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An Australian Government Initiative

Wheatbelt

Needs Assessment 2025-2027

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Wheatbelt Priorities

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Chronic diseases contribute significantly to the burden of disease in the Wheatbelt region. There are high rates of multimorbidity and avoidable deaths due to chronic conditions. Rates of clinician-diagnosed diabetes are above state levels. The region has high rates of risk factors for chronic conditions, including high levels of obesity and smoking, and low levels of physical activity.	There are high rates of Potentially Preventable Hospitalisations (PPHs) related to chronic conditions, particularly diabetes, chronic arthritis and chronic asthma.	**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.**	Wheatbelt	Population health	Chronic conditions

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Mental health is the second leading cause of disease burden in the Wheatbelt region. Suicide is a serious issue, accounting for 3% of all local deaths. Youth mental health is a significant issue, with mental health being the leading cause of disease burden for youth in the Wheatbelt, with high levels of self-harm and suicidal ideation among residents aged 12 to 17 years.	There are high rates of mental health-related Emergency Department (ED) presentations, and high rates of self-harm hospitalisations, including among young people under 25. Access to primary mental health services is limited in the Wheatbelt region with a relatively low rate of psychologists per 10,000 people and only 1% of the population accessing a clinical psychologist or psychiatrist through Medicare Benefits Schedule (MBS) services. Two local providers deliver suicide prevention services for the region. Access to youth-focused mental health care is required to offset the concerning levels of need in this group, however Western Australia (WA) youth mental health providers face challenges meeting demand.	**Support general practices in identifying people at risk of suicide and referring to appropriate services, including telehealth mental health providers.** **Enable access to culturally appropriate mental health care and early intervention suicide prevention services, including for young people.**	Wheatbelt	Mental health	Access Early intervention and prevention
Residents are at risk of harm from alcohol use, smoking and illicit drug use. Rates of clinician-diagnosed chronic alcohol misuse and chronic drug misused are significantly higher in the Wheatbelt - North Statistical Area Level 3 (SA3) compared to the state rate.	Alcohol and Other Drugs (AOD)-related ED presentations are relatively high in the Wheatbelt - North SA3 compared to other areas in Country WA.	**Enable access to screening and AOD treatment services.**	Wheatbelt	Alcohol and other drugs	Access

Health need	Service need	Priority	Priority location	Priority area	Priority sub-category
Childhood immunisation levels in the Wheatbelt region are below the 95% target for Aboriginal and non-Aboriginal children.	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.** **Minimise the risk of vaccine-preventable illnesses by ensuring children are up to date with their immunisation program.**	Wheatbelt	Population health	Immunisation
Aboriginal people in the Wheatbelt region experience significant levels of socioeconomic disadvantage compared to Aboriginal people in other parts of WA, and may be at risk of experiencing poor health outcomes related to social determinants of health.	Aboriginal people in the Wheatbelt - North SA3 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.**	Wheatbelt	Aboriginal health	Appropriate care (including cultural safety)
The Wheatbelt region has a large and growing older adult population. By 2030, 1 in 4 residents will be aged over 65. Older people are more likely to be living with a chronic condition compared to the general population, and 1 in 10 have three or more long-term conditions.	Despite having a relatively high number of aged care services in the region, there is a considerable wait list for at-home support and the Wheatbelt - North SA3 has a low aged care beds-to-population ratio. The growing population of older people in the region will place increased pressure on aged care services.	**Support health and aged care providers to effectively manage chronic conditions for older people and help them live independently for as long as possible.** **Enable access to age-appropriate digital health services.** **Enable access to local aged care services, including residential and at-home.**	Wheatbelt	Aged care	Access Chronic conditions
Most Australians would prefer to die at home rather than in a hospital or aged care facility. For many Aboriginal people, this 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 and only one locally-based palliative care service.	**Enable access to local at-home palliative care services, and ensure they are culturally appropriate for Aboriginal people.**	Wheatbelt	Aged care	Access Palliative care

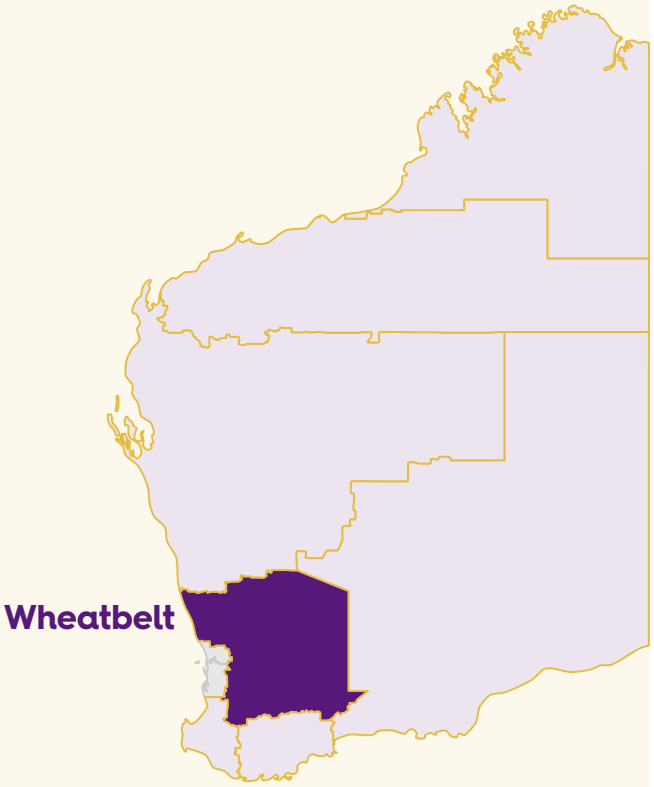
Wheatbelt

Overview

The Wheatbelt is unique in its population distribution across the region. People in the Wheatbelt live in small communities and towns with no single central town to locate essential services. The dominant health concerns in the region are the increasing ageing population, chronic disease, mental health and access to workforce and services. The Wheatbelt has a large ageing population. Chronic disease is of increasing concern particularly as the population ages. The population in the Wheatbelt had significantly high prevalence rates of risk factors for chronic disease, particularly high blood pressure, low levels of physical activity, obesity and high levels of smoking. Cancer, mental health and cardiovascular disease are among the leading causes of disease burden in the region.

Self-harm and suicide impact communities in the Wheatbelt. The Wheatbelt has high rates of emergency department presentations for mental health issues. As with many rural and remote locations across Western Australia (WA), there is limited access to psychologists and mental health services in the Wheatbelt. Mental health is a continuing priority for the region, along with alcohol and other drugs.

Workforce and access to services is a continuing issue for all rural communities and the Wheatbelt is similarly impacted. Many towns have limited access to General Practitioners (GPs) in the community. Local intelligence has highlighted that some areas struggle to attract workforce due to low housing availability.



Population demographics

The Wheatbelt region covers approximately 158,000 square kilometres in the south-west of WA. It partially surrounds the Perth metropolitan area, extending north from Perth to the Mid West region, and east to the Goldfields region. It is bordered to the south by the South West and Great Southern regions, and to the west by the Indian Ocean, Perth metropolitan area and the Peel region.

