Description of Health Service Use, Workforce and Consumer Need for Northern Queensland Primary Health Network
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Glossary and abbreviations

ABS . . . . . Australian Bureau of Statistics
AGS . . . . . Australian Statistical Geographical Standard
AIHW . . . . Australian Institute of Health and Welfare
COPD . . . . . Chronic obstructive pulmonary disease
CVD . . . . . Cardiovascular disease
DoH . . . . . Commonwealth Department of Health
ED . . . . . . Emergency department
GP . . . . . . General Practitioner
HHS . . . . . Hospital and Health Service
HNA . . . . . Health Needs Assessment
IRSD . . . . . Index of Relative Socio-Economic Disadvantage
LGA . . . . . Local Government Area
MH . . . . . Mental Health
NEAT . . . . National Emergency Access Targets
NQPHN . . . . Northern Queensland Primary Health Network
PHN . . . . . Primary Health Network
PPH . . . . . Potentially preventable hospitalisation
QH . . . . . Queensland Health
SEIFA . . . . Socio-Economic Indexes for Areas

Aboriginal and Torres Strait Islander persons referred to as Indigenous Australians
**Foreword**

This is the inaugural Health Needs Assessment (HNA) for Northern Queensland Primary Health Network (NQPHN). It describes our population demography, lifestyle behaviours, health service use, and health service provision across the primary and tertiary health sectors.

The process of assessing health needs has identified 15 key priority areas specific to our PHN region, to which we will now tailor resource allocation. The role of the PHN is to commission additional services to address the key priority areas that improve access to health services and maximise service delivery efficiency, and the HNA will enable us to do this efficiently and with direct relevance to our communities.

This initial Health Needs Assessment highlights the diversity of our population across the Northern Queensland PHN region. We support a high proportion of Aboriginal and Torres Strait Islander people, the traditional custodians of the land we now live on; rural and remote persons, often living in situations of social isolation; mining communities with large numbers of fly-in fly-out workers; and a high proportion of young families who often have complex maternal and early childhood needs.

To address the needs of our communities across such a diverse region, Northern Queensland PHN is committed to providing equity in health service delivery. We recognise and are committed to fulfilling our role in partnering with organisations and governments to improve the underlying social determinants of health, to enable long-term, sustainable health advancements across the Northern Queensland PHN region.

As the Chair of the Northern Queensland PHN Board, I endorse this Health Needs Assessment.

Northern Queensland Primary Health Network (NQPHN) is committed to improving health outcomes for Aboriginal and Torres Strait Islander people.

This Health Needs Assessment identifies Aboriginal and Torres Strait Islander persons as a key priority area for additional resource allocation. We embrace the opportunity to work together with Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services, and mainstream service providers to improve access to culturally appropriate primary health services and programs that effectively engage local communities.

NQPHN acknowledges that primary health services and programs require a deeper understanding of Aboriginal and Torres Strait Islander histories, cultural and social factors, which will help towards reducing the health inequalities within our communities.

I endorse the Northern Queensland Primary Health Network Health Needs Assessment.

---

Trent Twomey  
CHAIRMAN  
Northern Queensland Primary Health Network

Peter Malouf  
GENERAL MANAGER – INDIGENOUS HEALTH  
Northern Queensland Primary Health Network
Northern Queensland Primary Health Network (PHN) commits to the implementation of this Health Needs Assessment and continued development of partnerships and collaboration with communities and health providers – with the aim to continually improve and respond to the current and future health needs of our community.

This document commences discussion about the health needs of the population within the Northern Queensland PHN region.

This initial Health Needs Assessment will evolve to more accurately represent health service provision and health consumer need across the Northern Queensland PHN region.

As the CEO of the Northern Queensland PHN, I endorse this Health Needs Assessment.

Robin Moore
CHIEF EXECUTIVE OFFICER
Northern Queensland Primary Health Network
Overview

The purpose of this Health Needs Assessment (HNA) is to commence discussion about the health needs of the population within the Northern Queensland Primary Health Network (NQPHN) region. This needs assessment incorporates the needs of consumers and the needs of the health workforce as they are essential to the delivery of health services to consumers.

By combining consumer need and service need, the HNA identifies the key priority areas specific to the NQPHN. The identification of these key priority areas inform the strategic plans for the entire organisation. The HNA is not an exhaustive list of all services and consumer needs, rather, it is an essential process in identifying key areas specific to our community. Within each key area, various strategies may then be applied, with a variety of measurable outcomes.

This document has been developed in line with Commonwealth guidelines using primary data sources obtained from Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), the Department of Health (DoH), in addition to specific data provided by Queensland Health (QH). Furthermore, we include summaries of workshops obtained during stakeholder consultation, and limited consumer consultation that was available within the public domain.

The HNA is a document that evolves as new and more relevant information becomes available. It is intended that there are updates and documentation of health needs in the NQPHN region, thus all feedback on health needs, data availability and service delivery improvements is welcome.

Northern Queensland Primary Health Network (PHN) is one of 31 PHNs across Australia. Funded by the DoH, they enable local administration of health services to target delivery of health services specific to each PHN community. Our goal is that patients receive the right care in the right place at the right time. Within this framework, we commission service delivery with the key objective of increasing the efficiency and effectiveness of health services for patients, particularly those at most risk of poor health outcomes.

Northern Queensland PHN region is unique. Spanning an area of 510,000km², approximately twice the land size of the UK, this tropical environment is home to 730,000 people. The majority of the population are located within the regional centres of Cairns, Townsville and Mackay, but a significant amount of the population live outside of the cities in rural and remote areas.

Northern Queensland PHN region has nine Aboriginal Medical Services (AMS) and 150+ Aboriginal Health Workers (AHW).

Top 6 Local Health Priority Areas

1. Improve access to health services in rural and remote areas
2. Improve access to mental health services
3. Promote health workforce expansion and sustainability
4. Transition chronic disease management to community level care
5. Improve Aboriginal and Torres Strait Islander health
6. Improve childhood and maternal health
Acknowledgements

Northern Queensland PHN gratefully acknowledges the valued input from their eight Board Members and 20 Clinical Council Members, as well as all NQPHN staff who provided contributions.

We also wish to thank community members, primary health professionals including General Practitioners and allied health professionals who engaged with us on our Listening Tours.

We recognise the contributions of our four Hospital and Health Services (HHSs) and 10 National Aboriginal Community Controlled Health Services (NACCHSs) within our PHN region, and we thank them for their input and support.

We thank the two previous Medicare Local organisations for their cooperation. And lastly, we wish to thank all health consumers across the PHN region for whom we are working to improve health outcomes.
Summary of findings

Four Hospital and Health Services (HHS); 31 Local Government Areas (LGA); spanning an area twice the size of the UK; home to approx. 730,000 people (2016), 83,000 who are Indigenous Australians.

Cairns and Hinterland
- Home to ~260,400 people
- 13.1% of population are Indigenous
- 9 LGAs covering 142,452km²

Townsville
- Home to ~251,200 people
- 8.5% of population are Indigenous
- 7 LGAs covering 147,789km²

Mackay
- Home to ~192,500 people
- 5% of population are Indigenous
- 3 LGAs covering 90,125km²

Torres and Cape
- Home to ~25,900 people
- 68.2% of population are Indigenous
- 12 LGAs covering 129,769km²

Our Community

Northern Queensland PHN region is comprised of some very remote areas with a diverse range of health needs. For health consumers, remoteness generally translates to reduced access to health services while for providers, remoteness is associated with difficulty in attracting and retaining workforce.

Remoteness and distance can also increase the cost of fresh fruit and vegetables, which can impact on the population’s health and wellbeing.

Overcrowding is highly associated with increased disease, in particular childhood ear and diarrhoeal diseases. These can have long-term implications as ear disease leads to hearing loss, and deafness and long-term diarrhoeal diseases are associated with malnutrition in infants, identified as a leading cause of morbidity in Indigenous Australian children.

The Torres Strait Islands and Cape York Peninsula region in particular has reduced access to private transport. This when coupled with greater distances indicates reduced access to health care. Overcrowding is highly associated with increased disease, in particular childhood ear and diarrhoeal diseases. These can have long-term implications as ear disease leads to hearing loss, and deafness and long-term diarrhoeal diseases are associated with malnutrition in infants, identified as a leading cause of morbidity in Indigenous Australian children.

21  LGAs have people living in very remote areas
8%  of the population live in ‘remote’ or ‘very remote’ areas
80%  of the population live in ‘outer regional Australia’
The socio-economic status provides useful insight into the broader determinants of health within a population. The level of economic resources impacts families in a number of ways which can impact their health, for example their ability to afford healthy food or travel in order to access health care.

There are pockets of extreme disadvantage in our area, which are resulting in poor health outcomes for those people. A coordinated approach to the delivery of health and other services, such as education, will be critical to improving health outcomes in this area.

It is estimated that nearly two thirds of the NQPHN population can be classified as overweight or obese. NQPHN has a higher overall proportion of overweight and obese than the state. Men are more likely to be overweight or obese than women. The Torres and Cape region has the highest estimated proportion of overweight and obese people in the NQPHN region.

There are high rates of smoking in NQPHN’s region, particularly in the Torres and Cape. Health services that reduce rates of smoking will achieve substantial health outcomes for the region.

The population of NQPHN has a higher risk of alcohol-related illness than the rest of the State. Health services that reduce the levels of alcohol consumption will improve health outcomes in the region.
Our health

Our region has lower life expectancy across all regions than Queensland. The life expectancy in Torres and Cape region is on average 12 years less than the state average for Queensland.

Across all ages, the leading causes of death in Queensland are primarily cardiovascular disease (CVD) and cancer.

**Overall**
the leading causes of death are **heart disease and cancer**

**For 15 to 44 year olds**
the leading causes of death are **intentional self harm** (suicide)

Different diseases often present at different ages. The leading cause for death in the 15 to 44 age group is intentional self-harm (suicide). Results from a report commissioned by the Queensland Suicide Register indicate suicide rates for the NQPHN region (2011-2013) to be 1.5 times the national rate. Furthermore, across some sections of the NQPHN region, suicide is reported at five times the National rate. The combined high rates of diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease indicate need for change to primary health care delivery with increased chronic disease plans.

High burden of disease, PARTICULARLY IN TORRES & CAPE REGION

**Diabetes rate** in Torres and Cape is ~4 times higher than that of Queensland

**Coronary heart disease** rates in Cape York are ~2 times higher than Queensland

**Chronic obstructive pulmonary disease** rates in Cape York are ~2 times higher than Queensland

**Stroke** rates in Torres and Cape York are ~2 times higher than Queensland

~25,400 potentially preventable hospitalisations (PPHs) IN FY 14/15 IN OUR REGION

12,700 PPHs for chronic episodes of care

11,700 PPHs for acute episodes of care

1,000 vaccine preventable admissions representing 16.4% of all hospital admissions

Our primary health workforce

191+ General Practices

600 General Practitioners

940 Nurse & midwife practitioners

390 Pharmacists

300 Dentists

850 other Allied Health Professionals

A large proportion of COPD and diabetes acute presentations to emergency departments (EDs) may have been preventable if appropriately managed by community HHS services or primary health providers (GPs). The monitoring of these disease presentations provides an indication of coordination of care and management by community primary health services.

OUR REGION’S HOSPITAL & HEALTH SERVICES

4 Hospital and Health Services (HHSs)

15 Emergency Departments

2 Tertiary referral hospitals
Northern Queensland Primary Health Network Local Priority Areas

These priority areas have been identified through the process of triangulating our PHN population, the current services available, and the current and projected needs of health consumers.

We need to increase access to health care in rural and remote areas: Our region encompasses vast distances. Health service delivery to rural and remote areas can be challenging. NQPHN is committed to improving access to health services in these rural and remote areas by increasing services, improving their coordination, and applying innovative methods such as telehealth and e-health.

We recognise the importance of improving access to mental health services: This is a high priority for our PHN as young people are most at risk. We are dedicated to improving access to mental health services, reducing the unmeasured burden of disease of mild and moderate areas, and reducing self-harm rates.

Our workforce is our backbone. We value the retention and expansion of our health workforce to service the health needs of our community: Supporting our workforce and providers to access relevant professional development is critical to maintaining quality service delivery and long-term sustainability of our health services.

To maximise the outcomes of health consumers burdened with chronic disease, our PHN will focus on transitioning chronic disease management to community level care: Community providers are best placed to tackle chronic disease early and reduce the number of presentations to hospital.

Close the Gap. We will strive to improve Aboriginal and Torres Strait Islander Health: Our continued commitment to improving health outcomes for Aboriginal and Torres Strait Islander peoples is a priority for NQPHN.

Children and pregnant mothers are arguably the most vulnerable groups within the community. We aim to improve health service delivery for our future generation: Instilling health behaviours in our children will better equip them to lead healthy, illness-free lives.

We will provide and enable improved substance misuse support services in the community: Tackling substance misuse will improve the long-term outcomes for the individual, reduce hospital admissions, and improve social outcomes for the community.

We want to improve access to specialist clinics: Providing specialist care at the right time is important. Access to services can be maximised by improving pathways between the community and hospital systems.

We will provide better access to after-hours health services: Improving community after-hours access will reduce pressure on hospitals, improve wait times, and support community providers to offer comprehensive services.

We will continue to support preventive health measures including screening, immunisation and promoting healthy behaviours: Prevention is often the best cure, and addressing the risk factors for diseases will produce better outcomes for individuals and communities.

We value our elderly and want to support their care in the community management: Elderly patients are best cared for by community providers. We will support the provision of primary health care to elderly persons, especially those in residential aged care facilities.

We will map primary health services across the PHN: We wish to improve health service access to those most in need. We must first understand what services are available to our health consumers across the PHN to identify where gaps exist.

We will integrate My Health Record into routine primary health and HHS patient care: My Health Record is a key platform to establish a more integrated and coordinated health system through effective communication of health services.

We want to improve access to health transport: our workforce and consumers have voiced their concerns about transport to and from health services. We recognise that transport is integral to access.

We will improve pathways between primary health care and the Hospital and Health Services: We want to support integrated approaches to care that will improve patient pathways in and out of hospital.
1. Introduction

Northern Queensland Primary Health Network (NQPHN) extends across a geographically vast and demographically diverse area. Within the catchment of NQPHN, the population has mixed health status with pockets of high advantage that rest in stark contrast to large areas of extreme disadvantage.

This is compounded by the remoteness of the region and scattered Aboriginal and Torres Strait Islander communities, reporting a higher incidence of chronic disease and subsequent lower life expectancy when compared with Queensland and the rest of Australia. The challenge for NQPHN is to improve the health outcomes and increase health access to the people of North Queensland with the greatest need. NQPHN is especially committed to addressing Aboriginal and Torres Strait Islander health inequity and will support or commission culturally appropriate services.

1.1 BACKGROUND ON THE HEALTH NEEDS ASSESSMENT

The Health Needs Assessment (HNA) is a document that evolves as new and more relevant information becomes available. It provides an overview of who our PHN population are and what their greatest health needs are, and this information is then used to identify our key priority areas. These key areas in-turn, inform effective commissioning of services for Northern Queensland PHN. This document commences the commissioning process and will evolve with the health service market and as the health needs of the community change. The HNA is not an exhaustive list of all services and consumer needs, rather it is an essential process in identifying key areas specific to our community. Within each key area, various strategies may then be applied, with a variety of measureable outcomes.

This document has been developed in line with Commonwealth guidelines using primary data sources obtained from Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), the Commonwealth Department of Health (DoH), in addition to specific data provided by Queensland Health and other local health service providers. Furthermore, we include summaries of workshops obtained during stakeholder consultation, and report PHN-specific consumer consultation as available within the public domain.
1.2 METHODS

This document was created in partnership with internal and external stakeholders, including the two previous Medicare Locals (ML): Townsville-Mackay Medicare Local (TMML) and Far North Queensland Medicare Local (FNQML). It aims to understand the population’s health needs and the services available across the Primary Health Network footprint. The process of the HNA analysis identified gaps where changes to services, service delivery, communication between services, and assistance with service provider needs could enhance existing services to ultimately improve population health. This HNA maps a series of identified gaps to better describe the trajectory of innovative change: from one upstream change may stem several downstream health benefits to our PHN population. This HNA informs and prioritises strategies to be implemented across the PHN, which include a range of activities such as commissioning of services and improved health care coordination.

Where possible, data was sourced by Local Government Area (LGA). For the main document, data has been presented at a HHS region level (refer to chapter 2.1). Please refer to the LGA snapshots from page 74 onwards for LGA-specific health data.

Limitations:

1. Data availability, often disease rates were only available by SA3 or HHS level, where detailed data would enable a more comprehensive assessment of need

2. Data from General Practitioners (PENCAT) was not available at the time of writing of this report

Source: Department of Health, PHN profiles December 2015 [1]

Figure 1: Northern Queensland Primary Health Network region
2. Geographic profile of Northern Queensland Primary Health Network region

Knowledge about the geography of an area can influence the way in which health services are designed and delivered. In turn, this affects the overall health of a community in terms of their health status and needs.

The Northern Queensland PHN area spans a total area of over 510,000 km² (twice the size of the greater UK: Scotland and Northern Ireland included) from Mackay up to the Torres Strait Islands and as far west as Croydon. The area holds some of the most diverse terrain in Queensland and Australia, and includes tropical savannah, farmland, rainforest and islands.

2.1 SUB REGIONS

For the purpose of the Health Needs Assessment, we have considered data for the 31 LGAs where possible, and aligned them to the four HHS regions within Northern Queensland.

The HHS regions referred to throughout the document are as follows:

1. Torres and Cape HHS region – 25,900 people (68% Indigenous Australian)
   The Torres and Cape HHS region is the most remote of the four with a small population covering 129,769km². It includes the LGAs of: Aurukun, Cook, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Pormpuraaw, Torres, Torres Strait Island and Weipa.

2. Cairns and Hinterland HHS region – 260,400 people (13% Indigenous Australian)
   The Cairns and Hinterland HHS region spans 142,452km² and comprises of the LGAs: Cairns, Cassowary Coast, Croydon, Douglas, Etheridge, Mareeba, Tableland, Wujal Wujal and Yarrabah.
   Note that part of Cassowary Coast falls within the Townsville HHS region, but for the purposes of the Health Needs Assessment, it has been considered in the Cairns and Hinterland Region.
   Also note that Douglas and Mareeba became LGAs on 1 January 2014. Previously, they were part of Cairns and Tablelands respectively. For some of the analysis they have been considered as part of the old LGAs dependant on the split of the data obtained.

3. Townsville HHS region – 251,300 people (9% Indigenous Australian)
   The Townsville HHS region spans 147,789km² covering the LGAs of: Burdekin, Charters Towers, Flinders, Hinchinbrook, Palm Island, Richmond and Townsville.

4. Mackay HHS region – 192,500 people (5% Indigenous Australian)
   The Mackay HHS region is the smallest area of the four, spanning 90,125km². It includes the LGAs of: Isaac, Mackay and Whitsundays.

Source: Queensland Health
Figure 2: HHS regions across the NQPHN region
2.2 REMOTENESS

It is important to consider the remoteness area of the PHN region, as this is often a key indicator of health access. Those living in more remote areas have reduced access to health services greater distances to travel for medical attention, and generally have higher rates of ill health and mortality compared to those living in larger cities. Those living in rural areas generally have higher levels of social cohesiveness [2].

The map below shows the region by remoteness as based on the Modified Monash Model classifications, and further illustrates the distances from very remote regions to regional areas. Note: 1 is equivalent to ‘Major City’ and 7 is equivalent to ‘Very Remote’. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities.

There are 14 LGAs (of 31) in the region that are considered to be very remote, making distance and travel big considerations when planning service delivery. Innovative ways of delivering services are needed in these very remote areas. For example, telehealth and telehealth monitoring of chronic conditions should be considered.

Implication:

- Northern Queensland PHN region is comprised of some very remote areas with a diverse range of health needs. For health consumers, remoteness generally translates to reduced access to health services while for providers, remoteness is associated with difficulty in attracting and retaining workforce. Remoteness and distance can also increase the cost of fresh fruit and vegetables, which can impact on the population’s health and wellbeing.

Source: Department of Health, PHN profiles December 2015[1]

Figure 3: Remoteness as based on the Modified Monash Classifications across NQPHN
3. Demographics

The demographic profile of a region is an important component in determining health needs. Demographic analysis allows for the planning of current and future service delivery to meet the changing needs of the population. Examples of how the demographic characteristics of a population influence health and healthcare include:

- The number of older people in the population strongly influences morbidity and mortality for many chronic conditions, and demand for health and aged care services.
- The composition of the population (for example, in terms of language diversity) and its geographic spread influences the provision of specialised health services and modes of delivery.
- The population aged 15 – 64 years are generally representative of the workforce available in a region, therefore impacting not only on the economic status of the region but also the available workforce for industries including health services [3].

3.1 POPULATION AND PROJECTED POPULATION GROWTH

Awareness about the population size and projected growth provides an indication of expected demand for health services in the future. This impacts health service facility and workforce planning, as health services will need to consider how much more capacity will be required over the next 20 years and whether the appropriate workforce exists to meet projected demand.

Northern Queensland PHN region has an estimated population of 730,100 (as per 2016 projected estimate from 2011 Census data). Table 1 below show the HHS projected populations to 2036.

