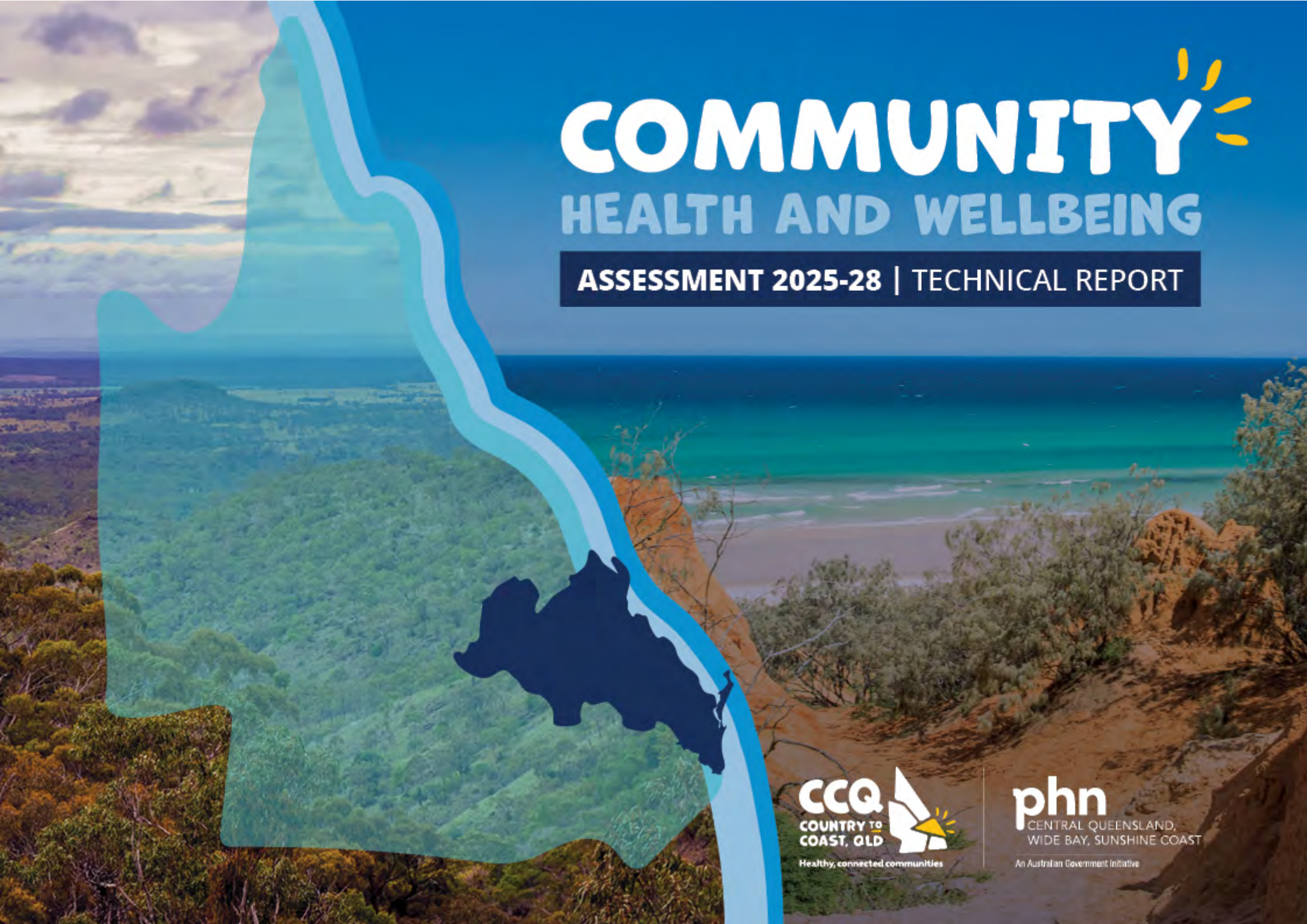

COMMUNITY HEALTH AND WELLBEING

ASSESSMENT 2025-28 | TECHNICAL REPORT

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

We acknowledge the Kabi Kabi (Gubbi Gubbi), Jinibara, Wakka Wakka, Wulli Wulli, Auburn Hawkwood, Butchulla, Bailai, Gooreng Gooreng, Gurang, Taribelang Bunda, Darumbul, Woopaburra, Barada Kabalbara Yetimarla, Gaangalu, Kangoulu, Wadja, Gayiri, Bidjara, Karingbal, and Iman people and pay our respects to these Traditional Custodians of the lands that we live and work upon.

For all enquiries relating to the Community Health and Wellbeing Assessment 2025-28 Technical Report, please email analytics@c2coast.org.au

Contents

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- CCQ Clinical Advisory Council
- Aboriginal and Torres Strait Islander Health Roundtable
- Banana Shire Council
- Bundaberg Regional Council
- Central Highlands Regional Council
- Fraser Coast Regional Council
- Gladstone Regional Council
- Gympie Regional Council
- Livingstone Regional Council
- Noosa Shire Council
- North Burnett Shire Council
- Rockhampton Regional Council
- Sunshine Coast Regional Council
- Woorabinda Shire Council
- CCQ staff

Acronyms

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Teams
ACCHO	Aboriginal Community Controlled Health Organisations
ACPR	Aged Care Planning Region
ADF	Australian Defence Force
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
AIR	Australian Immunisation Register
ASGS	Australian Statistical Geography Standard
ASR	Age standardised rate
CALD	Culturally and Linguistically Diverse
CCQ	Country to Coast Queensland
CHSP	Commonwealth Home Support Program
COPD	Chronic obstructive pulmonary disease
DES	Disability Employment Services
DFV	Domestic and Family Violence
DOGIT	Deed of grant in trust
ED	Emergency Department
ELT	Executive Leadership Team
ERP	Estimated Resident Population
ESB	English speaking background
FASD	Fetal alcohol spectrum disorder
GP	General Practitioner
HCP	Home Care Program
HHS	Hospital and Health Service
HNA	Health Needs Assessment
IRSD	Index of Relative Socio-economic Disadvantage
JRNA	Joint Regional Needs Assessment
LANA	Local Area Needs Assessment
LGA	Local Government Area
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning and/or asexual
MBS	Medicare Benefits Scheme
MMM	Modified Monash Model
NHMRC	National Health and Medical Research Council
NDIS	National Disability Insurance Scheme
PBS	Pharmaceutical Benefits Scheme
PHC	Primary health care
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PPH	Potentially Preventable Hospitalisation
QLD	Queensland
QGSO	Queensland Government Statisticians Office
QoL	Quality of Life
RACH	Residential Aged Care Homes
SA1-4	Statistical Area Level 1-4
SEIFA	Socio-Economic Indexes for Areas
SDG	Sustainable Development Goals
SHS	Specialist Homeless Services
URP	Usual resident population
WHO	World Health Organization

EXECUTIVE SUMMARY

CCQ COUNTRY TO COAST, QLD
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Executive summary

Report structure

This document is the technical report for the Country to Coast Queensland (CCQ) region's Community health and wellbeing assessment 2025-28. Further work to communicate the key findings from this technical report will include developing short-reports on the priority areas, local government fact sheets, *My Healthy Community* survey report, and an interactive website.

This report commences with an introduction to CCQ and our approach to undertaking the needs assessment, including the Joint Regional Needs Assessment (JRNA) framework. The introduction includes setting the scene with the role of primary health care and the sustainable development goals.

The assessment commences with a population profile of the region, including key population demographics and geographic indicators. Following is a summary of key priority population groups within the CCQ region and a summary of the *My Healthy Community* survey results on overall sense of community across the region.

Health and wellbeing indicators are presented next followed by conditions that affect health and wellbeing in order of burden of disease. The remainder of the assessment is structured around the socioecological determinants of health: cultural, social, natural, built, economic, and political environments. The final chapter covers individual characteristics affecting health and wellbeing, including behaviours.

The report concludes with an overview of the short-listed priorities, including collected evidence for inclusion, types of needs according to Bradshaw's Typology of Need, alignment with the Sustainable Development Goals (SDGs), and how CCQ could be placed to address the identified need.

Values and principles

The HNA Report was guided by the following principles:

Salutogenic approach[1]

Where possible, the report takes a strength-based and salutogenic approach to health and wellbeing. The focus is on factors that support health, wellbeing, happiness and meaning in life. This is opposed to a deficit approach which focusses on risk factors for illness and disease. For example, the prevalence of people eating recommended serves of fruit and vegetables has been reported rather than those that are not meeting the dietary guidelines.

Holistic and ecological view of health

This report acknowledges the important role of socio-ecological determinants of health, which includes social, cultural, built, natural, economic, political and historical determinants in real improvements to health and wellbeing of populations and reducing inequalities. Using this approach, the report acknowledges that people exist in multiple ecosystems, from the individual to the family, group, community and population levels; and all parts within systems impact on each other.[1]

Indigenous data sovereignty

Data sovereignty, as it relates to Aboriginal and Torres Strait Islander peoples, is the "*right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as their right to maintain, control, protect and develop their intellectual property over these*"[2]

Whilst a significant amount of work is yet to be done to truly acknowledge Indigenous data sovereignty, this HNA has made attempts to embed this where possible. When available, Indigenous secondary data has been presented using the *Indigenous Areas* geographical classification rather than traditional political structures, such as local government areas or PHN boundaries.[A] This data has also been compared with other Indigenous data (where possible) rather than being benchmarked directly with non-Indigenous data. The HNA project team also sought feedback from our internal Aboriginal and Torres Strait Islander Health Directorate at various stages in the report's development.

It was also decided to embed Aboriginal and Torres Strait Islander data throughout the report, rather than creating and isolated chapter. An isolated chapter has the potential to further isolate these communities by painting a picture that all Aboriginal and Torres Strait Islander communities are vulnerable and disadvantaged, which is not the case. There are considerable assets and strengths to acknowledge.

One of CCQ's local government areas (LGA), Woorabinda, is classified as a discrete Indigenous community. Discrete Indigenous communities are bounded geographical locations inhabited predominantly by Aboriginal and Torres Strait Islander people, with housing or infrastructure owned or managed on a community basis.[3] The Queensland Government defines an Indigenous discrete community differently as a community situated on land held as a deed of grant in trust (DOGIT).

Robust and accurate reporting and interpretation

This report uses consistent approaches for highlighting statistically significant results. Throughout the report differences in data that are statistically significant have been noted using colours:

red – significantly higher/poorer
green – significantly lower/better

In instances where statistical significance was not reported, data was benchmarked against Queensland and the CCQ region overall. Higher and lower numbers have been **bolded** and shaded grey.

Tables and maps that contain multiple colours have specific indicators to highlight differences in results and outcomes across the region.

Equity across the life course

Disparities in health and wellbeing by age, gender, disability, socioeconomic status, and geography reflect limitations and inequities in the socioeconomic determinants for different groups and different abilities. The HNA considers the needs at different stages of the life course (including childhood, adolescence, adulthood and older age), different levels of current health and wellbeing with a priority towards addressing disparities and reducing inequalities.

[A] Indigenous Areas (IAREs) are medium sized geographic areas built from whole Indigenous Locations. They are designed for the release and analysis of more detailed statistics for Aboriginal and Torres Strait Islander people. Whole Indigenous Areas aggregate to form Indigenous Regions. There are 431 Indigenous Areas covering the whole of Australia without gaps or overlaps.

Short-listed priority areas

From the assessment, 23 short-listed health needs and four health service needs were identified. Further detail on each need is outlined at the end of the assessment.

Health needs

1. Healthy communities with spaces and opportunities to safely engage with nature, play and be active
2. Getting around in communities
3. Alcohol and drug use
4. Child development/school readiness/access to quality childcare
5. Chronic disease /lifestyle risk factors
6. Chronic disease morbidity/ mortality
7. Community safety
8. Dementia/Alzheimer's
9. Disaster resilience and readiness
10. Domestic and family violence (prevalence and access to services)
11. Injury and poisoning
12. Health literacy
13. Housing/ homelessness/community displacement
14. Immunisation
15. Income/ education/employment
16. Perinatal health
17. Mental health morbidity/ mortality, including suicide and self-harm
18. Sexual health
19. Individual social and emotional wellbeing, support and resilience
20. Community social cohesion, inclusivity and capital
21. Supporting healthy ageing
22. Women's health
23. Palliative and End of life care

Health service needs

1. Access to primary healthcare, including affordable, quality, timely and during the after hours
2. Appropriate and safe primary healthcare for priority populations, including persons identifying as CALD, with a disability, LGBTIQA+, Aboriginal and Torres Strait Islander, experiencing homelessness
3. Health promotion/prevention services
4. Workforce shortages, maldistribution and models of care.

INTRODUCTION & BACKGROUND

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

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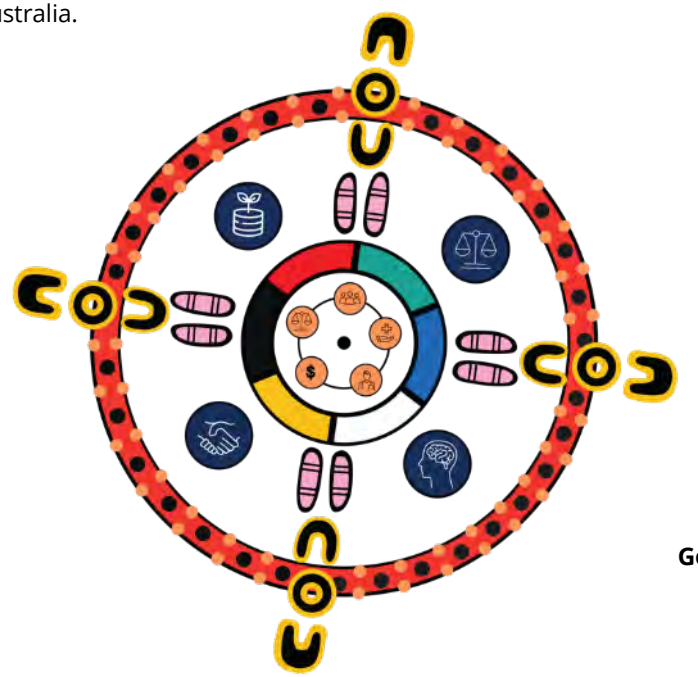
Introduction and background

Country to Coast Queensland (CCQ) delivers the Primary Health Network (PHN) program for the Commonwealth Department of Health and Aged Care (the Department) across the Central Queensland, Sunshine Coast, and Wide Bay regions.

PHNs were established with the key objective of increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure clients receive the right care in the right place at the right time.

Country to Coast QLD

CCQ is an independent not-for-profit commissioning organisation funded by the Commonwealth Department of Health and Aged Care to improve the health outcomes of the region. We are one of 31 PHNs throughout the country servicing all the regions of Australia.



Gordon Browning

CCQ covers a broad geographic area, with the vision to build healthy, resilient, connected communities. Gordon Browning told the story of our PHN with this colourful design which is explained below:

- The multi-coloured circle at the core of this design represents our PHN's key values of respect, diversity, innovation, collaboration, courage, excellence, and being people centred.
- Moving outwards, the six green dots represent our PHN's health priorities: chronic disease prevention and management; maternal and child health services; mental health and suicide prevention; alcohol and other drugs; older persons' health care; and palliative care.
- The health of Aboriginal and Torres Strait Islanders is a key priority in our region, so each is represented by the inclusion of each flag's colours in the next layer.
- Pointing outwards are message sticks, highlighting the communication pathways and partnerships that have been built to connect our communities.
- Between each pair of message sticks is a blue circle to draw attention to our enablers - that help us do what we do. These are: workforce development; system integration and collaboration; health intelligence and data analytics; and governance / clinical governance.
- The orange path is the linking point between the various communities within our region.
- The outer dotted circles represent the communities we have provided funding to support ongoing service delivery.

CCQ's Health Needs Assessment

Every 3 years, each PHN is required to produce a Health Needs Assessment (HNA) for the Department of Health and Ageing. HNAs are described in the literature as a systematic method for assessing the health assets and needs facing a population, leading to agreed priorities and resource allocation to improve wellbeing and reduce inequalities. From a PHN perspective, they are a key driver of commissioning in ensuring activity and practice meets local needs. HNAs are informed by wide range of data from different perspectives (e.g. health and other administrative datasets, and community and stakeholder perspectives and insights) across different types of needs (e.g. felt, expressed, normative and comparative).[4]

HNAs are not designed to identify all the problems in a region or provide the solutions to be implemented, they provide a balanced view of issues and strengths in our communities that can be leveraged to improve population-level health outcomes and reduce inequalities.

HNAs inform the Australian Government's key priorities, and vice versa, they guide the development of HNAs. The current seven national priority areas are:

1. Mental health
2. Aboriginal and Torres Strait Islander health
3. Population health
4. Health workforce
5. Digital health
6. Aged care
7. Alcohol and other drugs

In addition, CCQ have identified the following strategic priorities aligned with contemporary global policy directives:

- Climate resilience and mitigation
- Social cohesion
- First 2000 days
- Social determinants of health

Rather than simply meeting compliance requirements, CCQ are taking the opportunity to reimagine what a HNA is and can do for a community. Our bold aim is to move the HNA from a triennial project to an ongoing body of work to better understand the unique health and wellbeing assets and needs within our region. This will enable us and other organisations to better align commissioned services and programs to community needs, leverage and strengthen community assets to improve health and wellbeing, influence our funding landscapes, and build long-term, sustainable relationships for multisectoral approaches for population health outcomes.

The objectives of this HNA were to:

- Understand the health and wellbeing needs of communities and populations across the CCQ region.
- Form new, and further develop existing, internal and external partnerships among entities with a stake holding in health and wellbeing within the CCQ region.
- Raise awareness of the health and wellbeing priorities and their contributing determinants across directorates in CCQ, and externally with community members, and stakeholders in the CCQ region.
- Inform internal and external strategic investment in directing resources and activity to meet identified priority health and wellbeing needs of communities and populations across the CCQ region.
- Communicate to the academic and broader community, CCQ's application of best practice approaches to delivering the HNA, and other associated projects.

How this HNA is different:

- An asset-based perspective that focuses on leveraging existing strengths within communities to improve population-level health outcomes and reduce inequalities.
- A Report that is designed to be digestible and accessible for organisations outside of CCQ.
- This overarching regional-level Report is the first stage in our renewed HNA Program, which will be followed by a series of localised place-based HNAs used to initiate community-driven action
- Extensive internal socialisation of the HNA
- A community health and wellbeing survey – moving beyond health services to better understand the determinants of health and wellbeing.
- Reporting of Aboriginal and Torres Strait Islander data by Indigenous Areas.

This Report is the first step for CCQ to better understand the region's health and wellbeing needs. The findings from this Report will:

- Inform deep-dives into priority areas to learn more about their root causes
- Identify geographic areas and population groups we need to learn more about (e.g. Aboriginal and Torres Strait Islander peoples)
- Support joint regional governance, planning and action.

The methodology used for this HNA is outlined in Appendix A.

Joint Regional Needs Assessments

At a statewide level, there is evolving work to align PHN HNAs, Hospital and Health Service Local Area Needs Assessments (LANAs) and Mental Health Regional Joint Planning to aim for a complimentary approach to needs assessment. The *Joint Regional Needs Assessment (JRNA) Framework*[5] and *Implementation Toolkit* were released in April 2024 to provide guidance to PHNs, Hospital and Health Services (HHSs) and other agencies to jointly assess health and wellbeing assets and needs across their regions.

The JRNA Framework is a guideline document, which supersedes and replaces the LANA framework for the HHSs, and the HNA Policy Guide for Primary Health Networks (PHNs) in Queensland.

The Framework offers opportunities for regional planning that can enhance service delivery and reduce fragmentation in the system. Due to the late release of the Framework, not all aspects were implemented. Instead, emphasis was placed on building relationships with our regional partners, joint prioritisation, and planning for joint needs assessments moving forward.

The role of primary health care

CCQ has a primary function within the PHN program in coordinating primary health care for the region.

What is primary health care?

Primary health care (PHC) is not about providing health facilities and is broader than primary care, known as essential, first-contact care provided in a community.[6] PHC is a whole-of society approach to organising and strengthening systems to respond to peoples' health and wellbeing needs at all ages more effectively. It enables people and communities to have healthier happy lives, prevent diseases, and access early detection, treatment and recovery services. PHC approaches use on-the-ground action, rather than disease-specific approaches, focusing on the person and their preferences rather than disease states providing supports in peoples' everyday environments. PHC includes health promotion, prevention, treatment, rehabilitation and palliation, and referral to secondary or tertiary care facilities, including hospitals, when the need arises.[7]

PHC encompasses three aspects:

1. multisectoral policy and action to address the broader determinants of health
2. empowering individuals, families and communities to take charge of their own health, and
3. integrating services to meet people's health and wellbeing needs throughout their lives.

Why is primary health care important?

The Sustainable Development Goals (SDG) are committed to making health for all a reality. PHC is recognised as one of the best tools available for achieving that goal providing the 'programmatic engine' for universal health coverage. An estimated 75% of the projected health gains from the SDGs are reported to be able to be achieved through PHC.[8] PHC is widely regarded as the most inclusive, equitable and cost-effective way to achieve universal health coverage. It is also key to strengthening the resilience of health systems to prepare for, respond to and recover from shocks and crises.

There is a growing body of evidence that support economic arguments in favour of increasing investment in PHC. Evidence shows that health systems with a primary health care-based foundation result in:

- improved clinical outcomes
- increased efficiency
- better quality of care, and
- enhanced patient satisfaction.[8]

PHC is reported as the most inclusive, equitable, cost-effective and efficient approach to enhance people's physical and mental health, as well as social wellbeing.[8] Evidence of wide-ranging impact of investment in PHC continues to grow around the world, particularly in times of crisis such as the COVID-19 pandemic. Across the world, investments in PHC improve equity and access, health care performance, accountability of health systems, and health outcomes. While some of these factors are directly related to the health system and access to health services, the evidence is clear that a broad range of factors beyond health services play a critical role in shaping health and well-being. These include social protection, food systems, education, and environmental factors, among others.

PHC principles

PHC is rooted in global policy with clear principles in its approach. The principles of PHC were first outlined in the Declaration of Alma-Ata in 1978, a seminal milestone in global health. Forty years later, global leaders ratified the Declaration of Astana at the Global Conference on Primary Health Care which took place in Astana, Kazakhstan in October 2018. The following year, at the UN high-level meeting on universal health coverage, countries declared their commitment to "expand the delivery of and prioritise PHC as a cornerstone of a sustainable people-centred, community-based and integrated health system and the foundation for achieving universal health coverage."

Underpinning definitions of what constitutes quality health care in society have also evolved over the last 15 years. The Quintuple Aim is a concept of healthcare transformation that leads to improved health outcomes. Since 2008, the Triple Aim (as it was first conceptualised) has evolved from improved patient experience, better outcomes, and lower costs to include a focus on clinician experience of care and health equity as the key to health care and system transformation. The Quintuple Aim, as it is now referred, recognises that understanding and addressing the social determinants of health and health inequities is critical for achieving health and wellbeing for all (Figure 1).

Figure 1: Quintuple Aim

Policy environment

The policy environment plays an important role in shaping the health and wellbeing of our communities. Understanding the policy landscape allows CCQ to identify both the opportunities and challenges that influence efforts in promoting health equity and improving overall wellbeing.

By examining policies related to healthcare access, mental health, chronic disease management and social determinants of health, CCQ can better understand how these directives align with our goals. Additionally, this will highlight gaps and areas where advocacy and collaboration with policymakers could drive meaningful changes, ensuring that the needs of our diverse communities are adequately addressed.

A high-level rapid policy review was undertaken in December 2023 to inform the HNA (Appendix B).

Sustainable Development Goals

The Sustainable Development Goals (SDGs) are a universal call for action by all countries – poor, rich and middle-income – to promote prosperity while protecting the planet.[9] Seventeen SDGs were adopted by the United Nations in 2015 to ensure that by 2030 all people enjoy peace and prosperity.

The SDGs recognise that ending poverty must go hand-in-hand with strategies that build economic growth and address a range of social needs including education, health, social protection, and job opportunities, while tackling climate change and environmental protection.[9]

The 17 SDGs are integrated - they recognise that action in one area will affect outcomes in others, and that development must balance social, economic and environmental sustainability.

Identified theme areas in the HNA have been mapped to show where action will contribute to achieving the SDGs.

POPULATION PROFILE

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Population profile

Geographic boundaries

The CCQ catchment covers approximately 158,000km^2, incorporating the Central Queensland, Wide Bay and Sunshine Coast Hospital and Health Service regions, 12 local government areas, and 12 Indigenous areas. A full concordance of geographical boundaries is available in Appendix C.

The CCQ region covers Darumbal, Gangulu, Bayali, Wadjigu, Bayali, Gayiri, Goreng Goreng, Gureng, Taribelang Bunda, Butchulla, Waka Waka, Wuli Wuli and Kabi Kabi Nations. It begins as far south as Glasshouse Mountains and stretches north of Yeppoon; west beyond Emerald, encompassing Rockhampton, Hervey Bay, Maryborough, the Sunshine Coast and its Hinterland, Gayndah, Gladstone and Bundaberg.

Rurality

Around 7 million people – or 28% of the Australian population – live in rural and remote areas, which encompass many diverse locations and communities (ABS 2023h). These Australians face unique challenges due to their geographic location and often have poorer health outcomes than people living in metropolitan areas. Data show that people living in rural and remote areas have higher rates of hospitalisations, deaths and injury and also have poorer access to, and use of, primary health care services, than people living in major cities.

Approximately 31% of the population in the CCQ region live in Metropolitan areas, 36% live in regional centres, 32% live in rural towns and the remainder live in remote areas (Figure 2).

Figure 2: Modified Monash Model of Remoteness for the CCQ region

Defining rural and remote

There are two key remoteness structure classification systems. The Australian Statistical Geography Standard (ASGS) Remoteness Structure defines remoteness areas in 5 classes of relative remoteness:

- Major cities
- Inner regional
- Outer regional
- Remote
- Very remote.[10]

These remoteness areas are centred on the Accessibility/Remoteness Index of Australia, which is based on the road distances people have to travel for services.[10]

The Modified Monash Model (MMM) is based on the ASGS Remoteness Structure and also town size. It classifies metropolitan, regional, rural and remote areas in Australia into seven categories:

- MM 1: Metropolitan areas
- MM 2: Regional centres
- MM 3: Large rural towns
- MM 4: Medium rural towns
- MM 5: Small rural towns
- MM 6: Remote communities
- MM 7: Very remote communities[11]

Areas classified MM 2 to MM 7 are considered to be rural or remote.

The MMM was developed to better target health workforce programs and to attract health professionals to more remote and smaller communities.[11]

Over **950,000** estimated residents in 2023[12]

Over **1.2 MILLION** residents by 2046[12]

8% living in outer regional & remote areas[12]

3 Hospital and Health Service regions

12 local government areas

Geographic area of **158,000KM²**, of which over **16%** is protected parks, forests or reserves[12]

16% born overseas[12]

4.9% identify as Aboriginal and/or Torres Strait Islander[13]

45 per **10,000** persons are homelessness[12]

Over **120,000** recipients of aged care pension

Median annual family income is under **$91,000** and **14% LOWER** than QLD average[12]

4.1% are current or previous Australian Defence Force personnel

5.6% of residents speak a language other than English at home[12]

Nearly one third of residents have one or more long-term health conditions

Over **15%** of residents undertake voluntary work[12]

Nearly **40,000** recipients of disability support pension

Less than **1%** of residents have poor proficiency in English[12]

Top 5 Urban Areas by population:

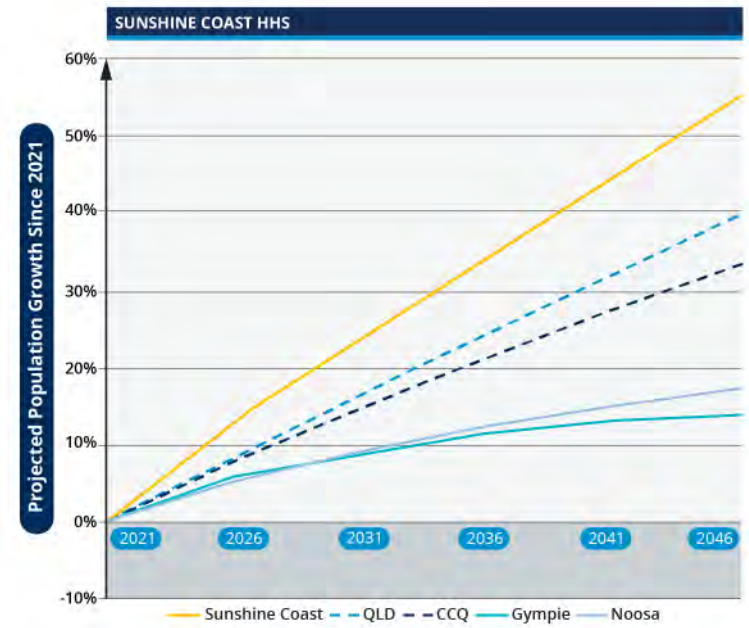
1. Sunshine Coast/Noosa
2. Rockhampton
3. Hervey Bay
4. Bundaberg
5. Gladstone

Community demographics

Population ERP and distributions

The estimated resident population of CCQ is **951,164** and is expected to grow to over 1,200,000 by 2046 (2023 ERP).[12]

Figure 3: Population projections 2021 to 2046, by Sunshine Coast region LGAs[12]



Population projections

The CCQ region's population is expected to grow by 33% by 2046, with growth driven primarily by Sunshine Coast (Figure 3) and Livingstone LGAs (Figure 4). North Burnett and Banana LGAs are expected to shrink in population over the next 25 years (Figure 5), further exacerbating the issues driven by remoteness.

Figure 4: Population projections 2021 to 2046, by Central Queensland region LGAs[12]

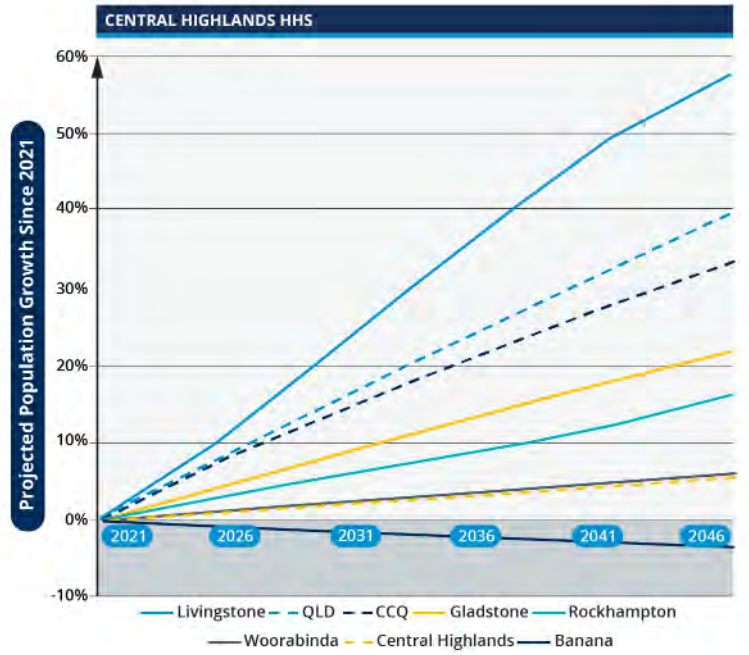
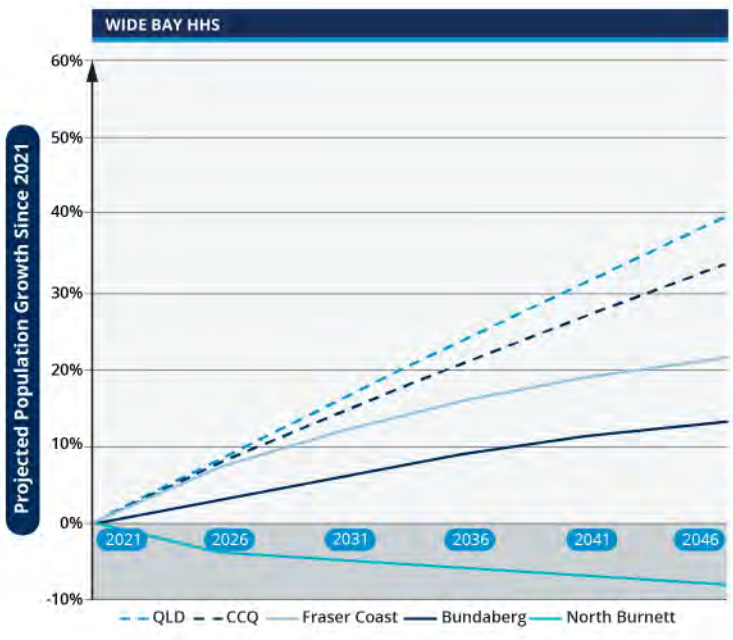


Figure 5: Population projections 2021 to 2046, by Wide Bay region LGAs[12]



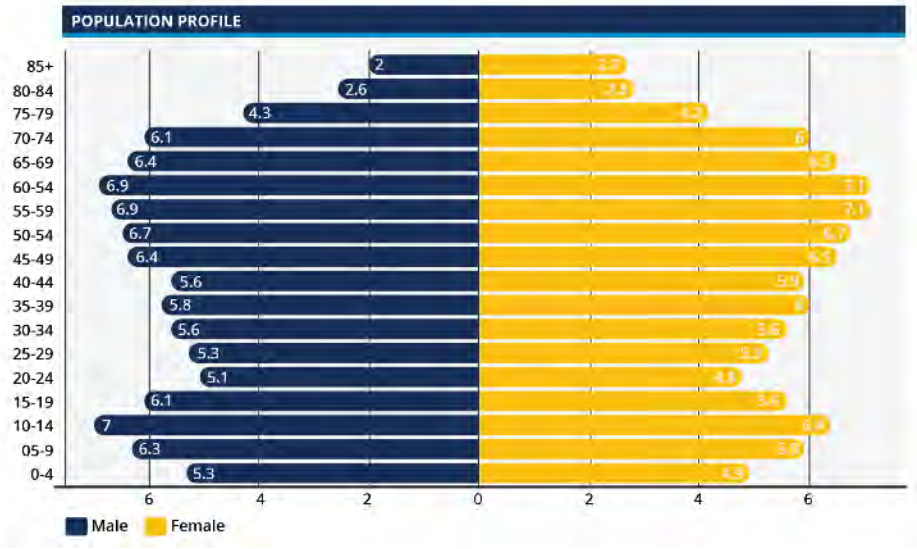
Livingstone LGA, in particular, will see transformative growth that will put strain on existing infrastructure for health unless action is taken to meet the needs of the growing community through a consultative and preventative approach.

