Local Area Needs Assessment (2022)

Queensland Government

South West Hospital and Health Service Local Area Needs Assessment (2022)

Contents

Acknowledgements

South West Hospital and Health Service acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Owners and Custodians of this country and recognise their connection to land, wind, water and community.

We pay our respect to them, their culture, and to the Elders both past and present.

The lands and waters within the South West Hospital and Health Service region encompass the following Traditional Owner Groups:

Location / facility	Traditional Owners
Augathella	Bidjara (bid-jara) people
Bollon	Kooma (coo-ma) people
Charleville	Bidjara (bid-jara) people
Cunnamulla	Kunja (koun-yah) people, with other interests
Dirranbandi	Yuwaalaraay / Euahlayi (You-wal-a-ray / You-al-e-i) people
Eromanga	Boonthamurra (boon-tha-murra) people
Injune	Kongabula (kong-ga-bull-a) people
Mitchell	Gunggari (gon-gari) people
Morven	Bidjara (bid-jara) people
Mungindi	Kamilaroi (Car-milla-roy) people
Quilpie	Mardigan (Mar-d-gan) people
Roma	Mandandanji (mand-an-dand-gee) people
St George	Kooma (coo-ma) people with Kamilroi, Mandandanji, Bigambul and Gungarri interests
Surat	Mandandanji (mand-an-dand-gee) people
Thargomindah	Kullilla (cool-lee-lar) people
Wallumbilla	Mandandanji (mand-an-dand-gee) people
Waroona	Bidjara (bid-jara) people
Westhaven	Mandandanji (mand-an-dand-gee) people

We would also like to thank our community, our staff, our service partners, and the wider Queensland Health team, for their valuable assistance and insight to inform this Local Area Needs Assessment.

Abbreviations and terminology

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community-Controlled Health Organisation
ACCO	Aboriginal Community-Controlled Organisation
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ASR	Age-standardised rate
ATS	Australasian Triage Scale
ATSICHHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
BMI	Body Mass Index
CAGR	Compound annual growth rate
CALD	Culturally and linguistically diverse
CAN	Consumer Advisory Network
CAOHS	Child and adolescent oral health services
CI	Confidence interval
COPD	Chronic obstructive pulmonary disease
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islander Corporation for Health
DNA	Data Not Available
DWS	District of workforce shortage
ED	Emergency Department
ELT	Executive Leadership Team
FTE	Full time equivalent
GP	General Practitioner
HHS	Hospital and Health Service
ICD	International Classification of Disease
Identified position	A position in relation to which it is lawful to discriminate in favour of a person possessing one or more of the attributes set out in section 7 of the *Anti-Discrimination Act 1991*, e.g., gender, race, age, impairment, sexuality, religious belief, or religious activity, for any of the purposes contained in section 25 of that Act.
IDR	Insufficient data recorded
IRSD	Index of Relative Socioeconomic Disadvantage
LANA	Local Area Needs Assessment
LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer people
MAC	Monthly Activity Collection
MBS	Medicare Benefits Schedule
NGO	Nongovernmental Organisation
OBD	Occupied Bed Day
OOS	Occasion of service
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
QAS	Queensland Ambulance Service

QHAPDC	Queensland Health Admitted Patient Data Collection
QHNAPDC	Queensland Health Non-admitted Patient Data Collection
Qld	Queensland
QPHU	Queensland Preventive Health Survey
RFDS	Royal Flying Doctor Service
SA2	Statistical Area Level Two
SA3	Statistical Area Level Three
SEIFA	Socio-Economic Indexes for Areas
SQRH	Southern Queensland Rural Health
SRG	Service-Related Group
STI	Sexually Transmitted Infections
SWHHS	South West Hospital and Health Service
TAFE	Technical and Further Education
WQPHN	Western Queensland Primary Health Network

Executive summary

Introduction

Background

Queensland Health aims to improve relative equity across the health system. Through the comprehensive assessment of community health and service needs, Queensland Health continually transforms and enhances its approach to health service planning, models of care development and service commissioning.

The introduction of a Local Area Needs Assessment (LANA) across each region enables the detailed assessment of health need, based on data analysis across multiple domains and consultation with local stakeholders, clinicians, consumers, and health organisations. The Hospital and Health Services (HHSs) providing services in Queensland have conducted the LANA for their jurisdictions and published a report on community health needs, service needs, gaps, and priorities.

Need
in health care is commonly defined as the capacity to benefit. If health needs are to be identified, then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available.

Healthcare needs
are those that can benefit from health care (health education, disease prevention, diagnosis, treatment, rehabilitation, terminal care). Most doctors will consider needs in terms of healthcare services that they can supply. Patients, however, may have a different view of what would make them healthier — for example, a job, a bus route to the hospital or health centre, or decent housing.

Health needs
incorporate the wider social and environmental determinants of health, such as deprivation, housing, diet, education, employment. This wider definition allows us to look beyond the confines of the medical model based on health services, to the wider influences on health (box). Health needs of a population will be constantly changing, and many will not be amenable to medical intervention.

Wright, Williams, & Wilkinson, 1998, p. 1310

Scope

The LANA has been developed by the South West Hospital and Health Service (SWHHS) to capture the health need of the SWHHS community.

The *LANA Framework* provides guidance on a minimum data set for analysis by all HHSs. This minimum data set for population health is categorised by data based on the following:

- The region: geography and demography

- Health risks: social determinants, health determinants/behaviours

- Health status: morbidity and mortality

- Service profile: providers, locations, service types, and workforce

- Service utilisation: service use by the HHS residents

- Service access and availability: timeliness, availability, and equity of service access in the HHS.

Development of this LANA utilises both quantitative and qualitative data, extracted from national, state, and local sources as well as engagement with health providers and consumers in the SWHHS catchment. The SWHHS used both minimum data sets, as well as other data sources that support the priorities put forward for the catchment.

Limitations

There are a number of limitations to the analysis and consultation undertaken for the purposes of the LANA and this report. These limitations include:

- The consultation process was intended to involve a wide range of stakeholders (e.g., service providers as well as consumers) to capture a diverse perspective on the future health priorities for the SWHHS catchment. 12 Consumer Advisory Networks were not avaliable for consultation during the development of this LANA. It is important to note that during the consultation process, community representatives (Council Chief Executive Officers and Council Mayors) were widely consulted. It is understood that these stakeholders are also consumers and represent the end user of services within the region. It is also important to note that the SWHHS regularly engages with the Consumer Advisory Networks on a range of health and wellbeing matters. The SWHHS is confident that the views of consumers are captured within health priorities and enablers identified. The SWHHS is also committed to engage with community and consumers to share progress on addressing these priorities to ensure that there is ongoing alignment between the SWWHS and the community.

- The analysis within this report is based on publicly available data and data collected internally by the SWHHS. Where data and information was limited or unavailable, qualitative analysis of the stakeholder consultation themes has been used to understand and assess the 'felt' need of the SWHHS catchment. It is unlikely that the limited access to certain datasets has materially impacted any of the identified priorities, enablers or conclusions.

- The limited availability of data to inform the service mapping exercise for the SWHHS catchment. This service mapping exercise used publicly available information to describe the type and nature of services offered in the SWHHS catchment. It is important to note that there may be other services that are offered in particular parts of the SWHHS catchment that have not been captured in this report (e.g., telehealth services, private providers etc.).

The planning context

This section outlines the vision, strategic priorities, and policy context of the SWHHS in which the health needs identified in the LANA may be prioritised and inform future health service planning.

The SWHHS vision, purpose, and values

In 2022, the SWHHS released its *Strategic Plan (2022-2026)*. The SWHHS' core vision, purpose, and values provided within the *Strategic Plan (2022-2026)* are provided below.

Our Vision
To be a trusted and valued leader in the delivery of health services to rural and remote communities.

Our Purpose
To provide safe, effective, responsible, and sustainable rural and remote health services that people trust and value.

Our Values
Quality: Striving for excellence and the highest standards of care
Compassion: Treating people with kindness, respect, and dignity
Accountability: Showing reliability and taking ownership
Engagement: Connecting with others to work effectively and inclusively
Adaptability: Constantly learning, changing, and growing

SWHHS Strategic Plan (2022-2026)

The SWHHS strategic priorities

The SWHHS has four (4) strategic priorities in alignment with its vision, purpose, and values. An overview of these priorities is provided below.

Strategic Priority 1: Our Communities
The key objectives in this priority are to place people first; close the gap on health-inequalities for all; and enable strong primary care services with a preventative care approach to deliver care that is safe, trusted and as close to home as possible.

Strategic Priority 2: Our Teams
The key objectives in this priority are to design, attract and retain the best talent for the workforce of the future; empower our people through a strong culture of teamwork and leadership with a 'can do' attitude; and to embrace and promote a safe, healthy workplace with a focus on resilience and wellbeing.

Indicators of demand

There are a number of indicators that indicate a change in health need and the demand for health services. These indicators typically include:

- Population growth which can signal an increased need for health services or, when population growth is declining, a change in the type of health need (e.g., a focus on wellbeing and the social determinants of health).

- Changes in the socioeconomics of a population which gives consideration to the social determinants of health, the health literacy of a population, and their involvement in risky health behaviours (e.g., smoking and alcohol consumption).

- Changes in the current utilisation of services, for example, an increase in separations or presentations to emergency departments (EDs) for a particular geography may indicate an ongoing demand for health services that needs to be managed or addressed.

This LANA provides an overview of the indicators of demand for services in **Section 1** with further analysis provided in **Appendices 1-6**.

The SWHHS catchment is sparsely populated and the statistical areas (or planning areas) within the region (Roma Region, Charleville, Balonne, and Far South West) are classified rural and remote areas. Based on the analysis of Census data, the SWHHS population is predicted to decrease overall by 5.46 per cent by 2036. Most of this population decrease is expected to be realised in remote and very remote regions, with there being an 8.73 per cent increase in the population in Roma.

Figure (i) below illustrates that the current population density across the SWHHS region varies and that the region is much less sparsely populated when compared to the Queensland average. This analysis breaks down the SWHHS region by Statistical Area Level 2s (SA2s) (used interchangeably with 'Planning Regions') – which are areas with populations ranging from 3,000 to 25,000 that interact together both economically and socially. The five (5) SA2s in SWHHS are: Roma, the Roma Region, Balonne, Charleville, and the Far South West. The Roma SA2 is the smallest geographical area and has a high population density of 89.16 persons per square kilometre. The Roma Region (0.10), Balonne (0.14), Charleville (0.10), and Far South West (0.01) SA2s have relatively low population densities when compared to the Queensland average (2.98).

Figure (i) Current Population Density in the SWHHS by SA2 (2020)[1]
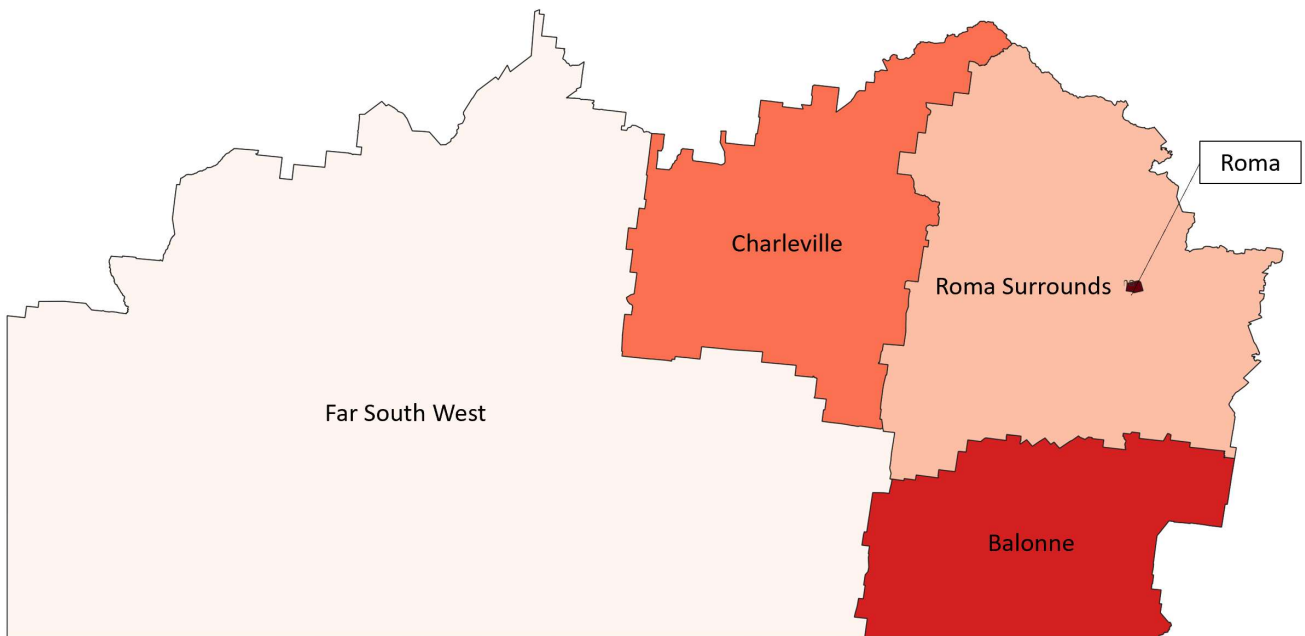
SA2	Population Density (persons per square km)
Roma	89.16
Roma Surrounds	0.10
Charleville	0.10
Balonne	0.14
Far South West	0.01

Given the low population density of the SWHHS catchment, the degree of remoteness and the decreasing population in remote and very remote areas, much of the SWHHS catchment does not have a consistently high level of demand to support the establishment of permanent health services. Therefore, the delivery of healthcare services usually involves transporting patients to larger centres (within or outside the SWHHS catchment), transporting clinicians to remote locations, or identifying ways to deliver healthcare in a virtual environment.

Rural and remote populations, such as the SWHHS catchment, can face multiple challenges due to their geographic isolation, and often experience poorer health outcomes than people living in cities[2]. The proportion of adults engaging in many behaviours associated with poorer health is higher in rural and remote areas than in metropolitan areas (for example, 22 per cent of people in Outer regional/Remote areas smoke daily compared with 13 per cent of people in Major cities)[3]. Analysis of the data relating to

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[1] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population (prepared on QGIS).

[2] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p254.

[3] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p254.

health risks and morbidity shows similar results for people living in the SWHHS catchment. This is discussed in more detail in **Section 1**.

As shown in **Figure (ii)** below, Charleville (7 per cent) and Far South West (5.7 per cent) have the highest proportion of ED presentations per capita in the region. Roma has the third highest proportion of ED presentations at 5.6 per cent, followed by the Balonne region (5.1 per cent) and Roma Surrounds (1 per cent). The greater rate of ED presentations in Charleville and the Far South West may indicate need in a range of areas. For example, these two (2) Planning Regions have the highest rates of premature death from circulatory and respiratory system diseases[4]. In addition, Charleville also has the highest rates of adult obesity within the SWHHS catchment[5]. Individuals from these regions may also present to the ED due to limited access to community-based care services or poorer health literacy in relation to navigating the health system outside tertiary care settings.

Figure (ii) ED Presentations in the SWHHS by SA2 (2020)[6]
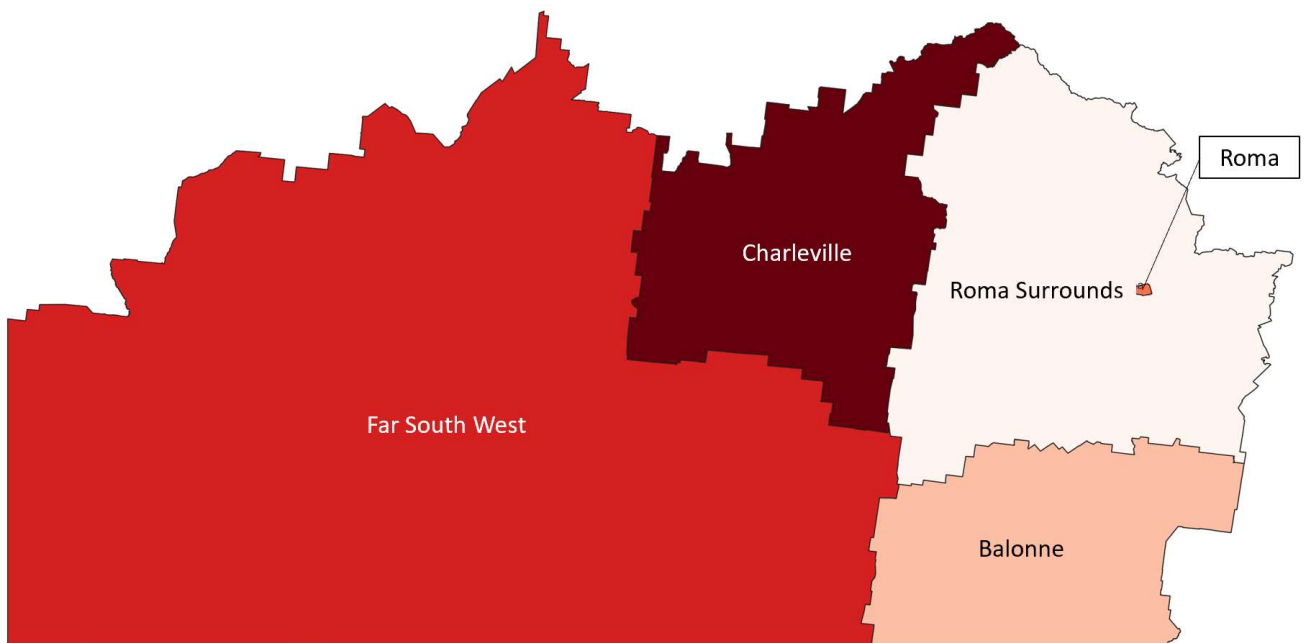
SA2	Proportion of ED presentations per capita
Roma	5.6 %
Roma Surrounds	1.0 %
Charleville	7.0 %
Balonne	5.1 %
Far South West	5.7 %

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[4] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas.

[5] Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.

[6] Queensland Health Planning Portal (2020), Emergency Department Presentation by SA2 for SWHHS (prepared on QGIS).

Indicators of supply

A service mapping exercise has been completed to understand the type of services currently available to people in the SWHHS catchment. Desktop review of the services available in the SWHHS catchment indicates that there are several public and private services that people currently access to meet their health and wellbeing needs. This service mapping exercise has supported an understanding of where there may be unmet health needs.

The services available in the SWHHS catchment include:

- three (3) hospitals

- four (4) rural community clinics

- four (4) disability services

- four (4) alcohol and other drugs services

- eight (8) ambulance stations

- nine (9) general practices

- nine (9) multi-purpose facilities

- twelve (12) pharmacies

There are also emergency treatment spaces in Roma, St George, Charleville, Cunnamulla, Mitchell, Thargomindah, Quilpie, Augathella, Injune, Surat, Wallumbilla, Mungindi, Dirranbandi, and Bollon.

Service mapping has enabled the identification of a number of opportunities where services could be enhanced to better meet community health needs:

- There are two (2) mental health services in the SWHHS catchment (i.e., in Roma and Charleville). Consultation with stakeholders has highlighted that it is difficult to access mental health services outside these two major hubs as there are few non-government or virtual options. The issues around accessing mental health services are further exacerbated by stigmas associated with mental health concerns and people feeling uncomfortable accessing support[7]. This indicates that there may be opportunities to increase or augment services to better meet the needs of the SWHHS community (e.g., working with partners to identify virtual mental health and wellbeing support options, enabling better continuity of care for people accessing mental health services outside of the catchment, etc.).

- The westernmost permanent GP is in Cunnamulla. While there is a small population of people living in the Far South West region, the lack of GP options suggests that there may be unmet primary healthcare needs and that there is a need for periodic and ongoing engagement with people in the Far South West region. Given that the Far South West region has the highest rate of smoking in the SWHHS catchment and a relatively high rate of ED presentations per capita, the expansion of GP service provision may need to be considered and evaluated (refer **Section 1** for further analysis).

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[7] National Rural Health Alliance Inc. Fact Sheet - Mental Health in Rural and Remote Australia. December 2017.

- Consultation with stakeholders has identified that transit to major hubs may be provided to those requiring specialised services such as medical imaging.

- There is one (1) private multidisciplinary allied service in the SWHHS catchment. Based on consultation and desktop analysis, it is understood that this service has a substantial wait period which signals an unmet need for allied health services in the SWHHS region.

The service access and capacity are further explored in **Section 2** and **Appendix 5**.

Priority health needs

Based on the data analysis and consultation outcomes, the following three (3) priority health needs for the SWHHS have been identified. It is important to note that all these priorities are given equal weighting.

Priority 1: Encouraging and enabling healthy behaviours

There is an opportunity to encourage and enable healthier behaviours across the SWHHS catchment and improve health outcomes by targeting smoking, drinking, drug usage, rates of exercise, and fruit/vegetable consumption.

People in the SWHHS catchment have a lower average life expectancy, compared with the Queensland average. The social determinants of health have a considerable impact on the health inequities experienced by the SWHHS population (refer **Appendix 2** for further analysis).

Factors such as socioeconomic position, conditions of employment, the distribution of wealth, empowerment and social support influence the health behaviours and outcomes of individuals living in the SWHHS catchment. By recognising the impact of the social determinants of health on the lifestyles of individuals, the SWHHS has an opportunity to tailor its services and health promotion activities to encourage and enable healthy behaviours in the community.

Encouraging and enabling healthy behaviours will improve morbidity and mortality rates in the SWHHS catchment. It will also reduce high service utilisation associated with morbidities, such as cardiovascular disease and respiratory disease.

Priority 2: Improving mental health services

The SWHHS has the opportunity to improve to mental health services to promote mental wellbeing and preventative mental healthcare.

Even though there is a relatively low number of ED presentations for mental health episodes in the SWHHS catchment, mental health services are a priority because the SWHHS has a higher-than-average age standardised rate (ASR) of self-harm and suicide.

The SWHHS can work to promote the normalisation of mental health check-ups and wellbeing initiatives. There may also be an opportunity to provide greater continuity of care for patients when they need to access acute mental healthcare services outside of the SWHHS catchment.

Priority 3: Improving primary and specialist healthcare

The SWHHS has the opportunity to strengthen primary and specialist healthcare in communities that experience gaps in service provision.

Primary and specialist care is usually delivered by a range of medical, nursing, and allied health professionals in various private and not-for-profit settings. However, many residents of the SWHHS catchment struggle to access primary and specialist health services in a timely manner.

Stakeholders indicated that they often have to travel long distances to access primary and specialist healthcare. Access to primary and specialist healthcare could therefore be improved by the SWHHS exploring options to leverage telehealth and virtual platforms as a means of delivering GP, allied health, and specialist consultations.

Overview of enablers

During the consultation with stakeholders around the health need priorities, a number of enablers were identified for improving health outcomes.

Enabler 1: Workforce

The development of a sustainable and well supported health workforce is important for the delivery of high quality and accessible healthcare services in the SWHHS catchment.

A number of stakeholders acknowledged that recruiting and retaining health workforce was a significant problem and that this issue was not unique to the SWHHS catchment. Workforce was typically identified as a key enabler for reducing wait times and limitations around access to services (e.g., wait times for allied healthcare such as physiotherapy).

To develop a sustainable workforce, it will be important to identify the incentives and supports that health workers need to deliver services in the SWHHS region. Stakeholders identified professional development opportunities, flexible working arrangements, and living and family support for individuals as important aspects for recruiting and retaining clinicians in the SWHHS region.

Enabler 2: Partnerships

Partnerships may include formal contractual partnerships or collaborative partnerships based on mutually agreed health priorities.

Given that the health priorities identified for the LANA include services that are delivered by non-government organisations, private healthcare providers, Aboriginal Community Controlled Organisations (ACCOs), and other local organisations (e.g., councils), it will be important for the SWHHS to maintain productive working relationships with these partners.

There may be opportunities to formalise existing partnerships or to establish new agreements with appropriate partners. This would ensure clear accountability for the organisations responsible for progressing specific aspects of the priority health needs of the SWHHS catchment. Improving linkages

between the SWHHS and local organisations can also foster new mechanisms to engage with community early and provide tailored and culturally safe healthcare in a holistic manner.

Enabler 3: Continuity of care

Continuity of care includes the continuity of information to support clinical decision-making and the continuity of patient management to enable consistent care and advice.

Maintaining continuity of care has been identified as an enabler for decreasing patient mortality[8], as clinicians are more familiar with their patients' specific habits and needs.

In the context of the priority health needs, stakeholders described the importance of being able to exchange information between one provider and another (e.g., between hospital and GP) to support improvements in mental health and specialist care. This could be supported through formalised information sharing workflows and enabling technology.

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[8] Baker, R et al. Primacy medical care continuity and patient mortality: a systematic review. *British Journal of General Practice*. 2020. 70 (698).

1 Health need and demand for services

This section of the LANA describes the indicators of health need and demand for health services in the SWHHS catchment. The analysis provided in this section has informed the identification of a series of priority health needs (refer **Section 2**). This section of this report outlines that the residents of SWHHS engage in unhealthy behaviours such as lifetime risky drinking, smoking, insufficient physical exercise, at a comparatively higher rate than the Queensland averages. In comparison with the Queensland averages, there are also lower rates of fruit consumption and higher obesity/overweight rates within the SWHHS catchment.

1.1 Health risks

Considering different age structures, people living in rural and remote areas are more likely to have higher rates of health risk factors. Compared with people in Major cities, people in Outer regional/Remote areas have higher rates of daily smoking, risky alcohol consumption, physical inactivity, and obesity[9].

1.1.1 Risky health behaviours

Table 1.1.1 illustrates that while some areas within the SWHHS catchment consume more fruit and vegetables than the average Queenslander, there is an opportunity to increase fruit and vegetable intake in regions such as Outer Roma, Charleville, and Far South West. **Table 1.1.1** also shows that all regions in the SWHHS catchment have higher than average rates of obesity, smoking, and risky alcohol consumption. This indicates that there is an opportunity to improve the adoption of healthy behaviours in the SWHHS catchment.

Table 1.1.1 Healthy behaviour Indicators in the SWHHS by SA2 (2018)[10]

Description	Queensland	SWHHS	Roma	Outer Roma	Charleville	Balonne	Far South West
Adults consuming recommended fruit intake (%)	52.10%	50.50%	56.00%	45.90%	47.80%	50.60%	49.50%
Adults consuming recommended vegetable intake (%)	8.40%	7.70%	8.60%	8.00%	9.80%	10.40%	11.90%
Adults with sufficient physical activity (%)	58.30%	51.50%	52.60%	55.80%	39.80%	43.70%	43.60%
Estimated Adult Obesity/Overweight Rate (%)	60.00%	68.70%	65.60%	62.10%	75.40%	77.70%	66.30%
Lifetime risky drinking (%)	21.60%	26.90%	25.10%	27.50%	21.80%	37.70%	29.20%
Proportion of the population that smoke daily (%)	10.80%	13.40%	13.00%	11.70%	12.20%	16.10%	18.70%

[9] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p262

[10] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p254

Health status and risky health behaviours are analysed further in **Appendix 3**.

Encouraging the adoption of healthy behaviours in rural and remote regions can be challenging as these populations face multiple challenges due to their geographic isolation[11]. The proportion of adults engaging in many behaviours associated with poorer health is higher in rural and remote areas than in metropolitan areas (e.g., 22 per cent of people in Outer regional/Remote areas smoke daily compared with 13 per cent of people in Major cities)[12].

1.1.2   Morbidity and mortality

Table 1.1.2 shows the mortality indicators for the SWHHS catchment, including the cancer rates, life expectancy and quality of life indicators. This analysis shows that there is a lower life expectancy for men in the SWHHS region compared to the Queensland average and a higher rate of cancers in some Planning Regions compared with the Queensland averages (e.g., Charleville and the Far South West for males and Balonne for females). Adopting healthy behaviours can substantially reduce premature mortality and prolong life expectancy[13]. The analysis in **Tables 1.1.1 and 1.1.2** indicates that promoting a reduction in substance use, healthier eating, and more exercise, may lead to improvements in the mortality of people living in the SWHHS catchment.

Table 1.1.2 Mortality Indicators in the SWHHS by SA2 (2014-2018)[14]

Description	Queensland	SWHHS	Roma	Outer Roma	Charleville	Balonne	Far South West
All cancers - females (ASR/100k)	515	516	516	505	545	505	515
All cancers - males (ASR/100k)	663	607	607	697	596	697	663
Life Expectancy - Male	80.3	79.2	79.2	76.5	79.2	76.5	80.3
Life Expectancy - Female	84.8	84.5	84.5	81.2	84.5	81.2	84.8
Potential years of life lost, all persons 2014-2018 (ASR/1000)	42.0	50.8	50.8	61.2	53.3	61.2	42.0
Potential years of life lost, First Nations Peoples 2014-2018 (ASR/1000)	79.2	184.0	81.7	39.7	183.5	144.9	79.2

Table 1.1.3 shows the number of overnight separations per Service-Related Group (SRG). This analysis indicates that SRGs such as respiratory medicine and cardiology, which are typically associated with risky behaviours, have a high representation in service utilisation. Separations associated with these SRGs could also be reduced with encouraging and enabling healthy behaviours.

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[11] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p254

[12] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p254

[13] Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. Canberra: AIHW, p262.

[14] Public Health Information Development Unit (PHIDU) (2022), Social Health Atlas of Australia: Population Health Areas.

Top 10 SRGs	2020/2021
Respiratory Medicine	302
Non-Subspecialty Medicine	320
Gastroenterology	272
Cardiology	286
Non-Subspecialty Surgery	249
Obstetrics	195
Orthopaedics	178
Unqualified Neonate	169
Neurology	201
Immunology & Infections	194
Grand Total	2,366

Table 1.1.4 indicates that the rate of premature deaths and the number of potential years of life lost due to suicide and self-inflicted injuries in the SWHHS catchment is higher than the Queensland average ASR. This analysis shows that:

- Mental and behavioural disorders represent between 9.76 per cent and 23.69 per cent of potential years of life lost across the SWHHS catchment.

- First Nations peoples are a particularly vulnerable group to mental health and behavioural disorders with First Nations peoples overrepresented in the mental health related ED presentations (i.e., First Nations peoples account for 32.40 per cent of ED presentations and 13.05 per cent of the SWHHS population).

Mental and behavioural disorders for the general population represented 2.03 per cent of total ED presentations. There was 2,577 mental health ED in the SWHHS between 2015-16 and 2019-20 of 127,205 in total.

This analysis indicates that there is a substantive unmet mental health need in the SWHHS as although mental health illness represented between 9.76 per cent and 23.69 per cent of potential years of life lost, mental health illnesses only represented 2.03 per cent of ED presentations. There may be a number of drivers for this unmet mental health need, including:

- There may not be routine self-reflection on mental health and wellbeing as a normalised and encouraged behaviour.

- There may still be stigma associated with needing or accessing mental health services.

- There may not be sufficient supply of mental health services for people to access appropriate support with there only being 16 psychologists in a relatively large geographic area.

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[15] Queensland Health Planning Portal (2022), Overnight Admissions Data

- There may not be a sufficient supply of culturally appropriate mental health and wellbeing supports.

These drivers could be addressed through promotion and prevention initiatives as well as changes to service design.

Table 1.1.4 Mental Health-related Behaviours and Mortality Rates in the SWHHS by SA2 (2014-2018)[16]

Description	Queensland	Roma	Outer Roma	Charleville	Balonne	Far South West
Mental and behavioural problems (ASR/100)	23	20.65	20.65	n.p.	21.42	n.p.
Premature deaths from suicide and self-inflicted injuries, ages 0 – 74 years, 2014-2018 (ASR/100,000)	15	24.5	24.5	36.3	13.7	36.3
Potential years of life lost from suicide and self-inflicted injuries, ages 0 – 74 years, 2014-2018 (ASR/1000)	5.1	8.7	8.7	14.5	5.2	14.5
Percentage of potential years of life lost attributable to suicide and self-inflicted injuries (%)	12.14%	17.13%	17.13%	23.69%	9.76%	23.69%

1.1.3   Social Determinants of Health

Table 1.1.5 provides a comparison of key indicators for the social determinants of health between regions within the SWHHS catchment and Queensland.

Assessing the social determinants of health (i.e., education rates, income, crime rates, and access to internet) against Queensland averages suggests that regions within the SWHHS have a greater proportion of disadvantaged or vulnerable populations. There may be opportunities for the SWHHS to assess the extent to which the social determinants impact health equity, particularly in remote areas of the catchment. This may involve assessing:

- The access to face-to-face healthcare in locations where internet access is too low to enable effective uptake telehealth (e.g., outreach/in reach services, locum services, and transit services to access specialty healthcare, particularly in the Charleville and Far South West regions).

- The level and appropriateness of health promotion being delivered to communities with lower rates of education in order to increase health literacy.

- The healthcare services and health communication designed specifically for First Nations communities in order to increase health literacy and create a culturally safe and welcoming place for First Nations peoples to access services.

Social determinants of health within the region are explored further in **Appendix 2.**

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[16] Public Health Information Development Unit (PHIDU) (2022), Social Health Atlas of Australia: Population Health Areas

Table 1.1.5 Social Determinants of Health in the SWHHS (2016)[17]

Description	Year	Queensland	SWHHS	Roma	Outer Roma	Charleville	Balonne	Far South West
Highest schooling level completed by First Nations Peoples being Year 11 or 12 (%)	2016	49%	36%	41%	25%	35%	38%	37%
Highest schooling level completed by non-First Nations Peoples being Year 11 or 12 (%)	2016	64%	51%	58%	46%	53%	49%	48%
Homeless persons (per 10,000)	2016	45.6	45.7	23.9	40.1	39.2	72.3	55.2
Median total family income ($/wk.)	2016	1661	N/A	1842	1473	1490	1485	1327
Criminal Offences per 100,000 persons)	2018-20	10,190	14,739	N/A	N/A	N/A	N/A	N/A
Proportion of population that cannot access the internet (%)	2016	13%	25%	20%	25%	26%	25%	32%
Socio-Economic Index for Areas (SEIFA) Score	2016	N/A	N/A	1001	989	943	973	925
Social Housing Rate (%)	2016	4%	5%	3%	3%	8%	3%	8%
Unemployment Rate (%)[2]	2021-2022	4.70%	5.60%	6.20%	3.20%	5.60%	6.20%	8.50%

1.2 Service utilisation

1.2.1   Service utlisation within the SWHHS

Figure 1.2.1 illustrates the projected population of the SWHHS catchment over the next 20 years. It indicates that the overall population of the SWHHS catchment is projected to decline over time.

Figure 1.2.1 Population Projection in the SWHHS (2021/2022 to 2041/2042)[18]
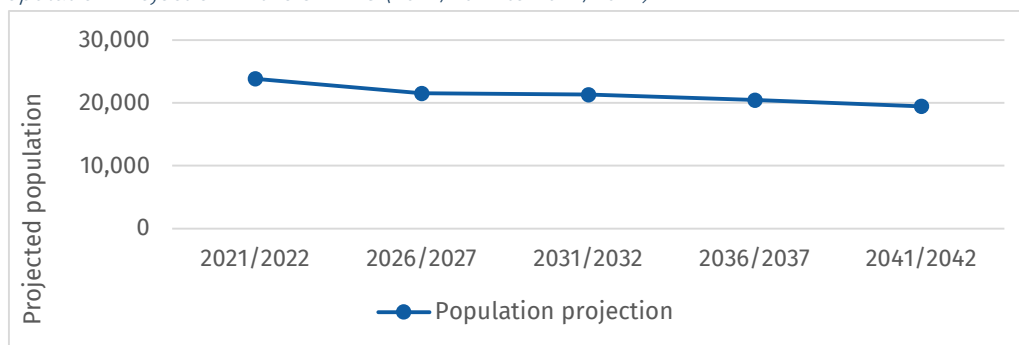
[17] Australian Bureau of Statistics (ABS) (2016), 2016 Census Data

[18] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

The population of the SWHHS is projected to decrease by 18.4 per cent from 2021/2022 to 2041/2042. Over the same time, hospital separation projections are forecasted to increase by 38.75 per cent to approximately 8,500 per year. This means that per capita separations are expected to increase by 68 per cent between 2021/2022 and 2041/2042 as illustrated in **Figure 1.2.2**.

The forecast separations in **Figure 1.2.2** are informed by historical service utilisation and makes no assumptions about alternative non-hospital interventions. For example, a reduction in risk behaviours such as alcohol consumption and smoking (as outlined in **Section 1.1**) may slow the projected growth in the rate of separations per capita, specifically for respiratory and cardiovascular disease. This analysis indicates the need for earlier health interventions to manage the projected increase in the number of hospital separations per person, including health promotion, education, and access to primary and allied healthcare.

In 2020, 3,900 South West residents were aged 65 or more, equating to approximately 16 per cent of the total population, and of whom 468 were aged over 85. Between 2018 and 2019, 15 per cent of the SWHHS's total of 1,826 hospitalisations were attributed to conditions relating to ageing and disability. This included 222 hospitalisations for falls in people over 65, which was amongst the lowest in the state.

It is acknowledged, that given the projected population is decreasing whilst the presentation volume is increasing, a proportion of those who present are from outside the HHS (as evidenced by self sufficiency rates in *4.6.3.3 Local hospital self-sufficiency rates*). Opportunities to enhance continuity of care to reduce presentations for this population is minimal, given their residence outside the HHS.

Figure 1.2.2 Projected Separations within the SWHHS (2021/2022 to 2041/2042)[19]
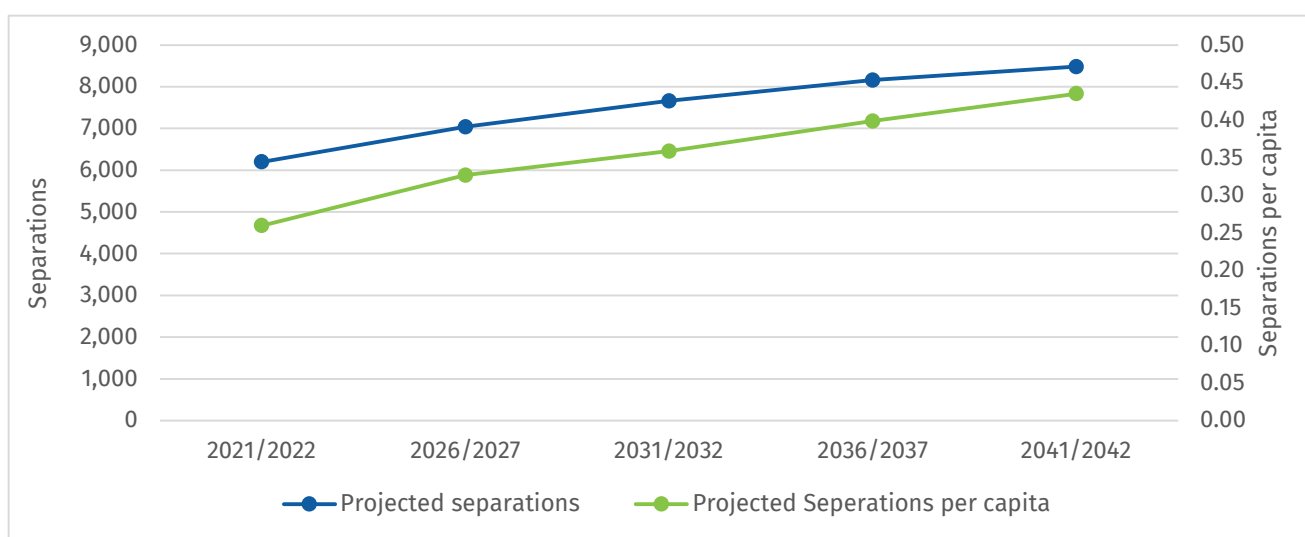
Detailed separations data is provided in **Appendix 6**.

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[19] Queensland Health Planning Portal (2022), Projected Separations within SWHHS (prepared by System Planning Branch)

1.2.2 Service utilisation outside the SWHHS

Over the forecast period, there is an increasing proportion of individuals from the SWHHS catchment that are predicted to receive healthcare services at other HHSs across Queensland (as shown in **Figure 1.2.3**). It is expected that, although the population of the SWHHS catchment is decreasing, the SWHHS catchment residents will account for over 3,000 separations in other HHSs by 2041/42. This represents growth of 25.30 per cent over the period.

Figure 1.2.3 Projected Separations for Individuals from the SWHHS Catchment Receiving Healthcare Services at other HHSs (2021/2022 to 2041/2042)[20]
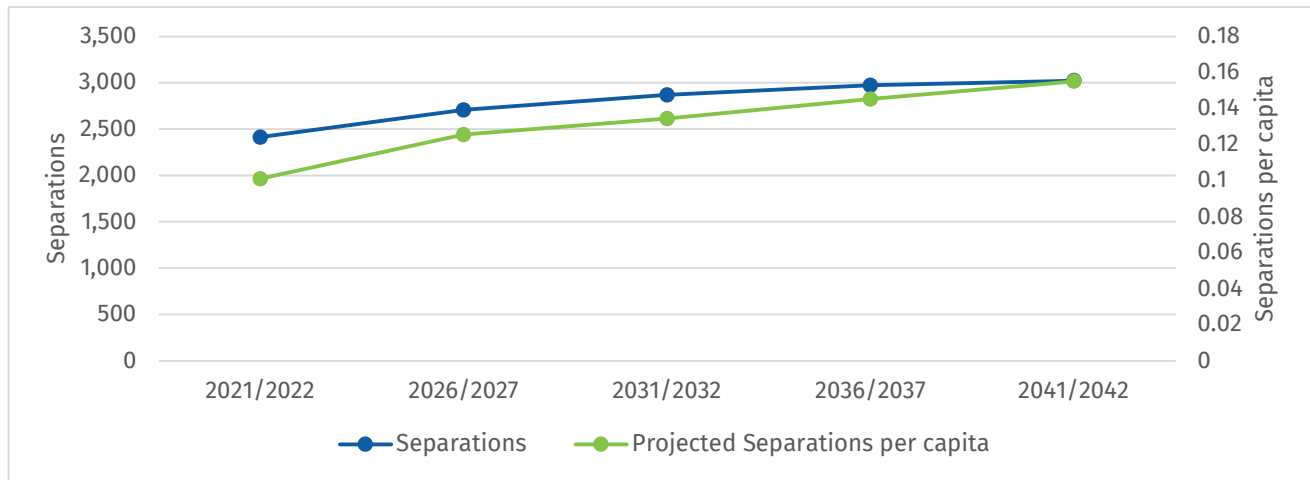
The number of people from outside the SWHHS catchment presenting at public SWHHS facilities, has increased by approximately 26 per cent since 2014/15, with private separations remaining relatively stable over the same period. Despite the lower forecast levels, growth in this patient cohort is expected to increase by approximately 14 per cent per annum over the forecast period.

This is illustrated in **Figure 1.2.4**.

Please note that the gap in the line in **Figure 1.2.4** represents current activity, which could not be illustrated.

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[20] Queensland Health Planning Portal (2022), Projected Separations outside SWHHS (prepared by System Planning Branch)

This analysis in **Figures 1.2.3 and 1.2.4** indicates the ongoing need to focus on increased coordination of care to enable those people who travel outside the catchment for treatment to better manage their health once they return home. Given that the volume of separations per capita is still forecast to increase (refer **Section 1.2.1**) there will be an ongoing need to consider how SWHHS will deliver care in a way that is sustainable and self-sufficient.

Service utlisation, service flows and self-sufficiency analysis are provided in **Appendix 6.**

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[21] Queensland Health Planning Portal (2022), Projected Separations from outside the catchment within SWHHS (prepared by System Planning Branch)

2 Supply of health services

This section of the LANA describes the types of health services available in the SWHHS catchment and the extent to which there are any barriers to access. An important component of the approach for understanding the supply of services is the use of service mapping. Through desktop analysis and validation with service partners, the service mapping captures the range of public and private health and support services available in the SWHHS catchment. The service mapping informs the identification of potential opportunities to enhance the availability of services to better meet the needs of the population.

2.1.1 Health service network within SWHHS catchment

The service mapping indicates that the hospital services are provided in the larger towns, including Roma, Charleville and St George. There are also multipurpose health services in smaller towns including Augathella, Cunnamulla, Mitchell, Mungundi, Quilpie, Surat, Injune, and Dirranbandi; and community clinics in Thargomindah, Bollon, Morven, and Wallumbilla. There are also ten (10) health services specifically for Aboriginal and Torres Strait Islander people that are delivered by four (4) ACCHOs in the SWHHS catchment.

The services available in the SWHHS catchment include:

- three (3) hospitals
- four (4) rural community clinics
- four (4) disability services
- four (4) alcohol and other drugs services
- eight (8) ambulance stations
- nine (9) general practices
- nine (9) multi-purpose facilities
- twelve (12) pharmacies.

There are also emergency treatment spaces in Roma, St George, Charleville, Cunnamulla, Mitchell, Thargomindah, Quilpie, Augathella, Injune, Surat, Wallumbilla, Mungindi, Dirranbandi, and Bollon.

2.1.2 SWHHS facilities

The service mapping indicates that the hospital services are provided in the larger towns, including Roma, Charleville, and St George (**Figure 2.1.1**).

Figure 2.1.1 Hospitals in the SWHHS (2022)
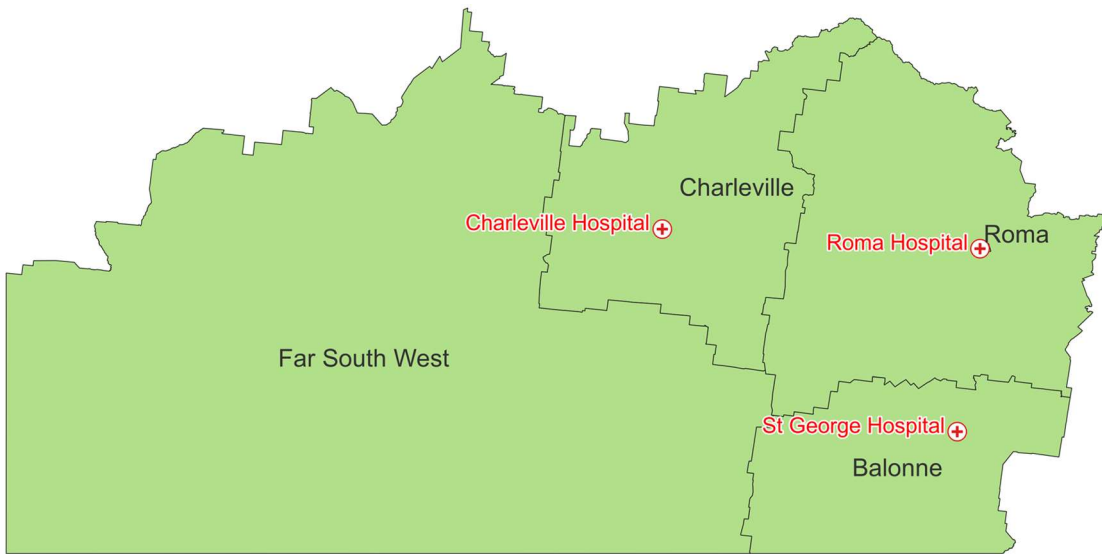
There are also multipurpose health services in smaller towns including Augathella, Waroona, Mungundi, Quilpie, Surat, Injune, Cunnamulla, and Dirranbandi; and community clinics in Thargomindah, Bollon, Morven, and Wallumbilla (**Figure 2.1.2**).

Figure 2.1.2 Multi-Purpose Health Services in the SWHHS (2022)
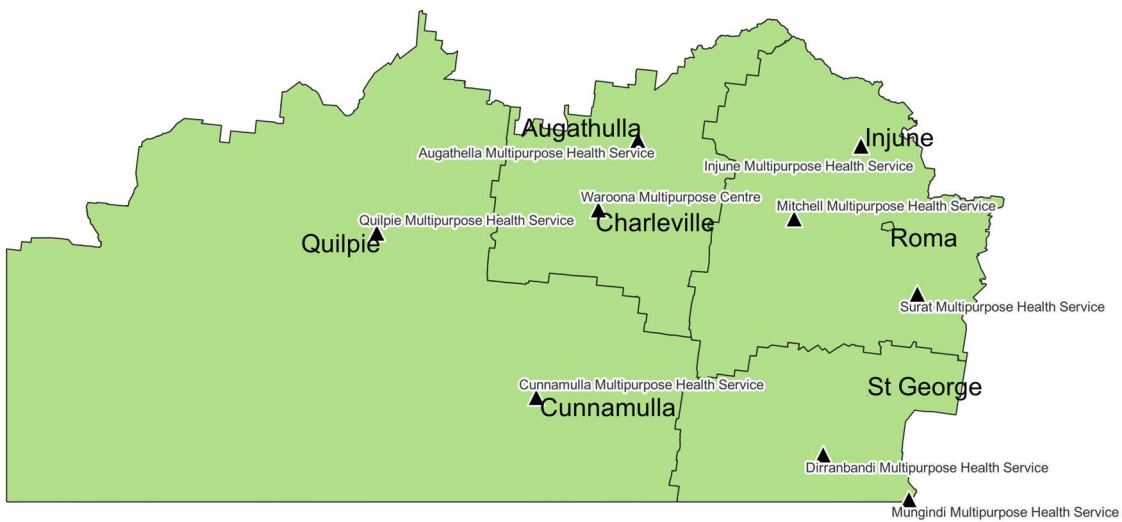
There are also ten (10) health services specifically for Aboriginal and Torres Strait Islander people that are delivered by four (4) ACCHOs in the region (**Figure 2.1.3**).

South West Hospital and Health Service Local Area Needs Assessment (2022)

Figure 2.1.3 ACCHOs in the SWHHS (2022)
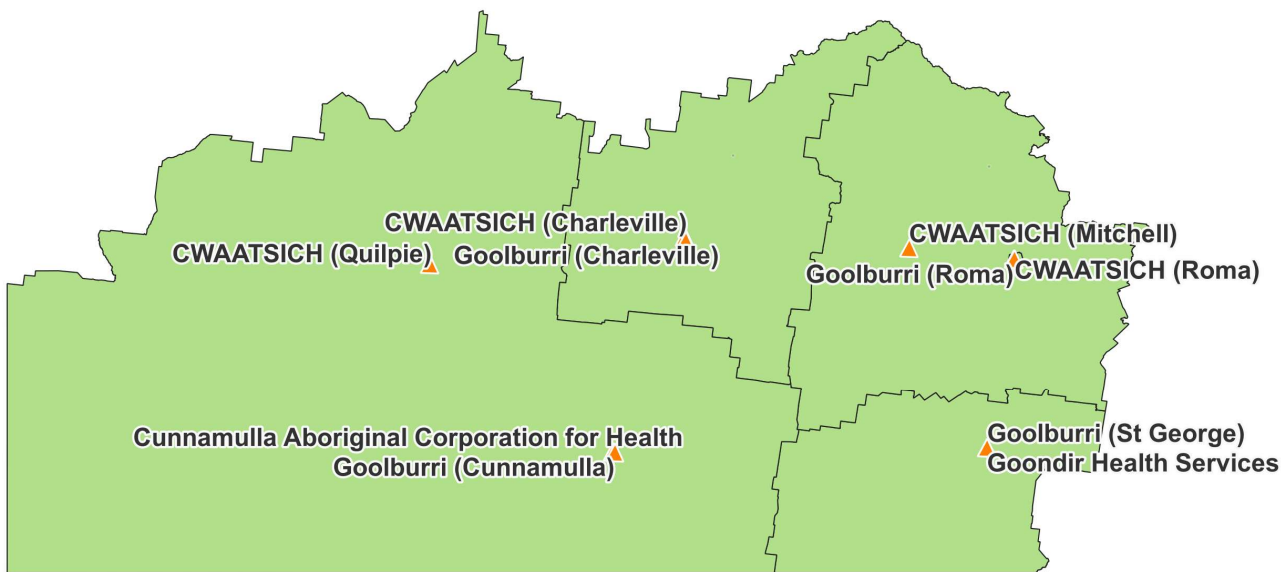
All service maps and the total list of avaliable services are provided in **Appendix 6.**

2.1.3   Service supply gaps

In 2012, the Australian Health Ministers' Advisory Council (AHMAC) Rural Health Standing Committee put forward a framework for health service planning in rural and remote areas: The *National Strategic Framework for Rural and Remote Health*. While this framework is dated (i.e., ten years old), many of the parameters outlined in this framework are still relevant to health service planning in rural and remote contexts. The *National Strategic Framework for Rural and Remote Health* noted that planning, managing, and delivering public hospital services in rural and remote locations is complex because rural and remote locations generally:

- are smaller than metropolitan centres;

- have high fixed costs of operation;

- are less able to achieve economies of scale experienced in large hospitals;

- are often the default service provider in the absence of private sector options and adequate primary health and aged care services; and

- consistently struggle to attract and retain a skilled clinical workforce.

Within the context of the findings of *National Strategic Framework for Rural and Remote Health*, the service mapping enabled the identification of a number of opportunities for enhancing health services in the SWHHS catchment, including:

- There may be an opportunity to improve the availability of community mental health and low-medium acuity mental health service offerings. The self-assessed Clinical Services Capability Framework (CSCF) results show that the SWHHS does have high-acuity mental healthcare services (see **Appendix 5**). However, further consultation highlighted that there was inadequate access to mental health services outside major hubs. Given that the potential years of life lost from suicide and self-harm in the Charleville and the Far South West regions is three times higher than the Queensland average (refer **Section 1.1.2**), this indicates that there may be an opportunity to deliver mental health services in a different way that better engages with the community. Stakeholders indicated that these could involve a suite of initiatives that aim to

normalise mental health concerns and reduce the stigma of mental health support (refer **Section 3**).

- The westernmost permanent General Practice was found in Cunnamulla. While there is a small population of people living in the Far South West region, this suggests that there may be gaps in the supply of primary healthcare. This is important to consider as the Far South West region has the highest rate of smoking in the SWHHS catchment and a relatively high rate of ED presentations per capita (refer **Section 1**). Stakeholders therefore indicated that further and ongoing engagement with the Far West Region was required to identify and address any potential gaps in primary healthcare.

- Whilst there are imaging services available in the SWHHS catchment, stakeholders indicated that people are still travelling outside the SWHHS catchment (e.g., to Toowoomba) to obtain a diagnostic image. This occurs often when people are receiving ongoing treatment with a specialist outside of the SWHHS catchment. Some stakeholders noted that there is an opportunity for people to have their medical imaging done in the SWHHS catchment. There is also an opportunity to improve the exchange of information and continuity of care for people accessing specialist services outside of SWHHS region and wanting to have their condition managed closer to home.

- The service mapping identified one (1) private multidisciplinary allied service. Based on consultation and desktop analysis, it is understood that this service has a substantial wait period which signals an unmet need for allied health services in the SWHHS region.

2.1.4   Telehealth and virtual health service offerings

It is likely that telehealth and virtual health services for both primary and specialist care delivered throughout the SWHHS catchment are not captured in this service mapping exercise. However, given the relatively low uptake of telehealth services and comparatively lower rates of internet access in the remote regions of the SWHHS catchment, there may be opportunities to increase virtual health and telehealth options. Stakeholders indicated that telehealth mental health service options might prompt more people to seek help early as it is perceived as a more confidential service delivery approach than going to a shopfront or facility that is known to be a mental health service provider.

In some remote geographies across Australia, telehealth facilities may be used to deliver healthcare to patients or provide decision support to clinicians. The SWHHS has a relatively low number of telehealth consultations (1.7 consultations per 100 people), compared to the Queensland average of 5.7 consultations per 100 people in 2020/2021. Whilst there are connectivity issues in a number of remote regions (e.g., Balonne), this analysis indicates that there may be an opportunity to increase the use of telehealth facilities to support better access to specialists and primary and allied healthcare.

Table 2.1.1 shows the count of long waits per speciality in the SWHHS. It identifies that there are a high number of category 1 and category 2 referral long waits across physiotherapy, nutrition, orthopaedics, and cardiology. A full list of wait times and count of long waits is provided in **Appendix 5**.

Table 2.1.1 Count of Long Waits per Specialty in the SWHHS (May 2022)[22]

Description	Category		
	1	2	3
Physiotherapy	83	111	44
Ophthalmology	1	18	170
Podiatry	18	38	120
Orthopaedics – General	0	45	111
Nutrition/Dietetics	16	28	78
Cardiology General	4	58	40
Occupational Therapy	15	66	12
Paediatric Medicine	3	22	60
General Surgery	10	27	26

Table 2.1.2 shows the number and proportion of people who did not attend the GP when they needed to for various reasons, in comparison to the Queensland average. It identifies that a significant proportion of people in the Western Queensland PHN catchment did not attend the GP because it was too far away. If people delay a consultation with a GP it may lead to potentially preventable hospital admissions.

Table 2.1.2 Patient reported experience of why they did not see a GP in the Western Queensland PHN region when needed (2016)[23]

Reported Experience	Western Queensland PHN		Queensland (Average)	
	Sum of Estimate	Average of Percentage (%)	Sum of Estimate	Average of Percentage (%)
Cost of appointment	605	10.9	83,643	19.0
Could not get an appointment when needed to	2,709	48.9	201,795	49.4
No GP nearby	1,266	22.8	16,846	6.6
Other	2,173	39.2	173,947	42.5
Total	5,541	100.0	407,393	100.0

Service utlisation analysis is provided in **Appendix 6.**

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[22] South West Hospital and Health Service (2022), Category and Number of Long Waits

[23] Australian Institute of Health and Welfare (2016), Coordination of health care, experiences of health care use by Primary Health Network

3 Priority health needs

Based on the analysis of health needs (refer **Section 1**) and the supply of services (refer **Section 2**), this section identifies the priority health needs and the criteria for identifying these priorities. The priority health needs were identified through an iterative process of consultation. **Appendix 7** describes this approach in more detail.

