scanner, for example will help avoid transfer of care outside the region, improve diagnoses and management, as well as play a crucial role from emergency and trauma presentations through to cancer screening and surveillance.
- Addition transport services are required to support people in more isolated communities to travel to their local larger towns for healthcare appointments, as well as basic shopping and care.
- Work creatively and collaboratively to more comprehensively understand the available funding within a region, identifying and leveraging synergies, and working to reduce gaps. Consider the use of volunteers where this is appropriate.

- Ongoing and continuous advocacy is required to expand and enhance the healthcare services available in the region. The health outcomes of our communities are poor, and we need to engage in more proactive health and wellness activities within the community.

### 5.6.3 Insights from community consultation

Consultation with community took the form of a review of insights gathered by WQPHN staff at community events over the past 12 months.

**A range of strategies to improve health outcomes have been identified:**

- Enhance communication and partnership across health care providers. This will help improve knowledge and promotion of services, enhance accessibility, as well as improved coordination to help avoid duplicative effort.
- Service delivery models cannot simply be lifted from metro areas and expected to work effectively in rural and remote communities. Models need to be adapted to ensure they're fit for purpose for rural communities, and appropriate incentives needs to be applied to ensure sustainability.
- Upgrading medical devices from 3G to 4G or 5G need to be prioritised to improve healthcare service delivery.
- Enhanced collaborative efforts are needed to ensure appropriate and effective support is provided to people with disabilities. This includes collaboration across primary care, Aboriginal Medical Services and aged care services. By defining clear roles and responsibilities, these services can work more effectively together to support people with disabilities, particularly as they age.
- Improved transport services remain a critical need in the region, with reliable and consistent services required to improve access to necessary healthcare, as well as other essential services that enhance community wellbeing.

