WA Primary Health Alliance
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An Australian Government Initiative

Great Southern

Needs Assessment 2025-2027

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Great Southern Priorities

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Chronic diseases contribute significantly to the burden of disease in the Great Southern region. There are high rates of multimorbidity and avoidable deaths due to chronic conditions. The region has high rates of risk factors for chronic conditions, particularly obesity and high blood pressure. Rates of clinician-diagnosed diabetes are above state levels.	Residents in the Great Southern region have high rates of PPHs related to chronic conditions, including diabetes, congestive cardiac failure, chronic angina, chronic iron deficiency anaemia and chronic asthma. The rate of general practitioner (GP) workforce per 100,000 people is below state levels. The high prevalence of risk factors and avoidable mortality rate 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 health care providers to promote healthy lifestyle changes and improve screening for chronic disease risk factors.**	Great Southern	Population health	Chronic conditions
Mental health is the leading cause of disease burden in the region. Depressive disorders and anxiety disorders contributed to the majority of the disease burden. Rates of clinician-diagnosed depression are significantly higher in the Albany Statistical Area Level 3 (SA3) compared to the state rate.	Access to primary mental health services is limited in the Great Southern region with only 1% of the population accessing a clinical psychologist, other psychologist or psychiatrist through Medicare Benefits Schedule (MBS) services.	**Enable access to mental health services.**	Great Southern	Mental health	Access

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Residents are at risk of harm from alcohol and illicit drug use. Harmful alcohol consumption causes multiple chronic diseases resulting in complex care needs. In the Great Southern region, 1 in 4 residents are at high risk of long-term harm from alcohol consumption. Rates of clinician-diagnosed chronic alcohol misuse and chronic drug misuse are significantly higher in the Albany SA3 compared to the state rate.	Alcohol and other drugs (AOD)-related ED presentations are above state rates in the Albany SA3, placing burden on hospital EDs. Early screening and intervention are needed to reduce the impact of harmful alcohol use. Evidence has shown GPs to be crucial in the effectiveness of interventions and management of alcohol-related issues.	**Enable access to early screening and treatment for harmful alcohol use and support primary health care providers in managing alcohol-related issues.**	Great Southern	Alcohol and other drugs	Access
Aboriginal people in the Great Southern region experience significant levels of socioeconomic disadvantage compared to Aboriginal people in other parts of Western Australia (WA), and may be at risk of experiencing poor health outcomes related to social determinants of health.	Aboriginal people in the Great Southern region have high rates of avoidable hospitalisation, including potentially preventable hospitalisation (PPH) presentations and non-urgent ED presentations.	**Enable access to coordinated culturally appropriate primary care for Aboriginal people.**	Great Southern	Aboriginal health	Appropriate care (including cultural safety)
Childhood immunisation levels in the Great Southern 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 hospital care.	**Support primary health care providers to increase childhood immunisation rates overall, and deliver culturally appropriate and accessible vaccination programs for Aboriginal children.**	Great Southern	Population health	Immunisation

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
The Great Southern region has a large and growing population of older adults. By 2030, 1 in 4 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. In the Great Southern region coronary heart disease, chronic obstructive pulmonary disease (COPD) and dementia are among the leading causes of disease burden for people aged 65 and over.	Despite having a high proportion of older people, there is a relatively low residential aged care homes (RACHs) beds-to-population ratio and moderate number of 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. 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.**	Great Southern	Aged care	Access Chronic conditions
Most Australians would prefer to die at home rather than in a hospital or aged care facility. For many Aboriginal people, this means dying at home connected to country.	There is limited home palliative care available in the region, 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.**	Great Southern	Aged care	Access Palliative care

Great Southern

Overview

The Great Southern 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, Aboriginal health and aged care.

Workforce and access to services is a continuing issue for all rural communities and the Great Southern is similarly impacted. The region has a relatively moderate workforce need for GPs and shortage of rebated psychology services.

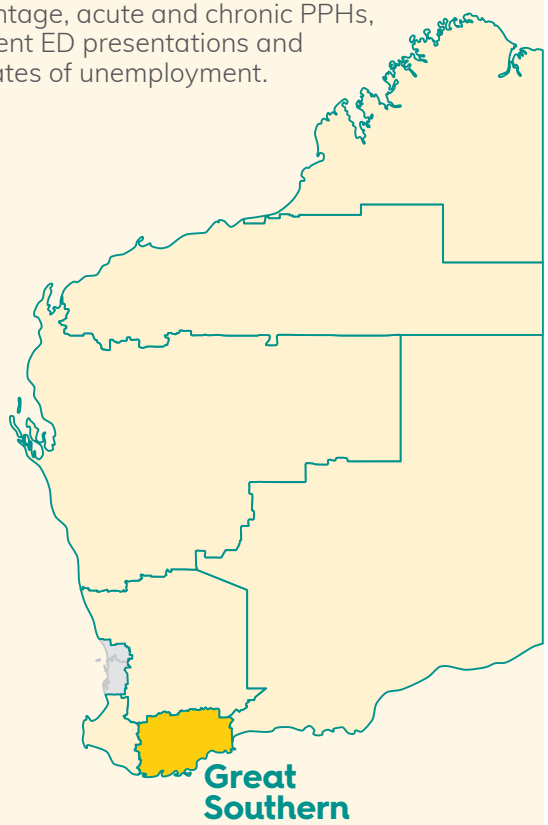
The Great Southern region has a significantly higher prevalence of clinician-diagnosed depression compared to the state. Mental ill-health was the leading cause of disease burden in the region but only 1% of the population accessed a clinical psychologist through the Better Access Medicare Benefits Schedule (MBS) program.