The Wheatbelt region is divided into two main statistical areas:

- The Wheatbelt - North Statistical Area Level 3 (SA3) has a population of 58,397 residents and includes the towns of Chittering, Cunderdin, Dowerin, Gingin, Dandaragan, Merredin, Moora, Mukinbudin, Northam, Toodyay, York and Beverley.
- The Wheatbelt - South SA3 has a population of 19,926 and includes Brookton, Kulin, Murray, Narrogin and Wagin.

The Wheatbelt region includes a rich and diverse Aboriginal community with a number of distinct language groups, including Nyunar, Walmajarri, Kriol, Wangkatha and Bardi. Approximately 1 in 16 (6%) of residents in both the Wheatbelt - North SA3 and Wheatbelt - South SA3s identify as Aboriginal, equating to nearly 5,000 individuals across the Wheatbelt region.

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, reliance on welfare for income and housing support.

Compared to other parts of WA (Index of Relative Socio-economic Disadvantage, IRSD = 1012), the Wheatbelt region is an area of socioeconomic disadvantage. This is evident in both SA3s, however is more pronounced in the Wheatbelt - North SA3 (IRSD=977) compared to the Wheatbelt - South SA3 (IRSD=983). A lower IRSD score indicates a lower level of advantage. Approximately 1 in 2 households in the Wheatbelt - North (51%) and Wheatbelt - South (50%) SA3s are classified as low-income households; above the state rate of 40%. The proportion of low income, welfare dependent families with children is slightly above the state rate of 5%, with 7% each in the Wheatbelt - North and Wheatbelt - South SA3s.

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; Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual, and other identities (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 Wheatbelt region includes several under-served populations who are at risk of poor health outcomes. Specifically:

- Approximately 3,500 Wheatbelt - North SA3 residents were born in a non-English speaking country, equating to 6% of the local population. A further 912 Wheatbelt - South residents were born in a non-English speaking country, representing 5% of the local population. These compare to 18% across WA.
- 6% of residents in the Wheatbelt - North SA3 and Wheatbelt - South SA3s have a profound or severe disability compared to 5% across WA.
- 11% of residents in the Wheatbelt - North and Wheatbelt - South SA3s provide unpaid assistance to people with a disability; equal to the state rate.
- Approximately 1 in 4 children in the Wheatbelt - North SA3 (24%) and Wheatbelt - South SA3 (28%) were developmentally vulnerable on one or more domains; above the state rate of 20%.
- An estimated 184 people in the Wheatbelt - North SA3 are experiencing homelessness. This equates to 36 people per 10,000; equal to the state rate of 36 per 10,000. Though homelessness is always concerning, it is less prevalent the Wheatbelt - South SA3, where approximately 41 people are experiencing homelessness, equating to 23 people per 10,000 this is below the state rate. Homelessness figures include people living in overcrowded dwellings.

Multicultural populations

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

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

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

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

There are two primary health care services specialising in care for the multicultural population in the Country WA region, located in the Goldfields SA3 and East Pilbara SA3. The Wheatbelt - North SA3 (Composite Index Score (CIS)=-0.30) has a low-moderate level of unmet need for multicultural services in WA. Although 3,551 residents are born

in a predominantly non-English speaking country, nearly all residents (99,7%) speak English well. While the rate of GP-type Emergency Department (ED) presentations for this population group is slightly above state level (2,096 vs. 1,912 per 10,000 across WA), it is considerably below the rates of other areas in the Country WA.

In contrast, the Wheatbelt - South SA3 has the second lowest level of unmet demand for multicultural services in the Country WA region (CIS=-0.65).

LGBTIQA+ populations

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

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

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

More than 4 in 10 (42%) of young Australian trans people have encountered medical services who did not respect, understand or have prior experience with gender diverse people. Please refer to the Mental Health section for further details about mental health and suicide prevention for LGBTIQA+ populations. Local intelligence has highlighted supply-side challenges, including a lack of LGBTIQA+-friendly services in the region, and many individuals travelling to Perth for services. Furthermore, there is limited understanding and education within the health sector about trans and intersex people. Significant proportions of LGBTIQA+ people have not felt they can safely disclose their LGBTIQA+ identity to GPs or have been misgendered in practices. Improved training and promotion of LGBTIQA+-friendly practices would be welcomed by the LGBTIQA+ community to address these issues.

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

Clinical

Access to appropriate:

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

Cultural

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

Organisational

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

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

- *Australian Charter of Health Care Rights – LGBTQI+*
- *Rainbow Tick guide to LGBTI-inclusive practice*
- *Australian Medical Association (AMA) LGBTQIASB+ Position Statement*
- *Australian Health Practitioner Regulation Agency (AHPRA) 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, limited transport availability and lack of a fixed address mean keeping appointments is difficult.

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

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

The areas of greatest need for homelessness support are the Kimberley, East Pilbara, Gascoyne and Goldfields SA3s.

There is a relatively low level of unmet need for homelessness services in the Wheatbelt - North and Wheatbelt - South SA3s (CIS=-0.46 and -0.49 respectively). An estimated 187 Wheatbelt - North and 43 Wheatbelt - South residents are at risk of or currently experiencing homelessness; equating to 32 people per 10,000 in the Wheatbelt - North SA3 and 22 per 10,000 in the Wheatbelt - South SA3. Each of these is below the state rate of 48 per 10,000.

Services supporting people experiencing homelessness in the Wheatbelt region are provided by the WA Country Health Service (WACHS) Wheatbelt 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 through prevention, early intervention, response, and recovery and healing. Aligning with this, WA's Family and Domestic Violence Prevention Strategy details initiatives to prevent and respond to family, domestic, and sexual violence, the key outcomes for which are prevention and early intervention; safety for victims through timely and accessible services; and accountability for perpetrators along with 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, three in four (75%) were female.

WA Police statistics indicated that in the 12 months from July 2023 to June 2024, there were 651 reports of family related assault in the Wheatbelt region, equating to an average of 54 reports per month .

Chronic disease

Chronic diseases are long-term, non-communicable conditions and play a significant part in mental and physical ill health, disability, and premature death. People with chronic disease often have two or more conditions (multi-morbidity) such as a mental health condition as well as a physical condition, creating complex health needs and presenting challenges for treatment. This section focuses on chronic conditions other than mental and behavioural conditions, which are discussed in the Mental Health section.

Chronic disease contributes significantly to the differences in life expectancy between Aboriginal and non-Aboriginal people. Aboriginal people experience 2.3 times the rate of disease burden, with an age-standardised death rate for chronic disease 3.8 times the rate among non-Aboriginal people. In the 2021 Census, the age-standardised rate (ASR) per 100 of Aboriginal people who reported they had one or more long-term health conditions was 25.7.