Table 1: Population projections for NQPHN by LGA

<table>
<thead>
<tr>
<th>HHS Region</th>
<th>2011 (census)</th>
<th>2016p</th>
<th>2036p</th>
<th>Average annual growth rate</th>
<th>Area (km²)</th>
<th>Population density (2016p)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no.</td>
<td>no.</td>
<td>no. (2011-2036)</td>
<td>no.</td>
<td></td>
<td>people/km²</td>
</tr>
<tr>
<td>Torres and Cape</td>
<td>24,336</td>
<td>25,900</td>
<td>30,800</td>
<td>1.0%</td>
<td>129,769</td>
<td>0.20</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>240,069</td>
<td>260,400</td>
<td>354,800</td>
<td>1.6%</td>
<td>142,452</td>
<td>1.83</td>
</tr>
<tr>
<td>Townsville</td>
<td>227,365</td>
<td>251,300</td>
<td>363,600</td>
<td>1.9%</td>
<td>147,789</td>
<td>1.70</td>
</tr>
<tr>
<td>Mackay</td>
<td>171,564</td>
<td>192,500</td>
<td>284,300</td>
<td>2.0%</td>
<td>90,125</td>
<td>2.14</td>
</tr>
<tr>
<td>NQPHN region total</td>
<td>663,334</td>
<td>730,100</td>
<td>1,033,500</td>
<td>1.8%</td>
<td>510,136</td>
<td>1.43</td>
</tr>
<tr>
<td>Queensland total</td>
<td>4,476,778</td>
<td>4,946,300</td>
<td>7,095,200</td>
<td>1.9%</td>
<td>1,729,958</td>
<td>2.86</td>
</tr>
</tbody>
</table>

Source: Census data 2011 [4]

Population projections are generated by applying assumptions regarding future trends in the components of population change. These assumptions include: fertility, mortality and migration. From 2016 to 2036, the population for the PHN region is projected to increase from 730,100 people to 1,033,500 people, which is a percentage increase of 42 per cent (~303,400 people). Higher growth is expected in Cairns, Mackay, Townsville, Isaac, Whitsundays and Weipa, whereas a decrease in population is expected for some of the small LGAs (population < 800) including Lockhart River, Wujal Wujal and Richmond. A small population decrease is also expected for Flinders and Hinchinbrook.
3.2 AGE STRUCTURE

The distribution of age can have a profound effect on the health services required by a population. Many diseases are typical only at certain ages. Reliance on the need for social support can also change with age. Nationally, there is a growing proportion of elderly, which indicates many regions need to invest in aged care to meet future demand.

Consistent with State and National trends, the evidence suggests that NQPHN will have a greater number of elderly in future years, assuming that elderly populations do not move to other locations outside of the region for retirement.

Implication:

With an ageing population, there is likely to be an increased demand on aged care services and disease types that typically occur later in life such as dementia. Our PHN also supports a higher proportion of young people with high fertility rates. This suggests that there will be greater need for childhood health services now and in the future.
### 3.3 Indigenous Australian Population

Indigenous Australians have higher levels of ill health across all stages of life [6]. The Indigenous Australian population is based on the 2011 Census of Population and Housing question about Indigenous status where each person is asked to identify whether they are of Aboriginal and/or Torres Strait Islander origin. The proportion of Aboriginal and Torres Strait Islander population by HHS is shown in the table below.

#### Table 2: Indigenous Australian population of NQPHN region by HHS region in 2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>17,200</td>
<td>25,200</td>
<td>68%</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>32,800</td>
<td>250,000</td>
<td>13%</td>
</tr>
<tr>
<td>Townsville</td>
<td>20,300</td>
<td>239,300</td>
<td>8%</td>
</tr>
<tr>
<td>Mackay</td>
<td>9,100</td>
<td>182,000</td>
<td>5%</td>
</tr>
<tr>
<td>NQPHN total</td>
<td>79,300</td>
<td>696,600</td>
<td>11%</td>
</tr>
<tr>
<td>Queensland Total</td>
<td>203,000</td>
<td>4,722,400</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Source: ABS [7]*

The NQPHN region has a higher proportion of Aboriginal and Torres Strait Islander residents than the State and in 13 of 31 LGAs, the majority of the population are from an Indigenous Australian background. LGAs with a majority of Indigenous Australian residents are located in remote areas.

Additionally, NQPHN region comprises approximately 11% of the total Australian Indigenous population.

### Implication:

Understanding how to best provide health services to Indigenous people in rural and remote areas will be crucial to achieving improved health outcomes in NQPHN.

### 3.4 Life Expectancy, Leading Causes of Death and Mortality

Life expectancy, death rates and leading causes of death are useful summary measures of long-term health outcomes that can be used to compare the health of one population with other populations. This can provide insight into the unique health needs of the population and the services it may require.

#### 3.4.1 Life Expectancy

Life expectancy is a summary indicator of long-term health outcomes. It provides useful information on current mortality across different age groups and allows comparisons of groups with different population structures. Life expectancy at birth is the average number of years newborns would be expected to live if current mortality rates remain unchanged through their entire lifetimes.

On average, each male and female in Torres and Cape region lives 12 years less than their counterparts elsewhere in Queensland. For the rest of the Northern Queensland PHN region, life expectancy is just under (within 1 year) that of Queensland’s average for both males and females.
3.4.2 DEATH RATES BY INDIGENOUS AUSTRALIAN STATUS

Indigenous Australians have been reported to have poorer health outcomes and a reduced life expectancy than non-Indigenous Australians. Calculations such as life expectancy can mask some important indicators of the health of a population such as infant mortality, and the effect of remoteness on health. The table below shows national death rates for Indigenous Australian populations living in cities compared to those living in remote areas. This data clearly shows that infant mortality and age standardised death rates are higher in remote areas than in the cities.

<table>
<thead>
<tr>
<th></th>
<th>Indigenous population</th>
<th>Non-Indigenous population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Infant mortality rates</td>
<td>Standardised death rates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Cities</td>
<td>5.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Inner and Outer Regional</td>
<td>7.7</td>
<td>8.5</td>
</tr>
<tr>
<td>Remote and Very Remote</td>
<td>10.5</td>
<td>14.3</td>
</tr>
<tr>
<td>Total (Australia)</td>
<td>7.8</td>
<td>9.6</td>
</tr>
</tbody>
</table>

The standardised death rate for Indigenous Australian persons living in remote or very remote locations across Australia report age-standardised death rate of 14.3, compared with 5.2 reported from their non-Indigenous counterparts based within the same remoteness category. The Indigenous Australian mean age of death is less than 60 across all remoteness categories, while for non-Indigenous persons it is greater than 76.
3.4.3 LEADING CAUSES OF DEATH

The leading causes of death are often a flag for the major health issues affecting a population. The table below shows the leading causes of death in Queensland as an indication of the leading causes of death within NQPHN.

Leading causes of death for NQPHN’s region was not obtained in time to inform this HNA. For this reason, whole of Queensland statistics have been presented in the table below.

Table 4: Leading causes of death, Queensland 2013

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Number of deaths (2013)</th>
<th>Age-specific Death Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Ischaemic heart diseases</td>
<td>2,217</td>
<td>1,782</td>
</tr>
<tr>
<td>Malignant neoplasms of digestive organs</td>
<td>1,340</td>
<td>941</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>774</td>
<td>1,228</td>
</tr>
<tr>
<td>Malignant neoplasms of respiratory and intrathoracic organs</td>
<td>1,105</td>
<td>619</td>
</tr>
<tr>
<td>Organic, including symptomatic, mental disorders</td>
<td>529</td>
<td>893</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>748</td>
<td>595</td>
</tr>
<tr>
<td>Other forms of heart disease</td>
<td>610</td>
<td>711</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>401</td>
<td>375</td>
</tr>
<tr>
<td>Malignant neoplasms of lymphoid, haematopoietic and related tissue</td>
<td>438</td>
<td>306</td>
</tr>
<tr>
<td>Malignant neoplasms of male genital organs</td>
<td>677</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: ABS 2015 [10]

Implication:

- The combined effects of poorer health across a lifetime may be intensified when health care access is inadequate. These factors ensure that Indigenous Australian people living in remote areas are the most vulnerable group within our PHN. Addressing issues that affect poor health for these people is consistent with the Commonwealth Department of Health initiatives for improving health outcomes for these groups.

Across all ages, the leading causes of death in Queensland are primarily cardiovascular disease and cancer.

Different diseases often present at different ages. The leading cause for death in the 15 to 44 age group is intentional self-harm: suicide.

The most common cause of death of Indigenous Australian infants was ‘conditions originating in the perinatal period’, accounting for 48% of deaths in 2008–2012 (3.0 per 1,000 live births). Infant deaths (that is, deaths of children aged less than 1 year) represented 4% of Indigenous Australian deaths in 2008–2012, but only 1% of non-Indigenous deaths (Refer to Chapter 13 for childhood and maternal health).
3.5 COUNTRY OF BIRTH AND ENGLISH PROFICIENCY

The cultural composition of a population provides insight into level of need and service requirements for equitable access and outcomes. It is important that services are accessible and culturally sensitive to those who may not be proficient in English in order to deliver health outcomes for these populations.

Data on country of birth and language is derived from the 2011 Census of Population and Housing questions. This is based on persons by place of usual residence.

NQPHN region: Country of birth

- Australia: 78.8%
- Not stated: 0.9%
- United Kingdom: 1.0%
- New Zealand: 0.7%
- Maritime South-East Asia: 1.1%
- Western Europe: 0.6%
- Southern and East Africa: 2.6%
- Southern Europe: 3.6%

NQPHN region: English proficiency

- Speaks English only: 78.8%
- Speaks English - very well: 0.3%
- Speaks English - well: 6.6%
- Speaks English - not well: 0.9%
- Speaks English - not at all: 2.6%
- Not stated: 5.0%

Within the Northern Queensland PHN region, 89,913 persons (or 14.0%) were born overseas, compared to 888,636 persons (or 20.5%) across Queensland. Majority of persons born overseas were born in English-speaking countries (England and New Zealand). Within the region, Cairns LGA had the largest number of persons born overseas with 29,516, while the highest proportion of persons born overseas within the region was Cook LGA with 23.1%.

30,552 persons (or 34.0%) stated they spoke a language other than English at home. This compares to the whole of Queensland where 319,949 persons (or 36.0%). Just 1.2% of the NQPHN population report speaking English ‘not well’ or ‘not at all’, which is on par with Queensland’s reported proficiency. However, this proportion is higher in some far north communities, for example:

- Torres Strait Islands: 22.3% report speaking English ‘not well’ or ‘not at all’
- Northern Peninsula Area: 14.4% report speaking English ‘not well’ or ‘not at all’
- Pormpuraaw: 13.6% report speaking English ‘not well’ or ‘not at all’
- Lockhart River: 12.9% report speaking English ‘not well’ or ‘not at all’

Implication:

Proficiency of English, particularly in Indigenous Australian communities, could affect access to health services and health literacy levels in some LGAs. Services that are culturally appropriate and available in languages other than English will be critical for equitable health outcomes across all LGAs.
4. Social determinants of health

The socio-economic status provides useful insight into the broader determinants of health within a population. The level of economic resources impacts families in a number of ways which can impact their health, for example their ability to afford healthy food or travel in order to access health care.

4.1 SOCIO-ECONOMIC INDEX FOR AREAS – DISADVANTAGE

Socio-Economic Index for Areas (SEIFA) is a summary measure of the social and economic conditions of geographic areas across Australia, enabling the assessment of the welfare of Australian communities. SEIFA comprises a number of indexes, which is generated by ABS from the Census of Population and Housing. Produced in 2011, the Index of Relative Socioeconomic Disadvantage (IRSD) ranks geographical areas to reflect disadvantage of social and economic conditions. The index focuses on low income earners, relatively lower education attainment, high unemployment, and dwellings without motor vehicles. Low index values represent areas of most disadvantage and high values represent areas of least disadvantage. This is based on persons by place of usual residence. High disadvantage groups identified by the SEIFA index usually have a low income and lower education background, which have been shown to be strong predictors of a range of physical and mental health (MH) problems, including respiratory viruses, arthritis, coronary disease, and schizophrenia. These problems may be due to environmental conditions in their workplace, or, in the case of mental illnesses, may be the entire cause of that person’s social predicament.

Thus the socio-economic status characteristics point to broader determinants of health of a population, and provide further insight into the level of need that exists and the type of services required. The level of economic resources impacts families in a number of ways (for example: their ability to afford healthy food, which influences the nutrition of children).

Deprivation by socio-economic index

![Figure 8: Deprivation by the Index of Relative Socioeconomic Disadvantage (IRSD) by region](image)
Overall, the population in NQPHN region suffers greater disadvantage than that of Queensland as a whole. Just under 50% of the population fall in the first two quintiles of the index representing those that are most disadvantaged. For Torres and Cape regions, 73% of the population are within the most disadvantaged quintile, with only Weipa with people in quintile 4 and 5 (least disadvantaged). One third of the population in the Cairns Hinterland region are in the most disadvantaged quintile.

There are pockets of extreme disadvantage across the region; there are 12 LGAs (of 31) in Northern Queensland PHN region with 100% of the population in the most disadvantaged quintile (9 within the Torres and Cape region). This often correlates to areas that are highly remote.

### 4.2 HOUSEHOLD INCOME

Looking more closely at the IRSDe deprivation score and its components enables decision makers to understand the underlying causes of deprivation and develop interventions to target these. Economic factors such as income, occupation and education are powerful determinants of health directly and also indirectly through health literacy. There are various material and psychosocial reasons why people living in disadvantaged areas experience poorer health. Low household income can negatively impact housing standards or reduce access to medical services.

The lack of a sense of financial security or control over one’s life may create chronic stress which can negatively impact on physical and mental wellbeing [13].

Estimates for weekly income are based on information disclosed by individuals (over minimum working age) in the 2011 Census.

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**Implication:**

There are pockets of extreme disadvantage in NQPHN, which are resulting in poor health outcomes for those people. A coordinated approach to the delivery of health and other services such as education will be critical to improving health outcomes in this area.

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**Proportion of the population in lowest income bracket**

Source: 2011 Census of Population and Housing, ABS (Table Builder) [4]

*Figure 9: Population proportion in lowest income bracket by LGA, 2011*
Household income in the Northern Queensland PHN region approximately follows that for Queensland more broadly, however there are pockets of the region that have significantly lower incomes than the state average. 43% of Torres and Cape population fall in the lowest income bracket (<$400/week or $20,800/year), compared to 32% across NQPHN (or 35% in Queensland). In Aurukun, Wujal Wujal, Yarrabah, Hope Vale, Kowanyama, Lockhart River, Mapoon, Napranum, Northern Peninsula Area, Pormpuraaw, Torres Strait Island and Palm Island over 50% of the population falls in the lowest income bracket.

4.3 UNEMPLOYMENT AND LABOUR FORCE PARTICIPATION

Unemployment is a key component in measuring disadvantage. Not only does it affect health directly through income, it also indirectly affects health behaviour as an indication of level of literacy and a productive use of time.

Positive health impacts of employment include:
- Financial security
- Opportunities to increase skills
- Interaction with others
- Meaningful life goals
- Purpose of providing a sense of personal achievement.

Unemployed people are therefore defined as people who, during a specified period, meet all of the abovementioned criteria.

The labour force participation rate is the percentage of working-age persons in an economy who:
- Employed
- Unemployed but looking for a job.

Typically ‘working-age persons’ is defined as people between the ages of 16-64. People in those age groups who are not counted as participating in the labour force are typically students, homemakers, and persons under the age of 64 who are retired.

The graph below shows the unemployment and labour participation rates across HHS regions, calculated using 2011 Census data.

Source: 2011 Census of Population and Housing, ABS (Table Builder) [4]

Figure 10: Unemployment and labour force participation rate (2011)

Implication:

Affordable and accessible health services in rural and remote areas where there is a high proportion of people who are low income earners will be critical to delivering improved health outcomes in the NQPHN region.
Overall, NQPHN region’s labour force participation rate is on par with Queensland, with its unemployment rate of 5.4% lower than that of Queensland (6.1%). Noticeable variations from this average are:

- Mackay HHS region has the lowest unemployment rate (3.6%) and the highest labour force participation rate
- Torres and Cape region has the highest unemployment rate (8.7%) and lowest labour force participation rate of 53%
- Yarrabah, Aurukun, Hope Vale, Napranum and Palm Island LGAs have unemployment rates over 20%, as well as noticeably lower labour force participation rates indicating a significantly lower proportion of working population.

4.4 RECEIVING GOVERNMENT BENEFITS

Understanding the proportion of people on government benefits develops the understanding of the proportion of the population that may suffer disadvantage. For example, those on disability or age pensions may not be picked up in the unemployment rate for a variety of reasons.

Proportion of applicable population receiving benefits - NQPHN region vs Queensland

![Chart showing the proportion of applicable population receiving benefits in NQPHN region vs Queensland.](figure11.png)

**Implication:**

Higher rates of unemployment are associated with poverty and lower social emotional wellbeing. Low social-emotional wellbeing when exacerbated by financial difficulties (low income) is highly associated with mental health illness, one of the high priority areas identified to be addressed by PHNs (Senator Ley).

*See Notes on the data regarding % coverage >100

Figure 11: Proportion of applicable population receiving benefits – NQPHN region vs Queensland

Source: PHIDU 2015 [12]
In almost all categories, the Northern Queensland PHN region shows a higher proportion of people on government benefits than the State and National averages. Although most indicators are approximately 1% higher than the State average, some LGA are far above the average.

Over 30% of the populations aged 16 to 64 in Aurukun, Wujal Wujal and Yarrabah receive an unemployment benefit. These LGAs also have higher proportions of people receiving unemployment benefits for more than six months (Aurukun 25.6%, Wujal Wujal 37.1% and Yarrabah 36.3%).

Poverty is more likely to affect young children than any other group. The number of low income, welfare-dependent families (with children) is higher in some LGAs such as Northern Peninsula Area, Torres, and Torres Strait Island, where the proportion of families in this category is over 30%. Over 40% of children in Cook, Northern Peninsula Area, Torres and Wujal Wujal areas live in low income, welfare-dependent families.

4.5 HOUSING AND TRANSPORT

Access to safe and stable accommodation is important to support positive health outcomes and support other socio-economic outcomes such as employment. An indication of housing availability is the reliance on housing from the Government Housing Authority.

Access to transport is important for people to live connected and active lives. Transport is required to easily access health care, in particular primary health care. Access to a motor vehicle is an indicator of family access to reliable transport, particularly in remote areas.

Implication:

- Lower educational achievement is strongly associated with higher levels of dependence on government benefits. In addition to indicators of poverty, these socio-economic indicators identity a group of very vulnerable people within the population who are often trapped in a downward spiralling poverty cycle.

Source: 2011 Census of Population and Housing, ABS (Table Builder) [4]

Figure 12: Public housing, no motor vehicles and potential overcrowding
On average people in the Northern Queensland PHN region have a slightly higher percentage of dwellings without a registered motor vehicle. In some small remote LGAs this percentage is much higher, though a vehicle may not be necessary to access local infrastructure and services.

Overcrowding is highly associated with increased disease carriage rates, in particular childhood ear and diarrhoeal diseases. These both have long-term sequelae as ear disease leads to hearing loss and deafness, and long-term diarrhoeal diseases are associated with malnutrition, failure to thrive, and stunting in infants [13], [14].

4.6 EDUCATION

Education is an important social determinant of health. Education can positively impact levels of social engagement which is important in generating a more cohesive, safer and healthier society. Evidence shows that those with more years of schooling tend to have better health and wellbeing and healthier behaviours. This is due to education acting as a mechanism for enhancing the health and wellbeing of individuals by reducing the need for health care, the associated costs of dependence and lost earnings. It also helps promote and sustain healthy lifestyles and positive choices, supporting and nurturing human development, human relationships and personal, family and community wellbeing [15].

Data obtained from the 2011 Census shows the distribution of the applicable population by the highest year of school completed. The graph below shows the breakdown by HHS region against the NQPHN and Queensland total.

Implication:

> Torres and Cape region in particular has reduced access to private transport, this when coupled with greater distances indicates reduced access to health care. High rates of overcrowding in Torres and Cape could be leading to long-term negative health outcomes for children in this area.

*Note that ‘year 12 or equivalent’ (41% for NQPHN) and ‘not stated’ (10.3% for NQPHN) have not been included in the graph.

Figure 13: Highest year of school completed for individuals in NQPHN
2,263 people across NQPHN did not go to school, with a further 62,000 (13%) who did not complete year 10.

Torres and Cape has the lowest proportion of people that completed year 12 (33.9% against 46.6% for Queensland) and the highest proportion that did not finish year 10 (16.7%, against 11.7% for Queensland).

In Croydon, Etheridge, Wujal Wujal, Yarrabah, Aurukun, Hope Vale, Kowanyama, Napranum, Torres Strait Island, Charters Towers, Flinders and Hinchinbrook, 20% or more did not finish year 10. In Mapoon, Pormpuraaw and Palm Island, 30% or more did not complete year 10.

**Implication:**

Low rates of completed schooling in Torres and Cape and other remote areas indicate that there may be reduced health literacy in these areas. Health services and health promotion measures will need to be tailored appropriately to the context of the area.

4.7 DISABILITY

The identification of those with disabilities enables targeted programs to assist one of the most vulnerable groups within the community. Those with profound disability have increased need of health care services, and reduced access due to their disability. Health care planning for these groups can provide better access to services.

