WA Primary Health Alliance
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An Australian Government Initiative

Goldfields – Esperance

Needs Assessment 2025-2027

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Goldfields – Esperance Priorities

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Chronic diseases contribute significantly to the burden of disease in the Goldfields – Esperance region. There are high rates of multimorbidity and avoidable deaths due to chronic conditions. Rates of clinician-diagnosed diabetes are above state levels. The region has high rates of risk factors for chronic conditions, particularly in the Goldfields Statistical Area Level Three (SA3). This includes high levels of obesity and smoking, and low levels of physical activity.	There are high rates of Potentially Preventable Hospitalisations (PPHs) related to chronic conditions, particularly chronic congestive failure, diabetes, chronic obstructive pulmonary disease and chronic angina. The high prevalence of risk factors related to chronic disease make it a complex population from a clinical perspective.	**Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.** **Support primary care to promote healthy weight and healthy lifestyle changes.**	Goldfields – Esperance	Population health	Chronic conditions
Cardiovascular disease is the leading cause of total disease burden in the Goldfields – Esperance region, and coronary heart disease is the leading cause of death in both the Goldfields and Esperance SA3s.	There is a high and concerning rate of PPHs for congestive heart failure in the Esperance and Goldfields SA3s, and a high rate of PPHs for chronic angina in the Goldfields SA3. Though utilisation of General Practitioner (GP) chronic disease management plans has increased over time, levels remain below national levels for remote areas.	**Enable access to best-practice management for people with coronary heart disease or chronic heart failure.**	Goldfields – Esperance	Population health	Chronic conditions
The Goldfields – Esperance region has one of the highest rates of avoidable deaths from cancer in Western Australia (WA), and cancer is the second leading cause of disease burden in the region.	Breast and cervical cancer screening are among the lowest in WA in the Goldfields SA3, and cervical screening is below state levels in the Esperance SA3.	**Improve the rates of cancer screening to reduce avoidable deaths from cancer.**	Goldfields – Esperance	Population health	Chronic conditions

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Mental health is the third leading cause of disease burden in the region, and there are high rates of clinician-diagnosed depression and anxiety.	Access to primary mental health services is limited in the Goldfields region with less than 1% of the population accessing a clinical psychologist through Medicare Benefits Schedule (MBS) services.	**Enable access to mental health services and ensure accessibility to fly-in-fly-out (FIFO) workers.**	Goldfields – Esperance	Mental health	Access
Suicide is a serious issue in the Goldfields SA3. It is the fifth leading cause of death and contributes to 4% of all local deaths.	Access to primary mental health services is limited in the Goldfields – Esperance region with less than 1% of the population accessing a clinical psychologist through MBS services and only one local provider delivering targeted suicide prevention services for the whole region.	**Enable access to mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk.**	Goldfields – Esperance	Mental health	Access Early intervention and prevention
Residents are at risk of short-term and long-term harm from alcohol use, smoking and illicit drug use. Rates of clinician-diagnosed chronic alcohol misuse and chronic drug misuse are significantly higher in Esperance compared to the state rate.	There is a high rate of alcohol and other drug (AOD)-related Emergency Department (ED) presentations in the Goldfields SA3. Despite the high level of community need, there is only one inpatient rehabilitation service in the region. Relative to other areas in the Country WA Primary Health Network (PHN), there is a moderate number of providers offering alcohol and other drug-related treatment or support in the region, all located in the Goldfields SA3.	**Enable access to screening and alcohol and other drug treatment services.**	Goldfields – Esperance	Alcohol and other drugs	Access
More people are experiencing homelessness within the Goldfields SA3. Evidence shows that people experiencing homelessness often also experience mental health issues, substance use issues and/or have at least one chronic condition.	Existing homeless health care health care services are under considerable strain and unable to expand their services due to resource constraints.	**Increase the capacity of homeless health care services to respond appropriately to the primary care needs of people experiencing or at risk of experiencing homelessness.**	Goldfields – Esperance	Population health	Access Chronic conditions

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Aboriginal people in the Goldfields – Esperance region experience some of the highest levels of socioeconomic disadvantage in WA and may be at risk of experiencing poor health outcomes related to social determinants of health.	Aboriginal people in the Goldfields – Esperance region have high rates of avoidable hospitalisation, including PPH presentations and non-urgent ED presentations.	**Enable access to coordinated culturally appropriate primary care for Aboriginal people.**	Goldfields – Esperance	Aboriginal health	Appropriate care (including cultural safety)
Childhood immunisation levels in the Goldfields – Esperance region are below the 95% target for Aboriginal and non-Aboriginal children. Minimise the risk of vaccine-preventable illnesses by ensuring children are up to date with their immunisation program.	Under-vaccination increases risk of vaccine-preventable illnesses and creates avoidable burden on primary health care and the Aboriginal health workforce.	**Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children.**	Goldfields – Esperance	Aboriginal health	Immunisation
The Goldfields – Esperance region has a growing older adult population. By 2030, in 7 Goldfields SA3 residents and 1 in 4 Esperance SA3 residents will be aged over 65. Older people are more likely to be living with a chronic condition compared to the general population, and 1 in 10 have three or more long-term conditions.	Despite having a relatively high proportion of older people, there is a low residential aged care homes (RACHs) beds-to-population ratio and limited access to home care services available in the region. Older people need support from their primary health care providers to manage chronic conditions, including multimorbidity, and to live independently for as long as possible. Compared to other parts of WA, Esperance has a low supply of nurses working in aged care compared to state rates. The growing population of older people will place increased pressure on aged care services.	**Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible.** **Enable access to age-appropriate digital health services.** **Enable access to local aged care services, including residential and at-home.**	Goldfields – Esperance	Aged care	Access Chronic conditions

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Most Australians would prefer to die at home rather than in a hospital or aged care facility. For many Aboriginal people, this includes dying at home connected to country.	There is limited home palliative care available, with many older people dying in hospitals or aged care services.	**Enable access to local at-home palliative care services, and ensure they are culturally appropriate for Aboriginal people.**	Goldfields – Esperance	Aged care	Access Palliative care

Goldfields – Esperance

Overview

The Goldfields – Esperance region includes a diverse Aboriginal community with many distinct language groups and remote communities. The pertinent health concerns in the region are mental health, chronic disease, alcohol and other drugs, and access to workforce and services, including barriers that limit the accessibility and effectiveness of digital health in the region.

Workforce and access to services is a continuing issue for all rural communities and Goldfields – Esperance is similarly impacted. The region has limited access to allied health professionals and a shortage of mental health professionals.

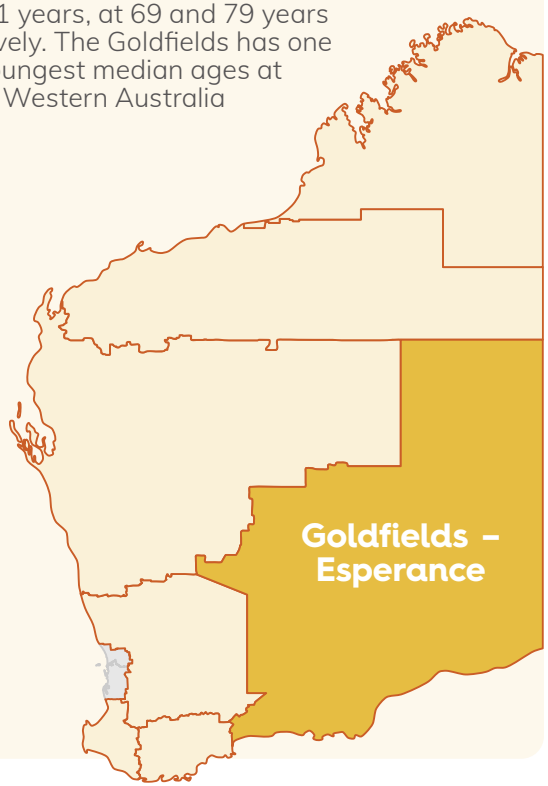
The Goldfields – Esperance region has a high rate of suicide contributing to 5% of all deaths in the region. Mental ill-health was the third leading cause of disease burden in the region but less than 1% of the population accessed a clinical psychologist through the Better Access MBS program.

The population in the Goldfields – Esperance region has a high prevalence of chronic, acute and vaccine-preventable potentially preventable hospitalisations (PPHs), particularly for chronic congestive cardiac failure, chronic diabetes complications and chronic obstructive pulmonary disease (COPD), as well as acute cellulitis, acute urinary tract infections and acute gangrene. Moreover, the region has the second highest cardiovascular burden in the state, together with a low utilisation of GP chronic disease management plans (CDMPs).

Esperance has a large and growing ageing population, but has a low residential aged care home (RACH) beds-to-population ratio with only one RACH located in the region.

Residents experiencing long-term harm from alcohol use, smoking and illicit drug use, unintentional drug-induced deaths and ED presentations related to alcohol and other drug (also known as AOD) were concerning, particularly in the Goldfields Statistical Area Level Three (SA3). Aboriginal people in the Goldfields region experience some of the highest levels of socioeconomic disadvantage, non-urgent Emergency Department (ED) presentations, unemployment, poor housing suitability and adolescents not attending secondary school.

Sadly, the median age of death in the Goldfields and Esperance SA3s is below the state median age of 81 years, at 69 and 79 years respectively. The Goldfields has one of the youngest median ages at death in Western Australia (WA).



Population demographics

The Goldfields – Esperance region spans 771,276 square kilometres and consists of two Australian Bureau of Statistics (ABS) SA3 sub-regions: the Goldfields SA3 and Esperance SA3. The Goldfields SA3 includes the towns of Kalgoorlie – Boulder, Leonora, Leinster, Laverton, Menzies, Coolgardie, Kambalda, Norseman, Ngaanyatjarraku Shire and Wiluna, and borders both South Australia and the Northern Territory. The geographical classification of the Wiluna IARE has changed over time. In 2021, it joined the Goldfields SA3, but previously fell within in the Mid West SA3. For this reason, it will be reported in both the Goldfields and Mid West regional reports, due to legacy issues of this re-classification on various data sets.

The Esperance SA3 sits between the Goldfields SA3 and the southernmost coastline of WA, and includes the towns of Esperance, Ravensthorpe, and Hopetoun.

The Goldfields SA3's economy is heavily based in mining, and is home to 40,259 people. In contrast, the Esperance SA3 has 16,700 residents and an agricultural economy, as well as an aquaculture economy along the coastal boundary. Together, the Goldfields and Esperance SA3s account for 2% of WA's population.

