phn
NORTHERN QUEENSLAND
An Australian Government Initiative

Northern Queensland PHN

Health Needs Assessment 2022-24

Acknowledgements

The updated Health Needs Assessment report for Northern Queensland Primary Health Network (NQPHN) was conducted in late 2021 in collaboration between the NQPHN and its regional partners, stakeholders, health care services providers, community organisations, and residents.

NQPHN wishes to acknowledge the contribution of its Board, Clinical Councils, and staff, regional partners, health care service providers, and the residents of northern Queensland for their contributions to the development of this needs assessment. We also recognise the contributions of our four Hospital and Health Services (HHS) and 14 Aboriginal Community Controlled Health Organisations (ACCHOs) within our region, and we thank them for their input and support.

Northern Queensland Primary Health Network acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land.

We respect their continued cultural and spiritual connection to country, waters, kin, and community.

We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

We are committed to making a valued contribution to the well-being of all Aboriginal and Torres Strait Islander peoples of northern Queensland.

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List of abbreviations

Abbreviation	Meaning
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ADHD	Attention-Deficit Hyperactivity Disorder
AHA	Allied Health Assistant
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AOD	Alcohol and Other Drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
APSGN	Acute Post-Streptococcal Glomerulonephritis
ASGS	Australian Statistical Geography Standard
BHNQ	Better Health North Queensland
CALD	Culturally And Linguistically Diverse
CHHHS	Cairns and Hinterland Hospital and Health Service
CEO	Chief Executive Officer
CHO	Chief Health Officer
COPD	Chronic Obstructive Pulmonary Disease
COVID	Corona Virus Disease
DM	Diabetes Mellitus
ED	Emergency Department
FTE	Full Time Equivalent
GAS	Group A Streptococcal infection
GP	General Practitioner
HeaDSUPP	Health Demand and Supply Utilisation Patterns Planning
HF	Heart Failure
HHS	Hospital and Health Service
HIV	Human Immunodeficiency Virus
HNA	Health Needs Assessment
IRSD	Index of Relative Socio-economic Disadvantage

Abbreviation	Meaning
ISPHCS	Indigenous Specific Primary Health Care Service
LANA	Local Area Needs Assessment
LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer +
MBS	Medicare Benefits Schedule
MDMA	Methylenedioxy-Methamphetamine
MHHS	Mackay Hospital and Health Service
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NDIS	National Disability Insurance Scheme
NPA	Northern Peninsula Area
NQPHN	Northern Queensland Primary Health Network
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PIP QI	Practice Incentives Program Quality Improvement
PPH	Potentially Preventable Hospitalisation
PTSD	Post-traumatic stress disorder
QAIHC	Queensland Aboriginal and Islander Health Council
RACF	Residential Aged Care Facility
RANZP	Royal Australian and New Zealand College of Psychiatrists
RFDS	Royal Flying Doctor Service
SA	Statistical Area
SEIFA	Socio-Economic Indexes For Areas
SES	Socio-Economic Status
SEWB	Social and Emotional Wellbeing
STI	Sexually Transmissible Infection
THHS	Townsville Hospital and Health Service
TCHHS	Torres and Cape Hospital and Health Service
WHO	World Health Organization

Executive summary

NQPHN is one of 31 regionalised and independent PHNs established nationally by the Commonwealth Department of Health to provide local communities with better access to improved primary healthcare services. The NQPHN region extends from Moranbah in the south, up to the Torres Strait in the north, and west to Croydon and Kowanyama.

We aim to improve health outcomes for all residents by supporting, investing in, and working collaboratively with other health organisations and the community to deliver better primary care.

Our vision is for northern Queenslanders to live happier, healthier, longer lives. Our needs assessment identifies our organisation's priorities to achieve this vision. This needs assessment is informed by robust stakeholder consultation and supported by data and evidence. This approach ensures that the services we fund meet the clearly identified health and healthcare needs for our communities.

NQPHN is home to an estimated 730,000 people who live within our 510,000 square kilometre catchment. The health of our population is improving but there are significant ongoing challenges related to chronic conditions, ageing, and disability. Our population is characterised by broad cultural and socio-economic diversity and a range of health care needs. The major challenge our community face is meeting the primary health needs of a population that is regionally dispersed, culturally and socio-economically diverse, growing in size, and affected by a substantial chronic disease and mental health illness burden. Health services are struggling to cope with demands, leading to avoidable hospitalisations and emergency department presentations.

Ensuring that all members of our community have access to comprehensive primary care will result in better health outcomes. Our priorities include to commission services that address primary care needs affecting a significant proportion of our population, that have a disproportionate impact on people's health, and that affect people in the community who need help the most. We will continue to build our primary care workforce capacity and capability and will work with our partners to undertake joint regional planning to identify and address priority primary care needs in our community.

Almost 12% of our population identify as Aboriginal and/or Torres Strait Islander. Our Aboriginal and Torres Strait Islander communities continue to experience poorer health than the rest of our community. Our priorities are to improve health outcomes for Aboriginal and/or Torres Strait Islander members of our community. We will prioritise prevention, promotion, and early intervention focusing on maternity and postnatal care, sexual and reproductive health, infectious diseases including the substantial rheumatic heart and renal disease burden, and chronic disease.

Our priorities include to increase service continuity in the Torres and Cape, actively support building the Aboriginal and/or Torres Strait Islander health workforce, and support comprehensive chronic conditions management. We recognise that Aboriginal Community Controlled Health Organisations (ACCHOs) are central to delivering comprehensive, coordinated, culturally tailored care for Aboriginal and/or Torres Strait Islander peoples and will work with ACCHOs and partner organisations to facilitate community responses to health priorities. We also recognise some chronic conditions care needs are addressed by mainstream services. In collaboration with ACCHOs, we will support delivery of culturally safe mainstream services that are integrated with services provided by ACCHOs.

Chronic conditions remain one of the greatest challenges facing our health system. Improving health outcomes for people with chronic conditions will not only improve quality of life for this group, but will ease the burden on our hospitals. Our priority is to improve the management of chronic conditions in our community, from a reactive model of primary care to care that is planned and comprehensive and our key priorities reflect this approach to transformation. We are committed to supporting primary care providers in their preventive activities in clinical practice, in using a data-driven approach to improvement, and in implementing comprehensive, evidence-based care for people with chronic conditions.

Mental illness is a major problem that has a substantial social and economic impact on our community, with about 1 in 5 people in our community experiencing mental illness in any year. We intend to address this issue by commissioning services that support a stepped care approach or continuum of care, an evidence-based,

staged system with different levels of mental health interventions. We will continue to support community suicide prevention, improve access to mental health services for young people and improve mental health data quality.

Use of alcohol and other drugs is a major cause of preventable disease, illness, and death. Alcohol is the main cause of substance-related harm in our community. It contributes to mental illness, domestic violence, and injuries. Our priority is to build the capacity of the alcohol and other drugs treatment sector to better meet people's needs, better integrating specialist alcohol and other drugs services with primary care, and improving information sharing between services. Misuse of prescription opioids is a priority issue in our population. We will work with our partners to reduce opioid-related harm in our community.

Introduction

The completion of the triennial Health Needs Assessment (HNA) provides an opportunity for Northern Queensland Primary Health Network (NQPHN) to profile the consumer health needs, identify service delivery gaps, and health workforce challenges for our region.

This information is then used in the broader NQPHN commissioning framework to assist with planning and commissioning services to support better health outcomes for North Queenslanders. This needs assessment utilises evidence derived from many sources and is refreshed annually every other year as new and emerging quantitative and qualitative health data becomes available.

By combining evidence-based need and service need, in alignment with NQPHN's Strategic Plan, this document assists NQPHN to identify key priorities that it can focus on over the following three-year period.

The HNA is not an exhaustive list of all service and health needs. Rather, it identifies gaps in healthcare provision that could be filled through effective commissioning, stakeholder partnership, collaboration, and sector development.

It is envisaged that this document will be referenced by service providers looking to tender for service provision opportunities funded by NQPHN.

Our organisation

NQPHN is one of 31 Primary Health Networks (PHNs) nationally. Our purpose, set by the Commonwealth Government, is to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Our Strategic Plan

NQPHN's Strategic Plan 2021-2026 describes strategies our organisation has adopted to address health care issues and priorities in our community.

Our vision

Our vision is for Northern Queenslanders to live happier, healthier, longer lives.

Our role

NQPHN is the lead organisation for developing – with our partners – an integrated and coordinated primary healthcare system that delivers the best care possible to achieve measurable health improvements for the people of North Queensland.

How we will do this

We will do this through a focus on:

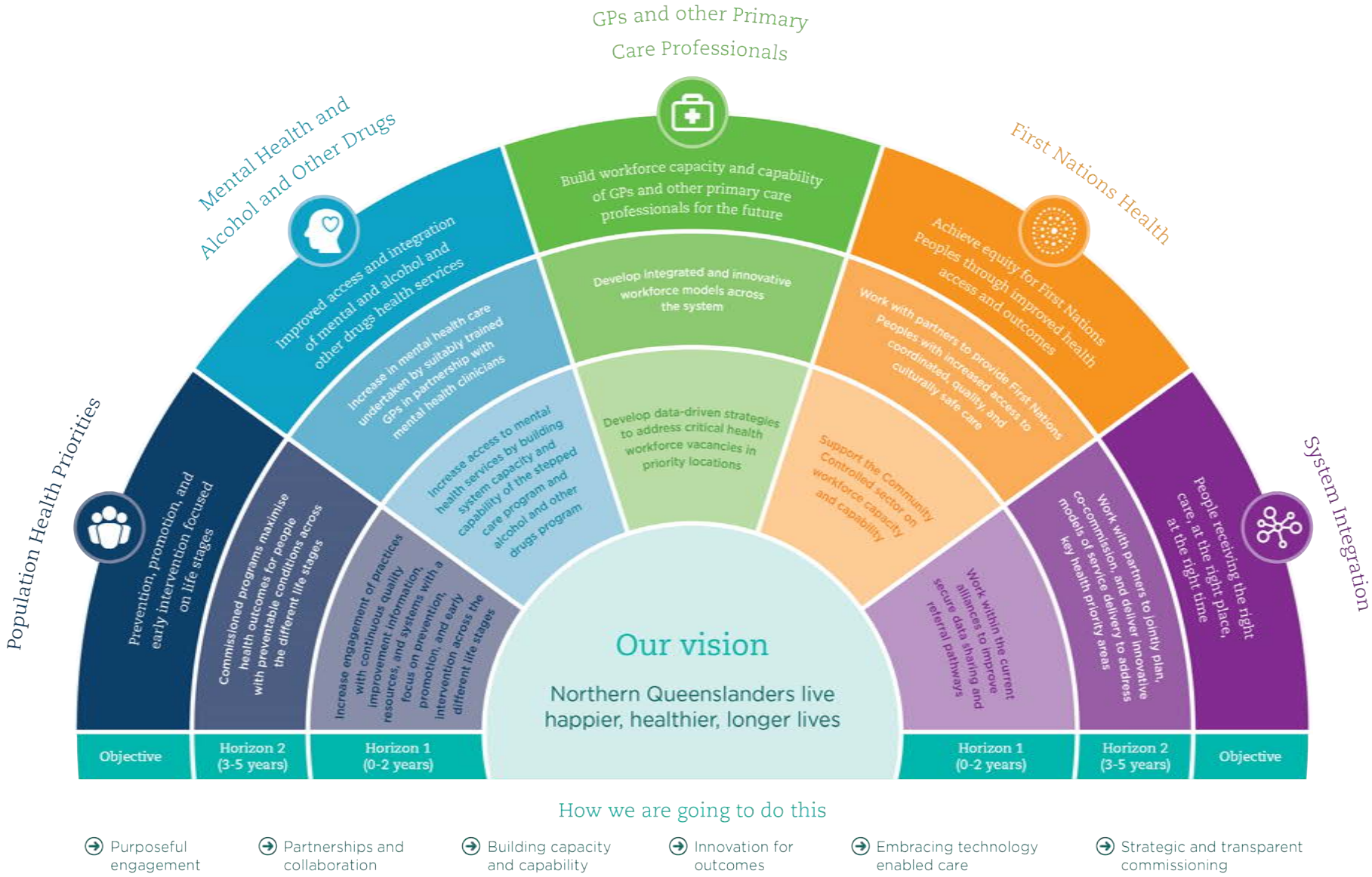
- purposeful engagement
- partnerships and collaboration
- building capacity and capability
- innovation for outcomes
- embracing technology enabled care
- strategic and transparent commissioning.

Our priority areas

Our Board has set five priority areas for action, each with strategic objectives we will work towards and outcomes we will achieve. The priority areas include:

- Population health
- Mental Health and Alcohol and Other Drugs
- GPs and other Primary Care Professionals
- First Nations Health
- System integration

Figure 1. NQPHN Strategic Plan priorities and objectives



Our needs assessment methods

The Commonwealth Department of Health mandates each PHN undertake and maintain an evidence-based Health Needs Assessment (HNA) to identify unique regional and local priorities. This work is guided by national health priorities, including:

- chronic conditions
- mental health
- alcohol and other drugs treatment
- Aboriginal and Torres Strait Islander health.

Our needs assessment methods include a background analysis of policy and strategy environment, a review of peer-reviewed and 'grey' literature, data analysis (mix of qualitative and quantitative) and stakeholder consultation. Our data analysis included analysis of:

- Australian epidemiological datasets obtained through the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), the Population Health Information Development Unit (PHIDU), national aged care and disability datasets
- Australian health workforce service mapping data obtained through the Australian Government Health Demand and Supply Utilisation Patterns Planning tool (HeadS UPP)
- Queensland Government hospitals, emergency department, and population survey data
- NQPHN general practice, health workforce service maps, commissioned service provider quantitative and qualitative data, information, and reports.

Our stakeholder consultation included workshops, interviews, surveys, and written feedback from:

- Better Health North Queensland (BHNQ)
- NQPHN's Clinical Council and Community Advisory Committee
- Hospital and Health Services (HHSs)
- public and private sector medical
- nursing and allied health service providers and consumers
- Aboriginal Community Controlled Health Organisations (ACCHOs)
- rural workforce stakeholders
- people from culturally and linguistically diverse backgrounds
- other relevant stakeholder groups.

Our priority setting process was informed by triangulation of issues and needs from:

- background analysis
- health needs analysis
- service needs analysis
- stakeholder consultation.

Priorities align with NQPHN's Strategic Plan, national, Queensland, regional priorities, and the priorities of our partner organisations.

The HNA process was led by NQPHN's Health Services Integration and Innovation Team.

The final report was submitted to the NQPHN CEO and the Board for endorsement.

The policy context for this Health Needs Assessment

The Commonwealth and State governments have a shared responsibility to produce the best health outcomes for people regardless of their geographic location. Joint planning and funding at local levels is key to deliver the health outcomes that matter most to individuals and communities.

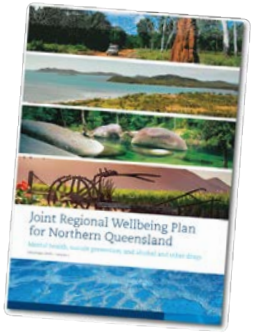
NQPHN affirms its commitment to working in partnership to better understand the health and service needs of the northern Queensland region. Our HNA aligns directly with the following federal, state, and local priorities.

The Northern Queensland Health Service Master Plan

This plan represents an exciting and new approach to the delivery of health services for northern Queensland by articulating a regional view on, and approach to, health.

The Joint Regional Wellbeing Plan for Northern Queensland (December 2020)

This plan sets out a vision for improved mental health wellbeing for all northern Queenslanders. As part of NQPHN's commitment to deliver on actions within the Fifth National Mental Health and Suicide Prevention Plan, this joint regional mental health and suicide prevention plan supports integrated mental health and alcohol and other drugs service delivery.

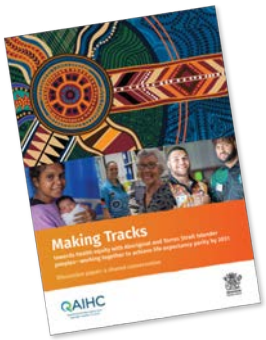


My health, Queensland's future: Advancing Health 2026 and Our Future State: Advancing Queensland's Priorities

These two plans produced by the Queensland Government identify aspirations for the Queensland population to be among the healthiest in the world. This includes working across sectors to create environments that deliver better health outcomes.

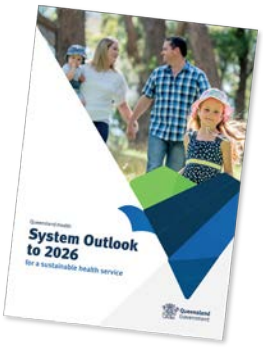
Making Tracks Towards Health Equity with Aboriginal and Torres Strait Islander Peoples

Following the passing of Queensland legislation in 2020, Hospital and Health Services (HHSs) are developing and implementing Health Equity Strategies. Queensland Health, in partnership with the Queensland Aboriginal and Islander Health Council, supported the development of Making Tracks. The vision is that HHSs will co-design, co-own, and co-implement HHSs with their local Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs) and other partners, including NQPHN.



System Outlook to 2026

The Queensland Department of Health and partners have articulated an integrated approach to planning health services, including moving away from traditional acute hospital models and reducing reliance on acute hospital services and beds. A key priority is to transform and optimise existing service delivery as part of the plan for managing growing hospital service demand.



Our community

About our community

There are an estimated 727,000 people who live in the NQPHN catchment, representing 14% of Queensland's population.[1] Approximately 80,000 people (11.7%) identify as Aboriginal or Torres Strait Islander (compared with 4% in Queensland) and 52,000 people (7.5%) are from a non-English speaking background.

NQPHN's geographical catchment covers over 510,000 square kilometres – one of the largest geographical areas of all PHNs. Most of our geographical catchment is classified by the Australian Statistical Geography Standard (ASGS) as 'Remote' and 'Very Remote' (Figure 2).[2]

Figure 2. NQPHN Remoteness Areas by Australian Statistical Geography Standard

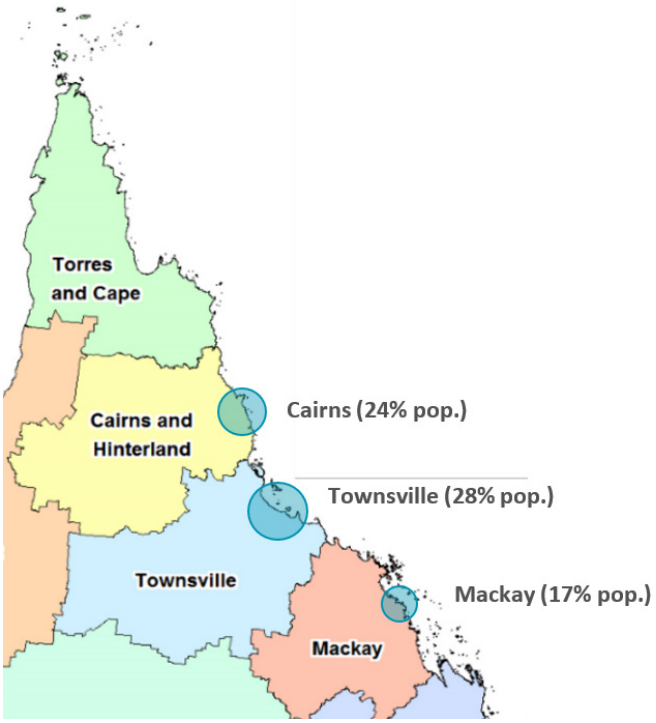
Living in a remote or very remote area presents challenges to healthcare, including difficulty attracting health workers and the need for community members to travel to large population centres to access specialist healthcare.

Most of our population (69%) lives in the major regional centres of Mackay, Townsville, and Cairns.[3] There are four Queensland Hospital and Health Services (HHSs) that serve our population (Figure 3). These are:

- Torres and Cape
- Cairns and Hinterland
- Townsville
- Mackay.

Each HHS represents a local network of public hospitals and health services. They each have their own board and are responsible for delivering public health services in their areas.

Figure 3. The four Hospital and Health Services of the NQPHN and the three most population-dense regional areas.



Our population is growing

Services will be needed to deliver care to a growing number of people in our community over the next 20 years. By 2041 our projected population will be 933,700 people, an increase of 28% (206,000) compared with 2021.[4]

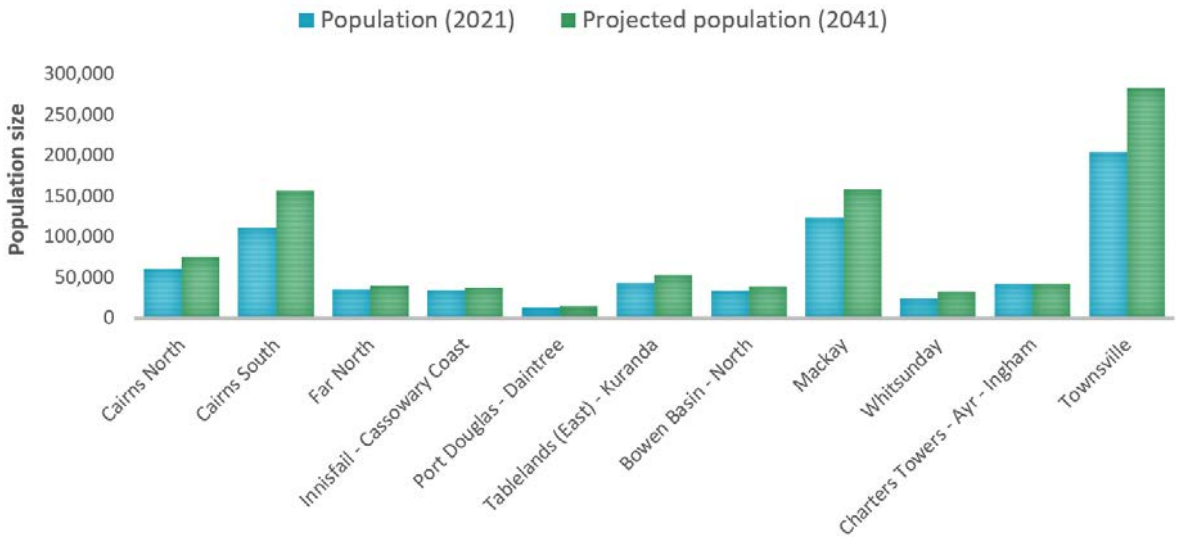
The size of our catchment population is anticipated to increase over time in all local areas except Charters Towers/Ayr, where the population size is projected to remain relatively unchanged (Figure 4).[5]

Percentage growth in the population is projected to be greatest in Cairns South, Townsville, and the Whitsunday regions. NQPHN is accounting for population growth in its planning processes (Table 1).[6]

Table 1. Percentage change in population, SA3 | 2021–41

SA3	% change in population
Cairns South	42
Townsville	38
Whitsunday	37
Mackay	28
Cairns North	26
Tablelands (East) - Kuranda	21
Port Douglas - Daintree	20
Bowen Basin - North	17
Far North	11
Innisfail - Cassowary Coast	9
Charters Towers - Ayr - Ingham	-2

Figure 4. Population projections, NQPHN SA3 areas | 2021–41



Our population is ageing

Figure 5 illustrates our population pyramid – the distribution of age groups by sex in our community. The population pyramid demonstrates a 'working-age bulge', where people aged between 25 and 59 years are more strongly represented than younger adults.[7] When the population of working age people entering older age is larger than the younger population entering the workforce, it can result in workforce challenges to care for people with chronic disease and disability.

The median age of our population is projected to increase over time (Figure 6).[8] This will result in a larger percentage of our population in the 70+ years age groups.

Although most older people experience good health and are independent into older age, many older people experience a higher disease burden than younger people. This will contribute to increased demand for health services in our community.

Figure 5. Age and sex distribution, NQPHN population | 2016

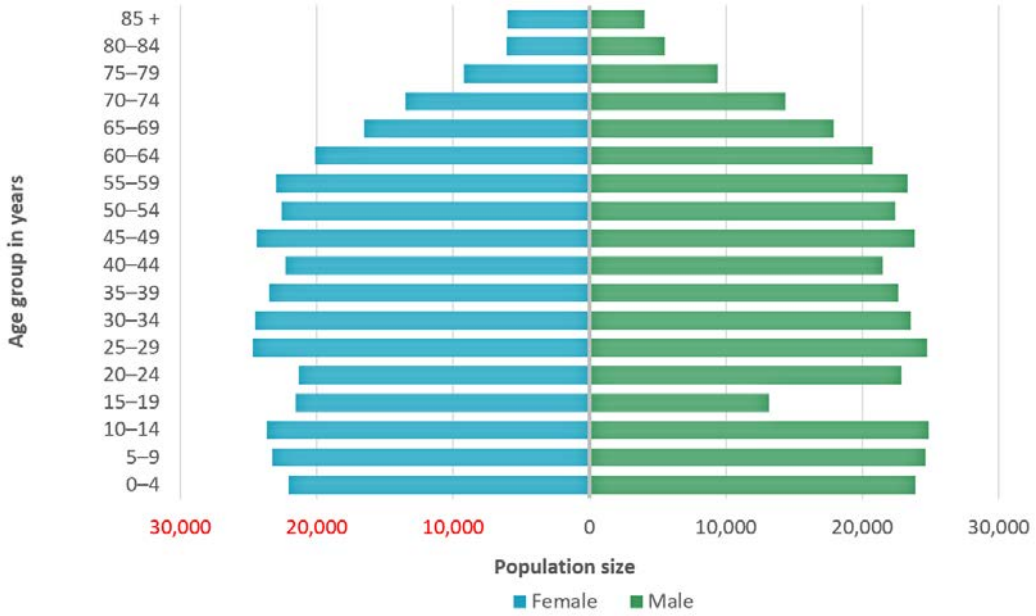
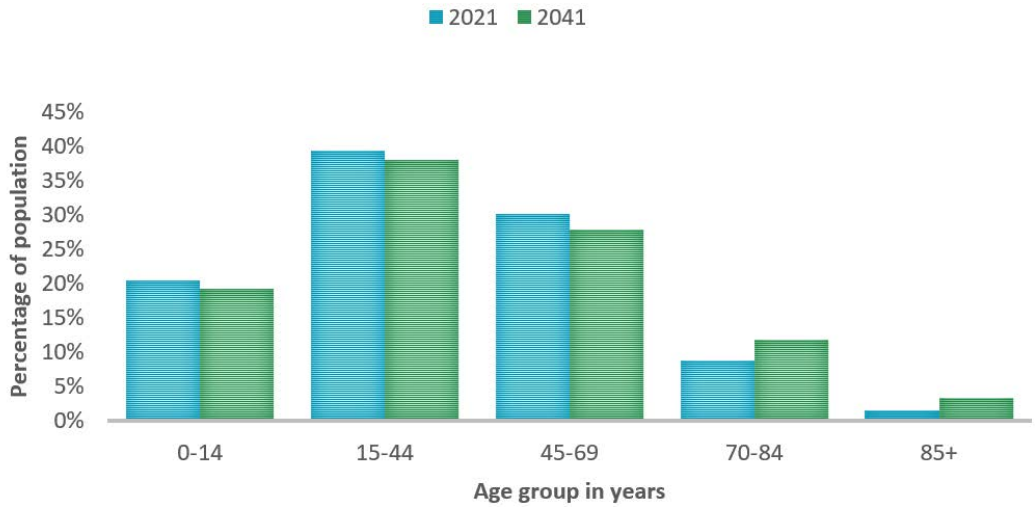


Figure 6. Age projections, NQPHN | 2021–41



Our population is culturally diverse

Aboriginal and Torres Strait Islander people represent 11.7% of our total population.[9] Our HNA explores the health of our Aboriginal and Torres Strait Islander population in detail in further chapters.

English language proficiency helps people to navigate the health system. In the NQPHN, 24% of people were born in countries other than Australia. Of these, nearly 8% are from non-English speaking backgrounds. This is compared with 33% and 18%, respectively, for Australia overall.[10]

Nationally, the main birthplaces of people from non-English speaking backgrounds are China (2.2%), India (1.9%) and the Philippines (1%). In the NQPHN catchment, India (0.6%), Italy (0.5%), Germany (0.4%) and China (0.3%) are the main birthplaces of people from non-English speaking backgrounds.[11]

More needs to be done to understand the primary care needs of our refugee population.

Our population is socio-economically diverse

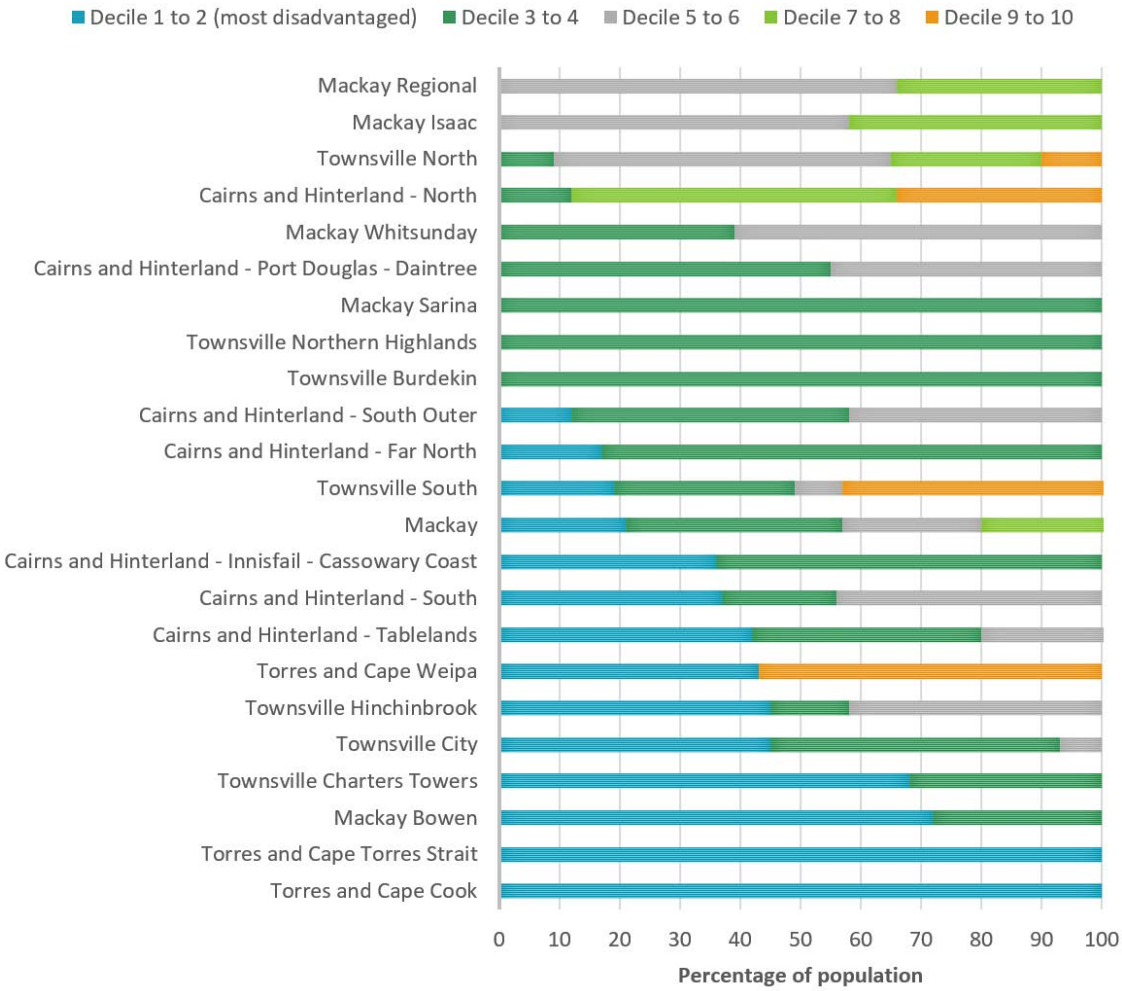
Socio-economic disadvantage is a strong predictor of poor health outcomes and lower life expectancy.[12] Our socio-economic status is influenced by our income, education, occupation, and ability to participate in our community.

Our most disadvantaged communities are in Far North Queensland, where 100% of the population are in the most disadvantaged income category (Figure 7).[13]

Chronic conditions are more common in areas with lower socioeconomic status (SES), and these areas are disproportionately affected by chronic disease burden.[14]

More needs to be done to understand the primary care needs of our homeless population and of people sleeping rough.

Figure 7. Percentage of population in SEIFA deciles by planning region | 2016



Many people in our community live with disability

Over 18% of Queenslanders have a disability.[15] Disability can be described by degree of limitation. A person has a limitation if they have difficulty, need assistance from another person, or use an aid or other equipment to perform one or more core activities (communication, mobility, and self-care). Table 2 describes what different degree of limitation mean for a person with a disability.

Table 2. Descriptions of disability by degree of limitation

Degree of limitation	What this means for people with a disability
Profound	Greatest need for help, that is, always needs help with at least one core activity
Severe	Needs help sometimes or has difficulty with a core activity
Moderate	No need for help but has difficulty
Mild	No need for help and no difficulty, but uses aids or has limitations

Source: ABS. Disability, Ageing and Carers, Australia. 2018

About 5% of NQPHN catchment residents have a profound or severe disability and need daily assistance due to disability.[16] In the 2016 Census, 1 in 10 people in our community reported that they provide unpaid assistance to people with a disability. Rates of disability increase with increasing age (Figure 8).[17]

Increasing numbers of people aged 65+ in our community are likely to be associated with more people with disability requiring assistance, and with more people providing unpaid assistance to people with a disability. In the NQPHN catchment, 3% of people aged 0–64 have a severe or profound disability compared with 16% of people aged 65 and over.[18]

Some people have low health literacy

Health literacy is the knowledge and skills people need to be able find, understand and use information and services to make decisions about their health and healthcare. People with low health literacy are more likely to have worse health outcomes and higher hospital admission rates.[19]

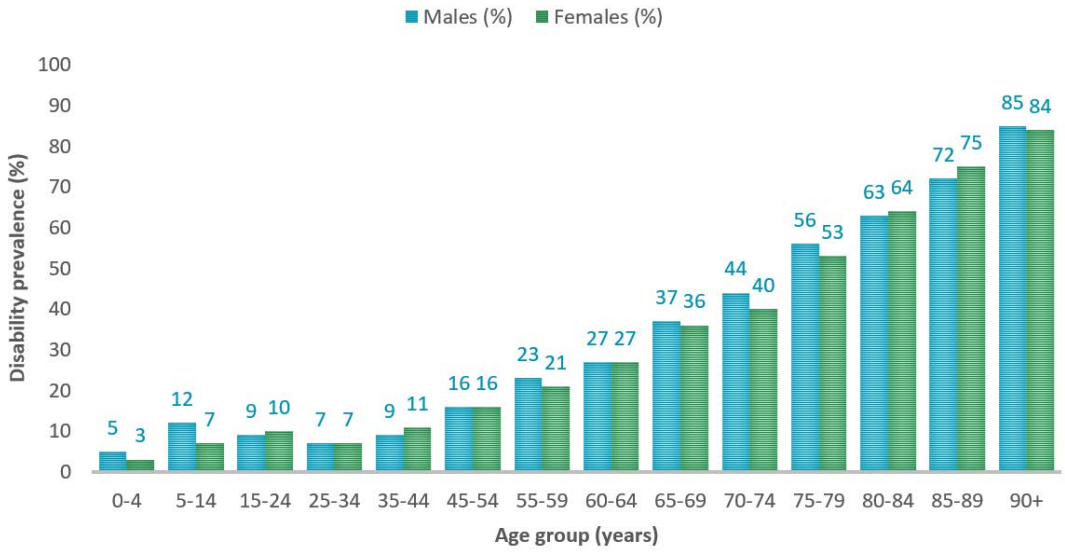
Many factors influence people's health literacy including their personal characteristics, the support available to them, their community and environment, and their access to services.

Many people in our community find it hard to:

- access health information and services
- understand information
- use information to make informed choices.

Younger people (aged 18–24) find navigating the healthcare system more difficult than older people (aged 65+) (19% versus 8%, respectively). Of people who do not speak English in the home, 20% strongly feel they are understood and supported by healthcare providers, compared with 33% of people who speak English in the home.[20]

Figure 8. Disability prevalence rates by age and sex, Australia | 2018



Our health

Our health status

The health status of the population is assessed using a wide range of indicators – qualities or features of our population that we can measure to describe our health. We have used the following indicators to assess our population's broad health status:

- self-assessed health
- life expectancy
- infant mortality
- causes of death
- chronic health conditions.

We have high self-assessed health

Self-assessed health is one of the most frequently measured indicators of population health and wellbeing. This measure reflects the physical health, mental health, and health behaviours of the population.

People who live in northern Queensland report high levels of self-assessed health.

In 2017-18, 84.9% of northern Queenslanders considered themselves to be in excellent, very good, or good health. This compares favourably with Australia as a whole, where 85.3% of Australians aged 15 years and over rate their health as excellent, very good, or good.[21]

Our self-assessed health status has remained relatively constant over the last 10 years.[22]

Our life expectancy is low but improving

Life expectancy is the number of years a person can expect to live, depending on the age they have already reached.

Life expectancy has increased significantly over the past few decades in Australia, reflecting a decline in premature deaths from infectious diseases and from chronic health conditions.

People who live in northern Queensland have a lower life expectancy than Queenslanders overall. The median age of death is 77 years for people living in the Cairns and Hinterland HHS region, 78 years for people in Townsville and Mackay, and 68 years in Torres and Cape. This compares with 80 years for Queensland overall.[23]

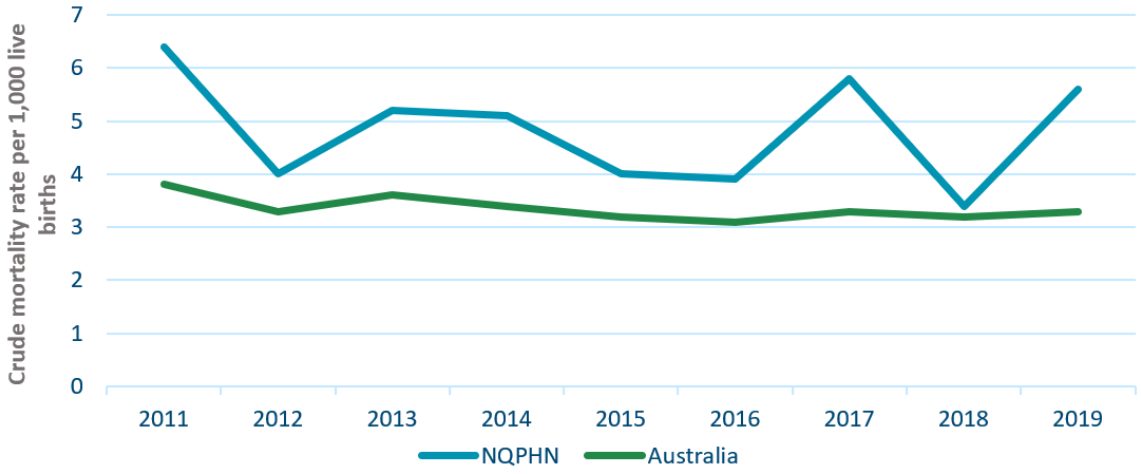
The lower life expectancy in our region partly reflects the lower life expectancy of people living in rural areas, people experiencing socio-economic disadvantage, and Aboriginal and Torres Strait Islander peoples.

Our infant death rate is high

Infant mortality (that is, deaths under one year of age) is an important indicator of the general health and wellbeing of a population and has a large influence on life expectancy at birth. Infant mortality rates have been trending downwards in Queensland and nationally over the past decade (Figure 9).

Infant mortality rates in the NQPHN catchment are higher than the Australian average.

Figure 9. Infant (under 1), crude mortality rate (per 1,000 live births), NQPHN and Australia | 2011–19



Infant mortality rates in Aboriginal and Torres Strait Islander peoples are nearly twice the rate of non-Indigenous people in our catchment.[24]

Infant deaths are twice as high in remote and very remote areas (6 per 1,000 live births) compared with major cities (2.9 per 1,000 live births). Infant deaths are also higher in the lowest socioeconomic areas compared to the highest socioeconomic areas (4.6 compared with 2.5 per 1,000 live births, respectively).[25]

Indigenous mothers and babies are at greater risk of poor maternal and child health outcomes. Across Queensland, 13.7% of Aboriginal and Torres Strait Islander births are pre-term compared with 8.7% of non-Indigenous births. An estimated 42.5% of Indigenous mothers smoke during pregnancy, compared with 8.9% of non-Indigenous mothers. 65% of Indigenous mothers have 8 or more antenatal visits during their pregnancy compared with 80% of non-Indigenous mothers.

Risk factors for poor perinatal outcomes affect mothers and babies across NQPHN HHS regions (Figure 10).[26]

Chronic diseases are responsible for most deaths

Causes of death data tell us about the health conditions that affect our community and influence our life expectancy. The most common causes of death in our community are related to chronic diseases.

Between 2015 and 2019, our leading causes of death were cancer and cardiovascular disease (Table 3).[27]

Table 3. Causes of death, NQPHN | 2015–19

Cause of death	Number of deaths	% of all deaths
Cardiovascular disease (coronary heart disease, stroke and heart failure)	3,972	18.8
Cancer (lung, bowel, prostate, pancreas, breast, liver)	3,559	16.9
Dementia	1,387	6.6
Chronic obstructive pulmonary disease	1,059	5.0
Diabetes	723	3.4
Suicide	671	3.2

Figure 10. Perinatal risk factors, NQPHN Hospital and Health Services | 2018

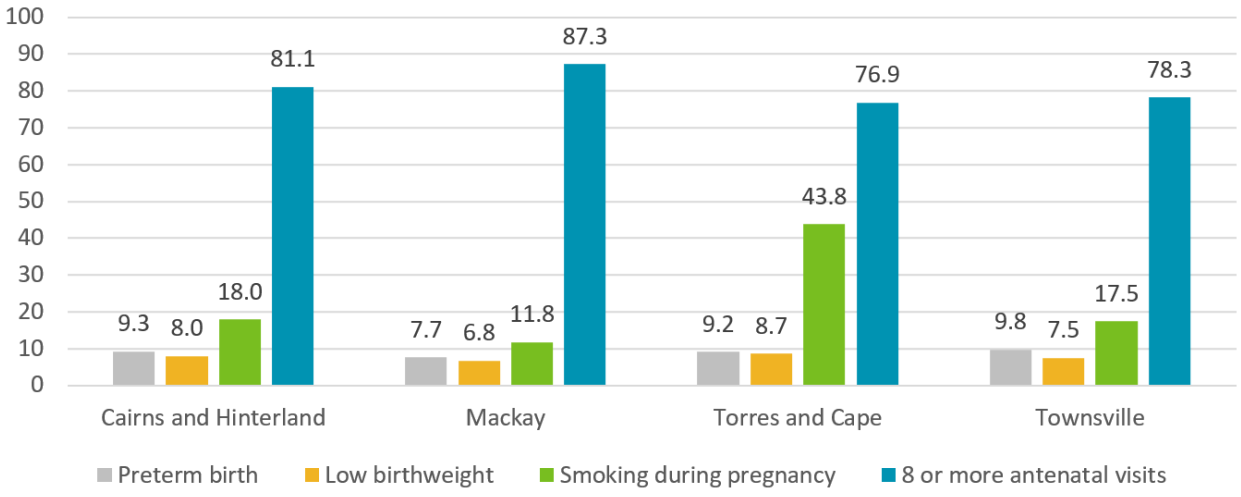


Table 4 illustrates NQPHN's top causes of death in each of our HHS regions. These data show the higher age-standardised rates of death from chronic diseases across our catchment, particularly in the Torres and Cape HHS, compared with Queensland overall.[28]

Some deaths are considered to be premature because they occur under the age of 75 years. NQPHN has the sixth highest rate of premature deaths of all 31 PHNs.[28] Relative to the rest of Australia, our rate of deaths due to coronary heart disease, stroke, lung and cancer and chronic obstructive pulmonary disease are high. Rates of death due to dementia are the same as the rest of Australia.[29]

Most children are fully immunised

Immunisation is an important public health intervention that protects against communicable diseases. Our community has high rates of immunisation and children in the Torres and Cape HHS have the highest immunisation rates of any HHS in Queensland (Figure 11).[30]

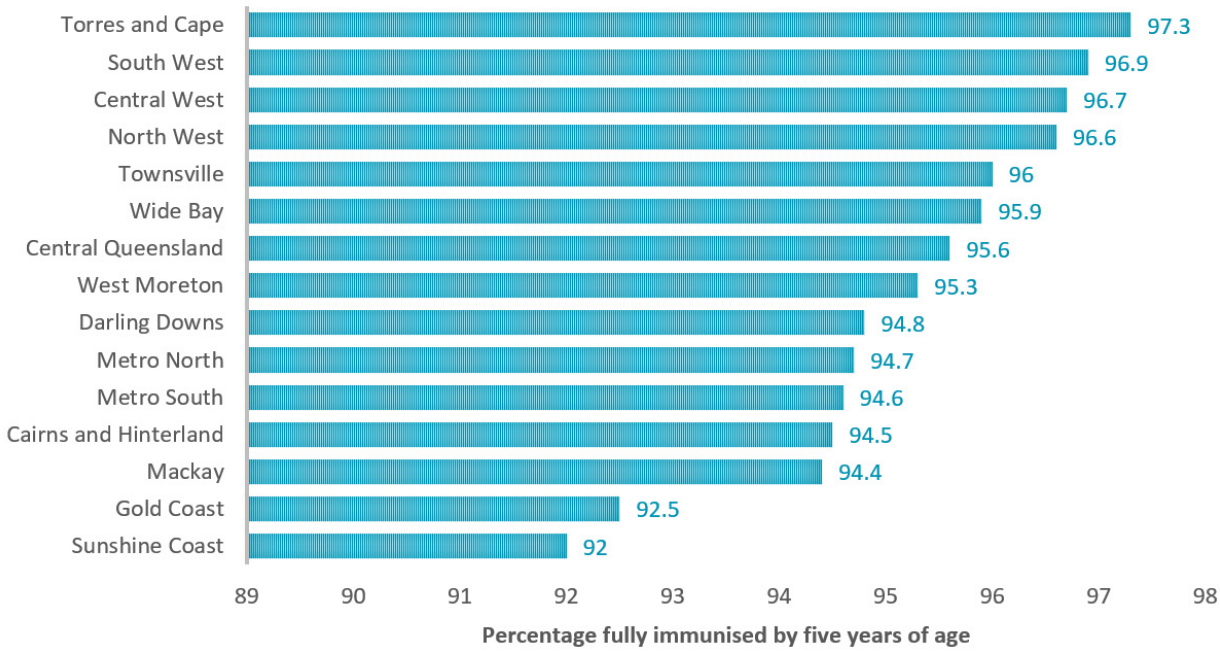
There is currently no regular or nationally consistent source of data with which to estimate vaccination coverage in adolescents and adults in Australia.

