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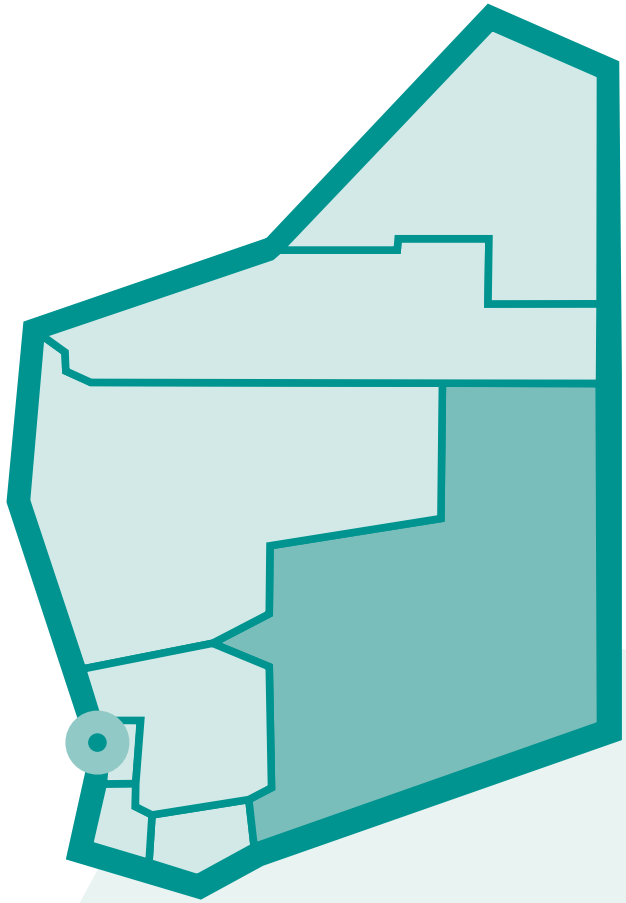
An Australian Government Initiative

Goldfields-Esperance

Needs Assessment 2022-2024

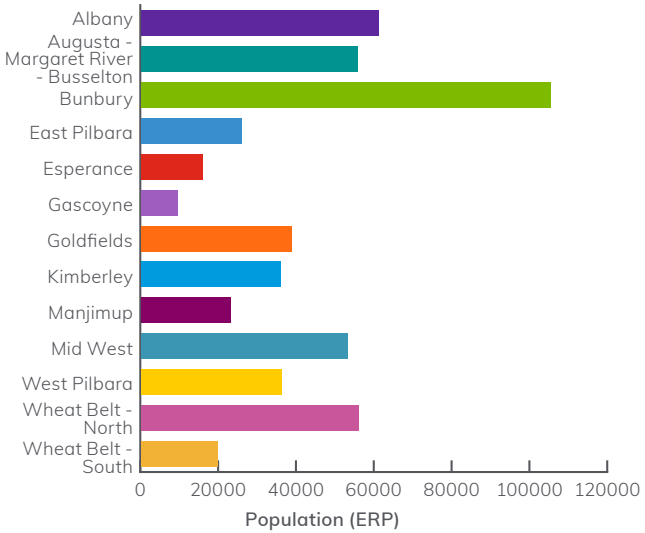


Goldfields-Esperance

Population Demographics

The Goldfields-Esperance region spans 771,276 square kilometres and consists of two ABS Statistical Area Level Three sub-regions: Goldfields SA3 and Esperance SA3 (note that the health region boundary does not include the Shire of Wiluna). Goldfields SA3 includes the towns of Kalgoorlie-Boulder, Leonora, Leinster, Laverton, Menzies, Coolgardie, Kambalda, Norseman, and the Ngaanyatjarraku Shire and borders both South Australia and the Northern Territory. Esperance SA3 includes the towns of Esperance, Ravensthorpe, and Hopetoun.

Figure 1 - Population (ERP 2019) in Country WA PHN by SA3 (Public Health Information Development Unit, 2021)



The population of Country WA PHN is 530,725 people compared to the state's population of 2,621,509 people (ERP 2019). There are 38,580 people living in Goldfields SA3 and 15,813 people in

Cardiovascular disease is the leading cause of disease burden

39% of adults aged 16+ years are **obese**

22% of adults aged 16+ years have **high blood pressure**

3RD **Mental ill-health** is the third leading cause of disease burden

4% of the population in Goldfields SA3 and 3% in Esperance SA3 accessed a GP **mental health treatment plan**

Less than **1%** of the population accessed a **clinical psychologist** through Medicare

8.4% of people in Goldfields SA3 and **18%** in Esperance SA3 are aged **65 years and over**

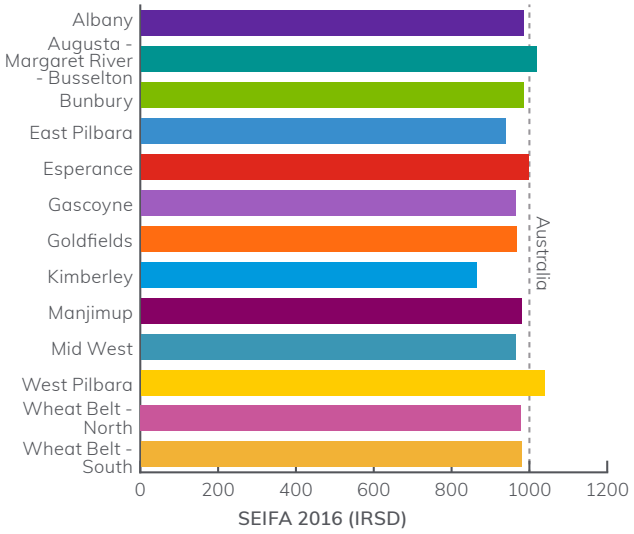
Coronary heart disease, COPD and **dementia** are among the leading causes of disease burden for people aged 65 and over

There are an estimated **7249 Aboriginal people** residing in the region

24% of Aboriginal people in Goldfields SA3 and **15%** in Esperance SA3 received an **Indigenous-specific health check** through Medicare in 2019-20

Esperance SA3. Goldfields SA3 has a higher level of socioeconomic disadvantage (IRSD=964) compared to Esperance SA3 (IRSD=997). About 16% of people in Goldfields SA3 identify as Aboriginal and Torres Strait Islander (Aboriginal)[1] compared to only 5.4% in Esperance SA3 (ERP 2016).

Figure 2 - SEIFA 2016 Index of Relative Socioeconomic Disadvantage (IRSD) score in Country WA PHN by SA3 (Public Health Information Development Unit, 2021)



1 Throughout this document the word Aboriginal is used to denote both Aboriginal and Torres Strait Islander peoples.

Vulnerable Population Groups

People in vulnerable groups are more likely than the general population to experience poor health outcomes due to physical, social, and economic factors. Vulnerable groups include people who are: culturally and linguistically diverse (CALD); lesbian, gay, bisexual, transgender, intersex, or queer (LGBTIQ+); homeless; living with a severe disability or caring for someone with a disability; developmentally vulnerable; and victims of family, domestic or sexual violence.