The data for ‘persons with a profound or severe disability’ has been derived from the 2011 Census of Population and Housing variable ‘core activity need for assistance’. Persons with a profound or severe disability are defined as needing 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 (six months or more), a disability (lasting six months or more), or old age.

In 2015, there were 26,548 persons in the NQPHN region (3.9%) reported as ‘has need for assistance with core activities’. Of these, 2,389 were Indigenous Australian persons ~9%. Those with disabilities represent 3.0% of the entire Indigenous Australian population of the NQPHN region.

**Implication:**

Persons with disabilities are identified as one of the most vulnerable groups within a society. Within the NQPHN region, a large proportion of those who report a disability were Indigenous Australian. Persons with disabilities and those who care for them require additional supports and equality of access to primary health services. Early detection of a disability also enables better management and outcomes for these persons, often with extensive allied health professional involvement.

**Data Source:** 2011 Census of Population and Housing (Table builder) [4]

**Figure 14:** Disability category for NQPHN
5. Behavioural health risk factors

Our lifestyle choices and behaviours can predispose to chronic disease such as diabetes, cardiovascular disease (CVD), chronic obstructive pulmonary disease (COPD), and other health risks. Rates of smoking, obesity and alcohol are highly associated with diabetes, cardiovascular disease and cancer, in addition to disability [16]. Many individuals have multiple behavioural risk factors, and the greater the burden of risk, the greater the loss of quality of life, in addition to the greater the risk of chronic disease development or short-term acute illness.

5.1 OVERWEIGHT AND OBESE

Overweight and obese persons are more likely to develop diabetes and cardiovascular disease (mainly heart disease and stroke, which were the leading cause of death globally in 2012); musculoskeletal disorders (especially osteoarthritis, a highly disabling degenerative disease of the joints); and some cancers (endometrial, breast, and colon) [16].

Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults (weight in kilograms divided by the square of the height in metres (kg/m²)). A BMI score of over 25 is categorized as overweight and a BMI score of over 30 is categorized as obese [17]. Having a high BMI can increase your risk of type 2 diabetes and certain types of cancer.

It is estimated that nearly two thirds of the NQPHN population can be classified as overweight or obese. Our area has a higher overall proportion of overweight and obese than the State. Men are more likely to be overweight or obese than women. Torres and Cape HHS region has the highest estimated proportion of overweight and obese people in the NQPHN region.

Implication:

Our region reports high numbers of overweight and obese adults, which is likely to increase rates of chronic diseases such as diabetes. This will increase the demand for chronic disease management and related health services longer term, and supports an approach that targets improved healthy eating and exercise.

Source: Queensland Government [18]

Figure 15: Proportion of overweight and obese persons
5.2 HEALTHY EATING AND EXERCISE

Fruit and vegetables are the foundation food group within the recommended food intake. They provide valuable nutrients, fibre, and essential vitamins and minerals. An adequate intake of fruit and vegetables helps to protect against major diseases like heart disease, stroke, high blood pressure, and some cancers. Given the complexity of measuring total diet quality, one simple measure of good health is to examine the fruit and vegetable intake as an indicator for overall dietary choices. The Australian Dietary guidelines recommend that men eat between six servings of vegetables and at least two servings of fruit per day, and women eat five servings of vegetables and two servings of fruit per day [19].

![Nutrition: recommended fruit and vegetable intake](image)

Overall, NQPHN’s population reports that 55% eat the recommended daily fruit intake (compared to 58% for Queensland), and 9% eat the recommended vegetable intake which is the same as Queensland.

Regular physical activity can be protective against the development of health conditions such as obesity, diabetes, heart disease and hypertension, and mental health conditions such as depression and anxiety. It is also important for maintaining a healthy weight, and preventing and reducing obesity. Sufficient physical activity is reported as achieving 30 minutes or more of at least moderate physical activity on five or more days a week [21].

Overall, the NQPHN region reports a similar level of physical activity to the State. There are lower levels of sufficient physical activity in women than men. Women in the Torres and Cape region reported lower levels of sufficient physical activity than other women in the NQPHN region, which also correlates to a high level of obesity for women in this area.
Implication:

Though the intake of fruit and vegetables and level of exercise of people in the NQPHN region is on par with State indicators, the overall levels are poor. Health services that encourage a healthy diet and regular exercise are likely to improve health outcomes of people in the region.
5.3 SMOKING

Smoking is a leading modifier of disease associated with Chronic Obstructive Pulmonary Disease (COPD) and all cancers, with causation established for lung, throat and tongue cancers, and breast cancer. Additionally, cigarette smokers have a significantly higher risk of susceptibility to viral and bacterial pneumonias, and other communicable diseases. Tobacco smoking is a leading cause of preventable death and disease in Queensland [23]. The risk of preventable death and disease from tobacco increases the earlier the individual starts to smoke, however the risk also starts to decrease as soon as an individual stops smoking. The Health of Queenslanders 2014 report identifies two-thirds of deaths in current Queensland smokers can be directly attributed to their smoking behaviour [23].

The NQPHN region has a higher proportion of daily smokers than the rest of the State. Torres and Cape has a much higher rate of smoking than the rest of NQPHN’s region, with over a quarter of all men estimated to be daily smokers. Women in our PHN region smoke much more than the State average.

Implication:

There are high rates of smoking in NQPHN, particularly in the Torres and Cape. Interventions that reduce rates of smoking will achieve substantial health outcomes for the region.

5.4 ALCOHOL CONSUMPTION

Risky consumption of alcohol (daily drinking >2 standard drinks and binge drinking) is strongly associated with liver disease (cirrhosis of the liver), weight gain (over weight/obesity), and mental health disease.

To reduce the risk of alcohol related harm over a lifetime, it is recommended that adults consume no more than two standard drinks on any day.

The graph on the following page shows the proportion of the population in our area that consume more than two standard drinks daily on a regular basis.

There are a greater proportion of people in our area who consume more than two drinks per day on average. Both men and women drink more than the State average. Torres and Cape and Mackay regions had the highest rates of lifetime risky alcohol consumption.

![Proportion of daily smokers](figure18.png)


Figure 18: Proportion of daily smokers
On a single occasion the risk to injury increases with the amount of alcohol consumed [25]. To reduce the risk of alcohol-related injury, it is recommended that adults consume no more than four standard drinks on a single occasion.

The graph below shows the proportion of the population that drink more than four drinks in a single occasion at least once a week.

Source: Queensland Government [25]
There are significantly higher rates of single occasion risky drinking in our area than the State. Torres and Cape and Mackay have the highest rates of at least weekly single risky alcohol consumption overall. Across our region, men are more likely to drink more than four drinks on a single occasion than women. Women in Torres and Cape have the highest rates of at least weekly single occasion risky drinking in the State.

Implication:

Our population has a higher risk of alcohol-related illness, and alcohol related-injury than the rest of the State. This also makes our population susceptible to other issues related to alcohol consumption such as violence, family breakdown, and child neglect. Interventions that reduce the levels of alcohol consumption will improve health outcomes in the region.
6. Chronic disease prevalence

Chronic diseases are conditions that persist or are long-lasting. Furthermore, they are often present slowly over a long period of time as body organs deteriorate. The most common chronic diseases are cardiovascular disease (CVD), diabetes, chronic liver failure, chronic obstructive pulmonary disease (COPD), and end-stage renal disease. For the most part, chronic disease progression is directly associated with unhealthy behaviours such as smoking, excessive alcohol consumption, and inadequate exercise and poor diet, which leads to obesity.

By examining rates of chronic diseases within the community and rates of presentation to the HHS with chronic disease conditions across the NQPHN region, this enables the identification of high need areas that can be targeted for improved management. Health promotion that assists the uptake of healthy lifestyle behaviours can reduce the incidence of chronic diseases, slow their progression, and improve the outcomes for those who have established conditions. Location specific delivery of prevention measures can reduce the health burden from these diseases in the next generation.

As chronic diseases are long-term conditions (tertiary hospitals focus on acute illness presentations), they are best managed within the community by primary health care services or community health facilities (HHS - secondary health care). Community management enables the coordination of services with increased access to allied health services such as dietitians and physiotherapists. Patients can access these services via secondary community centres or through their preferred GPs using a chronic disease management plan (GPMP). Effective community management of chronic disease is associated with fewer hospitalisations, including potentially preventable hospitalisations (PPH). For these reasons, the management of chronic diseases (with establishment of population risk) are a priority area for the Commonwealth DoH and PHN service delivery.

Source: Queensland Government [23]

Figure 21: Hospitalisation rates for selected conditions by HHS and Queensland, 2009-10 to 2011-12
Across our PHN region, we report higher rates of diabetes, chronic obstructive pulmonary disorder (COPD), coronary heart disease, and stroke than Queensland averages. Diabetes is a precursor to other chronic diseases such as End Stage Renal Disease (ESRD), which requires ongoing dialysis or kidney transplant for survival. Similarly, CVD leads to heart attacks and strokes, which again lower life expectancy. Both conditions are highly associated with obesity and sedentary lifestyles (CVD is also linked with smoking and excessive alcohol consumption), and are largely preventable with changes that improve healthy behaviours.

Implication:

The combined high rates of hospitalisations associated with chronic diseases: Diabetes, COPD and cardiovascular disease, especially across the Torres and Cape, supports community-managed care approaches. Increases to community management of chronic diseases will lead to reduced hospitalisations for these conditions. Furthermore, behaviour modification that increases exercise and reduces obesity and rates of smoking and excessive alcohol consumption will slow the onset of chronic disease, and improve the management and outcomes for those with pre-existing conditions.
7. Protective and early detection health practices

Health outcomes of the population can be drastically improved if disease states are prevented from occurring or identified and treated early in development. Immunisation and cancer screening have been chosen to give an indication of protective and early detection practices.

7.1 IMMUNISATION

Immunisation programs help to protect the community against the spread of potentially serious illness and disease but their success depends on maintaining high rates of the population immunised, known as ‘herd immunity’. The Department of Health has a target of 95 per cent of the population to be immunised [26]. Children who are not fully immunised are spread unevenly across the country and illnesses like measles and whooping cough can more easily spread in areas of low coverage.

All Australian children should have completed their childhood immunisations in the National Immunisation Program Schedule before the age of five (60 months). The aim is to provide maximum protection appropriate for their age if they come into contact with harmful viruses and bacteria.

Immunisation rates across the HHS regions within NQPHN are inline or higher than Queensland and National averages. However, data on hospital admissions for potentially preventable hospitalisations (PPH) section 9 indicate that presentations to NQPHN HHSs continue to occur for vaccine preventable illnesses, indicating opportunities for improvement in immunisation rates across the NQPHN.

Figure 22: Percentage of fully immunised children at 5 years old across NQPHN (as at September 2015)

*Note: data obtained is by SA3 level and so have roughly been aligned to HHS areas

**Note: The inclusion of additional immunisations to the coverage calculation has caused a drop in the coverage rates. The coverage rate for 24-27 months has dropped because the criteria to be assessed as fully immunised now includes more vaccines.
7.2 CANCER SCREENING

For the health care consumer, cancer screening offers early detection, often prior to the development of symptoms of a disease. Simple screening tests look for particular changes and early signs of cancer before it has developed or before any symptoms emerge. Early detection increases the opportunities to offer treatment offering improved outcomes. For health care services, screening for early detection can enable planned admissions to hospital for treatment, reducing hospital emergency pressures.

In Australia, there are three cancers for which screening is recommended—breast, cervical and bowel. Each cancer has a national screening program, with both Australian Government and State and Territory government components.

Australia’s three targeted screening programs and their participation rates are:

1. **BreastScreen Australia**: targets women aged 50 - 74 years for two-yearly screening mammograms. Overall NQPHN reports 63.0% participation rate (2013-14), which is significantly higher than the national average of 54.2 per cent [28].

2. **National Cervical Screening Program**: Cervical screening aims to prevent cervical cancer by detecting early pre-cancerous changes in the cervix. It is recommended for women aged over 18 - 20 years who have been sexually active to have a Pap test every two years (including those who have had the HPV vaccination). Overall the NQPHN report 57.4% participation (2013-14) [28].

3. **National Bowel Cancer Screening Program**: targeted at those turning 55 and 65 years, with program expansion occurring in January 2015 to include those aged 50 - 74 years (biennial screening). Overall NQPHN reported 36.1% participation in screening (2013-14) [28].

Table 5: Cancer Incidence (average) 2009-2012, for major cancers by HHS.

<table>
<thead>
<tr>
<th>HHS region</th>
<th>Prostate</th>
<th>Melanoma</th>
<th>Colorectal</th>
<th>Breast</th>
<th>Lung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>170</td>
<td>161</td>
<td>162</td>
<td>153</td>
<td>115</td>
</tr>
<tr>
<td>Townsville</td>
<td>203</td>
<td>147</td>
<td>131</td>
<td>119</td>
<td>99</td>
</tr>
<tr>
<td>Mackay</td>
<td>162</td>
<td>97</td>
<td>97</td>
<td>84</td>
<td>72</td>
</tr>
<tr>
<td><strong>NQPHN total</strong></td>
<td><strong>539</strong></td>
<td><strong>413</strong></td>
<td><strong>395</strong></td>
<td><strong>361</strong></td>
<td><strong>295</strong></td>
</tr>
</tbody>
</table>

Source: AIHW [28]

Nationally there are three cancer screening programs [28]. However, high rates of melanoma and lung cancer also exist in the NQPHN region. Initiatives that support healthy behaviours to prevent the onset of these cancers should be supported in the first instance. Following that, early detection of these cancers can assist health management and improve patient outcomes.

Other preventative cancers of note in our PHN region include lung cancer and skin cancer, which have similarly been identified as increasing nationally[24], [30]. Lung cancer is the fifth most common cancer in Australia but the most common cause of cancer death, and Australia reports the highest rates for skin cancers in the world (basal cell carcinoma (BCC), squamous cell carcinoma (SCC), and melanoma [29]. Skin cancers are largely preventable if consumers practise positive sun-smart behaviours, such as wearing sun protection, and lung cancer has a causal relationship with smoking, so incidence of lung cancer can be reduced by actively promoting smoking cessation in our community.
Immunisation and cancer screening are indicators of positive health behaviours. The majority of vaccines target childhood disease, thus a fully-vaccinated community will experience fewer potentially preventable hospitalisations, while offering protection from many common childhood pathogens. Health services should continue to target high immunisation rates across the NQPHN region.

Prevention of many cancers is maximised with healthy behaviours. Participation in cancer screening enables the NQPHN to maintain a continued focus on positive health behaviours. Following this, early cancer detection offers the best health consumer outcomes and reduces costs to HHSs for unscheduled emergency treatments.
8. Primary health care

Primary health care services provide front-line health services to community members. Across the NQPHN there are multiple services and providers available including but not limited to; General Practices, allied health services, pharmacies, dental services, Aboriginal Medical Services (AMS), and community health workers. When services are coordinated across primary health providers, disease and management of illness within the community is often more effective, leading to improved outcomes for the patient, while avoiding unnecessary hospital admissions.

![Primary health workforce (NQPHN region)](image)

**Figure 24: Northern Queensland Primary Health workforce with rate per 100,000 people by HHS**

**Source:** Health Workforce database as listed on PHN website with calculated rates based on ABS population [1], [4]

**Data:** Using the Health Workforce database (PHN website portal), the 2014 primary health workforce was identified by filtering for FTE currently employed in the workforce, acting as a clinician, or in a direct client care role in a primary care setting. Note that the majority of clinicians identified as working in job settings such as hospitals, outpatients, and correctional and education facilities were excluded, however GPs who worked as private practitioners delivering care via a hospital setting were retained. This is important to note, as a high proportion of Thursday Island-based GPs practice privately (bulk-bill) from within the hospital complex (8 GPs out of 13), overinflating the rate of GPs per 100,000 population.

**Figure 24:** Northern Queensland Primary Health workforce with rate per 100,000 people by HHS
8.1 PRIMARY HEALTH WORKFORCE

The health workforce encompasses all individuals who deliver health care to community members. To better forecast health workforce needs we must first understand the current workforce capacity including the models of care offered. Once these items are identified, planning of health services can be undertaken to define appropriate services to be delivered. Additionally, planning often involves training of health professionals, which may need to be initiated years in advance to fully address projected workforce shortages.

Although the Torres and Cape has the highest workforce rate for population (690 per 100,000 people), half of these are nurses, and there are no physiotherapists, occupational therapists or radiographers.

![GP rate by LGA for NQPHN region, comparison with National and State averages](chart)

Source: Health Workforce database [1], [4] based on ABS projections

**Figure 25: GP rate by LGA for NQPHN region, comparison with National and State averages**

The GP rate is calculated as number of GPs per 100,000 people and is based on the 2014 Health Workforce database and Census population projection. For GPs, hospital staff have been included in the count. The average GP Service Rate for Northern Queensland PHN is 86. This can be compared to the 1998 benchmark national average of 110.6 GPs per 100,000 population, and 104.5 in Queensland [31]. Of the four HHSs, Torres and Cape has the highest GP rate of 134, while Townsville has the lowest GP rate of 72.

**Table 6: Number of General Practices approved for PIP incentives in NQPHN**

<table>
<thead>
<tr>
<th>RRMA category</th>
<th>Metropolitan</th>
<th>Large Rural</th>
<th>Other Rural</th>
<th>Remote Centre</th>
<th>Other Remote</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQPHN total</td>
<td>42</td>
<td>57</td>
<td>40</td>
<td>10</td>
<td>6</td>
<td>155</td>
</tr>
</tbody>
</table>

Source: Australian Government [32]
8.2 PRIMARY HEALTH SERVICE USE AND ACCESS

Service use by community members provides an indication of access and need.

Data limitation: the NQPHN are yet to survey community members face-to-face to obtain accurate health consumer feedback. However, we presently have available survey data collected only from the NQPHN region indicating access to GP services.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults who reported excellent, very good or good health</td>
<td>83%</td>
</tr>
<tr>
<td>Percentage of adults who saw a GP in the preceding 12 months</td>
<td>79%</td>
</tr>
<tr>
<td>Percentage of people who attended a GP 12 to 19 times in the year (frequent attenders)</td>
<td>7%</td>
</tr>
<tr>
<td>Percentage of people who attended a GP 20 times or more in the year (very high attenders)</td>
<td>3%</td>
</tr>
<tr>
<td>Percentage of adults who saw a GP after hours in the preceding 12 months</td>
<td>9%</td>
</tr>
<tr>
<td>Average number of GP attendances per person</td>
<td>5.1</td>
</tr>
<tr>
<td>Average number of GP care plans and case conferences per person</td>
<td>0.16</td>
</tr>
</tbody>
</table>

Source: National Health Performance Authority 2013-14 [34]
The table above provides an overview of which MBS services are most frequently delivered across the NQPHN region. MBS reporting groups do not allow separation of Practice Nurse from Aboriginal health worker, so these data were reported combined. When compared with the all of Queensland final column, this information can be used to identify potential areas of change. From this data, GP visits for chronic disease total 7.9% of MBS items for NQPHN, while for Queensland these are 8.2%. GP visits for mental health (3.5%) and allied health visits for mental health (1.8%) are both higher within the NQPHN than for Queensland (3.2% and 1.3% respectively), indicating greater use of these services. MBS services for nurse practitioners (0.3%) and Aboriginal Health Workers (1.5%) were both lower for NQPHN than for Queensland (0.5% and 1.9% respectively), providing evidence where potential increases in service can be made. The proportion of allied health MBS items was higher for NQPHN than for Queensland, indicating greater access to allied health services available in the community.

Table 8: Medicare Benefits Scheme counts of service and items by MBS reporting group (primary health provider)

<table>
<thead>
<tr>
<th>MBS reporting group</th>
<th>Number of patient occasions of service</th>
<th>Total MBS Services itemised</th>
<th>Proportion of total for NQPHN</th>
<th>Proportion of total for QLD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health</td>
<td>47851</td>
<td>110516</td>
<td>3.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Allied Mental Health</td>
<td>22691</td>
<td>85719</td>
<td>1.8%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Early Intervention/Children with Disabilities</td>
<td>275</td>
<td>275</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>GP After Hours/Emergency Attendance</td>
<td>172345</td>
<td>250852</td>
<td>10.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td>GP Attendances (VR/Non-VR)</td>
<td>118960</td>
<td>281199</td>
<td>5.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>GP Chronic Disease</td>
<td>143649</td>
<td>191864</td>
<td>7.9%</td>
<td>8.2%</td>
</tr>
<tr>
<td>GP Health Assessments</td>
<td>50050</td>
<td>51125</td>
<td>1.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>GP Mental Health</td>
<td>56241</td>
<td>72820</td>
<td>3.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Level A VR Consultation Item 3</td>
<td>56139</td>
<td>85197</td>
<td>3.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Level B VR Consultation Item 23</td>
<td>567525</td>
<td>2245391</td>
<td>32.6%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Level C VR Consultation Item 36</td>
<td>212069</td>
<td>415567</td>
<td>12.5%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Level D VR Consultation Item 44</td>
<td>31292</td>
<td>41339</td>
<td>1.6%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>9526</td>
<td>15023</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Optometry</td>
<td>202439</td>
<td>214437</td>
<td>12.8%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Other GP Attendances</td>
<td>14461</td>
<td>14911</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other Primary Care Attendances</td>
<td>1819</td>
<td>4848</td>
<td>0.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Practice Nurse/Aboriginal Health Worker</td>
<td>33620</td>
<td>62985</td>
<td>1.5%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Telehealth</td>
<td>5651</td>
<td>8842</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>1746603</td>
<td>4152910</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: PHN website MBS data 2014/15 [1] [35]
8.3 PRIMARY HEALTH CARE SERVICES ON THURSDAY ISLAND

The Thursday Island Community Wellness Centre (CWC) operates on the same site as the Thursday Island Hospital, opened on 29 November 2014. The CWC was part of the State Government’s strategy aimed at improving health outcomes for Aboriginal and Torres Strait Islander people and was funded under Rehabilitation Pathways and Chronic Disease facility programs by the Australian government. It operates normal business hours from Monday to Friday and no emergency services. Services include: medical services: primary health care GP clinics with triage room, three GP consulting rooms and two treatment rooms; specialist clinics for 15 different visiting services; rehabilitation and allied health services; podiatrist, physiotherapy, occupational therapists; allied health co-worker; primary health care outreach services; clinical nurse consultant; ophthalmology; Telehealth coordinator; chronic disease team. Also offered is renal dialysis, with 12 dialysis chairs. The CWC receive, on average, 2,769 patients in this primary health care setting per month.

