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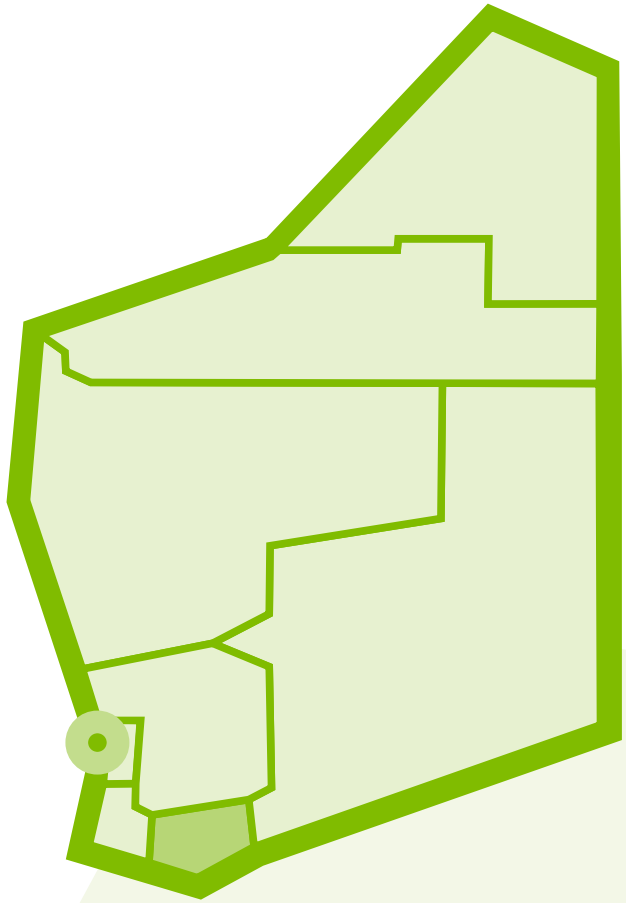
Great Southern

Needs Assessment 2022-2024



Great Southern

Population Demographics

The Great Southern region is located on the south coast of Western Australia and is bounded by the South West region on the west and the Wheatbelt region to the north. The total land area of 39,007 square kilometres and represents about 1.5% of the total area of Western Australia.

In 2021, the population of Country WA PHN was 529,933 people compared to the state's population of 2,660,026 people (Public Health Information Development Unit, 2022). There are 61,880 people living in the Great Southern region, made up of Albany SA3.

Figure 1 - Population (URP 2021) in Country WA PHN by SA3

1ST

Mental ill-health is the leading cause of disease burden

7% of the population accessed a GP **mental health treatment plan**

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

36% of adults aged 16+ years are **obese**

20% of adults aged 16+ years have **high blood pressure**

22% of adults aged 16+ years do **no leisure time physical activity**

21% of people are **aged 65 years and over**

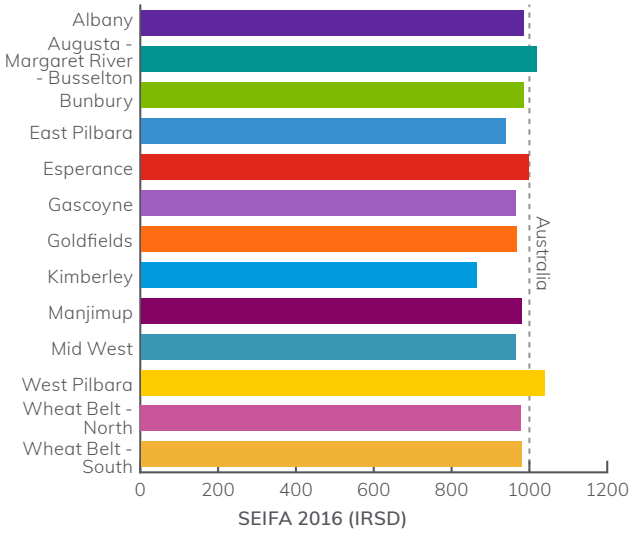
Coronary heart disease, COPD and **dementia** are among the leading causes of disease burden for people aged 65 and over

There are an estimated **2853 Aboriginal people** residing in the region

28% of Aboriginal people received an **Indigenous-specific health check** through Medicare in 2019-20

The region is relatively socioeconomically disadvantaged compared to the rest of WA, with a SEIFA score of 983, against WA's overall score of 1,016 (Public Health Information Development Unit, 2021b). About 4.0% of the population is Aboriginal (Public Health Information Development Unit, 2022).

