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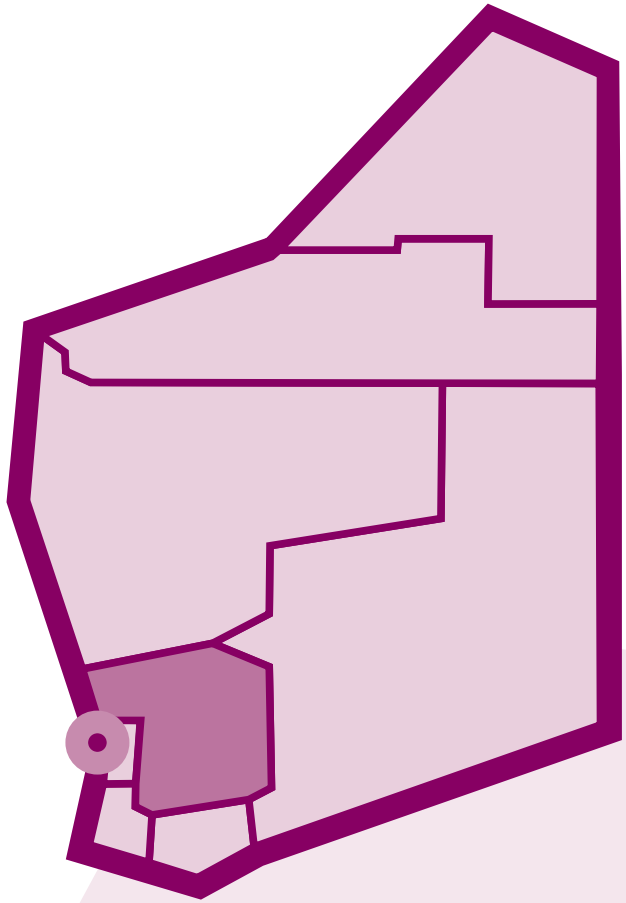
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative

Wheatbelt

Needs Assessment 2022-2024



Wheatbelt

Population Demographics

The Wheatbelt region covers 158,000 square kilometres in the south-west of Western Australia. It partially surrounds the Perth metropolitan area, extending north from Perth to the Midwest region, and east to the Goldfields region. It is bordered to the south by the South West and Great Southern regions, and to the west by the Indian Ocean, Perth metropolitan area and the Peel region. In contrast to other Country regions, the population in the Wheatbelt is distributed across the region with no larger central town.

The Wheatbelt region is divided into two main statistical areas (Public Health Information Development Unit, 2022):

- Wheat Belt – North SA3 (pop 55,937) includes the towns of Chittering, Cunderdin, Dowerin, Gingin, Dandaragan, Merredin, Moora, Mukinbudin, Northam, Toodyay, York, and Beverley.
- Wheat Belt - South SA3 (pop 19,357) includes Brookton, Kulin, Murray, Narrogin, and Wagin.

Coronary heart disease and **COPD** were among the **leading causes** of disease burden

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

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

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

2ND

Mental ill-health was the **second leading** cause of disease burden

6% of the population in Wheat Belt – North SA3 and **5%** in Wheat Belt – South SA3 accessed a **GP mental health treatment plan**

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

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

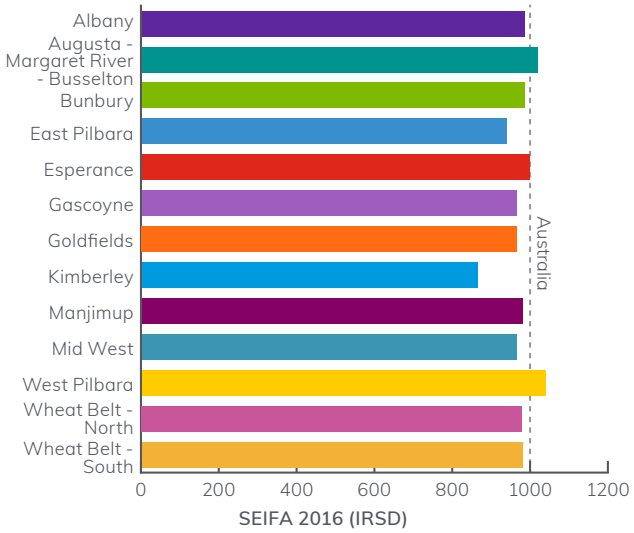
There are an estimated **4,512 Aboriginal people** residing in the region