Social determinants of health

Social determinants of health are the conditions in which people are born, grow and live, including factors such as a person's socioeconomic position, education, neighbourhood and physical environment. These factors underpin a wide range of health and quality of life outcomes and can contribute to avoidable inequities in health care access.

The Socio-economic Index for Areas (SEIFA) provides a measure of the relative social and economic disadvantage within a region based on a wide range of indicators reflecting disadvantage, including low income, low educational attainment, high unemployment, and reliance on welfare for income and housing support.

Compared to other parts of WA (Index of Relative Socio-economic Disadvantage, IRSD = 1012), the Goldfields – Esperance region is an area of socioeconomic disadvantage. This is evident in both SA3s, however it is more pronounced in the Goldfields SA3 (IRSD=969) compared to the Esperance SA3 (IRSD=996).

Approximately 1 in 10 Goldfields SA3 residents (9%) live in social housing, which is above the state rate of 3%. A similar proportion (10%) are in low income, welfare-dependent families with children, compared to 5% in WA overall. In contrast, 4% of Esperance SA3 residents live in social housing and 6% are in low income, welfare-dependent families with children.

Approximately 1 in 7 (15%) of residents in the Goldfields SA3 identify as Aboriginal and Torres Strait Islander (Aboriginal), compared to 1 in 17 (6%) residents in the Esperance SA3.

Under-served population groups

People at risk of avoidable, unjust health inequities are more likely than the general population to experience poor health outcomes due to physical, social, and economic factors, and include people who are multicultural; LGBTIQA+; experiencing homelessness; living with a severe disability or caring for someone with a disability; developmentally vulnerable; and victims of family, domestic or sexual violence.

The Goldfields – Esperance region has a number of under-served people who are at risk of poor health outcomes. Specifically:

- Nearly 4,000 Goldfields SA3 residents were born in a non-English speaking country, equating to 10% of the local population. Further, 738 Esperance SA3 residents were born in a non-English speaking country, representing 5% of the local population. These compare to 18% across WA.
- 3% of residents in the Goldfields SA3 and 5% in the Esperance SA3 have a profound or severe disability, compared to 5% across the state.
- 7% of residents in the Goldfields SA3 and 10% in the Esperance SA3 provide unpaid assistance to people with a disability compared to 11% across WA.
- 29% of children in the Goldfields SA3 and 18% in the Esperance SA3 are developmentally vulnerable on one or more domains, compared to 20% across WA.
- An estimated 489 people in the Goldfields SA3 and 62 people in the Esperance SA3 are experiencing homelessness. This equates to 98 people per 10,000 residents and 39 per 10,000 respectively; above the state rate of 36 per 10,000. This includes people living in overcrowded dwellings.

Multicultural populations

A bespoke review into the needs of multicultural people in WA identified that they face significant challenges accessing primary health care, including difficulties navigating the health care system, financial barriers and linguistic barriers when making appointments, articulating their health concerns and understanding medical terminology. Service providers require more training to effectively and appropriately support multicultural patients, including greater understanding of different cultures and the importance of using plain language or interpreters. Mental health, psychosocial support and vaccinations were identified as key needs for multicultural people.

For many multicultural communities, mental health is a significant issue, including comorbidity with alcohol and other drugs, and trauma. Some multicultural patients hesitate in seeking health care related to psychological concerns for fear of stigma, and difficulties in articulating their concerns.

Vaccinations can be difficult for migrants to plan for on arrival, as patient medical records are often inaccessible or need to be translated. This is significant for all migrants, particularly children, whose vaccinations must be aligned to the appropriate vaccine schedule.

Psychosocial strategies to provide a sense of connection and build independence are important for many people within multicultural communities, including support to set up a bank account, access Centrelink, improve English and obtain a driving license. These skills are critical in overcoming some of the barriers multicultural people face in accessing health care. There is a need to provide this connection and support in a safe and culturally appropriate setting and in a targeted manner to aid the transition to life in Australia.

There are two primary health care services specialising in care for the multicultural population in the Country WA region, located in the Goldfields SA3 and East Pilbara SA3. The Goldfields SA3

(Composite Index Score, CIS=0.27) has the fourth highest level of unmet need for multicultural services in WA, driven by a considerable local population of people from multicultural communities (40,259) and one of the highest proportions of people born in a predominantly non-English speaking country (10%) in the Country WA region. In contrast, the Esperance SA3 has the lowest level of unmet need for multicultural services in WA (CIS=-0.74).

LGBTIQA+ populations

Many LGBTIQA+ people face discrimination and disparities connected to their gender identification and/or sexuality that impact their physical and mental health and access to health care and other services. Whilst not all LGBTIQA+ people experience challenges in their lives, many do, and LGBTIQA+ people are known to have a higher risk of certain chronic diseases such as cancers, asthma and cardiovascular disease. Studies indicate that LGBTIQA+ people experience intimate partner violence at similar or higher rates compared to heterosexual people.

The Private Lives survey is Australia's largest national survey of the health and wellbeing of LGBTIQA+ people to date. In the latest results, LGBTIQA+ people reported lower self-rated health status than the general Australian population, with fewer than 1 in 3 (31%) rating their health as very good or excellent compared to more than half (56%) of the general Australian population aged over 15 years. Two in five (40%) cisgender men rated their health as very good or excellent compared to only 29% of cisgender women, 26% of trans women, 20% of non-binary participants and 19% of trans men.

More than a third (39%) of participants reported living with a disability or long-term health condition. When accessing a health or support service, 30% of those with a severe disability or long-term health condition felt accepted compared to LGBTIQA+ people who did not report a disability or long-term health condition (51%). More than three quarters (78%) with a severe disability or long-term health condition reported being treated unfairly by others in the past 12 months because of their disability or long-term health condition. This was followed by 56% of people with a moderate disability or long-term health condition and 43% with a mild disability or long-term health condition.

More than 4 in 10 (42%) of young Australian trans people have encountered medical services who did not respect, understand or have prior experience with gender diverse people. Please refer to the Mental Health section for further details about mental health and suicide prevention for LGBTIQA+ populations.

Local intelligence has highlighted supply-side challenges, including limited understanding and education within the health sector about trans and intersex people. Significant proportions of LGBTIQA+ people do not feel they can safely disclose their LGBTIQA+ identity to GPs or have been misgendered in practices. It can be difficult to find LGBTIQA+ friendly services due to lack of advertising or promotion; subsequently many rely on word of mouth for this. Improved training and promotion of LGBTIQA+-friendly practices would be welcomed by the LGBTIQA+ community to address these issues.

It is important to note that there is a critical lack of research into the area of health of LGBTIQA+ people at an Australian population level. Furthermore, each sub-group within the LGBTQIA+ population has its own unique health care needs, and it is inaccurate to treat these needs as homogenous across the LGBTIQA+ population. However, the lack of data, especially at a regional level, significantly limits the ability to identify and address the specific needs of each group – something WAPHA will continue to lobby to improve. Some needs relevant across the LGBTIQA+ population include:

Clinical

Access to appropriate:

- **Health and medical care** that is inclusive, delivered by health care providers trained to deliver LGBTIQA+ affirming care, such as using correct names and pronouns and understanding gender identity and sexual orientation.
- **Preventive care**, such as tailored cancer screenings (e.g., cervical cancer for transgender men, prostate exams for transgender women) and routine health checks that address unique risk factors for different sub-groups.
- **Mental health support** delivered by culturally competent mental health providers who understand the unique stressors LGBTQIA+ individuals can experience, including stigma, discrimination, and identity-related challenges.

Cultural

- **Respectful, non-judgemental treatment:** health care free from stigma and discrimination, ensuring all LGBTQIA+ patients feel safe and respected.
- **Relevant and affirming health information:** Resources that reflect and respect LGBTQIA+ identities, such as educational materials on sexual health, mental well-being, and healthy relationships.
- **Community support and peer networks:** Programs that connect LGBTQIA+ individuals to peer groups, mental health resources, and LGBTQIA+ community organisations that provide culturally relevant support.
- **Visibility of LGBTQIA+ friendly signage:** Clear signs, symbols, and inclusive language in health care facilities to signal a safe space for LGBTQIA+ patients.

Organisational

- **Inclusive policies and protocols** (e.g. anti-discrimination policies, use of inclusive terms on health care forms).
- **Ongoing cultural competency and LGBTQIA+ sensitivity training** for all health care workers.
- **Improved data collection** on LGBTQIA+ health needs (e.g., sexual orientation and gender identity data in patient records), helping to inform equitable policy and service delivery.
- **Collaboration across LGBTQIA+ organisations** to create referral networks, share resources, and ensure service delivery aligns with community needs.
- **Strict adherence to confidentiality policies**, especially regarding sensitive information related to gender identity and sexual orientation, to build trust with LGBTQIA+ patients.

Further information regarding health care standards in Australia that support the LGBTIQA+ community can be found at:

- *Australian Charter of Health Care Rights – LGBTQI+*
- *Rainbow Tick guide to LGBTI-inclusive practice*
- *Australian Medical Association (AMA) LGBTQIASB+ Position Statement*
- *Australian Health Practitioner Regulation Agency (AHPRA) LGBTIQA+ Communities guidance for health practitioners*
- *General Practice Supervision Australia (GPSA) LGBTQIA+ Health and Inclusive Health care.*

People experiencing homelessness

State-wide, health care barriers exist for people at-risk of or experiencing homelessness. A bespoke study into the needs of these people identified that many have had poor experiences with GP clinics and feel unheard when accessing primary health services. Experiences of fear, shame, and stigma were reported, often compounded by a clinical environment where some people feel out of place or unwelcome. Other barriers, including difficulty interacting with non-clinical staff (e.g., reception, security), fear of losing possessions to attend mainstream services, and financial barriers can also make it difficult for patients to make an appointment and see a clinician. Long wait times for appointments, transport availability and lack of fixed address mean keeping appointments is difficult.

Dual diagnoses and comorbidity can create complexities in accessing health care services, impacting eligibility for certain services and resulting in individuals feeling like they are being passed between different service providers in search of the right care. People experiencing homelessness indicated that it can be difficult to find the language to talk to clinicians about their concerns, and that clinicians may try to "fix everything all at once" as opposed to one thing at a time.

In WA, 68% of the homeless population have at least one chronic health condition, 68% are living with mental health challenges, and 62% have a substance use disorder. More than one third (38%) have poor health from all three of these concerns (physical, mental and substance issues).