Some SA2s are expected to more than double by 2046 including *Parkhurst – Kawana* (102%) in the Rockhampton LGA, and the Sunshine Coast LGAs of *Caloundra - Kings Beach* (110%), *Landsborough* (286%), and *Caloundra West – Baringa* (389%).[13]

Age distribution

The CCQ region has a greater proportion of older people compared to Queensland. Adults aged 45-69 are the largest proportion, followed by children aged 10-14 (Figure 6). There is a significant dip in the population of people aged 20-45 compared to national and Queensland age profiles.

Figure 6: Population profile for males and females in the CCQ region



Population density

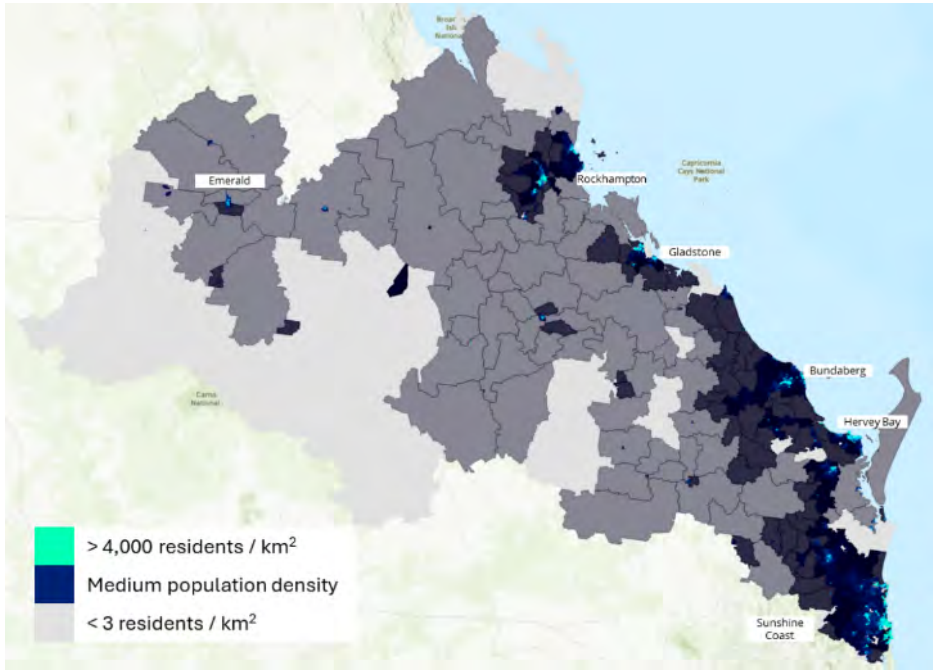
CCQ's population is primarily concentrated in coastal regions and along the Bruce Highway with some notable inland regional hubs, such as Emerald and Biloela. Over two thirds of the population live in the region's ten largest urban areas (Table 1).

Figure 7 shows the population density across the CCQ region.

Table 1: Largest urban areas in the CCQ region by population (2021 Census)

Population Ranking	Urban Centre and Locality	Population
1	Sunshine Coast / Noosa	294,290
2	Rockhampton	65,711
3	Hervey Bay	60,183
4	Bundaberg	56,419
5	Gladstone	35,888
6	Maryborough	26,470
7	Nambour	26,139
8	Gympie	23,921
9	Yeppoon	21,032
10	Emerald	14,824

Figure 7: Residential population density (2021 Census)



Age projections

Australia's population is ageing due to longer life expectancy and declining fertility rates, leading to a growing number of older Australians. As of June 2020, there were approximately 4.2 million people aged 65 and over, representing 16% of the total Australian population.[14] This marks a significant increase from 1 million (8.3%) in 1970 and is projected to rise to 21-23% by 2066. Specifically, those aged 85 and older, who made up 2.1% of the Australian population in 2020, are expected to reach 3.6-4.4% by 2066. The age profile of the older population is shifting, with more individuals in the 75-84 age group and a notable increase in those aged 85 and older.

Banana, Central Highlands, Gladstone, Livingstone, Rockhampton and Woorabinda LGAs all have younger populations than the Queensland average (Table 2). Bundaberg, Fraser Coast, Gympie, Noosa, North Burnett and the Sunshine Coast LGAs have ageing populations.

The median age projections for CCQ residents in 2046 is varied across the region, with the youngest expected in Woorabinda LGA (26.8 years) and oldest in Fraser Coast LGA (57.1 years). Overall, the median age is projected to increase across all LGAs in CCQ[12], which is expected to increase the burden on the health system beyond just the previously discussed population growth. A population approach to support older people to live healthier for longer is required.

Table 2: Age projections 2026 to 2046 by LGA[12]

LGA	As at 30 June			Change
	2026	2036	2046	2026-2046
	- years -			years
Banana	**39.6**	**41.0**	**41.8**	**2.2**
Bundaberg	**48.0**	**49.5**	**50.9**	**2.9**
Central Highlands	35.2	36.4	37.1	1.9
Fraser Coast	**53.2**	**55.6**	**57.1**	**3.9**
Gladstone	38.5	38.8	39.0	0.5
Gympie	**50.0**	**52.3**	**54.0**	**3.9**
Livingstone	**44.9**	**47.1**	**48.4**	**3.5**
Noosa	**51.8**	**53.2**	**54.5**	**2.8**
North Burnett	**49.8**	**50.5**	**51.9**	**2.0**
Rockhampton	37.9	38.8	39.4	1.5
Sunshine Coast	**43.9**	**45.4**	**46.5**	**2.6**
Woorabinda	24.8	26.3	26.8	1.9
Queensland	***39.5***	***40.8***	***41.6***	***2.0***

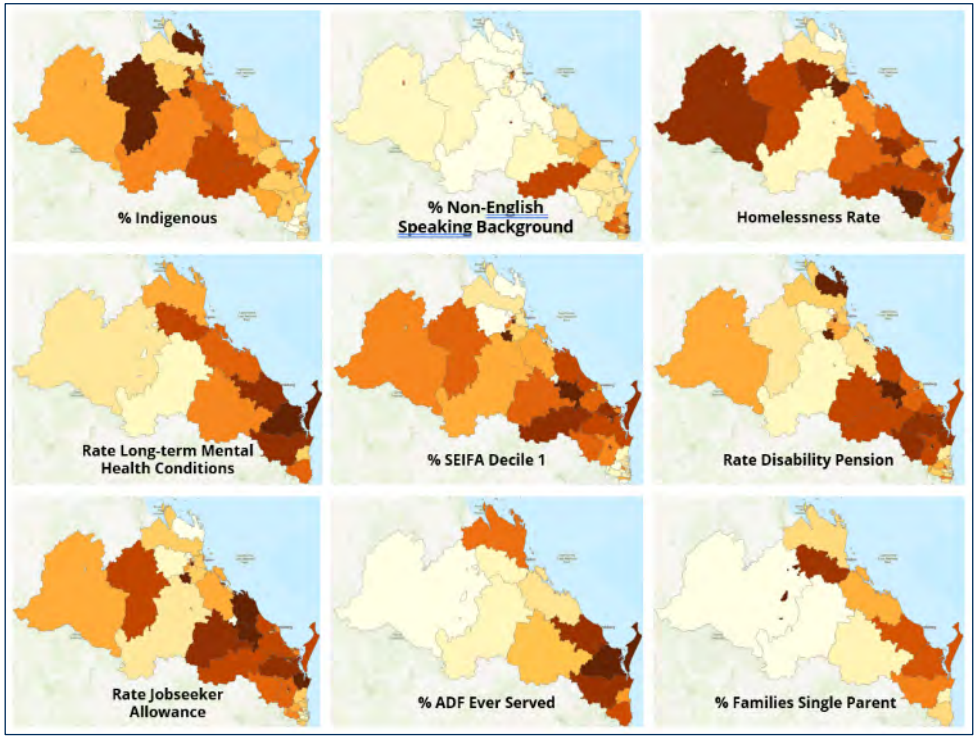
Overview of priority populations

There are various groups within our communities who experience a disproportionate burden of disease, leading to differences in health outcomes and life expectancy.[15] The inequities arise from systemic failures and poor distribution of resources between different populations groups.

Some of these communities can include Aboriginal and Torres Strait Islander people; multicultural communities; people experiencing homelessness; people living in rural, regional and remote communities; Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual and/or other sexuality and gender diverse people (LGBTQIA+); People of low socioeconomic status; people with disability; people with mental illness; veterans; and vulnerable older adults.

The distribution of priority populations in the CCQ region demonstrate the region's diversity: the greatest density of different priority populations occurs in differing locales, emphasising the importance of local place-based design and community consultation when implementing initiatives to improve the health, wellbeing and lives of the population (Figure 8). Consideration of the inequities built into societal systems and structures is vital in understanding there impacts on the health and wellbeing of these communities.

Figure 8: Geographical distribution of select priority populations in the CCQ region (darker colour = higher proportion)



Community assets and strengths

An asset and strength assessment focuses on identifying, leveraging and strengthening community assets or strengths to enable its members to have more control over their health and wellbeing. Rather than simply identifying and responding to problems and needs, this approach appreciates and values connections and potential within a community and builds on the existing skills capacities, and resources of individuals and communities.[16] In a health context, an asset is any resource that improves an individual's or community's ability to maintain good health, wellbeing and reduce inequalities; for example, people's skills, knowledge and resources framed in the context of determinants of health rather than determinants of disease. Asset-based approaches are underpinned by a set of values and principles, and a way of thinking (Figure 9).

This is a community-based process where residents collaboratively identify local resources and their experiences and knowledge about these places. Assets also include individual skills and local institutions such as social groups, churches, businesses and schools (Figure 10). This process helps create a comprehensive and detailed map of a community's resources and strengths, reflecting both formal and informal assets that support and enrich community life.[17]

Figure 9: Principles of asset-based approach[19]

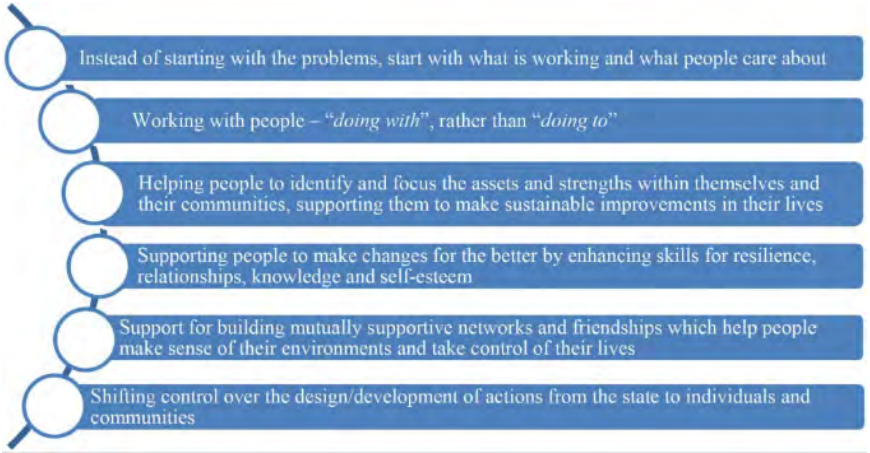


Figure 10: Community asset mapping framework[17]

Key aspects of an asset and strength-based approach include:

- **Building on community strengths:** leveraging existing community strengths and human capital, recognising the capacity of individuals to contribute positively to their community.
- **Empowering communities:** viewing community members as co-producers of health and wellbeing, promoting active community involvement and participation, fostering cohesion and empowerment among community members.
- **Shared awareness and understanding** facilitating a collective understanding of community assets by bringing residents together to identify, discuss and map these assets, often uncovering resources and strengths previously unrecognised.

- **Fostering resilience:** supporting communities in developing coping strategies and resilience skills to better handle stress and challenges.
- **Effective strategic planning:** supporting strategic planning efforts, helping communities manage resources, development and planning more effectively.
- **Identifying barriers and opportunities:** this approach can reveal barriers to accessing community assets, which can guide organisations targeting improvements to enhance community wellbeing.
- **Sustainable solutions:** ensuring long-term sustainability by involving the whole system, building on what works and eliminating barriers.

This approach aligns with the theory of salutogenesis, which emphasises successes rather than failures. This method promotes a shift from a deficit-based model to one that sees the community from a "glass half-full" perspective, empowering individuals and communities to actively participate in their own development and health improvement.[16]

By adopting this approach health professionals can empower communities by focusing on their strengths rather than deficiencies. This method encourages community-led initiatives, which can lead to more sustainable and effective health solutions. By sharing power and decision-making with the community, long-term health improvements can be fostered and reduce service demands over time. Additionally, this approach complements traditional service delivery, leading to a balanced strategy that enhances both services and community involvement in health improvement efforts.

Implementing an assets and strengths-based approach requires an initial investment in community development and support for local networks and associations to build confidence and empowerment. Community assets should be incorporated into planning and performance processes, using tools and frameworks such as the Community Based Participatory Action Research (CBPAR) framework[18] or participatory asset mapping[17] for a comprehensive view of local potential.

Developing people-centred partnerships and fostering co-production with communities is paramount, as is adopting leadership models that focus on connection and relationship building. Engaging communities in service design and improvement, along with training staff in this innovative way of working, is essential for a successful shift in the culture surrounding community health and wellbeing assessments and subsequent health improvement initiatives.

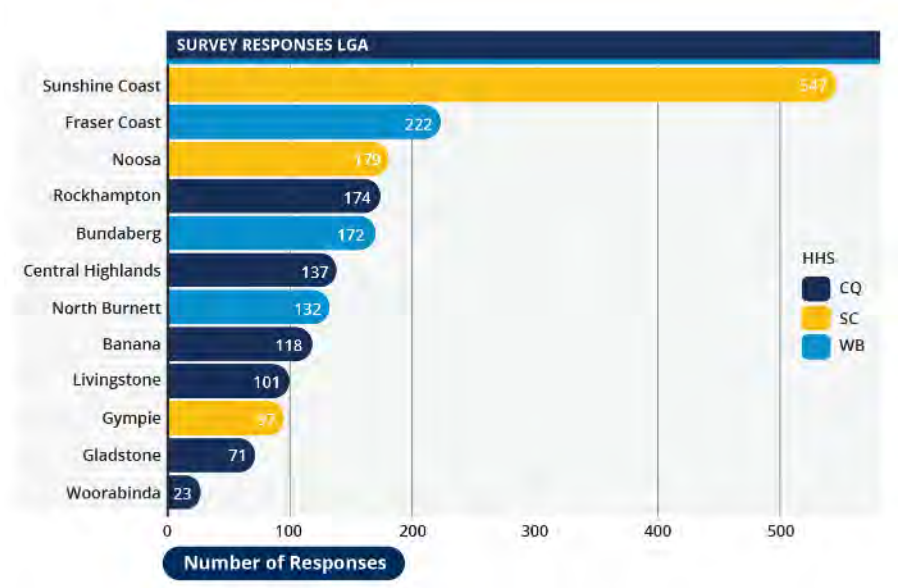
CCQ supports a strengths and assets-based approach, recognising the importance of community-led approaches to strengthening existing community resources and capacities to health creation. Acknowledging the value of this method, CCQ is committed to utilising this approach in future place-based deep-dives, ensuring that community assets and local strengths are fully mapped, and community voice provides the foundation of planning and commissioning initiatives.

Community views and perceptions

Community members' perceptions and values of health and wellbeing and what they consider to be important and influencing quality of life are critical in guiding planning for health and wellbeing of communities and person-centred approaches to healthcare. Community voice is vital in determining health and wellbeing needs of communities and ensuring health planning aligns with community values.

Through the *My Healthy Community* survey, conducted in June and July 2024 across the region, CCQ heard from 2,054 residents who shared their views on the strengths of their community and ways they would like to see it improve (Figure 11).

Figure 11: Responses to the My Healthy Community survey broken down by LGA

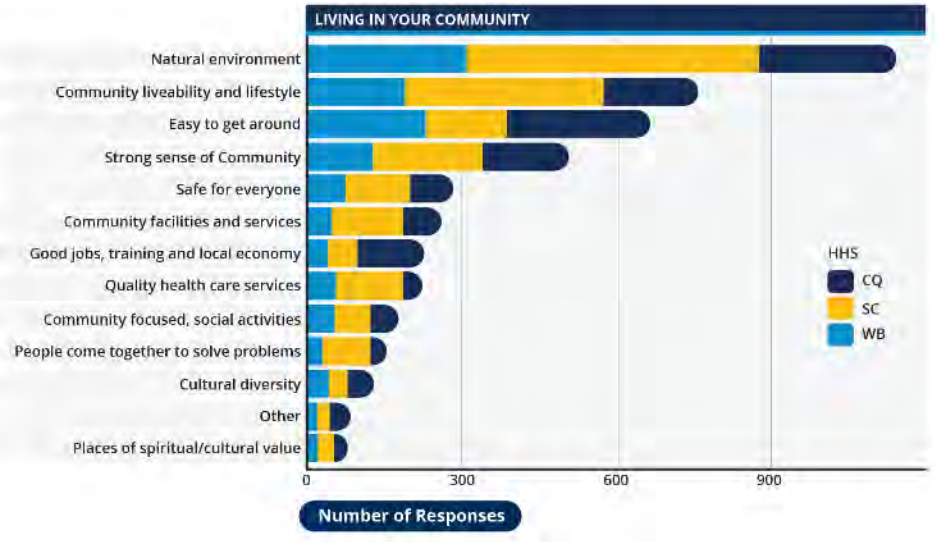


The My Healthy Community survey results have been derived from an opinion survey conducted with a convenience sample. While these results reflect the views and perspectives of the individuals who completed the survey, they should be regarded as indicative only when applied to the broader community. As such, any generalisation or extrapolation of these findings to a wider population should be approached with caution and mindful consideration of the sample's representativeness.

My Healthy Community survey participants were asked to select the aspects they liked most and valued about living in their community. The top-ranking aspects included:

- Natural environment
- Community liveability and lifestyle opportunities (e.g. walking paths, parks), and
- It being easy to get around (Figure 12).

Figure 12: Aspects CCQ My Healthy Community survey participants reported liking most about living in their community, by HHS



A strong sense of community also ranked among the top three for participants in the Sunshine Coast Hospital and Health Service area.

Participants commented:

"Plenty of playgroups for children, yearly events for families with children" (survey participant, Elliott Heads)

"People in the street keep an eye out for one another especially with amount of crime going on in [other areas]" (survey participant, Kleinton)

"The unspoilt (so far) beauty, open skies and calm unhurried pace of life" (survey participant, Point Vernon)

HEALTH & WELLBEING

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Health and wellbeing

The health and wellbeing of our communities are foundational to the overall prosperity, happiness and quality of life for CCQ residents. This section will delve into the multifaceted dimensions of health and wellbeing, exploring the complex interplay between aspects of health and wellbeing and their impact on quality of life.

Our approach is grounded in a holistic understanding that health extends beyond the absence of disease, aligning with the World Health Organisation's definition of health, being that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[19] This encompasses physical vitality, mental resilience, social connections and the ability to adapt and thrive amidst life's challenges.

The HNA was also guided by an Aboriginal and Torres Strait Islander understanding of health.

Aboriginal health does not mean the physical wellbeing of an individual, but refers to the social, emotional, and cultural wellbeing of the whole community. For Aboriginal people this is seen in terms of the whole-life-view.[20]

An Aboriginal and Torres Strait Islander holistic understanding of health and wellbeing involves the whole community throughout the entire life-course. It includes broad issues like social justice, equity, and rights, as well as traditional knowledge, traditional healing, and connection to country.[21]

Supports for health and wellbeing

My Healthy Community survey participants were asked what they believed to be important to improve the quality of life in their community. Overall, participants the top-ranking aspects identified included:

- "Access to affordable and quality health care" and
- "Mental and emotional wellbeing" (Figure 13).

These priorities underscore the importance participants placed on health and wellbeing as cornerstones of a fulfilling life. Participants clearly recognised the need for quality health services when needed as important to the quality of life in communities, along with mental and emotional wellbeing. Health plays an important role in quality of life. The survey results acknowledge the understanding that many aspects of health are created outside of the health system in broader structures and systems. Supports for the creation of health and wellbeing need to include health promotion and prevention, and where needed, to treatment and rehabilitation services.

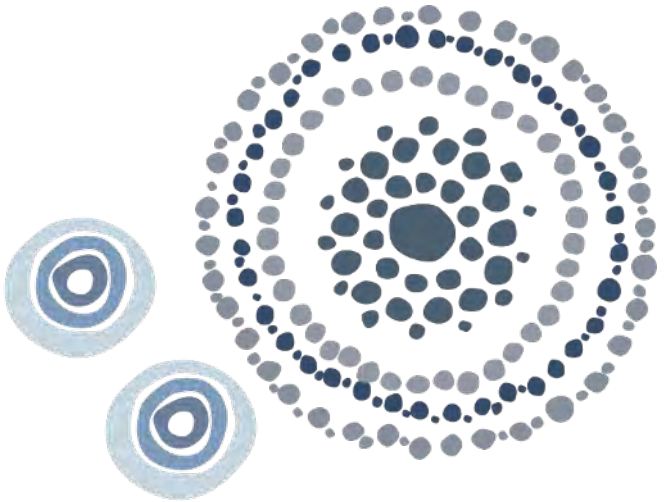
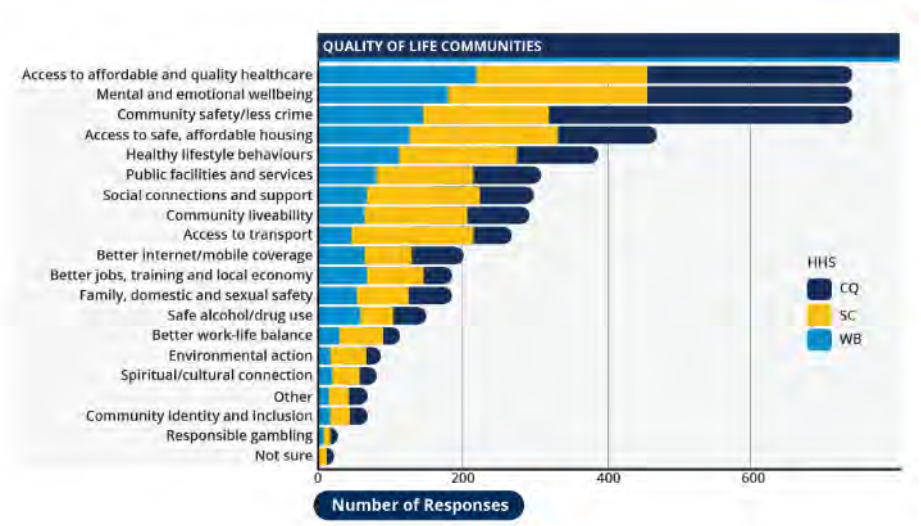


Figure 13: Most important factors to improve the quality of life for communities in the My Healthy Community survey, by HHS



The desired result of quality primary health should be a healthier, more fulfilling life for residents. This perspective shifts the focus from simply expanding services to improving their efficacy and accessibility. By prioritising outcomes, we can ensure that healthcare interventions are truly beneficial, addressing the root causes of health issues and fostering long-term wellbeing.

Further examination of the survey results as a whole revealed that there was no direct correlation between respondents' perceptions of their personal health and wellbeing and their views on the quality of healthcare services in their community. This indicates that **while residents express a desire for access to affordable quality health care options, the solution to their health concerns does not necessarily lie in increasing the number of health services**. Instead, it suggests a need for a more holistic approach that considers various factors influencing health, such as social support, environmental conditions, and mental health resources.

While the call for better health care is clear, it is imperative to understand that improving residents' quality of life involves more than just expanding health care infrastructure and workforce. It requires a comprehensive strategy that addresses the broader determinants of health, ensuring that the health care system not only treats illnesses but also promotes overall wellbeing and resilience within the community.

The community's understanding of health encompasses not just the availability of medical services but also the broader social determinants that contribute to overall wellbeing. Survey respondents noted improvements in crime and safety, access to safe and affordable housing, and the promotion of healthy lifestyle behaviours as critical to enhancing their quality of life. These responses highlight an awareness that factors such as safety, housing stability, and lifestyle choices are integral to one's health status.

To truly help people live their healthiest lives, it is imperative to recognise that health is influenced by a myriad of elements beyond the traditional health care system. For instance, feeling safe in one's community can significantly reduce stress and anxiety levels, contributing to better mental and physical health. Similarly, having access to safe, affordable housing ensures that residents have stable environments that support healthy living practices.

In our commitment to fostering the healthiest community possible, we must look beyond what can be directly influenced or purchased. It is about creating a supportive ecosystem where individuals feel empowered and equipped to make healthier choices. By addressing the broader socio-economic and environmental factors, we can lay the foundation for a resilient, health-conscious community. This comprehensive approach will not only improve individual health outcomes but also enhance the collective wellbeing of the entire region.

Overall health and wellbeing

Quality of life

Quality of life (QoL) is a complex and multifaceted measure that reflects an individual's overall wellbeing and life satisfaction. It is viewed as an individual's perception of their position in life in context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns.[22] It includes various dimensions such as physical health, psychological state, level of independence, social relationships, personal beliefs, and the individual's relationship with their environment. However, accurately measuring Quality of Life is inherently challenging, and there is a notable scarcity of data that directly addresses this, particularly at a local level.

Quality of life is typically self-assessed, meaning individuals rate their own health and wellbeing across multiple dimensions that they personally value. This subjective nature requires large sample sizes to accurately reflect the broader community's experiences and perceptions.

Through the *My Healthy Community* survey, CCQ collected some data on this topic. It should be noted that these data are indicative and serves as an introductory piece for further community research. This future research will aim to delve deeper into the various dimensions of Quality of Life discussed earlier, providing a more comprehensive understanding of the wellbeing of our communities.

Nearly one quarter of survey participants cited cost of living as the biggest factor impacting their quality of life at the moment. The rising prices for basic essentials like rent, electricity, and food have created significant stress for families trying to make ends meet. In areas such as Bundaberg, Nambour, and Burnside, participants voiced their struggles with the relentless increase in vital services, housing, and petrol. These communities are witnessing a troubling pattern of businesses closing down due to unsustainable rent hikes, contributing to a landscape dotted with empty shops and a declining sense of local prosperity.

"Continuing increases to all vital services, housing, food, petrol but no increase to wages." (survey participant, Burnside)

"Lots of empty shops in town. People going out of business due to rent hikes." (survey participant, Nambour)

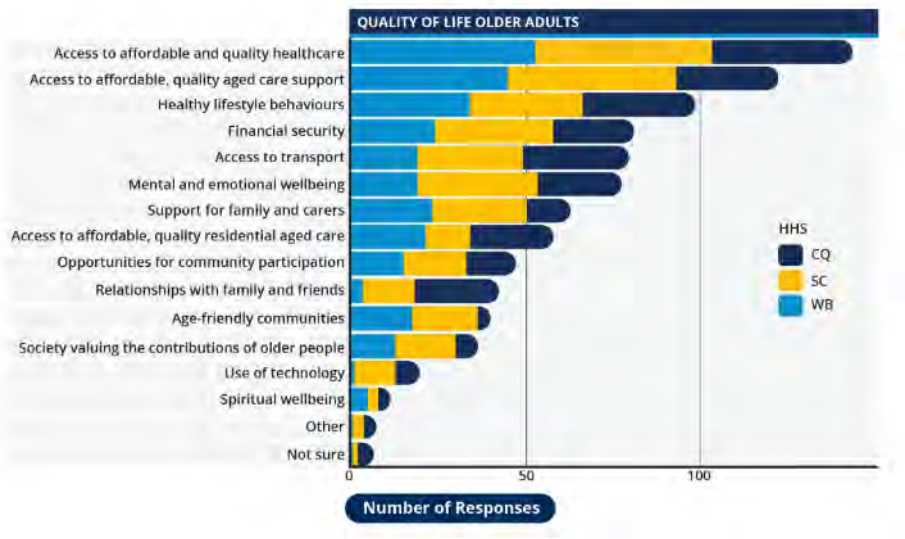
"Cost of living for basic essentials like rent, electricity and food and access to these needs." (survey participant, Bundaberg)

For many, the dream of securing safe and affordable housing has become a daunting challenge. The financial burden of maintaining a stable living environment for their families is exacerbated by stagnant wages that do not keep pace with the surging costs of living. This precarious situation not only threatens individual wellbeing but also undermines the cohesion and resilience of the community as a whole. Addressing these issues requires a multi-faceted approach that goes beyond immediate economic relief, aiming instead to create a supportive ecosystem where every resident has the opportunity to thrive.

Older Adults

In responses gathered through the *My Healthy Community* survey, older adults expressed a desire for affordable and quality health care to support their quality of life (Figure 14Figure). With the financial burden of maintaining a stable living environment already being a significant challenge, accessible health care becomes even more crucial. The integration of quality health care is seen as a vital component of their overall quality of life but also highlights the necessity of a health system that not only addresses immediate medical needs but also ensures long-term wellbeing and healthy ageing.

Figure 14: Most important factors to improve the quality of life for older adults in the My Healthy Community survey (participants aged 65+), by HHS

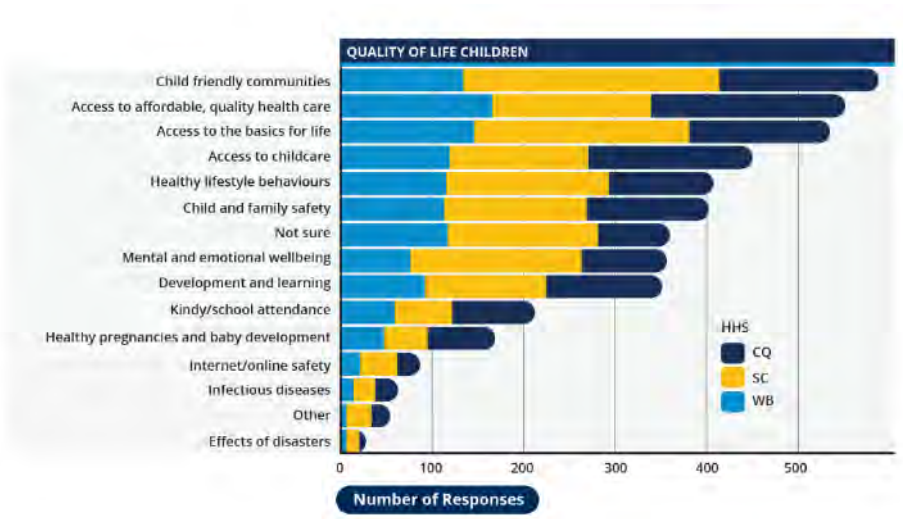


These responses emphasise a strong desire from older adults to lead independent healthy lives with access to affordable quality health care, when needed and the importance of lifestyle in overall quality of life. It also highlights health services as one part of the broader picture of how we support older people to live healthier for longer.

Children and Families

The *My Healthy Community* survey responses indicate a community perception that creating more child-friendly community spaces and activities was important in improving the quality of life for the younger generation (Figure 15). Child-friendly place-making is where children feel safe and secure, have access to services, can play, learn and grow and their voices heard.[23] It includes children being able to play independently on the streets and with their neighbours, in parks, playgrounds, and recreational facilities more accessible and safe for children, families could engage more freely in outdoor activities, fostering a stronger sense of community and belonging. Additionally, the survey results indicated a clear demand for affordable and accessible essentials, including health care, which are crucial for maintaining a stable and healthy living environment.

Figure 15: Most important factors to improve the quality of life for children in the My Healthy Community survey



This focus on child-friendly community development and the accessibility of basic needs underscores the community's commitment to improving the lives of its younger generation. By indicating a desire to invest in these areas, the community has expressed a desire to create a nurturing environment where children can thrive. Such an approach not only supports the immediate well-being of families but also lays the foundation for a healthier, more resilient community in the long term. The survey's findings reflect a collective vision towards a holistic development strategy that prioritises the health and happiness of children, ensuring they grow up in a supportive and resource-rich environment.

Life expectancy

Life expectancy is a measure reflects the overall mortality level of a population used to describe population health.[24] It measures how long, on average, a person is expected to live from birth based on current age- and sex- specific death rates. It serves as an indicator of the effectiveness of healthcare systems, socio-economic conditions, environmental factors, and public health interventions. A higher life expectancy typically correlates with better access to healthcare, improved living standards, education levels, and preventative healthcare measures.[25]

Conversely, lower life expectancy may indicate disparities in healthcare access, higher prevalence of chronic diseases, socio-economic inequalities, or environmental hazards affecting health. Analysing life expectancy trends over time helps identify health priorities, assess the impact of policies, and guide targeted interventions to improve overall population health outcomes.

Life expectancy in Australia has improved dramatically for both sexes in the last century, particularly life expectancy at birth. Compared with their counterparts in 1891–1900, boys and girls born in 2020–2022 can expect to live around 30 years longer. But, for the first time since the mid-1990s, life expectancy in Australia decreased in 2020–2022. This is likely to be due to the large increase in deaths in 2022 of which close to half were due to COVID-19 and the remainder due to increases in other causes.

Aboriginal and Torres Strait Islander people have a lower life expectancy than non-Indigenous Australians. In Queensland, Aboriginal and Torres Strait Islander life expectancy was 7.4 years less for males and 7 years less for females that non-Indigenous Australians.[26]

In the CCQ region, life expectancy is lower for males and females in Central Queensland and Wide Bay (SA4) compared with Sunshine Coast (SA4), Queensland and Australia (Table 3).