## 5.7 Prioritised needs – South West Queensland region

| Tier | Description | Intended action |
|---|---|---|
| 1 | **These needs emerged as top-tiered needs following prioritisation.**<br>The need or issue aligns with the existing priorities of either the WQPHN or the relevant HHS. Resources are available to support activities to address the need, and activity is expected to occur within the next 12 months. In some cases, existing activities to address the need will already be underway, acknowledging some may require minor tailoring to best address the need. | Ensure these key needs are incorporated into relevant workplans for 2025. |
| 2 | **These needs emerged in-between the top and lower-tiered needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unlikely to be fully addressed within current resources. The partnering agencies will continue to advocate for resources to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 2-3 years. |
| 3 | **These needs emerged as lower-tier needs following prioritisation.**<br>The need or issue is not currently aligned with existing activities of either the WQPHN or the relevant HHS. The need is noted as having a negative impact on the health outcomes of the population, however is unable to be addressed within current resources. The partnering agencies will explore opportunities to partner with other relevant agencies to address these unmet community needs. | With ongoing advocacy, work to address these needs could be included in relevant workplans within 4+ years. |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Ageing | • There is an aging population in the SWHHS region, which will require the expansion of health and aged care services, with a particular focus on long-term care and chronic disease management. | 1 | WQPHN | WQPHN Care Finders, SWHHS HA program |
| | • There is limited availability of aged care facilities available for people in the SWHHS region, particularly home care services. | 2 | Advocacy WQPHN | MAC, CF, HCQ, advocacy |
| | • There is a need for greater access to aged care assessments and packages of care for older people in the SWHHS region, including CHSP support. | 1 | SWHHS | MAC, WQPHN, NDIS services |
| Cancer Care | • People across the SWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical and Breast). | 1 | WQPHN | WQPHN Practice supports HSS, Goondir, CACH RFDS and private primary care services |
| | • People across the SWHHS region require increased access to cancer treatment services, including chemotherapy. | 2 | SWHHS | PTSS, Nukal Murra, Cancer Council QLD. |
| | • People across the SWHHS region require a dedicated community based service for routine skin checks, with effective onward referral pathways. | 3 | SWHHS | WQPHN Practice supports HSS, Goondir, CACH RFDS and private primary care services |
| | • People across the SWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence | 2 | SWHHS | WQPHN Practice supports HSS, Goondir, CACH RFDS and private primary care services. |
| Child and Maternal Health | • Pregnant women and new mothers in the SWHHS region require consistent access to culturally appropriate child and maternal health services in community, including screening, health promotion and early intervention services. | 1 | SWHHS | WQPHN Practice supports HSS, Goondir, CACH RFDS and private primary care services, |
| | • Families in the SWHHS region require improved access to child development services. | 1 | WQPHN | NDIS, Local Schools for screening, WQPHN Healthy Outback Kids, CSP-Bush Kids |
| Chronic Disease | • People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of **cardiovascular** disease, including consideration of partnership arrangements to better address these needs. | 1 | SWHHS | WQPHN Practice supports HSS, Goondir, CACH RFDS and private primary care services. PHASES. Heart of Australia, Heart Foundation, Qld Health |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of **kidney** disease, including consideration of partnership arrangements to better address these needs. | 1 | SWHHS | WQPHN Practice supports HSS, AMS and private primary care services, Qld Health |
| | • People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of **respiratory** disease, including consideration of partnership arrangements to better address these needs. | 1 | SWHHS | WQPHN Practice supports HSS, CACH, Goondir and private primary care services, Qld Health |
| | • People within the SWHHS region require enhanced access to screening, treatment and services to support ongoing management of **diabetes**, including consideration of partnership arrangements to better address these needs. | 2 | SWHHS | WQPHN, CACH, Goondir, DAQ, |
| | • The uptake of influenza vaccines is low for people with COPD in the SWHHS region. | 3 | WQPHN | WQPHN Practice supports HSS, Goondir, CACH and private primary care services, Qld Health |
| Coordination, Integration and Continuity of Care | • Services in the SWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | WQPHN HPW, Digital Health, | RHealth, SWHHS, eHealth Qld |
| | • People in the SWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | WQPHN | WQPHN Practice supports HSS, Goondir, CACH and private primary care services, Qld Health |
| | • People in the SWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 1 | WQPHN | WQPHN Practice supports HSS, AMS and private primary care services, Qld Health |
| | • Upon return to home, people in the SWHHS region require improved coordination of follow-up care including having received following care received outside of catchment. | 2 | SWHHS | WQPHN – Digital Health, RHealth, SWHHS, eHealth Qld |
| | • Establishment of position(s) to communicate (outreach and eligibility) visiting services of the HHS and NGO providers. | 1 | WQPHN HPW, Digital Health, | Rhealth, SWHHS, eHealth Qld |
| | • Communities in the SWHHS region require a commitment from services to more holistic models of care that recognise the physical, psychological, social and spiritual aspects of wellbeing | 1 | WQPHN | HOC Alliance expanded to region. ORR- SW Alliance. |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Domestic and Family Violence | • Culturally safe, rapidly responsive, domestic and family violence supports are needed in communities. | 2 | WQPHN | QAS, QPS, DV Connect, CACH |
| Digital Health | • There is a need for enhanced access to digital technologies to support care closer to home for people living in the SWHHS region. | 3 | WQPHN HPW, Digital Health, | RHealth, SWHHS, eHealth Qld |
| | • There is a need for improved information sharing (where legislation allows) and consolidation of data analytics practices across service providers in the SWHHS region. | 2 | WQPHN HPW, Digital Health, | RHealth, SWHHS, eHealth Qld |
| Disability | • There is a lack of disability support services in the SWHHS region, including general supports, allied health services and accommodation services. | 2 | Neither | MAC, WQPHN, NDIS services |
| Audiology | • Increase access to audiology services in the SWHHS region | 3 | Checkup | SWHHS, WQPHN, RFDS |
| Optometry | • Increase access to optometry services in the SWHHS region. | 3 | Checkup | SWHHS, WQPHN, RFDS |
| Aboriginal and Torres Strait Islander | • Improved health outcomes and increase life expectancy of Aboriginal and Torres Strait Islander peoples. | 1 | Nukal Murra Alliance | SWHHS, CACH, Goondir, Other WQPHN-CSPs, Primary Care services |
| | • Increase Aboriginal and Torres Strait Islander peoples participation in health checks. | 1 | WQPHN | WQPHN Practice supports HSS, AMS and private primary care services, Qld Health, SW Alliance |
| | • There is a lack of Aboriginal and Torres Strait Islander culturally appropriate mental health services available in the SWHHS region. | 2 | Nukal Murra Alliance | SWHHS, CACH, Goondir, Other WQPHN-CSPs, Primary Care services |
| | • Aboriginal and Torres Strait Islander communities in the SWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | Nukal Murra Alliance | WQPHN, SWHHS and CheckUP CSPs, QHAIC |
| Health literacy | • People across the SWHHS region require improved health literacy, prevention and health-promotion services tailored to their diverse needs to improve health and wellbeing. | 1 | SWHHS | WQPHN Practice supports HSS, AMS and private primary care services, Qld Health, SW Alliance |
| Infrastructure, facilities and equipment | • • There is a lack of access to contemporary medical imaging facilities in the SWHHS region.. Currently, there is one privately owned CT scanner at Roma for the entire district and no MRI service. | 1 | SWHHS | Private and travelling providers |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Mental Health | • People experiencing mental illness and psychological distress in the SWHHS region require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including early access, addressing suicidality and substance use issues. | 1 | WQPHN | WQPHN – H2H, SWHHS, RHealth, MH CSPS |
| | • People experiencing higher acuity mental illness in the SWHHS region require ongoing support following intensive support provided out of catchment. | 2 | SWHHS | WQPHN – H2H, SWHHS, RHealth, MH CSPS |
| | • No inpatient mental health beds / service provision in SWHHS | 1 | SWHHS | WQPHN – H2H, SWHHS, RHealth, MH CSPS |
| | • People in the CWHHS region require improved access to specialised eating disorder services. | 3 | WQPHN | Vital Health, SWHHS, Qld Health pathways for ED |
| | • Communities within the SWHHS region require enhanced and timely access to early intervention mental health services and supports to improve outcomes. | 1 | WQPHN | WQPHN – H2H, SWHHS, RHealth, MH CSPS |
| | • Services in the SWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities | 1 | WQPHN | HOC Alliance expanded to region. ORR- SW Alliance. |
| Obesity | • Increase access to education and physical activity programs in the SWHHS region. | 1 | WQPHN | HOC Alliance expanded to region. ORR- SW Alliance. |
| End of Life Care | • People in the SWHHS region require a palliative care system that supports seamless integration of healthcare services in order to achieve person-centred end-of-life care. | 2 | WQPHN (coord/facilitates) | SWHHS unit, Comwth funded NGOs. |
| | • There is a need for service providers across sectors to have a stronger connection and better integration to ensure better support for patients at the end of life. | 2 | WQPHN (coord/facilitates) | SWHHS unit, Comwth funded NGOs. |
| People experiencing homelessness | • There is a lack of support for people experiencing homelessness in the region. | 3 | WQPHN | HCS- SBO-Toowoomba |
| Physical rehabilitation | • People in the SWHHS region require improved access to physical rehabilitation and occupational therapy services. | 3 | SWHHS | WQPHN - CSPs |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Preventive healthcare | • There is continued need for placed based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 1 | SWHHS | WQPHN Practice supports HSS, Goodir, CACH and private primary care services<br>QLD HEALTH<br>SW Alliance |
| Primary care | • People in the SWHHS region, including those in small remote communities, require access to sustainable and consistent primary and community care services, including after hours | 1 | WQPHN | WQPHN Practice supports HSS, Goondir, CACH and private primary care services<br>QLD HEALTH<br>SW Alliance |
| Respite Care | • There is a lack of respite services and supports in the SWHHS region, irrespective of the type of care provided/needed. | 3 | SWHHS | WQPHN Advocacy, NDIS providers, |
| Retrieval services | • People in the SWHHS region receiving care out of catchment require greater support following transfer by retrieval services to optimise health outcomes following treatment, including care at place of treatment that recognises being away from home, and dedicated support to ensure return to home in a supported manner. | 2 | SWHHS | WQPHN Practice supports HSS, Goodir, CACH and private primary care services, Qld Health, QLD, SW Alliance |
| Sexual health | • There is a lack of sexual and reproductive health service and support available in the SWHHS region. | 3 | SWHHS | WQPHN Practice supports HSS, Goodir, CACH and private primary care services, Qld Health, QLD, SW Alliance |
| Specialist care | • · People in the SWHHS region require improved access to specialist services to increase diagnosis, treatment and ongoing management of health concerns. | 1 | SWHHS | WQPHN Practice supports HSS, Goodir, CACH and private primary care services, Private diagnostics |
| Stroke | • · There is a need for a dedicated service to support people in the SWHHS region who have experienced a stroke or stroke-like episode. | 3 | SWHHS | Stroke Foundation, WQPHN-Promotion - practice support |
| Substance Use | • People experiencing alcohol and substance use issues in the SWHHS region require increased education and access to support, treatment, detox and rehabilitation services. | 1 | WQPHN | WQPHN- LLW, |
| System Issues | • Support the further establishment of independent practitioner services, currently being piloted in SWHHS. | 2 | SW Alliance | OOR, SWHHS, WQPHN-Practice Support |