The areas of greatest need for homelessness support are the Kimberley, East Pilbara, Gascoyne and Goldfields SA3s. The unmet need in the Goldfields SA3 (CIS=0.57) is driven by its high rate of homeless persons and high proportions of people experiencing socioeconomic disadvantage. In contrast, the Esperance SA3 has one of the lowest levels of unmet need for homelessness services in the Country WA region (CIS=-0.69).

People experiencing family, domestic and sexual violence

The Australian National Plan to End Violence against Women and Children 2022 – 2032 aims to end gender-based violence by way of prevention, early intervention, response, and through recovery and healing. Aligning with this, WA's Family and Domestic Violence Prevention Strategy details initiatives to prevent and respond to family, domestic and sexual violence. The key outcomes of this strategy are prevention and early intervention; safety for victims through timely and accessible services; and accountability for perpetrators and support to cease violent behaviour.

One in six Australian women and one in eighteen men (since the age of fifteen) have been subjected to physical and/or sexual violence by a current or previous cohabiting partner. Moreover, one in six women and one in nine men were physically or sexually abused before the age of 15 years. The following groups have been identified as being more at risk to family, domestic and/or sexual violence:

- women
- children
- people living with a disability
- Aboriginal people
- people from multicultural backgrounds
- people in rural and remote Australia
- older people
- LGBTIQA+ people
- people experiencing socioeconomic disadvantage

In 2018, partner violence was ranked as the fourth leading risk factor contributing to total disease burden for women aged 15-44, with child abuse and neglect during childhood being the leading risk factor. Family and domestic violence is also a leading cause of homelessness. In 2022-2023, approximately 104,000 (38%) of clients assisted by specialist homelessness services (SHS) had experienced family and domestic violence and of these, more than three in four (75%) were female.

WA Police statistics indicated that in the 12 months from July 2023 to June 2024, there were 1,749 reports of family related assault in the Goldfields – Esperance region, equating to an average of 146 reports per month.

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

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 the 2021 Census, the age-standardised rate (ASR) per 100 of Aboriginal people who reported they had one or more long-term health conditions was 25.7 Aboriginal people.

Prevalence of chronic disease

For the first time in 2021, the Census collected information on ten common long-term health conditions in Australia, which included arthritis, asthma, cancer (including remission), dementia (including Alzheimer's disease), diabetes (excluding gestational diabetes), heart disease (including heart attack or angina), kidney disease, lung conditions (including COPD or emphysema), stroke, and mental health conditions (including depression and anxiety). In the 2021 Census, 19% of all West Australians (484,000) reported they have one of the above conditions and 5% reported they have two of the selected conditions.

The Goldfields SA3 has a concerning level of chronic disease among its residents, and the highest or second highest rate in the Country WA Primary Health Network (PHN) for six of the ten chronic conditions reported by the Census. Specifically, it has the highest ASR per 100 people for heart disease at 4.0 people per 100, and for lung conditions at 2.0 per 100. It also has the second highest ASR in the Country WA PHN for diabetes (5.8 per 100), kidney disease (1.3 per 100), stroke (0.9 per 100) and dementia (including Alzheimer's Disease) (0.8 per 100). Each of these exceeds the state rate:

	ASR per 100 people	
	Goldfields SA3	WA
Heart disease (including heart attack and angina)	4.0	3.7
Lung conditions (including COPD)	2.0	1.7
Diabetes (excluding gestational diabetes)	5.8	4.5
Kidney disease	1.3	0.8
Stroke	0.9	0.9
Dementia (including Alzheimer's disease)	0.8	0.7

In comparison, chronic disease in the Esperance SA3 is less of relative need overall, however, it does exceed the WA level for people reporting they have asthma, with 8.1 people per 100 in the SA3, compared to 7.4 per 100 across WA.

Using WAPHA's new method of estimating condition prevalence from general practice data, rates of clinician-diagnosed diabetes were significantly higher than the state level of 7.9% in the Esperance and Goldfields SA3's at 9.0% and 8.7% respectively.

Local intelligence highlighted concerns that certain chronic conditions with significant community need in the Goldfields SA3 may be under-reported, specifically diabetes, cardiology and respiratory-related illnesses. Specifically, it was noted that there is under-reporting across multiple sources of the high local need for cardiology, and that the lack of a sophisticated data reporting system has contributed to some surprising conclusions about the Goldfields SA3 not being a diabetes hotspot. Local providers challenge this and noted that anecdotally the Goldfields is the bariatric capital of WA. Furthermore, local subject matter experts highlighted the high prevalence of respiratory issues in the Goldfields SA3. There is a shortage of affordable, publicly available cardiology services in the Goldfields and travelling to Perth for cardiology services can be challenging. As a result, people aren't seeking treatment and can end up in the hospital ED for something that could be managed in the primary health care system if the existing local barriers can be addressed. This is less of an issue in the Esperance SA3, which is serviced by outreach cardiology services.

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. Risk factors for chronic disease tend to be more prevalent in areas experiencing socioeconomic disadvantage and in regional and remote areas.

Concerningly, the Goldfields – Esperance region has significantly higher rates of risk factors compared to the state levels, particularly in the Goldfields SA3. This includes high levels of residents experiencing obesity, smoking tobacco and not engaging in any physical activity for leisure purposes.

The estimated prevalence for people experiencing obesity is significantly higher in both the Goldfields and Esperance SA3s compared to the WA rate of 36%. Concerningly, nearly 1 in 2 (47%) residents in the Goldfields SA3 are experiencing obesity -

the highest rate in the Country WA PHN overall and second highest in WA, after Kwinana at 50%. Obesity levels are also of concern in the Esperance SA3, with 2 in 5 (39%) residents living with obesity.

The Goldfields SA3 has the highest proportion of residents not engaging in any physical activity for leisure purposes in WA, with this accounting for 25% Goldfields residents compared to 17% of Western Australians overall. The Esperance SA3 is also above the state rate at 21%.

Both the Goldfields and Esperance SA3s have prevalence levels above the state rate of 11% for smoking. Approximately 1 in 5 (19%) Goldfields SA3 residents currently smoke, which is the third highest rate in WA overall. In Esperance SA3, approximately 1 in 8 (14%) residents currently smoke.

While high blood pressure is not a significant need in the Goldfields – Esperance region relative to other parts of WA, approximately 1 in 5 residents have high blood pressure in both the Goldfields and Esperance SA3s (20% and 19% respectively, compared to 23% across WA).

Reported stress levels in the Goldfields SA3 are above the state rate, with nearly one quarter (22%) of residents reporting stress, compared to 12% across WA.

Healthy Weight Action Plan

WAPHA is a steward of the WA Healthy Weight Action Plan 2019-24, which focuses on early intervention of people identified as at-risk of becoming overweight and management of people who currently live with obesity. This involves multi-component, multi-levelled strategies delivered as part of an integrated shared care model. Through the Healthy Weight GP project, WAPHA has committed to supporting GPs to provide options for patients who want to improve their health. Key deliverables include the development of a weight management 'hub' (website) with links to Clinical Referral 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.

Local Government Public Health Plan

The City of Kalgoorlie – Boulder Public Health Plan 2023-2027 details six public health priorities for the region and outlines the strategies to support the community in achieving optimal health. The six priorities are Aboriginal wellbeing; reduction of drug misuse, tobacco and e-cigarettes; mental health support; increasing access to affordable housing; increasing access to nutritious, affordable food, and environmental health protection. Actions are underway for each priority.

The Shire of Esperance Public Health Plan 2021-2026 aims to inform and empower people to make positive health choices which enhance their physical and mental wellbeing by promoting healthier options and advocating against challenging behaviors. Key actions include making educational material available on the Shire's website; enhancing outdoor public fitness equipment; supporting community markets and other food security and sustainability initiatives; and partnering with local, state, and federal health promotion bodies and campaigns to facilitate and help promote physical exercise and active living.

Burden of disease

Burden of disease measures the impact of different diseases or injuries on a population. It combines the years of healthy life lost due to living with ill health (non-fatal burden) with the years of life lost due to dying prematurely (fatal burden) to give a total burden reported using the disability-adjusted life years (DALYs) measure. Chronic disease accounts for two thirds (67%) of the burden of disease in WA.

The Western Australian Burden of Disease Study indicated that the Goldfields – Esperance region had a 1.4 times higher rate of fatal burden and a 1.1 times higher rate of non-fatal burden compared to WA's metropolitan regions. The Goldfields – Esperance region had the second highest cardiovascular burden in the state (after Kimberley), accounting for 17% of the total burden in the region. Coronary heart disease, COPD and backpain were also among the five leading causes of disease burden, along with suicide/self-inflicted injuries and lung cancer for males and anxiety disorders and dementia for females.

Leading causes of total disease burden in the Goldfields – Esperance region

Condition	%	ASR per 1,000
Cardiovascular	17%	37.6
Cancer	16%	34.2
Mental	15%	27.8
Injury	13%	23.9
Musculoskeletal	9%	18.4

Potentially preventable hospitalisations for chronic conditions

Potentially preventable hospitalisations (PPHs) are certain hospital admissions that could have potentially been prevented by timely and adequate health care in the community. Chronic conditions that are classified as potentially preventable through behaviour modification, lifestyle change and timely care include: angina, asthma, COPD, congestive cardiac failure, diabetes complications, hypertension and iron deficiency anaemia. This report includes insights from public hospital data.

Across the state, the ASR of PPHs for total chronic conditions was 903 per 100,000 and the highest rates were for chronic congestive cardiac failure (196), chronic obstructive pulmonary disease (184) and chronic diabetes (178).

Relative to other parts of WA, the Goldfields SA3 has a higher rate for total chronic conditions (1,632 people per 100,000, compared to 903 per 100,000 across WA). This is driven by higher rates in the Goldfields SA3 compared to WA for COPD (378 vs. 184), congestive cardiac failure (420 vs. 196) and diabetes (399 vs. 178). Similarly, the Esperance SA3 exceeds state rates for total chronic conditions (1,037 per 100,000), driven by higher rates for COPD (222 vs. 184), congestive cardiac failure (229 vs. 196) and diabetes (186 vs. 178). The Esperance SA3 also has a high rate of PPHs due to iron deficiency anaemia compared to the state rate (285 vs. 140).

Management of chronic disease in primary care

Chronic Disease Management Plans (CDMPs) are Medicare-rebated for GPs to manage chronic or terminal medical conditions, including preparing, coordinating, reviewing or contributing to chronic disease management plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Across WA, 14% of residents have utilised a GP CDMP. Residents of the Goldfields and Esperance SA3s have comparatively lower utilisation, at 11% and 6% respectively.