Table 3: Life expectancy, by SA4 (2020-22)[27]

SA4	2020-22		
	Females	**Males**	**Persons**
Central Queensland*	**83.8**	**79.3**	**81.5**
Sunshine Coast*	85.9	82.2	84.0
Wide Bay*	**83.5**	**78.4**	**80.9**
Queensland*	85.0	80.7	82.8
Queensland (Aboriginal and Torres Strait Islander)	*76.6*	*72.9*	-
Australia*	**85.3**	**81.2**	**83.2**

* All persons

Overall death rates

Data on death rates offers information about population health by examining the frequency and causes of mortality within a specific population over a defined period. It is a key indicator of overall health status, reflecting the effectiveness of healthcare systems, public health interventions, and socio-economic conditions. Trends in death rates can highlight prevalent diseases, disparities in healthcare access, and the impact of lifestyle factors such as diet, physical activity and substance use. Examining death rate data enables healthcare professionals to identify priority areas for intervention and track progress in improving population health outcomes over time.

In the CCQ region, infant mortality rates are similar to that for the nation except for Central Highlands, Fraser Coast, Gladstone and Bundaberg (Table 4). Mortality rates for young people in CCQ are significantly higher than the nation and particularly high in Central Highlands, Noosa, Fraser Coast and Sunshine Coast. Median age of death for males and females is similar to the nation. And when comparing male median age at death was similar for Aboriginal males to state and national Aboriginal figures, but lower for some Indigenous Areas including Nanango-Kilkivan, Cooloola-Gympie, and Central Capricorn.

Table 4: Mortality indicators[28,29]

LGA	Average annual infant mortality rate per 1,000 (2017-2021)	Average annual death rate, 15-24 years ASR per 100,000 (2017-2021)^	Median age at death, males (2017-21)	Median age at death, females (2017-21)	Median age at death, all persons (2017-21)	Median age at death, Aboriginal males (2016-20)	Median age at death, Aboriginal females (2016-20)	Median age at death, Aboriginal all persons (2016-20)
Banana	-	73.0	78.0	82.0	80.0	-	-	41.0
Bundaberg	3.8	50.4	78.0	83.0	80.0	61.0	65.5	64.0
Central Highlands (Central Capricorn)	4.9	95.8	71.0	74.0	72.0	58.0	59.0	58.0
Fraser Coast	4.2	57.5	78.0	82.0	79.0	62.5	72.0	65.0
Gladstone	4.0	40.7	72.0	79.0	75.0	58.0	62.0	60.5
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	2.3	50.9	76.0	82.0	78.0	58.0 62.0	56.0 41.0	57.0 53.0
Livingstone (Rockhampton-Yeppoon)	-	52.4	77.0	83.0	80.0	60.0	69.0	63.0
Noosa	-	75.0	80.0	84.0	82.0	75.0	73.0	75.0
North Burnett	-	..	77.0	82.0	79.0	64.0	69.0	66.5
Rockhampton (Rockhampton-Yeppoon)	3.3	53.2	76.0	84.0	80.0	60.0	69.0	63.0
Sunshine Coast (Maroochy; Caloundra)	3.1	48.5	80.0	85.0	82.0	61.5 59.5	69.0 68.0	64.5 66.0
Woorabinda (Central Capricorn)	-	..	58.0	60.0	58.0	58.0	59.0	58.0
CCQ	***3.3***	***54.0***	***78.0***	***83.0***	***80.0***	***60.5***	***67.0***	***63.0***
Queensland	***3.9***	***42.9***	***77.0***	***83.0***	***80.0***	***59.0***	***65.0***	***61.0***
AUSTRALIA	***3.2***	***37.3***	***78.0***	***84.0***	***81.0***	***58.0****	***63.0****	***60.0****

Highlighted areas were reported as significant in data source compared with national figures (Red highlight = poorer status)
* NSW, Qld, SA, WA and NT only

Self-reported health

Self-rated health is a subjective indicator of health status that integrates biological, mental, social and functional aspects of a person, including individual beliefs and health behaviours, and is considered a strong predictor of health indicators, such as mortality.[30]

For all persons, CCQ, and some LGAs within the region, had significantly lower levels of self-reported health than Queensland, including Gladstone, Gympie, Rockhampton, Fraser Coast and Bundaberg (Table 5). In 2017-18, Queensland also had significantly lower levels of self-rated health than Australia.[31] Aboriginal and Torres Strait Islander persons across the region overall, rated their health slightly lower than the total population (Table 5).[31] Aboriginal and Torres Strait Islander persons across Indigenous Areas in CCQ had similar, and some slightly lower levels of, self-rated health compared with other Aboriginal and Torres Strait Islander persons across Australia.[31]

Number of unhealthy days are an estimate of the overall number of days during the previous 30 days when a person felt that either his or her physical or mental health was not good. Overall, CCQ had a similar number of average mental unhealthy days to Queensland, but significantly greater number of unhealthy physical and total unhealthy days. There were also variations in the average number of unhealthy days across LGAs (Table 5).

Table 5: Self-reported health of adults

LGA (Indigenous Area^^)	Level of self-rated health for all persons 18+ years (2021^-22)[32]	Level of self-rated health for Aboriginal persons 15+ years (2018-19)[29]	Number of mental unhealthy ^days[32]		
	Excellent/ very good/ good (%)	Excellent/ very good/ good (est. ASR pe)100)^	Mean number of unhealthy days in past 30 days for all persons 18+ years (2021-22)		
Banana	80.4	79.2	3.8	4.1	6.9
Bundaberg	73.4	75.8	6.7	6.5	10.7
Central Highlands (Central Capricorn)	84.2	80.1	4.8	3.9	7.7
Fraser Coast	75.1	73.9	6.0	7.3	10.9
Gladstone	79.4	78.1	6.2	4.8	9.2
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	77.8	75.7	5.5	6.2	9.9
Livingstone (Rockhampton-Yeppoon)	82.4	76.0	4.7	4.7	8.2
Noosa	87.7	77.2	4.0	3.9	6.9
North Burnett	76.9	79.2	5.4	5.6	9.2
Rockhampton (Rockhampton-Yeppoon)	75.9	76.0	5.7	5.0	8.8
Sunshine Coast (Maroochy; Caloundra)	85.4	75.8 77.8	5.5	5.0	9.1
Woorabinda (Central Capricorn)	-	80.1	-	-	-
CCQ Region	***80.9***	***--***	***5.6***	***5.4***	***9.3***
Queensland	***83.5***	***76.1***	***5.5***	***4.7***	***8.7***
AUSTRALIA	***--***	***76.0***	***--***	***--***	***--***

- Data not releasable; -- Data not available. Highlighted areas were reported as significant in for source compared with national figures. (Red highlight = poorer status; green = higher status), substantial numerical differences are shown in different coloured text; ^^ where Indigenous Area is known by another name

Overall burden of disease

Burden of disease is a measure of the impact of diseases and injuries on a population. It combines the years of healthy life lost due to living with ill health with the years of life lost due to dying prematurely. This measure, reported in the Australian Burden of Disease Study,[33] allows for an understanding of health by combining both the mortality and morbidity impacts of a condition. This enables the direct comparison of various conditions, which is crucial for policy decision-making. Over the last 20 years, the rate of total disease burden in Australia has remained relatively stable. However, living with illness or injury has contributed more to the overall disease burden than dying prematurely. In other words, there are more people living with conditions than dying from them. Between 2003 and 2023, there was a 13% decrease in the rate of premature deaths and 15% increase in the rate of living with ill health.[33]

Premature death

Premature death refers to deaths that occur at an age earlier than expected, which for Australian premature death data, is before the age of 75 years for all person.[24] Overall, males and total persons rates of premature death by all causes were significantly higher than Australian rates, but similar for females (Table 6).

Many LGAs in the region had significantly higher rates or premature death than Australia, for both males and females. For Aboriginal persons, premature deaths were significantly lower than state and national benchmarks in Bundaberg, but higher for Nanango-Kilkivan and Banana.

Table 6: Rates of premature death (average annual ASR per 100,000), by LGA[28,29]

LGA (Indigenous area)	All males, 0 to 74 years (2017-21)	All females, 0 to 74 years (2017-21)	All persons, 0 to 74 years (2017-21)	Aboriginal males, 0 to 54 years (2016-20)	Aboriginal females, 0 to 54 years (2016-20)	All Aboriginal person, 0 to 54 years (2016-20)
Banana	291.1	185.7	243.2	-	-	347.7
Bundaberg	358.0	201.4	280.7	149.0	85.4	118.4
Central Highlands (Central Capricorn)	318.7	206.3	268.7	281.6	192.8	241.4
Fraser Coast	344.5	211.8	278.8	175.4	141.4	163.3
Gladstone	330.7	203.1	272.0	210.4	109.8	154.9
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	329.5	207.1	270.0	- -	.- -	146.6 363.4
Livingstone (Rockhampton-Yeppoon)	300.3	175.7	240.9	219.8	140.6	179.9
Noosa	232.8	153.6	199.1	-	-	-
North Burnett	381.4	193.1	293.1	-	-	-
Rockhampton (Rockhampton-Yeppoon)	417.0	255.4	337.8	219.8	140.6	179.9
Sunshine Coast (Maroochy; Caloundra)	243.3	151.3	196.1	161.8 201.1	86.7 100.1	127.6 152.2
Woorabinda (Central Capricorn)	1,605.7	634.4	1,081.6	281.6	192.8	241.4
CCQ Region	***303.8***	***184.0***	***244.3***	***199.2***	***123.0***	***161.9***
Queensland	***305.6***	***187.7***	***246.9***	***222.1***	***139.1***	***180.9***
Australia	***291.9***	***181.1***	***236.5***	***233.0****	***153.6****	***193.7****

Highlighted areas were reported as significant in data source compared with national figures. (Red highlight = poorer status; green = higher status)
*NSW, Qld, SA, WA and NT only

People with a disability

Disability is a spectrum ranging from minor impairments to complete loss of function, caused by genetic disorders, illnesses, accidents or aging. Disability can limit daily activities like self-care, mobility and communication, as well as affect social and economic participation due to barriers in the physical environment and societal attitudes. Approximately 1 in 6 Australians (4.4 million people) experience disability, with prevalence increasing with age; 7.6% among children (0-14 years), 13% among adults (15-64 years) and 50% among the older population (65 years and older). Despite active participation in society, people with disability often face challenges such as lower employment rates, higher unemployment, lower income, and reduced educational attainment compared to those without disabilities.[34]

Disability can be conceptualised in a range of ways, including how we understand disability and how it is experienced by different people. **The Social Model of Disability is widely recognised and accepted way of perceiving inequality as it acknowledges that disability stems from communities, services and spaces that are not accessible or inclusive**. In the Social Model of Disability, it is society that places limits on a person, not their disability.[35]

In Australia, limitations in data and reporting of disability prevalence stem from varying definitions across data sources, leading to inconsistent data collection. Under-reporting due to lack of identification mechanisms in mainstream services further complicates obtaining accurate prevalence rates.

Around 18% of the Australian population – or one in six Australians – currently experience disability.[36,37] This number is increasing partly due to an ageing population and the increase in the prevalence of noncommunicable diseases.[37] People with disability include, but are not restricted to, those who have long-term physical, mental, cognitive, intellectual or sensory impairments. People with disability have specific needs, priorities and perspectives based on their individual identities including their gender, age, sexuality, race and cultural background, and can face additional barriers and inequities.[37]

There are several LGAs within the region with a fifth of the population living with a disability (Table 7). Fraser Coast has the highest proportion of people with a profound or severe core activity limitation in the region; higher than the state average of 7.3%. The high prevalence in these areas is also reflected in higher proportions of people providing unpaid assistance to someone with a disability, those receiving a disability support pension and numbers of NDIS participants.

Table 7: Indicators of disability

LGA (Indigenous Area)	Estimated proportion of people with a disability (2018)[38]	Proportion of people who have a need for assistance with core activities (2021)[38]	Estimated proportion of people with disability aged 0-64 years whose need for assistance with core activities is fully met (2018)[38]	Proportion of all persons with a profound or severe disability (incl. in long-term accommodation) by LGA (2021)[28]			Proportion of Aboriginal people with a profound or severe disability (incl. in long-term accommodation) by Indigenous Area (2021)[28]			Proportion of people aged 15 years and over providing unpaid assistance to people with a disability (2021)[28]		Proportion of people aged 16 to 64 years receiving disability support pension (June 2023)[28]	NDIS participants (ASR per 100), all persons (June 2023)^[28]
				0-64 years	65+ years	All ages	0-64 years	65+ years	All ages	Aboriginal people	All persons		
Banana	15.8	4.1	2.4	2.7	14.5	4.6	5.1	10.3	5.4	9.7	10.1	4.1	2.0
Bundaberg	24.3	**9.6**	4.7	**6.4**	**20.1**	**10.0**	**11.0**	**30.3**	**12.5**	**15.7**	**13.7**	**9.8**	3.9
Central Highlands (Central Capricorn)	13.1	3.4	3.0	2.8	12.4	3.7	4.7	22.7	5.7	9.8	8.3	3.1	1.8
Fraser Coast	31.4	**10.8**	6.2	**7.4**	**20.3**	**11.3**	**11.4**	**31.3**	**13.1**	**16.0**	**14.5**	**12.0**	3.7
Gladstone	18.4	5.8	2.8	**4.3**	17.1	6.1	7.0	26.7	7.8	**13.7**	11.1	**5.7**	2.8
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	32.7	**9.7**	5.6	**6.9**	**20.0**	**10.2**	**10.9; 12.7**	**39.1; 30.0**	**12.8; 14.5**	**17.3; 16.0**	**14.4**	**12.2**	3.8
Livingstone (Rockhampton-Yeppoon)	24.1	5.7	3.0	3.3	16.3	6.0	6.8	28.2	8.0	12.4	**12.4**	4.6	2.4
Noosa	24.2	5.6	2.4	3.4	12.5	5.9	**8.5**	17.9	**9.8**	**15.6**	**12.1**	4.9	2.0
North Burnett	24.1	**8.0**	3.3	**4.9**	**19.2**	**8.8**	**8.9**	**33.8**	**12.0**	**17.3**	**12.9**	**10.0**	2.4
Rockhampton (Rockhampton-Yeppoon)	23.8	**7.5**	3.2	**5.0**	**22.6**	**7.9**	6.8	28.2	8.0	12.4	**12.1**	**7.4**	3.7
Sunshine Coast (Maroochy; Caloundra)	20.0	**6.2**	2.5	3.6	16.8	**6.4**	**7.8; 8.4**	23.2; 28.4	**8.8; 9.5**	**14.3; 13.8**	**11.8**	4.8	2.4
Woorabinda (Central Capricorn)	-	3.9	-	3.1	**30.2**	3.8	4.7	22.7	5.7	9.8	10.4	**7.6**	2.6
CCQ	*--*	*--*	*--*	***4.6***	***18.0***	***7.6***	***8.4***	***29.0***	***9.7***	***14.1***	***12.4***	***6.8***	***2.9***
QLD	*--*	*6.0*	*--*	***3.7***	***18.6***	***6.3***	***6.9***	***29.2***	***8.2***	***13.1***	***11.5***	***5.0***	***2.4***
AUSTRALIA	*--*	*5.8*	*--*	***3.3***	***18.9***	***6.0***	***7.0***	***27.9***	***8.2***	***14.0***	***11.9***	***4.7***	***2.3***

- data not releasable; -- data not reported; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status). Substantial numerical differences are shown in bold.

Disability groups

The ABS broadly groups disability into 6 groups depending on whether they relate to functioning of the mind or the senses, or to anatomy or physiology.[39] Each disability group may refer to a single disability or be composed of a number of broadly similar disabilities, including:

1. **Sensory and speech disability group** (includes loss of sight, loss of hearing, and speech difficulties disability types)
2. **Intellectual** (relates to difficulty learning or understanding things)
3. **Physical** (includes such disability types as breathing difficulties, blackouts, seizures or loss of consciousness, chronic or recurrent pain, incomplete use of limbs, and more)
4. **Psychosocial** (includes nervous or emotional conditions, mental illness, memory problems, and social or behavioural difficulties disability types)
5. **Head injury, stroke or acquired brain injury** disability group
6. **Other disability** (includes restrictions in everyday activities due to other long-term conditions or ailments).[39]

National Disability Insurance Scheme (NDIS)

The National Disability Insurance Scheme (NDIS) offers essential funding to eligible individuals with disabilities, enabling them to spend more time with family and friends, gain greater independence, acquire new skills, pursue employment or volunteer opportunities, and ultimately enhance their quality of life.[40] The NDIS, administered by the National Disability Insurance Agency (NDIA), is jointly funded and governed by the Australian, state and territory governments.[41] Beyond funding, the NDIS connects people with disabilities to a wide range of community services, including healthcare providers, community groups, sporting clubs, support networks, libraries, and educational institutions. It also provides vital information on the support available from state and territory governments.

Currently the NDIS supports over 500,000 Australians, including approximately 80,000 children with developmental delays.[40] Through individually tailored plans, participants can use their allocated budgets to obtain the services and supports they need, enhancing their overall quality of life. The scheme also includes an early childhood approach, benefiting approximately 92,400 children under seven years of age with developmental delays or disabilities, ensuring they receive timely interventions for the best possible outcomes. The NDIS fosters connections to vital community services and promotes an inclusive society where all individuals with disabilities can thrive.

Generally, the number of NDIS active participants per LGA in the CCQ region (Figure 16) follows the size of the population, however Figure 17 shows that there is variation across LGAs in the per capita rate of NDIS active participants. Six of the twelve LGAs, split across the three HHS areas, in the CCQ region have a higher per capita rate of NDIS active participants than the Queensland average.

Figure 16: Active NDIS participants by LGA (Q4 FY23/24)[42]

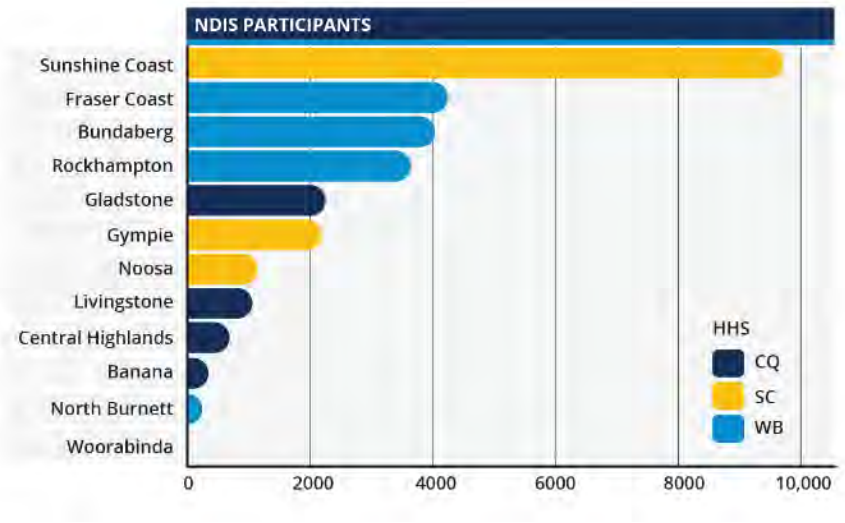
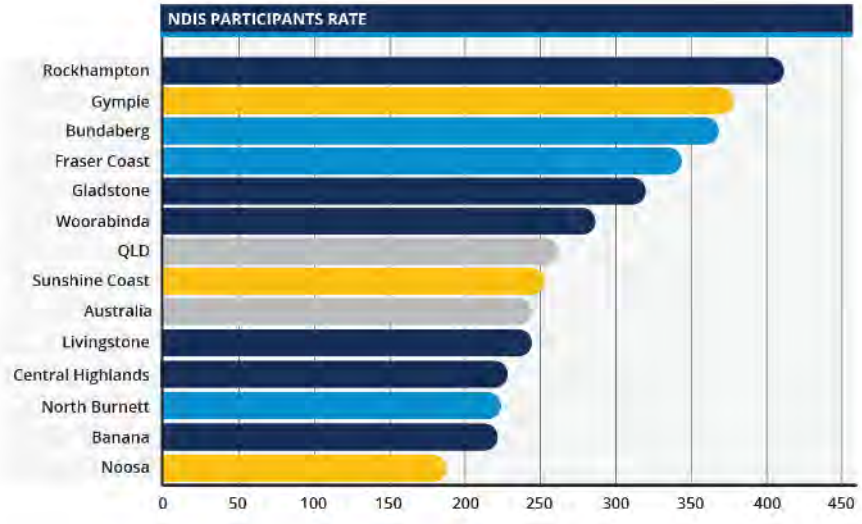


Figure 17: Active NDIS participants per 100,000 population (Q4 FY23/24)[42]



Over the most recent 12 months of data (Q2 FY22/23 to Q1 FY23/24), the primary disabilities of NDIS participants living in the CCQ region were **autism**, **developmental delays** and **intellectual disability**. This was consistent across LGAs with the exception of Noosa, with more residents with a psychosocial disability than developmental delays. In Woorabinda, in most instances the primary disabilities were autism and intellectual disability. Numbers for other disabilities were too small for reporting (i.e. <11).[42] There has been an increase in the number of Aboriginal and Torres Strait Islander NDIS participants from 2282 in 2022/2023 financial year to 2633 in 2023/2024 financial year.

Disability Employment Services

Disability Employment Services (DES) is an Australian Government initiative designed to assist individuals with disabilities in finding and maintaining employment. DES provides tailored support to eligible people with disabilities, injuries or health conditions, offering services such as career advice, resume development, training, job searching assistance and ongoing workplace support.[43] This includes funding for workplace modifications and wage subsidies to employers. DES is delivered by a diverse range of providers, including large, medium and small for-profit and non-for-profit organisations, which also work with employers to foster inclusive workplace practices.

As of 31 December 2022, DES had 273,000 participants nationally, with key demographics including:

- 51% male and 49% female participants
- 43% aged 44 and under, 51% aged 45-64 years, and 6% aged 65 years and over
- The top five primary disability types are physical disorder (43%), psychiatric (40%), autism (4.3%), neurological (3.6%) and intellectual (3.3%).[41]

In the 2021-22 financial year, DES achieved 107,000 employment placements, a 6% increase from the previous year and a 51% increase in 26-week sustained employment outcomes, reflecting improved economic and labour market conditions.

CONDITIONS AFFECTING HEALTH & WELLBEING

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Conditions affecting health and wellbeing

Conditions causing burden of disease

In 2023, chronic diseases caused most of the burden of disease (64%) in 5 disease groups: cancer, mental health conditions and substance use disorders, musculoskeletal conditions, cardiovascular diseases, and neurological conditions across Australia (Table 8).

Table 8: Five leading disease groups causing burden in Australia (2023)

Disease	% total burden	% disease burden due premature death	Change ASR between 2003 and 2023
1. Cancer	17	91	▼
2. Mental health and substance use	15	2	▲
3. Musculoskeletal	13	3	▼
4. Cardiovascular	12	74	▼
5. Neurological	8	49	▲

For individual diseases, coronary heart disease was the leading cause of burden but has had the largest absolute reduction over time (due to declines in premature deaths), followed by dementia, backpain and problems, anxiety disorder and chronic obstructive pulmonary disease (COPD) (Table 9).

Table 9: Leading individual diseases causing burden by number in Australia (2023)

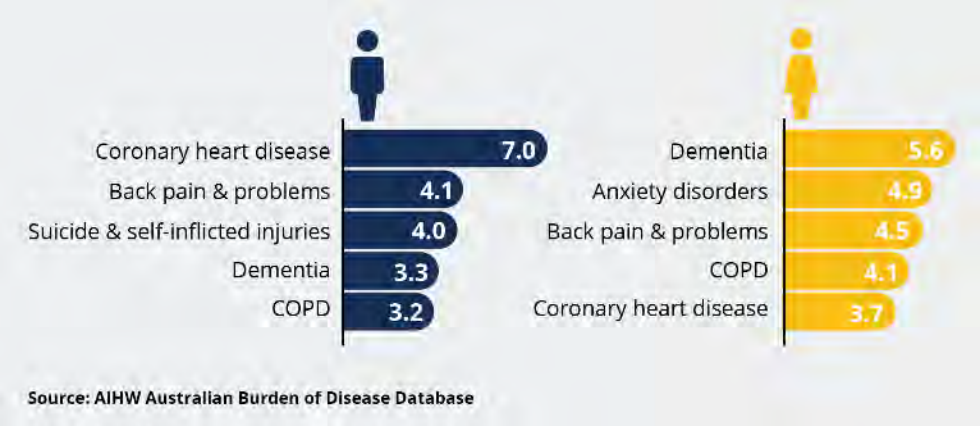
Disease	ASR per 1,000 total burden	ASR per 1,000 due premature death burden	% change ASR between 2003 and 2023	
Coronary heart disease	11.50	8.93	▼	(-58.2)
Dementia	9.35	5.47	▲	(39.8)^
Back pain and problems	9.14	0.05	▲	(8.3)
Anxiety disorders	8.29	0.01	▲	(33.2)
Chronic obstructive pulmonary disease (COPD)	7.73	4.03	▼	(-12.9)
Depressive disorders	6.31	0.02	▲	(11.2)
Lung cancer	6.01	5.86	▼	(-31.4)
Suicide and self-inflicted injuries	5.88	5.83	▲	(16.6)
Osteoarthritis	5.41	0.02	▲	(26.7)
Asthma	5.34	0.31	▲	(8.9)

^ Increase due in part due to changes in coding deaths due to dementia

Cancer; Mental health and substance use; Musculoskeletal; Cardiovascular; Neurological; Respiratory; Injury (external cause)

In 2023, males experienced more total disease burden than females in Australia (Figure 18), with the leading causes of total burden among males being coronary heart disease, back pain and problems, and suicide and self-inflicted injuries. Among females, the leading cause was dementia, anxiety disorders, and back pain and problems. Males experienced three times the amount of burden due to suicide and self-inflicted injuries and two times the amount of burden from coronary heart disease than females. Females experienced more burden from dementia and anxiety disorders.

Figure 18: Leading causes of total burden by sex and proportion of total burden in Australia (2023)



Between 2003 and 2023, the crude rate of total burden:

- decreased for coronary heart disease, stroke, lung, bowel and breast cancer and rheumatoid arthritis.
- substantially increased for dementia (partly due to changes in coding deaths due to dementia).
- increased for back pain and problems, anxiety disorders, chronic obstructive pulmonary disease (COPD), depressive disorders, osteoarthritis, asthma and type 2 diabetes.

Leading burden of disease conditions by lifespan are shown in Table 10.

Table 10: Five leading causes of total disease burden by sex and age in Australia, 2023

Age group	Males	Females
Under 5 years	1. Infant and congenital conditions 2. Birth trauma / asphyxia 3. Cardiovascular defects 4. Sudden infant death syndrome 5. Asthma	1. Infant and congenital conditions 2. Birth trauma / asphyxia 3. Cardiovascular defects 4. Sudden infant death syndrome 5. Asthma
5-14 years	1. Autism spectrum disorder 2. Asthma 3. Anxiety disorders 4. Conduct disorder 5. Depressive disorder	1. Anxiety disorders 2. Depressive disorders 3. Eating disorders 4. Bipolar affective disorder 5. Asthma
15-24 years	1. Suicide/ self-inflicted injuries 2. Anxiety disorders 3. Depressive disorders 4. Autism spectrum disorders 5. Asthma	1. Anxiety disorders 2. Depressive disorders 3. Eating disorders 4. Bipolar affective disorder 5. Asthma
25-44 years	1. Suicide/ self-inflicted injuries 2. Backpain and problems 3. Anxiety disorders 4. Depressive disorders 5. Poisoning	1. Anxiety disorders 2. Backpain and problems 3. Depressive disorders 4. Asthma 5. Eating disorders
45-64 years	1. Coronary heart disease 2. Backpain and problems 3. Suicide/ self-inflicted injuries 4. Lung cancer 5. Chronic liver disease	1. Backpain and problems 2. Osteoporosis 3. Breast cancer 4. Anxiety disorders 5. Rheumatoid arthritis
65-84 years	1. Coronary heart disease 2. COPD 3. Dementia 4. Lung cancer 5. Type 2 diabetes	1. Dementia 2. COPD 3. Coronary heart disease 4. Osteoporosis 5. Lung cancer
85+ years	1. Dementia 2. Coronary heart disease 3. COPD 4. Stroke 5. Prostate cancer	1. Dementia 2. Coronary heart disease 3. COPD 4. Stroke 5. Falls

Health conditions

Living with long-term health conditions

Long-term or chronic conditions are an ongoing cause of substantial ill health, disability and premature death and are generally characterised by their long-lasting and had persistent effects.[44] CCQ has significantly higher self-reported prevalence of long-term health conditions compared with Australia for all persons including children and young people (Figure 11).

Some LGAs have lower rates such as Banana, Central Highlands and Noosa, while others higher rates such as Woorabinda, Rockhampton, Bundaberg and Fraser Coast. For Aboriginal persons, overall rates are lower for Central Capricorn Indigenous Area, and higher for Nanango-Kilkivan, Cooloola-Gympie, Gladstone, Fraser Coast and Bundaberg.

Table 11: Self-reported prevalence (ASR per 100) of long-term conditions, by number of conditions and place of residence ^[28,29]

LGA (Indigenous Area)	All children and young people (0-14 years), 2021			All adults (15+ years), 2021			All Aboriginal people, 2018-19		
	One long-term health condition	Two long-term health conditions	One or more long-term health conditions	One long-term health condition	Two long-term health conditions	Three or more long-term health conditions	One long-term health condition	Two long-term health conditions	Three or more long-term health conditions
Banana	7.2	0.3	7.6	19.4	6.6	3.2	19.0	6.5	3.0
Bundaberg	10.3	1.0	11.4	23.0	8.8	5.3	21.9	7.7	5.4
Central Highlands (Central Capricorn)	6.8	0.4	7.3	19.2	6.7	3.3	17.5	5.2	3.2
Fraser Coast	10.8	1.0	11.9	22.9	9.1	5.6	21.8	8.2	6.3
Gladstone	8.4	0.5	9.0	21.3	7.7	4.4	19.9	7.9	3.8
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	9.8	0.9	10.8	22.5	8.3	5.1	22.0; 17.3	8.0; 8.0	5.7; 5.7
Livingstone (Rockhampton-Yeppoon)	8.9	0.3	9.2	20.4	7.4	3.8	19.6	6.4	4.5
Noosa	6.8	0.4	7.2	20.3	5.8	2.8	23.1	7.4	2.6
North Burnett	7.4	0.2	7.7	20.3	8.0	4.5	22.8	9.0	4.4
Rockhampton (Rockhampton-Yeppoon)	10.4	0.9	11.3	23.0	9.0	5.7	19.6	6.4	4.5
Sunshine Coast (Maroochy; Caloundra)	8.3	0.6	8.9	21.7	7.1	3.5	20.5; 21.6	6.7; 7.6	3.7; 4.2
Woorabinda (Central Capricorn)	4.7	0.0	5.5	28.4	9.8	10.3	17.5	5.2	3.2
CCQ	**8.9**	**0.7**	**9.6**	**21.9**	**7.7**	**4.3**	**20.7**	**7.2**	**4.6**
QLD	**8.4**	**0.6**	**9.0**	**21.8**	**7.5**	**4.1**	**20.0**	**6.6**	**4.0**
Australia	**8.1**	**0.5**	**8.7**	**21.2**	**7.1**	**3.7**	**20.6**	**6.7**	**4.0**

^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

This section reports preventable chronic diseases in disease grouping in order of total burden.

Cancer

Cancer is a large range of diseases in which some of the body's cells become defective, begin to multiply out of control, can invade and damage the area around them, and can also spread to other parts of the body to cause further damage.[45] The most diagnosed cancers in Australian males are prostate cancer, melanoma of the skin, colorectal cancer and lung cancer. The most diagnosed cancers in females are breast, colorectal, melanoma of the skin and lung. Age-standardised rates for all cancers have remained similar over the last 20 years. However, with an ageing population, the number of cases of cancer are expected to increase by 22% over the next 10 years, at a higher rate than the ageing population of 15%. Nationwide, cancer survival rates have increased, and cancer mortality rates continue to drop.

The overall prevalence of cancer and incidence rates in CCQ are significantly higher than Australia and across many LGAs in the region except for breast cancer (Table 12 and Table 13). Premature death rates for cancer are also higher in CCQ and in the same LGAs, except for the Sunshine Coast where it is lower. Rockhampton was the only LGA with rates of premature mortality caused by colorectal cancer that were significantly higher than the Australian average. Similarly, Gladstone rates of premature mortality caused by breast cancer in females was also significantly higher than the national average. However, the majority of LGAs and the CCQ region overall had significantly higher rates of lung cancer compared to the national average (Table 12).

Cancer screening programs can reduce illness and death from certain cancers by providing early detection, intervention and treatment.[46] Programs involve testing for signs of cancer or conditions before a person has symptoms. In Australia, national population-based screening programs exist for breast, cervical and bowel cancers.

Cancer screening rates in CCQ are lower than national and state benchmarks for Woorabinda, Central Highlands, Gladstone and Banana. Breast screening rates are similar or better than state and national benchmarks. Cervical screening rates are lower for all LGAs except Gladstone, Noosa, Sunshine Coast and Woorabinda.

Skin cancer is the most diagnosed cancer in Queensland. For melanoma and other skin cancers, exposure to UV radiation is a well-established risk factor. Sunburn during childhood, frequent sunburn and sunburn that blisters the skin all increase a person's susceptibility to future UV-related carcinogenesis. Sun-safe behaviours include wearing a broad brimmed hat, clothing that protects against the sun (long in sleeves or long pants), wrap-around sunglasses, seeking shade and applying sunscreen with SPF 30 or higher.

About 1 in 2 Queensland adults report being sunburnt in the past 12 months. Just over 1 in 2 Queensland adults practiced at least three of the five sun-safe behaviours most or all the time they spent in the sun during summer. Adults who met this benchmark were more likely to be female, older and live in regional and remote areas. There was no change in the proportion of adults getting sunburnt over the last decade. Just under 1 in 2 Queensland children practiced at least three of the five sun-safe behaviours most or all the time they spent in the sun during summer. Younger children were significantly more likely to meet this benchmark.

Sun burn rates in CCQ over the past 12 months are similar to Queensland overall, except for Central Highlands and Rockhampton where they are higher. Given skin cancer being the most commonly diagnosed cancer in Queensland, sun safety continues to be a priority (Table 15).