| Need Area | Health and Service Needs (SW region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | • Current restrictions on MBS billing for Nurses and Nurse Practitioners limits the ability to utilise an effective and available workforce in regional communities within the SWHHS region. | 1 | WQPHN | SWHHS, ORR, SWA |
| Transport | • People in the SWHHS region require transport and accommodation support to facilitate access to necessary health services in other locations. | 2 | PTSS-HHS | CACH, GOONDIR, Primary care |
| | • There is a need for greater awareness of, and access to, scheduled outreach services provided by the HHS / other NGO for smaller communities. | 1 | SWA | SWHHS, WQPHN, CheckUP, |
| Workforce | • There are significant challenges in attracting, recruiting and retaining qualified medical, nursing and allied health professionals in the SWHHS region. This might be alleviated by growing our own across all grades and professions in a sustainable manner. | 1 | SWA | SWHHS, WQPHN, CheckUP, |
| | • The SWHHS region requires increased representation of Aboriginal and Torres Strait Islander peoples within its health workforce to reflect legislative requirements. Through appropriate training, our wider staff and teams also need to ensure culturally competent care for the communities they serve. | 2 | Nukal Murra Alliance | SWHHS, CACH, Goondir, Other WQPHN-CSPs, Primary Care services |
| Young People | • Young people in the SWHHS region experience a high rate of admissions for accident or injury when compared with the State average. | 3 | SWHHS | WQPHN Practice supports HSS, Goodir, CACH and private primary care services, Qld Health, SW Alliance |

# 6 Multicultural communities – HNA

## 6.1 Demographics

According to the 2021 Australian Bureau of Statistics (ABS) census, WQ's multicultural population numbered 12,639 individuals. While each WQ LGA has a multicultural population, by a large margin the largest population resides in Mount Isa and the wider NWQ sub-region.

Mount Isa alone has 4,872 multicultural residents, comprising 26% of the city's population. In the wider NWQ shires, the multicultural population represents between 19% and 27% of local populations, including Cloncurry (25%), McKinlay (23%), Burke (27%), and Carpentaria (19%).

By contrast, Barcoo in Central Western Queensland (CWQ) has the smallest number (31), but Diamantina has the highest percentage (36%) of multicultural individuals, though the numbers total 96 people. In Winton, multicultural residents make up 21% of the population.

Nearly a third (30%) of WQ's multicultural population had arrived in Australia in the past 1 to 5 years, which likely contributes to limited knowledge of and familiarity with local health and social services and ability to access and navigate the same.

## 6.2 Diversity of the population

The largest groups in WQ's multicultural population are from New Zealand and the Pacific Islands (1,846 people, 15%), followed by North West Europe (1,116 people, 9%) and South East Asia (1,142 people, 9%). Smaller numbers come from South Central Asia (456 people, 4%) and Sub-Saharan Africa (561 people, 4%).

Nearly half of WQ's population born outside of Australia (6,811 people) did not specify their country of origin, and regional migration numbers are likely to have substantially increased since the ending of COVID pandemic border restrictions.

## 6.3 Health service access

There is a lack of multicultural-specific health services in WQ, though very limited pockets of non-health specific programs exist to more broadly support persons of multicultural background – such as in Mt Isa and Roma.

Many local health providers are from multicultural backgrounds themselves, which can both aid and hinder service access due to the small, close-knit nature of many communities.

Reported barriers to healthcare include:

- Low awareness of available health care and social services, particularly primary care and preventative services, which may stem from the relatively short residency of many multicultural individuals in the region (30% arriving in the past 1 to 5 years).
- High health services workforce turnover and the rapid churn of such services also affects service access.
- Health system navigation skills are not well developed, and many people are unsure about the costs, privacy, and confidentiality of services.
- Where English proficiency is an issue, community interpreters (often informal volunteers or family members) are reportedly used, raising concerns about privacy, confidentiality and timely access to care.
- There is also limited choice of providers in WQ, and where these are available, many individuals are unaware of supports to access such services through specific mechanisms such as Medicare Benefits Schedule (MBS) numbers. This is of particular concern for more sensitive health issues such as sexual and reproductive health, substance use, domestic violence, and mental health concerns.

- Fear of stigma, discrimination, and community shame further deter access to health services, particularly in small, isolated communities where privacy is difficult to maintain and again, especially regarding sensitive issues such as mental health or AOD use.
- Cultural differences in health beliefs and understandings of illness, treatment, and prevention also create barriers to seeking care.

## 6.4 Cultural and structural barriers

Cultural beliefs about health and illness—ranging from illness prevention to treatment and help-seeking behaviour can impact access to healthcare. Systems and services to address these issues, including health literacy improvement programmes, have not kept pace with growth in population, need and diversity in multicultural communities, particularly in NWQ.

Outside of some specific Hospital Health Services (HHS), there are very few health services in WQ that provide promotional materials in languages other than English, which reportedly limits accessibility for non-English proficient speakers.

## 6.5 Conclusions

**Improved Access is Critical**

Despite the relatively small size of the multicultural population in WQ, in many communities, people from multicultural backgrounds can comprise a significant percentage of the population. This, alongside the growing cultural diversity of WQ's communities, requires culturally appropriate, coordinated health services responses. This includes improving awareness of available services and addressing language barriers, health literacy, and particularly for more sensitive and often stigmatised health needs or concerns.

**Capacity Building**

Local health services must be supported to adopt innovative, culturally competent approaches to better serve multicultural communities no matter the size, especially in remote areas where service access and delivery is already constrained by workforce shortages and limited resources.

**Provider capacity development support**

Health and social service providers require regularly delivered training and other supports to better understand the diverse cultural and health-related needs of multicultural populations, with a focus on cultural competence and improving system navigation skills for such consumers.

**Policy and Funding Considerations**

Policy and funding decision making must recognise the growing regional multicultural population needs, particularly in NWQ. Funding should be allocated in ways that ensure sustainable, feasible effective services for multicultural communities. Mindful of the plethora of remote WQ service delivery challenges, such services must be supported to reflect the diversity of the population and be tailored to the specific needs of multicultural groups.

# 7 People experiencing homelessness – HNA

## 7.1 Demographics

Since 2017-18, homelessness in regional Australia has grown at double the rate of capital cities (13% vs. 6%). Regional Queensland has seen the sharpest increase (29%), with Western Queensland (WQ) seeing a notable rise in homelessness. The 'Queensland Outback' has the third-highest rate of homelessness across all Australian States and Territories.

In 2021, WQ had 1,684 individuals experiencing homelessness, which represents 2.2% of the total regional population. Homelessness, by a large margin is a far greater issue in North Western Queensland (NWQ), with four of the NWQ subregion's Local Government Areas (LGAs) ranking among the top 10 in the State for homelessness rates:

Doomadgee had the highest rate, with 25.7% of its population experiencing homelessness (375 individuals) – with the composition of homelessness being almost wholly 'crowded dwellings' or 'severely crowded dwellings' (98%).

Mornington (12.8%) and Carpentaria (3.7%) each reported 128 individuals experiencing homeless - with 'crowded dwellings' or 'severely crowded dwellings' comprising 67% of reported homelessness.