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



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.

- Only 0.8% of people in Albany SA3 were born overseas and have poor English proficiency (445 people) compared to 1.8% of people across the state (44,521 people) (Public Health Information Development Unit, 2022).
- About 5.9% of people in Albany SA3 have a profound or severe disability compared to 4.6% of people across the state (Australian Bureau of Statistics, 2021a).
- About 13% of people in Albany SA3 provide unpaid assistance to people with a disability compared to 11% of people across the state (Public Health Information Development Unit, 2022).
- About 23% of children in Albany SA3 were developmentally vulnerable on one or more domains compared to 19% of children across the state (Public Health Information Development Unit, 2021b).
- In 2016, it was estimated that 148 people in Albany SA3 experienced homelessness (Australian Bureau of Statistics, 2018). About 32% of homeless people 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. Feedback from local stakeholders indicated that the large elderly population in the Great Southern has resulted in an increased demand for chronic disease services and that integration between aged care, palliative care and chronic conditions was a priority in the region.

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

Figure 3 - The proportion of Aboriginal population versus non-Indigenous population with listed type of chronic conditions for the Great Southern.

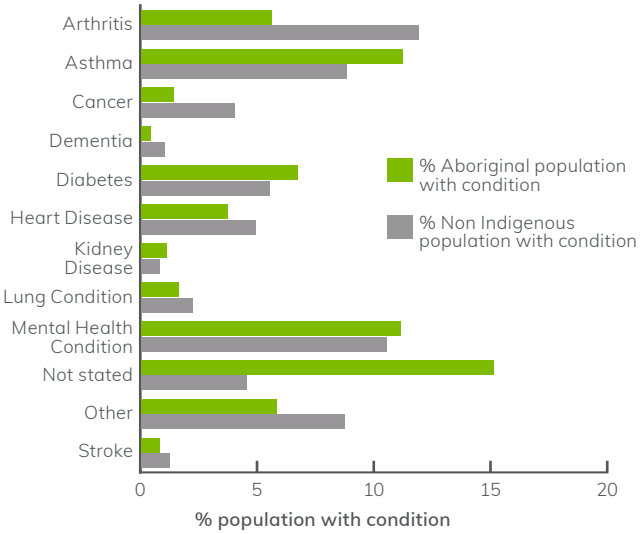
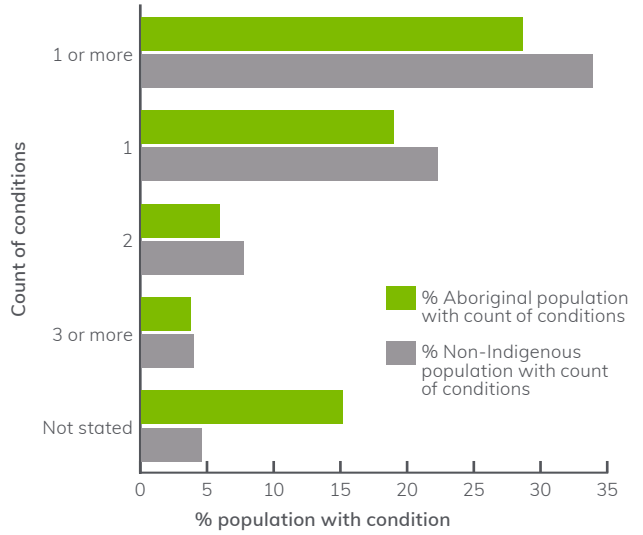


Figure 4 - The proportion of Aboriginal population versus non-Indigenous population with listed number of chronic conditions for the Great Southern.