Prevalence of chronic disease

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

The Wheatbelt region has a concerning level of chronic disease among its residents, particularly in the Wheatbelt - North SA3, which has high reported rates of chronic asthma, arthritis, heart disease, kidney disease and lung conditions:

	ASR per 100 people	
	Wheatbelt - North SA3	WA
Arthritis	8.3	7.9
Asthma	8.1	7.4
Heart disease (including heart attack or angina)	3.9	3.7
Lung conditions (including COPD)	1.9	1.7
Kidney disease	0.9	0.8

Using WAPHA's new method of estimating condition prevalence from general practice data, rates of clinician-diagnosed diabetes were significantly higher in the Wheatbelt - North SA3 at 11.8%, compared to the state level of 7.9%.

In the Wheatbelt - South SA3, high rates are reported for asthma, arthritis and lung conditions:

	ASR per 100 people	
	Wheatbelt - South SA3	WA
Arthritis	9.0	7.9
Asthma	7.9	7.4
Lung conditions (including COPD)	1.8	1.7

WAPHA's new method of estimating condition prevalence from general practice data also identified significantly higher rates of clinician-diagnosed diabetes in the Wheatbelt - South SA3 at 11.5%, compared to the state level of 7.9%.

Risk factors

Established risk factors for chronic disease include having high blood pressure, being overweight or obese, smoking, doing little or no exercise and having high levels of stress. Psychosocial factors such as social isolation and loneliness also contribute to chronic ill health. Risk factors for chronic disease tend to be more prevalent in areas experiencing socioeconomic disadvantage and in regional and remote areas.

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

Concerningly, 2 in 5 residents in the Wheatbelt - North (43%) and Wheatbelt - South (44%) SA3s are experiencing obesity; above the state rate of 36%.

Approximately 1 in 5 residents in the Wheatbelt - North (21%) and Wheatbelt - South (23%) SA3s are not engaging in any physical activity for leisure purposes; significantly higher than the WA level of 17%.

Smoking is a concern in the Wheatbelt - South SA3, with nearly 1 in 5 residents reporting they currently smoke, compared to 11% across WA.

While high blood pressure is not a significant need in the Wheatbelt region relative to other parts of WA, approximately 1 in 4 residents have high blood pressure in both the Wheatbelt - North and Wheatbelt - South SA3s (25% and 23% respectively). This is comparable to the state rate of 23%.

Reported stress levels in the Wheatbelt - South SA3 are slightly above the state rate, with 15% of residents reporting stress, compared to of 12% across WA.

Healthy Weight Action Plan

WA Primary Health Alliance (WAPHA) is a steward of the WA Healthy Weight Action Plan 2019-24, which focuses on early intervention of people identified as at-risk of becoming overweight and management of people who currently live with obesity. This involves multi-component, multi-levelled strategies delivered as part of an integrated shared care model. Through the Healthy Weight GP Project, WAPHA has committed to supporting GPs to provide options for patients who want to improve their health. Key deliverables include the development of a weight management 'hub' (website) with links to Health Pathways and local services for weight management, training for general practice staff, and tools to assist general practices in implementing weight management services as a quality improvement activity.

Potentially preventable hospitalisations for chronic conditions

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

Across the state, the age-standardised rate of PPHs per 100,000 for total chronic conditions was 903 people per 100,000 and the highest rates were for chronic congestive cardiac failure (196), COPD (184) and chronic diabetes (178). Relative to other parts of WA, the Wheatbelt - North SA3 has a higher rate for total chronic conditions (1,233 per 100,000). This is driven by higher rates in the Wheatbelt - North SA3 for all conditions except chronic angina compared to WA. Similarly, the Wheatbelt - South SA3 exceeds state rates for total chronic conditions (1,331 per 100,000), driven by higher rates than WA for all conditions except asthma and chronic anaemia.

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 Wheatbelt - South and Wheatbelt - North SA3s have the second highest utilisation in WA, at 19% each. Only Mandurah, located in the Perth South Primary Health Network (PHN), exceeds these levels SA3.

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

The Australian Immunisation Register (AIR) reports that the Wheatbelt - North SA3 fell slightly below target of 95% for children aged 1, 2, and 5 years at 92%, 89%, and 92% respectively. In contrast, the Wheatbelt - South SA3 met the benchmark for children aged 5 years at 96% but was below target for children aged 1 and 2, being 93% for children aged 1 year and 91% for children aged 2 years.

Cancer screening

There are three national cancer screening programs in Australia: BreastScreen Australia, National Cervical Cancer Screening Program (NCSP), and National Bowel Cancer Screening Program (NBCSP).

Though not the lowest in the state, cancer screening participation rates in the Wheatbelt region are concerningly low, especially in context of the high disease burden due to cancer in the Wheatbelt region, and high rates of avoidable deaths due to cancer in the Wheatbelt - North SA3.

Only 2 in 5 eligible residents in the Wheatbelt - North (40%) and Wheatbelt - South (41%) have participated in bowel cancer screening, compared to the state level of 42%, which in itself is low. A similar proportion (43%) in the Wheatbelt - South SA3 have participated in breast cancer screening; below the rate for the Wheatbelt - North SA3 (50%) and overall state rate of 51%.

While still low, rates of cervical cancer screening were slightly more encouraging, with 54% of residents in the Wheatbelt - North SA3 and 58% in the Wheatbelt - South SA3, compared to 69% across WA.

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 (2018-21).

Avoidable mortality

The median age of death in the Wheatbelt - North and Wheatbelt - South SA3s is slightly below the state median age of 81 years, at 78 and 80 years respectively.

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 Wheatbelt - North and Wheatbelt - South SA3s exceed the state rate of 117.6 per 100,000 at 156.2 and 149.1 per 100,000 respectively. Transport accidents are a leading cause of avoidable deaths in the region: the Wheatbelt - South SA3 has the highest rate in WA at 26.6 per 100,000, and the Wheatbelt - North SA3 has the third highest rate at 24.1 per 100,000; well above the state rate of 6.6 per 100,000.

Sadly, at 22.2 per 100,000, the Wheatbelt - South SA3 has the third highest rate in WA for avoidable deaths due to suicide and self-inflicted injuries. The rate in the Wheatbelt - North SA3 (21.6) is also above the state rate of 14.9 per 100,000.

There is a high rate of avoidable deaths from colorectal cancer in the Wheatbelt - North (11 per 100,000) and Wheatbelt - South (9.4) SA3s, compared to 8.7 per 100,000 across WA.

According to the Mortality Over Regions and Time (MORT) data, the rate of premature deaths (people under 75 years) in the Wheatbelt - North and Wheatbelt - South SA3s is above the state level of 195 per 100,000, at 252 and 287 per 100,000 respectively.