The population in the Great Southern region has a high prevalence of total chronic PPHs, particularly for chronic angina, chronic asthma, diabetes and chronic iron deficiency anaemia. Moreover, the region had the highest infant and congenital conditions burden in the state. Although there is a comparatively higher utilisation of chronic disease management plans (CDMPs), the Great Southern region has high rates of chronic disease risk factors, particularly obesity, high blood pressure and high rates of avoidable mortality.

The Great Southern region has an adequate supply of aged care beds and aged care nurses compared to state levels, though the high and growing population of older adults in the region will place increased pressure on the aged care services.

Residents experiencing long-term harm from alcohol use, smoking and illicit drugs, unintentional drug-induced deaths and emergency department (ED) presentations related to AOD were concerning. Furthermore, the prevalence of clinician-diagnosed chronic alcohol misuse was significantly higher in the Albany SA3 compared to the state.

Aboriginal people in the Great Southern region experience moderate levels of socioeconomic disadvantage, acute and chronic PPHs, non-urgent ED presentations and higher rates of unemployment.



Population demographics

The Great Southern region is located on the south coast of Western Australia (WA) and is bounded by the South West, Wheatbelt and Goldfields-Esperance regions. The region spans 39,007 square kilometres and consists of one Australian Bureau of Statistics (ABS) Statistical Area Level Three (SA3) region: Albany SA3. The Albany SA3 includes the major towns of Albany, Denmark, Katanning, and Mount Barker. The Albany SA3's economy is reliant on agriculture, retail, tourism and construction and is home to 64,408 people, accounting for about 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 Socioeconomic Disadvantage = 1012), the Great

Southern region is an area of disadvantage, SEIFA score of 981 for Albany SA3. Approximately 1 in 20 Albany SA3 residents (5%) live in social housing, which is above the state rate of 3%. A similar proportion (6%) are in low income, welfare-dependent families with children, compared to 5% in WA overall. Approximately 1 in 20 (5%) of residents in the Albany SA3 identify as Aboriginal and Torres Strait Islander (Aboriginal).

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 Great Southern region has a number of under-served people who are at risk of poor health outcomes. Specifically:

- Over 4,500 Albany SA3 residents were born in a non-English speaking country, equating to 7% of the local population, compared to 18% across WA.
- 6% of residents in the Albany SA3 have a profound or severe disability, compared to 5% across the state.
- 13% of residents in the Albany SA3 provide unpaid assistance to people with a disability compared to 11% across WA.
- 24% of children in the Albany SA3 were developmentally vulnerable on one or more domains, compared to 20% across WA.
- An estimated 327 people in Albany SA3 experienced homelessness which equates to 58 per 10,000 people. 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 Albany SA3 (CIS=0.09) has a moderate level of unmet need for multicultural services, driven by the rate of general practitioner (GP)-type ED presentations among multicultural residents that is above the state level (2,286 per 10,000 people born in a non-English speaking country, vs. 1,912 across WA) . However, this rate is below other parts of the Country WA region, and the Albany SA3 has a moderate proportion of residents born in a non-English speaking country compared to other parts of WA, nearly all (99.3%) of whom speak English well.

LGBTIQA+ populations

LGBTIQA+ is an acronym commonly used to describe lesbian, gay, bisexual, trans/transgender, intersex, queer/questioning, asexual, and other sexuality, gender, and bodily diverse people and communities. 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. LGBTIQA+ people are known to have a higher risk of certain chronic diseases such as cancers, asthma and cardiovascular disease. Moreover, some members of LGBTIQA+ communities, particularly gay, lesbian and bisexual people, are 2.0 times as likely to smoke daily compared to heterosexual people which increases their risk of developing a chronic disease.

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 than the general Australian population, with fewer than 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 a disability or long-term health condition, with 12% reporting a profound or severe disability, 20% a moderate disability and 6% a mild 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 residents 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 a lack of LGBTIQA+ friendly services in the region, and many individuals travelling to Perth for services. Furthermore, there is limited understanding and education within the health sector about trans and intersex people. Significant proportions of LGBTIQA+ people have not felt they can safely disclose their LGBTIQA+ identity to GPs or have been misgendered in practices. 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) LGBTQIA+ 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 on 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 (physical, mental and substance issues).

There is only one primary health service specialising in care for people experiencing homelessness in the Country WA Primary Health Network (PHN), located in Albany. However, the areas of greatest need for homelessness support are the Kimberley, East Pilbara, Gascoyne and Goldfields SA3s.