Table 4. Age-standardised rate of death per 100,000 population by condition | 2016–17

Condition	Hospital and Health Service				Queensland
	Torres and Cape	Cairns and Hinterland	Townsville	Mackay	
Malignant neoplasms	207	177	165	158	160
Circulatory disease	190	138	154	153	144
Respiratory disease	NR*	55	57	51	47
Dementia	NR*	27	27	32	29

*NR=not reported as numbers are too small

Figure 11. Percentage fully immunised by 5 years of age, Queensland Hospital and Health Service | 2019–20



COVID-19 impacts

In March 2020 the World Health Organisation (WHO) declared a global pandemic of coronavirus (COVID-19).

The coronavirus pandemic COVID-19 has had a significant impact on our population. Whilst the number of people in northern Queensland who have acquired COVID-19 infection is small (at the time of writing), the pandemic has had broader impacts on people's health and wellbeing.

Evidence suggests that we can expect an increase in the burden of mental health-related disorders because of COVID-19. Post-traumatic stress disorder (PTSD) and major depression will be the major mental health disorders among survivors of severe COVID-19 illness and health workers. Children who are isolated or quarantined during a pandemic are more likely to develop acute stress disorder, mood disorders, adjustment disorder and experience grief reactions.

NQPHN will continue to monitor the impacts of COVID-19 on the primary care needs of the community as they emerge.

Our health services

People in northern Queensland receive health services from a broad range of public and private health service providers distributed across our geographical catchment. The scope of services is broad, from population health and prevention through to general practice and community health, emergency health services and hospital care, and rehabilitation and palliative care.

The focus of NQPHN is the delivery of primary health care. While we support many health system partners in prevention and health promotion, and in the delivery of hospital and specialist services, our organisation's focus is clinical care delivered to people outside the hospital.

Many people associate primary health care with their local general practitioner (GP). While general practice is the cornerstone of primary care, primary care also includes care provided through Aboriginal Community Controlled Health Organisations (ACCHOs), community-based nurses and allied health professionals, midwives, pharmacists, and health workers.

Primary health care can be provided in the home or in community-based settings such as general practices, other private medical practices, community health centres, local government, and non-government service settings, such as Aboriginal Community Controlled Health Services. It is not provided in hospitals – this type of care is known as acute care.

We have a regionally distributed public hospital network

Our population is served by four Queensland Hospital and Health Services (HHSs):

- Torres and Cape
- Cairns and Hinterland
- Townsville
- Mackay.

Each HHS delivers health care through a network of hospitals and health services (Table 5).

Table 5. NQPHN Hospital and Health Services

Hospital and Health Service	Affiliated hospitals and health unit	
Torres and Cape	» Bamaga Hospital » Cooktown Hospital	» Thursday Island Hospital » Weipa Hospital
Cairns and Hinterland	» Atherton Hospital » Babinda Hospital » Cairns Hospital » Gordonvale Hospital » Herberton Hospital	» Innisfail Hospital » Mareeba Hospital » Mossman Hospital » Tully Hospital
Townsville	» Ayr Hospital » Charters Towers Hospital » Charters Towers Rehabilitation Unit » Home Hill Hospital » Hughenden Hospital	» Ingham Hospital » Joyce Palmer Health Service » Kirwan Rehabilitation Unit » Richmond Hospital » Townsville University Hospital
Mackay	» Bowen Hospital » Clermont Hospital » Collinsville Hospital » Dysart Hospital	» Mackay Base Hospital » MoranbahHospital » Proserpine Hospital » Sarina Hospital

Demand for public hospital services is increasing

Cairns and Hinterland, Townsville and Mackay HHSs are each experiencing rising demand for public hospital inpatient services, including acute, subacute and mental health admissions (Figure 12).[31]

Between 2018-19 and 2019-20 the number of presentations to hospital emergency departments decreased in the three HHSs with hospital emergency departments (EDs) (Figure 13).[32]

Figure 12. Admissions to public hospitals, all cause, Hospital and Health Services | July 2017– June 2020

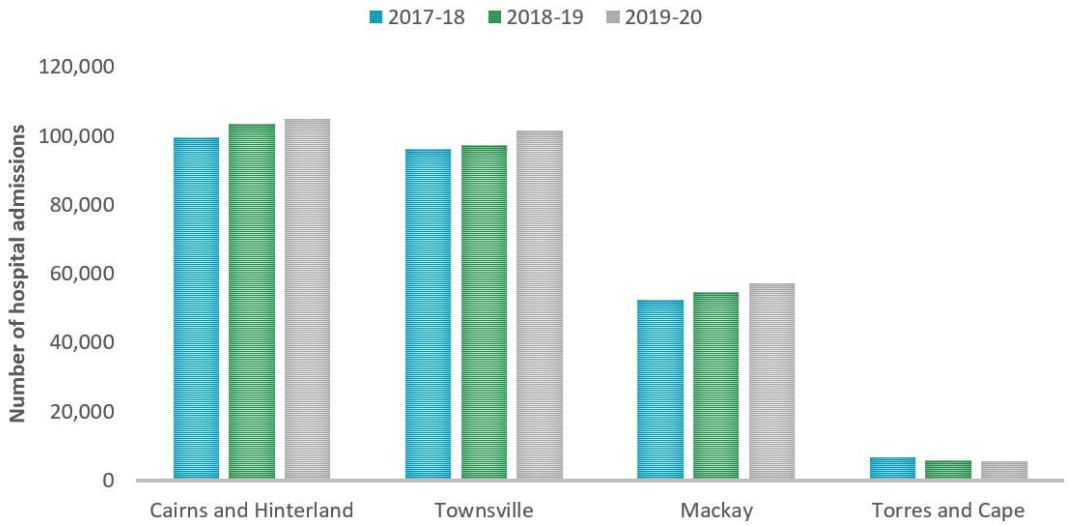


Figure 13. Hospital emergency department presentations, Hospital and Health Services | July 2018 – June 2020

The population each HHS serves is anticipated to continue to increase in size until 2041, which is expected to place further demands on health services (Figure 14).[33]

We have lower general practice availability

There are an estimated 1,500 GPs (793 full-time equivalent GPs) in the NQPHN catchment. We have fewer GPs per 1,000 population than most PHNs in Queensland (Figure 15).[34]

Figure 14. Population projections, northern Queensland Hospital and Health Services | 2021–41

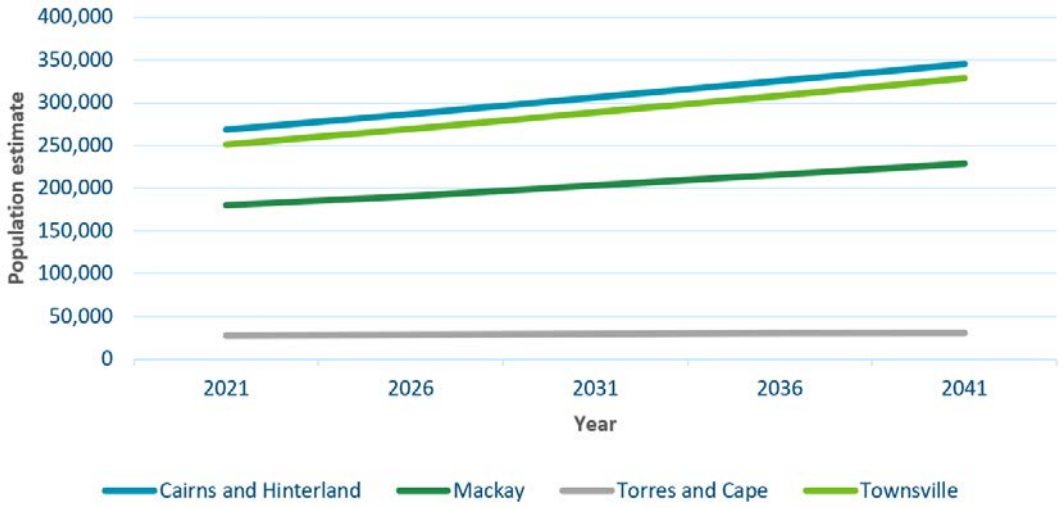
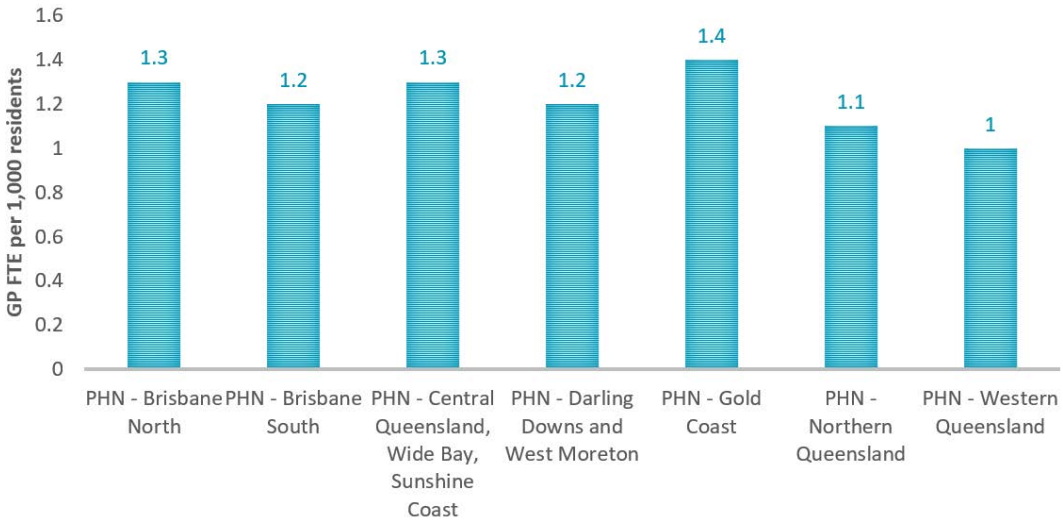


Figure 15. GP FTE per 1,000 residents, Qld PHNs | 2020



Most people attend general practices each year

In 2020, there were 4.46 million GP services delivered across the NQPHN catchment to 635,677 people (91% of our population). Most of these services were standard general practice consultations provided in business hours from a general practice (Figure 16).[35]

The number of MBS billed GP services provided to people in 2020 varied across regions of our catchment, from an average of 2.5 GP services per person in the far north to 8.1 in Cairns – South (Figure 17).[36]

Figure 16. General practice services by reporting group, NQPHN | 2020

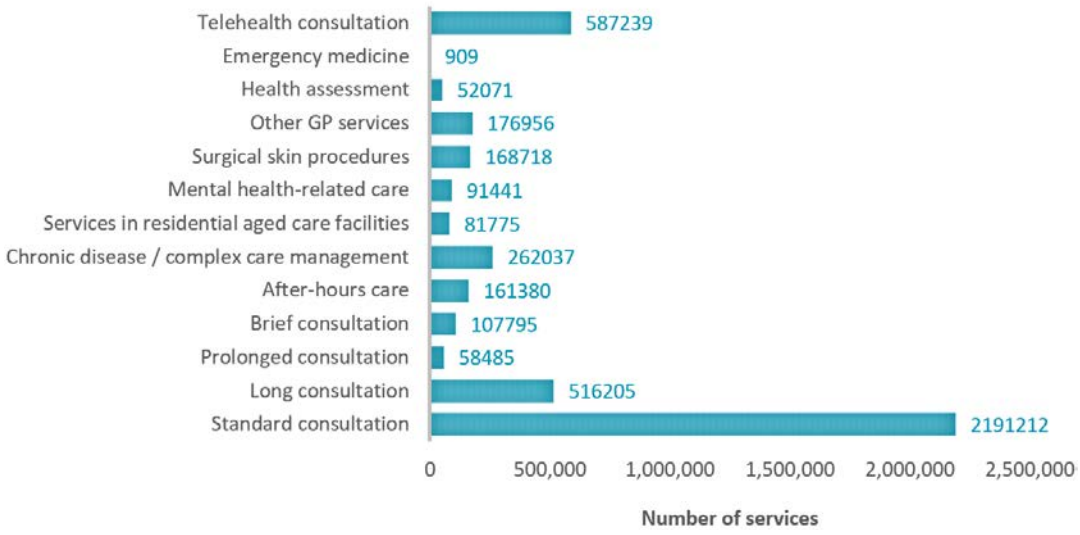
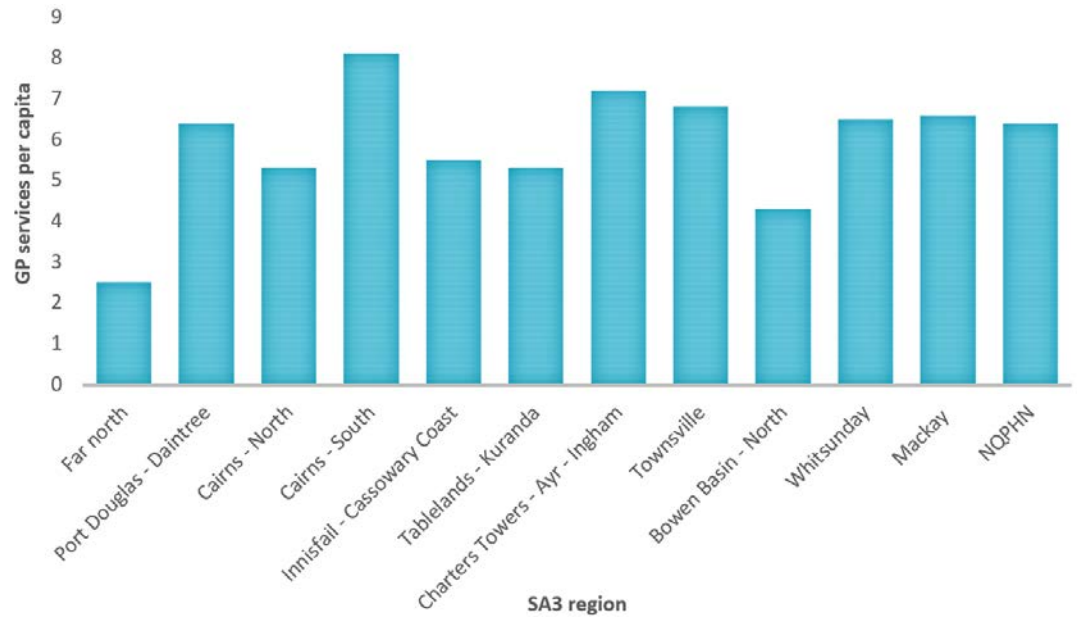


Figure 17. GP services (MBS billed) per capita, NQPHN catchment | 2020



The delivery of general practice services is increasing

The number of GP services delivered across the NQPHN catchment is increasing over time (Figure 18).[37] However, the number of patients receiving a GP service is increasing much slowly. This may reflect the impact of chronic diseases on the population and a requirement for more frequent GP attendance for some population subgroups in our community.

The decrease in number of patients receiving a GP service in 2020 is attributed to changes in patient attendance during COVID-19 (Figure 19).[38]

Figure 18. Number of general practice services, NQPHN | 2015–20

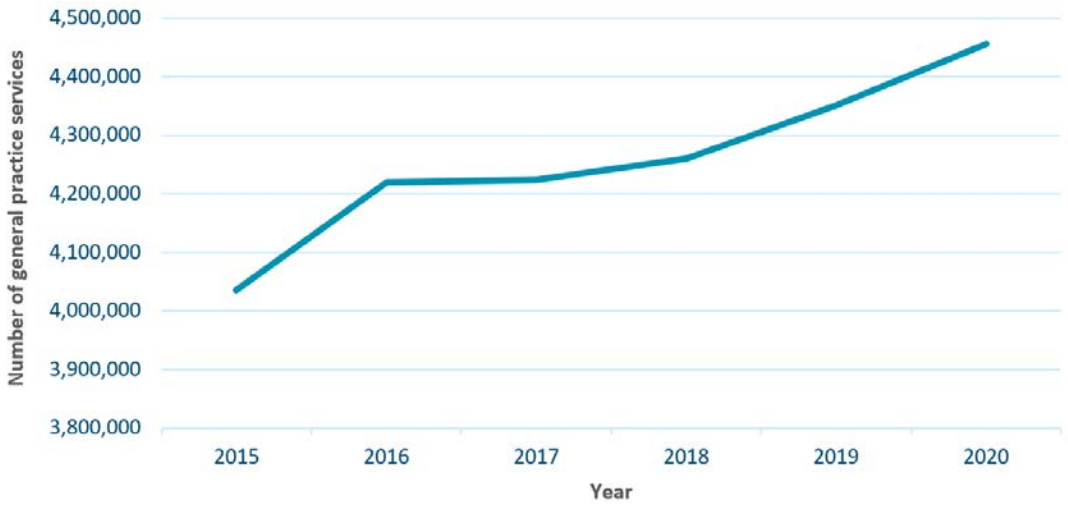
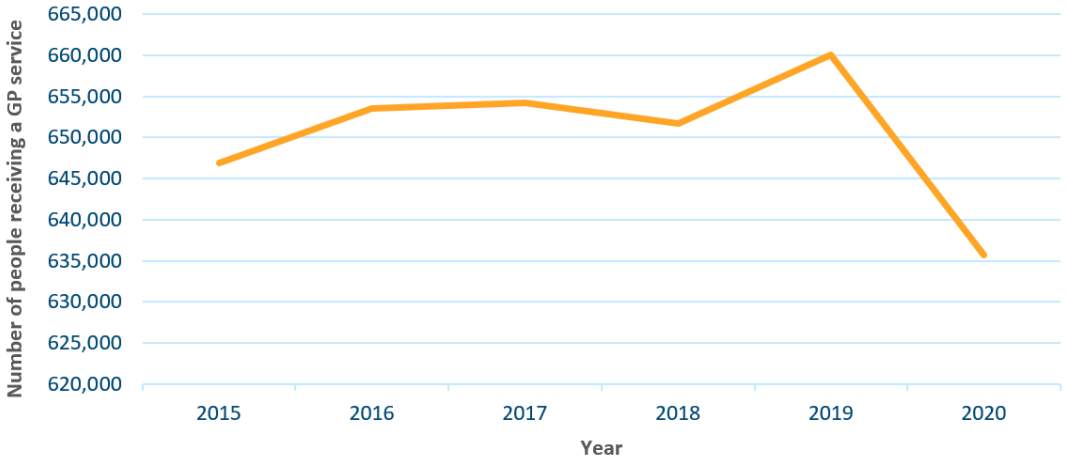


Figure 19. Number of people who received a GP service, NQPHN | 2015–20



Telehealth service use has increased significantly

The coronavirus pandemic COVID-19 has prompted greater and widespread use of telehealth. This has been adopted enthusiastically by both health professionals and consumers and has great potential for ongoing use given our regionally dispersed population. Telehealth is not intended to replace face-to-face health consultations entirely, but rather it brings opportunities to reduce the barriers and make healthcare more accessible for people who have difficulty due to transport or disability.

Telehealth MBS item numbers were expanded in 2020. Prior to 2020, there had been a small increase in telehealth MBS use over time. In 2020, telehealth use increased significantly in the NQPHN catchment (Table 6).[39] The majority of telehealth services are delivered via telephone only. More needs to be done to promote the use of telehealth video and patient monitoring solutions to maintain a high quality of care.

After-hours MBS billed primary care services are decreasing

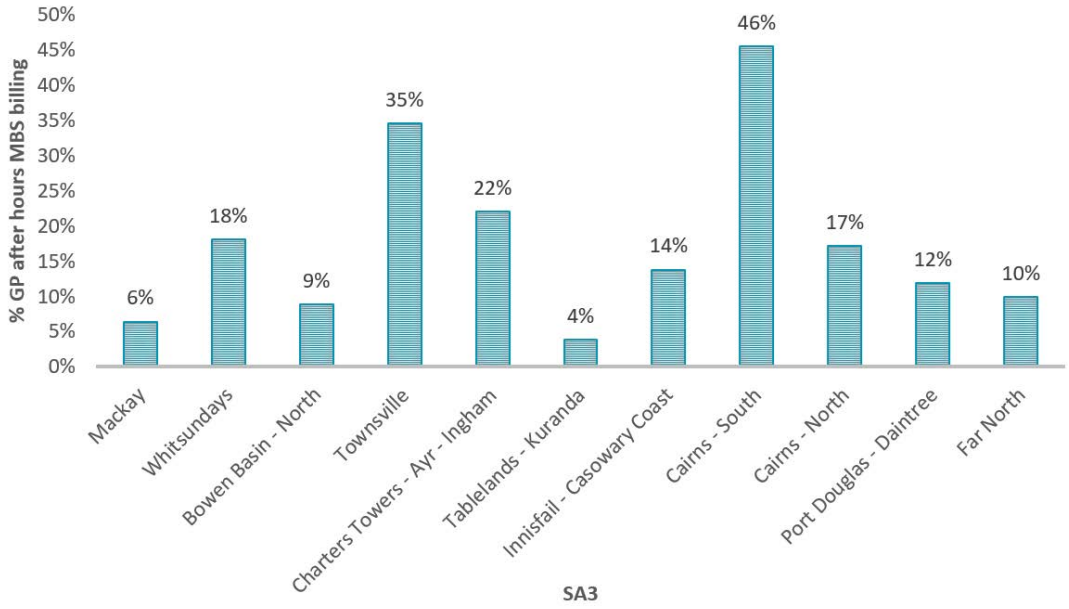
The Commonwealth Department of Health defines after-hours primary health care as "accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available".[40] In practice, this typically means overnight and parts of the daytime on weekends. For reimbursement purposes, the after-hours period is divided between sociable hours and unsociable hours.

GPs provide after-hours services in private practice and through arrangements with local public hospitals and health centres. In 2020 the rate of delivery of MBS billed after-hours GP services relative to local population size was highest in the Cairns – South SA3 region and lowest in Tablelands – Kuranda SA3 region (Figure 20).[41]

Table 6. Telehealth Medicare Benefits Schedule use, NQPHN | 2015–20

	2015	2016	2017	2018	2019	2020
Telehealth and phone consultation	3,430	3,300	3,560	3,948	4,418	587,239

Figure 20. After-hours MBS billed GP services as a percentage of total population, NQPHN SA3 regions | 2020



The number of after-hours MBS billed GP items is decreasing over time in the NQPHN catchment (Figure 21).[42]

Some allied health services are less accessible

NQPHN has greater availability of primary and community allied health professionals than Queensland in Aboriginal and Torres Strait Islander health worker, occupational therapy and physiotherapy disciplines and lower availability in the dental, optometry, pharmacy, podiatry, and psychology disciplines (Figure 22).[43,44]

Allied health data are unavailable for disciplines not registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Within the NQPHN catchment, overall availability of allied health practitioner time per 1,000 population is lowest in far north Queensland and highest in Townsville and Cairns – South. Pharmacy, dental, psychology, and physiotherapy hours are generally more available in each SA3, and podiatry hours are generally least available across SA3 regions (Figure 23).[45]

Figure 21. MBS billed after-hours GP items, NQPHN | 2015–20

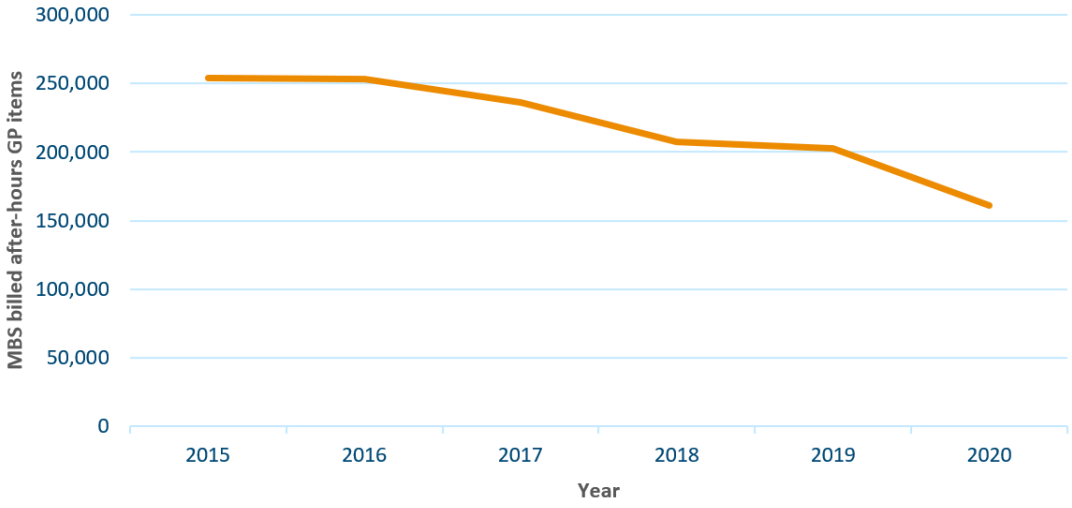


Figure 22. Available hours of primary and community allied health practitioner time per 1,000 population, NQPHN versus Qld | 2019

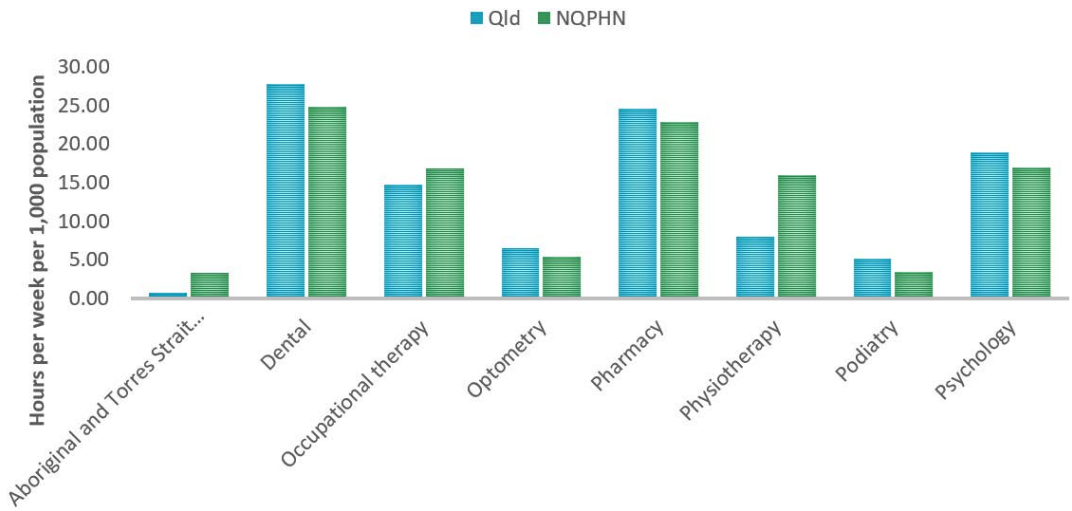
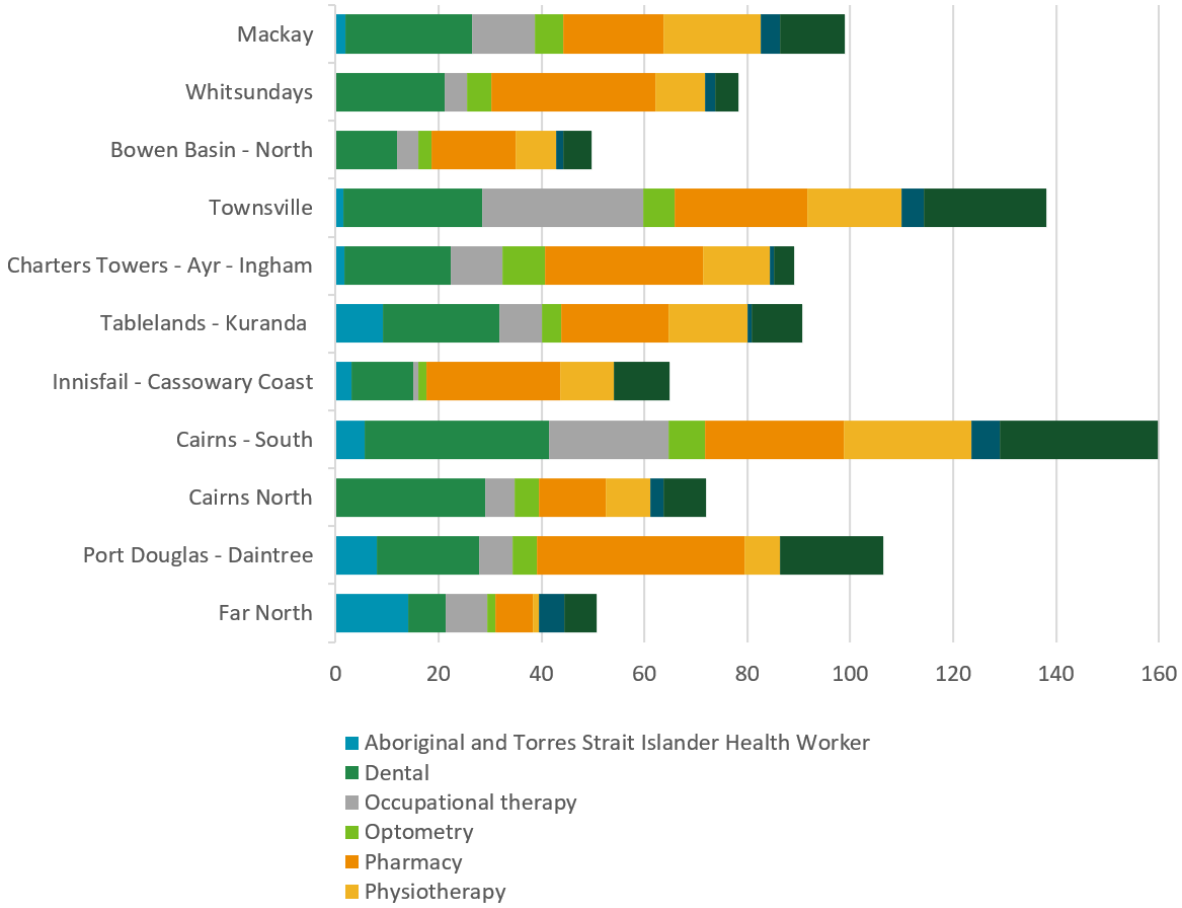


Figure 23. Available hours of primary and community allied health practitioner time per 1,000 population, NQPHN SA3 | 2019



Aged care service availability varies geographically

Among people aged 50 years and over, 10.7% in the NQPHN catchment have a core activity need for assistance compared with 11.7% nationally.[46] (Core activity need for assistance is a measure of the number of people with severe or profound disability used by the ABS in population surveys). People need help or assistance in one or more of the three core activity areas of self-care, mobility and communication, because of a long-term health condition (lasting six months or more), a disability (lasting six months or more), or old age.[47]

An estimated 24.8% of people aged 65 years and over in our community live alone, compared with 23.7% for Queensland.[48]

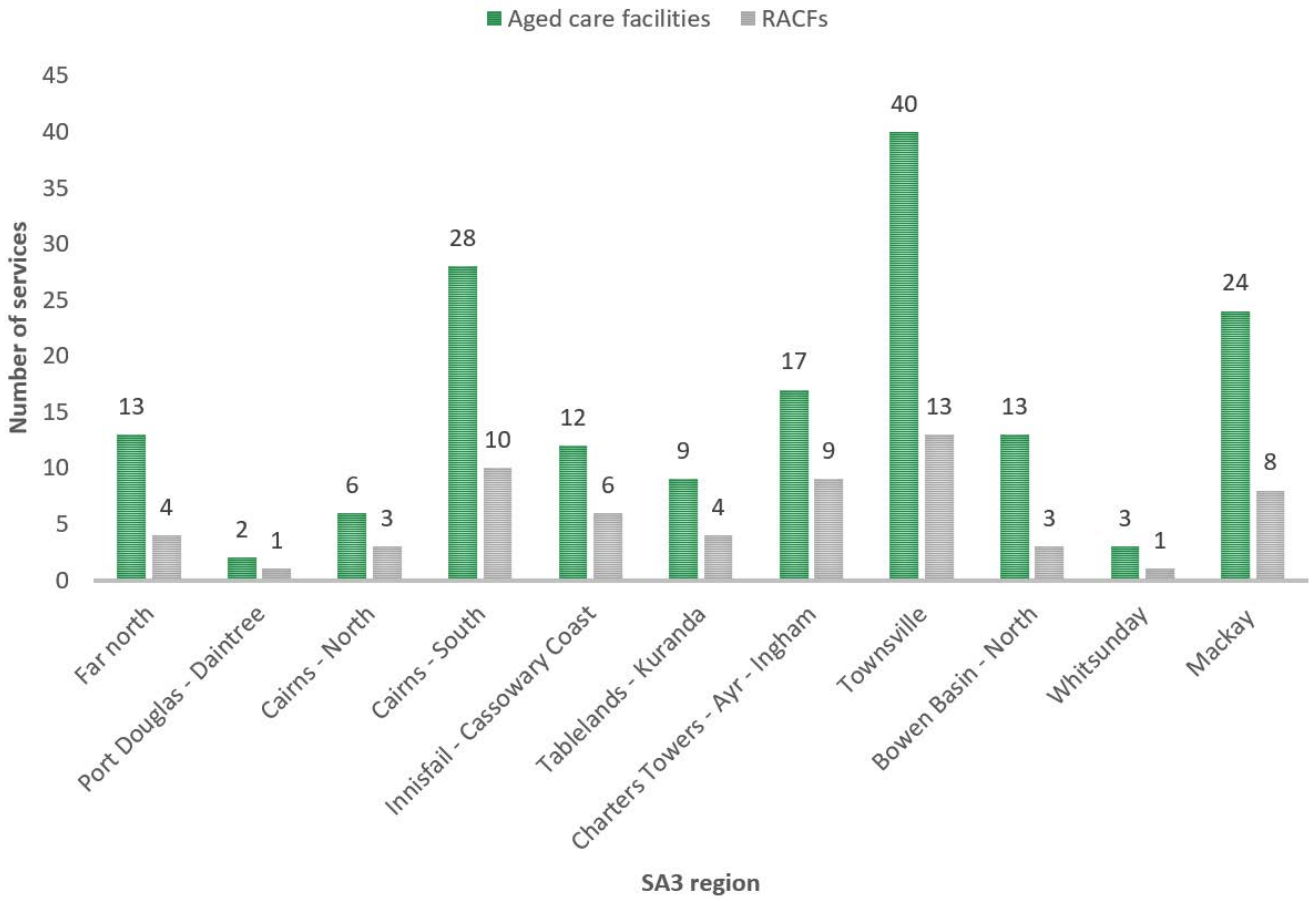
There are an estimated 172 aged care services across the NQPHN catchment, of which 62 are Residential Aged Care Facilities (RACFs), 96 provide home care and 14 are other types of aged care facilities. There are a further 138 services and outlets that provide home support. On 30 June 2020, the most recent data available, occupancy rate for residential aged care in NQPHN catchment was 84.9%.[49]

The largest number of residential aged care services is in Townsville and the smallest number is in the Port Douglas – Daintree SA3 region (Figure 24).[50]

Residential aged care services are generally less available in NQPHN than Queensland or nationally. In 2020, there were 71.9 places in residential care per 1,000 people aged 70 years and older across the NQPHN catchment, compared with 74.8 places nationally.[51]

An estimated 55% of people using permanent residential care in NQPHN's catchment have a diagnosis of dementia.[52]

Figure 24. Number of residential aged care services, SA3, NQPHN catchment | 2020



Demand for palliative care is increasing

The goal of palliative care is to "improve the quality of life of patients with an active, progressive disease that has little or no prospect of a cure".[53] With the growth and ageing of Australia's population, and an increase of chronic and generally incurable illnesses, the types of patient groups requiring palliative care has widened.[54]

Palliative care is provided in a range of settings, including in a patient's home, residential aged care facilities, hospitals, hospices, respite care, and after-hours services. Palliative care is not limited to specialist care services but includes primary and community service providers.[55]

- General palliative care is provided by primary care professionals and those treating patients with life-threating illnesses.
- Specialist palliative care is provided by specialist teams for patients with complex conditions.

Most people receiving palliative care do not access specialist palliative care services. About 70% of palliative care is delivered outside the specialist, hospital settings and is delivered by primary care providers such as GPs, health and community services, aged care services and community and volunteer organisations and groups.[56]

Some groups have more difficulty accessing palliative care that is appropriate for their needs, including:[57]

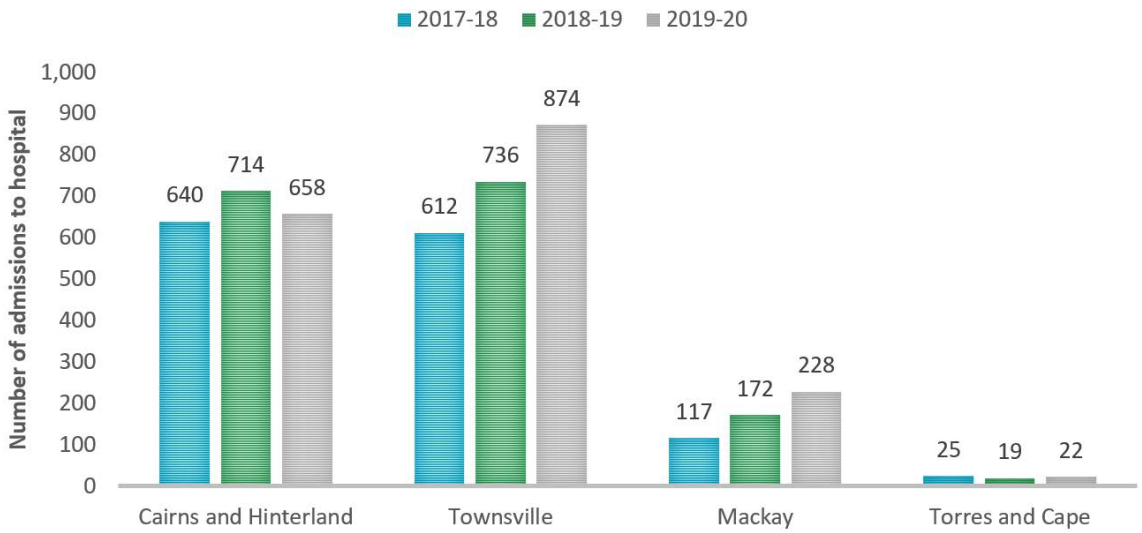
- people who are lesbian, gay, bisexual, transgender or intersex (LGBTI)
- people from culturally and linguistically diverse (CALD) backgrounds
- Aboriginal and Torres Strait Islander peoples
- people with a disability
- people experiencing homelessness
- veterans
- refugees
- prisoners
- care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations) and people affected by forced adoption or removal.

Even though most people want to die at home, more than 75% die in hospital or residential aged care.[58]

Palliative care needs are increasing over time. Over the next 20 years the number of people who die each year will double. This is due to the baby boomer generation transitioning into older age; the proportion of older people in the population is growing faster than population growth.[59] Rates of admissions to public hospitals for palliative care have increased overall across northern Queensland HHSs (Figure 25).[60]

There are no publicly available datasets which reliably capture community-based palliative care service delivery.

Figure 25. Palliative care admissions to public hospitals, northern Queensland Hospital and Health Services | July 2017 – June 2020



Stakeholder perspectives

The health system faces many pressures. The growing demand for services is fuelled by population growth and an increasing chronic disease burden.

Primary care services are not accessible for all people

People want access to services in the community and as close to home as possible. Barriers that people may experience in accessing a regular GP include:

- out-of-pocket costs
- lengthy waiting times to see a regular GP
- health literacy problems that are not addressed in current service delivery models
- difficulty accessing transport
- primary care services not meeting people's cultural care needs.

Maternal and child health outcomes can be improved

A holistic approach to pregnancy care is needed to improve maternal and child health outcomes. Aboriginal and Torres Strait Islander mothers and babies have poorer outcomes than non-Indigenous women and babies. Aboriginal and Torres Strait Islander mothers, mothers from lower socio-economic backgrounds, and mothers in rural areas have lower access to antenatal and postnatal care.

Primary healthcare that improves access to antenatal, perinatal, and postnatal care is a priority to improve maternal and child health outcomes.

There are gaps in sexual and reproductive health care and blood borne virus management

People with sexually transmissible infections and/or blood borne viruses affect the health of priority populations in the NQPHN catchment, including Aboriginal and Torres Strait Islander peoples, LGBTIQ+, and homeless population groups. Primary care improves access to assessment and comprehensive management, but inclusive, safe services are not available to priority populations in some geographical areas.

Access to affordable services that support women's reproductive choices, particularly for priority populations, are essential to enable women to make informed reproductive choices. Primary care services are inaccessible for some population groups.

Our LGBTIQ+ community have distinct health care needs

It is important to ensure that Lesbian, Gay, Bisexual, Transgender, Intersex, Queer + (LGBTIQ+) people do not feel marginalised within mainstream service delivery, either from service providers or from other consumers. It is essential that primary care services are inclusive and safe, and welcome all to participate.

Stakeholders report barriers to accessing primary care for LGBTIQ+ people. For young Aboriginal people experiencing a period of uncertainty about gender or orientation, they may experience difficulties in accessing inclusive and safe primary care.

Primary care workforce shortages limit our ability to meet people's primary care needs

Providers experience significant and ongoing challenges in recruiting and retaining a workforce with the skills that are required to deliver comprehensive primary care.

There are workforce shortages in general practice, nursing, and most allied health disciplines.

Delivering care in the after-hours period is challenging

GPs are increasingly unwilling to provide a fully comprehensive after-hours service. Other services, such as pharmacies, also choose not to open beyond core hours because it is not economically sustainable. Consequently, consumers find it harder to access after-hours care, particularly where primary care services are already more limited in normal hours, such as in rural and remote areas.

The limited availability of services after hours can lead to the potentially inappropriate use of EDs and other urgent-care services.[61]

From a consumer perspective, public hospital EDs are a visible and trusted destination for seeking urgent after-hours care. They are always open, have imaging and pathology available, and provide care at no additional cost to consumers. A challenge for governments is to increase the provision of after-hours services, encourage use of the most appropriate service for each health issue, ensure equitable access for different areas and for all consumer groups, and ensure these services are provided efficiently. As urgent-care needs range from minor to life-threatening, clear routes of escalation are required throughout the system.[62]

End-of-life care and aged primary care can be improved

People want to die a better death. They want to choose where and with whom they die. Most want to die comfortably at home supported by family and friends if they can. In most instances, people's palliative care needs relate to primary care, personal care, respite services, and equipment rather than specialist services.

Issues identified by stakeholders include:

- people who are isolated, difficult to reach, from different cultural groups, or live with a disability experience difficulties accessing palliative care
- physical and financial resources may not be available to support people to die in their place of choice
- some staff in RACFs need more support and sills development to provide end-of-life care
- consumers and carers are confused about available services and different services delivering care at one time
- providers of care do not always have ready access to the person's Advanced Care Plan.

People in residential aged care experience difficulties accessing comprehensive primary care. People's care needs incorporate chronic conditions management, mental health care, psychogeriatric care, and end of life care. People need care to be coordinated between providers involved in their care and information about their health goals and wishes to be shared between providers.