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 Australian Immunisation Register (AIR) from 1January 2023 to 31 December 2023 indicated that in the Country WA PHN, childhood immunisation coverage was comparable to the state average for all ages (1, 2 and 5 years), but was still below the 95% target. Approximately 90% of children were fully immunised at 1 year and 92% at 5 years, compared to only 87% at 2 years.

AIR reports that the Esperance SA3 met the 95% immunisation target for children aged 2 years but fell slightly below target for children aged 1 and 5 years at 94% each. In contrast, the Goldfields SA3 were below target across all ages, being 90% for children aged 1 year and 2 years, and 94% for children aged 5 years.

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 2020-21, cancer screening participation rates in the Goldfields SA3 were concerningly low, well under state levels and among the lowest in WA. Only one in four (27%) eligible residents had participated in bowel cancer screening, compared to the state level of 42%, which in itself is low. Approximately 2 in 5 (42%) had partcipated in breast cancer screening (compared to 51% across WA), and one in two (52%) had participated in cervical cancer screening, compared to the state level of 69%. The Esperance SA3 also fell below state levels for cervical cancer screening at 60%, but exceeded state levels for bowel and breast cancer screening of eligible residents at 44% and 60% respectively.

These levels are particularly concerning given the rate of avoidable deaths from cancer in both the Goldfields and Esperance SA3s exceed state levels. Please note, participation in the new five-year program for cervical cancer screening cannot be accurately reported until there are 5 years of data available.

Syphilis rates

The number of infectious syphilis notifications in WA has remained stable with 1,037 in 2022-2023. Encouragingly, crude rates of notifications across WA have dropped from 31.8 to 28.8 per 100,000 based on completed enhance surveillance forms from notifying clinicians. Those aged 25-34 years had the highest percent of infectious syphilis notification from 2022-2023, accounting for over a third of the notifications (38%). At 72.9 per 100,000, the rate of syphilis notifications in the Goldfields – Esperance region was more than double the state rate of 28.8 per 100,000; an increase of 47% when compared to the previous period (2021-2022).

Avoidable mortality

Avoidable mortality refers to deaths of people under 75 years from conditions that are potentially preventable or treatable through primary/hospital care. The rate of avoidable deaths in the Goldfields and Esperance SA3s exceed the state rate of 117.6 per 100,000 at 229.2 and 139.3 per 100,000 respectively. The Goldfields SA3 has the highest rate of avoidable deaths from breast cancer in WA (21.7 vs. 14.0 per 100,000 across WA) and the second highest rate for ischaemic heart disease (58 vs. 21.6 per 100,000 across WA). The Esperance SA3 has the second highest rate of avoidable deaths from colorectal cancer in WA at 13 per 100,000; above the state rate of 9 per 100,000.

The five leading causes of death and their percentage with respect to all death causes within the Goldfields and Esperance SA3s are:

Rank	WA	Esperance	Goldfields
1	Coronary heart disease (11%)	Coronary heart disease (15%)	Coronary heart disease (13%)
2	Dementia (including Alzheimer's) (9%)	Dementia (including Alzheimer's) (7%)	Lung cancer (6%)
3	Cerebrovascular disease (5%)	Lung cancer (6%)	COPD (6%)
4	Lung cancer (5%)	Diabetes (5%)	Land transport accidents (5%)
5	COPD (4%)	Cerebrovascular disease (5%)	Suicide (5%)

Utilisation of primary care services

GP utilisation in the Goldfields and Esperance SA3s are below state levels and declined between 2021-2022 and 2022-2023. In 2022-2023, approximately three quarters of residents in the Goldfields (72%) and Esperance (76%) SA3s visited a GP; compared to 84% across WA. This was a reduction from 2021-22 levels, where 80% of Goldfields residents and 81% of Esperance residents had utilised a GP.

The PHN After-hours Program aims to improve access to GP services in the after-hours period, being before 8am and after 6pm weekdays; before 8am and after 12pm Saturday; and all-day Sunday and public holidays, particularly for people at risk of or experiencing homelessness.

A targeted analysis on need, unmet demand and supply indicators was undertaken to assess relative local demand for after-hours care. A composite index score (CIS) was calculated based on the after-hours demand and supply indices, with each SA3 in WA ranked by relative demand from highest to lowest score.

In the Country WA region, there are 146 primary health services open after-hours, contributing 17% of all after-hours primary health services in WA. Primary health services collectively operate for 29 hours weekly per 10,000 population; below the state level of 45 hours. There are 11 MBS after-hours GP services (urgent and non-urgent) claimed per 100 people across WA. This was highest in the Goldfields SA3, at 22 per 100 people, and reflects the availability of local after-hours services. For this reason the Goldfields – Esperance region is not a significant area of need for after-hours care relative to other parts of WA. The Goldfields SA3 (CIS=-0.27) is placed ninth out of the thirteen SA3s in the Country WA region for unmet after-hours need, while the Esperance SA3 (CIS=-0.81) is eleventh.

Stakeholder consultations further revealed two insights for after-hours primary health care across WA. First, operating after-hours services is not financially viable for most GP practices, with prevalent financial barriers including insufficient MBS incentivisation for after-hours services, financial risk due to unpredictable demand in after-hours patient volume and, workforce constraints due to inability to incentivise staff to work during the after-hours period. Second, the Royal Commission into Aged Care Quality and Safety recommendations have increased demand for after-hours GP care for residential aged care (RAC) providers. The stronger regulation of RACs to ensure older people receive appropriate care relative to their needs has increased the reliance of RACs on GPs, resulting in an increase in the number of calls made by RACs to GPs during the after-hours period due to fear of potential repercussions if the RACs fail to report or respond to medical incidents, irrespective of the severity of the health concern presented.

Residents of the Goldfields SA3 have greater utilisation of GP health assessments compared to the state (7% vs. 5%). In contrast, the Esperance SA3 has the lowest utilisation in WA, at only 2%. Please note, these data only include Medicare-subsidised services, and it is not currently possible to obtain data by type of health assessment.

The majority of Medicare-subsidised allied health services are for optometry services, and Medicare-subsidised allied health services only account for a portion of allied health service use in Australia. This is because they are only available to patients with a GP or specialist referral, and exclude non-Medicare subsidised services, such as those provided by Aboriginal health services and other non-government organisations.

Medicare-subsidised nurse practitioner services are not heavily used in the region. The latest data reports that 3% of Esperance SA3 residents have used a nurse practitioner service, equal to the state rate. Data for the Goldfields SA3 is suppressed, with this occurring when there are fewer than 6 patients, less than 20 attendances or where one provider has delivered more than 85% of services.

The nursing and Aboriginal health worker service group consists of Medicare-subsidised services delivered by a nurse practitioner, practice nurse, midwife or Aboriginal health worker. Approximately 1 in 14 (7%) residents in the Goldfields SA3 used a Medicare-subsidised practice nurse/Aboriginal health worker, equal to the state rate. There is lower utilisation in the Esperance SA3, at 4%.

Access Relative to Need 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 Full Time Equivalent (FTE) working at each location.

- The demographic and socioeconomic characteristics of the population.
- In 2024, WAPHA updated the ARN index to identify areas with a low access to GPs relative to need.

Relative to other areas in WA, there is moderate access to GP services across the Goldfields – Esperance region. Overall, 30% of SA3s across WA have higher access relative to need compared to the Goldfields SA3, while 50% of SA3s across WA have higher access relative to need than Esperance SA3.

Consumer views of accessing GPs

To better understand the experiences of Western Australians experiencing socioeconomic disadvantage accessing primary health care, particularly GPs, when they need it, WAPHA commissioned consumer research in 2021.

Most people experiencing socioeconomic disadvantage were able to access a GP when needed. Although 31% of respondents encountered barriers when visiting a GP, 92% had visited a GP within the last year. However, approximately 1 in 10 respondents (11%) had needed a GP on at least one occasion but had not visited one. This was higher among Aboriginal people (22%), people aged 18-39 (20%), those living with disability (16%) and females (15%). The main reasons these people needed a GP were illness, concerns about mental health, to get a prescription and to help with the management of a long-term health condition. Only 8% of these people sought help from an alternative health care professional, such as a pharmacist. A lack of available appointments was the main reason for not seeing a GP when needed, cited by nearly half (43%) of this group. A further 25% reported a lack of time and other commitments, while 16% felt afraid of being judged.

Among the full sample, the most common reason to visit a GP was to get a prescription (53%), followed by managing a chronic condition (28%) and general check-up (25%).

Accessibility factors such as appointment availability were the most cited barrier to accessing a GP, followed by transportation issues and conflicting commitments. Women, people with young children, young people, people from multicultural communities, people living with a disability and Aboriginal people were most likely to experience barriers.

Cost did not appear to play a large role in limiting access to a GP, with only 1 in 10 (10%) mentioning it as a barrier. This finding is attributed to over 80% of the survey cohort indicating that their GP service was bulk billed. If the availability of bulk billed appointments decreased this would seriously impact access to a GP for people experiencing social and economic disadvantage.

The impact of having a regular GP on a patient's experience was clear. Respondents with a regular GP reported finding it significantly easier to visit their GP and were significantly more likely to have had a positive experience, even compared to those with a regular GP practice, but not a regular GP.

Nearly 9 in 10 (87%) prefer attending a GP appointment in person but 2 in 3 (67%) would be comfortable with a telehealth appointment under some circumstances, such as for follow-up appointments.

Workforce

General practitioners

Accurate, up-to-date GP FTE figures are unavailable, so the Department of Health and Aged Care comprised a proxy measure which calculates a GP's workload based on MBS services claimed, with one GP FTE representing a 40-hour week over 46 weeks of the year. For each Medicare provider, the new measure attributes an estimate of the amount of time they have spent on their claims in relation to what would be worked by a fulltime GP (billable time, non-billable time, and non-clinical time). It is an estimation of GP workforce service utilisation and not an exact count of GP FTE available. For this report, we will refer to this measure as the GP Claimed Service Equivalent (GPCSE).

Based on the latest data, the Goldfields SA3 has 77 GPCSE per 100,000 residents and the Esperance SA3 has 71 GPCSE per 100,000. Each of these is below the state rate of 102 per 100,000.

In addition to their normal remuneration, GPs can access additional financial incentives based on how remote the location in which they work is. Areas are classified from metropolitan through to rural, remote and very remote.