Mount Isa had the largest number of homeless people (642 individuals), with 3% of its population affected, and 'rough sleeping' a significant feature of homelessness.

While rates of homelessness in multiple NWQ communities are very high compared to elsewhere in the State; in the other two WQ subregions, i.e., Central Western Queensland (CWQ) and South Western Queensland (SWQ), homeless rates and numbers fluctuate more but overall, are generally far lower than in NWQ. This difference may be reflecting a greater capacity in SWQ and CWQ sub-regional communities to respond due to more established infrastructure. The composition of the forms of homelessness also differs from NWQ;

In SWQ, there were 76 individuals experienced homeless in the Maranoa LGA; comprising 0.5% of its population and 26% of the population experiencing homelessness lived in 'crowded dwellings'. The bulk of those experiencing homelessness were in 'supported accommodation for the homeless' (37%) or 'staying temporarily with others' (20%). Another 9% were 'in other improvised dwellings' and 8% were 'marginally housed in caravan parks'.

In the CWQ LGA of Blackall/Tambo there were nine individuals experiencing homelessness; five people (56%) were 'staying temporarily with other households' and the other four people (44%) 'marginally housed in caravan parks'.

## 7.2 Key drivers

Domestic and family violence (DFV) accounts for about 40% of women seeking specialist homelessness service (SHS) support in Queensland, and the HHNA participants also affirmed that this is a common driver of homelessness, particularly for women, and women with children.

Inadequate housing stock (and maintenance of the same) is also a major driver of homelessness. This has been a chronic issue in Aboriginal and Torres Strait Islander communities particularly, where crowding and severe crowding are common forms of homelessness – and amplify infectious and other disease burdens.

Housing affordability stress is a relatively new and increasing driver in a number of WQ communities, with the increasing cost of living pushing more people into homelessness. The 2022 *Australian Homelessness Monitor* reported a 27% rise in the average monthly number of people requiring Specialist Homelessness Services (SHS).

The affordability crisis and housing shortages are particularly problematic to improving health outcomes in remote WQ communities, with often already thinly spread service providers (and busy community members) in a number of locations expected or obliged to respond to increasing demand and complexity of presentation.

## 7.3 Health and psychosocial issues

People experiencing homelessness in WQ often face a complex range of issues, including:

- Severe problematic alcohol and other drug (AOD) use
- Domestic and family violence
- Higher incidence of mental health issues and greater severity of the same
- Financial instability
- Criminal justice involvement

Individuals experiencing homelessness in WQ often require the coordination and provision of complex, multi-faceted health and social interventions. However, small, remote WQ communities are already known to face significant barriers to providing integrated services due to limited resources and healthcare infrastructure.

Stigma and discrimination - particularly related to problematic AOD use and mental health issues are significant barriers to accessing help. These issues are compounded by privacy and confidentiality concerns in small close-knit communities.

Many of the HHNA participants interviewed from health and social service backgrounds were not fully aware of the dire impacts (and evidence) of even short periods of homelessness on the health and longevity of those who experience forms of homelessness. Nor are they necessarily aware of international homelessness-health best-practices.

Further, a number of non-SHS HHNA participants had not considered that addressing the risk of, or actual homelessness, was an urgent health matter, nor that it might be prevented (with consequent and proven multiple health-benefits).

## 7.4 Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander populations experience homelessness at far higher rates than non-Indigenous populations in WQ. In Doomadgee, nearly all homelessness is experienced as crowded/severely crowded housing (98%) but only 2% are in supported accommodation for homelessness, a stark contrast to other areas such as Blackall/Tambo, where 44% of those experiencing homelessness are supported to stay in caravan parks.

Key stakeholders considered that due to the scale, and chronic highly visible nature of forms of homelessness commonly endured by Aboriginal and Torres Strait Islander peoples, the experience of homelessness has been 'normalised'. Also, homelessness in many Aboriginal and Torres Strait Islander communities can be viewed as being 'too great and too complicated' to meaningfully prevent. Subsequently perhaps, the focus appears to be on *treating* the impacts or sequelae of such homelessness (e.g., Rheumatic Heart Disease), rather than adopting the universal homelessness 'housing first' model - particularly for crowded housing homelessness.

## 7.5 Service delivery challenges

Some SHS in WQ are challenged to meet demand due to resource limitations. This is particularly the case for services in the NWQ sub-region, including Mt Isa, where both homelessness and service delivery pressures are significant.

It is well known that experienced health and social services personnel with specialist skills, such as mental health and AOD practitioners, social workers, psychologists and relationship therapists are needed to most effectively support those experiencing homelessness. However, attracting and retaining such experienced and specialist personnel to WQ is a perennial challenge.

As a relatively new development, health and social services staff working in the region are now also at increasing risk of homelessness themselves due to housing shortages and affordability of the same. Some have reported that these pressures have already forced them to leave their roles and relocate out of the region.

## 7.6 Conclusions

The rising homelessness crisis in WQ, and particularly the not-new crisis among Aboriginal and Torres Strait Islander communities, and the compelling evidence regarding the severe negative impact of homelessness on health and lifespan, underscores the urgent need for targeted investment and action.

Aboriginal and Torres Strait Islander communities bear a disproportionate burden of homelessness, with overcrowded housing being the most common form of homelessness, and rough sleeping also a significant issue in some areas, such as Mount Isa.

Housing affordability and domestic violence (with the latter often intersecting with severe substance use issues) are primary drivers, contributing to a growing demand for homelessness and comprehensive supporting health services. However, some existing SHS and co-responding health services are under increasing strain due to limited resources and perennial workforce capacity and supply issues.

Generalist and specialist health workforce personnel appear not well aware of the evidence regarding the profound negative health effects of homelessness, nor that homelessness is an urgent health matter, and can and should be prevented.

People experiencing homelessness in WQ often face complex and intertwined health and psychosocial issues that require coordinated, holistic support—yet, service gaps and stigma make timely intervention difficult.