3.1 Prioritisation criteria

3.1.1 Prioritisation criteria

A number of health needs were identified for the SWHHS based on quantitative analysis of the publicly available data for the SWHHS catchment as well as the Queensland Health System Planning Branch internal datasets. These health needs were then tested and validated through stakeholder consultations to understand whether they were critical health needs or gaps in terms of being:

- 'felt' health needs that were identified during prior community consultation;

- 'normative' needs that can be identified in research or clinical standards; and/or

- 'comparative' needs that were identified as a need or gap based on comparison with another geography.

The health needs identified through data analysis were then tested using the following criteria to understand the extent to which the health need was a priority, before being further tested with community stakeholders.

Prioritisation Criteria

- **Governmental / Departmental direction** – the extent to which the health need aligns with government and Departmental strategic directions, targets, election commitments, or formal obligations contained within the HHS Service Agreement.

- **Validation of need** – the extent to which the health need has been identified using more than one method (e.g., consultation, literature review, and data analysis).

- **Risk of unmet need** – the extent of the potential consequences if the health need is not addressed (e.g., whether the existing health inequalities or inequities will persist or exacerbate over time if not addressed).

- **Feasibility** – whether the potential solution to this need can be implemented within available resources. (e.g., the extent to which the solution can be implemented within the health system, geographical, political, social, and financial conditions).

- **Impact** – the extent to which the health need or issue has a long-term impact on the community.

- **Acceptability** – the extent to which people delivering and receiving healthcare interventions to address the health need are likely to consider those interventions palatable or satisfactory.

The key benefits of applying criteria to the identified health needs include:

- An ability to conduct a robust assessment of priorities where multiple data points are considered (i.e., both quantitative and qualitative data).

- The flexibility to use a place-based lens to select and refine the priority health needs where further information is available (e.g., where a stakeholder can provide further context around a gap in health services or preferences for service access).

- An ability to communicate the evidence base and rationale for priority health needs to community members and check whether there are additional priorities that need to be considered.

Based on the quantitative data analysis and application against the prioritisation criteria, five (5) draft priority health needs where identified. The draft priority health needs are provided in **Appendix 7.** Following consultation, these priorities have been refined and presented in **Section 3.2.**

A deeper analysis of the themes from consultation are available in **Appendix 7.**

3.2 Priority health needs

The final priority health needs for the SWHHS were developed through quantitative data analysis and refined through validation with stakeholders. This section explores the three (3) priority health needs. It provides the summary of insights from data analysis, assessment against prioritisation criteria, the themes and key insights from consultation, and enablers could support addressing the priorities.

3.2.1   Overview of priority health needs

Based on the data analysis and consultation outcomes, the following three (3) priority health needs for SWHHS were identified. It is important to note that all these priorities are given equal weighting.

Priority 1: Encouraging and enabling healthy behaviours

There is an opportunity to encourage and enable healthier behaviours across the SWHHS catchment and improve health outcomes by targeting smoking, drinking, drug usage, rates of exercise, and fruit/vegetable consumption.

People in the SWHHS catchment have a lower average life expectancy, compared with the Queensland average. The social determinants of health have a considerable impact on the health inequities experienced by the SWHHS population (refer **Appendix 2** for further analysis).

Factors such as socioeconomic position, conditions of employment, the distribution of wealth, empowerment and social support influence the health behaviours and outcomes of individuals living in the SWHHS catchment. By recognising the impact of the social determinants of health on the lifestyles of individuals, the SWHHS has an opportunity to tailor its services and health promotion activities to encourage and enable healthy behaviours in the community.

Encouraging and enabling healthy behaviours will improve morbidity and mortality rates in the SWHHS catchment. It will also reduce high service utilisation associated with morbidities, such as cardiovascular disease and respiratory disease.

Priority 2: Improving mental health services

The SWHHS has the opportunity to improve to mental health services to promote mental wellbeing and preventative mental healthcare.

Even though there is a relatively low number of ED presentations for mental health episodes in the SWHHS catchment, mental health services are a priority because the SWHHS has a higher-than-average age standardised rate (ASR) of self-harm and suicide.

The SWHHS can work to promote the normalisation of mental health check-ups and wellbeing initiatives. There may also be an opportunity to provide greater continuity of care for patients when they need to access acute mental healthcare services outside of the SWHHS catchment.

Priority 3: Improving primary and specialist healthcare

The SWHHS has the opportunity to strengthen primary and specialist healthcare in communities that experience gaps in service provision.

Primary and specialist care is usually delivered by a range of medical, nursing, and allied health professionals in various private and not-for-profit settings. However, many residents of the SWHHS catchment struggle to access primary and specialist health services in a timely manner.

Stakeholders indicated that they often have to travel long distances to access primary and specialist healthcare. Access to primary and specialist healthcare could therefore be improved by the SWHHS exploring options to leverage telehealth and virtual platforms as a means of delivering GP, allied health, and specialist consultations.

3.2.2 Overview of enablers

During the consultation with stakeholders around the health need priorities, a number of enablers were identified for improving health outcomes.

Enabler 1: Workforce

The development of a sustainable and well supported health workforce is important for the delivery of high quality and accessible healthcare services in the SWHHS catchment.

A number of stakeholders acknowledged that recruiting and retaining health workforce was a significant problem and that this issue was not unique to the SWHHS catchment. Workforce was typically identified as a key enabler for reducing wait times and limitations around access to services (e.g., wait times for allied healthcare such as physiotherapy).

To develop a sustainable workforce, it will be important to identify the incentives and supports that health workers need to deliver services in the SWHHS region. Stakeholders identified professional development opportunities, flexible working arrangements, and living and family support for individuals as important aspects for recruiting and retaining clinicians in the SWHHS region.

Enabler 2: Partnerships

Partnerships may include formal contractual partnerships or collaborative partnerships based on mutually agreed health priorities.

Given that the health priorities identified for the LANA include services that are delivered by non-government organisations, private healthcare providers, Aboriginal Community Controlled Organisations (ACCOs), and other local organisations (e.g., councils), it will be important for the SWHHS to maintain productive working relationships with these partners.

There may be opportunities to formalise existing partnerships or to establish new agreements with appropriate partners. This would ensure clear accountability for the organisations responsible for progressing specific aspects of the priority health needs of the SWHHS catchment. Improving linkages between the SWHHS and local organisations can also foster new mechanisms to engage with community early and provide tailored and culturally safe healthcare in a holistic manner.

Enabler 3: Continuity of care

Continuity of care includes the continuity of information to support clinical decision-making and the continuity of patient management to enable consistent care and advice.

Maintaining continuity of care has been identified as an enabler for decreasing patient mortality[24], as clinicians are more familiar with their patients' specific habits and needs.

In the context of the priority health needs, stakeholders described the importance of being able to exchange information between one provider and another (e.g., between hospital and GP) to support improvements in mental health and specialist care. This could be supported through formalised information sharing workflows and enabling technology.

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[24] Baker, R et al. Primacy medical care continuity and patient mortality: a systematic review. *British Journal of General Practice*. 2020. 70 (698).

4 Appendices

4.1 Appendix 1: The Region

This section provides the analysis used to support a description of the SWHHS catchment, including geographic and demographic analysis.

4.1.1 Geographic area

4.1.1.1 Statistical areas of the SWHHS catchment

Table 4.1.1 and **Table 4.1.2** indicate that the SWHHS covers a land area of approximately 319,800 square kilometres (18 per cent of Queensland), and has an estimated resident population (ERP) of 23,907 as of 2020. The SWHHS consists of five (5) SA2s (Planning Regions): Roma, Roma Region, Balonne, Charleville, and Far South West. The SWHHS also contains parts of two (2) SA3s, 38 per cent of the Darling Downs (West)-Maranoa and 40 per cent of Outback South.

4.1.1.2 Local Government Areas of the SWHHS catchment

The SWHHS consists of six (6) Local Government Areas (LGAs): Balonne, Bulloo, Murweh, Paroo and Quilpie Shire Councils and the Maranoa Regional Council. The SWHHS forms part of the Queensland State electorate of Warrego and is a part of a wider larger Maranoa Federal Electoral Division which also includes 11 Queensland Shire and Regional Councils to the north and west of the SWHHS. The SWHHS also comprises five Indigenous Area (IAREs): Balonne, Bulloo – Quilpie – Barcoo (80.67 per cent), Maranoa – Roma – Mitchell, Murweh and Paroo. For health service planning purposes, three Planning Regions are identified within the SWHHS, and include Roma, Roma Region, and South West remainder. These areas constitute the local service catchments for Charleville, Cunnamulla, Roma, and St George public hospitals.

The SWHHS catchment area also runs adjacent to New South Wales and South Australia along its southern perimeter, and is:

- One of four Rural and Remote HHSs across Queensland, alongside Central West, North West, and Torres & Cape.

- A founding member of the Western Queensland PHN (WQPHN) established in partnership with Central West HHS and North West HHS.

- Part of the 'Western Corridor' of Queensland HHSs, comprising Darling Downs, West Moreton, and Metro South.

Table 4.1.1 Geographical regions, SWHHS, 2021[25]

SA3 name	Planning region	SA2 name	Indigenous Area (IARE)
Darling Downs (West) Maranoa – 38.31%)	Roma	Roma	Maranoa – Roma – Mitchell
Outback – South (40.44%)	Roma Region	Roma Surrounds	Maranoa – Roma – Mitchell
		Balonne	Balonne
	South West remainder	Charleville	Murweh
		Far South West	Bulloo – Quilpie – Barcoo Paroo

Table 4.1.2 Population density per SA2, SWHHS, 2020[26]

SA2 name/ Geographical region	Area (Sq Km)	ERP 2020	Population Density (persons per sq. km)
Roma	78	6,932	89.16
Roma Region	58,394	5,787	0.10
Balonne	31,466	4,321	0.14
Charleville	40,401	4,220	0.10
Far South West	189,462	2,647	0.01
SWHHS total	319,800	23,907	0.07
Queensland	1,734,110	5,176,081	2.98

[25] Concordance file sourced from Queensland Government Digitised Statistical Level Area boundaries Australian Statistical Geography Standards (ASGC). 2008 and 2010, Australian Bureau of Statistics 2014 Hospital and Health Services by Area (Sq Km) HHS as of 1 July 2012. Prepared by System Planning Branch, Planning Portal.

[26] Concordance file sourced from Queensland Government Digitised Statistical Level Area boundaries Australian Geography Standards (ASGC). Australian Bureau of Statistics, Australian Statistical Geography Standard (ASGS). Prepared by System Planning Branch Planning Portal.

Figure 4.1.1 Geographical area by SA2, SWHHS, 2016[27]
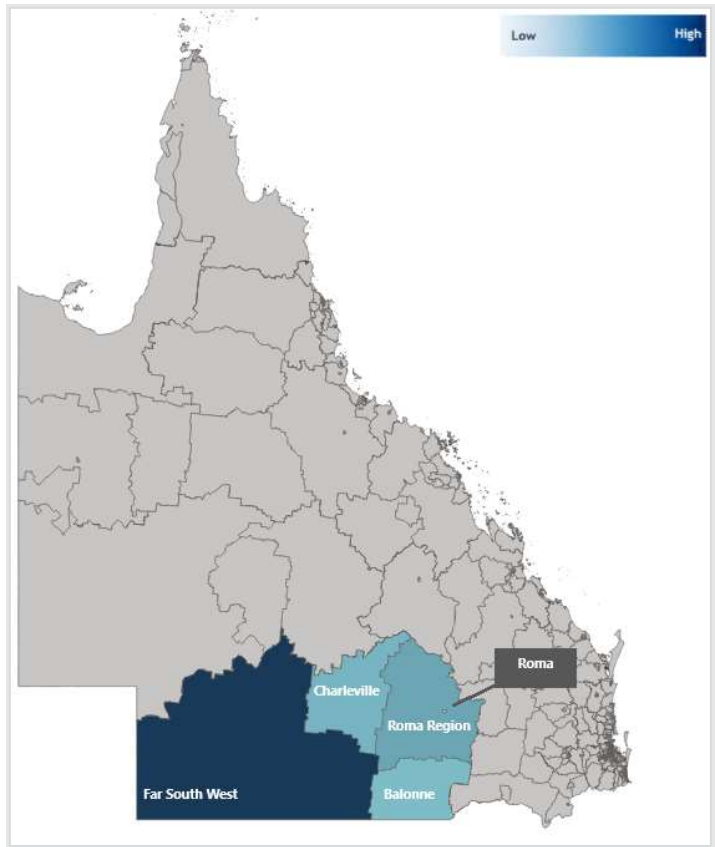
Figure 4.1.2 Geographical area, HHS to Indigenous Area (IARE) (2022)[28]
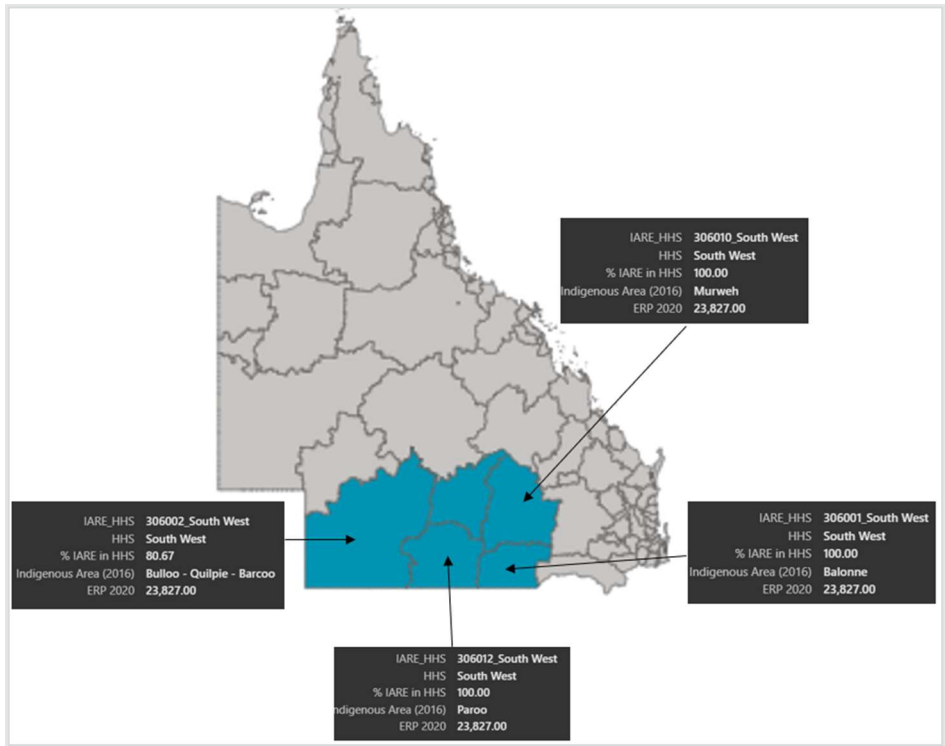
4.1.2   Demography

4.1.2.1   Total estimated resident population (ERP)

The SWHHS has a total estimated resident population (ERP) of 23,907 as of 2020. **Table 4.1.3** illustrates that since 2012, the SWHHS population decreased by 8.9 per cent, down from 26,244 people. The compound annual growth rate (CAGR) was -1.16 per cent per annum, while the Queensland CAGR was 1.62 per cent per annum. Far South West Planning Region had the greatest reduction in population between 2012 and 2020 (-19.69 per cent), while Roma Planning Region experienced the smallest reduction in population (-3.12 per cent). Broadly, overall population numbers are relatively higher in the eastern region of the SWHHS, particularly around the administrative centre of Roma.

Table 4.1.3 Total estimated SA2 resident population, 2011-2020[29]

SA2/ Geographical region	2012 ERP	2020 ERP	Absolute growth (#)	Relative growth (%)	Compound Annual Growth Rate (CAGR), 2012-2020 (%)
Roma	7,155	6,932	-223	-3.12%	-0.40%
Roma Region	6,269	5,787	-482	-7.69%	-1.00%
Balonne	4,787	4,321	-466	-9.73%	-1.27%
Charleville	4,737	4,220	-517	-10.91%	-1.43%
Far South West	3,296	2,647	-649	-19.69%	-2.70%
SWHHS total	26,244	23,907	-2,337	-8.90%	-1.16%
Queensland	5,093,884	5,176,189	82,302	1.62%	1.57%

4.1.2.2   Total projected resident population (PRP)

From 2020 to 2036, the overall population of the SWHHS is forecasted to decline at a rate of -0.35 per cent per year. This represents a decrease of approximately 1,305 people (from 23,907 people to 22,602 people). In comparison, the annual average growth rate is 1.66 per cent across Queensland. Roma is the only Planning Region within the SWHHS projected to increase (CAGR 0.52 per cent) between 2020 to 2036. Far South West Planning Region is projected to have the greatest reduction in population, with a CAGR -1.54 per cent between 2020 to 2036 (2,647 residents reducing to an estimated 2,065).

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[27] Australian Bureau of Statistics, *Australian Statistical Geography Standard (*ASGS). Prepared by System Planning Branch Planning Portal.

[28] Australian Bureau of Statistics, *Australian Statistical Geography Standard (*ASGS). Prepared by System Planning Branch Planning Portal.

[29] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

One possible reason for this projected decline in population is urbanisation away from remote and very remote areas, as indicated by the negative CAGRs of both the Charleville and the Far South West SA2s.

Table 4.1.4 Projected population, SWHHS, 2020-2036[30]

SA2/ Geographical region	Projected population (PRP)			Projected growth	
	2020 (ERP, base year)	2026	2036	CAGR 2020-2026 (%)	CAGR 2020-2036 (%)
Roma	6,932	7,133	7,537	0.48%	0.52%
Roma Region	5,787	5,599	5,366	-0.55%	-0.47%
Balonne	4,321	4,164	3,928	-0.59%	-0.59%
Charleville	4,220	3,911	3,706	-1.26%	-0.81%
Far South West	2,647	2,351	2,065	-1.96%	-1.54%
SWHHS total	23,907	23,159	22,602	-0.53%	-0.35
Queensland	5,176,186	5,772,780	6,686,604	1.69%	1.66%

Data source: ERP: Queensland Government Statistician's Office (QGSO) – ABS consultancy for QGSO, September 2020. These estimates correspond with 30 June 2001-2019. ERP by SA2 as released in Regional Population Growth, Australia, 2018-19 (cat.no. 3218.0) and Regional Population by Age and Sex, Australia, 2019 (cat no. 3235.0). Prepared by QGSO, Statistical Reporting and Coordination Unit (SRC) and Statistical Analysis Linkage Unit (SALU). PRP: Queensland Government population projections, 2018 edition; Australian Bureau of Statistics, Population by age and sex, regions of Australia, 2016 (cat. no. 3235.0). <u>Note:</u> CAGR=compound annual growth rate. File prepared by System Planning Branch, Planning Portal.

4.1.2.3   Population density and remoteness of the SWHHS catchment

Roma Region (0.10), Balonne (0.14) and Charleville (0.10) Planning Regions have relatively low population densities when compared to the state average (2.98). Far South West Planning Region has a much lower population density of 0.01 persons per square kilometre. Roma Planning Region is the smallest geographical area and has a high population density of 89.16 persons per square kilometre.

Using the Australian Statistical Geography Standard (ASGS) Remoteness Structure (Australian Bureau of Statistics, 2016), Roma Planning Region is classed as an 'outer regional' area, Far South West and Charleville Planning Regions are classed as 'Very Remote', and Roma Region and Balonne Planning Region are classed as 'Remote'. Using the Modified Monash Model (MMM) (Commonwealth of Australia, 2021), MM 4 is a 'medium rural town', and MM 7 is 'very remote communities', with these scores used to determine eligibility for health workforce programs. All Planning Regions within the SWHHS are classed as MM 7, except Roma Planning Region which is classed as an MM 4.

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[30] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population Projections

4.1.2.4 Population by age

In the SWHHS, the age distribution of residents generally aligned with the State age distribution. As indicated in **Figure 4.1.3** and **Table 4.1.5**, the 15 to 24 and 25-to-44-year age groups are slightly below the average age distribution across Queensland and there is a greater proportion of the population below the age of 14.

Figure 4.3 Estimated resident population by age group (2020)[31]
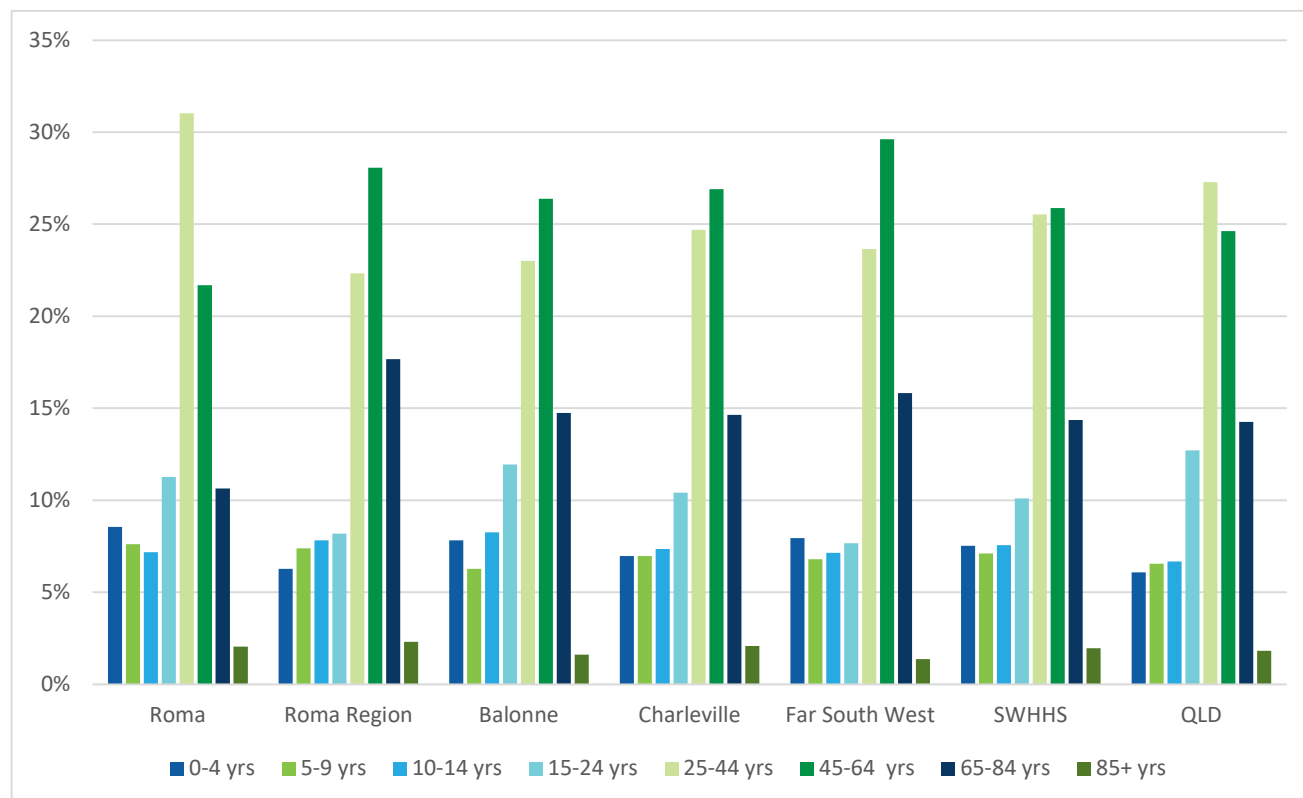
[31] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

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Table 4.1.5 Population by age group and SA2, SWHHS, 2020 [32]

SA2/ Geographical area	0-4 yrs		5-9 yrs		10-14 yrs		15-24 yrs		25-44 yrs		45-64 yrs		65-84 yrs		85+ yrs		Total
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Roma	593	9	528	8	497	7	781	11	2,151	31	1,503	22	737	11	142	2	6,932
Roma Region	360	6	423	7	448	8	469	8	1,280	22	1,609	28	1,013	18	132	2	5,734
Balonne	342	8	274	6	361	8	522	12	1,006	23	1,154	26	645	15	70	2	4,374
Charleville	294	7	294	7	310	7	439	10	1,042	25	1,135	27	618	15	88	2	4,220
Far South West	210	8	180	7	189	7	203	8	626	24	784	30	419	16	36	1	2,647
SWHHS	1,799	8	1,699	7	1,805	8	2,414	10	6,105	26	6,185	26	3,432	14	468	2	23,907
QLD	314,602	6	339,247	7	345,205	7	657,838	13	1,412,436	27	1,274,977	25	737,615	14	94,266	2	5,176,186

Figure 4.1.4 Proportion of population distribution (ERP) per age group, SWHHS, 2020 [33]
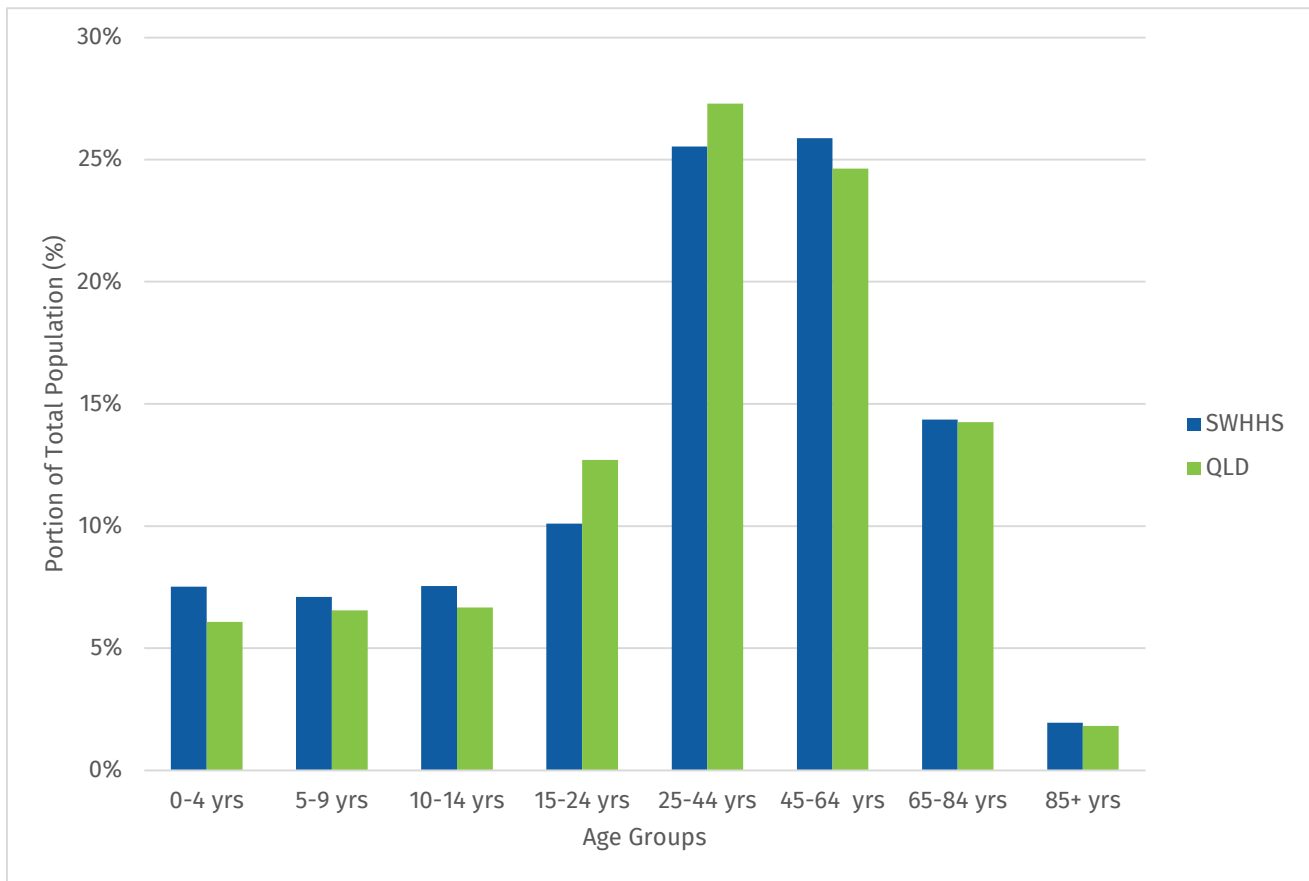
4.1.2.5   First Nations Peoples

Figure 4.1.5, **Figure 4.1.6**, **Figure 4.1.7,** and **Table 4.1.6** illustrate that in 2020, the estimated proportion of the population in the SWHHS who identify as First Nations Peoples (13.05 per cent) is more than double the Queensland state average (4.67 per cent). The very remote Planning Regions of Balonne and Far South West had the largest proportion of First Nations Peoples aged zero (0) to 49 years 34.25 per cent and 21.79 per cent respectively. Roma and Roma Region have smaller proportions of the 15–49-year age cohort than the Planning Regions of Balonne, Charleville, and Far South West. The Far South West Planning Region has the highest percentage of First Nations Peoples within their total Planning Region population, with the largest age bracket being between zero (0) to four (4) years of age.

[33] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

Figure 4.1.5 Proportion of First Nations residents by age group and SA2, 2020[34]

Legend: ■ 0-14 years ■ 15-49 years ■ 50+ years
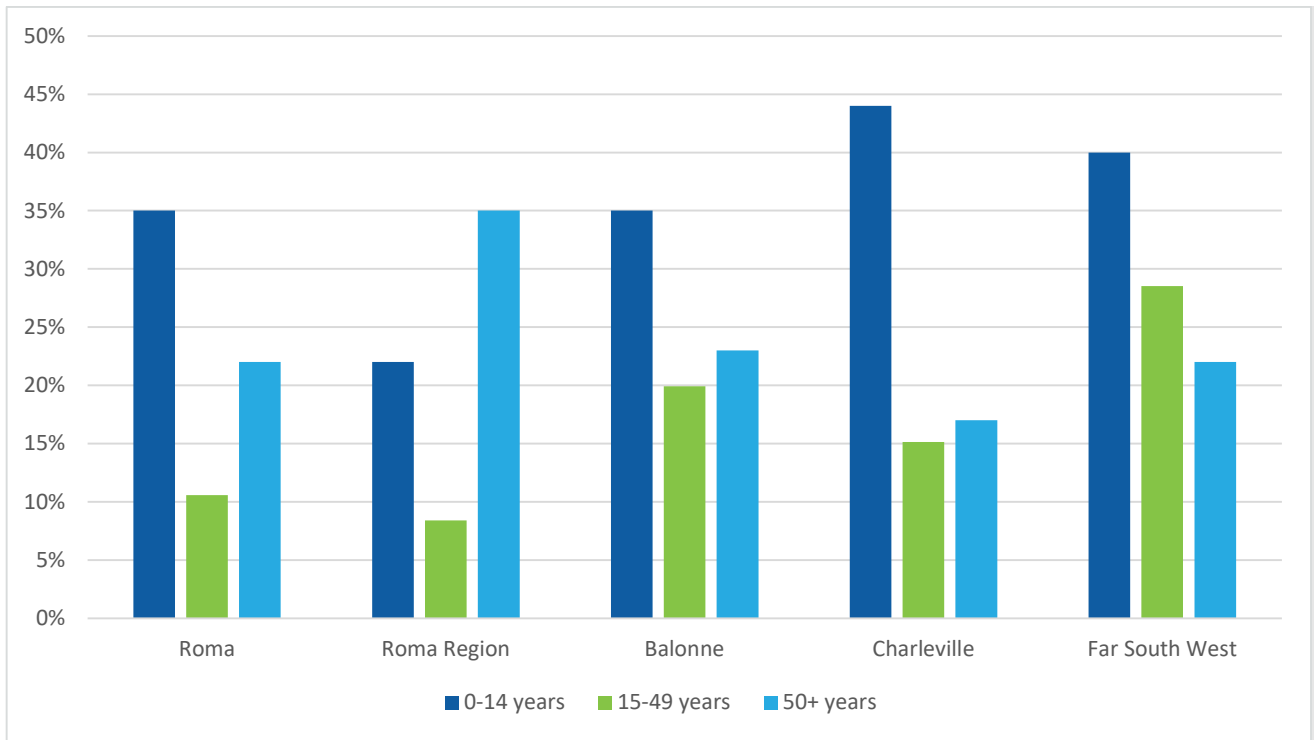
Figure A1.6 First Nations Peoples age distribution per SA2, aged 0-19 years, 2020[35]
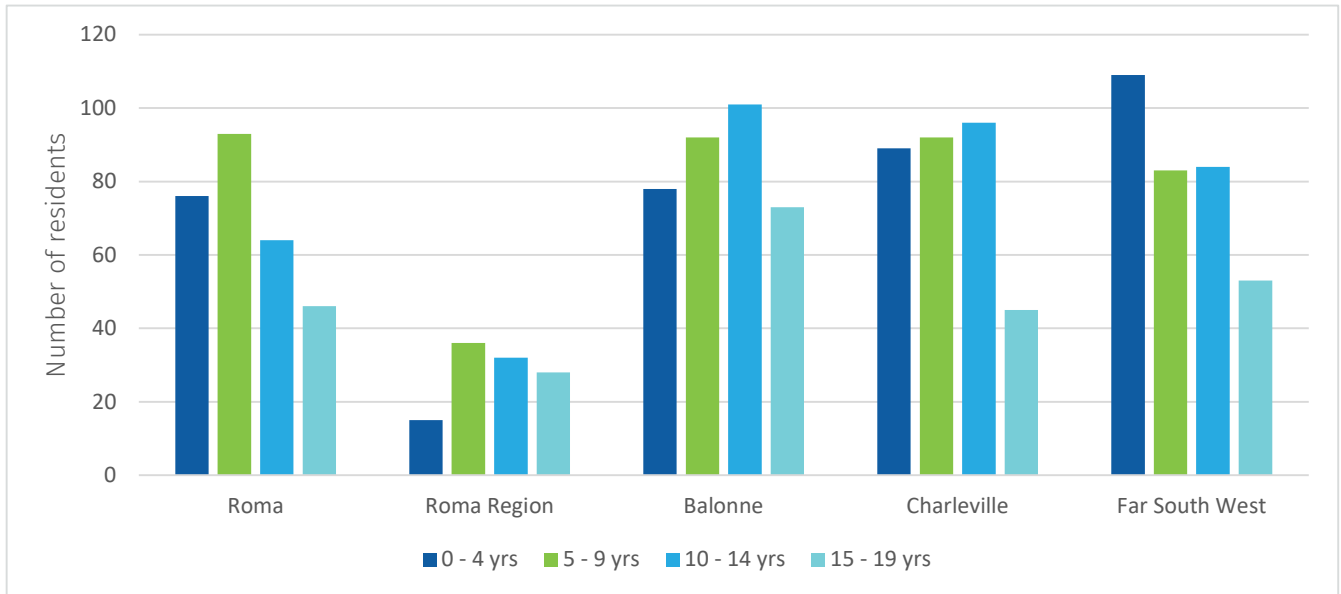
Legend: ■ 0 - 4 yrs ■ 5 - 9 yrs ■ 10 - 14 yrs ■ 15 - 19 yrs

[34] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

[35] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

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Table 4.1.6 First Nations Peoples population, SWHHS, 2020[36]

SA2/Geographical region	Indigenous Area (IARE)	Total First Nations Peoples (N)	Percentage of total resident population (ERP 2020)	Percentage of First Nations Peoples in SWHHS	Percentage of total SWHHS population
Roma	Balonne	661	10%	21%	3%
Roma Region	Maranoa – Roma - Mitchell	374	7%	12%	2%
Balonne	Paroo	772	18%	25%	3%
Charleville	Murweh	631	15%	20%	3%
Far South West	Bulloo – Quilpie-Barcoo	683	26%	22%	3%
SWHHS	-	3,121	13%	-	-
Queensland	-	241,749	5%	-	-

4.1.2.6   Country of birth and languages

In 2016, 84 per cent of the SWHHS residents had been born in Australia as illustrated in **Table 4.1.7**. This is 13 per cent higher than the state average (71 per cent). As illustrated in **Table 4.1.7**, other than English, the top three languages spoken by residents in the SWHHS are: Vietnamese, Southeast Asian Austronesian languages (Tagalog and Filipino), and Indo Aryan languages Punjabi. Australian Indigenous Languages were spoken at home by a total of 21 residents. 0.5 per cent of residents in the SWHHS reported that they speak another language and speaks English not well or at all.

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[36] Queensland Government Statistician's Office (QGSO) (2020), Estimated Resident Population

Table 4.1.7 Country of birth, SWHHS residents, 2016[37]

SA2/Geographic region	Born in Australia	Born Overseas in Non-English-Speaking Background	Born Overseas in English Speaking Background	Born Overseas Total
Balonne	85%	2%	3%	6%
Roma	78%	6%	4%	10%
Roma Region	87%	2%	2%	4%
Charleville	85%	4%	2%	7%
Far South West	87%	2%	3%	5%
SWHHS	84%	3%	3%	7%
Queensland	71%	11%	11%	22%

Table 4.1.8 Percentage of residents and language, SWHHS, 2016[38]

SA2/Geographic region	Speaks English Only	Speaks other language and speaks English well or very well	Speaks other language and speaks English not well or at all	Speaks other language and speaks English total
Balonne	89.1%	3.0%	0.4%	3.4%
Roma	83.0%	5.4%	0.6%	6.0%
Roma Region	90.7%	1.4%	0.1%	1.6%
Charleville	88.9%	2.9%	1.5%	4.5%
Far South West	92.1%	1.6%	0.0%	1.6%
SWHHS	88.1%	3.1%	0.5%	3.7%

Table 4.1.9 Estimated top three (3) languages spoken by SWHHS residents born overseas, 2016[39]

SA2	Top 3 English speaking countries of birth			Top 3 Non-English-Speaking countries of birth		
	Rank	Country of birth	Proportion of born overseas (%)	Rank	Country of birth	Proportion of born overseas (%)
Roma	1	New Zealand	16%	1	Philippines	25%
	2	England	10%	2	India	11%
	3	South Africa	4%	3	China	3%
Roma Region	1	New Zealand	19%	1	India	6%
	2	England	19%	2	Philippines	5%
	3	South Africa	6%	3	Germany	2%
Balonne	1	New Zealand	18%	1	Philippines	5%
	2	England	14%	2	Germany	5%
	3	South Africa	14%	3	India	5%
Charleville	1	New Zealand	15%	1	Vietnam	35%
	2	England	10%	2	Philippines	7%
	3	South Africa	2%	3	Zimbabwe	2%
Far South West	1	England	26%	1	India	2%
	2	New Zealand	19%	2	Germany	2%
	3	Ireland	6%	3	Netherlands	2%

4.1.2.7 Annual births and fertility rates

Table 4.1.10 illustrates that in 2019, Roma Planning Region residents had the highest birth rate in the South West HHS with 39 per cent of the total births, approximately double the rate of births in other Planning Regions. There are a range of factors which impact on fertility rates including the demography, health, education, and religious beliefs in a community. The analysis shows that the fertility rate for SWHHS catchment is increasing. This data pertains to SWHHS catchment residents. The registered births may be occurring in SWHHS facilities or outside the SWHHS catchment (e.g., in Toowoomba, Ipswich or Brisbane). The growing fertility rate indicates that there is an ongoing need for antenatal and postnatal care. Though it may seem that these birthing rates are caused by pregnant mothers travelling to Roma

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[39] Australian Bureau of Statistics: Category G13 Language Spoken at home (a) by Proficiency in Spoken English Language by Sex. File prepared by System Planning Branch, Planning Portal.

to give birth, as there are only few beds in the maternity section of the Roma hospital, so this is unlikely to be a significant factor.

Table 4.1.10 indicates that the portion of First Nations Peoples births (18 per cent) in the SWHHS was more than double the state average (7.4 per cent). This can be largely attributed to the much larger representation of First Nations peoples in the area.

Table 4.1.10 SWHHS births and fertility rates, 2019[40]

SA2/Geographical region	Number of registered births	Proportion of HHS births (%)	Number of First Nations Peoples births (#)	Proportion of First Nations Peoples births (%)	Total fertility rate*
Roma	136	39%	22	16%	2.2
Roma Region	64	18%	n.p.	n.p.	2.5
Balonne	59	17%	11	19%	3.1
Charleville	58	16%	n.p.	n.p.	2.1
Far South West	36	10%	13	36%	2.5
SWHHS	353	n.p.	65	18%	2.5
Queensland	60,443	n.p.	4.502	7.4%	1.8

Notes: *Total fertility rate is calculated as the sum of age-specific fertility rates per woman. It represents the number of children a woman would bear during her lifetime if she experienced current age-specific fertility rates at each age of her reproductive life. Age-specific fertility rates are the number of live births during the calendar year, according to the age band of the mother, per 1,000 of the female resident population of the same age on 30 June.

Data source: Queensland Perinatal Data Collection (QPDC), Statistical Services Branch, Queensland Health. Prepared by: Statistical Reporting and Coordination, Statistical Services Branch, Queensland Health. Date: 4 March 2020. QPDC includes all live births and stillbirths of at least 20 weeks' gestation and/or at least 400 grams in weight. File prepared by System Planning Branch, Planning Portal.

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[40] Queensland Perinatal Data Collection (QPDC), Statistical Services Branch, Queensland Health. Prepared by: Statistical Reporting and Coordination, Statistical Services Branch, Queensland Health. Date: 4 March 2020. QPDC includes all live births and stillbirths of at least 20 weeks' gestation and/or at least 400 grams in weight. File prepared by System Planning Branch, Planning Portal

4.1.2.8 Other vulnerable groups

In addition to healthcare outcomes, there are also other important vulnerable population groups who require appropriate support, resources, and expertise, including people:

- with a disability (either from birth or subsequently acquired);

- who are at risk of or experiencing family, domestic and sexual violence, abuse, or neglect;

- have, or live with a person with, a mental illness or drug or alcohol dependency;

- have unresolved trauma; and

- are primary carers.

Given the SWHHS's extensive network of primary and community care providers and partners, SWHHS is committed to ensuring all residents are provided with the appropriate support they require to enable supported independence and quality of life within the community.

4.2 Appendix 2: Social determinants of health

Figure 4.2.1 The Dahlgren-Whitehead model, 1991[41]
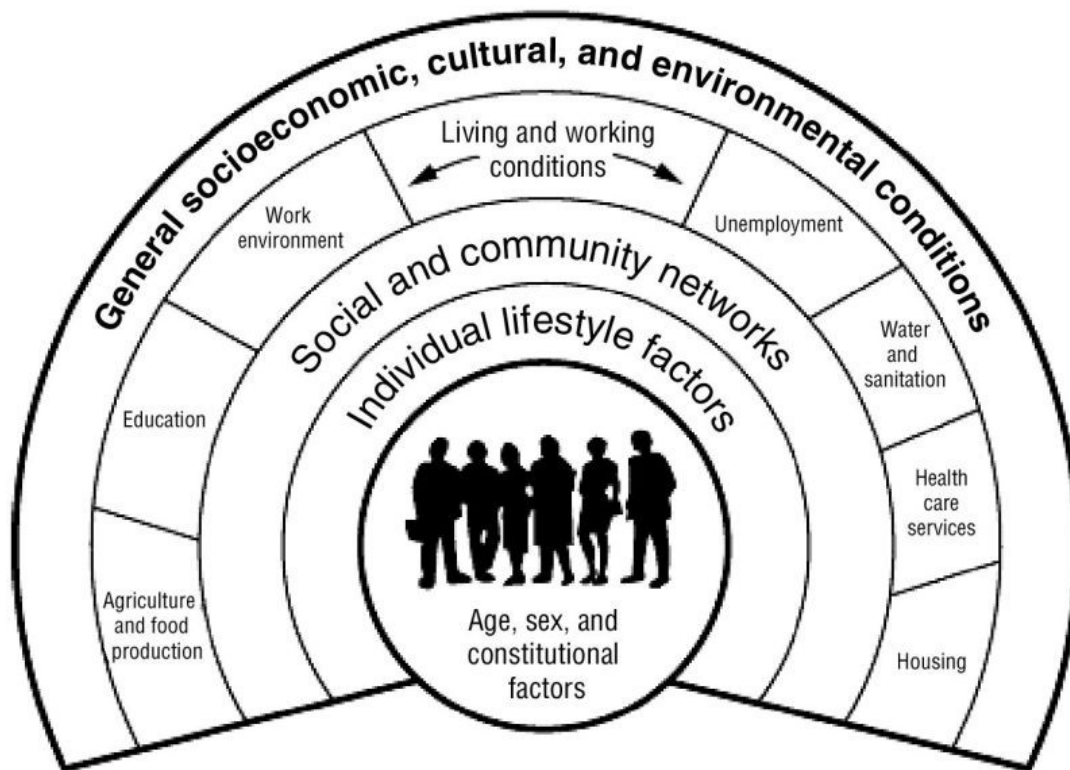
"The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.

The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

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[41] Institute of Medicine (US) Committee on Assuring the Health of the Public in the 21st Century, 2002

— Income and social protection
— Education
— Unemployment and job insecurity
— Working life conditions
— Food insecurity
— Housing, basic amenities and the environment
— Early childhood development
— Social inclusion and non-discrimination
— Structural conflict
— Access to affordable health services of decent quality.

Research shows that the social determinants can be more important than healthcare or lifestyle choices in influencing health. For example, numerous studies suggest that SDH account for between 30-55 per cent of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector. Addressing SDH appropriately is fundamental for improving health and reducing longstanding inequities in health, which requires action by all sectors and civil society.

World Health Organization, 2022

4.2.1   Economic

It has been observed that rural and remote Australians encounter vastly differently challenges than those in urban areas. Data from the SWHHS indicates that there are higher rates of poverty and lower rates of education compared to the Queensland averages. This section analyses the gap between the SWHHS economic outcomes compared to the Queensland benchmark.

4.2.1.1   SEIFA score

Socio-economic Indexes for Areas (SEIFA) indicate the average socio-economic characteristics of the people, families, and households living in an area. The ABS broadly defines relative socio-economic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in society[42] (Australian Bureau of Statistics, 2018).

In 2016, 11.6 per cent of the SWHHS population were categorised as being most disadvantaged (Deciles 1-2) compared to other regions in Australia. This indicates that this area has a relatively greater disadvantage in general, and this could be due to many households with low income, many people with no qualifications, or many people in low skill occupations. Within the SWHHS, all Planning Regions

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[42] Australian Bureau of Statistics. (2018, March 27). Census of population and housing: Socio-economic indexes for areas (SEIFA), Australia, 2016.

except for Roma had a minimum of 50 per cent of their population classified as SEIFA deciles 1-4.

Approximately 81 per cent of the population in Charleville were classified within deciles 1-4. Far South West Planning Region had the highest percentage (45 per cent) of their population categorised with higher relative levels of disadvantage (deciles 1-2) within the SWHHS, followed by Charleville (34 per cent), Balonne (26 per cent), and Roma Region (25 per cent). Charleville (47 per cent), Roma (40 per cent), and Balonne (35 per cent). Planning Regions had a higher percentage than other Planning Regions in the region of population classified as having relatively low-moderate levels of socio-economic disadvantage (deciles 3-4).

Residents of the SWHHS are generally found to be relatively disadvantaged in socio-economic terms in relation to the broader Queensland population.

Figure 4.2.2 Percentage of population in SEIFA deciles by HHS, 2016[43]
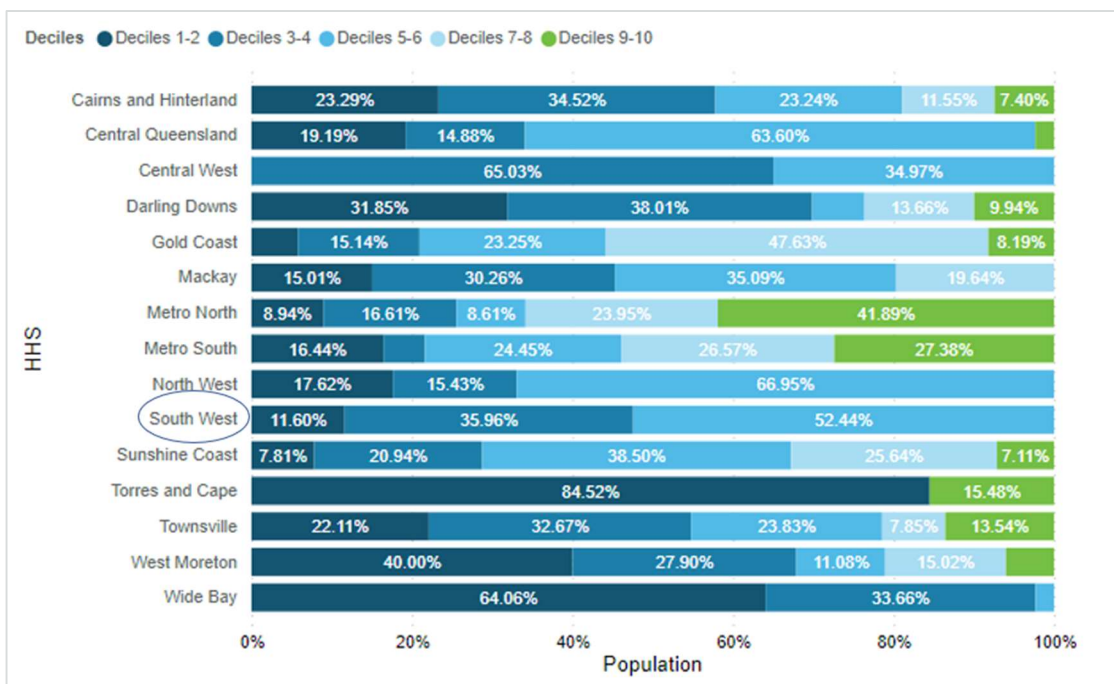
[43] Australian Statistical Geography Standard (ASGS 2016) and Australian Bureau of Statistics, 20330.55001 Socio-Economic Indexes for Australian (SEIFA) 2016. Prepared by System Planning Branch, Planning Portal.

Figure 4.2.3 Percentage of population in SEIFA deciles by SA2, SWHHS, 2016[44]
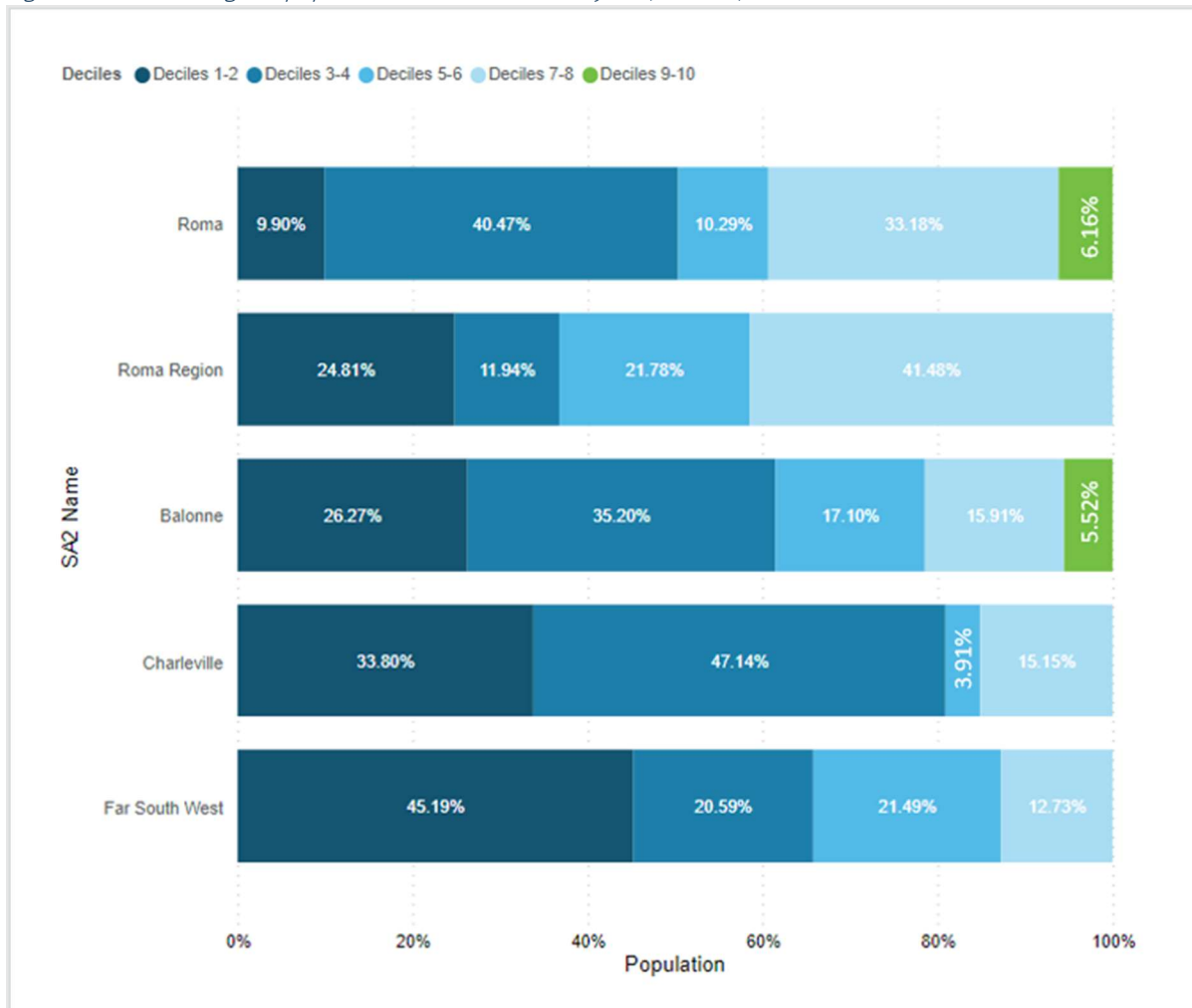
4.2.1.1.1   Index of Relative Socio-Economic Disadvantage (IRSD)

The Index of Relative Socio-Economic Disadvantage (IRSD) summarises a range of information about the economic and social conditions of people and households in an area and includes only measures of relative disadvantage.

When compared with other HHSs classified as remote, all the Planning Regions in the SWHHS had an IRSD score greater than or equal to 925, indicating that South West generally has a lower level of socio-economic disadvantage, in comparison to other remote areas in Queensland.

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[44] Australian Statistical Geography Standard (ASGS 2016) and Australian Bureau of Statistics, 20330.55001 Socio-Economic Indexes for Australian (SEIFA) 2016. Prepared by System Planning Branch, Planning Portal.

Table 4.2.1 IRSD scores across Queensland HHSs classified as 'Remote', by SA2, 2016[45]

HHS Name	SA2 Name	IRSD Scores
Torres and Cape	Weipa	1064
South West	Roma	1001
Central West	Longreach	999
North West	Mount Isa	991
South West	Roma Region	989
Central West	Barcaldine - Blackall	979
South West	Balonne	973
North West	Mount Isa Region	949
North West	Far Central West	946
South West	Charleville	943
South West	Far South West	925
Torres and Cape	Torres	901
Torres and Cape	Cape York	783
North West	Carpentaria	717
Torres and Cape	Northern Peninsula	694
Torres and Cape	Torres Strait Islands	672
Torres and Cape	Kowanyama - Pormpuraaw	612
Torres and Cape	Aurukun	504

4.2.1.2   Total family income

Median total family income

As shown in **Table 4.2.2**, Roma was the only Planning Region in 2021 with a total family median income greater than the State median. Far South West Planning Region had the lowest median total family income in the SWHHS, $588 per week less than the Queensland median. That is, the median family income in the Far South West Planning Region was 71 per cent of the Queensland median.

Median total personal income

As shown in **Table 4.2.2**, the median total personal income for Roma Planning Region in 2021 was $170 per week greater than the Queensland median. Far South West Planning Region had the lowest median total personal income in the SWHHS, $107 per week less than the Queensland median. The median total personal income for the other Planning Regions (Roma Region, Balonne, and Charleville) lay within $10 per week above or below the Queensland median.

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[45] Australian Statistical Geography Standard (ASGS 2016) and Australian Bureau of Statistics, 20330.55001 Socio-Economic Indexes for Australian (SEIFA) 2016. Prepared by System Planning Branch, Planning Portal.

Table 4.2.2 Median incomes, family and personal, by SA2, 2021[46]

SA2/ Planning Region	Median total family income ($/wk.)	Median total personal income ($/wk.)
Roma	$2,171.00	$957.00
Roma Region	$1,872.00	$770.00
Balonne	$1,704.00	$780.00
Charleville	$1,766.00	$798.00
Far South West	$1,436.00	$680.00
Queensland	$2,024.00	$787.00

4.2.1.3   Financial hardship

As shown in **Figure 4.2.5**, the Roma Planning Region in 2014 had the highest estimated number of people aged 18 years and over receiving government support as their main source of income for:

- 13 months or more within the last 24 months; and

- the last two (2) years.

Roma also had the highest estimated number of people aged 18 years and over whose household could raise $2,000 within a week. Balonne Planning Region had the lowest number of people aged 18 years and over whose household could raise $2,000 within a week. However, the data used on financial hardship is rather dated and is not conclusive of the current financial situations in the Planning Regions.

Mortgage stress

As illustrated in **Table 4.2.3**, in 2016, the SWHHS had an overall rate of mortgage stress of 7.82 per cent, which is less than the state rate of 8.47 per cent. Balonne Planning Region had the highest rate in the SWHHS of mortgage stress with 9.62 per cent. The Planning Regions classified as 'very remote' (Charleville and Far South West) had the lowest level of mortgage stress (both 6.72 per cent).

As illustrated in **Table 4.2.4,** Charleville and Far South West Planning Regions had the highest rates (7.82 per cent) of rented social housing within the SWHHS approximately double that of the State rate (3.71 per cent). These Planning Regions were classified as having the highest level of disadvantage within the SWHHS according to the SEIFA score. Balonne had the lowest rates of rented social housing (3.34 per cent) for the SWHHS. The low rate of mortgage stress in Charleville and Far South West Planning Regions may indicate that there are less owner-occupied dwellings and more people who rent or live-in social housing. Conversely, the higher rates of mortgage stress in Balonne Planning Region may indicate that there are more owner-occupied dwellings and less rental and social housing dwellings.