8.4 GENERAL PRACTITIONER HEALTH MANAGEMENT PLANS

The GP Management Plan (GPMP) scheme increases the access of patients with specific health care needs (mental health or chronic disease management) to additional services by subsidising the costs for services. These care plans are offered to all Australian residents via the Medical Benefits Scheme (MBS). The care plans extend regular GP services to include allied health professionals. Additional benefits may be accessed for coordinated care involving multiple health professionals.

Chronic care plans as itemised by MBS: Preparing a management plan for a patient who has a chronic or terminal medical condition with or without multidisciplinary care needs (Item 721); Coordinating the preparation of team care arrangements for a patient who has a chronic or terminal medical condition and requires ongoing care from a multidisciplinary team of at least three health or care providers (Item 723); and Reviewing a GP Management Plan (Item 732).

Mental health as itemised by MBS: Preparation of a GP Mental Health Treatment Plan (MBS items 2700, 2701, 2715 or 2717); Review of a GP Mental Health Treatment Plan (MBS item 2712); and GP Mental Health Treatment Consultation (MBS item 2713).

This data provides an indication of service access for these two priority areas. For chronic disease, the number of MBS reporting items for the NQPHN was 60,000 chronic disease Management Plans (GPMP) for FY 2014/15, and almost two-thirds of these were reviewed (37,294). Additionally, over 40,000 coordinated team care arrangements were made to improve the care provided to those suffering from a chronic disease. For mental health care plans, fewer patients accessed the plans (<30,000) and only one in four returned for a review of their care plan. Almost as many patients accessed single mental health treatment consultations (~20,000) as did care plans.

<table>
<thead>
<tr>
<th>MBS Reporting Group</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing a management plan</td>
<td>58,869</td>
</tr>
<tr>
<td>Coordinating Team Care Arrangements</td>
<td>44,733</td>
</tr>
<tr>
<td>Reviewing a GP Management Plan</td>
<td>37,294</td>
</tr>
<tr>
<td>Preparation of a GP Mental Health Treatment Plan</td>
<td>27,360</td>
</tr>
<tr>
<td>Review of a GP Mental Health Treatment Plan</td>
<td>7,257</td>
</tr>
<tr>
<td>GP Mental Health Treatment Consultation</td>
<td>21,354</td>
</tr>
</tbody>
</table>

Table 10: MBS counts of care plans instigated across NQPHN FY 2014-15

Table 9: Community Wellness Centre Staffing 2015

<table>
<thead>
<tr>
<th>CWC Building</th>
<th>Approved FTE</th>
<th>Current Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>20.2</td>
<td>19</td>
</tr>
<tr>
<td>Health Practitioner</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Administration</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Health Workers</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

Implication:

MBS data indicate consumer access to chronic disease and mental health services via GPs. This data is useful for NQPHN to maintain a continued focus on monitoring access and improving service delivery to these two priority areas. The availability of MBS data means monitoring service use is feasible.
8.5 PRIMARY HEALTH CONSUMER EXPERIENCE

Patient experience provides direct feedback on health services to health providers and this can reaffirm the provision of adequate health care, or be applied to improve the health care system. Patient feedback can also inform of barriers to accessing health services that may impede health improvement, access to health care such as the availability of GPs, and the impact of varying levels of service. The coordination of health care is also essential in ensuring an accessible, high-quality health care system for those in greater need.

Data collection: The ABS Patient Experience Survey is conducted annually and collects data on access and barriers to a range of health care services, including: General Practitioners, medical specialists, dental professionals, imaging and pathology tests, hospital admissions, and emergency department visits. Information is collected from people aged 15 years and over.

The majority of NQPHN people interviewed (76%) reported having a preferred GP, although one in five reported a longer than acceptable wait time to get an appointment and ~30% reported they could not get an appointment with their preferred GP at all in the last 12 months. One in 12 people (9%) saw an after-hours GP in the previous 12 months. A greater proportion (~20%) reported attending ED for a condition they felt could have been seen by their GP.

Of those who saw three or more health professionals for the same condition, 73% of people reported that a health professional helped coordinate their care. The health professional most likely to coordinate care was a GP, followed by a medical specialist. Among those who saw three or more health professionals for the same condition, one in five (20%) reported that there were issues caused by a lack of communication between the health professionals.

Table 11: Responses from the ABS Patient Experience Survey on GP access, FY 2013-14

<table>
<thead>
<tr>
<th>Survey question</th>
<th>Proportion of NQPHN Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a preferred GP</td>
<td>76.5%</td>
</tr>
<tr>
<td>Waited longer than felt acceptable to get an appointment with a GP in the last 12 months</td>
<td>19.5%</td>
</tr>
<tr>
<td>Reported they could not see preferred GP at any time in the last 12 months</td>
<td>28.2%</td>
</tr>
<tr>
<td>Attended the hospital emergency department for their own health and at the time, felt the care could have been provided by a GP</td>
<td>18.6%</td>
</tr>
<tr>
<td>Proportion of people who saw a GP after hours for their own health in the last 12 months</td>
<td>8.7%</td>
</tr>
<tr>
<td>Delayed getting or did not get prescription medication due to cost in the last 12 months</td>
<td>9.6%</td>
</tr>
<tr>
<td>Admitted to hospital in the last 12 months</td>
<td>16.4%</td>
</tr>
<tr>
<td>Reported having a long-term health condition</td>
<td>48.1%</td>
</tr>
<tr>
<td>Reported a health professional helped coordinate care, any time saw three or more health professionals in last 12 months</td>
<td>73.4%</td>
</tr>
<tr>
<td>Reported issues caused by lack of communication between health professionals for any time saw three or more health professionals in last 12 months</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

Source: ABS [37]
The main reasons reported for not attending the GP when they felt they needed to see one were ‘too busy’ and ‘other’, while the next most commonly voiced reason (one in five) was ‘waiting time too long’ and ‘service not available’ (one in eight). Only one in 20 (5%) of people who needed to see a GP delayed or did not attend due to cost.

NQPHN people who did not see a GP when needed in the last 12 months: Main reason did not see GP

- Cost
- Dislike or fear of service
- Waiting time too long
- Service not available when required
- Too busy
- Other

NQPHN people who went to an ED for their own health: Main reason went to ED instead of GP on most recent occasion in last 12 months

- Taken by ambulance or condition was serious
- GP not available when required
- Sent to emergency by GP
- Waiting time for GP appointment too long
- Other

Figure 26: Participant response to question ‘Main reason did not see a GP when needed to in last 12 months’

Source: ABS Patient Experience Survey [37]

Note: Cost’ and ‘Dislike or fear of service’ have a high standard error and should be interpreted with caution.

Figure 27: Participant response to question ‘Main reason went to ED instead of GP on most recent occasion in last 12 months’

Note: ‘Sent to emergency by GP’ and ‘Waiting time for GP appointment too long’ have a high standard error and should be interpreted with caution.
There are four Queensland Health operated Hospital and Health Services (HHSs) in the region:

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

Each region offers one major referral hospital offering specialist services. The capacity of Thursday Island Hospital (Torres and Cape) to offer specialist services is limited, so patients may be referred to Cairns and Townsville hospitals for these services. Queensland Health also services multiple smaller hospitals and community health centres within each HHS. Private hospitals offer additional services, including day-stay theatre in Cairns, Townsville and Mackay.

9.1 EMERGENCY DEPARTMENT PRESENTATIONS

The counts of ED presentations presented below indicate high numbers of patients are presenting to ED – equivalent to 46% of the population each year (if each visit was a different person), and 93% of the Torres and Cape population. These can be compared to the national ED presentation rate of 25%.

Many are presenting with lower acuity triage categories (4 and 5). A proportion of these lower acuity presentations may be treatable within the community by GPs, community nurse practitioners or allied health professionals, thereby reducing access block to ED and supporting the access targets (see 9.2 below).

Implication:

Low acuity presentations may be treatable in the community by primary health care services.
9.2 NATIONAL EMERGENCY ACCESS TARGETS

Over the last decade Australian Emergency Departments have experienced excessive overcrowding with prolonged Length of Stay (LoS) in ED. These factors were subsequently linked to much poorer outcomes for patients who presented to ED. Additionally, reduced access (access block) resulting in non-admitted patients remaining in ED for longer than necessary, reduced access for new patients presenting at the ED, and delayed ambulance offloads. To address this system wide issue, the Department of Health issued a new national standard of care for Emergency Department treatment: National Emergency Access Target (NEAT). It applies only to hospitals that currently report the National ED Data Set, and hospitals who comply with the NEAT targets are provided with significant remuneration.

The NEAT target is that 90% of all patients will leave the Emergency Department (ED) within four hours: discharged home, admitted to hospital, or transferred to another hospital for treatment. The target does not overrule clinical judgement, and all ED patients are included in the target.

All three major public hospitals within NQPHN’s region meet the NEAT targets more than 50% of the time, but none >90% of the time. NEAT targets are an indicator or access block for each HHS. This data can be used to monitor improvements to access due to partnerships between the PHN and HHSs.

Implication:

NEAT targets are an indicator or access block for each HHS. This data can be used to monitor improvements to access due to partnerships between the PHN and HHSs.
9.3 NON-ADMITTED HOSPITAL SEPARATIONS

Non-admitted patients are defined by those hospitalised for less than 24 hours. Sometimes surgery or diagnostic tests performed under anaesthetic are performed without the need for an overnight hospital stay. Many services provided to outpatients are best suited to relatively healthy patients undergoing minor or intermediate procedures (limited urologic, ophthalmologic, or ear, nose, and throat procedures and procedures involving the extremities) [39].

Non-admitted presentations to Queensland Health hospitals presented above indicate high numbers of patients presenting for diagnostic tests and outpatient appointments. Outpatient clinics are utilised for pre-admission planning (elective surgery) and specialist medical clinics. These presentation counts provide an indication of access to these services, and this data can be used to monitor improvements to access due to partnerships between the PHN and HHSs.

![Non-admitted hospital separations 2013/2014](image_url)

**Implication:**

Non-admission presentation counts provide an indication of access to these services, and this data can be used to monitor improvements to access due to partnerships between the PHN and HHSs.
9.4 IN-PATIENT HOSPITALISATION

In-patient hospitalised care provides around-the-clock care from nurses, medical practitioners and allied health professionals, who are employed by the hospital. All meals, bedding and cleaning are provided by the hospital. Ideally, hospital employed staff work with community primary health care providers to transition patients back to their care upon discharge. Well-coordinated care is associated with a shorter average length of stay (LoS) and improved health care management when returned to community primary health care services.

In-patient episodes of care of HHSs presented below indicate high numbers of patients requiring hospitalisation with the higher mean LoS reported from Cairns and Hinterland HHS and Townsville HHS. Many patients present for diagnostic tests and outpatient appointments. Outpatient clinics are utilised for pre-admission planning (elective surgery) and specialist medical clinics. These presentation counts provide an indication of access to these services and this data can be used to monitor improvements to access due to partnerships between the PHN and HHSs.

<table>
<thead>
<tr>
<th>Number of episodes / patient days</th>
<th>Length of stay (LoS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>2.77</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>2.97</td>
</tr>
<tr>
<td>Townsville</td>
<td>3.42</td>
</tr>
<tr>
<td>Mackay</td>
<td>2.22</td>
</tr>
</tbody>
</table>

**Source:** QH [40]

**Figure 31:** In-patient episodes of care with Length of Stay (LoS) for 2013/2014 for HHSs within NQPHN

**Implication:**
Episodes of care as both out-patient and in-patient provide an indication of consumer use of the public hospital system (HHS). LoS is a reliable measure of access to in-patient services, costs of in-patient services, and it also functions as a marker of system health: a gauge of hospital bed-flow function and management. LoS is directly and inversely associated with patient outcomes: longer length of stay is associated with poorer outcomes.
9.5 EMERGENCY DEPARTMENT PRESENTATIONS FOR ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND DIABETES

Exacerbation of COPD (chronic obstructive pulmonary disease) is commonly triggered by infection or by improper use of medications, leading to an acute state of poor airflow requiring hospitalisation. However, with appropriate management in the primary health care setting, many exacerbations could be prevented, and thus they are considered ‘avoidable’.

Similarly, diabetes when well managed within the community setting can reduce the likelihood of acute presentations to HHS. Blood sugar monitoring with exercise and close management will also reduce the risk of acquiring long-term complications.

These conditions are presented as they constitute a high proportion of Potentially Preventable Hospitalisation (PPH) and therefore, monitoring Emergency Department presentations enables the PHN to track its progress in transitioning the management of these conditions to community run primary health care services. Furthermore, these chronic diseases have been identified as having high rates of re-admission due to poor community management.

Emergency Department presentations for acute exacerbation of COPD and diabetes, as a proportion of total Emergency Department presentations

Source: Queensland Health Emergency Department data for PHNs, December 2015

Data: Emergency Department presentations for Acute exacerbation of COPD and diabetes (adults—aged >16 years) (ICD10 codes J44.9=COPD exc, for Diabetes ICD10 codes: E10.65- diabetes, E10.12- diabetic coma (ID), E11.12- diabetic coma (NID), E10.8- diabetes complication, E10.11—DKA (ID), E11.11-DKA-(NID)

Figure 32: Emergency Department presentations for Acute Exacerbation of COPD and Diabetes as a proportion of all presentations to >16 years, by HHS for FY 2014/15
Presentations to the Emergency Department with Exacerbation of COPD constituted 0.72% of presentations across the PHN during FY 2014/15, with Cairns and Hinterland reporting the highest proportion of COPD admissions to ED at 0.85%. Diabetes presentations were ~0.1% of all admissions, and when combined with COPD presentations constitute 0.85% of admissions. A large proportion of these presentations may have been preventable if appropriately managed by community HHS services or primary health providers (GPs) (see PPH 9.6). Furthermore, these chronic diseases have been identified as having high rates of re-admission due to lack of community management.

**9.6 POTENTIALLY PREVENTABLE HOSPITALISATIONS**

The majority of hospitalisations occur due to acute need, however about 16% of these are identified as potentially preventable hospitalisations (PPHs), as they may have not resulted in a hospital admission if they have been appropriately managed in the community. They are largely preventable if managed long-term, or if delivery of vaccination occurs and the population are ‘fully vaccinated’ (herd immunity). Almost 30% of all hospital admissions for Torres and Cape were PPH.

**Implication:**

A large proportion of COPD and diabetes acute presentations to ED may have been preventable if appropriately managed by community HHS services or primary health providers (GPs). The monitoring of these disease presentations provides an indication of coordination of care and management by community primary health services.

Potentially Preventable Hospitalisations for public and private hospitals by HHS, FY 2013/14

![Graph showing potentially preventable hospitalisations for different regions in Australia.](source)

Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Health Statistics Unit, Department of Health, December 2015 [41]

Figure 33: Potentially preventable hospitalisations for public and private hospitals by HHS, FY 2013/14
Implication:

Large numbers of PPH present to all HHS across the NQPHN, representing 165 of all hospital admissions. While counts were low for vaccine preventable, there were still several hundred each year for each HHS. Chronic and acute presentations (often of exacerbation of chronic conditions) can be avoidable if well managed in the community by primary health care services. The monitoring of PPH presentations provides an indication of coordination of care and management by community primary health services.
10. Mental health care

Mental illness comprises a wide range of disorders and varies in its severity. The effect of mental illness can be severe on the individuals and families concerned and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment, or reduced productivity and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma.

Around 45% of Australians aged 16–85 will experience a mental health-related condition such as depression, anxiety or a substance use disorder in their lifetime, according to the 2007 National Survey of Mental Health and Wellbeing. The second national household survey of the mental health and wellbeing of Australian children and adolescents (Young Minds Matter) released in August 2015 estimates that 560,000 child and adolescents aged 4–17 (almost 14%) experienced mental health disorders in 2012–13.

Today, self-harm is the leading cause of death for age-groups 15-44 (ABS leading causes of death). According to the Access to Allied Psychological Services (ATAPS) report and the report commissioned by the Queensland Suicide Register, for the North Queensland PHN region:

- 25% have a mental health care plan
- North Queensland mental health hospital presentation rates were higher at 11.4 per 100,000 compared with 10.3 per 10,000 for Queensland
- The North Queensland suicide rate for 2011-2013 was 1.5 times the National suicide rate at 17.0 compared with 10.9 per 100,000 people
- Furthermore, across some sections of the NQPHN suicide is reported up to 5.2 times the National rate.

Data limitations: Mental health services are offered across the public, private and non-government organisation (NGO) sectors, however not all data pertaining to these services was available to us during the production of this document. While private practices and the NGO sector (Headpace, RFDS and Aboriginal Medical Services (AMS) offer day time mental health services, NQPHN could only access Queensland Health data specific for the mental health workforce (total primary health workforce is presented in section 8), and we have included MBS occasions of service that include private medical and allied health services as well as NGO (AMS) occasions of service delivery (see section 8). For in-patient hospital use specific to mental health illness, NQPHN collated hospital data provided by both public and private hospitals across the PHN by HHS (NGOs do not offer overnight facilities), so all data is presented here. For health transport access, NQPHN was able to access data on HHS transfers to and from other HHS facilities, but was unable to present NGO (RFDS) transfers.
10.1 MENTAL HEALTH SERVICES STAFFING

The data above indicates numbers of FTEs health providers employed by Queensland Health servicing the mental health sector. The figure is an extrapolated rate of service per 100,000 population. Both depict low access to mental health professionals, which is especially underscored across the Torres and Cape region. Other than nursing staff, Queensland Health only provide access to one social worker across the Torres and Cape, and there is no access to any medical practitioners or other allied health services across this region. FTEs are also low across the Mackay region compared with Cairns and Townsville. This data indicates capacity for improvement across this sector. It also provides a baseline for which to gauge increases to services and access, especially in rural and remote areas across the PHN.

Rate of mental health staff, 2013/14

Note: Admin and domestic staff FTE excluded; rate calculation 100,000/population*number staff, based on ABS Census 2011 [4], [42]

Figure 34: Public sector (QH) mental health services staffing (FTE) by HHS, 2012/2013
10.2 MENTAL HEALTH CONSUMER USE AND ACCESS

In-patient episodes of care due to mental health disorders have increased between 2013/14 and 2014/15 across all but three age groups (10-15, 35-39, 40-44). This is a marked increasing trend for in-patient episodes of care in younger age groups (15-39) and older age groups (45+), across public and private hospitals specifically admitted for mental health illness.

North Queensland in-patient episodes of mental health or behavioural disorders by age group (combined HHS data)

Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Health Statistics Unit, Department of Health, December 2015 [43]

Figure 35: Mental health care presentations to public or private hospitals by age groups, FY 2013/15 versus FY 2014/15
The in-patient episodes of care with a primary diagnosis of mental health disorder represented 3% of all inpatient care in both public and private hospital systems of our PHN, during 2014/2015. This was highest in the Cairns and Hinterland HHS at 4% of all episodes of care. Indigenous Australian persons reported 17% of in-patient care and non-Indigenous 83%, although this varied across HHSs with Torres and Cape reporting 71% Indigenous Australian and 29% non-Indigenous.

Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Health Statistics Unit, Department of Health, December 2015 [43]

Figure 36: In-patient episodes of mental health or behavioural disorders, by Indigenous Australian status (public and private hospitals combined data) 2014/2015
Substance misuse and mental health issues are reportedly rising nationally [44]. Presentations to ED for the four HHS regions across the PHN indicate that presentations associated with substance misuse (non-alcohol) account for ~0.4% of all presentations in over 16 year olds. Alcohol intoxication or alcohol-related illness account for 0.9% of presentations, while mental health illness accounts for 3.7% of all presentations. When combined they constitute 5% of all ED presentations, with 5.5% reported from Cairns and Hinterland HHS. Many of these presentations to ED may be avoidable if access to primary health care were improved for this sector.