Priority actions

Our needs assessment shows that in the NQPHN catchment, accessible primary care is needed to achieve better health outcomes for our community.

Priority actions for our community are presented in alignment with our Strategic Plan.

Population Health

NQPHN's priority is to commission services that address primary care needs affecting a significant proportion of our population, that have a disproportionate impact on people's health, or that affect those in our community that need help the most (that is, priority populations).

Our needs assessment demonstrates our priority populations are Aboriginal and Torres Strait Islander peoples, people living in rural and remote areas, people experiencing social and economic disadvantage, people with palliative care and / or aged care needs, refugees and LGBTIQ+ people.

NQPHN will continue to improve its ability to make more equitable, evidence-based resource allocation decisions. To support this, we have developed tools that we will increasingly apply in making equity-informed funding decisions.

NQPHN's priority is to support improved delivery of maternal and infant primary care services to populations experiencing disproportionately poorer outcomes. NQPHN will continue to work with partners to plan and support delivery of rural maternity primary care services for priority populations, including mothers and babies in rural communities, who are experiencing socio-economic disadvantage, and for Aboriginal and Torres Strait Islander mothers and babies.

GPs and other Primary Care Professionals

NQPHN's priority is to build our primary care workforce capacity and capability:

- to address workforce shortages
- to strengthen the delivery of after-hours primary care.

This needs assessment describes gaps in primary care service provision including to:

- people in rural areas
- people in residential aged care facilities
- people with urgent palliative care
- mental health or drug and alcohol care needs
- people with sexual and reproductive health and blood borne virus care needs
- people with culturally tailored primary care needs.

NQPHN will continue to work with primary care providers, HHSs, and other health system partners to improve access to primary care in these priority populations.

Our needs assessment demonstrates we need to continue to develop and support the implementation of innovative primary care workforce solutions and new workforce models across our catchment to build workforce capacity and capability, in response to our significant and long-term primary care workforce shortages.

Our needs assessment shows declining availability of after-hour primary care. NQPHN will continue to work with after-hours stakeholders to support after-hours primary care service delivery.

NQPHN's priority is to support the delivery of comprehensive primary care to people in residential aged care. We will work with our HHS and community partners to improve information sharing, service accessibility, and coordination of care between providers.

Palliative care that respects patient goals and wishes is a priority for NQPHN. We will continue to support primary care providers to partner with palliative care providers to deliver comprehensive end of life care.

First Nations Health

We have a detailed chapter in this needs assessment that describes health needs and primary care needs for Aboriginal and Torres Strait Islander peoples in our catchment.

System Integration

NQPHN's priority is to build on our purposeful engagement, partnerships, and collaboration to undertake joint regional planning with our HHSs to identify and address priority primary care needs affecting our community. The goal of our planning is to improve system integration – the delivery of the right primary care to the right people in the right place at the right time.

- NQPHN will continue to work with HHS partners to support development of Local Area Needs Assessments (LANA) by our four HHSs that identify regional health needs, service gaps, and priorities.
- NQPHN will continue to work with HHSs, local governments and communities, and Aboriginal Community Controlled Health Organisations (ACCHOs) to plan for the delivery of regional palliative care services. Our focus is on regional service delivery in the Townsville HHS region in the first instance, where demand for palliative care has grown significantly over the past three years.

NQPHN's priority is to enable health information continuity between providers through embracing technology-enabled care, electronic communication, and information-sharing. This will reduce the administrative burden on clinicians and increase the availability of information for clinical decision support to improve the patient experience of care. We will continue to work with providers to increase eReferral uptake, shared electronic health record adoption, and other digital solutions to enable delivery of better care for chronic conditions.

Robust data will be used to inform and measure health outcomes. Through enhancement of our health intelligence capabilities, we will continue to support practices to use computer-based technology to track clinical, operational, and patient experience metrics to monitor progress towards our goals and objectives.

Chronic conditions

Overview

Chronic conditions are the biggest health challenge facing our health system today. Our growing population, increasing chronic disease burden, and rising healthcare costs are placing unprecedented strain upon individuals, communities, and health resources.

What are chronic conditions?

A disease is defined as a physical or mental disturbance involving symptoms such as pain or feeling unwell; loss of function; or damage that may lead to ill health.[63] Diseases can be acute – coming on sharply, often brief, and intense or severe; or chronic – long-lasting with persistent effects ranging from mild to severe. In some cases, disease can be both acute and chronic.

Common features of chronic diseases (also called chronic conditions) include a long development period in which there may be no symptoms; a prolonged course of illness perhaps leading to other health complications; and associated loss of function or disability.[64]

Why are chronic conditions important?

Changes to our lifestyles and reduction in other diseases in the last 100 years have meant that chronic conditions are increasingly common and now cause most of the burden of ill health. In addition to the personal and community costs, chronic conditions result in a significant economic burden because of the combined effects of healthcare costs and lost productivity from illness and death.[65]

What is our role in addressing chronic conditions?

A key focus of our health system is the prevention and better management of chronic conditions to improve health outcomes.[66] The health system is broad and includes services responsible for health promotion, primary prevention, primary care, and specialist and hospital services.

PHNs are primary care organisations. While NQPHN supports other organisations whose primary purpose is health promotion and primary prevention, and in the delivery of specialist and hospital-based clinical services, our main focus in primary health care.

Primary care is generally the first contact a person has with Australia's health system. It relates to the treatment of patients who are not admitted to hospital.

Many people associate primary care with their local GP. While general practice is the cornerstone of primary care in Australia, primary care is provided by many health professionals across a range of settings, such as private medical practices, community health centres, and ACCHOs. It is not provided in hospitals – this type of care is known as acute care.[67]

NQPHN's aim is to improve the management of chronic conditions and improve coordination of care to enhance primary care services. This is particularly important for people at risk of poor health outcomes.

Primary care relates to the treatment of patients who are not admitted to hospital.

Health needs

Most adults have a chronic condition

Chronic conditions are very common. In 2017–18, just under half (47.3%) of adults had one or more chronic conditions. This is an increase from 42.2% only 10 years earlier.[68]

Chronic conditions are more common among older people; 60% of people aged 65+ have more than one chronic condition. Around 9 in every 10 deaths are associated with chronic conditions.[69]

Many people with chronic conditions do not have a single, predominant condition, but rather they experience multimorbidity - the presence of two or more chronic conditions in a person at the same time.[70]

Common chronic health conditions self-reported by our population are described at Table 7. Musculoskeletal problems causing persistent pain and loss of function (back pain and arthritis) are the most common chronic conditions affecting our population.

Some population groups experience a higher chronic disease burden

The prevalence of chronic conditions in our population is linked with ageing, socio-economic disadvantage, rurality, and high rates of health risk factors (tobacco smoking, alcohol consumption, poor nutrition, physical inactivity and obesity.[71]

The percentage of people aged 65+ affected by each chronic condition is higher than in the general population, except for asthma.[72]

Many chronic conditions are not life-threatening in the short term. However, they can worsen over time and become more serious. Chronic conditions can lower quality of life and may affect a person's independence, cause disability, and shorten life expectancy.[73]

A greater proportion of people living in rural and remote areas (54%) have one or more chronic disease, compared with those living in major cities (48%).[74]

An estimated 64% of the total burden of disease for Aboriginal and Torres Strait Islander peoples is caused by chronic disease, and accounts for 70% of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people in Queensland.[75]

The burden of chronic conditions will continue to increase

Changes in population demographics in the NQPHN catchment will create further demand for health services to manage chronic conditions. Between 2021 and 2041 our population will increase by over 200,000 people. An estimated 74,500 of these people will be in the 65+ age group.[76,77]

This means nearly 35,000 additional people with arthritis and over 20,000 people with back problems aged 65 years and over will need primary care (Table 8).[78]

Table 7. Self-reported chronic health conditions, Queensland | 2017–18

Condition	% of population	% of 65+ population
Back problems	16.8	27.5
Arthritis	14.1	47.0
Asthma	11.9	12.0
Diabetes mellitus	4.7	14.0
Heart, stroke, and vascular disease	4.5	18.9
Osteoporosis	3.8	16.2
Chronic obstructive pulmonary disease (COPD)	3.4	8.5
Cancer	1.6	7.1
Kidney disease	1.0	3.1

Table 8. Self-reported chronic health conditions, NQPHN projections | 65+ age group

Condition	2021	2041	Increase in numbers of people with condition
Back problems	30,223	50,684	20,461
Arthritis	51,654	86,623	34,969
Asthma	13,188	22,117	8,928
Diabetes mellitus	15,386	25,803	10,416
Heart, stroke, and vascular disease	20,772	34,834	14,062
Osteoporosis	17,804	29,857	12,053
Chronic obstructive pulmonary disease (COPD)	9,342	15,666	6,324
Cancer	7,803	13,086	5,283
Kidney disease	3,407	5,713	2,306

Risk factors for chronic conditions are common

Health risk factors are characteristics associated with an increased risk of developing an illness or health condition. They are the lifestyle factors that we can influence and can work to change, with the right supports.

The major preventable behavioural risk factors for disease are tobacco smoking, excess alcohol consumption, physical inactivity, poor nutrition, and overweight and obesity.

Tobacco smoking rates are high

Tobacco smoking is a leading cause of preventable disease and death. Lung cancer, chronic obstructive pulmonary disease (COPD), and ischaemic heart disease account for more than 75% of the tobacco-related disease burden. Many other diseases are also associated with smoking (for example, lung and other cardiovascular diseases, other cancers, and pregnancy complications).[79]

Tobacco smoking rates are higher than the Queensland rate in our 4 HHS regions and are highest in the Torres and Cape HHS region (Table 9).[80]

Table 9. Daily smoking by HHS, NQPHN catchment | 2019–20

Region	% of daily smoking (adults)
Torres and Cape HHS	26.7
Cairns and Hinterland HHS	14.9
Townsville HHS	12.1
Mackay HHS	13.7
Queensland	10.8

Alcohol consumption rates are high

Excess alcohol consumption falls into two main categories – single-occasion risk and lifetime risk. Single-occasion risk is the risk of alcohol-related harm from drinking more than four standard drinks on a single occasion. Lifetime risk is the accumulated risk from either drinking on many drinking occasions, or drinking on a regular basis (for example, daily) over a lifetime.

Drinking too much alcohol is directly associated with a range of harm including road injuries, suicide, and violence, as well as longer-term health problems such as liver cirrhosis, mental health problems, pancreatitis, foetal growth restriction, and several types of cancer.[81]

Lifetime risky drinking and single occasion risky drinking rates are higher than Queensland rates in all four HHS regions in our catchment (Table 10).[82]

We need to improve our diet and physical activity levels

Sufficient physical activity for adults is based on physical activity guidelines requiring an average of ≥150 mins of physical activity (or ≥75 mins of vigorous activity) per week over five or more sessions.[83] Almost 50% of adults aged 18–75 do not get sufficient physical activity. Being physically inactive contributes to cardiovascular disease, mental health problems, type 2 diabetes, and some cancers.[84]

The food and beverages we eat and drink (our diet) also play an important role in our overall health and wellbeing. Health conditions that are often affected by our diet include overweight and obesity, coronary heart disease, stroke, high blood pressure, some forms of cancer and type 2 diabetes.[85] Almost 50% of all adults consume the recommended serves of fruit each day and over 90% do not consume the recommended serves of vegetables (Table 11).

Table 10. Excess alcohol consumption by HHS, NQPHN catchment | 2019–20

Region	% of lifetime risky drinking	% of single occasion risk (at least monthly)
Torres and Cape HHS	28.3	54.9
Cairns and Hinterland HHS	26.4	32.9
Townsville HHS	25.4	32.9
Mackay HHS	26.6	37.4
Queensland	21.6	30.0

Table 11. Nutrition and physical activity in adults by HHS, NQPHN catchment | 2019–20

Region	% who meet recommended fruit intake	% who meet recommended vegetable intake	% who have sufficient physical activity (18–75 years)
Torres and Cape	58.9	np	53.0
Cairns and Hinterland	52.1	7.8	58.2
Townsville	49.2	7.6	56.9
Mackay	52.4	8.1	54.3
Queensland	52.1	8.4	58.2

We have high rates of overweight and obesity

Excess weight, especially obesity, is a major risk factor for cardiovascular disease, type 2 diabetes, some musculoskeletal conditions and some cancers. As the level of excess weight increases, so does the risk of developing these conditions. In addition, being overweight can hamper the ability to control or manage chronic conditions.[86] Rates of overweight and obesity are higher in children (aged 5–17) in our catchment, and in adults in Torres and Cape, Townsville, and Mackay HHSs, compared with Queensland as a whole (Table 12).

Primary care providers have an important role in assessing lifestyle risk factors in their patients and in delivering evidence-based primary care to address risk.

Cancer affects a significant proportion of our population

Cancer is a leading cause of death in the NQPHN catchment, accounting for 1,260 deaths each year. The crude incidence of cancer and the death rate due to cancer is highest in the Cairns and Hinterland HHS, followed by Townsville, Mackay, and Torres and Cape HHSs. However, cancer is more common with older age and the Torres and Strait HHS has a younger median age than other HHSs in our catchment. After adjusting for the differences in age structure, Torres and Cape HHS has the highest death rate due to cancers in our HHS (Table 13).[87]

Cancer incidence and mortality vary by type of cancer (Table 14).[88,89]

- Lung cancer incidence and death rates are generally higher than the Australian rate. Deaths due to lung cancer are highest in the Port Douglas – Daintree region.
- Breast cancer mortality is generally lower than the Australian rate.
- Mortality due to prostate cancer in the Bowen Basin – North region is almost twice the national age-standardised mortality rate.
- The incidence of melanoma is higher than the Australian rate across the NQPHN catchment.

Table 12. Overweight and obesity by HHS, NQPHN catchment | 2019–20

Region	% overweight / obesity (adult)	% overweight / obesity (5-17 years)
Torres and Cape	64.7	np
Cairns and Hinterland	58.4	28.5
Townsville	64.4	31.2
Mackay	65.1	31.1
Queensland	59.9	27.0

*np=not provided

Table 13. Cancer incidence and deaths, NQPHN HHSs | 2016–18

Region	Per 100,000 population		
	Crude incidence 2017–18	Crude mortality 2016– 18	Age-standardised mortality 2016–18
Torres and Cape	346	103	222
Cairns and Hinterland	643	204	177
Townsville	600	181	172
Mackay	543	161	163

Table 14. Age-standardised cancer incidence and deaths per 100,000 population, NQPHN SA3 areas | 2010–14

Region	All-cause		Lung		Breast		Bowel		Prostate		Melanoma	
	Incidence	Deaths	Incidence	Deaths	Incidence	Deaths	Incidence	Deaths	Incidence	Deaths	Incidence	Deaths
Bowen Basin – North	456	178	44	38	42	np	52	18	90	23	57	np
Cairns North	506	161	34	27	68	10	61	19	62	16	86	np
Cairns South	546	185	48	42	67	10	73	21	72	13	73	6
Charters Towers - Ayr - Ingham	556	173	49	32	55	9	68	24	109	15	60	7
Far North	505	200	77	36	41	np	48	29	63	np	36	np
Innisfail - Cassowary Coast	491	206	50	45	53	10	58	20	65	18	50	np
Mackay	530	185	41	35	68	9	67	25	91	13	56	7
Port Douglas - Daintree	527	196	66	51	65	np	75	np	60	np	69	np
Tablelands (East) - Kuranda	521	186	46	36	62	11	71	24	65	19	77	9
Townsville	566	182	50	40	60	11	58	19	96	14	77	8
Whitsunday	531	202	55	45	55	np	65	28	87	np	78	np
Australia	496	169	43	32	64	11	59	20	77	12	50	6

np=not provided

Tobacco smoking is a risk factor for cancers and contributes to a large lung cancer disease burden for our region.

Cancer screening can be improved

Cancer screening programs aim to reduce illness and death from cancer through early detection. Cancers detected through screening are less likely to cause death than those diagnosed in people who have never participated in a screening program.[90] Primary care providers play an important role in cancer screening.

Australia has three population-level cancer screening programs. They are for:

- breast cancer
- bowel cancer
- cervical cancer.

BreastScreen Australia was established in 1991. It provides free screening mammograms to women aged 40+ every 2 years, and actively targets women aged 50–74.

The *National Cervical Screening Program*, established in 1991, targets women aged 20–69 for a Papanicolau smear, or 'Pap test,' every two years. In December 2017, the Cervical Screening Test replaced the Pap test in Australia. The Cervical Screening Test is more effective than the Pap test at preventing cervical cancers because it detects the human papillomavirus – a common infection that can cause cervical cell changes that may lead to cervical cancer. The Cervical Screening Test is performed every five years in women aged 25–74.

The *National Bowel Cancer Screening Program*, established in 2006, currently targets men and women turning 50, 54, 55, 58, 60, 64, 68, 70, 72, and 74, inviting them to screen for bowel cancer using a free faecal occult blood test.

Rates of cancer screening participation can be improved across the NQPHN catchment. Participation in breast cancer screening ranged from 46% (Far North) to 68% (Charters Towers – Ayr – Ingham). Bowel cancer screening participation ranged from 15% (Far North) to 45% (Tablelands East – Kuranda). Cervical screening participation ranged from 37% (Bowen Basin North) to 52% (Mackay) (Table 15).[91]

Table 15. Cancer screening participation, SA3 | 2018–19

SA3	% of participation		
	Breast	Bowel	Cervix
Bowen Basin - North	64	40	37
Cairns North	np	np	np
Cairns South	58	39	48
Charters Towers - Ayr - Ingham	68	38	43
Far North	46	15	40
Innisfail - Cassowary Coast	58	41	46
Mackay	63	44	52
Port Douglas - Daintree	54	40	43
Tablelands (East) - Kuranda	56	45	48
Townsville	63	36	47
Whitsunday	61	40	45

*np=not provided

Prevalence of cardiovascular disease is high in many communities

There is an almost 3-fold variation in the prevalence of cardiovascular disease (heart, stroke and vascular disease) across our population. Data are not available for smaller communities, including the Torres and Cape region (Figure 26).[92]

High blood pressure and type 2 diabetes mellitus are risk factors for heart, stroke and vascular disease. Estimated rates of hypertension and type 2 diabetes mellitus in people aged 18+ years are generally higher across the NQPHN catchment than Queensland and Australian rates (Figure 27 and Figure 28).[93,94]

Figure 26. Modelled prevalence of heart, stroke and vascular disease, 18+ years | 2017–18

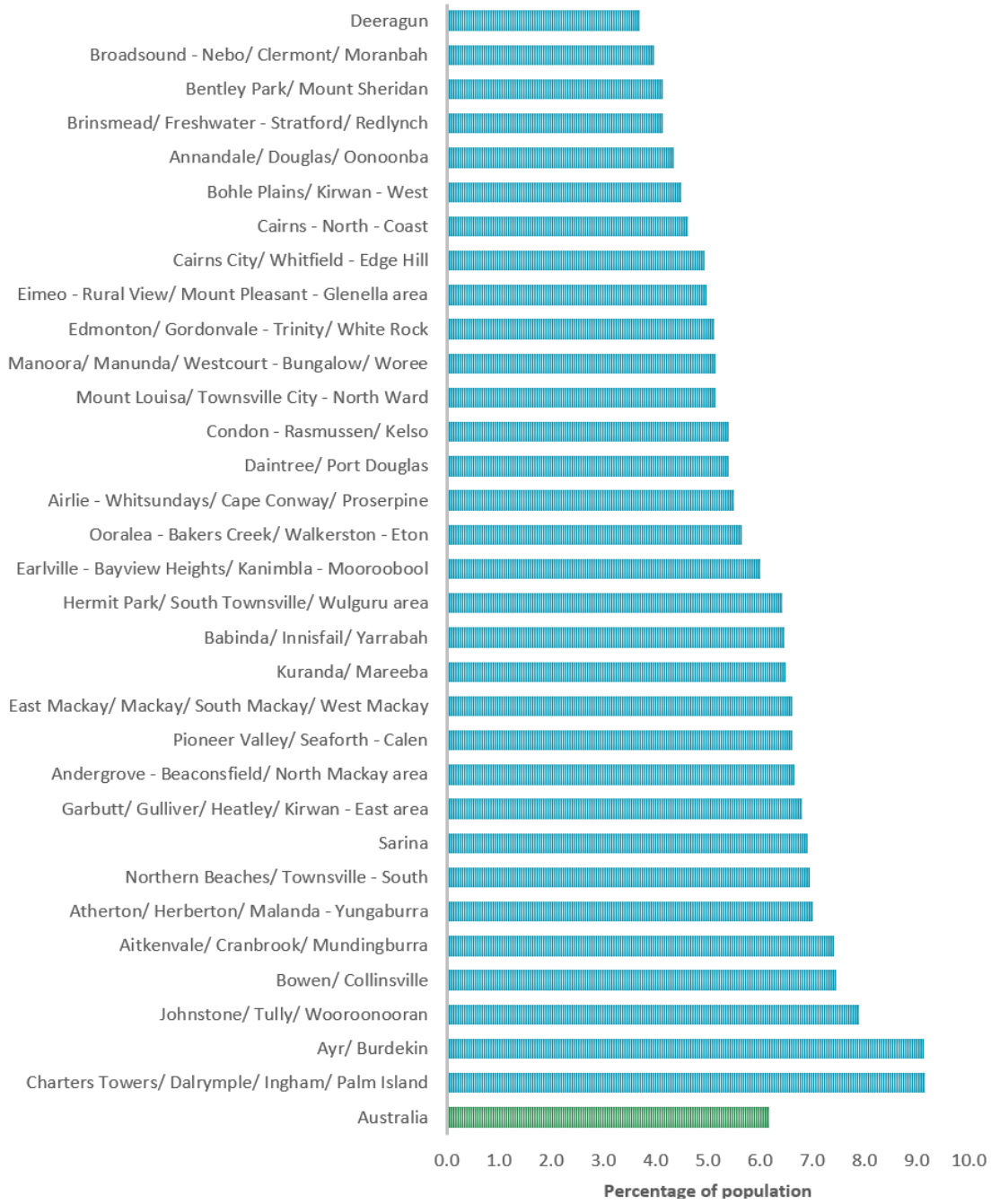


Figure 27. Age-standardised rate of hypertension per 100 persons aged 18+, NQPHN areas | 2017–18

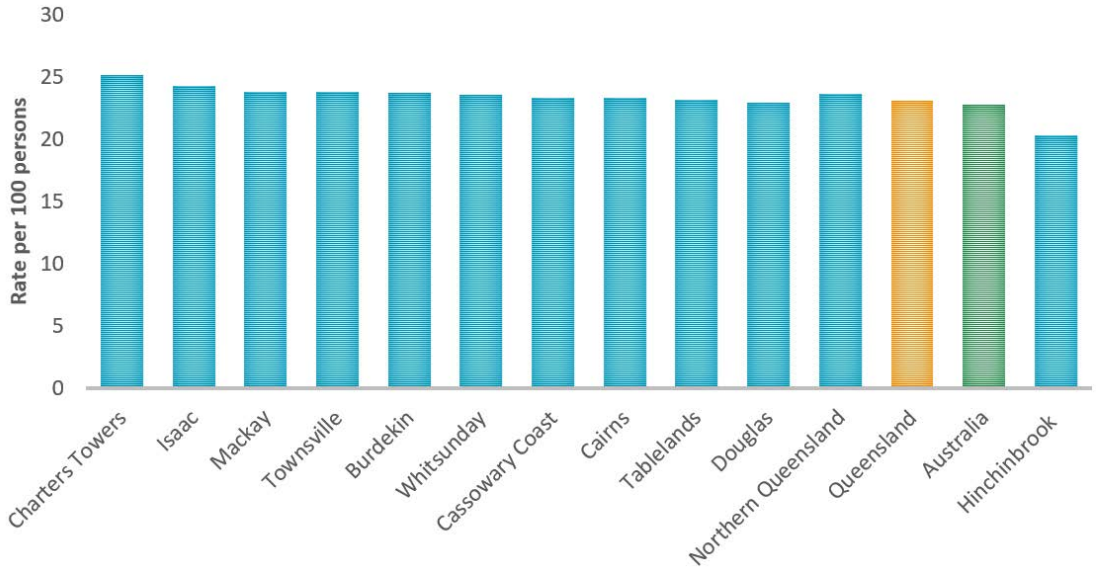
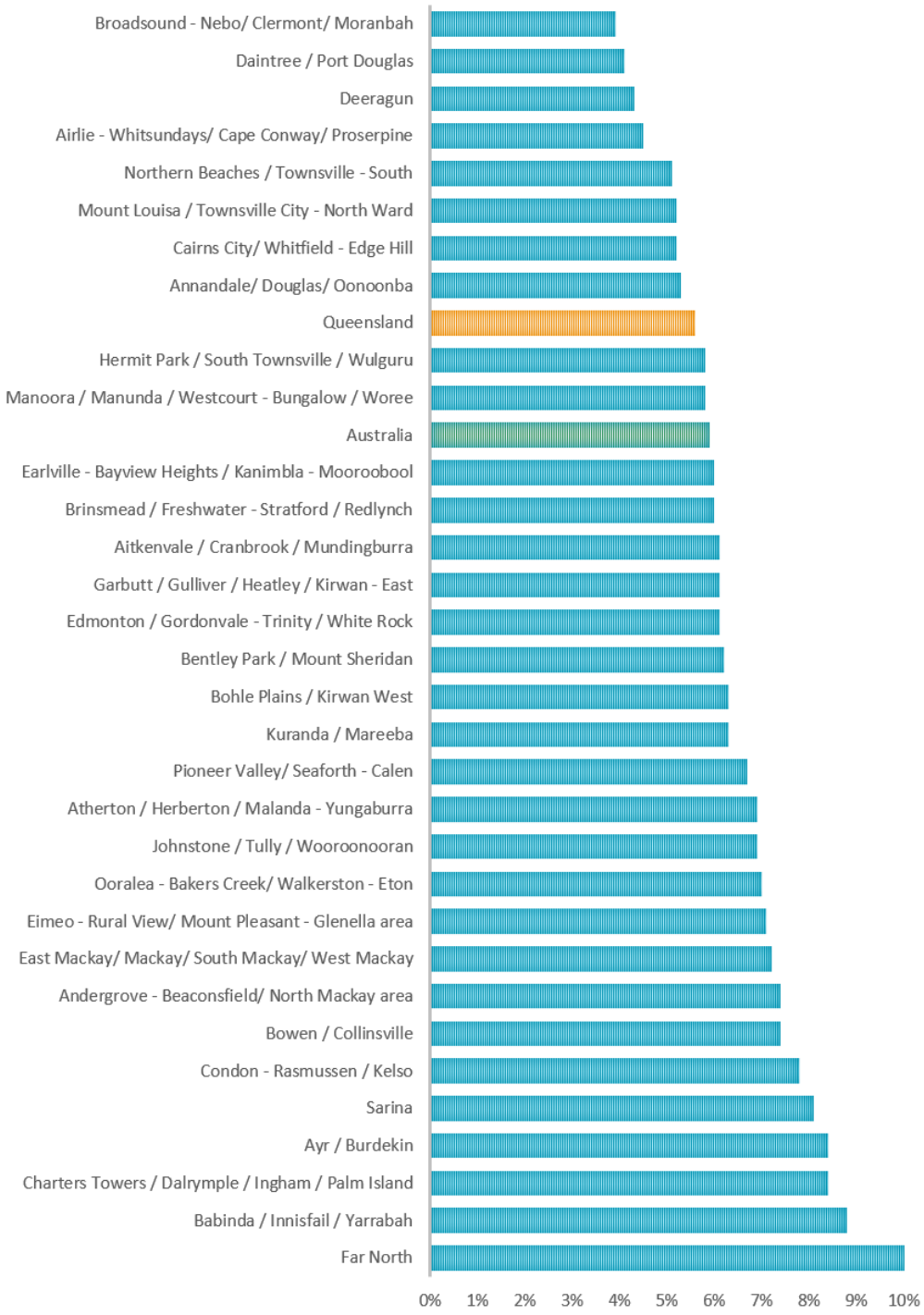


Figure 28. Crude rate of type 2 diabetes (%), NQPHN areas | 2018



Service needs

Most people in our community visit a GP at least once a year.

In northern Queensland, most general practices contribute data to NQPHN to inform our understanding of care delivered to people in general practice. These data show that, although most people accessing our GPs live in the NQPHN region, people come to our region from all over Australia and visit our GPs when they are here (Figure 29).

Most chronic conditions are managed in general practice

People with chronic conditions need access to primary and community health services to manage their conditions well and reduce the risk of hospitalisations. Nationally, the most frequent chronic problems managed are hypertension, mental health problems, musculoskeletal problems, diabetes, and lipid disorders.[95] Since January 2017, 45% of patients who visited NQPHN GPs have at least one chronic condition recorded. The main chronic conditions for which patients visit a GP are cardiovascular conditions, mental health problems, musculoskeletal problems, and respiratory conditions (Figure 30).

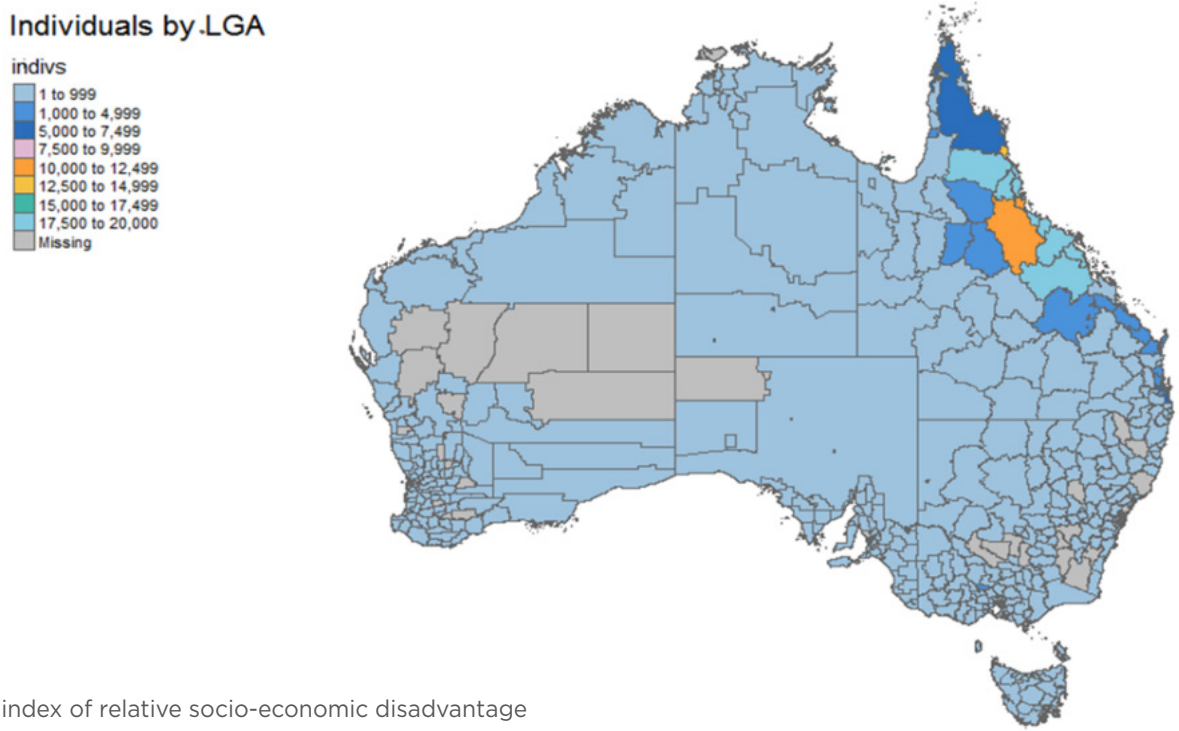
Nearly all patients with a chronic condition have more than one chronic condition recorded. In total, 42% of individuals in our GP data have detectable multimorbidity, where multimorbidity is defined as having two or more of the following chronic conditions or condition clusters:

- chronic cardiac conditions
- musculoskeletal conditions
- chronic obstructive pulmonary disease
- asthma
- diabetes mellitus
- depression or anxiety
- vascular conditions
- cancer
- hypertension
- hyperlipidaemia.

Most people who have a chronic condition recorded are socially and economically disadvantaged. People in our lowest income quintile (income equivalent to the lowest 20% of the population nationally) are disproportionately represented in general practice data with cardiovascular disease risk factors and mental health problems (Figure 31).[i]

Medication management is an important part of chronic disease management. The main medications prescribed for people with chronic conditions in our GP data are antidepressants, pain killers, steroids, and cholesterol lowering medications (Figure 32).

Figure 29. Patient Local Government Area (LGA) of residence, GP services, NQPHN primary care data | January 2017 – July 2021



[i]IRSD = index of relative socio-economic disadvantage

Figure 30. Percentage of patients with recorded chronic condition groups, NQPHN general practice | January 2017 – July 2021

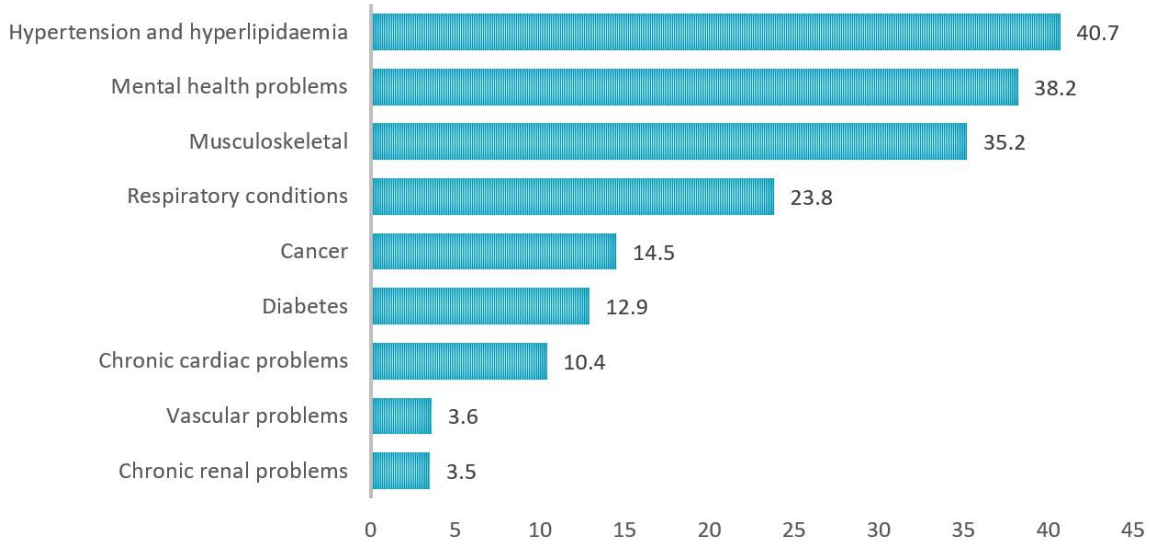


Figure 31. Top 15 coded conditions reported by socioeconomic disadvantage, NQPHN | January 2017 – July 2021

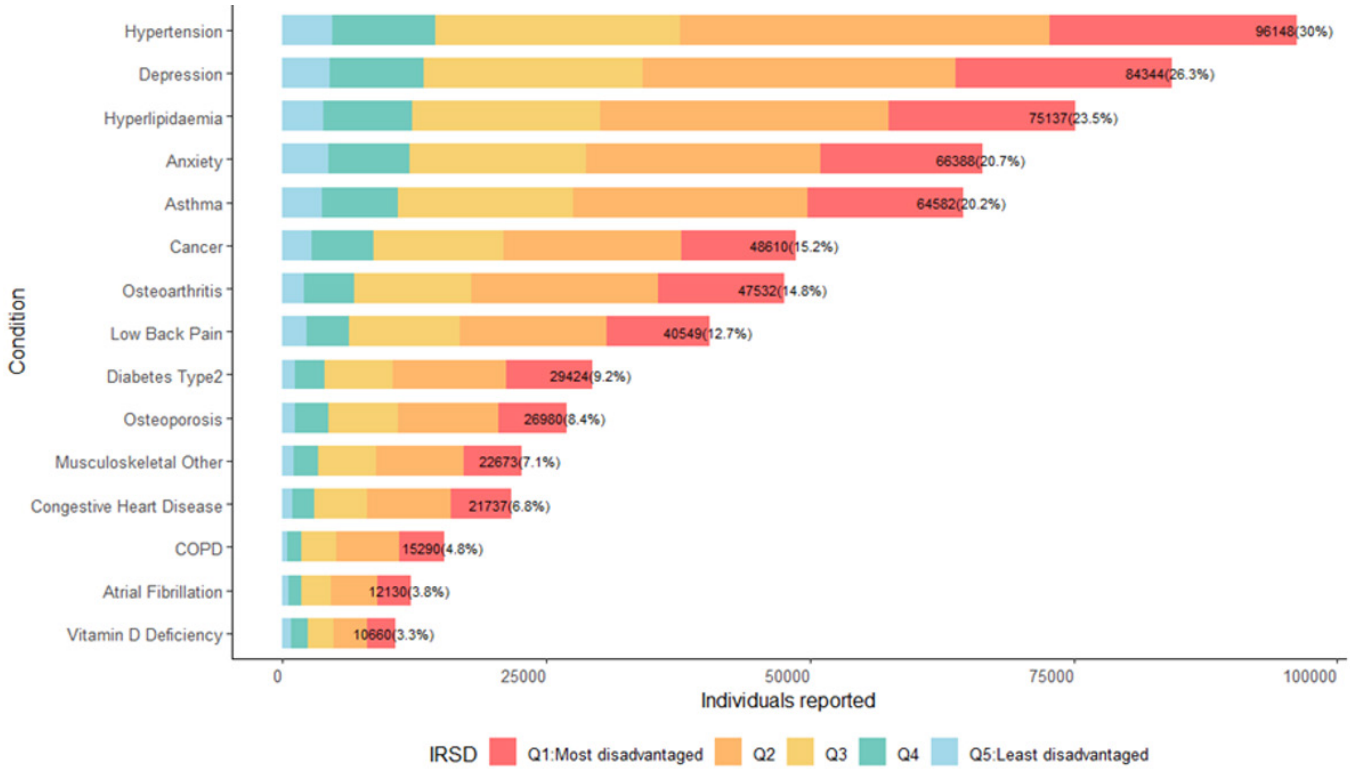
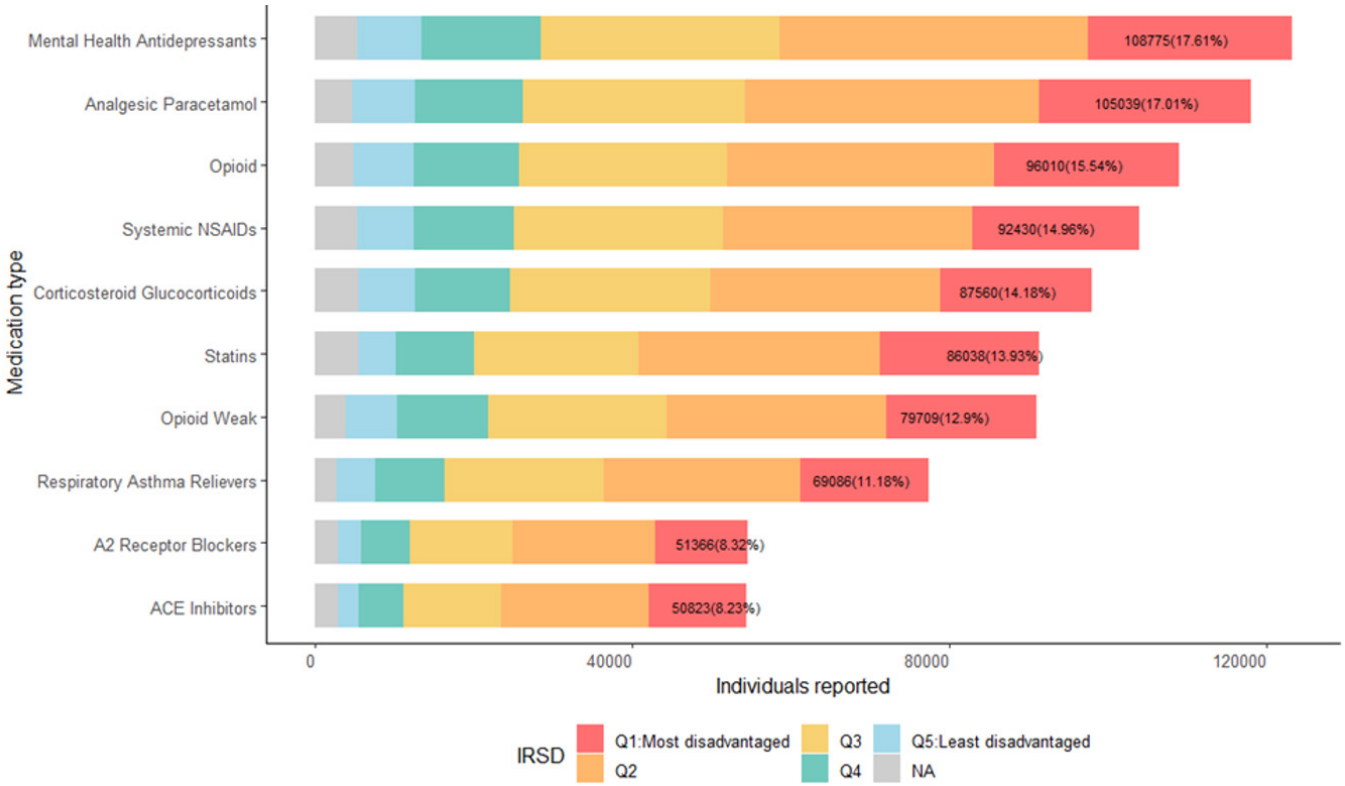


Figure 32. Top 10 medications (excluding immunisations, reported by socioeconomic disadvantage) NQPHN | January 2017 – July 2021



There are gaps in availability of GPs

Availability of GPs varies across our catchment. Availability per 1,000 population is generally higher in the larger population centres and lower in rural areas of our catchment and in the Torres and Cape region (Figure 33).[96]

According to the most recent patient experience survey results, in the NQPHN catchment:[97]

- 14.7% of people needed to see a GP but did not at least once in the preceding 12 months, compared with 14.1% nationally
- 19.5% waited longer than acceptable to get an appointment with a GP at least once in the previous 12 months, compared with 22.6% nationally.

Across the NQPHN catchment:[98]

- people see the GP an average of 5.7 times per year, compared with 6.1 nationally
- 83.4% of GP attendances are bulk billed, compared with 85.7% nationally
- people in residential aged care facilities receive 14.2 GP attendances per year, compared with 16.6 nationally.

Figure 33. GP FTE per 1,000 residents, NQPHN catchment | 2019

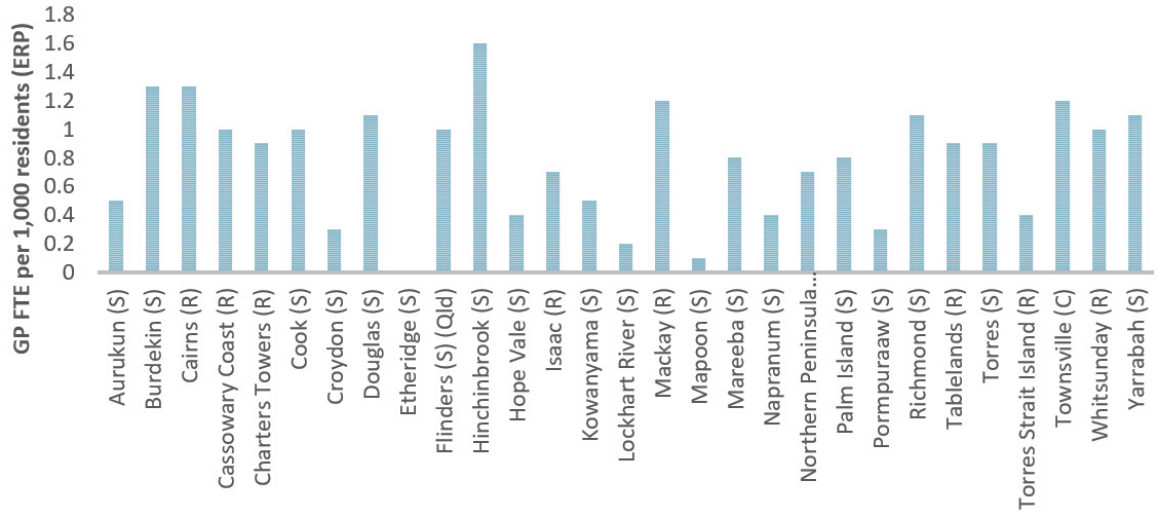
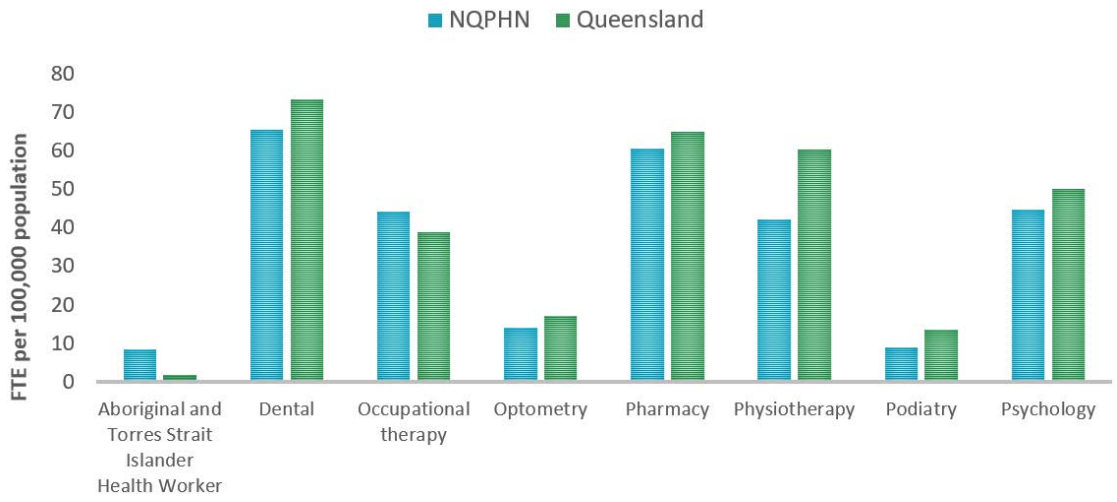


Figure 34. Allied Health FTE per 100,000 population, NQPHN and Queensland | 2019



Some people with chronic conditions may be missing out on allied health care

NQPHN has a higher FTE of Aboriginal and Torres Strait Islander health workers and occupational therapists than Queensland but a lower FTE per 100,000 population than Queensland for other allied health disciplines (Figure 34).