There is a moderate level of unmet need for homelessness services in the Albany SA3 (CIS=-0.32). An estimated 324 residents are at risk of or currently experiencing homelessness; equating to a rate similar to the state (50 people per 10,000 in the Albany SA3 compared to 48 per 10,000 across WA). However, this rate is markedly below some other areas in the Country WA region.

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 through prevention, early intervention, response, and 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 for which 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 827 reports of family related assault in the Great Southern region, equating to an average of 69 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.

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 emphysema or chronic obstructive pulmonary disease (COPD)), stroke, and mental health conditions (including depression or anxiety). In the 2021 Census, 19% of all West Australians (484,000) reported they had one of the above conditions and 5% reported they have two of the selected conditions.

The Albany SA3 has a concerning level of chronic disease among its residents, and the highest or second highest rate in the Country WA PHN for four of the ten chronic conditions reported by the Census. Specifically, it has the highest age-standardised rates (ASR) for stroke at 0.9 people per 100. It also has the second highest ASR in the Country WA PHN for asthma (8.4 per 100) and cancer (including remission) (3.0 per 100). Each of these exceeds the state rate:

	ASR per 100 people	
	Albany SA3	WA
Mental health (including depression or anxiety)*	10.1	8.3
Lung conditions (including COPD)	1.7	1.7
Stroke	0.9	0.9
Arthritis	9.0	7.9
Asthma	8.4	7.4
Cancer (including remission)	3.0	2.9

**This the first time the chronic conditions have been collected in the Census, and there is some evidence that there may be biases in reporting mental health conditions. Therefore, these number should be interpreted with caution.*

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 Albany SA3 at 9.7%.

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.

The Great Southern region has higher rates of risk factors compared to the state levels, particularly in Albany SA3. This includes high levels of residents experiencing obesity, having high blood pressure, smoking tobacco and not engaging in any physical activity for leisure purposes.

The estimated prevalence for people experiencing obesity is higher in Albany SA3 compared to the WA rate of 36%. Nearly 2 in 5 (39%) residents in Albany SA3 are experiencing obesity. About 1 in 5 (20%) residents in Albany SA3 are not engaging in any physical activity for leisure purposes, compared to 17% of Western Australians overall.

Albany SA3 has a prevalence level slightly above the state rate of 11% for smoking with approximately 1 in 8 (12%) Albany SA3 residents who currently smoke.

High blood pressure is a health need in the Great Southern region, with approximately 1 in 4 residents having high blood pressure in Albany SA3 (23%) similar to the state rate of 23%.

Reported stress levels in the Albany SA3 are below the state rate, with around 1 in 9 (12%) of residents reporting stress, compared to 12% of WA.

Healthy Weight Action Plan

WA Primary Health Alliance (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.

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 Great Southern region had a 1.3 times higher rate of fatal burden and 1.3 times higher non-fatal burden compared to the metropolitan regions. The Great Southern region had the highest infant and congenital conditions burden in the state (3% of the total burden in the region) and third highest injury burden in the state (after Kimberley and Wheatbelt), accounting for 11% of the total burden in the region. Depressive disorders, anxiety disorders, coronary heart disease and COPD (27% of burden for females and 26% for males) were also among the five leading causes of disease burden, along with back pain/problems for females and suicide/self-inflicted injuries for males:

Leading causes of total disease burden in the Great Southern region		
Condition	%	ASR per 1,000
Mental	19%	52.9
Cancer	19%	35.0
Cardiovascular	12%	20.1
Injury	11%	29.0
Musculoskeletal	8%	16.7

Potentially preventable hospitalisations for chronic conditions

Potentially preventable hospitalisations (PPHs) are certain hospital admissions that potentially could have 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 age-standardised rate 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 Albany SA3 has a higher rate for total chronic conditions (1,178 people per 100,000, compared to 903 per 100,000 across WA). This is driven by higher rates in the Albany SA3 compared to WA for chronic angina (187 per 100,000 vs. 90), Chronic asthma (88 vs. 57) and diabetes (322 vs. 178). The Albany SA3 also has a high rate of PPHs due to chronic iron deficiency anaemia compared to the state rate (148 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 chronic disease management plan (CDMPs). Residents of Albany SA3 have comparatively higher utilisation at 15%.

Childhood immunisation rates

The National Immunisation Program (NIP) aims to increase national immunisation coverage to reduce the number of vaccine-preventable diseases in Australia. A key priority of the program is to work towards achieving immunisation coverage rates of at least 95% for children aged 1, 2 and 5 years. Data from the Australia Immunisation Register (AIR) from 1 January 2023 to 31 December 2023 indicated that in 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. About 90% of children were fully immunised at 1 year and 92% at 5 years, compared to only 87% at 2 years.

The AIR reports that the Albany SA3 childhood immunisation rates were below the 95% immunisation target across all ages, being 92% for children aged 1 year and 5 years, and 89% for children aged 2 years. The lower rate at 2 years suggests that interventions should be targeted to increase immunisation coverage for this age group.

Cancer screening

There are three national cancer screening programs in Australia: BreastScreen Australia, National Cervical Cancer Screening Program (NCSP), and National Bowel Cancer Screening Program (NBCSP). In 2020-21, the cancer screening participation rates in the Albany SA3 for two of the three cancer screening programs were under state levels.