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 Great Southern region had prevalence rates of risk factors that were significantly higher than state rates. In 2017-18, children aged 2-17 years in Albany 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 36% in Albany SA3 compared to 30% across the state (Epidemiology Branch, 2021a). The region also had higher rates of high blood pressure (20%) and people who do no leisure time physical activity (22%).

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.

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 Albany SA3 (12 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 80% in Albany 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 56% in Albany 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 41% in Albany 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.

Burden and prevalence of disease

Burden of disease measures the impact of different diseases or injuries on a population, including both physical and mental ill health and substance use disorders. 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 Great Southern region had a 1.3 times higher rate of fatal and non-fatal burden compared to the metropolitan regions. Chronic disease accounted for a substantial proportion of the burden of disease. Coronary heart disease and COPD were among the leading five causes of burden for both males and females and back pain/problems were the fifth leading cause for females. For people aged 45-64 years, chronic liver disease was the third leading cause of disease burden.

The 2021 Census indicated that after adjusting for age, 18% of people across the state had one long-term health condition (including both physical and mental health conditions) and 8.2% had two or more co-morbid conditions (Public Health Information Development Unit, 2022). In the Great Southern region, age-adjusted prevalence rates were 20% for one long-term condition and 9.1% for two or more conditions. Compared to the state, the Great Southern had relatively high rates of asthma (ASR=8.4% compared to 7.4%) and arthritis (ASR=9.0% compared to 7.9%). For a discussion on the methodologies of estimating the prevalence of long-term health conditions, please refer to the 'Additional Data Needs and Gaps' section in the Introduction.

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, Albany SA3 had a similar rate for total chronic conditions (1114).

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, Katanning Population Health Area (PHA) was a hotspot for total chronic conditions as well as for asthma and hypertension.

Management of chronic disease in primary care

In 2020-21, percentage-of-population utilisation of GP chronic disease management plans (CDMPs) was 16% in Albany SA3 and was comparable to the national rate for SA3s in outer regional areas (Australian Institute of Health and Welfare, 2021d).

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 (Department of Health, 2021b). 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.

In the Great Southern region, childhood immunisation rates in Albany SA3 were below target, especially for children at 2 years. About 94.5% of children were fully immunised at 1 year, 90.2% at 2 years, and 94.2% at 5 years. The lower rate at 2 years suggests that interventions should be targeted to increase immunisation coverage for this age group.

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 cancer screening participation rates in Albany SA3 were at or above state rates: 51% for bowel cancer screening, 58% for breast cancer screening, and 48% 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 81 years in Albany SA3 (50% of people who died were younger than 81 years) 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, the age-standardised death rate per 100,000 from all avoidable causes in Albany SA3 (128) was not significantly higher than the state rate (122) (Public Health Information Development Unit, 2021b). Death rates for selected causes were also not significantly different from state rates.

Utilisation of primary care services

The COVID-19 pandemic impacted the utilisation of primary care services across the state. Between

2018-19 and 2020-21, the proportion of the population visiting a GP decreased from 88% to 86% of the population in Albany SA3 (consistent with the national rate for SA3s in outer regional areas) (Australian Institute of Health and Welfare, 2021d).

The percentage utilising after-hours GP services increased from 3.4% in 2018-19 to 4.3% in 2020-21 but was still well below the national rate for outer regional areas (11%). The utilisation rate of GP health assessments (5.4%) was slightly below the national rate for outer regional areas (6.2%) (Australian Institute of Health and Welfare, 2021d). 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.

About 37% of the population in Albany SA3 utilised Medicare-subsidised allied health services and 30% of the population utilised optometry (Australian Institute of Health and Welfare, 2021d). 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.

Utilisation of nurses and Aboriginal health workers in Albany SA3 remained constant at 12%, above the national rate of 10% for outer regional areas (Australian Institute of Health and Welfare, 2021d).

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. Within the Great Southern region, Kojonup SA2, Plantagenet SA2 and Denmark SA2 in Albany SA3 were in the second decile (access relative to need was lower than 80% of SA2s in the state) for access to bulk-billing GPs, while Kojonup SA2 and Plantagenet SA2 were in the third decile for access to any GP.