Medicare Benefits Schedule (MBS) item numbers for health assessments, mental health, and chronic disease care planning can be used to facilitate access to allied health providers. NQPHN GP data shows chronic disease, mental health, and health assessment item numbers were not claimed for most patients in whom they were potentially eligible in the 12 months to August 2021 (Table 16).

Table 16. Selected MBS item numbers for chronic conditions, mental health and health assessment. NQPHN GP dataset, 12 months to August 2021*

Item	Patients in whom items were claimed	% of potentially eligible patients
Mental health care plan items	39,787	39%
MBS715	11,240	18%
MBS721	56,036	19%
MBS723	43,924	15%
MBS732	38,305	4%

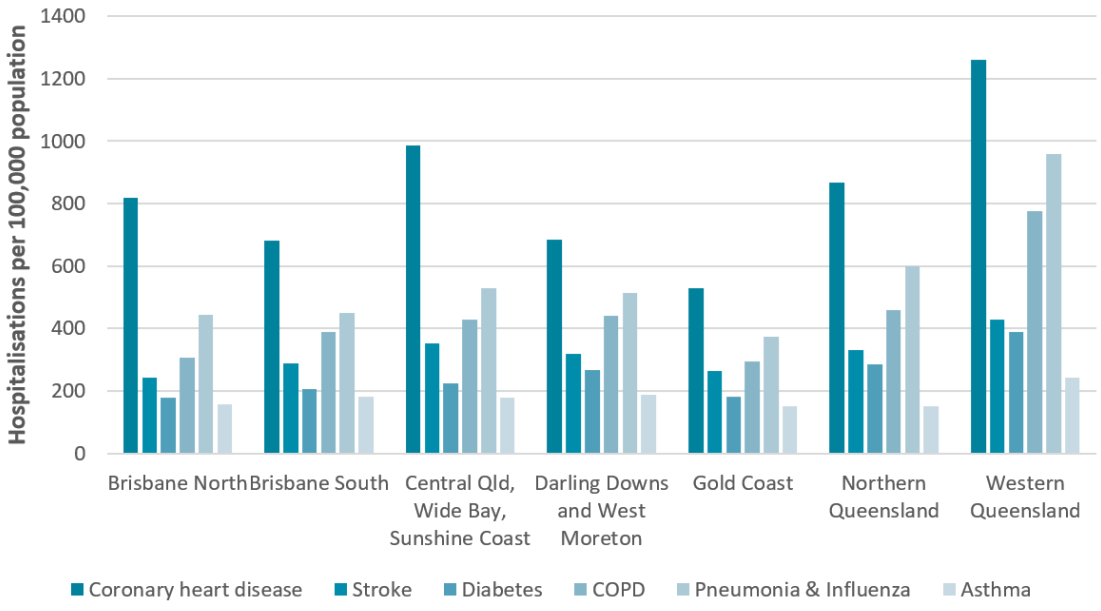
*Not all patients with recorded mental health or chronic disease diagnoses may be eligible for MBS items, patients may not wish to participate in health assessment or care planning, and GPs may not feel health assessment or care planning is clinically indicated. COVID-19 may have reduced care planning and disease management activities in general practice.

Many people with chronic conditions access hospital care

Hospitalisations for chronic conditions vary according to the type of chronic condition. Compared with other Queensland PHNs, NQPHN has the third highest rate of hospitalisations for coronary heart disease and stroke, and the second highest rate for diabetes, COPD, and pneumonia or influenza. Compared with other PHNs in Queensland, rates of hospitalisation for asthma are low.

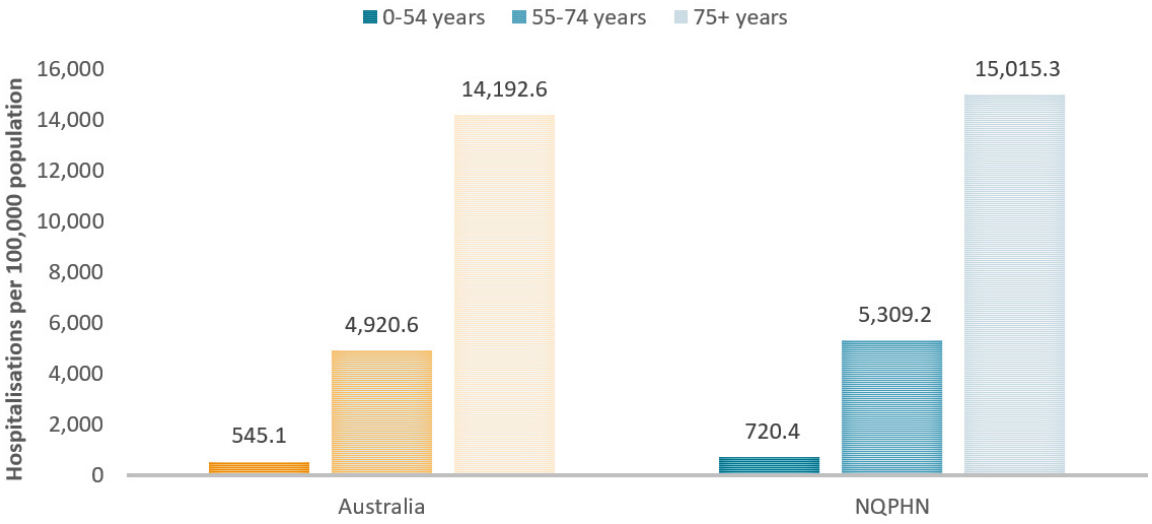
Although not a chronic condition, hospitalisations for pneumonia and influenza are considered here as people with underlying chronic conditions are more likely to be hospitalised with pneumonia and influenza. Hospitalisations for cancer are not considered here as different models of care for cancer influence hospitalisation rates, which makes comparisons between different regions problematic (Figure 35).[99]

Figure 35. Age-standardised hospitalisations per 100,000 population | 2018–19



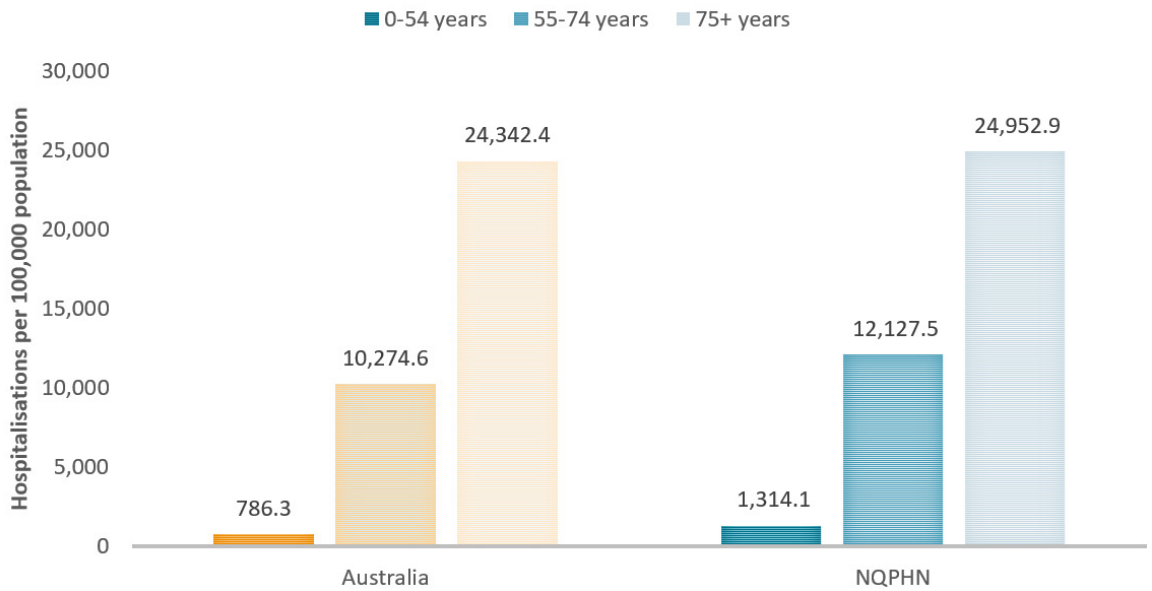
Cardiovascular disease hospitalisations are mainly comprised of hospitalisations for coronary heart disease and stroke. Rates of hospitalisations increase with increasing age and are highest in the 75+ age category, both within the NQPHN catchment and Australia. Rates are higher in the NQPHN catchment than Australia as a whole (Figure 36).[100]

Figure 36. Hospitalisations with cardiovascular disease as the principal diagnosis, Australia and NQPHN | 2017–18



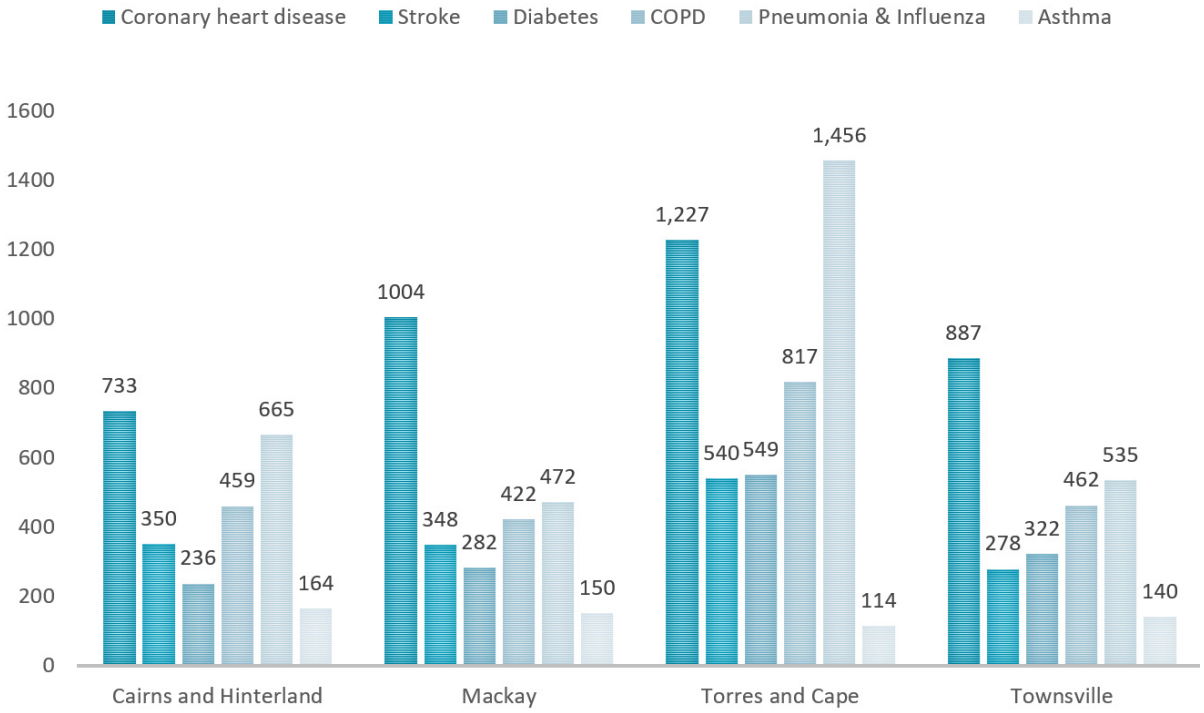
Although rates of hospitalisation for type 2 diabetes as a principal diagnosis are lower than for cardiovascular disease, diabetes is a contributing factor to hospitalisations for other reasons. When hospitalisations for diabetes as a principal or additional diagnosis are analysed, rates are higher in the NQPHN catchment than Australia, particularly in younger age groups (Figure 37).[101]

Figure 37. Hospitalisations with type 2 diabetes as the principal or additional diagnosis, Australia and NQPHN | 2017–18



Hospitalisations for chronic diseases vary between HHSs. Torres and Cape HHS has the highest rates of hospitalisation for selected chronic conditions except for asthma (Figure 38).[102]

Figure 38. Age-standardised hospitalisations per 100,000 population, HHS | 2018–19



Some hospitalisations are preventable

The term "potentially preventable hospitalisations" (PPHs) refers to hospital admissions for conditions that are considered manageable through timely and effective primary care. Internationally and in Australia the concept of preventable hospitalisations is used as an indicator of health system performance.

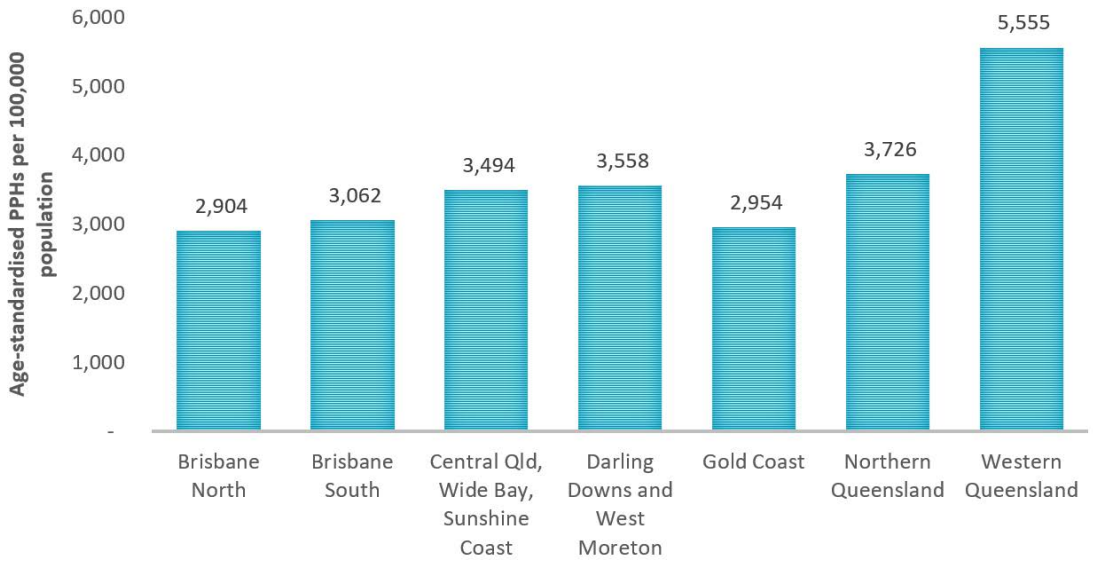
Potentially preventable hospitalisations are grouped into three broad categories:

- vaccine-preventable
- acute conditions
- chronic conditions.

In 2018–19, there were 26,851 potentially preventable public hospital admissions in the NQPHN catchment. Approximately 50% of these were due to acute conditions and 42% due to chronic conditions. COPD, heart failure, and diabetes account for the largest chronic disease avoidable admission burden and urinary tract infections and cellulitis for the largest acute disease burden (Figure 39).

NQPHN has the second highest rate of PPHs of all PHNs in Queensland.[103]

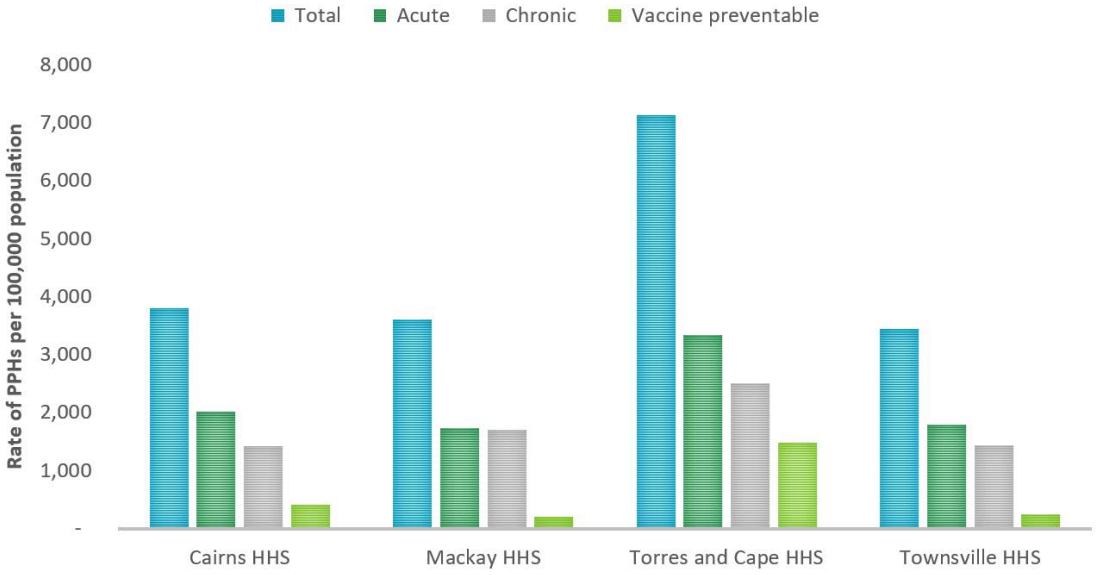
Figure 39. Age-standardised PPHs per 100,000 population, Queensland PHNs | 2018–19



People from our most disadvantaged communities are over-represented in our preventable hospitalisations. Low income, combined with a lack of access to affordable primary healthcare, increases the incidence of poor health and associated chronic conditions.

Rates of potentially preventable hospitalisations are highest in the Torres and Cape HHS (Figure 40).[104]

Figure 40. Age-standardised PPHs per 100,000 population, NQPHN HHSs | 2018–19



Stakeholder perspectives

Primary care services are less accessible for some people with chronic conditions in our community.

People with chronic conditions experience fragmented health services

People with chronic conditions find it difficult to navigate a complex health system. Communication and information-sharing between providers is often poor. Consumers with chronic conditions report:

- poor coordination of care between service providers, both in community and acute hospital settings
- a lack of communication and information sharing between GPs, community allied health services, acute hospitals, and residential aged care facilities.

People with chronic conditions report clinicians do not readily share their information between each other, resulting in them having to tell their story multiple times and, in many cases, contributing to duplication of radiology and pathology testing by providers. People with chronic conditions want access to coordinated health services that share patient information between providers and across hospital and community settings.

Many people with chronic conditions need support to self-manage

People with chronic conditions need to self-manage their conditions to achieve good health and wellbeing outcomes. For many people, poor health literacy and a lack of available self-management support limits their ability to navigate the health system and seek care from the right providers, in the right place, at the right time.

For some people with chronic conditions, they need help to coordinate their care. Some people only need help to coordinate care periodically whereas others need care coordination support on an ongoing basis.

People with chronic conditions want primary care services to be easy to navigate and health information and services to be easy to understand and use.

People with chronic conditions need accessible, affordable care

Reasons people defer seeing a GP include lack of availability, inability to obtain an appointment, unable to afford the cost, and unable to obtain an appointment within a timeframe suitable to the patient.

People with chronic conditions may experience financial disadvantage because their health problems decrease their participation in employment and because of substantial and ongoing out-of-pocket costs associated with their chronic conditions. Some people in our community experience greater socio-economic disadvantage than Australians overall and general practice bulk-billing rates in our catchment are lower than the Australian average, particularly in areas outside our major population centres.

People with chronic health conditions experiencing social and economic disadvantage report difficulty accessing affordable primary care and will avoid seeing health professionals or filling prescriptions due to cost.

Aboriginal and Torres Strait Islander peoples may defer seeking care from mainstream services because the care they receive is not always culturally safe or appropriate. See the Aboriginal and Torres Strait Islander chapter for more information about this.

People with chronic conditions have difficulty accessing services due to primary care workforce shortages

People with chronic conditions need continuity of health care to help manage their chronic conditions and keep people well and out of hospital. They also need timely access to health care when their care needs escalate, and they become acutely unwell.

Many regions in our catchment have insufficient medical, nursing, and allied health professionals to meet the care needs of people with chronic conditions. In rural areas and in the Torres and Cape HHS, communities may rely heavily on visiting health professionals. This means that when the health professional is not visiting the local community, there is effectively no service available locally in that health discipline.

We need sustainable solutions to address our health workforce challenges that deliver continuity of local health services wherever possible. Non-clinical community members play a key role in supporting people with chronic conditions and in facilitating their access to clinical services when the need arises. NQPHN could explore community-based training opportunities to upskill community members to support the delivery of primary care.

Priority actions

Our priority actions for chronic conditions align with our Strategic Plan. Our goal is to develop, with our partners, an integrated and coordinated primary healthcare system that delivers the best care possible to achieve measurable health improvements for people with chronic conditions.

We will achieve our goal through purposeful engagement, partnerships and collaboration, building capacity and capability, innovation, embracing technology-enabled care, and strategic and transparent commissioning.

COVID-19 has placed additional demands on NQPHN to respond to primary care needs in our community. We anticipate NQPHN will continue to support primary care professionals and the community in responding to COVID-19 over the next triennium.

Population Health

NQPHN is a system partner in prevention and health promotion. Within primary care, our preventive efforts will focus on supporting primary care providers in the assessment and management of tobacco smoking, alcohol use, overweight, and obesity.

Through our quality improvement activities, we will also support primary care to increase cancer screening in our community and to address biomedical risk factors for cardiovascular disease, including hypertension, hypercholesterolaemia, and diabetes.

A healthy pregnancy and birth are a pre-condition for health in later life and for reducing chronic disease burden later in life. NQPHN will work with primary care organisations, clinicians, and consumers to support the delivery of maternal and infant health services, with a focus on priority populations (people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people experiencing social and economic disadvantage).

GPs and other Primary Care Professionals

Our community needs an accessible, capable primary care workforce to deliver care. NQPHN's priority is to build our primary care workforce capacity and capability, to address workforce shortages and to strengthen the delivery of continuity of primary care in priority geographical areas and priority population groups. We will:

- Work with our health system partners to provide people with chronic conditions access to a suitably trained, knowledgeable, resourced and distributed primary care workforce.
- Support the upskilling of community members in primary care workforce support roles.
- Collaborate with partners to support development of innovative workforce solutions and implementation of new workforce roles in the health system to improve health service efficiency for people with chronic conditions.
- Support the implementation of team-based ways of working in primary care to support people with chronic conditions.
- Agree models of care with clinicians and consumers.

An NQPHN priority is to build on our efforts to improve evidence-based care. To be effective, care for chronic conditions should be based on evidence. NQPHN will continue to work with primary care providers to implement HealthPathways. Through this work, providers are supported to deliver evidence-based care.

A related NQPHN priority is to improve the delivery of evidence-based primary care for people with dementia. Using HealthPathways and other NQPHN program supports, we will improve service integration and assist clinicians to navigate care and support for people with dementia.

Data is important to drive evidence-based care. NQPHN's priority is to continue to work with GPs and other primary care providers to collect, analyse and share health data that improves health outcomes for people with, or at risk of, those chronic diseases that contribute significantly to the disease burden in our population.

Most people with chronic conditions are affected by multiple conditions at the same time (that is, 'multimorbidity'). People with multimorbidity are disproportionately impacted by some specific chronic conditions that increase morbidity and mortality, reduce quality of life, consume a large and growing proportion of healthcare resources, and have the capacity to be improved. They include:

- arthritis and musculoskeletal conditions
- cardiovascular disease
- diabetes
- cancer
- chronic respiratory conditions.

NQPHN's priority is to continue to work with HHSs and primary care providers to support continuous quality improvement in managing these priority chronic conditions. Through our PIP QI quality improvement initiative, we will work with general practice partners to reduce chronic disease impacts on individuals, communities and the health system.

First Nations Health

We recognise that Aboriginal Community Controlled Health Organisations (ACCHOs) deliver comprehensive, coordinated, culturally tailored care for Aboriginal and Torres Strait Islander peoples, including those with chronic conditions. Some chronic conditions care needs are addressed by mainstream services. These need to be culturally safe and integrated with services provided by Aboriginal Community Controlled Health Organisations.

- We will work with partners to provide Aboriginal and Torres Strait Islander peoples with access to mainstream primary health services that are culturally safe and support Aboriginal and Torres Strait Islander peoples to access their comprehensive Aboriginal Community Controlled Health Services.

Priorities are described further in the Aboriginal and Torres Strait Islander chapter of this needs assessment.

System Integration

Through purposeful engagement, partnerships, and collaboration, we will undertake joint regional planning with our HHSs to identify and address priority primary care needs for people with chronic conditions. We will:

- work within current alliances (for example, Better Health NQ) to improve secure data sharing and referral pathways between primary care and hospital services
- work with partners to jointly plan, co-commission, and deliver innovative models of service delivery for people with chronic conditions.
- continue to work with providers to increase eReferral, shared electronic health record adoption and other digital health solutions to enable delivery of better care for chronic conditions.

Mental health

Overview

Promoting good mental health, preventing mental illness, and reducing stigma and discrimination associated with mental illness is a shared responsibility between our government, service providers, individuals, and communities.

Our policy and planning context

In 2020, the *Joint Regional Wellbeing Plan for Northern Queensland* was released. The plan describes the collaborative approach of NQPHN, HHSs, and other partner organisations to deliver mental health, suicide prevention, and alcohol and other drugs services. The *Joint Regional Wellbeing Plan* is part of our commitment to deliver on actions within the *Fifth National Mental Health and Suicide Prevention Plan*.

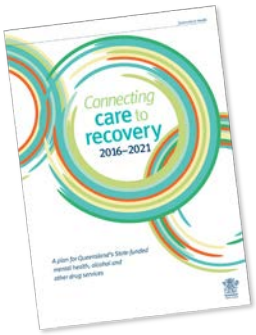
NQPHN has a strong commitment to integrated mental health service planning and delivery. Our mental health service priorities are guided by the following Queensland policies and plans.

Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan, 2018–2023

This plan sets the 5-year direction for improving the mental health and wellbeing of Queenslanders. It aims to strengthen and reform Queensland's mental health, alcohol and other drugs, suicide prevention and related systems to deliver a system that is comprehensive, integrated and recovery oriented.

Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services

Under the *Connecting Care to Recovery* plan, funding is being allocated to expand mental health, alcohol and other drug services across a range of initiatives aimed at optimising the level and mix of services across the care continuum. The plan focuses on the continued expansion of care and treatment, rehabilitation and support delivered in the community.

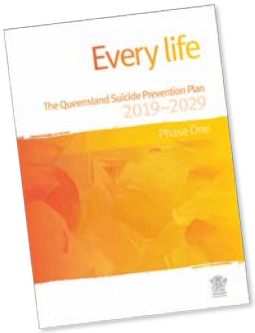


Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021

The vision of this plan is elimination of the gap in mental health outcomes between Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders. It focuses on improving the responsiveness and effectiveness of Queensland Health's mental health services to the needs of Aboriginal and Torres Strait Islander Queenslanders with severe mental illness.

Every Life: The Queensland Suicide Prevention Plan 2019–2029

Every life is a whole-of-government plan that provides a renewed approach for suicide prevention in Queensland, as well as renewed drive and urgency to reduce suicide. The plan aligns with national and international best practice, evidence and innovation.



Health needs

Mental health problems are a major part of our burden of disease

Mental illnesses are one of the greatest causes of disability, reduced quality of life, and impaired productivity in our community. Mental illness and substance use disorders make up 12% of our total burden of disease; combined, they are the fourth highest disease groups contributing to total burden.[105]

Mental illness is a significant health issue in the NQPHN catchment with a substantial social and economic impact on our community. The burden of mental illness makes it harder for people with mental illness to live fulfilling lives. Mental illness has direct economic impact through increased use of health and other services, and indirect economic impact due to lost productivity when people are unable to work.[106]

Most people with mental health problems experience mild to moderate illness

Most of us experience mental health problems at some time in our lives. These are problems that interfere with how we think, feel, and behave. Some mental health problems are mental illnesses – a mental health problem that is diagnosed according to standardised criteria and that significantly interferes with a person's cognitive, emotional, or social abilities.[107]

Almost 130,000 people in northern Queensland have either a mild, moderate, or severe mental illness. Most people with mental illness are living with a mild mental illness. However, a 91,000 people in northern Queensland have mental health problems that put them at risk of developing a mental illness (Table 17).[108]

There are many risk factors for mental health problems, including:[109]

- individual factors - lifestyle factors, substance use, sexual orientation, obesity
- family factors - lack of support, partner loss, out-of-home care and the perinatal period
- social relationships – social support, loneliness, social media and cyberbullying
- adverse life events – migration, refugee status, exposure to violence, chronic illness, homelessness, natural disasters
- ethnicity – Aboriginal and Torres Strait Islander and cultural and linguistic diversity
- work and school environment
- economic factors
- living environment.

Table 17. Estimated people experiencing a mental health burden, northern Queensland | 2020

Illness severity	Number of people
Mild	69,953
Moderate	35,468
Severe	23,738

Anxiety and affective disorders are the most common mental health problems

Almost half (45%) of the population aged 16–85 years will experience a mental illness at some time in their life. About 1 in 5 people will experience a mental illness in any 12-month period. Anxiety disorders (such as social phobia) are the most prevalent, occurring in 1 in 7 (14%) of the population, followed by affective disorders such as depression (6%), and substance use disorders such as alcohol dependence (5%).[110]

Younger people experience high levels of psychological distress

Self-reported psychological distress is a measure of the burden of diagnosed and undiagnosed mental illness affecting our population. An estimated 17.3% of our adult NQPHN population self-report high or very high levels of psychological distress, compared with 13.8% of Queensland adults and 13% nationally.[111] Rates of psychological distress are highest in the Townsville HHS catchment (22.3%), followed by Cairns and Hinterland (18.7%) and Mackay (17.3%). Rates are not reported for Torres and Cape HHS.[112]

Levels of psychological distress are particularly high among younger people in our population (Figure 41).

Rates of people experiencing 'mentally unhealthy days' are increasing

Queensland preventive health surveys record 'mentally unhealthy days' experienced by survey respondents. The mean mentally unhealthy days in the past 30 days experienced by Queenslanders was 4.9 days in 2020, an increase from 4.4 days in 2017. In our catchment, the mean mentally unhealthy days was 4.5 days in 2017-18 and increased to 5.4 days in 2019–20, the highest of all PHNs in Queensland. Survey respondents in the Townsville HHS have the highest percentage of adults experiencing 5 or more mentally unhealthy days in the previous 30 days (Table 18).[113]

Figure 41. Proportion of people who report high or very high psychological distress, Queensland | 2017–18

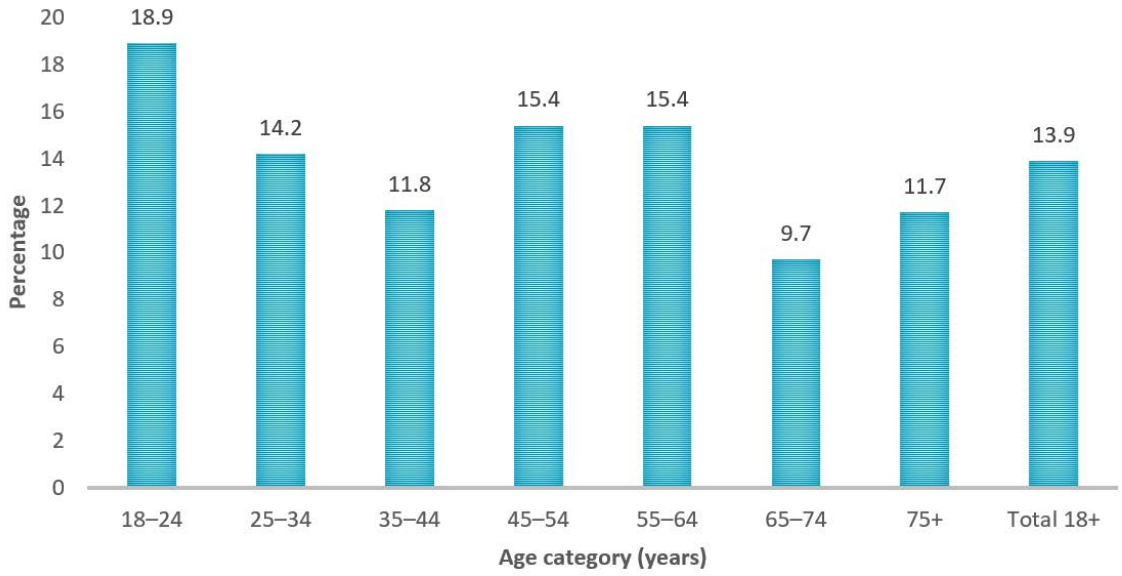


Table 18. Mentally unhealthy days, adults, NQPHN HHS | 2019–20

Hospital and Health Service	% adults ≥5 mentally unhealthy days
Cairns and Hinterland	30
Mackay	26
Torres and Cape	13
Townsville	35

People with mental illness have other chronic diseases

People living with mental illness often have poorer physical health than other people in our community. For people who reporting having a mental illness:[114]

- the most common additional health conditions that people living with mental illness experience are arthritis (including back problems), asthma and heart and vascular disease
- compared with the general population, people in our catchment with self-reported mental illness experience significantly more:
  - heart disease, stroke or vascular disease (7% vs 4%)
  - arthritis (23% vs 13%)
  - diabetes (7% vs 4%).

Evidence suggests that people with mental illness are more likely to develop physical illness due to a combination of lifestyle, socioeconomic and system-level factors such as social stigma, lack of health service integration, and a lack of clarity about who is responsible for physical health monitoring in people with mental illness. Medication side effects (for example, weight gain and hyperlipidaemia – elevated levels of lipids in the blood) may also be a significant contributor for some individuals.[115]

Physical health treatment rates for people living with mental illness are reported to be around 50% lower than for people with only a physical illness. This leads to physical conditions being undiagnosed and untreated, which can prove fatal.[116]

Older people may experience complex mental health care needs that are often difficult to distinguish from underlying organic illness. Dementia, delirium and chronic conditions that affect mood account for a significant burden of disease in our catchment (described in the Chronic Conditions chapter).

People with severe and complex mental health problems have a reduced life expectancy

International studies report a reduced life expectancy in psychiatric patients of 20 years in males and 15 years in females.[117] Australian research found that the gap in life expectancy for people with psychiatric disorders increased between 1985 and 2005. For males the gap grew from 13.5 to 15.9 years, and for females the gap increased from 10.4 to 12 years. Most of the increased deaths were attributed to physical health conditions such as cardiovascular disease, respiratory disease, and cancer.[118]

We need to decrease deaths due to suicide

Suicide prevention has been identified as a national priority. In December 2018, it was elevated to a whole-of-government issue. The *Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)* commits all governments to work together to achieve better mental health and suicide prevention outcomes, including through integration in planning and service delivery at a regional level.

The reasons for suicide are complex and multifaceted. Suicide is not always connected to mental illness. Suicide attempts are often linked to feelings of helplessness or being overwhelmed by a situation. These stressful life events can include relationship difficulties, social isolation, loss of a job or income and financial or housing stress.[119] People who are Australian Defence Forces personnel are also at increased risk of death due to suicide.[120]

Improvements in mental health services are imperative. An effective suicide prevention response may require concerted action by law enforcement agencies, planning and infrastructure developers, transport providers, social support agencies, housing providers, and health agencies.[121]

The age-standardised rate of suicide in Queensland is 16 per 100,000 population. Rates are higher in males (25 per 100,000 population) than females (7 per 100,000 population).[122] Age-standardised rates of deaths by suicide and self-inflicted injury are highest in the Mackay HHS (Table 19).

Suicide affects people of all ages, except young children. The highest proportion of deaths by suicide occurs among young and middle-aged people, and the proportion decreases in progressively older age groups. The median age at death for suicide is 44 years, which is considerably lower than the median age for all deaths (82 years).[123]

Table 19. Age-standardised rate of deaths from suicide and self-inflicted injury per 100,000 population, NQPHN HHSs | 2016–17

HHS	Age-standardised rate per 100,000 population	Total deaths
Cairns and Hinterland	18	92
Townville	17	80
Mackay	20	69
Torres and Cape	Not reported	Not reported

Service needs

Our mental health service system is complex

Our mental health service system is comprised of a broad range of clinical and non-clinical providers with mental health skills and training. Some clinical providers are specialists in the delivery of mental health care (for example, psychiatrists, psychologists, mental health nurses) whereas others deliver mental health care as part of a broader healthcare role (for example, GPs, social workers).

In northern Queensland our clinical mental health service providers include:

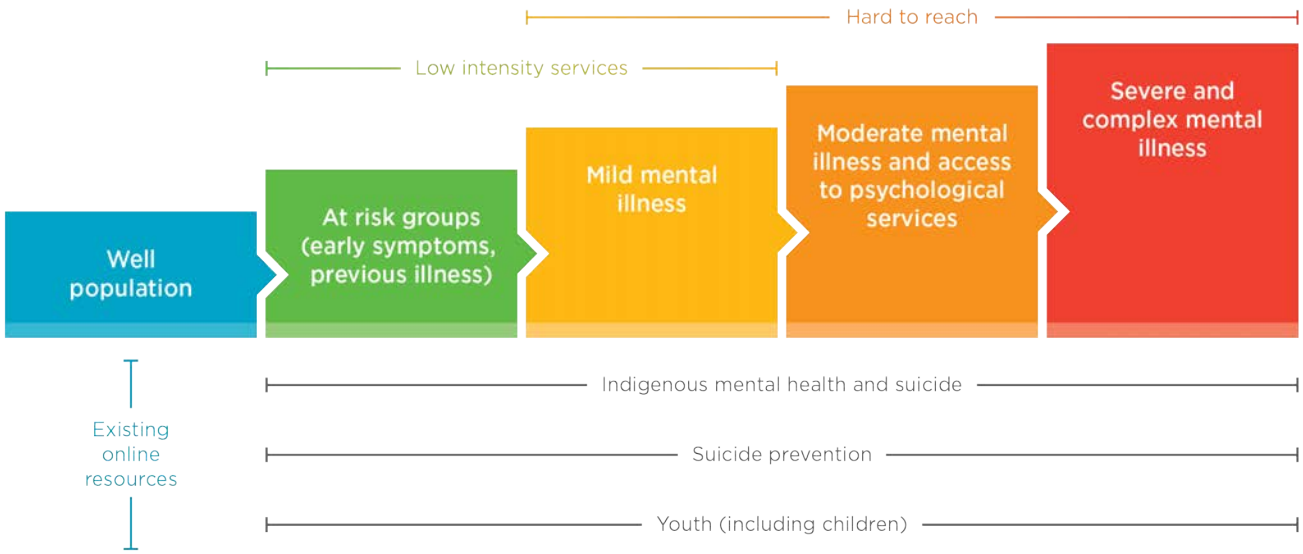
- primary healthcare services
- social and emotional wellbeing services provided through Aboriginal Community Controlled Health Organisations (ACCHOs)
- community organisations that provide individual and group programs, and psychosocial support programs
- HHS specialist mental health services
- private mental health service providers.

HHSs focus on delivering services to people who have the most severe and complex mental health problems. Care is delivered in acute inpatient settings and in the community.

Primary care providers focus on delivering mental health services for people with less complex mental health problems, and in supporting specialist mental health services in delivering comprehensive, team-based care to meet the person's care needs.

The delivery of mental health care is aligned with the intensity of the person's care needs. Clinical services are delivered according to a 'stepped care' model – a staged approach with a hierarchy of interventions – from the least to the most intensive – matched to the person's needs. The transition of clients from one part of the system to another is critically important, particularly for a person's recovery and continuity of care (Figure 42).[124]

Figure 42. Stepped care model of mental health care



Many people receive hospital care for mental health problems

People with mental health problems often present to emergency departments

Emergency department (ED) presentations for mental health-related problems comprise approximately 4% of all public hospital presentations.[125] The number of mental health-related public hospital ED presentations in the NQPHN catchment varies each year (Figure 43).[126]

Some people with mental illness require admission to hospital

There are an estimated 11,000 hospitalisations for mental health problems each year in our catchment. This represents 5% of total hospitalisations in people aged between 0 and 85 years.[127]

The proportion of hospitalisations due to mental and behavioural problems in Aboriginal and Torres Strait Islander people in Queensland is similar to non-Indigenous people (4% versus 5%). However, after adjusting for the younger median age of the Aboriginal and Torres Strait Islander population, age-standardised hospitalisations rates for mental and behavioural disorders are higher in Aboriginal and Torres Strait Islander people (3,533 versus 2,508 per 100,000 persons).[128]

NQPHN has the lowest age-standardised rate of hospitalisations for mental and behavioural disorders of all PHNs in Queensland (Figure 44).[129]

Figure 43. Emergency department presentations in public hospitals by Queensland PHN | 2014-15 to 2019–20

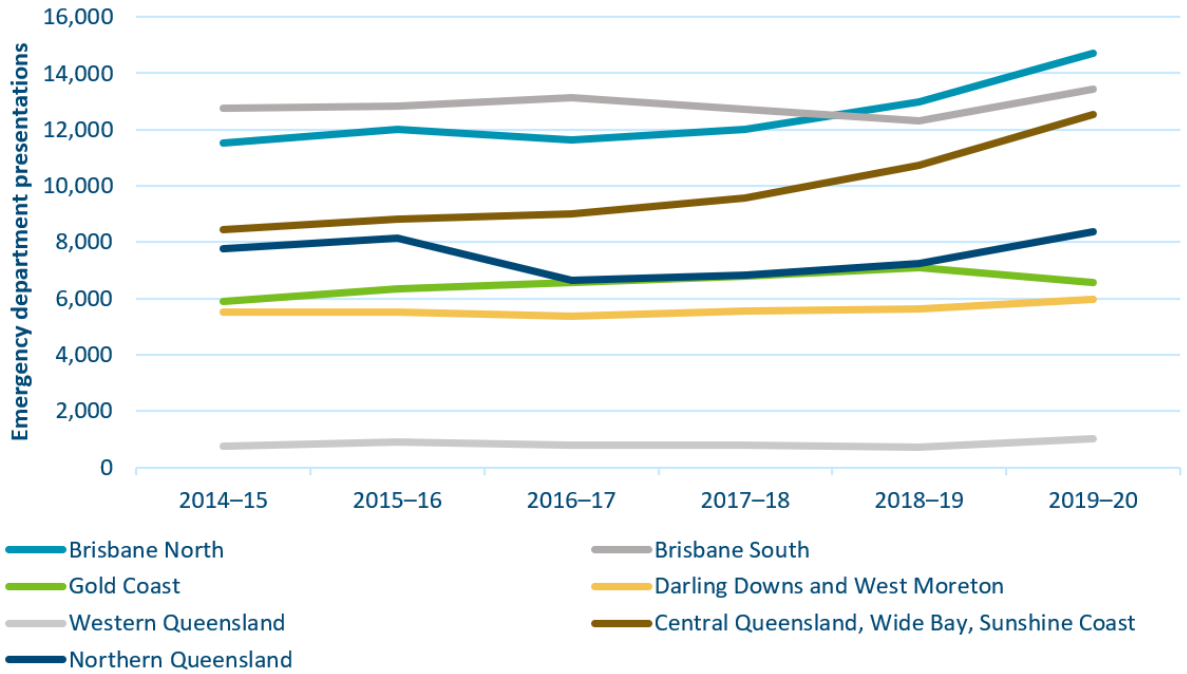
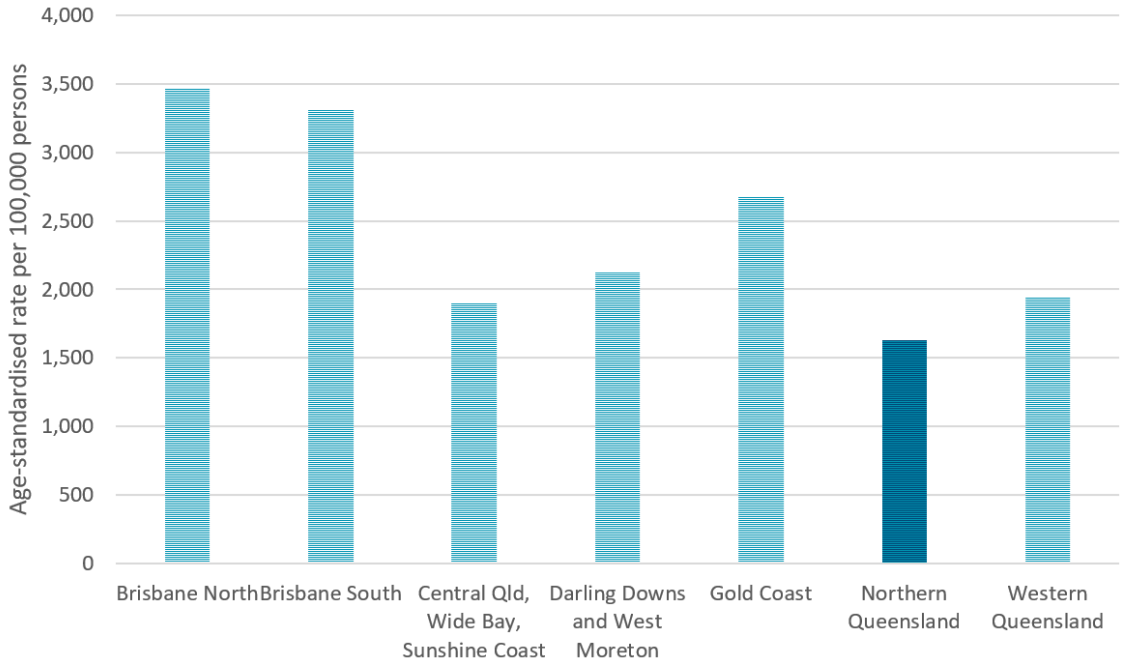


Figure 44. Age-standardised hospitalisations, mental and behavioural disorders, Queensland PHNs | 2018–19



Crude and age-standardised hospitalisation rates are lowest in the Torres and Cape HHS (Table 20).[130]

Mood disorders (anxiety and affective disorders), schizophrenia and self-harm contribute to the mental health disease burden in our community. In 2019–20, hospitalisations for these selected mental health disorders were most common for anxiety disorders (Table 21).[131]

Table 20. Hospitalisation rates for mental and behavioural disorders per 100,000 population, NQPHN HHS regions | 2018–19

Hospital and Health Service	Crude rate	Age-standardised rate
Cairns and Hinterland	1,791	1,807
Mackay	1,033	1,072
Torres and Cape	860	952
Townsville	1,876	1,937

Table 21. Public hospital separations, selected mental health problems | 2019–20

Hospital and Health Service	Anxiety	BPAD*	Depression	Schizophrenia	Self-harm	Total
Cairns and Hinterland	492	544	316	641	598	2,591
Mackay	411	151	234	309	322	1,427
Torres and Cape	29	6	13	61	42	151
Townsville	1,892	456	995	588	516	4,447
Total	2,824	1,157	1,558	1,599	1,478	8,616

*Bipolar affective disorder

Some mental health problems result in longer lengths of hospital stay. In 2019–20, the largest number of patient days in hospital were for people requiring care for schizophrenia (Table 22).