The five leading causes of death and their percentages with respect to all death causes within the Wheatbelt - North and Wheatbelt - South SA3s are:

Rank	WA	Wheatbelt - North SA3	Whatbelt - South SA3
1	Coronary heart disease (11%)	Coronary heart disease (12%)	Coronary heart disease (11%)
2	Dementia (including Alzheimer's) (9%)	Lung cancer (7%)	Dementia (including Alzheimer's) (8%)
3	Cerebro-vascular disease (5%)	COPD (5%)	Lung cancer (6%)
4	Lung cancer (5%)	Dementia (including Alzheimer's) (5%)	COPD (6%)
5	COPD (4%)	Diabetes (4%)	Cerebro-vascular disease (4%)

Women's health: hysterectomy and endometrial ablation

In Australia, heavy menstrual bleeding affects one in four women of reproductive age with many also experiencing pain, fatigue and anxiety. Of women experiencing heavy menstrual bleeding, less than half seek medical treatment and more than 60% are iron deficient. A range of treatment options are available, from oral medication (non-hormonal and hormonal) to the more invasive treatments of endometrial ablation and hysterectomy.

The Australian Commission on Safety and Quality in Health Care recently published a revised Heavy Menstrual Bleeding Clinical Care Standard (2024 June) with an emphasis on informing patients about their treatment options and potential benefits and risks, and participation in shared decision making based on their preferences, priorities and clinical situation. It notes that hysterectomies for management of heavy menstrual bleeding should only be considered when alternative treatment options are ineffective or unsuitable, or at the patient's request. It also notes that the patient be fully informed of the potential risks and benefits before deciding. Separately, the Women's Health Focus Report maps geographic variation in hysterectomy and endometrial ablation hospitalisation rates, to investigate whether appropriate care is being delivered and improve the range of treatment options available to women experiencing heavy menstrual bleeding.

Hysterectomy is mostly performed for benign gynecological conditions of which heavy menstrual bleeding is one of the most common. Between 2014-15 to 2021-2022, there was a 24% decrease in WA (312 to 236) in hysterectomy hospitalisation ASR (non-cancer diagnoses) per 100,000 women aged 15 years and older. However, the Wheatbelt - South SA3 has a high rate of hysterectomy, at 339 per 100,000 compared to 239 per 100,000 across WA.

Whilst not usually as effective in managing heavy menstrual bleeding as a hysterectomy, endometrial ablation has a shorter recovery period and lower risk of short-term effects. Between 2013-16 and 2019-22, there was a 10% increase in endometrial ablation hospitalisation ASR (non-cancer diagnoses) per 100,000 women aged 15 years and older in WA (from 164 to 181). Relative to other parts of WA, the Wheatbelt - South SA3 has a high rate of endometrial ablation, at 230 per 100,000 (vs. 181 per 100,000 across the state).

Relative to other parts of WA, the Country WA PHN has higher endometrial ablation rates per 100,000 than the state, with higher rates reported in regional and remote areas consistently over time. In the Wheatbelt region, Wheatbelt - North SA3 reported below state rate at 181 per 100,000, whilst Wheatbelt - South SA3 reported above state rate at 230 per 100,000. At 97 per 100,000, Aboriginal women in WA have a lower endometrial ablation hospitalisation rate than the overall state rate.

Utilisation of primary care services

Based on the latest data, GP utilisation in the region is similar to the state rate, with approximately 4 in 5 residents in the Wheatbelt - North (84%) and Wheatbelt - South (83%) SA3s having visited a GP; compared to 84% across WA. This is slightly below levels from the year prior, when 85% of Wheatbelt - North residents and 86% of Wheatbelt - South residents had engaged 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 CIS was calculated based on the after-hours demand and supply indices, and each SA3 in WA ranked by relative demand from highest to lowest score.

In the Country WA region, there are 146 primary health services open after-hours, contributing 17% of all after-hours primary health services in WA. Primary health services collectively operate for 29 hours weekly per 10,000 population; below the state level of 45 hours. There are 11 Medicare Benefits Schedule (MBS) after-hours GP services (urgent and non-urgent) claimed per 100 people across WA. The Wheatbelt - North and Wheatbelt - South SA3s have a relatively high level of unmet need (CIS=0.71 and 0.87 respectively) for after-hours services in WA; ranked fourth and fifth within the Country WA region overall. The need in the Wheatbelt - North SA3 is driven by its high proportion of residents within the age groups most likely to require after hours care, being 0-4 and over 65 years, while in the Wheatbelt - South, the need is driven by a limited supply of primary health services.

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 Wheatbelt - North (7%) and Wheatbelt - South (8%) SA3s have higher utilisation of GP health assessments compared to the state rate (5%). Please note, these data only include Medicare-subsidised services, and it is not currently possible to obtain data by type of health assessment.

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

Medicare-subsidised nurse practitioner services are not heavily used in the region. The latest data reports that 3% of Wheatbelt - North and 4% of Wheatbelt - South SA3 residents have used a nurse practitioner service, similar to the state rate of 3%.

The nursing and Aboriginal health worker service group consists of Medicare-subsidised services delivered by a nurse practitioner, practice nurse, midwife or Aboriginal health worker. Utilisation of Medicare-subsidised practice nurse/Aboriginal health workers in the Wheatbelt - North (6%) and Wheatbelt - South (8%) SA3s is similar to the state rate of 7%.

Access Relative to Need index

The Access Relative to Need (ARN) index measures access to primary health care relative to predicted need and is based on methodology developed by the Australian Institute of Health and Welfare in 2014. The ARN index is based on the following information:

- The location of health services and the populations they serve.
- The number of GP 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.

Compared to other areas in WA, there is relatively low access to GP services across the Wheatbelt region. Overall, 60% of SA3s across WA have higher ARN compared to the Wheatbelt - North SA3, while 70% of SA3s across WA have higher ARN than the Wheatbelt - South 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 in the last year. However, approximately 1 in 10 respondents (11%) had needed a GP on at least one occasion but had not visited one. This was higher among Aboriginal people (22%), people

aged 18-39 (20%), those living with disability (16%) and females (15%). The main reasons these people needed a GP were illness, concerns about mental health, to get a prescription and to help with the management of a long-term health condition. Only 8% of these people sought help from an alternative healthcare professional, such as a pharmacist. A lack of available appointments was the main reason for not seeing a GP when needed, cited by nearly half (43%) of this group. A further 25% reported a lack of time and other commitments, while 16% felt afraid of being judged.

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

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

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

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

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

Workforce

General practitioners

Accurate, up-to-date GP Full-Time Equivalent (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 full-time GP (billable time, non-billable time, and non-clinical time). It is an estimation of GP workforce service utilisation and not an exact count of GP FTE available. For this report, we will refer to this measure as the GP Claimed Service Equivalent (GPCSE).

Based on the latest data, the Wheatbelt - North SA3 has 77 GPCSE per 100,000 residents and the Wheatbelt - South SA3 has 73 GPCSE per 100,000. Each of these is below the state rate of 102 per 100,000.

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

Compared to other areas in WA, some areas within the Wheatbelt region are noted as having relatively high need for additional GP workforce include the GP catchments of Dalwallinu, Gingin – Lancelin, Moora, Narrogin, Wongan Hills and York.

Dalwallinu (located in the Wheatbelt - North SA3) has one general practice, which is accredited for training GP Registrars and has capacity to accept a registrar immediately. The practice supports the local hospital for in-patient services and for emergencies. There is no Indigenous Australians' Health Program (IAHP) funded Aboriginal Community Controlled Health Organisation (ACCHOs) within the catchment, despite nearly 1 in 10 (9%) residents identifying as Aboriginal.