Compared to other areas in WA, Kalgoorlie – Boulder and Warburton GP catchments are noted as being of particularly high need for GP workforce, largely due to recruitment challenges linked to the financial incentives locally available. Kalgoorlie is an isolated, inland city located 595km east of Perth, anecdotally comparable to Alice Springs. However, it is classified as a large rural town, while Alice Springs is classified as a remote community, thereby offering higher levels of financial incentives and other supports to attract GPs to the region. The current classification of Kalgoorlie – Boulder and Warburton is proving detrimental to attracting GP Registrars to the catchment, and efforts advocating for a change to its classification are underway. The affordability of housing in the area also presents a barrier to GPs choosing to reside in the area, with the average weekly rental cost being $390 (and in some areas up to $564); above the median cost of $355 per week across Country WA GP catchments. There is capacity to locally train GP Registrars if these barriers can be overcome, and financial incentives are made available to support GP Registrars in relocating.

Based on its geographic access to health services, the Warburton GP catchment (within the Goldfields SA3) is classified as very remote, and there is currently a low supply of GP workforce. A high proportion of residents are experiencing socioeconomic disadvantage, with 80% in the most disadvantaged quintiles in WA. Approximately three quarters (78%) of residents identify as Aboriginal.

There are financial incentives available to support GP Registrars in undertaking training in Warburton, available via remote supervision from one accredited general practice. However, housing availability presents a significant challenge, with the latest data showing no residential vacancies in the mainstream market.

Norseman (based in the Goldfields SA3) has relatively high need for GP workforce, with one local general practice and the ability to accept GP Registrars immediately. A high proportion of residents are experiencing socioeconomic disadvantage, with 82% in the most disadvantaged quintiles in WA. Approximately 1 in 5 (22%) residents identify as Aboriginal.

Within the Esperance SA3, the GP catchments of Esperance and Hopetoun are classified as having relatively high need for GP workforce. The Esperance GP catchment has four local general practices, all of which are accredited to train GP registrars. More than half of residents fall within WA's most disadvantaged socioeconomic quintiles. The Hopetoun GP catchment has three local general practices, of which two are accredited to accept GP Registrars. It has a relatively high level of socioeconomic disadvantage, with approximately 2 in 3 (67%) residents falling within the most disadvantaged quintiles. To increase GP workforce in Leinster – Leonora (located in the Goldfields SA3), local general practices require support to become accredited training facilities.

Primary care nurses

The Goldfields SA3 has a relatively high supply of primary care nurses at 155 primary care nurse FTE or 385 FTE per 100,000 residents compared to 251 FTE per 100,000 across WA. In contrast there is a lower supply of primary care nurses in the Esperance SA3, which has 31 FTE or 187 FTE per 100,000.

Aged care

The Goldfields region has a large and growing aged population. In 2022, there were 3,742 people aged 65 years and over in the Goldfields SA3 and 3,198 in the Esperance SA3, representing 9.3% and 19.1% of the population respectively. This is projected to increase to 13% of the population in the Goldfields SA3 and 26% in the Esperance SA3 by 2030 compared to 18% across the state and 20% across the Country WA PHN.

Age is an important determinant of health and people aged 65 years and over are more likely to have complex and/or chronic conditions as well as comorbidities. Moreover, geriatric syndromes later in life (usually after the age of 85 years), including pressure ulcers, incontinence, falls, and delirium have substantial implications for quality of life as well as health care utilisation.

The Western Australian Burden of Disease Study 2018 reported that the five leading causes of disease burden for older people aged 65 to 84 years were coronary heart disease, COPD, lung cancer, dementia and type 2 diabetes mellitus. For older people aged 85 years and over, dementia was reported as the leading cause of total burden of disease.

The 2021 Census reported that 10% of Western Australians aged 65 years and older have three or more long-term health conditions. This was similar in the Goldfields and Esperance SA3s, with 11% and 9% of residents aged 65 years and older living with three or more long-term health conditions.

Approximately 3 in 5 (59%) general practice patients aged 65 years or older were diagnosed with three or more chronic conditions across WA. The Esperance SA3 has the second highest proportion in the Country WA PHN with approximately 2 in 3 (64%) diagnosed with three or more chronic conditions. In contrast, the rate in the Goldfields SA3 is slightly below the state level at 56%. Please note, this data includes private general practices only and does not include GP services provided by non-government organisations.

Utilisation of health services

Across WA, approximately 2 in 5 (39%) of people aged 80 years and over had a GP Health Assessment in 2022-2023.

In residential aged care homes (RACHs) there were 15.5 GP attendances per patient across WA. The rate in the Country WA PHN overall was similar at 15.0 attendances per patient.

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. General practice data indicate that approximately 1 in 4 (28%) of patients aged 75 years and over across WA have had a GP health assessment. The Goldfields and Esperance SA3s each fall below the state rate at 20% and 14% respectively.

The Royal Commission into Aged Care Quality and Safety noted that people receiving aged care, particularly those in residential aged care, do not consistently receive the health care they need. This includes doctor visits, mental health services, oral and dental health care, and preventative and holistic care.

Palliative care

The goal of palliative care is to improve the quality of life of patients with an active, progressive disease that has little or no prospect of a cure.

Most Australians would prefer to die at home, rather than in hospital or residential aged care. However, many older people use both hospital and aged care services in their final years of life and often die in one of these settings.

The Royal Commission into Aged Care Quality and Safety made key recommendations for palliative care including:

- Compulsory palliative care training for aged care workers.
- Comprehensive sector funding specifically including palliative care and end-of-life care.
- A review of the Aged Care Quality Standards to regulate high quality palliative care in residential aged care.
- Access to multidisciplinary outreach services; and a new Aged Care Act that includes the right to access palliative care and end-of-life care.

From 1 October 2022, a new funding model, the Australian National Aged Care Classification (AN-ACC) replaced the Aged Care Funding Instrument (ACFI). The AN-ACC provides equitable funding through three components to approved residential aged care providers based on the service type delivered and each residents' care needs.

Primary Health Networks will receive funding from the Greater Choice for At-home palliative care Program to improve palliative care coordination in their local communities.

In 2022, there were 27.7 total FTE Palliative Medicine Physicians and 333.2 FTE Palliative Care Nurses employed in WA. Whilst it is recognised that the palliative care workforce is made up of a broad range of professional groups including other medical specialists and allied health professionals, the existing national data sources cannot accurately capture information on palliative care services provided by these health professionals, hence have not been reported.

Palliative care nurses across WA are working 65.0 total weekly hours per 1,000 patients aged 75 and over. The rate is similar in the Goldfields SA3, and below state levels in Esperance SA3 at 65.6 and 80.2 total weekly hours per 1,000 aged 75 and over respectively. Palliative Medicine Physicians across WA are working 5.7 total weekly hours per 1,000 aged 75 and over. Data was not provided for the Goldfields and Esperance SA3s because there were no palliative medicine physicians working in either region as a primary location.

Aged care services

The aged care system in Australia offers three main types of service: the Commonwealth Home Support Programme (CHSP), the Home Care Packages (HCP) program, and residential care. Across Australia, more than two-thirds of people using aged care services access support from home.

Commonwealth Home Support Programme

The CHSP provides entry-level support for older people so they can continue to live independently at home. For FY 2022-2023 in WA, domestic assistance had the highest number of clients serviced and had the highest expenditure; however, social support groups had the highest amount of services provided by hours.

Home Care Packages program

The HCP program provides structured 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.

There are currently four home care services in the Goldfields SA3, being Juniper, Amana Living, Lifecare and Coolgardie Community Care. Similarly, there are three home care providers in the Esperance SA3, being Chorus, Brightwater at Home and Esperance Home Care. As at December 2023, there were 201 people in an HCP in the Goldfields Aged Care Planning Region (ACPR), which includes the Esperance SA3, and a further 45 people waiting for an HCP at their approved level.

WA has 249 residential aged care services with a total of 19,887 residential places. Despite having a relatively high proportion of elderly population, the Esperance SA3 has a low beds-to-population ratio with only one residential aged care home located in the region at 45 beds per 1,000 people aged 70 years and over; below the state rate of 64 per 1,000. In contrast, the Goldfields SA3 has three residential aged care homes and a beds-to-population rate similar to the state rate, at 63 beds per 1,000 people.

The Goldfields SA3 has a relatively high supply of nurses working in aged care at 14.4 FTE per 1,000 people aged 70 years and over, while Esperance has a relatively low supply at 7.2 FTE per 1,000 people aged 70 years and over. This compares to 12.2 FTE per 1,000 across WA.

Alcohol and other drugs

Alcohol and drug use is a significant issue in the Goldfields SA3. Approximately 1 in 3 (34%) residents are at risk of long-term harm from alcohol, significantly higher than the state rate of 26%. Levels of short-term alcohol harm (18%) and high risk alcohol consumption (52%) are also significantly higher than state rates (10% and 32% respectively). Furthermore, the Goldfields SA3 has the third greatest proportion of current smokers (20%), nearly double that of the state rate of 11%.

Compared to the Goldfields and other parts of WA, risky drinking is less of an issue in the Esperance SA3. It is below state levels for long-term (24%) and short-term (11%) alcohol harm and smoking (14%).

Using WAPHA's new method of estimating condition prevalence from General Practice Data, compared to state rates, patients in Esperance have statistically significantly higher rates of clinician-diagnosed chronic alcohol misuse (2.1%) and chronic drug misuse (2.7%).

Local intelligence highlights significant community need with regards to alcohol and other drug use in the Goldfields. There are considerable gaps in the availability of mental health services for those under the influence of substances, and people who may be experiencing substance-induced psychosis often have contact with the justice system instead of receiving appropriate health care.

AOD burden of disease

The WA Burden of Disease Study 2015 has the latest regional recording for risks associated with burden of disease for the Goldfields region. Tobacco use contributed to 23% of cancer burden and 19% of cardiovascular disease with people aged 45-64 years having the highest risk of burden. Men (13%) in the Goldfields region also had a high risk of disease due to tobacco use compared to women (8%).

Alcohol contributed to the burden of 20% of mental and substance use disorders, 16% of injuries, 5% of cancer and 3% of cardiovascular disease. The 15–24-year age group had the greatest risk of alcohol leading to disease. Illicit drug use made the highest contribution to burden of disease for females aged 25-44 years. Illicit drugs contributed to 0.5% of cancer burden, 11% of mental and substance use disorders and 19% of injuries in the Goldfields.