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[46] Australian Bureau of Statistics: (2021) 'Median Weekly Incomes (a)', 2021 Census All persons Quickstats

Figure 4.2.5 Financial hardship, by SA3, 2014[47]

- ■ Estimated number of people aged 18 years and over who had government support as their main source of income in the last 2 years
- ■ Estimated number of people aged 18 years and over who had government support as their main source of income, for 13 months or more, within the past 24 months
- ■ Estimated number of people aged 18 years and over whose household could raise $2,000 within a week

Table 4.2.3 Mortgage stress, 2016[48]

SA2/Geographical region	Low-income households in the bottom 40% of income distribution, with mortgage stress (#)	Mortgaged private dwellings (#)	Estimated rate of mortgage stress (%)
Roma	46.67	596.30	7.83%
Roma Region	39.02	498.51	7.83%
Balonne	36.84	382.84	9.62%
Charleville	26.45	393.46	6.72%
Far South West	16.38	243.68	6.72%
SWHHS	165.36	2114.80	7.82%
Queensland Total	47,552.00	561,722.00	8.47%

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[47] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. File prepared by System Planning Branch, Planning Portal.

[48] Based on Public Health Information Development Init (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal

Table 4.2.4 Social housing (rented dwellings), 2020[49]

SA2/Geographical region	Number of social housing – rented dwellings (#)	Total number of dwellings	Estimated rate (%)
Roma	127	2,518	5.04%
Roma Region	69	2,063	3.34%
Balonne	139	1,588	8.75%
Charleville	138	1,528	9.03%
Far South West	114	1,092	10.44%
SWHHS	587	8,789	6.68%
Queensland Total	61,474.00	1,656,833.00	3.71%

Table 4.2.5 Rental stress by SA2, SWHHS, 2016[50]

SA2 Geographical region	Low-income households (households in bottom 40% of income distribution) with rental stress	Rented private dwellings	Rate rental stress (%)
Balonne	95.15	422.85	22.50
Roma	126.88	785.14	16.16
Roma Region	106.07	656.39	16.16
Charleville	66.60	493.60	13.49
Far South West	41.25	305.70	13.49

4.2.1.4   Unemployment rates

At five per cent in March 2021, the SWHHS unemployment rate was 2.27 per cent lower than the State rate, as illustrated in **Table 4.2.6**, however there are important variations within the region:

- Far South West Planning Region had the highest unemployment rate within the SWHHS and was the only Planning Region with an unemployment rate higher than the state rate (8.44 per cent and 7.27 per cent respectively).

- Roma Region Planning Region had the lowest unemployment rate (2.46 per cent).

- The unemployment rate was greater in the more western Planning Regions. The Far South West Planning Region rate was 1.17 per cent higher, that the state rate. This aligns with increased levels of disadvantage (based on SEIFA score) in this area.

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[49] Department of Housing and Public Works | Housing Services (2021), Queensland Housing Profiles: Custom Region (SWHHS)

[50] Based on Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal.

Table 4.2.6 Unemployment, persons aged over 15 years, by SA2, 2021[51]

SA2/Geographical area	Number of persons unemployed	Number of persons – Labour force	Rate of unemployment
Roma	197.00	4,117.00	4.79%
Roma Region	85.00	3,456.00	2.46%
Balonne	119.00	2,503.00	4.75%
Charleville	171.00	2,435.00	7.02%
Far South West	130.00	1,540.00	8.44%
SWHHS	702.00	14,051.00	5.00%
Queensland Total	197,394.00	2,713,807.00	7.27%

4.2.2   Education

4.2.2.1   Highest level of schooling

Education and health are intrinsically linked, with the level of educational attainment strongly associated with life expectancy, morbidity, and health behaviours (The Lancet, 2020). Education can also increase the capacity for better decision-making regarding one's health and provide scope for increasing social and personal resources that are vital for physical and mental health (Shankar, et al., 2013).

Table 4.2.7 illustrates that in 2016 in the SWHHS, Rates of school completion at Year 8 or below was higher (9 per cent) than the Queensland average (5 per cent). Roma Planning Region had the highest rate of school completion at Years 11 or 12 for both First Nations Peoples (41 per cent) and other Australians (58 per cent). Roma Region Planning Region had the lowest rates of school completion at Years 11 or 12 for First Nations Peoples (25 per cent) and other Australians (46 per cent).

First Nations Peoples

Table 4.2.8 illustrates that in 2016 in the SWHHS, First Nations Peoples were less likely to have completed Year 11 or 12 (36 per cent) than other Australians (51 per cent). First Nations Peoples were also more likely to not attend school than other First Nations Peoples state-wide, with rates being 2 and 1 per cent respectively. First Nations Peoples were completing school at year 8 or below (16 per cent) at higher rates than other Australians (9 per cent) and other First Nations Peoples state-wide (8 per cent). First Nations Peoples were more likely to complete school at year 9 or 10 (39 per cent) than year 11 or 12 (36 per cent).

[51] Small Area Labour Markets (SALM, March Quarter 2021. Labour Market Information Portal (lmip.gov.au). Prepared by System Planning Branch, Planning Portal.

Table 4.2.7 Highest schooling level completed by SA2, non-First Nations People, SWHHS, 2016[52]

SA2/Geographical region	Did not attend school (#)	Did not attend school (%)	Year 8 or below (#)	Year 8 or below (%)	Year 9 or10 (#)	Year 9 or10 (%)	Year 11 or 12 (#)	Year 11 or 12 (%)	Not stated (#)	Not stated (%)	Total population (#)
Roma	28	1	261	6	1,319	31	2,438	58	185	4	4,228
Roma Region	23	1	410	11	1,515	39	1,772	46	140	4	3,861
Balonne	17	1	225	9	871	34	1,386	53	94	4	2,592
Charleville	19	1	289	10	987	36	1,346	49	120	4	2,762
Far South West	14	1	149	9	639	38	804	48	65	4	1,672
SWHHS Total	101	1	1334	9	5,331	35	7,746	51	604	4	15,115

Note: The percentage for each SA2 may not add to 100% due to rounding and/or perturbation.

[52] Queensland Government. (2022). Highest schooling level including First Nations Peoples 2016. Retrieved from Planning portal

Table 4.2.8 Highest schooling level completed by SA2, First Nations Peoples, SWHHS 2016 [53]

SA2/Geographical region	Did not attend school (#)	Did not attend school (%)	Year 8 or below (#)	Year 8 or below (%)	Year 9 or 10 (#)	Year 9 or 10 (%)	Year 11 or 12 (#)	Year 11 or 12 (%)	Not stated (#)	Not stated (%)	Total population (#)
Roma	<10	1	41	12	144	42	140	41	21	6	342
Roma Region	<10	2	34	16	107	49	54	25	<10	4	217
Balonne	<5	1	73	17	165	38	168	38	21	5	439
Charleville	<10	2	56	18	105	34	108	35	26	9	306
Far South West	<10	2	60	16	141	37	141	37	34	9	382
SWHHS Total	25	2	111	16	662	39	611	36	111	7	1,686
Queensland Total	944	1	8,779	8	38,803	35	53,695	49	8,327	8	110,672

Note: The per centage for each SA2 may not add to 100% due to rounding and/or perturbation.

[53] Queensland Government. (2022). Highest schooling level including First Nations Peoples 2016. Retrieved from Planning portal

4.2.2.2 Children developmentally vulnerable

The Australian Early Development Census (AEDC) is an Australian Government initiative to measure five areas, or domains, of early childhood development that form the foundations for later good health, education, and social outcomes (Commonwealth of Australia, 2019). The five developmental domains include:

- Physical health and wellbeing

- Social competence

- Emotional maturity

- Language and cognitive skills (school-based)

- Communication skills and general knowledge

Children considered "developmentally vulnerable" are those who score in the lowest 10 per cent of the national population, based on a teacher-completed instrument (Commonwealth of Australia, 2019).

Table 4.2.9 illustrates that:

- In 2018, children identified as developmentally vulnerable in one or more domains residing within the SWHHS (33 per cent) was estimated to be greater than the state rate (26 per cent).

- In 2018, children identified as developmentally vulnerable in two or more domains residing within the SWHHS (18 per cent) was estimated to be greater than the state rate (14 per cent).

- Far South West and Charleville SA2s had the highest estimated rate of childhood developmental vulnerability within the SWHHS. This SA2 is classified as very remote.

Table 4.2.9 Children's development, 2021, SWHHS[54]

SA2/Geographical region	Children identified as developmentally vulnerable					
	One or more domains			Two or more domains		
	Number of children Identified (#)	Total children assessed (#)	Proportion of children identified among children assessed (%)	Number of children Identified (#)	Total children assessed (#)	Proportion of children identified among children assessed (%)
Roma	22	100	22.0	12	100	12.0
Roma Region	16	87	18.4	7	87	8.0
Balonne	16	58	27.6	8	58	13.8
Charleville	5	57	43.9	17	57	29.8
Far South West	18	37	48.6	7	37	18.9
SWHHS Total	77	339	22.7	51	339	15.0
Queensland Total	15,143	61,279	24.7	8,088	61,385	13.2

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[54] Queensland Government. (2022). Public Table by Statistical Area Level 2 (SA2) 2009-2021

4.2.3   Housing

4.2.3.1 Homelessness

Homeless persons

Table 4.2.10 illustrates that in 2016 in the SWHHS, the rate of homeless persons was similar to the state rate, 45.7 and 45.6 per 10,000 respectively. Roma Region SA2 has the highest rate of homelessness at 72.3 per 10,000.

Table 4.2.10 Homeless persons by SA2, SWHHS, 2016[55]

SA2/Geographical region	Homeless persons (number)	Rate of homeless persons (per 10,000)	Total persons
Roma	17	23.9	7,105
Balonne	18	40.1	4,488
Roma Region	49	72.3	6,781
Charleville	18	39.2	4,596
Far South West	18	55.2	3,262
SWHHS	120	45.7	26,232
Queensland	21,715	45.6	4,760,598

Homelessness Services

The number of client specialist homeless services across the SWHHS decreased between 2014-15 and 2018-19.

Table 4.2.11 Homelessness services by SA2, SWHHS, 2016[56]

SA2/Geographical region	2014-15 (#)	2015-16 (#)	2016-17 (#)	2017-18 (#)	2018-19 (#)
Balonne	20	13	9	15	12
Roma	112	39	35	50	75
Roma Region	13	18	9	4	6
Charleville	41	48	39	23	21
Far South West	4	3	1	10	13
SWHHS	190	121	93	102	127
Queensland	38,443	37,065	36,776	37,648	39,605

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[55] Queensland Government. (2022). Homeless persons 2016. Retrieved from Planning portal

[56] Queensland Government. (2016). Homelessness services 2016. Retrieved from Planning portal

Note: Includes persons that experienced homelessness or were at risk of homelessness and were registered clients with the Specialist Homelessness Services (SHS) provider. These figures reflect people who approach SHS agencies for support and do not measure the population level unmet demand for support.

4.2.3.2   Access to housing

As illustrated in **Table 4.2.12** in 2016, Maranoa LGA had the highest total number of social housing applications (48 applications – on behalf of 93 people), of which 20 applications on behalf of 59 people were submitted by First Nations Peoples (56 per cent). Across all LGAs in the SWHHS, 68 per cent of applications were for First Nations Peoples compared to 30 per cent for applications for First Nations Peoples state-wide. Paroo had the highest rate of First Nations Peoples applying for social housing (93 per cent). 112 First Nations Peoples were on 56 housing applications in the SWHHS. 34 other Australians were on 25 housing applications in the SWHHS during the same period.

Table 4.2.12 Applications to social housing register, LGA, 2016[57]

LGA	Number of applications			
	First Nations	Non-First Nations	Total	First Nations rate
Balonne	8	< 5	10	80%
Maranoa	27	20	48	56%
Murweh	7	2	9	78%
Paroo	14	<5	15	93%
South West	56	25	82	68%
Queensland	7,664	16,116	25,851	30%

4.2.3.3   Crowded dwellings

Australian national and state governments review crowding as a factor in determining social policy about housing. The Australian Bureau of Statistics (ABS) follows principles established by the Canadian National Occupancy Standard (CNOS), which is based on density measures of the number of bedrooms in a dwelling and household demographic factors that include the number of usual residents, their relationships, age, and sex.

According to this standard, a "severely" crowded dwelling is assessed as needing four or more additional bedrooms to accommodate all persons currently living in the household. The ABS classifies persons living in "severely" crowded dwellings as one of their six "Homeless Operational Groups" as

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[57] Queensland Government. (2022). Homeless persons 2016. Retrieved from Planning portal

these persons have been determined to have "lack of control of and access to space for social relations...and are considered not to have accommodation alternatives when remaining in such extreme living arrangements" (Australian Bureau of Statistics, 2012).

As illustrated in **Table 4.2.13**, in 2016 in the SWHHS:

- First Nations Peoples were living in crowded dwellings at a rate of 13 per cent, which was 6 per cent lower than the state First Nations Peoples rate of 19 per cent.

- First Nations Peoples were more likely to live in crowded dwellings (13%) when compared with 5 per cent of total residents classified as living in crowded dwellings.

- Charleville and Far South West SA2s had the highest rate of persons (First Nations and Total persons) living in crowded dwellings (14 per cent and 7 per cent respectively). Both SA2s are classified as very remote.

- Roma and Roma Region SA2s had the lowest rate of persons (First Nations and Total persons) living in crowded dwellings (10 per cent and 4 per cent respectively). This is lower than the state rate (6 per cent).

- Severely crowded data has not been included in this report as data is limited.

Table 4.2.13 Crowded dwellings, SWHHS, 2016[58]

SA2/Geographical region	First Nations persons			Total persons		
	Number in crowded dwellings (#)	Total number in dwellings (#)	Crowded dwellings rate (%)	Number in crowded dwellings (#)	Total number in dwellings (#)	Crowded dwellings rate (%)
Roma	38.09	381.44	9.99%	195.28	5,660.70	3.45%
Roma Region	31.84	318.89	9.99%	163.26	4,732.40	3.45%
Balonne	41.36	332.67	12.43%	188.94	3,681.77	5.13%
Charleville	93.52	658.92	14.19%	248.45	3,837.30	6.47%
Far South West	57.92	408.08	14.19%	153.87	2,376.54	6.47%
SWHHS Total	262.74	2100.00	12.51%	949.80	20,288.71	4.68%
Queensland Total	33,110.00	176,379.00	18.77%	243,689.00	4,302,315.00	5.66%

Data Source: Communities, Housing and Digital Economy: social Housing Register, Published on the Open Data Portal (QLD). Prepared by System Planning Branch, Planning Portal.

Note: Severely crowded data has not been included in this report as data is limited.

[58] Queensland Government. (2022). Crowded dwellings 2016. Retrieved from Planning portal

4.2.3.4 Household composition

Household arrangements represent the context in which individuals with a family tie perform a daily exchange of resources of a diverse nature, such as economic, emotional, care, information, etc (World Health Organization, 2010). The ABS defines a family as two or more people, with one person aged 15 years or more, who are related by blood, marriage (registered or de-facto), adoption or fostering or in a stepfamily relationship and who are usually residents in the same household. A household is defined as one person or two or more related or unrelated persons who usually live in the same private dwelling.

Household composition may influence health outcomes in numerous ways, and the effects may differ by specific family tie, such as persons living with a partner versus alone, or families living with children; outcomes may be further mediated by other social determinants of health such as education level attained and economic status[59]

As illustrated in **Table 4.2.14**, in 2016 in the SWHHS, one-family households were the most common household composition, followed by lone households. Group households followed by multiple family households were the least common household compositions. This is reflected similarly across Queensland.

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[59] Gumà, J., Solé-Auró, A., & Arpino, B. (2019) Examining social determinants of health: The role of education, household arrangements and country groups by gender

Table 4.2.14 Household composition, by SA2, 2016[60]

SA2/Geographical region	First Nations Peoples				Other Australians			
	Lone person households (#)	One-family households (#)	Multiple family households (#)	Group households (#)	Lone person households (#)	One-family households (#)	Multiple family households (#)	Group households (#)
Roma	37	197	< 10	16	654	1,400	15	70
Roma Region	25	118	< 10	< 10	526	1,330	18	40
Balonne	53	217	10	< 10	365	856	10	28
Charleville	39	166	< 10	< 10	460	890	< 10	34
Far South West	74	170	< 10	10	313	487	0	21
SWHHS Total	228	868	30	39	2,318	4,963	50	193
Queensland Total	10,174	55,370	3,386	4,067	378,917	1,102,671	26,365	73,250

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[60] Queensland Government. (2022). Households' composition including First Nations Peoples 2016. Retrieved from Planning portal

4.2.4   Barriers to accessing healthcare

Table 4.2.15 illustrates that the rates of barriers to healthcare in the SA2s of Balonne, Roma and Roma Region are lower than the Queensland ASR. A strong limitation of this data is that it is from 2014 though and the data for Charleville and the Far South West is unavailable. As such, it is not highly reliable for estimating the 2022 barriers to accessing healthcare in the SWHHS.

Table 4.2.15 Persons who experienced a barrier to healthcare when needed it in the last 12 months, with main reason being cost of service, by SA2, 2014[61]

SA2*/Geographical area	Number of people	ASR per 100
Balonne	67	2.11
Roma	99	2.0
Roma Region	83	2.0
Queensland	95,971	2.7

Note: PHIDU did not publish data for Charleville or Far South West SA2s

As previously detailed, parallels may be drawn – but are not necessarily the determining factor - between income, relative disadvantage and health outcomes which may be further exacerbated by a range of social barriers.

The AIHW observe[62]:

> *"Having timely access to health-care professionals when a person needs it is crucial to preventing, treating, and managing health conditions. In 2016, 1 in 4 patients did not see a GP, and 1 in 8 patients did not see a specialist, even when they felt they needed to."*

Broad factors noted by AIHW include personal and health system influences, which can delay a patient receiving appropriate care, and ultimately lead to poorer health outcomes, such as:

- Individual understanding of the urgency of their need and / or attitude toward accessing healthcare (for instance based on perceived, or previous negative experiences and the 'sensitivity' of their condition making people unwilling to seek help)

- Personal work commitments and / or other life pressures

- Service(s) might not be available where the patient lives

- Cost of access might be too high and / or there might be a long waiting list

- Being unable to get a convenient appointment

  Age, gender, and long-term conditions may also be determining factors with the ABS noting, during the 2020-21 financial year[63], that females were more likely than males to access a range of

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[61] Queensland Government. (2022). Health behaviours - PHIDU. Retrieved from Planning portal

[62] AIHW 2020 Coordination of health care: experiences of barriers to accessing health services among patients aged 45 and over

[63] ABS (2021), Patient Experiences in Australia: Summary of Findings

healthcare services, as were people aged 85 or older compared to 15–24-year-old and people diagnosed with long term conditions, compared to those who have not.

4.2.5   Market share

At a statewide level, the balance of hospital market share across Queensland has progressively shifted over the past decade from the private to the public sector. As of 30 June 2020, and reflective of the SWHHS's position as the principal provider of services across the region, public hospital market share was 80.27 percent – having grown by approximately five per cent per annum from 2012-13, which is slightly below statewide rate of increase.

In relation to First Nations people, the SWHHS's total market share was 96.36 per cent as of 30 June 2020, which is commensurate with comparatively low uptake of private health insurance within First Nations communities. Considering remoteness, overall market share may be due in part to limited availably of private medical insurance services or providers compared to cities and other regional areas.

Although reforms have previously been introduced to allow private health insurers to offer travel and accommodation benefits in support of patients living in regional and rural areas who need to travel for treatment, the AIHW, informed by ABS data, has noted that people living in major cities and those within the higher deciles of social advantage, continue to be most likely to hold, and utilise, private health insurance. More broadly, the ABS observed people living in major cities were more likely than those living in outer regional, remote, or very remote areas to see a dental / medical professional or access an out of hours GP service.

Conversely, people living in outer regional, remote, or very remote areas were more likely to visit a hospital ED or be admitted than those living in major cities or delay getting - or go without - prescription medication which suggests scope for earlier intervention and support in community settings to better manage their conditions and avoid people presenting to ED or requiring a hospital stay.

4.2.6   Internet access

Access to a reliable internet connection is an increasingly vital component in providing healthcare in remote areas, supporting telehealth and other virtual models of care which provide convenience and equitable access to health professionals and services equivalent to those available for metropolitan residents and to also promote health literacy – supporting people and communities to be informed and empowered so that they participate actively in their own health.

For health providers, the ability to establish virtual clinics, access support during emergency situations, share and access data to inform supportive decision making and collaboration with patients and multidisciplinary colleagues online has obvious benefits in terms of convenience, efficiency and effectiveness and resultant health outcomes.

Table 4.2.16 illustrates that in 2016, 25 per cent of the SWHHS dwellings reported that internet is not accessed, which is 12 per cent higher than the state rate of 13 per cent. The more remote SA2s (Charleville and Far South West) reported having the highest rate of no internet access (26 and 32 per cent respectively).

Table 4.2.16 Access to internet, by SA2, 2016[64]

SA2/Geographical area	Internet NOT accessed from dwelling	Proportion of dwellings where internet is not accessed*
Roma	486	20%
Roma Region	512	25%
Balonne	382	25%
Charleville	417	26%
Far South West	348	32%
SWHHS	2,145	25%
Queensland Total	224,562	13%

Note: Proportion of dwellings where internet is not accessed data was calculated based only on the dwellings that participated in the 2016 Census

4.2.7 Motor vehicle availability

Table 4.2.17 illustrates that in 2016 in the SWHHS had an estimated 5.39 per cent of dwellings had no motor vehicle, compared to 5.86 per cent of Queensland residents as a total. Charleville and Far South West SA2s reported approximately 2 per cent higher rates of dwellings with no motor vehicle than other SA2s.

Table 4.2.17 Dwellings with no motor vehicle, SWHHS, 2021[65]

SA2/Geographical area	Private dwellings with no Motor vehicle	Proportion of private dwellings with no Motor vehicle (%)
Roma	154	6.1%
Roma Region	65	3.2%
Balonne	72	4.5%
Charleville	92	6.0%
Far South West	102	9.3%
SWHHS	485	5.52%
Queensland Total	106,309	5.7%

[64] Australian Bureau of Statistics 2016 Dwelling Internet Connection (a) by Dwelling structure. Retrieved from Planning portal

[65] Australian Bureau of Statistics. (2022). 'Number of registered motor vehicles', 2021. All persons Quickstats

4.2.8   Reported offences

Repeated exposure to crime and violence may be linked to an increase in negative health outcomes, and addressing exposure as a public health issue may help prevent and reduce harms to individual and community health and wellbeing (United States Department of Health and Human Services, n.d.)

Data on reported offences allows comparability across planning regions on the types of offenses reported, and the development of rates across population groups. Data is derived from Queensland Police Services (QPS), which is reported at LGA level[66]. Data available in the Planning Portal maps these geographical borders at LGA level to HHS and sub-HHS level, enabling expanded use for planning purposes, providing the HHS, LGA, offence (grouped and detailed), number of offences, and a population rate per 100,000 ERP. Where LGAs are split across multiple HHSs, the offence rates are held constant. Years provided include 2018, 2019 and 2020. QPS advise that comparing complete years is preferred over monthly data to account for seasonal variations.

As illustrated in **Table 4.2.18** and **Figure 4.2.6,** from 2018-2020 the SWHHS saw a 50% greater rate of criminal offences than the State average with 44,218 offences per 100,000 versus 30,573 per 100,000.

Table 4.2.18 Offence rate per 100,000 ERP, SWHHS and QLD, 2018-20[67]

Year	Year		
	2018	2019	2020
SWHHS	17,363.00	14,063.00	12,792.00
QLD	10,316.05	10,635.47	9,621.96

Figure 4.2.6 Offence rate (per 100,000 ERP), Queensland and SWHHS, 2018-20[68]
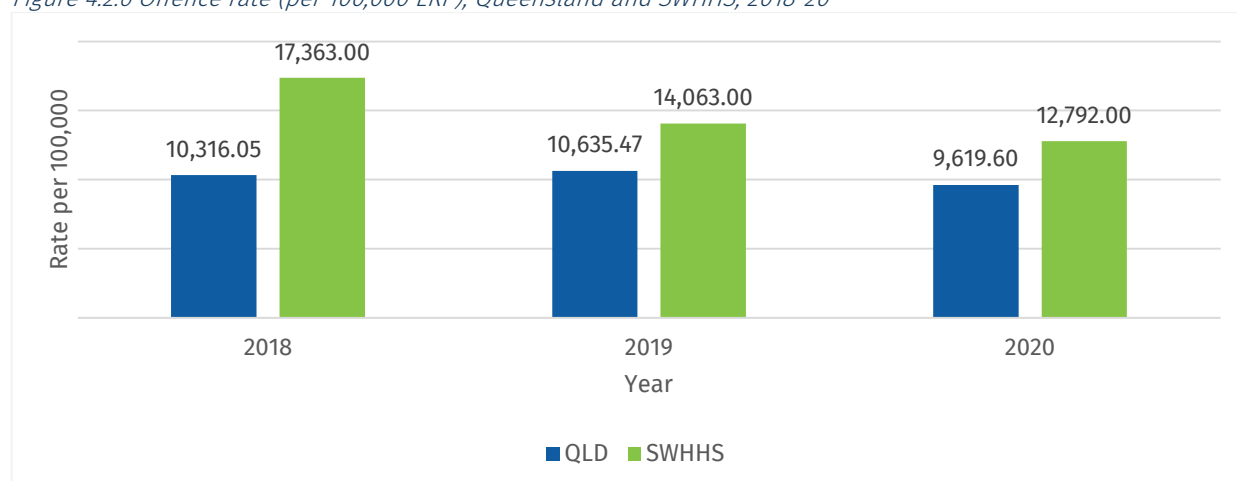
Figure 4.2.7, Figure 4.2.8, and Table 4.2.19 highlight that the reported drug offences were the highest reported offence followed by good order offences. Reported offences across all categories declined,

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[66] Queensland Police Service (2022) Maps and statistics

[67] Queensland Government. (2022). Reported offences 2020. Retrieved from Planning portal

[68] Queensland Government. (2022). Reported offences 2020. Retrieved from Planning portal

except for assaults and breach of domestic violence protection orders which increased. During 2020 in the SWHHS other theft offences were significantly lower than the state average. Breach domestic violence protection orders and unlawful entry offences were reported as similar rates to the state average. Traffic related offences remained the third highest reported offence in 2018 and 2019, however in 2020 other theft was the third highest reported offence.

Figure 4.2.7 Reported offences, SWHHS, 2018-20 [69]
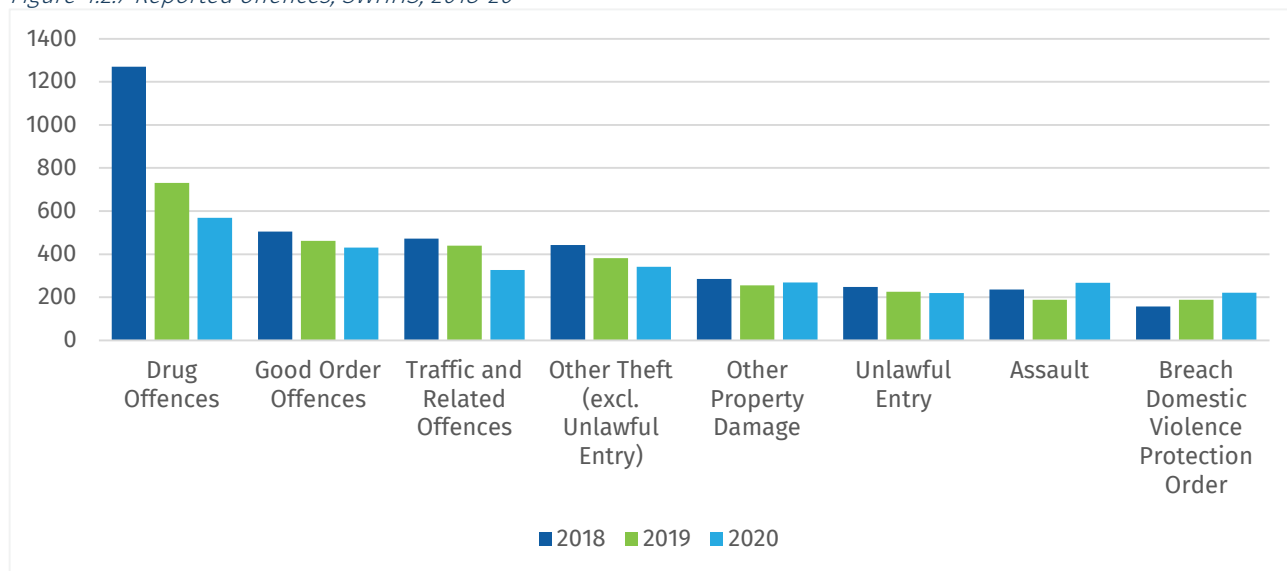
Figure 4.2.8 Reported offences as a percentage of total offences per region, SWHHS, 2020 [70]
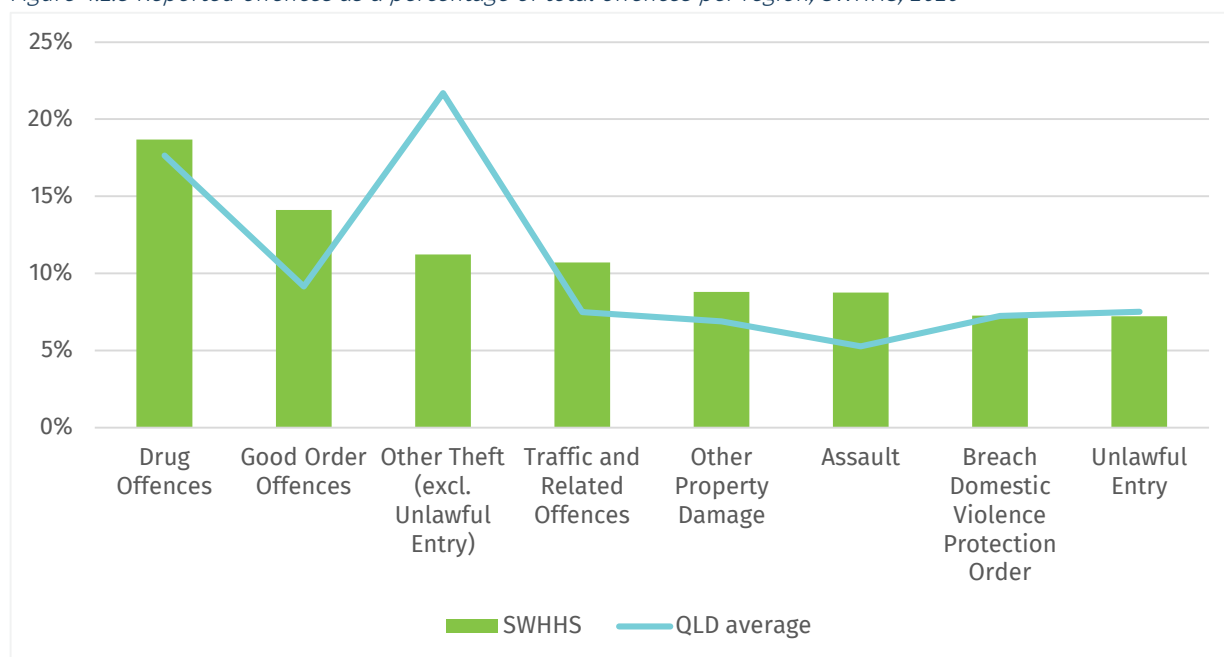
[69] Queensland Government. (2022). Reported offences 2020. Retrieved from Planning portal

[70] Queensland Government. (2022). Reported offences 2020. Retrieved from Planning portal

Table 4.2.19 Reported offences, SWHHS, 2020[71]

Offence	SWHHS number of offences	SWHHS	QLD number of offences	QLD average
Drug Offences	569	19%	87,922	18%
Good Order Offences	430	14%	45,604	9%
Other Theft (excl. Unlawful Entry)	342	11%	108,098	22%
Traffic and Related Offences	326	11%	37,285	7%
Other Property Damage	268	9%	34,340	7%
Assault	267	9%	26,340	5%
Breach Domestic Violence Protection Order	221	7%	36,037	7%
Unlawful Entry	220	7%	37,404	8%
Trespassing and Vagrancy	66	2%	5,787	1%
Unlawful Use of Motor Vehicle	66	2%	15,010	3%
Fraud	64	2%	27,030	5%
Weapons Act Offences	54	2%	8,055	2%
Other Offences Against the Person	44	1%	5,097	1%
Sexual Offences	39	1%	7,022	1%
Liquor (excl. Drunkenness)	23	1%	3,134	1%
Handling Stolen Goods	19	1%	6,414	1%
Miscellaneous Offences	17	1%	4,231	1%
Arson	<10	0%	1,222	0%
Robbery	<10	0%	2,172	0%
Stock Related Offences	<10	0%	25	0%
Gaming Racing & Betting Offences	0	0%	<10	0%
Homicide (Murder)	0	0%	45	0%
Other Homicide	0	0%	84	0%
Prostitution Offences	0	0%	81	0%
Total	3,048		498,440	

[71] Queensland Government. (2022). Reported offences 2020. Retrieved from Planning portal

4.3 Appendix 3: Health-specific risks and behaviours

4.3.1 Summary of key findings

The observations from the data analysis indicate that there may be an ongoing need for targeted health initiatives around healthy behaviours such as reducing smoking and drinking and eating well. The engagement with risky behaviours such as smoking, alcohol consumption and a low level of exercise, may be contributing to higher-than-average morbidity and mortality rates.

The consumption of alcohol and smoking can be 'self-medicating' behaviours that people engage with as a response to poor wellbeing or other pressures (e.g., economic or relationship pressures). This means that there may also be a need in the SWHHS region for services that respond to the possible drivers of these behaviours. These services could include social inclusion initiatives; initiatives that consider the employment or housing options for people in the SWHHS region; and other wellbeing initiatives that promote exercise and a more active lifestyle.

4.3.2 Health determinants and behaviours

4.3.2.1 Disability

4.3.2.1.1 Population living in need of assistance with profound or severe disability

Due to a range of factors, people with a disability generally experience significantly poorer health outcomes and access to supportive services. The individual needs of people with disabilities living in rural and remote areas also face additional challenges that are distinctly different from people who live in metropolitan areas.

As a proportion of the population, self-reported numbers of people who required assistance with core activities in 2016 was slightly lower in the South West, at four percent, compared to five percent at both a state and national level.

Numbers of people that provided unpaid care to people with disabilities were also slightly lower, at seven (7) percent, compared to nine (9) percent in both Queensland and Australia.

Table 4.3.1 and **Table 4.3.2** indicate that in 2016 in SWHHS, it was estimated that the proportion of people living with profound or severe disability in the community or in long term accommodation across all age groups (4.51 per cent) is less than the state average (5.29 per cent).

Table 4.3.1 Estimated need of assistance by disability level, SWHHS, 2016[72]

| SA2/Geographical region* | Estimated people with profound or severe disability and living in the community | | | | | |
	Number of people aged 0-64 years	Proportion aged 0-64 years (%)	Number of people aged 65 years or above	Proportion of people aged 65 years or above (%)	Number of total population	Proportion of total population (%)
Roma	242	2.28	108	11.97	134	3.56
Roma Region	112	2.28	90	11.97	203	3.56
Balonne	120	3.80	82	12.25	200	5.24
Charleville	85	2.43	82	11.35	168	3.99
Far South West	52	2.43	51	11.35	104	3.99
SWHHS	503	2.57	413	11.82	917	3.97
Queensland Total	119,761	3.09	96,488	13.42	216,341	4.71

*System Planning Branch has applied the PHA rate to all SA2s, within the PHA. Numerator and denominator data has been population weighted (the estimated resident population (ERP) in an SA2 is divided by the sum of the ERP in the PHA and the SA2 specific proportion is applied to the numerator and denominator values published by PHIDU). This calculation maintains the PHA rate published by PHIDU, while allowing data to be aggregated to larger areas based on geographic hierarchies.

[72] Queensland Government. (2022). Need of assistance by disability level 2016. Retrieved from Planning portal

Table 4.3.2 Estimated need of assistance by disability level, SWHHS, 2016[73]

*System Planning Branch has applied the PHA rate to all SA2s, within the PHA. Numerator and denominator data has been population weighted (the estimated resident population (ERP) in an SA2 is divided by the sum of the ERP in the PHA and the SA2 specific proportion is applied to the numerator and denominator values published by PHIDU). This calculation maintains the PHA rate published by PHIDU, while allowing data to be aggregated to larger areas based on geographic hierarchies.

SA2/Geographical region*	Estimated people living with profound or severe disability living in long term accommodation					
	Proportion aged 0-64 years (%)	Number of people aged 65 years or above	Proportion of people aged 65 years or above (%)	Number of total population	Proportion of total population (%)	Proportion aged 0-64 years (%)
Roma	135	2.29	149	16.48	285	4.19
Roma Region	113	2.29	125	16.48	238	4.19
Balonne	82	3.8	120	15.15	200	5.78
Charleville	86	2.47	96	13.32	184	4.37
Far South West	53	2.47	59	13.32	114	4.37
SWHHS	507	2.58	530	15.17	1, 041	4.51
Queensland Total	121,931	3.15	120,790	16.80	242,948	5.29

[73] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas (Disability tab). Retrieved from planning portal

4.3.2.2 Obesity (adult)

4.3.2.2.1 Obesity rates

Overweight and obesity are a significant public health challenge given the complexity of their causal pathways and the subsequent difficulties in implementing population-based interventions. Obesity and 'healthy weight' are multifaceted conditions, with individual status often influenced by multiple interactions involving genes, social determinants of health, our social and physical environments, diet, physical activity and other diseases, disorders, and disabilities (Queensland Health, 2020).

Adult: Obesity
- **Figure 4.3.1** and **Table 4.3.3** indicate that in 2019-20 in the SWHHS, it was estimated that:
    o The adult obesity rate (14.1 per cent) was the second highest in Queensland.
    o Charleville SA2 had the highest adult obesity rate (48.8 per cent), which was higher than the Queensland rate (25.0 per cent).
    o Roma Region had the lowest adult obesity rate (29.9 per cent), which was higher than the Queensland rate (25.0 per cent).

Adult: Overweight
- **Table 4.3.3** indicates that in 2019-20 in the SWHHS, it was estimated that:
    o The HHS had a lower rate of adults who were overweight (33.2 per cent) compared to Queensland (34.9 per cent).
    o Balonne SA2 had the highest adult overweight rate (42.0 per cent) for the region, which was higher than the Queensland rate (34.9 per cent).
    o Far South West SA2 had the lowest adult overweight rate in the SWHHS (30.5 per cent), which was lower than the Queensland rate (34.9 per cent).

Adult: Overweight / Obese
- **Table 4.3.3** indicates that in 2019-20 in the SWHHS, it was estimated that:
    o The adult rate of overweight/obesity was greater (68.7 per cent) than the Queensland rate (60.0 per cent).
    o The highest rates of adult overweight/obesity were in Balonne (77.7 per cent) and Charleville (75.4 per cent) SA2s.
    o Roma Region SA2 had the lowest rate of adult overweight/obesity (62.1 per cent) in the SWHHS, which was higher than the Queensland rate (60.0 per cent).

Childhood Obesity:
- **Table 4.3.4** indicates that in 2019-20 in the SWHHS, it was estimated that:
    o The childhood overweight/obesity rate (33.9 per cent) was higher than the Queensland rate (25.6 per cent).
    o The childhood obesity rate (14.1 per cent) was the third highest in Queensland.
    o The childhood obesity rate (14.1 per cent) was higher than the Queensland rate (8.3 per cent).
    o The childhood overweight rate (19.9 per cent) was higher than the Queensland rate (17.4 per cent).

Figure 4.3.1 Obesity rates by HHS, 2019-20[74]
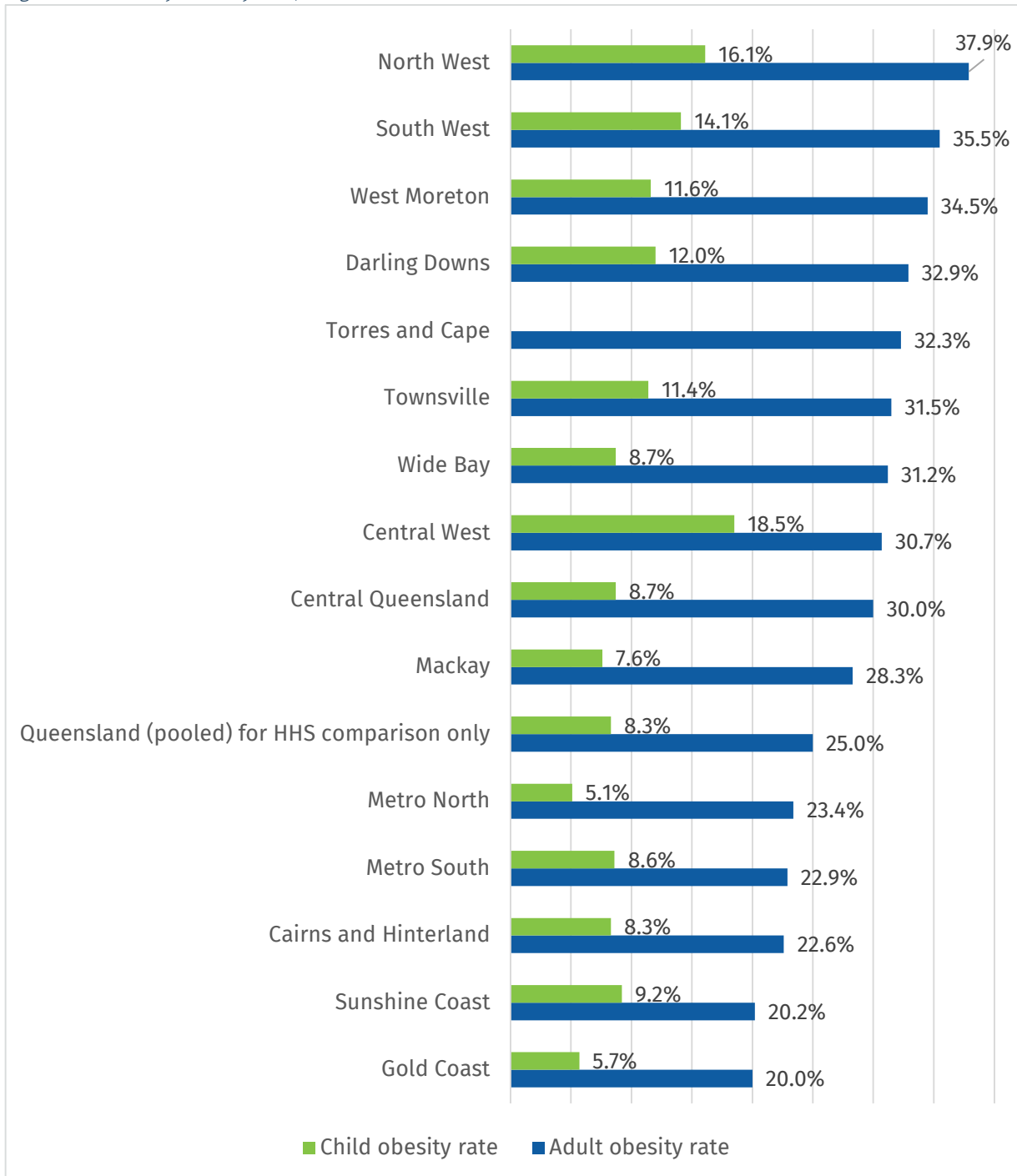
Legend:
- Child obesity rate (green)
- Adult obesity rate (blue)

HHS	Child obesity rate	Adult obesity rate
North West	16.1%	37.9%
South West	14.1%	35.5%
West Moreton	11.6%	34.5%
Darling Downs	12.0%	32.9%
Torres and Cape		32.3%
Townsville	11.4%	31.5%
Wide Bay	8.7%	31.2%
Central West	18.5%	30.7%
Central Queensland	8.7%	30.0%
Mackay	7.6%	28.3%
Queensland (pooled) for HHS comparison only	8.3%	25.0%
Metro North	5.1%	23.4%
Metro South	8.6%	22.9%
Cairns and Hinterland	8.3%	22.6%
Sunshine Coast	9.2%	20.2%
Gold Coast	5.7%	20.0%

Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020. Report prepared by System Planning Branch, Planning Portal.
Note Childhood obesity data is not available for publication for the Torres and Cape HHS.

[74] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

Table 4.3.3 Estimated obesity rates, adults, SWHHS, 2019-20[75]

SA2/Geographical region	Adults – Prevalence		
	Estimated obesity rates	Estimated overweight rates	Estimated overweight/obese
Roma	32.4%	33.2%	65.6%
Roma Region	29.6%	32.6%	62.1%
Balonne	35.7%	42.0%	77.7%
Charleville	48.8%	26.6%	75.4%
Far South West	35.8%	30.5%	66.3%
SWHHS	35.5%	33.2%	68.7%
Queensland	25.0%	34.9%	60.0%

Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

Table 4.3.4 Estimated obesity rates, children, SWHHS, 2019-20[76]

SA2/Geographical region	Children – Prevalence		
	Estimated obesity rates	Estimated overweight rates	Estimated overweight/obese
SWHHS	14.1%	19.9%	33.9%
Queensland	8.3%	17.4%	25.6%

Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

4.3.2.2.2   Obesity among mothers

Table 4.3.5 illustrates that in 2019 in the SWHHS the rate of obesity in mothers (25 per cent) was higher than the Queensland rate (22 per cent). Charleville SA2 had the highest rate of obesity in mothers (33 per cent) and Balonne SA2 had the lowest obesity rate in mothers (19 per cent).

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[75] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

[76] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

Table 4.3.5 Obese mothers, SWHHS, 2019 [77]

Geographic region	First Nations plus Non-First Nations			First Nations		
	Obese mothers (#)	Number of mothers (#)	Proportion (%)	Obese mothers (#)	Number of mothers (#)	Proportion (%)
Roma	32	130	25%	n.p.	21	n.p.
Roma Region	14	62	23%	n.p.	n.p.	n.p.
Balonne	11	57	19%	n.p.	11	n.p.
Charleville	19	58	33%	n.p.	n.p.	n.p.
Far South West	n.p.	33	np	n.p.	12	n.p.
SWHHS	85	340	25%	20	63	32%
Queensland Total	13,173	59,559	22%	1,369	4,440	31%

Data Source: Queensland Perinatal Data Collection (QPDC), Statistical Services Branch, Queensland Health. Prepared by Statistical Reporting and Coordination. Prepared by System Planning Branch, Planning Portal

Note: to maintain confidentiality of individuals, suppression has been applied to cells with a count less than ten (10). These cells are noted as n.p.

4.3.2.3 Physical activity

Figure 4.3.2 and **Figure 4.3.3** illustrates that in 2019-20 in the SWHHS, it was estimated that:

o   Adults had the second lowest rate of sufficient physical activity (150 minutes or more over five or more sessions) in Queensland, with only 51.5 per cent participating in sufficient physical activity.

o   Adult rates of sufficient physical activity (51.5 per cent) were lower than the Queensland rate (58.3 per cent).

o   Adults in Roma Region and Roma SA2s had the lowest levels of physical activity, with 55.8 and 52.6 per cent of adults reporting insufficient physical activity.

o   Children aged 5 to 17 years were the most active when compared to all other HHSs and the state, with a rate of 59.1 per cent being active every day of the past week.

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[77] Queensland Government. (2022). Health status - fertility and perinatal 2019. Retrieved from Planning portal

Figure 4.3.2 Physical activity by HHS, Children and adult 2019-20

Estimated physical activity by HHS 2019-20

HHS	Children: Active every day of past week	Adults: Sufficient physical activity (150+ min over 5+ sessions)
Sunshine Coast	42.4%	63.3%
Gold Coast	44.1%	63.0%
Metro North	43.0%	62.5%
Queensland (pooled) for HHS comparison only	47.1%	58.3%
Cairns and Hinterland	55.3%	58.2%
Townsville	52.5%	56.9%
North West	53.8%	56.8%
Metro South	44.8%	56.3%
Central West	50.2%	54.8%
West Moreton	51.6%	54.3%
Mackay	49.1%	54.3%
Wide Bay	52.4%	54.1%
Torres and Cape		53.0%
Central Queensland	50.6%	52.2%
South West	59.1%	51.5%
Darling Downs	53.9%	49.8%

Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

South West Hospital and Health Service Local Area Needs Assessment (2022)

Figure 4.3.3 Past week insufficient physical activity, by SA2, 2019-20[78]
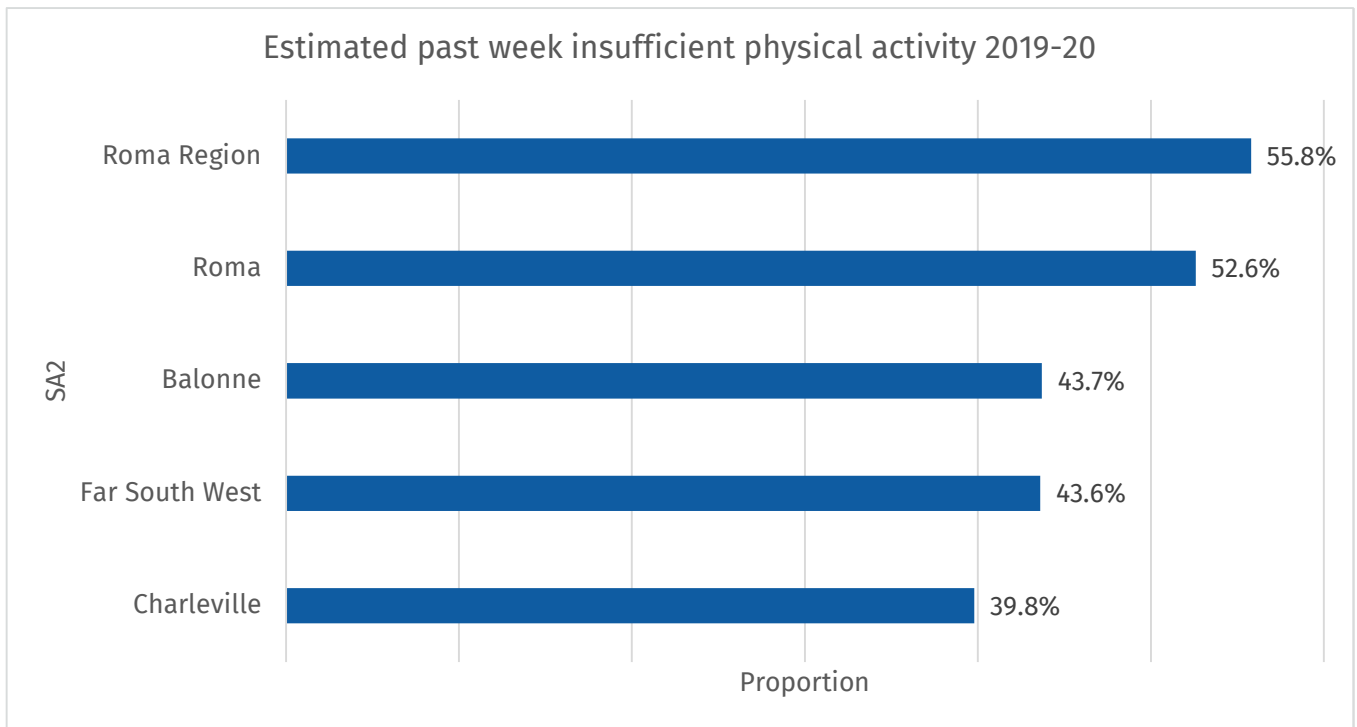
Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

4.3.2.4   Nutrition

4.3.2.4.1   Fruit and vegetable intake

Adults

Figure 4.3.4 and **Figure 4.3.5** illustrate that in 2018-19 in the SWHHS, it was estimated that:

- Roma Region SA2 had the highest rates of insufficient fruit intake (54.1 per cent) amongst adults within the SWHHS, followed by Charleville (52.2 per cent) and Far South West (50.5 per cent) SA2s.
- Roma Region SA2 had the highest rate of insufficient vegetable intake (92.0 per cent) amongst adults within the SWHHS, followed by Roma (91.4 per cent).

Children

Figure 4.3.4 and **Figure 4.3.5** illustrate that in 2018-19 in the SWHHS, it was estimated that:

- 9.4 per cent of children consumed the recommended number of vegetables- this was the highest rate amongst all Queensland HHSs.
- 67.5 per cent of children were estimated to have consumed the recommended amount of fruit, comparable to rates in other HHSs across Queensland.

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[78] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

Figure 4.3.4 Fruit and vegetable intake by HHS, 2019-20

Adults Factor comparison by HHS

Risk & Protective Factors ● Recommended fruit ● Recommended vegetables

HHS	Recommended fruit	Recommended vegetables
Sunshine Coast	54.5%	10.3%
Gold Coast	52.9%	9.7%
Wide Bay	53.0%	9.0%
Metro North	53.2%	8.0%
Darling Downs	52.4%	8.3%
Mackay	52.4%	8.1%
Queensland	52.1%	8.4%
Cairns & Hinterland	52.1%	7.8%
Torres and Cape	58.9%	
West Moreton	50.8%	8.1%
Metro South	51.0%	7.7%
South West	50.5%	7.7%
Central Queensland	50.7%	7.1%
Townsville	49.2%	7.6%
Central West	45.4%	7.8%
North West	41.0%	8.5%

Children Factor comparison by HHS

Risk & Prote... ● Recommended fruit ● Recommended vegetables

HHS	Recommended fruit	Recommended vegetables
Sunshine Coast	74.3%	4.1%
Darling Downs	71.1%	6.7%
South West	67.5%	9.4%
Metro North	70.3%	5.0%
Wide Bay	68.5%	6.3%
Queensland	69.0%	4.3%
Metro South	68.5%	3.3%
West Moreton	67.0%	4.7%
Gold Coast	66.9%	4.7%
Mackay	71.0%	
North West	70.9%	
Central Queensland	66.9%	3.5%
Townsville	66.0%	3.6%
Cairns & Hinterland	66.9%	1.9%
Central West	51.2%	

Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

Figure 4.3.5 Insufficient fruit and vegetable intake by SA2, 2019-20
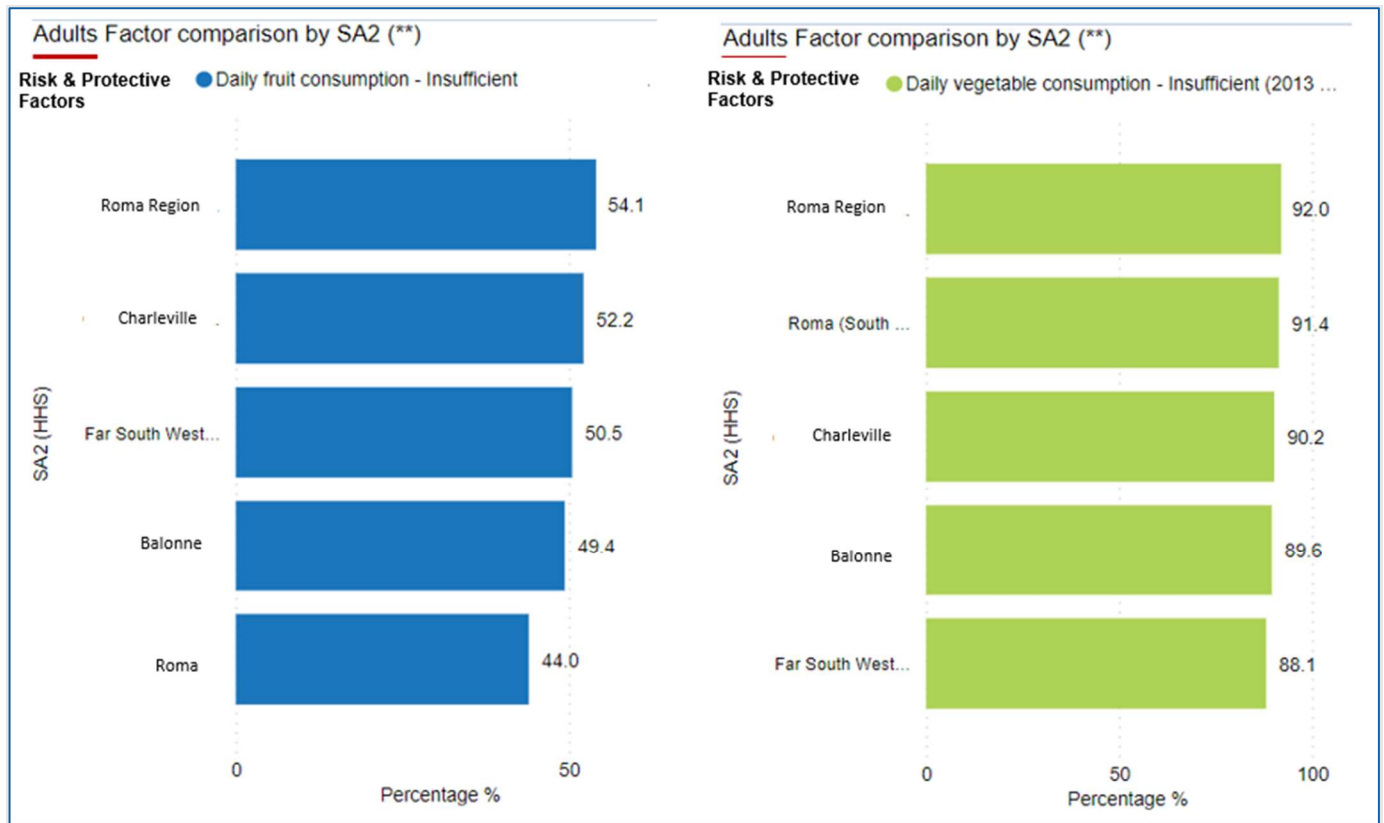
Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal

4.3.2.5   Substance use

4.3.2.5.1   Smoking (adults)

Figure 4.3.6, Figure 4.3.7, Figure 4.3.8, Table 4.3.6, and Table 4.3.7 illustrate that in 2019-20 in the SWHHS, it was estimated that:

- o   The rate of adult daily smoking was 13.4 per cent, higher than the Queensland rate of 10.8 per cent.
- o   Far South West SA2 had the highest rate of adult daily smoking, with 18.7 per cent, which is higher than the estimated Queensland rate (10.8 per cent).
- o   Roma Region SA2 had the lowest estimated rate of adult daily smoking (11.7 per cent).
- o   At an SA2 level, it was estimated that between 81.3 to 88.3 per cent of adults were non-smokers and non-daily smokers.

