RAPAD POSITION ON

HEALTH IN CENTRAL WESTERN QUEENSLAND

RAPAD
REMOTE AREA PLANNING & DEVELOPMENT BOARD

April 2024

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ACKNOWLEDGEMENT OF COUNTRY

The CWQ Remote Area Planning and Developement Board acknowledges the traditional custodians of the lands in Central Western Queensland and we pay respects to ancestors and Elders, past, present and emerging.

About our cover artwork

TITLE: Together

ARTIST: Ari Terare, Barcaldine

INTERPRETATION:
The communities of Central West Queensland coming together sharing our history, knowledge and understanding with respect for each other.

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1. EXECUTIVE SUMMARY

RAPAD Strategic Plan 2022-25:

RAPAD will advocate, and support councils, ensuring health services in the RAPAD region reach world class standards for rural and regional communities.

In Australia, rural and remote communities experience poorer health outcomes and a burden of disease 1.4 times higher than those living in major cities. Life expectancy also decreases with remoteness, with higher mortality rates and higher rates of potentially avoidable deaths.[1]

Disparity in equitable health outcomes for rural and remote people are due to remoteness combined with the social determinants of health and disease risk factors, greater environmental vulnerability, and barriers to equitable access to care. As a complex issue with many contributing factors, consideration of increased and more considered investment into rural health is needed.

The Central Western Queensland Remote Area Planning and Development Board (RAPAD) represents the interests of communities of central western Queensland. The regions people are one of its strengths; understanding the factors that both impact and enhance lifestyles and by default by 'wellness', is key to building sustainable communities.

This paper, on behalf of RAPAD and its seven local governments, draws on research undertaken by the Western Queensland Alliance of Councils to dive deeper into health and wellbeing for people in the Central Western Queensland region including the factors that both enhance and challenge health equity highlighting the importance of quality data to identify problems and solutions, demonstrate impact and justify investment.

The Central West Hospital and Health Service Local Area Needs Assessment Summary Report[2] identified the importance of primary health care as a priority to support early intervention in patient care and reduce the likelihood of presentations to emergency departments, hospital admissions and multifaceted treatment options due to the complexity of health issues.[3]

Higher service delivery costs for rural and remote areas and the impact of underlying social determinants of health require increased investment in health care to move towards equitable health outcomes. This may require funding adaptive and locally based rather than generalised statewide solutions, acknowledging that measures of success may be different in and between rural communities.

1 Australian Institute of Health and Welfare (2023h).
2 Queensland Government, Queensland Health (2022 a).
3 National Rural Health Alliance June (2023).

Our region has unique challenges due to a range of factors including remoteness, high levels of risk factors and burden of disease, workforce distribution, availability of services and high costs of service provision. Innovative coordinated primary care strategies, that addresses local issues and involve health practitioners, patients and the community in local solutions and is adequately funded would assist with better coordination of services and reduce duplication. The role of social prescribing[4] and linking people to non-medical community support in western Queensland could also assist in improving patient outcomes, reduce health practitioner workloads and service delivery costs.

Chronic diseases are a leading cause of illness, disability and death in Australia.[5] Australian Institute of Health and Welfare (AIHW) mortality data by Primary Health Network (PHN) shows Western Queensland has the highest age standardised mortality rate (Figure 2), the highest rates of premature death (47%) and potentially avoidable premature death (55.5%) across the 31 Australian PHN's.[6]

Coronary heart disease is the leading cause of death in Western Queensland (13.2%) and one in five Western Queensland adults (25-64years) are diagnosed with hypertension and or hyperlipidaemia (high levels or lipids or fats in the blood).

Diabetes is more prevalent in CWQ than the Queensland average (5.3% compared the 4.5%). Diabetes complications form a quarter of all potentially preventable hospitalisations in Western Queensland. Diabetes related deaths are twice as high in Western Queensland compared to nationally.[7]

Multimorbidity rates (one or more chronic conditions) are higher in Western Queensland. Indigenous Australians, poorer Australians, those with less education, and those living in rural and remote areas face the biggest barriers to health and are far more likely to be diagnosed with many common chronic diseases.[8]

Modifiable risk factors influence the likelihood of developing disease or health disorders. Rates for daily smoking in CWQ are decreasing however are higher than state averages. However, the rate of risky alcohol consumption remains high (28.3% compared to the Queensland average of 21.6%). Other protective factors like fruit and vegetable intake and physical activity are also among the lowest in the state for the region.[9]

Cancer is a leading cause of illness in Australia[10] and the need to improve cancer survival rates and screening and treatment has been identified as a priority need in CWQ.[11] Recorded incidence rates of cancer are lower in remote and very remote areas, but mortality is higher than the Australian average. This likely reflects the lower detection rates and delays in seeking treatment when cancers are more advanced.[12] Participation in national bowel, breast and cervical screening programs are lower in rural and remote areas than national averages.[13]

Mental health and social and emotional wellbeing is a priority for the region, including access to acute mental health services and continuity of care pathways. [14] Rates of suicide and self-harm are higher in rural and remote areas than elsewhere in Australia, with more people also reporting psychological distress in the region compared to the rest of Queensland.[15]

Health workforce gaps Workforce gaps were identified in audiology, podiatry, optometry, nursing/midwifery, occupational therapy, dentistry, exercise physiology and physiotherapy, nutrition and diabetic education. There are a variety of issues and challenges that impact health workforce and services and a range of innovative strategies to try and meet them that start with training schemes that set graduates up for success in rural settings by imbedding rural issues and concepts into curriculum and supporting students with a rural background to apply and complete studies. Health care practitioners who are well supported professionally and welcomed and supported by communities are more likely to stay and manage the demands of their roles.

Digital health service use including telehealth, expanded during the COVID-19 pandemic offering huge potential in supporting patients by identifying the need for early care and focussing on prevention much earlier than before patients might present for care, which is especially relevant in rural and remote communities due to the challenges of access and availability of services, and distance. It also increases options for training, education, and supervision for health practitioners, which would benefit rural and remote communities. Expansion of these services, increasingly technologically based, relies heavily on high quality, affordable and high-speed internet.

4 'Social prescribing is a way of linking patients with non-medical support and activity in the community, in order to improve mental and physical health and wellbeing and best manage their health'. Melbourne Academic Centre for Health (2023)..

5 Western Queensland Primary Health Network (2022).

6 AIHW (2023e).

7 AIHW (2023h).

8 Breadon et al (2023).

9 Queensland Government, Queensland Health (2020b).

10 Australian Institute of Health and Welfare (2021).

11 Queensland Government, Queensland Health (2022a)

12 AIHW (2021).

13 AIHW (2023b)

14 Queensland Government, Queensland Health (2022 a,b,c).

15 Queensland Government, Queensland Health (2022b)

Aged care services are increasingly important as the population ages. Across the region that are variations in percentage of population aged 65 years and over but potential health service implications as rates of chronic disease, disability and dementia increase with age. Disability services are impacted by concentrated markets and less choice and control for services through the National Disability Insurance Scheme (NDIS). Actual need for services is difficult to quantity as many people, though eligible, do not have NDIS plans.

Maternal and child health services support women across the perinatal period (conception to 12 months after pregnancy or birth). This service offers a continuity of care model where multidisciplinary teams collaborate to provide care. Many women are required to travel to Longreach for perinatal care and wait for their babies to be born. There are a range of impacts for women moving away from their support networks to give birth.

Changes to climate are already directly and indirectly challenging the health of communities in western Queensland and are a significant public health issue. Extreme weather events will put increasing pressure on existing services, infrastructure, the regional economy and communities. Local Governments have a role in embedding climate risk in planning and supporting state and federal government climate adaption policies. Supporting existing health services to better manage as impacts of climate change are also important.

Life expectancy is Australia is rising but we need to focus on better health not just living longer. Recent research backs up what many local governments already know; they are well positioned and have an important role to play in addressing health inequities. While health is not and cannot be their core business, there is nevertheless potential to help improve population health. As major employers in many communities with a direct connection and involvement in the community and relationships with other health partners, local governments can model and advocate for health equity[16] and help address impacts of social determinants.

16 Schultz et al (2023).

2. RECOMMENDATIONS AND ACTIONS

Australia has one of the best health systems in the world, yet access to health care is not universal. Central Western Queensland, like other rural and remote communities face some of the greatest challenges and increasing declining health; they have some of the greatest needs but lowest supply of health professionals and availability of services.

State and federal governments continue to work at addressing these challenges at a systems level. Health services providers at all levels, local governments, communities and individuals have a role to play at a regional and local level in addressing inequality with a focus on inclusion, access, and prevention.

Social determinants that underpin health status such as socioeconomic status, education, housing, transport, food security, social support networks, community engagement and the physical environment can all be influenced locally, for impactful change in health status.

The RAPAD board and member councils are committed to working with health service providers and stakeholders to improve health and wellbeing in Central Western Queensland to reinforce thriving communities.

RAPAD:

- Continues to advocate on health matters in conjunction with its Western Queensland Alliance of Councils fellow members.
- Advocates for increased investment in rural and remote and Indigenous healthcare, with a focus on primary health to improve preventative health care, early diagnosis and treatment and reduce time spent in hospitals. Targeted increased investment would extend life expectancy and improve quality of life (less years of ill-health) and 'potentially drive economic growth and productivity'[17] and allow people to actively participate in their communities.
- Commits to supporting the National Agreement on Closing the Gap by working with the community and health partners including Aboriginal Community Controlled Health Organisations (ACCHO) to address social determinants of health, involving Aboriginal and Torres Strait Islander peoples in planning, management and decision making and looking for shared training and development opportunities.
- Commits to supporting service providers to continue and improve service coordination and explore innovative options to improve outcomes for clients and efficiency in spending through increased integration, improved service quality and clarity for clients and community.
- Supports calls to increase certainty on health provider program funding and subsequent service provision by extending funding cycle periods. Greater clarity and certainty around funding would support providers to develop a longer-term, comprehensive plan to build a culturally competent workforce, that meets local needs and priorities as well as organisational goals. In addition, being able to provide competitive employee remuneration helps services remain viable, providing security for them and the communities that they work in.
- Supports expansion of virtual care to improve outcomes for patients through increased access to services closer to home and efficiency and coordination of services. Utilising technology to deliver services supports care for patients with chronic disease, provides opportunities for health promotion and potential opportunity for early access to care and subsequent better outcomes for patients and less hospital admissions. It also increases options for training, education and supervision for current staff, who are better supported and given learning opportunities, and to attract and recruit new staff to the region. These benefits are only possible with the provision of affordable and high-speed internet, which continues to be a priority for local governments and community.
- Supports opportunities for partnerships between health service providers, RAPAD and Local Government Area's (LGA's), to work together on regional resident attraction campaigns, such as the Central West's 'Go Far Out' strategy[18] and utilise social media to attract and retain a regional health workforce promoting Central Western Queensland as a place to live, work and invest, to support individual organisation recruitment strategies.
- Will connect with Western Queensland community health lobby group Remote Areas Matter (RAM) to review the 'Charleville Charter' and look for synergies to develop community led solutions to providing minimum standards for primary health care, based on community feedback and design.
- Supports the establishment of a Regional University Study Hub (RUSH), in collaboration with Country University Centre (CUC), in the region as an opportunity to create learning environments and provide support to train and skill communities from the inside out. RUSH's and CUC's are a pipeline for future workers to meet workforce requirements and chance to grow a local health workforce who understands the needs of rural and remote communities.

17 AMA (2023b).

18 The Go Far out campaign aims to overcome workforce challenges, the lack of a regional narrative to help prospective employees make more informed decisions about coming to the region and to attract workers who have never considered working in Western Queensland. https://gofarout.com.au/ accessed October 2023.

- Advocates and supports new models for the rural and remote medical training and education pipelines, by expanding the number of educational places, investing in primary care as a teaching, training and research opportunity not just patient care, implementing a single employer model for general practitioner (GP) training to allow GP's to settle in the one place and receive the benefits of full time employment and improving coordination by integrating existing training programs.[19]
- Acknowledges and supports the role local governments play in attracting and retaining health workers and services through building welcoming communities, providing social amenities, encouraging investment, and supporting local business.
- Supports working with health partners to develop resources to raise local government health literacy on chronic disease and social determinants of health to build understanding, skills and the culture for health equity and be better placed to look to local solutions to address health challenges and support behavioural change in addressing chronic disease.
- Supports social prescribing to address underlying causes of health and wellness issues. Local governments have a role in identifying community services and groups, and keeping listings updated on My Community Directory. There are opportunities to support local capacity and resources through these groups to deliver sustainable and locally relevant services.
- Advocates for community social, emotional and mental well-being encouraging member local governments to work with health partners to find local opportunities to facilitate access to and normalise mental-health checkups and other mental health awareness activities and programs, extending to social supports networks and identifying and supporting the most vulnerable members of the community.
- Advocates for leadership and coordination between care providers to improve regional disability services, support workforce supply, increase uptake of National Disability Insurance Scheme (NDIS) care plans and support the collection of data to demonstrate hidden need for services. RAPAD support's using this data to increase services such as Supported Independent Living and Specialist Disability Accommodation.
- Commits to being an active member of 'communities of practice' in the health, aged care, and disability sectors.
- Advocates for aged care service innovation to help keep older people in their communities, supported by a range of services and connected to the community.
- Advocates and supports Medicare changes that increase the regional health workforce through incentives, adequately remunerates health practitioners and extends service provision and care for Western Queenslanders. We support developing quality metrics to capture data to measure impacts of systemic change.
- Supports the Dementia-Friendly Communities program to help create dementia inclusive local communities, building understanding and support for people with dementia. RAPAD also supports using similar approaches for the elderly, disabled or people impacted by mental health issues who also live with stigmas, isolation and discrimination.
- Supports the key role member local governments play in promoting community ownership and participation in individual health care journeys to move away from the 'sickcare system rather than a holistic health care system'.[20]
- Advocates to its member local governments and to the state and federal governments to continue funding for infrastructure which supports and enhances health and well-being.

Local governments are ideally placed as employers and central to their communities to implement policies, programs and actions that support and model health behaviours and make local impacts on modifiable risk factors for chronic disease.