- About 8.9% of people in Goldfields SA3 and 3.8% of people in Esperance SA3 were born in a non-English speaking country compared to 17% across the state (Public Health Information Development Unit, 2021b).
- About 2.7% of people in Goldfields SA3 and 3.8% of people in Esperance SA3 have a profound or severe disability compared to 4.1% across the state (Public Health Information Development Unit, 2021b).
- About 7.5% of people in Goldfields SA3 and 9.1% of people in Esperance SA3 provide unpaid assistance to people with a disability compared to 9.8% across the state (Public Health Information Development Unit, 2021b).
- About 22% of children in Goldfields SA3 and 15% of children in Esperance SA3 were developmentally vulnerable on one or more domains compared to 19% across the state (Public Health Information Development Unit, 2021b).
- In 2016, it was estimated that 44 people in Esperance SA3 and 479 people in Goldfields SA3 experienced homelessness (Australian Bureau of Statistics, 2018a). About 16% of homeless people in Esperance SA3 and 63% in Goldfields SA3 were living in 'severely' crowded' dwellings, requiring at least four extra bedrooms to accommodate the people usually living there.

LGBTIQ+ populations

LGBTIQ+ is an acronym commonly used to describe lesbian, gay, bisexual, trans/transgender, intersex, queer and other sexuality, gender, and bodily diverse people and communities. Many LGBTIQ+ people face discrimination and disparities connected to their gender identification and/or sexuality that impact their physical and mental health and access to healthcare and other services (Equality Australia, 2020). LGBTIQ+ people are known to have a higher risk of certain chronic diseases such as cancers, asthma, obesity, and cardiovascular disease (Conron et al., 2010; McKay, 2011; Simoni et al., 2017). Moreover, some members of LGBTIQ+ communities, particularly lesbian and bisexual women, have higher rates of smoking compared to the general population (Praeger et al., 2019), which increases their risk of developing a chronic disease.

Family violence is a significant concern and is compounded by isolation and reduced access to services (Rainbow Health Victoria, 2020). Studies indicate that the LGBTIQ+ people experience intimate partner violence at similar or higher rates compared to heterosexual people (Rollè et al., 2018). There is evidence that LGBTIQ+ people are more likely to experience homelessness (McNair et al., 2017) and that discrimination can lead to adverse outcomes in terms of employment and income, particularly for trans and gender diverse people (Mizock & Mueser, 2014).

Chronic Disease

Chronic diseases are long-term, non-communicable conditions and play a significant part in mental and physical ill health, disability, and premature death. Moreover, people with chronic disease often have two or more conditions (multi-morbidity) such as a mental health condition as well as a physical condition, creating complex health needs and presenting challenges for treatment. In Australia, national surveillance focuses on 10 types of chronic conditions: arthritis, asthma, back problems, cancer, cardiovascular diseases, chronic

obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, mental and behavioural conditions, and osteoporosis (Australian Institute of Health and Welfare, 2020b). In 2017-18, almost half of all Australians (47%) were estimated to have at least one of the above conditions and 20% were estimated to have at least two conditions (Australian Bureau of Statistics, 2018b). Age is an important determinant of health and people aged 65 years and over are more likely to be diagnosed with a chronic condition. In the Goldfields - Esperance region, cardiovascular disease was the leading cause of total disease burden, followed by cancer.

This section focuses on chronic conditions other than mental and behavioral conditions, which are discussed in the Mental Health section.

Risk factors

Established risk factors for chronic disease include having high blood pressure, being overweight or obese, smoking, doing little or no exercise and having high levels of stress. Psychosocial factors such as social isolation and loneliness also contribute to chronic ill health (Royal Australian College of General Practitioners, 2020). Risk factors tend to be more prevalent in the lowest socioeconomic areas and in regional and remote areas (Australian Institute of Health and Welfare, 2020b). The Goldfields - Esperance region had prevalence rates of risk factors that were significantly higher than state rates, especially in Goldfields SA3. In 2017-18, children aged 2-17 years in Goldfields SA3 were significantly more likely to be obese (ASR=11%) compared to the state (ASR=7.9%) (Public Health Information Development Unit, 2021b). Moreover, data from the Health and Wellbeing Surveillance System (HWSS) survey 2015-19 indicated that estimated prevalence rates of obesity among adults aged 16 years and over were significantly higher at 41% in Goldfields SA3 and 37% in Esperance SA3 compared to 30% across the state (Epidemiology Branch, 2021a). The region also had significantly higher rates of high blood pressure (23% in Esperance SA3 and 21% in Goldfields SA3) and Goldfields SA3 had a significantly higher rate of current smokers (18%) as well as people who do no leisure time physical activity (24%) (Epidemiology Branch, 2021a).

Feedback from local stakeholders suggests that the high burden of disease from cancer may be related in part to exposure to farming chemicals, particularly in Esperance.

General Practice Incentives Program Quality Improvement Incentive (PIP QI)

The Practice Incentives Program Quality Improvement incentive (PIP QI) is a payment to encourage practices to participate in quality improvement activities, aimed at improving patient outcomes through the delivery of quality care. Improvement measures include the proportion of patients with their weight classification recorded within the last 12 months, the proportion of patients with information available to calculate risk of cardiovascular disease (CVD), and the proportion of patients with diabetes that have a HbA1c measurement recorded. PIP QI data indicated the following for Goldfields SA3 (seven practices) and Esperance SA3 (five practices) compared to the state (497 practices).

- The percentage of general practice records for clients aged 15 years and over that did not have a weight classification recorded within the last 12 months was 73% in Goldfields SA3 and 68% in Esperance SA3 compared to 76% across the state.
- The percentage of general practice records for clients aged between 45-74 years that did not have information available to calculate their absolute risk of cardiovascular disease (CVD) was 39% in Goldfields SA3 and 37% in Esperance SA3 compared to 43% across the state.
- The percentage of general practice records for clients with a diagnosis of diabetes that did not have a HbA1c measurement result recorded within the last 12 months was 34% in Goldfields SA3 and 22% in Esperance SA3 compared to 28% across the state.

We note that PIP QI data include private general practices only and do not include GP services provided by non-government organisations.

Healthy Weight Action Plan

WAPHA is a steward of the WA Healthy Weight Action Plan 2019-24, which focuses on early intervention of people identified as at-risk of becoming overweight and management of people who currently live with obesity. This involves multi-component, multi-levelled strategies delivered as part of an integrated shared care model. Through the Healthy Weight GP project, WAPHA has committed to supporting GPs to provide options for patients who want to improve their health. Key deliverables include the development of a weight management 'hub' (website) with links to Health Pathways and local services for weight management, training for general practice staff, and tools to assist general practices in implementing weight management services as a quality improvement activity. The website is due for launch in the third quarter of 2021.

The Goldfields Healthy Weight Action Workshops were delivered in November 2020 and provided an opportunity for local stakeholders to contribute to the discussion and collaborative ideas for change. The following were some key discussion themes from the workshops.

- Connect better by improving collaboration, coordination, communication and sharing of information on the early intervention and management of excess weight gain between all service and support agency stakeholders and consumers across the region.
- Better access and care coordination by collaborating across the region to define clear service pathways, eligibility, and processes to improve access and make every healthy weight contact count.
- Change how we talk about weight, to improve the language, approach and positive talk related to overweight and obesity amongst community

members, health professionals and service providers.