Accidental overdose

Australia's Annual Overdose Report, produced by the Penington Institute, reported an increase in unintentional drug-induced (accidental poisoning) deaths in WA from 2004 (2.7 per 100,000) to 2021 (8 per 100,000) suggesting that drug use is a growing health concern. Of this, males account for two thirds (70.5%) of unintentional drug-induced death compared to women. People aged 40-49 had 455 (27.2%) unintentional drug-induced deaths in 2021 and were found to be the most at-risk age bracket.

In 2021, opioids continued to be the largest overall drug group identified in unintentional drug-induced deaths in 2021 (45.7%), followed by benzodiazepines (32.5%) and anti-depressants (19.3%).

WA had the second highest rate of heroin death in 2021 with 1.5 deaths per 100,000 people. This corresponds with higher rates of death for other opioids such as fentanyl/pethidine/tramadol in 2021 (0.8 deaths per 100,000). There has also been an increase in deaths involving benzodiazepines in WA from 2013 to 2021 (1.1 to 3 deaths per 100,000), and stimulants such as methamphetamine and amphetamines (1.3 to 3 deaths per 100,000).

Between 2017-2021, there were 25 unintentional drug-induced deaths in the Goldfields SA3, equating to a rate of 12.5 per 100,000 people – the fourth highest rate in WA, and above the state average of 8 per 100,000. In contrast, unintentional drug-induced deaths were less of an issue in the Esperance SA3, which was slightly below the state level at 6.1 per 100,000; representing 6 deaths.

Hepatitis B and C

Hepatitis B and C are bloodborne viruses. Hepatitis B is spread between people by body fluids while hepatitis C is spread through blood-to-blood contact and is commonly spread through unsafe injecting practices. Untreated Hepatitis B and C can lead to liver disease (including cirrhosis), liver cancer and death.

Since 1982, a vaccine has been developed for hepatitis B with the recommendation that babies and adolescents are vaccinated. Currently there is no vaccination available for hepatitis C, although antiviral treatment is available. Treatment is now more than 95% effective at curing hepatitis C and available to most people via prescription from their GP.

In WA, notifications of hepatitis B and C have been declining. Between 2017 and 2023, notification rates of hepatitis B have slightly reduced from 21 to 18 notifications per 100,000. Hepatitis C notification rates decreased (from 62 to 47 notifications) between 2004 and 2017 and has continued to decrease with 32 notifications per 100,000 people in WA in 2023.

The proportion of people with chronic hepatitis B (CHB) in the Goldfields and Esperance SA3s is similar to the state rate of 0.8%, at 1% and 0.5% respectively. However, at 5%, treatment uptake in the Goldfields is slightly below the state levels of 9%. Treatment uptake is suppressed for the Esperance SA3 due to low numbers.

Chronic hepatitis C (CHC) levels in the Goldfields – Esperance region are also comparable to the state rate of 0.7%, with 1.2% prevalence in the Goldfields SA3 and 1.3% in Esperance. The CHC treatment uptake was 22% in the Goldfields SA3 and 29% in the Esperance SA3; each considerably below that of the state level of 42%.

Alcohol and other drug services

Reported statistics on AOD treatment show that across the Country WA PHN, 412.6 per 100,000 people understood treatment during the 2022-2023 period. Alcohol treatment represented more than half (53%) of the drug of concerns, followed by cannabis (23%) and amphetamines (18%). Men make up nearly two thirds of clients (64% vs. 36%), with 30–39-year-olds (28%) making up the largest age group of clients.

AOD services are provided by the WA Country Health Service (WACHS) and non-government organisations in the Goldfields – Esperance regions. The Goldfields Community Alcohol and Drug Service is provided by Hope Community Services and funded by the Mental Health Commission. They have three primary bases in Kalgoorlie – Boulder, Leonora and Esperance, and provide outreach services to surrounding communities through treatment and intervention counselling.

The Goldfields Rehabilitation Services Inc., based in Kalgoorlie – Boulder, provides residential services and counselling in a drug and alcohol-

free environment to those over 18-years. The Nangganawili Aboriginal Health Service provide drug and alcohol misuse programs, counselling and referral services in Wiluna. Additionally, headspace Centres in both the Goldfields and Esperance SA3s supply AOD counselling for youth under 25 years.

Mental health

Mental health was the third leading cause of disease burden in the Goldfields – Esperance region, contributing 15% to the total disease burden for the region. Across the Goldfields – Esperance region, 23,649 community mental health occasions of service were recorded, with females accounting for 61% of the total figure. Women in the Goldfields – Esperance region were impacted by depressive disorders (7%) while suicide and self-inflicted injuries contributed to the disease burden for men(5%).

Approximately 1 in 8 residents in the Goldfields SA3 report that they have been diagnosed with anxiety (13%), depression (13%) and high or very high psychological distress (16%). The prevalence of anxiety and depression is similar to state levels at 12% and 11% across WA, while the proportion experiencing psychological distress in the Goldfields SA3 is slightly above the state level (13%). In contrast, rates of anxiety, depression, and psychological distress in the Esperance SA3 are below the Goldfields SA3 prevalence, but similar to state rates at 11%, 9% and 12% respectively.

Using WAPHA's new method of estimating condition prevalence from General Practice Data, rates of clinician-diagnosed depression and anxiety were statistically significantly higher in the Goldfields (11.9%, 7.2%). Diagnoses of mixed depression and anxiety are included in both disease estimates.

In recent years, fly-in-fly-out (FIFO) workers have been the focus of community and political concern in Kalgoorlie – Boulder and the Northern Goldfields with reports in the media related to the impact of FIFO work, mental health and suicide. The mining industry in the Goldfields region, particularly in the more remote regions around Laverton, Leonora and Wiluna, has created a working population that includes a large number of FIFO workers associated with the mining industry. A survey of 3,000 FIFO workers found one third (33%) experienced high or very high levels of psychological distress.

Suicide and self-harm

From 2018 to 2022, 1,919 people sadly died from suicide in WA; a rate of 14.1 per 100,000 people and above the national rate of 12.3 per 100,000. In WA, suicide represents 3% of all deaths and is the ninth leading cause of death.

At a rate of 21.6 per 100,000 people, suicide in the Goldfields SA3 is above state levels and an area of considerable concern. Forty-four people died from suicide in the Goldfields SA3 between 2018 to 2022. Suicide is the fifth leading cause of death, representing 5% of all deaths in the region between 2017-2021.

Suicide is significantly less of a concern in the Esperance SA3, which has the lowest rate in WA. Eight people died from suicide between 2018 to 2022, and it is the nineteenth leading cause of death, representing 1% of all deaths between 2017-2021.

The Health and Wellbeing Surveillance Survey collects data on suicidal ideation among adults aged 16 years and over. In the Goldfields SA3, 1 in 10 (10%) indicated that they had thought seriously about ending their own lives – the highest rate across WA, and above the state rate of 7%. In contrast, suicidal ideation in the Esperance SA3 is equal to the state rate at 7%.

Self-harm is a strong risk factor for suicide. At a rate of 176.6 per 100,000 residents, hospitalisations for self-harm in the Goldfields is above the state level (97.9 per 100,000). Self-harm hospitalisations were highest for females and for people aged 25-44 years. The self-harm hospitalisation rate is suppressed for the Esperance SA3 due to low numbers.

Youth mental health

Primary mental health care services play an important role in prevention and early intervention efforts reduce the prevalence and impact of mental health problems amongst young people. Approximately one in seven young people aged 4-to-17-years experience mental illness in any given year, and 75% of severe mental health problems emerge before the age of 25. Early intervention in childhood and adolescent years can prevent or mitigate potentially lifelong mental illness.

A recent survey of WA school children found that mental health was a critical issue with a substantial number of Year 7 to 12 students reporting poor life satisfaction, low self-esteem, high levels of stress and the feeling they can't cope with life's challenges. Approximately 1 in 4 (26%) female year 7 to 12 students rate their life satisfaction as 0 to 4 with '0' being the worst possible life. This was double the proportion of males who felt the same (13%).

Self-harm is approximately twice as high in females compared with males, and in older adolescents compared with younger adolescents. Females aged 16-17 years have the highest rates of self-harm, with 17% having engaged in an act of self-harm.

In WA, mental health services for young people are provided through general practice, the public mental health system (such as the Child and Adolescent Mental Health Service), not-for-profit organisations (headspace) and private providers such as psychologists.

Hospital EDs also play a role in treating mental illness. People seek mental health-related services in EDs for a variety of reasons, often as an initial point of contact or for after-hours care. Between July 2022 and June 2024, 6,780 Western Australians aged 12-17 years presented to hospital EDs for mental-health related reasons; a rate of 370 per 10,000 people aged 12-17 years.

Compared to other areas in WA, youth mental health is a significant concern in the Goldfields – Esperance region. Both the Goldfields and Esperance SA3s have Mental Disorder-related ED presentations above state rates, at 606 and 482 per 10,000 12-17-year-olds as compared to 370 per 10,000 across WA.

Headspace centres and services support young people across Australia to be mentally healthy and engaged in their communities. There are two headspace centres in the Goldfields – Esperance region, based in Kalgoorlie and Esperance. The Esperance SA3 has one of the highest utilisation levels at 6% of residents aged 12-25; above the state level of 2%. Utilisation in the Goldfields SA3 is similar to the state rate at 3%. Each patient's episode of care comprised of an average of 4.3 occasions of service (i.e. interactions with the service or mental health worker) in the Goldfields SA3 and 4.7 in the Esperance SA3; comparable to the WA average of 4.2.

The Australian Youth Self-Harm Atlas reports that while the overall prevalence of suicidality (suicidal thoughts or behaviours, including ideation, plans, and attempts) in both the Goldfields and Esperance SA3s are equal to the state rate of 8%, the specific prevalence rates of self-harm (regardless of intent) and suicidal ideation are above the state rate of 10% and 7% respectively.

Major depression and anxiety disorders are risk factors associated with higher self-harm prevalence among 12 to 17-year-olds and are of considerable concern in the Goldfields – Esperance region. The proportion of 12 to 17-year-olds experiencing major depression or anxiety disorders in the Goldfields and Esperance SA3s are both above the state level, at 13% and 11% respectively compared to 9% across WA.

In the Goldfields – Esperance region, suicide and self-inflicted injuries are the leading cause of disease burden for 15-to-24-year-olds, contributing to 21% of the disease burden for this age group. Hospital admissions for self-harm can be an indication of unmet need for accessible mental health services. It is concerning to note self-harm hospitalisations among people aged 0-24 years in the Goldfields SA3 are above state levels (191.1 vs. 139.7 per 100,000). The rate is suppressed for Esperance due to low numbers.

