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An Australian Government Initiative

Kimberley

Needs Assessment 2025-2027

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Kimberley Priorities

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
The median age of death in the Kimberley region is significantly below state rates, and avoidable mortality is the highest in WA. Chronic diseases contribute significantly to the burden of disease in the Kimberley region, particularly cancer, cardiovascular diseases, musculoskeletal diseases and respiratory diseases. The region has high rates of smoking, a known risk factor for chronic disease.	The Kimberley has the highest rate of Potentially Preventable Hospitalisations (PPHs) in Western Australia (WA). There are high rates of PPHs related to chronic conditions, particularly chronic congestive failure, chronic obstructive pulmonary disease, diabetes, chronic angina and chronic iron deficiency anaemia. General Practitioner (GP) utilisation has decreased in the last five years. The high PPHs rate make it a complex region 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, including smoking cessation.**	Kimberley	Population health	Chronic conditions
Mental health is the second leading cause of disease burden in the region. Depression, self-harm, and suicide impact communities in the Kimberley with the region recording the highest rates of self-harm in WA.	Mental health-related Emergency Department (ED) presentations are the second highest in WA, placing burden on the hospital ED. Less than 1% of the population access psychological services through Medicare Benefits Schedule (MBS).	**Enable access to culturally appropriate mental health services for people who experience mental health challenges across the spectrum.**	Kimberley	Mental health	Early intervention and prevention System integration
Suicide is a serious issue for the Kimberley region, being the third leading cause of all deaths and accounting for 6% of deaths; significantly above state rates.	Access to suicide prevention services is limited in the Kimberley region with only one local provider. Fewer than 1% of the population have access a clinical psychologist through MBS services.	**Enable access to culturally appropriate mental health and early intervention suicide prevention services and support primary health care providers in identifying people at risk.**	Kimberley	Mental health	Access Early intervention and prevention

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Some residents are at risk of harm from alcohol misuse. Harmful alcohol consumption causes multiple chronic diseases resulting in complex care needs. In the Kimberley, 2 in 5 residents are at high risk of long-term harm from alcohol consumption.	Alcohol and other drug (AOD)-related ED presentations were the highest in the state, placing burden on the hospital ED.	**Enable access to early screening and treatment for harmful alcohol use and support primary health care providers in managing alcohol-related issues.**	Kimberley	Alcohol and other drugs	Access
More people are experiencing homelessness within the Kimberley region. Evidence shows that people experiencing homelessness often also experience mental health issues, substance use issues and/or at least one chronic condition.	Existing homeless 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.**	Kimberley	Population health	Access Chronic conditions
Childhood immunisation levels in the Kimberley 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.**	Kimberley	Population health	Immunisation

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
People from multicultural communities face challenges navigating the Australian health care system as well as financial and linguistic barriers to making appointments. Limited access to translator/ language services is creating significant difficulties for consumers to articulate their health concerns. Mental health, vaccines and psychosocial support are key areas with unmet need for multicultural people.	The Kimberely has the highest rate in the Country WA region of GP-type ED presentations by people born in predominantly non-English speaking countries relative to the size of its local multicultural population. Whilst there are two primary health care services in the Country WA region specialising in care for multicultural people, neither of these are located in the Kimbereley region. Service providers require more training to effectively and appropriately communicate with, and support, multicultural patients.	**Improve access to primary care services, early intervention, cultural safety and health literacy for multicultural communities through a care navigation service.**	Kimberley	Population health	Access Appropriate care (including cultural safety)
Aboriginal people in the Kimberley region experience some of the highest levels of socioeconomic disadvantage in WA and are impacted by poor health outcomes related to social determinants of health.	Aboriginal people in the Kimberley 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.**	Kimberley	Aboriginal health	Appropriate care (including cultural safety)

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Though the Kimberley has a relatively small proportion of older people compared to state rates, it is projected to increase and will represent 4,000 residents by 2030.	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. The growing population of older people will place increased pressure on aged care services.	**Support health and aged care providers in supporting older people 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.**	Kimberley	Aged care	Access
The Kimberley has a large Aboriginal population.	Access to aged care may be required at a younger age compared to other regions. Some older Aboriginal people may experience challenges in accessing aged care that meets their needs.	**Support health care and aged care providers in delivering patient-centred culturally appropriate care for older Aboriginal people.** **Enable access to culturally appropriate local aged care services for Aboriginal people aged 50+ years.**	Kimberley	Aged care	Access
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.**	Kimberley	Aged care	Access

Kimberley

Overview

The Kimberley region has the highest Aboriginal population in the state of Western Australia (WA), with over 100 Aboriginal communities of various population sizes, scattered throughout the region. The pertinent health concerns in the region are mental health, suicide and self-harm, chronic disease, alcohol and other drugs (also know as AOD).