- Innovation to explore a culture of experimentation regarding collaborative funding, provision, and sustainability of healthy weight related initiatives in the region.

Local Government Public Health Plan

The Shire of Esperance Public Health Plan 2021-2016 (Shire of Esperance, 2021) aims to inform and empower people to make positive health choices which enhance their physical and mental wellbeing by promoting healthier options and advocating against adverse behaviours. Key actions include making educational material available on the Shire's **website**; enhancing outdoor public fitness equipment; supporting community markets and other food security and sustainability initiatives; and partnering with local, state, and federal health promotion bodies and campaigns to facilitate and help promote physical exercise and active living. We note that Local Government Public Health Plans are due by 2024 and the remaining nine Shires within the Goldfields – Esperance region are yet to complete their plans.

Burden and prevalence of disease

Burden of disease measures the impact of different diseases or injuries on a population. It combines the years of healthy life lost due to living with ill-health (non-fatal burden) with the years of life lost due to dying prematurely (fatal burden) to give a total burden reported using the disability-adjusted life years (DALYs) measure. The Western Australian Burden of Disease Study 2015 (Department of Health Western Australia, 2021) indicated that the Goldfields - Esperance region had a 1.4 times higher rate of fatal burden and a 1.1 times higher rate of non-fatal burden compared to the metropolitan regions. Chronic disease accounted for a substantial proportion of the burden of disease. The Goldfields – Esperance region had the second highest cardiovascular burden in the state (after the Kimberley), accounting for 17% of the total burden in the region. Coronary heart disease (7% of burden for females and 14% for males) and COPD (5.5% of burden for females and 4.9% for males) were among the leading five causes of burden, back pain/problems were the third leading cause for females (6% of burden), while lung cancer was the fifth leading cause for males (3.7% of burden).

In 2017-18, Goldfields SA3 was estimated to have a significantly higher rate of people with diabetes (ASR=6.4%) compared to the state (ASR=4.5%). However, the rate of osteoporosis was significantly lower in Goldfields SA3 and the Esperance population health area (ASR=1.9%) compared to the state (ASR=3.2%) (Public Health Information Development Unit, 2021b).

Potentially preventable hospitalisations (PPHs) for chronic conditions

Potentially preventable hospitalisations (PPHs) are certain hospital admissions (both public and private) that potentially could have been prevented by timely and adequate health care in the community. There are 10 chronic conditions that are classified as potentially preventable through behaviour modification, lifestyle change and timely care: angina, asthma, bronchiectasis, COPD, congestive cardiac failure, diabetes complications, hypertension, iron deficiency anaemia, nutritional deficiencies, and rheumatic heart diseases.

Across the state in 2017-18, the age-standardised rate of PPHs per 100,000 for total chronic conditions was 1109 and the highest rates were for COPD (232), congestive cardiac failure (220), and iron deficiency anaemia (188) (Australian Institute of Health and Welfare, 2019). Compared to the state, Goldfields SA3 had a much higher rate for total chronic conditions (1940), as well as the top three conditions: COPD (468), congestive cardiac failure (423), and iron deficiency anaemia (268). On the other hand, Esperance SA3 had a lower rate for total chronic conditions (1014) including COPD (222) and congestive cardiac failure (170); however, the rate for iron deficiency anaemia was relatively high (208).

In this report, we regard a PPH 'hotspot' as an area with a hospitalisation rate that is more than 50% above the Australian rate for at least four out of five consecutive years (Public Health Information Development Unit, 2020). In the five years from 2012-13 to 2016-17, there were three population health areas (PHAs) in the region that were hotspots for chronic conditions, as follows. Of these, Kalgoorlie PHA had the highest number of hospitalisations for total chronic conditions in the region and was a hotspot for six chronic conditions.

- Kalgoorlie PHA: total chronic conditions, angina, congestive cardiac failure, COPD, diabetes complications, iron deficiencies, and rheumatic heart diseases.
- Boulder/Kambalda – Coolgardie – Norseman PHA: total chronic conditions, congestive cardiac failure, and diabetes complications.
- Leinster – Leonora PHA: asthma, bronchiectasis, and rheumatic heart diseases.

Management of chronic disease in primary care

From 2013-14 to 2018-19, percentage of population utilisation of GP chronic disease management plans (CDMPs) increased substantially in the region from 3.9% to 9.1% in Goldfields SA3 and from 2.2% to 6.2% in Esperance SA3 (Australian Institute of Health and Welfare, 2020c). However, utilisation was still considerably below the national rate for SA3s in remote areas, which increased from 8.8% to 12% over the same period.

Childhood immunisation rates

The National Immunisation Program (NIP) aims to increase national immunisation coverage to reduce the number of vaccine-preventable diseases in Australia. A key priority of the program is to work towards achieving immunisation coverage rates of at least 95% for children aged 1, 2 and 5 years. Data from the Australia Immunisation Register from 1st April 2020 to 31st March 2021 indicated that in Country WA PHN, immunisation coverage

was relatively low for children aged 2 years. About 94.1% of children were fully immunised at 1 year and 94.5% at 5 years compared to only 90.3% at 2 years (Department of Health, 2021b).

In the Goldfields – Esperance region, Esperance SA3 met immunisation targets for children at 2 years and 5 years; however, rates for children at 1 year were slightly below target (93.7%). Immunisation rates for Goldfields SA3 were lower than Esperance SA3 and were below target for children at 1 year (93.1%) and 2 years (90.5%).

Cancer screening

There are three national cancer screening programs in Australia: BreastScreen Australia, National Cervical Cancer Screening Program (NCSP), and National Bowel Cancer Screening Program (NBCSP). In 2018-19, cancer screening participation rates across WA were 46% for bowel cancer (people aged 50-74 years), 55% for breast cancer (women aged 25-74 years) and 48% for cervical cancer (women aged 25-74 years) (Australian Institute of Health and Welfare, 2021a). The data indicated that compared to the state, cancer screening participation rates were low in Goldfields SA3, particularly for breast cancer. Participation rates were 31% in Goldfields SA3 and 49% in Esperance SA3 for bowel cancer screening, 31% in Goldfields SA3 and 61% in Esperance SA3 for breast cancer screening, and 35% in Goldfields SA3 and 43% in Esperance SA3 for cervical cancer screening. We note that participation in the new five-year program for cervical cancer screening cannot be accurately reported until there are 5 years of data available (2018-22).

Avoidable mortality

In 2013-17, the median age of death was 68 years in Goldfields SA3 (50% of people who died were younger than 68 years) and 78 years in Esperance SA3 compared to 80 years across the state (Public Health Information Development Unit, 2021b).

Avoidable mortality refers to deaths of people under 75 years that are potentially avoidable under the current health care system (primary or hospital care). In 2013-17, age-standardised death rates per 100,000 from avoidable causes in Esperance SA3 (163) and Goldfields SA3 (217) were significantly high compared to the state (122) (Public Health Information Development Unit, 2021b). Esperance SA3 had a significantly high rate of avoidable deaths from circulatory system diseases (54) and ischaemic heart disease (41), while Goldfields SA3 had significantly high rates for all selected conditions with age-standardised rates per 100,000 as follows: diabetes (17), respiratory system diseases (17), COPD (17), circulatory system diseases (75), cerebrovascular (16), and ischaemic heart disease (53).