Local intelligence highlights mental health among children below the age of 15 years as a significant need in the Goldfields SA3, including intergenerational trauma and complex post-traumatic stress disorder (PTSD) among children who have experienced prolonged or repeated trauma.

Mental health services

Mental health services in the Goldfields – Esperance region are provided by the WA Country Health Service (WACHS) and not-for-profit organisations. There are approximately 15 mental health services in the region, 4 of which have dedicated youth services. The WACHS provides adult community mental health services and inpatient mental health services in Kalgoorlie – Boulder, as well as adult community mental health and a child and adolescent mental health services in both Esperance and Kalgoorlie – Boulder. Youth mental health provider, headspace, offers psychological services for youth in Kalgoorlie – Boulder and a headspace satellite in Esperance. Centrecare provides counselling services in Kalgoorlie – Boulder, Coolgardie, Kambalda, Esperance, Norseman, Ravensthorpe, Leonora, and Wiluna. Suicide Prevention Networks in Kalgoorlie – Boulder and Esperance aim to reduce stigma and prevent suicide through education and conversation. The Goldfields – Esperance region also has access to the National Indigenous Critical Response service that provides support to individuals and families after a traumatic event. Bega Garnbirringu is one of nine Aboriginal Community-controlled organisations across WA to receive a contract to build early suicide identification and intervention skills in the Goldfields.

Two community liaison officers based in Kalgoorlie – Boulder work to reduce rates of suicide as part of the WA Suicide Prevention Framework.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. In the Goldfields and Esperance SA3s, 4% have accessed a GP mental health treatment plan in each area; below the state level of 8%.

There are low numbers of mental health professionals such as psychiatrists, mental health nurses and psychologists in regional and remote areas. In both the Goldfields and Esperance SA3s the rate of psychologists per 10,000 people is below the state rate, at 5.5 and 3.8 respectively compared to 13.2 per 10,000 across WA. In each area fewer than 1% of residents accessed a clinical psychologist, compared to 2.2% across WA. Given the high prevalence of mental health concerns in the region, these figures indicate insufficient access to rebated psychology services in the Goldfields and Esperance SA3s and a reliance on services provided by the WA Country Health Service and the not-for-profit sector.

In 2021, there was only one reported clinical psychologist in Kalgoorlie – Boulder, and local intelligence has highlighted significant shortages of local mental health services, including after-hours care, support for people under the influence of substances or in need of crisis mental health care. Some services are provided sporadically, such as for two hours every second month, leading to accessibility challenges for residents. Emergency telehealth services are available in cases involving young people, but there is no equivalent for adults. Transport barriers prevent residents from accessing much needed support further afield.

Aboriginal health

An estimated 7,231 Aboriginal people reside in the Goldfields – Esperance region. The Goldfields Aboriginal community is diverse with approximately 15 distinct language groups and 19 remote communities. Communities include the Wankatja/ Wangkatha people of Kalgoorlie – Boulder, Leonora and Laverton, the Ngadju people of Coolgardie, Norsemen and Esperance, the Martu people of Wiluna, the Tjuntjuntjara Spinifex People of the Great Victoria Desert region and the people of the Ngaanyatjarra lands adjoining the Northern Territory and South Australian borders.

Aboriginal populations are dispersed throughout the nine Local Government Shires that comprise the Goldfields – Esperance region. The 2021 Census reports that in the Ngaanyatjarra Lands, Aboriginal people comprise 80% of the population dispersed across ten communities (Warburton, Warakurna, Jameson, Blackstone, Wingellina, Patjarr, Wanarn, Tjirrkarli, Tjukurla, Kanpa). In the Shire of Ngaanyatjarraku and Wiluna, Aboriginal people comprise 85% and 26% of the population respectively and in the Northern Goldfields; Laverton, Leonora (10%), Menzies (21%), Kalgoorlie – Boulder (8%), Esperance (4%) Dundas (14%), Ravensthorpe (4%).

The Aboriginal people in the Goldfields region, spanning the Indigenous Regional Areas (IAREs) of Esperance – Ravensthorpe, Kalgoorlie – Dundas – Goldfields, Kalgoorlie – Ningia Mia, Laverton – Ngaanyatjarraku, Menzies – Leonora, Warburton and Wiluna, experience some of the highest levels of socioeconomic disadvantage in WA and are impacted by poor health outcomes. The highest levels of disadvantage have been observed in the Warburton, Laverton – Ngaanyatarraku, Wiluna and Menzies – Leonora IAREs, which have Indigenous Relative Socioeconomic Outcomes (IRSEO) index scores of 99, 90, 89 and 84 respectively, compared to 51 for WA overall. A higher IRSEO score indicates a greater level of socioeconomic disadvantage for the region. In contrast, Aboriginal people in the Esperance – Ravensthorpe IARE experience a similar level of disadvantage as other Aboriginal people in WA with an IRSEO score of 51.

Unemployment is higher in Warburton with an estimated 53% of Aboriginal residents without work. This is followed by the Laverton and Ngaanyatjarraku Shire population outside Warburton, with almost 26% of residents unemployed. Warburton and Wiluna also experience poor housing sustainability, with above 50% of households requiring extra bedrooms to accommodate residents.

There is an average participation rate in full time secondary education at age 16 of 65% across WA. Participation in some areas of the Goldfields – Esperance region are among the lowest in WA and a significant concern. Participation within the Esperance – Ravensthorpe IARE is also concerning at 48% participation.

Rheumatic heart disease (RHD) is noted as being a considerable concern in the Goldfields – Esperance region. RHD is a preventable condition that disproportionately affects Aboriginal people, with nearly 9 in 10 (89%) of Western Australians living with RHD being Aboriginal. It is caused by a bacterial infection of the throat and skin, and without treatment, can lead to permanent damage to the heart.

Local intelligence highlights the need for trauma-informed, culturally appropriate services for Aboriginal people, particularly in the Goldfields SA3. Intergenerational trauma and complex PTSD are significant issues among Aboriginal people. Furthermore, there is a need for more allied health support in schools, specifically speech pathology and occupational therapy.

Please note, in collecting local intelligence, concerns were raised about the accuracy of available data, particularly Census data, regarding the population of Aboriginal people in some areas within the Goldfields – Esperance region. Concerns stated that data available does not provide a complete picture of the needs in the region. This demonstrates the critical importance of gathering and utilising local intelligence when undertaking health needs assessments and planning.

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. Immunisation is below target for all age groups in the Goldfields SA3, at 90% for 1 and 2-year-olds and 94% for 5 year olds. The Kalgoorlie – Ningia Mia IARE recorded childhood immunisation rates below target for children aged 1 and 2 years of age (86%), but met the immunisation target for 5 year olds (95%). This suggests that interventions should be targeted to increase immunisation coverage for the 1 and 2 year age groups. The Laverton – Ngaanyatjarraku IARE met the target for 5 year olds at a 100% rate. Immunisation rates in Esperance – Ravensthorpe IARE were either equal to or above the target rate for 1 and 2 year old. The rate for 5-year-olds was suppressed due to low numbers.

Lower urgency emergency department presentations

High rates of lower urgency ED attendances can be indicative of a gap in primary health care services, however in the Goldfields – Esperance region this is not a significant area of need compared to other parts of WA. Lower urgency ED presentations by Aboriginal people in the Goldfields are slightly below state levels, at 5,774, though, they are slightly above in the Esperance SA3s with 6,573 per 10,000 Aboriginal people, compared to 6,167 per 10,000 across WA.

Avoidable deaths by selected causes

Avoidable deaths data is suppressed for a number of IAREs due to low numbers. Based on the available

data, there were 117.6 avoidable deaths per 100,000 across WA among Aboriginal people aged 0 to 74 years in the 2017-2021 period. When looking at Aboriginal deaths from all avoidable causes in total, all IAREs in the Goldfields SA3 are concerningly above the state level. These are Warburton (678.3 per 100,000), Kalgoorlie – Ninga Mia (476.0), Laverton – Ngaanyatarraku (457.7), Kalgoorlie – Dundas – Goldfields (341.1) and Menzies – Leonora (325.3). Data for avoidable deaths related to specific conditions is insufficient for a number of IAREs in the Goldfields SA3. Of those with sufficient data available, the following IAREs exceed state levels:

- Circulatory system diseases: Kalgoorlie – Ninga Mia (142 per 100,000), Laverton – Ngaanyatjarraku (124) and Kalgoorlie – Dundas – Goldfields (117) compared to 86 per 100,000 across WA.
- Ischaemic heart disease: Kalgoorlie – Dundas – Goldfields (116 per 100,000), Kalgoorlie – Ningia Mia (99) and Laverton – Ngaanyatarraku (87) compared to 57 per 100,000 across WA.
- Diabetes: Kalgoorlie – Ninga Mia (51 per 100,000) compared to 35 per 100,000 across WA.
- Cancer: Kalgoorlie – Ninga Mia (57 per 100,000) compared to 20 per 100,000 across WA.

Avoidable deaths among Aboriginal people in the Esperance SA3 (aligned with the Esperance – Ravensthorpe IARE) is not as significant a need, with levels below the state rate, at 224.1 per 100,000. Data for avoidable deaths related to specific conditions is insufficient in the Esperance area.

Concerningly, the Goldfields and Esperance SA3s each recorded levels above the state rate for all avoidable causes, at 229.2 and 139.3 per 100,000 respectively. The Goldfields SA3 exceeds state levels on all reported conditions underpinning avoidable deaths, with the most concerning being circulatory system diseases (75.4 per 100,000), ischaemic heart disease (58.2), other external causes (e.g., transport accidents, accidental drowning) (35.9), cancer (35.6), suicide (21.7), breast cancer (21.7) and COPD (21.4). Ischaemic heart disease and circulatory system diseases were higher than the PHN in Kalgoorlie – Dundas – Goldfields, Laverton – Ngaanyatjarraku and Kalgoorlie – Ningia Mia IAREs. There was limited data available for the IAREs for avoidable deaths from suicide and self-inflicted harm, however Kalgoorlie – Ningia Mia exceeded the state rate (60.5 vs. 32.6 per 100,000).

Avoidable deaths in the Esperance SA3 were not as prevalent as the Goldfields, however still exceeded state rates in several instances. The most significant included deaths related to circulatory system diseases (45.6 per 100,000), ischaemic heart disease (35.1), other external causes (e.g., transport accidents, accidental drowning) (32.1) and cancer (29.4).