Examples of LGA led activities to improve health and wellbeing:

- Explore options to work with local food and produce suppliers to address food security
- Develop food security plans as part of community planning.
- Grants or subsidy payments to store owners to reduce transport costs of nutritious food, especially fruit and vegetables, to reduce mark up on the price of goods.
- Partner in providing school breakfasts.
- Partner with dieticians and nutritionists to provide public information sessions on healthy eating, shopping and meal preparation.
- Encourage food suppliers to include healthy items on menu e.g. especially in LGA owned/managed facilities like swimming pools
- Provide access to cooled water bubblers.
- Explore community and workplace-based solutions to getting more people physically active. LGA's could introduce workplace challenges (counting steps etc), introduce incentives such as paying gym memberships for employee, create work gyms and support training by providing a local personal trainer or allow employees to take 30mins of work time to get physically active or develop workplace strategies to encourage movement breaks throughout the day.

19 Murray R, Craig H (2023). 2

20 AMA (2023b).

- Undertake audits of community infrastructure and community resources to provide options for sports and coaching and training for adults to support children.
- Linking to existing local or online private enterprise expertise such as online fitness business specifically designed for rural and remote communities, for example, *Off the Track Training* or *The Yoga Partnership*
- Use LGA networks to promote cancer detection/ screening programs in the region to increase utilisation of these free and potentially life-saving services.
- Provide shade and promote sun protection practices.
- Investigate the feasibility of hosting parkrun to promote physical activity and community connectedness.
- Utilising health service partner exercise physiologists and dieticians to increase physical activity, increase strength and functional mobility, modifying risk factors for chronic disease, improving mental health and supporting social connectedness. There are already examples of programs operating in the region for local government staff to support healthy lifestyles choices, increase physical activity and improving health that could be modified partnering with other primary care providers working in the region and involve physiotherapist, nutritionists and exercise physiologists. See Box 1.

Recommendations:

While health service provision is not local government's core business, they are well placed as major employers, with a direct connection and involvement in their community and relationships with other health partners, to play a role in supporting the health of people in the region and addressing inequalities by modelling and advocating for health equity.

This paper offers four recommendations for RAPAD:

- To support the recommendations of the Western Queensland Alliance of Councils 'Regional Health Review'.
- To work with health partners to develop key metrics based on health sector and community data that will accurately reflect the state of health for individuals and communities in Central Western Queensland and identify priority areas of need to drive advocacy for equitable service provision.
- To connect with health partners working within the region to build and grow partnerships, and a link to blend local government knowledge and experience of community with health service organisations and projects and programs, advocating for adequate funding and supporting health literacy and service uptake in the community.
- To support and advocate for and on behalf of health partner activities, ideas and projects that align with the RAPAD strategic plan and organisational values contributing to the resilience of Central Western communities.

BOX 1

Balonne Shire Council's healthy lifestyle program

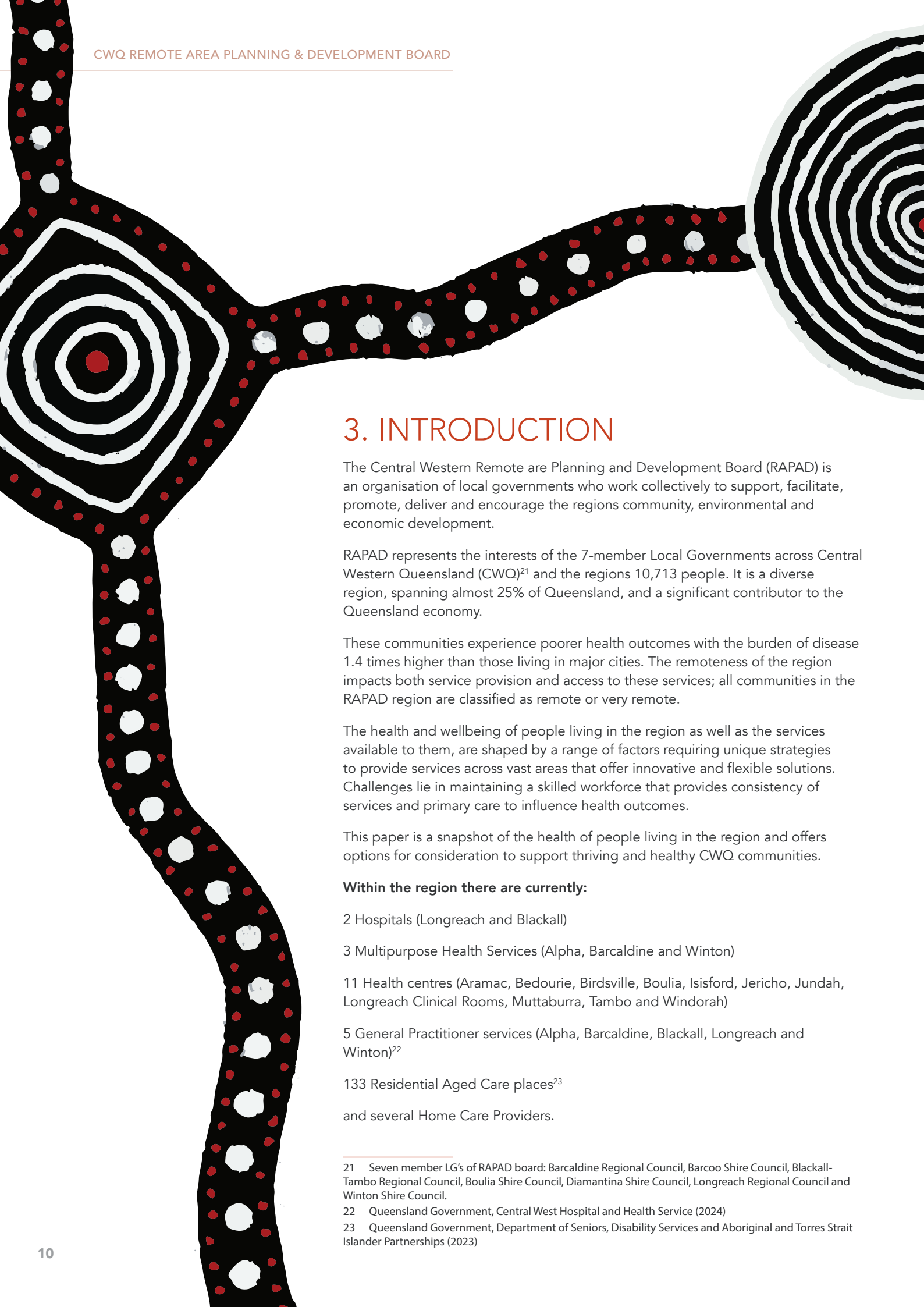
Southern Queensland Rural Health offers the Health Lifestyles Program as a group exercise and education program for the St George community.

Offered twice weekly, the program aims to help people make healthy lifestyles choices, increase physical activity and personal health improvements across the lifespan.

Participants work with allied health professionals and students and involves supervised exercise sessions, education sessions, stress management guidance and activities such as cooking demonstrations.

In addition, a specific program for Balonne Shire Council staff and their families is also being run including exercise and education sessions.

Source: https://www.sqrh.com.au/health-lifestyles-program-st-george#anchor-staff_of_balonne_shire_council



3. INTRODUCTION

The Central Western Remote are Planning and Development Board (RAPAD) is an organisation of local governments who work collectively to support, facilitate, promote, deliver and encourage the regions community, environmental and economic development.

RAPAD represents the interests of the 7-member Local Governments across Central Western Queensland (CWQ)[21] and the regions 10,713 people. It is a diverse region, spanning almost 25% of Queensland, and a significant contributor to the Queensland economy.

These communities experience poorer health outcomes with the burden of disease 1.4 times higher than those living in major cities. The remoteness of the region impacts both service provision and access to these services; all communities in the RAPAD region are classified as remote or very remote.

The health and wellbeing of people living in the region as well as the services available to them, are shaped by a range of factors requiring unique strategies to provide services across vast areas that offer innovative and flexible solutions. Challenges lie in maintaining a skilled workforce that provides consistency of services and primary care to influence health outcomes.

This paper is a snapshot of the health of people living in the region and offers options for consideration to support thriving and healthy CWQ communities.

Within the region there are currently:

2 Hospitals (Longreach and Blackall)

3 Multipurpose Health Services (Alpha, Barcaldine and Winton)

11 Health centres (Aramac, Bedourie, Birdsville, Boulia, Isisford, Jericho, Jundah, Longreach Clinical Rooms, Muttaburra, Tambo and Windorah)

5 General Practitioner services (Alpha, Barcaldine, Blackall, Longreach and Winton)[22]

133 Residential Aged Care places[23]

and several Home Care Providers.

21 Seven member LG's of RAPAD board: Barcaldine Regional Council, Barcoo Shire Council, Blackall-Tambo Regional Council, Boulia Shire Council, Diamantina Shire Council, Longreach Regional Council and Winton Shire Council.

22 Queensland Government, Central West Hospital and Health Service (2024)

23 Queensland Government, Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023)

4. EQUITY IN HEALTH

The concept of 'good health' looks different for each of us, though primarily involves being physically, mentally and socially well. Our health is our greatest resource and key to engaging in a functional and fulfilling life. This paper examines a range of factors that influence health and wellbeing in CWQ that will be supported by the following cornerstones of good health including:

- Feeling safe, included and connected in your community.
- Access to quality, affordable nutritious food.
- Meeting minimum levels physical activity.
- Access to quality health services and staff, including disease screening, allied health and dental services.
- Access to aged care and disability services including respite.
- Support for mental health and managing stress.
- Minimising risk factors like alcohol and tobacco consumption and other drug use.
- Sleeping well and taking time to rest.
- Access to safe and clean water and ensuring adequate intake.
- Being safe in the workplace.

'Health and health equity are determined by the conditions in which people are born, grown, live, work, play and age as well as biological determinants'.[24] Health equity means people have a fair and just opportunity to attain their full health potential and may need different levels and types of support to reduce disadvantage. There are a range of factors that both impact and enable health equity.

4.1 IMPACTS ON HEALTH EQUITY

Remoteness

The health needs of rural and remote Australians and the delivery of services that meet the unique needs of each community are variable. The Australian Statistical Geography Standard and Modified Monash Model is used to classify remoteness measuring geographical remoteness and population size; all communities in the RAPAD region are classified as remote or very remote. Life expectancy also decreases with remoteness, with higher mortality rates and higher rates of potentially avoidable death.[25] These impacts are even more significant for Aboriginal and Torres Strait Islander people, the majority of whom live outside major cities. Just over 8% of CWQ residents identify as Aboriginal or Torres Strait Islander.[26] Combined with social determinants of health and disease risk factors, greater environmental vulnerability, and barriers to equitable access to care, there is a disparity in equitable health outcomes for rural and remote people, especially Aboriginal and Torres Strait Islanders. The 'Closing the Gap' campaign was launched in 2007 as a Council of Australian Governments (COAG) response to the 2005 Social Justice report which sought to achieve lasting improvements in health status for Aboriginal and Torres Strait Islander peoples[27]. The Productivity Commission reports that there has been limited progress on targets for 'Closing the Gap' since that time. 'Rates of adult imprisonment, children in out-of-home care and suicide have all increased, and children's early development outcomes at the start of school have declined.'[28]

24 World Health Organisation (2024). https://www.who.int/health-topics/health-equity#tab=tab_1 accessed February 2024.

25 AIHW (2023h).

26 Queensland Government Statistician's Office, Queensland Treasury (2023e)

27 Human Rights and Equal Opportunity Commission (2005).

28 The central objective of the National Agreement on Closing the Gap is '…to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their outcomes are equal to all Australian'. Progress to meeting the targets set in this agreement has been limited and some are getting worse. https://www.pc.gov.au/closing-the-gap-data/annual-data-report/report/closing-the-gap-annual-data-compilation-report-july2023.pdf accessed October 2023.

Investment in rural health

As a complex issue with many contributing factors, the need for increased and more considered investment into rural health is paramount. While difficult to quantify, modelling by the Nous Group on behalf of the National Rural Health Alliance suggests that there is a shortfall in health expenditure for rural and remote communities, compounded by greater service delivery costs.[29]

There is an immediate need to ensure that the health programs and services operating in CWQ, and any other vulnerable community, are adequately funded and resourced to support people living and aging well and reflect the unique needs of communities and individuals of the region.

To meet the unique needs and care for our CWQ communities more sustainably, strategic investment in the health sector is required if we are to see more equitable and positive health outcomes and address compounding issues such as health workforce challenges, to fortify community health and decrease the burden of chronic disease and associated morbidity and mortality.

Ongoing investment in training and education to develop health system capacity for rural and remote health is critical and a cornerstone to addressing health inequity for rural and remote regions like CWQ where health needs are greatest but where there are the fewer health professionals. Workforce is discussed further in this paper.

Rural communities are disproportionately high contributors to the nation's economy from the resource and energy, agriculture and tourism sectors; healthier rural communities represent a significant opportunity for return on investment.

29 Nous Group (2023).

Access to health services

Primary health care is usually the first level of contact people have with the health system to promote health, prevent, and care for illness and manage ongoing problems. The Local Area Needs Assessment for Central West Hospital and Health Service identified provision of primary health care services as priorities.[30] Increasing remoteness and living outside major cities generally means people have less access to health professionals and healthcare services and will wait until their health deteriorates before accessing health services for treatment rather than potentially preventative services. This increases the likelihood of increased presentations to emergency departments, hospital admissions and often multifaceted treatment options due to the complexity of health issues.[31] Other costs such as transportation and the higher costs of service delivery where a greater burden of disease requires greater emergency or hospital care are also driving higher health service costs.

Models of primary health care delivery that focus on building a resilient health workforce, including doctors, nurses, midwives, dentists and allied health professionals, that are funded for long term success and grounded in partnerships and planning between state and the federal government, other health care providers, local governments and communities are required. That will need a willingness from governments to acknowledge that adaptive and locally based rather than generalised solutions are required and acknowledging that measures of success may be different in and between rural and remote areas to strengthen health equity.

To transform the current system, changes to how we fund, how much is allocated and who is funded have been proposed by many key health stakeholders. All agree that reform is required and would consider factors (not exclusively) such as an outdated Medicare program,[32] hospital funding based on activity[33] and short-term grant-based funding being too short impacting on who and what services can be delivered.