Mental health or substance misuse presentations as a proportion of all ED presentations

<table>
<thead>
<tr>
<th></th>
<th>Torres and Cape</th>
<th>Cairns and Hinterland</th>
<th>Townsville</th>
<th>Mackay</th>
<th>NQPHN total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance (non-ETOH) misuse associated presentation</td>
<td>4.5%</td>
<td>4.0%</td>
<td>3.5%</td>
<td>3.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Alcohol intoxication related presentations</td>
<td>4.0%</td>
<td>3.0%</td>
<td>2.5%</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Mental health presentation</td>
<td>3.5%</td>
<td>3.0%</td>
<td>2.5%</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

Source: Queensland Health, December 2015 ED

Data definitions: ICD10 codes for alcohol (F10.0 alcohol intoxication, F10.3- alcohol withdrawal, F10.5- alcohol hallucinations). ICD10 codes for Substance misuse (F19.2- Drug addiction, G40.5- Drug withdrawal, F19.9- Drug induced Mental Health Issue, F18.0- Volatile substance intoxication, F05.5- Altered Mental state (non etoh).ICD10 codes for mental health (F41.9-Anxiety, F31.1-Bipolar affective disorder, F29-Psychotic episode, F60.9-Personality Disorder, F32.3- Depressive Psychotic, F99-Mental Illness, F32.9-Depression, F20.9 Schizophrenia, F41.0-Panic Attack, F50.0- Anorexia nervosa, F43.9-emotional crisis, R45.81- Suicide ideation, F43.9-severe stress, X84-self harm, F19.9- Drug induced Mental health issue)

Figure 37: Mental health, alcohol and substance misuse presentations to ED >16 years.
The proportion of transfers to HHSs with mental health issues accounted for ~3% of all transfers across the four HHSs. For receiving HHSs, the highest HHS was Cairns and Hinterland: mental health transfers accounted for 5% of patient transfers. The highest referring HHS was Torres and Cape York from where 5.1% of transfers associated with acute mental health illness.

Table 12: Transfers for receiving HHS by boat, fixed wing, road or helicopter 7/2014-3/2015 by receiving HHS. Last column shows the proportion of patients transferred by referring HHS

<table>
<thead>
<tr>
<th>Receiving HHS</th>
<th>Females</th>
<th>Males</th>
<th>Total proportion receiving</th>
<th>Total proportion referring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>1</td>
<td>4</td>
<td>2.00%</td>
<td>5.10%</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>35</td>
<td>37</td>
<td>5.00%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Townsville</td>
<td>9</td>
<td>28</td>
<td>1.90%</td>
<td>1.50%</td>
</tr>
<tr>
<td>Mackay</td>
<td>6</td>
<td>11</td>
<td>3.40%</td>
<td>1.80%</td>
</tr>
<tr>
<td><strong>NQPHN total</strong></td>
<td><strong>51</strong></td>
<td><strong>80</strong></td>
<td><strong>3.10%</strong></td>
<td><strong>2.90%</strong></td>
</tr>
</tbody>
</table>

Source: QH 2015 [45]

Data definition: The mental health illness assessment included hanging, overdose, self harm, or psychiatric. Available data did not include patient age, so the total proportion calculated included paediatric transfers. Indigenous/non-Indigenous status was not included, so this data is presented by gender.

Implication:

The combined implications of acute mental health need, as indicated by high self-harm rates, mental health service use and access, with fewer service FTEs across the PHN, indicates an overwhelming need for increases in services and access, especially for Torres and Cape. The high levels of acute presentations requiring inter-facility transfer (often self-harm associated) indicate deeper levels of unmet need in mental health service. High rates of substance misuse presentations to HHSs is highly associated with mental health conditions, often presented in acute care settings as a dual diagnosis. Numbers of acute presentations are indicative of underlying need in the community for identification of (often) long-standing symptoms that if detected early, may be preventatively managed. This is especially relevant across the rural and remote areas of NQPHN, with particular need identified for those from Torres and Cape, who have no access to acute mental health beds and poor access to mental health professionals, as indicated by their low FTE provided for this service area. Although NQPHN only presents data from Queensland Health collated from their services, what we present provides an indication of the increasing need for additional mental health services across the PHN within all organisations that provide mental health services.
11. Aged care health care use

Aged care services often provide the first point of care for elderly people. Information on aged care services are provided by the Commonwealth Department of Health and Ageing. Information is based on the location of the service, rather than the region in which the service is delivered.

In some instances, aged care services may have provided the address information of their approved provider in place of the address information of the individual aged care service. Users should be aware of this limitation when using this data.

Table 13: Aged Care Services by LGA, Northern Queensland PHN region and Queensland, 30 June 2013

<table>
<thead>
<tr>
<th>HHS region</th>
<th>Aged Care services (no.)</th>
<th>Community care</th>
<th>Residential aged care</th>
<th>Transition care</th>
<th>Total places</th>
<th>Australian funding ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>12</td>
<td>112</td>
<td>85</td>
<td>0</td>
<td>197</td>
<td>3.8</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>52</td>
<td>636</td>
<td>1,517</td>
<td>38</td>
<td>2,191</td>
<td>87.9</td>
</tr>
<tr>
<td>Townsville</td>
<td>45</td>
<td>506</td>
<td>1,451</td>
<td>71</td>
<td>2,028</td>
<td>82.7</td>
</tr>
<tr>
<td>Mackay</td>
<td>36</td>
<td>364</td>
<td>988</td>
<td>0</td>
<td>1,352</td>
<td>53.5</td>
</tr>
<tr>
<td><strong>NQPHN total</strong></td>
<td><strong>145</strong></td>
<td><strong>1,618</strong></td>
<td><strong>4,041</strong></td>
<td><strong>109</strong></td>
<td><strong>5,768</strong></td>
<td><strong>227.9</strong></td>
</tr>
<tr>
<td><strong>Queensland total</strong></td>
<td><strong>995</strong></td>
<td><strong>11,390</strong></td>
<td><strong>33,742</strong></td>
<td><strong>733</strong></td>
<td><strong>45,865</strong></td>
<td><strong>1,912.3</strong></td>
</tr>
</tbody>
</table>

Source: Aged care services TMML December 2015.

Across the NQPHN there were 145 aged care services (30 June 2013) with 5,768 aged care operational places (beds). Within the region, Townsville LGA had the largest number of aged care service operational places (1,401). This compares with Queensland with 995 aged care services (30 June 2013) and 45,865 aged care operational places.

**Implication:**

All areas across Australia have an increasing aged care population: a higher proportion of the population over the age of 65, with a higher proportion of elderly people with significant needs in their later years requiring residential care. Planning for additional infrastructure and workforce to support projected need will enable NQPHN to deliver appropriate care for this vulnerable group.
12. After hours access to health services

After hours primary care (after hours) has traditionally been viewed as non-life threatening care that requires attention within 12 hours, and is provided outside usual business hours: 8am to 6pm weekdays, 8am to 12noon Saturdays. After-hours primary care is an emerging issue of importance in many western countries, as it forms an integral component of health service provision.

In Australia, medical treatment (mostly provided by General Practitioners) primary care services delivered after hours are funded through the Medicare Benefits Schedule (MBS) and incentivised through the Practice Incentives Program (PIP). The new PIP After Hours incentive simplifies the funding process to encourage General Practices’ to provide access to after hours services as per national accreditation standards.

Primary health care Medical Benefits Scheme (MBS) data is not yet available with the new PIP incentive components provided for after hours service delivery. However based on the previous item numbers, there were multiple occasions of after hours care delivered across the PHN during 2015, with item number 597 attracting the most services.

Table 14: Number of after hours MBS item claims for services across the NQPHN, includes reporting number of practitioners during 2015 (Jan-Dec)

<table>
<thead>
<tr>
<th>Item number and description</th>
<th>Services</th>
<th>Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>599 Urgent attendance during the unsociable hours period (11pm – 7am) by a General Practitioner Group A1- Vocationally Registered</td>
<td>4,994</td>
<td>116</td>
</tr>
<tr>
<td>600 Urgent attendance during the unsociable hours period (11pm – 7am) by a General Practitioner Group A2- Non-Vocationally Registered</td>
<td>106</td>
<td>22</td>
</tr>
<tr>
<td>597 Urgent attendance during the sociable hours period 7am – 8am or 6pm – 11pm- weekdays or after 12 on weekends by a General Practitioner Group A1- Vocationally Registered</td>
<td>50,640</td>
<td>220</td>
</tr>
<tr>
<td>598 Urgent attendance during the sociable hours period 7am – 8am or 6pm – 11pm- weekdays or after 12 on weekends by a General Practitioner Group A2- Non-Vocationally Registered</td>
<td>886</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: MBS website 2016 [46]

ED presentations during the after hours period accounted for half the ED presentations annually. The greatest number of presentations were for triage category 4 in all locations except Torres and Cape, for which it was category 5, the lowest acuity level.

The majority of NQPHN people interviewed (76%) reported having a preferred GP, although one-fifth reported a longer than acceptable wait time to get an appointment and ~30% reported they could not get an appointment with their preferred GP at all in the last 12 months. One in 12 people (9%) saw an after-hours GP in the previous 12 months. A greater proportion (~20%) reported attending ED for a condition they felt could have been seen by their GP. Furthermore, previously reported in Table 16, section 8.2, over 10% of MBS occasions of service were due to accessing GPs after hours.
After hours ED presentations by triage level for 2014/15 in NQPHN region

Source: Queensland Health, December 2015

Data reported. The after-hours period includes presentations after 6pm-8am weekdays, all presentations on weekends (Sat/Sun) and Public Holidays (Labour Day-6/10/2014, Christmas Day- 25/12/2014, Boxing Day- 26/12/2014, New Year’s Day- 1/1/2015, Australia Day- 26/1/2015, ANZAC Day-25/4/2015, Good Friday- 3/4/2015, Easter Monday- 6/4/2015, Bank Holiday- 8/6/2015); Show day was not included as this differs for each regional centre.

Figure 38: After hours emergency department presentations for each HHS by triage level

Table 15: Responses from the ABS Patient Experience Survey on GP access, FY 2013-14

<table>
<thead>
<tr>
<th>Survey question</th>
<th>Proportion of NQPHN Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have a preferred GP</td>
<td>76.5%</td>
</tr>
<tr>
<td>Waited longer than felt acceptable to get an appointment with a GP in the last 12 months</td>
<td>19.5%</td>
</tr>
<tr>
<td>Reported they could not see preferred GP at any time in the last 12 months</td>
<td>28.2%</td>
</tr>
<tr>
<td>Attended the hospital emergency department for their own health and at the time, felt the care could have been provided by a GP</td>
<td>18.6%</td>
</tr>
<tr>
<td>Proportion of people who saw a GP after hours for their own health in the last 12 months</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Source: ABS Patient Experience Survey [37]

Table 16: Australasian Triage Scale

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Should be seen by provider within</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resuscitation</td>
<td>0 minutes</td>
</tr>
<tr>
<td>2</td>
<td>Emergency</td>
<td>10 minutes</td>
</tr>
<tr>
<td>3</td>
<td>Urgent</td>
<td>30 minutes</td>
</tr>
<tr>
<td>4</td>
<td>Semi-urgent</td>
<td>60 minutes</td>
</tr>
<tr>
<td>5</td>
<td>Non-urgent</td>
<td>120 minutes</td>
</tr>
</tbody>
</table>

Source: Queensland Health, December 2015
Furthermore, additional challenges have been identified (from workforce and consumers) for the delivery of effective after-hours services across regional, rural and remote areas, including low transport access, lack of home visits, poor internet access, and widespread health care workforce insufficiencies.

Implication:

All areas across Australia are facing challenges to increasing access to primary health services during the after-hours period. Planning for additional infrastructure and workforce to support after-hours access will enable NQPHN to deliver appropriate care to its population during this time period, while reducing pressures on the HHSs.
13. Childhood and maternal health

Maintaining good health before, during and after pregnancy supports positive health outcomes for both mothers and babies. Infants born at full term, within the normal weight range, and to a mother in good health is a major contributor to good health and wellbeing outcomes in childhood. Likewise, the early years of an infant’s life is a critical period of development, which affects their health and wellbeing in later life [23]. For Queensland, the leading cause of death for an infant under the age of one year is newborn affected by maternal factors or complicated by pregnancy and delivery [47].

Northern Queensland has a greater percentage of infants and children (0-14 yrs) than all of Queensland. Furthermore, our children and pregnant women are vulnerable, with a high percentage of Aboriginal and Torres Strait Islander population who report lower socio-economic background with more behavioural health risks.

SMOKING DURING PREGNANCY

Smoking during pregnancy is harmful to both mother and child and is highly associated with low birth-weight (LBW) babies. NQPHN reports 6.6% of babies are born with low birth rate (<2.5kg), which is higher than that reported nationally at 6.2% [48]. Pre-term births are more common to mothers who smoked. Babies whose mothers smoked during pregnancy were 1.5 times as likely to be born pre-term (12%) as those whose mothers did not smoke during pregnancy (8%) [53]. There are high rates of smoking during pregnancy in NQPHN’s region, with Townsville and Mackay regions estimated at 19.5% of pregnant women smoking and Cairns and Hinterland and Torres and Cape 27.3% of pregnant women smoking [48]. Additionally, babies born of Indigenous Australian mothers were more likely to be LBW (12.2%) compared with those of non-Indigenous mothers (6.1%). Remoteness was also more highly associated with LBW babies, with 10.6% of LBW babies born to mothers from very remote areas, compared with 6.3% of babies born to mothers living in major cities [48].

Rate of smoking during pregnancy

Source: The Health of Queenslanders [23]

Figure 39: Rate of smoking during pregnancy
Smoking during pregnancy is particularly high in Aboriginal and Torres Strait Islander women, with Townsville and Mackay regions reporting 51.5% of Indigenous Australian women smoking during pregnancy and Cairns and Hinterland and Torres and Cape 55.6% of Indigenous Australian women smoking during pregnancy [23].

Based on the AIHW Metadata Online registry (2015), notable LGAs with high low birth weight rates compared with Queensland (8.3%) are: Palm Island (20.9%), Aurukun (13.1%), and Hope Vale (22.0%). This data is indicative of poor maternal nutrition and inadequate anti-natal care. Services to improve health access for pregnant women will have long-term benefits to the health of the next generation.

ED presentations by age group

![Graph showing ED presentations by age group](image)

**Figure 40: ED presentation proportions for children under 5 years, 5 to under 16 years and adults, by HHS, 2014/15**

Childhood presentations (under 5 years) account for 10% of all ED presentations across NQPHN. A similar proportion are reported for children aged 5 to under 16 years. The highest proportions of childhood ED presentations are reported from Torres and Cape York HHS, 14% and 13% for under 5s and 5s to 16 year olds respectively. Services to improve health access for children will have long-term benefits to the health of the next generation.

The most common cause of death of Indigenous Australian infants was ‘conditions originating in the perinatal period’ (such as birth trauma, disorders related to foetal growth, and complications of pregnancy, labour and delivery), accounting for 48% of deaths in 2008–2012 (3.0 per 1,000 live births) [42]. Infant deaths (that is, deaths of children aged less than one year) represented 4% of Indigenous Australian deaths in 2008–2012, but only 1% of non-Indigenous deaths.
For children aged 1-14 years, the leading causes of death for Queensland in 2012 were accidental drowning and pedestrian injury by transport [47].

Overcrowding is highly associated with increased disease carriage rates, in particular childhood ear and diarrhoeal diseases [49]. These both have long-term sequelae as ear disease leads to hearing loss and deafness, and long-term diarrhoeal diseases are associated with failure to thrive and malnutrition in infants.

Implication:

While other PHNs have an increasing ageing population, NQPHN also supports a higher proportion of young children who often have high needs (Aboriginal and Torres Strait Islander children). To improve infant health and reduce long-term risks associated with LBW babies, NQPHN will need to invest in midwifery, obstetrics and neonatal paediatric services to deliver optimal health care for the next generation. This is especially important for Closing the Gap for Aboriginal and Torres Strait Islander populations within the next generation.
14. Health transport use

Health transport infrastructure and service is particularly important for NQPHN due to the large geographical area. They provide an indication of consumer access to health services (primary, secondary and tertiary). An example of distances faced includes over 815km between Cairns and Weipa, equating to a 16-hour drive.

To service the area, aerial flights (fixed and rotary wing) are required to transport patients to and from very remote areas, as road access is poor and distances too great when patients are in critical condition. Furthermore, transport has been flagged by consumers as a significant issue reducing access to health services across regional, rural and remote areas (see chapter 15).

Queensland Ambulance Service (QAS) is integral to the primary health care sector in Queensland, providing patient transport services, co-ordination of aero medical services, inter-facility ambulance transport, planning and coordination of multi-casualty incidents and disasters, and casualty room services to the Queensland community.

Table 17: Occasions of transfer by transport mode to receiving HHS destination (June 2014 to March 2015 - not a complete year)

<table>
<thead>
<tr>
<th>Receiving HHS</th>
<th>Boat</th>
<th>Fixed Wing</th>
<th>Mode of transport</th>
<th>Road</th>
<th>Rotary Wing</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torres and Cape</td>
<td>1</td>
<td>37</td>
<td></td>
<td>0</td>
<td>182</td>
<td>2</td>
<td>222</td>
</tr>
<tr>
<td>Cairns and Hinterland</td>
<td>0</td>
<td>891</td>
<td>101</td>
<td>244</td>
<td>22</td>
<td>1,258</td>
<td></td>
</tr>
<tr>
<td>Townsville</td>
<td>9</td>
<td>908</td>
<td>91</td>
<td>298</td>
<td>15</td>
<td>1,321</td>
<td></td>
</tr>
<tr>
<td>Mackay</td>
<td>6</td>
<td>192</td>
<td>18</td>
<td>174</td>
<td>10</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td>NQPHN total</td>
<td>16</td>
<td>2,028</td>
<td>210</td>
<td>898</td>
<td>49</td>
<td>3,201</td>
<td></td>
</tr>
</tbody>
</table>

Source: QH [45]

Occurrences of service by QAS indicate lower use by the Torres and Cape HHS with a lower proportion of emergency call outs (29%) compared to the other HHSs (~40%). The higher use of non-emergency responses to Torres and Cape HHS indicates that the ambulance service may be the only transport service option in this remote setting, leading to use for lower acuity transfers in addition to emergency and urgent responses.

Implication:

Transport is more important for NQPHN than for other PHNs due to our large geographical areas. Access to health services can be improved with appropriate transport infrastructure and services. This will enable equitable health service delivery to populations residing in regional centres and those residing in very remote areas.
Ambulance occasions of service, 2014/15

Source: Data provided directly from QAS data by HHS regions, February 2016

Figure 41: Queensland Ambulance Service responses by triage level, HHS, for FY 2014/15
15. Community consultation

15.1 WORKFORCE FEEDBACK ON WORKFORCE NEEDS

Community consultation was undertaken across three major sites (Cairns, Mackay and Townsville) during June (38 participants) and during August (115 participants) 2015. A later session was offered in Mackay offering focus groups on dentistry and pharmacy (39 participants attended). Participants included General Practitioners, nurses, practice managers, Aboriginal Medical Services, allied health professionals (pharmacies, dental clinics, podiatrists, psychologists, occupational therapists and speech pathologists), disability services, aged care specialist groups, Queensland Health (HHS) representatives, fitness / sport and recreation organisations, and university and TAFE representatives. A summary of the top priority areas, as identified by participants, are presented below.