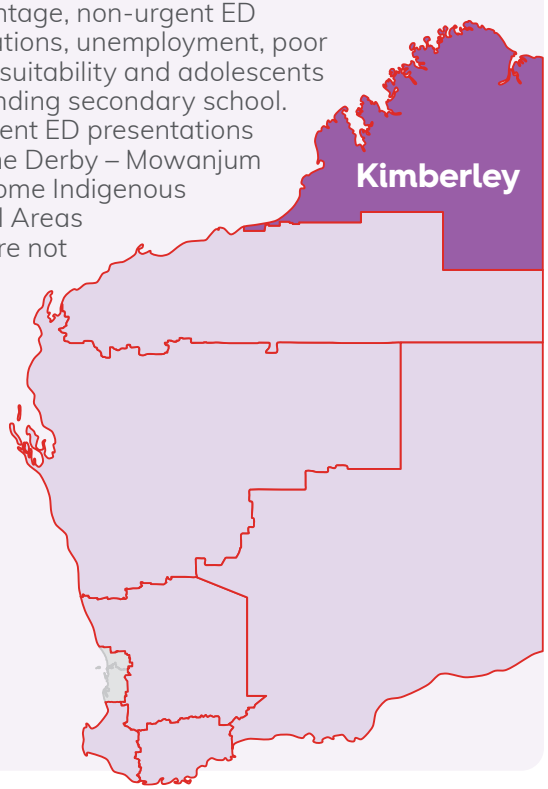
Workforce and access to services is a continuing issue for all rural communities and the Kimberley is similarly impacted. The region has limited access to allied health professionals and a shortage of mental health professionals.

The Kimberley Statistical Area Level Three (SA3) has the highest rate of suicide in the state, contributing to 6% of all deaths in the region. Mental ill-health was the second leading cause of disease burden in the region, but less than 1% of the population accessed a clinical psychologist through the Better Access Medicare Benefits Schedule (MBS) program.

The population in the Kimberley 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 dental conditions and acute urinary tract infections. Moreover, the region has the fourth highest cardiovascular burden in the region, together with a low utilisation of GP chronic disease management plans (CDMPs).

Kimberley has a moderate and growing ageing population expected to increase by 2% in the next 5 years, though it has a high residential aged care (RAC) service beds-to-population ratio compared to other SA3s in the Country WA Primary Health Network (PHN) with four residential aged care homes located in the region.

Residents experiencing short-term and long-term harm risk from alcohol use and high risk alcohol consumption, smoking, suicide and self-harm (including youth related) and ED presentations related to AOD were concerning. Aboriginal people in the Kimberley region experience some of the highest levels of socioeconomic disadvantage, non-urgent ED presentations, unemployment, poor housing suitability and adolescents not attending secondary school. Non-urgent ED presentations within the Derby – Mowanjum and Broome Indigenous Regional Areas (IARE) are not only the highest in the region, but also the highest in the state.



Population demographics

The Kimberley region is WA's northern most region and spans over 400,000 square kilometres. The Kimberley is made up of six major townships and over 200 small remote Aboriginal communities. The three largest towns of the Kimberley are Broome, Derby and Kununurra.

Major industries include mining and resources, tourism, agriculture, and aquaculture. The Kimberley is a major contributor to food production in WA with over 93 pastoral stations farming cattle and extensive crop production in the Ord River Irrigation Area. The aquaculture industry is dominated by pearling and barramundi farms while the mining and resources industry includes Iron Ore, Mineral Sand and Liquefied Natural Gas (LNG). The Kimberley has a sizeable tourism industry which attracts over 400,000 domestic and international visitors per year.

The population of the Kimberley region is 38,925, accounting for 7% of the Country WA PHN population of 563,438 (ERP 2022). Stakeholders have indicated that the Kimberley population is transient with locals moving frequently between various towns and communities.

Across the state, the Kimberley has the highest levels of socioeconomic disadvantage (Index of Relative Socio-economic Disadvantage=861, compared to 1012 in WA) as well as the largest population of Aboriginal people (14,402 people) representing 41% of the total population (ERP 2021).

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.

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

- Over 2,000 the Kimberley Statistical Area Three (SA3) residents were born in a non-English speaking country, equating to 6% of the local population, compared to 18% across the state.
- 3% of residents in the Kimberley SA3 have a profound or severe disability compared to 5% of residents across the state.
- 8% of residents in the Kimberley SA3 provide unpaid assistance to people with a disability compared to 11% of residents across WA.
- 41% of children in the Kimberley SA3 are developmentally vulnerable on one or more domains, compared to 20% across WA.
- The Kimberley has the largest homeless population in WA. In 2021, it was estimated that 1,035 people in the Kimberley SA3 experienced homelessness. This equates to 202 people per 10,000; above the state rate of 36 per 10,000. This includes 63% of residents experiencing homelessness 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 Kimberley SA3 (Composite Index Score, CIS=0.63) has the second highest level of unmet need for multicultural services in WA, driven by a high rate of GP-type ED presentations among people born in a predominantly non-English speaking country (6,794 per 10,000 people born in a predominantly non-English speaking country compared to 1,912 per 10,000 across WA). The rate in the Kimberley is the highest in the Country WA region.

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 status than the general Australian population, with fewer than one in (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.

Encouragingly, positive work is being done in the Kimberley, however, 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 level10. 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 Kimberley SA3 (CIS=2.55) is driven by its high rate of homeless persons and high level of socioeconomic disadvantage relative to other areas of WA. An estimated 1,032 residents are at risk of or currently experiencing homelessness; equating to the highest rate in WA, well above the state level (265 people per 10,000 compared to 48 per 10,000 across WA). The proportion of people staying in severely overcrowded dwellings is more prevalent in the Kimberley.

There are three local services supporting people experiencing homelessness, being Men's Outreach Broome, Derby Aboriginal Short Stay Accommodation (DASSA) operated by Mercy Care, and services delivered by the WA Country Health Service (WACHS) Kimberely division.