Multidisciplinary health care team approaches address disparity and target funding for the challenges of equitable access to rural and remote health care services around models of care, workforce, health infrastructure, integrated population health initiatives that move beyond cause of direct illness or injury to address 'the causes of the causes'[34] (social determinants). For example, provision of childcare and other early childhood services supports early learning and brain development.[35] Factors such as anti-natal care and housing stability in the first two years of a child's life can impact public health and 'broader social issues such as criminality, problems with literacy and numeracy, and economic participation, highlighting the impact and complexity of individual health.[36]

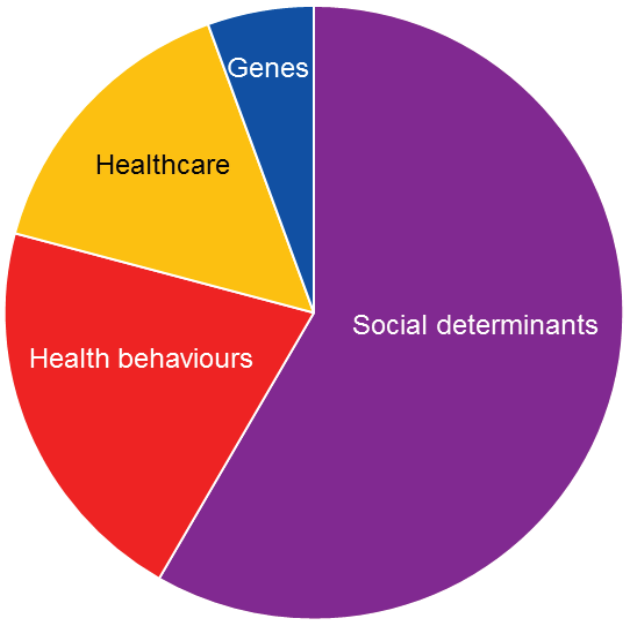
30 Queensland Government, Queensland Health (2022 a,b,c)
31 National Rural Health Alliance June (2023).
32 Breadon et al (2022).
33 AIHW (2018).
34 World Health organisation (2008).
35 Nous Group (2023).
36 Strong Foundations Collaboration (2019).

Social determinants of health

Social determinants of health are the wider forces and systems that shape our lives such as education, higher costs of health access and deliver, income and occupation, early childhood experiences, access to transport, distance, social exclusion and isolation, housing and nutrition also lead to inequalities and 'subsequent impacts on health'. These factors may also influence health behaviours and lifestyle factors such as smoking and excessive alcohol use, rates of overweight and obesity which are all reportedly higher in rural and remote areas combined with lower levels of physical activity[37] and contribute to chronic disease and impact mental health. Achieving equitable health means more than reducing morbidity and risk factors and should focus on the underlying social determinants of health. Social determinants of health largely responsible for inequalities in health outcomes. Figure 1 provides a simplistic representation of social determinant impact on health; exact weightings vary between countries and contexts.

The Australian Medical Association reports that Aboriginal and Torres Strait Islander peoples and people who live in remote Australia are vulnerable 'not only in relation to prevalence of disease or health condition, but also in terms of earlier onset, greater severity and greater complexity in management.'[38]

Figure 1: The determinants of health and their impact



Source: Victorian Government. Department of Health. Social determinants of health. https://www.health.vic.gov.au/your-health-report-of-the-chief-health-officer-victoria-2018/health-inequalities/social accessed October 2023.

37 Partnershops AIHW (2028).

38 Australian Medical Association (2020)

4.2 FACTORS THAT ENABLE AND PROMOTE HEALTH EQUITY

The role of local government

Recent research shows local governments are well positioned and have a role to play in addressing overall health inequity.[39] Equity in health dictates that everyone has a fair and just opportunity to attain their highest degree of health and the tools to do it. As major employers in many communities, with a direct connection and involvement in the community and relationships with other health partners, local governments can both model, support and advocate for health equity.[40]

Often ill health is related to personal behaviour and choices that are targeted by health services. Health equity has an upstream focus that shifts to the causes of health disparities. A clear understanding of what health equality, social determinants of health, priority groups and social disadvantage to build knowledge through training across whole local government organisations is one way of building a health equity culture. Embedding equity as a core organisational value supported by organisational 'equity champions' are opportunities for local governments to build a culture and policy based on equity. The concept of equity moves across all areas and positions in local government.[41]

To build health equity capacity, local governments can identify and/or collect reliable community data across a range of indicators and using tools to identify health inequalities (a number of these tools exist already), develop policy with the community and other stakeholders and determines ways of measuring and monitoring health equity over time. Local governments would also be more successful if supported by policy and adequately funded by other levels of government.[42]

Addressing health equity is complex and challenging from a local government perspective especially when state and federal governments can more easily influence determinants like education, employment and housing. However, moving towards equity, could help change the social gradient[43] of local communities. This is consistent with community views of the changing role of local governments in Australia; 91% of people agreed local government should participate in service delivery that contribute to health and fairness in local communities with 67% indicating local governments are best able to make decisions about local issues.[44]

Partnerships

There are already several partnerships operating between RAPAD and member councils including Central West Hospital and Health Service, Western Queensland Public Health Network, Royal Flying Doctor Service and other government and non-government agencies and health service providers, universities and training organisations, community groups and community members as trusted and credible partners. The collaborative COVID-19 vaccination program response between local councils and health partners is a positive demonstration of effective partnerships during crisis. Extension of ongoing relationships beyond crisis are evidenced in projects like NWPHN's 'Healthy Outback Communities' currently being trialled in the Barcoo Shire. Supporting these types of relationships, for local level action can impact determinants and locally identified priorities. The community-based company of limited guarantee 'Remote Australians Matter Ltd' was established to provide a forum and conduit for remote and very remote Australians to get involved in the design and development of primary care options that are appropriate to their needs. Their aim to help the Federal Government deliver solutions ensuring equitable access to a minimal standard for primary health care and as an organisation with a vested interest in collaboration and focus on health and welfare share local governments' health equity intent.

Access to quality data

Quality data supports advocacy. When the right data is collected it can be used to describe circumstances, identify problems, help identify solutions, support continuity of care, illustrate impact and justify financial investment.

To be effective, quality data should be accurate and reliable, complete, and timely. To drive change, data on the quantity and magnitude of issues needs to be communicated and utilised by people and organisations that can make a difference.

Herein lies a challenge and opportunity for the health sector in CWQ. Capturing the right data using the most useful metrics and relating it to context will continue to drive change. To illustrate, capturing and identifying data such as number of clinic days available per person per year in a remote community provides a snapshot of health service availability, highlights service gaps and potential for targeted funding to improve outcomes.

39 Schultz et al (2023).

40 Schultz et al (2023).

41 Schultz et al (2023).

42 Schultz et al (2023).

43 The social gradient describes the phenomenon where people who are socioeconomically disadvantaged have the worst health (and shorter lives). The curve gets steeper with increasing health inequality. In Australia, Aboriginal and Torres Strait Islander people, people living in rural and remote areas, people living with disability or mental illness and older adults are among the groups who are often more vulnerable to disadvantage.

44 Chou et al (2023).

5. CWQ CHALLENGES TO HEALTH EQUITY

5.1 CHRONIC DISEASE

'Chronic diseases are a leading cause of illness, disability and death in Australia and are defined as any condition which is long lasting and with persistent effects'.[45]

Chronic conditions account for 85% of Australia's total disease burden[46] and are attributed to complex and multiple causes, developing gradually and requiring long term management. Chronic conditions can also contribute to increased vulnerability for other communicable diseases such as influenza and COVID-19.

Australian Institute of Health and Welfare mortality data by PHN shows Western Queensland has the highest age standardised mortality rate (Figure 2), the highest rates of premature death (47%) and potentially avoidable premature death (55.5%) across the 31 Australian PHN's.

The leading cause of death in Western Queensland is coronary heart disease (13.2%) and one in five Western Queensland adults (25-64years) are diagnosed with hypertension and or hyperlipidaemia (high levels or lipids or fats in the blood). Diabetes prevalence rates in CWQ are higher than the national rate. Diabetes complications form a quarter of all potentially preventable hospitalisations in Western Queensland. Diabetes related deaths are twice as high in Western Queensland compared to nationally. These statistics are consistent with trends in other very remote areas of Australia (refer to Figure 3).

It is estimated that 47 per cent of the Australian population have one or more chronic conditions impacting quality of life. Multimorbidity[47] affects 20 percent of Australians which is more common with increasing disadvantage.[48] Indigenous Australians, poorer Australians, those with less education, and those living in rural and remote areas face the biggest barriers to health and are far more likely to be diagnosed with many common chronic diseases.[49]

Indigenous Australians have lower life expectancies, higher burden of disease, poorer self-reported health and a higher likelihood of being hospitalised than non-Indigenous Australians.[50] Chronic diseases account for about 80 per cent of the life expectancy gap between Indigenous and non-Indigenous Australians.[51]

Chronic disease risk factors are often preventable or treatable such as tobacco smoking, physical inactivity, unhealthy eating, being overweight or obese, diabetes, high cholesterol, high blood pressure and alcohol consumption. With 9 out of 10 deaths in Australia attributable to chronic disease, preventing these factors and/or changing behaviours significantly reduces illness and rates of death.[52]

Childhood obesity is associated with a higher chance of premature death and disability in adulthood. Worldwide the prevalence of overweight and obesity amongst children has dramatically risen. The Queensland Preventative Health Survey, conducted annually by Queensland Health, estimates children (aged 5-17 years) have higher rates of overweight and obesity in Western Queensland compared to Queensland averages.[53] In CWQ 18.5% of children compared to the Queensland average of 8.5% and 30.7% of CWQ adults compared to 25% of Queensland adults are obese.[54]

Grattan Institute analysis estimates the direct cost of treating chronic disease is more than $70 billion a year. In addition, there are personal costs for the people living with chronic disease and those caring for them as well as economic costs[55] related to being unable to work, reduced productivity and absenteeism.

Investment and initiatives to manage chronic disease will not be enough; prevention is crucial in improving quality of life for individuals and reducing economic costs. However, chronic disease prevention is underfunded in Australia compared to other countries (see Figure 4) with less expenditure in public health compared to hospitals and primary care (see Figure 5).

In CWQ some modifiable risk factors such as smoking are slowly decreasing, however the rate of risky alcohol consumption remains high. Other protective factors like fruit and vegetable intake in CWQ are some of the lowest in the state and well below recommended rates.[56]

45 WQPHN (2022).

46 Our World in Data (2023).

47 Multimorbidity refers to 'the coexistence of two or more chronic conditions, where one is not necessarily more central than the others' and no particular disease is looked at exclusively. In a primary care setting the patient and health professional can base care on presenting symptoms to manage multiple conditions. Boyd CM, Fortin M (2010).

48 AIHW (2023c).

49 Breadon et al (2023).

50 AIHW (2023h).

51 Breadon et al (2023).

52 AIHW (2023c).

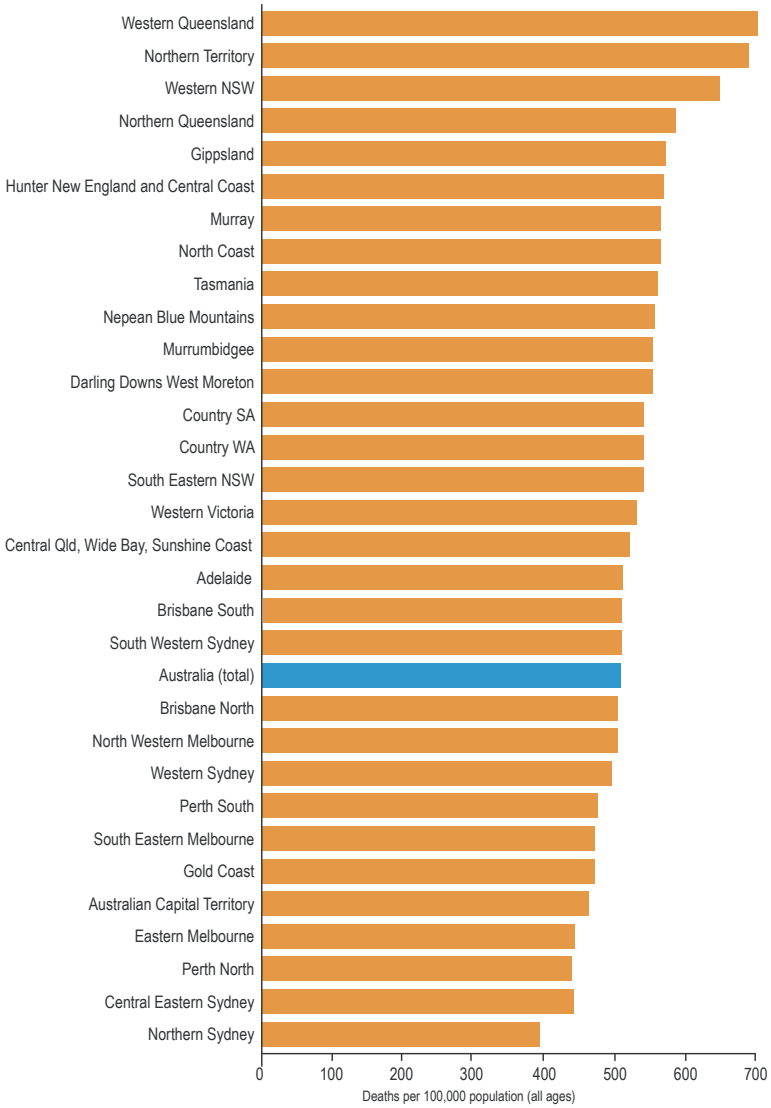
53 WQPHN (2022).