# 7.7 Appendices

## Appendix 1-North West Hospital and Health Service- Health Needs Assessment 2024 (Priorities)

| Health Area | Health Issues | Service Issues | Identified Need | Tier of Need |
|---|---|---|---|---|
| Mental Health | • The prevalence of mental health issues is greater in the region than the state average<br>• The incidence of mental health issues is growing | • Mental health service waiting times<br>• Access to community mental health services as consumers transition from acute to subacute care | • Access to culturally sensitive mental health and social and emotional wellbeing services. Information for communities on outreach service provision to enable access | Mental health is a priority for the HHS and is a Tier 1 need |
| Chronic Disease | • Increasing chronic disease across all diagnoses including diabetes, rheumatic heart disease and renal disease | • Increased chronic disease services for screening and treatment and maintenance of chronic disease | • Access to primary care services for early diagnosis and management of all chronic diseases including rheumatic heart disease and sexually transmitted diseases | Chronic disease is a priority for the HHS and is a Tier 1 need |
| Substance Use | • Alcohol consumption (10std drinks per week) 6.4% higher than Queensland | • Access to support and rehabilitation services for alcohol and other drugs | • Access to support and rehabilitation services for alcohol and other drugs. | Substance use is a priority for the HHS and is a Tier 1 need |
| Oral Health | • Poor oral health leading to increasing emergency presentations for oral health interventions | • Consistent dental services across the region | • Increase in oral health prevention and treatment | Oral heath forms part of Primary Health and is a Tier 1 need for the HHS |
| Preventive Health | • Increasing chronic diseases, cancer and potentially preventable hospitalisations<br>• There is continued need for placed based prevention health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake | • Increased disease prevention, promotion and health literacy programs.<br>• Increased access to education and preventative programs targeted to reduce cancer incidence | • Consumers need more health literacy, prevention, screening and promotion services and programs to address cancer (Prostate, Bowel, Cervical, Colorectal, Lung). Except Breast<br>• Consumers need prevention health initiatives targeted at diet, exercise, smoking cessation and alcohol intake | Health prevention, promotion and literacy is a priority for the HHS and is a Tier 1 need |

| Health Area | Health Issues | Service Issues | Identified Need | Tier of Need |
|---|---|---|---|---|
| | • People across the HHS region require increased access to education and preventive programs targeted to reduce cancer incidence | | | |
| First Nations communities | • Significant health issues impacting the wellbeing and mortality of communities | • Culturally informed and capable care for First Nations communities | • The health and wellbeing needs of First Nations' people across all aspects of health needs to be a priority. | The health of First Nations communities is a priority for the HHS and is a Tier 1 need |
| Older people | • Long -term chronic conditions impacting independence of older people | • Increased aged care services in community and collaboration with residential aged care facilities | • Need for aged care community services<br>• Need for collaboration with aged care facilities for service provision | Improving the health of older people is a Tier 2 priority for the HHS |
| Young people | • Developmentally vulnerable children in more than one domain<br>• Children and young people in psychological distress<br>• Sexual health | • Service provision in a culturally safe environment to cater to needs of patient | • Youth safety - Physical harms (accidents, injury, poisoning.)<br>• Need for consistent mental health and sexual health services | Primary health care, mental health and access to screening and health literacy programs are a priority for the HHS and is a Tier 1 need |
| People experiencing homelessness | • Undiagnosed/ uncontrolled health needs | • Providing flexible services to residents outside hospital and within the community | • Need for food and shelter security | Services for people experiencing homelessness is a Tier 2 need as this is delivered in collaboration with other service providers |
| People from CALD backgrounds | • Chronic disease and poor health outcomes across most health challenges | • Services need to be more welcoming and delivered in a non-judgemental way | • Need for more appropriate health services catering to the extensive needs of people from CALD backgrounds | Services for people from CALD backgrounds are a Tier 2 need |
| People from LGBTIQ+ communities | • Chronic disease and poor health outcomes across most health challenges | • Services need to be more welcoming and delivered in a non-judgemental way<br>• Stigma associated with seeking care | • Need for more appropriate health services catering to the extensive needs of people from LGBTIQ+ communities | Services for people from LGBTIQ+ communities are a Tier 2 need |

| Health Area | Health Issues | Service Issues | Identified Need | Tier of Need |
|---|---|---|---|---|
| Culturally safe care | • Confidential and safe services especially for mental health, sexual services and vulnerable populations (where stigma is associated with seeking help) | • Flexible service delivery | • Increased access to health care that is flexible, culturally safe and responsive to local contexts and different population groups | Providing culturally safe care is a Tier 2 need as this will be a medium-term goal with continuous improvements |
| Enhanced coordination and integration | • Co-ordinated care across all health and service needs<br>• Transitioning of patients through the patient journey from community to primary to tertiary care and back to community and across service providers | • Integrated Care co-ordination across service providers.<br>• Access to screening and follow-up care across community, primary, secondary, tertiary, specialist and allied health services including dental services | • Person/family-centred care requires integrated health system that people can seamlessly navigate regardless of their health care needs | This is a Tier 2 need for the HHS as this is reliant on collaboration and partnerships and is a continuous improvement goal |
| Child and maternal health | • Developmentally vulnerable children in more than one domain<br>• Children and young people in psychological distress | • Access to culturally sensitive services to improve screening and early intervention during and post pregnancy<br>• Minimal access to child development services | • Access to culturally sensitive consistent child and maternal health services within the community.<br>• Access to child development services | Child and maternal health is a priority for the HHS and is a Tier 1 need |
| Self-awareness health literacy | • Consumers have different health literacy levels to influence how they care for themselves and their families | • Flexible service provision providing care in the community | • Build capacity and capability of young families to manage their own health and navigate the local healthcare system | Health prevention, promotion and literacy is a priority for the HHS and is a Tier 1 need |
| Domestic Violence | • Domestic and family violence | • Confidential and culturally appropriate services | • Need for trained staff and need for information and pathways to community services for people vulnerable to and experiencing domestic violence | The HHS response to Domestic violence is a Tier 1 need |
| Primary care provision | • Health inequity linked to MBS item eligibility and utilisation for GP and AH services | • Access to sustainable and consistent primary and community care services within the community.<br>• Consistent primary care services at Urandangi and Bidunggu communities | • Need for flexible eligibility options for access to GP and After-Hours services | Primacy health care is a priority for the HHS and is a Tier 1 need |

| Health Area | Health Issues | Service Issues | Identified Need | Tier of Need |
|---|---|---|---|---|
| ARF and RHD | • Incidence and prevalence of ARF and RHD significantly higher in HHS communities | • Maintain and improve the prevention, testing, treatment of acute rheumatic fever and rheumatic heart disease | • Need for increased prevention programs and community care<br>• Increased patient follow-up for bicillin compliance | Primary health care (ARF and RHD) is a priority for the HHS and is a Tier 1 need |
| Workforce | • Culturally informed and culturally appropriate health services | • Increased representation of First Nations' people across the NWHHS health workforce<br>• Workforce- Lack of GPs, Surgeons, Specialists, particularly local workers and reduce reliance on travelling locums | • Increased representation of First Nations employees and health workers across the health service | A comprehensive response to workforce is required and these strategies are a Tier 3 need for the HHS |
| After hours | • Access to Primary health care services | • Lack of after-hours GP services leading to high levels of low urgency (GP in-scope) ED presentations after hours | • Need for additional GPs across the HHS communities | Primacy health care is a priority for the HHS and is a Tier 1 need |
| Limited infrastructure | • Contemporary health service delivery | • Lack of access to imaging facilities/equipment particularly in the more remote areas of HHS | • Need for fit-for-purpose health infrastructure to support effective models of care and service delivery | Infrastructure is a Tier 3 need |