Emergency department presentations

Country regions had a higher rate of lower urgency emergency department (ED) presentations compared to the state as well as a higher percentage of total presentations that were classified as lower urgency. Between 2018 and 2020, about 52% of ED presentations across Country WA PHN were lower urgency compared to 40% across the state (Department of Health Western Australia, 2021a). Country WA PHN also had a lower percentage of presentations occurring after hours, at 36% compared to 42% across the state. This may indicate difficulties accessing primary care services in Country areas.

Between 2018 and 2020, Esperance SA3 had a higher percentage of lower urgency presentations (56%) compared to Goldfields (50%) (Department of Health Western Australia, 2021a). The rate of lower urgency presentations per 1000 population per year was 375 in Goldfields SA3 and 378 in Esperance SA3, in line with Country WA PHN (379) and above the state rate (160). About 35% of lower urgency presentations in Esperance SA3 occurred after hours compared to 39% in Goldfields SA3.

Utilisation of primary care services

Between 2013-14 and 2018-19, the percentage of the population who had visited a GP in the last year increased from 72% to 80% in Goldfields SA3 and from 73% to 82% in Esperance SA3, above the national rate for SA3s in remote areas (76%) (Australian Institute of Health and Welfare, 2020c). The percentage utilising after-hours GP services in Goldfields SA3 was very high, increasing from 19% to 27%; however, Esperance SA3 had a very low rate, increasing from only 1.9% to 4.4% over the same period, well below the national rate for remote areas (11%). In 2018-19, utilisation of GP health assessments in both SA3s did not change substantially and was very low at 5.8% in Goldfields SA3 and 2.4% in Esperance SA3 compared to 11% nationally for remote areas. We note that these data include Medicare-subsidised services only and may represent an under-estimate because ACCHOs and WACHS provide primary care services in this region.

Utilisation of Medicare-subsidised allied health services in the region was comparable to or above national rates for SA3s in remote areas. In 2018-19, about 25% of the population in Goldfields SA3 and 29% in Esperance SA3 utilised allied health services compared to 25% nationally in remote areas (Australian Institute of Health and Welfare, 2020c). About 22% of the population in Goldfields SA3 and 26% of the population in Esperance SA3 utilised optometry (21% nationally in remote areas). We note that optometry services are more likely to be subsidised by Medicare compared to other types of allied health services. These figures do not include allied health care provided by Aboriginal health services and other non-government organisations.

The region had a low percentage of population utilisation of nurse practitioners, increasing from 0.2% to 1.1% in Goldfields SA3 and from 0.5% to 0.9% in Esperance SA3 (2.5% nationally in remote areas) between 2013-14 and 2018-19 (Australian Institute of Health and Welfare, 2020c). Over the same period, utilisation of practice nurses/Aboriginal health workers increased substantially from 1.4%

to 5.3% in Goldfields SA3 and from 0.3% to 3.2% in Esperance SA3 but was still considerably below the national rate for remote areas (13%).

Access Relative to Need (ARN) Index

The Access Relative to Need (ARN) Index measures access to primary health care relative to predicted need and is based on methodology developed by the Australian Institute of Health and Welfare in 2014. The ARN index is based on the following information:

- The location of health services and the populations they serve
- The number of GP (FTE) working at each location (estimated using data at SA2 level – demand weighted distribution)
- The demographic and socioeconomic characteristics of the population.

In early 2021, WAPHA updated the ARN Index for SA2s in Western Australia to identify areas with a low access to GPs relative to need. Across the Goldfields - Esperance region, access to bulk billing GPs relative to need was low. Esperance Region SA2 and Esperance SA2 (Esperance SA3) and Kambalda – Coolgardie – Norseman SA2 (Goldfields SA3) were in the first decile (access relative to need was lower than 90% of SA2s in the state) for access to bulk billing GPs. In terms of access to any GP, Kambalda – Coolgardie - Norseman SA2 and Leinster – Leonora SA2 (Goldfields SA3) and Esperance Region SA2 (Esperance SA3) were in the second decile.

Workforce

General practitioners (GPs)

In 2020, Goldfields SA3 had 34 GP full-time equivalent (FTE) or 0.9 FTE per 1000 residents and Esperance SA3 had 13 GP FTE or 0.8 FTE per 1000 residents compared to 1.1 FTE per 1000 across the state[2]. The ratio of vocationally registered (VR) to non-VR GPs was very high in Esperance SA3 (35) compared to the state (12), in contrast to Goldfields SA3 (1.6), which had the lowest ratio in WA.

Primary care nurses

The Goldfields – Esperance region had a relatively high supply of primary care nurses compared to the state. In 2019, Goldfields SA3 had 97 primary care nurse full-time equivalent (FTE) or 2.5 FTE per 1000 residents and Esperance SA3 had 33 FTE or 2.1 FTE per 1000 residents compared to 1.7 FTE per 1000 across the state2. On average, primary care nurses in Goldfields SA3 worked the longest hours in WA, with an average of 41 hours per week compared to 30 hours per week across the state.

Aged Care

In 2019, there were 3230 people aged 65 years and over in Goldfields SA3 and 2862 in Esperance SA3 representing 8.4% and 18% of the population, respectively (Public Health Information Development Unit, 2021b). This is projected to increase to 13% of the population in Goldfields SA3 and 26% in Esperance SA3 by 2030 compared to 18% across the state and 20% across Country WA PHN.

Age is an important determinant of health and people aged 65 years and over are more likely to have complex and/or chronic conditions as well as comorbidities. Moreover, geriatric syndromes later in life (usually after the age of 85 years) including pressure ulcers, incontinence, falls, and delirium have substantial implications for quality of life as well as health care utilisation (Brown-O'Hara, 2013). The Western Australian Burden of Disease Study 2015 (Department of Health Western Australia, 2021) indicated that in the Goldfields health region, coronary heart disease, COPD and dementia were among the leading causes of disease burden for people aged 65 and over.

General practice data indicated that the percentage of clients aged 65 years and over diagnosed with a chronic condition that had two or more conditions was 57% in Goldfields SA3 (seven practices) and 55% in Esperance SA3 (five practices) compared to 54% across the state (481 practices). We note that these data include private general practices only and do not include GP services provided by non-government organisations.

Utilisation of health services

In Country WA PHN, 41% of people aged 80 years and over had a GP Health Assessment in 2018-19, consistent with the rate for regional PHNs (40%) and the national rate (37%) (Australian Institute of Health and Welfare, 2020c). The number of GP attendances in residential aged care facilities (RACFs) was 15.7 per patient compared to 15.8 for regional PHNs and 17.8 nationally. Data were not available at the SA3 or regional level.

Medicare items are available for in-depth assessment of a patient 75 years and over. This provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to interventions to improve health and quality of life. Data for participating practices demonstrated a wide range of uptake of over 75 health assessments, with 16% of older people in Esperance participating practices (5) recording this, but only 9% in Goldfields participating practices (7). These are both below the Country WA PHN average of 21%, representing an opportunity to improve care for older people. We note that these data include private general practices only and do not include GP services provided by non-government organisations.

Aged care services

The aged care system in Australia offers three main types of service: the Commonwealth Home Support Program, Home Care Packages, and residential care. Across Australia, more than two-thirds of people using aged care services access support from home (Royal Commission into Aged Care Quality and Safety, 2021).