Figure 4.3.6, Figure 4.3.7, Figure 4.3.8 and Table 4.3.6, and Table 4.3.7 illustrate that in 2017-18 in the SWHHS, it was estimated that:

- o   Men had higher rates of daily smoking (26 to 28 ASR per 100) than the Queensland average (ASR 19 per 100).

- o   Women had higher rates of daily smoking (17 to 18 ASR per 100) than the Queensland average (ASR 13 per 100).

- o   Men had higher rates of daily smoking (26 to 28 ASR per 100 than women (17 to 18 ASR per 100).

Figure 4.3.6 Daily smoking by HHS, adults, 2019-20[79]
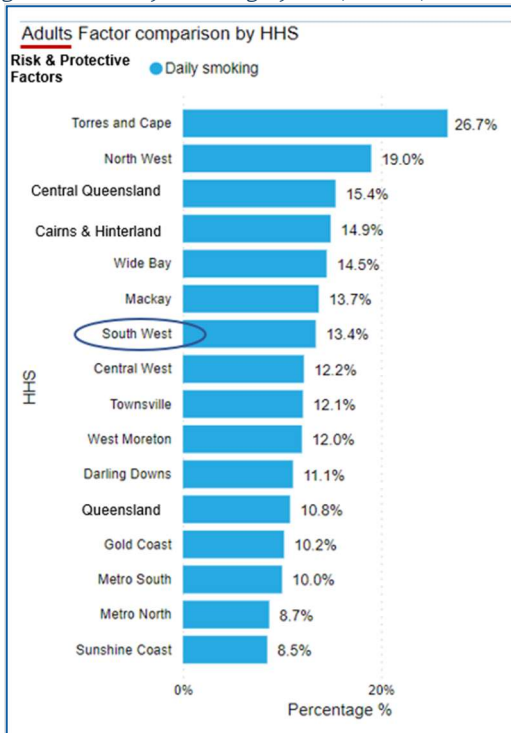
Figure 4.3.7 Daily smoking by SA2, adults who smoke daily, by SA2, 2019-20[80]
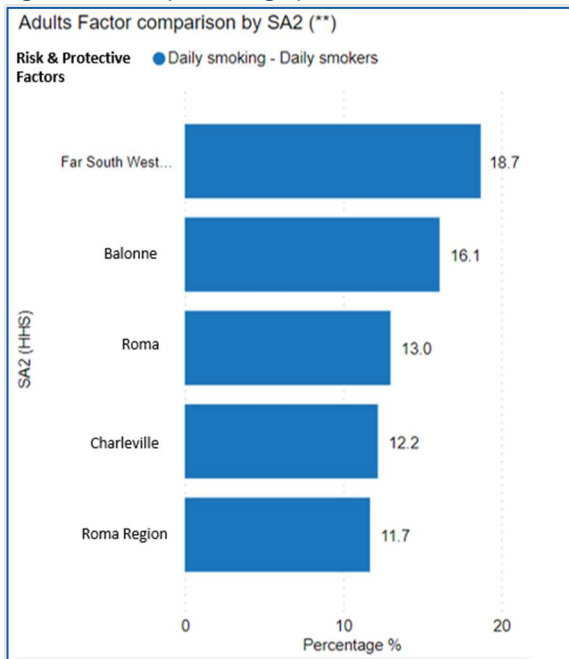
[79] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

[80] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

Figure 4.3.8 Daily smoking by SA2, adults who are non-smokers and non-daily smokers, by SA2, 2019-20[81]
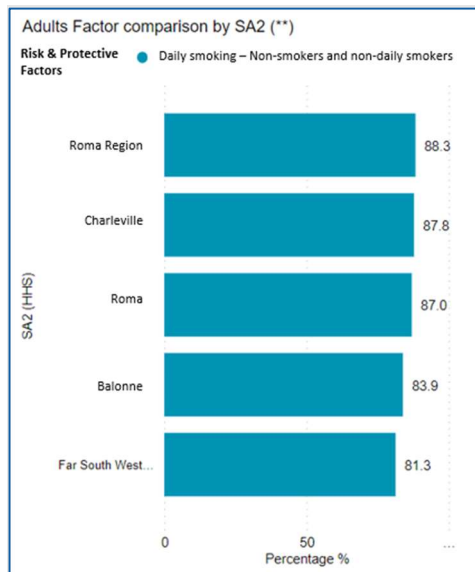
Data Source: Queensland Health. The Health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020.Prepared by System Planning Branch, Planning Portal.

Table 4.3.6 Estimated current smoker (males) by SA2, 2017-18[82]

SA2/Geographical region	Sex	Number	ASR per 100
Balonne	Males	455.16	28
Roma	Males	636.00	26
Roma Region	Males	532.70	26
Queensland	Males	349,156	19

Data Source: Public Health Information Development Init (PHIDU) material from: Social Health Atlas of Australia. Derived from estimates produced for selected health risk factors from the 2017-18 Nation Health Survey (NHS), 2014-15 National Health Survey (NHS), and the 2014 General Social Survey (GSS), conducted by the Australian Bureau of Statistics (ABS). Prepared by System Planning Branch, Planning Portal.

Table 4.3.7 Estimated current smoker (females) by SA2, 2017-18[83]

SA2/Geographical region	Sex	Number	ASR per 100
Balonne	Females	284.31	18
Roma	Females	407.46	17
Roma Region	Females	340.64	17
Queensland	Females	240,828	13

[81] Queensland Health. (2020). The health of Queenslanders 2020. Brisbane: Report of the Chief Health Officer Queensland.

[82] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

[83] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

4.3.2.5.1.1 Smoking during pregnancy

Smoking during pregnancy data is limited for the SWHHS and may require further analysis.

In 2019 in the SWHHS, the number of mothers who smoked during pregnancy was the fourth lowest amongst Queensland HHSs as illustrated in Figure **4.3.9**

Figure 4.3.9 Estimated smoking rates during pregnancy and number of births by HHS, 2019[84]
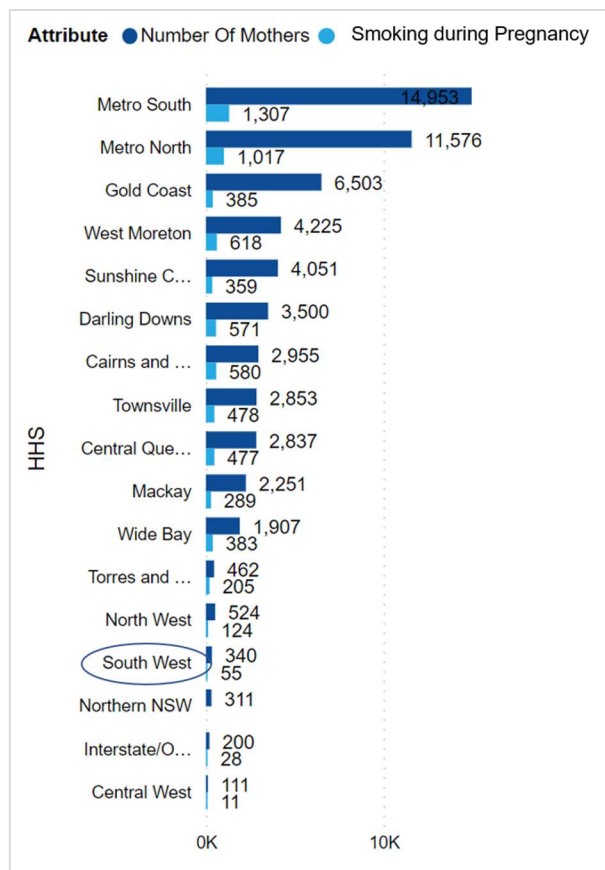
4.3.2.5.2 Alcohol consumption (adult)

Figure **4.3.10** and Figure **4.3.11** indicates that in 2019-20 in the SWHHS, it was estimated that:
- o Rates of lifetime (26.9 per cent) and single occasion risky drinking at least monthly (36.8) were amongst the highest in Queensland, rating fifth and fourth respectively amongst all Queensland HHS'.
- o Rates of lifetime risky drinking (26.9 per cent) were higher than the state average (21.6 per cent).
- o Rates of single occasion risky drinking at least monthly (36.8 per cent) were higher than the state average (30.0 per cent).
- o Balonne SA2 had the highest rate of lifetime risky drinking (37.7 per cent), while Charleville SA2 had the lowest (21.8 per cent).

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[84] Queensland Government. (2022). Health status - fertility and perinatal 2019. Retrieved from Planning portal

Figure 4.3.10 Lifetime risky drinking and single occasion risky drinking at least monthly by HHS, 2019-20[85]

Adults Factor comparison by HHS

Risk & Protective Factors ● Lifetime risky drinking ● Single occasion risky drinking

HHS	Lifetime risky drinking	Single occasion risky drinking
Torres and Cape	28.3%	54.9%
North West	28.4%	40.4%
Mackay	26.6%	37.4%
South West	26.9%	36.8%
Central West	28.3%	35.1%
Cairns and Hinterland	26.4%	32.9%
Sunshine Coast	28.0%	31.1%
Central Queensland	23.7%	34.7%
Townsville	25.4%	32.9%
Gold Coast	22.1%	30.3%
Wide Bay	23.7%	28.2%
Queensland	21.6%	30.0%
Metro North	20.1%	31.1%
Darling Downs	19.0%	26.2%
Metro South	17.9%	26.5%
West Moreton	18.0%	25.6%

Percentage %

[85] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

Figure 4.3.11 Lifetime risky drinking, by SA2, 2019-20[86]
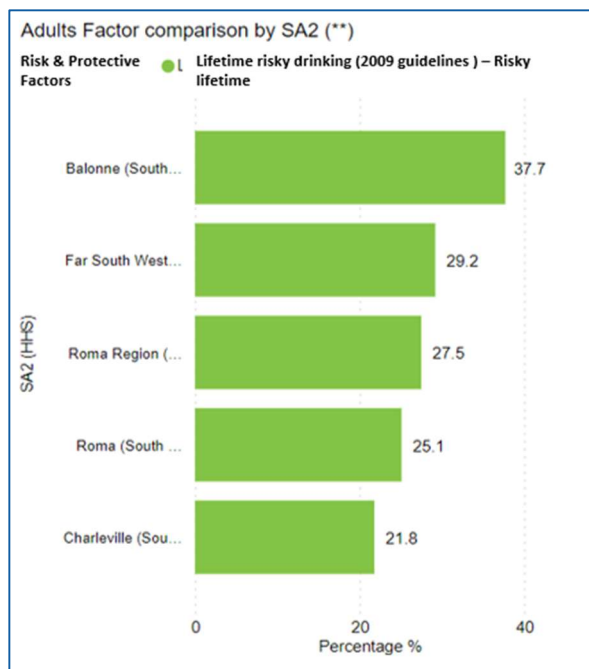
Table 4.3.8 and Table 4.3.9 indicate that in 2017-18 in the SWHHS, it was estimated that:

o   Men had higher ASRs of risky alcohol intake (38 per 100) than the Queensland rate (27 per 100).

o   Women higher ASRs of risky alcohol intake (15 ASR per 100) than the Queensland rate (10 ASR per 100).

o   Men had higher ASRs of risky alcohol intake (38 per 100) than women (15 per 100), which is a similar trend across the state.

Table 4.3.8 Estimated risky alcohol intake (males), by SA2, 2017-18[87]

SA2*/Geographical region	Sex	Number	ASR per 100
Balonne	Males	649.75	37
Roma	Males	939.92	38
Roma Region	Males	785.78	38
Queensland	Males	485,697	27

Note: Data not available for Charleville and Far South West SA2s.

[86] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

[87] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

Table 4.3.9 Estimated risky alcohol intake (females) by SA2, 2017-18[88]

SA2*/Geographical region	Sex	Number	ASR per 100
Balonne	Females	237.98	15
Roma	Females	361.59	15
Roma Region	Females	302.29	15
Queensland	Females	185,981	10

Note: Data not available for Charleville and Far South West SA2s.

4.3.2.5.3   Illicit drug use

The SWHHS region data regarding illicit drug use is not available. Consideration may be given to state-wide trends (below) and qualitative analysis.

Table 4.3.10 highlights that in Queensland, increases have been noted in:

– drinking count (by 400,000 from 2010 to 2019)

– cocaine use (from 50,000 in 2010, to 200,000 in 2019)

– inhalants (doubled from 20,000 in 2010 to 40,000 in 2019)

– In Queensland, decreases have been noted in; opioid and pain killer/reliever counts (by half from 200,000 in 2016 to 100,000 in 2019)

– Meth/amphetamine use (from 70,000 in 2010 to 50,000 in 2019)

– synthetic cannabinoids (from 60,000 in 2013 to 10,000 in 2019)

– In Queensland, Smoking rates remained stable from 2010 to 2019.

Table 4.3.10 Reported illicit drug use, Aged 14+ years, QLD, 2010-19[89]

Drug	2010	2013	2016	2019
Recent drinker	3,000,000	3,100,000	3,200,000	3,400,000
Current smoker	700,000	700,000	700,000	700,000
Any illicit	500,000	600,000	700,000	700,000
Any illicit excluding pharmaceuticals	400,000	500,000	500,000	600,000
Cannabis	400,000	400,000	500,000	500,000
Cocaine	50,000	80,000	80,000	200,000
Any pharmaceutical	N/A	N/A	200,000	200,000

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[88] Queensland Government. (2022). Health risks and behaviours (CHO). Retrieved from Planning portal

[89] Queensland Government. (2019). Illicit drug use (2019) by Primary Health Network (PHN). Retrieved from Planning portal

Drug	2010	2013	2016	2019
Ecstasy	100,000	90,000	80,000	100,000
Any opioid	N/A	N/A	200,000	100,000
Painkillers/pain-relievers and opioids	N/A	N/A	200,000	100,000
Hallucinogens	50,000	50,000	30,000	60,000
Tranquillisers/sleeping pills	50,000	60,000	50,000	60,000
Meth/amphetamine	70,000	90,000	60,000	50,000
Inhalants	20,000	30,000	40,000	40,000
Ketamine	N/A	N/A	N/A	20,000
Injected drugs	20,000	10,000	10,000	20,000
Steroids	N/A	N/A	N/A	10,000
Synthetic Cannabinoids		60,000	20,000	10,000
GHB	N/A	N/A	N/A	N/A
Heroin	N/A	N/A	N/A	N/A
Methadone or Buprenorphine	N/A	10,000	N/A	N/A
New and Emerging Psychoactive Substances	N/A	20,000	20,000	N/A
Pharmaceuticals	N/A	N/A	N/A	N/A

Data source: Australian Institute of Health and Welfare, National Drug Strategy Household Survey 2019. Prepared by System planning Branch, Planning Portal.

4.3.2.6 Antenatal care

4.3.2.6.1 Number of antenatal visits

Table 4.3.11 highlights that in 2019, there was 353 births. Of the 340 expectant mothers in the SWHHS, 307 had eight or more antenatal visits. Data for First Nations mothers is lacking and may require further investigation. In 2019, 88 per cent of Non-First Nations mothers and 84 percent of First Nations mothers in the SWHHS reported eight or more antenatal visits, which is higher than the Queensland rate of 81 per cent.

Table 4.3.11 Antenatal visits eight or more, by SA2., 2019[90]

SA2/Geographical region	First Nations Peoples			Other Australians		
	Number with antenatal visits 8 or more (#)	Number of mothers	Proportion (%)	Number with antenatal visits 8 or more (#)	Number of mothers	Proportion (%)
Roma	19	21	90%	105	114	92%
Roma Region	n.p.	n.p.	n.p.	46	54	85%
Balonne	n.p.	11	n.p.	44	48	92%
Charleville	n.p.	n.p.	n.p.	42	49	86%
Far South West	n.p.	12	n.p.	17	23	74%
SWHHS	53	63	84%	254	288	88%
Queensland	3,011	4,440	67%	45,054	55,941	81%

4.3.2.7 Cancer screening

4.3.2.7.1 Breast cancer screening

Table 4.3.12 highlights that in 2018-19, the SWHHS breast screening rate (for the target age group of 50 to 74 years) was comparable to the state average (56 per cent and 55 per cent respectively). Outback South SA3 had the higher rate of 59 per cent while Darling Downs (West – Maranoa) had a rate less than one per cent lower than the state rate at 54 per cent.

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[90] Queensland Government. (2022). Health status - fertility and perinatal 2019. Retrieved from Planning portal

Table 4.3.12 Breast cancer screening, by SA3, 2018-19[91]

SA3/Geographical area	Participants screened 50-74 years old (#)	Population (#)	Participation rate (%)
Darling Downs (West - Maranoa	1,255.91	2,310.29	54.36%
Outback South	649.03	1,093.44	59.36%
SWHHS	1,904.94	3,403.73	55.97%
Queensland	379,385	692,510	54.78%

Data source: Australian Institute of Health and Welfare analysis of National Cancer Screening Register data for people aged 50 to 74, 2018-19. Data has been collated by System Planning Branch and is presented via Queensland Health's Planning Portal. The 2-year period covers from 1 January in the first year to 31 December in the following year.

4.3.2.7.2   Bowel cancer screening

Table 4.3.13 highlights that in 2018-19, the bowel cancer screening rate in the SWHHS was 2.65 per cent lower than the state average (39.21 per cent and 41.86 per cent respectively).

Table 4.3.13 Bowel cancer screening by SA2, people aged 50 – 74, 2019-20[92]

SA3/Geographical area	Participants screened 50-74 years old (#)	Population (#)	Participation rate (%)
Roma	556	1,548	35.9
Roma Surrounds	463	1,137	40.7
Balonne	341	1,008	33.9
Charleville	389	978	39.8
Far South West	206	683	30.2
SWHHS	1,955	5,354	36.15%
Queensland	471,583	1,145,808	41.16%

[91] Queensland Government. (2022). Breast cancer screening 2018-2019. Retrieved from Planning portal

[92] Queensland Government. (2022). Bowel cancer screening 2018-2019. Retrieved from Planning portal

4.3.2.7.3   Cervical cancer screening

Table 4.3.14 illustrates that in 2018-19, the cervical cancer screening rate in the SWHHS was 3.88 per cent lower than the state average (42.93 per cent and 46.00 per cent respectively).

Table 4.3.14 Cervical cancer screening by SA2 aged 25-74, 2018-19 [93]

SA3/Geographical area	Participants screened 25-74 years old (#)	Population (#)	Participation rate (%)
Darling Downs (West - Maranoa	1,857.43	4,327.10	42.93%
Outback South	762.66	1,893.71	40.27%
SWHHS	2,620.09	6,220.81	42.12%
Queensland	620,938	1,349,937	46.00%

Data source: Australian Institute of Health and Welfare analysis of National Cancer Screening Register data for people aged 50 to 74, 2018-19. Data has been collated by System Planning Branch and is presented via Queensland Health's Planning Portal. The 2-year period covers from 1 January in the first year to 31 December in the following year.

4.3.2.8   13HEALTH call centre activity

Figure 4.3.11, **Figure 4.3.12** and **Table 4.3.15** illustrate that:

- The SWHHS reported a total of 412 calls for the 2020-21 financial year. There were more calls (220) in the first half of the financial year than the second half (192).

- During 2020-21, across the SWHHS, the total numbers of call to 13HEALTH ranged from 25–39 per month.

- The top reason for calling across both Darling Downs (West) – Maranoa and Outback South SA3s was digestive issues (59 calls, 17 percent and 13 calls, 21 per cent respectively), with the top advice given for this condition to contact medical practitioner (28 calls, 47.46 and 5 calls, 38.46 per cent respectively) or attend the ED (25 calls, 42.37 and 4 calls, 30.77 per cent respectively).

- Digestive system issues were also the top reason for calls in Queensland (51,299 calls, 18 per cent), with similar advice for this condition being to contact medical practitioner (26,656, 51.96 per cent) or attend the ED (17,557, 34.22 per cent).

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[93] Australian Institute of Health and Welfare. Australia's health snapshots: Determinants of health. Canberra: Australian Government; 2020.

Figure 4.3.11 SWHHS number of calls to 13HEALTH, 2020-21[94]
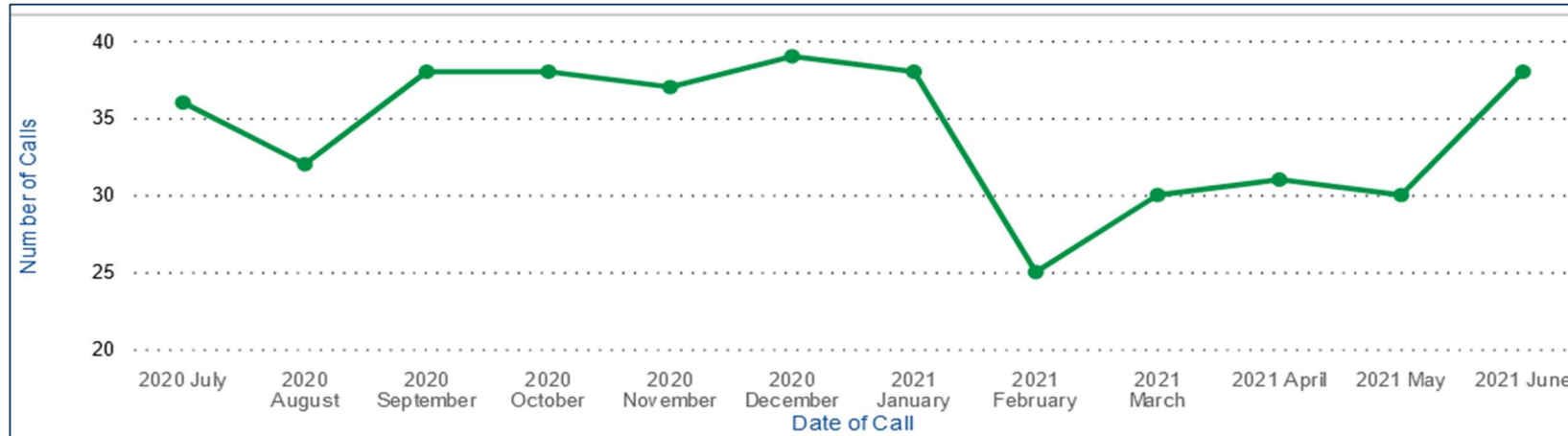
Figure 4.3.12 Darling Downs (West) – Maranoa SA3 number of calls to 13HEALTH, 2020-21[95]
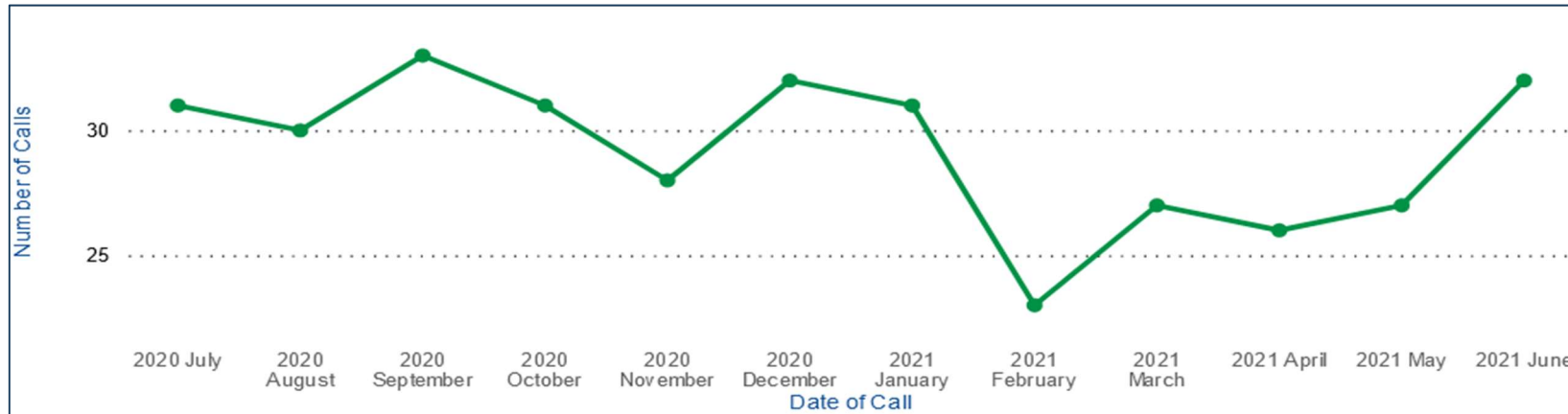
[94] Queensland Government. (2022). 13 HEALTH call center summary. Retrieved from Planning portal

[95] Queensland Government. (2022). 13 HEALTH call center summary. Retrieved from Planning portal

Table 4.3.15 13HEALTH top five comparison by reason for call and recommended care by SA3, 2020-21[96]

SA3/Geographical area	Reason for call				Recommended care			
	Rank	Reason for call	Number (#)	Prevalence (%)	Rank	Recommended care	Number (#)	Prevalence (%)
Darling Downs (West) - Maranoa	1	Digestive system issues	59	16.81%	1	Contact Medical Practitioner	153	43.59%
	2	Issues influencing health status	42	11.97%	2	Attend Emergency Department	106	30.20%
	3	Injuries, poisoning, toxic effects of rugs and trauma	39	11.11%	3	Self-Care Advice	50	14.25%
	4	Skin, subcutaneous and breast issues	31	8.83%	4	Urgent Ambulance Response	12	3.42%
	5	Musculoskeletal and connective tissues issues	27	7.69%	5	Contact Poisons Information	10	2.85%
Outback South	1	Digestive system issues	13	21.31%	1	Contact Medical Practitioner	32	52.46%
	2	Injuries, poisoning, toxic effects of rugs and trauma	8	13.11%	2	Attend Emergency Department	15	24.59%
	3	Issues influencing health status	5	8.20%	3	Self-Care Advice	11	18.03%
	4	Infant newborn issues	<5	6.56%	4	Health information	<5	1.64%

[96] Queensland Government. (2022). 13 HEALTH call center summary. Retrieved from Planning portal

SA3/Geographical area	Reason for call				Recommended care			
	Rank	Reason for call	Number (#)	Prevalence (%)	Rank	Recommended care	Number (#)	Prevalence (%)
	5	Kidney and urinary tract issues	<5	6.56%	5	Urgent ambulance response	<5	1.64%
SWHHS	1	Digestive system issues	72	17.48%	1	Contact Medical Practitioner	185	44.90%
	2	Injuries, poisoning, toxic effects of rugs and trauma	47	11.41%	2	Attend Emergency Department	121	29.37%
	3	Issues influencing health status	47	11.41%	3	Self-Care Advice	61	14.81%
	4	Skin, subcutaneous and breast issues	35	8.50%	4	Urgent Ambulance Response	13	3.16%
	5	Musculoskeletal and connective tissues issues	30	7.28%	5	Contact Poisons Information	10	2.43%
Queensland	1	Digestive system issues	51,299	17.54%	1	Contact Medical Practitioner	149,236	51.02%
	2	Issues influencing health status	37,032	12.66%	2	Attend Emergency Department	51.02	25.08%
	3	Injuries, poisoning, toxic effects of rugs and trauma	31,782	10.87%	3	Self-Care Advice	73,364	11.74%
	4	Skin, subcutaneous and breast issues	22,733	7.77%	4	Urgent ambulance response	34,328	5.49%
	5	Respiratory issues	22,015	7.53%	5	Health information	16,047	2.20%

4.3.2.9 Mental and psychological distress.

Table 4.3.16, **Table 4.3.17** and **Table 4.3.18** illustrate that in 2017-18 in the SWHHS, it was estimated that adults had lower rates of mental and behavioural problems (21.43 ASR per 100) than the state average (22.67 ASR per 100). ASRs for high psychological distress were lower than the state rates for both males (11.4 per 100) and females (14.5 per 100). Across SA2s, females had higher rates of high psychological distress (11.51 to 12.63 ASR per 100) than males (9.13 to 10.24 ASR per 100).

However, as illustrated in Figure 4.4.22, SWHHS's higher ASRs of suicide and self-harm indicate that these figures may underrepresent the true levels of psychological distress and mental/behavioural illness.

Table 4.3.16 High psychological distress (K10) (adult males), by SA2, 2017-18[97]

SA2/Geographical area	Number	ASR per 100
Balonne	172.66	10.24
Roma	224.52	9.13
Roma Region	187.70	9.13
Queensland	207,354	11.4

Table 4.3.17 High psychological distress (K10) (adult females), by SA2, 2017-18[98]

SA2/Geographical area	Number	ASR per 100
Balonne	199.33	12.63
Roma	277.36	11.51
Roma Region	231.88	11.51
Queensland	272,248	14.5

Table 4.3.18 Mental and behavioural problems (adults), by SA2, 2017-1[99]

SA2/Geographical area	Number	ASR per 100
Balonne	927.28	21.43
Roma	1343.55	20.65
Roma Region	1122.38	20.65
Queensland	1,089,817	22.67

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[97] Queensland Government. (2022). Estimated risk factors - adults 2017- 2018. Retrieved from Planning portal

[98] Queensland Government. (2022). Estimated risk factors - adults 2017- 2018. Retrieved from Planning portal

[99] Queensland Government. (2022). Estimated risk factors - adults 2017- 2018. Retrieved from Planning portal

4.4 Appendix 4: Health status

4.4.1 Summary of key findings

Analysis of the mortality data and social determinants of health indicates that the SWHHS population is generally healthy, compared to the average Queenslander. The analysis did indicate that there may be areas of health need in relation to:

- o Preventative health measures (e.g., targeted cancer screening and the promotion of healthy behaviours (e.g., eating well, reducing the use of alcohol, smoking and illicit substances)).
- o Treatment and management of chronic conditions (e.g., cardiovascular, and respiratory disease) in primary, secondary, and tertiary healthcare settings.

Below is a summary of the observations from analysis and key findings.

Cancer screening: The analysis of morbidity and mortality rates shows that much of the SWHHS region has a higher age-standardised rate (ASR) for cancers, compared to the Queensland average. There is, however, a higher ASR for cancers among men in Far South West and Charleville and a higher ASR for cancers among women in Balonne compared to the Queensland average. Although SWHHS's breast, bowel and cervical cancer screening rates are rather similar to the rest of Queensland, SWHHS's higher rates of alcohol usage, smoking, healthy eating, and exercise indicates that there may be a need for cancer screening and prevention programs. Especially targeting men in remote parts of the catchment (e.g., Charleville and Far South West), as incidence of cancer is notably higher in these regions.

Targeted and culturally sensitive cancer screening may also be a need within Roma, Outer Roma, Balonne, and Far South West. This is based on the higher rates of potential years of life lost due to cancer in First Nations communities within these regions.

Chronic conditions: The analysis of morbidity and mortality also shows that the ASR for cardiovascular, circulatory, metabolic, and respiratory diseases are higher than the state average. This indicates that there may be a need for the following types of services:

- o Increasing promotion of healthy lifestyles to reduce the rates of risky behaviours associated with alcohol consumption and smoking, and increase exercise and eating well, particularly in the Charleville and Balonne regions.
- o Early detection of chronic diseases and support for patients in self-managing chronic conditions to reduce the rate of avoidable deaths.

4.4.2 Morbidity

4.4.2.1 Preterm and low birthweight births

Data related to preterm and low birthweight births in the SWHHS is limited and is therefore only available to be compared at an HHS level.

Table 4.4.1 and **Table 4.4.2** highlight that during 2017 and 2018, the SWHHS had a similar rate of preterm births (eight per cent) to the Queensland rate (nine per cent). While the Queensland rate remain constant, the SWHHS rate increased to 12 per cent in 2019. There was also an increase in the total number of births in this HHS. Over the three years from 2017 to 2019, the rate of low birthweight-all

births varied between six and eight per cent and represented between 21 and 25 births. The rate of low birthweight-all births rate of the SWHHS was similar to that of Queensland (seven to eight per cent). First Nations preterm and low birthweight births has not been included as there is limited data is available.

Table 4.4.1 Preterm births, SWHHS and Queensland, 2017-19 [100]

Geographical area	2017			2018			2019		
	Total births	Preterm	Rate of preterm births	Total births	Preterm	Rate of preterm births	Total births	Preterm	Rate of preterm births
SWHHS	355	29	8%	324	25	8%	353	43	12%
Queensland	60,326	5,711	9%	60,503	5,473	9%	60,443	5,680	9%

Table 4.4.2 Low birthweight births, SWHHS and Queensland, 2017-19 [101]

Geographical area	2017			2018			2019		
	Total births	Low birthweight all births	Rate of LBW births	Total births	Low birthweight all births	Rate of LBW births	Total births	Low birthweight all births	Rate of LBW births
SWHHS	355	21	6%	324	25	8%	353	25	7%
Queensland	60,326	4,534	8%	60,503	4,360	7%	60,443	4,574	8%

4.4.2.2 Immunisation rates

Table 4.4.3, Table 4.4.4, and Table 4.4.5 indicate that:

- In 2018, it was estimated that children aged one, two and five years old had higher rates of immunisation than the estimated state average for each age group.
- Children in the SWHHS who identify as a First Nations Person were estimated to have had lower rates of childhood immunisation than Other Australians, both within the HHS and compared to other First Nations Persons at a Queensland level.
- Children residing in the Maranoa-Roma-Mitchell Indigenous Area were estimated to have had the lowest rate at ages one and two, with 78 and 80 per cent of children being fully immunised respectively.

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[100] Queensland Government. (2022). Perinatal summary 2017 to 2019. Retrieved from Planning portal

[101] Queensland Government. (2022). Perinatal summary 2017 to 2019. Retrieved from Planning portal

- In 2017 it was estimated that Balonne, Charleville, and Far South West Planning Regions had rates over 100 per cent for three dose coverage against human papillomavirus (HPV) infection, for both females and males. However, Roma and Roma Region Planning Regions had estimated rates at 76 and 84 per cent for females and males respectively.

Table 4.4.3 Childhood immunisation by SA2 (all children), SWHHS, 2018 [102]

SA2/Geographical region	Children fully immunised at 1 year of age		Children fully immunised at 2 years of age		Children fully immunised at 5 years of age	
	Number Immunised	% Immunised	Number Immunised	% Immunised	Number Immunised	% Immunised
Balonne	49.04	92.74	55.60	95.72	61.02	95.41
Roma	86.64	94.17	89.59	92.01	100.59	96.90
Roma Region	72.43	94.17	74.90	92.01	84.09	96.90
Charleville	52.90	96.55	51.96	92.44	59.04	96.15
Far South West	32.76	96.55	32.18	92.44	36.57	96.15
QLD	56,245	94.0	57,599	91.5	62,622	94.5

Data Sources: 1. Queensland Immunisation Program collated by System Planning Branch via the Queensland Health Planning Portal. 2. Australian Immunisation Register Coverage Report covering the period of October 2017 to September 2018.

Table 4.4.4 Childhood immunisation by Local Government Area (First Nations Peoples), SWHHS, 2018 [103]

Local Government Area	Aboriginal children fully immunised at 1 year of age		Aboriginal children fully immunised at		Aboriginal children fully immunised at 5 years of age	
	Number Immunised	% Immunised	2 years of age	% Immunised	Number Immunised	% Immunised
Balonne	21.99	95.65	21.99	91.67	17.99	90.00
Maranoa - Roma - Mitchell	18.00	78.26	20.00	80.00	24.00	96.00
Murweh	11.00	91.67	11.00	100.00	12.00	100.00
Paroo	n.p.	n.p.	10.47	85.71	n.p.	n.p.
Bulloo – Quilpie - Barcoo	<10	n.p.	<10	n.p.	<10	n.p.
QLD	4,936	92.30	4,4.3.1676	88.70	4,710	97.10

Data Source: 1. Queensland Immunisation Program collated by System Planning Branch via the Queensland Health Planning Portal. 2. Australian Immunisation Register Coverage Report covering the period of October 2017 to September 2018.

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[102] Queensland Government. (2022). Health behaviours - Childhood immunisation (PHIDU). Retrieved from Planning portal

[103] Queensland Government. (2022). Health behaviours - Childhood immunisation (PHIDU). Retrieved from Planning portal

Table 4.4.5 HPV three dose coverage aged 15 years, males, and females, by SA2, 2017 [104]

SA2/Geographical region	Children on 30 June 2017 who had received dose 3 of the HPV vaccine	
	Females aged 15 years	Males aged 15 years
Roma	29 (76.31%)	43 (84.09%)
Roma Region	24 (76.31%)	36 (84.09%)
Balonne	27 (113.6%)	28 (102.5%)
Charleville	24 (118.3%)	22 (114.1%)
Far South West	15 (118.3%)	14 (114.1%)
SWHHS	119 (113.6%)	143 (102.5%)
Queensland	23,476 (79.2%)	23,150 (73.8%)

Data Sources: 1. Queensland Immunisation Program collated by System Planning Branch via the Queensland Health Planning Portal. 2. Australian Immunisation Register Coverage Report covering the period of October 2017 to September 2018.

4.4.2.3   Incidence/prevalence of selected diseases and conditions

4.4.2.3.1   Chronic conditions

Tables 4.4.6 -4.4.12 highlight that in 2017-18:

- Mental and behavioural problems were estimated to have the highest incidence of all the chronic conditions across the SWHHS and Queensland.
- Osteoporosis was estimated to have the lowest incidence of all the chronic conditions across the SWHHS and Queensland.

Residents within the Planning Regions of the SWHHS were estimated to have:

- higher than state age standardised rates for arthritis, asthma, diabetes mellitus and heart stroke vascular disease; and
- lower than state age standardised rates of mental health behaviour problems and osteoporosis.
- The estimated incidence of arthritis in Roma, Roma Region and Balonne Planning Regions was higher than the Queensland rate.
- Higher estimated incidence of chronic conditions in the SWHHS, such as diabetes, arthritis, asthma, and cardiovascular disease, could be associated to lifestyle risk behaviours outlined earlier in the report, including:
    - high rates of obesity
    - insufficient physical activity
    - low vegetable intake
    - high daily smoking rates
    - risky alcohol intake

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[104] Queensland Government. (2022). Health behaviours - Childhood immunisation (PHIDU). Retrieved from Planning portal

Table 4.4.6 Mental and behavioural problems, by SA2, 2017-18 [105]

SA2 Name	Measure	Number	ASR per 100
Balonne	Mental and behavioural problems	927.28	21.42
Roma	Mental and behavioural problems	1,343.55	20.65
Roma Region	Mental and behavioural problems	1,122.38	20.65
Queensland	Mental and behavioural problems	1,089,817	22.67

Table 4.4.7 Arthritis, by SA2, 2017-18 [106]

SA2 Name	Measure	Number	ASR per 100
Balonne	Arthritis	780.61	16.04
Roma	Arthritis	1,052.51	16.31
Roma Region	Arthritis	879.07	16.31
Queensland	Arthritis	668,371	13.92

Table 4.4.8 Asthma, by SA2, 2017-18 [107]

SA2 Name	Measure	Number	ASR per 100
Balonne	Asthma	571.10	12.90
Roma	Asthma	870.44	13.11
Roma Region	Asthma	727.70	13.11
Queensland	Asthma	570,319	11.83

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[105] Queensland Government. (2022). Health status – diseases and conditions 2017-18. Retrieved from Planning portal

[106] Queensland Government. (2022). Health status – diseases and conditions 2017-18. Retrieved from Planning portal

[107] Queensland Government. (2022). Health status – diseases and conditions 2017-18. Retrieved from Planning portal

Table 4.4.9 Diabetes mellitus, by SA2, 2017-18 [108]

SA2 Name	Measure	Number	ASR per 100
Balonne	Diabetes mellitus	287.02	5.86
Roma	Diabetes mellitus	355.84	5.19
Roma Region	Diabetes mellitus	280.76	5.19
Queensland	Diabetes mellitus	227,958	4.73

Table 4.4.10 Heart/stroke/vascular disease, by SA2, 2017-18 [109]

SA2 Name	Measure	Number	ASR per 100
Balonne	Heart/stroke/vascular disease	260.35	5.39
Roma	Heart/stroke/vascular disease	343.62	5.30
Roma Region	Heart/stroke/vascular disease	287.27	5.30
Queensland	Heart/stroke/vascular disease	224,130	4.68

Table 4.4.11 COPD, by SA2, 2017-18 [110]

SA2 Name	Measure	Number	ASR per 100
Balonne	COPD	181.03	3.83
Roma	COPD	210.84	3.24
Roma Region	COPD	176.26	3.24
Queensland	COPD	168,721	3.53

Table 4.4.12 Osteoporosis, by SA2, 2017-18 [111]

SA2 Name	Measure	Number	ASR per 100
Balonne	Osteoporosis	108.25	2.21
Roma	Osteoporosis	153.43	2.38
Roma Region	Osteoporosis	128.27	2.38
Queensland	Osteoporosis	184,248	3.84

[108] Queensland Government. (2022). Health status - diseases and conditions 2017-18. Retrieved from Planning portal

[109] Queensland Government. (2022). Health status - diseases and conditions 2017-18. Retrieved from Planning portal

[110] Queensland Government. (2022). Health status - diseases and conditions 2017-18. Retrieved from Planning portal

[111] Queensland Government. (2022). Health status - diseases and conditions 2017-18. Retrieved from Planning portal

4.4.2.3.2 Cancers

The data pertaining to rates of cancer in SWHHS is very outdated. As such, it does not truly incorporate the advances and policy measures implemented by SWHHS in recent years. The data does, however, provide insight into the most common and extent of cancers in the region.

Tables 4.4.13 -4.4.20 illustrate that in 2010-14 in the SWHHS:

- the highest estimated incidence in cancers were prostate (males, 111), colorectal (persons, 95) and melanoma (persons, 84).
- had lower than Queensland rates of lymphoma, melanoma, and pancreatic cancer
- a comparable rate of leukaemia to the Queensland rate.
- pancreatic cancer had the least estimated incidence in the SWHHS (**the data/ ASR record was not complete for this cancer type)

In 2010-14:

- men in Charleville, Far South West and Balonne Planning Regions had a higher estimated incidence of cancer than the Queensland average (663 ASR per 100,000), with rates of 697, 697 and 596 ASR per 100,000 respectively.
- men in the SWHHS had a high estimated incidence of prostate cancer, with Charleville and Far South West Planning Regions experiencing the same estimated incidence as Queensland (181 ASR per 100,000). Roma, Roma Region and Balonne Planning Regions had a lower estimated incidence of prostate cancer, with 157, 157 and 142 ASR per 100,000 respectively.
- men in the SWHHS had a higher estimated incidence than average for colorectal cancer. Balonne, Roma, and Roma Region Planning Regions had an estimated incidence of 85, 83 and 83 ASR per 100,000 respectively. Charleville and Far South West Planning Region had an estimated incidence of 77 ASR per 100,000. The Queensland rate was 75 ASR per 100,000.
    - o A high estimated incidence of colorectal cancer in Balonne, Roma, and Roma Region SA2s could be associated with the low rate of bowel cancer screening uptake in the area (i.e., approximately 38 to 39 per cent of the targeted population).
- the estimated incidence of male lung cancer in Charleville, Far South West and Balonne exceeded the state average (62 ASR per 100,000), with these areas experiencing 100, 100 and 70 ASR per 100,000 during 2010-14. Roma and Roma Region Planning Regions experienced a similar estimated incidence of 61 ASR per 100,000.
- women in Balonne, Roma and Roma Region Planning Regions had a higher estimated incidence of cancer than the Queensland rate (515 ASR per 100,000), with 545, 516 and 516 ASR per 100,000 respectively.
- there was a high estimated incidence of breast cancer (71 women) in the SWHHS, with rates between 113 to 133 ASR per 100,000. SA2 incidence were less than the state rate (139 ASR per 100,000), however this was the most common cancer among women in the region.
- The SWHHS had a much higher estimated incidence (160 ASR per 100,000) of 'all other cancers' than the state average (111 ASR per 100,000). 'All other cancers' includes all cancers not listed in Table 60 and can be further analysed at https://www.aihw.gov.au/reports/cancer/cancer-in-australia-2019.
- females in Balonne, Roma and Roma Region Planning Regions had a higher estimated incidence of colorectal cancer than the Queensland rate (62 ASR per 100,000). The estimated incidence for these regions were 88, 83 and 83 ASR per 100,000 respectively.

o   A high estimated incidence of colorectal cancer in Balonne, Roma, and Roma Region SA2s could be associated with the low rate of bowel cancer screening uptake in the area (i.e., approximately 38 to 39 per cent of the targeted population).

Table 4.4.13 Cancer incidence by SA2, females, by SA2, 2010-14 [112]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	All cancers	Females	59	545
Charleville	All cancers	Females	58	505
Far South West	All cancers	Females	36	505
Roma	All cancers	Females	78	516
Roma Region	All cancers	Females	65	516
Queensland	All cancers	Females	56,227	515

Table 4.4.14 Cancer incidence by SA2, males, by SA2, 2010-14 [113]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	All cancers	Males	75	596
Charleville	All cancers	Males	99	697
Far South West	All cancers	Males	61	697
Roma	All cancers	Males	106	607
Roma Region	All cancers	Males	88	607
Queensland	All cancers	Males	73,011	663

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[112] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

[113] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

4.4.2.3.2.1   Male cancers

Figure 4.4.1 Incidence of cancers, males, ASR per 100,000, by SA2, 2010-14 [114]

	Stomach cancer	Bladder cancer	Leukaemia	Lymphoma	Kidney cancer	All other cancers	Head and neck cancer	Melanoma of the skin	Lung cancer	Colorectal cancer	Prostate cancer
Roma Region	n.p	n.p	21	19	22	n.p	45	65	61	83	157
Roma	n.p	n.p	21	19	22	n.p	45	65	61	83	157
Far South West	n.p	n.p	n.p	n.p	n.p	99	66	95	100	77	181
Charleville	n.p	n.p	n.p	n.p	n.p	99	66	95	100	77	181
Balonne	n.p	n.p	n.p	24	22	n.p	48	66	70	85	142

[114] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

Table 4.4.15 Incidence of prostate cancer by SA2, males, by SA2, 2010-14 [115]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	Prostate cancer	Males	18	142
Charleville	Prostate cancer	Males	26	181
Far South West	Prostate cancer	Males	16	181
Roma	Prostate cancer	Males	27	157
Roma Region	Prostate cancer	Males	23	157
Queensland	Prostate cancer	Males	20,114	181

Table 4.4.16 Incidence of colorectal cancer by SA2, males, by SA2, 2010-14 [116]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	Colorectal cancer	Males	11	85
Charleville	Colorectal cancer	Males	11	77
Far South West	Colorectal cancer	Males	7	77
Roma	Colorectal cancer	Males	14	83
Roma Region	Colorectal cancer	Males	12	83
Queensland	Colorectal cancer	Males	8,247	75

Table 4.4.17 Incidence of lung cancer by SA2, males, by SA2, 2010-14 [117]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	Lung cancer	Males	9	70
Charleville	Lung cancer	Males	14	100
Far South West	Lung cancer	Males	9	100
Roma	Lung cancer	Males	11	61
Roma Region	Lung cancer	Males	9	61
Queensland	Lung cancer	Males	6,782	62

[115] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

[116] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

[117] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

4.4.2.3.2.2 Female cancers

Figure 4.4.2 Incidence of cancers, females, ASR per 100,000, by SA2, 2010-14 [118]

Incidence of cancers 2010-14

	Leukaemia	Uterine cancer	Thyroid cancer	Ovarian cancer	Lymphoma	Lung cancer	Melanoma of the skin	All other cancers	Colorectal cancer	Breast cancer
Roma Region	n.p	n.p	n.p	20	27	27	53	n.p	83	133
Roma	n.p	n.p	n.p	20	27	27	53	n.p	83	133
Far South West	n.p	n.p	n.p	n.p	n.p	50	53	160	47	113
Charleville	n.p	n.p	n.p	n.p	n.p	50	53	160	47	113
Balonne	n.p	n.p	25	n.p	n.p	46	84	n.p	88	117

[118] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

Table 4.4.18 Incidence of breast cancer by SA2, females, by SA2, 2010-14[119]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	Breast cancer	Females	13	117
Charleville	Breast cancer	Females	13	113
Far South West	Breast cancer	Females	8	113
Roma	Breast cancer	Females	20	133
Roma Region	Breast cancer	Females	17	133
Queensland	Breast cancer	Females	15,490	139

Data Source: Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal.

Table 4.4.19 Incidence of all other cancers by SA2, females, by SA2, 2010-14[120]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Charleville	All other cancers	Females	18	160
Far South West	All other cancers	Females	11	160
Queensland	All other cancers	Females	11,966	111

Table 4.4.20 Incidence of colorectal cancer by SA2, females, by SA2, 2010-14[121]

SA2 / Planning Area	Measure	Sex	Number	ASR per 100K
Balonne	Colorectal cancer	Females	9	88
Charleville	Colorectal cancer	Females	5	47
Far South West	Colorectal cancer	Females	<5	47
Roma	Colorectal cancer	Females	12	83
Roma Region	Colorectal cancer	Females	10	83
Queensland	Colorectal cancer	Females	6,686	62

4.4.2.3.3   Communicable diseases

Table 4.4.21 demonstrates that from 2017-21, residents in SWHHS experienced:

- o   An increase in cases of chlamydia (from 67 to 101 persons/year)
- o   A low number of cases of gonorrhoea (from five to eight persons/year)
- o   A low number of cases of syphilis (less than five total between 2017-21)

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[119] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

[120] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

[121] Queensland Government. (2022). Cancer incidence 2010-14. Retrieved from Planning portal

Table 4.4.21 Communicable diseases, STIs, SWHHS, 2017-21 [122]

Notifiable condition	2017	2018	2019	2020	2021
Chlamydia (STI)	67	94	64	68	101
Gonorrhoea (STI)	8	4	5	9	5
Syphilis (infectious)	1	3	0	2	0
Total:	76	101	69	79	106

4.4.2.4 Average unhealthy days (adult)

Figure 4.4.3 illustrates that in 2019-20, the SWHHS rate of total unhealthy days in the past 30 days was comparable across all five Planning Regions, ranging from 6.6 to 8.7 per cent. The Queensland prevalence is 7.9 per cent. The number of unhealthy days in SWHHS is highly regional specific but is below the Queensland average.

4.4.2.4.1 State population

- In this report, the top five conditions have been analysed for acute and chronic potentially preventable hospitalisations.

- In 2019-20:

  - Urinary tract infection was the most common reason for admission of conditions classified as acute potentially preventable hospitalisation in Queensland (21,215). This represents 25.79 per cent of all acute potentially preventable hospitalisations.

  - In the SWHHS:

    - Cellulitis was the most common acute potentially preventable hospitalisation condition with 142 cases (25.38 per cent). The Queensland rate for cellulitis was 22.92 percent

    - Convulsions and epilepsy were the least common reason for admission for acute potential preventable hospitalisation condition.

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[122] Queensland Government. (2022). Communicable diseases - sexually transmitted infections 2017-21. Retrieved from Planning portal

PPH Condition distribution by HHS (Acute), 2019/2020
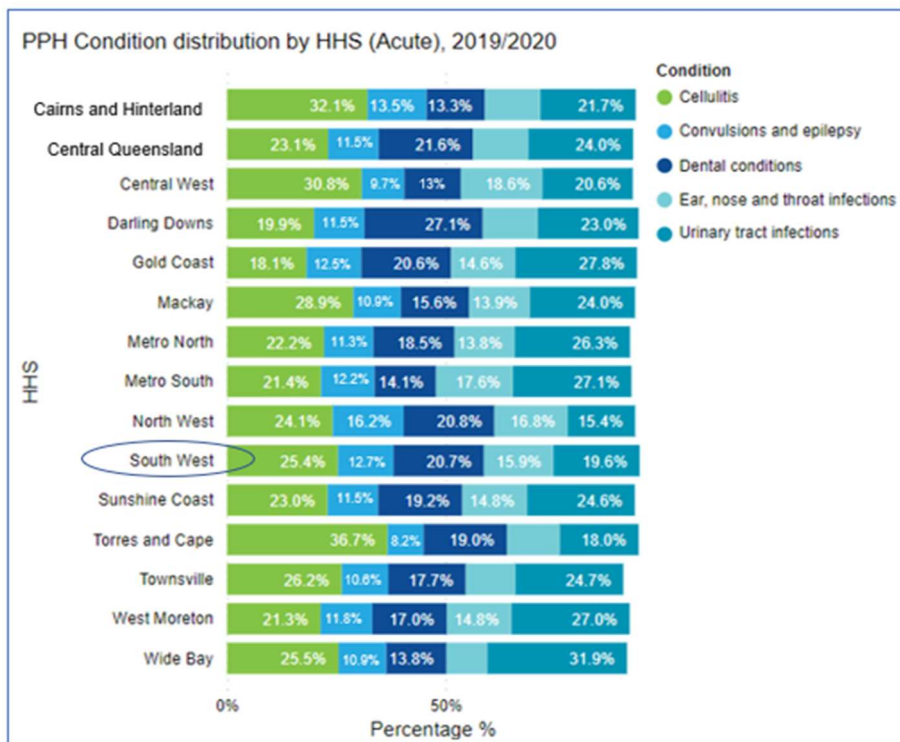
4.4.2.4.2   First Nations Peoples

Figures 4.4.5 to 4.4.10 illustrate that in 2019-20, ear, nose and throat infections were the most common acute potentially preventable hospitalisation for First Nations Peoples in the SWHHS (23.5 per cent).

- Overall, small numbers of First Nations Peoples were admitted for potentially preventable hospitalisation conditions (18 to 32 persons in 2019-20) in comparison to Other Australians 40-124 persons in 2019-2020).

- In 2019-20, diabetes complications were the most commonly experienced chronic potentially preventable hospitalisation condition by First Nations Peoples in the SWHHS (45.67 per cent).

- There were small numbers of First Nations People admitted for chronic potentially preventable hospitalisation conditions (11 to 95 persons in 2019-2020) in comparison to Other Australians (15 – 262 persons in 2019-2020).

- All First Nations Persons experiencing vaccine preventable hospitalisations in Balonne, Roma Region and Charleville were related to Influenza and pneumonia.

- Roma and Far South West SA2s admitted First Nations Peoples for both Influenza and pneumonia, and other preventable conditions. Vaccination rates identified earlier in this report does not shed light on this statement as not all data was available.

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[123] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

Figure 4.4.5 Selected acute PPHs, First Nations Peoples, 2019-20[124]

PPH by Condition - (South West - Multiple SA2s)2019/2020
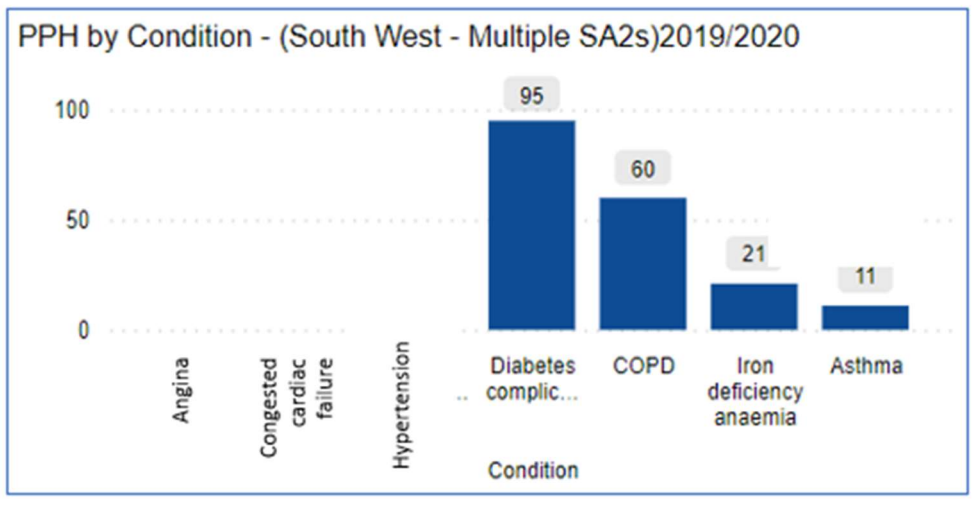
Figure 4.4.6 Selected chronic PPHs, First Nations Peoples, 2019-20[125]

Indigenous
PPH Condition distribution by HHS (Vaccine preventable), 2019/2020

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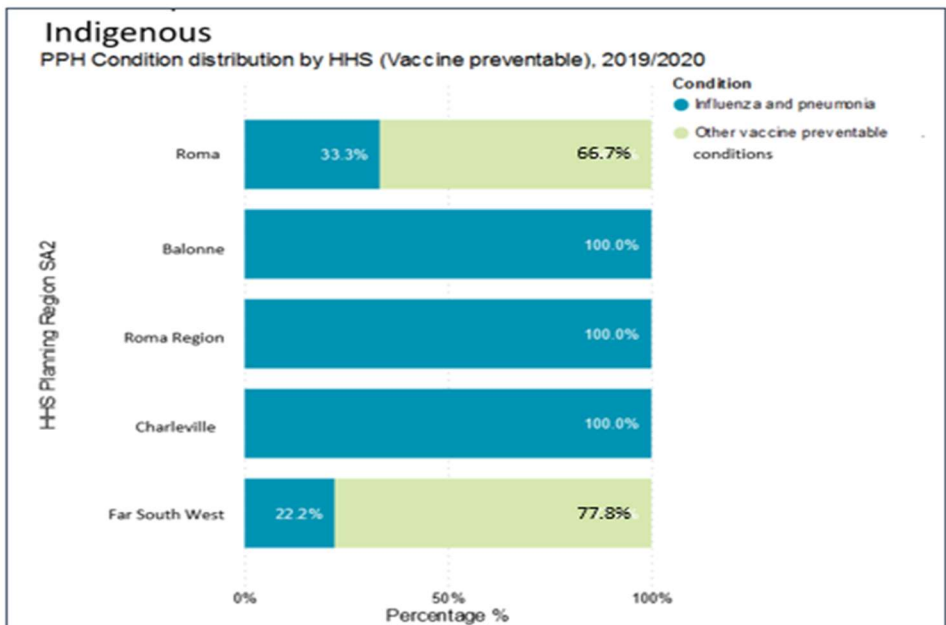
[124] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

[125] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal
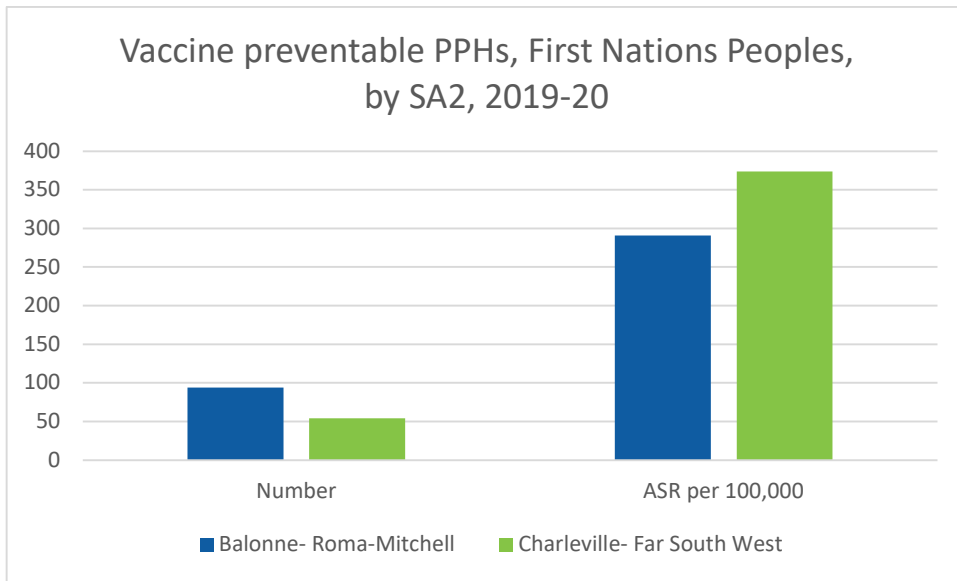
4.4.2.4.3   Other Australians

In 2019-20:

- cellulitis was the most common acute potentially preventable hospitalisation condition by Other Australians in the SWHHS (29.24 per cent).
- diabetes complications were the most common chronic potentially preventable hospitalisation condition throughout Queensland, including the SWHHS (47.63 per cent).
- The SWHHS had the third highest rate of vaccine preventable hospitalisations for influenza and pneumonia in Queensland.