54 Queensland Health (2020b)

55 Breadon et al (2023).

56 Queensland Health, Queensland Health (2020b).

Figure 2. Age standardised total death rates 2021



Source: Australian Institute of Health & Welfare. Mortality Over Regions and Time (MORT) books: Primary Health Network, 2017-2021

Figure 3. Leading cause of death by remoteness area, with comparison mortality rates with Australia overall 2017-2021

	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote
1	Coronary heart disease	Coronary heart disease	Coronary heart disease	Coronary heart disease	Coronary heart disease
2	Dementia including Alzheimer disease	Dementia including Alzheimer disease	Dementia including Alzheimer disease	Lung cancer	Diabetes
3	Cerebrovascular disease	Cerebrovascular disease	Lung cancer	Chronic obstructive pulmonary disease	Lung cancer
4	Lung cancer	Lung cancer	Chronic obstructive pulmonary disease	Dementia including Alzheimer disease	Chronic obstructive pulmonary disease
5	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease	Cerebrovascular disease	Cerebrovascular disease	Suicide
6	Colorectal cancer	Colorectal cancer	Colorectal cancer	Diabetes	Cerebrovascular disease
7	Diabetes	Diabetes	Diabetes	Suicide	Dementia including Alzheimer disease
8	Accidental falls	Prostate cancer	Prostate cancer	Colorectal cancer	Land transport accidents
9	Heart failure	Heart failure	Suicide	Land transport accidents	Kidney failure
10	Prostate cancer	Cancer of unknown or ill-defined primary site	Cancer of unknown or ill-defined primary site	Prostate cancer	Other ill-defined causes

Rate ratio (compared with all Australia)

<= 1.0	1.1–1.24	1.25–1.49	1.5–1.9	2.0–2.9	3.0–4.0

Source: Australian Institute of Health & Welfare. Rural and remote health. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health accessed Sept 2023.

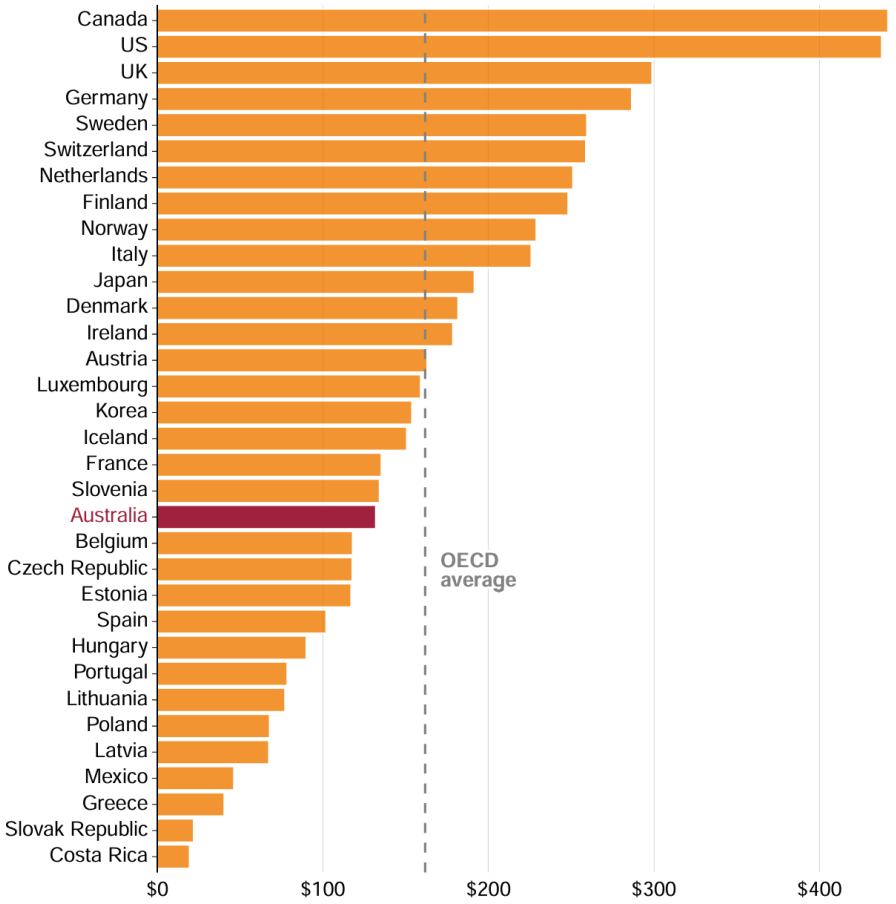
Notes

Rates are age-standardised to the 2001 Australian standard population.

Leading causes of death are listed in order of number of deaths in each remoteness area from 2017–2021.

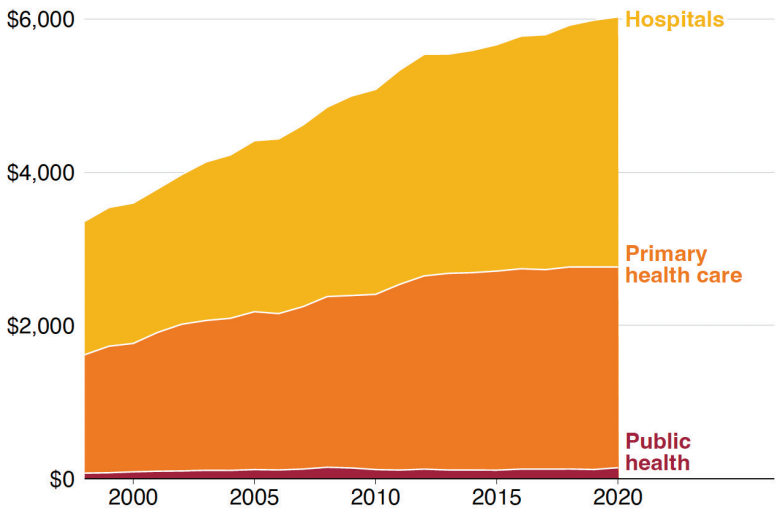
Boxes are coloured based on rate ratio comparing each region to Australia overall.

Figure 4. Annual preventative health expenditure per capita ($AUD, PPP adjusted 2018)



Source: Breadon et al (2023). *The Australian Centre for Disease Control (ACDC) Highway to Health*. Gratten Institute.

Figure 5. Yearly per capita expenditure on hospitals, primary healthcare, and public health



Notes: Primary health care spending excludes spending on public health. Includes government and non-government expenditure.

Source: Breadon et al (2023). *The Australian Centre for Disease Control (ACDC) Highway to Health*. Gratten Institute.

The right programs that target the right people using evidence-based ideas that are well coordinated, managed and communicated through partnerships and sustained over time can help impact modifiable risk factors and lead to behavioural change. See Box 2.

Australia is lagging other countries who have a range of food polices in place: at least 85 countries have some kind of tax on sweetened beverages, 43 countries have policies on reducing trans-fatty acids in food implicated as risk factors in cardiovascular disease. At least 80 countries have programs working on reducing salt consumption in food to reduce the risks associated with hypertension and kidney disease and to prevent heart attacks and strokes.

There are compelling reasons to make chronic disease prevention a priority and yet there are challenges. Just as chronic disease takes time to develop, the impacts of preventative changes also take time, well beyond government terms of office. These impacts can be hard to see and to measure when it's difficult to quantify which strategies were successful in preventing chronic conditions and for whom, given interventions occurring across the lifespan. Sustained prevention efforts over time are required to change behaviour.

There are also private interests that stand to lose from prevention programs, counteracting healthy messaging with coordinated campaigns, advertising and political lobbying and donations. As an example, food labelling policy, which is not compulsory and advertising regulation is influenced by industry rather than evidence of best practices.[57]

Over 80 percent of health status is related to social determinants of health.[58] This indicates prevention of chronic disease requires coordinated efforts across all levels of government and non-government sectors to make appreciable change.

BOX 2

A run in the park

parkrun is an international, volunteer-led, free for all running event originating in Teddington, United Kingdom in October 2004 with 13 runners as a no-cost way to engage people in running/moving. Fast forward to 2023 and there are six parkrun events being held weekly across Western Queensland.

parkrun is based on the basic principles of a free, weekly run or walk that is five kilometres in length, and accessible to everyone, forever. Once registered with parkrun, participants can run in any parkrun event across the globe. Volunteers are an important part of the events that are positive, welcoming, have no time limits and where no one finishes last.

parkrun's mission is to create a healthier, happier planet. With that in mind, the ever-inclusive event began in Longreach in 2020 as a low-cost way to engage people to connect and move growing from an informal partnership between community, Queensland Health, Longreach Regional Council and Education Queensland to impact physical and mental wellbeing.

57 Breadon et al (2023).
58 National Academy of Medicine (2021).

Table 1: Anti-tobacco initiative responsibilities shared across partners

	Federal	State	Local	NGO
Pricing regulations (i.e. taxes)	X			
Product, advertising, retail, and import regulations	X	X		
Provision and funding of health interventions	X	X		X
Environmental and place-based regulations (including enforcement)	X	X	X	
Education campaigns and provision of health information	X	X	X	X

Source: Breadon et al (2023). *The Australian Centre for Disease Control (ACDC) Highway to Health*. Gratten Institute.

Anti-tobacco initiatives have been highly successful in reducing the number of people smoking and associated health impacts but require sustained efforts over time that are complimentary between stakeholders. This campaign is an example of aligned efforts to create social and individual behavioural change. See Table 1.

Local governments are ideally placed as employers and central to their communities to implement policies, programs and actions that support and model health behaviours and make local impacts on modifiable risk factors for chronic disease. There are already examples of programs operating in the region for local government staff to support healthy lifestyles choices, increase physical activity and improving health that could be modified partnering with other primary care providers working in the region and involve physiotherapist, nutritionists and exercise physiologists. See Box 3.

Individuals can also influence their health outcomes and help prevent chronic disease. Self-care describes the role that each of us has in preventing disease, managing health and mental wellbeing and actively participating in our own healthcare which are key to disease prevention.[59] There are external forces that influence, enable and inform self-care which need to be considered; health policy and our health system complement self-care. Improving health literacy, providing tools and support to make behavioural change while integration self-care into the health system, enables people to be part of their own health journey and influence their own outcomes.

BOX 3

Balonne Shire Council's healthy lifestyle program

Southern Queensland Rural Health offers the Health Lifestyles Program as a group exercise and education program for the St George community.

Offered twice weekly, the program aims to help people make healthy lifestyles choices, increase physical activity and personal health improvements across the lifespan.

Participants work with allied health professionals and students and involves supervised exercise sessions, education sessions, stress management guidance and activities such as cooking demonstrations.

In addition, a specific program for Balonne Shire Council staff and their families is also being run including exercise and education sessions.

Source: https://www.sqrh.com.au/health-lifestyles-program-st-george#anchor-staff_of_balonne_shire_council

59 Australian Self-care Alliance (2023).

5.2 CANCER RATES AND SCREENING

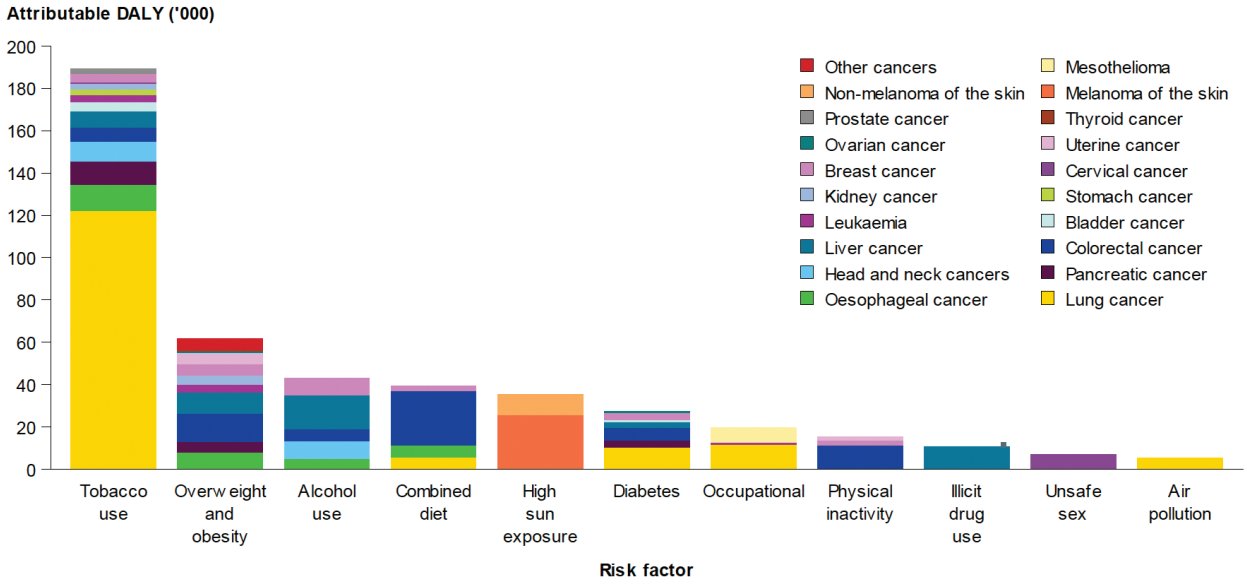
Cancer is a leading cause of illness in Australia[60] and the need to improve cancer survival rates and screening and treatment has been identified as a priority need in CWQ.[61]

Cancer health statistics in CWQ mirror those in other parts of remote Australia where incidence is higher, and people have poorer survival rates after cancer diagnosis. For Aboriginal and Torres Strait Islanders, for whom the larger proportion live in remote areas, incidence rates are higher and survival rates lower than the rest of the Australian population.[62]

The preventable risk factors of tobacco and alcohol use contribute significantly to cancer burden, see Figure 6. There are higher rates of both, reported in remote and very remote areas.[63] A strong drinking culture, limited options for socialising, boredom, the stresses of drought or isolation,[64] peer pressure and a lack of confidential counselling services combined with little support are some of the reasons alcohol use is higher. Similarly, a lower level of peer pressure to stop or more opportunities to smoke outdoors,[65] lack of knowledge on the health implications of smoking and support to quit continues to drive tobacco use in remote areas.

Figure 6. Cancer burden (DALY) attributable to specific risk factors, 2018

Source: Australian Institute of Health & Welfare. Cancer in Australia 2021.



Notes

1. Dietary risk factors are presented as the joint effect 'Combined diet'.

2. In this figure, 'Other cancers' comprises non-Hodgkin lymphoma, myeloma and gallbladder cancer. 'Head and neck cancers' comprises lip and oral cavity cancer, laryngeal cancer, nasopharyngeal cancer and other oral cavity and pharynx cancers.

3. Data for this figure are in online Table S2.1.

60 Australian Institute of Health and Welfare (2021).
61 Queensland Government, Queensland Health (2022a).
62 NRHA (2022).
63 AIHW (2020)
64 Australian Government Department of Health and Aged Care (2023a).
65 NRHA (2014).