2 Commonwealth Department of Health HeaDS UPP Tool, PHN Needs Assessment WPP, extracted 10/09/2021

The Home Care Packages (HCP) program provides support to older people with complex needs to help them live independently in their own home. Support provided includes help with household tasks, equipment, minor home modifications, personal care, and clinical care such as nursing and allied health services. There are four levels of HCPs from level 1 (basic care needs) to level 4 (high care needs). Across Australia, wait times for approved HCPs range from 3-6 months for level 1 to at least 12 months for level 2 and above (Department of Health, 2021a).

Home care in Esperance is provided by the local Shire while home care in the Goldfields is provided by religious, charitable, and community-based organizations. As December 2020, there were 100 people in a HCP in the Goldfields Aged Care Planning Region (ACPR) (Department of Health, 2021a). Additionally, there were 85 people waiting for a HCP at their approved level that had yet to be offered a lower-level HCP with 23 people (27%) requiring the highest level of care (level 4).

Despite a relatively large elderly population, Esperance SA3 had a low residential (RACF) beds-to-population ratio with only two residential aged care facilities located in the region. The number of residential beds to 1000 people aged 70 years and over was 50 in Esperance SA3 compared 97 in the Goldfields SA3 to 63 in Country WA PHN and 72 across the state (Australian Institute of Health and Welfare, 2021b). Additionally, Goldfields SA3 had seven residential aged care facilities.

In 2019, Esperance SA3 had a relatively low supply of nurses working in aged care, with 15 full-time equivalent (FTE) or 7.3 FTE per 1000 people aged 70 years and over compared to 12 FTE per 1000 across the state2. Goldfields SA3 had a higher supply, with 33 FTE or 18 FTE per 1000 people aged 70 years and over.

Alcohol and Other Drugs

Alcohol and other drug use

Stakeholders have indicated that harmful alcohol and other drug use is an issue in the Goldfields. In Country WA, 31.1% of residents in the Goldfields and 21.4% in Esperance SA3s were at risk of long-term harm from alcohol use (Epidemiology Branch, 2021b). Although these rates exceeded the state rate (26.5%), they were not statistically significantly higher than WA rate (Epidemiology Branch, 2021b). Goldfields SA3 had the third greatest proportion of current smokers (17.9%) whereas in the Esperance SA3 11.1% of the population are current smokers (Epidemiology Branch, 2021b).

Some of the key findings of the Esperance Wellbeing Survey, the report for Esperance AODHRG, LifeSPAN, and the MHC in November 2019 included (Shire of Esperance, 2021):

- One-quarter to one-third of respondents are consuming alcohol at unsafe levels. A greater proportion of respondents aged under 50 were classified as unsafe drinkers.
- The majority of respondents agreed alcohol is a problem worrying the community.
- Respondents perceive the results of drinking too much alcohol, taking illegal drugs causes harm, damage, and health problems within the community.

The Practice Incentives Program Quality Improvement incentive (PIP QI) is a payment to encourage practices to participate in quality improvement activities, aimed at improving patient outcomes through the delivery of quality care. Improvement measures include the proportion of patients with a smoking status and proportion of patients with an alcohol consumption status. The proportion of GP patient records which did not have smoking status recorded was 34% in Goldfields SA3 across seven practices and 33% in Esperance SA3 across five practices compared to 37% across the state. Goldfields SA3 had a higher percentage of GP patient records that did not have an alcohol consumption status recorded (53%) compared with Esperance (38%) as well as the state (46%). We note that these data include only private general practices and do not include health services provided by non-government organisations.

Impact of alcohol and drug use

During 2011-2015, there were 1.30 times the number of alcohol-attributable hospitalisations in Esperance compared with WA. During the same period, the rate of alcohol-attributed hospitalisations in Goldfields was 1.4 times the State rate (WA Country Health Service, 2018). For illicit drugs attributable hospitalisations, Esperance was 1.34 times higher than the WA rate (Shire of Esperance, 2021).

Accidental overdose

Australia's Annual Overdose Report, produced by the Penington Institute, reported 2,070 drug-related deaths in Australia in 2018 of which 1,556 were unintentional (Penington Institute, 2020). Of this, males were more than three times as likely than females to suffer an unintentional drug-induced death (71.5% of deaths) (Penington Institute, 2020). Middle-aged people were found to be most at risk of overdose (Penington Institute, 2020).

Opioids continued to be the largest overall drug group identified in drug-induced deaths (Penington Institute, 2020). In recent years, the greatest increase of unintentional drug-induced deaths has occurred in WA, increasing from 6.4 per 100,000 in 2012 to become the highest rate Australia-wide in 2018 at 8.8 per 100,000 (Penington Institute, 2020).

From 2014-2018, the rate of unintentional drug-induced deaths in Country WA was 8.3 per 100,000. In 2014-2018 Goldfields and Esperance SA3s had the second highest rate range of 7.5 to 9.9 deaths per 100,000 for unintentional drug-induced deaths (Penington Institute, 2020).

Emergency department presentations

Country regions had higher rates of emergency department (ED) presentations related to alcohol and other drugs (AOD) compared to the state. Between 2018 and 2020, around 1.1% of ED presentations across the region were AOD-related (Department of Health Western Australia, 2021a). About two-thirds of AOD presentations (66%) were made after hours. Presentation rates per 100k population per year in Goldfields SA3 (978) were much higher than in Esperance SA3 (354) and were more than 2.5 times the state rate (369). We note that some ED presentations may be related to alcohol and other drugs but primarily diagnosed as an injury (or other condition), so the data are likely to underestimate the rate of AOD-related ED presentations in the region.

Services

Drug and Alcohol services are provided by the WA Country Health Service and non-government organisations in the Goldfields-Esperance regions. The Goldfields Alcohol and other Drug service is based in Kalgoorlie-Boulder and Esperance and provides outreach to surrounding communities, the Goldfields Rehabilitation Services Inc based in Kalgoorlie-Boulder provides residential services and counselling, Hope Community Services provide counselling and coordination services and the Ngangganawili Aboriginal Health Service provide counselling and referral services in Wiluna.

Mental Health

Mental health was the third leading cause of disease burden in the Goldfields-Esperance region contributing 15% to the total disease burden for the region (Department of Health Western Australia, 2021). Women in the Goldfields-Esperance were impacted by depressive disorders while suicide and self-inflicted injuries contributed to the disease burden for men (Australian Institute of Health and Welfare, 2020a).

Rates of diagnosed anxiety and depression (9%) and high or very high psychological distress (8%) are uniform across the Goldfields and Esperance and are similar to WA rates (Epidemiology Branch, 2021b).

In recent years, FIFO workers have been the focus of community and political concern in Kalgoorlie – Boulder and the Northern Goldfields with reports in the media related to the impact of FIFO work, mental health and suicide (Parker & Fruhen, 2018). The mining industry in the Goldfields region, particularly in the more remote regions around Laverton, Leonora and Wiluna, has created a working population that includes a large number of FIFO and temporary contract workers (Australian Bureau of Statistics, 2003). A 2018 survey of 3,000 FIFO workers found one third experienced high or very high levels of psychological distress (Parker & Fruhen, 2018).