Table 12: Cancer indicators

LGA	Premature death for cancer (average annual ASR per 100,000) for all persons aged 0 to 74 years (2017-21)^[28]				Screening rates[28]			No sunburn in the past 12 months (%)[32]		Sun safe behaviours (%)[32]
	Type of cancer			All cancer	Bowel % all persons participating who were invited to participate (2020 and 2021)	Breast % females 50-74 years (2019 and 2020)	Cervical % females 25-74 years (2018, 19, 20)	Persons aged 18+ years (2019-20)	Children aged 5-17 years (2021-22)	Persons aged 18+ years (2019-20)
	Colorectal	Lung	Breast (females)							
Banana	10.6	22.9	-	90.0	36.6	59.8	45.7	49.4	-	21.1
Bundaberg	12.0	26.2	11.9	116.3	41.5	54.4	44.0	48.3	-	20.5
Central Highlands	10.4	32.1	16.0	99.1	32.1	53.8	44.8	36.5	-	24.2
Fraser Coast	11.1	25.0	18.7	112.6	43.2	50.2	41.0	57.0	-	25.0
Gladstone	10.5	26.0	23.5	108.5	33.6	54.1	52.8	43.5	-	26.7
Gympie	10.9	26.0	13.7	114.0	40.2	50.7	44.2	46.8	-	19.4
Livingstone	8.4	32.3	15.7	101.3	41.2	58.9	47.0	43.4	-	25.4
Noosa	8.4	15.1	13.5	86.1	43.4	49.4	51.8	52.8	-	22.3
North Burnett	13.7	33.3	-	110.6	38.9	57.1	41.4	51.5	-	24.5
Rockhampton	16.2	31.0	12.3	132.0	36.0	58.1	44.0	41.0	-	25.8
Sunshine Coast	9.5	17.4	15.9	89.6	42.3	52.5	50.7	46.2	-	20.3
Woorabinda	-	-	0.0	346.8	9.8	30.8	51.6	-	-	-
CCQ	***10.7***	***22.7***	***15.5***	***103.0***	***40.8***	***53.0***	***46.3***	***47.4***	***47.9***	***22.3***
Queensland	***10.4***	***21.6***	***14.9***	***100.8***	***37.5***	***52.3***	***47.2***	***47.5***	***54.3***	***20.4***
AUSTRALIA	***9.9***	***19.3***	***14.9***	***96.7***	***40.9***	***49.9***	***47.5***	***-***	***-***	***-***

- data not releasable; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status). Substantial numerical differences are shown in grey.

Table 13: Cancer incidence average ASR per 100,000 (2014-18)^[28]

LGA	Prostate, males	Melanoma, all persons	Colorectal, all persons	Breast, females	Lung, all persons	All cancers, all persons
Banana	179.5	81.5	67.0	132.1	46.7	590.3
Bundaberg	169.9	86.9	70.7	136.0	62.3	626.6
Central Highlands	118.4	68.1	70.5	132.5	67.0	559.6
Fraser Coast	177.1	96.1	74.8	145.3	64.0	667.6
Gladstone	164.9	78.3	76.1	135.7	61.0	612.1
Gympie	155.3	78.3	68.1	142.3	63.8	618.0
Livingstone	178.1	78.6	70.5	115.4	62.0	594.7
Noosa	198.4	80.9	58.3	154.1	39.1	579.2
North Burnett	164.4	83.6	54.2	90.1	61.4	548.6
Rockhampton	183.6	73.4	72.3	133.0	66.6	635.4
Sunshine Coast	193.0	92.2	64.3	143.9	50.2	612.9
Woorabinda	-	-	-	-	-	675.4
CCQ	***180.4***	***86.7***	***68.0***	***140.2***	***56.6***	***619.3***
Queensland	***175.9***	***82.9***	***67.6***	***143.8***	***55.8***	***614.0***
AUSTRALIA	***166.8***	***59.4***	***63.6***	***144.0***	***51.0***	***567.9***

- data not releasable; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

Participation in BreastScreen Australia have remained relatively consistent over time, with the exception of 2019-2020 due to the COVID-19 pandemic impacting participation (Table 14).

Table 14: Participation in BreastScreen Australia, by SA3, women aged 50-74 (2019-20)[47]

SA3	Percentage			
	2016-17	2017-18	2018-19	2019-20*
Biloela	59.6	61.2	60.2	57.5
Buderim	55.4	55.5	55.0	52.4
Bundaberg	59.8	60.1	60.4	55.0
Burnett	54.9	54.0	54.5	47.2
Caloundra	58.5	58.4	57.2	54.4
Central Highlands	54.2	54.4	55.3	53.1
Gladstone	57.3	57.4	55.5	54.1
Gympie - Cooloola	54.1	53.8	54.2	50.9
Hervey Bay	56.6	55.9	57.6	52.0
Maroochy	52.5	52.6	52.7	50.2
Maryborough	55.6	56.0	56.4	47.6
Nambour	58.0	58.7	58.1	55.1
Noosa	53.0	52.9	52.3	49.1
Noosa Hinterland	-	-	-	49.9
Rockhampton	61.3	61.7	63.9	58.4
Sunshine Coast Hinterland	51.2	52.3	53.2	51.0
AUSTRALIA	***55.0***	***54.8***	***54.8***	***49.9***

*COVID-19 pandemic impacted 2019–2020 participation.

Data on the proportion of children and young people getting sunburnt is incomplete, with most LGAs not having data that was releasable (Table 15). From the limited data we do have, it indicates that sunburn is higher in Central Queensland and Rockhampton compared with Queensland.

Table 15: Proportion of children and young people getting sunburnt (past 12 months), by HHS and LGA[32]

LGA	Children aged 5-17 years (2021-22)	Young people aged 18-29 years (2019-20)
Banana	-	**
Bundaberg	-	**
Central Highlands	-	**83.7%**
Fraser Coast	-	**
Gladstone	-	64.2%
Gympie	-	**
Livingstone	-	**
Noosa	-	**
North Burnett	-	**
Rockhampton	-	**80.7%**
Sunshine Coast	-	**
Woorabinda	-	**
Central Queensland HHS	**52.0%**	**-**
Sunshine Coast HHS	**52.2%**	**-**
Wide Bay HHS	**52.0%**	**-**
CCQ Region	**52.1%**	**74.6%**

**Not releasable

Mental health and substance use disorders

Some of the data in this report may cause distress. Services you can contact are detailed below:
24 hours, 7 days
Lifeline: 13 11 14
Suicide Call Back Service: 1300 659 467
Beyond Blue: 1300 224 636
MensLine Australia: 1300 789 978
Kids Helpline: 1800 551 800
13YARN: 13 92 76

Mental health is a key component of overall health and wellbeing.[48] Mental illness or disorder refers to a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour, usually associated with distress or impairment in important areas of functioning.[49] One in five Australians experienced a mental health disorder in the previous 12 months. It is estimated that over 2 in 5 Australians aged 16-85 years will experience a mental disorder at some time in their life.

The most common mental illnesses in Australia are anxiety disorders, affective disorders and substance use disorders. The prevalence of mental illness nationally has showed slight increases over the past 15 years, in females. There has been an increase in long-term mental illness in young female adults. In 2021, double the proportion of females aged 20–29 reported that they had been told by a doctor or nurse that they have a mental illness compared to males the same age (16% and 8%, respectively). Mental illness is higher in LGBTIQA+, people with a disability and people not in education, employment or training.

There are various risk factors of mental illness. These include loss (due to death, relationship, job or status), poor impulse control or compulsive, feelings of hopeless, helplessness, powerless or desperation, history of personal or family abuse, bullying or interpersonal violence, confusion or conflict about sexual orientation/identity, alcohol or substance use problems, extreme perfectionism, changes in family structure (e.g. death, divorce, remarriage, relocation), financial difficulties, stigma with help seeking, lack access to support services, and incarceration. Protective factors include having friends and support from significant others, hope and goals for future, feeling connected, resilience and problem-solving skills, family cohesion, safe and stable environment and opportunities to contribute and participate in broader community.

Support services for people with mental illness care provided by both the public and private sectors across a range of settings and services, including:

- specialised hospital services – public and private
- specialised residential mental health services
- specialised community mental health care services
- primary care services.

Mental health conditions and severity

One in seven young people in Australia experienced a mental health disorder in the previous 12 months. Attention deficit hyperactivity disorder, anxiety disorders, major depressive disorder and conduct disorder are the most common mental illness among children and adolescents. About 30% of adolescents with a mental illness experienced two or more mental illnesses at some time in the past 12 months. Male children and adolescents were more likely than females to have experienced mental illness in the previous 12 months, and the prevalence of mental illness was slightly higher for older females (aged 12–17) than younger (aged 4–11). Around 7% of Australian adolescents aged 15–17 had a long-term mental health condition which requires treatment, or a mental illness which requires help or supervision. This proportion has increased from 2% in 2003. In addition, 19% of Australians in this age group were estimated to be diagnosed with depression, anxiety or any other mental illness, an increase from 6% in 2009.[48]

Modelled estimates mental health disorders for PHNs and state and territories were produced based on data from the 2020-2022 National Study of Mental Health and Wellbeing. The estimates provide an indication of the likely number and age/sex distribution of people with particular mental health disorders in the CCQ region. Used in conjunction with an understanding of current local context, the estimates can support service planning.

Across the board, people in the CCQ region experience greater prevalence of all mental health and substance-use disorders across most age groups compared with Queensland averages (Figure 19 to Figure 23). This was also the case for people with comorbidity of any 12-month mental disorder and a physical condition. It was not reported whether these differences were statistically significant. Despite this, the data indicates almost half (49.9%) of all young females (16-24 years) and over a third (34.4%) of females aged 25-34 years in the CCQ region have experienced a mental disorder over the past 12 months. Severity of mental disorders is also high in younger females (16-24 years) with 15.1% experiencing a severe mental disorder in the last 12 months compared with 14.7% for Queensland (Table 16 to Table 18).

Figure 19: Modelled estimates of people with any 12-month disorder (%) based on the National Study of Mental Health and Wellbeing 2020-2022[52]

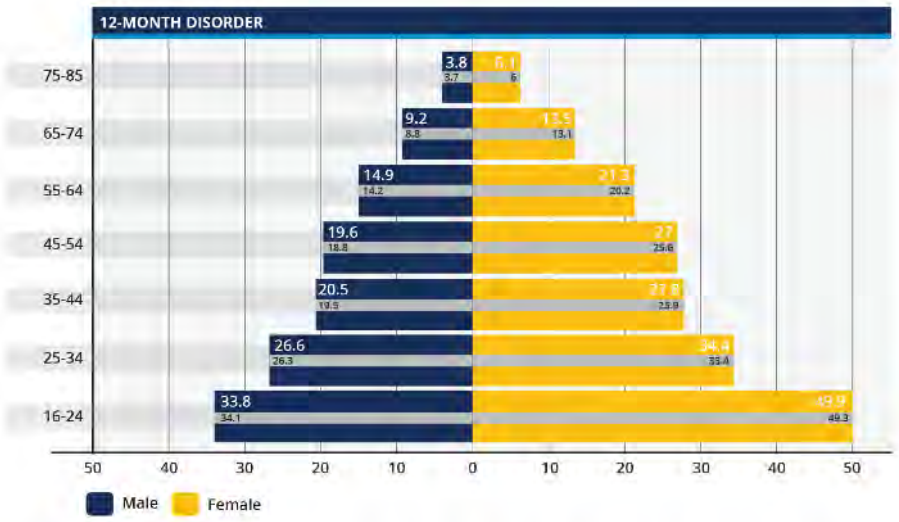


Figure 20: Modelled estimates of people with 12-month anxiety disorders (%) based on the National Study of Mental Health and Wellbeing 2020-2022[50]

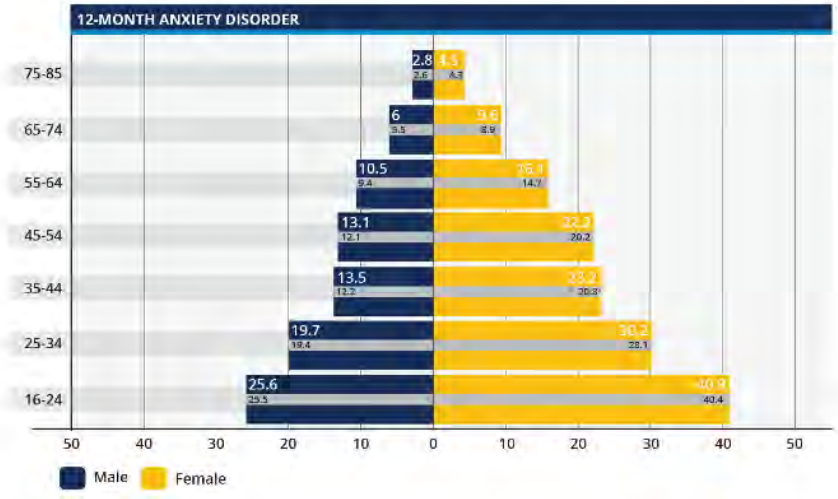


Figure 21: Modelled estimates of people with 12-month affective disorders (%) based on the National Study of Mental Health and Wellbeing 2020-2022[50]

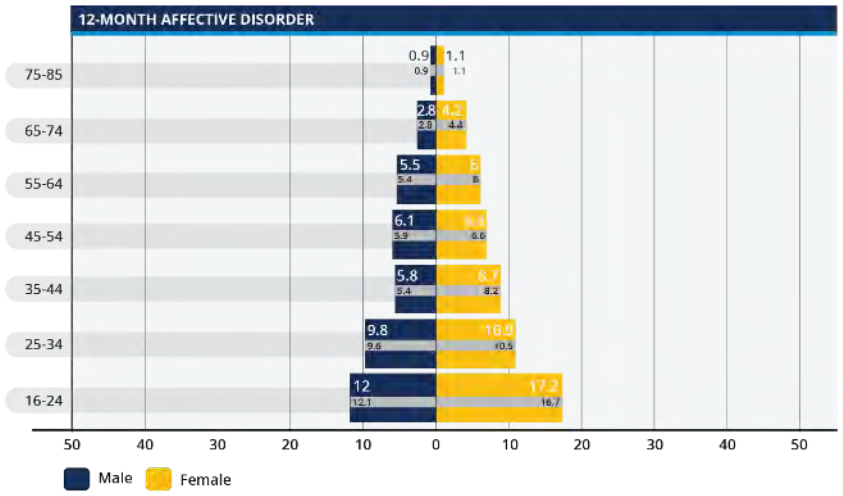


Figure 22: Modelled estimates of people with 12-month substance abuse disorders (%) based on the National Study of Mental Health and Wellbeing 2020-2022[50]

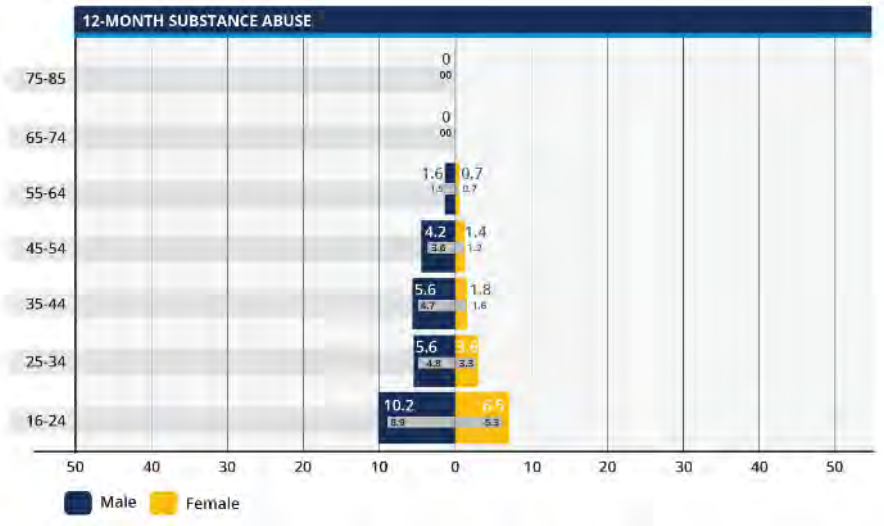
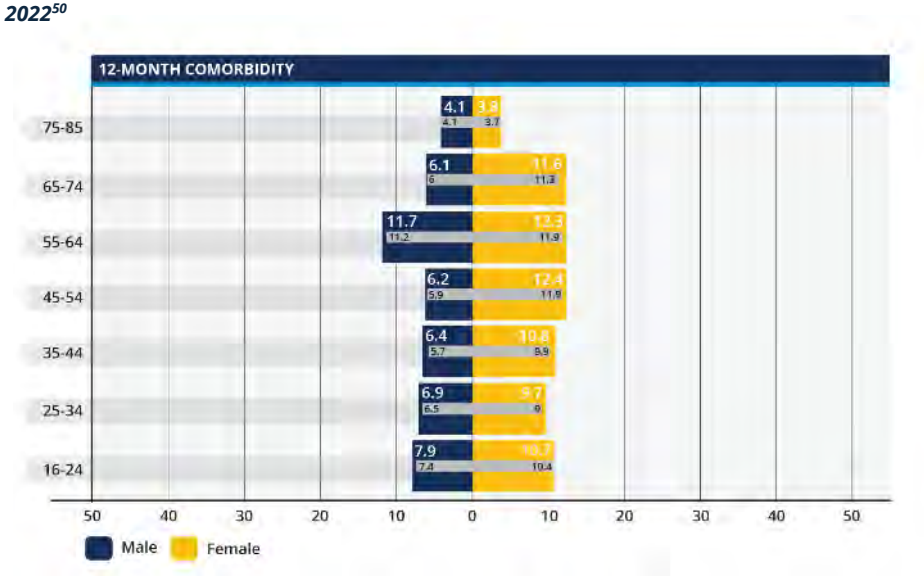


Figure 23: Modelled estimates of people with comorbidity of any 12-month mental disorder and a physical condition (%) based on the National Study of Mental Health and Wellbeing 2020-2022[50]



Definitions

Anxiety disorders differ from normal feelings of nervousness or anxiousness and involve excessive fear or anxiety. Anxiety disorders are the most common of mental disorders. There are different types of anxiety disorders, including Generalised anxiety disorder, Specific phobia, Panic disorder, Agoraphobia and Social anxiety disorder.

Affective disorders refer to conditions that disturb a person's mood to the point where it becomes difficult to function in relationships or at work. While people's experiences with affective disorders vary, they can cause a person to withdraw from social contact, lose interest in the important things in their life and make enjoyable activities seem like too much effort.

Lifetime mental disorders refer to the number of people who met the diagnostic criteria for having a mental disorder at some time in their life. This does not imply that a person has had a mental disorder throughout their entire life.

12-month mental disorders refers to the number of people who met the diagnostic criteria for having a mental disorder at some time in their life and had sufficient symptoms of that disorder in the 12 months prior to when they completed the survey.[50]

Table 16: Any 12-month mental disorder by mild severity[50]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	**9.3%**	**9.8%**	**9.6%**	**8.1%**	**8.9%**	**8.5%**	**6.3%**	**7.5%**	**6.9%**	**6.9%**	**8.3%**	**7.6%**	**4.8%**	**5.6%**	**5.2%**	**3.7%**	**4.3%**	**4.0%**
Queensland	9.0%	9.4%	9.2%	7.6%	8.2%	7.9%	5.9%	7.0%	6.5%	6.5%	7.8%	7.2%	4.7%	5.4%	5.0%	3.6%	4.1%	3.9%

Table 17: Any 12-month mental disorder by moderate severity[50]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	**15.9%**	21.1%	18.4%	11.2%	**13.9%**	**12.6%**	**7.7%**	**11.0%**	**9.4%**	**6.5%**	**9.8%**	**8.2%**	**4.7%**	**7.5%**	**6.1%**	**2.1%**	3.7%	2.9%
Queensland	15.6%	21.4%	18.5%	11.3%	13.5%	12.4%	7.6%	10.2%	8.9%	6.4%	9.2%	7.9%	4.5%	7.1%	5.9%	2.0%	3.7%	2.9%

Table 18: Any 12-month mental disorder by severe severity[50]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	8.3%	**15.1%**	11.6%	5.7%	**10.3%**	8.1%	**4.1%**	**7.0%**	**5.6%**	**4.2%**	6.1%	**5.2%**	3.3%	**4.7%**	**4.1%**	1.2%	1.7%	1.5%
Queensland	9.0%	14.7%	11.8%	6.1%	10.0%	8.1%	4.0%	6.6%	5.4%	4.1%	6.1%	5.1%	3.3%	4.4%	4.0%	1.2%	1.8%	1.5%

Long-term mental health conditions

The prevalence of long-term mental health conditions in CCQ were higher than Australia, as were many LGAs across the CCQ region (Table 19). For Aboriginal people, rates were higher in Bundaberg, Fraser Coast, Cooloola-Gympie, Caloundra, and Maroochy Indigenous areas. Central Capricorn and Rockhampton-Yeppoon were significantly better than national rates.

Table 19: Self-reported prevalence (ASR per 100) of long-term condition (mental health condition including depression and anxiety) among people aged 0 to 14 and 15 years and over, by males and females, by LGA (Aboriginal people by Indigenous areas) (2021)[28,29]

LGA (Indigenous areas)	People aged 0 to 14 years	People aged 15 years and over	Estimated males with mental and behavioural problems, 2017-18#	Estimated females with mental and behavioural problems, 2017-18#	Aboriginal people aged 0 to 14 years	Aboriginal people aged 15 years and over
Banana	1.4	8.0	18.8	23.1	0.0	13.2
Bundaberg	3.5	13.6	23.5	26.1	4.5	22.7
Central Highlands (Central Capricorn)	1.9	8.3	18.4	23.5	2.4	10.5
Fraser Coast	4.2	15.0	23.0	25.9	6.1	24.3
Gladstone	2.5	11.4	21.9	26.5	4.1	19.6
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	4.3	13.9	24.2	27.8	5.5; 4.5	26.4; 23.3
Livingstone	2.4	9.9	20.5	24.2	-	-
Noosa	2.1	9.3	18.4	23.0	6.0	17.0
North Burnett	2.1	10.5	22.8	25.5	3.7	19.1
Rockhampton (Rockhampton - Yeppoon)	3.2	13.0	24.6	28.4	3.6	16.0
Sunshine Coast (Caloundra; Maroochy)	2.7	11.0	19.0	23.4	5.3; 4.6	20.3; 20.1
Woorabinda (Central Capricorn)	0.0	5.4	18.4	..	2.4	10.5
CCQ	***2.9***	***11.9***	***21.1***	***25.0***	***-***	***-***
Queensland	***2.7***	***11.2***	***20.5***	***24.8***	***4.0***	***16.9***
AUSTRALIA	***2.1***	***10.3***	***17.8***	***22.3***	***4.0***	***17.7***

** Significantly different from Australia (Red highlighting = worse; Green highlighting = better) # Significance not reported

9% of persons in Australia reported that they have been told by a doctor of nurse that they have a mental illness (including depression or anxiety).[48] Rates are slightly higher in Queensland and the CCQ region at 10% (Table 20). Wide Bay SA4 has the highest rate in Queensland (12%).

Table 20: Prevalence of Australians who reported ever having ever been told by a doctor or nurse that they have a mental health condition (including depression or anxiety) by sex (2021)[48]

Region	Male		Female		Total	
	Number	%	Number	%	Number	%
Central Queensland SA4	8,355	7%	12,987	12%	21,345	9%
Sunshine Coast SA4	14,509	8%	22,195	11%	36,705	9%
Wide Bay SA4	**15,898**	**10%**	**21,217**	**14%**	**37,113**	**12%**
CCQ	**36,924**	**8%**	**54,065**	**12%**	**90,986**	**10%**
QLD	**-**	**-**	**-**	**-**	**496,662**	**10%**

Disordered eating

Disordered eating is a disturbed and unhealthy eating pattern that can include restrictive dieting, compulsive eating or skipping meals.

Disordered eating can include behaviours which reflect many but not all of the symptoms of feeding and eating disorders such as Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding and Eating Disorders (OSFED) or Avoidant/Restrictive Food Intake Disorder (ARFID).

Disordered eating behaviours, and in particular dieting are the most common indicators of the development of an eating disorder. Eating disorders are severe and life-threatening mental illnesses. An eating disorder is not a lifestyle choice.

Disordered eating can have a destructive impact upon a person's life and has been linked to a reduced ability to cope with stressful situations. There is also increased incidence of suicidal thoughts and behaviours in adolescents with disordered eating.

Examples of disordered eating include:

- Fasting or chronic restrained eating
- Skipping meals
- Binge eating
- Self-induced vomiting
- Restrictive dieting
- Unbalanced eating (e.g. restricting a major food group such as 'fatty' foods or carbohydrates)
- Laxative, diuretic, enema misuse
- Chewing and Spitting
- Steroid and creatine use – supplements designed to enhance athletic performance and alter physical appearance
- Using diet pills.

Eating disorders are associated with the highest mortality rate of any psychiatric disorder, with mortality risks representing substantial reductions in life expectancy of 10-20 years[51] and a mortality rate estimated at between one and a half to twelve times greater than the general population.[52] The most significant mortality rates are associated with Anorexia Nervosa where one in five deaths are attributable to suicide;[53] however, in addition to the impact of lives cut short, all eating disorders are associated with numerous physical and mental health complications and comorbidities.[54-57]

Prevalence estimates of eating disorders vary in the literature. Among Australian females, the 3-month point-prevalence is estimated to be roughly 16%.[58] Eating disorders are present among all sociodemographic groups with some data suggesting a higher occurrence of eating disorder diagnoses for LGBTQI+ people compared with their heterosexual peers and the general population[59,60] and the risk of developing an eating disorder appears to be 3-4 times higher for transgender and non-binary people than for the general population.[61]

Lifetime prevalence of eating disorders detailed in a report prepared by Deloitte Access Economics for the National Eating Disorders Collaboration (NEDC) estimated the prevalence rate for eating disorders in the CCQ region to be 3.65%, representing 32,100 distinct individuals.[62] This rate is comparable to that of the national average cited in the same study (3.97%) and accordingly, it would be reasonable to expect

similar rates of presentation to healthcare facilities and services in the region as for the rest of the nation.

In addition to the human cost, from an economic perspective, life-years lost due to eating disorder-related disability and death in Australia is estimated at $84 billion, and annual lost earnings estimates sit at or around $1.646 billion, with the highest lost-earnings peak seen in the age group 35-44 years.[B]

Perinatal mental health

It is difficult to know exactly how many parents experience mental health disorders like anxiety and depression during the perinatal period (a time usually defined as pregnancy through the first 12 months of a baby's life).[63]

Several factors make it difficult to estimate how many families are affected by perinatal mental health issues, including variations in data collection methods during research, and different ways of defining or diagnosing mental health issues. Despite this, there is agreement that mental health disorders in the perinatal period are common, are important public health issues, and can impact the health and wellbeing of the entire family.[64]

- Research undertaken in Australia and internationally suggests that around 15-22% of women experience **depression** during pregnancy and/or following the birth of their baby.[65,66]
- Current research about **perinatal anxiety** suggests 1 in 5 women report anxiety symptoms during pregnancy, and between 4-20% of women experience symptoms of an anxiety disorder after giving birth.[67]
- Between 4.2-9.3% of women will experience **both anxiety and depression**.[68]
- Therefore, up to1 in every 5 women may **experience symptoms of anxiety, depression, or both** during pregnancy and/or following birth.
- A small number of women will experience a rare but serious perinatal mental health disorder called **postnatal psychosis**. Research suggests that 1-2 women per 1000 women giving birth will experience postnatal psychosis.[69]

Women may also experience other less common perinatal mental health disorders, such as Post Traumatic Stress Disorder (PTSD), mood disorders including bipolar and schizophrenic disorders.[70-72]

The perinatal period is associated with an increased risk of both mental health relapse, and newly diagnosed mental health disorders. Research suggests many women diagnosed with mental health disorders become parents, and it is of utmost importance that their ongoing mental health care needs are identified and treated.[73]

Though **there is far less research available on paternal perinatal mental health**, the last decade of research suggests up to 10%, or 1 in 10 expecting or new fathers will experience depression and/or anxiety during the perinatal period.[74-77]

A recent review estimates that the prevalence of anxiety in men in the perinatal period is 3.4%-25%. Similar to research findings about maternal mental health, often men experience both anxiety and depression during the perinatal period.[75]

Having a partner with a mental health disorder is a risk factor for paternal perinatal mental ill-health - and untreated paternal mental health issues are associated with adverse outcomes for maternal mental health during the perinatal period.[74]

Families from minority communities face additional risks for perinatal anxiety and depression, and barriers to accessing safe, appropriate services. Populations more at risk include LGBTIQA+ parented families, Aboriginal and Torres Strait Islander families, and culturally and linguistically diverse families.[78-80]

Experiences of discrimination may increase isolation and discourage help-seeking at a time of particular risk for these vulnerable families.

[B] A special thank you to Juliette McAleer for providing the summary data and narrative for eating disorders. Juliette is a valued member of the CCQ Consumer Advisory Council and HNA Steering Committee.

Mental illness in older people accessing aged care services

Analysis by the AIHW demonstrated that many people aged 65 years and over, and many Aboriginal and Torres Strait Islander people aged 50 years and over, accessing Australian aged care services in 2017–2022 were recorded with a mental health condition at the time of their eligibility and/or funding assessment. On average, 23.1% of all people aged 65 years and over that started receiving a home care package and 57.7% of all people aged 65 years and over entering permanent residential aged care were recorded with a mental health condition, respectively.[81]

This proportion is higher than the reported prevalence of mental health conditions in the general population of older adults in the 2022 National Study of Mental Health and Wellbeing (7.9% of men and 11.1% of women aged 65 to 85 years). This may reflect a decline in mental health as care needs increase, and/or may in part be attributable to differences in data collection.[81]

In addition, data from the National Death Index indicates that **the average yearly age-standardised suicide rate among people aged 65 years and over using home care (22.5/100,000 users) is higher than the average yearly rate in permanent residential aged care (13.0/100,000 users) and in the general population of people in Australia aged 65 years and over (12.9/100,000 people).** This may reflect that receiving residential aged care is protective against suicide risk among those requiring care, limits access to means, and/or that the functional impairments that necessitate care limit the ability to engage in lethal self-harm.[81]

Risk factors

There is an association between high levels of psychological distress and serious mental health disorders. As a result, instruments such as K10 can be used in representative sample surveys as a broad indicator of the level of these disorders in the Australian population.[82]

In 2020-21, 15% of Australians experienced high or very high levels of psychological distress. More women experienced high or very high levels of psychological distress than men (19% compared with 12%). Younger Australians were more likely to experience high or very high levels of psychological distress than older Australians. One in five (20%) Australians aged 16-34 years experienced high or very high levels of psychological distress, more than twice the rate of those aged 65-85 years (9%).[83]

Unfortunately, psychological distress has not been reported at local levels since the *Australia's Health 2018* collection, so our understanding at the local level is potentially outdated (pre-COVID-19). In 2018-19, the CCQ region and half of our LGAs had higher rates of adults with high or very high psychological distress compared with Queensland (Table 21). The rates were more profound for Aboriginal people with nine of the 12 Indigenous areas with rates higher than Queensland.

Table 21: Estimated persons aged 18 years and over with high or very high psychological distress, based on the Kessler 10 Scale (K10) (2017-18) and Aboriginal people aged 18 years and over by Indigenous Area (2018-19)[28,29]

LGA	Males	Females	Persons	Aboriginal people (K5)[#]	Indigenous areas
	ASR per 100				
Banana - part b	9.0	12.2	10.6	29.3	Banana*
Bundaberg	**12.0**	**14.8**	**13.4**	**36.3**	Bundaberg
Central Highlands (Qld)	10.2	13.5	11.7	29.9	Central Capricorn
Fraser Coast	**13.8**	**17.0**	**15.5**	**41.5**	Fraser Coast
Gladstone	**11.9**	**15.4**	**13.6**	**36.4**	Gladstone
Gympie	**13.9**	**17.6**	**15.8**	**32.8** **32.8**	Cooloola-Gympie* Nanango-Kilkivan*
Livingstone	11.4	14.4	12.9		-
Noosa	10.9	14.1	12.5	**35.0**	Noosa*
North Burnett	**12.9**	**15.2**	**14.0**	29.3	North Burnett*
Rockhampton	**12.3**	**14.8**	**13.6**	**37.8**	Rockhampton - Yeppoon
Sunshine Coast	11.3	14.5	12.9	**33.9** **32.6**	Caloundra Maroochy
Woorabinda	9.0	12.2	10.6	-	-
CCQ	**11.9**	**15.0**	**13.5**	**-**	**-**
Queensland	**11.4**	**14.5**	**13.0**	**30.7**	**-**

* Sample size too small; derived using pooled areas [#] Based on the Kessler 5 Scale Substantial numerical differences are shown in grey.

Use of mental health services

Use of mental health services were lower in CCQ in all age groups (except for 35-44 years) for both mental health consultations and services via digital technologies (Table 23 and Table 24). Statistical significance was not reported, so it is unclear whether these differences are meaningful. The ABS also did not specify the type of mental health consultation, so it is unclear whether this is general practice, psychologist, psychiatrist or another consultation type.

Care should be taken when interpreting access data to assess prevalence of a condition. High access could indicate there is a high prevalence of mental illness or low access could mean that there are no or insufficient services to access. Given the high prevalence estimates of mental health disorders in the region, we would expect to see a higher service usage rate.

However, this is not the case. High hospital and ED presentations (shown below) in the Wide Bay and Central Queensland region may indicate a lack of mental health primary care in those regions. Further investigation to why is needed.

Hospital presentations

Table 22 highlights high hospital admission rates and emergency department presentations particularly in the Wide Bay regions of Bundaberg and Fraser Coast. This further demonstrates potential issues with access to mental health primary care services.