## Appendix 2 Central West Hospital and Health Service- Health Needs Assessment 2024 (Priorities)

| Need Area | Health and Service Needs (Central West region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Ageing | • There is an aging population in the Central West Hospital and Health Service (CWHHS) region, which will require the expansion of health and aged care services, with a particular focus on long-term care and chronic disease management. | 1 | CWHHS<br>NFP/NGO<br>Aged Care Providers<br>Local Government | PHN |
| | • There is limited availability of aged care facilities available for people in the CWHHS region, particularly home care services. | 1 | Aged Care Providers<br>NFP/NGO<br>CWHHS<br>Local Government | PHN |
| Cancers | • People across the CWHHS region require increased access to education and preventive programs targeted to reduce cancer incidence. | 3 | Responsible Queensland Government Agencies in collaboration with CWHHS | PHN |
| | • People across the CWHHS region require increased access to all cancer screening and diagnostic services (Bowel, Prostate, Skin, Cervical and Breast). | 2 | Responsible areas of Queensland Health in collaboration with<br>CWHHS | NFP/NGO |
| | • People across the CWHHS region require increased awareness of sun-safe practices. | 3 | Responsible Queensland Government | PHN |
| | | | Agencies<br>NFP/NGO | |
| Child & maternal health | • Pregnant women and new mothers in the CWHHS region require consistent access to culturally sensitive child and maternal health services in the community, including screening and early intervention services. | 3 | CWHHS | |
| | • Families in the CWHHS region require improved access to child development services. | 2 | CWHHS<br>RFDS | |
| Chronic disease | • People within the CWHHS region require enhanced access to chronic disease screening, treatment and services, including testing for rheumatic heart disease and acute rheumatic fever. | 1 | CWHHS<br>RFDS | PHN |
| Coordination, integration and continuity of care | • People in the CWHHS region require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | CWHHS<br>RFDS<br>NFP/NGO | PHN |
| | • People in the CWHHS region require support to navigate the service system, particularly people with chronic conditions and multiple morbidities. | 2 | CWHHS<br>PHN<br>NFP/NGO | Local Government |
| | • Services in the CWHHS region need to improve coordination both within and between service providers to enhance integration and ensure seamless healthcare. | 1 | CWHHS<br>PHN<br>NFP/NGO | Local Government |
| Domestic & family violence | • People in the CWHHS region are in need of culturally sensitive 24/7 support for domestic and family violence. | 1 | Responsible Queensland Government Agencies in collaboration with CWHHS | PHN<br>NFP/NGO |
| Disability | • There is a lack of disability support services in the CWHHS region, including general supports, allied health services and accommodation services. | 1 | NFP/NGO | PHN |

| Need Area | Health and Service Needs (Central West region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| | | | NDIS providers | CWHHS |
| | • There is a lack of respite services and supports in the CWHHS region, particularly for families of children with disabilities. | 1 | NFP/NGO<br>NDIS providers | PHN<br>CWHHS |
| | • There is a lack of support for families in the CWHHS region with children who are neurodivergent. | 3 | NFP/NGO<br>NDIS providers<br>CWHHS | PHN |
| | • There is need for enhanced training for practitioners supporting people with disabilities, including assessment training for the NDIS, as well as NDIS and aged care pathways literacy. | 3 | Commonwealth Programs<br>Responsible Queensland Government Agencies | |
| | • There is a lack of support for people with disabilities and their families, to navigate the disability service system, including service literacy, navigation support, referral pathways and advocacy. | 3 | Commonwealth Programs<br>Responsible Queensland Government Agencies | CWHHS |
| First Nations | • First Nations communities in the CWHHS region require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | CWHHS | |
| | • There is a lack of First Nations' culturally appropriate mental health services available in the CWHHS region. | 1 | CWHHS<br>RFDS<br>NFP/NGO | |
| | • Enhanced access to primary care for routine health checks among First Nations people in the CWHHS region. | 2 | CWHHS | PHN |
| Infrastructure, facilities & equipment | • There is a lack of accessible advanced imaging facilities in the CWHHS region, particularly in the more remote areas of the region. | 3 | CWHHS | |
| Mental Health | • People experiencing acute mental health issues in the CWHHS region require more timely interventions and, in some cases, retrieval services. | 3 | CWHHS | |
| | • People experiencing mental illness and psychological distress in the CWHHS region require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including addressing suicidality and substance use issues. | 1 | CWHHS<br>NFP/NGO<br>RFDS | PHN |
| | • Young people experiencing mental illness and/or psychological distress in the CWHHS region require enhanced and more a consistent access to targeted prevention and early intervention services. | 1 | CWHHS<br>Children's Health Qld HHS Child Youth and Mental Health Service (CYMHS)<br>NFP/NGO<br>RFDS | PHN |
| | • Communities within the CWHHS region require reduced waiting times for mental health services to improve access and outcomes. | 1 | CWHHS<br>NFP/NGO<br>RFDS | |
| | • Services in the CWHHS region need to collaboratively develop community wellbeing and resilience measures to support monitoring the mental health of the respective communities. | 1 | PHN<br>CWHHS<br>NFP/NGO<br>Local Government | |

| Need Area | Health and Service Needs (Central West region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Oral health | • People in the CWHHS region have limited access to oral health services, resulting in potentially preventable oral health conditions. | 2 | CWHHS<br>RFDS | |
| Physical activity | • There is a need for increased access to physical activity programs / facilities in the CWHHS region. | 3 | Local Government<br>Responsible Queensland Government Agencies | |
| Preventive healthcare | • There is continued need for place-based preventive health initiatives that build and leverage community interest, such as improved diet and exercise programs, smoking cessation, reduced alcohol intake. | 2 | PHN<br>CWHHS<br>NFP/NGO<br>Local Government<br>Responsible Queensland Government Agencies | |
| Primary care | • Young families in the CWHHS region need enhanced access to comprehensive primary health care to support optimal health outcomes for children. | 1 | CWHHS<br>RFDS | PHN |
| | • There is a lack of after-hours GP services in the CWHHS region which contributes to high rates of low urgency ED presentations. | 3 | CWHHS | PHN |
| Respite | • There is a lack of respite services and supports in the CWHHS region, particularly for people with dementia. | 2 | Aged-care Providers<br>NFP/NGO<br>CWHHS | PHN |
| Retrieval services | • People in the CWHHS region receiving care out of catchment require greater flexibility in offered services to optimise health outcomes following treatment. | 2 | CWHHS | |
| Sexual health | • People in the CWHHS region require increased access to sexual health screening, testing, and treatment services at the community level (in community). | 3 | CWHHS<br>Responsible Queensland Health areas | |
| Specialist care | • People in the CWHHS region require improved access to specialist services to increase diagnosis, treatment and ongoing management of health concerns. | 3 | CWHHS | Partner HHSs such as CQ, MN and MS |
| Substance use | • People within the CWHHS region have a higher rate of alcohol consumption when compared with the State average, suggesting the need for alcohol harm reduction strategies. | 2 | Responsible Queensland Government agencies in collaboration with CWHHS | PHN |
| | • There is need for increased awareness of the harms associated with substance misuse for people in the CWHHS region, including the association with domestic and family violence. | 1 | Responsible Queensland Government agencies in collaboration with CWHHS | PHN |
| | • People experiencing substance use issues in the CWHHS region require increased access to support, detox and rehabilitation services. | 3 | CWHHS<br>NFP/NGO | PHN |
| | • There is a lack of community-based substance use support services for people experiencing substance use issues in the CWHHS region. | 1 | NFP/NGO<br>CWHHS | PHN |