Other risk factors such as being overweight or obese, poor diet and low levels of physical activity also contribute to the increased cancer incidence and poor outcomes. Limited availability and higher prices for food in remotes areas make it hard for people to make healthy choices.[66] The average annual UV Index values[67] for CWQ are in the very high range across the region, increasing risk for long term damage to the DNA of skin cells that can lead to cancer.[68] Skin cancer rates in Queensland are the highest in Australia.[69]

Recorded incidence rates of cancer are lower in remote and very remote areas but mortality is higher than the Australian average. This likely reflects the lower detection rates and delays in seeking treatment when cancers are more advanced.[70] In the Central West, for example, the number of new bowel cancer cases is 62.10 per capita which is higher than the Queensland rate at 40.00 per capita.[71]

Australia's national screening programs for bowel, breast and cervical cancer programs aim to reduce morbidity and mortality through early detection across defined target groups to enable early intervention and better outcomes. Women are more active participants in these programs.[72] Participation in the National Bowel Cancer Screening Program in Western Queensland is 28.3% compared to the Australian average of 40.9%. Participation in the National Cervical Screening Program for Western Queensland was 57.6% which is also lower than the Australian average of 62.4%. The situation is better for Breastscreen Australia participation rates with participation in the program for Western Queensland at 55.7% compared to the national average of 40.9%.[73] This is an important service as positive screening results for asymptomatic people are higher in CWQ than the Queensland average (59.36% for CWQ compared to 54.80% for Queensland).[74] Rates of breast and bowel cancer screening are lower in Aboriginal people.[75] As these are screening services only, follow up additional diagnostic testing and treatment is required, often outside of the region. Access to health practitioners and other medical services for further diagnosis and treatment, transport and costs involved with travel are additional considerations for people living in CWQ. 'These factors contribute to delayed presentation for care and alteration of treatment choices.'[76] The establishment of local mammography services may increase screening and diagnostic mammogram rates.[77]

It is predicted that in the next 20 years the number of cancer cases detected will exceed population growth, driven by an aging population, whose life expectancy will also be increasing.[78] 'Projections suggest an overall 51% increase in the number of new cancer cases and a 36% increase in the number of cancer deaths' in Australia between 2022 and 2044. If survival rates are lower in rural Australia continued efforts to 'increase screening uptake and control risk factors'[79] are critical. Additionally, supporting the training and education of a localised specialised health workforce, increasing access to clinical trials, working to improve screening and earlier cancer treatment for Aboriginal peoples and supporting patient travel and accommodation through easily navigable processes and continued funding are also priorities.[80]

Increasing chronic disease, cancer and Australia's aging population are increasing demand for palliative care services for those with life-limiting illnesses. Factors such as a dispersed population, local and regional demographics and health workforce capabilities are all considerations in the way these services are delivered. Palliative care is available through Queensland Health providing coordinated care for people who are terminally ill and their families and friends.

66 NRHA (2013).

67 According to the Bureau of Meteorology Australia, the UV Index provides a measure of solar UV radiation level at the earth's surface and thereby potential for skin damage. Protective measure's need to be taken for UV Index values of 3 or above.

68 Cancer Council (2023).

69 The Royal Australian College of General Practitioners (2014).

70 AIHW (2021).

71 Queensland Government, Queensland Health (2022a) CWHHS (2022).

72 AIHW (2021).

73 AIHW (2023b).

74 Queensland Government, Queensland Health (2022a).

75 NRHA (2022).

76 NRHA (2022).

77 Queensland Government, Queensland Health (2022a).

78 AIHW (2021).

79 Luo et al. (2022).

80 NRHA (2022).

5.3 MENTAL HEALTH

Improving mental health and social and emotional wellbeing is a priority for CWQ as identified in the Central West Hospital and Health Services' Local Area Needs Assessments.[81] Mental health plays an important role in our overall health and wellbeing and people living in remote areas face unique stressors. There is a greater incidence of chronic disease and increased risk factors like illicit drug, tobacco and alcohol use as well as higher rates of leaving school earlier which may contribute to behavioural and coping difficulties.[82] Seasonal or fly-in fly-out employment, variable income from commodity prices and the associated changes to expenditure in small towns, isolation and the impact of natural disasters like flooding and drought add to the picture. Other social determinants of health also impact wellbeing.

Rates of suicide and self-harm are higher in rural and remote areas than elsewhere in Australia. Males are three times as likely to suicide, with more females self-harming. Self-harm in Queensland is three times the national rate.[83] Suicide is the leading cause of death for people aged 15 – 44 years.[84] Suicide rates in regional and remote areas are higher than in major cities. Aboriginal and Torres Strait Islander people experience higher rates of mental health issues than non-Indigenous Australians. Having a mental illness also increases the risk of having a physical illness and vice-versa.[85]

Currently in CWQ there are no acute inpatient mental health services available with other regional mental health services provided by practitioners based in Longreach. 'Acute presentations are managed by Rockhampton Mental Health Services via videoconference in the first instance'. Usually Royal Flying Doctor Service (RFDS) retrieval is utilised when face to face or inpatient assessments are required, however mental health patients can be deprioritised, challenging local health services to care for them appropriately.[86]

'General practice plays a central role in the provision of mental health care in Australia' accounting for a large proportion of their work. High-quality education and training in mental health[87] supports GP's to better support their patients. Providing a range of integrated, affordable services, that take advantage of initiatives like telehealth services, to support the spectrum of mental health issues delivered by a team of trained health care professionals, including psychiatrists, psychologists and mental health workers who are well supported in their roles, with the patient at the centre of care[88] would also support patient wellbeing. All aspects of mental health support and the workforce to deliver them are required across the whole region to avoid the situation where people do not seek help when needed as it's easier than the alternatives.[89]

As a community normalising mental health check-up's and reducing the stigmas associated with illness and seeking help is important, especially as people can feel highly visible and where stoicism can run high. Supporting social, emotional and mental wellbeing is everyone's responsibility, especially in small communities. Creating opportunities to provide mental health awareness and first-aid as well as social connections can be driven locally to support the most vulnerable in our community.

81 Queensland Government, Queensland Health (2022a).
82 Queensland Government, Queensland Health (2022a).
83 Queensland Government. Chief Health Officer of Queensland (2023d).
84 AIHW Australian Institute of Health and Wellbeing (2023d).
85 Commonwealth of Australia, Department of Health (2021).
86 Queensland Government, Queensland Health (2022a).
87 RACGP (2021).
88 WQPHN (2021a).
89 Queensland Government, Queensland Health (2022b).

5.4 WORKFORCE

Australia has a diverse health workforce working across a range of settings and includes primary care givers, medical practitioners, dental practitioners (oral health therapists, dental hygienists, dental therapists, dentists), nurses and midwives and allied health professionals (radiographers/ medical imaging technologists, occupational therapists, optometrists, osteopaths, paramedicine practitioners, pharmacists, physiotherapists, podiatrists, psychologists, Aboriginal and Torres Strait Islander health practitioners).

Workforce supply

While there has been investment into increasing Australia's health workforce supply, such as boosting the numbers of domestic and international graduate doctors, where Australia now has one of the highest rates of general practitioners per capita in the world[90] there is a maldistribution and undersupply of primary health care providers in rural and remote areas compared to other areas.[91] These workers also require a broad range of the right skills mix to work in these settings.[92] Skills such emergency medicine, palliative care, paediatrics, mental health, aged care[93] and health promotion, management and leadership are valuable skills in rural and remote communities.

In Western Queensland, quantifying the number of general practitioners working in general practice is complicated due to the employment agreements however, a WQPHN general practice census indicated the number of general practitioners declined from 2018 to 2020. As discussed, poorer health status means greater need for services and potentially longer consultation times are additional considerations.[94] The Central West, offers an innovative model of care where the hospital and health services employ salaried senior medical officers who work at both the hospital and general practice, sharing on-call responsibilities, and having a unique level of patient continuity of care.[95]

Endorsed and trained Nurse Practitioners who have high levels of expertise in nursing work autonomously and in collaboration with other health care providers to provide continuity of care in an advanced clinical role.

Workforce and service gaps

In the Central West Hospital and Health Service (CWHHS) highest rated workforce gaps were:

- Aboriginal and Torres Strait health
- Radiography/sonography
- Nursing/midwifery workforces

Highest service gaps in the CWHHS were:

- Disability
- Community-based rehabilitation
- Aged care
- Social support
- Other service gaps highlighted were Aboriginal and Torres Strait Islander Health Services, child and maternal health, mental health and health prevention/promotion[96]

Workforce challenges and issues

There are a range of issues and challenges that impact workforce and services including:

- Maldistribution of Australia's health workforce across medical, allied health and Aboriginal health sectors leading to undersupply in rural and remote areas.
- A young and transient workforce many of whom are new graduates.
- High turnover of staff. The profile of staff retention is also changing with one regionally based health provider anecdotally noting that in the past staff stayed for an average of two years; currently that average is 14 months.
- High costs associated with locums and agency staff. This issue reflects not only the high cost for service providers to provide staff but also contributes to competition between providers and a divide between what they can afford to pay and therefore who has access to staff.
- High costs and complexity of arrangements associated with fly-in, fly-out staffing scenarios.
- Stress, anxiety, and burnout associated with heavy and complex caseloads given the higher levels of chronic disease and comorbidities as well as other work-life balance issues such as on call rosters.
- Inadequate remuneration and incentives in primary care practices especially as state or territory run health services can often offer higher rates of pay, more attractive contractual arrangements and better conditions of employment such as housing and leave entitlements.[97]
- Lack of access to supervision, professional support, mentoring and continuing professional development.
- Workforce implications due to a lack of primary care services that contribute to increases in emergency department presentations and follow up hospital admissions due to complexities of health issues requiring more treatment for longer.
- Professional isolation with limited networking opportunities.
- Geographical isolation and lack of support networks like family and friends; recreational, social, and cultural isolation.

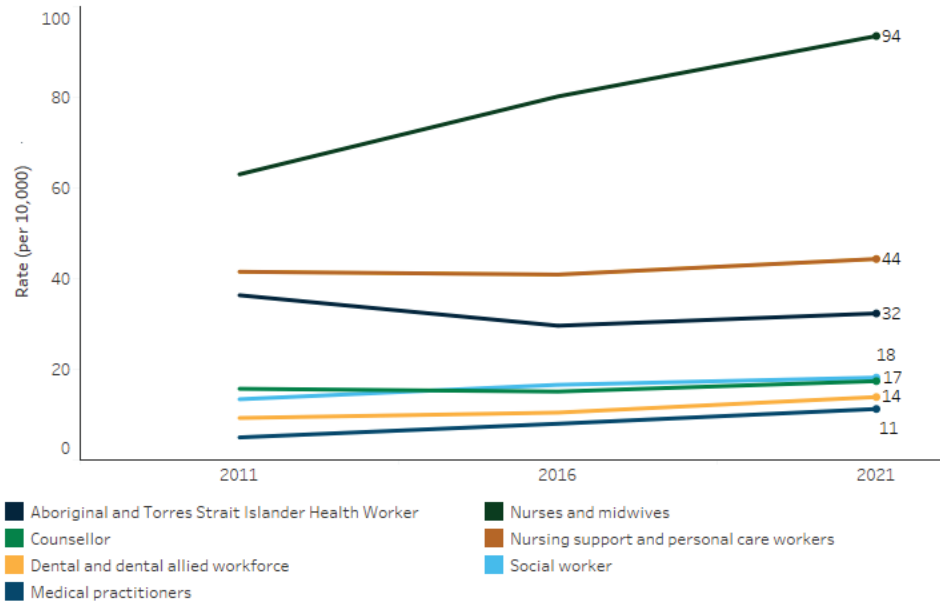
90 Breadon et al. (2022).
91 NRHA (2023).
92 Australian Medical Association (2017).
93 Kirkpatrick et al. (2014).
94 WQPHN (2022). Unique employment conditions all general practitioners in the CWHHS being employed as Senior Medical Officers providing services in hospitals and general practice, as well as visiting RFDS doctors in some areas.
95 James Cook University (2022).
96 Health Workforce Queensland (2023).
97 NRHA (2023).

- Limited professional or educational opportunities for partners and schools for children.
- High infrastructure and maintenance costs associated with setting up a practice and the related administrative burden and expertise required to run a business.[98]
- Less access to locum support.
- Impacts of downgrading or withdrawing other services.[99]
- Funding models that impact consistency and continuity of services and staffing, such as grants and short-term funding arrangements.[100]
- Funding of Commonwealth, state and hospital and health services and other community and regionally based services, can fragment and duplicate services impacting continuity of care. Changes to the Distribution Priority Areas (DPA)[101] classification system now provides DPA classification to some MM 1 & MM2 areas[102] making it more challenging to recruit doctors to rural and remote general practices, 'including international medical graduates and bonded Australian -trained graduates.'[103]

In addition, Aboriginal and Torres Strait Islander people, are underrepresented in the health workforce and this gap is widening, putting pressure on the current Indigenous workforce. Of the total number of Indigenous Australians employed in health-related occupations the highest percentage are employed as Aboriginal and Torres Strait Islander Health Workers and the least as medical practitioners,[104] see Figure 7.

Figure 7. Rate of people aged 15 and over employed in health-related occupations, by Indigenous status, Australia 2011 – 2021.

Source: Australian Institute of Health & Welfare. National Indigenous Agency. *Aboriginal and Torres Strait Islander people in the health workforce*. https://www.indigenoushpf.gov.au/measures/3-12-atsi-people-health-workforce#references accessed August 2023.



Supporting workforce training

There are long-established training schemes for the rural and remote workforce operating in Western Queensland as well as some more recent advancements with the hope of addressing workforce supply and distribution challenges. Across medicine, nursing and allied health, factors that enhance recruitment relate to students coming from a rural background, studying a curriculum that embeds rural issues and concepts and the provision of quality rural training opportunities.[105] The 'pipeline' concept across medicine and allied health starts when students apply and enrol for their health degrees, creating a pathway including key factors such as rural curriculum, creating rural student support groups, longitudinal integrated clerkships,[106] rural teachers and clinical mentors, and supportive rural social connections,[107] as well as ensuring universities accept a percentage of students from rural areas and there is increased government financial support for rural general practice training.[108]

98 NRHA (2023).

99 AMA (2017).

100 HWQ (2022).

101 The Distribution Priority Area (DPA) classification system identifies areas with a shortage of general practitioners. Areas are classified based on Medicare billing (by gender, age and socio-economic status) as well as remoteness under the Modified Monash Model (see https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm). From July 2022 all areas classified MM 2 -7 and the Northern Territory are classified DPA. https://www.health.gov.au/topics/rural-health-workforce/classifications/dpa accessed August 2023.