Suicide and self-harm

Forty-six people died from suicide in the Goldfields between 2014 to 2018 representing 5% of all deaths in the region (Australian Institute of Health and Welfare, 2020d). In Esperance, 12 people died from suicide between 2014 and 2018 representing 2% of all deaths (Australian Institute of Health and Welfare, 2020d). In WA, suicide represents 2% of all deaths.

The Health and Wellbeing Surveillance Survey collects data on suicidal ideation among adults aged 16 years and over. Survey participates are asked if they thought seriously about ending their own lives. In the Goldfields 7% of the population thought seriously about ending their own lives. This was 8% in Esperance (Epidemiology Branch, 2021b).

Self-harm is a strong risk factor for suicide. Hospitalisations for self-harm in the Goldfields (300 per 100,000 residents) were above state rates at 224 per 100,000 residents (Australian Institute of Health and Welfare, 2020d). Self-harm hospitalisations were highest for females and for people aged 25 – 44 years (Australian Institute of Health and Welfare, 2020d). Self-harm hospitalisation data is suppressed for the Esperance SA3.

Youth mental health

Suicide and self-inflicted injuries were the leading cause of disease burden for 15 to 24-year-olds, contributing to 20% of the disease burden for this age group (Epidemiology Branch, 2021b).

Hospital admissions for self-harm may also indicate a lack of access to mental health services. In the Goldfields people aged between 0-24 years were hospitalised for self-harm at a higher rate than the State and the PHN (Australian Institute of Health and Welfare, 2020d).

Emergency department presentations

Country regions had higher rates of mental health-related emergency department (ED) presentations compared to the state. Between 2018 and 2020, around 2.2% of ED presentations across the region were primarily mental health-related, excluding those related to alcohol and other drugs (Department of Health Western Australia, 2021a). Almost half of mental health ED presentations (44%) were made after hours. Presentation rates per 100k population per year in Goldfields SA3 (1653) and Esperance SA3 (1529) were above the state rate (1083). We note that some ED presentations may be related to mental health but primarily diagnosed as an injury (or other condition), so the data are likely to underestimate the rate of mental health ED presentations in the region.

Services

Mental health services in the Goldfields-Esperance region are provided by the WA Country Health Service and not for profit organisations. The WA Country Health Service provides adult community mental health services and inpatient mental health services in Kalgoorlie-Boulder and an adult community mental health and a child and adolescent mental health services in Esperance and Kalgoorlie-Boulder. headspace provides psychological services for youth in Kalgoorlie-Boulder and a satellite in Esperance. Centrecare provides counselling services in Kalgoorlie-Boulder, Coolgardie, Kambalda,

Esperance, Norseman, Ravensthorpe, Leonora, and Wiluna. Suicide Prevention Networks in Kalgoorlie-Boulder and Esperance aim to reduce stigma and prevent suicide through education and conversation. The Goldfields-Esperance region also has access to the National Indigenous Critical Response service that provides support to individuals and families after a traumatic event. Bega Garnbirringu is one of nine Aboriginal Community-controlled organisations across WA to receive a contract to build early suicide identification and intervention skills in the Goldfields. A new community liaison officer based in Kalgoorlie-Boulder will work to reduce rates of suicide. The new role is part of the WA Suicide Prevention Framework.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. In the Goldfields 4% of the population have accessed a GP mental health treatment plan (Australian Institute of Health and Welfare, 2020c). In Esperance 3% accessed the GP mental health treatment plan. This was a lower than the proportion for Country WA which is 6% (Australian Institute of Health and Welfare, 2020c).

In both the Goldfields and Esperance regions less than 1% of the population accessed a clinical psychologist through the Better Access MBS program (Australian Institute of Health and Welfare, 2020c). These figures indicate insufficient access to rebated psychology services in the Goldfields and Esperance regions and a reliance on services provided by the WA Country Health Service and the not-for-profit sector. Stakeholders have also identified a shortage of mental health professionals in the Goldfields-Esperance regions.

Aboriginal Health

In 2016, it was estimated that there were 7249 Aboriginal people living in the Goldfields – Esperance region (ERP 2016). The Goldfields Aboriginal community is diverse with 14 to 16 distinct language groups and 19 remote communities (Goldfields Aboriginal Language Centre, 2021). Communities include the Wankatja/Wangkatha people of Kalgoorlie-Boulder, Leonora and Laverton, the Ngadju people of Coolgardie, Norsemen and Esperance, the Martu people of Wiluna, the Tjuntjuntjara Spinifex People of the Great Victoria Desert region and the people of the Ngaanyatjarra lands adjoining the Northern Territory and South Australian borders.

Aboriginal populations are dispersed throughout the nine Local Government Shires that comprise Goldfields-Esperance. In the Ngaanyatjarra Lands, Aboriginal people comprise 80% of the population dispersed across ten communities (Warburton, Warakurna, Jameson, Blackstone, Wingellina, Patjarr, Wanarn, Tjirrkarli, Tjukurla, Kanpa). In the Shire of Wiluna, Aboriginal people comprise 30% of the population and in the Northern Goldfields; Laverton, Leonora & Menzies (22%), Kalgoorlie–Boulder (7%), Esperance (4%) Dundas; Norseman (3%) Ravensthorpe; Hopetoun (1%) (Australian Bureau of Statistics, 2016).

The Aboriginal people in the Goldfields region experience some of the highest levels of socioeconomic disadvantage and are impacted by poor health outcomes. The highest levels of disadvantage have been observed in Wiluna, Laverton and Ngaanyatjarraku Shire regions (Warburton etc.) (Public Health Information Development Unit, 2021a).

Unemployment is significantly higher in the towns of Warburton and Wiluna, with an estimated 50% of Aboriginal residents without work. This is followed by the Laverton and Ngaanyatjarraku Shire population outside Warburton, with almost 40% of residents unemployed. Warburton and Wiluna also experience poor housing sustainability, with 50% of households requiring extra bedrooms to accommodate resident (Public Health Information Development Unit, 2021a).

In the Laverton and Ngaanyatjarraku shire region only 42.9% of adolescents were attending secondary school and only 51.2% of adolescents participate in secondary education in Kalgoorlie-Boulder (Public Health Information Development Unit, 2021a).

The Practice Incentives Program Quality Improvement incentive (PIP QI) is a payment to encourage practices to participate in quality improvement activities, aimed at improving patient outcomes through the delivery of quality care. PIP QI data indicated that the proportion of general practice records for Indigenous clients aged between 35-44 years that did not have information available to calculate their absolute risk of cardiovascular disease (CVD) was 56% in Goldfields SA3 (seven practices) and 65% and 61% in Esperance SA3 (five practices) compared to 62% across the state (497 practices). We note that these data include only private general practices and do not include health services provided by non-government organisations. The percentage of GP patient records with Aboriginal status not recorded was 12% in Esperance SA3 and 11% in Goldfields SA3 compared to 33% across the state.

Child immunisation

A key priority of the National Immunisation Program Schedule is to work towards achieving immunisation coverage rates of at least 95% for children aged 1, 2 and 5 years. In Kalgoorlie and Boulder, childhood immunisation rates below target for children aged 2 years. This suggests that interventions should be targeted to increase immunisation coverage for this age group (Public Health Information Development Unit, 2021a).