| Need Area | Health and Service Needs (Central West region) | Tier | Lead Agency | Supporting Agencies |
|---|---|---|---|---|
| Suicide prevention | • The CWHHS region requires enhanced mental health resources, community awareness programs, crisis intervention services, youth engagement initiatives and collaboration with local organisations to address high suicide rates compared to the state average. | 1 | Responsible Queensland Government agencies in collaboration with<br>CWHHS<br>NFP/NGO | PHN |
| System issues | • Current restrictions on MBS billing for nurse practitioners (and inability to recruit to positions) limits the ability to utilise an effective and available workforce in regional communities within the CWHHS region. | 1 | Commonwealth programs<br>CWHHS | PHN |
| Transport | • People in the CWHHS region require transport and accommodation support to facilitate access to necessary health services in other locations | 1 | NFP/NGO<br>Local Government<br>CWHHS | |
| Workforce | • There are significant challenges in recruiting and retaining qualified medical, nursing, Aboriginal and Torres Strait Islander Health Workers, and allied health professionals in the CWHHS region. | 1 | CWHHS | |
| | • The CWHHS region requires increased representation of First Nations' peoples within its health workforce to better meet community needs. | 1 | CWHHS | |

# Appendix 3-South West Hospital and Health Service- Health Needs Assessment 2024 (Priorities)

**South West HHS health needs**

| REF | WQPHN category | SWHHS Theme | Type of need | Identified Need | SWHHS Tier | Lead Agency/s: | Supporting Agencies include, but not limited to: |
|---|---|---|---|---|---|---|---|
| H1 | Ageing | Aged Care | Health | • There is an ageing population in the South West, which requires the expansion of appropriate health and aged care services to manage long-term care and health impacts of chronic disease. | 1 | SWHHS / WQPHN | Care Finders, NGO providers |
| H2 | | | | • To maintain dignity and independence, there is a need for greater access to packages of care that support ageing in place for older people in the South West, including expansion of Commonwealth Home Support Program (CHSP) | 1 | SWHHS | MAC team, WQPHN, NDIS services, NGO providers |
| H3 | Child & maternal health | Child health | | • Families in the South West require improved access to child development services, including community paediatrics | 1 | WQPHN | NDIS, Local Schools for screening, WQPHN Healthy Outback Kids, CSP-Bushkids, ACCHO partners, primary care / NGO providers |
| H4 | Cancer care | Cancer Care | | • People across the South West require increased access to all cancer screening and diagnostic services and treatments, closer to home. | 1 | WQPHN | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| H5 | | | | • People across the South West require increased access to education and preventive programs targeted to reduce cancer incidence. | 2 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| H6 | First Nations | First Nations people and communities | | • South West HHS is committed to delivering equity of access, improved health outcomes and increased life expectancy of First Nations' peoples. | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| H7 | First Nations | First Nations people and communities | Health | • To better manage health and wellness, our First Nations communities require better access to and follow-up from health checks | 1 | SWHHS / WQPHN | PHN Practice supports HSS, ACCHO partners and private primary care services, Queensland Health, SW Primary Care Alliance |
| H8 | Obesity | Health and wellbeing and early intervention | | • South West communities require increased access to community led education and physical activity programs to address modifiable risk factors and decrease rates of obesity for adults and children | 1 | SWHHS / WQPHN | HOC Alliance expanded to region. ORR-SW Alliance. |
| H9 | Health Prevention Programs | | | • South West communities need improved access to preventative health initiatives that address key risky health behaviours like obesity, smoking, high alcohol intake. | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| H10 | Young people | | | • Young people in the South West currently experience a higher rate of admissions for accident or injury, compared with the State average. | 3 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| H11 | Mental health | Mental health, alcohol, and substance misuse | | • People experiencing mental illness and psychological distress in the South West require enhanced and more consistent access to quality community-based mental health support that is tailored to their particular needs, including early access, addressing suicidality and substance use issues. | 1 | SWHHS / WQPHN | Head to Health, SWHHS, Rhealth, MH CSPS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| H12 | Audiology | Access to specialist / specialised services / care | | • South West communities require increased access to audiology services. | 2 | CheckUP | SWHHS, WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |
| H13 | Optometry | | | • South West communities require increased access to optometry services. | 2 | CheckUP | SWHHS, CheckUP, WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |
| H14 | Transport | Integrated care continuum | | • Residents of the South West HHS need access to transport services, supporting attendance at health related appointments. | 2 | SWHHS | WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |

## South West HHS service needs

| REF | WQPHN category | SWHHS Theme | Type of need | Identified Need | SWHHS Tier | Lead Agency/s: | Supporting Agencies include, but not limited to: |
|---|---|---|---|---|---|---|---|
| S1 | Infrastructure, facilities & equipment | Access to specialist / specialised services / care | Service | • To drive safe & high-quality care, increased access to Computed Tomography (CT) scanners and Diagnostic Ultrasound is required. | 1 | SWHHS | Queensland Health, private and NGO providers |
| S2 | Specialist care | | | • People in the South West require increased access to specialist services, helping address the inequity of access that currently exists. | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| S3 | Physical rehabilitation | | | • People in the South West require increased access to physical rehabilitation and occupational therapy services to address current service inequity. | 2 | SWHHS | WQPHN - CSPs |
| S4 | Respite Care | | | • Our ageing population require increased access to respite care services. | 3 | SWHHS | WQPHN, NDIS providers, |
| S5 | Stroke | | | • People within the South West require greater access to stroke services. | 3 | SWHHS | WQPHN, Queensland Health |
| S6 | Chronic disease | Chronic disease management | | • People within the South West require enhanced access to screening, treatment and services to support ongoing management of:<br>▪ cardiovascular disease<br>▪ kidney disease<br>▪ respiratory disease<br>- including consideration of partnership arrangements to better address these needs. | 1 | SWHHS | WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |
| S7 | | | | | 1 | SWHHS | WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |
| S8 | | | | | 1 | SWHHS | WQPHN, RFDS, ACCHO and other NGO partners, Queensland Health |
| S9 | Chronic disease | Chronic disease management | | • People within the South West require enhanced access to screening, treatment and services to support ongoing management of diabetes, including consideration of partnership arrangements to better address these needs. | 1 | SWHHS | DAQ, WQPHN, ACCHO and other NGO partners |
| S10 | Chronic disease | Chronic disease management | Service | • People across the South West require increased access to cancer treatment services, including chemotherapy. | 2 | SWHHS | Nukal Murra, WQPHN, ACCHO and other NGO partners |
| S11 | | | | • People across the South West require improved access to skin checks and dermatology services | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers |
| S12 | Health literacy | Health and wellbeing and early intervention | | • People across the South West require improved health literacy, prevention and promotion programs to improve health and wellbeing. | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers |
| S13 | Primary care | | | • South West communities require access to sustainable and consistent primary and community care services, including after hours service models where appropriate | 1 | WQPHN | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| S14 | Domestic & family violence | | | • Enhanced access to culturally safe, rapid response, domestic and family violence supports are needed in South West communities. | 2 | SWHHS / WQPHN | QAS, QPS, DVConnect, ACCHO and other NGO partners |
| S15 | Sexual health | | | • Access to culturally appropriate women's and sexual health services | 3 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers |
| S16 | Coordination, integration and continuity of care | Integrated care continuum | | • Services in the South West need to improve collaboration and coordination between service providers to deliver seamless healthcare for the communities we serve. | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| S17 | | | | • People in the South West require improved access to screening and follow-up care across community, primary, secondary, tertiary, specialist, and allied health services, including oral health care. | 1 | SWHHS / WQPHN | PHN Practice supports HSS, Goondir, CACH and private primary care services, Queensland Health |

| REF | WQPHN category | SWHHS Theme | Type of need | Identified Need | SWHHS Tier | Lead Agency/s: | Supporting Agencies include, but not limited to: |
|---|---|---|---|---|---|---|---|
| S18 | Coordination, integration and continuity of care | Integrated care continuum Integrated care continuum | Service | • South West communities require better support to navigate the health system, particularly people with chronic conditions and multiple morbidities. | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| S19 | | | | • Establishment of position(s) to communicate (outreach and eligibility) visiting services of the HHS and NGO providers are required to support local communities, and raise wider awareness of services. | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| S20 | | | | • There is a need for greater co-ordination, awareness of, and access to, scheduled outreach services provided by the HHS / other NGO for smaller communities. | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| S21 | Transport | | | • Upon return to home, people in the South West require improved coordination of follow-up and step-down care after receiving treatment away from home | 1 | SWHHS | All providers of services to South West residents, and the communities we collectively serve |
| S22 | Digital health | | | • There is a need for enhanced access and support for digital technologies to enable delivery of care closer to home. | 2 | SWHHS | eHealth QLD |
| S23 | | | | • There is a need for seamless information transfer between service providers to ensure optimal care for all consumers, in addition to maturing data analytics. | 2 | QLD / CWTH partnership | SWHHS, WQPHN, ACCHO and other partners |
| S24 | Retrieval services | | | • People in the South West receiving care out of catchment require better care coordination to improve the patient experience and compliance with care away from home. | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers, Queensland Health |
| S25 | System issues | | | • To enhance service sustainability and access, a needs based approach to delivering independent practitioner services is required | 2 | SWHHS / SW Primary Care Alliance | WQPHN-Practice Support |
| S26 | Child & maternal health | Maternal care | Service | • Access to culturally appropriate child and maternal health services, including antenatal support, screening, health promotion and early intervention services. | 1 | SWHHS | WQPHN Practice supports HSS, ACCHO partners, RFDS and private primary care services / NGO providers |
| S27 | Substance use | Mental health, alcohol, and substance misuse | | • People in South West experiencing alcohol and substance use issues require increased education and access to support, treatment, detox and rehabilitation services. | 1 | SWHHS / WQPHN | WQPHN- LLW, ACCHO and other NGO / private partners |
| S28 | Mental Health | | | • Communities within the South West require enhanced and timely access to early intervention mental health services and supports to improve outcomes. | 2 | SWHHS / WQPHN | Head to Health, Rhealth, MH CSPS, ACHHO and other NGO / private partners |
| S29 | | | | • South West residents require access to appropriate Mental Health services, including inpatient services, closer to home. | 2 | SWHHS | Head to Health, Rhealth, MH CSPS, ACHHO and other NGO / private partners |
| S30 | | | | • Services in the South West need to collaboratively develop community wellbeing and resilience measures that support and are responsive to mental health needs of local communities and population groups. | 2 | WQPHN / SWHHS | HOC Alliance expanded to region, SW Primary Care Alliance, ACHHO and other NGO / private partners |
| S31 | | | | • People experiencing higher acuity mental illness in the South West require appropriate step-down care services closer to home. | 2 | SWHHS | Head to Health, Rhealth, MH CSPS, ACHHO and other NGO / private partners |
| S32 | | | | • People in the South West require improved access to specialised eating disorder services. | 3 | WQPHN / SWHHS | Vital Health, Queensland Health and other NGO partners |
| S33 | End of Life Care | Palliative & end-of-life care | | • People in the South West require a palliative care system, and wider end of life supports that ensures seamless integration of services to achieve person-centred end-of-life care. | 1 | WQPHN / SWHHS | NGO and other partners. |

| REF | WQPHN category | SWHHS Theme | Type of need | Identified Need | SWHHS Tier | Lead Agency/s: | Supporting Agencies include, but not limited to: |
|---|---|---|---|---|---|---|---|
| S34 | Disability | Disability care | Service | Currently, there is a lack of disability support services in the South West, including general supports, allied health services and accommodation services that meet the needs of rural and remote residents. | 2 | SWHHS | MAC team, WQPHN, NDIS services, NGOs and other partners |
| S35 | First Nations | First Nations people and communities | | First Nations communities in the South West require co-designed services to ensure meaningful client engagement and culturally appropriate care. | 1 | SWHHS / Nukal Murra Alliance | WQPHN, NGOs and other partners |
| S36 | | | | There is currently a lack of First Nations' culturally appropriate mental health services available across the South West. | 1 | SWHHS / Nukal Murra Alliance | ACCHO, NGOs and other partners |
| S37 | Workforce | | | The South West HHS requires increased representation of First Nations' peoples within its health workforce to ensure care delivery is culturally appropriate | 2 | SWHHS / Nukal Murra Alliance | All providers of services to South West residents, and the communities we collectively serve |
| S38 | People experiencing homelessness | Diverse population groups | | There is currently a lack of co-ordinated support between partners for people experiencing homelessness in the South West region. | 3 | SWHHS / WQPHN | HCS- SBO-Toowoomba, NGO and Local Government partners |