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 4,692 reports of family related assault in the Kimberley district, equating to an average of 391 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 COPD or emphysema), stroke, and mental health conditions (including depression or 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 Kimberley 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 ASR per 100 people for diabetes at 5.9 per 100, kidney disease at 1.5 people per 100, and for dementia (including Alzheimer's Disease) at 1.0 people per 100. It also has the second highest ASR in the Country WA PHN for heart disease (3.9 per 100). Each of these exceeds the state rate:

	ASR per 100 people	
	Kimberley SA3	WA
Heart disease (including heart attack and angina)	3.9	3.7
Diabetes (excluding gestational diabetes)	5.9	4.5
Kidney disease	1.5	0.8
Dementia (including Alzheimer's disease)	1.0	0.7

Rates of clinician-diagnosed diabetes using WAPHA's new method of estimating condition prevalence from general practice Data was not calculated for the Kimberley, as the data collected in general practice will not be reflective of the wider population.

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 Kimberley region has a significantly higher rate for the risk factor of residents smoking tobacco when compared to the state level. Concerningly, one in five (20%) residents are current smokers, the second highest rate in the County WA PHN and in WA, after East Pilbara at 22%.

The prevalence of diabetes within the Kimberley SA3 is among the top 5 SA3s (with the highest being Mid West at 8%) in the Country WA PHN, with the rate for the SA3 being on par with that of the state at 7%.

Reported stress levels in the Kimberley region are not only above the state rate, they are also the highest in WA, with nearly one quarter (22%) of residents reporting stress, compared to of 12% across WA.

A positive indicator in the Kimberley region is that the prevalence of residents who are not overweight or obese is significantly higher than WA, with 2 in 5 (36%) in the region being reported as such.

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.

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 Kimberley region had a 1.9 times higher rate of fatal burden and 1.4 times higher rate of non-fatal burden compared to the metropolitan regions. Chronic disease accounts for a substantial proportion of the burden of disease, with cancer, and cardiovascular burden in the state, accounting for 14, and 13% of the total burden in the region respectively, the highest in the state for each condition. Further, the region also had the equal third highest musculoskeletal disease burden in the state (equal to East Metro), accounting for 7% of the total burden in the region.

Coronary heart disease, chronic kidney disease and suicide were also among the five leading causes of disease burden, this was along with alcohol use disorders and COPD for males and road traffic incidents and Type 2 diabetes for females.

Leading causes of total disease burden in the Kimberley region		
Condition	%	ASR per 1,000
Injury	18%	39.2
Mental	15%	34.9
Cancer	14%	43.5
Cardiovascular	13%	37.9
Musculoskeletal	7%	22.5

Potentially preventable hospitalisations for chronic conditions

Potentially preventable hospitalisations (PPHs) are certain hospital admissions (both public and private) that could have potentially been prevented by timely and adequate health care in the community. However, only public hospitals data are reported in this document. 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.

Across the state as reported for 2020/21, the age-standardised rate of PPHs per 100,000 for total chronic conditions was 903 and the highest admission rates for WA were for chronic congestive cardiac failure (196), chronic obstructive pulmonary disease (184), and chronic diabetes (178).

Relative to other parts of WA, the Kimberley SA3 has the highest rate for total chronic conditions (4,009 people per 100,000, compared to 903 per 100,000 across WA). This is driven by having the highest rates for WA for chronic angina, chronic asthma, congestive cardiac failure, diabetes, chronic iron deficiency and COPD.

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 Kimberley SA3 have comparatively lower utilisation, at 12%.

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 93% of children were fully immunised at 1 year and 92% at 5 years, compared to only 90% at 2 years.

AIR reports that the Kimberley SA3 met the 95% immunisation target for children aged 5 years and though slightly lower for 1 (92%) and 2 years (90%), these figures were still above target.

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 Kimberley SA3 were concerningly low, well under state levels and among the lowest in WA. Slightly over one in five (22%) eligible residents had participated in bowel cancer screening, compared to the state level of 42%, which in itself is low. Approximately 2 in 5 (43%) had participated in breast cancer screening (compared to 51% across WA), and one in two (57%) had participated in cervical cancer screening, compared to the state level of 69%.

These levels are particularly concerning given the rate of avoidable deaths from cancer in the Kimberley SA3s is near to the state level. 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. Additionally, WA State crude rates of notifications have dropped from 31.8 to 28.8 per 100,000,

however only 56% of notifications had a completed enhance surveillance form 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 235.3 per 100,000, the rate of syphilis notifications in the Kimberley SA3 was more than eight times the state rate of 28.8 per 100,000. Though this has decreased by 39% compared to the 2021-2022 period, the Kimberley region has the highest syphilis notification rates among all regions in WA.

Avoidable mortality

The median age of death in the Kimberley SA3 is below the state median age of 81 years, at 62 years. Sadly, the Kimberley has the second youngest median age at death in WA, above the East Pilbara SA3 (59 years).

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 Kimberley SA3 exceeds the state rate of 117.6 per 100,000 at 307.1 per 100,000 and it is the highest in the state. The Kimberley SA3 has the highest rate of avoidable deaths in eight causes. These causes are diabetes, cerebrovascular diseases, ischaemic heart disease, suicide and self-inflicted injuries (both in 0 to 44 and 0 to 74 years), circulatory system diseases, other external causes of mortality (Transport accidents; Accidental drowning and submersion; etc.) and selected external causes of mortality (Falls; Fires, burns; Suicide and self-inflicted injuries; etc.).

According to the Mortality Over Regions and Time (MORT) data, the rate of premature deaths (people under 75 years) in the Kimberley SA3 is more than double the state rate of (489 vs. 195 per 100,000). This rate was the highest rate of premature deaths within WA.