In the Albany SA3, about 2 in 5 (46%) had participated in bowel cancer screening (compared to 42% across WA), about 2 in 5 (46%) had participated in breast cancer screening, below state level of 51% and about 3 in 5 (61%) had participated in cervical cancer screening, below state level of 69%.

These levels are particularly concerning given that the prevalence of cancer (including remission) in Albany SA3 exceed state levels and cancer is the 2 leading cause of total disease burden in the Great Southern region. 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.

Avoidable mortality

The median age of death in the Albany SA3 is 82 years, above the state median age of 80 years.

Avoidable mortality refers to deaths of people under 75 years that are potentially avoidable under the current health care system (primary or hospital care). The rate of avoidable deaths in the Albany SA3 exceed the state rate of 117.6 per 100,000 at 121.7 per 100,000. The Albany SA3 has above state levels for all avoidable death causes except for ischaemic heart disease, breast cancer (females) and circulatory system diseases.

According to the Mortality Over Regions and Time (MORT) data, the rate of premature deaths (people under 75 years) in the Albany SA3 was similar to the state, both at 195 per 100,000. The five leading causes of death and their percentage with respect to all death causes within the Albany SA3 is:

Rank	WA	Albany SA3
1	Coronary heart disease (11%)	Coronary heart disease (11%)
2	Dementia including Alzheimer's (9%)	Dementia including Alzheimer's (8%)
3	Cerebrovascular disease (5%)	Cerebrovascular disease (5%)
4	Lung cancer (5%)	Lung cancer (5%)
5	COPD (4%)	COPD (5%)

Utilisation of primary care services

GP utilisation in the Albany SA3 was above state levels but declined between 2018-19 and 2022-2023. In 2022-2023, about 4 in 5 residents in Albany SA3 (82%) visited a GP; compared to 84% across WA. This was a reduction from 2021-2022 levels, where 88% of Albany residents had utilised a GP service.

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 Saturdays; and all-day Sundays 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, and 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. The Albany SA3 (CIS=1.36) has the second highest level of unmet need for after-hours services in WA. It has the lowest utilisation of MBS-subsidised after-hours services relative to its population size, high volumes of people within the age groups (0-4 and over 65 years) likely to need after hours care, and high levels of residents with multimorbidity.

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 Albany SA3 have similar utilisation of GP health assessments compared to the state (5%). 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 utilised in the region are similar to the state rate. The latest reports that 4% of Albany SA3 residents have used a nurse practitioner service, slightly higher than the state rate of 3%.

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 13 (8%) residents in the Albany SA3 used a Medicare-subsidised practice nurse/Aboriginal health worker, slightly higher than the state rate of 7%.

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 (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 Great Southern region. Overall, 80% of SA3s across WA have higher access relative to need than Albany SA3.

Consumer views of accessing GPs

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

Most people experiencing socioeconomic disadvantage were able to access a General Practitioner when needed. Although 31% of respondents encountered barriers when visiting a GP, 92% had visited a GP in 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 benefit of having a regular GP to the quality of 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 GPFTE 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 full-time 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 Albany SA3 has 91 GPCSE per 100,000 residents 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, Albany, Denmark-Walpole, Katanning, Kojonup and Mount Barker catchments (all within Albany SA3) are noted as having moderate need for GP workforce due to the lack of local general practices and limited housing availability resulting as a significant barrier to workforce recruitment.

Albany catchment has a relatively moderate need for GP workforce, with 10 local general practices and the ability to accept GP Registrars immediately. More than half of the residents are experiencing socioeconomic disadvantage, with 57% in the most disadvantaged quintiles in WA.

Denmark-Walpole catchment has a relatively moderate need for GP workforce, with three local general practices and the ability to accept GP Registrars immediately. More than half of the residents are experiencing socioeconomic disadvantage, with 51% in the most disadvantaged quintiles in WA.

Katanning and Kojonup catchments have a relatively moderate need for GP workforce with three local general practices and a shared workforce between the two towns. The practices in Katanning have the ability to accept GP Registrars immediately. Around 7 in 10 residents (71%) in Katanning are experiencing socioeconomic disadvantage, and nearly one in two residents (46%) in Kojonup are experiencing socioeconomic disadvantage, where these populations are in the most disadvantaged quintiles in WA.

Mount Barker catchment has a relatively moderate need for GP workforce with one local general practice and the ability to accept GP Registrars with individual support. About 3 in 5 of the residents are experiencing socioeconomic disadvantage, with 64% in the most disadvantaged quintiles in WA.

Gnowangerup and Jerramungup catchments have no viability to support an increase in workforce due to small population sizes.

Primary care nurses

The Albany SA3 had a relatively high supply of primary care nurses at 182 full-time equivalent (FTE) or 283 FTE per 100,000 residents compared to 25 FTE per 1,000 across WA.

Aged care

The Albany SA3 has a large and growing aged population. In 2022, there were 14,710 people aged 65 years and over in Albany SA3, representing 23% of the population and this is projected to increase to 26% by 2030 compared to 18% across the state and 20% across Country WA PHN.