Table 22: Hospital admissions and ED presentations (public hospitals) by LGA (2020/21)[28]

LGA	Admissions for mental health related conditions, persons (2020/21) ASR per 100,000	Admissions for mood affective disorders, persons (2020/21) ASR per 100,000	Total ED presentations for mental and behavioural disorders (2020/21) ASR per 100,000	ED presentations for mental and behavioural disorders (2020/21) ASR per 100,000					
				0-14 years	15-24 years	25-44 years	45-64 years	65-74 years	75+ years
Banana	**1,406.3**	177.5	**376.7**	**	**	**424.6**	**402.7**	**	1,484.5
Bundaberg	**1,304.9**	172.4	**2,008.5**	**688.8**	**3,660.7**	**2,745.5**	**1,555.7**	**860.0**	**2,662.4**
Central Highlands	**899.6**	137.8	**230.7**	**	**382.4**	**333.5**	**229.4**	**	**
Fraser Coast	**1,642.6**	**279.0**	**3,073.9**	**1,110.0**	**5,317.4**	**4,184.6**	**2,622.5**	**1,507.1**	**3,388.2**
Gladstone	986.6	**144.7**	**2,448.8**	**900.2**	**4,570.0**	**3,703.4**	**1,796.2**	862.1	**2,511.4**
Gympie	**1,518.6**	**251.4**	**2,260.1**	**735.1**	**3,659.9**	**3,476.8**	**1,829.5**	**902.3**	**2,698.2**
Livingstone	**887.9**	140.6	**756.0**	**191.4**	**996.0**	**1,397.9**	**548.5**	**268.8**	913.4
Noosa	1,076.6	154.9	1,327.1	319.9	2,666.2	1,572.8	1,158.2	703.7	1,683.8
North Burnett	**1,515.9**	**402.1**	**823.6**	**	1,365.0	1,234.4	890.4	**	..
Rockhampton	1,012.1	**145.5**	**2,103.1**	**564.3**	**3,622.3**	**2,861.7**	**2,071.3**	796.1	**2,481.0**
Sunshine Coast	**1,283.5**	185.3	**1,592.9**	441.4	**2,894.3**	**2,343.7**	1,195.8	**782.8**	**1,917.3**
Woorabinda	823.8*	**	**	**	**	**	**	**	**
CCQ	***919.8***	***138.9***	***1,353.1***	***408.7***	***2,428.1***	***1,989.4***	***1,082.3***	***636.6***	***1,504.6***
Queensland	***1,147.4***	***190.6***	***1,307.9***	***371.5***	***2,406.0***	***1,860.3***	***1,108.1***	***647.4***	***1,256.8***
AUSTRALIA	***1,056.2***	***186.0***	***1,304.8***	***388.3***	***2,448.3***	***1,776.4***	***1,146.3***	***651.5***	***1,289.5***

*Data quality indicator: poor **Not releasable Significantly different from Australia (Red highlighting = worse; Green highlighting = better)

Table 23: Modelled estimates of people who had at least one consultation for mental health (2020-22)[50]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-74			75-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	15.8%	34.8%	25.1%	15.8%	31.6%	24.0%	14.7%	26.8%	21.0%	11.3%	21.8%	16.7%	11.0%	12.8%	12.0%	6.1%	8.1%	7.1%	3.3%	6.8%	5.1%
Queensland	16.9%	35.8%	26.2%	16.6%	31.7%	24.3%	14.8%	26.0%	20.6%	11.6%	21.8%	16.8%	11.5%	13.4%	12.5%	6.5%	8.8%	7.7%	3.5%	7.3%	5.5%

Table 24: Modelled estimates of people who accessed at least one service via digital technologies (2020-22)[50]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	5.7%	12.9%	9.2%	4.2%	8.9%	6.6%	4.3%	6.5%	5.4%	2.4%	4.0%	3.2%	2.1%	2.4%	2.3%	0.5%	1.0%	0.8%
Queensland	6.2%	13.2%	9.7%	4.6%	9.2%	6.9%	4.5%	6.6%	5.5%	2.6%	4.2%	3.4%	2.3%	2.5%	2.4%	0.6%	1.1%	0.9%

Mental health workforce

Although there is no universal definition of what a 'mental health worker' is, there is broad agreement that the workforce is divided into three inter-related sectors - specialist, generalist and lived experience.[84]

Specialist workers provide mental health services directly and may include professionals with tertiary training in a mental health-related field. Below, the specialist workforce is considered to include psychiatrists, mental health nurses, psychologists, mental health occupational therapists and accredited mental health social workers.

Generalist workers include other professionals who engage in mental health-related work or with people experiencing mental illness, but who may not have specialist training in mental health. Alternatively, generalist workers may include people in administrative or research roles that support the specialist workforce. A range of different professions and roles may be included under the broad category of generalist mental health workers. The availability of data varies considerably depending on the accreditation framework of each role. Examples include General Practitioners, Paramedics, Aboriginal and Torres Strait Islander health practitioners, social workers, Counsellors and psychotherapists, and support line volunteers.

Lived experience workers, also called peer workers, are people who have themselves experienced mental illness or cared for someone who has and can bring valuable insight into the caring experience. People with lived experience may also have specialist or generalist qualifications. Because of the broad scope of lived experience workers' engagement with the mental health care sector, there are little reliable data on the total number of lived experience workers in Australia.

Mental health workers may be employed in a wide variety of settings, including state-run health services, private or not-for-profit care providers, and/or private practice. Each state and territory have a mental health workforce plan, intended to guide and support the development of the mental health workforce to ensure it meets the needs of residents.[84]

The **availability of specialist mental health workers in the CCQ region is below Queensland and Australian rates** for psychiatrists, mental health nurses, psychologists, and mental health occupational therapists (Table 25). At a local level, **Central Queensland (SA4) and Wide Bay (SA4) also have access to a lower rate of accredited mental health social workers compared with Queensland and Australia**. The Sunshine Coast (SA4) is the exception with higher access to mental health nurses, psychologists, mental health occupational therapists, and accredited mental health social workers compared with the CCQ region overall, Queensland and Australia.

Table 25: Specialist mental health workers (rate per 100,000) in 2023[85]

Region	Psychiatrists	Mental health nurses	Psychologists	Mental health occupational therapists	Accredited mental health social workers
Central Queensland SA4	**9**	**68**	**72**	**5**	**8**
Sunshine Coast SA4	**13**	100	138	12	20
Wide Bay SA4	**4**	**59**	**51**	**2**	**7**
CCQ	**10**	**81**	**96**	**7**	13
Queensland	**16**	**91**	**115**	**10**	**11**
Australia	**16**	**96**	**125**	**10**	**11**

Mental health prescriptions

About 18% of the Australian population were dispensed a mental health-related prescription in 2022–23. The population rate of people receiving mental health-related prescriptions in 2022–23, was lowest for the youngest age groups and increased by age. A higher rate of females (219 per 1,000 population) were dispensed mental health-related prescriptions than males (148). A greater rate of people living in *Inner regional* areas were dispensed mental health-related medications (227 per 1,000 population), than people living in other remoteness areas.

Across all age groups, the CCQ region and each SA4 exceeded national patient and prescription rates for mental health prescriptions (Table 26 and Table 27).

The Wide Bay SA4 region had the highest rate in the country of mental health-related medications dispensed in 2022–23 (2,530 per 1,000 of the population). High prescription rates can indicate both high prevalence and/or mental illnesses not being managed effectively.[86]

Table 26: Mental health related prescriptions - Patient rate per 1,000 (2022-23)[86]

Region	0-17 years	18–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years +	Male	Female	Total
Central Queensland SA4	83	190	207	227	256	257	323	169	249	208
Sunshine Coast SA4	70	195	210	227	250	257	333	180	259	221
Wide Bay SA4	94	238	254	279	297	296	333	217	296	257
CCQ	***81***	***206***	***222***	***240***	***265***	***271***	***332***	***189***	***268***	***229***
Queensland	-	-	-	-	-	-	-	-	-	***202***
AUSTRALIA	-	***147***	***160***	***187***	***229***	***239***	-	***148***	***219***	***184***

Table 27: Mental health related prescriptions - Prescription rate per 1,000 population (2022-23)[86]

Region	0-17 years	18–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65 years +	Male	Female	Total
Central Queensland SA4	580	1,389	1,695	2,124	2,669	2,761	**3,414**	1,548	2,417	1,987
Sunshine Coast SA4	522	1,470	1,736	2,026	2,363	2,516	3,114	1,582	2,381	2,007
Wide Bay SA4	**704**	**1,717**	**2,167**	**2,830**	**3,203**	**3,207**	3,312	**2,074**	**2,939**	**2,530**
CCQ	***592***	***1,517***	***1,841***	***2,254***	***2,674***	***2,805***	***3,245***	***1,725***	***2,562***	***2,164***
Queensland	-	-	-	-	-	-	-	-	-	***1,914***
AUSTRALIA	-	***1,166***	***1,354***	***1,744***	***2,277***	***2,413***	-	***1,355***	***2,083***	***1,732***

Youth mental health

The recent National study of mental health and wellbeing in Australia (2020-22) showed a **50% increase in prevalence of diagnostic-level mental disorders in people aged 16-24 years since 2007, reaching an annual prevalence rate of 39% in 2020-22, which reached nearly 50% in young women.** Given the national prevalence figures and those highlighted above for young people in the CCQ region, and the recent release of the Lancet Psychiatry Commission on youth mental health, it is important to highlight the trends and societal changes impacting the mental health of young people.

Long before the COVID-19 pandemic, **substantial evidence indicated that young people were facing rising rates of mental ill health, including anxiety, depressive symptoms, psychological distress, self-harm, and suicide**, with increases beginning in the early 2010s. Concern is growing that a **series of megatrends** that have arisen over the past two decades are harming the mental health of children and young people in their transition to adulthood (emerging adulthood). Insufficient action on climate change, an unregulated and unsafe digital world and social media environment, and social exclusion as reflected by insecure employment, reduced access to affordable housing, and intergenerational inequality have combined to create a bleak present and future for young people in many countries.

Young people with depression are more likely to smoke or vape, and poor mental health has been associated with a substantially increased risk of lifetime adverse physical health outcomes such as coronary heart disease or stroke and disparities of decades of life expectancy. Poor mental health in adolescence increases the risk of poor educational attainment, and non-participation in post-secondary education, unemployment, low income when working, and being the recipient of welfare payments.[87]

Musculoskeletal

Musculoskeletal conditions affect the bones, muscles, joints, and connective tissues. Common types include various forms of arthritis (rheumatoid arthritis, osteoarthritis, juvenile arthritis and gout), back problems and osteoporosis.[88]

Around 30% of Australians were estimated to be living with chronic musculoskeletal conditions, with overall rates remaining unchanged over the last 20 years. Of Australians with musculoskeletal conditions, about 16% are living with back problems, 15% living with arthritis, and 3% living with osteoporosis or osteopenia. Chronic musculoskeletal conditions are large contributors to illness, pain and disability in Australia, and often associated with co-morbidities.

Rates are higher in females and older people, and people living in inner regional and most disadvantaged areas. Musculoskeletal conditions are attributed to modifiable risk factors, including overweight and obesity, occupational exposures and hazards and smoking. Musculoskeletal conditions are usually managed by GPs and allied health professionals. Treatment can include physical therapy, medicines (for pain and inflammation), self-managed physical activity (such as diet and exercise), education on self-management and living with the condition, and referral to specialist care where necessary. There are currently no nationally consistent primary health care data collection to monitor provision of care by GPs. People living with musculoskeletal conditions that are very severe, or who require specialised treatment or surgery, may be admitted to hospital.

Arthritis

Arthritis includes a wide range of inflammatory conditions affecting the joints. Osteoarthritis, rheumatoid arthritis and gout are common types of arthritis.[89] It is most common in females, older people, and people living in inner regional areas and most disadvantaged areas. About 3 in 4 people with arthritis have comorbidities. The prevalence of arthritis in Australia has changed very little over the last 20 years. Various risk factors of arthritis are still not fully understood but thought to include genetics, environmental triggers such as virus or toxin, maintaining a healthy weight, physical activity, not smoking, eating a healthy diet low in sugar and healthy alcohol consumption. Avoiding sports injuries by having appropriate equipment, training and safe play and protecting your joints through good ergonomics are also protective factors. At present, there is no cure for arthritis, with treatment aiming to manage symptoms and maximise quality of life, with conditions predominantly managed in primary health care settings involves a combination of self-management (such as diet and exercise), education on living with the condition, physiotherapy, medication (for pain and inflammation), and referral to specialist care where necessary. There is currently no nationally consistent data collection to monitor provision of care by GPs.

Rates of arthritis in CCQ are significantly higher than for Australia, with most LGAs in the region having significantly higher rates than Australia (Table 28).

Osteoporosis

Osteoporosis is a condition that causes bones to become thin, weak and fragile. As a result, minor bumps or accidents such as falling out of a bed or chair, or tripping and falling while walking, can cause a broken bone. Quality of life can be severely compromised for people with osteoporosis, particularly if they fall and sustain a fracture. Fractures can make it hard for people to write, type, prepare meals, walk or perform personal care tasks and manage household chores. Fractures due to osteoporosis can result in chronic pain, disability, loss of independence and premature death.[90] The rate of fall burden attributed to low bone mineral density increased by 16% of the last 15 years. Because osteoporosis has no overt symptoms, it is often not diagnosed until a fracture occurs and is thought to be under-diagnosed. Diagnosis of osteoporosis requires an assessment of bone mineral density. Osteoporosis burden increases with age and is higher for females.

Treatment recommendations for osteoporosis are often based on an estimate of a person's risk of breaking a bone in the next 10 years using information such as age, gender, bone mineral density (BMD) measurements, family history of fractures, lifestyle factors like smoking and alcohol use, and the presence of conditions or medications that affect bone health.

Estimated osteoporosis prevalence within CCQ is higher than the national rate of 3.8 per 100 people (Table 28). Overall hospitalisation rates for musculoskeletal system and connective tissue disease in CCQ were significantly lower than the nation. However, many LGAs across the region have higher rates, including North Burnett, Fraser Coast, Bundaberg, Sunshine Coast, Gympie, Gladstone, Central Highlands, and Rockhampton. Emergency department presentation were also significantly higher than the nation for Fraser Coast, Sunshine Coast and Gympie.

Table 28: Musculoskeletal indicators[28]

LGA	Public hospital admissions, musculoskeletal system and connective tissue disease admissions, ASR per 100,000 (2020/21)^	Emergency department presentations for diseases of the musculoskeletal system and connective tissue (2020-21)^	Self-reported prevalence (ASR per 100) of long-term arthritis for all persons aged 15+ years (2020-21)^	Estimated prevalence (ASR per 100) of people with arthritis (2017-18)	Estimated prevalence (ASR per 100) of people with osteoporosis (2017-18)
Banana	1,049.8	258.1	9.6	13.4	2.3
Bundaberg	1,596.2	1,854.4	13.6	**15.6**	4.0
Central Highlands	1,319.5	278.9	9.0	14.0	2.2
Fraser Coast	1,794.9	2,540.6	13.6	**16.6**	**4.3**
Gladstone	1,326.1	1,864.0	11.4	14.4	3.5
Gympie	1,405.8	2,072.4	12.7	**14.9**	**4.3**
Livingstone	1,194.9	614.6	11.1	**15.4**	4.0
Noosa	847.1	905.1	9.1	12.3	4.1
North Burnett	2,047.0	543.3	11.9	**15.4**	2.9
Rockhampton	1,268.9	1,426.4	13.0	**15.4**	**4.1**
Sunshine Coast	1,405.6	2,472.1	10.9	13.9	**4.2**
Woorabinda	1,768.0	-	11.0	-	-
CCQ	***1,019.0***	***1,415.1***	***11.8***	***14.7***	***4.0***
Queensland	***1,176.1***	***1,500.5***	***10.9***	***13.9***	***3.8***
AUSTRALIA	***1,087.9***	***1,892.0***	***10.3***	***15.0***	***3.8***

- data not releasable; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status

Cardiovascular conditions

Cardiovascular conditions encompass a range of disorders affecting the heart and blood vessels such as coronary artery disease, stroke, and hypertension.

Heart disease is the most common cardiovascular disease and has two clinical forms, heart attack and angina.[91] Heart attack occurs when a blood vessel supplying the heart is suddenly blocked, threatening to damage the heart muscle and its functions and is considered life-threatening. Angina is chest pain caused by reduced blood flow to the heart and can be dangerous when unstable.

Heart disease is more common in men, older age, Aboriginal and Torres Strait Islander people, and people living in the most socioeconomically disadvantaged areas. The age-standardised rate of heart disease fell by 59% over the last 20 years, attributed to improvements in medical and surgical treatment, increased use of antithrombotic and drugs to lower blood pressure and cholesterol, as well as reductions in risk factors such as tobacco smoking, high blood cholesterol and blood pressure.

Rates of long-term heart disease in CCQ are significantly higher than Australia, with many LGAs across the region with higher prevalence estimates including Woorabinda, Rockhampton, Fraser Coast and Bundaberg (Table 29). PPHs for chronic angina in CCQ are significantly higher than Australia and across almost all LGAs, as is chronic congestive cardiac failure, and chronic hypertension a risk factor for heart disease which nationally is being reported as highly preventable and more well managed than in previous decades (Table 29).

Rates of stroke in CCQ are significantly higher than Australia and for some LGAs including Rockhampton, Bundaberg, Fraser Coast and Gympie (Table 29).

Ischemic heart disease, also known as coronary artery disease or coronary heart disease, is a condition characterised by reduced blood flow to the heart muscle, usually due to the build-up of fatty deposits (plaques) in the coronary arteries.

This reduced blood flow can lead to chest pain (angina), shortness of breath, and other symptoms. In severe cases, it can result in heart attacks. Ischemic heart disease is a leading cause of death globally, but it can often be prevented and managed with appropriate lifestyle changes, medical care, and treatment strategies.

Cerebrovascular disease refers to a group of conditions that affect the blood vessels and blood supply to the brain. These conditions can lead to serious and potentially life-threatening events, such as strokes or transient ischemic attacks. Risk factors for cerebrovascular disease include high blood pressure, smoking, diabetes, high cholesterol, obesity, physical inactivity, and a family history of stroke or heart disease. Prevention and management often focus on controlling these risk factors through lifestyle changes and medication.

Stroke occurs when a blood vessel supplying blood to the brain becomes blocked or ruptures and begins to bleed.[92] A stroke may result in part of the brain dying, leading to impairment that can affect a range of activities such as speaking, thinking, movement and communication and is often fatal.

Age-standardised rates of stroke events fell by one-quarter over the last 20 years. Risk factors for stroke include tobacco smoking, high blood pressure, abnormal blood lipids, healthy eating, physical activity, atrial fibrillation, diabetes and other heart disease. The prevalence of stroke is higher in males, older age groups, Aboriginal and Torres Strait Islander people and people living in the most disadvantaged areas.

Primary health care professionals, including general practitioners, practice nurses, nurse practitioners and Aboriginal and Torres Strait Islander health workers are often the first point-of-care for people who have non-acute cardiovascular disease. Primary health care professionals deliver a range of services, from health checks, diagnosis and treatment to prevention and rehabilitation activities. Primary health care professionals can also direct patients through the health system, including to specialised care when necessary.

Common actions by primary health care professionals when managing cardiovascular problems include undertaking checks, prescribing medicines, ordering pathology or imaging tests, and referral to specialists.

Stroke rehabilitation helps stroke survivors to relearn and maintain their skills and functioning. It also seeks to protect them from developing new medical problems. Therapy often in CCQ begins in hospital soon after the condition has stabilised. It can continue out-of-hospital, through attending outpatient units, or participating in home-based rehabilitation programs.

Given the high rates of cardiovascular conditions and PPHs across CCQ LGAs, percentages of persons with a GP chronic disease management plan should be high (though only access to crude percentages are available at a local level). Available data suggests that higher than expected in Gympie, Fraser Coast, Noosa and Sunshine Coast; but lower than expected for Central Highlands, Livingstone, Rockhampton, North Burnett and Banana (Table 30).

Given continued high rates of blood pressure in CCQ and stroke prevalence, prevention will be important, including prevention measures and management of blood pressure, cholesterol, diabetes and heart disease. Data is not available to assess health care management of cardiovascular conditions, including GP heart checks (BP, cholesterol), prescriptions, cardiac rehab, blood pressure and high cholesterol, and other related behavioural factors.

Table 29: Cardiovascular condition indicators[28,29]

LGA (Indigenous Area)	Self-reported prevalence (ASR per 100) of long-term conditions among people aged 15 years and over (2020-21)^		Estimated prevalence (ASR per 100) of heart, stroke and vascular disease among all people (2017-18)	Estimated prevalence (ASR per 100) of circulatory system conditions among Aboriginal people (2018-19)	Public hospital admissions (ASR per 100,000) for potentially preventable chronic conditions for all ages (2020/21)^			Hospital admissions (average annual ASR per 100,000) for potentially preventable chronic for all Aboriginal people (2017/18 to 2020/21) ^		Emergency department presentations (ASR per 100,000) for diseases of the circulatory system (2020-21)^	Premature mortality (ASR per 100,000) for all persons 0-74 years (2017-21)^		
	Heart disease	Stroke			Chronic angina	Chronic congestive cardiac failure	Chronic hypertension	Chronic angina	Chronic congestive cardiac failure		Ischaemic heart disease	Cerebrovascular disease	All circulatory system conditions
Banana	4.4	1.0	4.8	12.8	329.4	296.4	93.2	174.1	178.3	1,157.6	34.9	-	64.1
Bundaberg	5.7	1.4	4.8	15.6	275.6	310.7	79.5	240.6	66.3	3,742.4	22.8	7.5	42.3
Central Highlands (Central Capricorn)	4.8	1.0	5.1	17.1	224.9	281.7	85.5	123.9	291.6	698.1	21.0	8.9	45.2
Fraser Coast	5.8	1.4	4.8	15.9	233.1	386.0	61.8	244.1	111.6	4,895.2	24.9	7.7	44.7
Gladstone	5.1	1.2	5.0	14.5	127.1	291.9	87.4	176.5	150.4	4,071.6	28.4	11.1	55.4
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	5.3	1.3	4.8	15.2; 15.2	167.7	362.5	54.7	101.9; -	96.5; 95.8	3,652.5	25.1	8.1	45.9
Livingstone (Rockhampton-Yeppoon)	5.2	1.1	5.2	16.2	250.0	293.3	72.4	211.4	210.9	2,538.0	22.7	9.3	42.0
Noosa	4.2	1.0	3.9	15.7	83.6	146.4	33.5	101.9	96.5	993.3	15.4	5.7	29.6
North Burnett	5.3	1.1	5.3	12.8	493.5	280.1	199.4	-	178.3	1,843.5	37.7	9.0	59.1
Rockhampton (Rockhampton-Yeppoon)	6.4	1.5	5.2	16.2	214.2	260.0	113.1	211.4	210.9	4,758.5	35.4	9.4	59.4
Sunshine Coast (Maroochy; Caloundra)	4.7	1.2	4.3	14.3; 14.8	114.1	254.5	68.0	74.5; 79.8	92.2; 79.5	1,727.8	15.9	7.0	32.0
Woorabinda (Central Capricorn)	15.9	1.0	-	17.1	-	-	-	123.9	291.6	1,085.7	-	-	340.4
CCQ	**5.2**	**1.2**	**4.6**	**--**	**125.7**	**197.7**	**51.7**	**--**	**--**	**2,048.8**	**21.8**	**7.7**	**40.9**
Queensland	**5.1**	**1.2**	**4.7**	**16.3**	**103.4**	**210.5**	**65.5**	**162.9**	**216.2**	**1,607.6**	**23.0**	**8.2**	**44.1**
Australia	**4.8**	**1.1**	**4.8**	**15.3**	**82.2**	**210.3**	**47.7**	**134.5**	**222.6**	**1,429.4**	**21.1**	**7.8**	**42.1**

- data not releasable; -- data not reported; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status

Table 30: GP chronic disease management plan (2022/23)

SA3	Persons with a GP chronic disease management plan, all persons % (2022/23)^^
Biloela	14.99
Bundaberg	18.91
Central Highlands	8.90
Maryborough	20.29
Hervey Bay	20.15
Gladstone	11.05
Gympie-Cooloola	21.14
Rockhampton	14.34
Noosa	18.64
Noosa Hinterland	22.43
Burnett	14.88
Rockhampton	14.34
Buderim	18.85
Maroochy	20.28
Nambour	22.14
Sunshine Coast Hinterland	21.93
CCQ Region	***18.2***
Queensland	***-***
AUSTRALIA	***15.80***

^^ crude percent used. Interpret with caution. Not relative to those with a chronic disease.

Neurological – Dementia

Dementia includes a group of conditions characterised by gradual impairment of brain function affecting memory, speech, cognition (thought), behaviour, mobility and an individual's personality, and their health and functional ability.[93] Dementia is a significant and growing health and aged care issue in Australia that has a substantial impact on the health and quality of life of people with the condition, as well as for their family and friends. The exact number of people with dementia is unknown with estimates used.

Various risk factors have been associated with developing dementia. These include age, genetics and family history, as well as health behaviours including protective factors of high levels of education, physical activity and social engagement and risk factors of obesity, smoking, high blood pressure, hearing loss, depression and diabetes.

General practitioners and other medical specialists are crucial in diagnosing and managing dementia. If a GP suspects dementia, they typically refer the patient to a qualified specialist, such as a geriatrician, or to a memory clinic for a comprehensive assessment.

Although there is no cure for dementia, there are medications subsidised through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme, that may alleviate some of the symptoms and slow the progression of Alzheimer's disease. Medications are also used, along with non-pharmacological interventions for people with dementia that experience changed behaviours, such as aggression, agitation and delusions, commonly known as behaviours and psychological symptoms of dementia.

Dementia is more common with advancing age and occurs among people aged 65 and over – but it is not a normal part of ageing.

In 2022, 22.7% (*n* = 17,664) of QLD's dementia population (*n* = 77,720) lived in the CCQ region.[94] 55.2% of people using permanent residential care in CCQ on 30 June 2022 had a diagnosis of dementia (excluding unknown, probable and possible dementia).[95]

The number of people living with dementia is projected to more than double in Banana (102%), Bundaberg (101%), North Burnett (101%), Rockhampton (105%) and Sunshine Coast (104%) from 2024 to 2054 (Table 31). Rockhampton's increase is on par with Queensland's expected growth (105%); however, most of CCQ's LGQs will have larger growth than Australia (93%), including Fraser Coast (93%), Gympie (95%), Livingstone (95%) and Noosa (99%) as well as those listed above.

Latest mortality data indicated that together, dementia and Alzheimer's disease were the second leading cause of death in the CCQ region, responsible for 2,234 or 7.2% of deaths in the 2013-2017 period.

Around half of those (951, or 9% of deaths) occurred in Sunshine Coast LGA. Gladstone and Rockhampton LGAs have the highest rate (ASRs 43.3 per 100,000) of deaths due to dementia and Alzheimer's disease in the CCQ region (CCQ ASR 36.7 per 100,000; AUS 40.0 per 100,000). Livingstone LGA had the lowest rate (ASR 25.4 per 100,000).

Table 31: Dementia indicators[96]

LGA	Number of persons estimated with dementia		Percentage change 2024 to 2054	People in permanent residential care, with dementia (30 June 2022)[97]
	2024	2054		
Banana	227	458	102%	-
Bundaberg	2417	4859	101%	-
Central Highlands	227	421	85%	-
Fraser Coast	2982	5896	98%	-
Gladstone	732	1384	89%	-
Gympie	1163	2267	95%	-
Livingstone	707	1382	95%	-
Noosa	1406	2803	99%	-
North Burnett	253	508	101%	-
Rockhampton	1342	2752	105%	-
Sunshine Coast	7257	14803	104%	-
Woorabinda	0	5	0%	-
Fitzroy (ACPR)	***-***	***-***	***-***	***54.1%***
Sunshine Coast (ACPR)	***-***	***-***	***-***	***55.1%***
Wide Bay (ACPR)	***-***	***-***	***-***	***55.4%***
CCQ	***-***	***-***	***-***	***55.2%***
QLD	***82,270***	***168,300***	***105%***	***-***
AUSTRALIA	***421,000***	***812,500***	***93%***	***-***

Carers of people with dementia are often family members or friends of people with dementia who provide ongoing, informal assistance with daily activities. Caring can be a rewarding role with 38% of primary carers of people with dementia nationally reporting feeling closer to the care recipient. Caring can also be physically, mentally, emotionally, and economically demanding, with 3 in 4 carers nationally reporting it as affecting their physical and mental wellbeing. Data is not available on the number of carers of someone with dementia or their health and wellbeing needs.

Dementia prevention will be important as trends show substantial growth in burden of the disease, including providing cognitive, social and physical activities for people as they age and maintaining a healthy lifestyle; as is good management, including dementia friendly cities to support our aged population. We also need to better understand the needs of carers.

Respiratory conditions

Chronic respiratory conditions affect the airways, including lungs and passages that transfer air from the mouth and nose into the lungs.[98] Conditions are characterised by symptoms such as wheezing, shortness of breath, chest tightness and cough. Around 34% of Australians are estimated to have chronic respiratory conditions. Asthma and chronic obstructive pulmonary disease (COPD) are two common respiratory conditions associated with poor health and wellbeing.

COPD is a group of progressive lung diseases that obstruct airflow and make breathing difficult. The most common types of COPD are emphysema and chronic bronchitis. Causes of COPD include lifestyle factors (such as smoking), environmental factors (such as long-term exposure to air pollution) and in rare cases can be influenced by genetic factors. COPD is a chronic condition that requires ongoing management, but with appropriate treatment, individuals can maintain a good quality of life. COPD increases with age, highest among people living in outer regional and remote areas and most disadvantaged areas.

The prevalence of COPD has remained stable over the last 20 years. The leading cause of COPD is smoking. genetics, pre-existing asthma, second-hand smoke, air pollution, exposure to lung irritants such as dust or chemicals and a history of some infections are also recognised factors. There is no known cure for COPD. Treatment can help manage the condition. General practitioners play an important role in managing chronic respiratory conditions in the community.

COPD remains an issue for CCQ. Prevention measures, including smoking and treatment plans will be important.

Asthma is a long-term lung condition caused by narrowing of the airways when they become inflamed.[99] The causes of asthma are not completely understood but thought to include genetic predisposition with environmental exposure that provoke allergic reactions or irritate the airways. Natural disasters or extreme weather changes can affect asthma. The prevalence of asthma has remained relatively steady over the last 20 years.

Asthma was highest for people living in remote and very remote and the most disadvantaged areas. General practitioners play an important role in the management of asthma in the community, including in the assessment, diagnosis, prescription of regular medications, education, provision of written action plans, and regular review as well as managing asthma flare-ups. LGAs where conditions appear to be of most concern were Rockhampton, Fraser Coast and Bundaberg, given the higher rates of premature death. Little data are available on asthma management plans. Data that do exist suggest that CCQ region has a similar percent of persons on a plan compared with the nation.

Long-term lung condition prevalence was significantly higher in CCQ than Australia, and across most LGAs in the region (Table 32). PPHs for COPD are also significant higher across the region (Table 32). However, for Aboriginal and Torres Strait Islander people in the region, rates are significantly lower compared with Indigenous national rates (Table 32).

Table 32: Indicators of respiratory conditions[28]

LGA (Indigenous Area)	Self-reported prevalence (ASR per 100) of long-term conditions among people aged 15 years and over, by condition type (2020-21)^		Estimated prevalence (ASR per 100) among all people (2017-18)		Prevalence (ASR per 100) of respiratory system diseases among Aboriginal people (2018-19)	Public hospital admissions (ASR per 100,000) for potentially preventable chronic conditions for all ages (2020-21)^		Hospital admissions (average annual ASR per 100,000) for potentially preventable chronic conditions for all Aboriginal people (2017-18 to 2020-21)^		Rates of premature death (average annual ASR per 100,000) among all people aged 0 to 74 years (2017-21)^		Percentage of people with asthma cycle of care PIP by SA3, all persons (%) (2022-23)^^[100]
	Asthma	Lung condition	Asthma	COPD		Chronic asthma	COPD	Chronic asthma	COPD	COPD	All respiratory system conditions	
Banana	8.9	2.2	13.1	3.7	22.8	79.7	507.0	226.9	588.0	17.1	18.6	Biloela -
Bundaberg	10.2	3.4	12.9	3.9	26.4	109.8	443.0	195.7	556.4	13.9	20.9	Bundaberg 0.05 Burnett -
Central Highlands (Central Capricorn)	8.4	2.6	12.7	3.9	21.6	71.8	368.4	146.9	380.4	14.9	20.6	Central highlands -
Fraser Coast	10.5	3.8	13.1	4.0	27.9	128.4	540.4	252.6	270.4	15.0	20.7	Maryborough - Hervey Bay -
Gladstone	8.5	3.0	11.4	3.8	29.0	131.2	329.4	203.6	301.8	12.2	20.8	Gladstone -
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	9.4	3.3	14.6	3.9	24.8; 24.8	80.2	276.8	121.0; 377.7	255.6; 444.9	12.6	17.0	Gympie-Cooloola 0.09
Livingstone (Rockhampton-Yeppoon)	8.0	2.9	12.9	3.6	26.6	52.9	326.8	117.3	281.0	10.5	17.5	Rockhampton -
Noosa	7.7	2.0	11.6	3.0	26.7	42.4	118.4	121.0	255.6	5.6	7.8	Noosa - Noosa Hinterland -
North Burnett	9.3	2.4	12.3	3.0	22.8	148.9	536.9	-	-	12.7	15.9	Burnett -
Rockhampton (Rockhampton-Yeppoon)	10.6	3.4	13.0	4.0	26.6	62.8	329.6	117.3	281.0	19.1	28.7	Rockhampton -
Sunshine Coast (Maroochy; Caloundra)	8.6	2.2	12.2	3.3	27.5; 28.2	101.3	220.5	180.2; 98.5	200.8; 204.9	6.3	10.1	Buderim – Maroochy – Nambour – Sunshine Coast Hinterland 0.04
Woorabinda (Central Capricorn)	8.8	2.4	-	-	21.6	-	-	146.9	380.4	0.0	-	Central Highlands 8.9
CCQ	**9.2**	**2.8**	**12.2**	**3.6**		**70.6**	**227.4**	**--**	**--**	**10.7**	**16.3**	**0.02**
QLD	**9.0**	**2.5**	**11.7**	**3.5**	**25.2**	**92.9**	**227.5**	**215.2**	**473.9**	**10.6**	**15.9**	**--**
Australia	**8.5**	**2.1**	**11.2**	**2.5**	**29.2**	**85.5**	**119.7**	**189.8**	**536.0**	**9.6**	**15.5**	**0.02**

- data not releasable; -- data not reported; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status); ^^crude percent used. Interpret with caution. Not relative to those with a chronic disease.