The five leading causes of death and their percentage with respect to all death causes within the Kimberley SA3 are:

Rank	WA	Kimberley
1	Coronary heart disease (11%)	Coronary heart disease (11%)
2	Dementia (including Alzheimer's) (9%)	Diabetes (8%)
3	Cerebrovascular disease (5%)	Suicide (6%)
4	Lung cancer (5%)	Lung cancer (5%)
5	COPD (4%)	Land transport accidents (5%)

Utilisation of primary care services

GP utilisation in the Kimberley SA3s is below state levels and declined between 2021-2022 and 2022-2023. In 2022-2023, approximately 7 in 10 (68%) residents in the Kimberley SA3 visited a GP; compared to 84% across WA. This was a reduction from 2021-2022 levels, where 73% of Kimberley 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. The Kimberely SA3 (CIS=0.96) has the third highest level of unmet need for after-hours services in WA. It has the second lowest supply of after-hours primary care services relative to its population, as well as the highest rate of after-hours GP-type ED presentations, high level of socioeconomic disadvantage and high level of homelessness.

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 Kimberley SA3 have greater utilisation of GP health assessments compared to the state (11% vs. 5%). Not only is the rate higher

than WA, it is also the highest in the state. 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 and Allied Health services are not heavily used in the region with the rates being some of the lowest in the Country WA PHN. The latest data reports that 2% of Kimberley SA3 residents have used a nurse practitioner service, lower than the state rate. 16% of the population in Kimberley SA3 utilised Medicare-subsidised allied health services, which is well below utilisation rates of 36% for the state, however, stakeholders have indicated that Boab Health provide primary care allied health services across the region.

The nursing and Aboriginal health worker service group consists of Medicare-subsidised services delivered by a nurse practitioner, practice nurse, midwife or an Aboriginal health worker. Approximately 1 in 5 (17%) residents in the Kimberley SA3 used a Medicare-subsidised practice nurse/Aboriginal health worker, two and a half times greater than the state rate, along with being the highest rate in WA.

Visiting specialist services

The Kimberley relies on visiting specialists to provide care, often through monthly or quarterly visits (with some visits only occurring in larger town sites) and in some cases require patient trips to Perth. Feedback from local stakeholders has identified issues such as multiple referrals for clients being received and placed on the waiting list, remote clients booked in the following day for a specialist service (without awareness of the distance required to travel), and lack of financial support for families to travel if the care giver requires specialist appointments. Many clients living in remote areas require assistance from the Patient Assisted Travel Scheme (PATS) and Aboriginal clients may require top-up funds from Integrated Team Care (ITC) in order to access specialist services. Stakeholders also highlighted issues with communication from specialists back to the referring agency due to various health management systems in place. These coordination and communication issues represent barriers to accessing timely health care and may adversely impact patient experience of care.

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 low access to GP services across the Kimberley region. Overall, 70% of SA3s across WA have higher access relative to need compared to the Kimberley 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 one 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 one 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 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 Kimberley SA3 has 75 GPCSE per 100,000 residents. This 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, Broome, Derby and Kununurra GP catchments are noted as being of particularly high need for GP workforce, largely due to recruitment challenges linked to housing and childcare. Accredited training organisations continue to remain concerned at the lack of GP Registrars applying and choosing Broome as a placement location. The high cost of living, housing affordability and lack of childcare places are proving detrimental to attracting GP Registrars to the catchment. The affordability of housing is a barrier to GPs choosing to reside in the area, with the average weekly rental cost being $799, above the WA state median cost ($526 per week) and more than double the median cost of Country WA GP catchments ($355 per week). Further, shorter contracts do not work due to lack of rentals and childcare placement, thus, recommendations have been made to extend six month contracts in Broome to 12-18 months to incentivise GP Registrars to remain in the GP catchment. There is capacity available at all accredited training locations in Broome to locally train GP Registrars if these barriers can be overcome.

Based on its geographic access to health services, the Derby GP catchment (within the Kimberley 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 93% in the most disadvantaged quintile in WA. Approximately three fifths (63%) of residents identify as Aboriginal. There are potential financial incentives available with the ability for GP Registrars to request a 12-month placement, and access GP college flexible funds to assist with relocation and ongoing cost of living which may improve attraction to the GP catchment. Unfortunately, housing availability (reflected by the low residential vacancy rates that are below state rate), along with the 12-month waitlist for childcare placements, present a significant challenge.

The GP catchment of Kununurra is classified as having relatively high need for GP workforce. Both childcare and housing availability are noted as a significant barrier to recruitment. The catchment has three local general practices, two of which are accredited to train GP registrars. More than half of residents fall within WA's most disadvantaged socioeconomic quintile. 2 in 5 (44%) residents identify as Aboriginal.

Due to both Fitzroy Crossing and Halls Creek having no general practice, the shared recommended approach by GP colleges is that broader workforce strategies are required.

Primary care nurses

The Kimberley SA3 has the third highest supply of primary care nurses in the state at 254 primary care nurse FTE or 6.5 FTE per 1,000 residents compared to 2.5 FTE per 1,000 across WA.

Aged care

The Kimberley has a smaller proportion of people aged 65 years and over as compared to other Country WA PHN regions. In 2022, there were 2998 representing 8% of the population. This is projected to increase to 10% of the population or almost 4000 people 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 have three or more long-term health conditions. This was lower in the Kimberley SA3, with 7% of residents aged 65 years and older living with three or more long-term health conditions.