Gingin – Lancelin (located in the Wheatbelt - North SA3) has two local general practices. One practice is accredited to train GP Registrars, while the other is operated by a sole GP. A high proportion of residents are experiencing socioeconomic disadvantage, with 83% in the most disadvantaged quintile in WA. The area does not have a large population of Aboriginal people, with 3% of residents identifying as Aboriginal, compared to 4% across WA. There is no local IAHP funded Aboriginal Medical Service (AMS).

Moora (located in the Wheatbelt - North SA3) has three local general practices, two of which are accredited to train GP Registrars. Its need for additional GP workforce is largely due to recruitment challenges linked to the financial incentives locally available relative to other areas in WA. Approximately 3 in 5 (59%) residents are experiencing socioeconomic disadvantage. There is no local IAHP funded AMS, despite the proportion of Aboriginal residents being twice as high as the state proportion, at 8%.

Narrogin (located in the Wheatbelt - South SA3) has three local general practices, two of which are accredited to train GP Registrars. Approximately 3 in 5 (61%) residents are experiencing socioeconomic disadvantage. There is one local IAHP funded AMS, and 6% of residents identify as Aboriginal. Similar to Moora, the need for additional GP workforce in Narrogin is largely due to recruitment challenges linked to the financial incentives locally available relative to other areas in WA.

Wongan Hills (located in the Wheatbelt - North SA3) has one local general practice, which is accredited to train GP Registrars and can accept Registrars immediately. Nearly half (46%) of residents are experiencing socioeconomic disadvantage. There is no local IAHP funded AMS, though 7% of residents

identify as Aboriginal. Housing availability is a barrier to attracting additional GP workforce to the area, with residential vacancy rates below state and Country WA levels.

York (located in the Wheatbelt - North SA3) has one local general practice, which is accredited to train GP Registrars. Approximately 7 in 10 (70%) residents are experiencing socioeconomic disadvantage. There is no local IAHP funded AMS, and 5% of residents identify as Aboriginal.

Boddington (located in the Wheatbelt - South SA3) and Northam (located in the Wheatbelt - North SA3) also have relatively high need for additional GP workforce, but no ability to fulfil this through training GP Registrars.

To increase GP workforce in Mukinbudin and Toodyay (both located in the Wheatbelt - North SA3), local general practices require support to become accredited training facilities and enable them to bolster their local workforce by being able to train GP Registrars.

Primary care nurses

Relative to the rest of WA, the Wheatbelt - North SA3 has a slightly lower supply of primary care nurses, with 2.1 primary care nurse FTE per 1,000 residents. This compares to 2.8 FTE per 1,000 in the Wheatbelt - South SA3, and 2.5 FTE per 1,000 across WA.

Aged care

The Wheatbelt region has a large and growing aged population. In 2022, there were 13,647 people aged 65 years and over in the Wheatbelt - North SA3 and a further 4,453 in the Wheatbelt - South SA3. This represents nearly in 1 in 4 residents in each SA3 at 23% and 22% respectively, and is projected to increase to 27% of the population in the Wheatbelt - North SA3 and 26% in the Wheatbelt - South SA3 by 2030 – above the projected state proportion of 18% in the same time frame.

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 residents aged 65 years and older in the Wheatbelt - North and Wheatbelt - South SA3s have three or more long-term health conditions, equal to the state rate.

Approximately 3 in 5 (59%) general practice patients aged 65 years or older were diagnosed with three or more chronic conditions across WA, and within the Wheatbelt - South SA3. This proportion is slightly higher in Wheatbelt - North SA3, where nearly 2 in 3 (62%) have been diagnosed with three or more chronic conditions. Please note that 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. Medicare data indicate that approximately 1 in 4 (28%) of patients aged 75 years and over across WA have had a GP health assessment. The rate in the Wheatbelt - North SA3 is slightly higher than the state level at 32%, while the rate in the Wheatbelt - South SA3 is considerably higher at 59%.

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

Palliative care

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

Most Australians would prefer to die at home, rather than in hospital or RAC. 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 RAC.
- Access to multidisciplinary outreach services; and a new Aged Care Act that includes the right to access palliative care and end-of-life care.

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

PHNs will receive funding from the Greater Choices for At Home Palliative Care Program to improve palliative care coordination in their local communities.

In 2022, there were 27.7 total 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 in the Wheatbelt region is below the state level, with 38.6 total weekly hours per 1,000 residents aged 75 and over in the Wheatbelt - North SA3, and 21.8 in the Wheatbelt - South. 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 Wheatbelt - North and Wheatbelt - South 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), Home Care Packages (HCP), 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.

There are currently eleven home care services in the Wheatbelt - North SA3, including Bolton Clarke (formerly Acacia Living Group), Avivo: Live Life, Baptistcare WA, Catholic Homes Inc Home Care, Dowerin Home and Community Care, Home Caring WA, Juniper, Let's Get Care, Right at Home, Share and Care Community Services Group, Shire of Westonia, Silver Chain and Trilogy Care. A further two services operate in the Wheatbelt - South SA3, being Narrogin Regional Homecare and Wagin Homecare. As of December 2023, there were 1,317 people in a HCP in the Wheatbelt Aged Care Planning Region (ACPR), which includes both the Wheatbelt - North and Wheatbelt - South SA3s, and a further 163 people waiting for an HCP at their approved level.

WA has 249 residential aged care services with a total of 19,887 residential places, with a beds-to-population ratio of 64 per 1,000. Despite having a relatively high proportion of elderly population, both the Wheatbelt - North and Wheatbelt - South SA3s have a low beds-to-population ratio compared to the state rate. The Wheatbelt - North SA3 is the lowest in WA, at 17 beds per 1,000 people aged 70 years and over; offered by four local RACHs. While still below the state rate, the Wheatbelt - South SA3 is better serviced, at a rate of 53 beds per 1,000, dispersed across four RACHs.

Across WA, there are 12.2 FTE of nurses working in aged care per 1,000 people aged 70 years and over. In comparison, the Wheatbelt - North SA3 has slightly lower supply at 11.0 FTE per 1,000 people aged 70 years and over, while the Wheatbelt - South SA3 is slightly higher at 15.0 FTE per 1,000 people aged 70 years and over.

Alcohol and other drugs

Alcohol and Other Drug (AOD) use is an issue in the Wheatbelt - North SA3, particularly with regard to short-term alcohol-related harm. Approximately 1 in 7 (15%) residents are at risk of short-term harm from alcohol; above the state rate of 10%. Levels of long-term alcohol harm (31%) are higher than the state rate of 26%. Smoking prevalence is similar to the state rate, at 13% in the Wheatbelt - North SA3, compared to 11% across WA.

In the Wheatbelt - South SA3, the risk of short-term and long-term harm from alcohol is slightly increased, compared to state rates, at 12% for short-term harm and 30% for long-term harm, compared to 10% and 26% across WA. However, smoking is significantly more of an issue, with approximately 1 in 5 (19%) residents currently smoking, comparing to 11% across the state.