22% of Aboriginal people in Wheat Belt – North SA3 and **29%** in Wheat Belt – South SA3 received an **Indigenous-specific health check** through Medicare in 2019-20

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

There are similar levels of socioeconomic disadvantage in Wheat Belt – North SA3 (IRSD=977) and Wheat Belt – South SA3 (IRSD=978) and both sub-regions were more disadvantaged compared to the state (IRSD=1016) (Public Health Information Development Unit, 2021b). About4.6% of people in Wheat Belt – North SA3 and 4.3% of people in Wheat Belt – South SA3 are 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 0.4% of people in Wheat Belt – North SA3 (191 people) and 0.3% in Wheat Belt – South SA3 (46 people) were born overseas and have poor English proficiency compared to 1.8% across the state (44,521 people) (Public Health Information Development Unit, 2022).
- Around 5.3% of people in Wheat Belt – North SA3 and 5.2% in Wheat Belt – South SA3 have a profound or severe disability compared to 4.6% across the state (Australian Bureau of Statistics, 2021a).
- About 11% of people in Wheat Belt – North SA3 and Wheat Belt – South SA3 provide unpaid assistance to people with a disability, consistent with the state rate (Public Health Information Development Unit, 2022).
- About 21% of children in Wheat Belt - North SA3 and 16% in Wheat Belt – South 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 224 people in Wheat Belt - North SA3 and 49 people in Wheat Belt - South SA3 experienced homelessness (Australian Bureau of Statistics, 2018). About 28% of homeless people in Wheat Belt – North SA3 and 61% in Wheat Belt - South 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.

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 Wheatbelt.

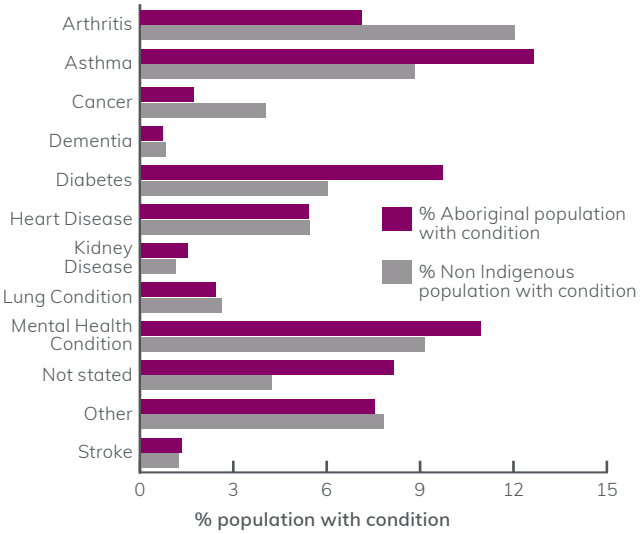
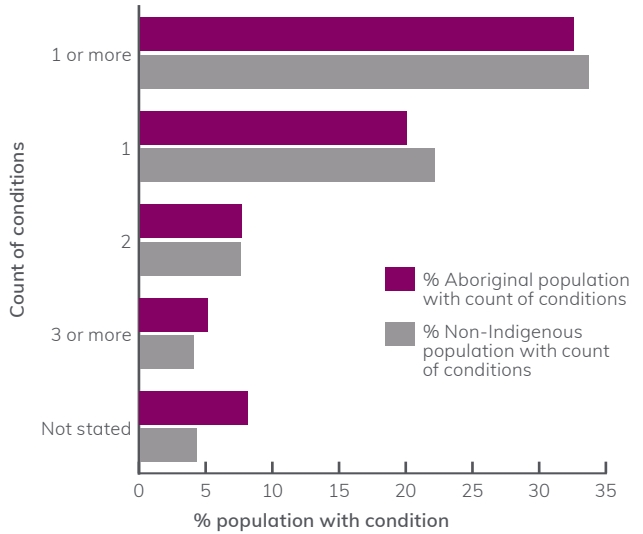


Figure 4 - The proportion of Aboriginal population versus non-Indigenous population with listed number of chronic conditions for the Wheatbelt.