Table 22. Public hospital bed days, selected mental health problems | 2019–20

Hospital and Health Service	Anxiety	BPAD*	Depression	Schizophrenia	Self-harm	Total
Cairns and Hinterland	4,009	5,558	2,999	9,117	2,845	24,528
Mackay	2,005	1,708	1,588	3,010	975	9,286
Torres and Cape	53	47	96	613	67	876
Townsville	6,644	3,874	7,033	13,885	997	32,433
Total	12,711	11,187	11,716	26,625	4,884	67,123

*Bipolar affective disorder

Most mental health care is delivered by primary and community mental health services

GPs provide care to most people with mental health problems

The 2007 National Survey of Mental Health and Wellbeing (the most recent survey) collected data on mental health service access in the preceding 12 months. From this survey, it was estimated that about one-third (35%) of people with symptoms of a mental disorder in the previous 12 months accessed mental health service providers. GPs were the most frequent service provider accessed at 71% (38% consulted a psychologist and 23% consulted a psychiatrist).[132] Since the introduction of Medicare-subsidised mental health treatment items, the percentage of people accessing mental health service providers has increased to 41%.[133]

Most general practices northern Queensland contribute data to NQPHN. This informs our understanding of care delivered to people in general practice. This data shows that mental health problems are the second most common chronic condition recorded in patients attending NQPHN general practices, with 38% of patients having a mental health condition ever recorded as a diagnosis. Depression and anxiety are the two most common mental health problems recorded, affecting 26.5% and 21% of patients, respectively (Figure 45).

Antidepressants are the most common medication prescribed to patients across NQPHN general practice. People who are more socially and economically disadvantaged (IRSD income quintiles 1, 2, and 3) comprise the largest numbers of patients prescribed antidepressants (Figure 46).

GPs can complete a GP mental health treatment plan and refer patients for allied health services that are subsidised through Medicare. Between January 2017 and July 2021, nearly 40,000 patients received a GP mental health treatment plan in general practices that contribute data to NQPHN. Of these patients, 64% were female, 8% were Aboriginal or Torres Strait Islander, and 16% were under the age of 18 years.

> The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area.
>
> (Australian Bureau of Statistics)

Figure 45. Top 5 chronic conditions ever recorded in patient record, NQPHN general practice | January 2017–July 2021

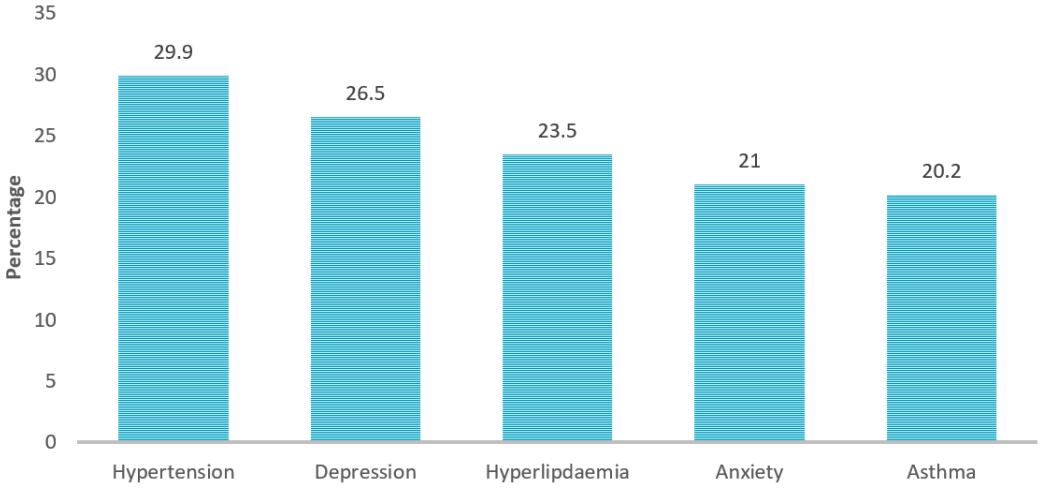
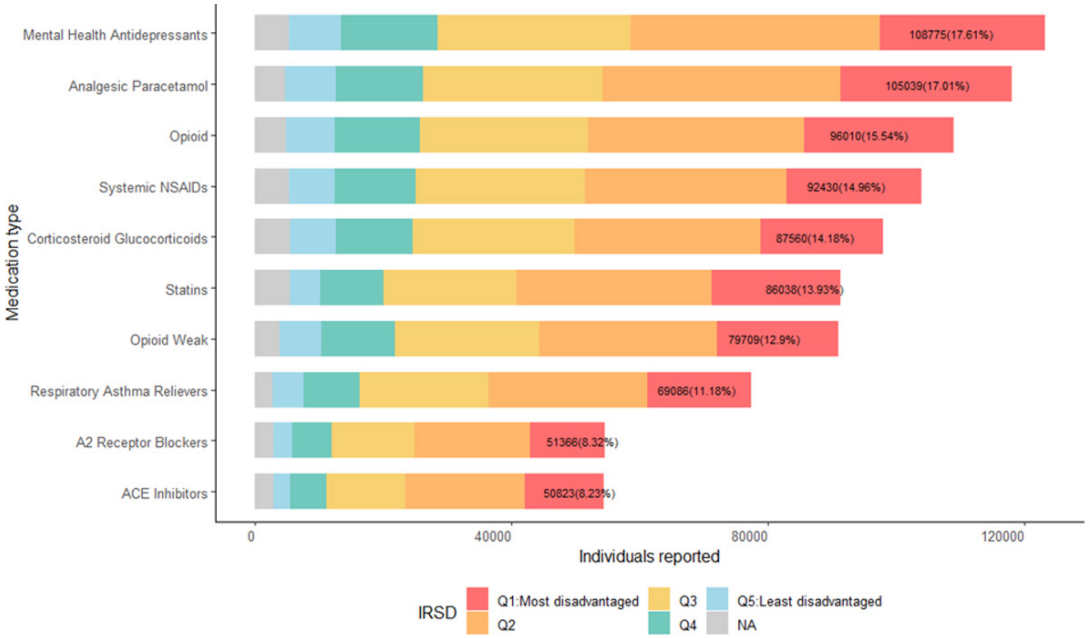


Figure 46. Top 10 medications (excluding immunisations, reported by socioeconomic disadvantage) NQPHN | January 2017 – July 2021

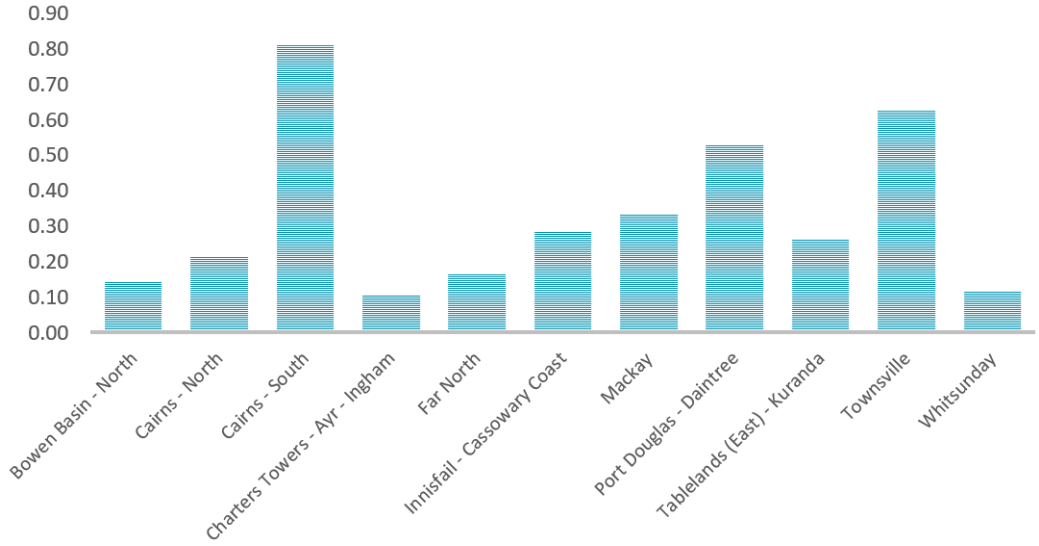


The psychology workforce is unequally distributed across our catchment

Psychologists are a core professional group that is essential for the delivery of primary and community mental health services. Psychologist workforce availability varies between different regions in our catchment. There is an 8-fold difference in the availability of full-time equivalent psychologists in primary and community settings per 1,000 population in the Cairns – South region compared with the Charters Towers/Ayr/Ingham region (Figure 47).

Under-served communities rely heavily on visiting psychologists and telehealth services to meet psychology care needs.

Figure 47. FTE psychologists per 1,000 population in primary and community settings, NQPHN SA3 regions | 2019



Our commissioned primary and community mental health services are improving outcomes

Data describing the use of community-based services by people with mental health problems are limited. There is no overarching data collection for community mental health services due to the diversity of community-based services that are available. People access mental health services through the public sector, private sector, and through organisations that deliver mental health care as their core purpose or as part of a broader range of services.

Funding by the Australian Government Department of Health is provided to PHNs nationally through a Primary Mental Health Care flexible funding pool to support commissioning of mental health and suicide prevention services. Key service delivery areas include:

- psychological interventions for people with, or at risk of, mild mental illness
- short-term psychological therapies delivered by mental health professionals
- psychological interventions for youth with severe mental health problems
- early intervention services for children and young people with, or at risk of mental illness
- services for adults with severe and complex mental illness who are being managed in a primary care setting
- psychosocial support for people with severe mental health problems.

The NQPHN also commissions psychological services for people in residential aged care and for people who are experiencing mental health impacts from natural disaster.

In the 3-year period from 2018–19 to 2020–21, 33,198 clients received a total of 141,348 NQPHN commissioned mental health services. In total, 64% of clients were female, 20% were aged 18 years or less and 15.3% were Aboriginal or Torres Strait Islander people. Some clients reside outside the NQPHN catchment.

The highest rate of delivery of mental health services per capita occurred in the Mackay SA3 region (Figure 49).

Some people who receive commissioned mental health services are at risk of suicide. NQPHN commissioned providers delivered mental health services to 3,771 people who had disclosed suicidal ideation. A total of 66% of referred clients had a mental health treatment plan completed by a GP.

Figure 48. Distribution of clients (who are residents of Queensland) by SA3 region | 2018–19 to 2020–21

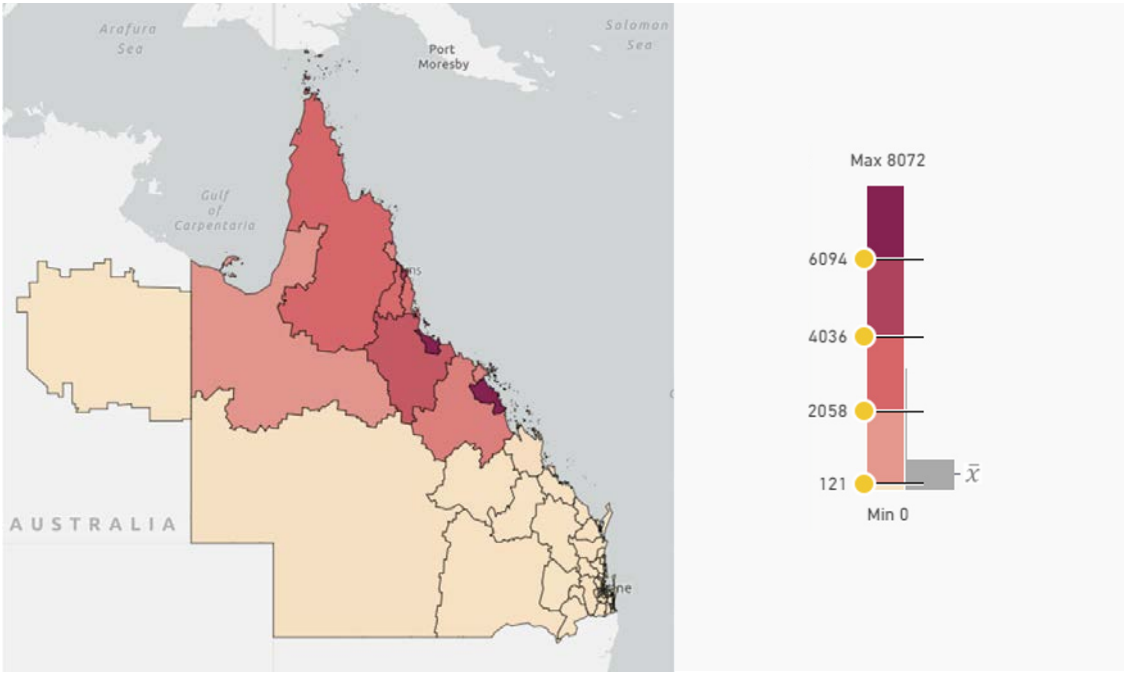
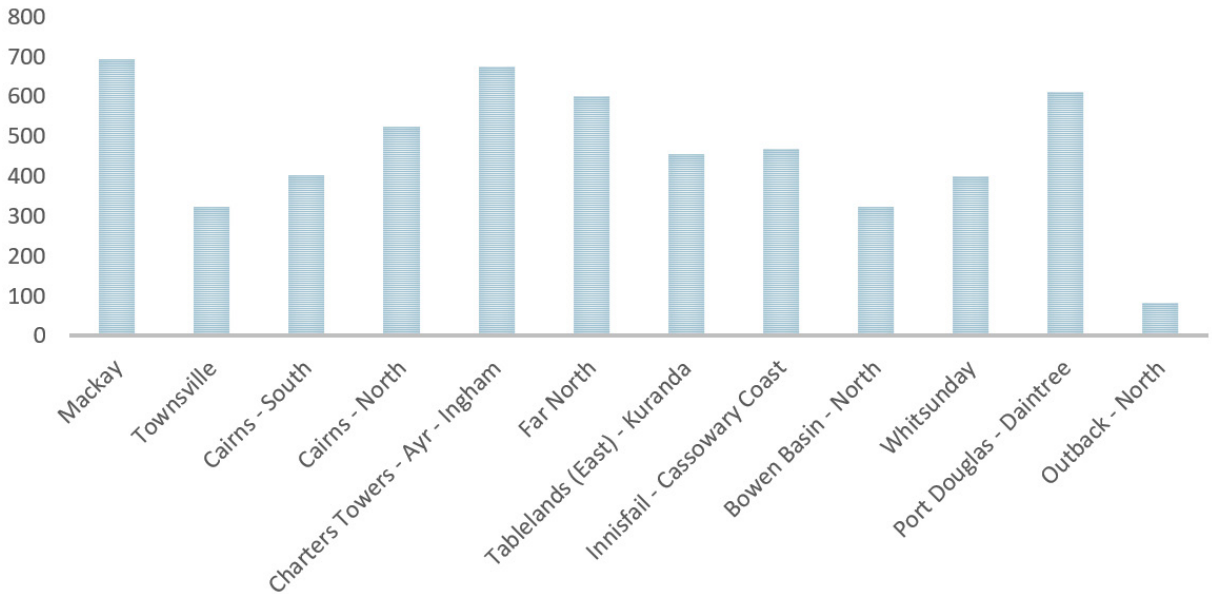


Figure 49. Rate of commissioned mental health services per 10,000 people, NQPHN SA3 regions | 2018–19 to 2020–21



NQPHN commissions different types of psychological treatments and support. Between 2018–19 and 2020–21, psychological therapies were the main type of treatment provided by commissioned providers.

The main diagnoses for which people received commissioned mental health services were anxiety and affective disorders, comprising 70% of all diagnoses (Figure 52).[a]

The most common medication people within commissioned mental health services were receiving was antidepressants (Figure 53).

Figure 50. Suicide referral flag for episode of care | 2018–19 to 2020–21

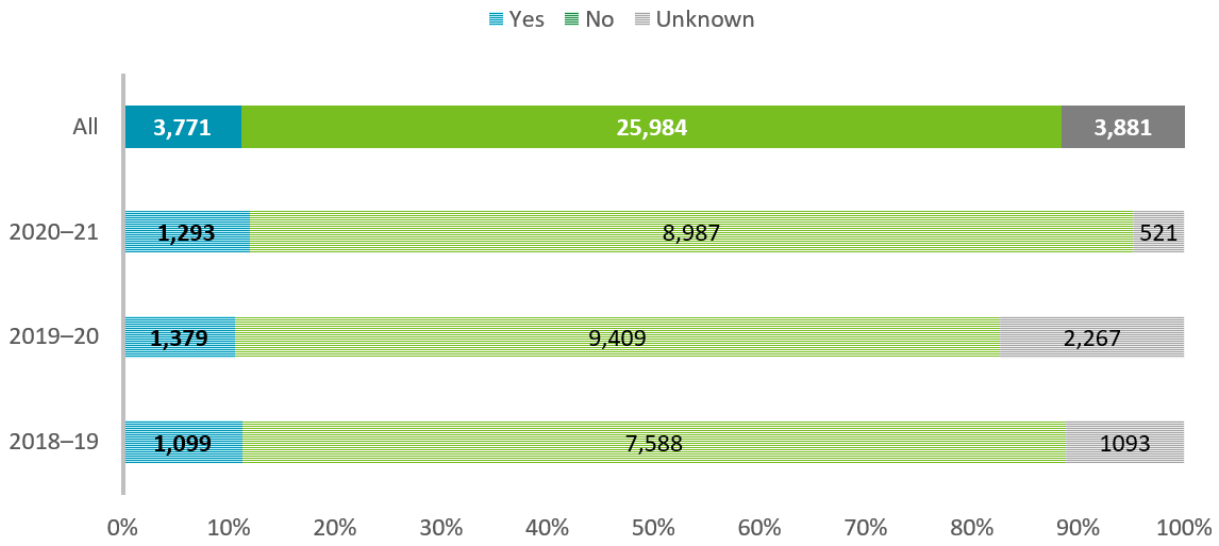
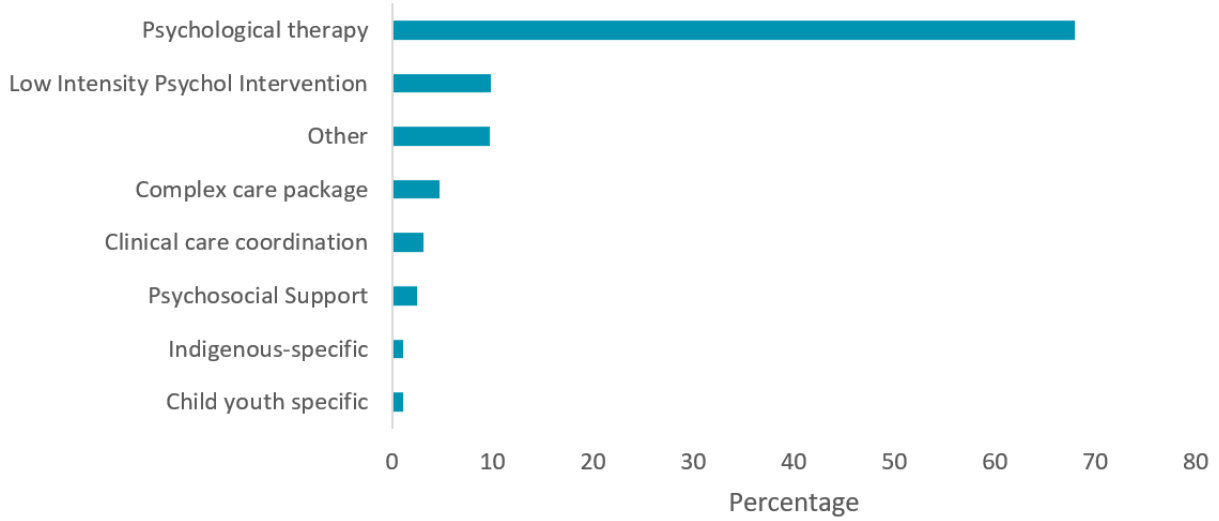


Figure 51. Distribution of principal focus of mental health episode of care | 2018–19 to 2020–21



[a] Anxiety disorders, Panic disorder, Agoraphobia, Social phobia, Generalised anxiety disorder, Obsessive-compulsive disorder, Post-traumatic stress disorder, Acute stress disorder, Other anxiety disorder, Affective (Mood) disorders (ATAPS), Major depressive disorder, Dysthymia, Depressive disorder NOS, Bipolar disorder, Cyclothymic disorder, Other affective disorder, Anxiety symptoms, Depressive symptoms, Mixed anxiety and depressive symptoms, Stress related.

Figure 52. Distribution of principal diagnosis of episode of care | 2018–19 to 2020–21

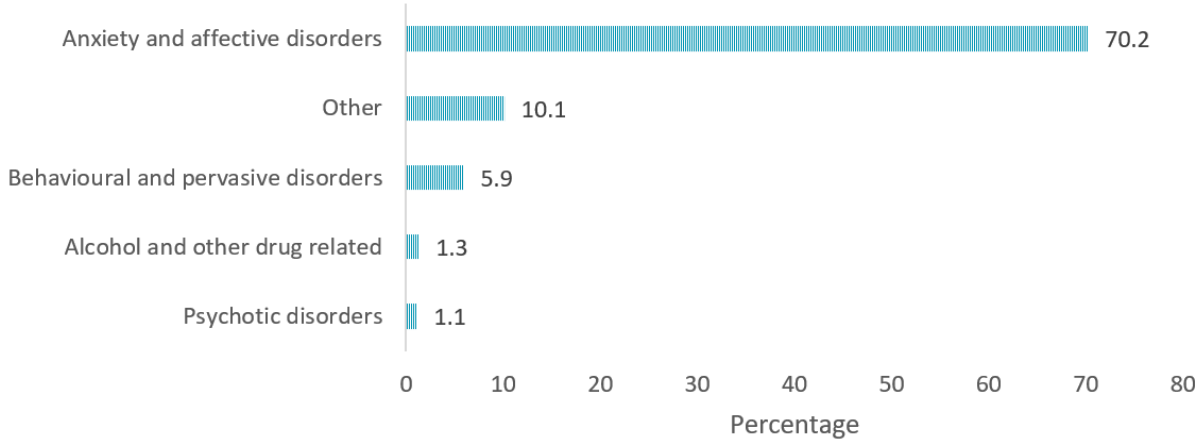
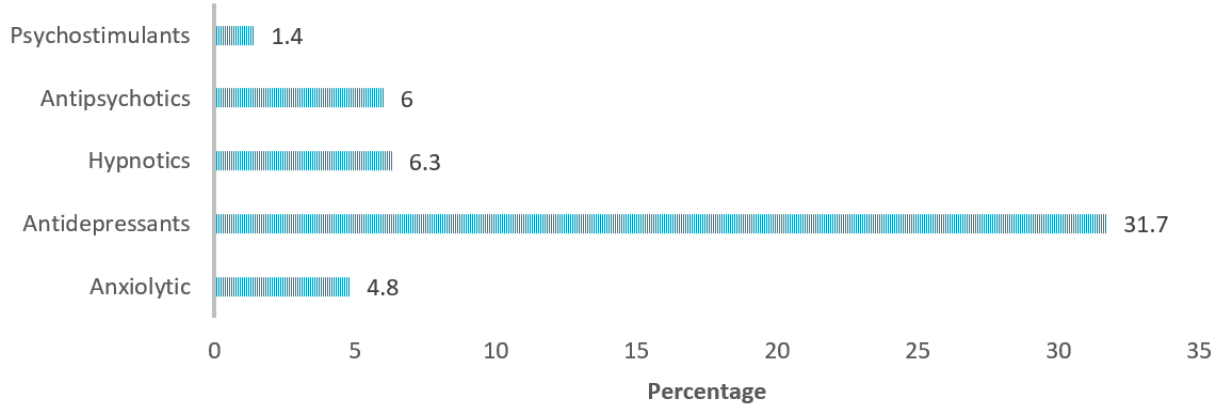


Figure 53. Distribution of mental health related medications | 2018–19 to 2020–21



Different types of service supports are provided by commissioned mental health service providers. Between 2018–19 and 2020–21 the most common type of service provided was structured psychological interventions (Table 23).

Table 23. Distribution of service contact type | 2018–19 to 2020–21

Contact type	%
No contact	6.7
Assessment	13.5
Structured psychological intervention	44.7
Other psychological intervention	8.6
Clinical care coordination	10
Clinical nursing services	3.6
Child or youth specific assistance	0.4
Suicide prevention specific assistance	2.2
Cultural specific assistance	0.1
Psychosocial support	10.2

NQPHN-commissioned mental health service providers have been successful in improving mental health outcomes for clients in whom measurements are reported. The Kessler 10 (K10) score, a measure of psychological distress, is used to measure distress at entry to mental health services and throughout treatment. For those patients in whom K10 scores were recorded, the mean K10 at baseline was 30.9 (severe psychological distress) and decreased to 27.5 (moderate psychological distress) over the course of treatment across all mental health services (Table 24). A limitation of the data is most clients accessing commissioned mental health services do not have baseline and follow-up measures of psychological distress recorded.

Table 24. Mean pre- and post-K10 scores (%) in NQPHN-commissioned mental health services | 2018–19 to 2020–21

	Pre-K10 (%)	Post-K10 (%)
Well (<20)	11.9	21.1
Mild (20-24)	12.2	17.7
Moderate (25-29)	16.9	19.5
Severe (>=30)	59.0	41.7

A Kessler 5 (K5) measure of psychological distress is often used in Aboriginal and Torres Strait Islander client groups. For those patients in whom K5 scores were recorded, the mean K5 at baseline was 14 (high psychological distress) and decreased to 11.7 (moderate psychological distress) over the course of treatment. Most clients experienced very high psychological distress at baseline. A significant reduction in the number of people experiencing very high psychological distress was observed (Table 25).

Some people who commence treatment with commissioned mental health services do not continue through to completion of their treatment episode.

Between 2018–19 and 2020–21, 57% of patients did not complete mental health treatment, 26% completed treatment and 16% were still receiving treatment at the time of analysis (August 2021).

Table 25. Mean pre- and post-K5 scores (%) in NQPHN-commissioned mental health services, Aboriginal and Torres Strait Islander client groups | 2018–19 to 2020–21

	Pre-K5 (%)	Post-K5 (%)
Low (5-7)	12.4	22.0
Moderate (8-11)	23.7	31.4
High (12-14)	16.0	19.6
Very high (>=15)	47.9	27.0

Stakeholder perspectives

COVID-19 is changing mental health disease burden and modes of service delivery

Clinicians and mental health service providers report that the primary and community mental health service system is undergoing significant changes. This is in part due to government responses to COVID-19.

Providers report that COVID-19 has increased the social and economic pressures facing many people in our community and demand for mental health services has increased.

The way mental health services are delivered is changing, with greater availability of telehealth services for mental health care.

- In March 2020, the Australian Government expanded Medicare-subsidised telehealth service to allow people to access health services from home or place of care and help limit the potential exposure of patients and health practitioners to the COVID-19 virus. This included new temporary MBS items for service providers to provide telehealth services, either by videoconference or by telephone, as a substitution for existing face-to-face MBS consultation services.
- The Australian Government subsequently announced additional funding for crisis lines (Lifeline, Beyond Blue and Kids Helpline), digital and online services, and support for health care professionals.
- The Australian Government funded Beyond Blue to create a dedicated Coronavirus Mental Wellbeing Support Service to provide free mental health support 24 hours a day, 7 days a week.
- The Queensland Government has also introduced a range of mental health support packages to better support the mental health and wellbeing of their residents. This includes provision for existing specialised mental health services to explore COVID-19 safe methods of service delivery and support for new and existing clients.

Workforce shortages limit access to mental health services

Although stakeholders are supportive of increasing service availability through telehealth, telephone, and online solutions, face-to-face services are still an essential component of mental health service delivery. Some government measures have been designed to improve access to face-to-face mental health services, but workforce shortages limit the ability of community members to take advantage of these, particularly in rural areas.

In August 2020, MBS-subsidised services under the Better Access initiative were expanded to provide 10 additions to the MBS-subsidised individual psychological therapy sessions for people in areas subject to lockdown restrictions. In the 2020–21 Federal Budget in October 2020, access was expanded to these 10 additional sessions to all Australians.

Primary care stakeholders report there has been limited uptake of this initiative due to a lack of mental health professionals to whom patients can be referred. In youth services, recruiting appropriately qualified mental health workers also remains a challenge. Providers also report access to specialist psychiatric services as challenging. Providers struggle to find suitably skilled and experienced staff to work in the youth mental health sector.

Staff turnover is reported as problematic in what is a very mobile workforce.

GPs provide most mental health services for people with mental health problems. Our region is experiencing ongoing shortages of GPs, particularly in rural areas.

There are gaps in our mental health service system

The setting where mental health care is delivered is important. Care is now delivered mainly in community settings, compared with the previous heavy reliance on hospitals. However, clinicians and consumers report there are still people who present to emergency departments and are treated in hospital that could be better cared for in the community.

Stakeholders report difficulty accessing mental health care and support in paediatric-friendly environments. Access outside the hospital environment is also difficult for older people with psychogeriatric care needs. People with mental health problems who reside in aged care or disability care settings often have difficulty accessing mental health services.

Mental health care outside usual business hours is generally limited to the hospital and to after hours general practice, where available. This is a problem for people in crisis who present to emergency departments for care during these periods. Limited options for mental health care during after hours and weekend periods are also a problem for people with mental health problems who are at work during normal working hours and for those with carer responsibilities.

People living in rural and remote areas report experiencing difficulties accessing mental health services. Internet connectivity in rural and remote areas can be limited and is a barrier in accessing online modality of mental health services. Service provision is heavily weighted towards the major population centres, where most of the population lives, but also where most of the specialist mental health workforce lives. This has implications for those living in regional areas who find it difficult to access local mental health support. This occurs due to transport disadvantage, long waiting lists, and large out-of-pocket expenses to see private psychiatrists.

Mental health services can be difficult to navigate

People accessing mental health services report difficulties navigating the mental health service system. It is unclear to patients and their families and caregivers which services they should access for specific mental health problems.

Mental health treatment and support needs to be provided in a continuous and coordinated manner by a range of service providers in and between a range of settings. According to stakeholders, communication and information sharing between different professionals and settings can be improved. When services are accessed, people report service providers do not always communicate and share relevant information with each other and contributes to gaps in continuity of mental health care.

People with severe mental health problems are increasingly accessing disability services through the National Disability Insurance Scheme (NDIS) to meet their care needs. People accessing NDIS services report limited information sharing and communication between disability and health providers, which contributes to gaps in coordination of care.

Mental health treatment and support needs to respect the consumer's social and cultural values, beliefs, practices, and stage of development. Stakeholders report a lack of availability of information to help people decide the most appropriate setting for them that will best meet their needs. Aboriginal and Torres Strait Islander people need mental health care and support that meets their cultural care needs and promotes social and emotional wellbeing.

Priority actions

Our needs assessment demonstrates mental health problems affect a large proportion of our community and that mental health illness burden is increasing. Responding to this large and growing illness burden is a priority for NQPHN.

NQPHN's objectives in the mental health priority area include to:

- increase access for North Queenslanders to access mental health services appropriate to their individual needs
- provide North Queenslander primary healthcare providers with an integrated approach to mental health care and suicide prevention
- commission quality mental health services to improve outcomes for patients.

Our priority actions align with our Strategic Plan. Elements of our approach to addressing mental health needs include:

- comprehensive assessment and referral to appropriate services for people with mental health problems
- building the capacity of primary care to respond to the needs of people with mental health problems
- collaborative, multidisciplinary approaches to the delivery of mental health care
- clear pathways between levels of mental health care as people's needs for care change, including streamlined pathways for re-entry to mental health services if required.

Mental Health

Implementing our mental health stepped-care model

NQPHN's priority is to continue to implement stepped care approaches in mental health that are responsive to consumer needs.

- Mental health stepped care is an evidence-based, staged system of care that includes a range of mental health interventions, from the least to most intensive. The level of intensity of care is matched to the complexity of the person's mental health needs. The model emphasises collaborative care, working with the patient, their general practitioner, care team and specialist mental health service providers when appropriate.
- NQPHN is working with stakeholders to implement adult mental health centres that provide comprehensive assessment of people's care needs, integrated delivery of mental health care and reduced fragmentation of mental health, alcohol and other drugs and physical health silos of care.
- The provision of psychological therapies and psychosocial support for people with severe and complex mental illness are key parts of our stepped care model. Our needs assessment shows delivery of mental health integrated complex care for people with severe and complex mental illness is an ongoing priority for NQPHN.
- Through the Connect to Wellbeing central intake and referral service, NQPHN is supporting people to access a single point of entry for a range of psychological services. GPs and other primary healthcare providers can refer all eligible individuals to stepped care services through the central intake service.
- NQPHN will continue to work to address gaps in mental health service delivery in community settings and into residential aged care settings. Commissioned psychological therapies that provide short-term free evidence-based mental health psychological services to individuals who have limited access to Medicare subsidised mental health service

Mental Health *(continued)*

is a priority for NQPHN. Our needs assessment demonstrates priority populations for psychological therapies include:

- children under the age of 12 years and young people aged 12–25 years
- people in rural and remote locations
- people who have self-harmed or attempted suicide or are at risk of suicide
- women experiencing perinatal depression or anxiety
- Aboriginal and Torres Strait Islander people
- people who are experiencing, or at risk of, homelessness.

Supporting the delivery of mental health and social and emotional wellbeing services for Aboriginal and Torres Strait Islander people is a priority for NQPHN. NQPHN funds Aboriginal Medical Services (AMs) and Aboriginal Community Controlled Organisations to provide these services in our community.

COVID-19 continues to affect the mental health and well-being of our population. Ensuring access to mental health support and addressing workforce gaps in the delivery of mental health care, including those contributed to by COVID-19, is a priority for NQPHN. Integrating Head to Health, the national digital gateway for mental health, into primary care service delivery will improve access to mental health resources and services, including providing COVID-19 support.

Supporting community-based suicide prevention

A key priority for NQPHN is to encourage and promote a regional approach to mental health and suicide prevention, including community-based activities, and liaison with local HHSs.

Development and implementation of Suicide Prevention Community Action Plans in each HHS district will provide a vital resource to the regions to support integrated delivery of suicide prevention activities in community and linking the continuum of care.

The Black Dog Institute's Lifespan model is being used as a framework for an evidence-based systems approach to integrated suicide prevention strategies, and to assist evaluation and alignment with the national Primary Health Network Suicide Prevention Program Guidelines.

Local Suicide Prevention Networks have been established and operate in the NQPHN region to guide development, implementation, and evaluation of these plans.

NQPHN and the four HHSs in the region are jointly working with stakeholders to develop the foundational NQPHN Mental Health, Alcohol, and Other Drugs and Suicide Prevention Regional Plan. The final plan will be released by mid-2022. The objectives of joint planning are:

- to embed integration of mental health and suicide prevention services and pathways for people with or at risk of mental illness or suicide through a whole of system approach
- joint regional plans should drive and inform evidence-based service development to address identified gaps and deliver on regional priorities.

Mental Health *(continued)*

In addition, NQPHN's stepped care model is inclusive of assessment and management of people with or at risk of suicide. Our service priorities include:

- suicide call-back services for around-the-clock telephone and online counselling to people affected by suicide
- supporting Operation Compass, a grass-roots community-wide campaign aimed at optimising wellbeing and reducing suicide in the ex-Australian Defence Forces community
- providing psychosocial support to people with severe and complex mental illness
- commissioning Way Back Support Services to provide support to individuals who have been admitted to hospital following a suicide attempt.

Improving mental health data quality

Most clients accessing commissioned mental health services do not have baseline and follow-up measures of mental health outcomes recorded. NQPHN will work with commissioned mental health providers to improve data quality.

Children less than 12 years of age have mental health problems. However, available data is limited to guide NQPHN's needs assessment of mental health service needs and priorities. NQPHN will work with stakeholders to assess mental health needs, service gaps and priorities for children under 12 years of age.

Improving access to mental health services for our young people

A priority for NQPHN is addressing the mental health needs of our young people.

- NQPHN will continue to commission Headspace services to provide early intervention and mental health services to 12- to 25-year-old people, along with assistance in promoting young peoples' wellbeing including their mental health, physical health, work, and study support and alcohol and other drug service needs.
- NQPHN commissions headspace services delivery in Cairns, Townsville, and Mackay. These services provide outreach to rural areas within our catchment. NQPHN will prioritise development of satellite services in Sarina and the Whitsundays to address the youth mental health disease burden identified in this needs assessment.
- Young people in the Torres and Cape HHS will be supported through the expansion of the Schools Up North program to upskill education providers regarding identification, support, and referral of young people with mental health problems.
- Young people with severe mental health problems are a priority. NQPHN commissions services for young people through trauma informed clinics based in headspace centres and augmented by psychological therapy services where GPs have indicated the young person can benefit from short-term psychological therapy support.

Alcohol and other drug treament

Overview

Alcohol and other drug use is a major cause of preventable disease, illness, and death in our community. Alcohol is the drug most used by people in our community and is associated with the largest burden of chronic disease and injury. It is also the most common drug for which people seek treatment. The consumption of alcohol is widespread within our population and entwined with many social and cultural activities.[134]

'Other drug use' or 'illicit drug use' (used interchangeably) can include:[135]

- illegal drugs – drugs that are prohibited from manufacture, sale, or possession in Australia, for example, cannabis and cocaine
- pharmaceuticals – drugs that are available from a pharmacy, over the counter, or by prescription, which may be subject to misuse; for example, opioid-based pain relief medications and over-the-counter codeine
- other psychoactive substances – legal or illegal, potentially used in a harmful way; for example, inhalants (such as petrol, paint or glue), kava, synthetic cannabis, and other synthetic drugs.