Using WAPHA's new method of estimating condition prevalence from general practice data, compared to state rates, patients in the Wheatbelt - North SA3 have statistically significantly higher rates of clinician-diagnosed chronic alcohol misuse (2.2%) and chronic drug misuse (2.2%) than the state rate of 1.5% and 1.4% respectively.

AOD burden of disease

WA Burden of Disease Study 2015 has the latest regional recording for risks associated with burden of disease for the Wheatbelt region. Tobacco use contributed to 30% of cancer burden and 14% of cardiovascular disease, with the population aged 45-64 and 65+ years having the highest risk of burden. Men in the Wheatbelt region had a higher risk of disease due to alcohol use (8%) and illicit drug use (6%) compared to women (3% and <1%).

Alcohol contributed to the burden of 15% of mental and substance use disorders, 19% of injuries, 3% of cancer burden and 3% of cardiovascular disease burden, with males in the 15-24 year age group having the most risk of alcohol use leading to disease.

Illicit drugs also had a high contribution to burden with 8% of mental and substance use disorders and 21% of injuries burden being attributed to illicit drug use in the Wheatbelt region in 2015.

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 deaths compared to women. People aged 40-49 accounted for 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 unintentional heroin-induced deaths in 2021 with 1.5 deaths per 100,000. This corresponds with higher rates of deaths for other opioids such as fentanyl/pethidine/ tramadol in 2021 (0.8 deaths per 100,000). There has also been an increase in deaths involving benzodiazepines in WA from 2013 to 2021 (1.1 to 3 deaths per 100,000), and stimulants such as methamphetamine and amphetamines (1.3 to 3 deaths per 100,000).

Between 2017- 2021, there were 25 unintentional drug-induced deaths in the Wheatbelt - North SA3, equating to a rate of 8.8 per 100,000 people; similar to the state rate of 8 per 100,000. In contrast, unintentional drug-induced deaths were less of an issue in the Wheatbelt - South SA3, which was below the state level at 2.5 per 100,000; representing 2 deaths.

Hepatitis B and C

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

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

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

The proportion of people with Chronic Hepatitis B (CHB) in the Wheatbelt - North SA3 is similar to the state rate of 0.8%, at 0.5%. However, at 4%, treatment uptake is below the state level of 9%. Treatment uptake is suppressed for the Wheatbelt - South SA3 due to low numbers.

Chronic Hepatitis C (CHC) levels in the Wheatbelt - North and Wheatbelt - South SA3s are equal at 0.87% each, similar to the state rate of 0.7%. The CHC treatment uptake was 37% in the Wheatbelt - North SA3 and 40% in the Wheatbelt - South SA3; each similar to the state level of 42%.

Alcohol and other drug services

Reported statistics on AOD treatment show that across the Country WA PHN, 412.57 per 100,000 people understood treatment during the 2022-2023 period. Alcohol treatment represented more than half (53%) of the drug of concerns, followed by cannabis (23%) and amphetamines (18%). Men make up nearly two thirds of clients (64% vs. 36%), with 30–39-year-olds (28%) making up the largest age group of clients.

AOD services are provided by the WACHS and Holyoake, a not-for-profit organisation in the Wheatbelt region. Funded by the Mental Health Commission, Holyoake operates the Wheatbelt Community Alcohol and Drug Service (WCADS). It provides assessment, referral and counselling services in Northam, Narrogin, and Merredin with outreach services in Moora, Gingin, Wyalkatchem, York, Goomalling, Wongan Hills, Brookton, Kellerberrin, Wagin and surrounding areas.

Mental health

Mental health was the second leading cause of disease burden in the Wheatbelt region, contributing 13% of the total disease burden for the region.

Depressive disorders were the greatest contributor to the disease burden for women in the Wheatbelt (6%), whilst for men suicide and self-inflicted injuries were the greatest contributor to the disease burden (5%).

Rates of reported anxiety, depression and psychological distress in the Wheatbelt region were comparable to state levels. In the Wheatbelt - North SA3, approximately 1 in 10 residents report that they have been diagnosed with anxiety (10%) or depression (10%), and 1 in 8 (13%) report being diagnosed with high or very high psychological distress. Each of these proportions aligns with state levels, with 12% of Western Australians reporting anxiety diagnoses, 11% depression, and 13% psychological distress. Similarly, reported rates in the Wheatbelt - South SA3 are comparable to state levels, with 13% of residents reporting an anxiety diagnoses, 9% depression diagnoses, and 12% psychological distress diagnoses.

Suicide and self-harm

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

At a rate of 22.1 people per 100,000 in the Wheatbelt - North SA3 and 22.5 in the Wheatbelt - South SA3, suicide in the Wheatbelt region is above the state rate of 14.1 and an area of considerable concern. Sixty-one people died from suicide in the Wheatbelt - North SA3 between 2018 to 2022, and a further 22 people died in the Wheatbelt - South SA3. Suicide is the ninth leading cause of death, representing 3% of all deaths in the Wheatbelt - North SA3 2017-2021. In the Wheatbelt - South SA3, it is the eleventh leading cause of death and represents 3% of all deaths.

The Health and Wellbeing Surveillance Survey collects data on suicidal ideation among adults aged 16 years and over. In the Wheatbelt - North SA3, 1 in 12 (8%) indicated that they had thought seriously about ending their own lives, similar to the state rate of 7%, and the rate in the Wheatbelt - South SA3 (7%).

Self-harm is a strong risk factor for suicide. At a rate of 110.3 per 100,000 residents, hospitalisations for self-harm in the Wheatbelt - South SA3 is above the state level (97.7 per 100,000). Self-harm hospitalisations in the Wheatbelt - North SA3 are slightly below the state rate, at 91.8 per 100,000, yet it is nevertheless a concern, as the Wheatbelt - North SA3 accounts for the fifth highest number of self-harm hospitalisations (53) in Country WA. Self-harm hospitalisations were higher for females than males in both Wheatbelt - South and Wheatbelt - North.

Youth mental health

Primary mental health care services play an important role in prevention and early intervention efforts reduce the prevalence and impact of mental health problems amongst young people. Approximately 1 in 7 young people aged 4-to-17-years experience mental illness in any given year, and 75% of severe mental health problems emerge before the age of 25. Early intervention in childhood and adolescent years can prevent or mitigate potentially lifelong mental illness.

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

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

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

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

Compared to other areas in WA, youth mental health is a concern in the Wheatbelt - North SA3, which has high rates of mental-disorder-related ED presentations, at 372 per 10,000 12-17-year-olds compared to 370 per 10,000 across WA. In contrast, the Wheatbelt - South SA3 is slightly below the state, at 306 per 10,000.

headspace centres and services support young people across Australia to be mentally healthy and engaged in their communities. There is one headspace centre in the Wheatbelt region, based in Northam. Despite this, the Wheatbelt - North and Wheatbelt - South SA3s have relatively low utilisation levels by people aged 12-25; at 2% and 1% respectively. Utilisation across WA is also low at 2%, though higher utilisation has been achieved in some areas. Each patient's episode of care comprised of an average of 3.8 occasions of service (i.e. interactions with the service or mental health

worker) in the Wheatbelt - North SA3 and 3.7 in the Wheatbelt - South SA3; similar 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 Wheatbelt - North and Wheatbelt - South SA3s are slightly below the state rate of 9%, at 7% each. However, the proportions who have engaged in self-harm (regardless of intent) are slightly higher than state levels, with 12.4% of 12-17-year-olds in the Wheatbelt - North SA3 and 13.3% in the Wheatbelt - South SA3, compared to 9.9% across WA.