Injury (external causes)

Injuries are a prominent public health concern in Australia, causing substantial morbidity, permanent disability, and mortality, thereby affecting the quality of life of individuals and families. They are the leading cause of death for people aged 1-44 and resulted in 1.9 million emergency department presentations (7,000 per 1000,000 population) and 549,000 hospitalisations (2,100 per 100,000 population) in 2022-23.

Injuries also accounted for 8.0% of the total burden of disease in 2023 and 7.3% of health spending in 2021-21. The main causes of injury hospitalisations are falls, contact with objects, and transport accidents, while the leading causes of injury deaths are falls, suicide, and accidental poisoning.[37] Males are more likely than females to present to ED, be hospitalised, and die from injuries.

Falls are particularly common among the youngest and oldest age groups. Trends over the past decade show a stable or slowing decreasing rate of injury hospitalisation and death among younger age groups, but an increase among adults aged 45 and older. Fractures and open wounds are often the most frequent types of injuries recorded in ED presentations and hospitalisations. Injuries in the home are the most common place occurrence, followed by on the streets, sports areas, and aged care facilities.[101]

CCQ has significantly higher rates of premature mortality due to road traffic injuries and suicide and self-harm compared to Australia (Table 33). The majority of LGAs also have significantly higher rates of premature mortality caused by road traffic injuries, although North Burnett is notably higher than the others. Similarly, most LGAs report significantly higher rates of premature mortality due to suicide and self-inflicted injuries, with North Burnett again reporting the highest rates.

Traffic injuries

Traffic crash injuries refer to physical harm or damage sustained by individuals involved in vehicular accidents, including drivers, passengers, pedestrians, and cyclists. Assessing trends of these injuries is important for allocating resources effectively to improve road safety and reduce fatalities. Approximately 1,200 people are killed and 40,000 are seriously injured on Australia's roads annually. Australia's National Road Safety Strategy 2021-30 outlines national strategies to improve safety on Australia's roads, with the overarching goal to reduce serious road trauma and fatalities to zero by 2050.[102]

CCQ has a significantly higher rate of public hospital admissions for transport crash injuries compared to Australia (Table 33). All LGAs reported significantly higher rates for all persons, as well as for males compared to national rates.

Falls

Falls are the leading cause of injury hospitalisation and death in Australia, accounting for 43% of injury hospitalisations and 42% of injury deaths. In 2021-22 there were 233,000 fall-related hospitalisation, and in 2020-21 5,800 deaths due to falls.[103] Falls are more common with increasing age and typically occur at home, with over half of hospitalisations involving fractures. For Indigenous Australians, the rate of fall-related hospitalisations is 1.4 times higher than non-Indigenous Australians. Despite disruptions caused by COVID-19, the ASR of fall hospitalisations has decreased slightly in recent years.[103]

Falls are common amongst people aged 65 years and over, with around 30% of adults over 65 experiencing at least one fall per year. More than half of all injury deaths in this age group are due to falls.[104] Injuries resulting from falls are the major cause of death, hospitalisation and emergency department presentations among elderly population. More than half of all injury deaths in this age group are due to falls. Falls are a major cause of hip fractures accounting for 91% of the hip fractures among elderly and greatly contribute towards reducing quality of life for the elderly.

There is variation in public hospital admission rates for falls across LGAs within the CCQ catchment, with most LGAs having significantly higher rates compared to Australian (Table 33). Falls are particularly varied for males, with some LGAs reporting significantly higher rates and Gladstone, Gympie, Noosa and Rockhampton having significantly lower rates than nationally. Overall, CCQ has higher rates of public hospital admissions due to falls compared to Australia.

Table 33: Public hospital admissions for falls (ASR per 100,000), by sex and LGA (2020-21)[28]

LGA	Public hospital admissions for falls (ASR per 100,000)		
	Male	Female	All persons
Banana	1313.5	1262.9	1711.2
Bundaberg	1125.0	1309.8	1492.2
Central Highlands (Qld)	707.7	884.6	1153.0
Fraser Coast	1053.2	1399.6	1468.0
Gladstone	701.2	923.2	1120.3
Gympie	728.1	1000.7	1070.7
Livingstone	1091.5	1505.4	1661.5
Noosa	718.6	974.3	1000.5
North Burnett	1077.8	1558.3	1606.5
Rockhampton	705.5	939.2	1102.8
Sunshine Coast	1167.1	1400.5	1612.0
Woorabinda	-	-	1224.3
CCQ	***918.1***	***1098.5***	***1005.5***
Queensland	***1019.2***	***1179.9***	***1098.7***
AUSTRALIA	***845.2***	***1012.3***	***929.5***

Highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

Table 34: Injury indicators[28,29]

LGA (Indigenous Area)	Premature deaths (average annual ASR per 100,000) among people aged 0-74 years (2017-21)^			Public hospital admissions (ASR per 100,000) for transport crash injuries (2020-21)^			Potential years of life lost (average annual ASR per 1,000) from road traffic injuries (deaths before 75 years of age; 2017-21)^	Public hospital admissions (ASR per 100,000) for injury, poisoning and other external causes (2020-21)^			Emergency department total presentations (ASR per 100,000) for injury, poisoning and certain other consequences of external causes (2020-21)^
	Overall premature mortality for all external causes	Suicide and self-inflicted injuries	Road traffic injuries	Male	Female	All persons		Males	Females	All persons	
Banana	33.3	10.6	13.8	631.4	494.9	750.9	5.4	4,347.1	3,542.7	5,260.9	3,177.9
Bundaberg	47.5	21.1	12.6	602.8	296.4	577.6	4.4	4,228.0	3,624.7	4,931.1	19,397.6
Central Highlands (Central Capricorn)	48.4	22.7	9.9	601.7	380.0	684.1	3.6	3,386.2	3,222.4	4,693.5	2,389.9
Fraser Coast	41.2	19.8	7.5	428.4	232.8	419.7	3.5	4,308.9	3,735.8	5,132.5	27,609.2
Gladstone	39.3	22.4	4.5	492.2	208.4	477.3	1.3	2,985.0	2,635.4	3,864.7	22,696.0
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	48.1	20.9	12.3	596.2	289.1	573.3	4.8	4,274.3	3,399.8	4,870.9	24,989.5
Livingstone (Rockhampton-Yeppoon)	38.8	17.0	8.0	462.7	252.2	470.1	3.8	3,862.9	3,320.8	4,671.5	9,171.7
Noosa	34.2	17.8	4.0	524.8	203.6	448.6	1.8	3,067.3	2,435.8	3,321.1	5,804.9
North Burnett	65.0	24.1	21.8	954.4	427.4	898.7	10.9	5,152.7	4,276.6	5,952.3	6,876.4
Rockhampton (Rockhampton-Yeppoon)	40.7	19.5	6.7	443.5	181.5	419.3	2.4	3,093.1	2,404.6	3,701.8	18,553.0
Sunshine Coast (Maroochy; Caloundra)	26.5	11.2	4.4	483.1	257.8	476.1	1.7	3,789.8	3,280.7	4,500.6	12,452.3
Woorabinda (Central Capricorn)	-	-	-	-	-	830.0	0.0	3,967.4	3,274.0	5,284.5	2,793.6
CCQ	**36.5**	**16.9**	**7.0**	**490.7**	**244.8**	**366.0**	**2.7**	**3,601.4**	**2,928.2**	**3,255.3**	**11,753.9**
QLD	**33.1**	**15.5**	**5.0**	**459.4**	**231.3**	**343.8**	**1.8**	**3,588.4**	**3,037.0**	**3,307.3**	**8,720.2**
Australia	**30.1**	**12.6**	**4.2**	**365.8**	**174.6**	**269.4**	**1.5**	**2,974.5**	**2,541.2**	**2,756.5**	**8,848.7**

- data not releasable; -- data not reported; ^highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

Suicide and self-harm

CCQ would like to acknowledge that each number represents a life lost along with the family, friends and communities who are grieving the loss of each of those people.

Suicide arises from an interaction between many vulnerabilities and risk factors in a person's life. However, suicide may also be influenced by social and economic circumstances and differences between cultures and individuals' experiences within society.[105] Rates and the information provided below is provided to support organisations and communities to do better. Suicide is not inevitable based on the rates or statistics presented; it is preventable.

Key considerations

- There are several considerations to keep in mind when examining suicide and self-harm data and information.
- The assembling and national reporting of deaths by suicide has up to an 18-month time lag.
- Deaths by suicide may be presented by year of occurrence of death or year of registration.
- Deaths by suicide are statistically rare events. Small numbers can raise privacy and confidentially issues but also statistical concerns.

Key facts - Suicide

- Males are 3 times more likely to take their own life than females
- Females are more likely to attempt suicide or be hospitalised for intentional self-harm than males
- Suicide is the leading cause of death for young people
- The rate of suicide among young Aboriginal and Torres Strait Islander people is three times that of young non-Indigenous Australians
- The highest proportion of deaths by suicide occur during mid-life
- Suicide rates are highest among middle aged and older males.[106]

Many factors contribute to suicide risk

A range of factors—at the individual, relationship, community, and societal levels—can increase suicide risk. These risk factors are situations or problems that can increase the possibility that a person will attempt suicide.[107]

Individual Risk Factors

These personal factors contribute to risk:

- Previous suicide attempt
- History of depression and other mental illnesses
- Serious illness such as chronic pain
- Criminal/legal problems
- Job/financial problems or loss
- Impulsive or aggressive tendencies
- Substance use
- Current or prior history of adverse childhood experiences
- Sense of hopelessness
- Violence victimisation and/or perpetration.

Relationship Risk Factors

These harmful or hurtful experiences within relationships contribute to risk:

- Bullying
- Family/loved one's history of suicide
- Loss of relationships
- High conflict or violent relationships
- Social isolation.

Community Risk Factors

These challenging issues within a person's community contribute to risk:

- Lack of access to healthcare
- Suicide cluster in the community
- Stress of acculturation
- Community violence
- Historical trauma
- Discrimination.

Societal Risk Factors

These cultural and environmental factors within the larger society contribute to risk:

- Stigma associated with help-seeking and mental illness
- Easy access to lethal means of suicide among people at risk
- Unsafe media portrayals of suicide.[107]

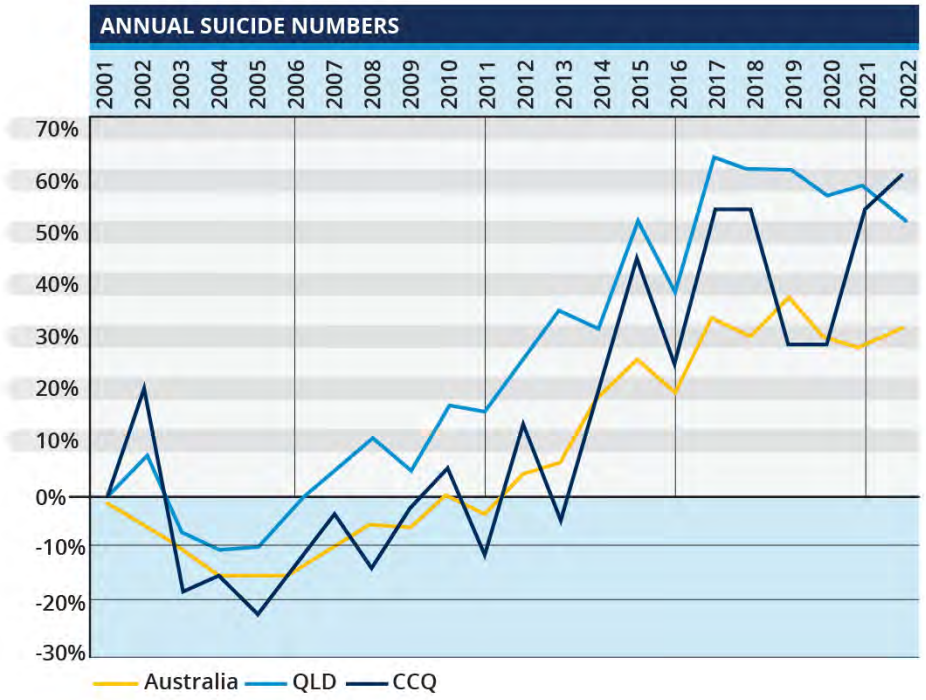
Suicide trends

In Australia in 2022, there were 3,249 deaths by suicide – and average of about 9 deaths per day – with a rate of 12.3 per 100,000 population. Figure 24 illustrates the growth of annual suicide numbers from 2001 onwards, comparing the CCQ region to Queensland and Australia as a whole. Initially, all three jurisdictions experienced a decrease in annual suicides up to 2005. However, from 2005 onwards, there was a discernible and steady increase in suicides across all three areas.

By 2022, the suicide rate in CCQ surpassed its 2001 baseline more than Queensland for the first time since 2002. This persistent rise in CCQ highlights the need for targeted interventions, programs and supports in the region to address the unique challenges faced by its population. It should also be noted that large fluctuations can arise due to the overall low numbers of cases, so overtime rates should be interpreted with care.

Suicide rates are notably higher among middle-aged and older males, with the highest proportion of suicides occurring during mid-life. This demographic trend underscores the vulnerability of this age group and the necessity for tailored preventive measures. Additionally, young Aboriginal and Torres Strait Islander people face a distressingly high suicide rate, three times that of their non-Indigenous counterparts, pointing to a critical area for culturally sensitive mental health support.

Figure 24: Number of annual suicides by jurisdiction compared to 2001 baseline[108]



Over the 5-year period 2018-2022, **Burnett SA3 had the second highest reported age-standardised suicide rates in Australia** in persons at the SA3 level (Table 35). Over the same period across Australia, reportable **suicides rates in males, at the SA4 level were the highest in the Wide Bay**.[109] Almost all SA3s within the CCQ region have rates higher than the national rate, with the exception of Caloundra and Buderim.

Table 35: Deaths by suicide 2018-2022[110]

SA3	Deaths by suicide					
	Persons		Males		Females	
	Age standardised rate (per 100,000)	Total number of deaths	Age standardised rate (per 100,000)	Total number of deaths	Age standardised rate (per 100,000)	Total number of deaths
Central Queensland SA4	**14.0**	**276**	**31**	**173**	**7.6**	**42**
Central Highlands	23.0	32	-	-	-	-
Rockhampton	18.7	109	-	-	-	-
Biloela	n.p.	9	-	-	-	-
Gladstone	20.8	65	-	-	-	-
Sunshine Coast SA4	**14.0**	**276**	**22.6**	**209**	**6.2**	**67**
Buderim	11.8	33	-	-	-	-
Caloundra	10.5	52	-	-	-	-
Maroochy	13.1	46	-	-	-	-
Noosa	15.1	38	-	-	-	-
Sunshine Coast Hinterland	16.2	45	-	-	-	-
Nambour	17.4	38	-	-	-	-
Noosa Hinterland	23.8	24	-	-	-	-
Wide Bay SA4	**22.3**	**327**	**37.6**	**261**	**7.7**	**66**
Bundaberg	21.2	94	-	-	-	-
Burnett*	32.3	77	-	-	-	-
Gympie - Cooloola	20.9	53	-	-	-	-
Hervey Bay	18.6	58	-	-	-	-
Maryborough	20.0	45	-	-	-	-
Queensland	***15.5***	-	-	-	-	-
AUSTRALIA	***12.7***	-	-	-	-	-

*Data from AIHW suggests that the age standardised rate is similar for the component of Burnett SA3 within the CCQ catchment.
n.p. Age-standardised rates are not reported where the population in any age group in an area is less than 30, or where there are fewer than 20 total deaths.
Bolded SA3s are higher than their corresponding SA4

Suicide among priority population groups

Suicide and self-harm can affect people of all ages (except very young children), races, ethnicities, sexual orientations and occupations. However, several subgroups are particularly important to examine in depth because their risk of suicide or self-harm is higher than that of other populations, the impact on the community is different or they have specific requirements for culturally appropriate suicide prevention or postvention services.

Although deaths by suicide occur more often in older age groups, it is the leading cause of death in Australian children and adolescents. Deaths by suicide at any age have profound effects on the families, friends and communities of those that die, but arguably, these effects are even greater when the person is young.

Similarly to employment in general, serving in the Australian Defence Force (ADF) seems to be protective against suicide as rates in both serving and reserve men are lower than that of all Australian men. However, **for ex-servicemen suicide rates are higher than the general population.**

The **suicide rate in Aboriginal and Torres Strait Islander peoples is twice that of the non-Indigenous population** although rates vary by community, age group and sex. The high rates experienced by Indigenous Australians are due to multiple, complex and interrelated social, cultural and historical influences, including colonisation, relocation of people to missions and reserves, transgenerational grief and trauma resulting from the removal of children, racism and continued socioeconomic disadvantage. However, it is important to acknowledge that Indigenous Australians may never experience suicidal behaviours or thoughts and aspects unique to their culture can be important protective factors against suicidal or self-harming behaviours.

Other population groups identified as priority populations for suicide prevention in Australia include lesbian, gay, bisexual, transgender or intersex (LGBTI) populations and culturally and linguistically diverse (CALD) communities. It is currently not possible to discern these groups in the available suicide and intentional self-harm data sets.

Suicide monitoring systems

In Queensland there are two systems that are used to monitor suicide deaths, the Queensland Suicide Register (QSR), which includes suicide data since 1990 and is used to monitor longer-term trends, and the interim Queensland Suicide Register (iQSR), which was established in 2011 to provide real-time information on suicide deaths. The QSR contains information on suicide deaths in Queensland for which the coroners' investigations have been finalised, whereas the iQSR records interim data on deaths suspected to be from suicide, shortly after the death occurs.[111]

Lived experience - Suicidal thoughts and behaviours

Suicidal thoughts and behaviours include suicidal ideation (thoughts about taking one's own life), making suicide plans and attempting suicide. People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts and those who experience all forms of suicidal thoughts and behaviours are at greater risk of dying by suicide.[112,113]

The CCQ region has higher rates of lifetime suicidal thoughts across both genders and all age-groups compared with Queensland (Table 36 and Table 37). These differences may not be statistically significant. For young people aged 16-24 and 25-34 years in the CCQ region, almost a quarter have experienced suicidal thoughts (24.4% and 24.8% respectively).

Public hospitals in the CCQ region report over 4,000 presentations per year for suicidal ideation (2021-22; 2022-23; 2023-24). Over half of these presentations occur in the after-hours period. Approximately a third are for individuals aged 15-24 years of age. The highest total number of presentations consistently occurs within the Central Queensland HHS with Rockhampton Hospital receiving the largest total number of presentations in 2023-24, followed by Sunshine Coast University Hospital, Gladstone, Bundaberg and Hervey Bay hospitals. [114]

Table 36: Persons with suicidal thoughts – lifetime (2020-22)[115]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-74 years			75-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	21.1%	27.9%	24.4%	24.3%	25.3%	24.8%	19.1%	20.1%	19.6%	20.5%	21.4%	21.0%	17.7%	20.3%	19.0%	15.1%	17.5%	16.3%	8.3%	9.8%	9.1%
Queensland	20.9%	27.0%	23.9%	22.9%	23.7%	23.3%	17.4%	18.5%	17.9%	19.1%	20.0%	19.5%	15.8%	18.6%	17.2%	14.0%	16.7%	15.4%	7.9%	9.6%	8.8%

Table 37: Persons with suicidal thoughts – last 12 months (2020-22)[115]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-74 years			75-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	4.8%	8.5%	6.6%	3.4%	4.8%	4.1%	2.1%	3.5%	2.8%	2.1%	2.5%	2.3%	2.0%	2.0%	2.0%	1.8%	2.0%	1.9%	1.8%	2.2%	2.0%
Queensland	5.0%	8.2%	6.6%	3.4%	4.4%	3.9%	2.0%	3.2%	2.6%	2.0%	2.5%	2.3%	1.9%	2.0%	2.0%	1.8%	2.0%	1.9%	1.8%	2.3%	2.1%

Self-harm

Intentional self-harm is often defined as deliberately injuring or hurting oneself, with or without the intention of dying. Intentional self-harm comes in many forms, and affects people from different backgrounds, ages and lifestyles. The reasons for self-harm are different for each person and are often complex.

It is often associated with underlying psychological issues such as depression, anxiety, or trauma, and it can be a coping mechanism for managing intense emotional pain or distress, or a sense of loss of control. Most people who self-harm do not go on to end their lives – but previous self-harm is a strong risk factor for suicide.[116]

It is imperative to approach individuals who self-harm with empathy and provide appropriate mental health support and intervention to address the root causes and promote healing.

In Australia, intentional self-harm resulted in 26,400 hospitalisations and 3,100 deaths in 2020-21. Females are more frequently hospitalised due to self-harm, with pharmaceutical drug poisoning being the most common cause.

Hospitalisation rates for intentional self-harm are notably higher among females aged 15-24 years. Indigenous Australians experience disproportionately higher rates of hospitalisation and death due to intentional self-harm compared to non-Indigenous Australians. Hospitalisation rates are highest amongst those living in very remote areas, with people in these areas nearly twice as likely to be hospitalised for self-harm compared to those in major cities. Trends show a recent decline in self-harm hospitalisation rates over the last decade.[117]

All LGAs in the CCQ region have higher rates of public hospital admissions due to self-harm than Australia, with only Banana and Noosa not significantly higher than nationally reported rates (Table 38).

Table 38: Self-inflicted injuries

LGA	Public hospital admissions for self-harm (2020-21)[28] ASR per 100,000		
	Male	Female	All persons
Banana	-	-	178.7
Bundaberg	182.0	298.1	313.8
Central Highlands (Qld)	105.3	219.4	224.5
Fraser Coast	155.0	265.9	273.1
Gladstone	114.5	232.3	237.8
Gympie	124.1	197.2	211.4
Livingstone	131.1	176.3	201.6
Noosa	81.6	146.8	144.5
North Burnett	-	-	218.4
Rockhampton	105.8	153.3	174.5
Sunshine Coast	99.2	199.8	196.4
Woorabinda	-	-	-
CCQ	**114.8**	**207.4**	**161.7**
Queensland	**132.6**	**241.3**	**187.7**
AUSTRALIA	**85.0**	**164.4**	**125.3**

Highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status)

PHN modelled estimates for self-harm rates over the past 12 months and lifetime rates are generally higher in females and younger age groups (Table 39 and Table 40). Whilst lifetime self-harm rates are higher in the CCQ region than Queensland they have not been identified as statistically significant. Lifetime self-harm rates are highest in the 16–24-year age group amongst females (29.6%) with rates declining over time (Table 39).

Table 39: Persons who have self-harmed in lifetime (2020-22)[115]

Region	16-24 years			25-34 years			35-44 years			45-54 years			55-64 years			65-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	16.7%	29.6%	23.0%	14.1%	20.7%	17.5%	7.3%	11.2%	9.3%	5.0%	6.8%	5.9%	2.7%	3.6%	3.2%	1.1%	1.3%	1.2%
Queensland	16.1%	27.8%	21.9%	13.6%	19.2%	16.5%	6.6%	10.5%	8.6%	4.7%	6.6%	5.7%	2.6%	3.6%	3.1%	1.1%	1.4%	1.2%

Table 40: Persons who have self-harmed in last 12 months (2020-22)[115]

Region	16-24 years			25-34 years			35-85 years		
	M	F	Persons	M	F	Persons	M	F	Persons
CCQ	5.8%	10.2%	7.9%	2.1%	4.0%	3.0%	0.5%	0.9%	0.7%
Queensland	5.7%	9.7%	7.7%	2.1%	3.9%	3.0%	0.6%	1.0%	0.8%

Ambulance attendances: suicidal and self-harm behaviours

The complete extent of non-fatal suicidal and self-harming behaviours in the community is unknown in Australia. This is because, in part, not all people seek medical treatment or support for suicide attempts and self-harm injuries. Further, there are also limitations to and gaps in our current data that capture information about these behaviours. For example, data on hospitalisations due to intentional self-harm under-report the true incidence of these behaviours in the community, as only those with serious physical or mental ill-health are admitted to hospital for further treatment.[118]

Health service use in the last year of life

A significant proportion of people who die by suicide have contact with the health system in their last year of life. These contacts points provide a potential touch point for suicide prevention activities. Clapperton et al (2021) argue, many prevention activities focus on people who access hospitals; however, significant proportions of people who die by suicide (particularly men) do not attend hospitals in their last year of life.[119] It is important to focus not just on people who use services but also on people who do not access services.[120]

In a study led by the AIHW, patterns of health service use and key factors related to variation in the patterns of health service use were identified.

- Overall, 49% of 15–64-year-olds who died by suicide **did not have** any contact with the hospital (emergency department (ED) presentation or hospital separation), compared to 24% who died by other causes.
- Of those who did access a health service in their last year of life, MBS and PBS services represented the highest proportion of services among those who died by either suicide or other causes. For those who died by suicide, the next most prevalent health service after MBS and PBS was ED presentations (3.8%) then hospital separations (2.4%).
- Of those who presented to ED and died from suicide, one quarter (25%) were people aged 35–44, whereas only 11% of those who presented to ED and died from other causes were in this age group.
- Out of those who died by suicide, the average number of services per person for any mental health MBS services was higher than for those who died by other causes, across all age groups.[121]

Endocrine disorders – Type 2 diabetes

Diabetes is a chronic condition marked by high levels of glucose (sugar) in the blood. It is caused by the inability to produce insulin (a hormone made by the pancreas to control blood glucose levels) or to use insulin effectively, or both.[122] Type 2 diabetes accounts for 85-90% of all diabetes cases and is a progressive disease that can lead to serious complications including death. The condition has strong genetic and family-related (non-modifiable) risk factors and is often associated with modifiable lifestyle risk factors, including diet, physical activity, and healthy weight. At present, there is no cure for diabetes, with early diagnosis and management involving a combination of self-management (such as diet and physical activity), education on living with the condition, oral medication and/or insulin injections, and referral to specialised care where necessary.

Over the last 20 years, there has been a steady decline in the age-standardised incidence rate for type 2 diabetes in Australia of 43%. This is consistent with global trends thought due to improved preventive measures such as screening, increased awareness and educational programs leading to behavioural changes and risk factor modification. Over the same time, incidence of type 1 diabetes has remained steady, whereas the incidence of gestational diabetes has more than doubled thought due to increasing maternal age, higher rates of maternal overweight and obesity, and a growing proportion of higher risk ethnic groups in the population, as well as the introduction of new diagnostic guidelines.

Overall, CCQ has a significantly lower estimated prevalence of long-term diabetes compared with Australia (Table 41). Some LGAs have significantly higher rates including Woorabinda, Rockhampton and Bundaberg. Although prevalence is low, the PPHs for chronic diabetes complications is significantly higher across CCQ and most LGAs (Table 41). This is also the case for Aboriginal and Torres Strait Islander people in North Burnett, Banana and Rockhampton-Yeppoon. This suggests that for people with diabetes, their condition may be managed better. In addition, rates of premature deaths from diabetes is similar to Australia, except for Fraser Coast where premature death from diabetes is significantly higher (Table 41).

Although diabetes incidence is declining, the management of the condition remains a priority for CCQ. Prevention of risk factors, early diagnosis and effective management will remain important. This may include evaluating the effectiveness of existing programs where participation rates are adequate, but the condition is not controlled.

Diabetes in pregnancy

Diabetes affecting pregnancy can be pre-existing (that is, type 1 or type 2) or may arise because of the pregnancy (gestational diabetes). It can have short-term and long-term implications for both mothers and their babies and the type and severity of complications may differ according to type of diabetes experienced in pregnancy.[123]

Since 2014, the proportion of women with gestational diabetes has been increasing (8.3% in 2014 compared with 17% in 2022).[123]

In 2022, mothers aged 40 or more (27%) and women who were born overseas (24%) had the highest proportions of gestational diabetes. Aboriginal and Torres Strait Islander mothers (2.4%) and women with a parity of 4 or more (2.1%) had the highest proportions of pre-existing diabetes.[123]

In 2022, 16.5% of women who gave birth in Queensland had gestational diabetes (9,977 of 60,450 women). In 2022, 1.1% of women who gave birth in Queensland had pre-existing diabetes (663 of 60,450 women).[123]

Data is not available at a PHN or local level.

Table 41: Indicators of diabetes

LGA (Indigenous Area)	Self-reported prevalence (ASR per 100) of long-term diabetes for all persons aged 15+ years (2020-21)[28]	Estimated prevalence (ASR per 100) of diabetes mellitus for all persons (2017-18)	Proportion of women who gave birth in QLD with gestational diabetes (2021)[123]	Public hospital admissions (ASR per 100,000) for potentially preventable chronic diabetes complications for all persons (2020/21)	Prevalence (ASR per 100) of endocrine, nutritional and metabolic disease (incl. diabetes) for all Aboriginal people^ (2018-19)	Public hospital admissions (average annual ASR per 100,000) for potentially preventable chronic conditions diabetes complications for all Aboriginal people^ (2017/18 to 2020/21)	Premature mortality for diabetes (average annual ASR per 100,000) for all persons aged 0 to 74 years (2017-21)	Diabetes annual cycle of care PIP, all persons (%) (22022-23)^^[100]	Diabetes education, all persons (%) (2022-23)^^[100]
Banana	5.5	5.3	-	732.9	12.4	1,221.9	9.2	Biloela 0.34	Biloela 0.73
Bundaberg	6.3	5.5	-	336.2	13.4	495.6	6.8	Bundaberg 0.34 Burnett 0.18	Bundaberg 0.91 Burnett 0.48
Central Highlands (Central Capricorn)	5.2	5.4	-	294.5	12.4	403.0	8.8	Central Highlands -	Central Highlands 0.50
Fraser Coast	5.9	5.4	-	416.0	16.0	221.0	9.3	Maryborough 0.44 Hervey Bay 0.17	Maryborough 0.77 Hervey Bay 0.49
Gladstone	6.0	4.4	-	218.6	12.9	351.3	7.5	Gladstone 0.17	Gladstone 0.85
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	5.5	5.0	-	270.9	13.5 13.5	370.6 244.3	6.9	Gympie-Cooloola 0.31	Gympie-Cooloola -
Livingstone (Rockhampton-Yeppoon)	5.0	4.7	-	278.3	16.2	484.5	7.0	Rockhampton 0.21	Rockhampton 1.24
Noosa	2.9	3.2	-	79.6	12.6	370.6	4.6	Noosa 0.08 Noosa Hinterland 0.26	Noosa 0.09 Noosa Hinterland 0.15
North Burnett	5.9	6.2	-	329.1	12.4	1,221.9	-	Burnett 0.18	Burnett 0.48
Rockhampton (Rockhampton-Yeppoon)	7.1	5.3	-	370.0	16.2	484.5	9.4	Rockhampton 0.21	Rockhampton 1.24
Sunshine Coast (Maroochy; Caloundra)	3.8	3.5	-	204.5	12.1 11.8	268.9 359.7	3.4	Buderim 0.11 Maroochy 0.11 Nambour 0.16 Sunshine Coast Hinterland 0.19	Buderim - Maroochy 0.11 Nambour 0.13 Sunshine Coast Hinterland 0.22
Woorabinda (Central Capricorn)	28.1	-	-	..	12.4	403.0	-	Central Highlands -	Central Highlands 0.50
CCQ	***5.0***	***4.5***		***201.6***	***-***	***-***	***6.1***	**0.20**	**0.54**
Queensland	***5.5***	***4.7***	***15.3%***	***219.3***	***13.2***	***472.0***	***7.7***	**-**	**-**
AUSTRALIA	***5.7***	***4.9***	***16.3%***	***195.0***	***12.3***	***419.3***	***6.9***	**0.14**	**0.22**

^ Indigenous Area used rather than LGA. ^^ Crude percent used. Interpret with caution. Not relative to those with a chronic disease. - Not available

Hearing disorders – Hearing loss

Hearing loss is a common condition affecting around one in six Australians, with approximately 3.6 million people experience some level of hearing loss.[124] It is notably prevalent among older adults and Aboriginal and Torres Strait Islander children.[125] Hearing loss can be caused by various factors such as aging, exposure to loud noise, infections and genetic predispositions.[124]

As the Australian population ages, the number of individuals with hearing impairments is projected to double, reaching an estimated 7.8 million by 2060.[124] Types of hearing loss include auditory processing disorders, conductive hearing loss, sensorineural hearing loss and mixed hearing loss. Symptoms often develop gradually and can include difficulty hearing in noisy environments, trouble understanding speech and needing higher volume levels on electronic devices.[124]

In 2018-2019, approximately 43% of Aboriginal and Torres Strait Islander peoples aged 7 and over had measured hearing loss.[126] This rate increased to 40% in remote areas. Hearing screening participation among eligible Aboriginal and Torres Strait Islander babies was high, ranging from 91% to 98%. In 2021-22, 6,500 Aboriginal and Torres Strait Islander people received Medicare-subsidised audiology services across the nation. Service rates for children aged 0-14 years increased from 12 per 1,000 (2010-11) to 19 per 1,000 (2014-15), before falling to 14 per 1,000 in 2021-22.

Hospitalisations for middle ear procedures in children aged 0-6 rose between 2010-11 and 2022, with waiting times for elective ear surgeries also increasing. In 2022, 36% of Aboriginal and Torres Strait Islander youth who used hearing aids or cochlear implants had received their first device between ages 0-4.

Progress has been seen in increased Medicare subsidised audiology services, higher rates of ear-related hospital procedures, and earlier fitting of hearing devices. However, emergency department presentations for ear issues continue to increase.[126]

The impacts of hearing loss can be profound, affecting children's ability to learn and communicate, reducing school attendance, and hindering education and employment opportunities. It also negatively influences social and emotional wellbeing, leading to issues like low self-esteem, memory loss, and depression. Managing hearing loss involves using hearing aids, minimising background noise, clear communication, and the use of written or app-based translation tools. Additionally, tinnitus, characterised by internal ringing or similar sounds, is commonly associated with hearing loss and should be appropriately managed by healthcare professionals.