Figure 4.4.8 Selected acute PPHs, other Australians, 2019-20[126]

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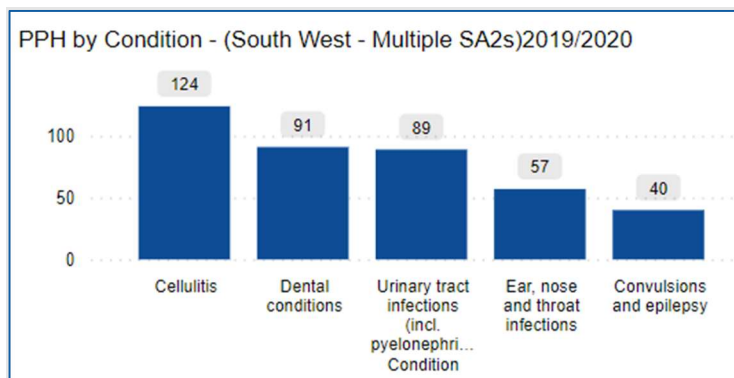
[126] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

Figure 4.4.9 Selected chronic PPHs, other Australians, 2019-20[127]
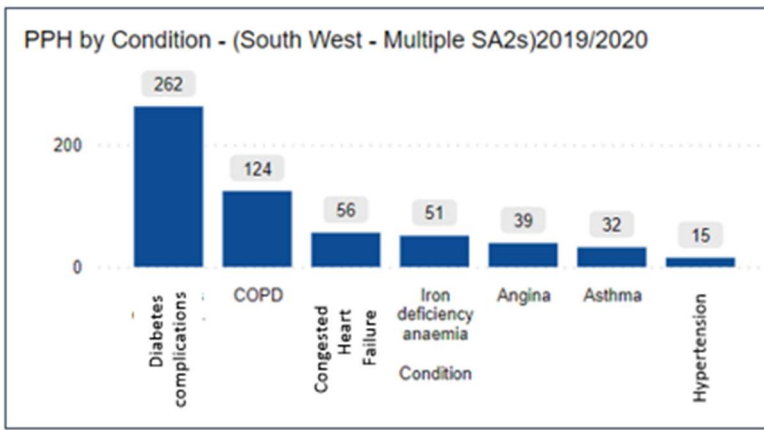
Figure 4.4.10 Vaccine preventable PPHs, Queenslander comparison, 2019-20[128]
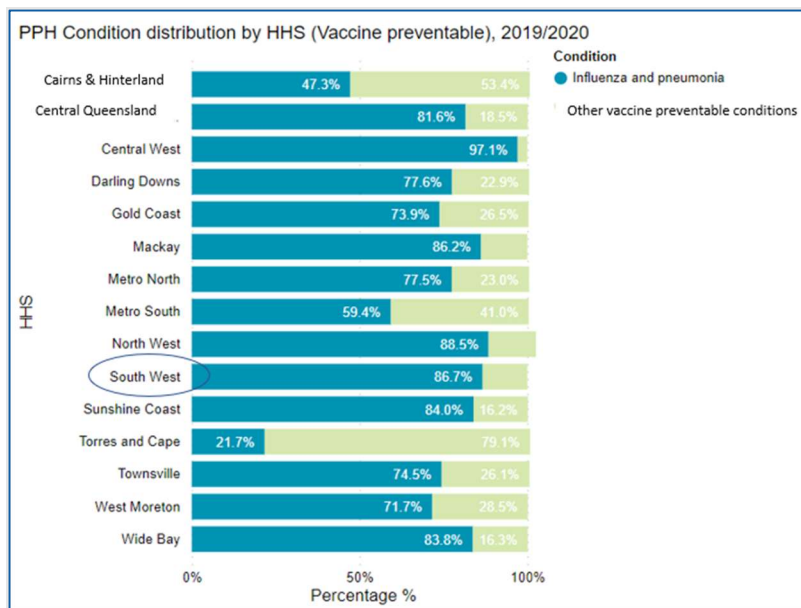
Data Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Statistical Services Branch, Queensland. Prepared by Statistical Reporting and Coordination, Statistical Services Branch, Queensland Health.

4.4.2.4.4   Total admitted separations for PPH dental-related conditions

- In 2019-20, dental conditions were the cause of 20.7 per cent of the SWHHS acute potentially preventable hospitalisations – the third highest in the state.

- First Nations Peoples had a lower rate of dental-related PPHs (18.4 per cent) when compared with other Australians (21.5 per cent) in the SWHHS.

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[127] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

[128] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

First Nations Peoples

- Charleville SAS2 had the highest rate of PPHs related to dental conditions for First Nations people in the SWHHS – 29.2 per cent.

- Balonne SA2 had the lowest rate of PPHs related to dental conditions for First Nations people in the SWHHS – 10.0 per cent.

Other Australians

- Roma Region SA2 had the highest rate of PPHs related to dental conditions for other Australians in the SWHHS – 31.6 per cent Charleville SA2 had the lowest rate of PPHs related to dental conditions for other Australians in the SWHHS – 9.8 per cent

Figure 4.4.11 Dental condition PPHs by HHS, 2019-20[129]

PPH Condition distribution by HHS (Acute), 2019/2020

Condition
● Dental conditions

HHS	Percentage %
Cairns and Hinterland	13.3%
Central Queensland	21.6%
Central West	13.0%
Darling Downs	27.1%
Gold Coast	20.6%
Mackay	15.6%
Metro North	18.5%
Metro South	14.1%
North West	20.8%
South West	20.7%
Sunshine Coast	19.2%
Torres and Cape	19.0%
Townsville	17.7%
West Moreton	17.0%
Wide Bay	13.8%

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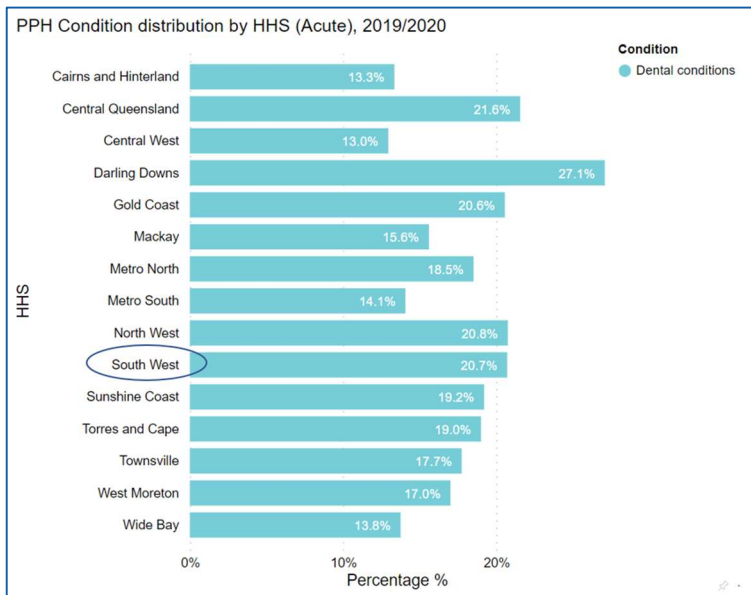
[129] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

Figure 4.4.12 Dental conditions, PPHs, by SA2, non-Indigenous, 2019-20[130]
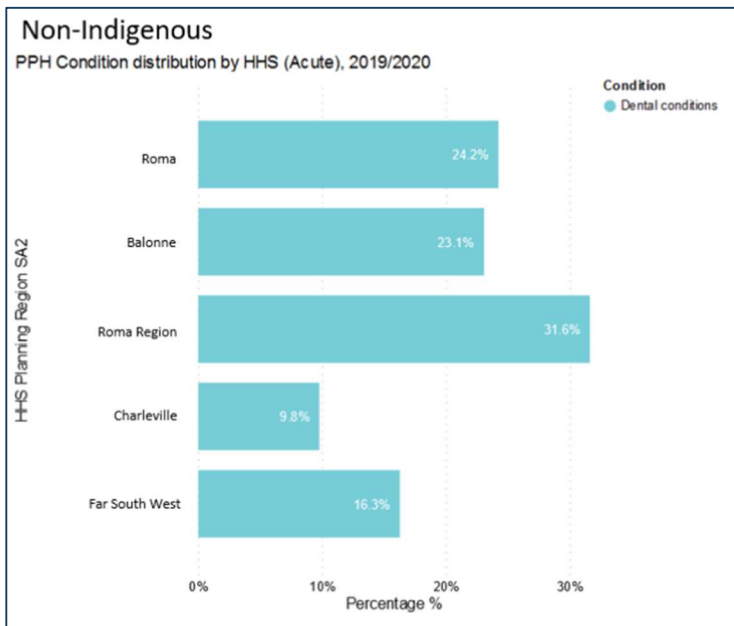
Figure 4.4.13 Dental conditions, PPHs, by SA2, First Nations Peoples, 2019-20[131]
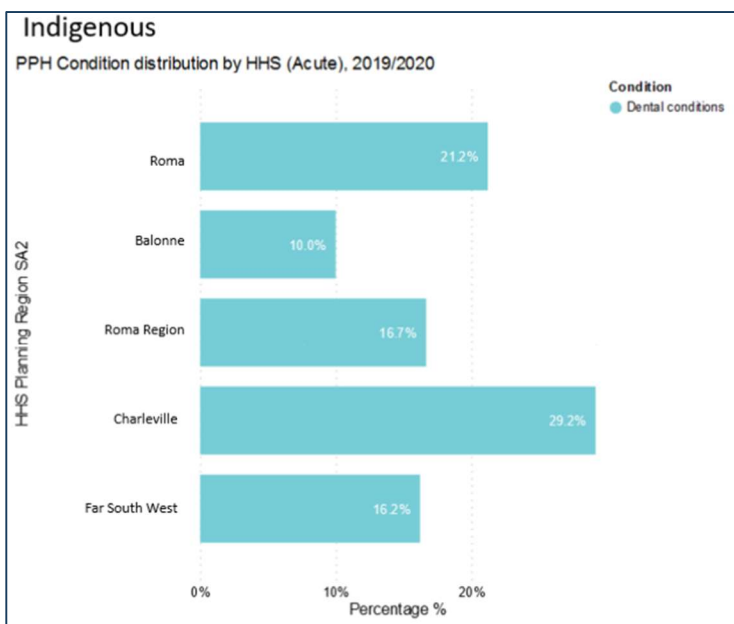
[130] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

[131] Queensland Government. (2022). Potentially preventable hospitalisations 2019-20. Retrieved from Planning portal

4.4.3   Mortality

4.4.3.1   Life expectancy

From 2017-19, Outback Queensland SA4 had the lowest life expectancy at birth in the state – 78.8 years. From 2013-15 to 2017-19, the life expectancy at birth was lower than the State rate for both males and females in the SA4s of - Darling Downs -Maranoa and Queensland Outback. The difference between the Outback Queensland SA4 and the State rate was between three (3) to five (5) years.
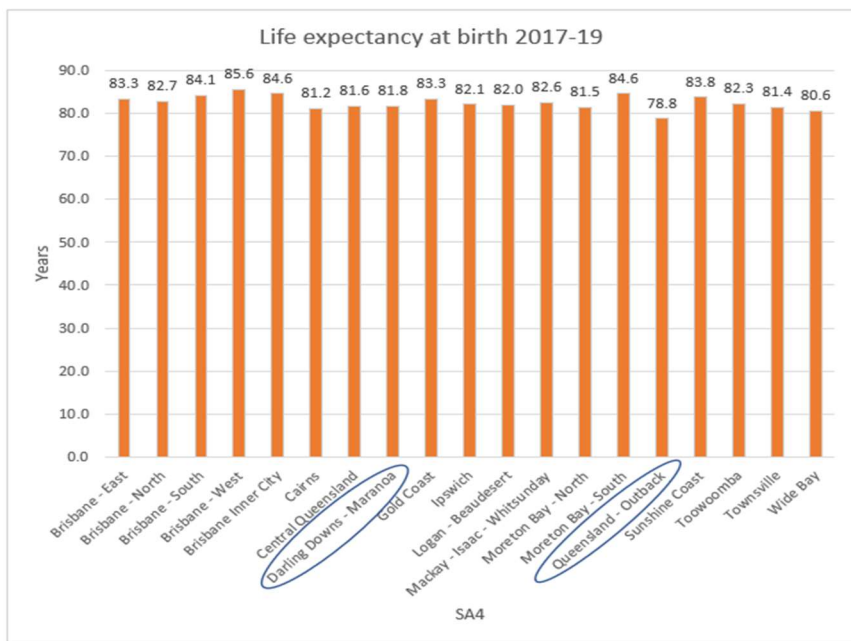
Figure 4.4.14 Life expectancy at birth by SA4, 2017-19[132]
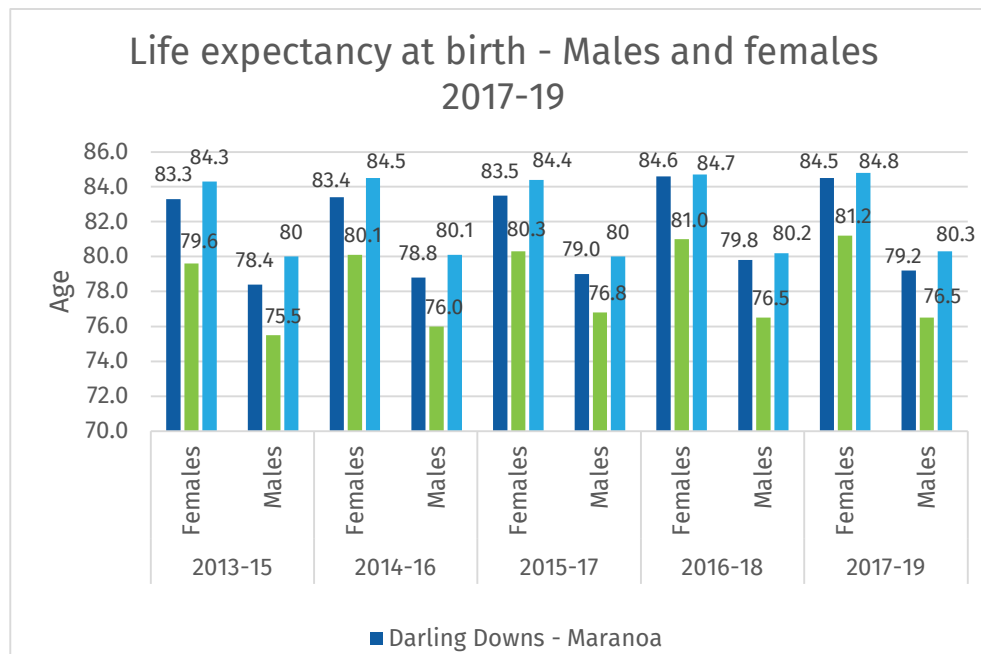
Figure 4.4.15 Life expectancy at birth by sex, SA4 and Queensland, 2017-19[133]

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[132] Queensland Government. (2022). Life expectancy 2010-12 to 2017-19. Retrieved from Planning portal

[133] Queensland Government. (2022, March). Life expectancy 2010-12 to 2017-19. Retrieved from Planning portal

4.4.3.2 Potential years of life lost

During 2014-18, in all the SWHHS IAREs except the Maranoa – Roma – Mitchell, the estimated potential years of life lost for the SWHHS residents aged less than 75 years was higher than the Queensland average. This applies to First Nations Peoples and other Australians. The estimated potential years of life lost ASR for First Nations Peoples was higher than the ASRs for other Australians. It was estimated that First Nation Peoples living in Queensland experienced approximately double the potential years of life lost ASR (80 ASR per 1,000) than other Australians in Queensland (42 ASR per 1,000).
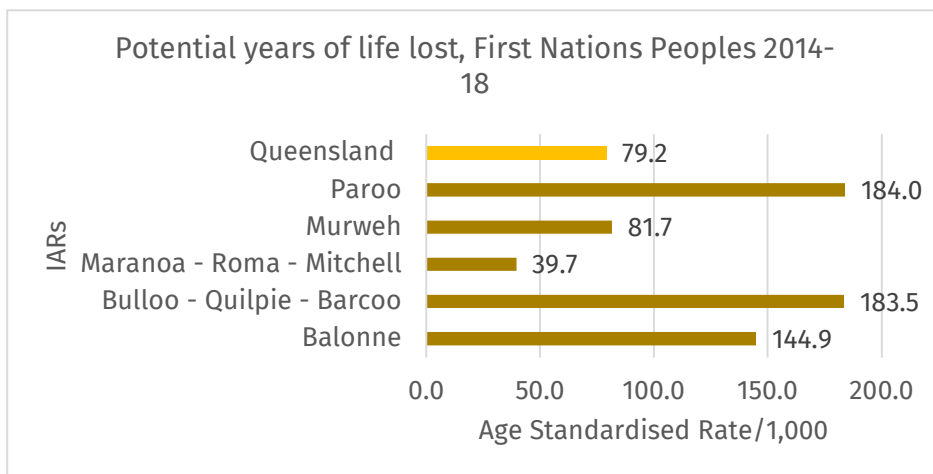
Figure 1.4.16 Potential years of life lost by IAREs, First Nations Peoples, <75 years, 2014-18[134],
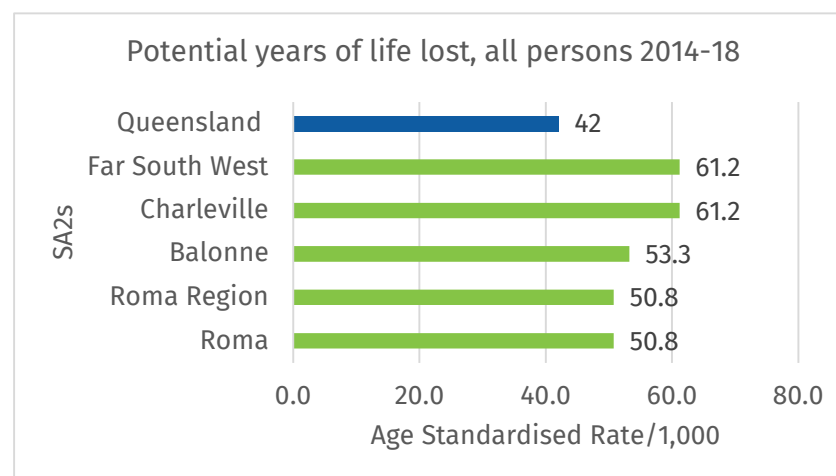
Figure 4.4.17 Potential years of life lost by SA2, all persons, <75 years, 2014-18[135]

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[134] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

[135] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

4.4.3.2.1 Cancer

In 2014-18, in all the SWHHS IAREs except the Maranoa – Roma – Mitchell, the estimated potential years of life lost from cancer was generally higher for First Nations Peoples. Queensland First Nations Peoples potential years of life lost ASR per 1,000 in the IAREs of Paroo, Murweh, Bulloo – Quilpie – Barcoo and Balonne were all estimated to be greater than the other Queensland and also other First Nations Peoples living in Queensland.
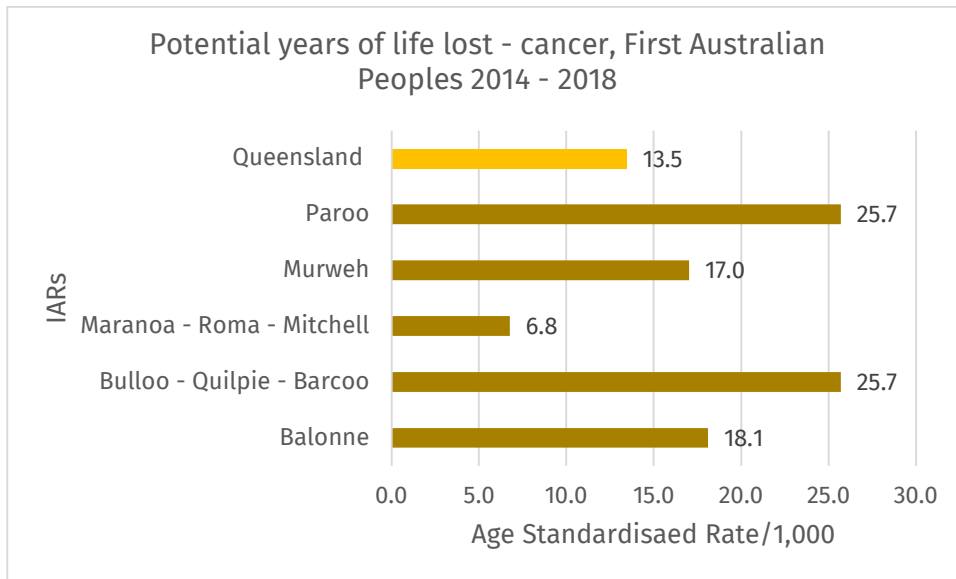
Figure 4.4.18 Potential years of life lost cancer, by IAREs, First Nations Peoples, <75 years, 2014-18 [136],
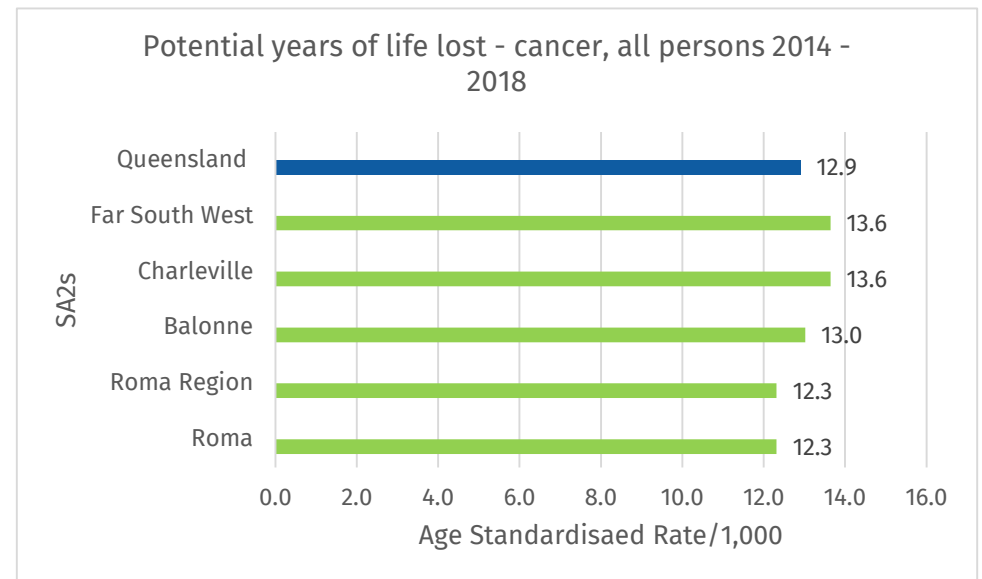
Figure 4.4.19 Potential years of life lost-cancer by SA2, all persons <75 years, 2014-18[137]

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[136] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

[137] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

4.4.3.2.2 Ischaemic Heart Disease (IHD)

No First Nations Peoples potential years of life lost data available for IHD. During 2014-18 in the SWHHS, the estimated potential years of life lost ASR/1,000 was greater than the Queensland rate. The more western SA2s had a higher estimated potential years of life lost rates of IHD than other SA2s.

Potential years of life lost - ischaemic heart disease, all persons 2014 - 2018

SA2	Age Standardised Rate/1,000
Queensland	2.9
Far South West	8.6
Charleville	8.6
Balonne	5.1
Roma Region	3.4
Roma	3.4
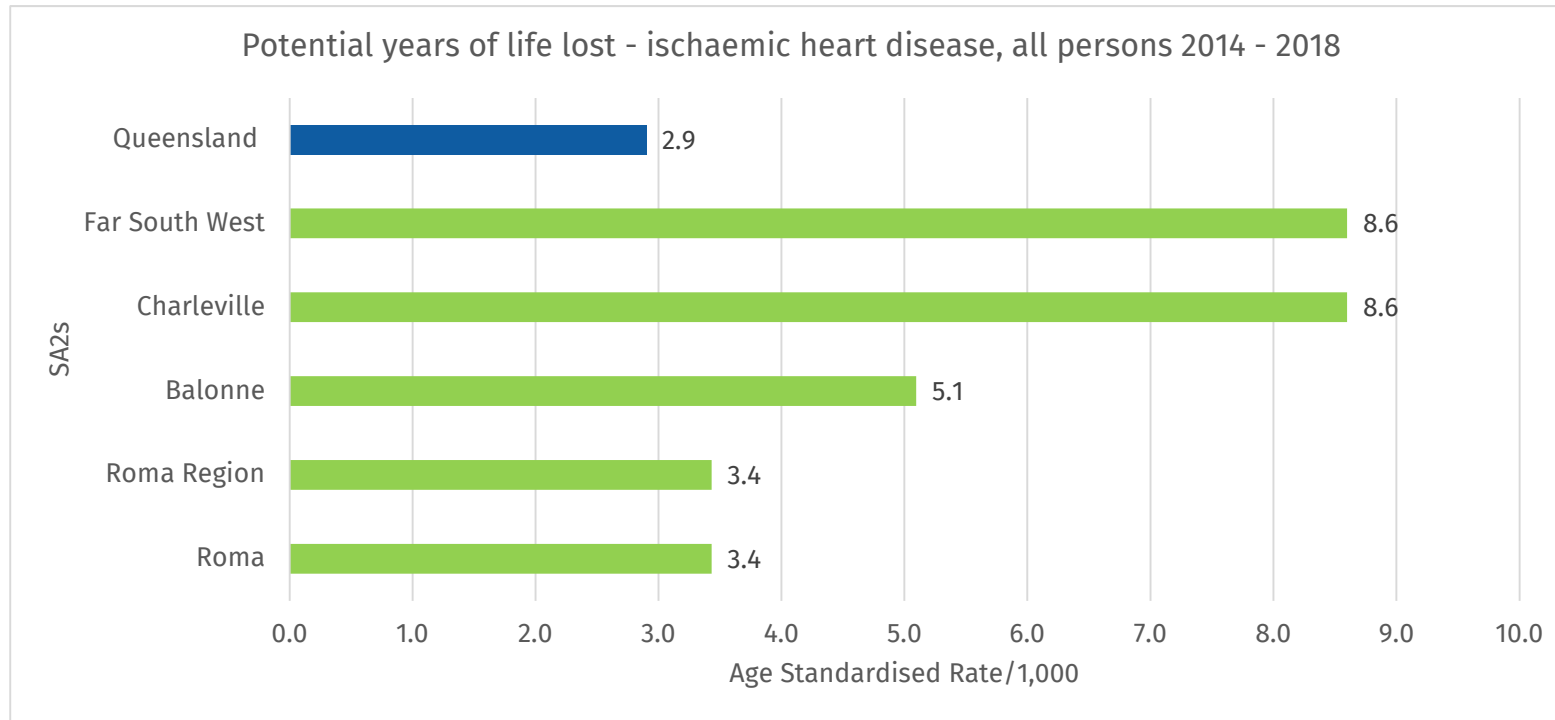
Figure 4.4.20 Potential years of life lost-ischaemic heart disease by SA2, all persons, <75 years, 2014-18 [138]

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[138] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

4.4.3.2.3   Circulatory system disease

In 2014-18, it was estimated that the Indigenous Regions of Paroo and Bulloo-Quilpie-Barcoo had five times the potential years of life lost rate from circulatory system disease than other First Nations Peoples living in Queensland. In the more western SA2s of Far South West and Charleville it was estimated that the rate of potential years of life lost rate from circulatory system disease was more than double the Queensland rate. The SWHHS had an estimated potential years of life lost rate greater than the Queensland rate. First Nations Peoples living in Queensland had an estimated potential years of life lost ASR (12 ASR per 1,000) for circulatory system disease at approximately double the rate of other Australians living in Queensland (6 ASR per 1,000).
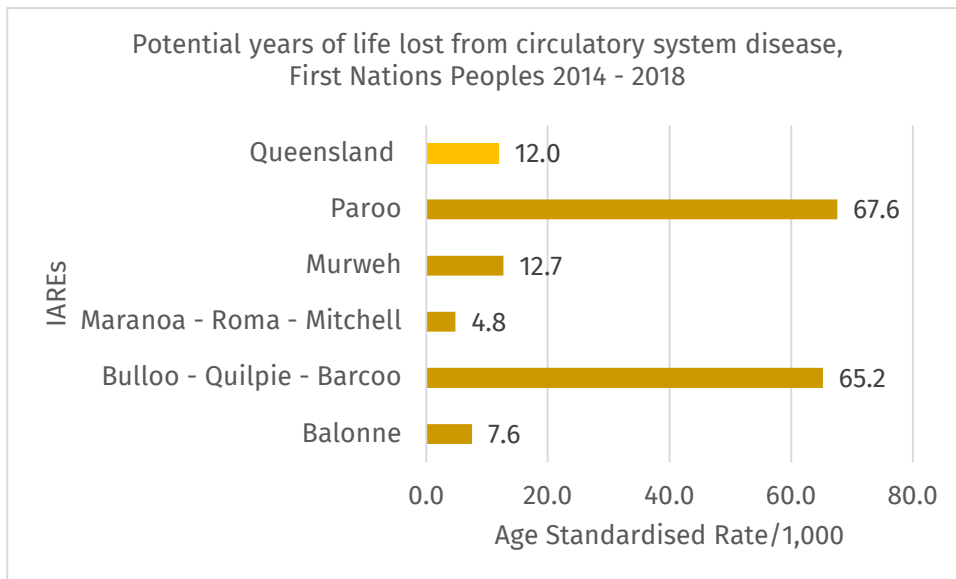
Figure 4.4.21 Potential years of life lost circulatory system disease, by IAREs, 2014-18
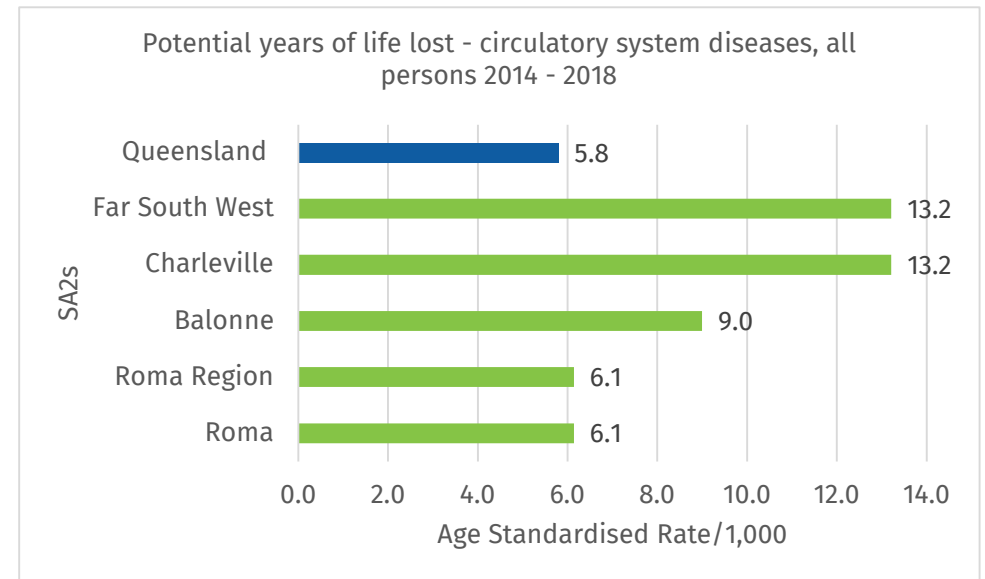
Figure 4.4.22 Potential years of life lost - circulatory system disease by SA2, all persons, <75 years, 2014-18 [139]

[139] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

4.4.3.2.4 Respiratory system disease

It is estimated that the Indigenous Regions of Paroo and Bulloo-Quilpie-Barcoo had more than three (3) times the potential years of life lost rate from respiratory system disease than the Queensland rate. All South West SA2s, except for Balonne, experienced estimated potential years of life lost rates from respiratory system disease greater than the state rate. The Queensland First Nations estimated potential years of life lost rate (4 ASR per 1,000) for respiratory system disease was approximately double the Queensland State rate (2 ASR per 1,000).
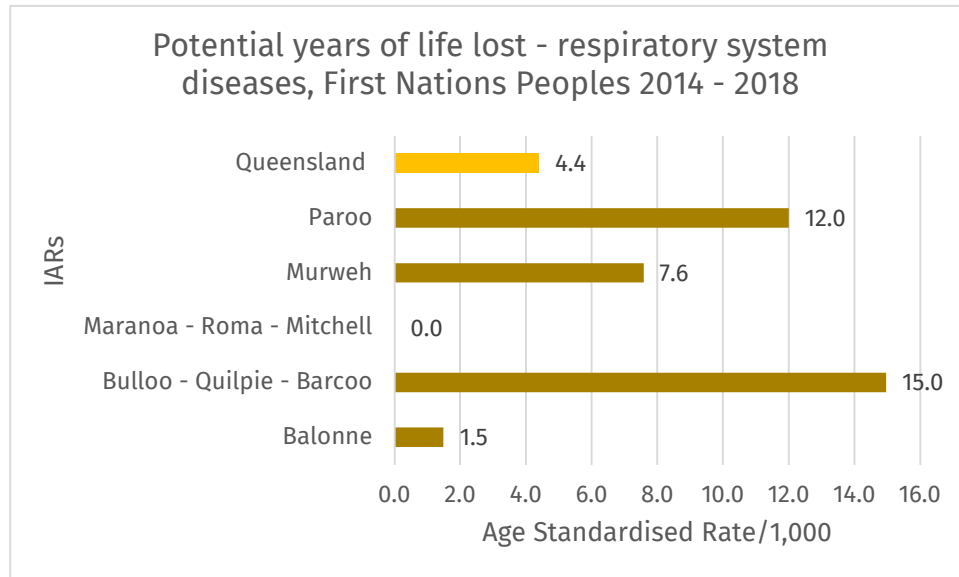
Figure 4.4.23 Potential years of life lost – Respiratory system disease by IAREs, First Nations People, 2014-2018
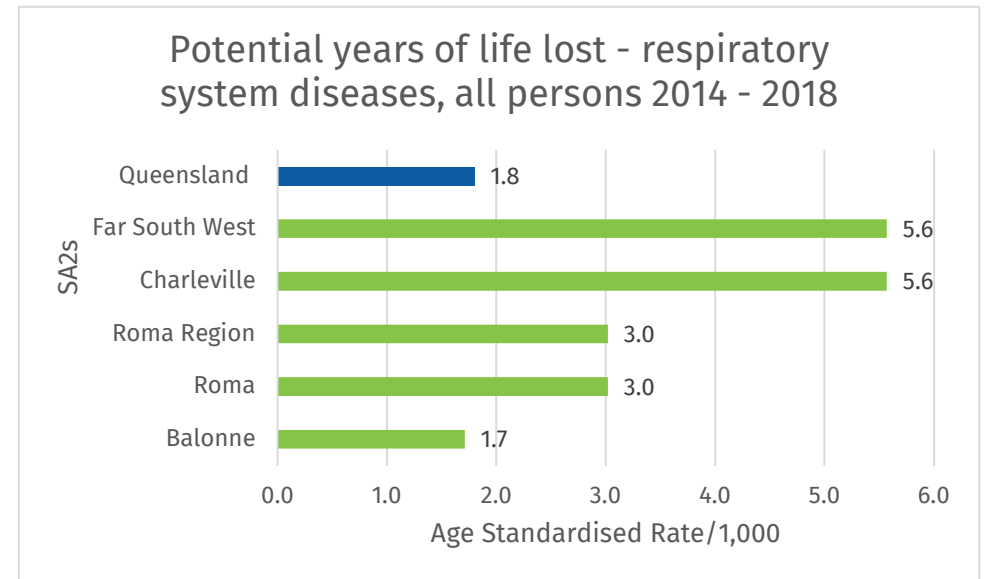
Figure 4.4.24 Potential years of life lost – Respiratory system disease by SA2, all persons, <75 years, 2014-18 *Error! Bookmark not defined.*

4.4.3.2.5 Diabetes

It is estimated that all SA2s had potential years of life lost rates from diabetes at rates greater than the State rate. The estimated potential years of life lost from diabetes by First Nations populations was approximately two (2) to seven (7) times greater than the Queensland rate. The estimated Queensland First Nations potential years of life lost from diabetes was approximately four (4) times greater than the Queensland State rate (3.9 and 0.9 ASR per 1,000 respectively).
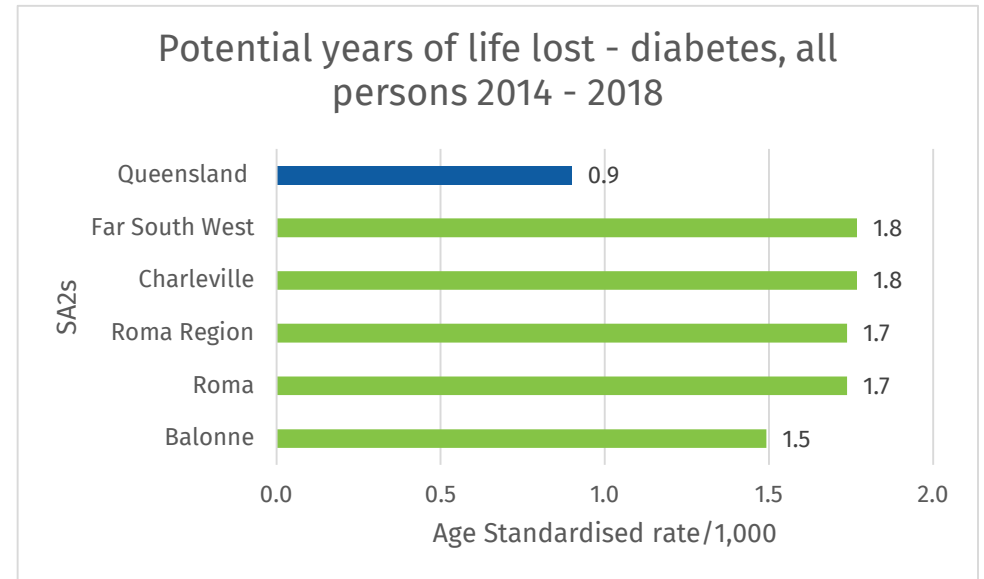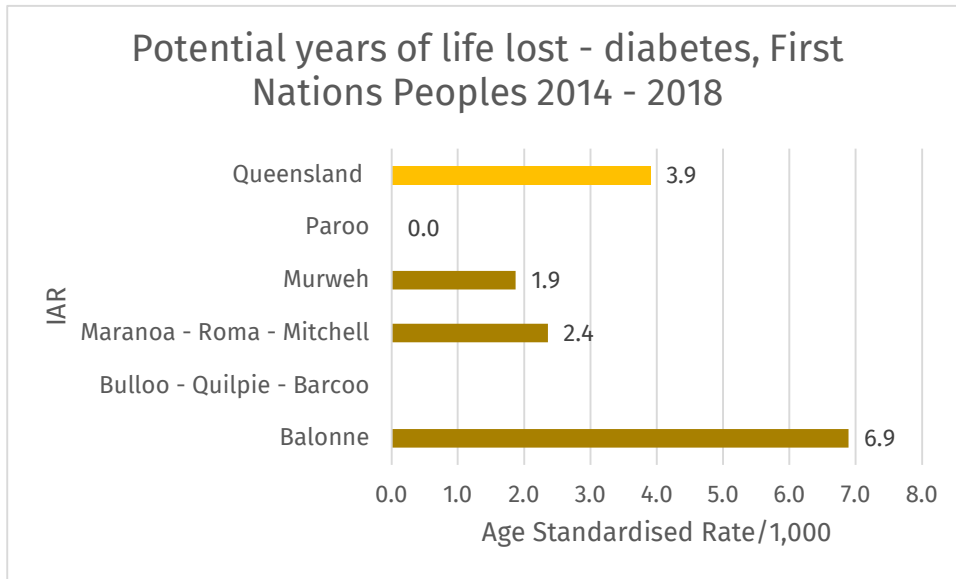
Figure 4.4.25 and Figure 4.4.26 Potential years of life lost – diabetes, by IAREs, First Nations Peoples, <75 years, and all persons 2014-18 [140,]

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[140] Queensland Government. (2022). Potential years of life lost, First Nations Peoples 2014-18. Retrieved from Planning portal

[141] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

4.4.3.2.6   Suicide and self-inflicted injuries

In 2014-18 in the SWHHS, for those aged below 75 years, it was estimated that:

- Charleville and Far South West SA2s had the highest ASRs of PYLL from suicide and self-inflicted injuries (both 14.5 per 100,000), followed by Roma and Roma Region SA2s (both 8.7 per 100,000) and Balonne SAs (5.2 SA2).
- All ASRs of PYLL from suicide and self-inflicted injuries (5.2-14.5 per 100,000) were higher than the Queensland rate of 5.12 per 100,000.

Table 4.4.22 Potential years of life lost from suicide and self-inflicted injuries, ages 0-74 years, SWHHS, 2014-18[142]

SA3/Geographical region	SA2 / Planning Region	Number	ASR per 100,000
Darling Downs (West) - Maranoa	Balonne	96	5.2
Darling Downs (West) - Maranoa	Roma	265	8.7
Darling Downs (West) - Maranoa	Roma Region	222	8.7
Outback - South	Charleville	286	14.5
Outback - South	Far South West	177	14.5
Queensland		115,479	5.12

4.4.3.3   Premature mortality

4.4.3.3.1   First Nations Peoples – All causes

- Limited First Nations data is available so only premature deaths from all causes for First Nations people is presented in this report.
- The IAREs of Paroo and Bulloo – Quilpie – Barcoo have estimated premature death rates more than double the Queensland First Nations rate.

Figure 4.4.27 Premature deaths from all causes, First Nations, <75 years, 2014-2018[143]

Deaths from all causes, First Nations Peoples 2014 - 2018

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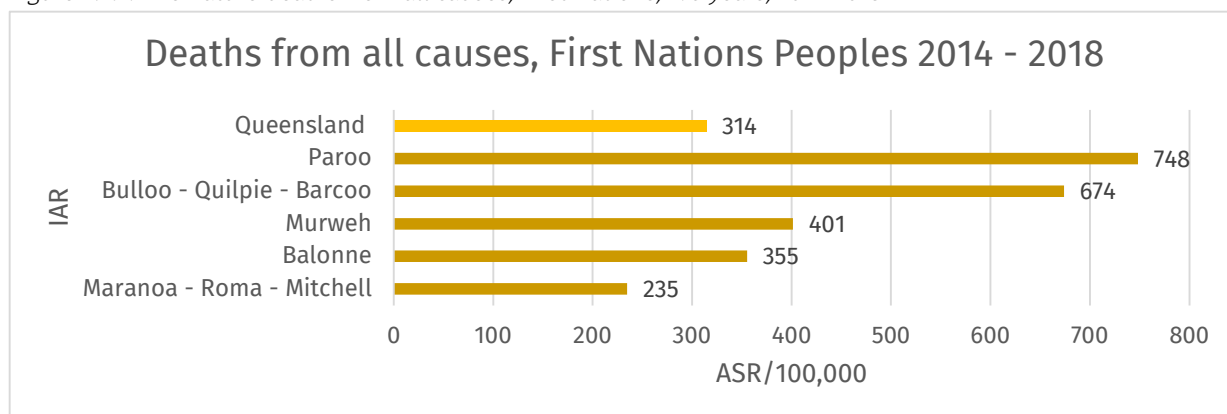
[142] Queensland Government. (2022). Potential years of life lost 2014-2018. Retrieved from Planning portal

[143] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Indigenous Areas. Prepared by System Planning Branch, Planning Portal.

4.4.3.3.2 All population (First Nations Peoples and other Australians)

4.4.3.3.2.1 Cancer

- In 2014-18, there were higher ASRs of estimated premature deaths from cancer than the Queensland rate.

Figure 4.4.28 Premature deaths – Cancer, <75 years, 2014-2018[144]

Premature deaths from cancer 2014 - 2018

SA2s	ASR/100,000
Queensland	102
Far South West	115
Charleville	115
Roma Region	108
Roma	108
Balonne	108
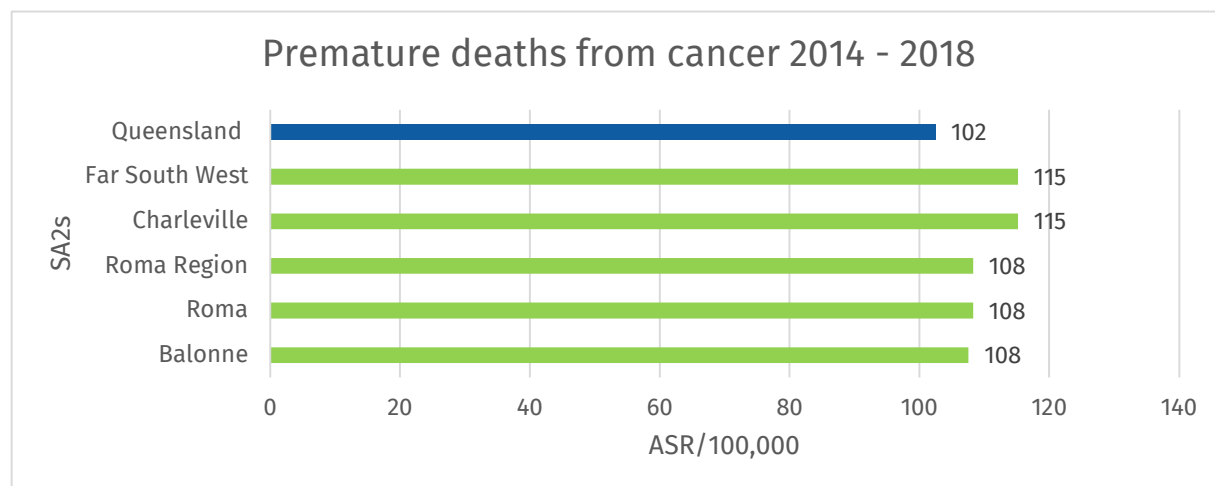
4.4.3.3.2.2 Diabetes

The estimated rate of premature death from diabetes was more than double the State rate for all SA2s in the South West.

Figure 4.4.29 Premature deaths – Diabetes, below <75 years, 2014-2018[145]

Premature deaths from diabetes 2014 - 2018

IAR	ASR/100,000
Queensland	7
Balonne	17
Roma Region	15
Roma	15
Far South West	14
Charleville	14
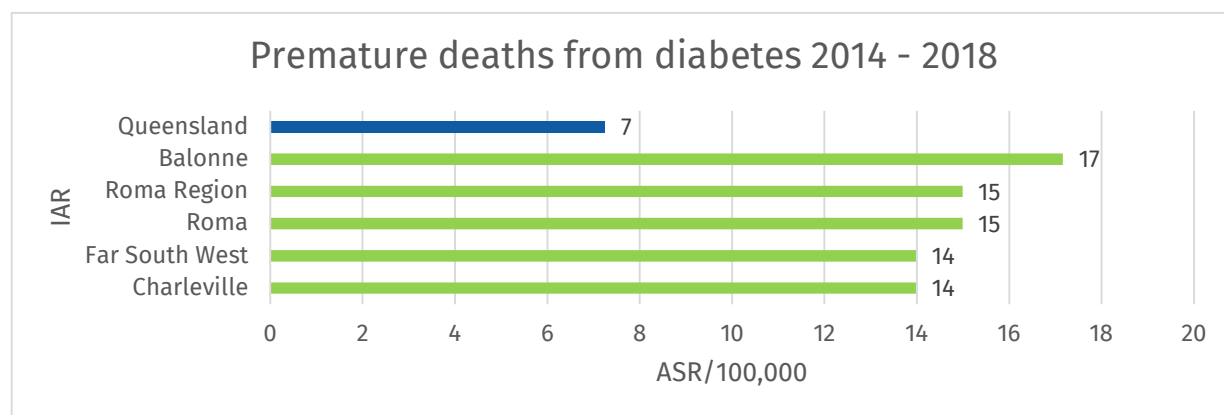
4.4.3.3.2.3 Circulatory System Diseases

The estimated rate of premature deaths from circulatory system diseases was comparable for the SA2s of Roma and Roma Region, though double the State rate in the more western SA2s of Far South West and Charleville.

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[144] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Indigenous Areas. Prepared by System Planning Branch, Planning Portal.

[145] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Indigenous Areas. Prepared by System Planning Branch, Planning Portal.

Figure 4.4.30 Premature deaths – Circulatory System Diseases, <75 years, 2014-2018[146]

Premature deaths from circulatory system diseases 2014 – 2018

SA2s	ASR per 100,000
Queensland	44
Far South West	88
Charleville	88
Balonne	61
Roma Region	45
Roma	45
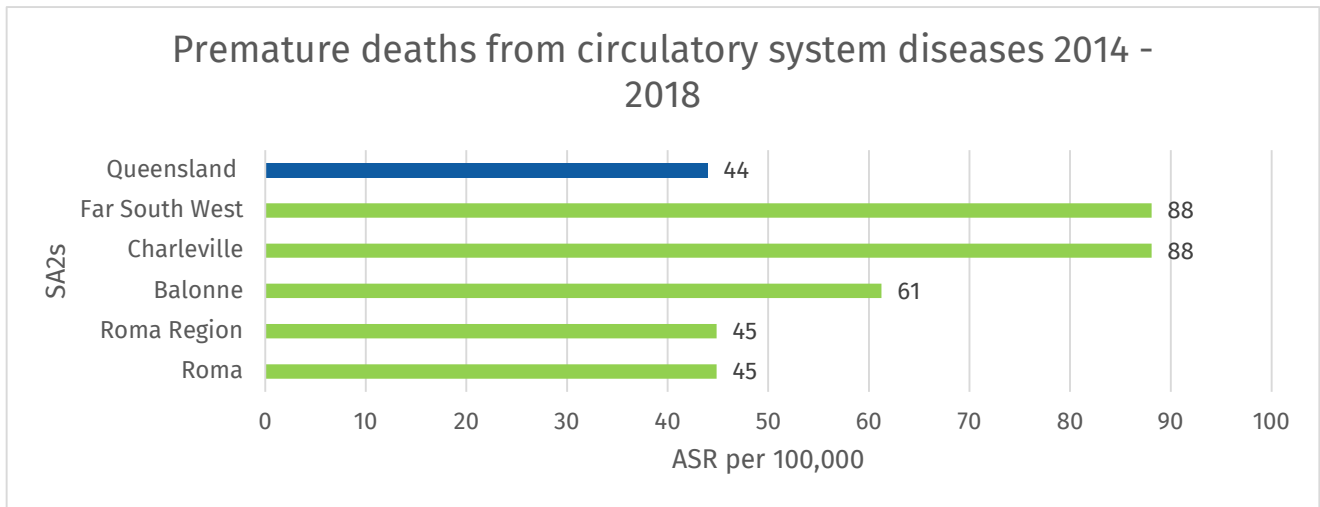
4.4.3.3.2.4   Respiratory System Disease

The estimated rates of premature deaths from Respiratory System Diseases were greater in all SA2s when compared to the State rate, though more than double in the more western SA2s of Far South West and Charleville.

Figure 4.4.31 Premature deaths – Respiratory System Diseases, <75 years, 2014-2018[147]

Premature deaths from respiratory system diseases 2014 – 2018

SA2s	ASR per 100,000
Queensland	16.6
Far South West	40.1
Charleville	40.1
Balonne	22.6
Roma Region	22.1
Roma	22.1
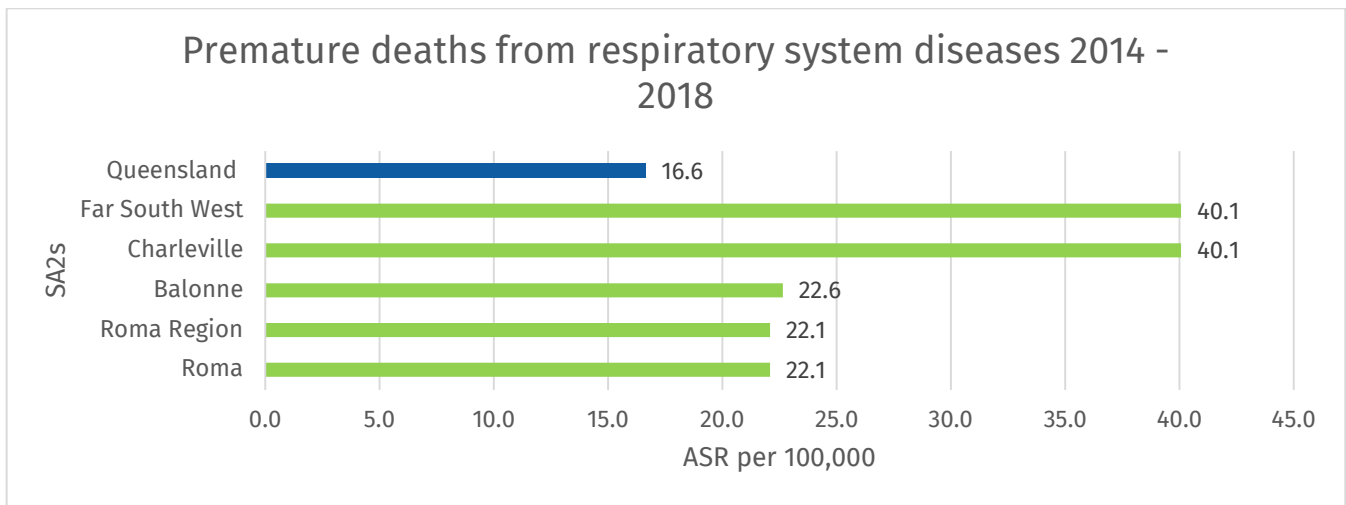
4.4.3.3.2.5   Chronic Obstructive Pulmonary Disease

The estimated rates of premature deaths from chronic obstructive pulmonary disease were greater in all SA2s when compared to the State rate, though approximately triple in the more western SA2s of Far South West and Charleville.

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[146] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Indigenous Areas. Prepared by System Planning Branch, Planning Portal.

[147] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal.

Premature deaths from chronic obstructive pulmonary disease 2014 - 2018

SA2s

Region	Value
Far South West	11
Far South West	34
Balonne	34
Balonne	19
Roma	16
Roma	16

ASR per 100,000
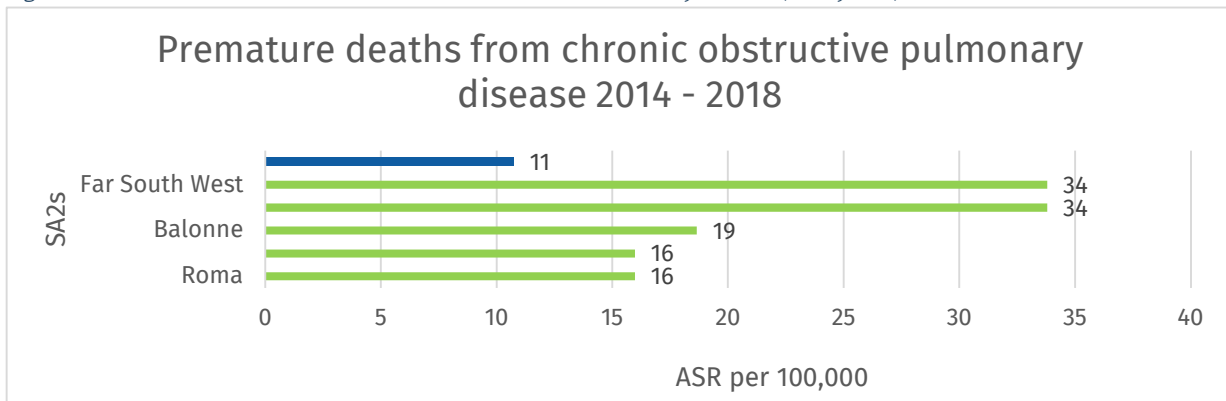
4.4.3.3.2.6 Suicide and self-inflicted injuries

- In 2014-18 in the SWHHS, for those aged below 75 years, it is estimated that:

  – Charleville and Far South West SA2s had the highest ASRs of premature deaths from suicide and self-inflicted injuries (36.3 per 100,000), followed by Roma and Roma Region SA2s (24.5 per 100,000) and Balonne SA2 (13.7 per 100,000).