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 Wheatbelt region had prevalence rates of risk factors that were significantly higher than state rates, with similar rates for Wheat Belt – North and Wheat Belt – South SA3s. In 2017-18, children aged 2-17 years in the region 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 in the region (39%) compared to the state (30%) (Epidemiology Branch, 2021a). The region also had higher rates of high blood pressure (22% in Wheat Belt – North SA3 and 21% in Wheat Belt - South SA3) and Wheat Belt – North SA3 had a significantly high rate of people who did no leisure time physical activity (24%). Interviews with local stakeholders indicated that a high proportion of people aged 65 years and over together with a lack of food security were significant risk factors for the development of chronic disease in the region.

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 Wheat Belt – North SA3 (24 practices) and Wheat Belt – South SA3 (nine 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 70% in Wheat Belt – North and 75% in Wheat Belt – South 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 32% in Wheat Belt – North and 35% in Wheat Belt – South 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 29% in Wheat Belt – North and 28% in Wheat Belt – South 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 Wheatbelt region had a 1.3 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. Coronary heart disease and COPD were among the leading five causes of burden for both males and females, while lung cancer was the third leading cause for males.

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 Wheatbelt region, age-adjusted prevalence rates in Wheat Belt – North SA3 and Wheat Belt – South SA3 respectively were 18% and 19% for one long-term condition and 8.7% and 8.4% for two or more conditions. Compared to the state, Wheat Belt - South SA3 had relatively high rates of arthritis (ASR=9.0% compared to 7.9%) and kidney disease (ASR=1.3% compared to 0.8%). 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.

In 2017-18, the age-standardised rate of PPHs per 100,000 for total chronic conditions was 1187 in Wheat Belt – North SA3 and 1283 in Wheat Belt – South SA3 compared to 1109 across the state (Australian Institute of Health and Welfare, 2019).

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. Cunderdin/Merredin/Mukinbudin PHA and Narrogin PHA were hotspots for COPD, while Dowerin/Moora/Toodyay PHA was a hotspot for diabetes complications.

Management of chronic disease in primary care

From 2018-19 to 2020-21, percentage of population utilisation of GP chronic disease management plans (CDMPs) increased from 15% to 17% in Wheat Belt – North SA3 and was consistent with the rate for SA3s in inner regional areas. Wheat Belt – South SA3 had a relatively high utilisation of CDMPs, increasing from 19% to 20% compared to 15% 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 Wheatbelt region, childhood immunisation rates were below target for children aged 2 years, at 93.0% in Wheat Belt – North SA3 and 91.9% in Wheat Belt - South SA3. This 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 indicate that compared to the state, cancer screening participation rates were lower in the Wheatbelt region for breast and cervical cancers. Participation rates were 46% in Wheat Belt - North SA3 and 48% in Wheat Belt - South SA3 for bowel cancer screening, 51% in Wheat Belt – North SA3 and 52% in Wheat Belt - South SA3 for breast cancer screening, and 39% in Wheat Belt - North SA3 and 42% in Wheat Belt – South 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 77 years in Wheat Belt – North SA3 (50% of people who died were younger than 77 years) and 79 years in Wheat Belt – South 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, the age-standardised death rate per 100,000 from avoidable causes in Wheat Belt – North SA3 (149) was significantly higher than the state rate (122) (Public Health Information Development Unit, 2021b). Wheat Belt – South SA3 avoidable death rates were similar to state rates.

Utilisation of primary care services

In 2020-21, the percentage of the population who visited a GP in the last year was similar in both SA3s and did not change substantially from 2018-19. About 85% of people in Wheat Belt – North SA3 and 86% in Wheat Belt – South SA3 visited a GP (Australian Institute of Health and Welfare, 2021d).