Workforce

General practitioners (GPs)

In 2020, Albany SA3 had 62 GP full-time equivalent (FTE) or 1.0 FTE per 1000 residents compared to 1.1 FTE per 1000 across the state2. The ratio of vocationally registered (VR) to non-VR GPs (41) was the highest in Country WA PHN and was well above the state ratio (12).

Primary care nurses

In 2019, Albany SA3 had a relatively high supply of primary care nurses, with 134 full-time equivalent (FTE) or 2.2 FTE per 1000 residents compared to 1.7 FTE per 1000 across the state[2].

Feedback from local stakeholders indicated that the COVID-19 pandemic has compounded workforce supply issues across the region due to travel restrictions and a shortage of rental housing. Moreover, the COVID-19 vaccine rollout and associated administrative burdens have affected GP appointment availability and increased pressure on GPs and other practice staff. An increase in the number of intrastate visitors to the region along with demand for short term accommodation has exacerbated the shortage of rental housing and increased pressure on health services during peak holiday periods.

Aged Care

In 2021, there were 14,190 people aged 65 years and over in Albany SA3, representing 23% of the population compared to 16% across the state (Australian Bureau of Statistics, 2021a).

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 Great Southern health region, coronary heart disease, COPD and dementia were among the leading causes of disease burden for people aged 65 and over.

Data from the 2021 Census (Australian Bureau of Statistics, 2021a) indicated that 31% of people aged 65 years and over across the Great Southern region had one long term health condition (including both physical and mental health conditions) and 26% had two or more co-morbid conditions, consistent with state rates. The most common types of conditions among older adults in the region were arthritis (29%), heart disease (15%), and diabetes (13%). For a discussion on the methodologies of estimating the prevalence of long-term health conditions, please refer to the 'Additional Data Needs and Gaps' section in the Introduction.

The Dementia in Australia 2022 report from the Australian Institute of Health and Welfare contains up-to-date information on the prevalence of dementia (Australian Institute of Health and Welfare, 2022). In 2021, it was estimated that there were 33,364 people in Western Australia living with dementia, with 6,569 in Country WA PHN. Around 60% of people with dementia were female. In the Great Southern region, there were 1,169 people with dementia, with the highest number in Albany

SA2 (431) (in the Census, 3,318 people self-reported living with dementia in Country WA PHN (Public Health Information Development Unit, 2022)). For a discussion on the methodologies of estimating dementia prevalence please refer to the 'Additional Data Needs and Gaps' section in the Introduction.

Utilisation of health services

In Country WA PHN, 41% of people aged 80 years and over had a GP Health Assessment in 2020-21, similar to the rate for regional PHNs (39%) and above the national rate (35%) (Australian Institute of Health and Welfare, 2021d). The number of GP attendances in residential aged care facilities (RACFs) was 16.1 per patient, compared to 15.4 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 general practices (nine in total) indicate that the Great Southern has a similar rate of people over 75 accessing health assessments as the Country WA PHN, at 20%. However, the proportionally higher older adult population in the Great Southern highlights this as a potential area for improvement in care.

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).

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 services in Albany are provided by the private sector, community based and charitable organizations. As at December 2020, there were 410 people in a HCP in the Great Southern Aged Care Planning Region (ACPR) (Department of Health, 2021a). Additionally, there were 196 people waiting for a HCP with 59 people (30%) requiring the highest level of care (level 4).

There are 13 residential aged care facilities in Albany SA3. There were 70 residential aged care (RACF) beds per 1000 people aged 70 years and over compared to 63 in Country WA PHN and 72 across the state (Australian Institute of Health and Welfare, 2021b).

In 2019, Albany SA3 had 112 aged care nurse full-time equivalent (FTE) or 13 FTE per 1000 people aged 70 years and over compared to 12 FTE per 1000 across the state2.

Feedback from local stakeholders indicated that a growing ageing population, together with workforce turnover and shortages have led to increased pressure on aged care services. There is a need for additional support for aged care workers to assist with workforce training and retention.