  – The ASRs of premature deaths from suicide and self-inflicted injuries in all SA2s (except Balonne) were higher than the state rate of 15.38 per 100,000.

Table 4.4.23 Premature deaths from suicide and self-inflicted injuries, ages 0-74 years, SWHHS, 2014-18[149]

SA3/Geographical region	SA2 / Planning Region	Number	ASR per 100,000
Darling Downs (West) - Maranoa	Balonne	<5	13.7
Darling Downs (West) - Maranoa	Roma	<10	24.5
Darling Downs (West) - Maranoa	Roma Region	<10	24.5
Outback - South	Charleville	<10	36.3
Outback - South	Far South West	<5	36.3
Queensland		3473	15.38

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[148] Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal.

[149] Queensland Government. (2022). Premature deaths 2014-2018. Retrieved from Planning portal

4.4.3.4 Potentially avoidable deaths

The IAREs of Paroo and Bulloo – Quilpie – Barcoo had estimated rates of death from all avoidable causes more than double the Queensland First Nations rate and triple the Queensland rate. Maranoa-Roma-Mitchell was the only IAREs that was below the Queensland ASR. First Nations data for potentially avoidable deaths is limited so specific conditions have not been presented in the analysis – only deaths from all causes.
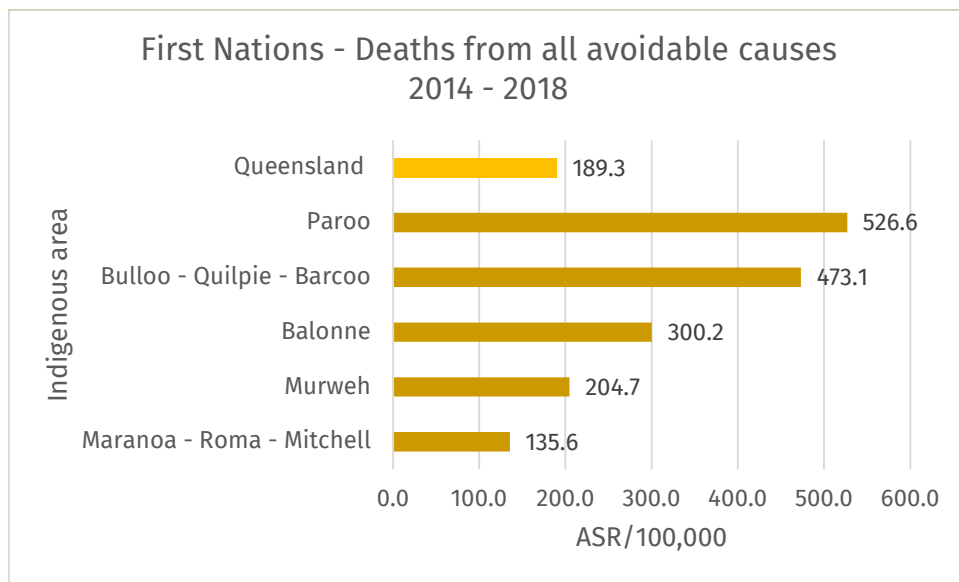
Figure 4.4.33 Potentially avoidable deaths-all causes, First Nations, <75 years, 2014-2018
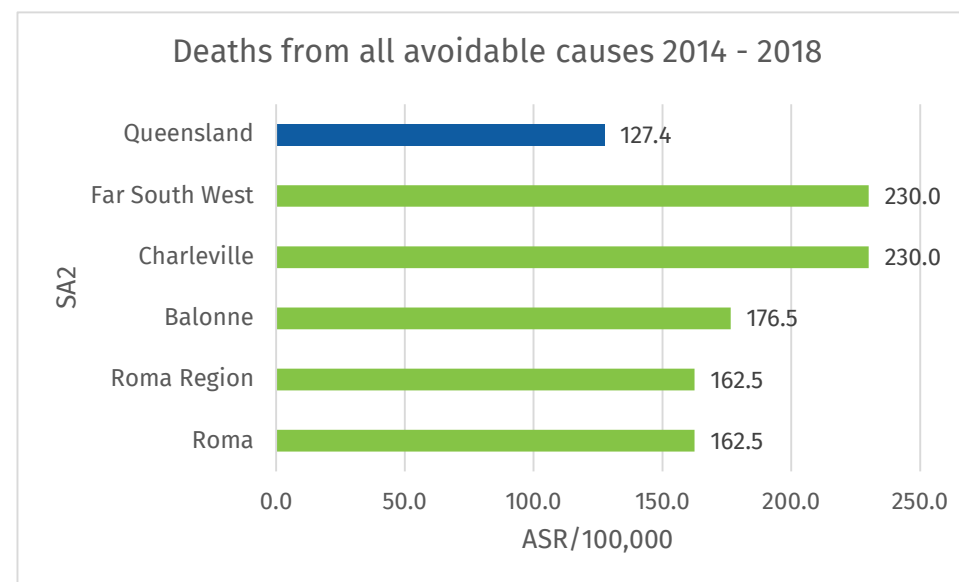
Figure 4.4.34 Potentially avoidable deaths - all causes, <75 years, 2014-2018

4.4.3.4.1 All population (First Nations Peoples and other Australians)[150]

4.4.3.4.1.1 Cancer

- The SA2s of Roma and Roma Region had estimated rates of avoidable deaths from cancer (ASR 29) that were less than the state ASR of 31.

Figure 4.4.35 Potentially avoidable deaths – cancer, <75 years, 2014-2018

Avoidable deaths from cancer 2014 - 2018

SA2	ASR/100,000
Queensland	31
Far South West	34
Charleville	34
Balonne	33
Roma Region	29
Roma	29
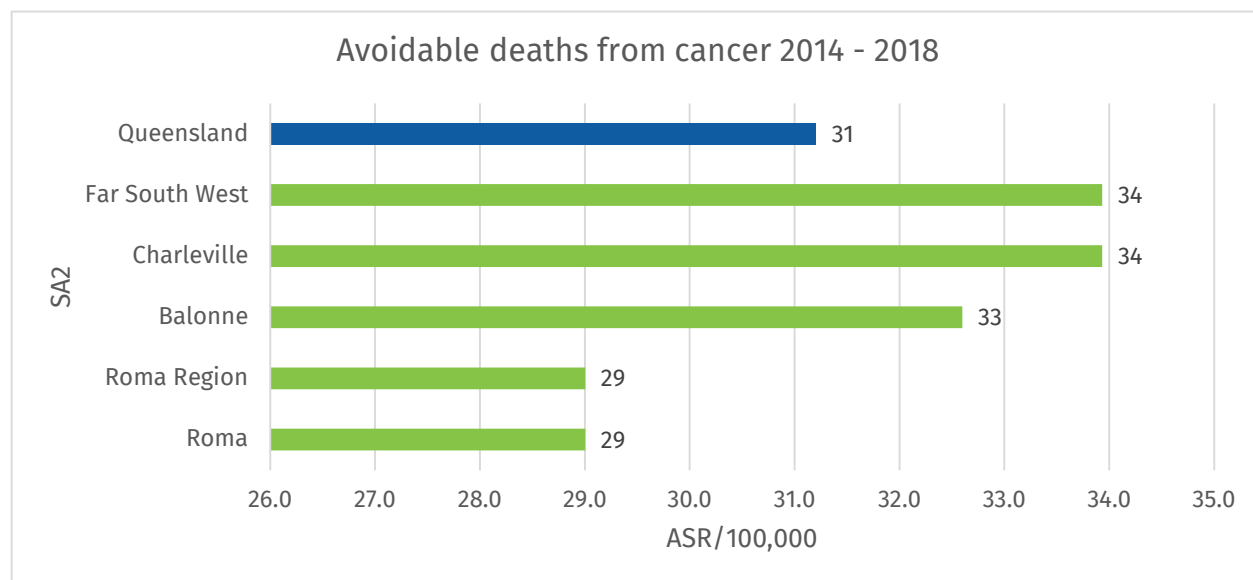
4.4.3.4.1.2 Ischaemic Heart Disease

- All of the SWHHS SA2s had estimated rates of avoidable deaths from ischaemic heart disease greater than the state rate.

Figure 4.4.36 Potentially avoidable deaths - ischaemic heart disease, <75 years, 2014-2018

Avoidable deaths from ischaemic heart disease 2014 - 2018

SA2s	ASR/100,000
Queensland	23
Far South West	58
Charleville	58
Balonne	38
Roma Region	26
Roma	26

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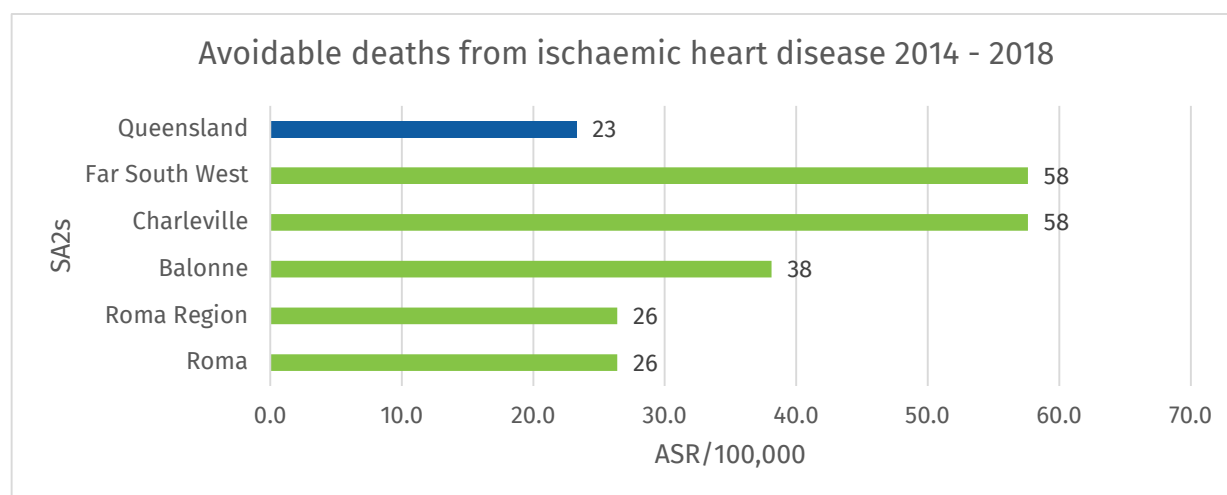
[150] Data Source: AIHW (Australian Institute of Health and Welfare) 2021. National Hospital Morbidity Database (NHMD) Statistical Area Level 3 (SA3. 2019-2020. Canberra: AIHW). Prepared by System Planning Branch, Planning Portal.

4.4.3.4.1.3   Respiratory System Diseases

- Between 2014 to 2018, all the SWHHS SA2s had estimated rates of avoidable deaths from respiratory system diseases greater than the state rate.

Figure 4.4.37 Potentially avoidable deaths - respiratory system disease, <75 years, 2014-2018

Avoidable deaths from respiratory system diseases 2014 – 2018

SA2s	ASR/100,000
Queensland	11.5
Far South West	33.9
Charleville	33.9
Balonne	18.8
Roma Region	18.6
Roma	18.6
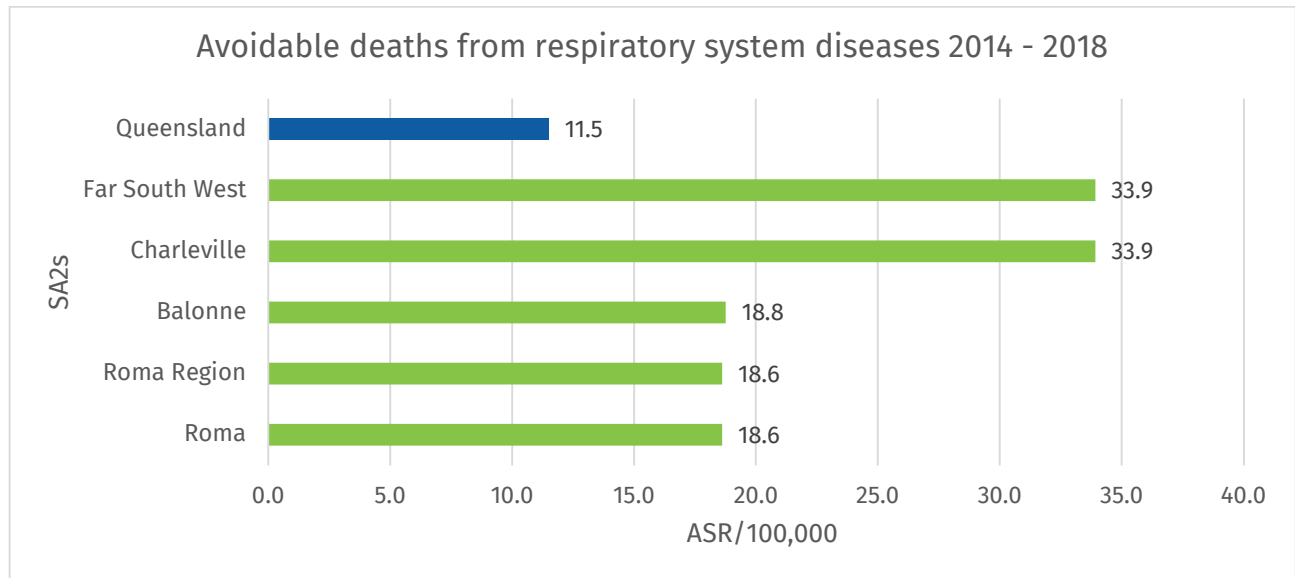
4.4.3.4.1.4   Diabetes

- Between 2014 to 2018, all the SWHHS SA2s had estimated rates of avoidable deaths from diabetes greater than the state rate.

Figure 4.4.38 Potentially avoidable deaths - diabetes, <75 years, 2014-2018

Avoidable deaths from diabetes 2014 – 2018

SA2s	ASR/100,000
Queensland	7.2
Balonne	17.2
Roma Region	15.0
Roma	15.0
Far South West	14.0
Charleville	14.0
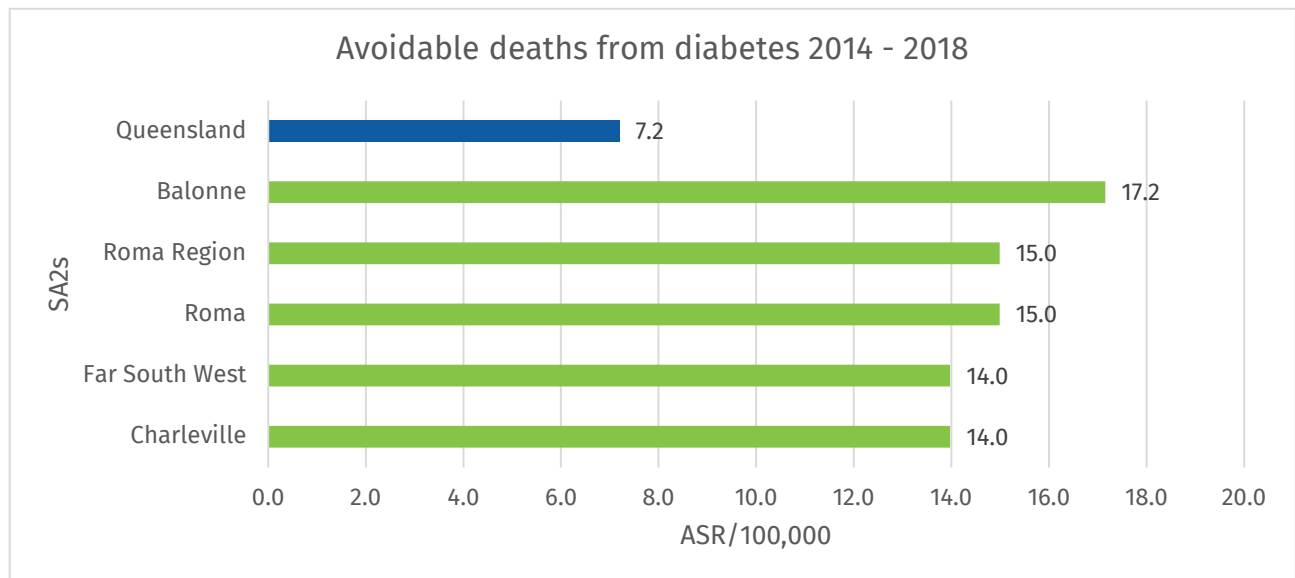
4.4.3.4.1.5   Suicide and self-inflicted injuries

- In 2016-20 in the SWHHS:
    - o   The ASR for suicide in Outback–South SA3 (24.7 per 100,000) was higher than Darling Downs (West)–Maranoa SA3 and Queensland ASRs (both 15.4 per 100,000).

Figure 4.4.39 Rate of deaths due to suicide by SA3, 2016-20, SWHHS[151]
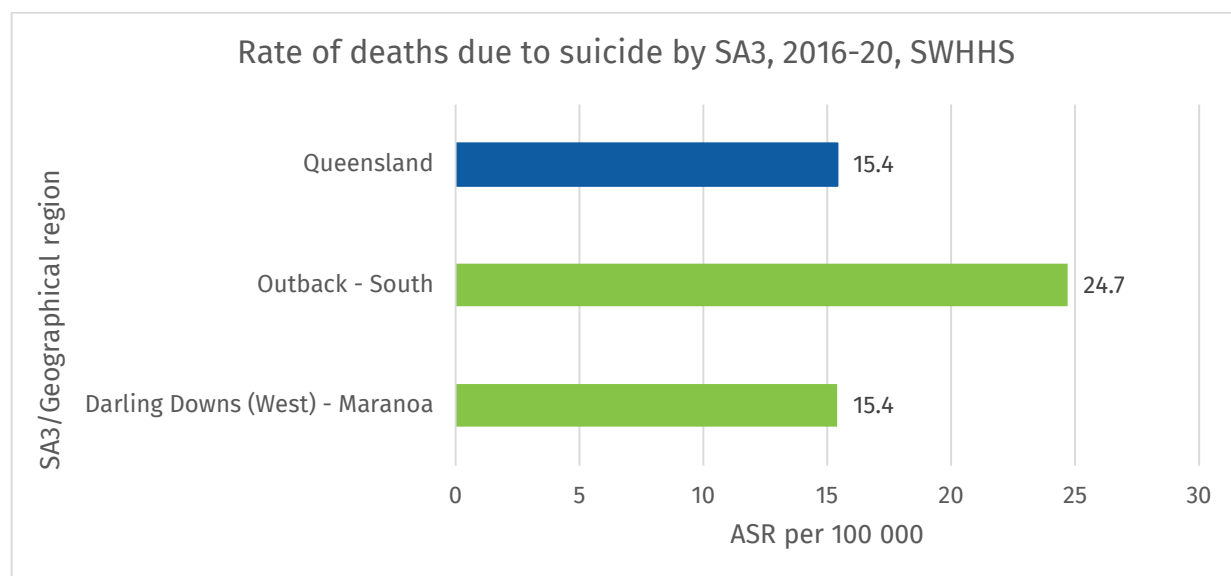
[151] Queensland Government. (2022). Rates of suicide. Retrieved from Planning portal

4.5 Appendix 5: Service access and availability

4.5.1 Overview

The SWHHS is the main provider of acute services, and the largest provider of aged care and primary healthcare services across the region. Informed by a state-wide Clinical Services Capability Framework (CSCF), and based around three core 'hubs' of Roma, St George and Charleville, the SWHHS services include: medical; surgical; emergency; obstetrics; paediatric; specialist outpatient clinics; mental health; community and allied health; oral health; critical care; clinical support services; residential aged care; and home and community care services.

Although strong collaborative ties are maintained with private providers established across the region, and WQPHN, the traditional model of privately-owned general practice is absent across many local communities. This has resulted in the SWHHS becoming a significant provider of bulk billed primary healthcare services through nine medical practices.

The SWHHS also operates a network of Multipurpose Health Services, and other community health facilities, which serve as the main care providers across the very remote communities within the region. These very remote communities are also supported by the RFDS and ACCHO partners, including:

- Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health Ltd
- Cunnamulla Aboriginal Corporation for Health and the Surat Aboriginal Corporation
- Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services

With a funding allocation of $95,279,570 for the 2022-23 Financial Year, as of 1 July 2022, the SWHHS comprised 26 facilities as follows:

- Three Clinical Service Capability Framework Level 3 Hospitals - at Roma, Charleville, and St George.
- Eight Multipurpose Health Services
- Four Community Health Clinics.
- Nine General Practices
- Two Residential Aged Care Facilities – at Westhaven in Roma, and Waroona in Charleville.

4.5.2 Workforce

4.5.2.1 Registered health workforce by profession

4.5.3 Workforce mapping

Figure 4.5.1 Managerial and Clerical Workforce Volume[152]

Managerial and Clerical Workforce Volume

	2018	2019	2020	2021	2022
MOHRI Occupied Headcount	199.42	194.98	185.59	193.75	205.89
MOHRI Occupied FTE	163.35	163.62	157.16	165.52	181.01
Appointed FTE	121.79	115.21	125.46	136.59	139.25
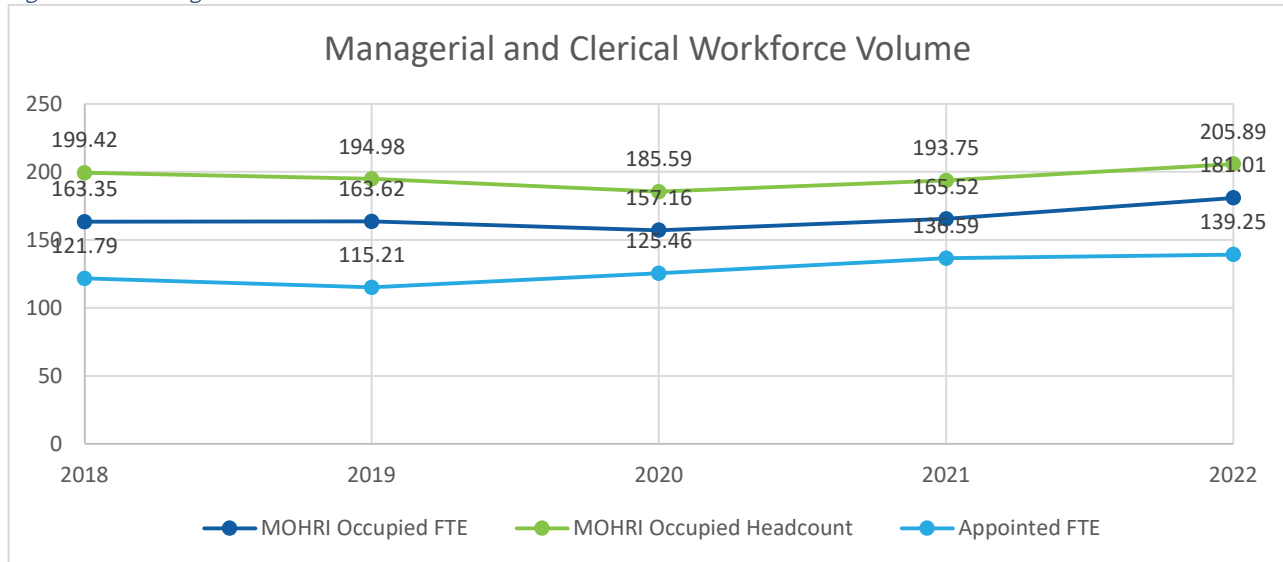
Figure 4.5.2 Medical (including VMOs) Workforce Volume[153]

Medical (including VMOs) Workforce Volume

	2018	2019	2020	2021	2022
MOHRI Occupied Headcount	28	33	32	31	38
MOHRI Occupied FTE	25.6	27.93	27.15	26	31.6
Appointed FTE	24.8	24.83	23.5	22.2	29.6

South West Hospital and Health Service Local Area Needs Assessment (2022)

Figure 4.5.3 Nursing Workforce Volume[154]

Nursing Workforce Volume

- MOHRI Occupied FTE
- MOHRI Occupied Headcount
- Appointed FTE

Year	MOHRI Occupied Headcount	MOHRI Occupied FTE	Appointed FTE
2018	432.55	361.64	326.15
2019	405.32	338.48	299.73
2020	439.25	371.99	319.49
2021	433.62	367.68	317.24
2022	454.17	388.17	305.12
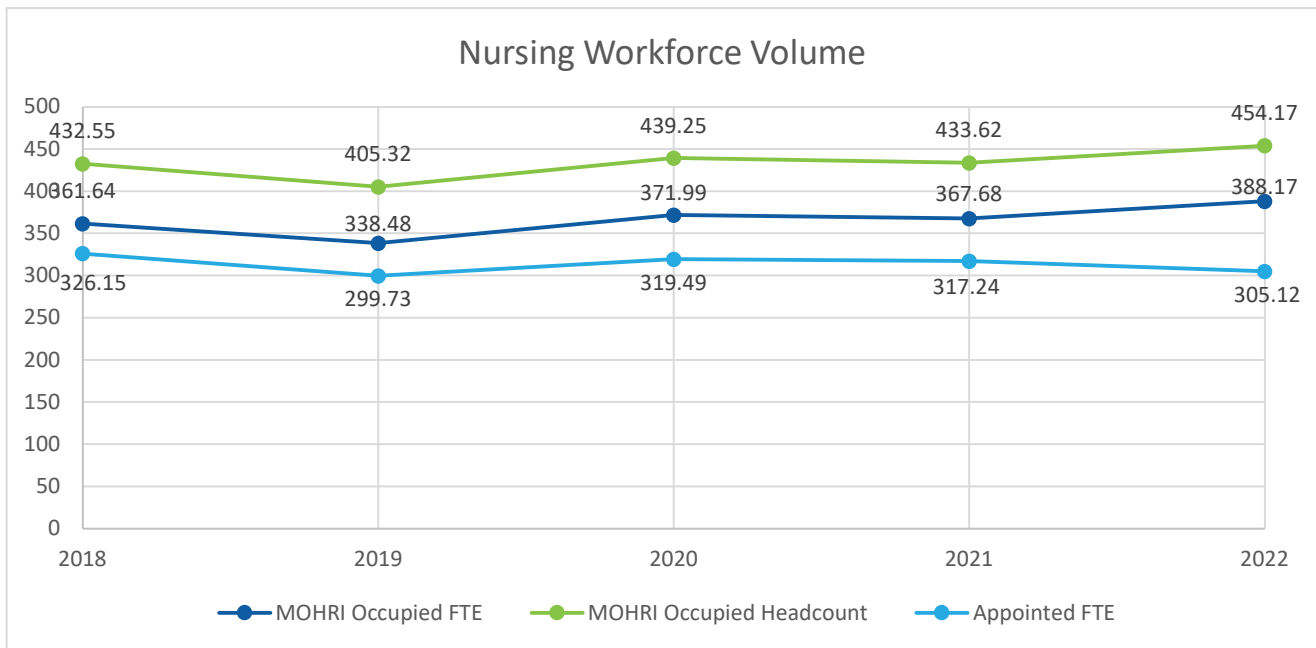
Figure 4.5.4 Operational Workforce Volume[155]

Operational Workforce Volume

- MOHRI Occupied FTE
- MOHRI Occupied Headcount
- Appointed FTE

Year	MOHRI Occupied Headcount	MOHRI Occupied FTE	Appointed FTE
2018	236.98	180.67	147.81
2019	234.91	178.82	146.11
2020	234.86	177.65	139.6
2021	204.82	155.32	123.59
2022	208.86	157.95	119.66
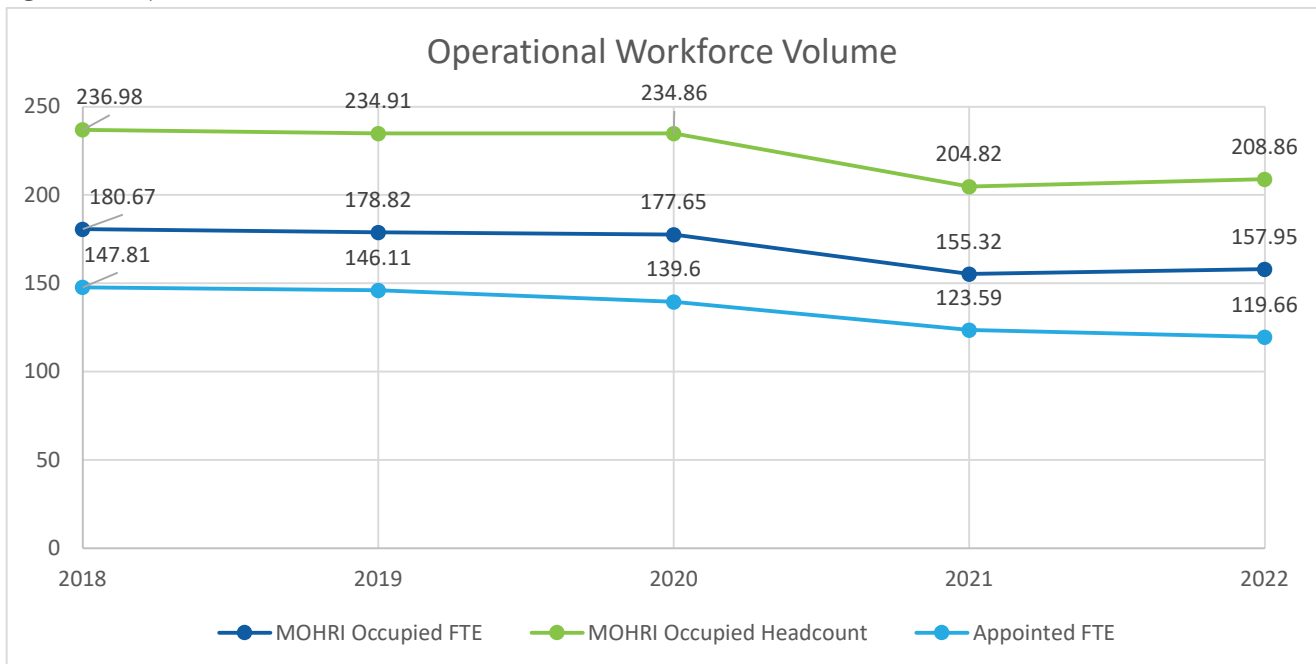
[154] South West Hospital and Health Service (2022), Workforce Dataset

[155] South West Hospital and Health Service (2022), Workforce Dataset

Figure 4.5.5 Trade and Artisans Workforce Volume[156]

Trade and Artisans Workforce Volume
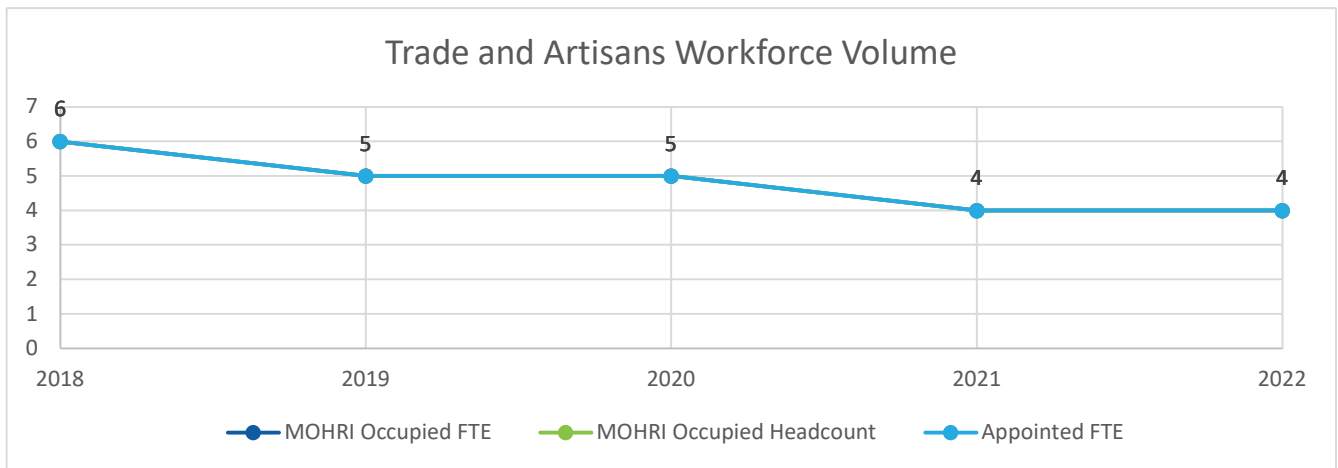
Figure 4.5.6 Professional and Technical Workforce Volume[157]

Professional and Technical Workforce Volume

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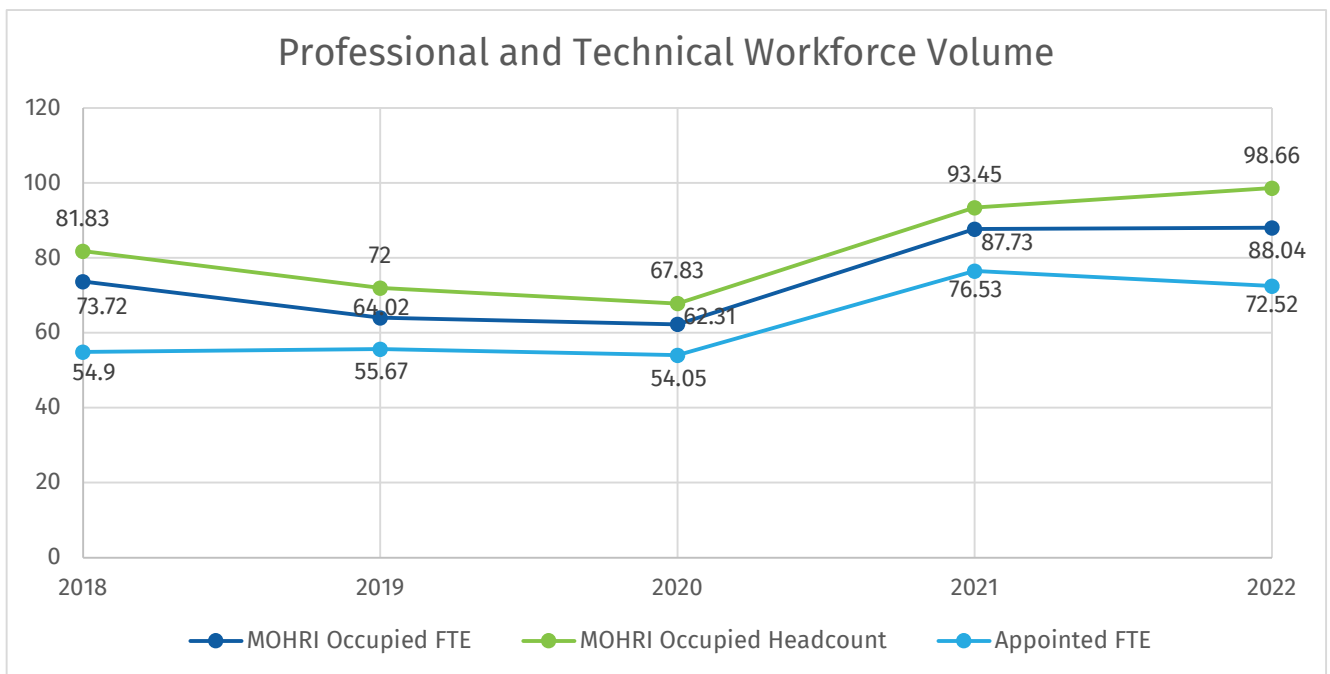
[156] South West Hospital and Health Service (2022), Workforce Dataset

[157] South West Hospital and Health Service (2022), Workforce Dataset

4.5.3.1 SWHHS workforce per 100K ERP

Table 4.5.1 SWHHS workforce per 100k ERP[158]

Workforce Type	MOHRI Occupied Headcount (2022)	Headcount per 100k
Managerial and Clerical	205.89	861.21
Medical incl VMOs	38.00	158.95
Nursing	454.17	1,899.74
Operational	208.86	873.64
Trade and Artisans	4.00	16.73
Professional and Technical	98.66	412.68
A&TSI Health Workforce	2.00	8.37

4.5.1 Hospital and health system capability

Table 4.5.2 Self assessed CSCF levels for SWHHS facilities (1)[159]

CSCF Service	CSCF Level						
	Roma	St George	Charleville	Cunnamulla	Augathella	Dirranbandi	Injune
Ambulatory (AOD)	3	3	3	2	2	2	2
Emergency (AOD)	3	3	3	2	2	2	2
Inpatient - adult (AOD)	3	3	3	-	-	-	-
Anaesthetic	3	3	3	-	-	-	-
Anaesthetic - child and youth	3	3	3	-	-	-	-
Medical Oncology	3	3	-	-	-	-	-
Cardiac Diagnostic and Interventional	3	-	-	-	-	-	-
Cardiac Medicine	3	3	3	-	-	-	-
Cardiac Rehabilitation - Outpatient	5	4	4	-	-	-	-
Cardiac - Rehabilitation - Ongoing prevention and maintenance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Close observation services (Children)	1	1	1	-	-	-	-
Emergency	3	3	3	2	2	2	2
Emergency geriatric care	3	3	3	2	2	2	2
Geriatric acute inpatient	3	3	3	-	-	-	-
Ambulatory (Geriatric)	3	2	2	1	1	1	1

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[158] South West Hospital and Health Service (2022), Workforce Dataset

[159] Clinical Excellence Queensland (2021). Long Term (three months or more) Clinical Services Capability Framework Service Level Change Notification Form – Hospital and Health Service Summary

CSCF Service	CSCF Level						
	Roma	St George	Charleville	Cunnamulla	Augathella	Dirranbandi	Injune
Consultation liaison (Geriatric)	3	-	-	-	-	-	-
Evaluation and management (Geriatric)	3	3	3	-	-	-	-
Interim care (Geriatric)	3	3	3	2	2	2	2
Geriatric rehabilitation	3						
Maternity	3	3	3	1	1	1	1
Medical	3	3	3	2	2	2	2
Medical–Children's	3	3	3	2	2	2	2
Medication	4	3	3	2	2	2	2
Medical Imaging	4	3	3	1	1	1	1
Mental Health–Adult (Ambulatory)	4	4	4	2	2	2	2
Mental Health–Adult (Acute Inpatient)	2	2	2	2	2	2	2
Mental Health–Child and Youth (Ambulatory)	3	3	3	2	2	2	2
Mental Health–Child and Youth (Acute Inpatient)	2	2	2	2	2	2	2
Mental Health–Older persons (Ambulatory)	3	3	3	2	2	2	2
Mental Health–Older persons (Acute Inpatient)	2	2	2	2	2	2	2
Mental Health-Perinatal and Infant	3	3	3	-	-	-	-
Neonatal	3	3	3	1	1	1	1
Palliative Care	4	3	3	2	2	2	2
Pathology	3	2	3	2	2	2	2
Perioperative (Day Surgery)	3	3	3	-	-	-	-
Perioperative (Endoscopy)	3	3	3	-	-	-	-
Perioperative (Operating Suite)	3	3	3	-	-	-	-
Perioperative (Post-Anaesthetic Care)	3	3	3	-	-	-	-
Perioperative (Children's Post-Anaesthetic Care)	3	3	3	-	-	-	-
Persistent Pain	2	2	2	2	2	2	2
Rehabilitation	4	3	3	2	2	2	2
Renal	1	1	1	1	1	1	1
Surgical	3	3	3	-	-	-	-
Surgical - Children's	3	3	3	-	-	-	-

Table 4.5.3 Self assessed CSCF levels for SWHHS facilities (3)[160]

CSCF Service	CSCF Level							
	Mitchell	Mungindi	Quilpie	Surat	Bollon	Morven	Thargomindah	Wallumbilla
Ambulatory (AOD)	2	2	2	2	1	1	1	1
Emergency (AOD)	2	2	2	2	1	1	1	1
Cardiac - Rehabilitation - Ongoing prevention and maintenance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency (Geriatric)	2	2	2	2	1	1	1	1
Ambulatory (Geriatric)	1	1	1	1	-	-	-	-
Interim Care (Geriatric)	2	2	2	2	-	-	-	-
Maternity	1	1	1	1	1	1	1	1
Medical	2	2	2	2	1	1	1	1
Medical–Children's	2	2	2	2	1	1	1	1
Medication	2	2	2	2	1	1	1	1
Medical Imaging	1	1	1	1	-	-	-	-
Mental Health–Adult (Ambulatory)	2	2	2	2	1	1	1	1
Mental Health–Adult (Acute Inpatient)	2	2	2	2	-	-	-	-
Mental Health–Child and Youth (Ambulatory)	2	2	2	2	1	1	1	1
Mental Health–Child and Youth (Acute Inpatient)	2	2	2	2	-	-	-	-
Mental Health–Older persons (Ambulatory)	2	2	2	2	1	1	1	1
Mental Health–Older persons (Acute Inpatient)	2	2	2	2	-	-	-	-
Neonatal	1	1	1	1	1	1	1	1
Palliative Care	2	2	2	2	1	1	1	1
Pathology	2	2	2	2	1	1	1	1
Persistent Pain	2	2	2	2	2	2	2	2
Rehabilitation	2	2	2	2	2	2	2	2
Renal	1	1	1	1	1	1	1	1

[160] Clinical Excellence Queensland (2021). Long Term (three months or more) Clinical Services Capability Framework Service Level Change Notification Form – Hospital and Health Service Summary

4.5.2   Hospital and health system capacity

4.5.2.1   Hospital beds per capita

Table 4.5.4 Hospital beds and beds per capita[161]

Planning Area	Year					Beds per 1000 ERP
	2018	2019	2020	2021	2022	
Balonne	**49**	**53**	**53**	**53**	**53**	**12.1**
Dirranbandi Hospital	6	7	7	7	7	
Dirranbandi MPHS	6	6	6	6	6	
Mungindi Hospital	3	3	3	3	3	
Mungindi MPHS	12	12	12	12	12	
St George Hospital	22	25	25	25	25	
Charleville	**21**	**21**	**21**	**21**	**21**	**5.24**
Augathella MPHS	6	6	6	6	6	
Charleville Hospital	15	15	15	15	15	
Far South West	**20**	**27**	**26**	**16**	**16**	**5.81**
Cunnamulla Hospital	10	17	16	6	6	
Cunnamulla MPHS	10	17	16	6	7	
Quilpie Hospital	6	6	6	6	6	
Quilpie MPHS	4	4	4	4	4	
Roma	**23**	**25**	**24**	**22**	**22**	**3.18**
Roma Hospital	23	25	24	22	22	
Roma Surrounds	**58**	**60**	**60**	**58**	**60**	**9.95**
Injune Hospital	7	7	7	7	7	
Injune MPHS	7	7	7	7	7	
Mitchell Hospital	12	12	12	12	12	
Mitchell MPHS	18	18	18	18	18	
Surat Hospital	4	4	4	4	4	
Surat MPHS	6	8	8	8	8	
Grand Total	**171**	**186**	**184**	**170**	**172**	**7.14**

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[161] South West Hospital and Health Service (2022). Avaliable Beds Data

4.5.2.2 GP clinics

Table 4.5.5 GP clinics within the SWHHS catchment

Provider	SA3/Planning Area	Location
Dirranbandi Medical Centre	Balonne	Dirranbandi
Mungindi Doctors Surgery	Balonne	Mungindi
Charleville Health Clinic	Charleville	Charleville
Cunnamulla Primary Health Care Centre	Far South West	Cunnamulla
Augathella Doctors Surgery	Charleville	Augathella
Injune Medical Practice	Roma Surrounds	Injune
Mitchell Medical Practice	Roma Surrounds	Mitchell
Surat Medical Practice	Roma Surrounds	Surat

4.5.2.3 Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHOs)

Table 4.5.6 ACCHOs within the SWHHS catchment

Provider	SA3/Planning Area	Location
Goolburri Aboriginal Health Advancement Company Limited	Balonne	St George
Goondir Health Services	Balonne	St George
CWAATSICH	Charleville	Charleville
Goolburri Aboriginal Health Advancement Company Limited	Charleville	Charleville
Cunnamulla Aboriginal Corporation for Health	Far South West	Cunnamulla
Goolburri Aboriginal Health Advancement Company Limited	Far South West	Cunnamulla
CWAATSICH	Far South West	Quilpie
Goolburri Aboriginal Health Advancement Company Limited	Roma	Roma
CWAATSICH	Roma	Roma
CWAATSICH	Roma Surrounds	Mitchell

4.5.2.4 Wait times

4.5.2.4.1 Elective surgery wait times

Table 4.5.7 Elective surgery wait times[162]

Item / Service	Average Wait Time		
	Category 1	Category 2	Category 3
Charleville	**18.34**	**55.17**	**279.90**
General Surgery	19.25	66.21	278.79
Gynaecology	25.33	57.20	328.17
Other Surgery	8.00	30.75	6.00
Roma	**16.38**	**56.49**	**198.63**
General Surgery	18.14	61.77	297.84
Gynaecology	17.20	60.54	321.88
Ophthalmology	7.17	58.90	124.36
Orthopaedic Surgery	13.00	54.81	306.80
Other Surgery	5.00	23.75	
Urology	15.00	42.18	111.39
St George	**11.41**	**26.96**	**99.30**
General Surgery	11.83	40.25	210.50
Gynaecology	9.50	17.00	71.50

Table 4.5.8 Number of long waits for elective surgeries[163]

Site / Service	Average Wait Time		
	Category 1	Category 2	Category 3
Charleville	**0**	**0**	**0**
General Surgery	0	0	0
Gynaecology	0	0	0
Other Surgery	0	0	0
Roma	**0**	**0**	**1**
General Surgery	0	0	0
Gynaecology	0	0	0
Ophthalmology	0	0	0
Orthopaedic Surgery	0	0	0
Other Surgery	0	0	
Urology	0	0	1
St George	**0**	**0**	**0**
General Surgery	0	0	0
Gynaecology	0	0	0

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[162] Queensland Health System Performance Reporting (2022). Elective surgery wait times.

[163] Queensland Health System Performance Reporting (2022). Elective surgery wait times.

4.5.2.4.2 Elective procedure wait times

Table 4.5.9 Elective procedure wait times[164]

Site / Service	Average Wait Time		
	Category 4	Category 5	Category 6
Charleville	**18.34**	**55.17**	**279.90**
Colonoscopy	24.47	90.84	287.80
Panendoscopy	21.21	77.96	306.83
Roma	**16.38**	**56.49**	**198.63**
Colonoscopy	21.69	74.06	273.56
Panendoscopy	23.50	77.97	289.71
St George	**11.41**	**26.96**	**99.30**
Colonoscopy	20.98	49.28	110.88
Panendoscopy	18.12	40.94	82.02

4.5.2.4.3 Outpatient wait times

Table 4.5.10 Outpatient services and wait times[165]

Site / Service	Average Wait Time			
	Category 1	Category 2	Category 3	Category 9
Augathella MPHS	**20.00**	**89.00**	**154.00**	**-**
Community Health Services - Child & Youth Health	-	78.00	-	-
Community Health Services - Chronic Health	-	102.00	-	-
Diabetes Education	-	57.00	-	-
Nutrition / Dietetics	20.00	-	52.00	-
Physiotherapy	-	64.00	-	-
Podiatry	-	145.00	162.00	-
Social Work	-	92.00	191.00	-
Bollon Community Clinic	**5.00**	**68.00**	**210.00**	**41.00**
Nutrition / Dietetics	-	-	226.00	-
Physiotherapy	5.00	59.00	-	-
Podiatry	-	126.00	199.00	41.00
Charleville Hospital	**44.00**	**81.00**	**152.00**	**173.00**
Cardiac Rehabilitation	69.00	103.00	-	-
Cardiology - Holter Clinic	-	63.00	77.00	-
Cardiology - Stress Test	15.00	38.00	-	-
Cardiology General	-	62.00	208.00	-
Community Health Services - Child & Youth Health	50.00	56.00	-	-
Community Health Services - Chronic Health	-	51.00	-	-
Community Health Services - Other	40.00	150.00	125.00	327.00
Diabetes Education	-	15.00	64.00	-

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[164] Queensland Health System Performance Reporting (2022). Elective procedure wait times.

[165] South West Hospital and Health Service (2022). List of Patients Currently on the Specialist and Non-Specialist Waiting List

Site / Service	Average Wait Time			
	Category 1	Category 2	Category 3	Category 9
Exclusion	-	340.00	326.00	-
General Surgery	10.00	52.00	144.00	-
Gynaecology	-	60.00	196.00	-
Hospital avoidance programs	-	8.00	-	-
Nutrition / Dietetics	44.00	86.00	88.00	-
Obstetrics - Antenatal	-	72.00	137.00	-
Occupational Therapy	17.00	30.00	68.00	-
Paediatric Medicine	32.00	51.00	181.00	-
Physiotherapy	69.00	21.00	279.00	-
Podiatry	8.00	54.00	97.00	19.00
Psychology	-	412.00	562.00	-
Social Work	112.00	115.00	137.00	-
Speech Pathology	-	95.00	17.00	-
Women's and Men's Health	-	95.00	-	-
Cunnamulla MPHS	**49.00**	**108.00**	**111.00**	**214.00**
Community Health Services - Child & Youth Health	-	69.00	-	-
General Surgery	33.00	134.00	108.00	-
Gynaecology	-	127.00	122.00	-
Nutrition / Dietetics	53.00	-	154.00	-
Occupational Therapy	34.00	110.00	90.00	-
Physiotherapy	86.00	-	223.00	-
Podiatry	82.00	11.00	53.00	-
Social Work	-	201.00	-	214.00
Speech Pathology	-	62.00	-	-
Dirranbandi MPHS	**83.00**	**120.00**	**229.00**	**8.00**
Diabetes Education	179.00	209.00	196.00	-
Nutrition / Dietetics	-	-	154.00	4.00
Occupational Therapy	-	28.00	-	-
Physiotherapy	63.00	45.00	-	4.00
Podiatry	27.00	429.00	267.00	12.00
Social Work	-	20.00	40.00	-
Injune MPHS	**962.00**	**109.00**	**196.00**	**-**
Community Health Services - Child & Youth Health	-	154.00	-	-
Diabetes Education	-	153.00	182.00	-
Midwifery	1,884.00	-	-	-
Nutrition / Dietetics	-	-	86.00	-
Occupational Therapy	40.00	61.00	-	-
Physiotherapy	-	20.00	-	-
Podiatry	-	50.00	218.00	-
Speech Pathology	-	329.00	-	-
Mitchell MPHS	**54.00**	**61.00**	**115.00**	**-**
Community Health Services - Child & Youth Health	124.00	139.00	-	-

Site / Service	Average Wait Time			
	Category 1	Category 2	Category 3	Category 9
Diabetes Education	-	79.00	119.00	-
Hospital avoidance programs	50.00	-	-	-
Nutrition / Dietetics	12.00	60.00	133.00	-
Occupational Therapy	48.00	36.00	-	-
Physiotherapy	38.00	26.00	133.00	-
Podiatry	-	68.00	80.00	-
Respiratory - General	-	-	194.00	-
Social Work	26.00	-	-	-
Speech Pathology	47.00	47.00	47.00	-
Morven Outpatients Clinic	**74.00**	**214.00**	**337.00**	**135.00**
Cardiac Rehabilitation	-	-	-	214.00
Community Health Services - Chronic Health	-	-	-	91.00
Nutrition / Dietetics	-	150.00	64.00	-
Occupational Therapy	-	-	-	189.00
Oncology - Medical Oncology Consultation	-	-	-	63.00
Physiotherapy	78.00	141.00	609.00	136.00
Podiatry	70.00	424.00	-	-
Social Work	-	-	-	110.00
Mungindi MPHS	**432.00**	**30.00**	**41.00**	**-**
Exclusion	432.00	-	-	-
Occupational Therapy	-	-	41.00	-
Physiotherapy	-	28.00	-	-
Social Work	-	35.00	-	-
Quilpie MPHS	**64.00**	**97.00**	**156.00**	**-**
Community Health Services - Child & Youth Health	19.00	-	7.00	-
Community Health Services - Other	-	418.00	78.00	-
Diabetes Education	-	27.00	-	-
Hospital avoidance programs	203.00	-	-	-
Nutrition / Dietetics	-	131.00	170.00	-
Occupational Therapy	-	90.00	61.00	-
Physiotherapy	60.00	66.00	-	-
Podiatry	22.00	44.00	201.00	-
Social Work	-	-	224.00	-
Roma Hospital	**116.00**	**135.00**	**177.00**	**101.00**
Anaesthetics	-	74.00	-	-
Cardiac Rehabilitation	31.00	-	-	-
Cardiology - Holter Clinic	-	39.00	211.00	-
Cardiology - Stress Test	9.00	58.00	50.00	-
Cardiology General	22.00	63.00	187.00	-
Community Health Services - Child & Youth Health	25.00	146.00	-	-
Community Health Services - Chronic Health	-	218.00	-	-
Community Health Services - Rehabilitation	-	239.00	-	-

Site / Service	Average Wait Time			
	Category 1	Category 2	Category 3	Category 9
Continence	21.00	-	54.00	-
Diabetes	-	-	273.00	-
Diabetes Education	6.00	30.00	59.00	-
Diagnostic - Clinical Measurement	32.00	621.00	194.00	-
Ear Nose and Throat	-	-	64.00	-
Exclusion	420.00	477.00	638.00	2,842.00
Exercise physiology	111.00	431.00	-	-
General Medicine	-	64.00	19.00	-
General Surgery	54.00	36.00	181.00	5.00
Geriatric Evaluation and Management (GEM)	-	66.00	139.00	-
Gynaecology	-	22.00	28.00	4.00
Hospital avoidance programs	14.00	-	-	-
Midwifery	1,960.00	-	-	-
Nutrition / Dietetics	12.00	54.00	60.00	-
Obstetrics - Antenatal	-	10.00	-	-
Occupational Therapy	7.00	39.00	438.00	-
Oncology - Medical Oncology Consultation	-	16.00	357.00	-
Ophthalmology	33.00	52.00	131.00	21.00
Orthopaedics - General	-	129.00	255.00	22.00
Paediatric Medicine	-	46.00	158.00	-
Paediatrics - Development	-	34.00	12.00	-
Palliative Care	-	-	120.00	-
Physiotherapy	12.00	56.00	96.00	-
Podiatry	62.00	54.00	81.00	-
Psychology	-	-	62.00	-
Respiratory - General	-	-	258.00	-
Social Work	20.00	90.00	44.00	-
Speech Pathology	56.00	72.00	73.00	-
Urology	-	-	64.00	-
Wound Management	10.00	-	-	-
St George Hospital	**43.00**	**58.00**	**129.00**	**9.00**
Cardiology General	-	45.00	64.00	-
Community Health Services - Child & Youth Health	-	15.00	-	-
Community Health Services - Chronic Health	26.00	-	-	15.00
Community Health Services - Rehabilitation	-	37.00	-	-
Continence	-	83.00	28.00	-
Diabetes Education	-	195.00	236.00	-
Exclusion	-	14.00	-	-
EXERCISE PHYSIOLOGY	-	12.00	-	-
General Medicine	8.00	6.00	214.00	-
General Surgery	-	44.00	70.00	15.00
Gynaecology	-	33.00	24.00	1.00

Site / Service	Average Wait Time			
	Category 1	Category 2	Category 3	Category 9
Nutrition / Dietetics	11.00	149.00	92.00	-
Obstetrics - Antenatal	-	62.00	-	-
Occupational Therapy	35.00	51.00	11.00	-
Oncology - Medical Oncology Consultation	-	-	300.00	-
Paediatric Medicine	60.00	7.00	174.00	-
Palliative Care	70.00	-	-	-
Physiotherapy	25.00	66.00	38.00	4.00
Podiatry	172.00	92.00	150.00	-
Social Work	-	31.00	-	-
Speech Pathology	-	53.00	-	-
Surat MPHS	**54.00**	**80.00**	**156.00**	**3.00**
Diabetes Education	-	134.00	169.00	-
Nutrition / Dietetics	-	62.00	85.00	3.00
Occupational Therapy	-	52.00	-	-
Physiotherapy	38.00	58.00	167.00	-
Podiatry	-	110.00	227.00	-
Respiratory - General	15.00	-	-	-
Speech Pathology	125.00	-	-	-
Thargomindah MPHS	**103.00**	**790.00**	**-**	**40.00**
Nutrition / Dietetics	74.00	-	-	-
Occupational Therapy	83.00	-	-	-
Physiotherapy	119.00	-	-	47.00
Podiatry	111.00	-	-	32.00
Social Work	78.00	790.00	-	-
Speech Pathology	64.00	-	-	-
Wallumbilla Outpatients Clinic	**41.00**	**58.00**	**133.00**	**-**
Community Health Services - Child & Youth Health	-	69.00	-	-
Diabetes Education	-	222.00	-	-
Nutrition / Dietetics	-	-	112.00	-
Occupational Therapy	41.00	49.00	-	-
Paediatrics - Development	-	28.00	-	-
Physiotherapy	41.00	68.00	137.00	-
Podiatry	-	23.00	140.00	-
Respiratory - General	-	38.00	-	-
Speech Pathology	-	47.00	-	-
Overall Average	**95.00**	**103.00**	**165.00**	**90.00**

4.6 Appendix 6: Service utilisation

4.6.1   Primary care attendance

Table 4.6.1 Primary care attendance by year (overall)[166]