Health needs

Risky alcohol use is decreasing

Rates of alcohol use have decreased between 2007 and 2019 in Queensland and Australia, both for short-term risky drinking ('binge' drinking) and lifetime risky drinking. Queensland continues to have higher rates of short-term and lifetime risky drinking compared with the rest of Australia (Figure 54).[136]

The proportion of people who drink daily or weekly is decreasing over time, and the proportion who drink monthly or less is increasing over time (Figure 55).[137]

Figure 54. Risky drinking, people aged 14 years and over, Queensland and Australia | 2007–2017

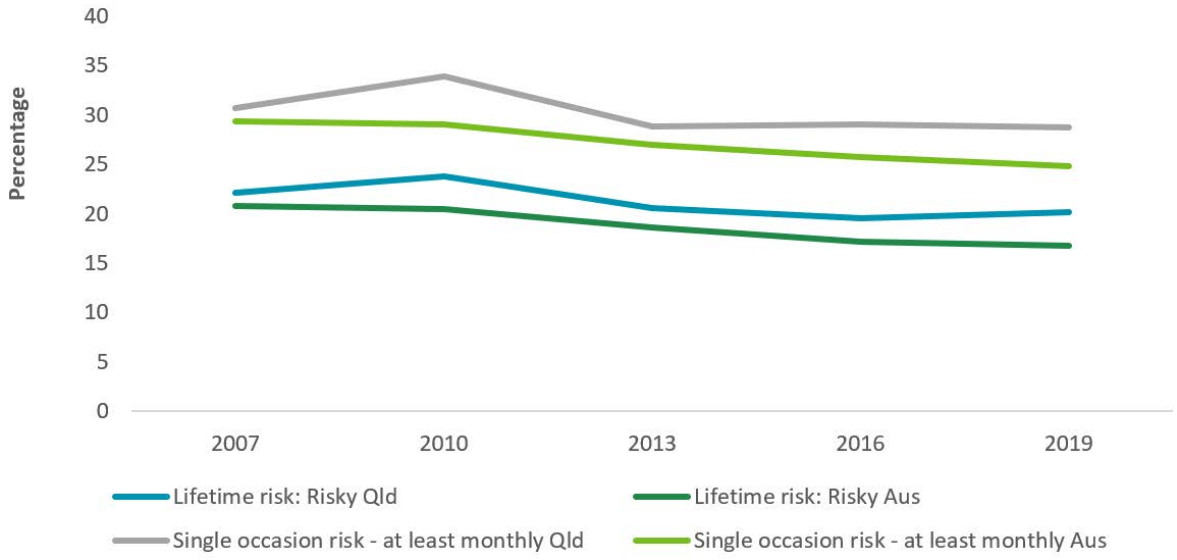
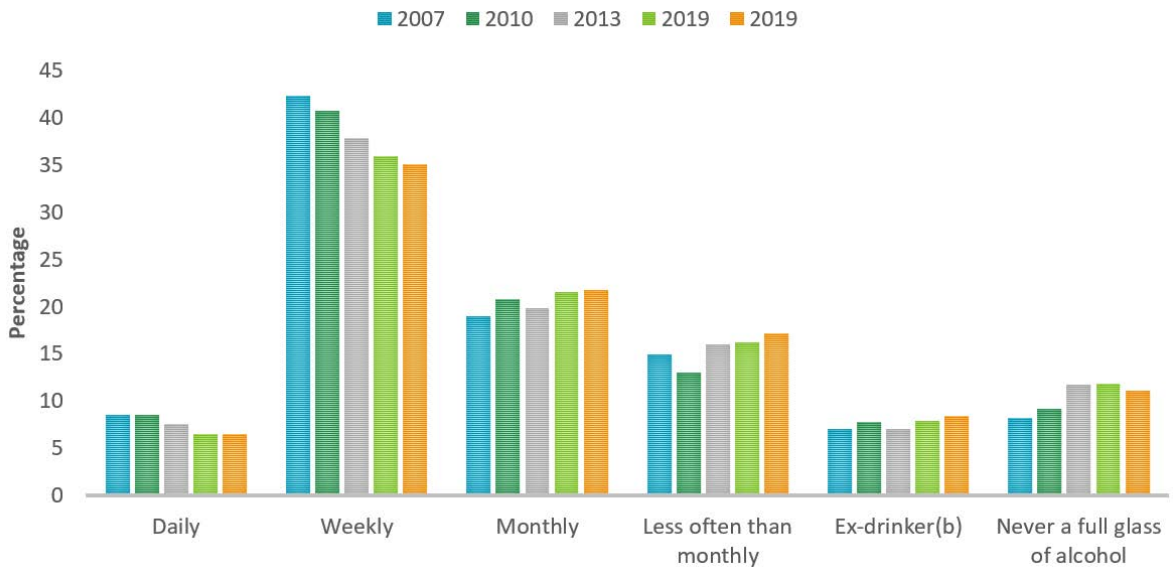


Figure 55. Alcohol drinking status, aged 14 years and over, Queensland | 2007–2019



Our rates of risky alcohol use are high

An estimated 26% of adults in the NQPHN catchment consume alcohol at levels contributing to lifetime risk of harm and 35% at levels contributing to single occasion risk. These are the second highest rates of all Queensland PHNs (Figure 56).[138]

Lifetime risky drinking and single occasion risky drinking rates are higher than Queensland rates in all four HHS regions in our catchment (Table 26).[139]

Figure 56. Crude proportion of alcohol consumption, persons aged 18 years and over, Queensland PHNs | 2020

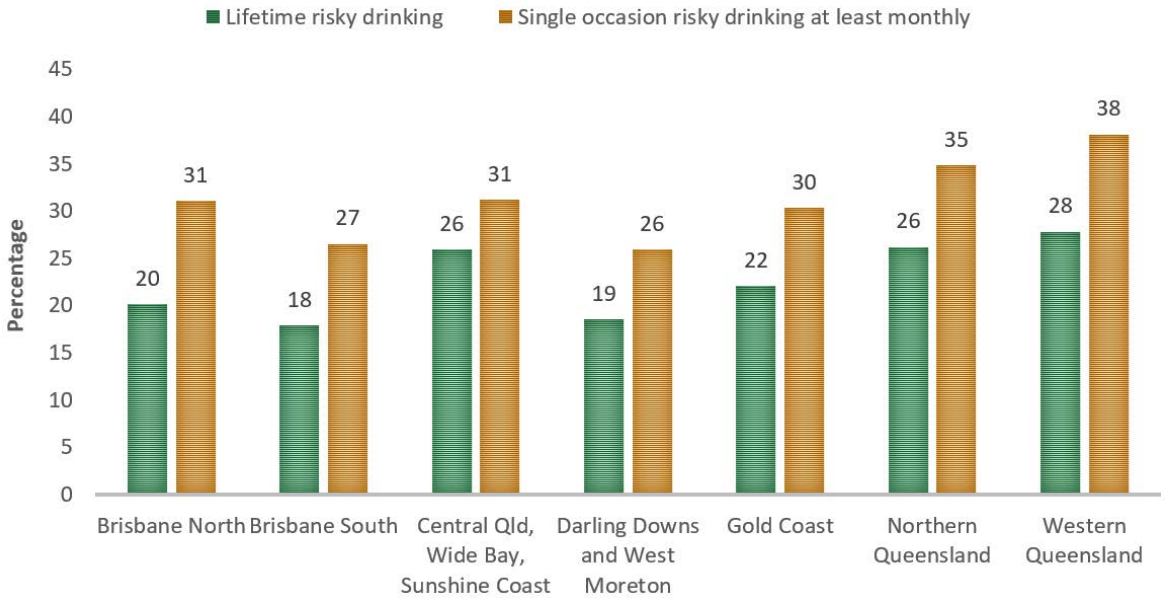


Table 26. Excess alcohol consumption for people 18+ years by HHS, NQPHN catchment | 2019–20

Region	% risky drinking	
	Lifetime	Single occasion at least monthly
Torres and Cape	28.3	54.9
Cairns and Hinterland	26.4	32.9
Townsville	25.4	32.9
Mackay	26.6	37.4
Queensland	21.6	30.0

Patterns of illicit drug use are changing

Nationally, more than 2 in 5 Australians have used an illicit drug in their lifetime. Rates of substance use are falling among younger generations nationally, with today's young people less likely to smoke, drink or use illicit drugs compared with 2001.[140]

Overall, illicit drug use increased between 2007 and 2019 in Queensland and Australia after a decline between 2001 and 2007. Rates of illicit drug use remained stable among Aboriginal and Torres Strait Islanders nationally but rose for non-Indigenous Australians.[141]

Patterns of drug use have varied between different drugs over time in Queensland. Cocaine use has increased since 2001 and methamphetamine use has decreased. Cannabis continues to be the most widely used illicit drug in our community (Figure 57).[142]

In 2019, an estimated 16.4% of people in the NQPHN had used illicit drugs over a 12-month period, a decrease from 17.7% in 2016 (Figure 58).[143]

Figure 57. Drug use in the previous 12 months, people aged 14 years and over, Queensland | 2001–2019

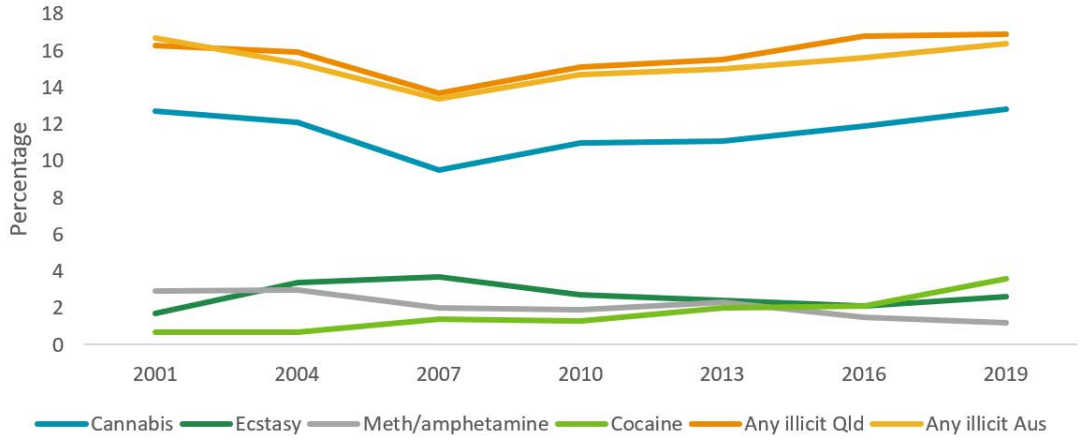
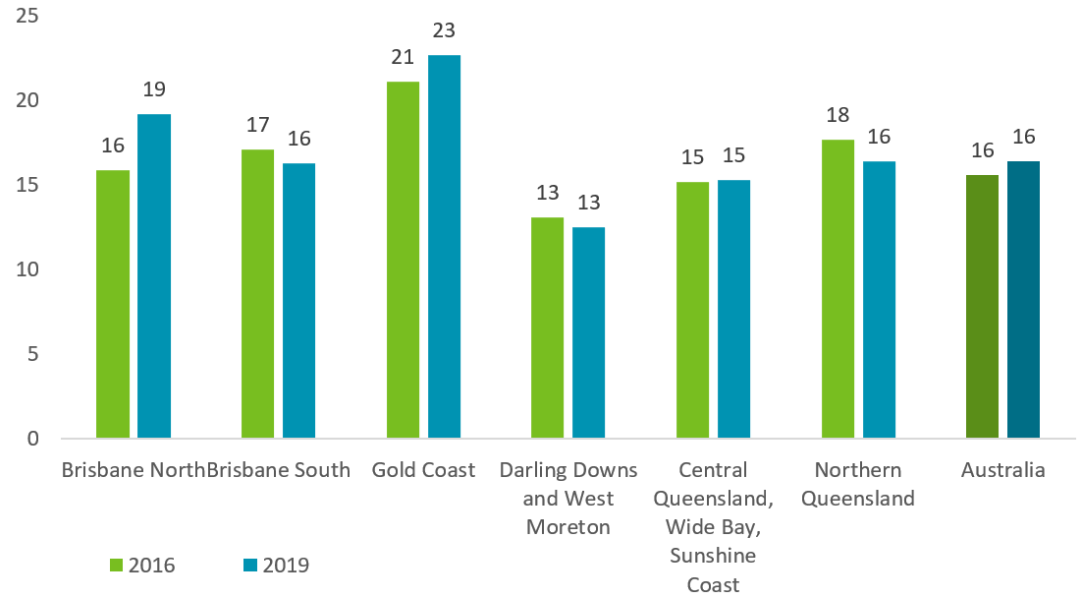


Figure 58. Illicit drug use, people aged 14 years and over, PHNs | 2016 and 2019



Alcohol and other drug harms

The harmful use of alcohol has both short-term and long-term health effects.[144]

- short-term effects are mainly related to potential injury suffered by the drinker and others who may be affected by the drinker's behaviour
- over the longer term, harmful drinking may result in alcohol dependence and other chronic conditions, such as high blood pressure, cardiovascular diseases, cirrhosis of the liver, types of dementia, mental health problems, and various cancers
- excessive drinking contributes to crime, violence, anti-social behaviours, and accidents
- alcohol use during pregnancy is associated with poorer perinatal outcomes, such as foetal alcohol syndrome and alcohol-related birth defects and developmental disorders.

Alcohol use is responsible for 5.1% of our total burden of disease and injury. It is estimated that 28% of road traffic injury burden (motor vehicle occupants), 24% of chronic liver disease burden, and 23% of the burden of suicide and self-inflicted injuries are due to alcohol use.[145]

Illicit drug use is associated with many risks of harm to the user and to their family and friends. It has both short-term and long-term health effects, which can be severe. These include poisoning, heart damage, mental illness, self-harm, suicide, and death. Illicit drug use also contributes to social and family disruptions, violence and crime, and community safety issues.[146]

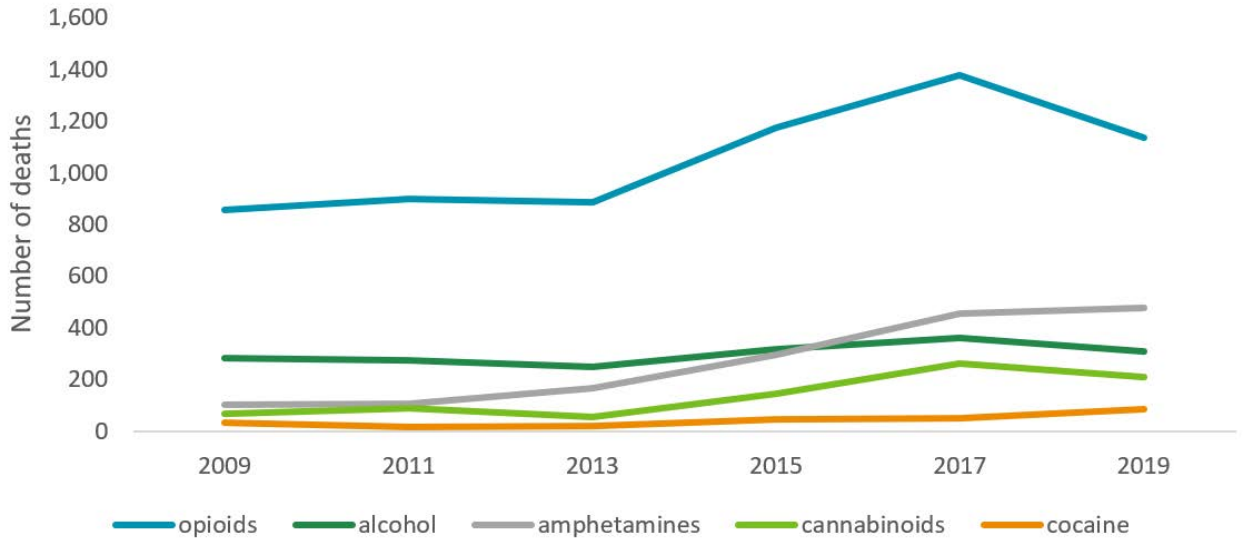
Illicit drug use is responsible for 1.8% of our total burden of disease and injury (including the impact of injecting drug use, and cocaine, opioid, amphetamine, and cannabis dependence).[147]

Alcohol and illicit drugs contribute to preventable deaths

The number of deaths due to alcohol and other drugs increased between 2009 and 2019. The highest number of deaths was opioid-related (Figure 59).[148]

The extent to which opioid-related harms are associated with prescription opioid misuse is unknown. Prescription opioids are used to treat persistent pain (both cancer and non-cancer related). Our HNA of chronic conditions identifies people with musculoskeletal conditions (back pain and osteoarthritis) comprise a large group of patients accessing general practice for chronic conditions management.

Figure 59. Drug-induced deaths by drug, Queensland | 2009–2019



Service needs

Hospitalisations for alcohol and other drug issues are increasing

In 2019–20, there were 28,884 hospitalisations for alcohol and other drugs problems across NQPHN HHS regions (Figure 60).

Although cannabis is the most widely used illicit drug, amphetamines account for the most hospitalisations. Hospitalisations for amphetamine use are continuing to increase over time (Figure 61).[149]

Figure 60. Hospital separations for alcohol and other drug problems, NQPHN HHSs | 2019–20

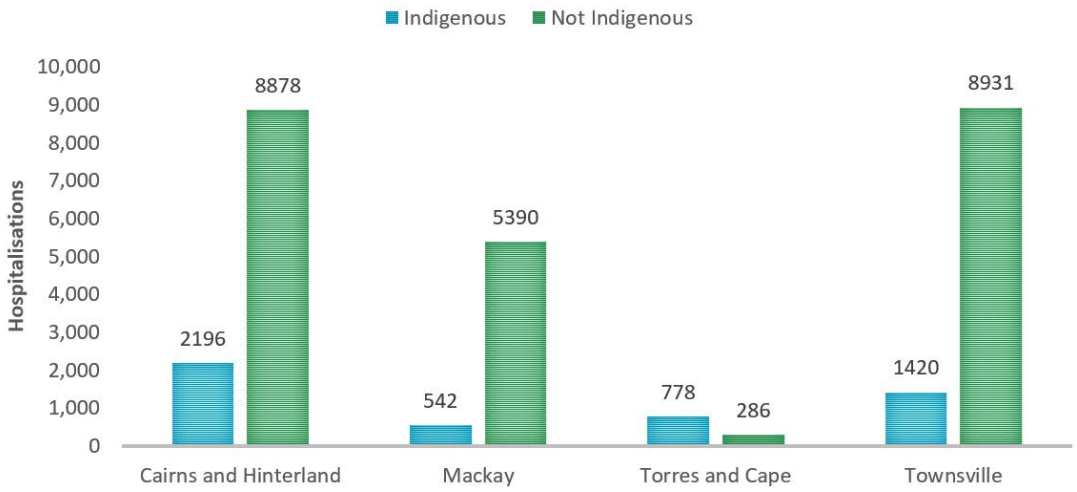
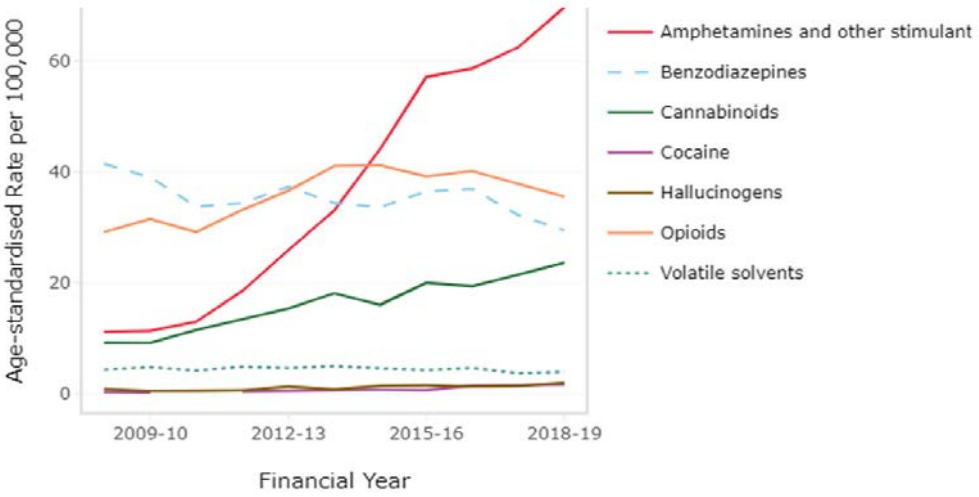


Figure 61. Age-standardised hospital separations for other drug use, Queensland, 2009–10 to 2018–19



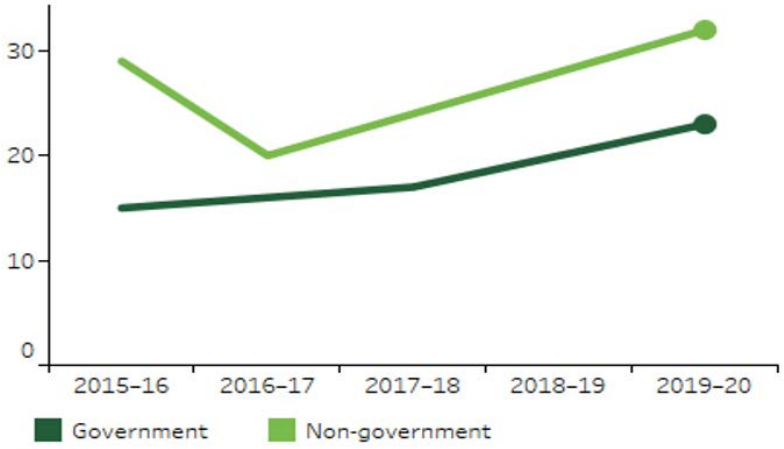
Specialist alcohol and other drug treatment services

NQPHN commissions locally based alcohol and other drug treatment services in line with community need. Services aim to improve access to, and effectiveness of, drug and alcohol treatment services in the community.

The main source of data about specialist drug and alcohol treatment services is the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). Commissioned providers collect data in accordance with the AODTS NMDS on specialist treatment services.

Between 2015-16 and 2019–20, the number of specialist alcohol and other drug treatment agencies in the NQPHN catchment increased (both government agencies and non-government agencies) (Figure 62).[150]

Figure 62. Number of agencies by sector, NQPHN catchment | 2015–16 to 2019–20



In 2019–20, 194 publicly funded alcohol and other drug treatment agencies in the NQPHN catchment provided 8,963 closed treatment episodes to 6,852 clients. Of these clients:

- 64% were male compared with 65% nationally.
- 30% identified as Indigenous compared with 17% nationally.
- 53% were aged between 20 and 39 years compared with 31% nationally.

The main treatment type provided was counselling. Counselling has increased as a proportion of treatment type over time (Figure 63).[151]

Most treatments were delivered in non-residential treatment facilities (62%), followed by outreach (26%), and residential treatment facilities (7%).

The principal drug of concern in the NQPHN catchment was alcohol. This has increased over time (Figure 64).[152]

Figure 63. Closed episodes by main treatment type (%), 2019–20; and yearly trend, 2015–16 to 2019–20

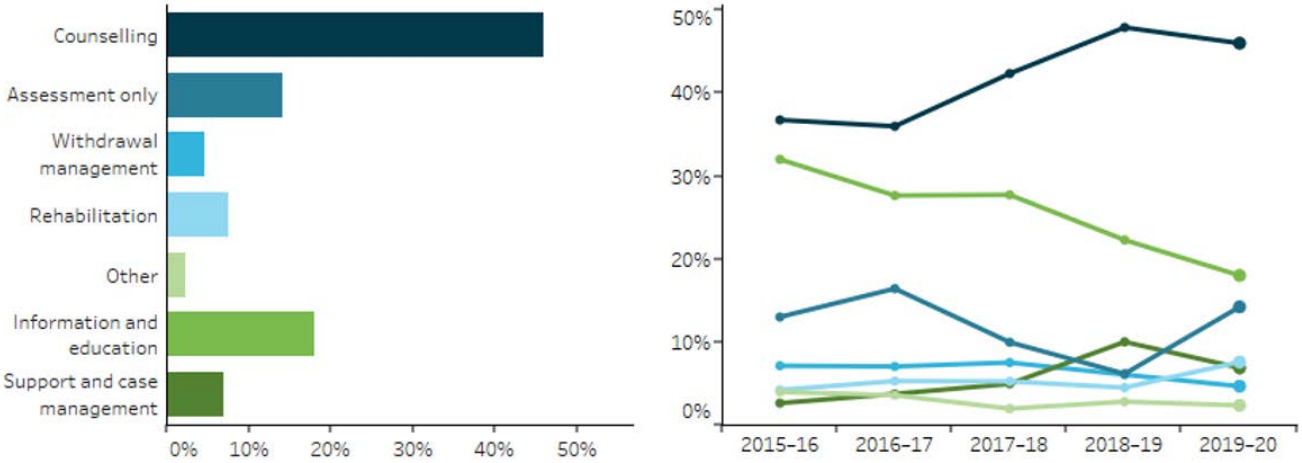
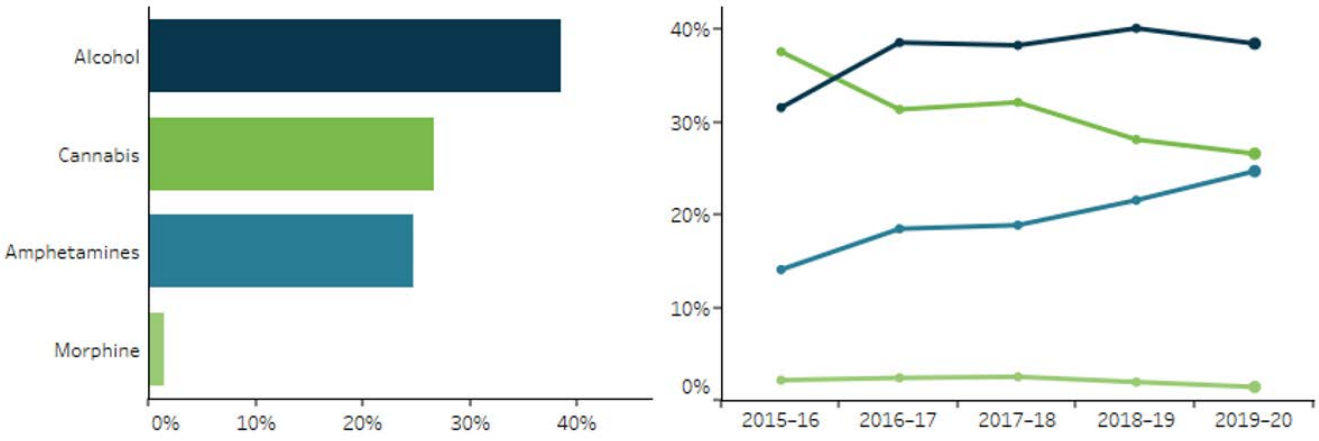
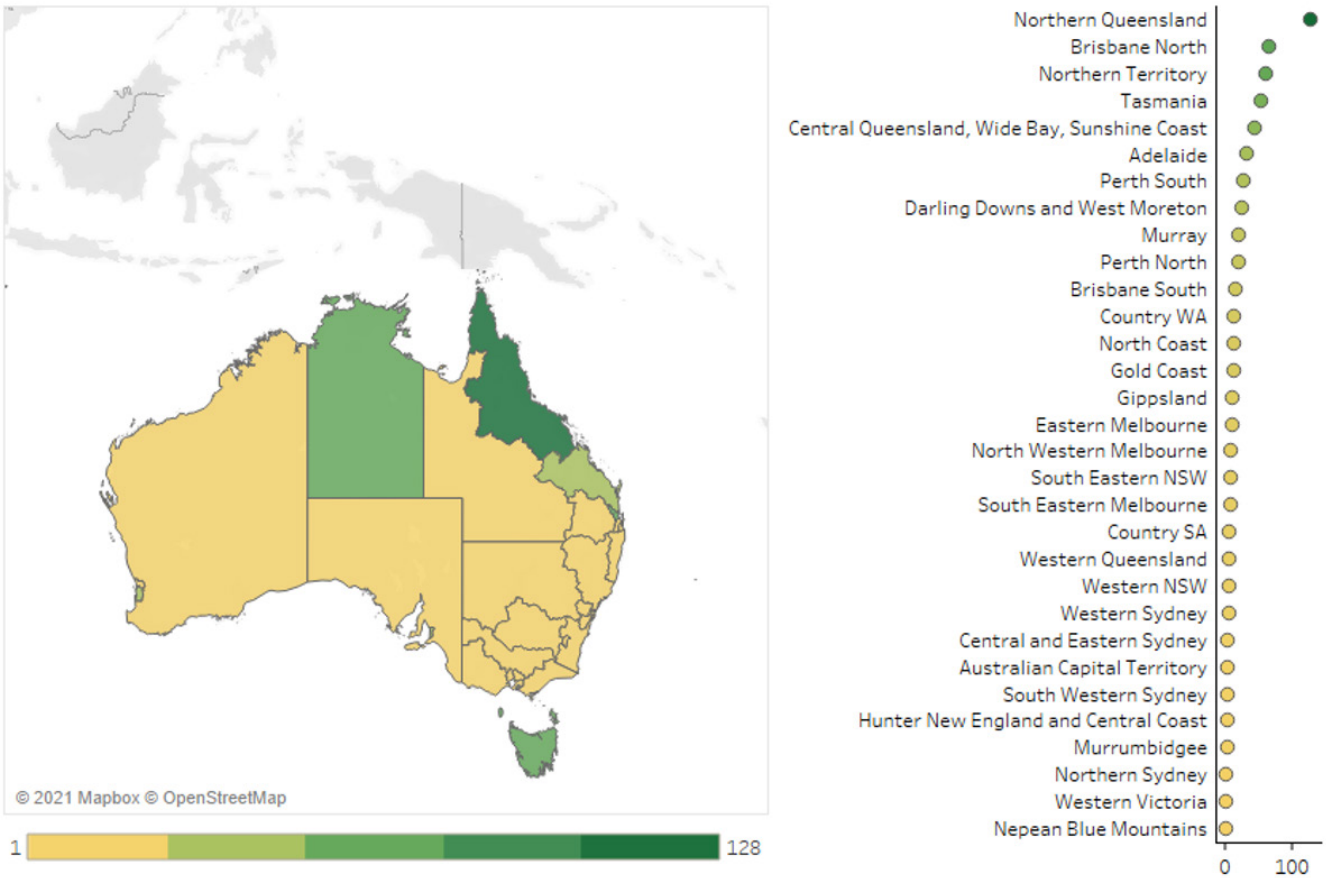


Figure 64. Most common principal drugs of concern (%), 2019–20; and trend, 2015–16 to 2019–20



Across 31 PHNs nationally, NQPHN recorded the highest number of closed treatment episodes for clients whose principal drug of concern was morphine (Figure 65) and the third highest for cannabis and MDMA (Ecstasy).[153]

Figure 65. Closed treatment episodes by PHN area, morphine | 2019–20



Stakeholder perspectives

Many people with alcohol and other drugs problems have other social and health problems including homelessness, mental health issues, chronic disease, and involvement with the justice system.

People with alcohol and other drugs problems need better access to primary care

Consultation with primary care stakeholder groups (including general practice, community allied health, and ACCHOs) indicates the most common substance use disorders that they manage relate to alcohol use.

Stakeholders report alcohol misuse can affect anyone in our community. However, people who experience trauma and neglect, mental health problems, poor living conditions, or who are socially isolated are at increased risk. In turn, alcohol misuse increases the risk of homelessness, mental ill-health, or involvement with the justice system. According to stakeholders, primary health care for people with alcohol misuse problems therefore needs to be holistic and simultaneously address mental, physical, and social care needs.

Managing alcohol misuse is within the scope of the primary care system to address for most people experiencing alcohol misuse problems. Alcohol and other drugs workers, GPs, ACCHOs, and primary care providers can give management if supported to do so.

There are barriers to accessing alcohol and other drugs services

Stakeholders report low availability of alcohol and other drugs counsellors to support other primary care providers in the management of alcohol misuse issues.

People with alcohol and other drugs problems present to emergency departments with intoxication, trauma, mental health crisis, and self-harm. Linkages between emergency departments and alcohol and other drugs primary care service providers could be improved to ensure continuity of care for people experiencing alcohol misuse problems.

People who use alcohol and other drugs have a right to respect and dignity, and a right to access services if they feel their use is becoming problematic. Stakeholders report people with alcohol and other drugs problems experience stigma and discrimination, which creates barriers to accessing primary care. Stakeholders report primary care services need to identify and address any barriers to care that involve issues of stigma and discrimination. Consistent client and consumer-friendly information on how to identify and access appropriate services could help people to better access care to meet their needs.

Complexity of care with other drug-related problems

Managing complex drug issues, particularly methamphetamine use, requires a coordinated approach to service delivery between specialist alcohol and other drugs services and primary care providers.

Referral pathways into counselling and specialist alcohol and other drugs services are important to facilitate management of patients with complex care needs. Stakeholders identified a need for improved service coordination between primary care and specialist alcohol and other drugs services.

Wait times for accessing specialist support are often prolonged. Stakeholders advocate for improved triage and assessment to expedite intake of patients with time critical alcohol and other drugs issues.

People with complex alcohol and other drugs needs often also have complex mental health comorbidities. Stakeholders report mental health and alcohol and other drug service integration could be improved.

Stakeholders also described:

- long wait-times and sometimes restrictive criteria to access services, particularly withdrawal management and residential rehabilitation services
- lengthy distances to travel to services, particularly for consumers from rural areas, as well as travel required between different services
- a lack of integration and communication between different services, including perceived lack of communication between government and non-government services.

Some providers are seeing increased or changing service needs with COVID

In response to the COVID-19 pandemic, a range of public health measures have been periodically in place, including the order that all non-essential services close temporarily. This included licensed liquor outlets such as pubs and clubs, excluding bottle shops attached to these venues. These measures could have led to changes in access to and consumption of alcohol, and access to and use of illicit drugs.

Stakeholders report they have not observed clear patterns of the effects of COVID-19 restrictions on alcohol and other drug consumption, with many stakeholders reporting unchanged levels of consumption and use. Some stakeholders report people may have initially increased or decreased alcohol and other drug use, but then reverted to their usual patterns.

The Australian Government announced in April 2020 that an additional $6 million would be allocated to online and phone support services for people experiencing drug and alcohol problems[154]. Primary care stakeholders report these services may not have led to increased access to care for alcohol and other drugs services in the NQPHN catchment as, in their experience, people prefer face-to-face care for issues related to alcohol and other drugs.

Priority actions

NQPHN's Strategic Plan identifies alcohol and other drugs as a priority area for action. Through strengthening community-based systems of care for people with alcohol and other drugs problems, we will reduce avoidable hospital admissions due to alcohol and other drugs.

Alcohol and other drug (AOD) treatment

Build the capacity of the AOD treatment sector

NQPHN's priority is to increase the availability of alcohol and other drug information and treatment services in our community. We are achieving this through our commissioning activities.

- We are working with stakeholders to improve access to alcohol and other drugs services through supporting workforce development and addressing workforce gaps, with a focus on rural areas and Aboriginal and Torres Strait Islander communities.
- We will continue to work with primary care, social, and community services to increase the availability of community alcohol and other drugs services that holistically address people's care needs. Our mental health and chronic conditions commissioning activities are improving the identification of comorbidities in people with alcohol and other drugs services and strengthening holistic assessment and planning to address care needs.
- There are service gaps in community residential rehabilitation services. Our commissioning is addressing gaps in availability of residential support, with a focus on delivering culturally tailored care for Aboriginal and Torres Strait Islander people.
- Most alcohol-related treatments and many treatments for other drugs can be delivered in the community by our primary care workforce. NQPHN is working to build the capability of the primary care workforce to respond to alcohol and other drug issues.
- We are working to ensure evidence-based, safe treatment is promoted throughout the AOD sector. Our HealthPathways program provides evidence-based support to GPs.
- Our Practice Incentives Program – Quality Improvement (PIP QI) will continue to work with general practice to identify patients in whom comprehensive assessment and management of alcohol and other drugs issues is indicated.

Alcohol and other drug (AOD) treatment *(continued)*

Improve data collection and transfer between services

Collecting high-quality data allows us to monitor and understand client outcomes in our catchment. A priority for NQPHN is to improve our evidence base to better coordinate and integrate services and improve client outcomes. To achieve this, we will address data gaps in commissioned services through better coordination, collaboration, and communication between the components of the current service system.

Currently, data on drug and alcohol use and client treatment and outcomes are collected in a range of different ways. A coordinated approach to data collection will enable transfer of consistent, complete information between services and improve the quality of treatment provided to clients.

Government-funded organisations are required to provide data to the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). However, the current minimum data set is focused on episodes of care and does not provide sufficient information about client outcomes.

System Integration

Better integration of specialist alcohol and other drugs services with primary care services

NQPHN's priority is to improve integration of alcohol and other drugs service delivery across the continuum of care from primary care through to specialist alcohol and other drugs services.

People's care needs sometimes require the input of specialist alcohol and other drugs services. Where this is the case, NQPHN is working to streamline processes of electronic communication, referral, and sharing of health information.

Electronic communication and information-sharing facilitates better triage and integration of services. NQPHN will continue to work with commissioned providers who care for people with alcohol and other drug treatment needs to increase the uptake of electronic health record adoption, eReferral, and other digital technologies.

Aboriginal and Torres Strait Islander Health

Our Aboriginal and Torres Strait Islander population

Aboriginal and Torres Strait Islander peoples comprise 11.7% of the NQPHN catchment population. NQPHN has the largest Aboriginal and Torres Strait Islander population of all PHNs in Queensland (Figure 66).[155]

Overall, 66% of Aboriginal and Torres Strait Islander peoples in the NQPHN catchment live in outer regional areas (Figure 67).[156]

Most Aboriginal and Torres Strait Islander peoples in our community live in the Far North Queensland region.[157]

Within Far North Queensland, the SA2 regions with the largest Aboriginal and Torres Strait Islander population are the Torres Strait Islands (4,833 people), Cape York (4,705 people) and Torres (2,947 people).[158]

Levels of social and economic disadvantage are very high in the Torres and Cape HHS region. An estimated 85% of the population are in the lowest income quintile, compared with 15% to 23% in the rest of the NQPHN catchment and 20% nationally.[159]

Figure 66. Estimated resident population, Aboriginal and Torres Strait Islander peoples, Queensland PHNs | 2019

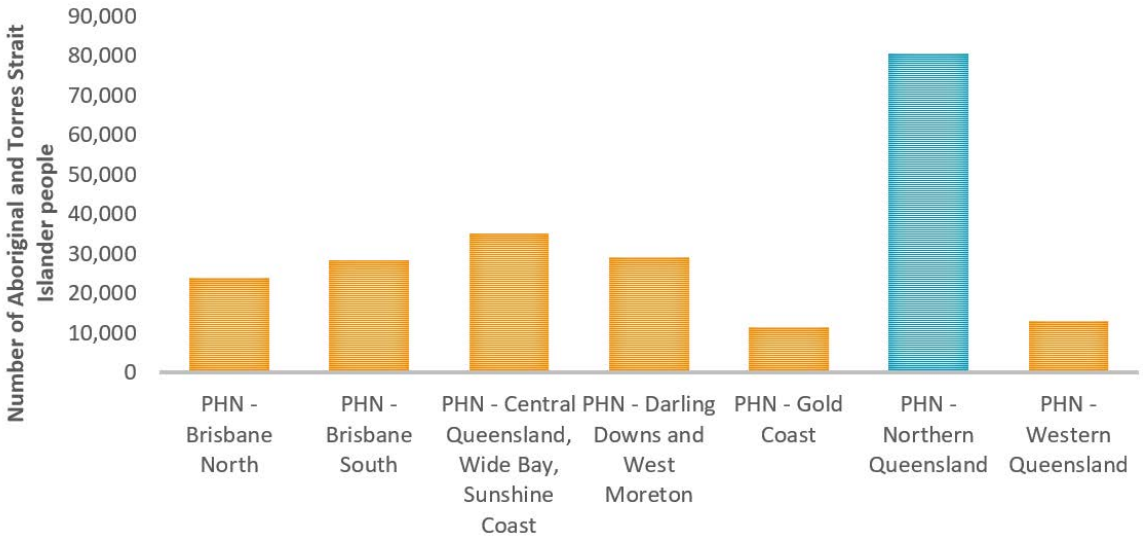


Figure 67. Top 5 SA3s by Aboriginal and Torres Strait Islander population, NQPHN | 2019

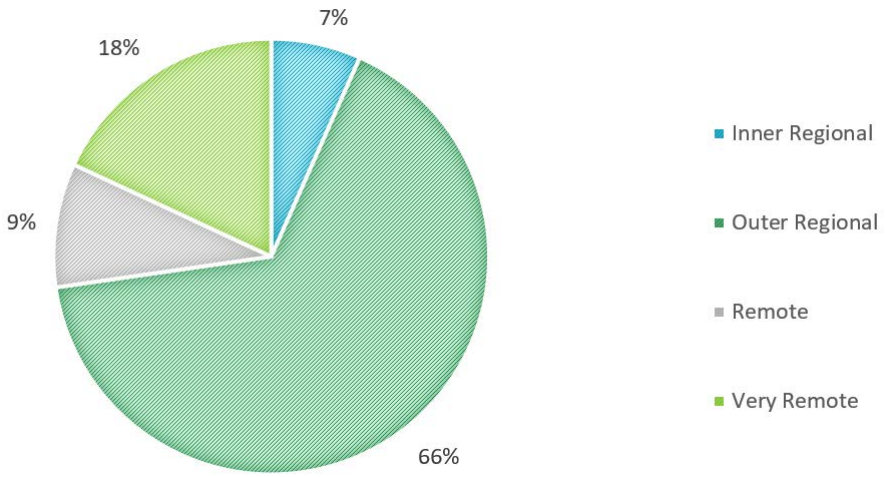


Table 27. Top 10 SA3s by Aboriginal and Torres Strait Islander population, NQPHN | 2019

SA3 Name	Aboriginal and Torres Strait Islander Population
Far North	20,475
Townsville	16,503
Cairns – South	14,156
Mackay	7,366
Innisfail – Cassowary Coast	6,723
Charters Towers – Ayr – Ingham	5,654
Tablelands (East) – Kuranda	4,310
Cairns – North	2,680
Bowen Basin – North	2,427
Port Douglas – Daintree	1,076

Within Far North Queensland, the SA2 regions with the largest Aboriginal and Torres Strait Islander population are the Torres Strait Islands (4,833 people), Cape York (4,705 people), and Torres (2,947 people).[160]

Levels of social and economic disadvantage are very high in the Torres and Cape HHS region. An estimated 85% of the population are in the lowest income quintile, compared with 15% to 23% in the rest of the NQPHN catchment and 20% nationally.[161]

Our Aboriginal and Torres Strait Islander population has a younger age structure

The age structure of our Aboriginal and Torres Strait Islander population is significantly different to the non-Indigenous population. The Aboriginal and Torres Strait Islander population on 30 June 2016 had a younger age structure than the non-Indigenous population, with larger proportions of young people and smaller proportions of older people (Figure 68, Figure 69).[162] This is reflective of higher fertility rates as well as higher mortality rates than the non-Indigenous population.[163]

Figure 68. Population pyramid, Queensland non-metropolitan, Indigenous distribution | 2016

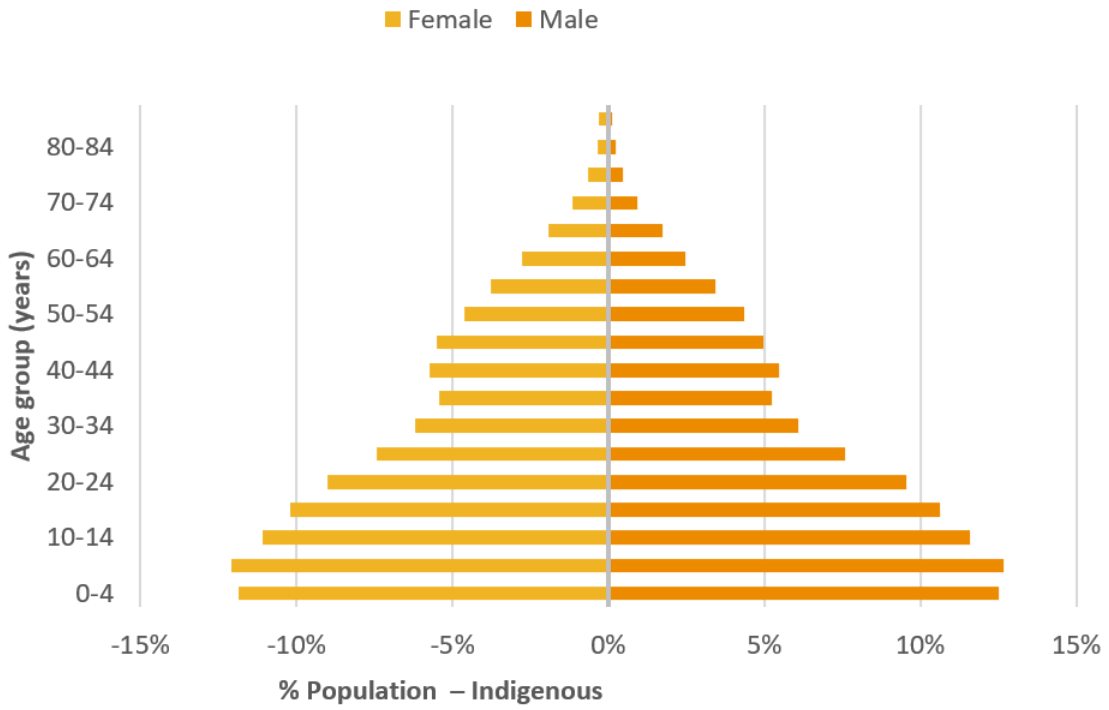
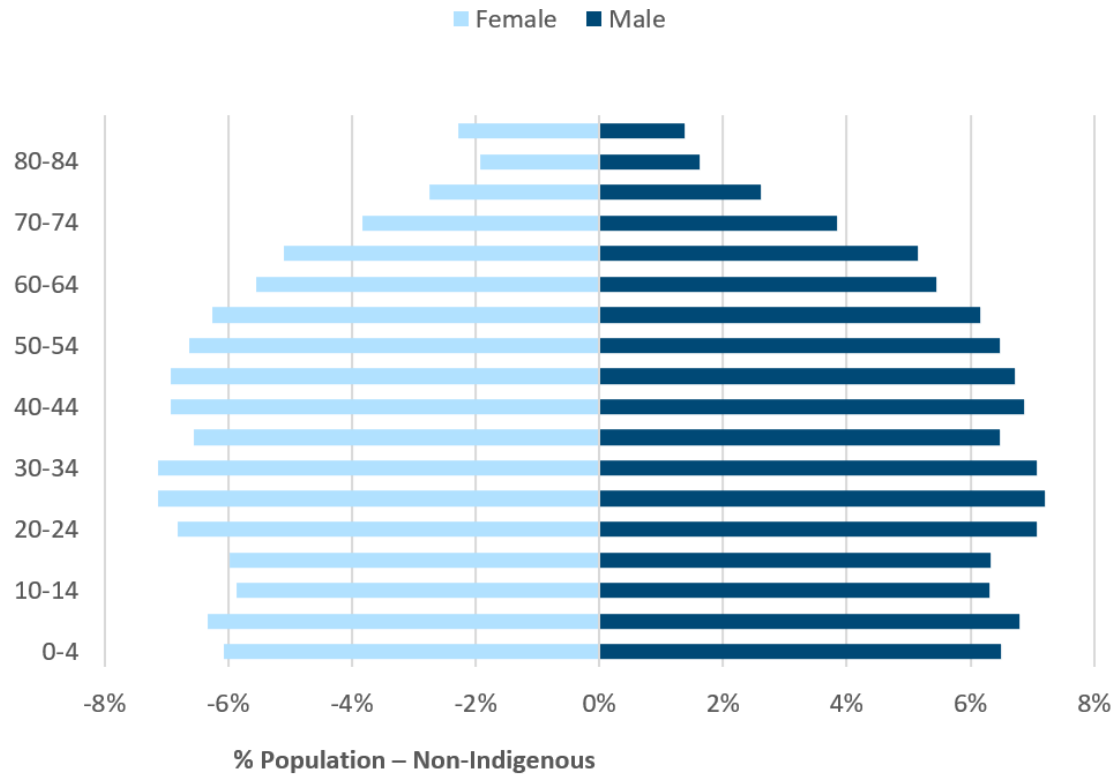


Figure 69. Population pyramid, Queensland non-metropolitan, non-Indigenous distribution | 2016



Health needs

The health status of populations is assessed using a wide range of indicators – qualities or features of the population we can use to describe health. Aboriginal and Torres Strait Islander peoples define health differently to non-Indigenous populations. For Aboriginal and Torres Strait Islander peoples, health is a broader concept that refers to social, emotional, and cultural wellbeing of the whole community. Each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.[164]

Our needs assessment provides information about a range of commonly used indicators of our Aboriginal and Torres Strait Islander population's broad health status. We recognise this is not the whole story.