Between 2018-19 and 2020-21, the percentage utilising after-hours GP services was low in both areas and decreased from 8.9% to 7.8% in Wheat Belt – North SA3 (9.3% in inner regional areas nationally) and from 5.8% to 4.7% in Wheat Belt – South SA3 (11% in outer regional areas nationally). However, both areas had utilisation rates of GP health assessments that were above the corresponding national rate for their socioeconomic group SA3s, at 6.3% in Wheat Belt – North SA3 (5.4% in inner regional areas nationally) and 7.0% in Wheat Belt – South SA3 (6.2% in outer regional areas nationally). 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 both SA3s was below corresponding national rates for their socioeconomic group. In 2020-21, about 35% of the population in Wheat Belt - North SA3 (41% nationally in inner regional areas) and 32% in Wheat Belt – South SA3 (37% nationally in outer regional areas) utilised allied health services (Australian Institute of Health and Welfare, 2021d). The percentage of the population that utilised optometry was 29% in Wheat Belt – North SA3 and 26% in Wheat Belt – South SA3. 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.

Between 2018-19 and 2020-21, utilisation of nurses and Aboriginal health workers increased from 8.7% to 10% in Wheat Belt – North SA3 (11% nationally in inner regional areas) and from 8.1% to 10% in Wheat Belt – South SA3 (the same as the national rate 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 Wheatbelt region, Gingin – Dandaragan SA2, Toodyay SA2, and Chittering SA2 in Wheat Belt – North SA3 and Murray SA2 in Wheat Belt – South SA3 were in the first decile (access relative to need

was lower than 90% of SA2s in the state) for access to any GPs as well as access to bulk billing GPs. Moreover, York - Beverley SA2 (Wheat Belt – North SA3) and Brookton SA2 (Wheat Belt – South SA3) were in the first decile for access to any GPs, while Mukinbudin SA2 and Moora SA2 (Wheat Belt – North SA3) were in the first decile for access to bulk billing GPs.

Workforce

General practitioners (GPs)

In 2020, Wheat Belt – North SA3 had 44 GP full-time equivalent (FTE) and Wheat Belt – South SA3 had 17 GP FTE, representing 0.8 FTE per 1000 residents in each sub-region compared to 1.1 FTE per 1000 across the state[2]. The ratio of vocationally registered (VR) to non-VR GPs was very low in Wheat Belt – South SA3 (4.3) compared to the state (12) and Wheat Belt – North SA3 had the second lowest ratio in WA (2.0).

Primary care nurses

In 2019, Wheat Belt – North SA3 had 80 primary care nurse full-time equivalent (FTE) or 1.4 FTE per 1000 residents and Wheat Belt – South SA3 had 36 FTE or 1.8 FTE per 1000 residents compared to 1.7 FTE per 1000 across the state[2].

Interviews with local stakeholders indicated that workforce issues such as high staff turnover and staff shortages affected the quality of primary care provided in the region.

Aged Care

The Wheatbelt region has a high proportion of older adults. In 2021, about 24% of people in Wheat Belt - North SA3 and 23% in Wheat Belt - South SA3 were aged 65 years and over compared to 16% across the state (Australian Bureau of Statistics, 2021a). Wheat Belt - North SA3 had the largest population in this age group with 13,215 people compared to 4,383 people in Wheat Belt - South SA3.

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 Wheatbelt 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 30% of people aged 65 years and over across the Wheatbelt region had one long-term health condition (including both physical and mental health conditions) and 25% had two or more co-morbid conditions compared to 31% and 26%, respectively across the state. The most common types of conditions among older adults in the region were arthritis (27%), 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 Wheatbelt region, there were 1,327 people with dementia, with the highest number in Northam SA2 (177) (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 indicate that the Wheatbelt has the highest rates of health assessments for people over 75 in the Country WA PHN, at 29% for Wheat Belt - North (23 practices) and 25% for Wheat Belt - South (eight practices) compared to 21% for Country WA PHN.