Alcohol and Other Drugs

In Albany SA3 21.6% of residents were at long-term risk from alcohol consumption, which is 4.9% lower than the state rate (26.5%) (Epidemiology Branch, 2021b). 11.8% of the population in Albany are current smokers, which is similar to the state rate of 11.2% (Epidemiology Branch, 2021b).

The Great Southern Community Alcohol and Drug Service (GSCADS), run by the Palmerston Association, provides support to communities across the region from Walpole to Bremer Bay, and north to Kojonup, Katanning and Lake Grace. GSCADS also runs a needle and syringe program (NSP) to reduce the harms associated with injecting drug use. Alcohol and other drug services are also commissioned by the WA Primary Health Alliance.

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. In Albany SA3 across 12 practices, 29% of GP patient records did not have a smoking status recorded (37% across the state) and 41% did not have an alcohol consumption status recorded (46% across the state). We note that these data include only private general practices and do not include health services provided by non-government organisations.

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. Albany SA3 had the highest rate of more than 10

deaths per 100,000 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, about 0.7% of ED presentations across the region were AOD-related (Department of Health Western Australia, 2021a). About two-thirds of AOD presentations (63%) were made after hours. Presentation rates per 100k population per year in Albany SA3 (468) were above 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.

Mental Health

Mental Health is the leading cause of disease burden in the Great Southern accounting for 19.4% of the total disease burden (Department of Health Western Australia, 2021).

The WA Health and Wellbeing Surveillance System (HWSS) survey was established in 2002 to monitor the health status of Western Australians. The data collected includes population-weighted estimates of the prevalence of mental health conditions such as anxiety, depression, psychological distress, and suicide ideation (Epidemiology Branch, 2021b). For a discussion on the methodologies of estimating the prevalence of mental health conditions, please refer to the 'Additional Data Needs and Gaps' section in the Introduction.

Anxiety, depression, and psychological distress

Between 2015 and 2019, 7.0% of the population in Albany SA3 had anxiety, 7.8% had depression, and 7.6% had high or very high psychological distress, similar to WA rates (Epidemiology Branch, 2021b) (after adjusting for age in the Census data, the prevalence of mental health conditions, including anxiety and depression, for all ages and people aged 15 years and over, respectively were 10% and 12% in Albany SA3 (Public Health Information Development Unit, 2022)).

Suicide and self-harm

Between 2014 to 2018, 44 people died from suicide in the Great Southern, representing 1.8% of deaths in the region (Australian Institute of Health and Welfare, 2020c).

The prevalence of people with suicide ideation in the Great Southern was not statistically significantly higher than the state rate. According to the Health and Wellbeing Surveillance System survey between 2015 and 2019, 4.9% of the population in Albany SA3 thought seriously about ending their own lives compared to 5.5% of people across the state (Epidemiology Branch, 2021b).

Self-harm is a strong risk factor for suicide. The hospitalisation rate for self-harm in the Great Southern (249 per 100,000 residents) was above state rates at 224 per 100,000 residents. Self-harm hospitalisations were higher for females and for people aged 25 – 44 years (Australian Institute of Health and Welfare, 2020d).

Youth mental health

Depressive and anxiety disorders were the leading cause of disease burden for 15 to 24-year-olds contributing to 17% (depression) and 8% (anxiety) of the disease burden for this age group (Department of Health Western Australia, 2021). Hospital admissions for self-harm may also indicate a lack of access to mental health services. In the Great Southern, people aged between 0-24 years were hospitalised for self-harm above State rates but lower than the rate for the rest of Country WA PHN (Australian Institute of Health and Welfare, 2020c).

Services

Mental health services in the Great Southern region are provided by organisations including the WA Country Health Service (WACHS) and various not-for-profit organisations. The WACHS Great Southern Mental Health Service (GSMHS) provides mental health care for inpatient and community clients in the region. The community teams consist of triage, adult, older adult, youth, child and adolescent teams. GSMHS also employs Aboriginal mental health workers to assist in providing culturally appropriate treatment. Community Mental Health clinics are located in Albany and Katanning. Youth Focus provides the region's headspace services, located in Albany, and also runs a web counselling service.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. The COVID-19 pandemic impacted utilisation of mental health services across the state. In 2020-21, 7.7% of the population in the Great Southern utilised GP mental health treatment plans, down from 8.2% in the previous year, but similar to the pre-pandemic rate of 7.5% in 2018-19 (Australian Institute of Health and Welfare, 2021d). In the Great Southern 1.8% of the population accessed a clinical psychologist through the Better Access MBS program (Australian Institute of Health and Welfare, 2021d). This is consistent with utilization across Country WA.