SA3/Geographic Region	Primary Care Attendance by Year					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Darling Downs (West) - Maranoa	361,373	388,054	399,877	405,026	408,076	410,696
Outback - South	129,695	155,818	156,843	158,079	157,490	158,194
Grand Total	491,068	543,872	556,720	563,105	565,566	568,890

Table 4.6.2 Primary care attendance by service [167]

Service	Number of Patients Per Year (Darling Downs (West) – Maranoa and Outback – South)					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Allied Health attendances (total)	51,672	54,387	54,987	56,396	56,477	58,575
Allied Health subtotal - Mental Health Care	759	830	947	1,038	1,244	1,447
Allied Health subtotal - Optometry	15,827	16,394	16,366	16,689	16,382	16,996
Allied Health subtotal - Other	1,483	1,864	1,937	2,026	2,246	2,290
Allied Health subtotal - Physical Health Care	781	1,077	1,270	1,368	1,559	1,631
Asthma Cycle of Care PIP	55	81	133	103	189	99
Audiology	-	-	10	21	24	17
Cervical Smear PIP	94	146	161	200	121	137
Chiropractic Services	-	-	-	-	-	167
Clinical Psychologist	239	231	245	349	371	403
Diabetes Education	20	74	73	41	173	151
Diabetes Mellitus Annual Cycle of Care PIP	480	580	737	748	793	883
Diagnostic Imaging (total)	65,487	68,042	65,308	63,348	63,518	63,792
Dietetics	565	705	593	520	558	611
Early Intervention Services for Children	-	-	-	25	-	-
Exercise Physiology	170	286	244	352	278	109
GP Acupuncture	55	36	73	59	32	20
GP After-hours (non-urgent)	4,608	4,548	5,368	6,169	5,879	6,190
GP After-hours (urgent)	1,479	1,596	2,267	2,728	2,134	1,585
GP attendances (total)	161,392	162,579	164,586	163,212	162,741	162,089
GP Chronic Disease Management Plan	5,918	5,885	6,205	6,938	5,707	7,653

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[166] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013–14 to 2018–19

[167] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013–14 to 2018–19

Service	Number of Patients Per Year (Darling Downs (West) – Maranoa and Outback – South)					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
GP Focussed Psychological Strategies and Family Group Therapy	–	–	–	–	–	31
GP Health Assessment	3,216	3,697	3,870	3,968	4,459	4,310
GP Long (Level C)	–	21,591	22,849	23,485	24,918	24,299
GP Mental Health	1,866	2,085	2,387	2,711	3,044	3,304
GP Multidisciplinary Case Conference	101	138	122	187	213	248
GP Prolonged - Imminent danger of death	72	45	57	83	132	170
GP Prolonged (Level D)	3014	3656	4444	4529	5210	5015
GP Short (Level A)	8,437	9,331	9,312	9,555	10,000	10,219
GP Standard (Level B)	35661	50895	51447	50732	50351	49848
GP subtotal - After-hours	5,911	5,918	7,162	8,302	7,512	7,396
GP subtotal - Enhanced Primary Care	9644	10228	10788	11675	12711	12831
GP subtotal - Other	52,981	53,452	54,090	53,478	53,345	53,118
GP subtotal - PIP	681	807	1028	1047	1096	1113
GP Telehealth (patient-end support)	267	470	560	704	815	907
Medication Management Review (domiciliary)	191	105	67	105	107	128
Medication Management Review (residential)	185	130	74	183	101	183
Midwifery	19	7	8	32	30	25
Nurse Practitioners	254	125	169	1,143	762	849
Nursing and Aboriginal Health Workers (total)	7400	9120	11314	13294	13321	10604
Occupational Therapy	18	30	63	–	82	121
Other Allied Health	–	–	144	216	234	170
Other Allied Mental Health	80	66	105	215	365	403
Other Non-referred Medical Practitioner attendances	2049	2300	2901	2750	2647	5849
Other Psychologist	463	510	576	511	558	693
Physiotherapy	586	765	877	1003	1135	1108
Podiatry	993	1,162	1,226	1,281	1,309	1,348
Practice Nurse/Aboriginal Health Worker	2189	2404	3044	3511	3719	3636
Psychiatry	398	448	408	472	417	457
Specialist attendances (total)	43253	45014	46056	45603	46473	45588
Speech Pathology	55	32	62	–	74	74
Grand Total	**491,068**	**543,872**	**556,720**	**563,105**	**565,566**	**568,890**

4.6.1.1 Average number of GP attendances per person

Table 4.6.3 Average number of GP attendances per person[168]

Geographic Area / GP Service	Average Number of GP Attendances per Person					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Outback - South	**4.96**	**4.87**	**4.95**	**4.94**	**5.07**	**4.95**
GP attendances (total)	5.68	6.03	6.21	6.36	6.57	6.5
GP subtotal - Other	5.27	5.69	5.8	5.85	5.99	5.94
GP Standard (Level B)	0	4.39	4.49	4.43	4.46	4.2
GP Long (Level C)	0	2.2	2.22	2.28	2.29	2.44
GP subtotal - Enhanced Primary Care	2.26	1.84	1.93	2	2.18	2.04
GP Short (Level A)	1.6	1.7	1.57	1.41	1.34	1.32
GP Chronic Disease Management Plan	1.9	1.44	1.57	1.71	0	2.17
GP subtotal - After-hours	2.09	1.28	1.48	1.58	1.34	1.29
GP Prolonged (Level D)	1	1.75	1.7	1.62	2.06	1.95
GP After-hours (non-urgent)	1.65	1.57	1.54	1.31	0	1.05
GP Health Assessment	1.05	1.04	1.04	1.04	1.03	1.04
GP Mental Health	1.68	1.7	1.54	1.45	1.44	1.5
GP After-hours (urgent)	1.23	1.2	1.16	1.13	1.16	1.2
GP Telehealth (patient-end support)	1.33	1.56	1.57	1.61	1.56	1.6
GP subtotal - PIP	1.01	1	1.01	1	1	1.02
GP Multidisciplinary Case Conference	1.17	2.32	1.96	1.55	1.16	1.22
GP Acupuncture	1.04	0	0	1.92	1.71	0
GP Prolonged - Imminent danger of death	2	0	0	1.79	4.55	0
GP Focussed Psychological Strategies and Family Group Therapy	0	0	0	0	0	0
GP Pregnancy Support Counselling	0	0	0	0	0	0
Darling Downs (West) - Maranoa	**5**	**4.9**	**5**	**4.91**	**4.95**	**4.93**
GP attendances (total)	5.93	6.12	6.37	6.33	6.44	6.42
GP subtotal - Other	5.36	5.49	5.68	5.57	5.63	5.59
GP Standard (Level B)	4.55	4.54	4.6	4.46	4.39	4.36
GP Long (Level C)	0	1.81	1.95	1.99	2.09	2.01
GP subtotal - Enhanced Primary Care	2.31	2.39	2.45	2.54	2.61	2.68
GP Chronic Disease Management Plan	1.9	1.92	2.03	2.13	2.29	2.25
GP Short (Level A)	2.55	2.92	2.27	2.1	2.4	2.48
GP subtotal - After-hours	1.57	1.61	1.92	2.06	1.74	1.68
GP After-hours (non-urgent)	1.88	1.91	1.83	1.87	1.88	1.78
GP Prolonged (Level D)	1.09	0.95	1.27	1.23	1.48	1.26
GP Mental Health	1.2	1.27	1	1.18	1.21	1.51
GP Health Assessment	1.45	1.57	1.47	1.33	1.29	1.18
GP After-hours (urgent)	1.2	1.16	1.19	1.16	1.18	1.19
GP subtotal - PIP	1	1	1	1.01	1.01	1.01

Geographic Area / GP Service	Average Number of GP Attendances per Person					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
GP Telehealth (patient-end support)	1.82	1.67	1.76	1.87	1.84	1.79
GP Multidisciplinary Case Conference	1.19	1.06	1.38	1.18	1.24	1.37
GP Acupuncture	3.35	2.71	2.77	1.97	1.01	0.6
GP Prolonged - Imminent danger of death	1.16	1.57	0.91	1.47	4.67	6.65
GP Focussed Psychological Strategies and Family Group Therapy	0	0	0	0	0	2.06
Grand Total	**4.99**	**4.89**	**4.99**	**4.92**	**4.98**	**4.94**

4.6.1.2   Bulk-billing rates

Table 4.6.4 Bulk billing rates[169]

SA3 / Geographic Area	Medicare bulk-billing rates (all services)					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Outback - South	92.55%	93.00%	92.54%	93.13%	92.94%	92.94%
Darling Downs (West) - Maranoa	87.63%	88.32%	88.09%	87.58%	86.83%	86.48%
Grand Total	**88.89%**	**89.65%**	**89.31%**	**89.12%**	**88.50%**	**88.24%**

4.6.1.3   After-hours GP usage rates

Table 4.6.5 After-hours GP usage rates[170]

Geographic region	After-hours GP usage rates					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Darling Downs (West) - Maranoa	**23181.3**	**24281.5**	**29791.8**	**34328.3**	**31259.3**	**30367.4**
No. of patients	8,512	8,876	11,090	12,684	11,332	11,188
No. of services	14,618	15,352	18,636	21,568	19,858	19,112
Percentage of people who had the service (%)	19	20	25	28	25	25
Services per 100 people	32	34	41	48	44	43
Attendances per person	5	5	5	5	5	5
Outback - South	**8,437**	**7,480**	**8,902**	**10,513**	**9,785**	**9,352**
No. of patients	3,486	3,186	3,707	4,515	4,193	3,983
No. of services	4,909	4,256	5,148	5,940	5,537	5,316
Percentage of people who had the service (%)	18	16	20	25	24	23
Services per 100 people	25	22	28	33	31	31
Attendances per person	5	4	4	4	3	4

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[169] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013–14 to 2018–19

[170] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013–14 to 2018–19

4.6.1.4   Services delivered by GP clinics

Table 4.6.6 Services delivered by GP clinics[171]

Geographic region	Total number of services delivered by GP clinics					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Darling Downs (West) - Maranoa	1,095,925	1,169,048	1,239,349	1,228,870	1,247,993	1,245,750
Outback - South	376,485	478,545	489,512	490,562	498,094	483,578
Grand Total	**1,472,410**	**1,647,593**	**1,728,861**	**1,719,432**	**1,746,087**	**1,729,328**

4.6.1.5   GP attendances to residential aged care

Table 4.6.7 GP attendances to residential aged care

Geographic region	GP attendances to residential aged care statistics					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
GP attendances per residential aged care patient	11.9	14.8	15.2	14.1	14	13.9
No. of GP residential aged care attendances	5,508	7,347	6,749	6,743	6,910	6,963
No. of GP residential aged care patients	464	495	443	478	494	501

4.6.1.6   Services delivered by allied health professionals

Table 4.6.8 Services delivered by allied health professionals

Geographic region	Total number of services delivered by allied health professionals					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of patients	**51672**	**54387**	**54987**	**56396**	**56477**	**58575**
Darling Downs (West) - Maranoa	37,891	40,231	40,397	42,149	42,096	43,992
Outback - South	13781	14156	14590	14247	14381	14583
No. of services	**86,442**	**94,733**	**97,189**	**100,739**	**104,892**	**111,147**
Darling Downs (West) - Maranoa	68535	75353	76308	79902	83523	89778
Outback - South	17,907	19,380	20,881	20,837	21,369	21,369
Services per 100 people	**616.46**	**670.58**	**702.56**	**737.22**	**766.19**	**799.73**
Darling Downs (West) - Maranoa	393	426	430	452	469	502
Outback - South	223.25	244.15	272.45	284.77	296.73	298.18

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[171] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health, and specialist health care across local areas: 2013–14 to 2018–19

Table 4.6.9 Mental health services delivered by allied health professionals[172]

Geographic region	Mental health services delivered by allied health professionals					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of patients	**759**	**830**	**947**	**1038**	**1244**	**1447**
Darling Downs (West) - Maranoa	660	714	805	865	1,070	1,285
Outback - South	99	116	142	173	174	162
No. of services	**2,638**	**3,049**	**3,456**	**3,775**	**4,597**	**5,530**
Darling Downs (West) - Maranoa	2323	2660	3009	3183	3982	4976
Outback - South	315	389	447	592	615	554
Services per 100 people	**6.74**	**7.88**	**9.05**	**10.4**	**12.34**	**14.25**
Darling Downs (West) - Maranoa	5	6	7	7	9	11
Outback - South	1.59	2	2.39	3.3	3.5	3.18

Table 4.6.10 Optometry services delivered by allied health professionals[173]

Geographic region	Optometry services delivered by allied health professionals					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of patients	**15827**	**16394**	**16366**	**16689**	**16382**	**16996**
Darling Downs (West) - Maranoa	11,368	11,914	11,806	12,254	11,954	12,498
Outback - South	4459	4480	4560	4435	4428	4498
No. of services	**20,472**	**21,393**	**21,042**	**21,293**	**20,987**	**22,078**
Darling Downs (West) - Maranoa	15141	16030	15559	15919	15620	16555
Outback - South	5,331	5,363	5,483	5,374	5,367	5,523
Services per 100 people	**60.44**	**62.96**	**63.77**	**65.41**	**65.2**	**68.55**
Darling Downs (West) - Maranoa	34	35	34	35	35	37
Outback - South	26.86	27.55	29.31	29.93	30.52	31.72

Table 4.6.11 Physical healthcare services delivered by allied health professionals[174]

Geographic region	Physical healthcare services delivered by allied health professionals					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of patients	**781**	**1077**	**1270**	**1368**	**1559**	**1631**
Darling Downs (West) - Maranoa	726	939	1,050	1,125	1,281	1,386
Outback - South	55	138	220	243	278	245
No. of services	**2,176**	**2,872**	**3,537**	**3,900**	**4,220**	**4,513**
Darling Downs (West) - Maranoa	2029	2580	3018	3304	3610	3962
Outback - South	147	292	519	596	610	551
Services per 100 people	**5.24**	**7.2**	**9.45**	**10.69**	**11.49**	**11.98**
Darling Downs (West) - Maranoa	5	6	7	7	8	9
Outback - South	0.74	1.5	2.77	3.32	3.47	3.16

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[172] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[173] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[174] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

Table 4.6.12 Other services delivered by allied health professionals[175]

Geographic region	Other services delivered by allied health professionals					
	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
No. of patients	**1483**	**1864**	**1937**	**2026**	**2246**	**2290**
Darling Downs (West) - Maranoa	1,401	1,662	1,702	1,826	1,997	2,028
Outback - South	82	202	235	200	249	262
No. of services	**3,529**	**4,264**	**4,361**	**4,610**	**5,160**	**4,928**
Darling Downs (West) - Maranoa	3352	3848	3849	4227	4629	4433
Outback - South	177	416	512	383	531	495
Services per 100 people	**8.32**	**10.64**	**11.26**	**11.55**	**13.3**	**12.7**
Darling Downs (West) - Maranoa	7	9	9	9	10	10
Outback - South	0.89	2.14	2.74	2.13	3.02	2.84

4.6.2 NDIS participation

Table 4.6.13 NDIS participant numbers[176]

SA2 / Planning Area	Number of Participants			
	2019	2020	2021	2022
Balonne	104	170	197	59
Charleville	190	303	344	97
Far South West	68	133	176	51
Roma	181	307	429	135
Roma Region	148	268	332	92
Grand Total	**691**	**1181**	**1478**	**434**

Table 4.6.14 NDIS services delivered in the region by proportion[177]

Toowoomba NDIS Service District	Proportion NDIS services delivered
Autism	26.12%
Intellectual Disability	20.02%
Psychosocial disability	8.64%
Developmental delay	7.88%
Other Physical	5.68%
Other Neurological	5.16%
ABI	4.69%
Hearing Impairment	4.24%
Cerebral Palsy	4.13%
Stroke	2.97%
Other	2.36%
Multiple Sclerosis	2.32%
Visual Impairment	2.22%
Spinal Cord Injury	1.98%
Global developmental delay	1.05%
Other Sensory/Speech	0.55%

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[175] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[176] National Disability Insurance Scheme (NDIS) (2022). Participant dataset

[177] National Disability Insurance Scheme (NDIS) (2022). Participant dataset

Table 4.6.15 NDIS services delivered in the region by age group[178]

Toowoomba NDIS Service District	Age distribution of participants
0 to 6	12.59%
7 to 14	20.80%
15 to 18	8.54%
19 to 24	8.13%
25 to 34	8.29%
35 to 44	9.00%
45 to 54	11.46%
55 to 64	15.36%
65+	5.82%

4.6.3 Hospitalisations

4.6.3.1 Total admitted patient hospital episodes

Table 4.6.16 Number of Same-Day Separations (2015-2021) for Top 10 SRGs[179]

SRG	Number of same-day separations					
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Diagnostic GI Endoscopy	314	382	374	415	419	421
Ophthalmology	224	365	317	347	333	371
Plastic & Reconstructive Surgery	126	149	173	171	129	137
Gastroenterology	150	149	125	127	133	158
Cardiology	132	124	121	137	123	138
Non-Subspecialty Medicine	85	111	162	207	106	91
Haematology	91	84	96	134	177	170
Non-Subspecialty Surgery	131	113	104	100	124	117
Orthopaedics	106	126	126	111	99	119
Neurology	92	119	102	101	104	111
Grand Total	**1,451**	**1,722**	**1,700**	**1,850**	**1,747**	**1,833**

[178] National Disability Insurance Scheme (NDIS) (2022). Participant dataset

[179] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.17 Number of Overnight Separations (2015-2021) for Top 10 SRGs[180]

SRG	Number of overnight separations					
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Respiratory Medicine	491	457	411	409	426	302
Non-Subspecialty Medicine	227	310	347	313	350	320
Gastroenterology	319	353	295	278	318	272
Cardiology	279	260	272	313	286	286
Non-Subspecialty Surgery	282	297	304	282	277	249
Obstetrics	270	217	232	227	203	195
Orthopaedics	195	203	168	184	175	178
Unqualified Neonate	209	184	188	184	163	169
Neurology	161	204	175	175	176	201
Immunology & Infections	136	159	173	200	219	194
Grand Total	**2,569**	**2,644**	**2,565**	**2,565**	**2,593**	**2,366**

Table 4.6.18 Number of Same-Day Separations per Age Group for Top 10 SRGs (2015-2021)[181]

SRG	Same-day separations per age group (2015-2021)					
	00 - 04	May-14	15 - 44	45 - 69	70 - 84	85+
Diagnostic GI Endoscopy	-	3	446	1,374	475	27
Ophthalmology	4	11	49	610	1,137	146
Plastic & Reconstructive Surgery	1	15	95	344	337	93
Gastroenterology	50	38	342	297	103	12
Cardiology	-	2	159	397	186	31
Non-Subspecialty Medicine	52	42	322	190	140	16
Haematology	2	11	228	189	223	99
Non-Subspecialty Surgery	33	59	324	176	74	23
Orthopaedics	21	96	228	228	82	32
Neurology	13	19	166	351	69	11
Grand Total	**176**	**296**	**2,359**	**4,156**	**2,826**	**490**

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[180] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[181] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.19 Number of Overnight Separations per Age Group for Top 10 SRGs (2015-2021)[182]

SRG	Overnight separations per age group (2015-2021)					
	00 - 04	May-14	15 - 44	45 - 69	70 - 84	85+
Respiratory Medicine	324	144	277	772	711	268
Non-Subspecialty Medicine	106	100	536	412	473	240
Gastroenterology	104	88	546	577	363	157
Cardiology	1	6	211	675	570	233
Non-Subspecialty Surgery	30	131	615	508	299	108
Obstetrics	–	–	1,344	–	–	–
Orthopaedics	12	60	266	328	266	171
Unqualified Neonate	1,097	–	–	–	–	–
Neurology	8	23	236	323	330	172
Immunology & Infections	52	39	319	314	235	122
Grand Total	1,734	591	4,350	3,909	3,247	1,471

Table 4.6.20 Number of Same-Day Separations per Age Group for Top 10 SRGs (2015-2021)[183]

SRG	Aboriginal and/or Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander	Grand Total	Proportion of ATSI
Diagnostic GI Endoscopy	177	2,148	2,325	8%
Ophthalmology	170	1,787	1,957	9%
Plastic & Reconstructive Surgery	43	842	885	5%
Gastroenterology	179	663	842	21%
Cardiology	138	637	775	18%
Non-Subspecialty Medicine	134	628	762	18%
Haematology	67	685	752	9%
Non-Subspecialty Surgery	136	553	689	20%
Orthopaedics	81	606	687	12%
Neurology	99	530	629	16%
Grand Total	1,224	9,079	10,303	
Proportion of separations	12%	88%	100%	
Proportion of population (ERP 2020)	13%	87%	100%	

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[182] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[183] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.21 Number of Overnight Separations per Age Group for Top 10 SRGs (2015-2021)[184]

SRG	Aboriginal and/or Torres Strait Islander	Neither Aboriginal nor Torres Strait Islander	Grand Total	Proportion of ATSI
Respiratory Medicine	603	1,893	2,496	24%
Non-Subspecialty Medicine	444	1,423	1,867	24%
Gastroenterology	402	1,433	1,835	22%
Cardiology	239	1,457	1,696	14%
Non-Subspecialty Surgery	291	1,400	1,691	17%
Obstetrics	278	1,066	1,344	21%
Orthopaedics	154	949	1,103	14%
Unqualified Neonate	285	812	1,097	26%
Neurology	182	910	1,092	17%
Immunology & Infections	189	892	1,081	17%
Grand Total	**3,067**	**12,235**	**15,302**	
Proportion of separations	20%	80%	149%	
Proportion of population	13%	87%	100%	

Table 4.6.21 Number of Same-Day Separations per Age Group for Top 10 SRGs (2015-2021)[185]

SRG	Roma	Roma Region	SWHHS remainder	Grand Total	Proportion of SWHHS remainder
Diagnostic GI Endoscopy	134	157	130	421	31%
Ophthalmology	170	140	61	371	16%
Haematology	64	65	41	170	24%
Gastroenterology	45	44	69	158	44%
Cardiology	38	57	43	138	31%
Plastic & Reconstructive Surgery	63	44	30	137	22%
Orthopaedics	39	33	47	119	39%
Non-Subspecialty Surgery	26	48	43	117	37%
Neurology	36	43	32	111	29%
Gynaecology	39	30	24	93	26%
Grand Total	**654**	**661**	**520**	**1,835**	
Proportion of separations	36%	36%	28%	100%	
Proportion of population (ERP 2020)	29%	24%	47%	100%	

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[184] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[185] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.22 Number of Overnight Separations per Age Group for Top 10 SRGs (2015-2021)[186]

SRG	Roma	Roma Region	SWHHS remainder	Grand Total	Proportion of SWHHS remainder
Non-Subspecialty Medicine	65	136	119	320	43%
Respiratory Medicine	70	136	96	302	32%
Cardiology	83	117	86	286	30%
Gastroenterology	57	133	82	272	30%
Non-Subspecialty Surgery	62	101	86	249	35%
Neurology	53	67	81	201	40%
Obstetrics	78	72	45	195	23%
Immunology & Infections	58	80	56	194	29%
Orthopaedics	51	52	75	178	42%
Unqualified Neonate	67	63	39	169	23%
Grand Total	**644**	**957**	**765**	**2,366**	
Proportion of separations	27%	40%	32%	100%	
Proportion of population (ERP 2020)	29%	24%	47%	100%	

Table 4.6.23 Number of Same-Day Separations per Age Group for Top 10 SRGs (2015-2021)[187]

SRG	Roma	Roma Region	SWHHS remainder	Grand Total	Proportion of SWHHS remainder
Diagnostic GI Endoscopy	140	221	111	472	24%
Chemotherapy	80	204	74	358	21%
Renal Dialysis	126	14	108	248	44%
Orthopaedics	36	55	40	131	31%
Ophthalmology	24	63	28	115	24%
Dentistry	47	46	20	113	18%
Gynaecology	29	54	24	107	22%
Ear, Nose & Throat	27	29	21	77	27%
Urology	18	35	21	74	28%
Obstetrics	19	14	17	50	34%
Grand Total	**546**	**735**	**464**	**1,745**	
Proportion of separations	31%	42%	27%	100%	
Proportion of population (ERP 2020)	29%	24%	47%	100%	

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[186] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[187] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.24 Number of Same-Day Separations per Age Group for Top 10 SRGs (2015-2021)[188]

SRG	Roma	Roma Region	SWHHS remainder	Grand Total	Proportion of SWHHS remainder
Orthopaedics	55	110	108	273	40%
Non-Subspecialty Surgery	22	59	47	128	37%
Obstetrics	41	46	30	117	26%
Urology	41	45	27	113	24%
Ear, Nose & Throat	26	39	21	86	24%
Respiratory Medicine	19	36	20	75	27%
Gastroenterology	23	25	24	72	33%
Upper GIT Surgery	21	26	25	72	35%
Unqualified Neonate	19	28	17	64	27%
Neurology	5	22	32	59	54%
Grand Total	**272**	**436**	**351**	**1,059**	
Proportion of separations	11%	18%	15%	45%	
Proportion of population (ERP 2020)	29%	24%	47%	100%	

4.6.3.2   Mental health hospitalisations

Table 4.6.25 Mental health hospitalisations[189]

Mental health DRG/SRG	Hospitalisations per year					
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Major Psychiatric Disorder	**72**	**71**	**74**	**62**	**78**	**64**
Major Affective Disorders, Major Complexity	1	1	1	1	–	–
Major Affective Disorders, Minor Complexity	10	13	12	15	20	16
Mental Health Treatment W/O Ect, Sameday	38	28	22	29	29	25
Paranoia and Acute Psychotic Disorders, Major Complexity	–	–	–	–	1	
Paranoia and Acute Psychotic Disorders, Minor Complexity	8	6	3	6	11	6
Schizophrenia Disorders, Major Complexity	1	–	1	2	3	
Schizophrenia Disorders, Minor Complexity	14	23	35	9	14	17
Other Psychiatry	**74**	**63**	**67**	**60**	**92**	**60**
Anxiety Disorders, Major Complexity	3	3	3	1	3	2
Anxiety Disorders, Minor Complexity	19	16	23	19	27	18
Childhood Mental Disorders, Minor Complexity	–	–	–	–	1	
Eating and Obsessive-Compulsive Disorders, Major Complexity	–	–	–	–	–	1
Eating and Obsessive-Compulsive Disorders, Minor Complexity	–	–	–	2	3	4
Other Affective and Somatoform Disorders, Major Complexity	4	3	3	1	13	5
Other Affective and Somatoform Disorders, Minor Complexity	36	21	28	24	30	22
Personality Disorders and Acute Reactions, Major Complexity	–	–	–	–	1	2
Personality Disorders and Acute Reactions, Minor Complexity	12	20	10	13	14	6
Grand Total	**146**	**134**	**141**	**122**	**170**	**124**

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[188] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[189] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.25 Mental health average bed days[190]

Mental Health	Average of Beddays (Total)					
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Overnight+	3.38	3.49	4.14	5.31	3.5	3.59
Same Day	2.11	1.47	1.83	2.64	1.38	1.47
Grand Total	**3.14**	**3.08**	**3.81**	**4.9**	**3.07**	**3.16**

4.6.3.3   Local hospital self-sufficiency rates

Table 4.6.26 Hospital self-sufficiency rates[191]

SA3 / Geographic Area	Self-sufficiency rates			
	Overnight+		Same Day	
	Within HHS	Outside HHS	Within HHS	Outside HHS
Roma				
Emergency	74.55%	25.45%	81.71%	18.29%
Non-Emergency	24.49%	75.51%	37.01%	62.99%
Roma Region				
Emergency	74.07%	25.93%	83.05%	16.95%
Non-Emergency	29.55%	70.45%	33.74%	66.26%
South West remainder				
Emergency	68.54%	31.46%	84.18%	15.82%
Non-Emergency	25.82%	74.18%	28.59%	71.41%

Table 4.6.27 Highest volume separations (Same day)[192]

SRG	Proportion of same day separations		Total number of separations
	Within HHS	Outside HHS	
Chemotherapy	5.28%	94.72%	530
Dentistry	24.74%	75.26%	194
Diagnostic GI Endoscopy	41.11%	58.89%	1024
Gastroenterology	79.80%	20.20%	198
Gynaecology	35.23%	64.77%	264
Haematology	62.04%	37.96%	274
Ophthalmology	59.74%	40.26%	621
Orthopaedics	35.74%	64.26%	333
Plastic & Reconstructive Surgery	60.35%	39.65%	227
Renal Dialysis	0.00%	100.00%	259

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[190] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[191] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[192] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.28 Highest volume separations (Overnight)[193]

SRG	Proportion of overnight separations		Total number of separations
	Within HHS	Outside HHS	
Cardiology	77.72%	22.28%	368
Gastroenterology	74.11%	25.89%	367
Immunology & Infections	78.54%	21.46%	247
Neurology	71.28%	28.72%	282
Non-Subspecialty Medicine	88.64%	11.36%	361
Non-Subspecialty Surgery	57.91%	42.09%	430
Obstetrics	50.65%	49.35%	385
Orthopaedics	27.73%	72.27%	642
Respiratory Medicine	70.89%	29.11%	426
Unqualified Neonate	63.06%	36.94%	268

Table 4.6.29 Significant flows[194]

SRG	Darling Downs	Metro North	Metro South	Mater Public Hospitals	Sunshine Coast	Gold Coast	Children's Health Queensland	Central Queensland	West Moreton
Chemotherapy	358	54	57	4	17	12		–	–
Diagnostic GI Endoscopy	521	80	38	–	11	7	5	3	3
Ear, Nose & Throat	163	24	9	1	2	2	4		1
Gynaecology	151	46	18	16	3	5		2	7
Non-Subspecialty Surgery	158	23	17	3	2	5	4	6	
Obstetrics	167	39	25	21	9	7		2	3
Ophthalmology	120	54	58	1	14	13	4	1	5
Orthopaedics	404	126	50	30	12	14	16	11	2
Renal Dialysis	248	7	–	–	4	–	–	–	–
Urology	187	11	22	1	1	5	6	4	1
Grand Total	2477	464	294	77	75	70	39	29	22

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[193] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set
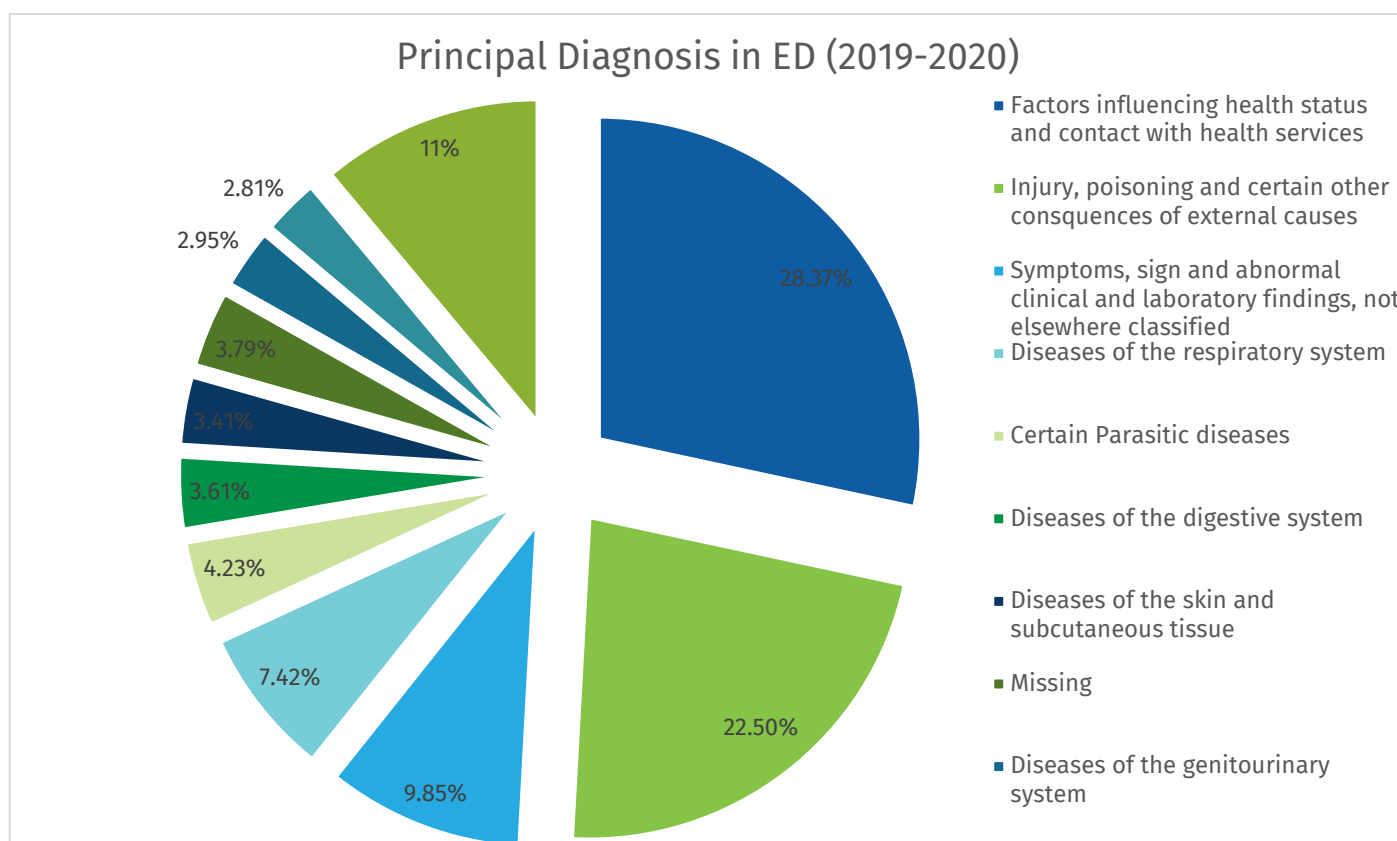
[194] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

4.6.3.4 Emergency department presentations

Table 4.6.30 Volume of ED presentations per year[195]

Site	Sum of ED presentations per year				
	2015/16	2016/17	2017/18	2018/19	2019/20
Charleville Hospital	6,176	6,110	5,864	4,979	5,268
Cunnamulla MPHS	2,211	2,179	2,340	2,829	2,624
Dirranbandi MPHS	–	–	1,306	1,109	849
Mitchell MPHS	–	–	1,065	1,117	1,039
Mungindi MPHS	–	–	1,215	944	1,001
Quilpie MPHS	–	–	2,243	2,401	2,383
Roma Hospital	9,205	8,924	9,514	8,536	8,785
St George Hospital	5,724	6,047	6,435	5,969	5,164
Surat MPHS	–	–	1,202	1,479	1,181
Grand Total	**23,316**	**23,260**	**31,184**	**29,363**	**28,294**

Figure 4.6.1 Principal Diagnosis at ED[196]

Principal Diagnosis in ED (2019-2020)

- Factors influencing health status and contact with health services
- Injury, poisoning and certain other consequences of external causes
- Symptoms, sign and abnormal clinical and laboratory findings, not elsewhere classified
- Diseases of the respiratory system
- Certain Parasitic diseases
- Diseases of the digestive system
- Diseases of the skin and subcutaneous tissue
- Missing
- Diseases of the genitourinary system

Table 4.6.31 Volume of potentially unnecessary ED presentations per year[197]

Site	Sum of potentially unnecessary ED presentations per year				
	2015/16	2016/17	2017/18	2018/19	2019/20
Augathella MPHS					
Charleville Hospital	2,393	2,539	1,860	1,273	1,356
Cunnamulla MPHS	1,248	1,253	1,271	1,918	1,712
Dirranbandi MPHS	–	–	854	515	469
Mitchell MPHS	–	–	344	348	307
Mungindi MPHS	–	–	709	457	514
Quilpie MPHS	–	–	1,753	2,018	1,903
Roma Hospital	2,399	2,703	2,864	2,191	2,301
St George Hospital	2,562	2,830	2,617	2,471	2,250
Surat MPHS	–	–	900	1,071	563
Grand Total	**8,602**	**9,325**	**13,172**	**12,262**	**11,375**

Note: Potentially unnecessary ED presentations were analysed by filtering data for "walked in/public or private transport" mode of arrival, Triage category 5 (Non-urgent), Admitted Status: Not Admitted, Episode End Status: Emergency service episode completed and discharged.

4.6.3.5 Virtual bed separations, Hospital in the Home

Table 4.6.32 Virtual bed separations (Hospital in the Home)[198]

SRG	Virtual bed separations		
	2019/2020	2020/2021	Grand Total
Non-Subspecialty Medicine	–	11	11
Orthopaedics	1	–	1
Palliative (non-acute)	1	–	1
Qualified Neonate	–	1	1
Grand Total	**2**	**12**	**14**

Table 4.6.33 Virtual bed days (total)[199]

SRG	Virtual beddays		
	2019/2020	2020/2021	Grand Total
Non-Subspecialty Medicine		119	119
Orthopaedics	34		34
Palliative (non-acute)	12		12
Qualified Neonate		10	10
Grand Total	**46**	**129**	**175**

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[197] Health Service Research, Analysis and Modelling Unit (Queensland Government) (2022). Emergency Department Baseline Data Set

[198] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[199] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

Table 4.6.34 Virtual separations for South West residents treated outside SWHHS[200]

SRG	Virtual separations (treated outside SWHHS)						Grand Total
	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	
Breast Surgery	-	-	-	1	-	-	1
Cardiology	-	-	1	1	-	1	3
Colorectal Surgery	1	1	-	-	-	-	2
Gastroenterology	-	1	-	-	-	-	1
Geriatric Management (non-acute)	-	1	1	-	-	1	3
Haematology	-	-	1	-	-	-	1
Immunology & Infections	1	2	-	2	-	2	7
Neurosurgery	-	2	-	-	-	-	2
Non-Subspecialty Medicine	1	-	3	-	-	-	4
Non-Subspecialty Surgery	-	-	-	1	-	1	2
Orthopaedics	1	3	-	-	-	2	6
Qualified Neonate	-	-	-	-	-	1	1
Renal Medicine	-	1	-	-	-	-	1
Respiratory Medicine	1	1	1	2	2	1	8
Upper GIT Surgery	-	1	-	-	-	-	1
Vascular Surgery	-	-	-	-	1	-	1
Grand Total	**5**	**13**	**7**	**7**	**3**	**9**	**44**

4.6.4   Non-admitted activity

4.6.4.1   Number of outpatient service events

Table 4.6.35 Number of outpatient service events[201]

Service delivery method	Number of outpatient service events				
	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Electronic mail	1,688	887	850	1,080	1,014
In person	111,887	181,524	191,478	190,492	197,606
Other	2	2			20
Postal/courier service	2	2	14	2	26
Telehealth - provider	1,216	1,044	1,403	1,692	2,018
Telehealth - recipient	3,984	4,268	4,539	5,355	5,545
Telephone	5,261	6,915	7,742	19,314	14,638
Unknown	28		10		6
Grand Total	**124,068**	**194,642**	**206,036**	**217,935**	**220,873**

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[200] System Planning Branch, Healthcare Purchasing and System Performance (2022). Historical Admitted DRG Data Set

[201] Health Service Branch, Analysis and Modelling Unit, System Planning Branch, Healthcare System and System Performance (2022). Historical Outpatients Activity Data Set

4.6.4.2 Number of Tier 2 Clinic type service events

Table 4.6.36 Number of Tier 2 type service events[202]

Service event	Number of Tier 2 Clinic type service events				
	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
20.06 General Practice and Primary Care	32,136	85,405	100,817	104,392	97,442
20.07 General Surgery	3,322	3,380	2,846	2,394	2,232
40.06 Occupational Therapy	5,464	5,717	5,078	5,390	5,100
40.08 Primary Health Care	15,299	21,312	21,743	33,839	30,269
40.09 Physiotherapy	13,514	10,262	10,506	9,465	11,258
40.11 Social Work	3,680	3,576	2,108	2,625	1,915
40.23 Nutrition/Dietetics	2,845	2,617	3,041	3,068	3,076
40.25 Podiatry	4,203	5,755	6,128	5,192	5,827
40.28 Midwifery and Maternity	8,802	11,457	10,366	10,157	10,115
72.15 Community Health Services - Child and Youth Health		2,482	5,087	6,434	3,692
Grand Total	**89,265**	**151,963**	**167,720**	**182,956**	**170,926**

4.6.4.3 Oral health

Table 4.6.37 Public oral health occasions of services[203]

SA2 / Planning Region	Oral health occasions of service					
	2017-2018		2018-2019		2019-2020	
	No. of patients	% of eligible population	No. of patients	% of eligible population	No. of patients	% of eligible population
Balonne	513	1.49%	398	1.36%	336	0.95%
Charleville	588	2.14%	480	1.48%	674	2.14%
Far South West	386	2.17%	309	1.85%	417	2.54%
Roma	1075	2.44%	834	2.04%	1094	2.47%
Roma Region	660	2.06%	537	1.42%	557	1.51%
Total	3222	2.06%	2558	1.63%	3078	1.92%

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[202] Health Service Branch, Analysis and Modelling Unit, System Planning Branch, Healthcare System and System Performance (2022). Historical Outpatients Activity Data Set

[203] Office of the Chief Dental Officer (2021). Queensland Health Oral Health Service Data Set

Figure 4.6.2 Volume of Patients Accessing Oral Health Care in SWHHS by Age Group[204]
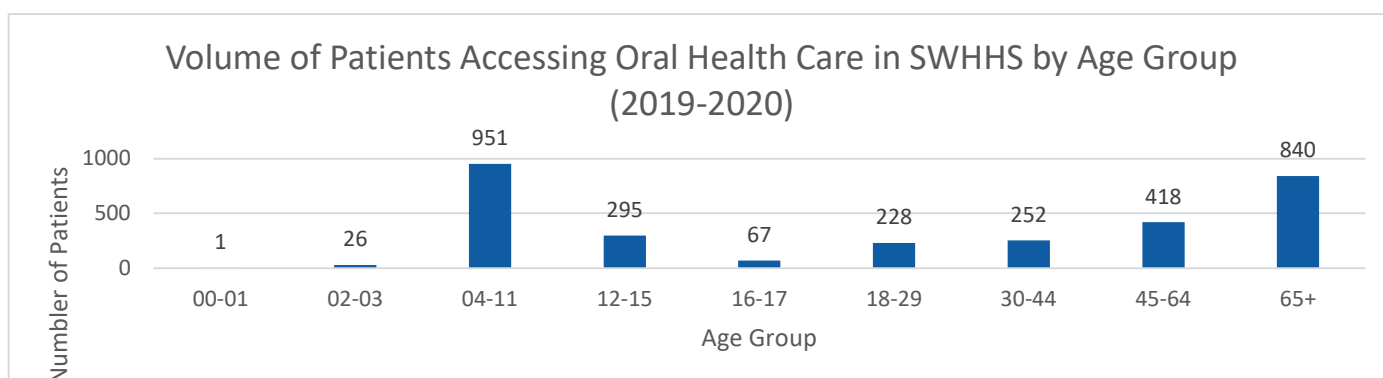
Table 4.6.38 Oral health activity by General Practice Oral Health Service clinic[205]

SA2 / Planning Regions	Clinic	GPOHS Weighted occasion of service		
		2017-2018	2018-2019	2019-2020
Balonne	Dirranbandi Dental Clinic	133.89	85.22	91.28
Balonne	Mungindi Dental Clinic	326.18	98.93	182.52
Balonne	St George	2883.29	2098.3	1676.47
Balonne Total WOOS		**3343.36**	**2282.45**	**1950.27**
Charleville	Augathella Dental Clinic	32.47	169.4	–
Charleville	Charleville Dental Clinic	6191.64	8691.55	10519.78
Charleville Total WOOS		**6224.11**	**8860.95**	**10519.78**
Far South West	Cunnamulla Dental Clinic	1571.39	1490.66	992.06
Far South West	Quilpie Dental Clinic	146.33	203.39	407.15
Far South West	Thargomindah Dental Service	63.03	98.8	78.88
Far South West Total WOOS		**1780.75**	**1792.85**	**1478.09**
Roma	Roma Hospital Dental Clinic	13316.58	16505.61	19071.24
Roma Total WOOS		**13316.58**	**16505.61**	**19071.24**
Roma Surrounds	Injune Hospital Dental Clinic	280.96	53.11	102.13
Roma Surrounds	Mitchell Hospital Dental Clinic	1310.96	305.06	547.59
Roma Surrounds	Surat Hospital Dental Clinic	401.91	43.95	48.37
Roma Surrounds Total WOOS		**1993.83**	**402.12**	**698.09**
NA	Drover 012 746 Qgs	296.64	11.67	17.54
NA	Mobile Dental Clinic 136A	3.26	10.23	50.84
NA	Mobile Dental Clinic 160A	–	–	44.32
NA	Mobile Dental Clinic 190A	–	26.76	54.77
NA	Mobile Dental Clinic 44A	46.34	89.51	–
Mobile Clinics Total WOOS		**346.24**	**138.17**	**167.47**

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[204] Office of the Chief Dental Officer (2021). Queensland Health Oral Health Service Data Set

[205] Office of the Chief Dental Officer (2021). Queensland Health Oral Health Service Data Set

Table 4.6.39 Oral health activity by Child and Adolescent Oral Health Services[206]

SA2 / Planning Regions	Clinic	CAOHS Weighted occasion of service		
		2017-2018	2018-2019	2019-2020
Balonne	Dirranbandi Dental Clinic	59.51	3.83	–
Balonne	Mungindi Dental Clinic	13.04	4.75	0.52
Balonne	St George	210.55	634.58	285.74
Balonne Total WOOS		**283.1**	**643.16**	**286.26**
Charleville	Augathella Dental Clinic	-	–	–
Charleville	Charleville Dental Clinic	595.6	1084.63	395.53
Charleville Total WOOS		**595.6**	**1084.63**	**395.53**
Far South West	Cunnamulla Dental Clinic	15.59	91.93	5.87
Far South West	Quilpie Dental Clinic	34.53	122.22	321.73
Far South West	Thargomindah Dental Service	8.3	189.81	–
Far South West Total WOOS		**58.42**	**403.96**	**327.6**
Roma	Roma Hospital Dental Clinic	1559.32	767.33	934
Roma Total WOOS		**1559.32**	**767.33**	**934**
Roma Surrounds	Injune Hospital Dental Clinic	2.49	5.88	–
Roma Surrounds	Mitchell Hospital Dental Clinic	117.24	15.03	2.05
Roma Surrounds	Surat Hospital Dental Clinic	20.11	–	–
Roma Surrounds Total WOOS		**139.84**	**20.91**	**2.05**
NA	Drover 012 746 Qgs	2131.51	833.64	1427.61
NA	Mobile Dental Clinic 136A	1338.75	1667.65	2117.34
NA	Mobile Dental Clinic 160A	297.98	–	1283.71
NA	Mobile Dental Clinic 180A	–	–	112.58
NA	Mobile Dental Clinic 190A	1471.77	856.99	2273.18
NA	Mobile Dental Clinic 44A	1923.9	2423.12	84.55
Mobile Clinics Total WOOS		**7163.91**	**5781.4**	**7298.97**

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[206] Office of the Chief Dental Officer (2021). Queensland Health Oral Health Service Data Set

4.6.4.4 Residential aged care

South West HHS provides 24/7 aged care services for residents at two facilities, in Roma and Charleville, in addition to MPHS beds - with other private facilities also located around the catchment area. Between 2014-15 and 2019-20, the SWHHS's total MPHS bed capacity increased from 49 to 61 across our seven facilities. However, the total number of available South West HHS aged nursing home beds at Waroona Multipurpose Service and Westhaven Residential Aged Care Facility have remained unchanged at 85 since 2008-09.

In total, there were 281 government, private and not for profit residential aged care places provided by 16 facilities across the SWHHS, as of 30 June 2019, which was approximately 0.6 per cent of the available places serviced by 565 providers across Queensland. With an aging population an increase in demand for aged care and residential services is therefore expected to provide additional challenges in terms of providing appropriate services for older people who potentially could be better managed within their local communities.

4.6.5   Health care planning

4.6.5.1 Mental health care plans

Table 4.6.40 Mental health care plan usage[207]

| SA3 / Geographic Area | Mental health care plan usage (number of patients (#) and proportion of population (%)) | | | | | | | | | | | |
| | 2013-14 | | 2014-15 | | 2015-16 | | 2016-17 | | 2017-18 | | 2018-19 | |
	#	%	#	%	#	%	#	%	#	%	#	%
Darling Downs (West) – Maranoa	1,483	3.3%	1,709	3.8%	1,916	4.2%	2,166	4.8%	2,462	5.5%	2,689	6.0%
Outback – South	383	1.9%	376	1.9%	471	2.5%	545	3.0%	582	3.3%	615	3.5%
Queensland	309,008	6.5%	341,735	7.1%	380,422	7.7%	409,974	8.2%	435,329	8.6%	461,934	9.0%

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[207] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

WQPHN Mental Health Plan Patients by Age Group (2018-2019)

Figure 4.6.4 Western Queensland Mental Health Care Plan Patients by Gender[209]

**WQPHN Mental Health Plan Patients by Gender (2018-2019)**

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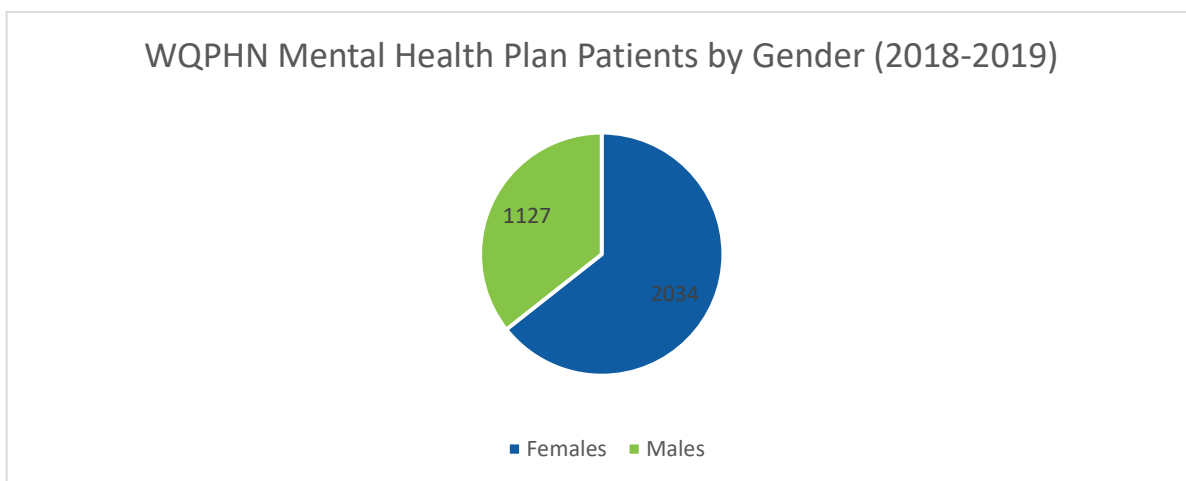
[208] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[209] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

4.6.5.1 Chronic disease plans

*Table 4.6.41 Chronic disease plan usage[210]*

SA3 / Geographic Area	Chronic disease plan usage (number of patients (#) and proportion of population (%))											
	2013-14		2014-15		2015-16		2016-17		2017-18		2018-19	
	#	%	#	%	#	%	#	%	#	%	#	%
Darling Downs (West) - Maranoa	4,641	10.3%	4,756	10.5%	4,856	10.8%	5,238	11.7%	5,707	12.7%	5,680	12.6%
Outback - South	1,277	6.4%	1,129	5.8%	1,349	7.2%	1,700	9.5%	0	0.0%	1,973	11.3%
Queensland	460,978	10.1%	523,790	11.2%	584,383	12.4%	656,347	13.7%	711,939	14.4%	761,919	15.3%

Table 4.6.5 Western Queensland Chronic Disease Management Patients by Age Group (2018-2019)[211]
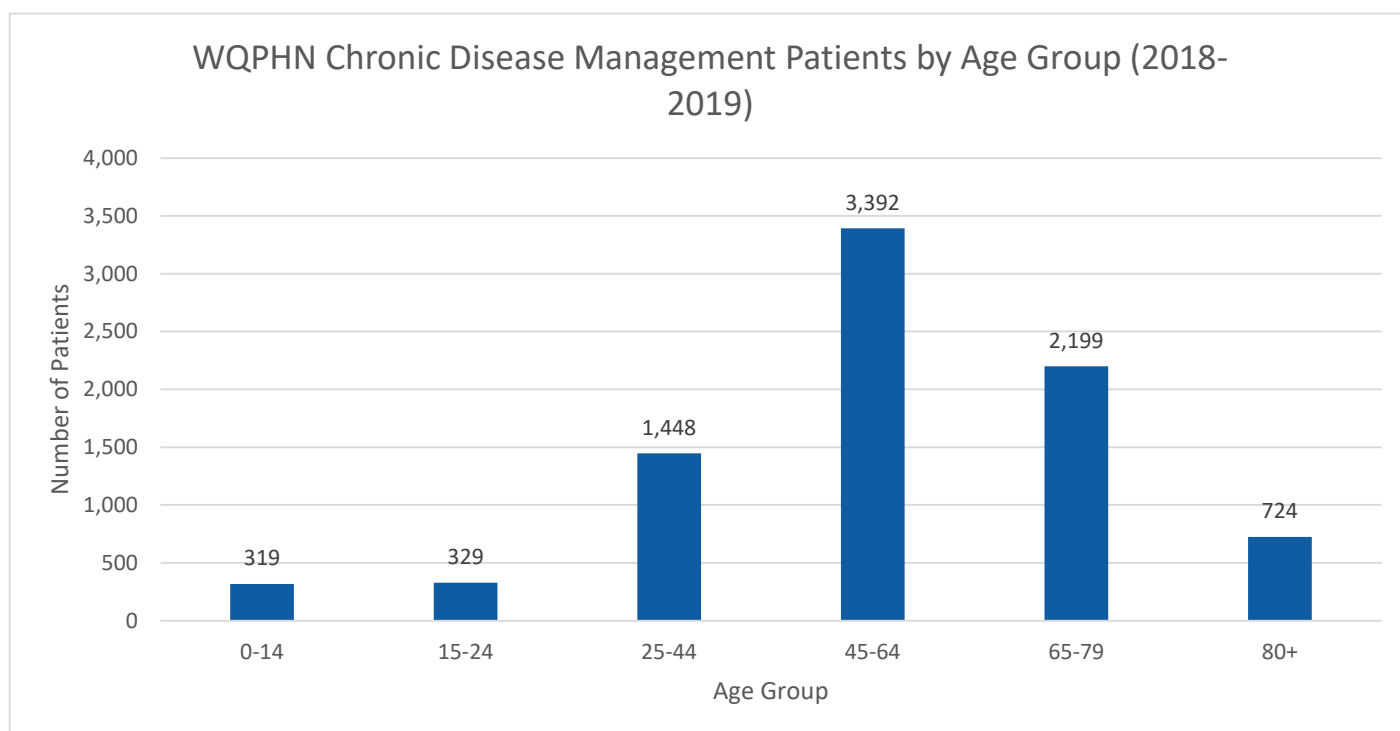
WQPHN Chronic Disease Management Patients by Age Group (2018-2019)

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[210] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[211] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

WQPHN Chronic Disease Management Patients by Gender (2018-2019)

3,907   4,503

■ Females   ■ Males

4.6.5.2   Aboriginal and Torres Strait Islander health checks

Table 4.6.42 Number and Proportion of Aboriginal and Torres Strait Islander population who had health checks [213]

| SA3 / Geographic Area | Aboriginal and Torres Strait Islander health check usage | | | |
| | 2018–19 | | 2019–20 | |
	Patients	% of Population	Patients	% of Population
Darling Downs (West) - Maranoa	1,545	40.5%	1,826	47.0%
Outback - South	810	36.1%	826	36.4%
Queensland	87,193	37.3%	83,984	35.2%

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[212] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

[213] Australian Institute of Health and Welfare (AIHW) (2020). Medicare-subsidised GP, allied health and specialist health care across local areas: 2013–14 to 2018–19

4.6.6   Service mapping

4.6.6.1 Service Maps

Hospitals

Figure 4.6.7 Public Hospitals within the SWHHS catchment
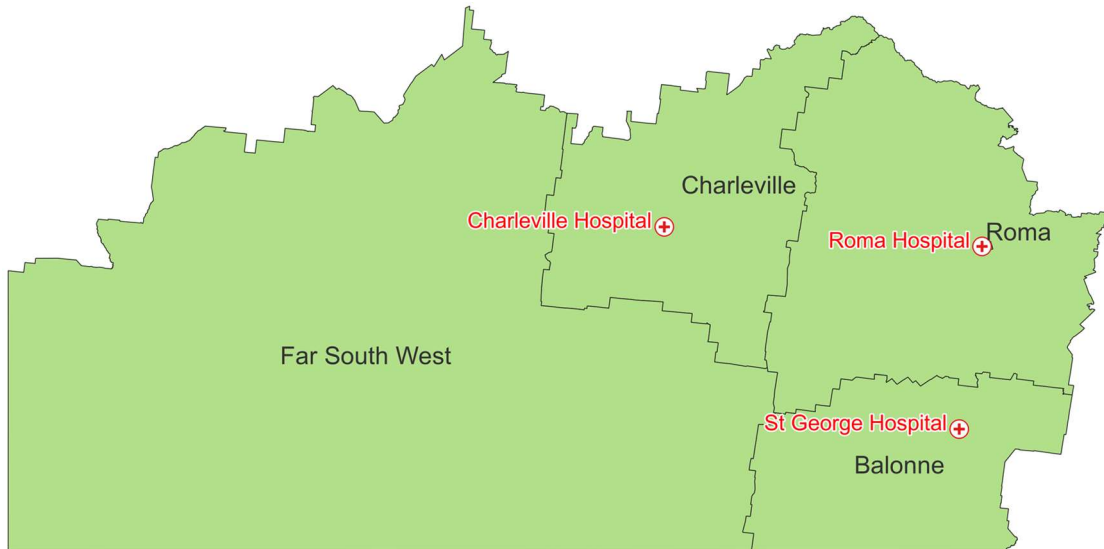
Multipurpose Health Services