102 NRHA (2023).

103 RACGP (2022).

104 Australian Government, Australian Institute of Health & Welfare, National Indigenous Australians Agency (2023).

105 Battye et al. (2019).

106 Longitudinal Integrated Clerkships usually occur in the later stages of a medical students training and allow students to be involved in the continuum of patient care over time with support from their supervisor/s as patient's progress through diagnosis, hospitalisation, treatments and rehabilitation.

107 Murray R and Craig H (2023).

108 In July 2023, the Albanese Government announced that universities can offer 'additional Commonwealth supported places (CSP's) for rural trained medical students as well as capital funding for new regional training facilities'. RACGP Media Release July 2023 RACGP welcomes rural medical student boost. https://www.racgp.org.au/gp-news/media-releases/2023-media-releases/july-2023/racgp-welcomes-rural-medical-student-boost accessed August 2023.

Medical schools and training institutions located outside major cities, quality supervision, community immersion, multidisciplinary exposure, vocational planning and developing capable clinical and non-clinical skills as well as post graduate opportunities also support the pipeline. James Cook University's (JCU) medical degree, for example, has a strong rural focus, offering rural placements to students. Rural general vocational training is offered by The Royal Australian College of General Practice and The Australian College of Rural and Remote Medicine with additional support for medical practitioners living in rural and remote areas to continue on the rural generalist pathway by distance education through The Remote Vocational Training Scheme. Medical rural generalists are GP's providing primary and emergency care and may have additional specialties such as dermatology, obstetrics, anaesthetics or mental health. Similarly, JCU offers a program to support early career allied health professionals developing the skills they need to thrive and stay in rural communities. Programs like these are important to build the number of health professionals working in Western Queensland and addressing workplace shortages.

All these programs have strong associations with hospital and primary care services in Western Queensland. In addition, JCU facilitates the North Queensland Regional Training Hub connecting students and doctors with the opportunities to work in rural and remote areas including the Central West and North West Queensland. In addition, the Country Universities Centre network of community owned and operated centres have identified a workforce pipeline and provide a range of services to support students to enrol and complete their studies.[109] See Box 4.

BOX 4

Build from within

Several local governments within the Western Queensland region are partnering with key stakeholders on a range of projects and initiatives to support students and education within the region and in effect building a workforce from within.

Some councils are supporting health students on practicums within the region with bursary's, scholarships, and other forms of financial assistance to support student travel costs, lost income and expenses such as rent, while away from home for extended periods of time.

There are other examples of councils and organisations providing accommodation for health students having been given access to State Government land to build appropriate facilities that enable students to come to the region.

The Country Universities Centre are part of the Regional University Study Hub network that enables students to study and potentially stay in the region when they complete their studies bringing new skills and opportunities for regional communities.

Each centre is owned and governed locally through a Board of Directors and are characterised by strong community support in small to medium sized towns that do not have university infrastructure and typically lower participation in higher education to provide equitable access to education. The CUC's provide spaces to study with flexible access and high-speed internet and other facilities and student services to support students.

Further information about Regional University Study Hubs and Country Universities Centre can be found here https://www.education.gov.au/regional-university-study-hubs ; https://www.cuc.edu.au/ ; https://www.rucnetwork.edu.au/

109 Country University Centres provide equitable access to higher education for rural people without needing to leave their community. Each CUC is community owned and governed and provides services to support learning and completion of study including study skills, academic support, study spaces and technology access. The retention rates for staying in local communities to work or undertake further study is high. https://www.cuc.edu.au/ accessed October 2023.

Local government's role

Western Queensland offers examples of the positive contribution local governments can make in attracting and retaining health staff. As noted, there are a range of factors that make any position attractive and financial remuneration is only one factor. See Box 5. There are community wide flow-on effects of improving local primary health care services such as attracting new people, especially families, to the community and preventing others, including older people, from leaving or making communities more attractive for investment.

Creating welcoming, safe and friendly communities is an important role for local governments and their communities in attracting and retaining a workforce. Opportunities to welcome new people into the culture of the community so they can actively contribute on a range of levels not just professionally is important. Other incentives such as providing or subsidising suitable housing, employment for partners, schools for children and infrastructure to support working from home such as affordable, high-speed internet are also supported by local governments partnering with health and other service providers.

There are opportunities for greater partnerships between health service providers and RAPAD to work together on regional resident attraction campaigns, such as the Central West's 'Go Far Out' strategy[110] and utilising social media to attract and retain a regional health workforce and promote Western Queensland as a place to live, work and invest.

A doctor for Julia Creek

A collaboration between McKinlay Shire Council and North West Hospital and Health Services (NWHHS) successfully attracted a permanent doctor (and family) to Julia Creek in North West Queensland.

The Julia Creek Multipurpose Health Service (MPHS) was opened in 2019 and included a general practice clinic with rights of private practice, however the HHS had difficulty recruiting a GP.

With a vested interest in the community, council decided to get involved and supported a joint recruitment effort with the NWHHS, providing a rent-free house to add to the salary package and contributed to the advertising campaign for the position.

The story was picked up by mainstream and social media focussing attention on the unique community and strategy. The widespread campaign resulted in six applicants applying for the position with a doctor appointed in late 2022.

Money is not everything and does not down downplay how challenging these medical positions are in communities like Julia Creek. As a point of difference, the HHS was able to offer attractive salary conditions, requiring the doctor to work from 9am-5pm, Monday to Friday with afterhours medical services through Mt Isa Hospital Accident and Emergency Department. In addition, the HHS provided opportunities for regular relief to be enable the doctor to access professional development and the MPHS boasts highly qualified and available staff to support the doctor.

Julia Creek is a welcoming and safe, supportive and social active community which helped the doctor and his family settle and become more involved in the community.

110 The Go Far out campaign aims to overcome workforce challenges, the lack of a regional narrative to help prospective employees make more informed decisions about coming to the region and to attract workers who have never considered working in Western Queensland. https://gofarout.com.au/ accessed October 2023.

5.5 COORDINATION AND SERVICE INNOVATION

As mentioned previously, primary care is well established in Australia. According to the World Health Organisation the characteristics of good primary care include comprehensive services where a wide range of services are offered across the population, with a variety of options to access this care to improve patient/client outcomes, where the quality of care is high and is centred on the patient/client, so they are involved in decisions about their health, and where there is service coordination involving multiple stakeholders.[111] Primary Health Networks (PHN) have a key role in identifying community health care needs and service gaps, working closely with other health care providers to integrate services and reduce duplication.

Navigating health care is complex and confusing, layered with client vulnerability due to the many programs and providers operating in the region. Some of these programs are short term, due to funding and contractual service arrangements for different groups, and the scope of programs may be similar between providers.

It takes time to build cultural competence and trust in communities. Competition for program funding and staff and short-term, outcome driven funding arrangements for service provider add to the complexity of providing services at all levels, providers, community and individual clients.

Western Queensland PHN has several priorities addressing key needs across the region and coordinating services across the continuum. Mapping of services and team-based care approaches decrease confusion for people accessing services across the community as well as service providers, which means increased efficiency, better client outcomes and value for money.

There is an appetite and need for change to customise care through programs such as Western Queensland Health Care Home[112] to create a pathway for care and those that focus on prevention and involve people in their own care. Enabling better use of resources through team-based care, that reduces duplication of services bringing value and improved outcomes for patients across the whole population.

Nukal Murra Health Support Service, Integrated Team Care, is an example of six groups forming an alliance to provide holistic, multidisciplinary care and improve service access for Aboriginal and Torres Strait Islander people in the region. The service makes it easier for clients to navigate the health system and receive the care they need to better manage chronic disease.[113]

Working with key stakeholders to review current models of care to innovate where needed and create local solutions in local communities, especially for priority areas such as disability services, care for older people, child and adolescent health, mental health, and alcohol and other drug services is a key role for health care providers and communities.

The Central West Mental Health Roundtable is an example of a community of interest; in this case mental health precipitated by drought, coming together to look for opportunities to improve client access to services, link stakeholders and create opportunities to integrate services around community resilience and mental health. It is a model that could be replicated to solve other challenges and better coordinate services but does rely on genuine interest and buy-in which could potentially be difficult for competitive service providers.

New models also recognise the important roles that allied health, nursing and midwifery play in population health which along with general practice need to be supported, (including administrative, human resource management and relief arrangements) to be sustainable. [114] The potential for social prescribing,[115] linking people to non-medical community support in CWQ which could improve patient outcomes, reduce health practitioner workloads and service delivery costs.

'Promoting local governance of health care spending' and service coordination supports community ownership which potentially increases community uptake of services and improves care as services are more relevant to local people.[116]

111 Mengistu T, Khatri R, Erku D, Assefa Y (2023).

112 WQPHN (2023).

113 WQPHN (2022).

114 WQPHN (2022).

115 'Social prescribing is a way of linking patients with non-medical support and activity in the community, in order to improve mental and physical health and wellbeing and best manage their health'. Melbourne Academic Centre for Health. Why social prescribing is important for improving health outcomes. https://machaustralia.org/why-social-prescribing-is-important-for-improving-health-outcomes/ accessed September 2023.

116 Nous group report for NRHA (2023).

Culturally appropriate care

Health service use by Indigenous Australians increases when culturally appropriate care is provided. The need for delivering sustainable, culturally safe and responsive healthcare services has been identified as a priority in the CWHHS First Nations Health Equity Strategy 2022-2025.[117]Aboriginal people in the workforce help reduce fear and build trust and relationships, which translates to more patients attending appointments and accepting treatment. Indigenous health workers can use both their health knowledge and community connections to help bridge cultural and communication challenges, dispelling fear and creating safety.[118] However, these health workers can face additional challenges including racism, family, community and cultural commitments, and accessing education and training. They require individualised support to address these issues including increased access to education, training and mentoring, and leave concessions as well as being part of workplaces with strategies in place for managing racism and building cross cultural understanding to help them stay and progress in the workforce. There is also evidence that Aboriginal students who are well supported, resourced, and supervised will have positive experiences and increase the likelihood that they will return to work in rural and remote Aboriginal health, helping to address workforce supply issues. In this situation students are also given the opportunity to build valuable relationship skills and cultural awareness.[119]

Service coordination

Coordination between health services and providers is important for patient outcomes and wellbeing when patients move between Hospital and Health Services to access the level of care required. Patients are already vulnerable, often having left local support networks and experience additional challenges around logistics and cost of travel and accommodation, pathways for care upon arrival at the destination, post discharge care and limited access to support services and rehabilitation in smaller local communities. Indigenous Health Liaison Officers have a role in supporting, advocating for, and educating patients and their families and other staff.[120] This is an effective model to support patient care that could be adapted as a primary care liaison officer for other vulnerable groups such as older people, isolated people, those from a non-English speaking background or any vulnerable person lacking social support.

117 State of Queensland, CWHHS (2022).
118 Lai G, Taylor E, Haigh M, Thompson S (2018).
119 Gwynne K, Lincoln M (2017).
120 Grant R and Draper N (2018).

5.6 AGEING

As a general national trend, Australia's population is ageing due to increasing life expectancy and declining fertility rates. CWQ is experiencing a similar pattern, but higher birth and death rates compared to Queensland averages (see Figures 8 & 9). It is expected that the over 65 years age group will be the fastest growing population group in the future with demands for aged care and health services growing[121] and projections of a 50 percent increase by 2036, and those over 85 years to increase by 103 percent.[122]

In CWQ, 19.6% percent of the population are aged over 65 years, compared to 16.9 percent for Queensland. There are variations across LGA's with Barcoo having the lowest (13.0%) compared to the Blackall-Tambo region with 26.5 percent of residents aged over 65 years.

There are currently 156 aged care places in the RAPAD region, with 74 of those places located in Longreach.[123] Multipurpose services offer integrated health and aged care services in communities that cannot operates both aged care homes and hospitals.[124] 'Due to disparities in health status and life expectancy, access to aged care services in Australia is made available from age 50 for the indigenous population and age 65 years and over among the non-Indigenous population'.[125] Home care and home support programs are also available to support older people to stay in their own homes for longer, facilitated by timely geriatric assessments and coordination of care.

Figure 8. Crude birth rate, RAPAD region and Queensland *

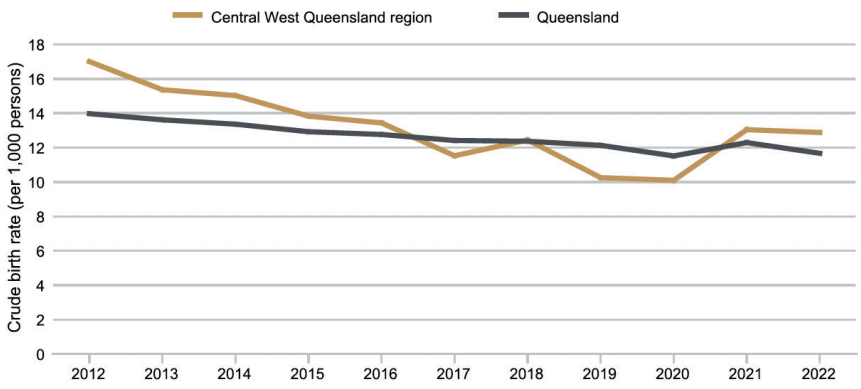
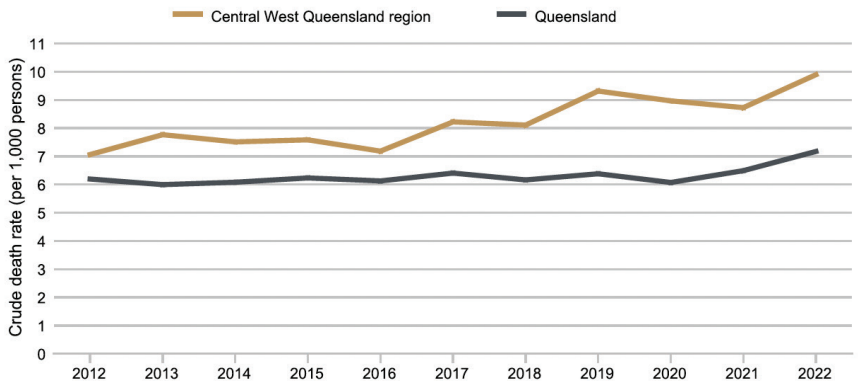


Figure 9. Crude death rate, RAPAD region and Queensland^



*^Queensland totals include deaths and births where the usual residence was overseas, no fixed abode, Offshore & Migratory, and Queensland undefined.