Aboriginal Health

Noongar people are the original inhabitants of the south-west of Western Australia and are one of the largest Aboriginal cultural nations in Australia. The Noongar nation is made up of fourteen different language groups, each of which corresponds to different geographical areas that are ecologically distinct. In the Great Southern, the Wagyl Kaip and Southern Noongar region refers to the Ganeang, Goreng and Minang dialectical groups.

In 2021, there were 2,498 Aboriginal people living in the Great Southern region (Australian Bureau of Statistics, 2021a). Data collected on Aboriginal socio-economic indicators by Aboriginal area (IARE) showed that in Albany, 32% of Aboriginal dwellings

had no internet connection and that in Kojonup – Gnowangerup, 23% of families were low income, 27% of dwellings were rented from the government housing authority and 48% of dwellings had no internet connection (Public Health Information Development Unit, 2021a).

For the first time, data on Chronic (Long Term Health) conditions were captured in the 2021 Census using a single question "Has the person been told by a doctor or nurse that they have any of these long-term health conditions?".

In the Great Southern region, more Aboriginal people reported having the following conditions compared to non-Aboriginal people:

- 11.2% of Aboriginal people reported having Asthma compared to 8.8% of non-Aboriginal people.
- 6.7% of Aboriginal people reported having diabetes compared to 5.5% of Non-Aboriginal people.

(Australian Bureau of Statistics, 2021a).

In the Great Southern, 471 (18.9%) Aboriginal persons responded as having 1 Chronic condition, 148 (5.9%) have two Chronic conditions, while 92 (3.7%) have three or more Chronic conditions, 1407 (56.3%) have no Chronic condition, while 378 (15.1%) didn't respond to the question.

Indicators of maternal and early childhood health outcomes showed that there were high rates of smoking during pregnancy for Aboriginal mothers in Albany (39%) and Kojonup – Gnowangerup (45%). Moreover, about 42% of Aboriginal children in Albany were developmentally vulnerable on one or more domains (Public Health Information Development Unit, 2021a).

Regions with the highest proportion of Aboriginal persons living in crowded dwellings were within the IAREs of Narrogin-Wagin-Katanning (18%), Kojunup-Gnowangerup (18%) and Manjimup-Denmark-Plantagenet (14%) (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 62% in Albany SA3 (12 practices) as well as 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 27% in Albany 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 (Public Health Information Development Unit, 2021a). In the Great Southern region, childhood immunisation rates below target for Aboriginal children aged 2 years were 76% in Narrogin-Wagin-Katanning and 85% in Kojunup-Gnowangerup IAREs. 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. 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). Within the Great Southern, rates of non-urgent ED presentations between 2017/18 were statistically significantly higher in the IARE of Albany for factors influencing health status (Public Health Information Development Unit, 2021a).

Avoidable deaths by selected causes

Rates of avoidable deaths (ASR per 100,000 Aboriginal persons) for Aboriginal persons aged 0 to 74 years were statistically significantly higher than state rates for:

- Circulatory system diseases: Narrogin-Wagin-Katanning (178 per 100,000)
- Other external causes: Narrogin-Wagin-Katanning (107 per 100,000).

Other external causes include transport accidents, accidental drowning, and submersion etc. (Public Health Information Development Unit, 2021a).

Potentially preventable hospitalisations (PPHs)

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

PPHs for chronic disease:

- Chronic angina: Albany (317 per 100,000)
- Diabetes in Kojunup-Gnowangerup (758 per 100,000)
- COPD: Albany (811 per 100,000).

PPHs for acute conditions:

- Acute dental: Albany (716 per 100,000).