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 in the Wheatbelt is provided by charitable and religious organisations and local government. There were 11 home care services available. As at December 2020, there were 648 people in a HCP in the Wheatbelt Aged Care Planning Region (ACPR) (Department of Health, 2021a). An additional 330 people were waiting for a HCP with 81 people (25%) requiring the highest level of care (level 4).

Despite having 18 residential aged care facilities Wheat Belt - North SA3 had a relatively low ratio of residential aged care (RACF) beds to population. The number of residential beds to 1000 people aged 70 years and over was only 47 in Wheat Belt - North SA3 compared to 63 in Country WA PHN and 72 across the state (Australian Institute of Health and Welfare, 2021b). Conversely, Wheat Belt - South SA3 had 8 residential facilities but 74 beds per 1000 people aged 70 years and over.

Wheat Belt – South SA3 had a relatively high supply of aged care nurses compared to the state. In 2019, aged care nurse full-time equivalent (FTE) per 1000 residents aged 70 years and over was 11 in Wheat Belt – North SA3 (84 FTE) and 21 in Wheat Belt – South SA3 (57 FTE) compared to 12 across the state[2]. Average weekly hours worked by aged care nurses were 36 hours per week in both sub-regions compared to 33 hours per week across the state.

Feedback from local stakeholders indicates that there are minimal community services to assist people to age in place in their own homes. A shortage of services means that people who are eligible for aged care packages may not be able to access the required services.

Alcohol and Other Drugs

In Country WA, 28.2% of residents in Wheat Belt - North and 23.7% in Wheat Belt - South SA3s were at long-term risk from alcohol consumption (Epidemiology Branch, 2021b). Although Wheat Belt - North exceeded the state rate (26.5%) it was not statistically significantly higher than WA rate (Epidemiology Branch, 2021b). The proportion of the population who are current smokers in Wheat Belt - North and Wheat Belt - South SA3s were 14.2% and 14.8% respectively, compared to 11.2% in WA (Epidemiology Branch, 2021b).

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 Country WA PHN, Wheat Belt - South SA3 (35% across nine practices) had a higher percentage of GP patient records that did not have a smoking status recorded compared to Wheat Belt - North SA3 (28% across 24 practices) and was similar to the state rate (37%). Similarly, the percentage of GP patient records that did not have an alcohol consumption status recorded was greater in Wheat Belt - South SA3 (46%) compared to Wheat Belt - North SA3 (38%) and was equal to the state rate.

Accidental overdose

Australia's Annual Overdose Report, produced by the Penington Institute, reported 2,070 drug-related deaths 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 (Penington Institute, 2020). In 2014-2018 Wheat Belt - North SA3 was categorised in the second highest rate range of 7.5-9.9 deaths per 100,000 for unintentional drug-induced deaths (Penington Institute, 2020). Due to insufficient data, a rate is unavailable for Wheat Belt - South SA3.

Services

The Wheatbelt region has established a Local Drug Action Team to prevent and minimise alcohol and other drug-related harms. The Brookton Pingelly team deliver alcohol and other drug harm prevention activities in Pingelly, Brookton, Popanyinning and Wandering.

The Wheatbelt Community Alcohol and Drug Service (WCADS), run by Holyoake, provides assessment, referral and counselling services in Northam, Narrogin, and Merredin with outreach services in Moora, Gingin, York, Goomalling, Wongan Hills, Brookton, Kellerberrin, Wagin and surrounding areas.

Mental Health

Mental health was the second leading cause of disease burden in the Wheatbelt region contributing 13% of the total disease burden for the region (Department of Health Western Australia, 2021). Depressive disorders contributed to the disease burden for women in the Wheatbelt. While suicide and self-inflicted injuries contributed to the disease burden for men.

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

In WA, 8.5% of people have been diagnosed with depression, 9.3% with anxiety and 8.8% experienced high psychological distress. Rates were similar in the Wheatbelt. For Wheat Belt – North and South, respectively, 7.5% and 7.0% had anxiety, 7.5% and 6.8% had depression, and 8.0% and 4.8% had high psychological distress (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 8.4% and 9.8% in Wheat Belt - North SA3 and 8.6% and 10% in Wheat Belt – South SA3 (Public Health Information Development Unit, 2022)).