Data gaps exist in prevalence rates, patient pathways, workforce details, and ear health among incarcerated populations, with efforts needed for better monitoring and reporting.

Gastrointestinal disorders

Gastrointestinal (GI) disorders are a significant public health concern in Australia, affecting a large portion of the population and placing considerable strain on the healthcare system. These disorders encompass a wide range of conditions, including irritable bowel syndrome (IBS), inflammatory bowel disease (IBD), coeliac disease and gastroesophageal reflux disease (GERD). Inflammatory bowel disease, which includes Crohn's disease and ulcerative colitis, is particularly prevalent in Australia, with one of the highest incidence rates in the world. The exact cause of many GI disorders remains unclear, but a combination of genetic, environmental and lifestyle factors is thought to contribute to their development

The impact of GI disorders on individuals and the healthcare system is substantial. These conditions often lead to chronic pain, fatigue, malnutrition and a reduced quality of life for those affected. They also contribute to significant healthcare costs due to the need for ongoing medical treatment, hospitalisations and in some cases surgical interventions. In response, Australian health authorities and research institutions are increasingly focusing on early diagnosis, effective management strategies and improving the overall care pathways for individuals with GI disorders. Public awareness campaigns and research into the prevention and treatment of these conditions are also crucial components of the national effort to address the growing burden of gastrointestinal health issues in the country.

Chronic kidney disease

Kidney disease is defined as the presence of impaired or reduced kidney function lasting at least 3 months. A person who has severe kidney disease (end-stage kidney disease), usually requires a kidney transplant or dialysis to survive. The elderly, Indigenous Australians and people living in remote and socioeconomically disadvantaged areas are at an increased risk of kidney disease. The prevalence of kidney disease has remained stable over the last 10 years. There are various risk factors of kidney disease. These include health behaviours such as smoking, diet, physical activity and alcohol consumption; biomedical factors such as diabetes, high blood pressure, cardiovascular disease and obesity; as well as ageing, family history and acute kidney injury.

Kidney disease is underdiagnosed in Australia. As such, targeted screening and health checks of individuals at increased risk of developing kidney disease is recommended. There is no cure for kidney disease. Management of the disease and its symptoms is the primary form of treatment. Collaboration between general practitioners, nurse practitioners, primary health care nurses and people with kidney disease is recognised as an important part of the ongoing treatment and management, and primary health care providers have a role in supporting individuals' self-management of this condition.

Prevalence of long-term kidney disease in CCQ is similar to Australia (Table 42). Rockhampton, Bundaberg and Fraser Coast have significantly higher rates than Australia.

Prevention, diagnosis using good practice health checks and management of kidney disease is still important for CCQ, particularly for the Rockhampton, Bundaberg and Fraser Coast areas.

Table 42: Kidney condition indicators

LGA	Self-reported prevalence (ASR per 100) of kidney disease among people aged 15 years and over (2020-21)[28]	Proportion of First Nations people reporting diagnosed long-term kidney disease, 2021[127]	Age-standardised rate (per 1000) of hospitalisations for First Nations people that were for chronic kidney disease (Excl. dialysis) (2017-18 to 2021-22)[127]
Banana	0.7	-	-
Bundaberg	1.4	-	-
Central Highlands	1.0	-	-
Fraser Coast	1.3	-	-
Gladstone	1.2	-	-
Gympie	1.2	-	-
Livingstone	1.1	-	-
Noosa	0.7	-	-
North Burnett	1.0	-	-
Rockhampton	1.5	-	-
Sunshine Coast	0.9	-	-
Woorabinda	1.8	-	-
Central Queensland SA4	-	1%	5.1
Sunshine Coast SA4	-	1.1%	3.9
Wide Bay SA4	-	1.5%	4.9
CCQ	***1.1***	***-***	***-***
Queensland	***1.1***	***1.2%***	***5.7***
AUSTRALIA	***1.1***	***1.3%***	***5.5***

Infectious diseases

Infectious diseases are caused by bacteria, viruses, parasites, fungi, and their exotic products.[128] These diseases are often communicable, meaning they can be transmitted directly through contact with bodily fluids or indirectly through contaminated food, water, air or surfaces, and by vectors like mosquitoes. Common examples include measles, malaria and chlamydia.

Throughout the 20th century, advances in sanitation, vaccination, and treatment significantly reduced the burden of infectious diseases in Australia. High vaccination rates have led to the elimination of diseases like polio and measles across the country, although global outbreaks still pose a threat. Despite the relatively small overall burden of infectious diseases (2.5% of total disease burden in 2023), many Australians will experience an infectious disease in their lifetime.[128] The rise of antimicrobial resistance and demographic, technological and environmental changes pose future threats.

Notifiable diseases are a specific subset of infectious diseases that must be reported to health authorities. This allows for monitoring trends, detecting outbreaks and implementing timely interventions. The National Notifiable Diseases Surveillance System (NNDSS) in Australia manages this data. In 2023, over 1.5 million cases of notifiable diseases were reported, with COVID-19, influenza and RSV being the most common.

COVID-19, which emerged in late 2019, has had a profound impact, with over 775 million cases and 7 million deaths globally by March 2024. In Australia, nearly 12 million cases and over 22,000 deaths have been reported. In 2023, COVID-19 accounted for 34% of the infectious disease burden in Australia.[128]

Not all infectious diseases are notifiable. Hospitalisation and mortality data provide insight into the impact of severe non-notifiable diseases. In 2021, there were over 362,600 hospitalisations for infectious diseases, primarily for non-notifiable diseases like lower respiratory tract infections.[128] In 2022, infectious diseases accounted for over 15,770 deaths in Australia, with COVID-19 responsible for the majority of these.[128] The ongoing challenges highlight the importance of robust public health measures, vaccination programs and effective surveillance systems.

Almost 702,000 cases of notifiable diseases were reported in Australia in 2021. Four diseases accounted for 89% of notifications:

- COVID-19
- Chlamydia (a sexually transmissible infection)
- Campylobacter (a gastrointestinal infection)
- Varicella zoster (which causes chickenpox and shingles).

Notifiable cases are relatively rare occurrences within the broader spectrum of public health, often representing the most severe or highly communicable conditions. The figures below have been modelled on nationally reported data. The Public Health Units should be consulted if further localised analysis is required as case number are very low.

Notifiable cases in the CCQ region by disease type are shown in Figure 25 to Figure 30.

Figure 25: Cases of notifiable bloodborne viruses, all persons, CCQ region (2019-2023)[129]

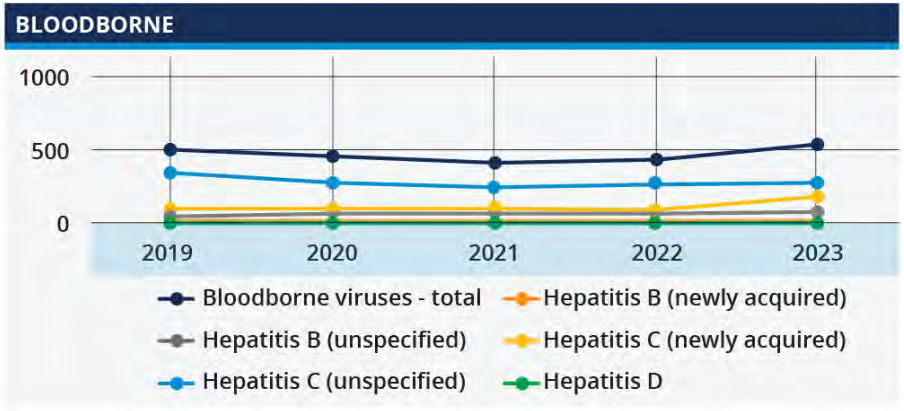


Figure 26: Cases of notifiable gastrointestinal diseases, all persons, CCQ region (2019-2023)[129]

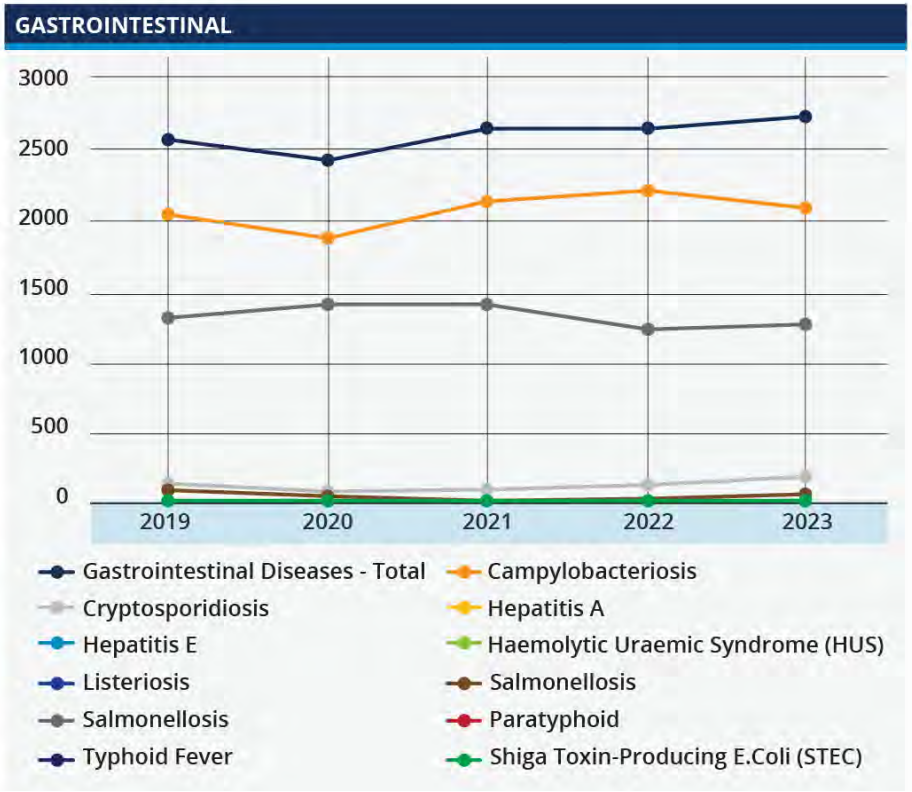


Figure 27: Cases of notifiable mosquito borne diseases, all persons, CCQ region (2019-2023)[129]

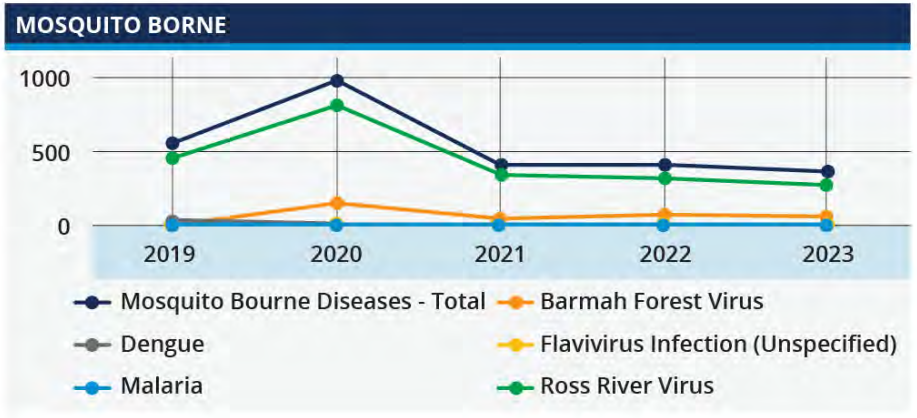


Figure 28: Cases of notifiable zoonotic diseases, all persons, CCQ region (2019-2023)[129]

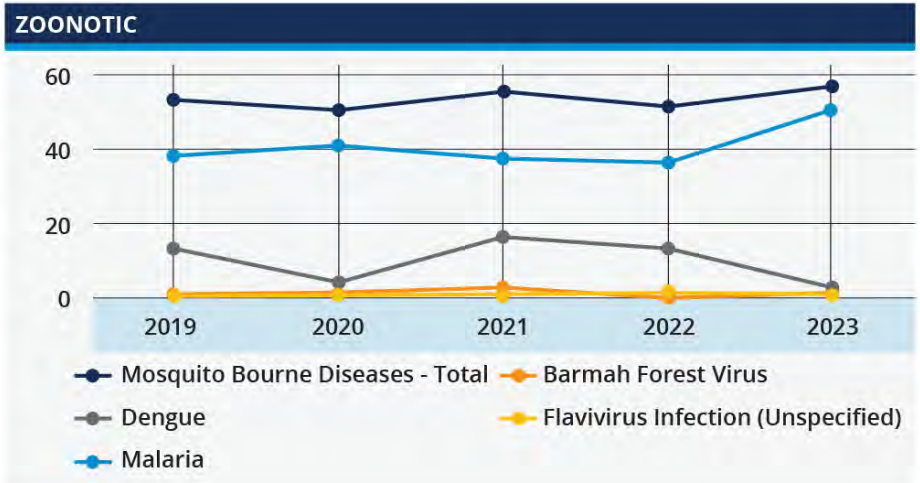
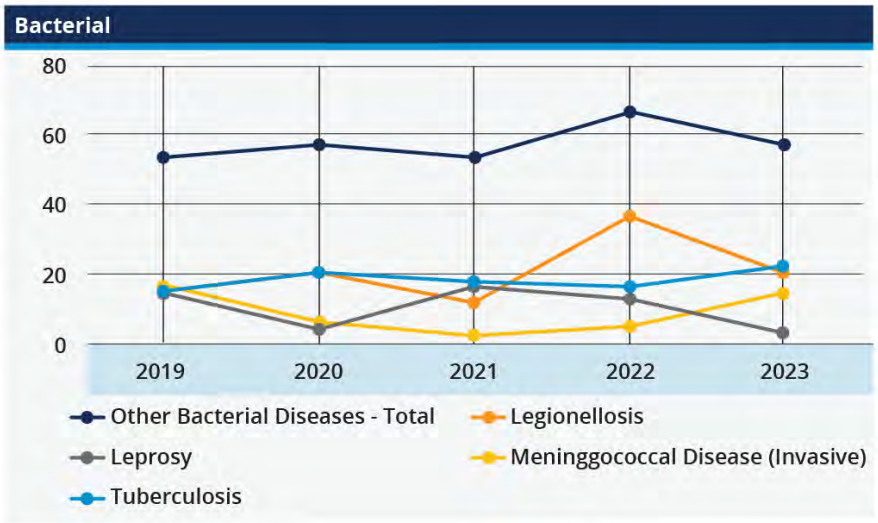


Figure 29: Cases of notifiable other bacterial diseases, all persons, CCQ region (2019-2023)[129]

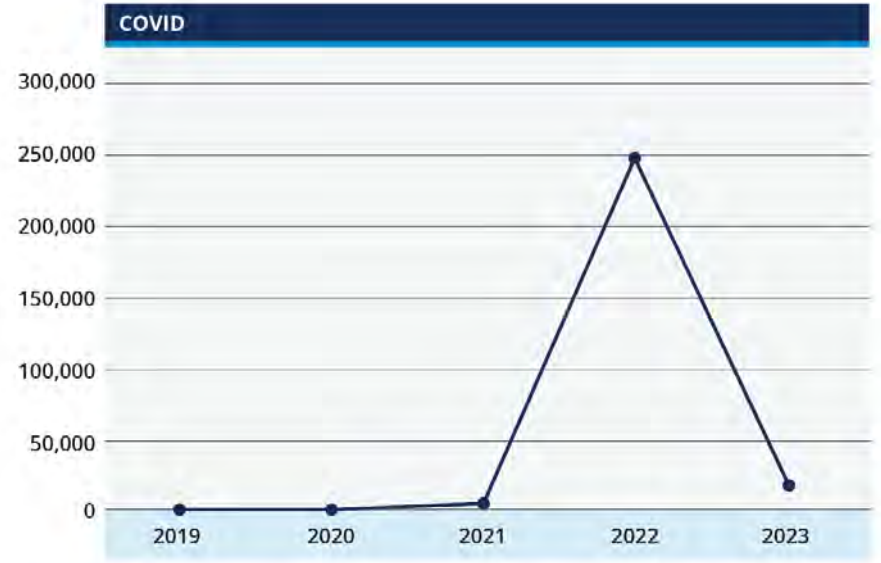


The impact of the pandemic on other infectious diseases

During the COVID-19 pandemic in 2020 and 2021, notifications of several diseases were reduced thought due to control measures in place and people being less likely to seek medical care for minor illnesses, which were under-diagnosed and –reported. These include:

- Diseases usually acquired overseas or offshore, e.g. dengue, Chikungunya virus and malaria.
- Measles, which is highly infectious but considered eliminated in Australia, with local outbreaks generally linked to a case brought in from overseas.
- Influenza, usually responsible for the most notifications in Australia.
- Chlamydia and gonorrhoea, which had been steadily increasing.
- Shigellosis, which is a bacterial gastrointestinal infection.

Figure 30: Cases of notifiable COVID-19, all persons, CCQ region (2019-2023)[129]



Vaccine-preventable conditions

Vaccine-preventable diseases are illnesses that can be prevented or mitigated through immunisation. Vaccines work by stimulating the immune system to protect against infections, and they have been recognised by the World Health Organization (WHO) as one of the most successful and cost-effective health interventions globally.[130] Despite this, vaccine hesitancy remains a significant public health challenge, with the WHO identifying it as a key global health threat.

Vaccine-preventable conditions are grouped as pneumonia and influenza (vaccine-preventable) and other vaccine-preventable conditions. Other vaccine-preventable conditions include:

- Chicken pox (varicella)
- Diphtheria
- Haemophilus meningitis
- Hepatitis B
- German measles (rubella)
- Measles
- Mumps
- Polio
- Rotavirus
- Tetanus
- Whooping cough (pertussis).

Several vaccine-preventable conditions, such as measles, rubella and diphtheria, are now rare in Australia as a result of Australia's high immunisation rates. Table 43 provides the total number of cases of selected vaccine-preventable conditions in the CCQ region from 2019 to 2023.

Overall, public hospital admission rates for all vaccine preventable conditions were significantly lower compared with national rates for all persons and Aboriginal and Torres Strait Islander people (Table 44). Rates of pneumonia and influenza were significantly higher for Aboriginal and Torres Strait Islander people in Central Capricorn.

Table 43: Cases of vaccine-preventable and related conditions, all persons, CCQ region (2019-23)[129]

Condition	2019	2020	2021	2022	2023
Diphtheria	2	1	2	2	1
Haemophilus influenza type B	0	1	1	0	0
Measles	11	2	0	0	4
Mumps	8	6	2	3	4
Pertussis	243	85	16	18	61
Poliomyelitis	0	0	0	0	0
Rotavirus	308	46	138	313	290
Tetanus	1	2	0	0	0
Varicella	1,741	1,736	1,891	1,693	1,861

Table 44: Pneumonia and influenza admissions (ASR per 100,000)

LGA (Indigenous Area)	Public hospital admissions for vaccine-preventable conditions, all persons (2020/21)[28]		Public hospital admissions for vaccine-preventable conditions, Aboriginal persons (2017/18-20/21)[29]	
	Pneumonia and influenza	Total – all vaccine preventable conditions	Pneumonia and influenza	Total – all vaccine preventable conditions
Banana	..	54.7	280.7	386.7
Bundaberg	15.8	62.9	170.3	459.0
Central Highlands (Central Capricorn)	..	..	328.9	489.2
Fraser Coast	12.9	68.1	162.8	334.6
Gladstone	..	27.9	112.7	216.5
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	..	102.5	207.0; 220.4	341.6; 317.9
Livingstone (Rockhampton-Yeppoon)	19.4	48.2	214.1	309.1
Noosa	..	53.8	280.7	386.7
North Burnett	..	71.4		
Rockhampton (Rockhampton-Yeppoon)	19.1	66.9	214.1	309.1
Sunshine Coast (Maroochy; Caloundra)	10.9	60.9	132.9; 132.7	203.7; 228.6
Woorabinda (Central Capricorn)	..	..	328.9	489.2
CCQ	**8.8**	**44.0**		
QLD	**12.0**	**84.4**	**248.9**	**537.6**
AUSTRALIA	**15.3**	**100.9**	**231.6**	**597.8**

Highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

Childhood immunisation

Immunisation has been one of the most successful public health interventions globally with vaccines available to prevent more than 20 life-threatening diseases. Immunisation currently prevents 3.5-5 million deaths globally every year from diseases like diphtheria, tetanus, pertussis, influenza and measles.

When enough people are vaccinated in a community against a disease to prevent it from spreading, this is known as 'herd immunity'. Herd immunity offers indirect protection to:

- unvaccinated people including children too young to be vaccinated
- people unable to be vaccinated for a range of valid medical reasons
- people for whom vaccination has not been fully effective.

To achieve herd immunity for infectious diseases, coverage needs to be high and varies by disease. For example, measles is highly infectious, so it needs a coverage rate of about 92% to 94%. In Australia, we have an aspirational coverage target of 95% for all vaccines.

The Queensland government has set the following vaccination targets for children and young people:

- 95% for childhood immunisations at one, two, and five years of age.
- Coverage is equal to or above non-Indigenous people across the lifespan
- 85% for adolescent recommended immunisations.[131]

The National Immunisation Program offers free vaccines to children from birth to 5 years of age. The Queensland government provides free vaccinations for children and adolescents aged 10 to 19 under the National Immunisation Program. Catch up vaccinations are available for school vaccinations through a catch-up school clinic, community immunisation clinics, or through general practice.

Current immunisation rates for all age-groups (1, 2 & 5) in the CCQ region fall below the national target of 95% (Figure 31). The rates have been declining since the COVID-19 pandemic. **At the local level, half of the region's SA3s have rates below the region average for all age-groups, including Gladstone – Biloela, Buderim, Maroochy, Nambour – Pomona, Noosa, Sunshine Coast Hinterland, Nambour, Noosa Hinterland and Gympie-Cooloola (Table 45).**

Figure 31: Children fully immunised at 1, 2 and 5 years of age, by CCQ region (2015-2023)[132]

Table 45: Children fully immunised at 1, 2 and 5 years of age, by SA3, Rolling four quarter coverage[132]

SA3	Fully immunised (%) – 30 June 2024		
	1-year olds	2-year-olds	5-year-olds
Central Highlands (Qld)	90.20%	**87.86%**	91.62%
Gladstone - Biloela	**88.41%**	89.52%	**90.81%**
Rockhampton	92.03%	92.89%	94.56%
Biloela	93.22%	92.62%	93.48%
Gladstone	90.75%	**86.40%**	91.33%
Buderim	**88.57%**	**88.51%**	**90.52%**
Caloundra	90.13%	**88.64%**	91.97%
Maroochy	**85.39%**	**85.43%**	**86.55%**
Nambour - Pomona	**84.65%**	**82.05%**	**84.31%**
Noosa	**80.38%**	**79.05%**	**86.12%**
Sunshine Coast Hinterland	**86.76%**	**85.69%**	**89.40%**
Nambour	**86.53%**	**84.84%**	**86.76%**
Noosa Hinterland	**80.82%**	**76.19%**	**74.71%**
Bundaberg	92.76%	91.28%	93.35%
Burnett	90.54%	**88.65%**	92.96%
Gympie - Cooloola	**85.38%**	**82.81%**	**87.61%**
Hervey Bay	92.94%	91.68%	94.38%
Maryborough	92.58%	91.32%	**90.78%**
CCQ region	***89.44%***	***88.37%***	***90.91%***
CCQ region – Aboriginal & Torres Strait Islander	***90.24%***	***87.92%%***	***94.91%***
NATIONAL TARGET	***95%***	***95%***	***95%***

Highlighted figures are below CCQ rates
NB: Figures shown for 5-year-olds

CCQ HPV Vaccination by postcode (all genders)

In the CCQ region, HPV vaccination is close to the national target of 85% for most postcodes. Over 75% of postcodes in all three HHS regions (SC, WB, and CQ) have HPV vaccination coverage rates over 80%, while Central Queensland has at least 75% of postcodes with coverage over 85% of either one or two doses of the HPV vaccine. There are some localised areas of concern, with some postcodes having vaccination rates as low as 75% coverage (Table 46).

Table 46: HPV coverage rates (A02 dose) below Queensland average (10 to <20 years) (2015-2024)

LGA	Postcode	Suburb	Coverage (%)
Sunshine Coast	4517	Beerburrum	68.6%
Central Highlands	4712	Duaringa	72.7%
Banana	4715	Biloela (and surrounding suburbs)	74.1%
Rockhampton	4699	Bajool, Port Alma	75.6%
Gympie	4600	Kilkivan (and surrounding suburbs)	77.4%
North Burnett	4601	Goomeri (and suburbs to north and south)	77.6%
North Burnett	4625	Gayndah (and surrounding suburbs)	77.8%
Bundaberg	4673	Yandaran (and surrounding suburbs)	77.8%
Central Highlands	4723	Capella (and surrounding suburbs)	78.0%
Gympie	4580	Cooloola, Cooloola Cove, Tin Can Bay	78.5%
Gympie	4574	Kenilworth (and surrounding suburbs)	79.6%
Bundaberg	4671	Lake Monduran (and surrounding suburbs)	79.8%
Noosa	4571	Kin Kin	80.0%
Rockhampton	4714	Leydens Hill (and surrounding suburbs)	80.3%
Bundaberg	4660	Childers (and surrounding suburbs)	80.9%
QLD (Male)*	-	-	***80.1%***
QLD (Male* Aboriginal and Torres Strait Islander)	-	-	***75.1%***
QLD (Female)*	-	-	***83.2%***
QLD (Female* Aboriginal and Torres Strait Islander)		-	***80.3%***

*2023

Measuring HPV vaccination rates over time is slightly complicated due to a change in administration and reporting of HPV vaccinations, with the introduction of a single-dose regime in 2023 replacing the two-dose method, this has resulted in increased measured rates of vaccinations from 2023 onwards.[133]

Oral health and wellbeing

Good oral health is important for overall wellbeing, affecting a person's quality of life and ability to eat, speak and socialise. Despite its importance, comprehensive national data on Australian's oral health and dental service usage is limited. Population surveys indicate that poor oral health, such as tooth decay, gum disease and tooth loss is prevalent among both Australian children and adults. In Australia, children aged 5-10 years have an average of 1.5 decayed, missing or filled teeth, with 27% having untreated decay.[134] Dental services can be accessed privately or through public clinics, with 44.8 million services subsidised by private health insurance and 4.7 million under the Child Dental Benefits Schedule in 2021-22.[134]

Dental visits offer preventative care and treatment, with most children making their first visit by age 5 and nearly half of adults visiting a dental professional annually. However, cost remains a barrier, with 33% of adults delaying or foregoing visits due to expense. In 2020-21, dental service spending in Australia totalled $11.1 billion, with individuals bearing the majority of costs.[134] The COVID-19 pandemic significantly impacted dental services, leading to restrictions and deferred treatments.

The CCQ region has experienced higher rates of public hospital admissions for acute dental conditions compared with state and national averages, including the LGAs of Bundaberg, Central Highlands, Fraser Coast, Gladstone, Gympie, Livingstone, and Rockhampton (Table 47).

Table 47: Public hospital admissions for potentially preventable acute conditions for all ages by LGA (age-standardised rate per 100,000, 2020/21)[72]

LGA	Acute dental conditions, all persons	Acute dental conditions, Aboriginal persons
Banana	143.3	607.2
Bundaberg	230.1	493.7
Central Highlands (Central Capricorn)	255.8	384.1
Fraser Coast	274.7	605.4
Gladstone	153.0	255.0
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	202.9	310.9; 288.8
Livingstone (Rockhampton-Yeppoon)	151.3	512.6
Noosa	82.2	310.9
North Burnett	179.9	607.2
Rockhampton (Rockhampton-Yeppoon)	213.9	512.6
Sunshine Coast (Maroochy; Caloundra)	116.2	337.6; 337.8
Woorabinda (Central Capricorn)	..	384.1
CCQ	***126.6***	*--*
Queensland	***121.4***	***417.3***
AUSTRALIA	***107.4***	***402.0***

Chronic pain

Chronic pain is pain that lasts beyond normal healing time after injury or illness. It is a common and complex condition, and the pain experienced may be anything from a mild niggle to debilitating. Older people with chronic pain can be at an increased risk of falling, reduced mobility and disability. In turn, people who experience falls, reduced mobility or disability may be at an increased risk of pain. Pain can also affect people's ability to look after themselves and remain independent in older age.[135,136]

Measuring how many people have chronic pain in Australia is difficult. Pain is a subjective experience, and the few national data sources that include measures of chronic pain use different definitions.

In 2016, almost 1 in 5 (19%, or 1.6 million) Australians aged 45 and over reported having chronic pain.[135] Chronic pain increased with increasing age, to almost 1 in 4 adults (24%) aged 85 and over. This may be because older people often experience medical conditions associated with pain, such as musculoskeletal conditions. Attitudes towards pain and biological changes in the perception of pain may also influence the experience of pain in older adults.

Chronic pain was 1.8 times as high for women aged 85 and over (28%) as women aged 45–54 (16%). Among men, chronic pain was 1.3 times as high in those aged 85 and over (18%) as in those aged 45–54 (13%). Overall, women had higher rates of chronic pain (21%) than men (17%). According to a different data source, the ABS Survey of Disability, Ageing and Carers, chronic pain rates in adults aged 45 and over remained stable between 2003 and 2015 for both males (20%) and females (25–26%).[135]

Frailty

Frailty is a multidimensional geriatric syndrome characterised by a decline of physical and cognitive reserves that leads to increased vulnerability. Frailty increases with age and is associated with falls, longer stays in hospital, difficulty recovering from illness and surgery, and mortality.[137]

There was approximately 14,200 people with pre-frailty and 3,700 people with frailty in 2019-20 in CCQ. A small-scale study involving 592 older people living in 10 aged care facilities in Queensland reported a much higher prevalence of frailty (44%) and pre-frailty (46%).[138] This suggests that there is a potentially higher number of undiagnosed cases of frailty and prefrailty.

People with frailty often experience poorer outcomes and mortality from contracting COVID-19.[138] People living in residential aged care homes are assessed for frailty as part of their aged care assessment. Regional data also suggests low COVID-19 vaccination rates in some of the RACHs located within the CCQ region, including Sunshine Coast, Noosa, Livingstone, Bundaberg, Gympie, North Burnett, Fraser Coast and Rockhampton LGAs.

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Acute conditions

Acute conditions are health problems that come on suddenly and usually have a short duration. They often require urgent or immediate care but typically resolve within a short period, either through treatment or recovery. Acute conditions differ from chronic conditions, which develop more slowly and last a long time, although acute conditions may lead to chronic conditions if not properly managed.

Acute conditions can have significant, often immediate, impacts on health, including:

- **Physical symptoms and functioning:** acute conditions typically cause sudden symptoms such as pain, fever, difficulty breathing or loss of function, which can impair daily activities and overall well-being.
- **Need for immediate care:** many acute conditions require prompt medical intervention to prevent complications or death. This can lead to hospitalisation, surgeries or emergency treatments.
- **Risk of complications:** if untreated or not managed quickly, acute conditions can lead to severe complications.
- **Emotional and mental health effects:** acute conditions often cause anxiety, stress and fear, especially if the condition is life-threatening or results in hospitalisation. The sudden disruption can also affect mental wellbeing.
- **Potential for chronic sequelae:** some acute conditions can lead to long-term or chronic health problems if not properly treated.

Though many acute conditions resolve with treatment, they can have lasting effects depending on severity, treatment and underlying health factors.

In Australia, acute conditions are often treated in primary healthcare settings like GPs for less severe cases, or in hospitals and emergency departments for more urgent and life-threatening conditions. For more complex or serious acute conditions, Australia's public and private healthcare sectors provide access to specialist care, intensive treatments and follow-up services. Australia's Medicare system ensures that most residents have access to medical care for acute conditions, including GP visits, emergency department services and certain hospital treatments.

The CCQ region experiences higher rates of public hospital admissions for potentially preventable acute conditions compared to the national average (Table 48). Queensland overall has slightly higher rates than CCQ. Several LGAs report notably elevated rates of hospital admissions, such as North Burnett and Woorabinda reporting total rates for public hospital admissions exceeding both CCQ and national figures. Woorabinda, in particular, shows significantly high rates of admissions for cellulitis, convulsions and epilepsy, indicating a substantial burden of acute health issues among its Indigenous population. Similarly, Central Highlands reports elevated rates across multiple acute conditions for both Indigenous and non-Indigenous populations.