Major depression and anxiety disorders are risk factors associated with higher self-harm prevalence among 12 to 17-year-olds. Approximately 1 in 12 12 to 17-year-olds in the Wheatbelt - North and Wheatbelt - South SA3s (8% each) are experiencing major depression or anxiety disorders; similar to the state rate of 9% across WA. Depressive disorders and anxiety disorders are the second and third leading causes of disease burden for 15-24-year-olds in the Wheatbelt - North and Wheatbelt - South SA3s, contributing 10% and 8% respectively.

Suicide and self-inflicted injuries are the leading cause of disease burden for 15-to-24-year-olds, in the Wheatbelt region, contributing to 20% of the disease burden for this age group. Hospital admissions for self-harm can be an indication of unmet need for accessible mental health services. It is concerning to note self-harm hospitalisations among people aged 0-24 years in the Wheatbelt - North SA3 are above state levels (172.4 vs. 139.7 per 100,000). The rate is suppressed for the Wheatbelt - South SA3 due to low numbers.

Mental health services

Mental health services in the Wheatbelt region are provided by the WACHS and not-for-profit organisations. There are approximately 22 mental health services in the region, 9 of which have dedicated youth services. The WA Country Health Service (WACHS) operates the Wheatbelt Mental Health Service, with teams located in Northam, Gingin, Merredin and Narrogin. Regular visits are made to outlying areas and outreach is supported by telephone consultation and videoconferencing. Clinical liaison is also provided to hospitals within the region. Services include mental health programs for Aboriginal people (all ages), adults (18-65 years), children and adolescents (0-18 years), youth (15-24 years) and seniors (65+ years).

Holyoake operates the Northam Head to Head Medicare Mental Health Centre (previously the Northam Head to Health Centre). It provides immediate, short-term and medium-term care, and connects patients to ongoing services when required. Patients can attend without an appointment or referral, and available services include initial assessment, one-to-one counselling, access to therapy groups, peer support, and care coordination with other services or agencies such as National Disability Insurance Scheme (NDIS). Holyoake also employs Suicide Prevention Coordinators for the Wheatbelt region, with offices in Northam and Narrogin and outreach capacity to all communities across the Wheatbelt.

The Integrated Primary Mental Health Care Program, operated by Amity Health, offers counselling services to people experiencing mental health challenges. The service is available at no cost to the patient, with eligible people being those aged 7 years or over, experiencing financial hardship, living in the Wheatbelt region, and not accessing other mental health services.

The Northam headspace centre is operated by Youth Focus, and provides free face-to-face and telehealth psychological services for young people aged 12-25 years.

Culturally appropriate psychosocial support services are offered to Aboriginal people by the Keedac Wheatbelt Aboriginal Corporation.

A GP mental health treatment plan can be used to refer patients to psychiatrists, psychologists, counsellors, social workers and occupational therapists. In the Wheatbelt - North and Wheatbelt - South SA3s, 6% have accessed a GP mental health treatment plan in each area; similar to the state level of 8%.

In both the Wheatbelt - North and Wheatbelt - South SA3s the rate of psychologists per 10,000 people is below the state rate, at 3.9 and 4.7 respectively compared to 13.2 per 10,000 across WA. In each area 1.3% of residents accessed a clinical psychologist, compared to 2.2% across WA. Given the high burden of disease due to mental health concerns in the region, these figures indicate insufficient access to rebated psychology services in the Wheatbelt - North and Wheatbelt - South SA3s, and a reliance on services provided by the WACHS and the not-for-profit sector.

There are low numbers of mental health professionals such as psychiatrists, mental health nurses and psychologists in regional and remote areas.

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

Aboriginal health

An estimated 4,772 Aboriginal people reside in the Wheatbelt region, representing 6% of the population in both the Wheatbelt - North and Wheatbelt - South SA3s. The Wheatbelt is home to three distinct Aboriginal groups, being the Njaki Njaki Nyoongar, the Ballardong Nyoongar and the Gubrun. The

main languages spoken locally include Nyunar, Walmajarri, Kriol, Wangkatha and Bardi. Aboriginal people are dispersed throughout the 28 Local Government Areas that comprise the Wheatbelt region.

The Aboriginal people in the Wheatbelt region, spanning the Indigenous Areas (IAREs) of Avon, Campion, Hotham – Kulin, Moora – Chittering, Murray – Waroona – Boddington and Narrogin – Wagin – Katanning, experience high levels of socioeconomic disadvantage and are impacted by poor health outcomes. The highest levels of disadvantage are experienced in the Northam, Hotham – Kulin, Narrogin – Wagin – Katanning, Campion, Moora – Chittering and Avon IAREs, which have Indigenous Relative Socioeconomic Outcomes (IRSEO) index scores of 83, 80, 76, 66, 62 and 59 respectively, compared to 51 for WA overall. A higher IRSEO score indicates a greater level of socioeconomic disadvantage for the region. In contrast, Aboriginal people in the Murray – Waroona – Boddington IARE are relatively more advantaged than other Aboriginal people in WA , with an IRSEO score of 30.

Unemployment is above state rates in all IAREs within the Wheatbelt region, except for Moora – Chittering. The Narrogin – Wagin – Katanning and Hotham – Kulin IAREs had an estimated 1 in 4 of Aboriginal residents without work (22% and 27% respectively), followed by approximately 1 in 5 in Northam, and then 17% in Campion, Murray – Waroona – Boddington and Avon.

The Hotham – Kulin IARE also has the highest proportion of Aboriginal people living in low-income households at 79%; above the state rate of 54%. Other IAREs with high rates of low-income households include Northam (72%), Narrogin – Wagin – Katanning (69%), Campion (65%), Avon (63%) and Moora – Chittering (58%).

There is an average participation rate in full-time secondary education at age 16 of 65% across WA. Participation in the Murray – Waroona – Boddington IARE (located in the Wheatbelt - South SA3) is concerningly low at 53% attendance; the lowest in the Wheatbelt region.

Of the IAREs with sufficient data, there is a high proportion of low-birth-weight babies in the Campion (35%) and Narrogin – Wagin – Katanning (18%) IAREs; above the 13% of Aboriginal babies who are classified as being of low birth weight across WA. Approximately 1 in 2 Aboriginal children in the Avon (56%), Narrogin – Wagin – Katanning (55%) and Northam (54%) IAREs are classified as developmentally vulnerable on one or more domains.