Suicide and self-harm

Between 2014 and 2018, 51 people died from suicide in Wheat Belt - North and 15 in Wheat Belt - South. Deaths from suicide were 15 per 100,000 for the state. In Wheat Belt - North deaths from suicide were 18 per 100,000.

The Health and Wellbeing Surveillance Survey collects data on suicidal ideation among adults aged 16 years and over. Survey participants are asked if they thought seriously about ending their own lives. About 3.3% of residents in Wheat Belt – North SA3 and 6.0% in Wheat Belt – South SA3 reported that they experienced suicide ideation compared to 5.5% of people across the state.

Self-harm is a strong risk factor for suicide. In 2018-19 Wheat Belt - South had the second highest rate of self-harm hospitalisation in the state. Self-harm hospitalisations were higher for females than males in both Wheatbelt- South and Wheat Belt - North.

Youth mental health

Mental health is the leading cause of disease burden for youth in the Wheatbelt. Suicide and self-inflicted injuries were the leading cause of burden of disease for people aged 15-24 years contributing to 19% of the disease burden. Depressive disorders were the second leading cause of disease burden for this age cohort followed by anxiety disorders which was the 3rd leading cause (Department of Health Western Australia, 2021).

In 2018-19 in Wheat Belt - South (209.2 per 100,000) were hospitalized for self-harm above state rates (129 per 100,000) (Australian Institute of Health and Welfare, 2020c).

Services

Mental health services in the Wheatbelt region are provided by organisations including the WA Country Health Service (WACHS) and various not-for-profit organisations. WACHS operates the Wheatbelt Mental Health Service, with teams located in Northam, Gingin, Merredin and Narrogin. Regular visits are made to outlying areas and outreach is supported by telephone consultation and videoconferencing. Clinical liaison is also provided to hospitals within the region. The following Mental Health programs are available: Aboriginal (all ages), Adult (18-65 years), Child and Adolescent (0-18 years), Seniors (65+ years), and Youth (15-24 years).

The unique population distribution of the Wheatbelt, with no single central town, together with its proximity to Perth makes it difficult to attract a stable workforce. No single place has the critical population size required to make business viable for service providers. As a result, residents often attend services in Perth.

There is a low supply of mental health professionals in the Wheatbelt. In 2020-21, the percentage of population utilisation of GP Mental Health Treatment Plans in the Wheatbelt region (7.4% in Wheat Belt - North and 7.0% in Wheat Belt - South) was comparable to Country WA PHN (7.1%). In the Wheatbelt, around 1.5% of the population accessed a clinical psychologist through the Better Access MBS program. This is consistent with utilisation across Country WA (Australian Institute of Health and Welfare, 2021d).

Aboriginal Health

In 2021, there were 3,426 Aboriginal people residing in the Wheatbelt region (Australian Bureau of Statistics, 2021a). The Wheatbelt is home to three distinct Aboriginal groups: Njaki Noongar, Ballardong Noongar and Gubrun.

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 Wheatbelt region, more Aboriginal people reported having the following conditions than non-Aboriginal people:

- 12.6% of Aboriginal people reported having Asthma compared to 8.8% non-Aboriginal people.
- 9.7% of Aboriginal people reported having Diabetes 6% of non-Aboriginal people.

Still in the Wheatbelt, 685 (20%) Aboriginal persons responded as having 1 Chronic condition, 260 (7.6%) have two Chronic conditions, while 174 (5.1%) have three or more Chronic conditions, 2045(59.7%) have no Chronic condition, while 277 (8.1%) didn’t respond to the question (Australian Bureau of Statistics, 2021a).

Data collected on Aboriginal socio-economic indicators by Indigenous area (IARE) showed that there was a significant level of disadvantage experienced by Aboriginal people in the Wheatbelt compared to Aboriginal people across WA. The most disadvantaged area in the region was Northam (IRSEO Index = 84). Of the seven IAREs in the region, five had low rates of female labour force participation. There were three areas with high rates of unemployment, two with high rates of Aboriginal low-income families, and three with high rates of Aboriginal jobless families with children aged under 15 years. All IAREs except Murray – Waroona – Boddington had a high rate of dwellings with no internet connection, and four areas had high rates

of government housing (Public Health Information Development Unit, 2021a).