Approximately three in five (59%) general practise patients aged 65 years or older were diagnosed with three or more chronic conditions across WA. Data for Kimberley SA3 is not provided due to poor representation of the population who accesses a primary health service in the region. Please note, these data include 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 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. Data for Kimberley SA3 is not provided due to poor representation of the population who accesses a primary health service in the region.

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 above state levels in Kimberley SA3 at 129.5 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. Data was not provided for the Kimberley 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 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 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.

Home care in the Kimberley is provided by community-based organizations, the WA Country Health Service and religious organisations. In 2023,

there were nine aged care services in Kimberley SA3. As at December 2023, there were 151 people in a HCP in the Kimberley Aged Care Planning Region (ACPR). An additional 32 people were waiting for a HCP with one person requiring the highest level of care (level 4).

WA has 249 residential aged care services with a total of 19,887 residential places. With one of the lower proportions of elderly population among the SA3s in the Country WA PHN, the Kimberley SA3 has a beds-to-population ratio that is above the state with 103 beds per 1,000 people aged 70 years and over (vs 64 per 1,000 in WA). Within the Kimberley SA3 there were four residential aged care homes totalling to 166 residential places; these include multipurpose facilities managed by the WA Country Health Service and specific Aboriginal aged care services. Although, the Kimberley has a relatively high ratio of beds to population, it does not take into account the large population of Aboriginal people, who are likely to require residential aged care services at a younger age.

The Kimberley SA3 has a relatively high supply of nurses working in aged care at 18.3 FTE per 1,000 people aged 70 years and over which compares to 12.2 FTE per 1,000 across WA. The relatively high ratio reflects the low number of people aged 70 years and over in the region.

Alcohol and other drugs

Alcohol and drug use is a significant issue in the Kimberley SA3. 2 in 5 (41%) residents are at risk of long-term harm from alcohol, significantly higher than the state rate of 26%. Levels of short-term alcohol harm (17%) and high risk alcohol consumption (60%) are also significantly higher than state rates (10% and 32% respectively). Furthermore, the Kimberley SA3 has the second greatest proportion of current smokers (20%), nearly double that of the state rate of 11%.

Rates of clinician-diagnosed chronic alcohol misuse and chronic drug misuse using WAPHA's new method of estimating condition prevalence from general practice Data was not calculated for the Kimberley, as the data collected in General Practice will not be reflective of the wider population.

In 2020-21 Injuries, Poisonings and Toxic Effects of Drugs were in the top five major diagnostics categories for ED attendances in the Kimberly region making up 9% of total ED attendances.

Stakeholders in the Kimberley region have concerns about Fetal Alcohol Spectrum Disorder (FASD) in their communities. Fitzroy Crossing in the West Kimberley region of WA has the highest reported prevalence in Australia with rates of FASD or partial FASD in 12 per 100 children. This is on par with the highest rates internationally.

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 Kimberley region. Tobacco use contributed to 23% of cancer burden and 26% of cardiovascular disease, with men aged 45-64 years and 65+ years having the highest risk of burden. Men in the Kimberley region also had a higher risk of disease due to alcohol use (17%), tobacco use (11%) and illicit drug use (7%) compared to women (8%, 7% and 4%).

Alcohol contributed to the burden of 40% of mental and substance use disorders, 27% of injuries, 10% of cancer and 2% of cardiovascular disease. The 15-24 year age group had the most risk of alcohol use leading to disease.

Illicit drugs also had a high contribution to burden with 12% of mental and substance use disorders, 17% of injuries and 2% of cancer burden being attributed to illicit drug use in the Kimberley in 2015.

Out of all the regions in WA, Kimberley had the highest rates of burden of disease from risk factors compared to State rates.

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 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 7 unintentional drug-induced deaths in the Kimberley SA3, equating to a rate of 3.7 per 100,000 people – the third lowest rate in WA, and below 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 Kimberley SA3 is above the state rate of 0.8%, at 3.3%. However, at 3%, treatment uptake in the Kimberley is slightly below the state levels of 9%.

Chronic hepatitis C (CHC) levels in the Kimberley region are comparable to the state rate of 0.7%, with 1.4% prevalence. The CHC treatment uptake of 25% in the Kimberley SA3 is considerably below that of the state level at 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, not-for-profit organisations and Aboriginal organisations. The WA Country Health Service provides the Kimberley Community Alcohol and Drug Service in Kununurra, Halls Creek, Derby, Fitzroy Crossing and Broome. This service provides assessment, counselling and referral and support for people experiencing alcohol and other drug issues to help reduce alcohol and other drug related harm in the region.

Cyrenian House – Milliya Rumurra Aboriginal Corporation provides individuals and their families with improved access to alcohol and other drug services on an outreach basis, servicing the communities north of Broome along the Dampier Peninsula and south to Bidyadanga. This service also provides residential treatment and rehabilitation services to Aboriginal people. Alcohol and other drug services are also provided by Aboriginal organisations in Wyndham, Fitzroy Crossing, Kununurra and Derby.

Mental health

Mental health was the second leading cause of disease burden in the Kimberley region contributing 15% to the total disease burden for the region. Suicide and self–inflicted injuries were the leading cause of burden of disease for males in the Kimberley contributing to 11% of the disease burden.

Approximately 1 in 10 residents in the Kimberley SA3 have been diagnosed with anxiety (13%), depression (11%) and high or very high psychological distress (10%). 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 Kimberley SA3 is slightly below the state level (13%).

Rates of clinician-diagnosed depression and anxiety using WAPHA's new method of estimating condition prevalence from general practice data was not calculated for the Kimberley, as the data collected in general practice will not be reflective of the wider population.