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

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 were reported to have three or more long-term health conditions. This was similar in Albany SA3, with 10% 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.

About 3 in 5 (60%) of general practice patients in the Albany SA3 aged 65 years and older are diagnosed with three or more chronic conditions. Please note that this data includes private general practices only and do 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 rates 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 a GP health assessment. The Albany SA3 is above the state rate at 30%.

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) has 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 Choices for At Home Palliative Care program to improve palliative care coordination in their local communities.

In 2022, there were 27.7 total full-time equivalent (FTE) palliative medicine physicians and 333.2 FTE palliative care nurses employed in WA. Whilst it is recognized 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 in this report.

Palliative care nurses across WA are working 65.0 total weekly hours per 1,000 patients aged 75 and

over. The rate is higher in the Albany SA3, at 100.9 total weekly hours per 1,000 patients aged 75 and over. Palliative medicine physicians across WA are working 5.7 total weekly hours per 1,000 aged 75 and over. The rate is higher in the Albany SA3, at 9.1 total weekly hours per 1,000 aged 75 and over.

Aged care services

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

Commonwealth Home Support Programme

The Commonwealth Home Support Programme (CHSP) provides entry-level support for older people so that 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 group had the highest amount of services provided by hours.

Home Care Packages program

The Home Care Packages (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 five home care services in the Albany SA3 provided being Albany Community Care Centre, Clarence Estate Home Care and Silver Chain Great Southern (HCP levels 2,3 and 4). As at December 2023, there were 707 people in a HCP in the Great Southern Aged Care Planning Region (ACPR), which includes the Albany SA3 and a further 144 people waiting for a 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 Albany SA3 has a low beds-to-population ratio with eight residential aged care homes at 49 beds per 1,000 people aged 70 years and over; below the state rate of 64 per 1,000.

The Albany SA3 has a moderate supply of nurses working in aged care at 12.8 FTE per 1,000 people aged 70 years; slightly above the state rate of 12.2 FTE per 1,000 for the cohort.

Alcohol and other drugs

About 1 in 4 (25%) residents in the Albany SA3 are at risk of long-term harm from alcohol, similar to the state rate of 26%. Levels of short-term alcohol harm (11%) and high risk alcohol consumption (32%) are similar to the state rate (10% and 32% respectively). Furthermore, about 1 in 8 (12%) residents in the Albany SA3 are current smokers, similar to the state rate of 11%.

Using WAPHA's new method of estimating condition prevalence from General Practice Data, compared to state rates, patients in Albany has statistically significantly higher rates of clinician-diagnosed chronic alcohol misuse (2.3%) and chronic drug misuse (1.6%).

Alcohol and Other Drugs Burden of Disease

WA Burden of Disease Study 2015 has the latest regional recording for risks associated with burden of disease for the Great Southern region. Tobacco use contributed to 18% of Cancer burden and 8% of cardiovascular disease, with people aged 65+ years having the highest risk of burden. Men (9%) in the Great Southern region also had a high risk of disease due to tobacco use compared to women (7%).

Alcohol contributed to the burden of 17% of injuries, 9% of mental and substance use disorders, 4% of cancer and 3% of cardiovascular disease. The 15-24-year and 25-44-year age groups had the greatest risk of alcohol leading to disease.

Illicit drug use did not present as a leading risk factor for any age group by sex. However, illicit drug use contributed to 6% of mental and substance use disorders and 0.1% of cancer in Great Southern.

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 age 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. 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 30 unintentional drug-induced deaths in the Albany SA3, equating to a rate 9.6 per 100,000 people, above the state average of 8 per 100,000.

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 Albany SA3 (0.5%) is below the state rate of 0.8%. Treatment uptake is suppressed for the Albany SA3 due to low numbers.

Chronic hepatitis C (CHC) levels in the Albany SA3 (0.9%) are slightly above the state rate of 0.7%. The CHC treatment uptake was 53% in the Albany SA3; above that of the state level of 42%.

Alcohol and other drug services

Reported statistics on alcohol and other drugs (AOD) treatment show that across the Country WA PHN, 412.57 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.

Drug and Alcohol services are provided by non-government organisations in the Great Southern region. The Community Alcohol and Drug Service (GSCADS) is provided by the Palmerston Association. They have three primary bases in Albany, Denmark, and Katanning, and provides support to surrounding communities, from Walpole to Bremer Bay, and north to Kojonup, Katanning, and Lake Grace by offering education, counselling and training for individuals and families and have culturally secure services for Aboriginal people. GSCADS also runs a needle and syringe program (NSP) to reduce the harms associated with injecting drug use. Additionally, the WA Primary Health Alliance (WAPHA) also commissioned Continuing Care Program services in Albany, Denmark and Katanning.

Mental health

Mental health was the leading cause of disease burden in the Great Southern region contributing 18% to the total disease burden for the region. Across the Great Southern region, 35,870 community mental health occasions of service were recorded, with females accounting for 55% of the total figure.

Approximately 1 in 9 residents in the Albany SA3 have been diagnosed with anxiety (11%), depression (11%) and high or very high psychological distress (12%). The prevalence of anxiety, depression and psychological distress is similar to the state levels at 12%, 11% and 13% across WA.