Indicators of maternal and early childhood health outcomes showed that about two-thirds of Aboriginal mothers in Campion IARE smoked during pregnancy, a quarter of Aboriginal babies born in Narrogin – Wagin – Katanning IARE were of low birth weight, and about half of all children in Moora – Chittering IARE were developmentally vulnerable on one or more domains (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 54% in Wheat Belt - North SA3 (24 practices) and 68% in Wheat Belt - South SA3 (nine 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 25% in Wheat Belt – North and 30% in Wheat Belt – South compared to 33% across the state.

Housing

Regions with the highest proportion of Aboriginal persons living in crowded dwellings were within the IAREs of Hotham-Kulin (21%), Moora-Chittering (20%) and Murray-Waroona-Boddington (19%) (Public Health Information Development Unit, 2021a).

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 the Wheat Belt region, childhood immunisation rates below target for children aged 2 years were 76% in Narrogin-Wagin-Katanning, 87% in Northam and 88% in Avon and 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. Rates of non-urgent ED presentation for Aboriginal people in the Wheatbelt were similar to state rates (Public Health Information Development Unit, 2021a).

Avoidable deaths by selected causes

Avoidable deaths by selected conditions for Aboriginal persons aged 0 to 74 years were statistically significantly higher in the following regions for:

- Circulatory system diseases: Narrogin-Wagin-Katanning (131 per 100,000).
- Diabetes: Narrogin-Wagin-Katanning (92 per 100,000)
- Avoidable deaths by external causes (transport accidents, accidental drowning and submersion): Northam (147 per 100,000) and Narrogin-Wagin-Katanning (107) (Public Health Information Development Unit, 2021a).

Potentially preventable hospitalisations (PPHs)

Between 2015-16 and 2017-18 the following PPHs were statistically significantly higher in the IAREs of the Wheatbelt region.

PPHs for chronic disease:

- Chronic angina: Northam (656 per 100,000) and Avon (339)
- Asthma: Moora – Chittering (831 per 100,000) and Narrogin – Wagin – Katanning (574)
- CCF: Narrogin – Wagin – Katanning (748 per 100,000), Moora – Chittering (502) and Northam (451)
- Diabetes: Narrogin – Wagin – Katanning (673 per 100,000)
- Iron deficiency: Avon (359 per 100,000) and Moora - Chittering (390)
- COPD: Moora - Chittering (951 per 100,000) and Narrogin – Wagin – Katanning (932) (Public Health Information Development Unit, 2020).

PPHs for acute conditions:

- Acute convulsions and epilepsy: Narrogin – Wagin – Katanning (1,301 per 100,000) and Northam (979)
- Acute dental: Narrogin – Wagin – Katanning (830 per 100,000) and Moora - Chittering (803)
- Acute ear, nose and throat infections: Narrogin – Wagin – Katanning (784 per 100,000).

PPHs for vaccine-preventable conditions:

- Pneumonia and influenza: Northam (382 per 100,000) (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. In WA, 60% of Aboriginal people have been diagnosed with at least one chronic condition.

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 the Indigenous population that received an Indigenous Health Check was higher in Wheat Belt – South SA3 at 29.4% compared to 21.6% in Wheat Belt - North and 25.1% across Country WA PHN. Face-to-face was the preferred method compared to telehealth, which had a low uptake of only 0.2% in Wheat Belt – North, the lowest in Country WA PHN. These rates are not publishable for Wheat Belt - South because of small numbers, confidentiality, or other concerns about the quality of the data. Both Wheat Belt – North (31.2%) and Wheat Belt – South (26.3%) had a lower proportion of patients that received follow up services compared to the State (46.8%) (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.

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).