Lower urgency emergency department presentations

High rates of non-urgent ED attendances indicate there may be a gap in primary care services (Public Health Information Development Unit, 2021a). Country WA PHN had a greater rate of total non-urgent ED presentations (ASR=10,742 per 100,000 people per year) in Aboriginal and Torres Strait Islander people compared to WA (7,742). In Country WA, top major diagnosis chapters included factors

influencing health status (3,626 ASR per 100,000) and injury and poisoning (ASR=2,763 per 100,000). Non-urgent ED presentations recorded between 2017/18 were statistically significantly higher than WA for:

- Diagnosis chapters factors influencing health status and contact with health services: Laverton-Ngaanyatjarraku, Kalgoorlie-Boulder, Kalgoorlie – Dundas – Goldfields.
- Injury, poisoning and certain other consequences of external causes: Laverton-Ngaanyatjarraku.

Avoidable deaths by selected causes

Avoidable deaths by selected conditions for Aboriginal persons aged 0 to 74 years were statistically significant in the following regions (ASR per 100,000 Aboriginal persons):

- Circulatory system diseases: Menzies-Leonora (188 per 100,000), Warburton (186) and Laverton-Ngaanyatjarraku (182).
- Diabetes: Kalgoorlie-Boulder (86 per 100,000, Laverton-Ngaanyatjarraku (63).
- Selected external causes (falls, fires, burns, suicide, and self-inflicted injuries): Kalgoorlie-Boulder (60 per 100,00).

Potentially preventable hospitalisations (PPHs)

Between 2015-16 and 2017-18 rates of the following PPHs were statistically significantly elevated in the IAREs of the Goldfields-Esperance region (Public Health Information Development Unit, 2020).

PPHs for chronic conditions:

- Chronic angina: Kalgoorlie-Dundas-Goldfields (758 per 100,000) and Kalgoorlie-Boulder (365)
- Asthma: Menzies – Leonora (751 per 100,000) and Laverton-Ngaanyatjarraku (447)
- Congestive cardiac failure: Kalgoorlie-Boulder (1,269 per 100,000) and Kalgoorlie- Dundas – Goldfields (1,019)
- Diabetes: Kalgoorlie-Dundas-Goldfields (1,037 per 100,000) and Kalgoorlie-Boulder (1,036)
- Iron deficiency anaemia: Kalgoorlie-Boulder (440 per 100,000)
- COPD: Kalgoorlie-Dundas-Goldfields (1,068 per 100,000).

PPHs for acute conditions were (Public Health Information Development Unit, 2020):

- Acute cellulitis: Wiluna (2,026 per 100,000), Kalgoorlie-Dundas-Goldfields (1,402) and Menzies – Leonora (1,199)
- Acute convulsions and epilepsy: Kalgoorlie-Dundas-Goldfields (1,091) and Kalgoorlie-Boulder (839)
- Acute ear, nose, and throat infections: Wiluna (1,340 per 100,000), Laverton-Ngaanyatjarraku (1,006) and Kalgoorlie-Boulder (870)
- Acute urinary tract infections (including pyelonephritis): Wiluna (1,198), and Kalgoorlie-Dundas-Goldfields (940).

PPHs for vaccine-preventable conditions:

- Pneumonia and influenza: Menzies – Leonora (492 per 100,000), Kalgoorlie-Dundas-Goldfields (402), Kalgoorlie-Boulder (305)
- Other: Laverton-Ngaanyatjarraku (2,371 per 100,000), Menzies – Leonora (2,271) and Warburton (2,015).

NOTE: Vaccine-preventable (other) includes diseases such as hepatitis B, measles, mumps, and chicken pox (Public Health Information Development Unit, 2020).

General Practice

Chronic disease contributes significantly to the differences in life expectancy between Aboriginal and non-Aboriginal people. Aboriginal people experience 2.3 times the rate of disease burden, with an age standardised death rate for chronic disease 3.8 times the rate among non-Aboriginal people (Australian Institute of Health and Welfare, 2017). In WA, 60% of Aboriginal people have been diagnosed with at least one chronic condition (Australian Institute of Health and Welfare, 2017).

Aboriginal and Torres Strait Islander people can access specific services aimed at Closing the Gap in health outcomes. It is important that General Practices ask all patients if they identify as Aboriginal and/or Torres Strait Islander. This assists with ensuring patients are provided with the option of accessing information and services specifically designed to meet their needs.

Through Medicare, Aboriginal and Torres Strait Islander people can receive Indigenous-specific health checks from their doctor, as well as referrals for Indigenous-specific follow-up services. In March 2020, telehealth items for Indigenous health checks were introduced in response to COVID-19 and associated restrictions (Australian Institute of Health and Welfare, 2021c). In 2019-20, the proportion of Aboriginal population who received an Indigenous Health Check was 14.7% in Esperance and 23.8% in Goldfields SA3s compared to 25.1% in Country WA PHN. Face-to-face was the preferred method compared to telehealth, which had a low uptake of only 0.5% in Goldfields and 0.6% across the state. These rates are not publishable for Esperance because of small numbers, confidentiality, or other concerns about the quality of the data. Goldfields (63.6%) had a higher utilisation of Indigenous Health Check patients who received follow-up services compared to State (46.8%), while Esperance (36.6%) had a lower rate (Australian Institute of Health and Welfare, 2021c). We note that differences in follow-up rates may partly reflect differences in health status and need for follow-up care.

Services

Aboriginal people living in the Goldfields-Esperance region can access primary care services through general practice, Aboriginal Community Controlled Health Services, Health Centres, and the hospital sector. There are four Aboriginal Medical Services in

the Goldfields region located in Kalgoorlie-Boulder, Wiluna, Ngaanyatjarra Lands and the Tjuntjuntjara-Spinifex Lands community.

The Bega Garnbirringu Health service is based in the centre of Kalgoorlie-Boulder. Medical services are provided not only to those clients who reside within the limits of the city itself but also to local and outlying communities by means of regular Outreach clinics. These are operated from two Mobile Clinics. Bega also operates a mobile clinic to the Northern Goldfields, Coolgardie, Dunus and Esperance Shires.

Ngangganawili Aboriginal Health Service Community is a community controlled Aboriginal corporation providing affordable and culturally appropriate health services to the Aboriginal and wider population of Wiluna and surrounding areas.

The Ngaanyatjarra Health Service has nine clinics operating within Ngaanyatjarra Lands. Community based health staff provide primary health care at community health clinics. This is delivered through a multidisciplinary approach incorporating Primary Health Care, Public Health Programs and Health Promotion Activities.

Spinifex Health Service is the name for an Aboriginal Community Controlled Health Service managed by Paupiyala Tjarutja Aboriginal Corporation (PTAC) in the remote community of Tjuntjuntjara on the Spinifex Lands. Spinifex Health Service is located 680 km northeast of Kalgoorlie-Boulder, in the Great Victoria Desert region of Western Australia.

Digital Health

Digital health includes a broad range of innovative technologies for the purposes of providing care and sharing information to enhance patient outcomes. Telehealth can deliver health services and facilitate communication between specialists and patients, whilst electronic medical records such as the national My Health Record can facilitate communication and coordinated care across multiple practitioners. In 2018, every Australian established a 'My Health Record' unless they choose to opt out. Information available through My Health Record can include a patient's health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.