Using WAPHA's new method of estimating condition prevalence from General Practice Data, rates of clinician-diagnosed depression were statistically significantly higher in the Albany SA3 (9.0%), whilst rates of diagnosed Anxiety were statistically significantly lower in the Albany SA3 (4.3%). Diagnoses of mixed Depression and Anxiety are included in both disease estimates.

Suicide and self-harm

From 2018 to 2022, 1,919 people sadly died from suicide in WA; a rate of 14.1 people 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 14.6 people per 100,000, suicide in the Albany SA3 is similar to state levels. Forty-six people died from suicide in the Albany SA3 between 2018 to 2022. Suicide is the twelfth leading cause of death, representing 2% of all deaths in the region between 2017-2021.

The Health and Wellbeing Surveillance Survey collects data on suicidal ideation among adults aged 16 years and over. In the Albany SA3, 1 in 13 (8%) indicated that they had thought seriously about ending their own lives, slightly above the state rate of 7%.

Self-harm is a strong risk factor for suicide. At a rate of 103.2 per 100,000 residents, hospitalisations for self-harm in the Albany SA3 is above the state level (97.9 per 100,000). Self-harm hospitalisations were highest for females and for people aged 0-24 years.

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 1 in 7 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 Great Southern region. The Albany SA3 has Mental Disorder-related ED presentations above state rates, at 494 per 10,000 12-17-year-olds 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 is one headspace centre in the Great Southern region, based in Albany. The Albany SA3 has the highest utilisation level in WA at 7% of residents aged 12-25; above the state level of 2%. Each patient's episode of care comprised of an average of 5.5 occasions of service (i.e. interactions with the service or mental health worker) in the Albany SA3; above 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 the Albany SA3 is below the state rate of 9%, the specific prevalence of self-harm (regardless of intent) (12%) is above the state proportions of 10%.

Major depression and anxiety disorders are risk factors associated with higher self-harm prevalence among 12 to 17-year-olds and is less of a considerable concern in the Great Southern region. The proportion of 12 to 17-year-olds experiencing major depression or anxiety disorders in the Albany SA3 (6%) is below the state level at 9% and one of the lowest proportions in WA.

In the Great Southern region, mental health is the leading cause of total disease burden (19%) in the region. Depressive disorders was the leading cause of disease burden for 15-to-24, 25-to-44 and 45-to-64-year-olds, contributing to 18%, 19% and 9% of disease burden for these age groups respectively. 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 Albany SA3 are above state levels (164.7 vs. 139.7 per 100,000).

Mental health services

Mental health services in the Great Southern region are provided by organisations including the WA Country Health Service (WACHS) and various not-for-profit organisations. There are approximately 15 mental health services in the region, 4 of which have dedicated youth services. The WACHS Great Southern Mental Health Service (GSMHS) provides mental health care for inpatient and community clients in the region. The Community Mental Health clinics are located in Albany and Katanning. The community teams consist of triage, adult, older adult, youth, child and adolescent teams. GSMHS also employs Aboriginal mental health workers to assist in providing culturally appropriate treatment.

headspace provides psychological services for youth in Albany and also runs a web counselling service. In addition to headspace, the WA Primary Health Alliance has commissioned two other services, run by Amity Health and Palmerston Association providing suicide prevention and counselling services.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. In Albany SA3, 6% have accessed a GP mental health treatment plan; below the state level of 8%. The region had 1.4% of residents who accessed a clinical psychologist, compared to 2.2% across WA. Given the high burden of mental health concerns in the region, these figures indicate insufficient access to rebated psychology services in the Albany SA3 and a reliance on services provided by the WA Country Health Service and the not-for-profit sector.

Aboriginal health

An estimated 3,359 Aboriginal people reside in the Great Southern region. The Great Southern Aboriginal community is diverse with approximately 14 distinct language groups and corresponding remote communities. Communities include the dialectal groups of the Ganeang, Goreng and Menang of the Wagyl Kaip.

Aboriginal people are dispersed throughout the 11 Local Government Shires that comprise the Great Southern region. The 2021 Census reports that in the Shire of Albany, Aboriginal people comprise 4% of the total population; Broomehill-Tambelup (13%), Cranbrook (2%), Denmark (1%), Gnowangerup (8%), Jerramungup (3%), Katanning (9%), Kent (1%), Kojonup (5%), Plantagenet (3%) and Woodanilling (2%).

The Aboriginal people in the Great Southern region, spanning the Indigenous Areas (IAREs) of Albany, Kojonup – Gnowangerup, Manjimup – Denmark – Plantagenet (area spans across to the South West region) and Narrogin – Wagin – Katanning (area spans across to the Wheatbelt region), experience some levels of socioeconomic disadvantage in WA and are impacted by poor health outcomes. The Indigenous Relative Socioeconomic Outcomes (IRSEO) index reflects the level of socioeconomic disadvantage experienced by Indigenous Australians living in each IARE Australia. A higher IRSEO score indicates a greater level of socioeconomic disadvantage for the region. Higher levels of disadvantage have been observed in Kojonup – Gnowangerup (77), Narrogin – Wagin – Katanning (76) and Albany (68); whilst Manjimup – Denmark – Plantagenet (45) was less disadvantaged, compared to 51 for WA overall.