Table 18: Top 5 priority areas for PHN involvement across workforces within our region.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Priority Area</th>
<th># Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Education, Training, Skilling / Workforce / Networking</td>
<td>77</td>
</tr>
<tr>
<td>2.</td>
<td>Directories / Available Services (34) / Service Mapping (8) / Service Gaps (8)</td>
<td>50</td>
</tr>
<tr>
<td>3.</td>
<td>Provider collaboration / Integration / Health Pathways / Holistic Care</td>
<td>30</td>
</tr>
<tr>
<td>4.</td>
<td>Communication esp. Health Reform / Gov. Updates / Funding Opportunities</td>
<td>25</td>
</tr>
<tr>
<td>5.</td>
<td>Billing Support / Practice Support</td>
<td>15</td>
</tr>
</tbody>
</table>

15.2 WORKFORCE FEEDBACK ON CONSUMER NEEDS

Torres and Cape HHS
- Workforce feedback indicated need for transport and access for Northern Peninsula Area and Torres Strait
- Equitable access to fresh fruit and vegetables for rural, remote and metropolitan areas

Cairns HHS
- Patient transport services raised as significant issue
- Identified need for direct referral of HHS patients (seeing outpatient specialists) to private allied health professionals within the community
- More Indigenous Australian education for engaging patients in their own health management
- Increasing ED attendance raised as an issue that needs to be addressed
- Communication between HHS and primary health needs improvement

Townsville HHS
- Transport was flagged as a huge issue for the region – for clients travelling from rural areas to regional centres for medical reasons, and also for clients travelling between rural areas (both for medical reasons and to visit family in care)
- Family support and social determinants of health raised as important
- Service mapping raised as important for identifying health access
- Telehealth identified as important, especially for elderly and children in remote areas
- Lack of counselling and mental health services for men who are perpetrators of domestic violence
- The local nursing home has issues with attracting/recruiting staff, mainly registered nurses, and currently relies on employing overseas nurses (457 visa)
- Equitable access to fresh fruit and vegetables for rural, remote and metropolitan areas

Mackay HHS
- Patient transport services raised as significant issue
- Improve and increase mental health services to the area
- Very little acute care provision
15.3 CONSUMER FEEDBACK ON CONSUMER NEEDS

Table 19: Responses from the ABS Patient Experience Survey on GP access, FY 2013-14

<table>
<thead>
<tr>
<th>Survey question</th>
<th>Proportion of NQPHN population</th>
</tr>
</thead>
<tbody>
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<td>19.5%</td>
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<td>Reported they could not see preferred GP at any time in the last 12 months</td>
<td>28.2%</td>
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<tr>
<td>Attended the hospital emergency department for their own health and at the time, felt the care could have been provided by a GP</td>
<td>18.6%</td>
</tr>
<tr>
<td>Proportion of people who saw a GP after hours for their own health in the last 12 months</td>
<td>8.7%</td>
</tr>
<tr>
<td>Delayed getting or did not get prescription medication due to cost in the last 12 months</td>
<td>9.6%</td>
</tr>
<tr>
<td>Admitted to hospital in the last 12 months</td>
<td>16.4%</td>
</tr>
<tr>
<td>Reported having a long-term health condition</td>
<td>48.1%</td>
</tr>
<tr>
<td>Reported a health professional helped coordinate care, any time saw three or more health professionals in last 12 months</td>
<td>73.4%</td>
</tr>
<tr>
<td>Reported issues caused by lack of communication between health professionals for any time saw three or more health professionals in last 12 months</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

Source: ABS Patient Experience Survey [37]

Implication:

Community feedback is essential to improving the performance of NQPHN. Feedback from the three identified strata of need indicate that the health workforce needs support and expansion to meet the needs of consumers. NQPHN has developed formal consumer feedback surveys to be distributed to enable the organisation to more respond to their needs and tailor services appropriately.
Appendices

LOCAL GOVERNMENT AREA SNAPSHOTs ........ 74

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This health infographic gives a picture of people’s health in Cairns compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Cairns Regional Council
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE (%)</th>
<th>FEMALE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAIRNS</td>
<td>23.3%</td>
<td>13.9%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>MALE (%)</th>
<th>FEMALE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRUIT</td>
<td>55.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>VEGETABLES</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>PPH</th>
<th>3,201</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH ACUTE</td>
<td>1,711</td>
</tr>
<tr>
<td>PPH CHRONIC</td>
<td>1,434</td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>73</td>
</tr>
</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS 65+</td>
<td>2,735</td>
</tr>
<tr>
<td>MENTAL AND BEHAVIOURAL</td>
<td>1,383</td>
</tr>
<tr>
<td>CORONARY HEART</td>
<td>722</td>
</tr>
<tr>
<td>PNEUMONIA AND FLU</td>
<td>375</td>
</tr>
<tr>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td>343</td>
</tr>
<tr>
<td>ROAD TRANSPORT INJURY</td>
<td>274</td>
</tr>
<tr>
<td>STROKE</td>
<td>237</td>
</tr>
<tr>
<td>DIABETES</td>
<td>226</td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th></th>
<th>CAIRNS (%)</th>
<th>QLD AVERAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8%</td>
<td>CAIRNS</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
<thead>
<tr>
<th></th>
<th>CAIRNS (%)</th>
<th>QLD AVERAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.1%</td>
<td>CAIRNS</td>
<td>60.1%</td>
</tr>
</tbody>
</table>

This health infographic gives a picture of people’s health in Cassowary Coast compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Cassowary Coast Regional Council
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
CASSOWARY COAST
34.4%
10.1%
QLD AVERAGE
22.8%
19.8%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

MALE
FEMALE
CASSOWARY COAST
65.6%
30.3%
QLD AVERAGE
58.4%
7.7%

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>PPH</th>
<th>PPH ACUTE</th>
<th>PPH CHRONIC</th>
<th>PPH VACCINE PREVENTABLE</th>
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</thead>
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<tr>
<td>FALLS 65+</td>
<td>3,201</td>
<td>1,711</td>
<td>1,434</td>
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</tr>
<tr>
<td>MENTAL AND BEHAVIOURAL</td>
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<td></td>
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Specific Conditions

<table>
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<td>STROKE</td>
<td>237</td>
</tr>
<tr>
<td>DIABETES</td>
<td>226</td>
</tr>
</tbody>
</table>

*Hospital admissions that potentially could have been prevented by appropriate utilisation of non-hospital health services

DISABILITY
Persons with a profound or severe disability

5.0%
CASSOWARY COAST
4.4%
QLD AVERAGE

61.1%
Cassowary Coast
60.1%
QLD AVERAGE

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

58.4%
CASSOWARY COAST
46.5%
QLD AVERAGE

This health infographic gives a picture of people’s health in Croydon compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Croydon Shire
2016

**ALCOHOL CONSUMPTION**
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CROYDON</td>
<td>31.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>22.1%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

**HEALTHY EATING**
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>FRUIT</th>
<th>VEGETABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CROYDON</td>
<td>57.3%</td>
<td>9.4%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

**HOSPITALISATION RATES**
Per 100,000 people
Cairns and Hinterland HHS 2009-2010 to 2011-2012

**Potentially Preventable Hospitalisations (PPH)**

- 3,201 PPH
- 1,711 PPH ACUTE
- 1,434 PPH CHRONIC
- 73 PPH VACCINE PREVENTABLE

**Specific Conditions**

- 2,735 FALLS 65+
- 1,383 MENTAL AND BEHAVIOURAL
- 722 CORONARY HEART
- 375 PNEUMONIA AND FLU

- 343 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- 274 ROAD TRANSPORT INJURY
- 237 STROKE
- 226 DIABETES

**DISABILITY**
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th></th>
<th>CROYDON</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9%</td>
<td>4.4%</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL ACTIVITY**
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

- 59.4% Croydon
- 60.1% QLD AVERAGE

---

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This health infographic gives a picture of people’s health in Douglas compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOTT

Douglas Shire 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOUGLAS</td>
<td>33.1%</td>
<td>13.9%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>23.3%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
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</thead>
<tbody>
<tr>
<td>DOUGLAS</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>55.5%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

<table>
<thead>
<tr>
<th>Condition</th>
<th>Douglas</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Preventable Hospitalisations (PPH)*</td>
<td>3,201</td>
<td>2,735</td>
</tr>
<tr>
<td>PPH ACUTE</td>
<td>1,711</td>
<td></td>
</tr>
<tr>
<td>PPH CHRONIC</td>
<td>1,434</td>
<td></td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>73</td>
<td></td>
</tr>
</tbody>
</table>

| Specific Conditions                      | 2,735   | 343         |
| FALLS 65+                                |         | CHRONIC OBSTRUCTIVE PULMONARY DISEASE |
| MENTAL AND BEHAVIOURAL                   | 1,383   | 274         |
| CORONARY HEART                           | 722     | ROAD TRANSPORT INJURY |
| PNEUMONIA AND FLU                        | 375     | STROKE      |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE    |         | DIABETES    |
| ROAD TRANSPORT INJURY                    |         |             |
| STROKE                                   |         |             |
| DIABETES                                 |         |             |

DISABILITY
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th></th>
<th>Douglas</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9%</td>
<td>4.4%</td>
<td></td>
</tr>
</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
<thead>
<tr>
<th></th>
<th>Douglas</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.1%</td>
<td>60.1%</td>
<td></td>
</tr>
</tbody>
</table>
This health infographic gives a picture of people’s health in Etheridge compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Etheridge Shire 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Etheridge</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,201 PPH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,711 PPH ACUTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,434 PPH CHRONIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>73 PPH VACCINE PREVENTABLE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Etheridge</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,735 FALLS 65+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,383 MENTAL AND BEHAVIOURAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>722 CORONARY HEART</td>
<td></td>
<td></td>
</tr>
<tr>
<td>375 PNEUMONIA AND FLU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>343 CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>274 ROAD TRANSPORT INJURY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>237 STROKE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>226 DIABETES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

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<thead>
<tr>
<th>Condition</th>
<th>Etheridge</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.4% Etheridge</td>
<td></td>
<td>60.1% QLD AVERAGE</td>
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</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

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<tr>
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This health infographic gives a picture of people’s health in Mareeba compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
**Alcohol Consumption**

Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mareeba</td>
<td>20.3%</td>
<td>19.8%</td>
</tr>
<tr>
<td>QLD average</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

**Healthy Eating**

People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>Fruit</th>
<th>Vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mareeba</td>
<td>59.3%</td>
<td>10.7%</td>
</tr>
<tr>
<td>QLD average</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

**Hospitalisation Rates**

Per 100,000 people

Cairns and Hinterland HHS 2009-2010 to 2011-2012

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mareeba</th>
<th>QLD average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Preventable Hospitalisations (PPH)*</td>
<td>3,201</td>
<td>1,711</td>
</tr>
<tr>
<td>Falls 65+</td>
<td>2,735</td>
<td>1,383</td>
</tr>
<tr>
<td>Mental and Behavioural Health</td>
<td>1,383</td>
<td>2,735</td>
</tr>
<tr>
<td>Coronary Heart</td>
<td>722</td>
<td>375</td>
</tr>
<tr>
<td>Pneumonia and Flu</td>
<td>343</td>
<td>274</td>
</tr>
<tr>
<td>Road Transport Injuries</td>
<td>237</td>
<td>226</td>
</tr>
<tr>
<td>Stroke</td>
<td>226</td>
<td>237</td>
</tr>
<tr>
<td>Diabetes</td>
<td>226</td>
<td>237</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Conditions</th>
<th>Mareeba</th>
<th>QLD average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>343</td>
<td>274</td>
</tr>
<tr>
<td>Road Transport Injury</td>
<td>237</td>
<td>226</td>
</tr>
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<td>Stroke</td>
<td>226</td>
<td>237</td>
</tr>
<tr>
<td>Diabetes</td>
<td>226</td>
<td>237</td>
</tr>
</tbody>
</table>

**Disability**

Persons with a profound or severe disability

<table>
<thead>
<tr>
<th></th>
<th>Mareeba</th>
<th>QLD average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mareeba</td>
<td>58.5%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

**Physical Activity**

Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
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<tr>
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<th>QLD average</th>
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</thead>
<tbody>
<tr>
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<td>4.4%</td>
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</tbody>
</table>
This health infographic gives a picture of people’s health in Tablelands compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Tablelands Regional Council 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
TABLELANDS
QLD AVERAGE

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
VEGETABLES
TABLELANDS
QLD AVERAGE

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>TABLELANDS</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH</td>
<td>3,201</td>
<td>2,735</td>
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<td>1,434</td>
<td></td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>73</td>
<td></td>
</tr>
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</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>TABLELANDS</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS 65+</td>
<td>2,735</td>
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<td>MENTAL AND BEHAVIOURAL</td>
<td>1,383</td>
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<tr>
<td>CORONARY HEART</td>
<td>722</td>
<td>237</td>
</tr>
<tr>
<td>PNEUMONIA AND FLU</td>
<td>375</td>
<td>226</td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th>Category</th>
<th>TABLELANDS</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2%</td>
<td>4.4%</td>
<td></td>
</tr>
</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

54.2% TABLELANDS
60.1% QLD AVERAGE

This health infographic gives a picture of people’s health in Yarrabah compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Yarrabah Aboriginal Shire

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YARRABAH</td>
<td>QLD AVERAGE</td>
<td>YARRABAH</td>
<td>QLD AVERAGE</td>
</tr>
<tr>
<td>MALE</td>
<td>22.1%</td>
<td>19.8%</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
<tr>
<td>FEMALE</td>
<td>22.1%</td>
<td>19.8%</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>FRUIT</th>
<th>VEGETABLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>57.3% YARRABAH</td>
<td>9.4% YARRABAH</td>
</tr>
<tr>
<td>FEMALE</td>
<td>58.4% QLD AVERAGE</td>
<td>8.8% QLD AVERAGE</td>
</tr>
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HOSPITALISATION RATES
PER 100,000 PEOPLE
Cairns and Hinterland HHS 2009-2010 to 2011-2012

<table>
<thead>
<tr>
<th>Category</th>
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<tr>
<td>Potentially Preventable Hospitalisations (PPH)*</td>
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<td>722</td>
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<td>375</td>
</tr>
<tr>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td>343</td>
</tr>
<tr>
<td>ROAD TRANSPORT INJURY</td>
<td>274</td>
</tr>
<tr>
<td>STROKE</td>
<td>237</td>
</tr>
<tr>
<td>DIABETES</td>
<td>226</td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

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<thead>
<tr>
<th></th>
<th>YARRABAH</th>
<th>QLD AVERAGE</th>
</tr>
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<tbody>
<tr>
<td>2.7%</td>
<td>YARRABAH</td>
<td>4.4% QLD AVERAGE</td>
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</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

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<tr>
<th></th>
<th>YARRABAH</th>
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</thead>
<tbody>
<tr>
<td>59.4%</td>
<td>YARRABAH</td>
<td>60.1% QLD AVERAGE</td>
</tr>
</tbody>
</table>

*Hospital admissions that potentially could have been prevented by appropriate utilisation of non-hospital health services

This health infographic gives a picture of people's health in Burdekin compared to Queensland. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

**Burdekin Shire**

- **Estimated Resident Population 2014**: 17,916
- **6.1%** Identify as Aboriginal and Torres Strait Islander

**POPULATION**

- **LIFE EXPECTANCY**
  - Burdekin: 83.5 years (F), 84 years (M)
  - Queensland Average: 78.5 years (F), 79.1 years (M)

**IMMUNISATION**

- Children that are fully vaccinated at 5 years: Burdekin 93.7%, Queensland Average 92.1%

**DAILY SMOKERS**

- Burdekin: 16.8% (F), 22% (M)
- Queensland Average: 13.8% (F), 15.6% (M)

**SMOKING IN PREGNANCY**

- Burdekin: 20%
- Queensland Average: 17%

**OVERWEIGHT & OBESE**

- Adults with a Body Mass Index above 25
  - Burdekin: 65.2%
  - Queensland Average: 57.8%

**DIABETES**

- Number of National Diabetes Services Scheme registrants
  - Burdekin: 5.8%
  - Queensland Average: 4.5%
HEALTH SNAPSHOT
Burdekin Shire

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burdekin</td>
<td>33.3%</td>
<td>6.8%</td>
</tr>
<tr>
<td>QLD Average</td>
<td>20.2%</td>
<td>19.8%</td>
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</table>

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

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<tr>
<th></th>
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<th>FEMALE</th>
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<tbody>
<tr>
<td>Burdekin</td>
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<td>8.2%</td>
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<td>QLD Average</td>
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<td>8.8%</td>
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HOSPITALISATION RATES PER 100,000 PEOPLE
Townsville HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th></th>
<th>Burdekin</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH</td>
<td>3,120</td>
<td>2,670</td>
</tr>
<tr>
<td>PPH ACUTE</td>
<td>1,525</td>
<td>694</td>
</tr>
<tr>
<td>PPH CHRONIC</td>
<td>1,523</td>
<td>666</td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>90</td>
<td>362</td>
</tr>
</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Burdekin</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS 65+</td>
<td>2,670</td>
<td>336</td>
</tr>
<tr>
<td>CORONARY HEART</td>
<td>694</td>
<td>331</td>
</tr>
<tr>
<td>MENTAL AND BEHAVIOURAL</td>
<td>666</td>
<td>253</td>
</tr>
<tr>
<td>DIABETES</td>
<td>362</td>
<td>218</td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

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<th></th>
<th>Burdekin</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
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<td>5.2%</td>
<td>4.4%</td>
<td></td>
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</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
<thead>
<tr>
<th></th>
<th>Burdekin</th>
<th>QLD Average</th>
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<tbody>
<tr>
<td>44.6%</td>
<td>60.1%</td>
<td></td>
</tr>
</tbody>
</table>

This health infographic gives a picture of people’s health in Charters Towers compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Estimated Resident Population 2014**

- **Charters Towers**: 12,517
- **QLD Average**: 8.8% Identify as Aboriginal and Torres Strait Islander

**Life Expectancy**

- **Charters Towers**
  - Males: 83.5 years
  - Females: 84 years
- **QLD Average**
  - Males: 78.5 years
  - Females: 79.1 years

**Daily Smokers**

- **Charters Towers**: 14.6%
- **QLD Average**: 13.8%

**Immunisation**

- Children that are fully vaccinated at 5 years
  - **Charters Towers**: 93.7%
  - **QLD Average**: 92.1%

**Smoking in Pregnancy**

- **Charters Towers**: 20%
- **QLD Average**: 17%

**Diabetes**

- Number of National Diabetes Services Scheme registrants
  - **Charters Towers**: 5.4%
  - **QLD Average**: 4.5%
  - **Charters Towers**: 67.4%
  - **QLD Average**: 64.6%

**Overweight & Obese**

- Adults with a Body Mass Index above 25
  - **Charters Towers**: 62.2%
  - **QLD Average**: 57.8%
HEALTH SNAPSHOT
Charters Towers Regional Council

2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

- **MALE**
  - CHARTERS TOWERS: 34.0%
  - QLD AVERAGE: 21.8%

- **FEMALE**
  - CHARTERS TOWERS: 9.5%
  - QLD AVERAGE: 19.8%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

- **FRUIT**
  - CHARTERS TOWERS: 53.6%
  - QLD AVERAGE: 58.4%

- **VEGETABLES**
  - CHARTERS TOWERS: 6.7%
  - QLD AVERAGE: 8.8%

HOSPITALISATION RATES
PER 100,000 PEOPLE
Townsville HHS 2009-2010 to 2011-2012

- **Potentially Preventable Hospitalisations (PPH)***
  - Charters Towers: 3,120
  - QLD AVERAGE: 2,670

- **Specific Conditions**
  - **FALLS 65+**: 2,670
  - **CORONARY HEART**: 694
  - **MENTAL AND BEHAVIOURAL**: 666
  - **DIABETES**: 362
  - **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**: 336
  - **PNEUMONIA AND FLU**: 331
  - **STROKE**: 253
  - **ROAD TRANSPORT INJURY**: 218

DISABILITY
Persons with a profound or severe disability

- **CHARTERS TOWERS**: 5.8%
- **QLD AVERAGE**: 4.4%

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

- **CHARTERS TOWERS**: 56.0%
- **QLD AVERAGE**: 60.1%

This health infographic gives a picture of people’s health in Flinders compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**POPULATION**
Estimated Resident Population 2014

- Flinders: 1,822
- QLD Average: 7.4% Identify as Aboriginal and Torres Strait Islander

**LIFE EXPECTANCY**
- FLINDERS: 83.5 YEARS
- QLD AVERAGE: 84 YEARS
- FLINDERS: 78.5 YEARS
- QLD AVERAGE: 79.1 YEARS

**DAILY SMOKERS**
- FLINDERS: 14.5%
- QLD AVERAGE: 13.8%

**DIABETES**
- FLINDERS: 4.7%
- QLD AVERAGE: 4.5%

**IMMUNISATION**
- Children that are fully vaccinated at 5 years

- FLINDERS: 93.7%
- QLD AVERAGE: 92.1%

**SMOKING in PREGNANCY**
- FLINDERS: 20%
- QLD AVERAGE: 17%

**OVERWEIGHT & OBSESE**
Adults with a Body Mass Index above 25

- FLINDERS: 71.9%
- QLD AVERAGE: 57.8%

**Estimated Resident Population 2014**

- Flinders Shire: 1,822
- QLD Average: 7.4% Identify as Aboriginal and Torres Strait Islander
HEALTH SNAPSHOT
Flinders Shire 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
FLINDERS
QLD AVERAGE
FLINDERS
QLD AVERAGE

31.8%
11.5%
21.7%
19.8%

30.3%
9.5%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
VEGETABLES

FLINDERS
QLD AVERAGE
FLINDERS
QLD AVERAGE
54.6%
7.6%
58.4%
8.8%

HOSPITALISATION RATES
PER 100,000 PEOPLE
Townsville HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Flinders</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH</td>
<td>3,120</td>
<td></td>
</tr>
<tr>
<td>PPH ACUTE</td>
<td>1,525</td>
<td></td>
</tr>
<tr>
<td>PPH CHRONIC</td>
<td>1,523</td>
<td></td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>90</td>
<td></td>
</tr>
</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Flinders</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS 65+</td>
<td>2,670</td>
<td></td>
</tr>
<tr>
<td>CORONARY HEART</td>
<td>694</td>
<td></td>
</tr>
<tr>
<td>MENTAL AND BEHAVIOURAL</td>
<td>666</td>
<td></td>
</tr>
<tr>
<td>DIABETES</td>
<td>362</td>
<td></td>
</tr>
</tbody>
</table>

*Hospital admissions that potentially could have been prevented by appropriate utilisation of non-hospital health services

DISABILITY
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th>Flinders</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
<thead>
<tr>
<th>Flinders</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.9%</td>
<td>60.1%</td>
</tr>
</tbody>
</table>
This health infographic gives a picture of people’s health in Hinchinbrook compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOTS
Hinchinbrook Shire
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

HOSPITALISATION RATES
Per 100,000 People
Townsville HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*
3,120 PPH
1,525 PPH ACUTE
1,523 PPH CHRONIC
90 PPH VACCINE PREVENTABLE

Specific Conditions
2,670 FALLS 65+
694 CORONARY HEART
666 MENTAL AND BEHAVIOURAL
362 DIABETES
336 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
331 PNEUMONIA AND FLU
253 STROKE
218 ROAD TRANSPORT INJURY

DISABILITY
Persons with a profound or severe disability

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

Hinchinbrook
62.5%
QLD AVERAGE
60.1%

This health infographic gives a picture of people’s health in Palm Island compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**POPULATION**

Estimated Resident Population 2014

- **Palm Island Aboriginal Shire 2016**: 2,617
- **95.4% Identify as Aboriginal and Torres Strait Islander**

**LIFE EXPECTANCY**

- **Palm Island**:
  - Female: 83.5 years
  - Male: 78.5 years
- **Queensland Average**:
  - Female: 84 years
  - Male: 79.1 years

**DAILY SMOKERS**

- **Palm Island**: 14.6%
- **Queensland Average**: 14.8%

**DIABETES**

- **Palm Island**: 4.6%
- **Queensland Average**: 4.5%

**IMMUNISATION**

- **Palm Island**: 93.7%
- **Queensland Average**: 92.1%

**SMOKING in PREGNANCY**

- **Palm Island**: 20%
- **Queensland Average**: 17%

**OVERWEIGHT & OBSESE**

- **Palm Island**:
  - Overweight: 71.9%
  - Obese: 64.6%
- **Queensland Average**:
  - Overweight: 56.7%
  - Obese: 50.9%

**Palm Island**

Aboriginal Shire

- Estimated Resident Population: 2,617
- 95.4% Identify as Aboriginal and Torres Strait Islander

**Queensland Average**

- Estimated Resident Population: 4,391,553
- 93.7% Identify as Aboriginal and Torres Strait Islander

**Number of National Diabetes Services Scheme registrants**

- **Palm Island**: 1,832
- **Queensland Average**: 1,247,222
HEALTH SNAPSHOT
Palm Island Aboriginal Shire

2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

HOSPITALISATION RATES
PER 100,000 PEOPLE
Townsville HHS 2009-2010 to 2011-2012

AVERAGE
Palm Island
QLD AVERAGE

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

ARE HEALTHY EATERS

PHYSICAL
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

DISABILITY
Persons with a profound or severe disability

Palm Island Aboriginal Shire

59.9%
60.1%

58.4%
8.8%

FALLS 65+
CORONARY HEART
MENTAL AND BEHAVIOURAL
DIABETES

336
331
253
218

59.9%
60.1%

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
PNEUMONIA AND FLU
STROKE
ROAD TRANSPORT INJURY

54.6%
7.6%

58.4%
8.8%

PALM ISLAND
PALM ISLAND

Palm Island
QLD AVERAGE

3.0%
4.4%

PALM ISLAND
QLD AVERAGE


Specific Conditions

Potentially Preventable Hospitalisations (PPH)*

3,120 PPH
1,525 PPH ACUTE
1,523 PPH CHRONIC
90 PPH VACCINE PREVENTABLE

*Hospital admissions that potentially could have been prevented by appropriate utilisation of non-hospital health services.