We need to improve maternal and child health outcomes

Infant mortality (deaths under one year of age) is an important measure of the general health of the population and reflects maternal health service delivery. Poorer access to maternal health services is associated with higher rates of pre-term birth and low birthweight.[165]

Infant mortality rates in Aboriginal and Torres Strait Islander peoples are nearly twice the rate of non-Indigenous people in our catchment (5.8 versus 3.2 deaths per 1,000 live births).[166]

Aboriginal and Torres Strait Islander women have lower access to antenatal care and higher rates of pre-term birth and low birthweight babies in Queensland.[167]

- 65% of Aboriginal and Torres Strait Islander mothers have eight or more antenatal visits during pregnancy compared with 80% of non-Indigenous mothers.
- 13.7% of Aboriginal and Torres Strait Islander births are preterm compared with 8.7% of non-Indigenous births.
- 12% of Aboriginal and Torres Strait Islander births are low birthweight (<2,500grams) compared with 7% of non-Indigenous births.

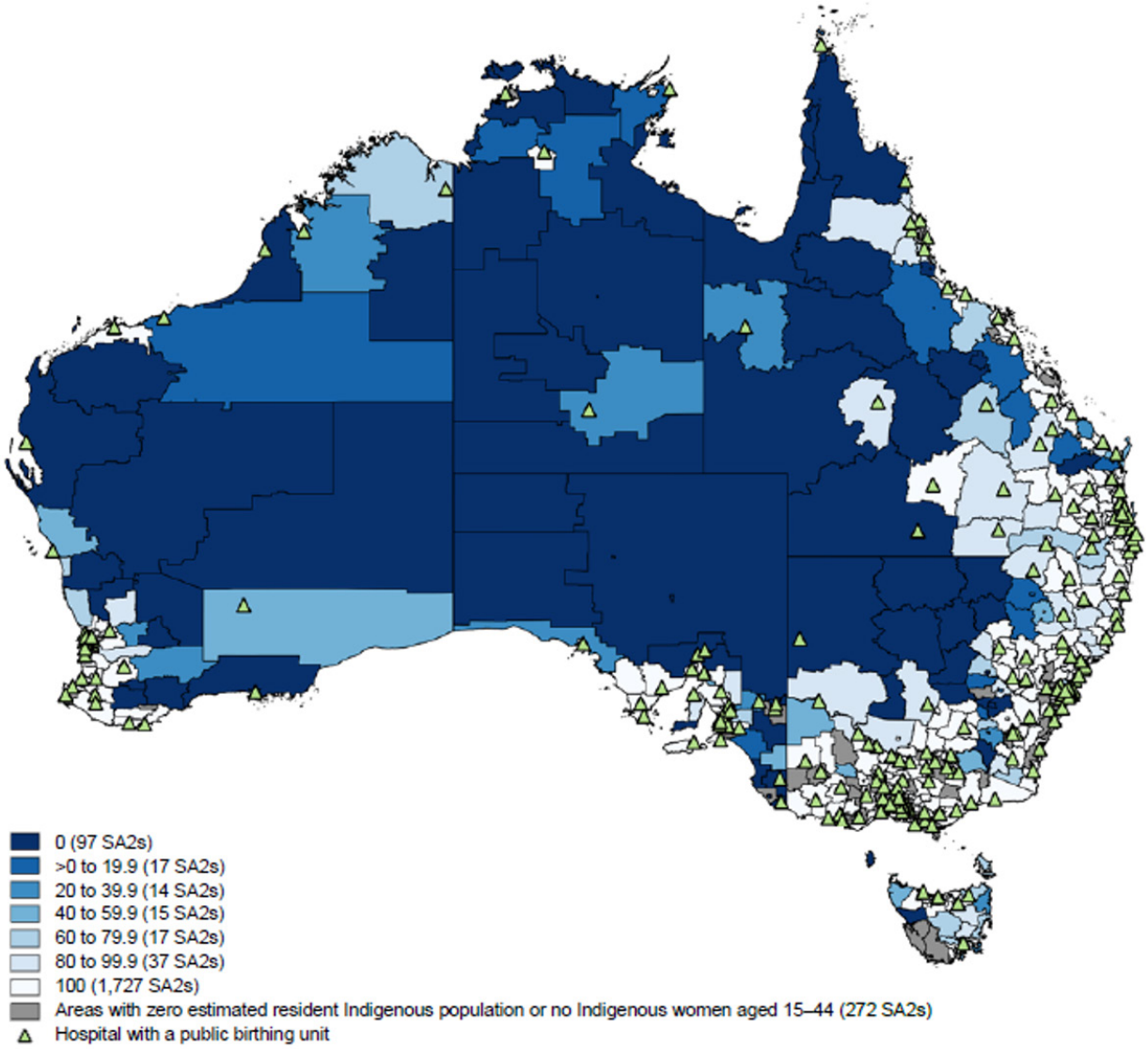
The national Closing the Gap target for child mortality is to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five within a decade (by 2018). Child mortality rates improved by 7% between 2008 and 2018. Non-Indigenous child mortality rates also improved between 2008 and 2018, and at a faster rate than for Aboriginal and Torres Strait Islander children. As a result, the gap between Indigenous and non-Indigenous child mortality rates has widened.[168]

Primary and maternity care is less accessible

Many of the factors that contribute to child mortality are within the scope of primary healthcare to manage. Maternal health (such as hypertension, obesity, and diabetes) and risk factors during pregnancy (such as smoking and alcohol use) are key drivers of birth outcomes and deaths. Access to high-quality primary and maternity care can improve the chances of having a healthy baby.[169]

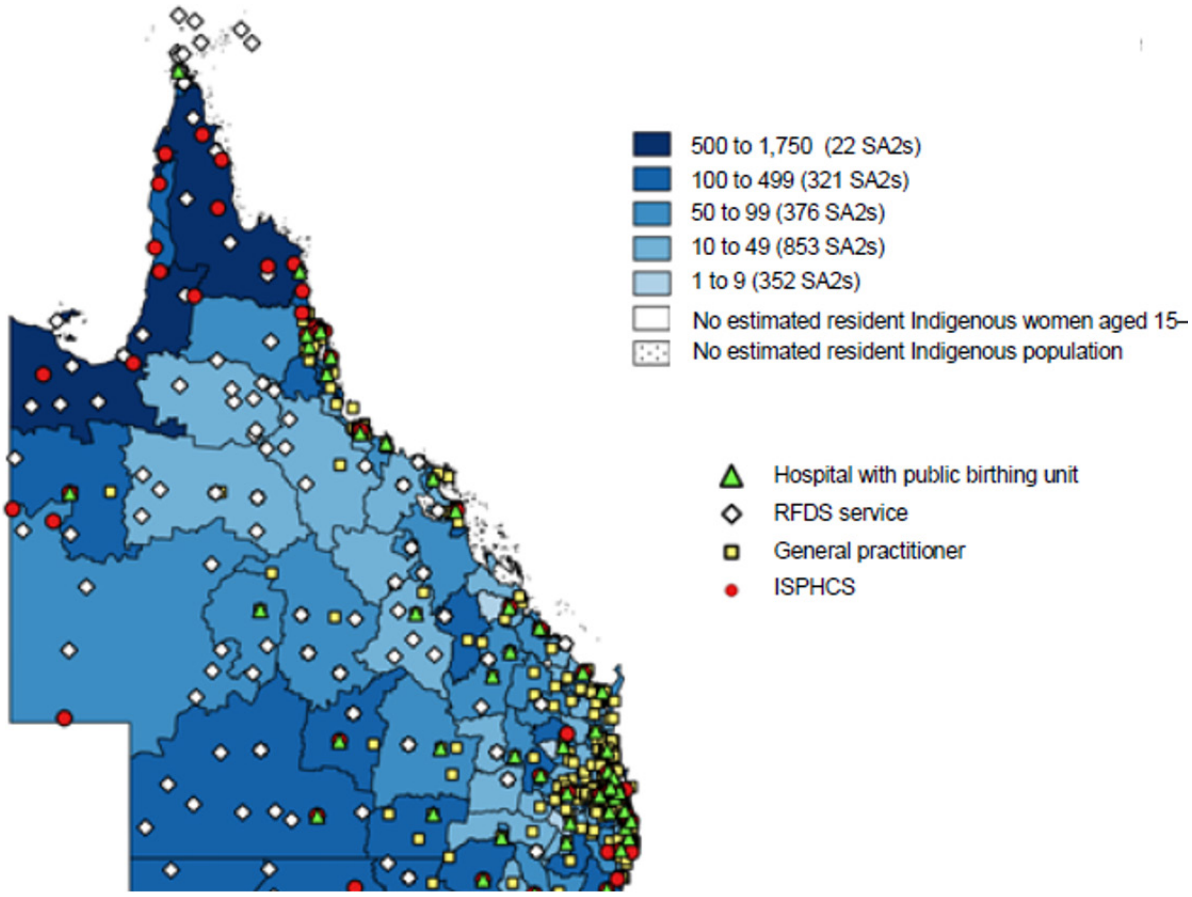
Many Aboriginal and Torres Strait Islander women in our catchment do not live within a one-hour drive of a hospital with a public birthing unit, nor do they have continuous access to primary care (Figure 70).[170]

Figure 70. Percentage of Aboriginal and Torres Strait Islander women of child-bearing age living within a one-hour drive of a hospital with a public birthing unit



There are 11 models of maternity care available to pregnant women nationally. Many Aboriginal and Torres Strait Islander women in our catchment have access to only one type of service. Further, these services may be visiting services to local communities, which means women may have access to no maternity care between visits (Figure 71).

Figure 71. Locations of maternal health services and number of Aboriginal and Torres Strait Islander women of child-bearing age



RFDS=Royal Flying Doctor Service. ISPHCS=Indigenous-specific primary health-care service

Aboriginal and Torres Strait Islander peoples have a lower life expectancy than non-Indigenous Australians, but this is improving

Life expectancy reflects the rates of mortality at different ages within a population. In 2015–17, Aboriginal and Torres Strait Islander life expectancy in Queensland was 72 years for males and 76.4 years for females.

Although life expectancy is improving, non-Indigenous life expectancy is also improving over time. As a result, the gap between Aboriginal and Torres Strait Islander and non-Indigenous life expectancy has not narrowed and the target to close the life expectancy gap by 2031 is not on track in Queensland or nationally.[171]

Mortality gaps are different across age groups

There is a gap in mortality rates between Aboriginal and Torres Strait Islander and non-Indigenous Australians in all age groups (except people already aged 85+ years). For males, the largest differences were in the 40- to 44-year and 45- to 49-year age groups, where mortality rates for Aboriginal and Torres Strait Islander males were around 4 times higher than rates for non-Indigenous males. For females, the largest differences were in the 30- to 34-year and 35- to 39-year age groups, where mortality rates for Aboriginal and Torres Strait Islander females were more than four times higher than rates for non-Indigenous females (Figure 72).[172]

Life expectancy is an overarching target which is dependent not only on healthcare, but also on the social determinants (such as education, employment status, housing and income). Social determinants are estimated to be responsible for at least 34% of the health gap between Aboriginal and Torres Strait Islander and non Indigenous Australians. Behavioural risk factors, such as smoking, obesity, alcohol use, and diet account for around 19% of the gap.[173]

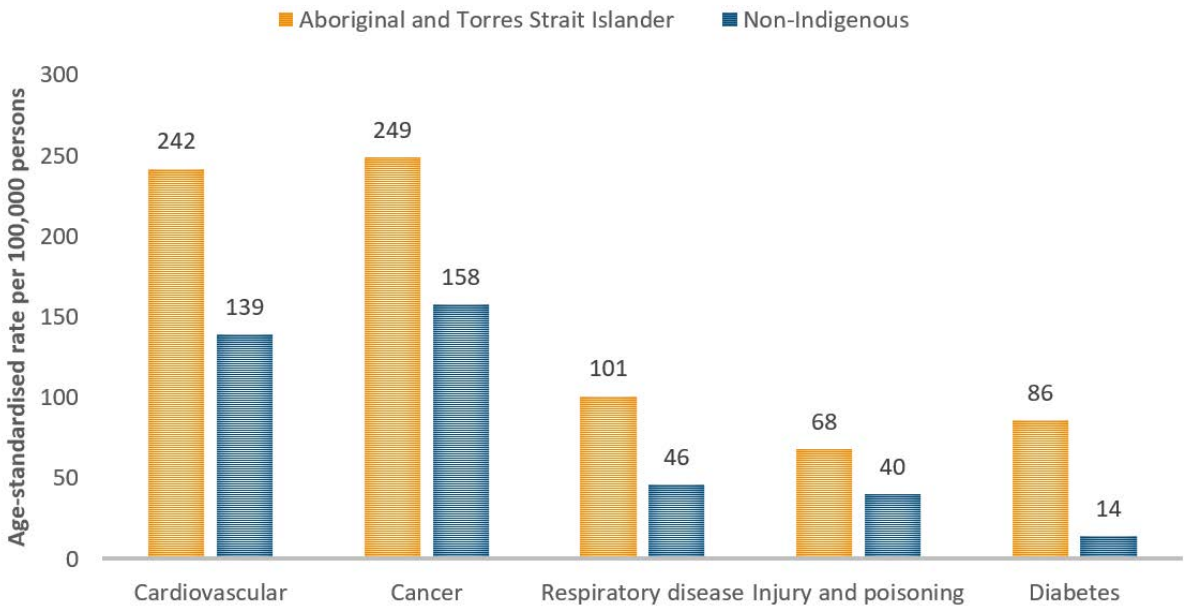
Chronic diseases are responsible for most deaths

Causes of death data tell us about the health conditions that affect our population and influence life expectancy. The most common causes of death in Aboriginal and Torres Strait Islander peoples in our community are cardiovascular disease and cancer. Age-standardised mortality rates are higher in Aboriginal and Torres Strait Islander peoples than non-Indigenous people (Figure 73).[174]

Tobacco smoking is a major contributor to chronic disease burden and death in our Aboriginal and Torres Strait Islander population.

Figure 72. Ratio of mortality rates, Aboriginal and Torres Strait Islander and non-Indigenous population | 2015-17

Figure 73. Age-standardised mortality (per 100,000 population) in Aboriginal and Torres Strait Islander versus non-Indigenous persons, Queensland | 2016–18



Diabetes is a leading cause of chronic kidney disease in our Aboriginal and Torres Strait Islander population. Comprehensive primary care is essential for the early identification of people with chronic kidney disease to prevent disease progression to kidney failure.

Mental health conditions are also a cause of death in our community. Age-standardised mortality rates for mental health conditions, suicide, and self-inflicted injury are higher in Aboriginal and Torres Strait Islander peoples than non-Indigenous people (Figure 74).[175]

Figure 74. Age-standardised mental health mortality (per 100,000 population) in Aboriginal and Torres Strait Islander versus non-Indigenous persons, Queensland | 2016–18

Cancer outcomes can be improved

Cancer is a leading cause of death among our population, including among Aboriginal and Torres Strait Islander peoples. Patterns of cancer incidence and mortality for specific cancer are different between Aboriginal and Torres Strait Islander and non-Indigenous people in our community. Although prostate, breast, and melanoma cancers are the most common cancers diagnosed across our population, their incidence is lower in Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people. In comparison, the incidence of lung cancer is almost double the rate in Aboriginal and Torres Strait Islander peoples compared with non-Indigenous people (Figure 75).[176]

Although prostate and breast cancer incidence is lower in Aboriginal and Torres Strait Islander peoples, cancer mortality for these cancers is not. Further, mortality due to lung cancer is almost three times greater in Aboriginal and Torres Strait Islander peoples than non-Indigenous people (Figure 76).[177]

Figure 75. Age-standardised cancer incidence (per 100,000 population) in Aboriginal and Torres Strait Islander versus non-Indigenous persons, Queensland | 2015-17

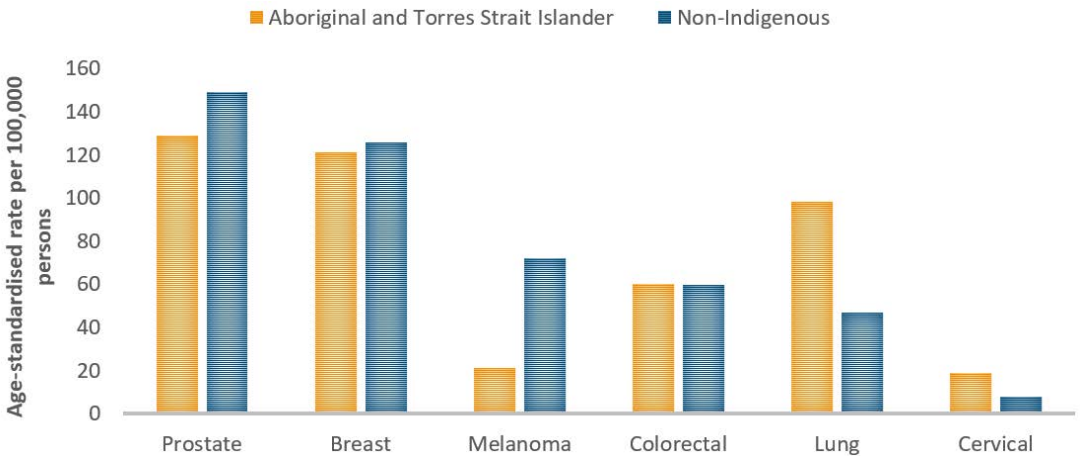
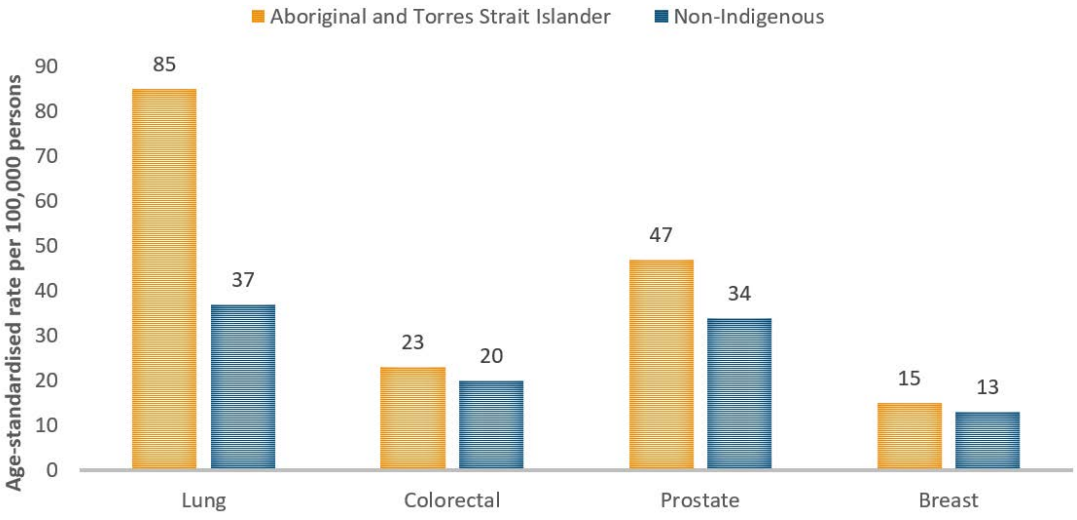


Figure 76. Age-standardised cancer mortality (per 100,000 population) in Aboriginal and Torres Strait Islander versus non-Indigenous persons, Queensland | 2016–18



Cancer screening participation can be improved

Cancer screening is an important way to identify cancer early and improve outcomes. Australia has three national cancer screening programs – bowel, breast, and cervical cancer.

There is a lower uptake of screening by Aboriginal and Torres Strait Islander peoples than non-Indigenous people. Aboriginal and Torres Strait Islander participation data for cancer screening is poor for different geographical regions. National cancer screening participation rates are seen in Table 28.[178]

Table 28. National cancer screening participation rates, Australia | 2018

Cancer type	Aboriginal and Torres Strait Islander peoples	Non-Indigenous people
Breast (women)	37.5%	54%
Bowel	19.5%	42.7%
Cervical	n/a	n/a

In summary:

- breast screening participation is 37.5% for Aboriginal and Torres Strait Islander women and 54% for non-Indigenous women
- bowel cancer screening participation is 19.5% for Aboriginal and Torres Strait Islander peoples and 42.7% for non-Indigenous people
- cervical screening participation data are not available.

Chronic conditions affect many people

An estimated 64% of the total burden of disease for Aboriginal and Torres Strait Islander peoples is caused by chronic disease, and accounts for 70% of the health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people in Queensland.[179]

Fewer than one-half (47.3%) of adults in our general population have one or more chronic conditions. In Aboriginal and Torres Strait Islander peoples, more than 70% of adults have one or more chronic conditions. Many have more than one chronic condition (that is, multimorbidity) (Table 29).[180]

Table 29. Number of current long-term health conditions, NATSIHS | 2018–19

Number of current long-term health conditions	% Aboriginal and Torres Strait Islander population
None	33.1
One	17.8
Two	13.1
Three or more	36.2

The prevalence of chronic conditions in our Aboriginal and Torres Strait Islander population is linked with socio-economic disadvantage, rurality, and high rates of health risk factors (tobacco smoking, alcohol consumption, poor nutrition, physical inactivity, and obesity).

The percentage of Aboriginal and Torres Strait Islander peoples that is affected by asthma, diabetes, heart, stroke, and vascular conditions and kidney disease is higher than the general population (Table 30).[181,182]

Table 30. Self-reported chronic health conditions, Queensland, 2017-18 and National Aboriginal and Torres Strait Islander Health Survey | 2018–19

Condition	% of population	% of Aboriginal and Torres Strait Islander population
Back problems	16.8	11.1
Arthritis	14.1	9.1
Asthma	11.9	13.7
Diabetes mellitus	4.7	8.7
Heart, stroke, and vascular disease	4.5	5.2
Osteoporosis	3.8	2.3
Chronic obstructive pulmonary disease (COPD)	3.4	2.7
Cancer	1.6	1.1
Kidney disease	1.0	1.6

Health risk factors contribute to chronic disease burden

According to the last National Aboriginal and Torres Strait Islander Health Survey (2018–19):

- 45% of Aboriginal and Torres Strait Islander Queenslanders were daily smokers
- 48.5% consumed alcohol in the past week
- 89.7% did not meet physical activity guidelines
- 97.5% had inadequate daily fruit and vegetable consumption.

Mental and behavioural conditions affect many people

Mental and behavioural conditions, including alcohol and other drugs issues, are chronic conditions that affect many people in our population. Depression and anxiety account for the largest percentage of mental and behavioural conditions.

The proportion of Aboriginal and Torres Strait Islander peoples with selected mental and behavioural conditions varies according to age. Overall prevalence of mental and behavioural conditions is highest in the 35- to 54-year age group.

Psychological distress is a proxy for mental health conditions; 30.2% of Queensland Aboriginal and Torres Strait Islander peoples were recorded as experiencing high or very high psychological distress at the time of the 2018–19 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (Table 31).[183]

Patterns of alcohol and other drugs use are changing over time. At the time of the 2018–19 National Aboriginal and Torres Strait Islander Health Survey, 54.2% of Queensland respondents exceeded single-occasion risk and 24.6% exceeded lifetime risk with alcohol consumption[184]. Overall, illicit drug use increased between 2007 and 2019 in Queensland and Australia in the general population after a decline between 2001 and 2007. Rates of illicit drug use remained stable among Aboriginal and Torres Strait Islanders but rose for non-Indigenous Australians.[185]

We have a high burden of infectious disease

Aboriginal and Torres Strait Islander peoples experience a greater infectious disease burden than non-Indigenous people in our community, regardless of where they live. People who live in rural and remote areas experience disproportionately higher rates of some infectious diseases than their urban counterparts.[186]

Children of Aboriginal and Torres Strait Islander background have higher rates of infectious diseases including skin, ear, respiratory and gastrointestinal

Table 31. Mental and behavioural conditions, proportion of Aboriginal and Torres Strait Islander persons by age group, NATSIHS | 2018–19

Condition	Proportion % per age group						
	0–14	15–24	25–34	35–44	45–54	55+	Total
Depression	2.5	15.0	15.8	20.3	22.7	20.0	13.3
Anxiety	6.9	17.9	24.6	23.7	21.0	18.3	16.5
Alcohol and drug problems	0.0	0.7	2.0	2.6	2.1	3.2	1.4
Behavioural or emotional problems	11.3	9.5	8.3	8.6	7.2	7.1	9.3
Total mental and behavioural conditions	14.8	24.4	30.4	31.8	31.3	27.0	24.2

infections, invasive infections, including bloodstream infections, pneumonia, and bronchiectasis, and are more likely to be hospitalised for infectious diseases than non-Indigenous children.[187,188] Acute and chronic otitis media and associated conductive hearing loss are more prevalent in remote communities compared with urban communities.[189,190]

Group A streptococcal (GAS) infections cause skin, soft tissue, and throat infections, invasive disease and the autoimmune sequelae of acute rheumatic fever and acute post-streptococcal glomerulonephritis (APSGN).[190] APSGN can lead to chronic renal failure and a requirement for renal dialysis. Mortality from rheumatic heart disease in Aboriginal and Torres Strait Islander peoples is the highest reported in the world.[191]

Skin infections are a major contributor to the burden of GAS. In remote communities, impetigo is predominantly caused by GAS and affects 45% of Aboriginal and Torres Strait Islander children at any one time. A high burden of scabies, affecting 50% of Aboriginal and Torres Strait Islander children, increases rates of impetigo. Adults in some remote communities also experience high rates of skin and soft tissue infections, up to 75% each year.[192]

Some chronic diseases increase risk of severe infections. Rates of type 2 diabetes are high in some remote communities. Diabetes contributes to respiratory tract infections, urinary tract infections, skin and soft tissue infections, ear infections and cholecystitis.[193] Serious infections resulting in sepsis are more common in some Aboriginal and Torres Strait Islander populations; rates of sepsis resulting in hospitalisation and intensive care admission are four-fold higher in Aboriginal and Torres Strait Islander than in non-Indigenous people.[194]

Notifications of sexually transmissible infections, including chlamydia, gonorrhoea and syphilis are higher in some Aboriginal and Torres Strait Islander communities.[195] HIV notification rates have doubled among Aboriginal and Torres Strait Islander men over the past five years and rates of chlamydia, gonorrhoea and infectious syphilis are 3, 10, and 6 times greater than the non-Indigenous population.[196] For many years, sexually transmissible infections (STIs) have been disproportionately affecting Aboriginal and Torres Strait Islander peoples in Queensland, particularly those living in northern Queensland. The re-emergence of infectious syphilis, with multiple outbreaks across northern Queensland, and the occurrences of baby deaths from congenital syphilis highlight the need for primary care response to STIs in the NQPHN catchment.

Unlike many non-communicable diseases, the occurrence of STIs and their related health complications can be significantly reduced for Aboriginal and Torres Strait Islander peoples over a relatively short timeframe through targeted screening, treatment, contact tracing, health promotion, and safe sexual practices. According to the Australian STI Management Guidelines, primary care plays an important role in promoting good sexual health, screening for STIs, and in diagnosing and managing infections.

Surveillance data indicate new cases of syphilis continue to be diagnosed in northern Queensland (Table 32).[197]

Table 32. Characteristics of category 1 infectious syphilis outbreak cases notified in Aboriginal and Torres Strait Islander peoples, northern Queensland to from January 2011 to 31 January 2021

Situation to 31 January 2021	Northern Queensland
Outbreak commencement	January 2011
Total number of cases (January 2011 to January 2021)	1,640
% Male / % Female (January 2011 to January 2021)	46% / 54%
» congenital cases, confirmed (probable)	4 (5)
» number of deaths in congenital cases, confirmed (probable)	3 (4)
Last reporting month (January 2021)	
Number of cases (January 2021 only)	4

Service needs

According to the 2020 Aboriginal and Torres Strait Islander Health Performance Framework, Aboriginal and Torres Strait Islander peoples access health care from a range of different health care professionals (Table 33).[198]

Table 33. Aboriginal and Torres Strait Islander persons accessing health care, Queensland | 2018–19

Type of care	% of Aboriginal and Torres Strait Islander population
Admitted to hospital in last 12 months	16.1
Visited casualty/outpatients in last 2 weeks	8.2
Doctor consultation in last 2 weeks	22.0
Dental consultation in last 2 weeks	5.7
Consultation with other health professionals in last 2 weeks	19.7

Aboriginal Community Controlled Health Organisations are essential to the delivery of primary care

Aboriginal and Torres Strait Islander peoples enjoy quality of life through whole-of-community self-determination and individual spiritual, cultural, physical, social and emotional wellbeing.[199]

Aboriginal Community Controlled Health Organisations (ACCHOs) are primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it.[200]

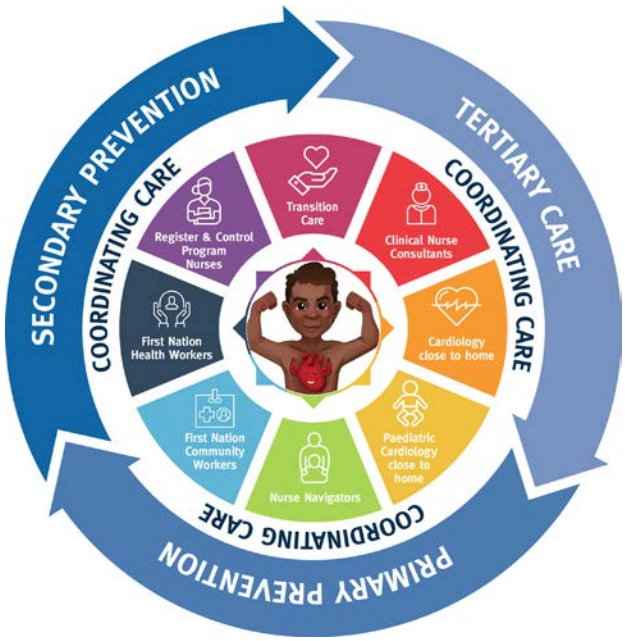
Northern Queensland has many Aboriginal and Torres Strait Islander Community Controlled Health Organisations. Organisations in the NQPHN catchment that are members of the Queensland Aboriginal and Islander Health Council (QAIHC) include:

- Aboriginal and Torres Strait Islander Community Health Service Mackay Ltd
- Apunipima Cape York Health Council Ltd
- Gindaja Treatment and Healing Centre – a 19-bed hostel catering for men and women with drug and alcohol related problems (Yarrabah)
- Girudala Community Cooperative Society Ltd (Bowen)
- Gurriny Yealamucka Health Service Aboriginal Corporation (Yarrabah)
- Mamu Health Services Ltd (Innisfail, Tully, Babinda, Ravenshoe)
- Mookai Rosie (women's health) (Cairns region)
- Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation (Sarina)
- Mulungu Aboriginal Corporation Primary Health Care Service (Mareeba)
- Northern Peninsula Area (NPA) Family and Community Services (Bamaga and Injinoo)
- Townsville Aboriginal and Islander Health Service
- Torres Health (Thursday Island)
- Wuchopperen Health Service Ltd (Cairns region).

In addition, Palm Island Community Corporation is undertaking a process to become a member of QAIHC.

Our ACCHOs are an integral part of our health system architecture. They improve health, create jobs, and ensure Aboriginal and Torres Strait Islander peoples receive culturally appropriate health care. Each ACCHO sets its own strategic direction, objectives, and priorities. Priorities are holistic and are broader than primary care services alone.[201]

Figure 77. Aboriginal and Torres Strait Islander persons accessing health care, Queensland | 2018–19



Mainstream general practice is essential to the delivery of primary care

In northern Queensland, most general practices contribute data to NQPHN to inform our understanding of care delivered to people in general practice. There are 66,591 patients who identified as being of Aboriginal or Torres Strait Islander origin for whom general practice data are available. This represents 81% of NQPHN's total Aboriginal and Torres Strait Islander population of 82,000 people.[202]

There were 54,540 people (82% of Aboriginal and Torres Strait Islander patients) whose last access to a mainstream GP was in 2020 or 2021. A total of 43% of patients are aged 20 years or less (Figure 78) and 53% are female. Most patients are recorded as being Aboriginal (Table 34).

Figure 78. Age distribution, Aboriginal and Torres Strait Islander patients, NQPHN GP data | January 2017 – July 2021

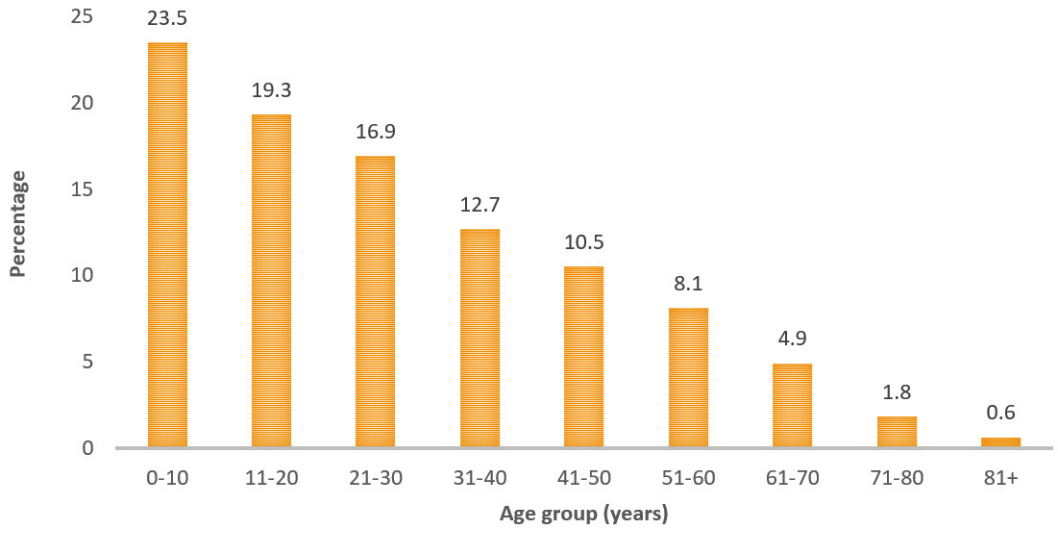


Table 34. Aboriginal and Torres Strait Islander patients, NQPHN GP data | January 2017 – July 2021

	%
Aboriginal	68.6
Aboriginal and Torres Strait Islander	16.9
Torres Strait Islander	14.5

Townsville is the local government area with the largest number of Aboriginal and Torres Strait Islander peoples accessing mainstream general practice, followed by Cairns (Figure 79).

The most common chronic conditions recorded for patients were asthma, depression, and hypertension (Figure 80).

Figure 79. SA3 of residence of Aboriginal and Torres Strait Islander patients accessing mainstream general practice, NQPHN GP data | January 2017 – July 2021

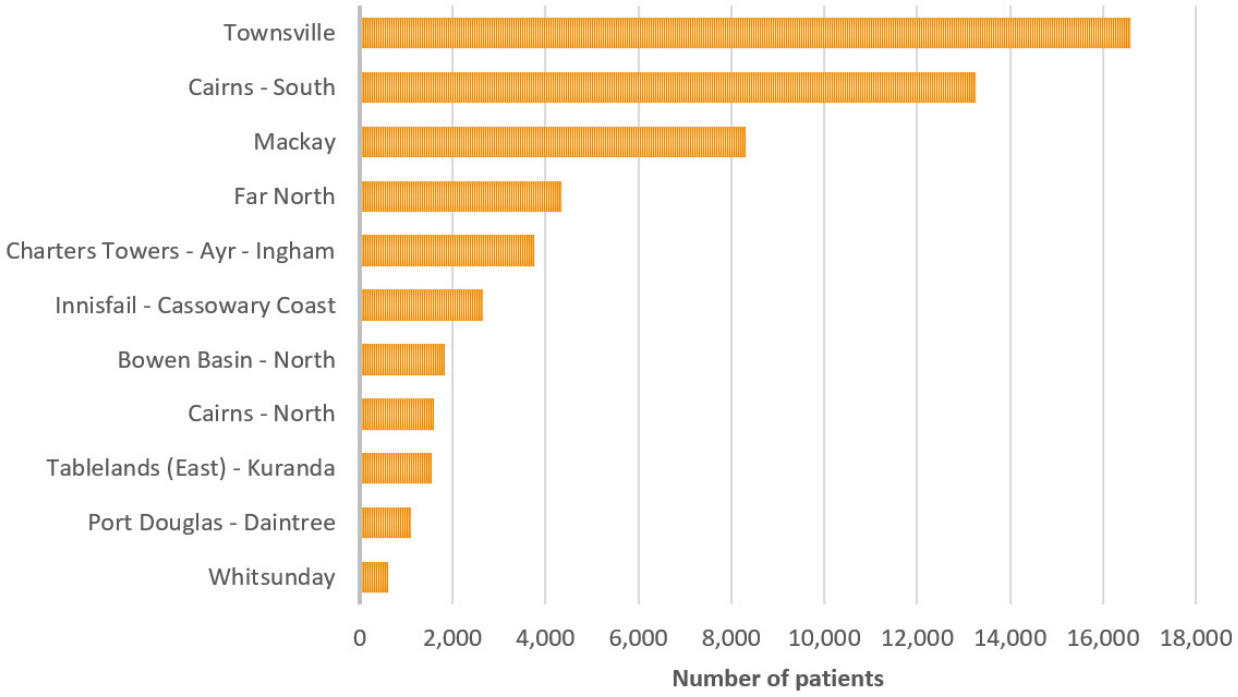
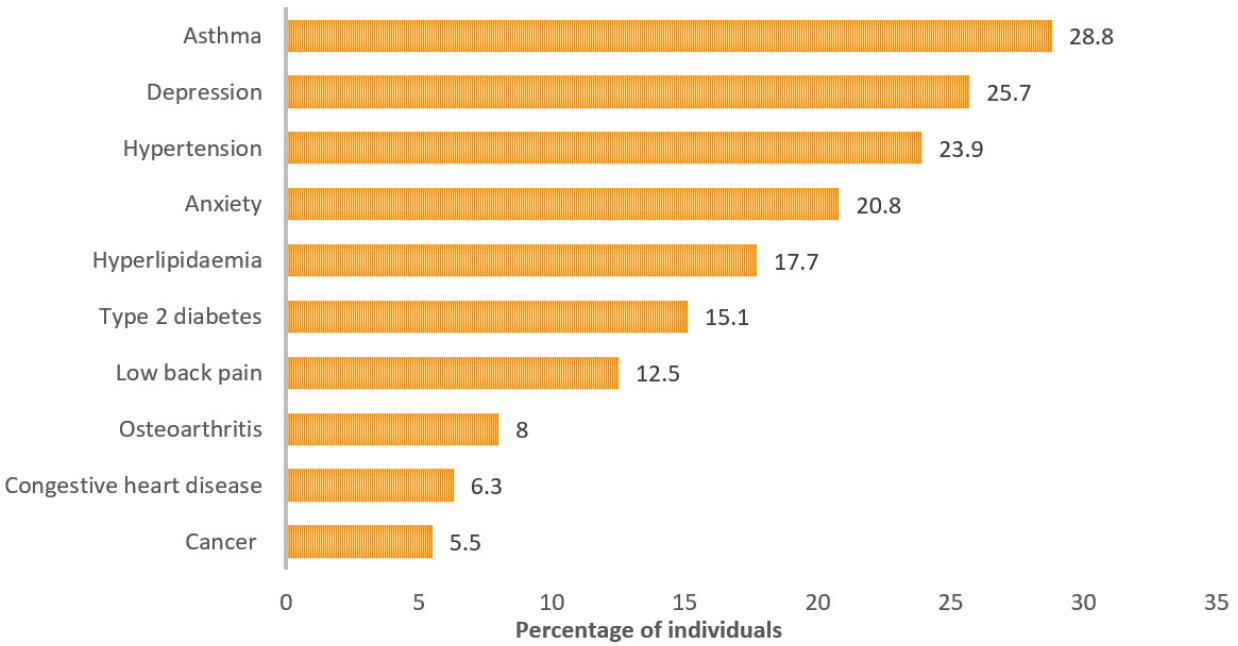


Figure 80. Aboriginal and Torres Strait Islander patients, percentage with chronic conditions, NQPHN GP data | January 2017 – July 2021



According to the Index of Relative Socioeconomic Disadvantage (IRSD), most patients accessing mainstream general practice with chronic conditions experience socioeconomic disadvantage (Figure 81).

Excluding immunisations, the most common medications reported were analgesics and respiratory asthma medications (Figure 82).

Figure 81. Frequency of top 15 coded conditions reported by socioeconomic disadvantage, NQPHN GP data | January 2017 – July 2021

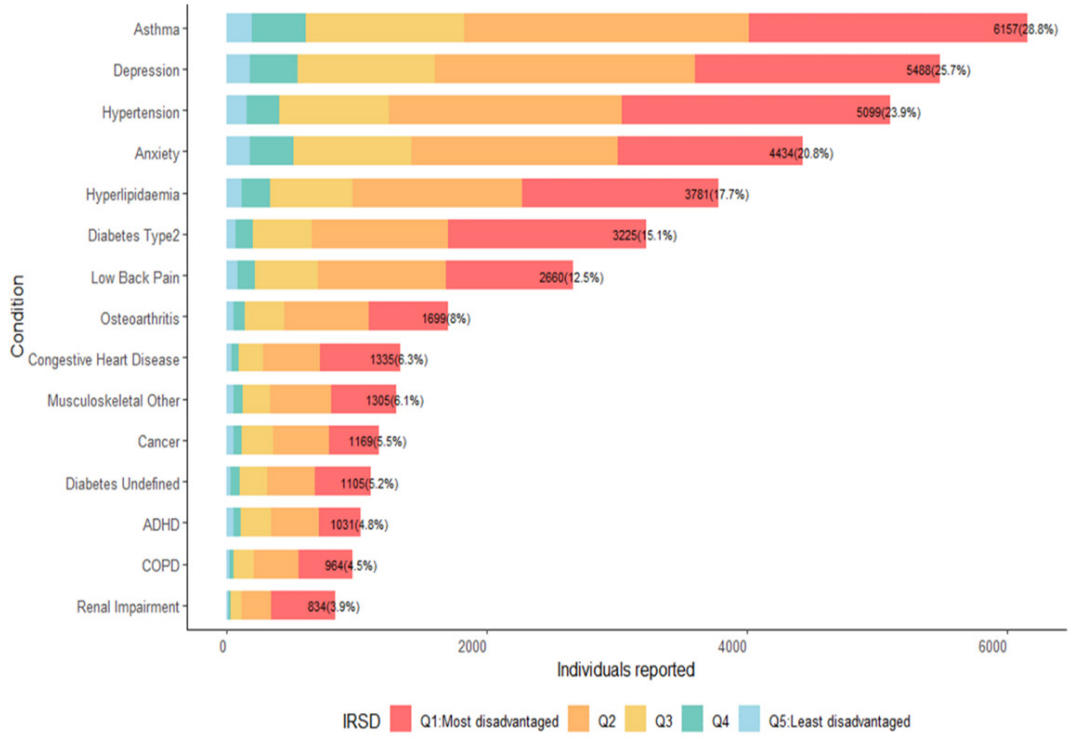
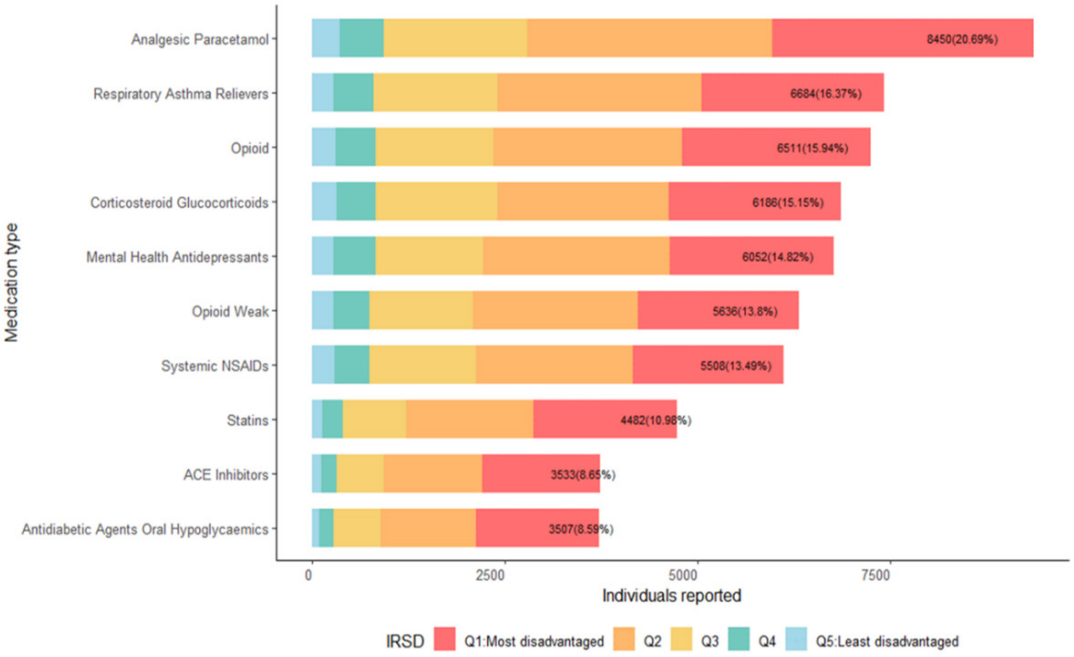


Figure 82. Top 10 medications reported, NQPHN GP data | January 2017 – July 2021



Mental health problems affect people accessing mainstream general practice

Anxiety and depression are the most frequent mental health conditions recorded in Aboriginal and Torres Strait Islander peoples who access mainstream general practice (Table 35).