Unemployment is high in Kojonup (19%) and Narrogin – Wagin – Katanning (22%); compared to the state at 16% across WA. Kojonup – Gnowangerup also experiences poor housing sustainability, with 20% of households require extra bedrooms to accommodate residents; compared to the state at 19%.

There is an average participation rate in full time secondary education at age 16 of 65% across WA. Participation within Albany (74%), Manjimup – Denmark – Plantagenet (88%) and Narrogin – Wagin – Katanning (82%) are higher; whilst Kojonup – Gnowangerup is an area of concern at only 21% participation.

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 above target for all age groups in the Great Southern region, except Albany IARE for children aged 1 year (94%). Manjimup – Denmark – Plantagenet IARE only had data for children aged one year, and Kojunup-Gnowangerup IARE only had data for children aged five years, in which both showed an 100% full immunisation rate. The Narrogin – Wagin – Katanning IARE showed an immunisation rate of 96-100% across all age groups.

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 Great Southern region this is not a significant area of need compared to other parts of WA. Lower urgency ED presentations by Aboriginal people in Albany SA3 are below state levels at 5,350 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. Concerningly, the Albany SA3 recorded levels above the state rate, at 121.7 per 100,000. The Albany SA3 exceeds state levels on all reported conditions underpinning avoidable deaths with the exception of ischaemic heart disease, breast cancer (females) and circulatory system diseases. The most concerning selected causes were other external causes (e.g., transport accidents, accidental drowning and submersion) (27.5 per 100,000), cancer (26.5) and selected external causes of mortality (19.0 per 100,000). There was limited data available for the IAREs for avoidable deaths from selected causes, however Kojonup – Gnowangerup (368.2) and Narrogin – Wagin – Katanning (400.0) exceeded the state rate for deaths from all avoidable causes.

Median age at death

Compared to other parts of WA, the median age of death for Aboriginal people in the Great Southern region are moderately young. The median age for WA overall is 58 years – significantly below that of non-Aboriginal people at 80 years. In the Great Southern region, Kojonup – Gnowangerup IARE has the lowest median age of death at only 54 years. Narrogin – Wagin – Katanning (65), Albany (64) and Manjimup – Denmark – Plantagenet (58) IAREs exceed the state median age of death.

Potentially preventable hospitalisations

The average annual rate of total PPHs per 100,000 for Aboriginal people is above state levels for Narrogin – Wagin – Katanning IARE in the Great Southern region. Across WA, there were 6,264 PPH admissions per 100,000 for Aboriginal people from 2017/18 to 2020/21. In the Great Southern region, the rate ranged from 2,974 to 8,666 per 100,000. Narrogin – Wagin – Katanning has the highest rate (8,666); followed by Kojonup – Gnowangerup (5,775), Albany (4,158) and Manjimup – Denmark – Plantagenet (2,974), all of which were below the state level.

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

- Chronic Angina: Narrogin – Wagin – Katanning (224 per 100,000), compared to 192 per 100,000 across WA.
- Chronic asthma: Narrogin – Wagin – Katanning (376 per 100,000) and Albany (226), compared to 206 per 100,000 across WA.
- Chronic congestive cardiac failure: Narrogin – Wagin – Katanning (411 per 100,000) compared to 405 per 100,000 across WA.
- Chronic diabetes complications: Kojonup – Gnowangerup (1340 per 100,000) and Narrogin – Wagin – Katanning (1042), compared to 567 per 100,000 across WA.

- Chronic iron deficiency anaemia: Narrogin – Wagin – Katanning (301 per 100,000), compared to 208 per 100,000 across WA.
- COPD: Narrogin – Wagin – Katanning (1586) and Albany (697), 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 Great Southern region, including:
- Acute cellulitis: Kojonup – Gnowangerup (943 per 100,000), compared to 816 per 100,000 across WA.
- Acute convulsions and epilepsy: Narrogin – Wagin – Katanning (1,644 per 100,000) and Manjimup – Denmark – Plantagenet (469), compared to 460 per 100,000 across WA.
- Acute dental condition: Albany (739 per 100,000), Narrogin – Wagin – Katanning (683), Kojonup – Gnowangerup (654), compared to 431 per 100,000 across WA.
- Acute ear, nose and throat infections (481 per 100,000), compared to 393 per 100,000 across WA.
- Acute urinary tract infections (including pyelonephritis): Narrogin – Wagin – Katanning (1,003 per 100,000), 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 for all IAREs in the Great Southern were below state rates.

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 associated restrictions.

In 2021-2022, the proportion of the 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 Great Southern can access primary care services through general practice, Aboriginal Community Controlled Health Services, integrated team care (ITC) programs and the hospital sector.

The Integrated Team Care (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 Great Southern region, the Country to City service is provided by Amity Health based in Albany.

There are two Aboriginal Community Controlled Health Organisations (ACCHOs) in the Great Southern located in Albany and Katanning.