DISABILITY

Persons with a profound or severe disability

59.9%
60.1%

Palm Island
QLD AVERAGE

5.0%
4.4%

PALM ISLAND
QLD AVERAGE

Palm Island Aboriginal Shire

59.9%
60.1%

58.4%
8.8%

FALLS 65+
CORONARY HEART
MENTAL AND BEHAVIOURAL
DIABETES

336
331
253
218

54.6%
7.6%

58.4%
8.8%

PALM ISLAND
PALM ISLAND

Palm Island
QLD AVERAGE

3.0%
4.4%

PALM ISLAND
QLD AVERAGE

This health infographic gives a picture of people’s health in Richmond compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Richmond Shire

**Estimated Resident Population 2014**

- **847**
- **47.3%** female
- **52.7%** male

**LIFE EXPECTANCY**

- **83.5** years Richmond
- **84** years Queensland average

- **78.5** years Richmond
- **79.1** years Queensland average

**IMMUNISATION**

- **93.7%** Richmond children fully vaccinated at 5 years
- **92.1%** Queensland average

**SMOKING in PREGNANCY**

- **14.5%** Richmond daily smokers
- **13.8%** Queensland average

- **14.3%** female
- **14.8%** male

**OVERWEIGHT & OBESE**

- **4.9%** Richmond
- **4.5%** Queensland average

- **71.9%** Richmond
- **56.7%** Queensland average

- Number of National Diabetes Services Scheme registrants

- **64.6%** Richmond
- **57.8%** Queensland average

- **64.6%** female
- **50.9%** male
**Health Snapshot 2016**

**Richmond Shire**

### Alcohol Consumption

- **Male**: Richmond: 21.7%, QLD Average: 30.3%
- **Female**: Richmond: 11.5%, QLD Average: 9.5%

### Healthy Eating

- **Fruits**: Richmond: 54.6%, QLD Average: 58.4%
- **Vegetables**: Richmond: 7.6%, QLD Average: 8.8%

### Hospitalisation Rates

- **Potentially Preventable Hospitalisations (PPH)**
  - Richmond: 3,120
  - QLD Average: 2,670
- **Specific Conditions**
  - Falls 65+: Richmond: 694, QLD Average: 336
  - Coronary Heart: Richmond: 666, QLD Average: 311
  - Mental and Behavioural: Richmond: 362, QLD Average: 253
  - Diabetes: Richmond: 336, QLD Average: 218

### Disability

- Richmond: 59.9%, QLD Average: 60.1%
- Richmond Shire: 3.6%, QLD Average: 4.4%

### Physical Activity

- Richmond: 60.1%
- QLD Average: 59.9%

---

This health infographic gives a picture of people’s health in Townsville compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

- **Estimated Resident Population 2014**: 192,038
- **7.6% Identify as Aboriginal and Torres Strait Islander**

**LIFE EXPECTANCY**
- **Townsville City 2016**
  - **83.5 years**
  - **84 years**
  - **78.5 years**
  - **79.1 years**

**IMMUNISATION**
- **Children that are fully vaccinated at 5 years**
  - **Townsville**: 93.7%
  - **QLD Average**: 92.1%

**DAILY SMOKERS**
- **14.6% Townsville**
- **13.3%**
- **15.8%**
- **13.8% QLD Average**
- **15.6%**
- **12.1%**

**DIABETES**
- **4.4% Townsville**
- **4.5% QLD Average**
- **72% Townsville**
- **55.7%**
- **64.6%**
- **50.9% QLD Average**
- **57.8%**

**SMOKING in PREGNANCY**
- **20% Townsville**
- **17% QLD Average**

**OVERWEIGHT & OBESE**
- **64.1% Townsville**
- **57.8% QLD Average**
- **4.5%**
- **4.4%**

**POPCULATION**
- **50%**
- **50%**

**IDENTIFY AS ABORIGINAL AND TORRES STRAIT ISLANDER**
- **93.7% Townsville**
- **92.1% QLD Average**

**TOWNSVILLE**
- **4.4%**
- **13.3%**
- **15.8%**
- **4.5%**
- **64.1%**
- **57.8%**

**QLD AVERAGE**
- **72%**
- **55.7%**
- **64.6%**
- **50.9%**
- **4.5%**
- **4.4%**
- **64.1%**
- **57.8%**
HEALTH SNAPSHOT
Townsville City 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
TOWNSVILLE

MALE
FEMALE
QLD AVERAGE

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
VEGETABLES

TOWNSVILLE

QLD AVERAGE

HOSPITALISATION RATES
PER 100,000 PEOPLE
Townsville HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total PPH</th>
<th>TOWNSVILLE</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls 65+</td>
<td>2,670</td>
<td>61.1%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Coronary Heart</td>
<td>694</td>
<td>12.3%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Mental and Behavioural</td>
<td>666</td>
<td>3.9%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>362</td>
<td>21.5%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>336</td>
<td>30.7%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Pneumonia and Flu</td>
<td>331</td>
<td>7.8%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Stroke</td>
<td>253</td>
<td>58.4%</td>
<td>58.4%</td>
</tr>
<tr>
<td>Road Transport Injury</td>
<td>218</td>
<td>8.8%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total</th>
<th>Townsville</th>
<th>QLD Average</th>
</tr>
</thead>
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<td>Falls 65+</td>
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<td>8.8%</td>
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</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th>Townsville</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.9%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

61.1%  
Townsville

60.1%  
QLD AVERAGE

HEALTH SNAPSHOT
Isaac Regional Council
2016

This health infographic gives a picture of people’s health in Isaac compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

POPOPULATION
Estimated Resident Population 2014

24,455

43.1%

56.9%

3.6% Identify as Aboriginal and Torres Strait Islander

IMMUNISATION
Children that are fully vaccinated at 5 years

83.3 YEARS
84 YEARS
78.3 YEARS
79.1 YEARS

LIFE EXPECTANCY

DIABETES
Number of National Diabetes Services Scheme registrants

16.2%

13.8%

17.8%

14%

13.8%

15.6%

12.1%

2.9%

4.5%

2.9%

4.5%

DIABETES
Number of National Diabetes Services Scheme registrants

SMOKING in PREGNANCY

OVERWEIGHT & OBESE
Adults with a Body Mass Index above 25

19%

17%

19%

17%

74.4%

59.3%

64.6%

50.9%

68.3%

57.8%
HEALTH SNAPSHOT
Isaac Regional Council
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

Healthy Eating
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

HOSPITALISATION RATES
Per 100,000 people
Mackay HHS 2009-2010 to 2011-2012

Specific Conditions
- PPH: 3,241
- PPH ACUTE: 1,628
- PPH CHRONIC: 1,538
- PPH VACCINE PREVENTABLE: 83

- Falls 65+: 2,920
- Coronary Heart: 835
- Mental and Behavioural: 790
- Road Transport Injury: 345
- Pneumonia and Flu: 306
- Chronic Obstructive Pulmonary Disease: 299
- Diabetes: 263
- Stroke: 250

Disability
Persons with a profound or severe disability

- Isaac: 1.4%
- QLD Average: 4.4%

Physical Activity
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

- Isaac: 56.4%
- QLD Average: 60.1%

This health infographic gives a picture of people’s health in Mackay compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Mackay Regional Council
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
MALE
FEMALE
MACKAY
QLD AVERAGE
MACKAY
QLD AVERAGE

MALE 40.2%
FEMALE 13.8%
MALE 27.6%
FEMALE 19.8%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
MALE 56.1%
FEMALE 58.4%
MALE 10.5%
FEMALE 8.8%

VEGETABLES

HOSPITALISATION RATES
PER 100,000 PEOPLE
Mackay HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*
3,241 PPH
1,628 PPH ACUTE
1,538 PPH CHRONIC
83 PPH VACCINE PREVENTABLE

Specific Conditions
2,920 FALLS 65+
835 CORONARY HEART
790 MENTAL AND BEHAVIOURAL
345 ROAD TRANSPORT INJURY

306 PNEUMONIA AND FLU
299 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
263 DIABETES
250 STROKE

DISABILITY
Persons with a profound or severe disability

MACKAY
QLD AVERAGE

3.7%
4.4%

62.4%
60.1%

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

MACKAY
QLD AVERAGE

56.1%
58.4%

This health infographic gives a picture of people’s health in Whitsunday compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
HHS AREA: MACKAY HOSPITAL AND HEALTH SERVICE

HEALTH SNAPSHOT
Whitsunday Regional Council
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE (%)</th>
<th>FEMALE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITSUNDAY</td>
<td>32.1%</td>
<td>19.8%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>MALE (%)</th>
<th>FEMALE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITSUNDAY</td>
<td>45.2%</td>
<td>8.5%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

HOSPITALISATION RATES
PER 100,000 PEOPLE
Mackay HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th></th>
<th>PPH</th>
<th>PPH ACUTE</th>
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<th>PPH VACCINE PREVENTABLE</th>
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</thead>
<tbody>
<tr>
<td>WHITSUNDAY</td>
<td>3,241</td>
<td>1,628</td>
<td>1,538</td>
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Specific Conditions

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<tr>
<th></th>
<th>PPH</th>
<th>PPH ACUTE</th>
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<th>PPH VACCINE PREVENTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITSUNDAY</td>
<td>2,920</td>
<td>835</td>
<td>790</td>
<td>345</td>
</tr>
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<td>QLD AVERAGE</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th></th>
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<th>PPH CHRONIC</th>
<th>PPH VACCINE PREVENTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITSUNDAY</td>
<td>306</td>
<td>299</td>
<td>263</td>
<td>250</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td></td>
<td></td>
<td></td>
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DISABILITY
Persons with a profound or severe disability

<table>
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<tr>
<th></th>
<th>WHITSUNDAY</th>
<th>QLD AVERAGE</th>
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</thead>
<tbody>
<tr>
<td>3.8%</td>
<td>4.4%</td>
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PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
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<tr>
<th></th>
<th>WHITSUNDAY</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>63.3%</td>
<td>60.1%</td>
<td></td>
</tr>
</tbody>
</table>

This health infographic gives a picture of people's health in Aurukun compared to Queensland. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

**Estimated Resident Population 2014**

- **Aurukun:** 1,410
- **QLD Average:**
  - Estimated Resident Population 2014: 1,410
  - Immuinisation: 94.8%
  - Children that are fully vaccinated at 5 years: 92.1%
  - Life Expectancy: 79.1 years
  - Smoking in Pregnancy: 48%
  - Obesity: 67.2%

**Health Needs Assessment**

- **HHS AREA:** Cape York Hospital and Health Service

**Population**

- **Aurukun:** 49.9%
- **QLD Average:** 50.1%

**Diabetes**

- **Aurukun:** 3.5%
- **QLD Average:** 4.5%

**Smoking in Pregnancy**

- **Aurukun:** 48%
- **QLD Average:** 17%

**Overweight & Obese**

- **Aurukun:**
  - Adults with a Body Mass Index above 25:
    - Male: 70.6%
    - Female: 63.2%
  - Number of National Diabetes Services Scheme registrants: 67.2%

- **QLD Average:**
  - Adults with a Body Mass Index above 25:
    - Male: 64.6%
    - Female: 50.9%
  - Number of National Diabetes Services Scheme registrants: 57.8%
**HEALTH SNAPSHOT**

**Aurukun Shire**

**2016**

**HEALTHY EATING**

**People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>58.4%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Aurukun</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

**ALCOHOL CONSUMPTION**

**Adults with lifetime risky consumption**

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland</td>
<td>13.5%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Aurukun</td>
<td>44.4%</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

**HOSPITALISATION RATES**

**Per 100,000 People**

Cape York HHS 2009-2010 to 2011-2012

**Potentially Preventable Hospitalisations (PPH)**

- **7,240** PPH
- **3,873** PPH ACUTE
- **3,192** PPH CHRONIC
- **251** PPH VACCINE PREVENTABLE

**Specific Conditions**

- **772** DIAHETES
- **563** STROKE
- **545** ROAD TRANSPORT INJURY
- **535** CHRONIC OBSTRUCTIVE PULMONARY DISEASE
- **2,249** FALLS 65+
- **1,482** MENTAL AND BEHAVIOURAL
- **1,375** CORONARY HEART
- **1,083** PNEUMONIA AND FLU

**DISABILITY**

**Persons with a profound or severe disability**

- **3.2%** Aurukun
- **4.4%** Queensland Average

**60.2%** Aurukun

**60.1%** Queensland Average

**PHYSICAL ACTIVITY**

**Those who do 30+ mins of moderate physical exercise, on at least 5 days a week**

- **60.2%** Aurukun
- **60.1%** Queensland Average

This health infographic gives a picture of people’s health in Cook compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
### Health Snapshot 2016

**Cook Shire**

#### Alcohol Consumption

- **Male**: 38.8%
- **Female**: 18.2%

**QLD Average**: 30.5%

- **Cook Shire**
  - **Male**: 19.8%
  - **Female**: 9.5%

#### Healthy Eating

- **Cook Shire**
  - **Male**: 46.7%
  - **Female**: 4.4%

**QLD Average**:
- **Male**: 58.4%
- **Female**: 8.8%

#### Hospitalisation Rates

**Per 100,000 People**

Cape York HHS 2009-2010 to 2011-2012

- **Potentially Preventable Hospitalisations (PPH)**
  - 7,240 PPH
  - 3,873 PPH ACUTE
  - 3,192 PPH CHRONIC
  - 251 PPH VACCINE PREVENTABLE

- **Specific Conditions**
  - 2,249 FALLS 65+
  - 1,482 MENTAL AND BEHAVIOURAL
  - 1,375 CORONARY HEART
  - 1,083 PNEUMONIA AND FLU
  - 772 DIABETES
  - 563 STROKE
  - 545 ROAD TRANSPORT INJURY
  - 535 CHRONIC OBSTRUCTIVE PULMONARY DISEASE

#### Disability

- **Persons with a profound or severe disability**
  - **Cook**: 3.2%
  - **QLD Average**: 4.4%

#### Physical Activity

- **Cook**: 55.5%
- **QLD Average**: 60.1%

---

This health infographic gives a picture of people’s health in Hope Vale compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Top 4 health challenges identified in Hope Vale**

- **Identify as Aboriginal and Torres Strait Islander**: 94.9%
- **Daily smokers**: 22.3%
- **Obesity**: 7.5% (Hope Vale) vs. 4.5% (QLD average)
- **Smoking in pregnancy**: 48% (Hope Vale) vs. 17% (QLD average)
- **Diabetes**: 7.5% (Hope Vale) vs. 4.5% (QLD average)

**Key Health Indicators**

- **Life Expectancy**
  - HOPE VALE: 74.2 years
  - QLD AVERAGE: 84 years
- **Children fully vaccinated at 5 years**
  - HOPE VALE: 94.8%
  - QLD AVERAGE: 92.1%

**Population and Immunisation**

- **Estimated resident population 2014**: 1,095
- **Immunisation**: 94.9% identify as Aboriginal and Torres Strait Islander

**Miscellaneous**

- **Hope Vale Aboriginal Shire**
- **1,095**
### Health Snapshot 2016

**Hope Vale Aboriginal Shire**

#### Alcohol Consumption

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hope Vale</strong></td>
<td>29.8%</td>
<td>19.8%</td>
</tr>
<tr>
<td><strong>QLD Average</strong></td>
<td>30.3%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

Adults with lifetime risky consumption

#### Healthy Eating

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hope Vale</strong></td>
<td>58.4%</td>
<td>6.9%</td>
</tr>
<tr>
<td><strong>QLD Average</strong></td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th>Vegetables</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hope Vale</strong></td>
<td>58.4%</td>
<td>6.9%</td>
</tr>
<tr>
<td><strong>QLD Average</strong></td>
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</tbody>
</table>

Are healthy eaters

#### Hospitalisation Rates

**Per 100,000 People**

Cape York HHS 2009-2010 to 2011-2012

<table>
<thead>
<tr>
<th>Condition</th>
<th>Hope Vale</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Potentially Preventable Hospitalisations (PPH)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls 65+</td>
<td>2,249</td>
<td>7,240</td>
</tr>
<tr>
<td>Mental and Behavioural</td>
<td>1,482</td>
<td>3,873</td>
</tr>
<tr>
<td>Coronary heart</td>
<td>1,375</td>
<td>3,192</td>
</tr>
<tr>
<td>Pneumonia and flu</td>
<td>1,083</td>
<td>525</td>
</tr>
<tr>
<td><strong>Total PPH</strong></td>
<td>7,240</td>
<td>3,873</td>
</tr>
<tr>
<td><strong>Specific Conditions</strong></td>
<td>2,249</td>
<td>7,240</td>
</tr>
<tr>
<td>Falls 65+</td>
<td>2,249</td>
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#### Disability

Persons with a profound or severe disability

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<thead>
<tr>
<th></th>
<th>Hope Vale</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.9%</strong></td>
<td>4.4%</td>
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</table>

#### Physical Activity

Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

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<th>Hope Vale</th>
<th>QLD Average</th>
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</thead>
<tbody>
<tr>
<td><strong>60.2%</strong></td>
<td>60.1%</td>
<td></td>
</tr>
</tbody>
</table>

### Data Sources

- QLD Health preventative health survey results (2015)
- The health of Queenslanders (2014) fifth report
- Map of National Diabetes Services Scheme (NDSS) Registrants (2014)
- QLD Regional Profiles (2015)
- Health Service Districts, 2006. Northern Queensland PHN 2016. All rights reserved. Version 1.0. Details correct at time of publishing. ©copyright 2016 NQPHN
This health infographic gives a picture of people’s health in Kowanyama compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Population**
1,125

- 52.2% Female
- 47.8% Male

**Immunisation**
- 94.8% Kowanyama
- 92.1% Queensland Average

**Life Expectancy**
- 74.2 years Kowanyama
- 84 years Queensland Average
- 69.7 years Kowanyama
- 79.1 years Queensland Average

**Daily Smokers**
- 22.3% Kowanyama
- 13.8% Queensland Average

**Smoking in Pregnancy**
- 48% Kowanyama
- 17% Queensland Average

**Overweight & Obese**
- 70.6% Kowanyama
- 67.2% Queensland Average
- 63.2%
- 64.6% Queensland Average
- 50.9% Average
- 57.8%
HEALTH SNAPSHOT
Kowanyama Aboriginal Shire
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE
KOWANYAMA
QLD AVERAGE
MALE
FEMALE
KOWANYAMA
QLD AVERAGE
44.4%
13.5%
29.8%
9.5%
19.8%
6.9%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
VEGETABLES
58.4%
58.4%
6.9%
8.8%
Kowanyama
Kowanyama

HOSPITALISATION RATES
Per 100,000 people
Cape York HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*
Specific Conditions

7,240 PPH
3,873 PPH ACUTE
3,192 PPH CHRONIC
251 PPH VACCINE PREVENTABLE
2,249 FALLS 65+
1,482 MENTAL AND BEHAVIOURAL
1,375 CORONARY HEART
1,083 PNEUMONIA AND FLU
772 DIABETES
563 STROKE
545 ROAD TRANSPORT INJURY
535 CHRONIC OBSTRUCTIVE PULMONARY DISEASE

*Hospital admissions that potentially could have been prevented by appropriate utilisation of non-hospital health services