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.

Suicide is a serious issue for the communities in the Kimberley. At a rate of 32.9 per 100,000 people, suicide in the Kimberley SA3 is above state levels and an area of great concern.Fifty-eight people died from suicide in the Kimberley SA3 between 2018 to 2022. Suicide ranks as the third leading cause of death in the Kimberley accounting for 6% 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 Kimberley SA3, 6% of the population indicated that they thought seriously about ending their own lives, slightly below the state rate of 7%.

Self-harm is a strong risk factor for suicide. At a rate of 255.7 per 100,000 residents, hospitalisations for self-harm in the Kimberley SA3 is two and a half times above the state level (97.9 per 100,000) and the highest rate in WA. Self-harm hospitalisations were highest for females and for people aged 25 – 44 years.

The State Coroner's Inquest into the deaths of thirteen children and young persons in the Kimberley noted the impact of intergenerational trauma in Aboriginal communities and recommended increased coordination and accountability between service providers and agencies. The Kimberley was identified as one of twelve locations across Australia to participate in the National Suicide Prevention Trial. The trial was aimed to develop a model of suicide prevention that meets the unique and culturally sensitive needs of the region's Aboriginal communities.

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 Kimberley region. The Kimberley SA3 has Mental Disorder-related ED presentations well above state rate, at 1,139 per 10,000 12-17-year-olds, it is three times the state rate when compared to the 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 Kimberley region, based in Broome and Kununurra. The Kimberley SA3 has the second highest utilisation levels at 7% of residents aged 12-25; above the state level of 2%. Each patient's episode of care comprised of an average of 5.2 occasions of service (i.e. interactions with the service or mental health worker) in the Kimberley SA3; slightly more interactions when compared to the WA average of 4.2.

The Australian Youth Self-Harm Atlas reports that the overall prevalence of suicidality (suicidal thoughts or behaviours, including ideation, plans, and attempts) in both the Kimberley SA3s are above the state rate of 9%, this is bolstered specifically by prevalence rates of self-harm (regardless of intent), non-suicidal self-harm and suicidal ideation, which 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 much concern in the Kimberley region. The proportion of 12 to 17-year-olds experiencing major depression or anxiety disorders in the Kimberley SA3s is well both above the state level, at 32% compared to 9% across WA.

Suicide and self-inflicted injuries were the leading course of disease burden for 15 to 24-year-olds contributing to 34% 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 greatly concerning to note self-harm hospitalisations among people aged 0-24 years in the Kimberley SA3 are above state levels (202.8 vs. 139.7 per 100,000).

Mental health services

Mental health services in the Kimberley are provided by the WA Country Health Service, not-for-profit organisations and Aboriginal Community Controlled Organisations. There are approximately 19 mental health services in the region, 8 of which have dedicated youth services. The WA Country Health Service provides adult community mental health services, child and adolescent mental health services and the Statewide Aboriginal Mental Health Service. Aboriginal Mental Health Workers play key roles in multidisciplinary teams, strengthening the cultural competence of the mental health services and improving access to services for Aboriginal people and Aboriginal communities. The headspace service provides psychological services to youth in Broome. Anglicare offers counselling services in Kununurra, Halls Creek, Broome and Derby. Boab Health Services provide psychological intervention for mild to moderate mental health issues across the Kimberley region and provide a mental health service for children and youth.

Stakeholders have indicated staff retention and the cost of travelling vast distances to provide clinical services as challenges to service provision in the Kimberley. Services are located in the major townships and outreach is hampered by travel barriers and costs particularly in the wet season as it can be prone to flooding.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. In the Kimberley SA3, 4% have accessed a GP mental health treatment plan; 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. The Kimberley itself has the greatest supply of psychologists in the Country WA PHN and is near the state rate, with 11 psychologists per 10,000 people in the region. Less than 1% of the population

access a clinical psychologist, compared to 2.2% across WA. This could indicate that there is a reliance for mental health care in the Kimberley on services provided by the WA Country Health Service, the not-for-profit sectors or at EDs.

Aboriginal health

The Kimberley region has the largest population of Aboriginal people in WA, with an estimated 19,856 Aboriginal people representing over half of the region's population. There are over 30 different language groups in the Kimberley and over 200 remote Aboriginal communities. English is often a second or third language for Aboriginal people in the Kimberley with the most common languages being Kriol, Jaru, Kukatja, Walmajarra and Kija.

Aboriginal people are dispersed throughout the four Local Government Shires that make up the Kimberley region. The 2021 Census reports that the WA Local Government Area (LGA) with the second and third most Aboriginal people were Broome (4,847) and Derby – West Kimberley (4,267). Further, Halls Creek (78%) and Derby – West Kimberley (60%) are in the top three LGAs with the greatest proportion of Aboriginal people.

The Aboriginal people in the Kimberley region, spanning the Indigenous Regional Areas (IAREs) of Broome, Broome – Surrounds, Derby – Mowanjum Fitzroy Crossing, Outer Derby – West Kimberley, Fitzroy River, Great Sandy Desert, Halls Creek, Halls Creek – Surrounds, Argyle – Warmun, North Kimberley, Kununurra, Wyndham and Kalumburu, are some of the most disadvantaged in the state. The Indigenous Relative Socio-economic Outcome Index (IRSEO) represents the Indigenous Areas (IAREs) of social and economic disadvantage among Aboriginal people. Indicators reflecting disadvantage include low income, low educational attainment, high unemployment, and reliance on housing support. A lower value represents a lower level of disadvantage, with a high value representing highly disadvantaged populations. The IRSEO score indicates that IAREs in the Kimberly region had a higher disadvantage compared to the score of 51 for WA overall, with all IAREs except Broome (Note: Data for Outer Derby – West Kimberley are not published) having an IRSEO of 80 or more. Kalumburu and Great Sandy Desert had the highest levels of disadvantage for Aboriginal people living in the Kimberley with IRSEOs of 97 and 94 respectively.