Health risk factors affect people accessing mainstream general practice

Aboriginal and Torres Strait Islander peoples aged between 31 and 40 years attending mainstream general practice are most likely to be recorded as daily smokers or people who consume alcohol (Figure 83).

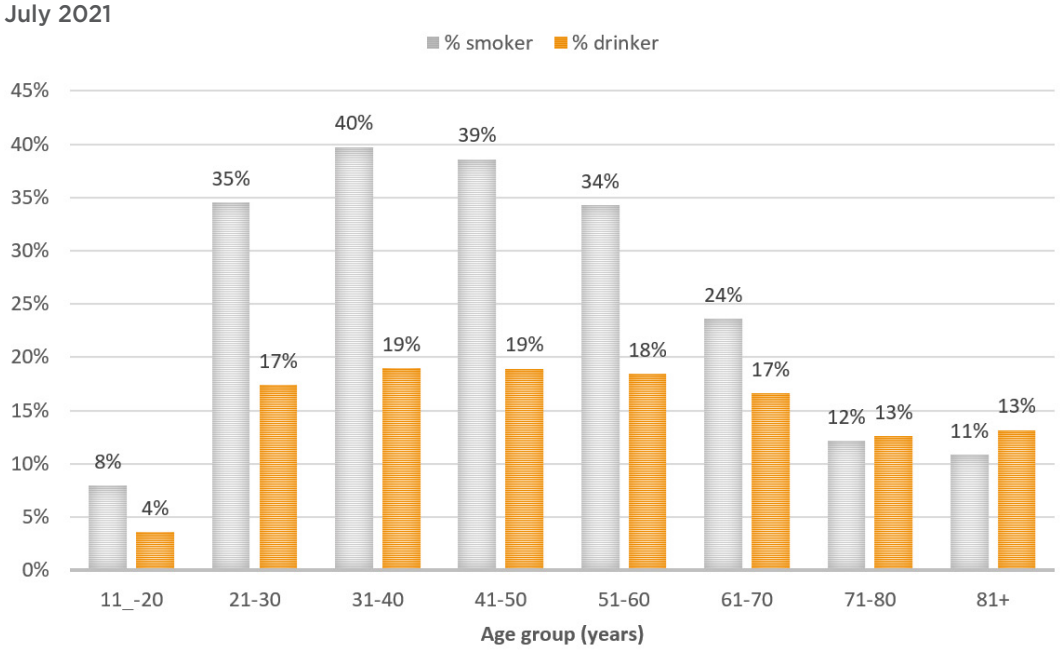
Chronic disease item numbers are used by GPs to manage chronic conditions

The Medicare Benefits Schedule includes specific item numbers that GPs can claim for delivering services relating to chronic conditions management. These items were claimed for the following number of Aboriginal and Torres Strait islander patients at least once in the NQPHN dataset (Table 36).

Table 35. Aboriginal and Torres Strait Islander patients recorded mental health conditions, NQPHN GP data | January 2017 – July 2021

Mental health condition	Aboriginal	Aboriginal and Torres Strait Islander	Torres Strait Islander
ADHD	833	181	86
Anxiety	3,545	713	492
Autism	323	81	31
Depression	4,439	822	582
Postnatal depression	183	39	38
Drug misuse	531	101	43
Schizophrenia	485	91	66

Figure 83. Aboriginal and Torres Strait Islander patients smoking and alcohol status, NQPHN GP data | January 2017 – July 2021



GPs can complete a GP mental health treatment plan and refer patients for allied health services subsidised through Medicare. Between January 2017 and July 2021 there were 39,787 patients who received a GP mental health treatment plan in general practices that contribute data to NQPHN. Of these, 8% were Aboriginal or Torres Strait Islander patients.

Table 36. Number of patients with MBS item claimed, NQPHN GP data | 12 months to August 2021

MBS Item number	Description	Number of patients
715	Aboriginal and Torres Strait Islander peoples Health Assessment	11,090
721	Preparation of a GP Management Plan	3,624
723	Coordination of Team Care Arrangements	2,823
732	Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	2,312

Aboriginal and Torres Strait Islander peoples Health Checks

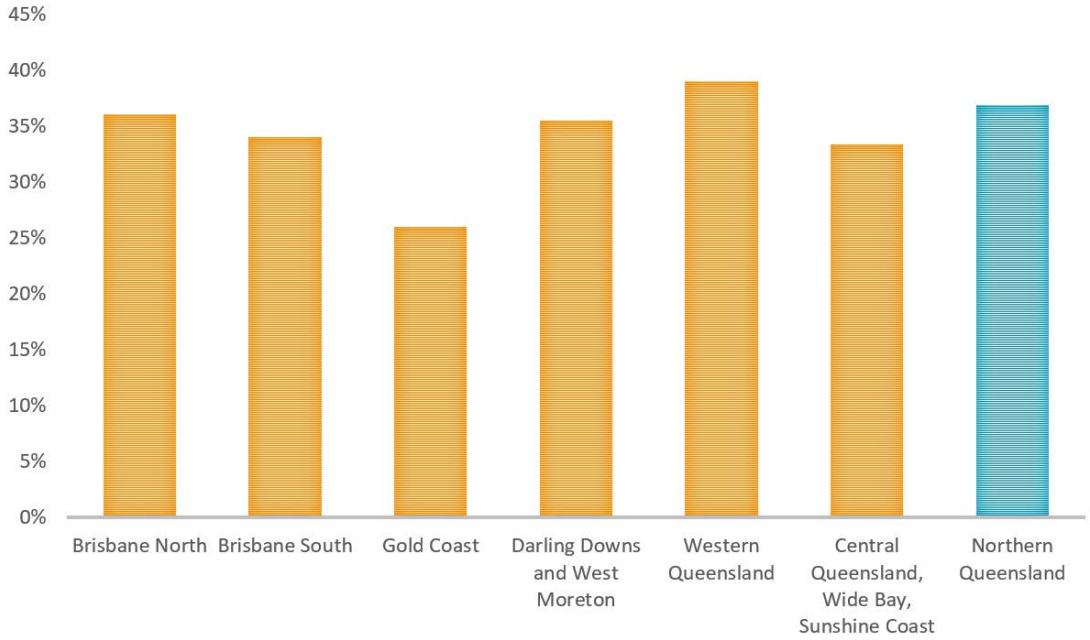
Medicare Australia also collects data regarding the number of Aboriginal and Torres Strait Islander peoples Health Assessments (item 715) that have been claimed in different geographical areas. These data indicate the number of Indigenous health assessments claimed decreased between 2018–19 and 2019–20 in the NQPHN catchment. Most health assessments were performed face-to-face (Table 37).[203]

In 2019–20, Western Queensland PHN performed the highest percentage of Indigenous health assessments within the eligible population of all PHNs in Queensland (Figure 84).[204]

Table 37. Indigenous health assessment rates by PHN, NQPHN | 2018–19 and 2019–20

Year	Service type	Patients	%
2018–19	Total (all face-to-face)	33,743	40.1
2019–20	Face-to-face	30,720	35.8
2019–20	Telehealth	1,064	1.2
2019–20	Total	31,653	36.9

Figure 84. Indigenous health assessments, percentage performed in eligible population, Queensland PHNs | 2019–20



Commissioned mental health services support delivery of mental health care

Funding by the Australian Government Department of Health has been provided to PHNs nationally through a Primary Mental Health Care flexible funding pool to support commissioning of mental health and suicide prevention services. Key service delivery areas include:

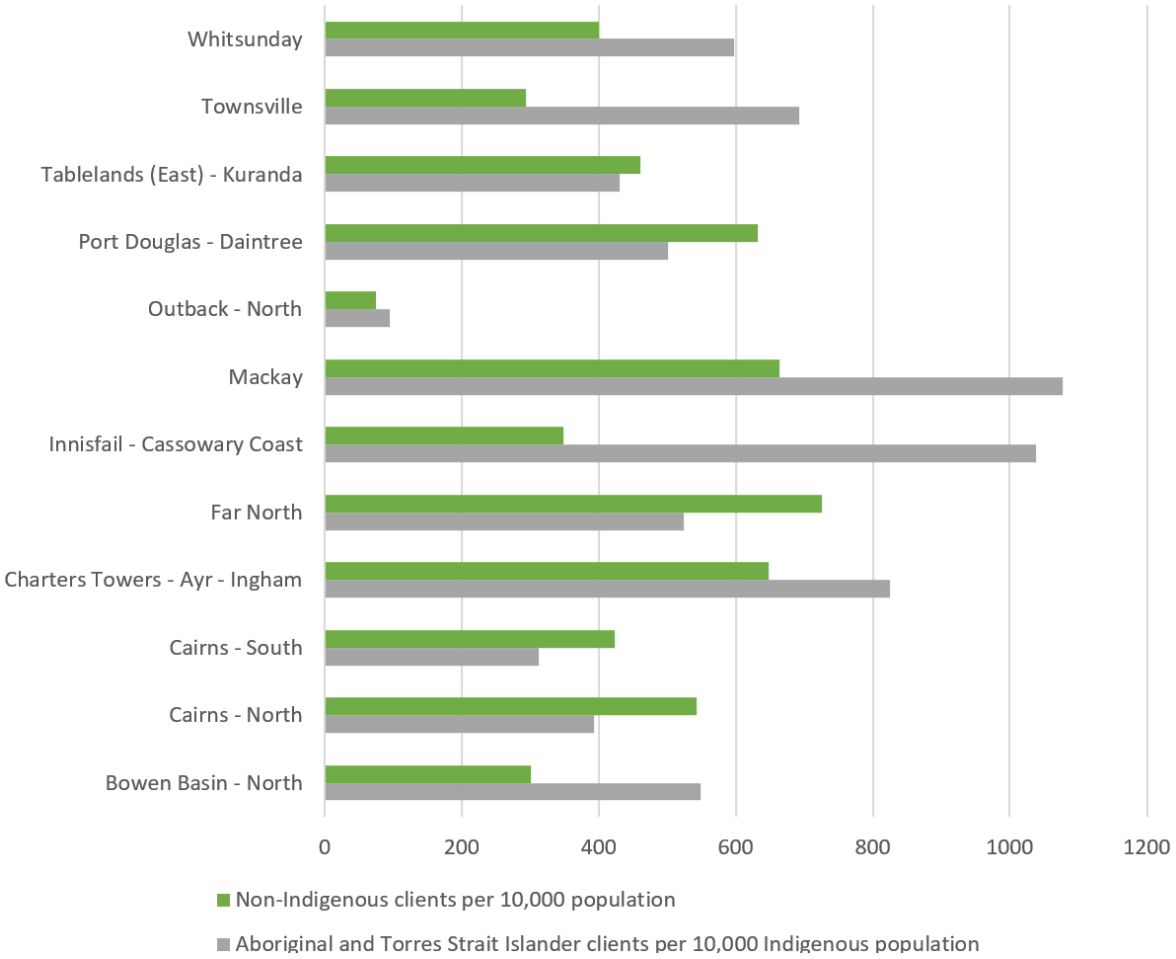
- psychological interventions for people with, or at risk of, mild mental illness
- short-term psychological therapies delivered by mental health professionals
- psychological interventions for youth with severe mental health problems
- early intervention services for children and young people with, or at risk of mental illness
- services for adults with severe and complex mental illness who are being managed in a primary care setting
- psychosocial support for people with severe mental health problems.

NQPHN also commissions psychological services for people in residential aged care and for people who are experiencing mental health impacts from natural disaster.

In the three years from 2018–19 to 2020-21, 33,198 clients received a total of 141,348 NQPHN-commissioned mental health services. In total, 15.3% were Aboriginal or Torres Strait Islander people.

The highest rates of service delivery per 10,000 Indigenous population were in the Mackay SA3 region.

Figure 85. Commissioned mental health services per 10,000 population, NQPHN SA3, 2018-19 to 2020-21



Mental health outcomes improve with delivery of commissioned mental health care

The impact of these services on mental health is measured by service providers. A Kessler 5 (K5) measure of psychological distress is often used in Aboriginal and Torres Strait Islander client groups. For those patients in whom K5 scores were recorded, the mean K5 at baseline was 14 (high psychological distress) and decreased to 11.7 (moderate psychological distress) over the course of treatment. A significant reduction in the number of people experiencing very high psychological distress was observed, particularly in people with very high levels of psychological distress (Table 38). More information is available in the Mental Health chapter of this health needs assessment.

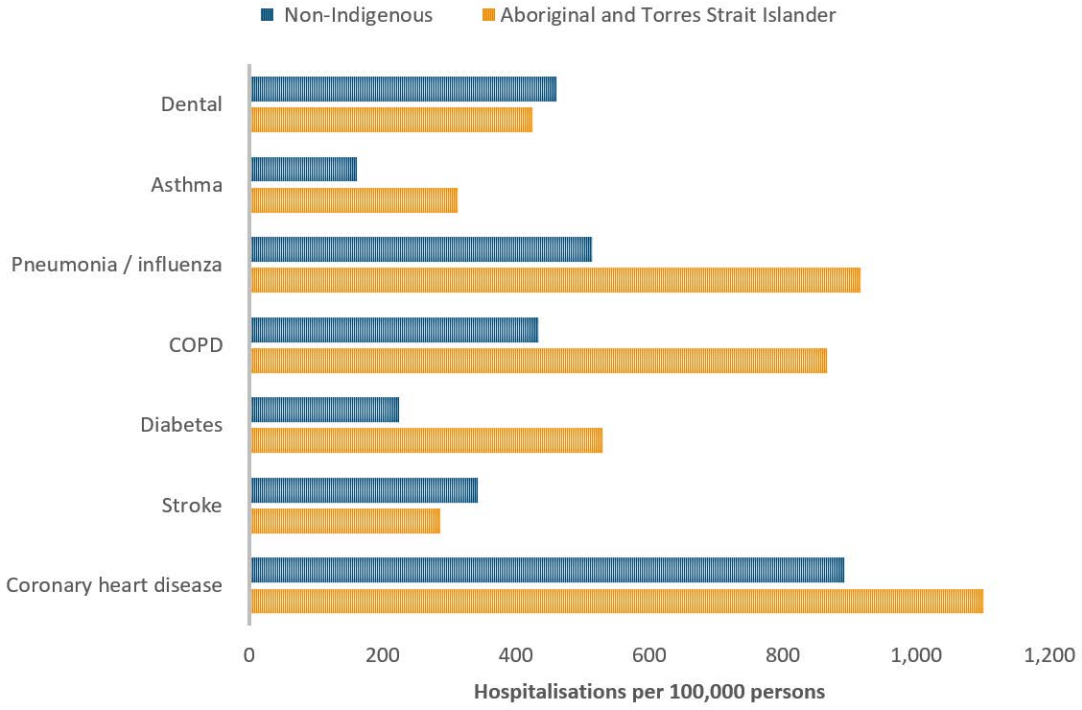
Rates of hospital admission are high for Aboriginal and Torres Strait Islander peoples

Hospital admissions data were not available for Aboriginal and Torres Strait Islander peoples in northern Queensland for this health needs assessment. Queensland hospitalisations data provide an indication of the rates of hospitalisation for selected chronic conditions in Aboriginal and Torres Strait Islander peoples. According to these data, the all-cause hospitalisation rate (2018–19) is 65,297 per 100,000 persons compared with 52,236 per 100,000 persons in the general population. Crude hospitalisation rates are highest for coronary heart disease (Figure 86).[205]

Table 38. Psychological distress (K5), baseline and follow-up | 2018–19 to 2020-21

Indicator	Result
Group of pre-K5 (Very high >=15)	47.9%
Group of post-K5 (Very high >=15)	27.0%

Figure 86. Selected crude hospitalisations per 100,000 persons, Queensland | 2018–19



Hospitalisation rates for mental and behavioural disorders are higher in Aboriginal and Torres Strait Islander peoples

The proportion of hospitalisations due to mental and behavioural problems in Aboriginal and Torres Strait Islander peoples in Queensland is approximately the same as non-Indigenous people (4% versus 5%). However, after adjusting for the younger median age of the Aboriginal and Torres Strait Islander population, age-standardised hospitalisation rates for mental and behavioural disorders are higher in Aboriginal and Torres Strait Islander peoples (3,533 versus 2,508 per 100,000 persons).[206]

Across NQPHN HHSs, the number of hospital admissions for selected mental health conditions is highest for alcohol and other drugs issues, followed by schizophrenia (Figure 87).[207]

Aboriginal and Torres Strait Islander peoples that are hospitalised for mental health problems are younger than non-Indigenous people. Most people who are hospitalised are aged between 25 and 44 years (Figure 88).[208]

Figure 87. Hospital admissions for selected mental health problems, Aboriginal and Torres Strait Islander peoples, NQPHN HHSs | 2019–20

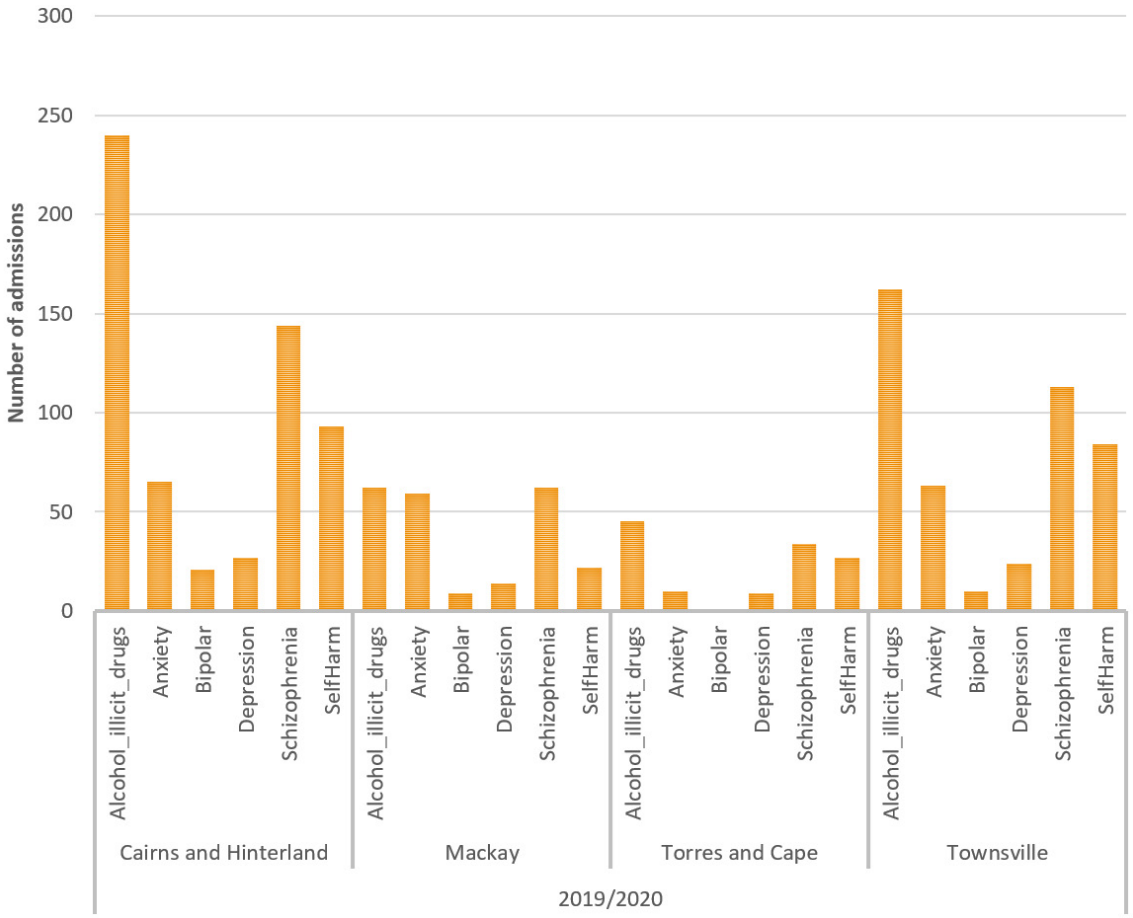
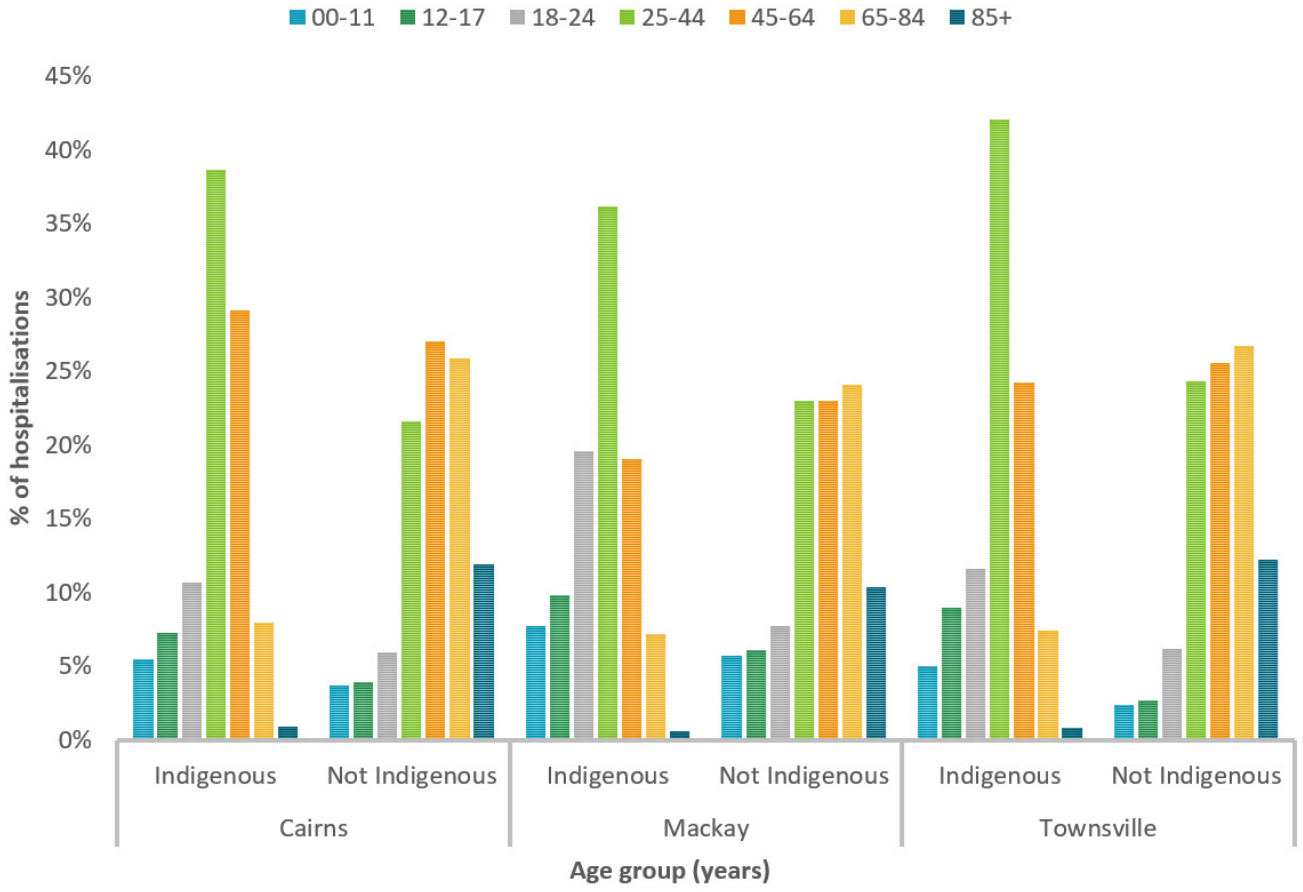


Figure 88. Hospitalisations for selected mental health problems, Indigenous and non-Indigenous people | 2019–20



There are gaps in the Aboriginal and Torres Strait Islander health workforce

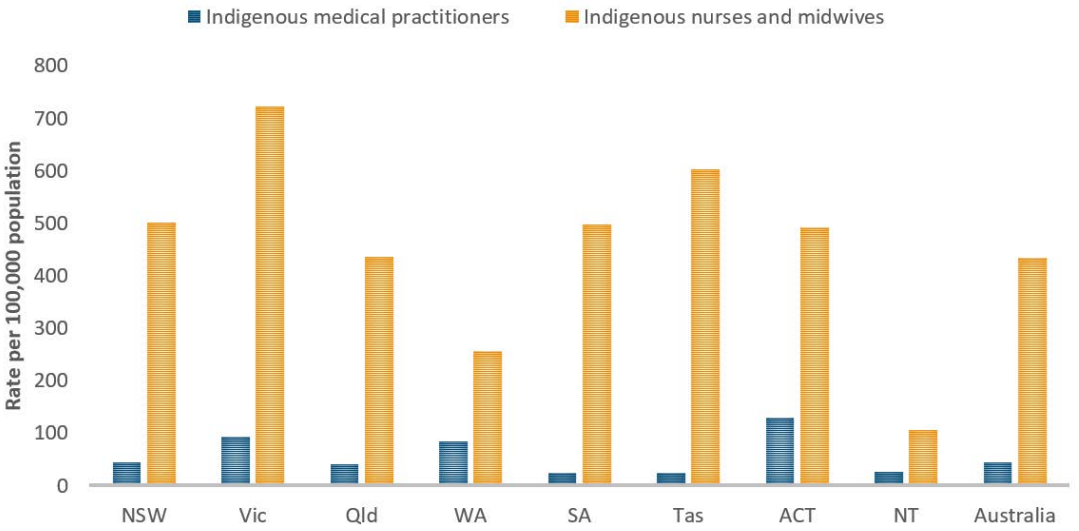
The Aboriginal and Torres Strait Islander health workforce is an enabler to improving health outcomes for Aboriginal and Torres Strait Islander peoples. The Queensland Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016–2026) seeks to increase Aboriginal and Torres Strait Islander health workforce across all occupations and levels of employment (medical, nursing, allied health, and support workforce). This, in turn, will support the broader economic and social wellbeing of Aboriginal and Torres Strait Islander peoples in our community.

In Queensland, the rate of employment of Aboriginal and Torres Strait Islander peoples in the health workforce has increased over time (Figure 89).[209]

Rates of employed Aboriginal and Torres Strait Islander medical practitioners, nurses, and midwives in Queensland per 100,000 population are similar to national rates (Figure 90).[210]

Figure 89. Employed persons aged 15+ in the health workforce, Queensland | 2006–16

Figure 90. Employed medical practitioners, nurses and midwives, Indigenous status, Queensland | 2017



The National Health Workforce Data Set includes the total fulltime equivalent of registered and employed primary and community Aboriginal and Torres Strait Islander Health Workers and Health Practitioners. There are 7.4 FTE of Aboriginal and Torres Strait Islander Health Workers employed in primary and community services per 10,000 Aboriginal and Torres Strait Islander peoples in the NQPHN catchment. This is higher than the Queensland and Australian FTE per 10,000 population (Figure 91).[211]

Within NQPHN there is a maldistribution in the Aboriginal and Torres Strait Islander Health Worker workforce across the NQPHN catchment. Some areas of the NQPHN have no recorded Aboriginal and Torres Strait Islander Health Worker FTEs in primary and community settings (Figure 92).[212]

Figure 91. Aboriginal and Torres Strait Islander Health Workers employed in primary and community per 10,000 Aboriginal and Torres Strait Islander persons | 2019

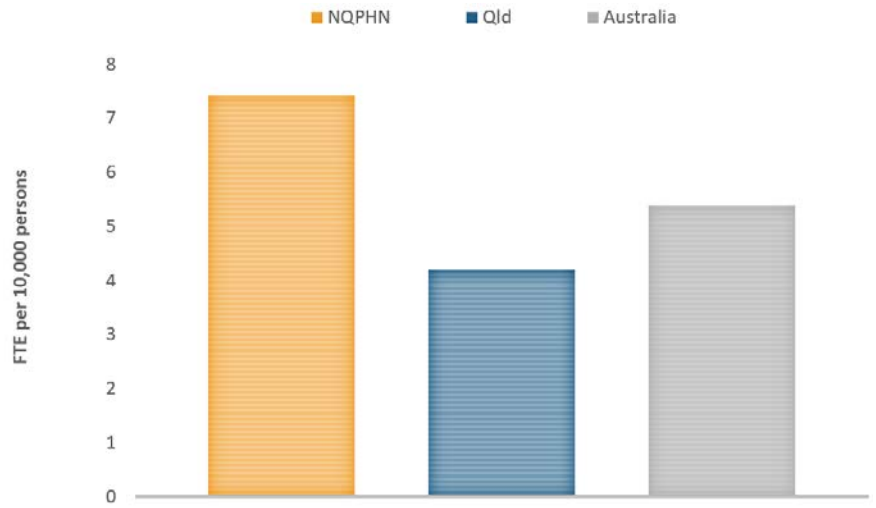
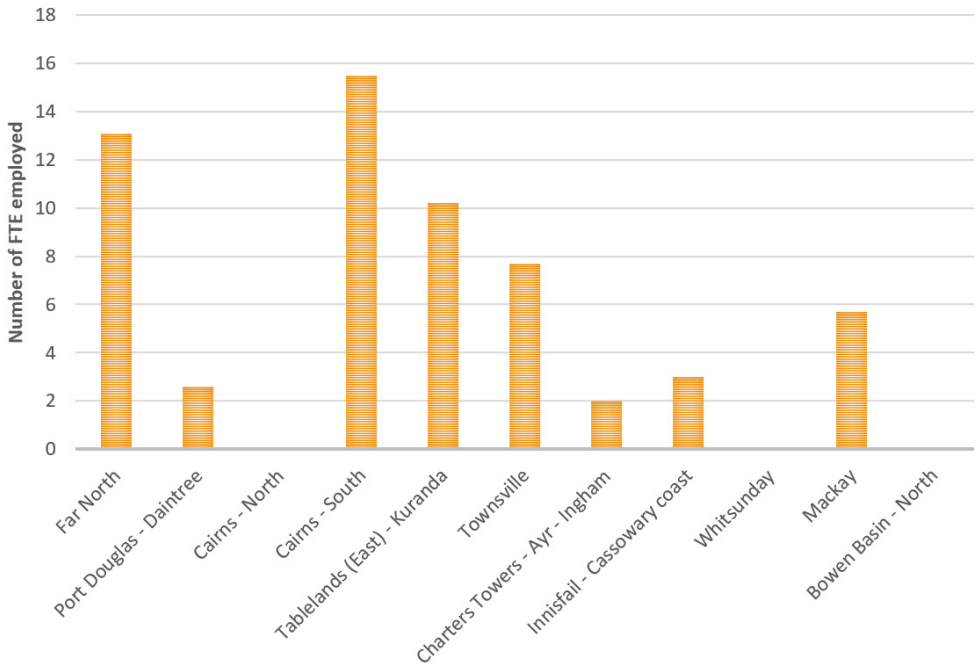


Figure 92. Full-time equivalent, Aboriginal and Torres Strait Islander Health Workers | 2019



Stakeholder perspectives

Community members, clinicians, ACCHOs, and other government and non-government stakeholder groups advocate for a broad range of improvements in primary care for Aboriginal and Torres Strait Islander peoples in our community.

People need holistic, culturally appropriate primary health care

According to stakeholders, ACCHOs are best placed to provide holistic, culturally appropriate primary health care.

Stakeholders report people defer seeking primary care for many reasons. A lack of availability of care, inability to obtain an appointment, inability to afford the cost of care, and culturally insensitive care are all reasons people may not seek care.

ACCHOs address many of these issues. ACCHOs are resourced to provide flexible and responsive services that are tailored to the needs of their local community. Aboriginal and Torres Strait Islander peoples with chronic conditions may experience financial disadvantage because of their health problems. Substantial and ongoing out-of-pocket costs are often associated with their chronic conditions. ACCHOs address this by supporting Aboriginal and Torres Strait Islander peoples with chronic conditions to access care without financial disadvantage.

Stakeholders report access to ACCHOs varies across the NQPHN catchment. People who live in the Torres and Cape HHS region have the poorest health outcomes of all HHSs in the NQPHN catchment. ACCHOs are also less available across the geographically dispersed Torres and Cape catchment.

Many ACCHOs provide services over and above their funded activities to ensure their community members get access to the services they need. ACCHOs need access to resources to support them to meet these needs where their organisation's existing resources are insufficient.

The cultural safety of mainstream services can be improved

Stakeholders report many mainstream services are not culturally appropriate. As a result, Aboriginal and Torres Strait Islander peoples may be reluctant to engage with those services. Service providers do not always understand trans-generational trauma and its impacts on mental health, use of alcohol and other drugs, deaths due to suicide, and overall health and wellbeing.

Aboriginal and Torres Strait Islander peoples may defer seeking care from mainstream services to their detriment. Stakeholders report many examples of cultural insensitivity by mainstream providers that resulted in people:

- not wishing to volunteer their Aboriginal or Torres Strait Islander status
- feeling unsafe or unwelcome in the service
- discharging themselves without treatment or not waiting for treatment
- not attending appointments with services.

Hospital Liaison Officers could potentially support people seeking care within hospitals. However, their role is often poorly understood and access to a Hospital Liaison Officer is not always offered to the patient.

People access ACCHOs and mainstream health services

People accessing health services report difficulties navigating the health service system. It is unclear to patients and their families and caregivers which services they should access for specific health problems.

Treatment and support should be provided in a continuous and coordinated manner by a range of service providers in and between a range of settings. ACCHOs are central to the delivery of comprehensive, coordinated health care for most Aboriginal and Torres Strait Islander peoples in the NQPHN catchment. Given the centrality of their role, ACCHOs need to be embedded in systems of communication and information sharing between health professionals.

According to stakeholders, communication and information-sharing between different professionals and settings and ACCHOs can be improved. When services are accessed, people report service providers do not always communicate and share relevant information with their ACCHO which contributes to gaps in continuity of care.

Mental health, alcohol and other drugs, and sexual and reproductive health treatment and support needs to respect the consumer's social and cultural values, beliefs, practices, and stage of development. Stakeholders report Aboriginal and Torres Strait Islander peoples need better access to primary health care and support that meets their cultural care needs and that promotes social and emotional wellbeing. Supporting ACCHOs to deliver these services could reduce reliance on mainstream mental health, alcohol and other drugs, and sexual and reproductive health service providers.

The lower survival rate for Aboriginal and Torres Strait Islander peoples for some cancers may be partly explained by factors such as lower participation in screening, later diagnosis, lower likelihood of receiving treatment, comorbidities, and a greater likelihood of being diagnosed with cancers with poorer survival.

Stakeholders report improvements in cancer care for Aboriginal and Torres Strait Islander peoples in our community are needed, including in cancer diagnosis, treatment, and health support services so they are more accessible and acceptable to Aboriginal and Torres Strait Islander peoples.

Health workforce gaps need to be addressed

Although the rate of employment of Aboriginal and Torres Strait Islander peoples in the health workforce has increased over time, more needs to be done to increase participation of Aboriginal and Torres Strait Islander peoples in the health workforce.

Stakeholders report there are not enough paid positions in the health workforce for Aboriginal and Torres Strait Islander peoples. Health workforce needs are broad and include doctors, nurses, midwives, allied health professionals, and ancillary workforce (including managers and administrative roles). More identified positions are needed in mental health, alcohol and other drugs, sexual health, chronic disease, and maternal and child health.

Aboriginal and Torres Strait Islander health workers and health practitioners provide specialised service delivery and fulfil a wide range of mainstream health care roles. They enhance the amount and quality of clinical services provided to Aboriginal and Torres Strait Islander peoples. According to stakeholders, the Aboriginal and Torres Strait Islander Health Worker and Health Practitioner workforce needs to be expanded to meet the primary health care needs of people in northern Queensland.

Stakeholders report Aboriginal and Torres Strait Islander peoples experience discrimination in the health workforce, where they may be the only employee who is Aboriginal or Torres Strait Islander. Ensuring Aboriginal and Torres Strait Islander health workers have good peer support is important to retain them in the workforce.

Priority actions

The importance of primary health care in improving health outcomes for Aboriginal and Torres Strait Islander peoples in our community cannot be understated. Clinicians and community members convey a sense of urgency in strengthening primary care and delivering holistic, comprehensive, and culturally appropriate healthcare across the NQPHN catchment.

Progress against the Closing the Gap targets indicates more needs to be done to improve primary care service delivery. Priorities for NQPHN are stronger partnerships with ACCHOs, supporting sustainable health workforce solutions to build local capacity and capability, improvements in the cultural competency of mainstream health services, and better integration of ACCHOs with the rest of the health service system.

Population Health

Maternal and child health

A priority for NQPHN is to improve prevention, promotion, and early intervention focused on maternity and postnatal care.

NQPHN will support the work of ACCHOs, HHSs, and system partners to commission programs and services that maximise maternity and postnatal outcomes for Aboriginal and Torres Strait Islander mothers and babies.

Our HNA demonstrates maternity care is less accessible for many women and babies in our catchment. NQPHN's priority is achieving equity for Aboriginal and Torres Strait Islander mothers and babies through improved access to maternity care that is coordinated, accessible, and culturally safe.

Sexual and reproductive health

Primary care has an important role to play in sexual and reproductive health, and in identifying and supporting management of STIs and bloodborne viruses (BBVs). Our HNA demonstrates Aboriginal and Torres Strait Islander peoples in northern Queensland have distinct care needs in these areas.

A priority for NQPHN is to support sexual and reproductive health and in reduction of burden of disease associated with STIs and BBVs in Aboriginal and Torres Strait Islander peoples in northern Queensland.

NQPHN will work with partners to identify opportunities to provide Aboriginal and Torres Strait Islander peoples with increased access to coordinated, accessible, and culturally safe primary care for people experiencing sexual and reproductive health problems, including STIs and BBVs.

Infectious diseases

A priority for NQPHN is to support ACCHOs and other system partners to address infectious disease priorities in northern Queensland, with a particular focus on the Torres and Cape region.

Our HNA identifies poorer outcomes from infectious diseases that can be identified and managed within primary care. Through our commissioning and partnerships, we will work with partners to respond to this significant health burden.

GPs and other Primary Care Professionals

Supporting the Aboriginal and Torres Strait Islander health workforce

A priority for NQPHN is to build workforce capacity and capability of Aboriginal and Torres Strait Islander health professionals. NQPHN will support ACCHOs and the Queensland Aboriginal and Islander Health Council (QAIHC) in the development and expansion of the Aboriginal and Torres Strait Islander health workforce in the NQPHN catchment.

Our HNA identifies gaps in funded identified primary care positions across our catchment. Through our commissioning of services and partnership approach, we support Aboriginal Community Controlled Organisations to increase the availability of Aboriginal and Torres Strait Islander health professionals to address their priorities.

Increasing service continuity in the Torres and Cape HHS

Our HNA identifies Torres and Cape HHS communities are an urgent priority. Aboriginal and Torres Strait Islander peoples in Torres and Cape HHS region have:

- the lowest life expectancy of all HHSs
- the most regionally dispersed population with the least access to a primary care workforce
- the poorest maternal and child health outcomes and least accessible maternity care
- the highest age-standardised mortality for cancer, cardiovascular disease, and diabetes
- the lowest participation in cancer screening.

Building the local Aboriginal and Torres Strait Islander health workforce, supporting Aboriginal Community Controlled Health service delivery, and establishing innovative models of primary care service delivery that facilitate coordinated, accessible primary care availability are a priority for NQPHN and our system partners.

System Integration

Supporting chronic conditions management

NQPHN's priority is to support the delivery of Integrated Team Care (ITC) services to contribute to improving health outcomes for Aboriginal and Torres Strait Islander peoples with chronic health conditions. With the commissioning support of NQPHN, ACCHOs will be able to improve access to care coordination, multidisciplinary care, and support for self-management for their community members.

First Nations Health

Partnering with Aboriginal Community Controlled Health Organisations

Communities each have their own health priorities and their own preferred solutions for addressing these priorities. Across the NQPHN catchment, primary care priorities are broad and include but are not limited to:

- maternal and child health
- sexual health
- chronic disease management
- mental health and alcohol and other drugs treatment.

A priority for NQPHN is to work with the Queensland Aboriginal and Islander Health Council (QAIHC), Queensland Health and partner organisations to progress Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples, as part of a partnership approach to the National Agreement on Closing the Gap (2020).

As part of our commitment to Making Tracks, NQPHN affirms its commitment to building the community-controlled sector and improving mainstream services.

Supporting delivery of culturally safe mainstream primary health services

Some people's health care needs are addressed by mainstream services. Our HNA demonstrates widespread engagement with mainstream general practice by Aboriginal and Torres Strait Islander peoples in our community. NQPHN's priority is to support culturally safe mainstream service delivery and improved integration of mainstream services with services provided by ACCHOs.

We will work with partners to provide Aboriginal and Torres Strait Islander peoples with access to mainstream primary health services that are culturally safe and support Aboriginal and Torres Strait Islander peoples to access their comprehensive ACCHOs.

NQPHN's priority is to work with ACCHOs to improve cultural safety of general practice services offered across the NQPHN catchment. This includes training to practices as well as measurement and monitoring of patient experiences at these services.

Mental Health and Alcohol and Other Drugs

Access to mental health and alcohol and other drug treatment services

Supporting the delivery of mental health and drug and alcohol services for Aboriginal and Torres Strait Islander peoples is a priority for NQPHN. NQPHN commissions ACCHOs to provide these services in our community.

Our HNA demonstrates priority populations include Aboriginal and Torres Strait Islander:

- children and adults
- people in rural and remote locations
- people who have self-harmed or attempted suicide or are at risk of suicide
- women experiencing perinatal depression or anxiety
- people with alcohol and or other drugs issues.

NQPHN's priority is to work with ACCHOs to improve access to mental health, alcohol and other drugs services through commissioning, partnerships and supporting workforce development and addressing workforce gaps.

Social and emotional wellbeing support

Supporting social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples is a priority for NQPHN. NQPHN funds Aboriginal Medical Services to provide this support in our community.

NQPHN's priority is to support implementation of the Joint Regional Wellbeing Plan for Northern Queensland. Aboriginal and Torres Strait Islander peoples' interpretation and application of social and emotional wellbeing varies between different groups and individuals. In consultation to develop the Joint Regional Plan, ACCHO stakeholders recommended referencing the National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing 2017–2023:

"In broad terms, social and emotional wellbeing is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It is a holistic concept which results from a network of relationships between individuals, family, kin, and community. It also recognises the importance of connections to land, culture, spirituality and ancestry, and how these affect the individual."

NQPHN recognises social and emotional wellbeing (SEWB) problems are distinct from mental illness. For example, there may be differences in severity, duration, and whether the presenting problems meet the criteria and threshold for a diagnosable condition. An Aboriginal or Torres Strait Islander person may require either SEWB or mental health services or at times have need of both. NQPHN's priority is to continue to support provision of mental health services and social and emotional wellbeing supports for our community.

Mental Health and Alcohol and Other Drugs *(continued)*

A goal of integrated team care (ITC) is to improve access to culturally appropriate mainstream primary care services for Aboriginal and Torres Strait Islander peoples with chronic conditions who need to access mainstream services. ITC will ensure their community members remain supported by their local, comprehensive primary care services while accessing mainstream support.

Building the capacity of the mental health and alcohol and other drugs treatment sector

NQPHN will continue to work to address gaps in mental health and drug and alcohol service delivery for Aboriginal and Torres Strait Islander peoples.

NQPHN's priority is to increase the availability of mental health, alcohol and other drug information and treatment services for Aboriginal and Torres Strait Islander peoples. NQPHN will continue to work with primary care, social and community services to increase the availability of Aboriginal and Torres Strait Islander health professionals in primary and community health services.

Appendices

Appendix 1: HNA stakeholder consultation details

EVENTS

Total events hosted over a one-week period **9** ⇨ **120** total attendees

events were face to face while the remaining four were mixed (ie. online and face to face)

FEEDBACK FORM

An online survey along with a recorded video presentation was shared with attendees and non attendees for feedback.

57

TOTAL RESPONSES

RESPONSE LOCATIONS	Cairns	Mackay	Townsville	Torres and Cape
	21	20	11	2

RESPONSE STAKEHOLDER TYPE	Community health providers	HHS staff	Community members	Community leaders	NQPHN staff
	29	12	10	3	3

46% of the respondents agreed the HNA presentation helped them understand the role of the PHN better, while 21.1% strongly agreed

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