DISABILITY
Persons with a profound or severe disability

3.5%
4.4%
Kowanyama
QLD AVERAGE

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

60.2%
60.1%
Kowanyama
QLD AVERAGE

This health infographic gives a picture of people’s health in Lockhart River compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Estimated Resident Population 2014**

- Lockhart River: 540
- Queensland Average: 90.4%

**Population**

- Female: 53.3%
- Male: 46.7%

**Life Expectancy**

- Lockhart River:
  - Life Expectancy: 74.2 years
  - 76.8% of life expectancy for Queensland average

- Queensland Average:
  - Life Expectancy: 84 years
  - 77.8% of life expectancy for Lockhart River

**Immunisation**

- Children that are fully vaccinated at 5 years:
  - Lockhart River: 94.8%
  - Queensland Average: 92.1%

**Smoking in Pregnancy**

- Lockhart River: 48%
- Queensland Average: 17%

**Diabetes**

- Number of National Diabetes Services Scheme registrants:
  - Lockhart River: 3.6%
  - Queensland Average: 4.5%

- Overweight & Obese:
  - Lockhart River: 67.2%
    - Men: 70.6%
    - Women: 63.2%
  - Queensland Average: 57.8%
    - Men: 64.6%
    - Women: 50.9%
HEALTH SNAPSHOT
Lockhart River Aboriginal Shire
2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
LOCKHART RIVER 29.8%
QLD AVERAGE 19.8%
FEMALE
LOCKHART RIVER 13.5%
QLD AVERAGE 9.5%

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
MALE
LOCKHART RIVER 58.4%
QLD AVERAGE 58.4%
FEMALE
LOCKHART RIVER 6.9%
QLD AVERAGE 8.8%

VEGETABLES

Hospitalisation Rates
Per 100,000 People
Cape York HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*
7,240 PPH
3,873 PPH ACUTE
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Specific Conditions
2,249 FALLS 65+
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772 DIABETES
563 STROKE
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Disability
Persons with a profound or severe disability

Lockhart River 1.2%
QLD AVERAGE 4.4%

Physical Activity
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

Lockhart River 60.2%
QLD AVERAGE 60.1%

This health infographic gives a picture of people’s health in Mapoon compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.
HEALTH SNAPSHOT
Mapoon Aboriginal Shire 2016

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cape York HHS 2009-2010 to 2011-2012

Disability
Persons with a profound or severe disability

Physical Activity
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

This health infographic gives a picture of people’s health in Napranum compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

HEALTH SNAPSHOT

Population

Estimated Resident Population 2014

943

97.2% Identify as Aboriginal and Torres Strait Islander

94.8% Napranum
97.2% QLD Average

Overweight & Obese

Adults with a Body Mass Index above 25

Napranum

Napranum

943

49.7%

50.3%

Female

Male

Life Expectancy

Napranum

QLD Average

Napranum

QLD Average

74.2 years

84 years

69.7 years

79.1 years

Daily Smokers

22.3%

17.2%

27%

13.8%

15.6%

12.1%

Napranum

QLD Average

Smoking in Pregnancy

48%

17%

Napranum

QLD Average

Diabetes

Number of National Diabetes Services Scheme registrants

16.5%

4.5%

16.5%

4.5%

Napranum

QLD Average

NQPHN | Health Needs Assessment

HHS AREA: CAPE YORK HOSPITAL AND HEALTH SERVICE
**ALCOHOL CONSUMPTION**
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th>NAPRANUM</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MALE</strong></td>
<td><strong>30.3%</strong></td>
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<tr>
<td>44.4%</td>
<td>19.8%</td>
</tr>
<tr>
<td><strong>FEMALE</strong></td>
<td><strong>9.5%</strong></td>
</tr>
<tr>
<td>13.5%</td>
<td>58.4%</td>
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**HEALTHY EATING**
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th>NAPRANUM</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FRUIT</strong></td>
<td><strong>58.4%</strong></td>
</tr>
<tr>
<td>6.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>VEGETABLES</strong></td>
<td><strong>58.4%</strong></td>
</tr>
<tr>
<td>13.5%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

**HOSPITALISATION RATES PER 100,000 PEOPLE**
Cape York HHS 2009-2010 to 2011-2012

- Potentially Preventable Hospitalisations (PPH)*
  - 7,240 PPH
  - 3,873 PPH ACUTE
  - 3,192 PPH CHRONIC
  - 251 PPH VACCINE PREVENTABLE

- Specific Conditions
  - 2,249 FALLS 65+
  - 1,482 MENTAL AND BEHAVIOURAL
  - 1,375 CORONARY HEART
  - 1,083 PNEUMONIA AND FLU
  - 772 DIABETES
  - 563 STROKE
  - 545 ROAD TRANSPORT INJURY
  - 535 CHRONIC OBSTRUCTIVE PULMONARY DISEASE

**DISABILITY**
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th>NAPRANUM</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.2%</strong></td>
<td><strong>4.4%</strong></td>
</tr>
</tbody>
</table>

**PHYSICAL ACTIVITY**
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

- Napranum: 60.2%
- QLD AVERAGE: 60.1%
This health infographic gives a picture of people’s health in Pormpuraaw compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Population**

- Estimated Resident Population 2014: 731
- 45.4% Female, 54.6% Male
- 91.1% Identify as Aboriginal and Torres Strait Islander

**Life Expectancy**

- 2014: 74.2 years
- Queensland Average: 84 years

**Immunisation**

- Children that are fully vaccinated at 5 years: 84 (79.1%)
- Queensland Average: 94.8%

**Daily Smokers**

- Pormpuraaw: 22.3%
- Queensland Average: 13.8%

**Diabetes**

- Number of National Diabetes Services Scheme registrants: 3.5% (Pormpuraaw), 4.5% (Queensland Average)

**Smoking in Pregnancy**

- Pormpuraaw: 48%
- Queensland Average: 17%

**Overweight & Obese**

- Adults with a Body Mass Index above 25:
  - Pormpuraaw: 70.6% (Men), 63.2% (Women)
  - Queensland Average: 64.6% (Men), 50.9% (Women)
HEALTH SNAPSHOT
Pormpuraaw Aboriginal Shire 2016

ALCOHOL CONSUMPTION

<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PORMPUAAW</td>
<td>QLD AVERAGE</td>
</tr>
<tr>
<td>44.4%</td>
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HEALTHY EATING

<table>
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<tbody>
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</tr>
<tr>
<td>58.4%</td>
<td>6.9%</td>
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</tbody>
</table>

HOSPITALISATION RATES

PER 100,000 PEOPLE
Cape York HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*
- 7,240 PPH
- 3,873 PPH ACUTE
- 3,192 PPH CHRONIC
- 251 PPH VACCINE PREVENTABLE

Specific Conditions
- 2,249 FALLS 65+
- 1,482 MENTAL AND BEHAVIOURAL
- 1,375 CORONARY HEART
- 1,083 PNEUMONIA AND FLU

Disability

60.2%
Pormpuraaw

60.1%
QLD AVERAGE

Physical Activity

Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

This health infographic gives a picture of people’s health in Weipa compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Estimated Resident Population 2014

F: 44.5%  M: 55.5%

LIFE EXPECTANCY

- Weipa: 74.2 years
- Queensland Average: 84 years
- Weipa: 69.7 years
- Queensland Average: 79.1 years

POPULATION

- Overweight: 4.5%
- Obese: 16.6%

IMMUNISATION

- Children that are fully vaccinated at 5 years: 94.8%
- Queensland Average: 92.1%

DAILY SMOKERS

- 21% in Weipa
- 27% in Queensland Average
- 17.2% in Weipa
- 12.1% in Queensland Average

SMOKING IN PREGNANCY

- 48% in Weipa
- 17% in Queensland Average

OVERWEIGHT & OBSESE

- Weipa: 70.6%
- Queensland Average: 63.2%
- Weipa: 64.6%
- Queensland Average: 57.8%

Diabetes

- Weipa: 16.6%
- Queensland Average: 4.5%
- Weipa: 57%
- Queensland Average: 57.8%
HEALTH SNAPSHOTS
Weipa Town Authority

ALEOHOL CONSUMPTION
Adults with lifetime risky consumption

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIPA</td>
<td>44.4%</td>
<td>13.5%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>32.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

HEALTHY EATING
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIPA</td>
<td>41.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>QLD AVERAGE</td>
<td>58.4%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

HOSPITALISATION RATES
PER 100,000 PEOPLE
Cape York HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th></th>
<th>PPH</th>
<th>PPH ACUTE</th>
<th>PPH CHRONIC</th>
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<tbody>
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Specific Conditions

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<tr>
<td>QLD AVERAGE</td>
<td>60.1%</td>
<td>60.1%</td>
<td>60.1%</td>
<td>60.1%</td>
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</tbody>
</table>

Disability
Persons with a profound or severe disability

<table>
<thead>
<tr>
<th></th>
<th>WEIPA</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.4%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Physical Activity
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

<table>
<thead>
<tr>
<th></th>
<th>Weipa</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>63.1%</td>
<td>60.1%</td>
</tr>
</tbody>
</table>

This health infographic gives a picture of people’s health in Wujal Wujal compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Wujal Wujal Aboriginal Shire 2016**

**Population**
- Estimated Resident Population 2014: 291
- 52.2% Female, 47.8% Male
- 96.9% Identify as Aboriginal and Torres Strait Islander

**Life Expectancy**
- Wujal Wujal: 74.2 years
- Queensland Average: 84 years

**Daily Smokers**
- Wujal Wujal: 22.3%
- Queensland Average: 13.8%

**Immunisation**
- Children that are fully vaccinated at 5 years:
  - Wujal Wujal: 94.8%
  - Queensland Average: 92.1%

**Smoking in Pregnancy**
- Wujal Wujal: 48%
- Queensland Average: 17%

**Diabetes**
- Number of National Diabetes Services Scheme registrants:
  - Wujal Wujal: 7.6%
  - Queensland Average: 4.5%

**Overweight & Obese**
- Adults with a Body Mass Index above 25:
  - Wujal Wujal: 70.6%
  - Queensland Average: 57.8%

**Identify as Aboriginal and Torres Strait Islander**
- Wujal Wujal: 96.9%
- Queensland Average: 92.1%
**Health Snapshot**

**Wujal Wujal Aboriginal Shire** 2016

**Alcohol Consumption**

- **Wujal Wujal:** Male 44.4%, Female 13.5%
- **QLD Average:** Male 29.8%, Female 19.8%

**Healthy Eating**

- **Fruit:** Male 58.4%, Female 9.5%
- **Vegetables:** Male 6.9%, Female 8.8%

**Hospitalisation Rates**

- **Potentially Preventable Hospitalisations (PPH)**
  - Total: 7,240
  - PPH Acute: 3,873
  - PPH Chronic: 3,192
  - PPH Vaccine Preventable: 251

- **Specific Conditions**
  - Falls 65+: 2,249
  - Mental and Behavioural: 1,482
  - Coronary Heart: 1,375
  - Pneumonia and Flu: 1,083
  - Diabetes: 772
  - Stroke: 563
  - Road Transport Injury: 545
  - Chronic Obstructive Pulmonary Disease: 535

**Disability**

- **Wujal Wujal:** 4.5%
- **QLD Average:** 4.4%

**Physical Activity**

- **Wujal Wujal:** 60.2%
- **QLD Average:** 60.1%

This health infographic gives a picture of people’s health in Northern Peninsula Area compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Population**
- Estimated Resident Population 2014: 2,663
- 51.7% Female, 48.3% Male
- 86.4% Identify as Aboriginal and Torres Strait Islander

**Life Expectancy**
- 70 years: Northern Peninsula
- 84 years: QLD Average
- 65 years: Northern Peninsula
- 79.1 years: QLD Average

**Daily Smokers**
- 22.3% Northern Peninsula
- 13.8% QLD Average
- 27% Male, 15.6% Female
- 17.2% Male, 12.1% Female

**Diabetes**
- 7.8% Northern Peninsula
- 4.5% QLD Average

**Immunisation**
- Children that are fully vaccinated at 5 years:
  - Northern Peninsula: 94.8%
  - QLD Average: 92.1%

**Smoking in Pregnancy**
- 54% Northern Peninsula
- 17% QLD Average

**Overweight & Obese**
- Adults with a Body Mass Index above 25:
  - Northern Peninsula: 70.6% Men, 67.2% Women
  - QLD Average: 63.2% Men, 57.8% Women

**Estimated Registered National Diabetes Services Scheme Registrants**
- Number of National Diabetes Services Scheme registrants:
  - Northern Peninsula: 64.6%
  - QLD Average: 50.9%
**HEALTH SNAPSHOT**
Northern Peninsula Area Regional Council 2016

**Alcohol Consumption**
Adults with lifetime risky consumption

- **Male**
  - Northern Peninsula: 29.8%
  - QLD Average: 19.8%

- **Female**
  - Northern Peninsula: 13.5%
  - QLD Average: 9.5%

**Healthy Eating**
People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

- **Fruit**
  - Northern Peninsula: 58.4%
  - QLD Average: 58.4%

- **Vegetables**
  - Northern Peninsula: 6.9%
  - QLD Average: 8.8%

**Hospitalisation Rates**
Per 100,000 people
Torres Strait – Northern Peninsula HHS 2009-2010 to 2011-2012

- **Potentially Preventable Hospitalisations (PPH)**
  - Total: 6,232
  - PPH Chronic: 3,181
  - PPH Acute: 2,875
  - PPH Vaccine Preventable: 372

- **Specific Conditions**
  - Falls 65+: 1,480
  - Diabetes: 1,226
  - Malignant and Behavioural: 802
  - Pneumonia and Flu: 758
  - Coronary Heart: 631
  - Stroke: 449
  - Chronic Obstructive Pulmonary Disease: 349
  - Road Transport Injury: 167

**Disability**
Persons with a profound or severe disability

- Northern Peninsula: 4.4%
- QLD Average: 4.4%

**Physical Activity**
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

- Northern Peninsula: 60.2%
- QLD Average: 60.1%
This health infographic gives a picture of people’s health in Torres compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**HEALTH SNAPSHOT**

**Population**
- Estimated Resident Population 2014: 3,651
- 73.4% Identify as Aboriginal and Torres Strait Islander

**Life Expectancy**
- Torres Shire: 70 years (Torres), 84 years (QLD Average)
- 65 years (Torres), 79.1 years (QLD Average)

**Overweight & Obese**
- Number of National Diabetes Services Scheme registrants
- Torres: 70.6% (Men), 67.2% (Women)
- QLD Average: 63.2% (Men), 57.8% (Women)

**Smoking in Pregnancy**
- Torres: 54% (Men), 17% (Women)
- QLD Average: 13.8% (Men), 12.1% (Women)

**Immunisation**
- Children that are fully vaccinated at 5 years
- Torres: 94.8% (Men), 92.1% (Women)
- QLD Average: 84% (Men), 79.1% (Women)

**Diabetes**
- Number of National Diabetes Services Scheme registrants
- Torres: 7.2% (Men), 4.5% (Women)
- QLD Average: 6.7% (Men), 4.5% (Women)
HEALTH SNAPSHOT 2016
Torres Shire

ALCOHOL CONSUMPTION
Adults with lifetime risky consumption

MALE
FEMALE

TORRES

QLD AVERAGE

MALE

29.8%

19.8%

13.5%

30.3%

FEMALE

VEGETABLES

People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT

TORRES

QLD AVERAGE

6.9%

58.4%

8.8%

58.4%

HEALTHY EATING

PHYSICAL

Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

HOSPITALISATION RATES PER 100,000 PEOPLE
Torres Strait–Northern Peninsula HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>TORRES</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPH</td>
<td>6,232</td>
<td></td>
</tr>
<tr>
<td>PPH CHRONIC</td>
<td>3,181</td>
<td></td>
</tr>
<tr>
<td>PPH ACUTE</td>
<td>2,875</td>
<td></td>
</tr>
<tr>
<td>PPH VACCINE PREVENTABLE</td>
<td>372</td>
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</tbody>
</table>

Specific Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>TORRES</th>
<th>QLD AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS 65+</td>
<td>1,480</td>
<td></td>
</tr>
<tr>
<td>DIABETES</td>
<td>1,226</td>
<td></td>
</tr>
<tr>
<td>MENTAL AND BEHAVIOURAL</td>
<td>802</td>
<td></td>
</tr>
<tr>
<td>PNEUMONIA AND FLU</td>
<td>758</td>
<td></td>
</tr>
<tr>
<td>CORONARY HEART</td>
<td>631</td>
<td></td>
</tr>
<tr>
<td>STROKE</td>
<td>449</td>
<td></td>
</tr>
<tr>
<td>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td>349</td>
<td></td>
</tr>
<tr>
<td>ROAD TRANSPORT INJURY</td>
<td>167</td>
<td></td>
</tr>
</tbody>
</table>

DISABILITY
Persons with a profound or severe disability

2.8%

TORRES

4.4%

QLD AVERAGE

PHYSICAL ACTIVITY
Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

60.2%

TORRES

60.1%

QLD AVERAGE

This health infographic gives a picture of people’s health in Torres Strait Island compared to Queensland. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

**Health Needs Assessment**

**Torres Strait Island**

**Regional Council**

**2016**

**Population**

Estimated Resident Population 2014

4,619

47.2% Identify as Aboriginal and Torres Strait Islander

52.8%

**Immunisation**

Children that are fully vaccinated at 5 years

**Torres Strait Island**

94.8%

**Queensland Average**

92.1%

**Life Expectancy**

<table>
<thead>
<tr>
<th></th>
<th>Torres Strait Island</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 years</td>
<td>70.6%</td>
<td>67.2%</td>
</tr>
<tr>
<td>84 years</td>
<td>63.2%</td>
<td>64.6%</td>
</tr>
<tr>
<td>65 years</td>
<td>57.8%</td>
<td>50.9%</td>
</tr>
<tr>
<td>79.1 years</td>
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</table>

**Daily Smokers**

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<thead>
<tr>
<th></th>
<th>Torres Strait Island</th>
<th>QLD Average</th>
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<tbody>
<tr>
<td>22.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.6%</td>
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<td></td>
</tr>
<tr>
<td>17.2%</td>
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**Smoking in Pregnancy**

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<tr>
<th></th>
<th>Torres Strait Island</th>
<th>QLD Average</th>
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<tbody>
<tr>
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<td></td>
<td></td>
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<tr>
<td>17%</td>
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</table>

**Overweight & Obese**

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<thead>
<tr>
<th></th>
<th>Torres Strait Island</th>
<th>QLD Average</th>
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</thead>
<tbody>
<tr>
<td>70.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>63.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>64.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57.8%</td>
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</tbody>
</table>

**Diabetes**

<table>
<thead>
<tr>
<th></th>
<th>Torres Strait Island</th>
<th>QLD Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5%</td>
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</tr>
</tbody>
</table>

**Number of National Diabetes Services Scheme registrants**

93.7% Identify as Aboriginal and Torres Strait Islander

Torres Strait Island

4.5% Queensland Average

93.7% Queensland Average

Identify as Aboriginal and Torres Strait Islander

94.8% Torres Strait Island

17% Queensland Average

27% Torres Strait Island

12.1% Queensland Average

22.3% Torres Strait Island

13.8% Queensland Average

27% Torres Strait Island

15.6% Queensland Average

93.7% Torres Strait Island

17% Queensland Average

4.5% Torres Strait Island

57.8% Queensland Average

7.1% Torres Strait Island

63.2% Queensland Average

67.2% Torres Strait Island

50.9% Queensland Average

64.6% Torres Strait Island

64.6% Queensland Average
HEALTH SNAPSHOT
Torres Strait Island Regional Council

2016

ALCOHOL CONSUMPTION

Adults with lifetime risky consumption

MALE
44.4%
FEMALE
13.5%
TORRES STRAIT ISLAND

MALE
29.8%
FEMALE
19.8%
QLD AVERAGE

HEALTHY EATING

People who eat 2 or more serves of fruit and 5 or more serves of vegetables a day

FRUIT
58.4%
TORRES STRAIT ISLAND
58.4%
QLD AVERAGE

VEGETABLES
6.9%
TORRES STRAIT ISLAND
8.8%
QLD AVERAGE

HOSPITALISATION RATES

PER 100,000 PEOPLE
Torres Strait–Northern Peninsula HHS 2009-2010 to 2011-2012

Potentially Preventable Hospitalisations (PPH)*

6,232 PPH
3,181 PPH CHRONIC
2,875 PPH ACUTE
372 PPH VACCINE PREVENTABLE

Specific Conditions

1,480 FALLS 65+
1,226 DIABETES
802 MENTAL AND BEHAVIOURAL
758 PNEUMONIA AND FLU

631 CORONARY HEART
449 STROKE
349 CHRONIC OBSTRUCTIVE PULMONARY DISEASE
167 ROAD TRANSPORT INJURY

DISABILITY

Persons with a profound or severe disability

2.8%
TORRES STRAIT ISLAND
4.4%
QLD AVERAGE

PHYSICAL ACTIVITY

Those who do 30+ mins of moderate physical exercise, on at least 5 days a week

60.2%
TORRES STRAIT ISLAND
60.1%
QLD AVERAGE

References


42. Queensland Government, *Number of full-time equivalent staff by financial year, Mental Health Service Organisation and staffing category* Queensland Health, Editor. 2015, Queensland Health: Brisbane.


49. Pholeros, P., et al., *Improving the state of health hardware in Australian Indigenous housing: building more houses is not the only answer*. Int J Circumpolar Health, 2013. 72