Unemployment is higher in the Great Sandy Desert IARE with an estimated 56% of Aboriginal residents without work. This is followed by the Halls Creek – Surrounds IARE, with approximately 39% of residents unemployed. Aboriginal households in the region had a low income, drastically greater than the state average of 54%, notably, 95% of households in IAREs of Fitzroy River, Great Sandy Desert, Halls Creek – Surrounds and Kalumburu have a low income.

Housing is an issue in the region, with approximately 43% of Aboriginal people living in social housing in the Kimberley SA3 compared to 33% of Aboriginal people across WA. In the Kimberley SA3, higher proportions of Aboriginal people are living in social housing in Kalumburu (99%), Fitzroy River (98%), Great Sandy Desert (95%), Broome – Surrounds (93%) and Outer Derby – West Kimberley (90%).

All IAREs in the Kimberley region experience poor housing sustainability, in particular Argyle – Warmun, Kalumburu, Great Sandy Desert and Fitzroy Crossing have 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 the Derby – Mowanjum, Halls Creek – Surrounds, Fitzroy River, Great Sandy Desert and Broome – Surrounds are concerningly low with less than 40% of Aboriginal people aged 16 participating in full-time secondary school education.

Aboriginal children in the Kimberley are also impacted by disadvantage. About 76% of Aboriginal children in the Halls Creek IARE, 72% in Fitzroy Crossing and 65% in Kununurra were developmentally vulnerable in one or more domains. In the Derby – Mowanjum, Outer Derby – West Kimberley, Fitzroy River and Fitzroy Crossing IARE, 63% of Aboriginal mothers smoked during pregnancy, though the Kimberley as a whole, is of great concern as each IARE that falls within the region is above the state rate of 44%. Further to this, the percentage of Aboriginal babies born with a low birthweight in Great Sandy Desert, Halls Creek and Halls Creek – Surrounds IAREs was higher than WA (22% respectively compared to 13%).

Rheumatic heart disease (RHD) is noted as being a significant concern in the Kimberley SA3. 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.

Childhood 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 on par with the target for 5-year-olds in the Kimberley SA3, however, it is below target for age groups for 1 (92%) and 2-year-olds (90%). In the Kimberley region, only IAREs Halls Creek and Derby – Mowanjum are above the target rate for all ages of children (where figures were not suppressed due to low numbers). Fitzroy Crossing had the lowest rates in the region for both 1 (84%) and 2 year olds (83%) and Broome – Surrounds had the lowest for 5-year-olds (70%). This suggests that interventions should be targeted to increase immunisation coverage for this age group.

Lower urgency emergency department presentations

High rates of lower urgency ED attendances can be indicative of a gap in primary health care services. In the Kimberley, the rate of total non-urgent ED presentations for Aboriginal people (13,091 per 10,000 Aboriginal people) is over double the rate when compared to WA (6,167 per 10,000). Within the whole of WA, the Kimberley SA3 had the second highest rate of non-urgent ED presentations after the Gascoyne SA3 (13,091 per 10,000 Aboriginal people vs 14,586).

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 Kimberley SA3 recorded the highest level, nearly three times the state rate, at 307.1 per 100,000. The Kimberley SA3 exceeds state levels on a majority of reported conditions underpinning avoidable deaths, with the most concerning being circulatory system diseases (100.1 per 100,000), ischaemic heart disease (58.9), diabetes (45.3) and other external causes (e.g., transport accidents, accidental drowning) (44.4). Circulatory system diseases were higher than the Country WA PHN rate (101.1 per 100,000) in the Great Sandy Desert, Broome – Surrounds, Argyle – Warmun, Fitzroy River, Halls Creek, Outer-Derby – West Kimberley, Kununurra and Fitzroy Crossing IAREs. Broome – Surrounds had the highest rate of diabetes and other external causes (e.g., transport accidents, accidental drowning) among all the IAREs in the Kimberley region. There was limited data available for the IAREs for avoidable deaths from suicide and self-inflicted harm with only the rate for the Broome IARE available, at 36.1 per 100,000 (above the state rate of 32.6 per 100,000).

Potentially preventable hospitalisations

The average annual rate of total PPHs per 100,000 for Aboriginal people is above the state level for seven of the fourteen IAREs. In the Kimberley region, the rates above state ranged from 7,416 to 23,010 per 100,000. Fitzroy Crossing has the highest rate, followed by Derby – Mowanjum (17,229), Halls Creek (16,978), Kununurra (15,393), Wyndham (12,153) Broome (10,931) and Kalumburu.