Median age at death

Compared to other parts of WA, the median age of death for Aboriginal people in the Goldfields – Esperance region is sadly young. The median age for WA overall is 58 years – significantly below that of non-Aboriginal people at 80 years – however across the Goldfields – Esperance region six of the seven IAREs are below the Aboriginal state median. Kalgoorlie – Dundas – Goldfields has the lowest median age of death at only 50 years, followed by Laverton – Ngaanyatjarraku, Menzies – Leonora, Warburton (each at 51 years) and Kalgoorlie – Ningia Mia (54 years). Only Wiluna and Esperance – Ravensthorpe IAREs were equal to the state median at 58 years, however, given the concerns about the reliability of data for some populations of Aboriginal people in the Goldfields – Esperance region, alongside high levels of socioeconomic disadvantage, high levels of chronic conditions and PPHs, this should be interpreted with caution.

Potentially preventable hospitalisations

The average annual rate of total PPHs per 100,000 for Aboriginal people is above state levels for all IAREs in the Goldfields region. Across WA, there were 6,264 PPH admissions per 100,000 Aboriginal people from 2017/18 to 2020/21. In the Goldfields region, the rate ranged from 8,137 to 14,784 per 100,000. Laverton – Ngaanyatjarraku has the highest rate (14,784), followed by Wiluna (14,642), Warburton (11,415), Menzies – Leonora (10,341, Kalgoorlie – Ningia Mia (9,535) and Kalgoorlie – Dundas – Goldfields (8,137). The Esperance – Ravensthorpe IARE was below the state level at 3,954 per 100,000.

Chronic conditions that are classified as potentially preventable through behaviour modification, lifestyle change and timely care are: angina, asthma, COPD, congestive cardiac failure, diabetes complications, hypertension and iron deficiency anaemia. The following rates for PPHs due to chronic conditions within Goldfields – Esperance region exceeded state rates:

- Chronic asthma: Laverton – Ngaanyatjarraku (669 per 100,000), Warburton (506), Menzies – Leonora (320) and Kalgoorlie – Ningia Mia (237), compared to 192 per 100,000 across WA.
- Chronic angina: Kalgoorlie – Dundas – Goldfields (579 per 100,000) and Kalgoorlie – Ningia Mia (299), compared to 206 per 100,000 across WA.
- Chronic congestive cardiac failure: Wiluna (1,050 per 100,000), Kalgoorlie – Ningia Mia (820), Laverton – Ngaanyatjarraku (742) and Warburton (604), compared to 405 per 100,000 across WA.
- Chronic diabetes complications: Menzies – Leonora (1,441 per 100,000), Wiluna (1,417), Laverton – Ngaanyatjarraku (1,018), Kalgoorlie – Ningia Mia (852), Warburton (719), and Kalgoorlie – Dundas – Goldfields (632), compared to 567 per 100,000 across WA.
- Chronic iron deficiency anaemia: Esperance – Ravensthorpe (386) and Kalgoorlie – Ningia Mia (325), compared to 208 per 100,000 across WA.
- COPD: Warburton (2,086 per 100,000), Laverton – Ngaanyatjarraku (1,100), Menzies – Leonora (843), Kalgoorlie – Dundas – Goldfields (768) and Kalgoorlie – Ningia Mia (648), compared to 608 per 100,000 across WA .

Acute PPHs relate to conditions that usually come on suddenly, and may not be preventable, but may not have resulted in hospitalisation if timely and adequate care was received in the community.

PPHs for total acute conditions also exceeded state rates across all reported conditions in the Goldfields region, including:

- Acute cellulitis: Wiluna (1,787 per 100,000) Menzies – Leonora (1,535), Laverton – Ngaanyatjarraku (1,332) and Warburton (917), compared to 816 per 100,000 across WA.
- Acute convulsions and epilepsy: Laverton – Ngaanyatjarraku (955 per 100,000), Menzies – Leonora (872), Kalgoorlie Ningia – Mia (730), Kalgoorlie – Dundas – Goldfields (537) and Esperance – Ravensthorpe (476), compared to 460 per 100,000 across WA.
- Acute dental conditions: Wiluna (723 per 100,000) and Laverton – Ngaanyatjarraku (447), compared to 431 per 100,000 across WA.
- Acute ear, nose, and throat infections: Wiluna (1,379 per 100,000), Laverton – Ngaanyatjarraku (1,061 per 100,000), Kalgoorlie – Dundas – Goldfields (892), Kalgoorlie – Ningia Mia (768) and Menzies – Leonora (742) compared to 393 per 100,000 across WA.
- Acute urinary tract infections (including pyelonephritis): Wiluna (1,605 per 100,000), Kalgoorlie – Dundas – Goldfields (717), Laverton – Ngaanyatjarraku (618) and Kalgoorlie – Ningia Mia (561) compared to 516 per 100,000 across WA.

Vaccine-preventable PPHs are hospitalisations due to conditions that can be prevented by vaccination. PPHs for total vaccine preventable conditions also exceeded state rates across all IAREs in the Goldfields region, including:

- Total PPHs for vaccine-preventable conditions: Laverton – Ngaanyatjarraku (4,291 per 100,000), Wiluna (3,344), Warburton (3,009), Kalgoorlie – Ningia Mia (2,035), Menzies – Leonora (1,904) and Kalgoorlie – Dundas – Goldfields (1,293), compared to 855 per 100,000 across WA.
- PPHs for pneumonia and influenza: Wiluna (1,244 per 100,000), Laverton – Ngaanyatjarraku (756), Menzies – Leonora (549) Kalgoorlie – Ningia Mia (526), Kalgoorlie – Dundas – Goldfields (292), compared to 278 per 100,000 across WA.

PPHs are notably less prevalent in the Esperance – Ravensthorpe IARE, which was below the state level for vaccine preventable PPHs, total acute PPHs, and total chronic conditions PPHs.

Primary care service access

Aboriginal 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 people can receive Aboriginal-specific health checks from their doctor, as well as referrals for Aboriginal-specific follow-up services. In March 2020, telehealth items for Aboriginal Health Checks were introduced in response to COVID-19 and its associated restrictions.

In 2021-2022, the proportion of Aboriginal people that received an Aboriginal Health Check was 23% in Country WA PHN compared to 22% across WA. Nationally, face-to-face Aboriginal Health Checks was the preferred method compared to telehealth.

Aboriginal people living in the Goldfields – Esperance region can access primary care services through general practice, Aboriginal Community Controlled Health Services, Integrated Team Care (ITC) programs and the hospital sector.

The ITC program supports Aboriginal people living with complex chronic conditions to access health care and funds teams of Aboriginal health project officers, outreach workers and care coordinators. In the Goldfields – Esperance region, the ITC program is serviced by Hope Community Services based in Kalgoorlie.

There are four Aboriginal Community Controlled Health Organisations (ACCHOs) in the Goldfields region located in Kalgoorlie – Boulder, Wiluna, Ngaanyatjarra Lands and the Tjuntjuntjara – Spinifex Lands community.

The Bega Garnbirringu Health Service (BGHS) is based in the centre of Kalgoorlie – Boulder. Medical services are provided not only to those clients who reside within the limits of the city itself but also to local and outlying communities by means of regular Outreach clinics. BGHS's mobile clinic visits the remote communities of Coolgardie, Esperance, Leonora, Menzies, Mount Margaret and Norseman.

The Ngangganawili Aboriginal Community Controlled Health & Medical is based in Wiluna, providing affordable and culturally appropriate health services to the Aboriginal and wider population of Wiluna and surrounding areas. Services offered include general practice, accident and emergency, maternal and child health, chronic disease management and some specialist services. In addition, social and emotional wellbeing, environmental health and community care programs are available.

The Ngaanyatjarra Health Service has nine clinics operating and provide care to people living in communities across the vast Ngaanyatjarra Lands in remote WA, near the Northern Territory/South Australian borders. Community based health staff provide primary health care at community health clinics. This is delivered through a multidisciplinary approach incorporating Primary Health Care, Public Health Programs and Health Promotion Activities.

Spinifex Health Service is the name for an Aboriginal Community Controlled Health Service managed by Paupiyala Tjarutja Aboriginal Corporation (PTAC) in the remote community of Tjuntjuntjara on the Spinifex Lands. It focuses on chronic disease

management, child and maternal health, disability, aged care, and social and emotional wellbeing. Spinifex Health Service is located 680 km northeast of Kalgoorlie – Boulder, in the Great Victoria Desert region of WA.

Digital health

Digital health includes a broad range of innovative technologies for the purposes of providing care and sharing information to enhance patient outcomes. Services include mobile health applications (Medicare Online, COVID check-in apps), electronic prescribing, electronic health records (My Health Record) and telehealth/telemedicine.

Australia-wide, the volume of My Health Record entries containing data had a growth of 520,000 from January 2023 to March 2024. The largest increase in use from 2023 to 2024 has been seen in specialist letters (78% increase), diagnostic imaging reports (34% increase), and pathology reports (25% increase). In March 2024, WA had 2.6 million My Health Record entries.

There has been a decrease in the proportion of people who have had at least one telehealth consultation in the 12-months from 30.8% in 2021-2022 to 27.7% in 2022-2023. Those who had a long-term health condition (37.1%) are more likely to use telehealth compared to those without one (17.3%). In addition, those aged 65-74 years (31.6%) are more likely to use telehealth than people aged 15-24 (20.9%). Unfortunately, those living in outer regional, remote or very remote areas (23.4%) are less likely to use telehealth than those living in major cities (28.3%) – there could be several reasons for this including, internet availability/access, telehealth compliant devices such as phones and laptops. Of people who used telehealth services in the past 12 months, 87.7% reported that they would use it again if offered.

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 low, 10 to 15%, rapidly moved to 60 to 80% across a range of clinics and hospitals. It appears that the focus on digital health including telehealth consultations during COVID-19 helped fast track the adoption of technology and more providers saw My Health Record as a valuable repository of health data as it is accessible to all health care providers without the need for fax machines or postal services. As of February 2024, there are now more than 23.5 million My Health Record entries Australia-wide and more than 23 million or 98% of them contain data. It is important to note that the COVID pandemic drove telehealth, but unfortunately, these gains have not been sustained as patients are favouring face to face consultations once again.

Local intelligence highlighted that whilst there are digital health services available in the Goldfields region, there are challenges in accessing them, including limited internet access, low digital literacy, language barriers, and the lack of a consistent approach to whether and how digital health is utilised across different providers, making it more difficult for consumers.

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Goldfields – Esperance Needs Assessment 2025-2027

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.

Disclaimer

Please be aware that this document does not contain references. For further details and source information, please refer to the full report: Country WA PHN Needs Assessment 2025-2027

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