Given the large geographical size of WA, COVID-19 saw a very rapid adoption of virtual methods of consultation of WA's hospital-based outpatient clinics. Rates that were previously in low 10 to 15% rapidly moved to the 60 to 80% across a range of clinics and hospitals (Koh, 2020). It appears that the focus on digital health including telehealth consultations during COVID-19 is helping fast track the adoption of technology and more providers are seeing the My Health Record as a valuable repository of health data as it is accessible to all healthcare providers without the need for fax machines or postal services. As of March 2021, there are now 22.93 million My Health Records Australia-wide and more than 20.4 million or 89 per cent of them contain health data (My Health Record, 2021).

A survey by The Royal Australian College of General Practitioners (RACGP) revealed more than 99% of surveyed GPs were offering patients consultation via telehealth, including phone and video options (The Royal Australian College of General Practitioners, 2020). More than 4.3 million health and medical services have been delivered to a total of more than three million patients through the telehealth items introduced by the Australian Government for the COVID-19 pandemic (Department of Health Western Australia, 2020).

According to a Household Impacts of COVID-19 Survey results conducted from 16-25 April 2021, 14% of Australians used a Telehealth service in the previous four weeks, with the most common reasons being for convenience (68%), saving time (42%) and not needing to travel (38%) (Australian Bureau of Statistics, 2021). The April 2021 Telehealth usage (14%) was a decrease from November 2020 (18%), June 2020 (20%) and May 2020 (17%) (Australian Bureau of Statistics, 2021). The survey also revealed that 30% of Australians now preferred to access telehealth services more compared to before COVID-19, particularly family households with children (39%), people aged 18 to 34 years (38%), women (34%) and men (26%) (Australian Bureau of Statistics, 2021).

Pre-COVID (2018-19) rates of MBS utilisation of telehealth were very low across Australia, at 0.21 per 100 people. However, Country WA and Esperance in particular appear to have been early adopters of telehealth, at 0.42 and 1.41 per 100 people. Temporary COVID-19 MBS telehealth items have been made available to GPs and other health professionals since March 2020 to help reduce the risk of community transmission of COVID-19. Although the COVID-19 MBS utilisation data is currently unavailable, we expect to see a significant increase in telehealth utilisation nationwide as a result of the pandemic.

Summary

The Goldfields-Esperance region has a diverse Aboriginal community with many distinct language groups and remote communities. The pertinent health concerns in the region are mental health, chronic disease, alcohol and other drugs and access to workforce and services.

Workforce and access to services is a continuing issue for all rural communities and Goldfields-Esperance is similarly impacted. The region has low access to bulk billing GPs relative to need, limited access to allied health professionals and a shortage of mental health professionals.

The Goldfields-Esperance region had a high rate of suicide contributing to 5% of all deaths in the region. Mental ill-health was the third leading cause of disease burden in the region but less than 1% of the population accessed a clinical psychologist through the Better Access MBS program.

The population in Goldfields-Esperance had significantly high prevalence rates of risk factors for chronic disease, particularly high blood pressure and obesity. Moreover, the region had the second highest cardiovascular burden in the state together with a low utilisation of GP chronic disease management plans (CDMPs).

Esperance had a large and growing ageing population but had a low residential (RACF) beds-to-population ratio with only two residential aged care facilities located in the region.

Residents experiencing long-term harm from alcohol use, smoking and illicit drugs, unintentional drug-induced deaths and ED presentations related to AOD were concerning. Aboriginal people in the Goldfields region experience some of the highest levels of socioeconomic disadvantage, non-urgent ED presentations, unemployment, poor housing suitability and adolescents who were not attending secondary school.

Priorities

Health Need	Service Need	Priority	Priority Area	Priority sub-category
The Goldfields-Esperance region had a high rate of suicide contributing to 5% of all deaths in the region. Mental health was the third leading cause of disease burden in the region.	Access to primary mental health services is limited in the Goldfields-Esperance Region with less than 1% of the population accessing a clinical psychologist through MBS services.	Increase access to mental health services and suicide prevention activities.	Mental Health	Access
The population in Goldfields-Esperance had significantly high-risk factors for chronic disease particularly high blood pressure and obesity.	Improve screening for chronic disease risk factors.	Support primary care to promote healthy weight and healthy lifestyle changes.	Population Health	Chronic conditions
The second highest cardiovascular burden in the state.	low utilization of GP chronic disease management plans (CDMPs) and PPHs hotspots for congestive heart failure.	Improve the self-management of heart disease especially chronic heart failure in Primary care.	Population Health	Chronic conditions
The Goldfields SA3 had a significantly higher rate of diabetes compared to the State.	There are PPH hotspots for diabetes complications in the Goldfields SA3.	Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	Population Health	Chronic conditions
Residents are at risk from long-term harm from alcohol use, smoking and illicit drug use.	ED presentations related to AOD were above state rates.	Improve access to screening and AOD treatment services	Alcohol and other drugs	Access
Aboriginal people living in the Goldfields-Esperance region have some of the poorest health outcomes in the state.	Aboriginal people in the Goldfields-Esperance region have high rates of PPH presentations and non-urgent ED presentations.	Improve access to coordinated culturally appropriate primary care for Aboriginal people.	Aboriginal and Torres Strait Islander Health	Appropriate care (including cultural safety)
The Goldfields-Esperance has a growing ageing population. People aged 65 years and over are more likely to have complex and/or chronic conditions.	The Goldfields-Esperance Region has limited access to aged care services particularly in home care services.	Promote healthy ageing at home and reduce early entry into residential care.	Aged Care	Early intervention and prevention.

Opportunities and options

Priority	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Increase access to mental health services and suicide prevention activities.	MH1 Rate of regional population receiving PHN commissioned low intensity psychological interventions. MH2 Rate of regional population receiving PHN commissioned psychological therapies delivered by mental health professionals. MH4 Formalised partnerships with other regional service providers to support integrated regional planning and service delivery.	Non-Government Organisations Community Mental Health Services General Practice
Support primary care to promote healthy weight and healthy lifestyle changes.	P4 Support provided to general practices and other health care providers.	General Practice Allied Health Service Providers
Improve the self-management of heart disease especially chronic heart failure in Primary care.	P2 Health system improvement and innovation	General Practice Local Hospital Networks The Heart Foundation
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	P9 Increase in the rate of people diagnosed with chronic conditions who receive GP team care arrangement and case conferences. P4 PHN delivers a range of support activities to general practices and other health care providers.	General Practice Allied Health Providers
Improve access to screening and AOD treatment services	AOD1 Rate of drug and alcohol commissioned providers actively delivering services.	General Practice Mental Health Commission WANADA
Improve access to coordinated culturally appropriate primary care for Aboriginal people.	IH5 ITC improves the cultural competency of mainstream primary health care services.	Aboriginal Medical Services Local Hospital Network Aboriginal Non-Government Organisations
Promote healthy ageing at home and reduce early entry into residential care.	AC2 Increase in the rate of people aged 75 years and over with a GP health assessment.	General Practice Aged Care Organizations Local Hospital Networks Local Governments

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Acknowledgement

WA Primary Health Alliance acknowledges and pays respect to the Traditional Owners and Elders of this country and recognises the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.

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