Rates of vaccine-preventable PPH conditions were similar to state rates (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, 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, 27.5% of Aboriginal people in Albany SA3 received an Aboriginal health check, similar to the rate for Country WA PHN (25.1%). Face-to-face was the preferred method compared to telehealth, which had a low uptake of only 0.6% in Albany and the rest of WA. During 2018-19, only 34.8% of Indigenous Health Check patients in Albany SA3 received follow-up services compared to 46.8% across WA (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 Great Southern can access primary care services through general practice, mainstream primary care services and the hospital sector. Until recently, there was no access to an Aboriginal Community Controlled Health Organisation (ACCHO). The South West Aboriginal Medical Service will soon be opening a branch in Katanning to provide services to the local Aboriginal and Torres Strait Islander people.

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, 2021b). The April 2021 Telehealth usage (14%) was a decrease from November 2020 (18%), June 2020 (20%) and May 2020 (17%) (Australian Bureau of Statistics, 2021b). 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, 2021b).

Prior to the COVID-19 pandemic, the MBS utilisation for telehealth services in Albany (0.44 per 100 resident population) was similar to Country WA (0.42) but higher than the national rate (0.21). 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. Data on GP COVID-19 consultations are only available at the state level. In the first year to February 2021, there were 80,661 telehealth consultations and 2,568,383 phone consultations across the state (Services Australia, 2022). These decreased to 62,589 telehealth and 1,959,459 phone consultations in the second year (to February 2022).

Summary

The pertinent health concerns in the Great Southern are the increasing ageing population, chronic disease, and mental health. Mental health is a continuing priority for the Great Southern and is the leading cause of disease burden in the region. Depressive disorders and anxiety disorders contributed to much of this burden. Access to primary mental health services is limited in the Great Southern region with less than 1% of the population accessing a clinical psychologist through MBS services.

The population in the Great Southern had significantly higher prevalence rates of risk factors for chronic disease, particularly high blood pressure and obesity. Coronary heart disease and COPD are among the leading causes of disease burden.

The Great Southern has a large ageing population impacted by chronic disease. Coronary heart disease, COPD and dementia were among the leading causes of disease burden for people aged 65 and over. Despite an adequate supply of aged care beds, feedback from local stakeholders indicated that a growing ageing population, together with workforce turnover and shortages have led to increased pressure on aged care services. Local intelligence also indicated that the COVID-19 pandemic has compounded workforce supply issues across the region due to travel restrictions and a shortage of rental housing.

Priorities

Health Need	Service Need	Priority	Priority Area	Priority sub-category
Mental Health is the leading cause of disease burden in the region. Depressive disorders and anxiety disorders contributed to the majority of the disease burden.	Access to primary mental health services is limited in the Great Southern region with less than 1% of the population accessing a clinical psychologist through MBS services.	Improve access to mental health services in the Great Southern.	Mental health	Access
Chronic disease accounted for a substantial proportion of the burden of disease. Coronary heart disease and COPD were among the leading cause of disease burden.	The Great Southern had high PPH rates for COPD, Congestive Heart Failure, and iron deficiency anaemia. Katanning was a hotspot for total chronic conditions as well as for asthma and hypertension.	Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	Population health	Chronic conditions
The Great Southern has a high proportion of older adults. Coronary heart disease, COPD and dementia were among the leading causes of disease burden for people aged 65 and over.	Despite an adequate supply of aged care beds, feedback from local stakeholders indicated that a growing ageing population, together with workforce turnover and shortages have led to increased pressure on aged care services.	Improve the management of chronic conditions for ageing populations and promote healthy ageing at home.	Aged care	Chronic conditions
Most Australians would prefer to die at home rather than in a hospital or aged care facility.	There is a lack of home care palliative care providers.	There is a need to increase access to at home palliative care services.	Aged care	Palliative care

Opportunities and options

Priority	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Improve access to mental health services in the Great Southern.	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.	Non-Government Organisations Community Mental Health Services General Practice
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 the management of chronic conditions for ageing populations and promote healthy ageing at home.	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
There is a need to increase access to at home palliative care services.	P2 A health system improvement, innovation or commissioning best practice.	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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