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 Kimberley region exceeded state rates:

- Chronic angina: Fitzroy Crossing (590 per 100,000), Derby – Mowanjum (344), Broome (290) and Kununurra (266), compared to 206 per 100,000 across WA.
- Chronic asthma: Kununurra (507 per 100,000), Halls Creek (462), Fitzroy Crossing (419), Derby – Mowanjum (362), Broome (206), Argyle – Warmun (205) and Wyndham (200), compared to 192 across WA.
- Chronic congestive cardiac failure: Fitzroy Crossing (1,455 per 100,000), Derby – Mowanjum (1041), Halls Creek (987), Kununurra (906), Broome (557), Wyndham (532) and Kalumburu (473), compared to 405 per 100,000 across WA.
- Chronic diabetes complications: Fitzroy Crossing (2,358 per 100,000), Halls Creek (1,537), Kununurra (1,454), Derby – Mowanjum (1,296), Wyndham (985), Broome (723) and Kalumburu (684), compared to 567 per 100,000 across WA.
- Chronic iron deficiency anaemia: Broome (697 per 100,000), Wyndham (390), Derby – Mowanjum (282), Halls Creek (281) and Fitzroy Crossing (257), compared to 208 per 100,000 across WA.
- COPD: Kununurra (2,177 per 100,000), Fitzroy Crossing (1,327), Derby – Mowanjum (1,099), Wyndham (1,070), Halls Creek (968), Kalumburu (943) and Broome (745), 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 Kimberley region, including:

- Acute cellulitis: Fitzroy Crossing (4,283 per 100,000), Derby – Mowanjum (3,624), Kununurra (2,523), Halls Creek (2,336), Wyndham (2,095), Broome (1,763), Kalumburu (1,462), North Kimberley (1,155), Argyle – Warmun (1,041) and Outer Derby – West Kimberley (1,035) compared to 816 per 100,000 across WA.
- Acute convulsions and epilepsy: Fitzroy Crossing (1,412 per 100,000), Halls Creek (1,207), Derby – Mowanjum (728), Broome (658), Kununurra (517) and Kalumburu (470), compared to 460 per 100,000 across WA.
- Acute dental condition: Fitzroy Crossing (965 per 100,000), Broome (806), Wyndham (791), Halls Creek (763), Derby – Mowanjum (737) and Kununurra (655), compared to 431 per 100,000 across WA.
- Acute ear, nose, and throat infections: Fitzroy Crossing (2,371 per 100,000), Derby – Mowanjum (1,732), Halls Creek (1,564), Wyndham (1,026), Kununurra (843), Kalumburu (782), North Kimberley (558), Halls Creek – Surrounds (544), Broome (475), Argyle – Wamin (468) and Outer Derby – West Kimberley (450) and Fitzroy River (440), compared to 393 per 100,000 across WA.
- Acute urinary tract infections (including pyelonephritis): Fitzroy Crossing (2,201 per 100,000), Halls Creek (1,419), Kununurra (1318), Derby – Mowanjum (1,230), Wyndham (903), Broome (813), Kalumburu (563), Outer Derby – West Kimberley (549) and North Kimberley (529), and 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 in the Kimberley region, including:

- Total PPHs for vaccine-preventable conditions: Halls Creek (3,132 per 100,000), Fitzroy Crossing (2,829), Derby – Mowanjum. (2,594), Kununurra (2,082), Broome (1,897), Wyndham (1,718) and North Kimberley (862), compared to 278 per 100,000 across WA.
- PPHs for pneumonia and influenza: Kununurra (872 per 100,000), Derby – Mowanjum (719), Wyndham (682), Halls Creek (679), Fitzroy Crossing (642), Broome (592), Argyle – Warmun (398) and North Kimberley (320), compared to 855 per 100,000 across WA.

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 Kimberley 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 and Torres Strait Islander health project officers, outreach workers and care coordinators. In the Kimberley region, the Country to City ITC service is provided by BOAB Health service.

Kimberley Aboriginal Community Controlled Health Organisations (ACCHOs) Kimberley Aboriginal Medical Services (KAMS) is a member based, regional ACCHO supporting and representing the interests of eight independent Kimberley ACCHOs, and Kimberley Renal Services. There are eight ACCHOs in the Kimberley region located in the Broome, Broome – Surrounds, Derby – Mowanjum, Kununurra, Halls Creek, Fitzroy Crossing and Great Sandy Desert IAREs.

The Broome Regional Aboriginal Medical Service (BRAMS) is based in Broome. BRAMS provides comprehensive, holistic and culturally responsive primary health care, social and emotional wellbeing services, and NDIS support to Aboriginal people living in Broome, delivering more than 40,000 of occasions of service each year.

Derby Aboriginal Health Services (DAHS) is an ACCHO providing culturally appropriate health education, promotion, and clinical services to the Derby community in WA. It provides primary health care services, regular allied health and medical specialist services as well as a range of programs via its main clinic in Derby. Further, it also delivers health services to seven remote Aboriginal communities in the Kimberley region.

Ord Valley Aboriginal Health Service (OVAHS) provides a comprehensive primary health care service to Aboriginal people in the East Kimberley region. Preventative and public health programs include maternal and child health, women's health, chronic disease, sexual health and along with the OVAHS Social Support Unit. The Social Support Unit offers alcohol and other drug services, mental health services, health promotion and education programs in the areas of FASD prevention, smoking cessation, chronic disease prevention, childhood health promotion and sexual health.

Nindilingarri Cultural Health Services (NCHS) is an ACCHO that provides a range of health promotion, health and environmental health services, and community services to people in the Fitzroy Valley.

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.

Whilst there are digital health initiatives to assist health providers ensure that primary health care services are delivered locally to the communities across the Kimberley, such as the 2021 initiative in 2021 by KAMS deploying a telehealth system across the region, there are challenges in accessing digital health services in some remote regions in WA. These challenges, which include 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, make it more difficult for consumers.

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Kimberley 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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