Child immunisation

A key priority of the National Immunisation Program Schedule is to work towards achieving immunisation coverage rates of at least 95% for children aged 1, 2 and 5 years. Across WA, immunisation is below the 95% target for all age groups, with 89% of 1-year olds, 84% of 2-year-olds and 94% of 5-year-olds fully immunised. There is insufficient data for all IAREs within the Wheatbelt region, suggesting that effort is needed to increase childhood immunisation across the region.

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 Wheatbelt - South SA3 this need is evident, with a slightly higher rate of these ED presentations at 6,867 per 10,000 compared to the WA rate of 6,167 per 10,000. It is not a significant need in the Wheatbelt - North SA3 compared to other parts of WA, with lower-urgency ED presentations below the state rate at 5,089 per 10,000.

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 266.7 avoidable deaths per 100,000 across WA among Aboriginal people aged 0 to 74 years in the 2017-2021 period. When looking at Aboriginal deaths from all avoidable causes in total, four of the seven IAREs in the Wheatbelt region are concerningly above the state level. The IAREs of greatest concern are Narrogin – Wagin – Katanning (400.4 per 100,000), Northam (343.9) and Hotham – Kulin (321.1). Though not as high, the Avon IARE also exceeds the state level at 279.0 per 100,000. Data for avoidable deaths related to specific conditions is insufficient for many conditions, however based on the available data, Narrogin – Wagin – Katanning is an area of particular concern, with avoidable deaths above state levels for circulatory system diseases (129.7 per 100,000 vs. 86.2 across WA) and ischaemic heart disease (111.2 per 100,000 vs. 57.2 across WA). The Avon IARE also has high rates of ischaemic heart disease at 86.6 per 100,000, as well as high rates of circulatory system diseases (97.1 per 100,000) and diabetes (56.5 per 100,000 vs. 35.4 across WA).

Median age at death

Across WA, the median age of death for Aboriginal people is sadly 58 years – significantly below that of non-Aboriginal people at 80 years. The median age of death for Aboriginal people in the Wheatbelt region varies considerably across IAREs, but is older than the median age for Aboriginal people across WA in all IAREs except Murray – Waroona – Boddington, which is sadly only 57 years. Following this, the Hotham – Kulin and Avon IAREs have the second lowest median age at death in the Wheatbelt region at 62 years each, then Northam at 63 and Narrogin – Wagin – Katanning at 65 years. The Moora – Chittering and Campion IAREs have the highest median age at death at 67 years and 68 years respectively.

Potentially preventable hospitalisations

The average annual rate of total PPHs per 100,000 for Aboriginal people is considerably below state levels for all IAREs except Narrogin – Wagin – Katanning and Northam in the Wheatbelt region. Across WA, there were 6,264 PPH admissions per 100,000 for Aboriginal people from 2017/18 to 2020/21. In the Wheatbelt region, the rate ranged

from 2,282 to 8,666 per 100,000. The Narrogin – Wagin – Katanning IARE has the highest rate (8,666), followed by Northam (7,608), Hotham – Kulin (4,649), Moora – Chittering (4,405), Avon (4,127), Campion (3,858) and Murray – Waroona – Boddington (2,282) each of which is below the state level.

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 the Wheatbelt region exceeded state rates:

- Chronic asthma: Narrogin – Wagin – Katanning (376 per 100,000), Moora – Chittering (322), Hotham – Kulin (283) and Avon (200), compared to 192 per 100,000 across WA.
- Chronic angina: Northam (561 per 100,000), Campion (269) and Narrogin – Wagin – Katanning (224), compared to 206 across WA).
- Chronic congestive cardiac failure: Northam (639 per 100,000), Moora (462) and Narrogin – Wagin-Katanning (411), compared to 405 per 100,000 across WA.
- Chronic diabetes complications: Narrogin – Wagin – Katanning (1,042 per 100,000), Hotham – Kulin (780) and Northam (671), compared to 547 per 100,000 across WA.
- Iron deficiency anaemia: Northam (685 per 100,000), Moora – Chittering (528), Narrogin – Wagin – Katanning (301) and Avon (266) compared to 208 per 100,000 across WA.
- COPD: Narrogin – Wagin – Katanning (1,586 per 100,000), Northam (1,261) and Moora – Chittering (704) 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 for all IAREs except Narrogin – Wagin – Katanning and Northam were also below state rates in the Wheatbelt region. The rate of PPHs due to acute conditions in Narrogin – Wagin – Katanning is 4,355 per 100,000 and in Northam 3,010 per 100,000, compared to across 2,905 per 100,000 across WA. However, although all other IAREs are below state levels overall, there are pockets of need across different acute conditions, with the following IAREs exceeding state rates:

- Acute convulsions and epilepsy: Narrogin – Wagin – Katanning (1,644 per 100,000), Northam (1004) and Hotha – Kulin (581) compared to 460 per 100,000 across WA.
- Acute dental conditions: Hotham – Kulin (704 per 100,000), Narrogin – Wagin – Katanning (683), Campion (629) and Northam (472), compared to 431 per 100,000 across WA.
- Acute ear, nose, and throat infections: Hotha – Kulin (806 per 100,000) compared to 393 per 100,000 across WA.
- Acute urinary tract infections (including pyelonephritis): Narrogin – Wagin – Katanning (1,003 per 100,000) compared to 516 per 100,000 across WA.

Vaccine-preventable PPHs are hospitalisations due to conditions that can be prevented by vaccination. Data regarding PPHs for total vaccine preventable conditions is suppressed for three of the seven IAREs in the Wheatbelt region due to small numbers. For those IAREs with sufficient data, all are well below state levels for vaccine-preventable PPHs, indicating that this is not a significant need in the Wheatbelt region compared to other part of WA, aside from Northam on PPHs for pneumonia and influenza (300 per 100,000, compared to 278 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 Coronavirus Disease 2019 (COVID-19) and associated restrictions.

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

Aboriginal people living in the Wheatbelt 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 Wheatbelt region, the two Country to City ITC service providers are the Wheatbelt Health Network and Amity Health.

The Amity Health is a not-for-profit organisation which provides health service access to people living in country WA. They operate Mental Health Wellbeing & Resiliency programs in Merredin, Moora and Narrogin supporting the physical and psychological health of Aboriginal communities in the region.

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

The Wheatbelt Aboriginal Health Service is based in Narrogin and provides culturally appropriate services in chronic disease management and multidisciplinary care.

Digital health

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

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

There has been a decrease in the proportion of people who have had at least one telehealth consultation in the 12-months from 30.8% in 2021-2022 to 27.7% in 2022-2023. 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 in low 10 to 15% rapidly moved to the 60 to 80% across a range of clinics and hospitals. It appears that the focus on digital health including telehealth consultations during COVID-19 helped fast track the adoption of technology and more providers saw the My Health Record as a valuable repository of health data as it is accessible to all health care providers without the need for fax machines or postal services.

As of February 2024, there are now more than 23.5 million My Health Record entries Australia-wide and more than 23 million or 98 % 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.

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An Australian Government Initiative

Wheatbelt 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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