Source: Queensland Governments Statistician's Office, Queensland Treasury, Queensland Regional Profiles: Resident profile for the RAPAD region.

121 Committee for Economic Development of Australia (2023).

122 Queensland Government (2022d).

123 Queensland Government Statistician's Office, Queensland Treasury (2023h).

124 Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023).

125 Primary Health Network Cooperative (2021).

Aged care services

In Australia there are three main types of aged care. The Commonwealth Home Support Program provides entry level support to help older people live independently at home and includes respite for carers. The Home Care Packages Program provides services beyond home support to keep older people in their homes and may including help with cooking and cleaning, nursing care and community transport and social support. Both these programs work towards older people staying safe and independent at home, delaying, or avoiding residential care. Residential aged care provides care and accommodation in an aged care home when an older person can no longer live at home.[126]

My Aged Care is an access point for Australian Government funded aged care services and information, for older people, their families and carers and health professionals available in person, by phone or through the website www.myagedcare.gov.au . *My Aged Care* assists with information about different types of care, assessments for aged care services, finder service providers and managing services.

Social changes indicate increasing awareness of health issues and increasing expectation for services. This means increasing support for accessing information and navigating aged care and health service options, culturally appropriate services and coordination between services is increasingly required.[127] There is also an increasing role for PHN's, as the population ages, and increased investment in the primary health sector to enable self-care support and access to preventative health services as demand increases with the rising prevalence of some conditions with age and falls becomes more common.[128]

As discussed previously, the impact of chronic disease in Western Queensland means more people are aging with lifestyle related disease and highlights the disparity in Aboriginal and Torres Strait Islander health outcomes.

Workforce shortages have been discussed elsewhere, however in the context of aging, extend to impacts on decreased workforce participation rates and aged care sector workforce challenges. Across the RAPAD region, population is projected to decline by 0.9% over the next 25 years, with the loss most prominent in the working age population, with growth in the over 65 years population.[129] As people can no longer work to the same capacity there will be impacts on the overall economy in terms of revenue and where expenditure will need to be directed to meet increased aged care service demand. Meeting workforce demand for staff across different roles and skill levels will be increasingly important in the region for the aged care sector. Recruitment, and staff salary and wages are some of the highest expenses for aged care providers.

The aged care sector is one of Australia's most regulated industries and is currently undergoing change following the release of the Royal Commission into Aged Care Quality and Safety in 2021 and as recommendations are implemented. While important, the requirements of regulation can tax staff already under high workloads.

Private health insurance uptake is on the rise across Australia especially in older age groups, Queensland has one of the lowest rates in the country at 41 percent.[130] We could expect low levels of private health insurance uptake in rural and remote areas, where there is less access to private hospitals and health services, and incomes are generally lower. It does however increase demand on the public health system.

There is an increasing demand for emergency services with increasing age including accident and emergency presentations and calls to Queensland Ambulance Service (QAS). More than a third of QAS demand is from people aged 65 years and over.[131]

Dementia is the second leading cause of death and second leading cause of disease burden in Australia. While currently Western Queensland has reportedly the lowest number of people with dementia across Australian PHN's there are challenges with underreporting, data collection methods and diagnosis being a long and timely process, requiring comprehensive cognitive and medical assessments. The number of people with dementia is expected to increase in the future as the population ages. People with dementia become more dependent on carers to maintain quality of life and independence as the condition progresses. The need for carers, and availability of respite and support services for them will be crucial.

As with disability, providing sustainable services for care and support for older people is challenged by the number of clients in a market-based industry. The role of privatisation and changes to the way aged care services are delivered and the costs involved across rural Australia has seen several aged care facilities close in other regions. Service model innovation and coordination that reflect growing need in these sectors as the population ages will become priorities. As will trying to keep people in their own communities, so they do not have to relocate to other places to access services and away from family and friends and the communities they are part of. There are some misconceptions for people seeking home based aged care services that once assessed they must relocate to access appropriate services which is a barrier and deters people from seeking services.[132]

Supporting older people to age safely and well at home, with dignity, respect, control and choice and providing a range of community connections, community transport options, home modifications and access to mental health services[133] require increased focus in CWQ especially as demand grows with predicated changing population demographics.

126 AIHW (2023g).

127 Primary Health Network Cooperative (2021).

128 AIHW (2014).

129 Queensland Government Statistician's Office, Queensland Treasury (2023f).

130 Australian Prudential Regulation Authority (2023).

131 Queensland Government (2022d).

132 Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023). Nous Group report: RAPAD Care Services Analysis.

133 WQPHN (2022). Health Needs Assessment. https://www.wqphn.com.au/uploads/documents/WQPHN_HNA_A4_Jan2022_FINAL.pdf accessed October 2023.

5.7 DISABILITY

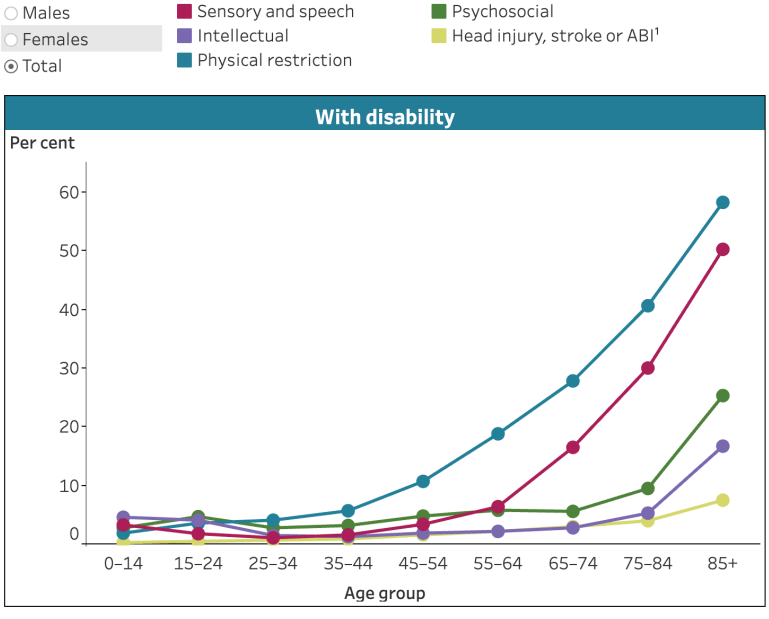
'Disability is an umbrella term for impairments of body function or structure, activity limitations or participation restrictions. People experience different degrees of impairment, activity limitation and participation restriction. Disability can be related to genetic disorders, illnesses, accidents, ageing, injuries or a combination of these factors. Importantly, how people experience disability is affected by environmental factors – including community attitudes and the opportunities, services and assistance they can access – as well as by personal factors.'[134] Prevalence of disability varies with age (increasing with age) and sex. [135] See Figure 9. Access to services will become increasing important with projected regional population decline and aging.[136] An example of regional population change is given in Figure 10.

CWQ faces unique challenges in providing specialist services for disabled people due the vastness of the region, lower prevalence of disability and the limited number of providers available, who are often concentrated in larger centres and operating under different service delivery models. The viability of services is also impeded by the time it takes to build 'business' in the region and low initial uptake as regional knowledge of the business grows. Costs associated with travel and distance to deliver services in different communities or the inability of people to travel to main centres for services due to transport access also contribute to service viability and therefore longevity.

The 2021 census data indicates that 491 people within the RAPAD region need disability assistance for profound or severe disability,[137] however only 188 have participated in the National Disability Insurance Scheme (NDIS) for funding and support.[138] This disparity is most significant in the Blackall-Tambo LGA which has the highest disability service needs in the region.[139] NDIS funding aims to give disabled people more choice and control over the services they can access to support them, by being part of the planning process and based on their individual needs.

This data suggests there are some people within the region living with disability who are not registered with NDIS, indicating a hidden and unmet need for services, impacting service delivery; greater demand would provide the scale to improve services. [140] Factors such as challenging application processes, availability of services, access and understanding of service information and complexity within the system all contribute to hidden and unmet needs. These factors are amplified due to low literacy levels and access to digital technology.

Figure 10: Prevalence of disability group by age group 2018



**Relative standard error greater than 50% and is considered too unreliable for general use.
*Relative standard error of 25–50% and should be used with caution.
¹Head injury, stroke or acquired brain injury.

Source: AIHW 2022: People with Disability in Australia. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability

134 AIHW 2022. People with disability in Australia. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability accessed October 2023.

135 AIHW 2022. AIHW 2022. People with disability in Australia. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability accessed October 2023.

136 Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023).

137 Queensland Government Statistician's Office, Queensland Treasury (2023g).

138 NDIS (2024). Explore Data.

139 WQPHN (2022). Health Needs Assessment

140 Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023).

Services across the region are delivered by a range of providers funded by multiple sources including the State and Federal Government (through NDIS and other funded programs) as well WQPHN. Additionally, unfunded services such as advocacy from community organisation, and families, carers and friends providing unpaid care are also included in the service delivery mix.
Delivery of care services can be uncoordinated and complex, especially for consumers in some parts of the region. It's been noted that 'strong leadership presence and a focus on community development may help to drive innovation and coordination across service delivery'.[141] Some of the benefits of providers working better together include the delivery of more effective services for clients to meet their needs and potentially reducing staffing, travel and administration costs. Service availability is a key barrier to access. Low numbers of providers have created market concentration in larger centres across the region. Some providers may be limited by availability of suitable infrastructure to deliver services. For service providers, the conundrum between establishing a trusted and utilised service, with staff who build an understanding of the people and region, building a client base balanced with the economic reality and the lengthy time this can take, is a legitimate consideration.

The disability sector, like other health sectors is impacted by supply of a skilled workforce. As noted previously, recruiting and retaining staff and meeting conditions of employment such as affordable and available housing, similarly effect the disability sector. Disability services that are missing in some parts of the region include recreational and day activities and mental health services with other health services like physiotherapy, occupational and speech therapy as well as medical specialists including paediatricians available, but in limited supply.

Additionally, some NDIS registered providers leave employers and become sole private providers. This can make services more expensive for clients if those sole provider operate outside the NDIS system and may account for underspent funds in client NDIS plans.

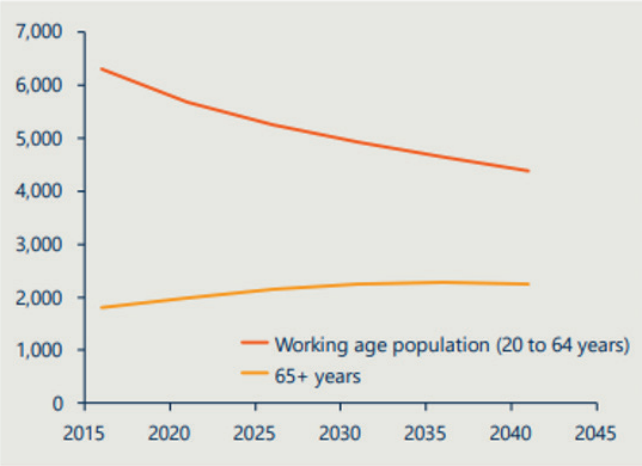
The 'Queensland Outback', Australian Statistical Geography Standard, Statistical Area Level 4 (SA4) which includes all RAPAD LGA's, has no Supported Independent Living (SIL) or Specialist Disability Accommodation (SDA) services. SDA is designed for people with high level needs or impairment. High costs to build this type of accommodation and additional barriers of high regional constructions costs due to distance from suppliers and trade labour shortages may contribute to the cautiousness of investors to build this type of accommodation in the region.

In the RAPAD region, no clients have SIL's or SDA's in their NDIS plans, though anecdotally the need for this type of accommodation has been suggested. Unfortunately, many families choose to relocate to access support in other regions and a lack of understanding of the true demand impacts reliable data.

The Disability Discrimination Act 1992 requires buildings (excluding housing) to be accessible to Australians living with disability, which includes footpaths, schools, shops, banks, swimming pools, clubs, pubs and restaurants, hospitals and medical facilities, libraries or any other premises the public is allowed access.

There are opportunities to create a disability community of interest for care service providers to support connection and learning opportunities and reduce professional isolation.

Figure 11: Projected RAPAD region population changes, 2016 to 2041



Source: Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023). Nous Group report: RAPAD Care Services Analysis.

141 Queensland Government. Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships (2023).

5.8 DIGITAL HEALTH AND TECHNOLOGY

Digital health refers to the range of technologies used in patient treatment as well as collecting and sharing an individual's personal health information. Broadly, this might involve mobile health apps such as SMS reminders, online booking systems, wellbeing apps and services like Medicare online, electronic health records like 'My Health Record', electronic prescribing, telehealth and telemedicine, wearable fitness devices, robotics and artificial intelligence,[142] education and research.

The COVID-19 pandemic was a key driver of change in the digital health sector with the need for innovative ways to support patients. Potential applications for this sector are huge but currently fragmented. There are opportunities for patients by identifying the need for early care and focussing on prevention much earlier before patients might present for care, which is especially relevant in rural and remote communities due to the challenges of access and availability of services, and distance. Innovation also supports equity in services where high quality care can be accessed remotely by most, enabled ideally by coordination of care between health care providers[143] who can make better informed treatment decisions for continuity of care. It also increases options for training, education and supervision, which would benefit rural and remote communities.

'The National Digital Health Strategy was established to evolve digital health capability through innovation, collaboration and leadership to facilitate digital health integration in the health system'[144] and lists a range of actions for implementation.

Digital health offers many opportunities for virtual care for Western Queensland communities especially increasing efficiency and coordination of care for people with complex, chronic conditions and in health promotion. In the Central West HHS, more than 60 disciplines are offered through telehealth services, contributing to reducing the number of patients who must leave the region to access care and costs involved with the Queensland Patient Transfer Subsidy Scheme[145]. However, these systems often rely on high quality, affordable and reliable high-speed internet. 'As mainstream healthcare provision becomes increasingly technology based and requires more and faster broadband services to operate, there is a real risk that regional, rural and remote areas of Australia will be left further and further behind in the ability to access quality health service'. [146]

Other considerations include security of information, data breaches and privacy;[147] the level of integration between different digital health platforms and therefore the comprehensiveness of patient information and level of functionality to meet provider needs; training for already time poor staff in using new technologies who have other more competing demands on their time; and data and technology use literacy.