Pre-COVID-19 MBS utilisation for telehealth services in Wheat Belt - North was equal to the national rate (0.21 per 100 resident population) while Wheat Belt - South recorded a higher rate at 0.39. Both SA3 areas exceeded Perth North PHN (0.01) and Perth South PHN (0.03), however were lower than Country WA (0.42). Unreliable internet connectivity has been identified as an issue in the Wheatbelt, which impacts telehealth utilisation (Regional Development Australia Wheatbelt WA, 2017).

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 Wheatbelt is unique in its population distribution across the region. People in the wheatbelt live in small communities and towns with no single central town to locate essential services. The dominant health concerns in the region are the increasing ageing population, chronic disease, mental health and access to workforce and services. The Wheatbelt has a large ageing population impacted by chronic disease with limited access to ageing and health services. Older adults in the Wheatbelt are impacted by coronary heart disease, COPD and dementia. Access to residential aged care facilities and home care is limited particularly in Wheat Belt – North, which has a relatively low ratio of residential aged care beds to population. Chronic disease is of increasing concern particularly as the population ages. The population in the Wheatbelt had significantly high 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 in the region.

Depression, self-harm, and suicide impact communities in the Wheatbelt, particularly men and young people. The Wheatbelt had the second highest rates of self-harm in Country WA and high rates of Emergency Department presentations for mental health issues. Similar to other regional and rural communities, the Wheatbelt has limited access to psychologists and mental health services. Mental health is a continuing priority for the Wheatbelt.

Workforce and access to services is a continuing issue for all rural communities and the Wheatbelt is similarly impacted. Many towns have limited access to General Practitioners and allied health despite high needs in the community. Stakeholders have also indicated that internet connectivity reduces the viability of adopting telehealth as proxy for a limited local workforce.

Priorities

Health Need	Service Need	Priority	Priority Area	Priority sub-category
The Wheatbelt has a high proportion of older adults. Older adults in the Wheatbelt are impacted by Coronary Heart Disease, COPD and Dementia.	Access to RACFs and home care is limited particularly in Wheat Belt - North which has a relatively low ratio of residential aged care beds to population. There are very limited if not any community services available east of Northam, York, Toodyay and Narrogin.	Improve the management of chronic conditions for ageing populations and ensure adequate service provision to promote healthy ageing at home.	Aged Care	Access
Mental health was the second leading cause of disease burden in the Wheatbelt region.	Access to primary mental health services is limited in the Wheatbelt Region with less than 1% of the population accessing a clinical psychologist through MBS services. There are very limited private mental health clinicians available in the region, especially east of the Avon and Central Wheatbelt.	Improve access to mental health services in the Wheatbelt. This is across the whole lifespan.	Mental Health	Access
Deaths from suicide were above state rates in the Wheatbelt and impact people across the lifespan.	The Wheatbelt had the second highest rates of self-harm hospitalisations in Country WA and high rates of Emergency Department presentations for mental health issues.	Increase access to suicide prevention and mental health services and promote an integrated mental health system for the Wheatbelt.	Mental Health	Access
COPD among the leading causes of disease burden for the Wheatbelt.	PPH hotspots were identified for COPD in the Wheatbelt.	Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	Population Health	Chronic Disease
The population in Wheatbelt had significantly high-risk factors for chronic disease particularly high blood pressure and obesity.	Screening rates for risk factors are low. Supply of General Practice to population need was in the lower deciles. (Access Relative to Need.)	Support primary care to promote healthy weight and healthy lifestyle changes.	Population Health	Chronic Disease

Opportunities and Options

Priority	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Improve the management of chronic conditions for ageing populations and ensure adequate service provision to 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
Improve access to mental health services in the Wheatbelt. This is across the whole lifespan.	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
Increase access to suicide prevention and mental health services and promote an integrated mental health system for the Wheatbelt.	MH5 Proportion of people referred to PHN commissioned services due to a recent suicide attempt or because they were at risk of suicide followed up within 7 days of referral.	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. P12 Decrease in PPH rates. Where the rate has been stable for at least three years, the performance criteria is to maintain the existing rate of PPH.	General Practice Allied Health Providers
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

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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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info@wapha.org.au
1300 855 702
/company/wapha
/waphaphns
/WAPHA_PHNs

www.wapha.org.au