The Great Southern Aboriginal Health Service has clinics located in Albany and Katanning. Medical services are provided to Aboriginal clients at home, in the community and clinics.

The South West Aboriginal Medical Service (SWAMS) is an Aboriginal Community Controlled Health Organisation and operates a mobile outreach clinic in Katanning.

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 Records.

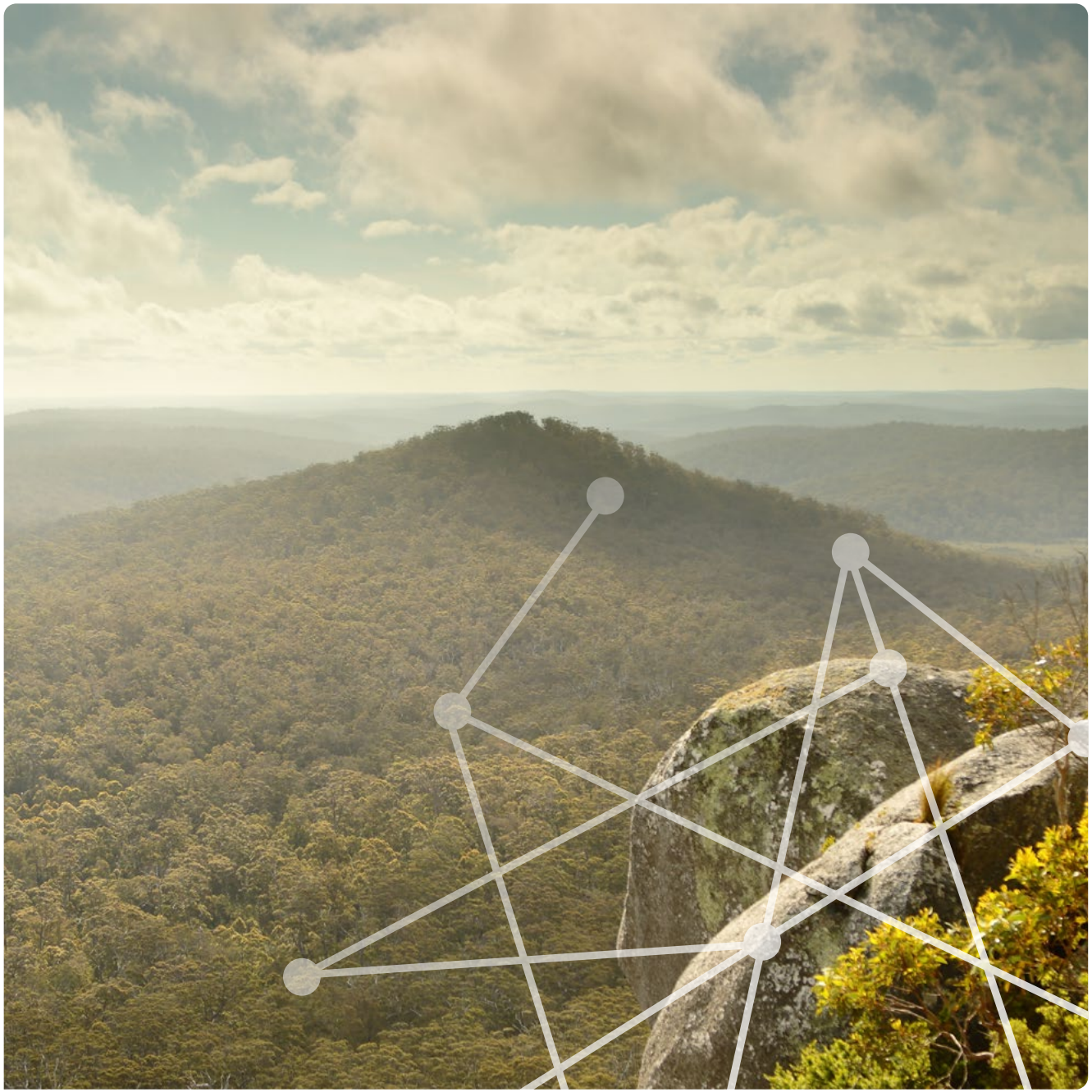
There has been a decrease in the proportion of people who have had at least one telehealth consultation in the 12-months from 30.8% in 2021-2022 to 27.7% in 2022-23. Those who had a long-term health condition (37.1%) are more likely to use telehealth compared to those without one (17.3%). In addition, 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 in low 10 to 15% rapidly moved to the 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 the 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 % entries 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 telehealth has become an essential part of health care service delivery in the Great Southern region, increasing accessibility to palliative care, specialist support and primary care from residential aged care places.

Palliative care can be delivered to terminally ill patients residing at home via videoconferencing; rural/remote doctors and nurses can receive support from a dedicated team of clinical specialists through The Command Centre (a virtual hub based in the Great Southern and Perth that operates 24/7); and GPs can access live patient readings during a telehealth consult through telehealth devices. It was also noted that Telehealth and My Record will add value to service coordination and care continuity while enhancing clinical governance.



WA Primary Health Alliance
Better health, together

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

Great Southern 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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