Figure 4.6.8 Multipurpose Health Services within the SWHHS catchment
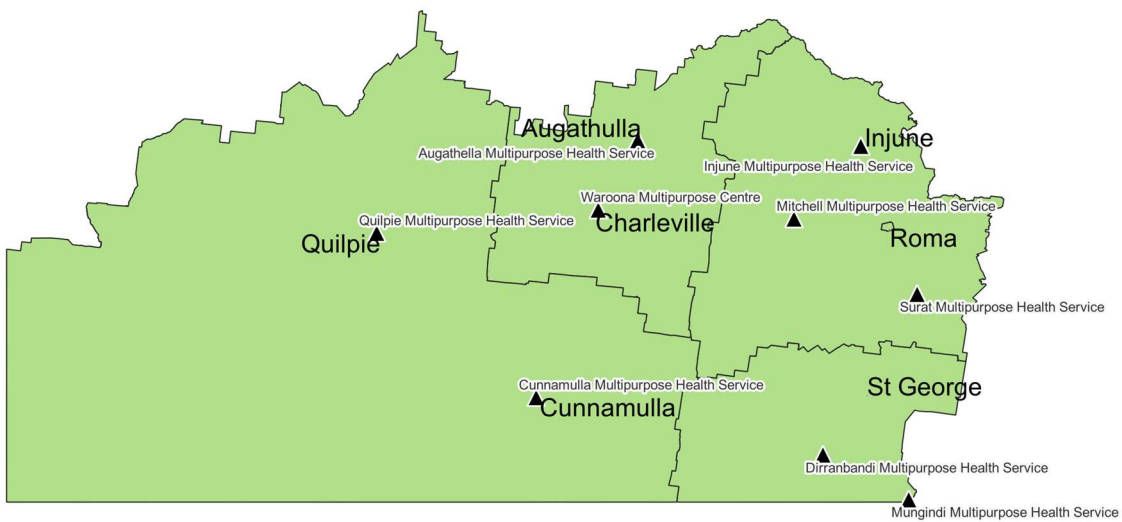
Aboriginal Community Controlled Health Organisations
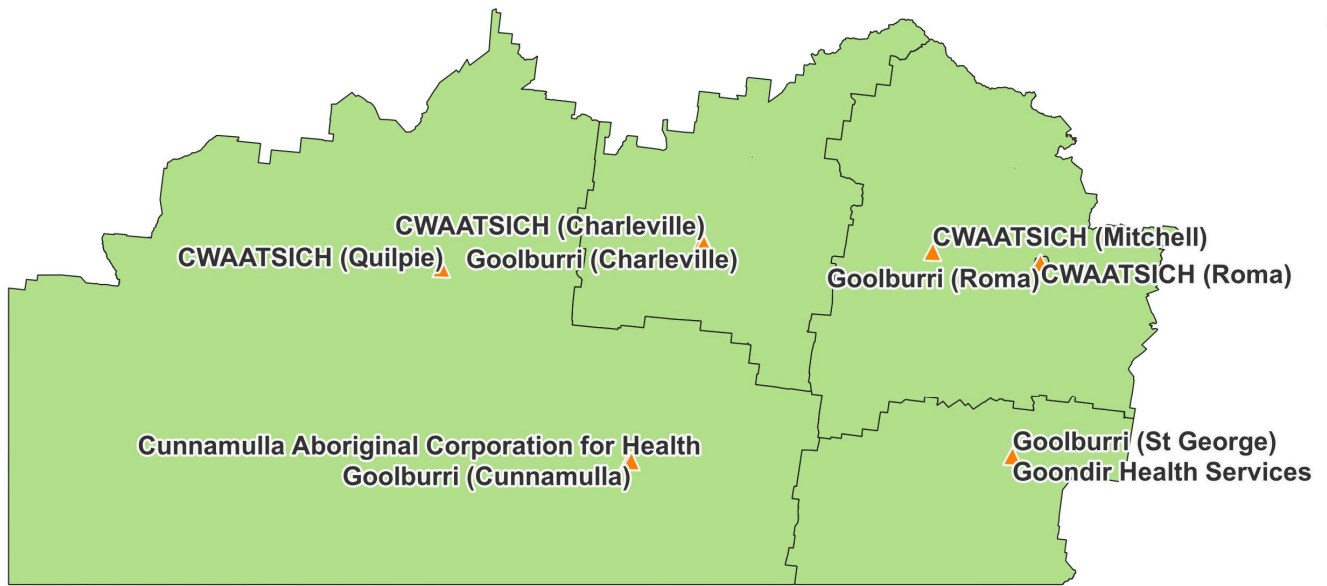
Figure 4.6.9 ACCHOs within the SWHHS catchment

Royal Flying Doctors Stations
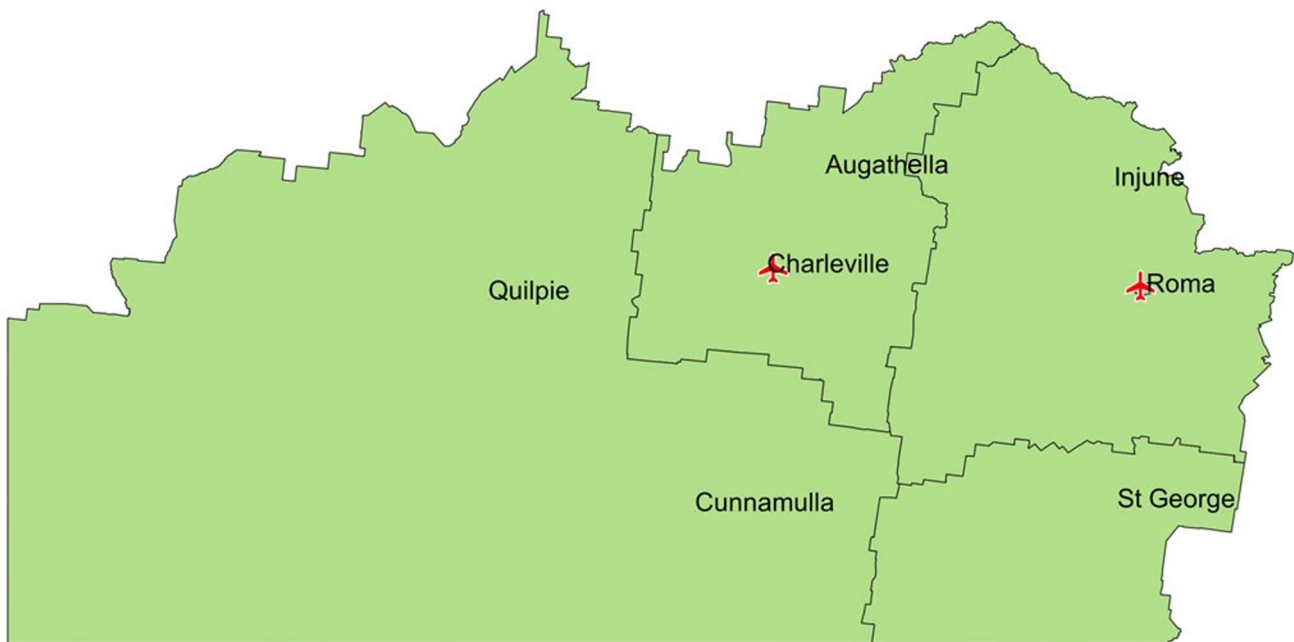
Figure 4.6.10 Royal Flying Doctors within the SWHHS catchment

Ambulance Stations
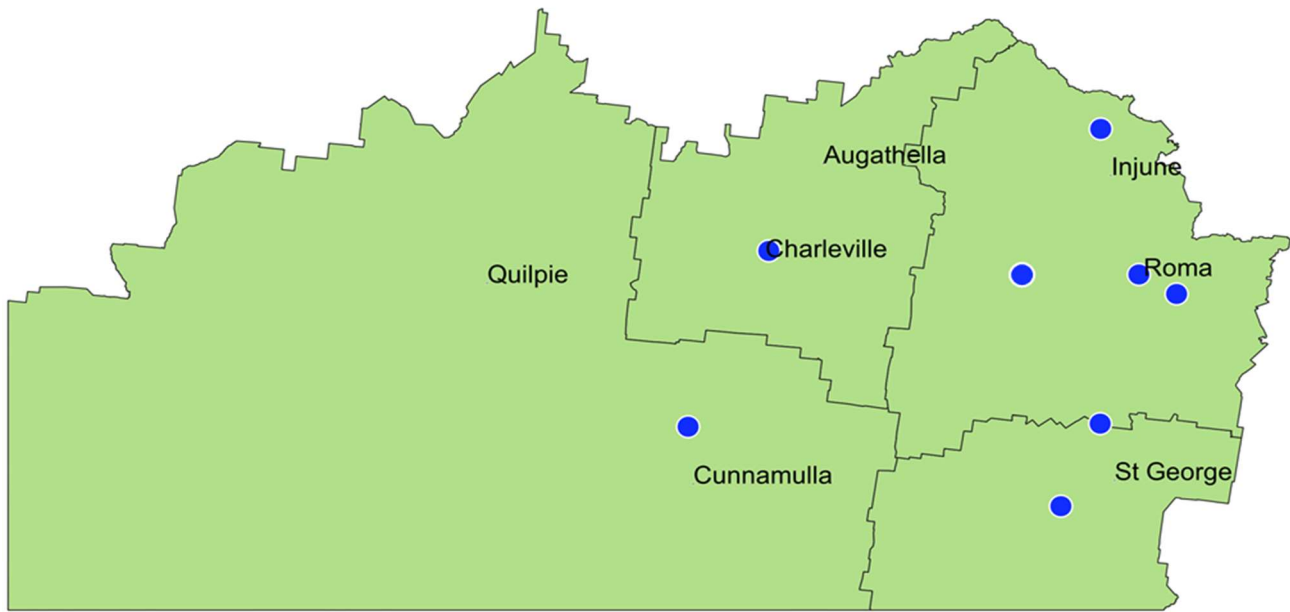
Figure 4.6.11 Ambulance Stations within the SWHHS catchment

Mental Health Services
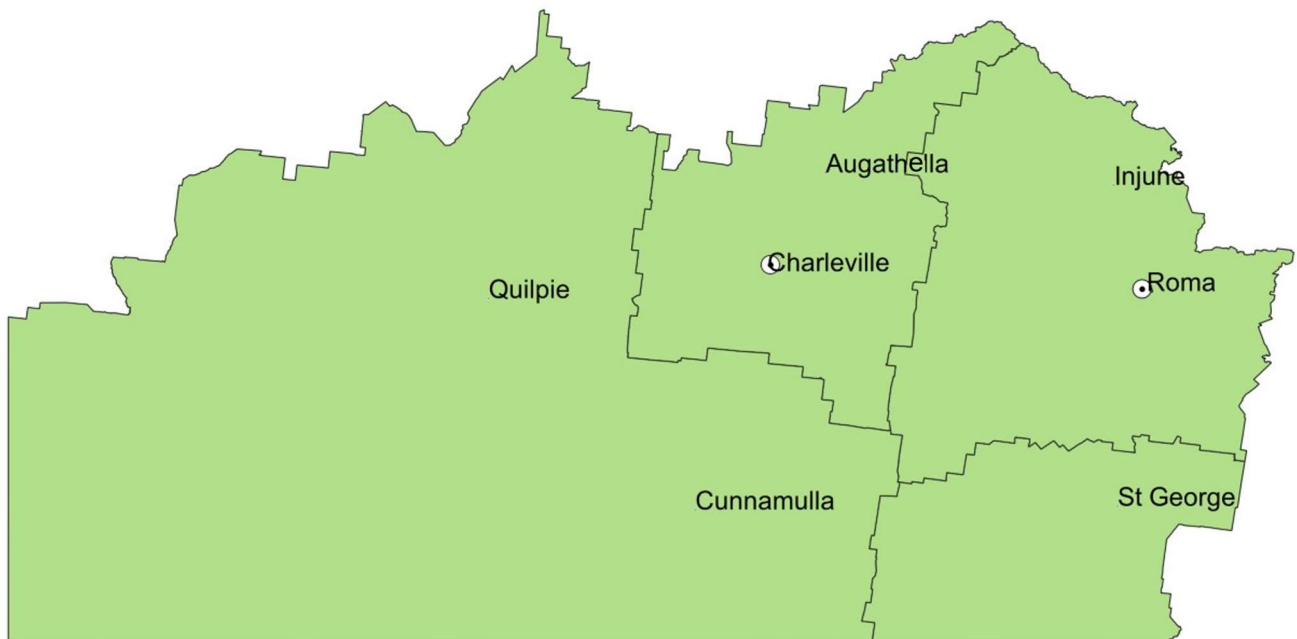
Figure 4.6.12 Mental Health Services within the SWHHS catchment (x3 sites, two of which based in Roma)

Alcohol and Other Drugs Services
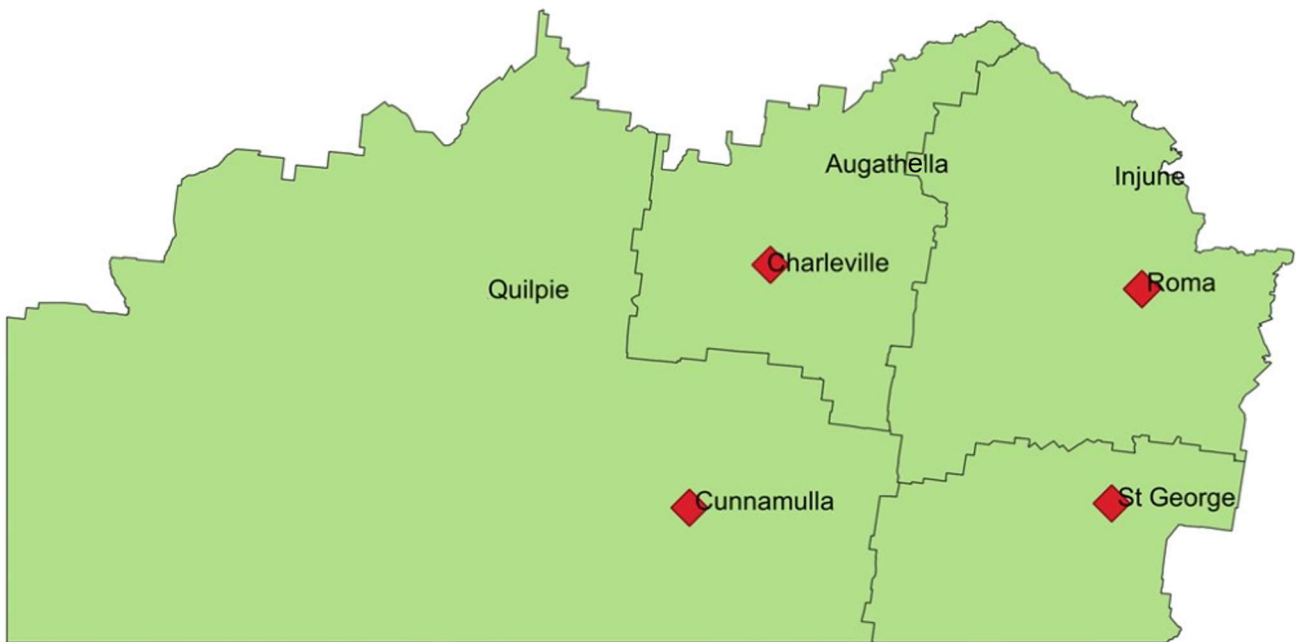
Figure 4.6.13 Alcohol and Other Drugs Services within the SWHHS catchment

Disability Services
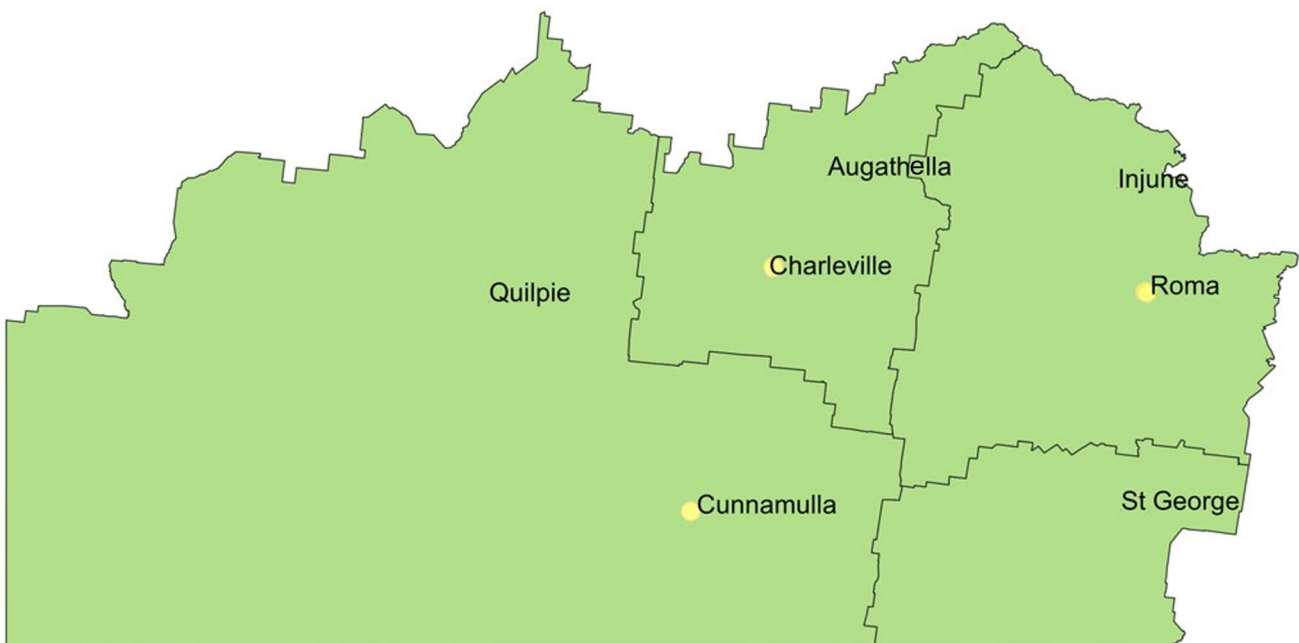
Figure 4.6.14 Disability Services within the SWHHS catchment

Social Services
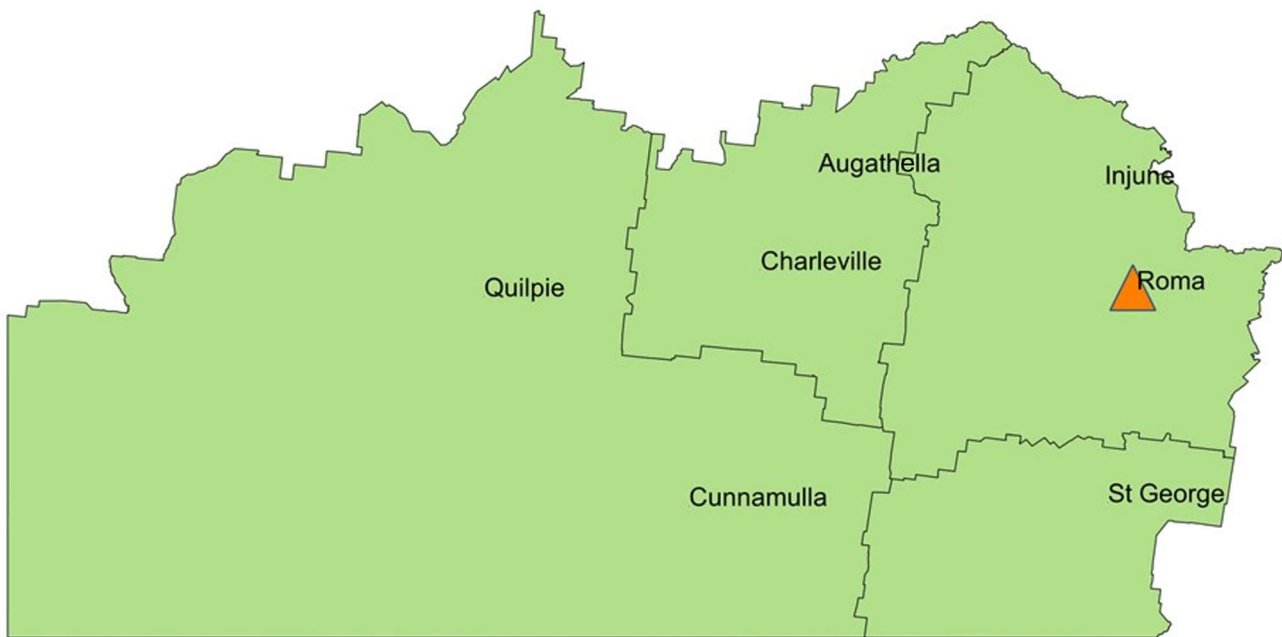
Figure 4.6.15 Social Services within the SWHHS catchment

General Practices
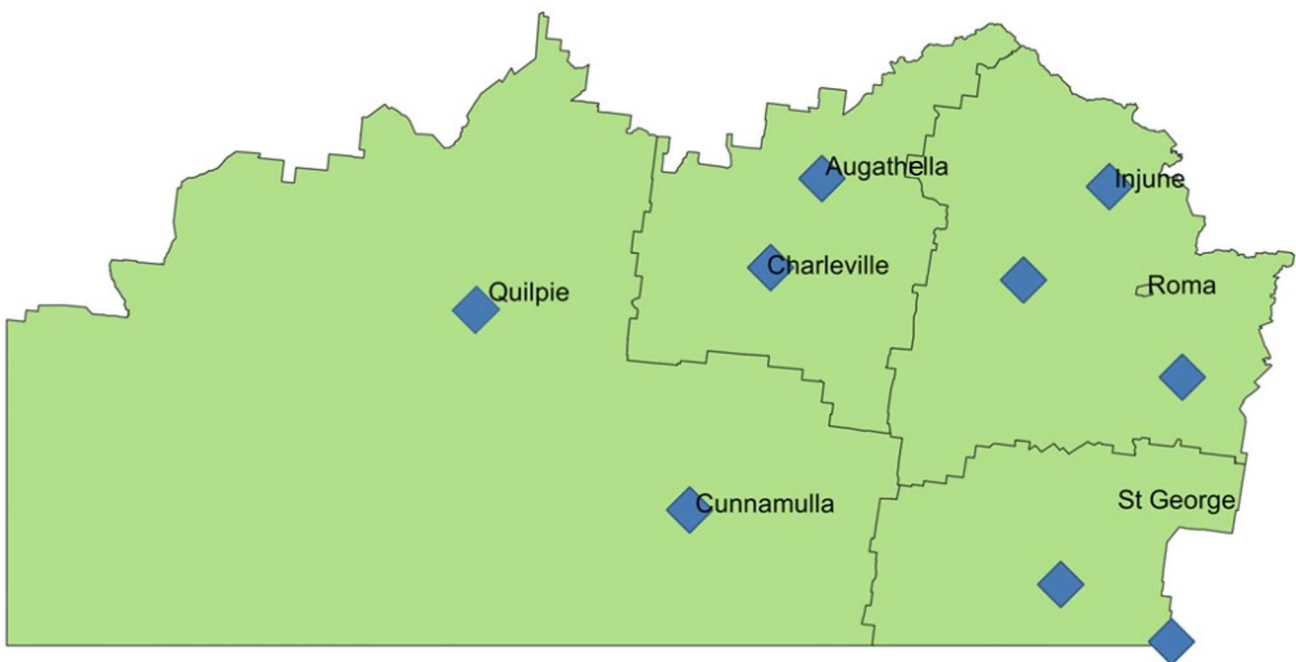
Figure 4.6.16 General Practices within the SWHHS catchment

Pharmacies
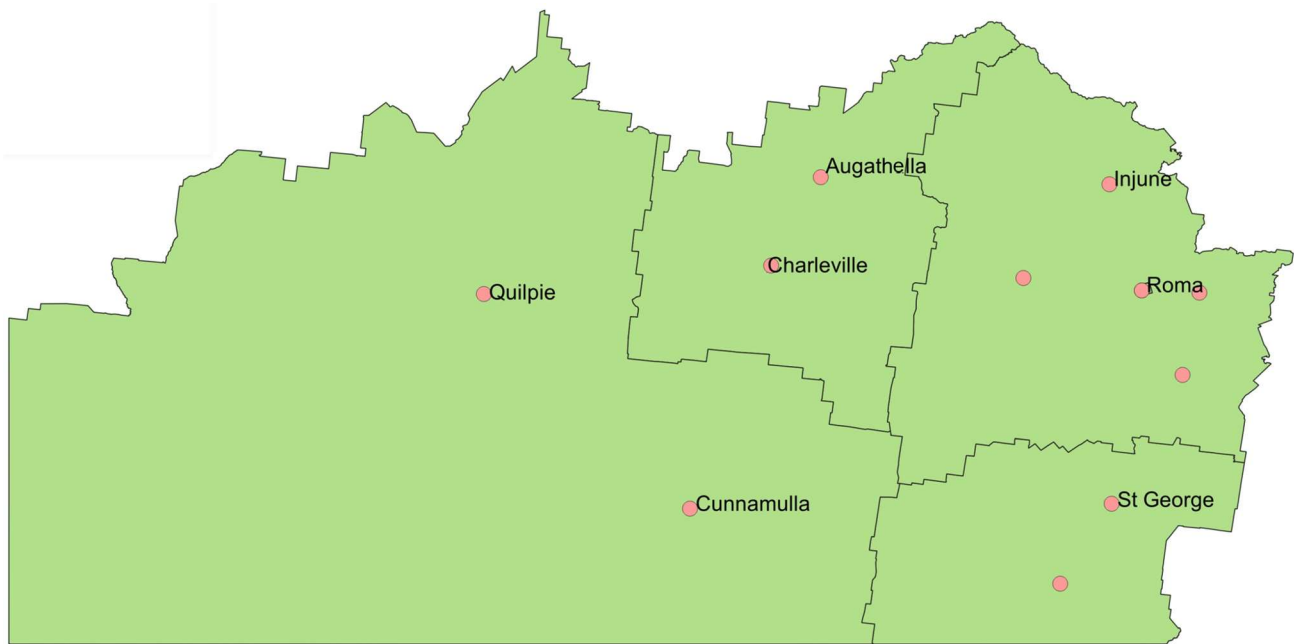
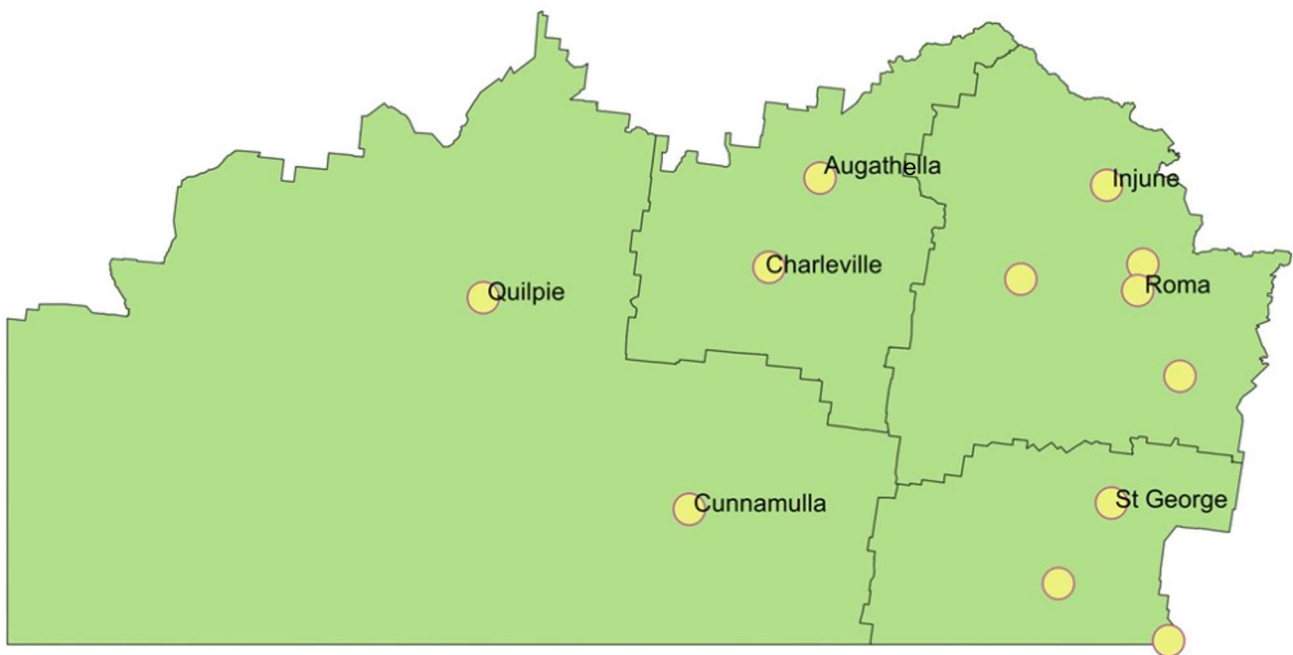*Figure 4.6.17 Pharmacies within the SWHHS catchment*

Medical Imaging Services

Figure 4.6.18 Medical Imaging Services within the SWHHS catchment

Community Clinics, Aged Care Facilities, and Allied Health Centres
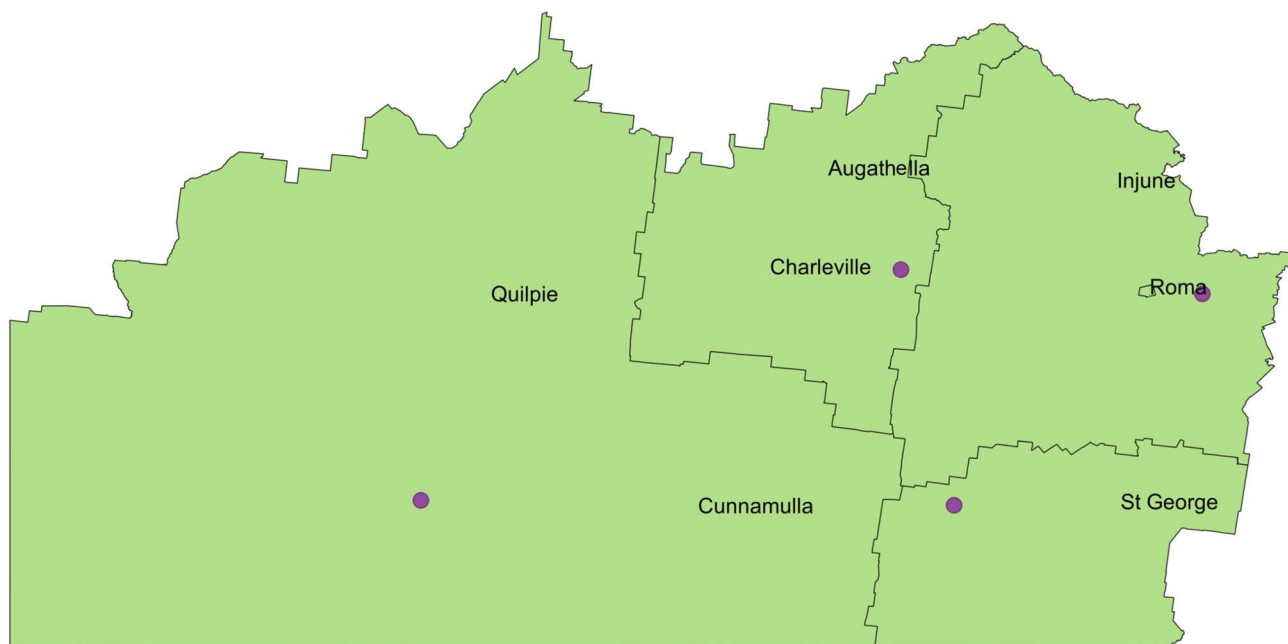
Figure 4.6.19 Community Clinics within the SWHHS catchment

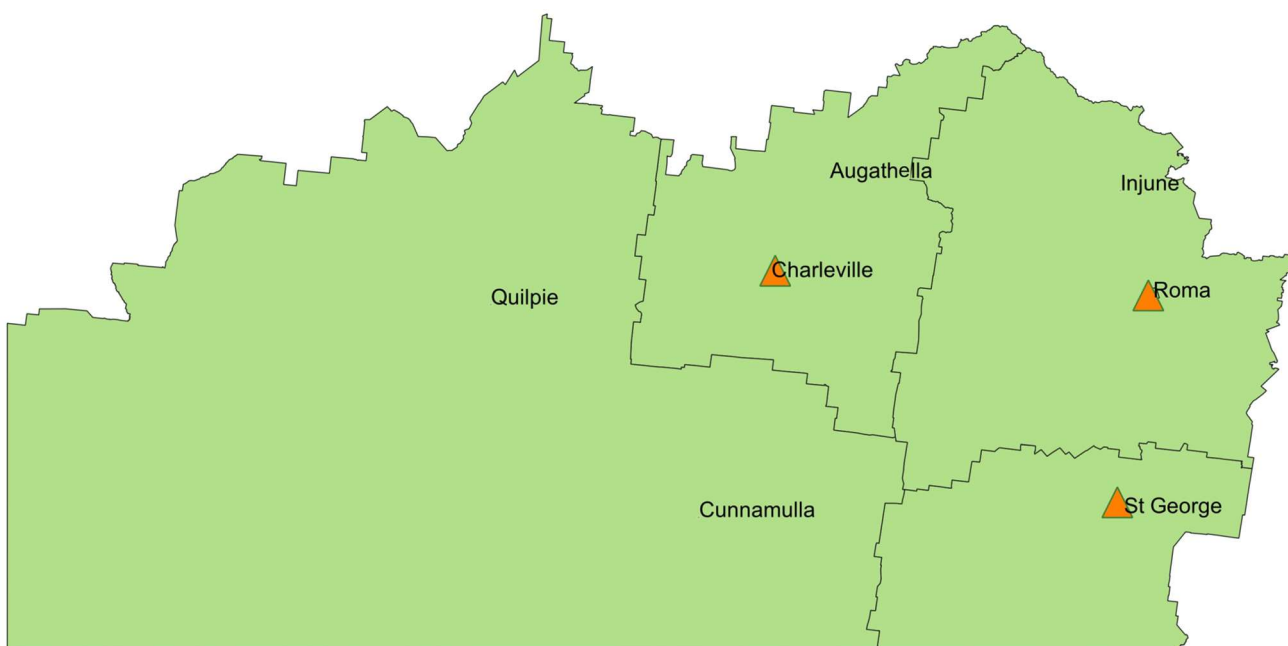*Figure 4.6.20 Allied Health Centres within the SWHHS catchment*

Figure 4.6.21 Aged Care Facilities within the SWHHS catchment

4.6.7   List of services within the SWHHS catchment

Table 4.6.43 List of services within the SWHHS catchment

Provider	Location	Service Type	Funding
Cunnamulla Aboriginal Corporation for Health	Cunnamulla	ACCHO	Commonwealth, Queensland Health
CWAATSICH	Charleville	ACCHO	Queensland Health, Commonwealth, primary health networks and the Medicare Benefits Schedule
Goolburri Aboriginal Health Advancement Company Limited	St George	ACCHO	Commonwealth, Queensland Health
Goolburri Aboriginal Health Advancement Company Limited	Roma	ACCHO	Commonwealth, Queensland Health
Goolburri Aboriginal Health Advancement Company Limited	Cunnamulla	ACCHO	Commonwealth, Queensland Health
Goolburri Aboriginal Health Advancement Company Limited	Charleville	ACCHO	Commonwealth, Queensland Health
Goondir Health Services	St George	ACCHO	Fee for service
CWAATSICH	Roma	ACCHO	Queensland Health, Commonwealth, primary health networks and MBS
CWAATSICH	Quilpie	ACCHO	Queensland Health, Commonwealth, primary health networks and MBS
CWAATSICH	Mitchell	ACCHO	Queensland Health, Commonwealth, primary health networks and MBS
Warrawee Aged Care	St George	Aged Care Facility	Commonwealth, fee for service

Provider	Location	Service Type	Funding
Pinaroo Roma	Roma	Aged Care Facility	Commonwealth, fee for service
Injune Hospital	Injune	Aged Care Facility	Queensland Health
Westhaven Aged Care Facility	Roma	Aged Care Facility	Queensland Health
Waroona	Charleville	Aged Care Facility	Queensland Health
Drug Arm	Charleville	Alcohol and Other Drug service	The Drug Awareness and Relief Foundation (Australia)
Drug Arm	Roma	Alcohol and Other Drug service	The Drug Awareness and Relief Foundation (Australia)
Drug Arm	St George	Alcohol and Other Drug service	The Drug Awareness and Relief Foundation (Australia)
Drug Arm	Cunnamulla	Alcohol and Other Drug service	The Drug Awareness and Relief Foundation (Australia)
Lives Lived Well	Roma	Alcohol and Other Drug service	Commonwealth, Queensland Health, fee for service
VitalHealth	Roma	Allied Health	MBS, Aboriginal Health organisations, NDIS, Check-up, Queensland Health, ResSleep, Healthwise, Amajun Aboriginal Health Service
VitalHealth	St George	Allied Health	MBS, Aboriginal Health organisations, NDIS, CheckUp, Queensland Health, ResSleep, Healthwise, Amajun Aboriginal Health Service
VitalHealth	Charleville	Allied Health	MBS, Aboriginal Health organisations, NDIS, CheckUp, Queensland Health, ResSleep, Healthwise, Amajun Aboriginal Health Service
Queensland Ambulance Station	Charleville	Ambulance	Queensland Health
Queensland Ambulance Station	Cunnamulla	Ambulance	Queensland Health
Queensland Ambulance Station	Dirranbandi	Ambulance	Queensland Health
Queensland Ambulance Station	Injune	Ambulance	Queensland Health
Queensland Ambulance Station	Mitchell	Ambulance	Queensland Health
Queensland Ambulance Station	Roma	Ambulance	Queensland Health
Queensland Ambulance Station	St George	Ambulance	Queensland Health
Queensland Ambulance Station	Surat	Ambulance	Queensland Health
Bollon Community Clinic	Bollon	Community Clinic	Queensland Health

Provider	Location	Service Type	Funding
Morven Community Clinic	Morven	Community Clinic	Fee for service, MBS
Thargomindah Community Clinic	Thargomindah	Community Clinic	Queensland Health
Wallumbilla Community Clinic	Wallumbilla	Community Clinic	Fee for service, MBS
BlueCare: Charleville Community Centre	Charleville	Disability Service	Queensland Health, Commonwealth, private health insurance, fee-for-service arrangements, and donations
BlueCare: Cunnamulla Community Centre	Cunnamulla	Disability Service	Queensland Health, Commonwealth, private health insurance, fee-for-service arrangements, and donations
BlueCare: Roma Community Centre	Roma	Disability Service	Queensland Health, Commonwealth, private health insurance, fee-for-service arrangements, and donations
Focused on Care	Roma	Disability Service	NDIS
Charleville Hospital	Charleville	Hospital	Queensland Health
Roma Hospital	Roma	Hospital	Queensland Health
St George Hospital	St George	Hospital	Queensland Health
Qscan	Roma	Medical Imaging	Fee for service
Mungindi Doctors Surgery	Mungindi	Medical Imaging	Fee for service, MBS
Charleville Hospital	Charleville	Medical Imaging	Queensland Health
Roma Hospital	Roma	Medical Imaging	Queensland Health
St George Hospital	St George	Medical Imaging	Queensland Health
Cunnamulla Multi-Purpose Health Service	Cunnamulla	Medical Imaging	Queensland Health
Augathella Multi-Purpose Health Service	Augathella	Medical Imaging	Queensland Health
Dirranbandi Multi-Purpose Health Service	Dirranbandi	Medical Imaging	Queensland Health
Injune Multi-Purpose Health Service	Injune	Medical Imaging	Queensland Health
Mitchell Multi-Purpose Health Service	Mitchell	Medical Imaging	Queensland Health
Mungindi Multipurpose Health Service	Mungindi	Medical Imaging	Queensland Health
Quilpie Multipurpose Health Service	Quilpie	Medical Imaging	Queensland Health
Surat Multipurpose Health Service	Surat	Medical Imaging	Queensland Health
Cunnamulla Multi-Purpose Health Service	Cunnamulla	Medical Imaging	Queensland Health
Waroona Multipurpose Centre	Charleville	Medical Imaging	Queensland Health
Augathella Doctors Surgery	Augathella	Medical practice	Fee for service, MBS
Charleville Health Clinic	Charleville	Medical practice	Fee for service, MBS
Cunnamulla Primary Health Care Centre	Cunnamulla	Medical practice	Queensland Health
Dirranbandi Medical Centre	Dirranbandi	Medical practice	Fee for service, MBS

Provider	Location	Service Type	Funding
Injune Medical Practice	Injune	Medical practice	Fee for service, MBS
Mitchell Medical Practice	Mitchell	Medical practice	Fee for service, MBS
Mungindi Doctors Surgery	Mungindi	Medical practice	Fee for service, MBS
Surat Medical Practice	Surat	Medical practice	Fee for service, MBS
Anglicare	Charleville	Mental health service	Commonwealth, Queensland Health, Fee for service funders (e.g., HHS)
Anglicare	Roma	Mental health service	Commonwealth, Queensland Health, Fee for service funders (e.g., HHS), NDIS
headspace	Roma	Mental health service	Australian Government Department of Health
Augathella Multi-Purpose Health Service	Augathella	Multi-purpose health service	Queensland Health
Cunnamulla Multi-Purpose Health Service	Cunnamulla	Multi-purpose health service	Queensland Health
Dirranbandi Multi-Purpose Health Service	Dirranbandi	Multi-purpose health service	Queensland Health
Injune Multi-Purpose Health Service	Injune	Multi-purpose health service	Queensland Health
Mitchell Multi-Purpose Health Service	Mitchell	Multi-purpose health service	Queensland Health
Mungindi Multipurpose Health Service	Mungindi	Multi-purpose health service	Queensland Health
Quilpie Multipurpose Health Service	Quilpie	Multi-purpose health service	Queensland Health
Surat Multipurpose Health Service	Surat	Multi-purpose health service	Queensland Health
Cunnamulla Multi-Purpose Health Service	Cunnamulla	Multi-purpose health service	Queensland Health
Waroona Multipurpose Centre	Charleville	Multi-purpose health service	Queensland Health
Health Plus Chemist	Roma	Pharmacy	Fee for service
United Chemists	Roma	Pharmacy	Fee for service
Wallumbilla Pharmacy	Wallumbilla	Pharmacy	Fee for service
Radiance Pharmacy	Surat	Pharmacy	Fee for service
Mitchell Pharmacy	Mitchell	Pharmacy	Fee for service
Radiance Pharmacy	Injune	Pharmacy	Fee for service
St George Pharmacy	St George	Pharmacy	Fee for service
Dirranbandi Community Pharmacy	Dirranbandi	Pharmacy	Fee for service
Augathella Pharmacy	Augathella	Pharmacy	Fee for service
Charleville Pharmacy	Charleville	Pharmacy	Fee for service
Cunnamulla Pharmacy	Cunnamulla	Pharmacy	Fee for service
Quilpie Pharmacy	Quilpie	Pharmacy	Fee for service
Royal Flying Doctors Service	Roma	Royal Flying Doctors Service	Commonwealth
Royal Flying Doctors Service	Charleville	Royal Flying Doctors Service	Commonwealth
CatholicCare Social Services	Roma	Social Services	Commonwealth, Queensland Health

4.7 Appendix 7: Prioritisation and Consultations Outcomes

4.7.1 Detailed assessment of priorities and consultation themes

This section explores the three (3) priority health needs summarised in **Section 3** in additional detail. It provides the application of criteria, the themes, and key insights from consultation, and how the enablers could support addressing the priorities.

4.7.1.1 Encouraging and enabling healthy behaviours

Prioritisation Matrix

Criteria	Assessment	Summary
Government / Departmental direction	High	Queensland Health has signaled the need for all Hospital and Health Services to focus on reducing risky behaviours such as excessive drinking, smoking and illicit drug use. The cessation of risky behaviours is a priority for the SWHHS, as evidenced in newly developed resources (e.g., smoking cessation online learning).
Validation of need	High	The data analysis shows that the SWHHS has a higher-than-average rate of smoking and obesity across the population. The analysis also showed that there is a lower-than-average rate of exercise and engagement across the population as well as low rates of fruit/vegetable intake.
Risk of unmet need	High	If the engagement in risky behaviours is not reduced, there could be a growing need for acute services to respond to the chronic diseases that typically result from substance use and / or poor eating habits (e.g., cardiovascular disease, diabetes, cancer).
Feasibility	Moderate	This need can be addressed within the SWHHS geography by continuing the existing work to target smoking cessation and looking at similar resources / programs that could be used to target other healthy behaviours (e.g., eating well).
Impact	High	There is also an opportunity to partner with primary healthcare providers (e.g., ACCOs) and community service providers to develop culturally safe and cohort-specific resources or engagement initiatives that promote healthy behaviours.
Acceptability	High	Risky behaviours present a significant and long-term risk to the SWHHS community as it has a direct relationship with morbidity and mortality outcomes as well as the demand for acute services (e.g., palliative care, cardiovascular care, rehabilitation). This will place increasing pressure on acute services for the SWHHS. Addressing risky behaviours could also have a positive impact on the wellbeing and mental health of the community.

Consultation Insights

Deep understanding of the challenges

The stakeholders consulted as part of the development of the LANA agreed that encouraging healthy behaviours was a priority.

Stakeholders pointed out that unhealthy behaviours are intrinsic to many social activities in rural and remote areas (e.g., going to the pub after work or drinking cold beers after a day of farm work).

Further to this, there are concerns with food security and lack of accessible and cheap exercise (i.e., no gyms or social sport) which exacerbates the issues.

Solutions-focused feedback

Many stakeholders pointed out there was already a lot of work underway within the SWHHS and also partner organisations (e.g., ACCOs) to support people with quitting smoking or managing alcohol consumption and drug use.

An example is the establishment of a new wellbeing centre by Goondir. The wellbeing centre aims to support young people with learning how to cook for themselves and adopt other healthy behaviours.

Enablers

Partnerships

Improving partnerships with local organisations, especially schools, sporting clubs and regional councils, will enable the establishment of more educational pathways for normalising healthy behaviours.

Continuity of care

Improving the continuity of information management between clinicians who are working with a patient will help to ensure consistency in the messaging around the importance of healthy behaviours in improving health outcomes.

4.7.1.2 Improving Mental Health Services

Prioritisation Matrix

Criteria	Assessment	Summary
Government / Departmental direction	High	Improving mental health services as a priority aligns with the SWHHS strategic direction. There is already a Consumer Advisory Network specific to Mental Health, the Birdie Tree initiative for children and young people and a dedicated Mental Health team at the SWHHS.
Validation of need	Moderate	All stakeholders identified this as a high priority need. The data analysis indicates that approximately 10 percent of mental health related emergency presentations are Triage category 1-2. Whilst there is not a high level of mental health related admissions, the stakeholders confirmed that there is a growing need for prevention and early intervention initiatives for mental health and substance abuse related issues.
Risk of unmet need	High	The risk of unmet need is that the SWHHS continues to have a higher-than-average rate of premature deaths from suicide and self-inflicted injuries (currently up to 36 per 100,000 people in some regions, compared with an average of 15 per 100,000 people across Queensland).
Feasibility	Moderate	It is feasible to do more work in the prevention and early intervention space, in collaboration with community service or primary healthcare partners. There is also an opportunity to improve the coordination and local management of people when they return to the SWHHS region after acute treatment in Toowoomba or Brisbane.
Impact	High	Improving mental health services, particularly for low-medium acuity services, would have a positive impact on the community (e.g., social, and emotional wellbeing initiatives, ongoing psychological support) Greater availability and access to mental health services will have significant and profound impacts to community (e.g., incentivising clinicians to facilitate telehealth appointments for follow-up).
Acceptability	High	High acceptability across all stakeholders. Some stakeholders considered this to be the 'top' priority.

Consultation Insights

Solutions-focused feedback

The community members and consumers consulted as part of the development of the LANA indicated that there is an interest in leveraging virtual platforms or telehealth for follow-up mental health appointments, where possible.

This would enable people to stay in their community to receive care. Telehealth enabled appointments can also feel more confidential than being seen walking into the mental health nurse or psychologist's rooms at the local multi-purpose health service or primary healthcare clinic.

Enablers

Partnerships

There are a range of non-government organisations in the SWHHS region that deliver social and emotional wellbeing services (e.g., Lives Lived Well) and medium acuity mental health services (e.g., the RFDS). There are also a number of ACCOs that have been commissioned by the Primary Healthcare Network to deliver social and emotional wellbeing services in a culturally appropriate way.

This signals the opportunity for formalising partnerships with these organisations to enable a planned approach for improving mental health services. This could involve formalising agreements on their shared accountability for particular at-risk cohorts (e.g., young First Nations people, or older farmers).

It could also involve formalising agreements about the linkages between particular types of services (e.g., the community mental health services delivered by the SWHHS and the medium acuity services delivered by the RFDS).

Continuity of care

A number of stakeholders noted the importance of continuity of patient management and information exchange as a critical enabler for improving mental healthcare.

This was particularly the case for people who might have an acute episode, receive care outside the SWHHS catchment (e.g., in Toowoomba) and then return to their community to be managed in a primary healthcare setting for patients.

Stakeholders explained that it was important to enable information sharing about the nature of treatment and medications with the primary healthcare clinic. Stakeholders also noted the importance of being able to see the same mental healthcare practitioner, even if this is enabled through a virtual platform rather than face-to-face.

4.7.1.3 Improving Primary and Specialist Healthcare

Prioritisation Matrix

Criteria	Assessment	Summary
Government / Departmental direction	Moderate	Aligns with South West Strategic Plan (2018-2022) to place people first, avoid preventable harm, and close the gap on health inequalities. It is noted that primary healthcare is generally not a priority in State Government directions as it is typically funded by the Commonwealth Government (i.e., MBS). However, in rural and remote areas, primary healthcare and allied health care are important tenants of ongoing care management for patients.
Validation of need	High	Validated across stakeholders and the data also shows that there a long wait lists for the specialist and / or allied health services that stakeholders identified.
Risk of unmet need	High	If this need is unmet, there may be people who wait too long for care that could get them back into work or an active lifestyle. This means that addressing this health need is linked to addressing Priority 1 (enabling health behaviours). Not addressing this health need may also result in higher rates of preventable hospitalisations and increasing morbidity and mortality.
Feasibility	Moderate	It is feasible to do more work in the prevention and early intervention space, in collaboration with community service or primary healthcare partners. There is also an opportunity to improve the coordination and local management of people when they return to the SWHHS region after acute treatment in Toowoomba or Brisbane.
Impact	High	Many stakeholders indicated the importance of increasing access to allied health and specialist care in order to maintain a healthy lifestyle. This indicates that addressing this health need would have a positive impact on the community by increasing the continuity of care for patients who consult with a specialist and improving overall wellbeing for people currently waiting to see an allied health professional. It may also reduce the cost-of-service delivery (e.g., allied health is typically less expensive to deliver than an admission for an acute admission if the health issue is prolonged and becomes more complex).
Acceptability	High	High acceptability across all stakeholders.

Consultation Insights

🌱 Solutions-focused feedback

Consumers understand that specialist services may not be available in the region but have suggested that enhancing the level of coordination to support those who travel to major centers for specialist care would be highly effective to improving the overall care experience and uptake.

This would include better utilisation of telehealth for follow-up and supporting staff when they do have to work outside their scope of service.

🏅 High quality of existing services

Although they may experience long wait times and challenges in accessing care, consumers and community are highly satisfied with the quality of care received in primary and specialist care settings.

Enablers

Workforce

As staffing is a significant limitation for service provision in the SWHHS, the development of a complete and capable workforce would expand access to both primary and specialist healthcare.

This would include identifying and implementing workforce strategies to increase recruitment and retention, providing additional supports for workforce (particularly those who may have to work above their scope of practice.

Partnerships

Developing partnerships with local organisations would assist the SWHHS to promote pathways to receiving primary and specialist healthcare.

This may include partnerships to support patients and familiars who leave their community to receive care through enhanced transport services and allowing greater use of the SWHHS managed virtual care settings for specialist and private providers to deliver care remotely to those in the SWHHHS catchment.

Continuity of care

Encouraging specialists to utilise virtual health wherever possible to maintain continuity of care will help the SWHHS catchment residents receive care without venturing significant distances.

This includes encouraging specialists to increase their scope of services that could reasonably delivered through virtual care. Further to this, increased information sharing would allow for greater continuity of care for patients who utilise multiple service delivery partners.

4.7.2　Five (5) draft health needs priorities tested with stakeholders

Priority 1: Encouraging and enabling greater access to healthy behaviours.

Priority 2: Improving access to mental health services.

Priority 3: Increasing access to primary healthcare, specialist healthcare, and allied healthcare.

Priority 4: Improving the social determinants of health.

Priority 5: Developing a complete and capable workforce to meet the growing demands of the SWHHS community.

4.7.3   Stakeholders consulted

A range of stakeholders across the SWHHS catchment were consulted to develop a greater understanding of the breadth and depth of health need in the SWHHS region, and to validate the draft priorities developed through quantitative analysis.

Consultation was completed with the following stakeholder groups:

- SWHHS Executives
- SWHHS Clinical Workforce
- Primary Health Networks operating within the region
- ACCHOs delivering services within the region
- Private and non-government organisation health service providers
- Health research and education institutions
- Consumer Advisory Network representatives
- Community leaders and representatives

The following principles for consultation guided the stakeholder engagement:

- **Inclusive and respectful**: Including representatives from critical stakeholders' groups and being open to their feedback and advice around the lived experience of people impacted by initiatives, programs, and services. All participants are experts in their own right and their input is valued.
- **Participatory:** The process is open, responsive, and empathetic to the experience of all participants, whether they be consumers interacting with health services or people managing and supporting the system.
- **Outcomes focussed:** Facilitating conversations in a guided way that allows stakeholders to have their voices heard fully and which is efficient in gaining their insights.

Group Name	Consultation date (2022)	Stakeholder Role
South West HHS	Thursday 30th June	Roma Group DON
		Charleville Group DON
		St George Group DON
		Health Service Chief Executive
		Board Chair
		Health Service Executive Leadership Team
Aboriginal and Torres Strait Islander Medical Services CEOs	Wednesday 29th June	Cunnamulla Aboriginal Corporation for Health
		CWAATSICH
		Goondir
SWHHS Partners	Tuesday 28th June	RFDS
		Vital Health
		QAS
		QPS District Officer Superintendent
		Director - Southern Queensland Rural Health
Council Mayors	Monday 11th July	Maranoa Regional Council
		Balonne Shire Council

Group Name	Consultation date (2022)	Stakeholder Role
		Bulloo Shire Council
		Quilpie Shire Council
		Paroo Shire Council
		Murweh Shire Council
Council CEOs	Friday 8th July	Maranoa Regional Council
		Balonne Shire Council
		Bulloo Shire Council
		Quilpie Shire Council
		Paroo Shire Council
		Murweh Shire Council
CANs	Wednesday 6th July	Dirranbandi Community Advisory Network
	Thursday 7th July	Morven Community Advisory Network

4.7.4   Consultation questions

Priority areas

1. *Do the priority areas align with the health needs in the community?*

2. *Are there any health needs that you've identified within the community that need to be prioritised?*

3. *How can South West HHS support in promoting and fostering health behaviours within the community? (i.e., What are the mechanisms to reduce smoking, reduce drinking, increase fruit/vegetable consumption, etc? are there initiatives that South West HHS can contribute to?)*

4. *What is the current state of mental health within your region? Have you identified a gap in mental health services within the community? What are the current challenges in accessing mental health services and what type of services is most needed?*

5. *Have you identified a gap in specialist and GP services within the community? What are the current challenges in accessing these services and what type of services is most needed?*

6. *How are other providers (such as government agencies and NGOs) working to improve outcomes of those within your region (e.g., housing, education, social and disability services)?*

Other considerations

7. *What other systems, policy tools and resources would be beneficial at a local and regional level?*

4.8 Appendix 8: Bibliography

Data sources used in the development of the LANA are listed in the References section and below each figure and table in this document. The most commonly used data sources are listed below.

For data that has been suppressed due to data limitations and/or privacy reasons, entries are listed as "n.p." (not provided).

National

Australian Bureau of Statistics

The Australian Bureau of Statistics (ABS) is Australia's national statistical agency and provides national data services, including the national Census.

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) is an independent Australian Government agency which collects, manages, and reports data regarding health and welfare issues. The data is sourced from state, territory, and federal government agencies.

Population Health Information Development Unit

The Population Health Information Development Unit (PHIDU) it was established at Torrens University Australia with funding from the Commonwealth Government. This unit collects and reports data on socioeconomic and geographical variations in health across national, jurisdictional, regional, and small areas in Australia.

National Health Services Directory

Launched in 2012, the National Health Services Directory (NHSD) is a comprehensive, national directory of health services and the practitioners that provide them.

State

Chief Health Officer reports – Queensland Health

The Chief Health Officer (CHO) publishes two biannual reports to inform Queenslanders about the health status of the population.

Decision Support System

Decision Support System (DSS) is a secure business intelligence tool that provides users with access to state-wide data for operational and strategic reporting, benchmarking, and analytics.

Planning Portal – Queensland Health

The Planning Portal provides users with dashboards and reports of current and historical health needs and service utilisation data through visualisations that are interactive and accessible across the state. The Planning Portal also presents data for measures under the LANA Framework.

Queensland Government Statistician's Office

Queensland Government Statistician's Office (QGSO) provides data, information and analysis for population dynamics and forecasts, residential dwelling activities, and urban land supply.

System Performance Reporting System

System Performance Reporting System (SPR) is Queensland Health's system-wide performance reporting platform.

Statistical Services Branch

The Statistical Services Branch (SSB) collects, processes, analyses and disseminates statistics on the health of Queenslanders and their use of health services.