Artificial intelligence (AI) is a new and emerging area of healthcare. It can potentially be used for benefit in generating text, for example, Chat GPT or Google Bard, using computers to analyse data and infer rather than be programmed to complete tasks or using medical robots in surgery. It could potentially be used to aid diagnosis, suggest treatments, or help health care practitioners and patients communicate. The use of AI should be bound by ethical principles and used to enhance decision making and care but with clear lines of accountability for decisions that are made. It does raise questions around patient privacy and confidentiality but presents opportunities and may improve efficiency. The Australian Medical Association 'upholds that human-delivered medical care must never be replaced by AI.' [148]

142 AIHW (2022a).
143 Flutter C, Keneally B, Arculus R, Baker J, Glass J, Zhu L, Marshall R (2023).
144 Australian Digital Health Agency (2020).
145 Queensland Government (2023b).
146 AMA (2022).
147 Calvetti M (2019).
148 AMA (2023a).

5.9 MATERNAL AND CHILD HEALTH

Maternal and child health services are provided in the Central West Hospital and Health Service (CWHHS) to support women across the perinatal period (conception to 12 months after pregnancy or birth). Birthing services are currently available at the Longreach Hospital (Clinical Services Capability Framework Level 3).[149] This service offers a continuity of care model where multidisciplinary teams collaborate to provide care, including (but not exclusively) general practitioners, hospital and community midwives, lactation consultants, and anaesthetic and diagnostic services, with women at the centre of care, deciding the options that work best for them.[150]

This means that many women are required to travel for perinatal care and wait in Longreach for their babies to be born. There are range of impacts for women moving away from their support networks to give birth, their family responsibilities if they have other children and financial impacts including costs of travel and accommodation. In Longreach, free accommodation is provided for 'waiting mum's'. Table 2 shows the proportion of women delivering in their usual HHS of residence between 2013 and 2017; there will be a portion of women within those percentages of births in their usual HHS who relocate within the HHS to access birthing services.

Medical risks may be greater when women need to travel on country roads where there is likelihood of travelling long distance, potential of hitting animals and poor mobile phone coverage. Additionally, there are emotional and logistical impacts when neonatal retrieval teams are required to transport the baby to another centre for care.[151]

As mentioned previously, social determinants of health will impact many aspects of health and wellbeing across the lifespan including obstetric care and outcomes for women and babies. Nutrition as well as overall health and wellbeing of mothers before and during pregnancy impacts birthweight, growth, and development in babies and into childhood. Poor maternal nutrition and substance abuse during pregnancy are key risk factors.[152] Approximately 28% of CWHHS expectant mothers were considered obese (Queensland average of 23%) for the 2019-2021 period.[153]

Table 2. Proportion of women who gave birth in the Hospital and Health Service (HHS) of their usual residence, Queensland 2013-2017

Source: Queensland Health (2020). *Rural Maternity Taskforce*

HHS of usual residence	HHS where birth occurred (where < 90% occurred in HHS of usual residence)	Births	Total births	% Births in HHS of usual residence
Torres and Cape		720	2,236	32%
	Cairns and Hinterland	*1,387*		
	Townsville	*720*		
Central West		397	587	68%
	Central Queensland	*57*		
	Townsville	*30*		
South West		1,196	1,556	77%
	Darling Downs	*273*		
West Moreton		12,906	16,509	78%
	Metro South	*2,248*		
	Darling Downs	*1,038*		
North West		2,366	2,674	89%
	Townsville	*176*		
	Cairns and Hinterland	*88*		
Mackay		8,019	8,675	92%
Wide Bay		9,779	10,432	94%
Central Queensland		10,958	11,498	95%
Sunshine Coast		14,168	14,949	95%
Darling Downs		13,337	13,846	96%
Metro South		51,191	53,396	96%
Metro North		37,039	38,602	96%
Gold Coast		21,994	22,749	97%
Cairns and Hinterland		13,391	13,659	98%
Townsville		12,594	12,704	99%

Count includes Queensland residents who gave birth in public facilities only.

149 The Clinical services Capability Framework (CSCF) describes Queensland's clinical and support services and sets the minimum standard criteria in Queensland public hospital and private health facilities. Queensland Health (2023).

150 Queensland Government. Queensland Health (2023 b,d,e)

151 Queensland Health (2020a).

152 WQPHN (2022).

153 Queensland Government, Report of the Chief Health Officer of Queensland (2024).

Birthweight is an indicator of overall infant and predictor of overall health through life. 'Most Aboriginal and Torres Strait Islander babies are born with a healthy birthweight, but the low birthweight rate among Aboriginal and Torres Strait Islander babies remains relatively high compared with non-Indigenous babies'.[154] In the CWHHS 33.3% of babies born to Aboriginal and Torres Strait Islander women were low birthweight compared to 6.3% of non-Aboriginal and Torres Strait Islander mothers.[155] Over 9 percent of babies are born pre-term in the CWHHS compared to the state average of 6.7%.[156]

Preventable health behaviours such as smoking and alcohol consumption during pregnancy are risk factors for pregnancy complications, associated with lower birthweight and smaller babies linking to preterm and perinatal death.[157] In the case of alcohol, the likelihood of low birthweight, complication and foetal alcohol spectrum disorder will depend on a range of other factors such as maternal age, amount and frequency of alcohol consumption, stress, nutrition and other health factors.[158] Over 13% of mothers smoke during pregnancy in the CWHHS compared to the Queensland average of 11.5%.[159]

Antenatal care increases the likelihood of positive outcomes for mothers and babies. Depending on whether it's a first or subsequent pregnancy and if there are complications, pregnancy care guidelines suggest between seven and ten antenatal visits are recommended.[160] During the period 2019 – 2021, 83.6% of mothers in the CWHHS area attended 8 or more antenatal visits (Queensland average of 81.7%).[161]The Queensland Closing the Gap Snapshot Report 2023 revealed that more Aboriginal and Torres Strait Islander women are attending antenatal visits than in the past;[162] for the 2015-2016 the CWHHS had the lowest proportion of Aboriginal and Torres Strait Islander women attending 5 or more antenatal visits in the state.[163]

'Local birthing is the keystone in rural Queensland's healthcare that ensures quality care for all community members, irrespective of age or demographics. Local birthing provides a point where clinical services capability and community needs can be balanced and strengthened and supported by medical, midwifery and nursing capability enables community access to anaesthetic, obstetric, paediatric and surgical services and in turn access high quality critical, perioperative and emergency care.

'The provision of maternity services in a rural or remote hospital, heralds and indeed supports the provision of other advanced services such as elective surgery, endoscopy, emergency medicine and the care of the seriously unwell. This service mix attracts and retains high quality staff with advanced skills that they use on a regular basis. To remove local birthing from a rural facility quickly diminishes other valuable services particularly in acute care, procedural interventions and management of serious illness or injury. Local birthing strengthens a community's health outcomes because the contribution it makes to access to health care and the amenity of community uniquely improves capacity to address social determinants of health'.[164]

Maintaining a range of maternal care services within CWQ, for the entire perinatal journey is paramount. Across the region many women want to deliver their babies as close to home as possible, be supported through their pregnancies with a range of culturally appropriate services that value safety and access, that are sustainable through an adequately funded services with a quality and committed workforce and appropriate infrastructure and keep women at the core. Women, have a key role in helping shape regional services to influence the level of care available through pregnancy birth and beyond.

Child and youth health is increasingly recognised as a precursor to adult health outcomes with a child's first thousand days (conception to the end of a child's second year) critical to impacting future health and wellbeing, including mental health, social functioning and cognitive development. 'Pathways that originate in early childhood contribute to challenges faced by adults such as mental health issues, obesity, heart disease, criminality and poor literacy and numeracy.'165 Local governments within the region are ideally placed to influence the world that children grow up in and ultimately the health of adults. Consider factors such as helping reduce poverty through employment strategies, the provision of affordable housing, supporting community networks and opportunities for social interaction, access to nutritious food and fresh produce, built environments that promote heathier lifestyles including social infrastructure and recreational facilities and access to green spaces.166

A range of child and youth services within the region help support health and wellbeing including vision and hearing screening and other health and development checks as well as parenting support. Immunisation rates in the CWHHS are amongst the highest in Queensland with 97.5% of five years olds being immunised.

154 AIHW (2023a).
155 WQPHN (2022).
156 Queensland Government, Report of the Chief Health Officer of Queensland (2024).
157 AIHW (2023a).
158 NOFASD (2023).
159 Queensland Government, Report of the Chief Health Officer of Queensland (2024).
160 Australian Government, Department of Health and Aged care (2024a).
161 Queensland Health, Report of the Chief Health Officer (2024).
162 State of Queensland (2023).
163 Queensland Health (2016).
164 Rural Doctors Association of Queensland (2023).
165 Strong Foundations Collaboration (2019).
166 Strong Foundations Collaboration (2019).

5.10 MEDICARE REFORM

Australia's universal health care system, Medicare was introduced in 1984 and has evolved over time. The final report of the Independent Review of Medicare Integrity and Compliance in April 2023 found that the current system is no longer fit for purpose having developed organically, changing over time in response to health system needs. The current health system requirements, changing burden of disease, aging population and the impact of workforce shortages especially in rural and remote areas were not being addressed through Medicare.

The review made 23 recommendations focusing on four areas - increasing primary care access including dental; technology and data management; developing multidisciplinary care teams and supporting change management.

The Federal Government committed $6.1 billion in the 2023-24 budget to begin reforms to Medicare with a raft of measures supported by peak industry groups. There are several positive impacts for rural and remote communities including:

- tripling bulk billing incentives
- new and amended Medicare Benefit Scheme listings
- longer phone consultations
- chronic disease management services
- preventive health initiatives
- support for general practitioner training
- investment into Aboriginal and Torres Strait Islander healthcare
- digitising additional health services
- establishing an interim Centre for Disease Control and
- workforce and training initiatives.

Examples such as modernising digital systems to improve patient information sharing between care providers, improving communication of test results and treatment and care plans for people who need to travel to larger centres for treatment or surgery could contribute to positive health care outcomes. Patients would not be required to provide the same information or history to multiple health professionals or duplicate tests. Reforms may also help with workforce incentive programs that will help address individual chronic disease management through multidisciplinary teams and the way care is funded.

As part of these Medicare reforms, the 'Working Better for Medicare Review' is currently underway with findings due for release in mid July 2024. The review will look at workforce issues especially for areas that find it hard to attract doctors and other health workers to develop and more sustainable and equitable health system. It will also review current workforce distribution levers, including Distribution Priority Area (DPA and the Modified Monash Model (MMM) which have been mentioned elsewhere in this paper.[167] In addition to the 263 submissions made to the review there have been numerous stakeholder engagement sessions from a broad range of stakeholders. The outcomes of this review will have implications for all RAPAD communities in the future.

167 Australian Government, Department of Health and Aged Care (2024b).

5.11 CLIMATE

Changes to climate are already directly and indirectly challenging the health of communities in CWQ and are becoming a more significant public health issue.

There will be impact variations from climate changes across the region given the diversity of landscapes and size of the region. It has been predicted that Western Queensland will experience higher temperatures, hotter and more frequent hot days, more drought, more intense rain downpours, less frequent but more intense tropical cyclones, rising sea levels, more frequent sea level extremes, warmer & more acidic seas, harsher fire weather, fewer frosts and less rainfall in winter and spring.[168]

Extreme weather events that will be more frequent, severe and longer lasting, increasing the risk of death, injury and illness will put increasing pressure on existing services, infrastructure, the regional economy and communities.

Heatwaves from increasing temperatures can cause heat stress, for both the land and people. Agricultural industries that dominate regional economic output and are also the largest employer, will be increasingly under pressure due to climate changes, with implications for food security and workplaces due to reduced productivity and absenteeism.[169]

Heat related illness and or death will increase especially in the most vulnerable groups such as the elderly, babies and indigenous communities, where risk rises with remoteness.[170] Heatwaves can also exacerbate pre-existing conditions such as respiratory, cardiovascular and kidney conditions, 'contribute to acute cerebral vascular accidents (stroke)',[171] and preterm birth.[172] Heat stress compounded by poor housing and 'power poverty' (lack of access to reliable electricity) can lead to increases in food spoilage and not being able to keep medicines such as insulin cool.[173]

Warmer climates and changing rainfall patterns will alter the distribution patterns of food-, water- and vector- borne diseases, parasitic diseases, illnesses from exposure to pathogens, such as gastroenteritis, and respiratory illness from exposure to moulds and fungi after floods. Flooding also increases the likelihood of injury and damage to infrastructure. There may also be impacts on tourism, such as shortened tourism seasons, damage to infrastructure and supply chains for example.

Changing climate threatens security water supply and quality. 'Severe weather events like floods and cyclones may interrupt water and sewage treatment services, as well as transportation of food, medicines and other supplies.'[174]

Bushfires, which may become more severe and frequent due to harsher fire conditions increase the risk of burns, smoke inhalation, heat stress, dehydration, trauma,[175] air pollution and asthma.[176]

Ongoing climate changes associated trauma and increased risks of distress and anxiety contributing to an overall decline in mental health and consequent economic and social impacts are already evidenced.

The Australian Government are currently reviewing submissions to develop the National Health and Climate Strategy to prepare for health challenges that will result from changes in temperatures, weather events and air quality.

Role of local government

Local Governments have a role in embedding climate risk in planning and supporting state and federal government climate adaption policies. Supporting existing health services to better manage as impacts of climate change are also important. Identifying and monitoring people in the community who are most vulnerable and at risk, partnering in disaster management, promoting energy efficient housing, providing example of decreasing energy usage and waste management and advocating for appropriate communication infrastructure are some of the activities local governments are already doing and will need to continue to evolve to support the health and wellbeing of the region, especially when viewed with a social determinants perspective.

168 Queensland Government. Department of Environment & Science (2019).
169 Queensland Climate Adaption Strategy (2018).
170 HEAL network & CRE-STRIDE (2021).
171 RACGP (2019).
172 Wang et al (2013).
173 HEAL network & CRE-STRIDE (2021).
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176 Queensland Government, Queensland Health (2018).

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