Table 48: Public hospital admissions for potentially preventable acute conditions for all ages by LGA (age-standardised rate per 100,000, 2020/21)[72]

LGA (Indigenous Area)	All persons						Aboriginal persons				
	Acute cellulitis	Acute convulsions and epilepsy	Acute ear, nose and throat infections	Acute gangrene	Acute urinary tract infections	Total	Acute cellulitis	Acute convulsions and epilepsy	Acute ear, nose and throat infections	Acute urinary tract infections	Total acute conditions
Banana	670.6	270.8	279.0	..	652.6	**2,142.0**	550.6	451.8	622.7	677.2	2,971.2
Bundaberg	500.6	266.0	184.6	86.7	524.4	**1,850.3**	410.2	438.3	314.7	437.8	2,174.5
Central Highlands (Central Capricorn)	637.2	258.1	237.2	36.8	583.0	**2,055.8**	907.4	551.3	579.8	519.0	3,039.0
Fraser Coast	692.1	301.8	169.2	132.3	790.4	**2,523.0**	481.5	300.8	287.3	413.9	2,191.7
Gladstone	392.7	270.6	211.7	71.6	509.6	**1,683.6**	353.6	464.3	279.0	285.0	1,712.0
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	604.6	258.3	189.5	80.9	452.9	**1,856.0**	363.8; 305.1	294.9; 256.1	374.2; 185.8	221.8; 326.1	1,635.5; 1,468.8
Livingstone (Rockhampton-Yeppoon)	499.8	179.5	200.0	60.6	517.2	**1,706.1**	596.7	507.2	360.4	590.7	2,667.7
Noosa	210.6	197.5	130.7	39.2	279.0	**981.4**	363.8	294.9	374.2	221.8	1,635.5
North Burnett	754.5	250.5	137.1	71.3	569.9	**2,057.6**	550.6	451.8	622.7	677.2	2,971.2
Rockhampton (Rockhampton-Yeppoon)	543.9	293.2	202.8	87.8	607.8	**2,005.4**	596.7	507.2	360.4	590.7	2,667.7
Sunshine Coast (Maroochy; Caloundra)	346.0	254.7	269.2	46.6	411.7	**1,490.2**	320.0; 307.5	311.4; 226.1	466.3; 438.8	388.8; 530.1	1,882.3; 1,932.1
Woorabinda (Central Capricorn)	857.6	..	..	..	696.2	**2,322.9**	907.4	551.3	579.8	519.0	3,039.0
CCQ	***333.4***	***191.4***	***164.9***	***50.2***	***363.7***	***1,277.2***	--	--	--	--	--
Queensland	***336.7***	***186.2***	***183.6***	***56.3***	***382.2***	***1,311.0***	***626.6***	***454.7***	***441.0***	***490.3***	***2,563.3***
AUSTRALIA	***234.9***	***156.8***	***130.7***	***46.1***	***279.2***	***996.1***	***515.5***	***404.8***	***385.4***	***402.8***	***2,307.7***

Highlighted areas were reported as significant in data source compared with national figures (red highlight = poorer status; green highlight = higher status)

Women's health conditions

Women's health is often simplified to include only sexual and reproductive health (SRH), which meaningfully underrepresents women's health burden. Women's health covers both sex-specific conditions (for example, endometriosis and menopause) and general health conditions that may affect women differently (higher disease burden) or disproportionately (higher prevalence).[139,140]

Research shows that SRH and maternal, newborn, and child health account for approximately 5% of women's health burden, although this is probably an underestimate. An estimated 56% of the burden comes from health conditions that are more prevalent and/or manifest differently in women. The remaining 43% stems from conditions that do not affect women disproportionately or differently based on current evidence.[139,140]

Women are most likely to be affected by a sex-specific condition between the ages of 15 and 50. Other conditions occur throughout women's lives, but nearly half of the health burden affects women in their working years, which often has an impact on their ability to earn money and support themselves and their families.[139,140]

Pelvic pain and endometriosis

Endometriosis is a condition where endometrial-like tissue is present outside the uterus and is associated with pelvic pain, infertility, and poor mental health.[141]

- One in nine Australian women is diagnosed with endometriosis by the age of 44 years.[142]
- The average time to get an endometriosis diagnosis is 7 years
- Approximately 5% of Queensland and Australian women in their early-to-mid 20s report having endometriosis.
- By their early 40s, the cumulative prevalence of endometriosis is higher among Queensland women (17%) than Australian wide (11%).
- One in ten (11.7%) Queensland women had undergone a hysterectomy or oophorectomy by age 43-48 (median age 46), with no clear difference by the area of residence.
- For Australian women, 1.3% experience premature menopause (before age 40 years) and 5.8% early menopause (between 40 and 44 years).[141]

Perimenopause and menopause

The average age of menopause for Queensland women is 50.8 years.[141]

For women currently aged 43-48 years:

- One in ten (10%) have undergone a hysterectomy or oophorectomy, one in four women (23%) are experiencing perimenopause, and 7.4% are already postmenopausal.
- Nearly half (48%) of women aged 43-48 years reported experiencing vasomotor symptoms (VMS; hot flushes and/or night sweats), with 29% having symptoms often/sometimes and 34% finding them bothersome (a little/a lot).
- Of those with symptoms often/sometimes, one in four (23%) sought help. This prevalence of VMS symptoms is similar to that found for Australian women.
- Among women who often experienced VMS, 11.9% were taking HRT (compared with 1.8% in women who never experienced VMS).[141]

For women aged 59-64 years:

- More than 95% of women had reached menopause (either naturally or surgically), 62% experienced natural menopause, and 34% had undergone a hysterectomy and/or bilateral oophorectomy.
- The trajectory or profile of symptoms occurs throughout the 50s and early 60s - as shown for hot flushes in Figure 13-26, with around 9% of Australian women aged 59-64 still experiencing hot flushes.
- Perimenopausal and menopausal symptoms persist long after menopause, with data lacking on menopause among Aboriginal and Torres Strait Islander women.[141]

Perinatal conditions

Proportion of mothers who are obese

Obesity in pregnancy contributes to increased risks of illness and death for both mother and baby. Pregnant women who are obese have an increased risk of thromboembolism, gestational diabetes, pre-eclampsia, post-partum haemorrhage (bleeding) and wound infections. They are also more likely to deliver via caesarean section. Babies of mothers who are obese have higher rates of congenital abnormality, pre-term birth, stillbirth and neonatal death than babies of mothers who are not obese.[143]

Body mass index (BMI) is a ratio used to classify weight ranges. It does not necessarily reflect body fat distribution or describe the same degree of fatness in different individuals. At a population level, however, it is a practical and useful measure to identify underweight and obesity.

In 2021, 28% of mothers were overweight and 23% were obese. The proportion of mothers who were obese was highest amongst:

- women with a parity of 3 (36%) or 4 or more (42%)
- women who lived in Very remote areas (30%)
- women who lived in the most disadvantaged areas (31%)
- who had a caesarean section birth (29%).[143]

In 2021, 2.7% of mothers were underweight. The proportion was highest amongst teenage mothers (aged under 20) (10%), women who lived in Very remote areas (4.0%) and Aboriginal and Torres Strait Islander mothers (5.7%).[143]

Annual births and fertility rate

Total fertility rate is the average number of children a woman would have during her lifetime should she experience the age-specific fertility rates present at the time. High or increasing fertility rates may indicate a future need for additional antenatal services within a region and infrastructure, such as schools and childcare facilities. The fertility rate is higher across a majority of the CCQ region compared with Queensland.

Low birthweight

Birthweight is a key health indicator for infants, with impacts on future development and growth. In 2021, 92% of babies born in Australia had a normal birthweight (2,500-4,499 grams), 1.2% had a high birthweight (4,500 grams or more) and 6.8% had a low birthweight (less than 2,500 grams).[144] Low birthweight is associated with higher risks of illness and death. Among liveborn low birthweight babies, 15% weighed less than 1,500 grams, and 6.5% weighed less than 1,000 grams. Pre-term births are often linked to low birthweight, with 71% of low birthweight babies being pre-term. The incidence of low birthweight babies is consistently higher in disadvantaged areas.[144]

In the CCQ region, prevalence of low birthweight babies is higher than Queensland averages in Bundaberg, Central Highlands (Central Capricorn) and Gladstone for Aboriginal and all mothers (Table 49). Infant mortality rates are also higher than state and national averages in Central Highlands, Fraser Coast and Gladstone LGAs.

Table 49: Postnatal indicators

LGA (Indigenous area)	Number of registered births (2022)[145]	Fertility rate[12]	% low birthweight babies (2019-2021)[28]	% low birthweight babies born to Aboriginal mothers (2019-2021)[29]	Average annual infant mortality rate per 1,000 (2017-2021)[28]
Banana	178	**2.08**	4.8%	**	**
Bundaberg	962	**1.84**	**7.1%**	**12.5%**	3.8%
Central Highlands (Central Capricorn)	412	**2.11**	**7.1%**	**12.8%**	**4.9%**
Fraser Coast	967	**2.00**	**7.7%**	10.2%	**4.2%**
Gladstone	815	**2.08**	**6.8%**	**11.0%**	**4.0%**
Gympie (Cooloola-Gympie; Nanango – Kilkivan)	533	**2.10**	**6.8%**	9.4% **	2.3%
Livingstone	449	**2.09**	4.4%	-	**
Noosa	389	1.59	4.3%	**	**
North Burnett	105	**2.10**	6.4%	**	**
Rockhampton (Rockhampton – Yeppoon)	1,104	**1.99**	**7.8%**	**10.9%**	3.3%
Sunshine Coast (Caloundra Maroochy)	3,491	1.68	5.6%	6.2% 8.0%	3.1%
Woorabinda	17	**1.98**	**10.0%**		**
CCQ Region	***-***	***-***	***6.4%***	***10.1%***	***3.3%***
Queensland	***62,094***	***1.72***	***6.7%***	***10.4%***	***3.9%***
AUSTRALIA	***-***	***-***	***6.5%***	***10.9%***	***3.2%***

** Not releasable - Not available Substantial numerical differences are shown in grey.

Gestational age – Pre-term babies

Most babies (92%) in Australia are born at term (37–41 weeks) (90.8% in Queensland), with 32% at early term (37 or 38 weeks) and 60% at full term (39–41 weeks). This is similar across the states and territories and has been stable over time.[146]

Perinatal deaths

Content warning: This content contains information some readers may find distressing as it relates to stillbirth and the loss of a newborn.

Australia is one of the safest places in the world for a baby to be born, yet death occurring within the perinatal period is not uncommon. On an average day in Australia, 6 babies are stillborn and 2 die within 28 days of birth (neonatal death). In 2021, in Australia, 3,016 babies died in the perinatal period (from 20 weeks of gestation to 28 days after birth). Three-quarters (2,278) were stillbirths and the remaining 738 were neonatal deaths.[147]

The overall rate of perinatal mortality in Australia in 2021 was 9.6 deaths per 1,000 births. Perinatal mortality rates were higher among babies born to:

- women who accessed 2 or fewer antenatal visits (96 perinatal deaths per 1,000 births)
- women with pre-existing diabetes mellitus (27 deaths per 1,000 births)
- women who have had a previous stillbirth (23 deaths per 1,000 births).
- women who were aged under 20 or 40 and over (21 and 14 deaths per 1,000 births, respectively)
- women who lived in *Very remote* areas (19 deaths per 1,000 births)
- women who have had four or more previous births (17 deaths per 1,000 births)
- Aboriginal and Torres Strait Islander women (17 deaths per 1,000 births)
- women who smoked throughout pregnancy (16 deaths per 1,000 births)
- women living in the most disadvantaged areas of Australia (12 deaths per 1,000 births for quintile 1).

Maternal deaths

The maternal mortality rate in Australia in 2021 was 5.8 deaths per 100,000 women giving birth (18 maternal deaths). In the decade from 2012 to 2021, there were 191 women reported to have died during pregnancy or within 42 days of the end of pregnancy and a maternal mortality rate of 6.3 deaths per 100,000 women giving birth.[148]

The most frequent causes of maternal death reported in Australia between 2012 and 2021 were:

For all maternal deaths:

- cardiovascular disease (26 deaths or 14%)
- sepsis (21 deaths or 11%).
- thromboembolism (20 deaths or 10%)
- suicide (20 deaths or 10%).

For direct maternal deaths:

- thromboembolism (19 deaths)
- amniotic fluid embolism (14 deaths)
- sepsis (12 deaths).

For indirect maternal deaths:

- complications of pre-existing cardiovascular disease (22 deaths)
- non-obstetric haemorrhage (mostly haemorrhage within the brain and haemorrhage from a ruptured aneurysm of the splenic artery) (14 deaths)
- suicide (12 deaths).[148]

Direct maternal deaths are those resulting from obstetric complications of pregnancy or its management. **Indirect** maternal deaths are those resulting from diseases or conditions that were not due to a direct obstetric cause, but were aggravated by the physiologic effects of pregnancy.[148]

SOCIO-ECOLOGICAL DETERMINANTS OF HEALTH

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Socio-ecological determinants of health

Health and wellbeing is influenced by the conditions in which people are born, live, work and play. Whilst individuals may take action to protect their own or their family's health, very often the circumstantial and environmental contexts in which they live determines their health. For example, individuals may be exposed to discrimination or stigma, or poor-quality housing, income and education level, and relationships with friends and family or other environmental factors that have a direct impact on physical, mental, spiritual or social wellbeing.

Factors such as the social gradient, urban settings, early development, employment conditions, education, gender equity, and globalisation are known as the social determinants of health. However, determinants extend well beyond this and also include cultural, economic, political, natural and built environments. These environments interact with individual factors (human biology, knowledge, attitudes, beliefs, behaviours and skills) to determine health and wellbeing. Collectively these environmental and individual factors are referred to as the socio-ecological determinants of health and wellbeing (Figure 32).[1]

When considering the determinants of health and wellbeing, consideration is also needed for the determinants for Aboriginal and Torres Strait Islander communities. These determinants are based on their understanding of social and emotional wellbeing and include those above (Figure 32) as well as historical and broader cultural determinants.

Figure 32: Determinants of health[151]

Figure 33: A model of Social and Emotional wellbeing[149]

Cultural environment

The cultural determinants of health originate from and promote a **strength-based** perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety**.**

Culture refers to the shared values, beliefs, customs and practices of a group or society. It influences how people perceive and respond to health and illness, including health behaviours, dietary practices, health-seeking behaviours and the utilisation of healthcare services. Cultural norms also shape social support systems and community networks, which are important for health and wellbeing. On the other hand, language encompasses the communication tools used by individuals, including spoken, written and non-verbal forms. In health contexts, language affects how well individuals can understand and engage with health information, interact with healthcare providers, and navigate health services. Language barriers can lead to misunderstandings, reduced access to appropriate care and lower health literacy.

Ethnicity

Aboriginal and Torres Strait Islander people

In Australia, Aboriginal people have occupied their traditional lands for the past 50,000 to 120,000 years and their continuity, history and cultural traditions are unrivalled in the world.[150,151]

Aboriginal and Torres Strait Islander people have a 'whole of life' view of health that incorporates the total wellbeing of their community and not just the individual.[152] Both social and cultural factors can have a profound impact on the health of Aboriginal and Torres Strait Islander people.[152-157] Both social and cultural factors can have a profound impact on the health of Aboriginal and Torres Strait Islander people.[153-157] It is evident that the ongoing impacts of colonisation (including oppression; exploitation; marginalisation; separation from culture, land and family; intergenerational trauma; racism; and poverty) have had negative impacts on health and wellbeing for many Aboriginal and Torres Strait Islander people.[151,153,158] Factors such as family and community; connection to Country and place; language; cultural identity, as well as self-determination have all been identified as having a positive impact on the health and wellbeing of Aboriginal and Torres Strait Islander people.[154]

The total estimated population of Aboriginal and Torres Strait Islander peoples in 2021 was 45,013 (3.8% of Australia's total population) (Table 50). Queensland had a higher proportion (5.2%) with 273,119 peoples. The proportion is CCQ was slightly lower at 4.9% (45,013 peoples).[28]

In Woorabinda, 95.8% of the population identifies as Aboriginal and/or Torres Strait Islander.

Table 50: Estimated resident Aboriginal and Torres Strait Islander population by LGA (30 June 2021)[28,159]

LGA	Estimated resident Aboriginal and Torres Strait Islander population (no.)	Total ERP (no.)	Proportion of total population
Banana*	**862**	**13,709**	**6.3%**
Bundaberg	**5,623**	**100,095**	**5.6%**
Central Highlands	**2,066**	**28,298**	**7.3%**
Fraser Coast	**6,450**	**112,070**	**5.8%**
Gladstone	**4,508**	**64,275**	**7.0%**
Gympie	2,710	53,851	5.0%
Livingstone	**2,482**	**39,877**	**6.2%**
Noosa	1,034	56,874	1.8%
North Burnett	**844**	**10,142**	**8.3%**
Rockhampton	**8,251**	**82,882**	**10.0%**
Sunshine Coast	9,184	346,634	2.6%
Woorabinda	**996**	**1,040**	**95.8%**
CCQ*	**45,013**	**909,793**	**4.9%**
QLD	**273,119**	**5,215,814**	**5.2%**

*PHIDU
Substantial numerical differences are shown in grey

Multicultural communities

People from multicultural or culturally and linguistically diverse (CALD) backgrounds refer to those whose cultural identity varies from the Anglo-Celtic majority or Aboriginal and Torres Strait Islander populations of Australia.[160] People arrive in Australia through a range if migration pathways (migrants arriving on work or family visas, people of refugee background, people seeking asylum, seasonal workers, international students and Trans-Tasman visa holders).

Australia has a diverse mix of cultural backgrounds consisting of more than 300 different ancestries.[160] Culture and language can have a profound influence on a person's health seeking behaviours, understanding of healthcare systems, and perceptions of what it means to be healthy.

People from multicultural backgrounds, particularly non-English speaking background, often face additional barriers to accessing and navigating the Australian health system, including:

- language barriers, for example, accessing appropriate interpreting services
- health literacy challenges
- cultural safety and appropriateness of available health services
- stigma and discrimination
- socioeconomic and systemic factors.

In CCQ, 145,473 residents (or 16.1%) were born overseas with 56,966 from non-English speaking background (non-ESB) countries.

Sunshine Coast LGA had the largest number of persons born overseas with 70,749 and Noosa LGA had the largest percentage (23%) of persons born overseas (15%) from English speaking countries and 8% from non-English speaking background countries (Table 51). The CCQ region has over 3,000 residents who do not speak English well or at all. The highest numbers are in the LGAs of Sunshine Coast (1,015), Bundaberg (775), and Rockhampton (610).

Table 51: People born overseas and reporting poor English proficiency by LGA (2021)[28]

LGA	Born overseas (number, %)			People born overseas reporting poor proficiency in English	
	Born in ESB countries	Born in non-ESB countries	Total born overseas	People born overseas who speak English not well or not at all	% born overseas who speak English not well or not at all
Banana – part b	397 (2.9%)	657 (4.8%)	1,054 (7.7%)	145	1.1%
Bundaberg	**6,751 (6.8%)**	**6,197 (6.2%)**	**12,948 (13.0%)**	**775**	**0.8%**
Central Highlands	1,748 (6.3%)	1,514 (5.4%)	3,255 (11.7%)	135	0.5%
Fraser Coast	**10,518 (9.5%)**	**6,156 (5.5%)**	**16,688 (15.0%)**	231	0.2%
Gladstone	4,781 (7.5%)	3,633 (5.7%)	8,429 (13.3%)	186	0.3%
Gympie	3,994 (7.5%)	2,173 (4.1%)	6,164 (11.6%)	86	0.2%
Livingstone	2,698 (6.8%)	1,289 (3.3%)	3,992 (10.1%)	52	0.1%
Noosa	**8,456 (15.0%)**	**4,513 (8.0%)**	**12,989 (23.1%)**	113	0.2%
North Burnett	415 (4.1%)	612 (6.1%)	1,029 (10.2%)	78	0.8%
Rockhampton	3,081 (3.8%)	5,088 (6.2%)	8,180 (10.0%)	**610**	0.8%
Sunshine Coast	**45,714 (13.3%)**	**25,041 (7.3%)**	**70,749 (20.7%)**	**1,015**	**0.3%**
Woorabinda	0 (0%)	0 (0%)	9 (0.9%)	0	0.0%
CCQ	***88,507 (9.8%)***	***56,966 (6.3%)***	***145,473 (16.1%)***	***3,397***	***0.4%***
Queensland	***524,705 (10.2%)***	***645,625 (12.5%)***	***1,170,330 (22.7%)***	***67,843***	***1.4%***

Substantial numerical differences are shown in grey.

Top five non-English speaking backgrounds	The top five non-English languages spoken at home
1. Philippines (0.7%)	1. Indo Aryan Languages (0.7%)
2. India (0.5%)	2. Southeast Asian Austronesian Languages (0.6%)
3. Germany (0.5%)	3. Chinese Languages (0.4%)
4. Netherlands (0.3%)	4. German (0.3%)
5. China excludes Special Administrative Regions and Taiwan (0.2%)	5. Afrikaans (0.3%)

Linguistic diversity

As highlighted above, 145,473 CCQ residents (or 16.1%) were born overseas with 56,966 from non-English speaking background countries. **Sunshine Coast LGA had the largest number of persons born overseas with 70,749** and **Noosa LGA had the largest percentage (23%) of persons born overseas** (15%) from English speaking countries and 8% from non-English speaking background countries (Table 52). The CCQ region has over 3,000 residents who do not speak English well or at all. The highest numbers are in the LGAs of Sunshine Coast (1,015), Bundaberg (775), and Rockhampton (610).

The PHN Multicultural Health Framework released in February 2024 identified a need for PHNs, primary care providers and commissioned service providers to consistently collect the following five key CALD data fields and be trained on how to do this in a sensitive way. CCQ are currently collecting all fields apart from year of arrival.

- Country of birth
- Language spoken
- Interpreter required
- Ethnicity/cultural background
- Year of arrival in Australia.

Cultural determinants of health for Aboriginal and Torres Strait Islander people

The cultural determinants of health for Aboriginal and Torres Strait Islander people originate from and promote a strength-based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety.[161] Cultural determinants include, but are not limited to:

- self-determination
- freedom from discrimination
- individual and collective rights
- importance and value of Aboriginal and Torres Strait Islander culture
- protection from removal/relocation
- connection to, custodianship, and utilisation of country and traditional lands
- reclamation, revitalisation, preservation and promotion of language and cultural practices
- protection and promotion of traditional knowledge and Aboriginal intellectual property
- understanding of lore, law and traditional roles and responsibilities.

Our understanding of these determinants by way of routine data collection is extremely poor, and very little is available at a local level. This significantly impacts our understanding of the cultural health status of Aboriginal and Torres Strait Islander people in the CCQ region.

The Stolen Generations

Between approximately 1910 and 1972, thousands of Aboriginal and Torres Strait Islander children were forcibly removed from their families and communities as a part of government policies across Australian jurisdictions. The Bringing them Home report (1997) estimated that this practice affected between 1 in 10 and 1 in 3 Aboriginal and Torres Strait Islander children during that period.[162]

In 2018–19, there were an estimated 33,600 Stolen Generations survivors across Australia. Around 1 in 3 Aboriginal and Torres Strait Islander adults were estimated to be descendants of the Stolen Generations.[163]

The Stolen Generations and their families are a particular group of Aboriginal and Torres Strait Islander people who experience greater disadvantage than other Aboriginal and Torres Strait Islander people.[163] Analysis of data from the 2014–15 National Aboriginal and Torres Strait Islander Social Survey showed that people who reported being removed from family were more likely than those who did not to have been imprisoned or arrested in the previous 5 years, to have low income, to have poor self-assessed health, to have poor mental health, and to have experienced homelessness in the previous 10 years. This disadvantage persisted through the generations, with adult descendants and co-resident children also experiencing poorer health and wellbeing outcomes compared with other Aboriginal and Torres Strait Islander people.[163]

Indigenous languages

Language is one of the key cultural determinants of health for Aboriginal and Torres Strait Islander people. Speaking language has been found to have many positive impacts for Aboriginal and Torres Strait Islander people, these include improved physical and mental health; educational performance; self-reported levels of happiness; community interconnectedness; cultural continuity; and social and economic benefits.[164] Prior to colonisation, there were around 260 Aboriginal and Torres Strait Islander language groups and 500 dialects.[164]

Nationally, 9.5% of Aboriginal or Torres Strait Islander people in the 2021 Census reported using or speaking an Aboriginal or Torres Strait Islander language at home (Aboriginal people: 8.9%, Torres Strait Islander people: 20%, people who are both Aboriginal and Torres Strait Islander: 12%). The proportion of people using or speaking an Aboriginal or Torres Strait Islander language at home varied by age, with the 25-44 years age-group having the largest proportion of speakers (11%), followed by 45-64 years (10%), 15-24 years (9.3%), and 0-14 years and 65 years and over (both 8.1%).[164]

Regional data suggest far fewer First Nation's people speak an Indigenous language at home compared with Queensland and Australia (Table 52). The highest rates are in Woorabinda (3.4%), Livingstone (2.6%) and Rockhampton (2.4%). Some of the Indigenous languages spoken, include Arnhem Land and Daly River Region languages, Yolngu Matha, Cape York Peninsula languages, Torres Strait Island languages, and Arandic.[165]

Table 52: Percentage of First Nations people who speak an Indigenous language at home, by LGA and Indigenous Areas[127]

LGA (Indigenous Areas)	Percentage of Aboriginal and Torres Strait Islander people who speak an Indigenous language at home (2021)
Banana	0.8%
Bundaberg	1.6%
Central Highlands (Central Capricorn)	1.6% 2.0%
Fraser Coast	1.8%
Gladstone	0.9%
Gympie (Cooloola-Gympie Nanango-Kilkivan)	0.8% 0.9% **
Livingstone	2.6%
Noosa	2.2%
North Burnett	2.3%
Rockhampton (Rockhampton-Yeppoon)	2.4% 2.4%
Sunshine Coast (Caloundra Maroochy)	1.2% 1.1% 1.4%
Woorabinda	3.4%
CCQ Region	-
Queensland	***8.5%***
AUSTRALIA	***10%***

Social environment

Evidence supports the close relationship between people's health and the living and working conditions which form their social environment.[166] Factors such as socioeconomic position, educational attainment, conditions of employment, the distribution of wealth, empowerment and social support – together known as the social determinants of health – can act to strengthen or undermine the health of individuals and communities.

According to the WHO, social determinants of health account for between 30–55% of health outcomes. They have an important influence on health inequities – the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income – including Australia – health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.[167]

Socioeconomic characteristics

Socioeconomic factors —such as income, employment, housing and education—can affect a person's health. People who are disadvantaged in one or more of these areas may have difficulty accessing health care, have poorer living conditions, and have limited opportunities or capacity to participate in sport or engage in other health-promoting activities. People with lower socioeconomic status (SES) have, on average, poorer health and die younger than those with more favourable SES.

SEIFA

Socio-Economic Indexes for Areas (SEIFA) combines Census data such as income, education, employment, occupation, housing, and family structure to summarise the socio-economic characteristics of an area. The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. IRSD only includes measures of relative disadvantage.[168]

A low score indicates relatively greater disadvantage. For example, an area could have a low score if there are: many households with low income, or many people without qualifications, and many people in low skilled occupations.[168]

Each area receives a IRSD score indicating how relatively disadvantaged that area is compared with other areas and benchmarked against Queensland.

Table 53 provides the IRSD scores for each LGA in the CCQ region. SA2s within the CCQ region within Decile 1 are listed in Table 54.

Table 53: Index of Relative Socio-economic Disadvantage (IRSD) by LGA, 2021[168]

LGA	IRSD Score	Decile	Proportion within Decile 1	Usual resident population	Indigenous Relative Socioeconomic Outcomes Index* (2021)	Aboriginal population (2021 URP)	Indigenous Areas
Noosa	1030	10	3.5%	56,298	10	916	Noosa
Sunshine Coast	1022	10	5.6%	342,541	14 13	3,509 4,834	Caloundra Maroochy
Livingstone	1005	9	9.7%	39,398			
Central Highlands	996	9	15.1%	27,836	**66**	**2,568**	**Central Capricorn**
Banana	992	8	16.5%	14,513	39	709	Banana (part b)
Gladstone	954	6	31.0%	63,515	**47**	**3,946**	**Gladstone**
Rockhampton	949	5	42.2%	81,968	43	9,219	Rockhampton - Yeppoon
Gympie	930	4	43.7%	53,242	**46** **68**	**2,121** **168**	**Cooloola – Gympie** **Nanango - Kilkivan (part b)**
Bundaberg	924	4	49.8%	99,215	**57**	**4,963**	**Bundaberg**
Fraser Coast	915	4	59.1%	111,032	**61**	**5,652**	**Fraser Coast**
North Burnett	902	3	60.5%	10,068	**72**	**708**	**North Burnett**
Woorabinda	492	1	100%	1019	**66**	2,568	Central Capricorn
					43	39,313	CCQ
					41	237,303	Queensland

*The Index ranges from 1 to 100, where a score of 1 represents the most relatively advantaged and a score of 100 represents the most relatively disadvantaged.

Table 54: SA2s in the lowest decile (1), 2021[168]

SA2	IRSD Score	Usual resident population (URP)
Rockhampton LGA		
Berserker	866	7024
Mount Morgan	796	2945
Rockhampton City	830	3364
Gladstone LGA		
Gladstone	872	6174
Bundaberg LGA		
Bundaberg	810	6247
Bundaberg North - Gooburrum	894	7448
Gin Gin	854	5402
Svensson Heights - Norville	888	5809
Walkervale - Avenell Heights	887	10,982
Gympie LGA		
Gympie - North	893	14,866
Fraser Coast LGA		
Granville	856	3051
Maryborough (Qld)	853	18558
Maryborough Surrounds - South	894	9548

CCQ is home to a broad range of socioeconomic diversity, encompassing some of the most socioeconomically advantaged areas in Australia, such as Noosa, and the least advantaged LGA in Australia, Woorabinda.[168]

These disparities underscore the critical necessity for a local approach when designing and implementing interventions and programs. Tailoring these initiatives to the specific needs and conditions of the local populations is essential for ensuring effectiveness and inclusivity. Moreover, maintaining a focus on increasing equity across the region is vital to provide all residents with the opportunity to live their healthiest lives.

In addition to Woorabinda, the areas experiencing the greatest disadvantage are predominantly regional towns and cities, especially those located near the Bruce Highway. These localities often face unique socioeconomic challenges, such as limited access to healthcare, education, and employment opportunities, which can significantly impact residents' quality of life. The need for targeted, localised solutions in these areas is paramount to foster community wellbeing and economic resilience.

My Healthy Community survey findings indicated that residents from more advantaged areas, such as the Sunshine Coast Hospital and Health Service region, generally expressed a positive outlook on community aspects, including good relationships, effective leadership, and a strong sense of mission. In contrast, those from the Wide Bay region presented mixed sentiments, with notably lower scores in certain areas. Rockhampton residents, in particular, articulated negative views about their community, starkly contrasting with the more favourable perceptions observed elsewhere.

Education

Access to quality education is fundamental to health and wellbeing. This is highlighted in the Sustainable Development Goal #4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Research suggests the relationship between education and health is attributable to three general classes of mediators: economic; social, psychological, and interpersonal; and behavioural health.[169] Economic variables such as income and occupation mediate the relationship between education and health by controlling and determining access to acute and preventive medical care. Social, psychological, and interpersonal resources allow people with different levels of education to access coping resources and strategies, social support, and problem-solving and cognitive abilities to handle ill-health consequences such as stress.

Healthy behaviours enable educated individuals to recognise symptoms of ill health in a timely manner and seek appropriate medical help.

There is an iterative relationship between education and health. While poor education is associated with poor health due to income, resources, healthy behaviours, healthy neighbourhood, and other socioeconomic factors, poor health, in turn, is associated with educational setbacks and interference with schooling through difficulties with learning disabilities, absenteeism, or cognitive disorders. **Education is therefore considered an important social determinant of health**.

Apart from Noosa and Sunshine Coast LGAs, all LGAs in the CCQ region have lower levels of participation in secondary school at age 16; learning or earning, and participation in higher education compared to state and national averages (Table 55).

Table 55: Learning and education indicators[28]

LGA	Proportion of 4- and 5-year-olds enrolled in preschool (%)		People who left school at Year 10 or below, or did not go to school (ASR per 100)	Full-time participation in secondary school education at age 16 (%)	Learning or earning at ages 15 to 24 years (%)	School leaver participation in higher education (%)
	2018	2020*	2021	2021	2021	2023
Banana	**41.6**	42.2	**36.0**	**66.4%**	**77.6%**	**7.0%**
Bundaberg	50.8	47.1	**37.3**	**76.0%**	**79.4%**	**12.1%**
Central Highlands	**48.8**	48.2	**34.3**	**76.5%**	**79.0%**	**10.7%**
Fraser Coast	**45.1**	43.6	**36.2**	**76.6%**	**75.5%**	**10.9%**
Gladstone	**45.1**	44.9	**36.1**	83.8%	**80.5%**	**13.0%**
Gympie	**48.4**	46.3	**36.8**	**73.8%**	**79.7%**	**11.0%**
Livingstone	50.0	48.0	**33.9**	**77.5%**	**81.9%**	**11.1%**
Noosa	56.9	49.3	21.7	85.9%	86.2%	**20.6%**
North Burnett	**40.4**	47.6	**38.1**	**70.1%**	**75.6%**	**7.5%**
Rockhampton	**48.9**	45.8	**35.6**	80.3%	**79.3%**	**9.7%**
Sunshine Coast	52.4	50.7	26.1	83.2%	86.8%	23.6%
Woorabinda	**46.3**	64.3	**74.5**	**65.0%**	**40.1%**	**0.0%**
CCQ PHN	***50.9***	***47.7***	***31.4***	***80.3%***	***82.2%***	***16.5%***
Queensland	***50.2***	***46.2***	***27.9***	***83.1%***	***83.7%***	***22.9%***
AUSTRALIA	-	-	***25.4***	***85.3%***	***85.4%***	***29.1%***

* Due to the COVID-19 pandemic, various restrictions were in place when the National Early Childhood Education and Care Collection (NECECC) was conducted. This has substantially affected the data captured from 2020.

Literacy and reading levels

'Reading level' is the level of education someone needs to be able to read text. It is one way to measure literacy. In Australia, about 44% of adults read at literacy level 1 to 2 (a low level), 38% of adults read at level 3, and about 15% read at level 4 to 5 (the highest level).

Australian adult reading levels

Reading level	Percentage of adults at each level (%)
Pre-primary level (below level 1)	3.7
Pre-year 1 to year 6 (level 1)	10.0
Year 7 to year 10 (level 2)	30.0
Years 11 and 12 (level 3)	38.0
Certificate IV (level 4)	14.0
Diploma and above (level 5)	1.2

Note: Percentages do not add to 100.

People with higher literacy – as measured by reading level – generally have had access to a better education. Many factors influence people's access to education, including where they live. Post-school education is easier to access if you live in a major city. For example, people in cities are more likely to have a Bachelor degree than people in regional areas. But there are also areas of disadvantage in the major cities.[170]

An education doesn't guarantee a reading level that matches the qualification. For example, about 30% of Australians have a diploma or higher, but only 1.2% of Australians can read at that level. Many people maintain their high-school reading level even if they go on to tertiary studies.[170]

Child development

Child development is an important indicator of long-term health. A developmental delay occurs when a young child is slower to develop physical, emotional, social, communication and thinking skills than expected. Developmental delay can show up in the way children move, communicate, think and learn, or behave with others. When more than one of these areas is affected, it is referred to as a global developmental delay.[171]

The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development at the time children commence their first year of full-time school. The AEDC is held every three years, with the 2024 AEDC data collection being the sixth collection due in Term 2. The census involves teachers completing the Australian version of the Early Development Instrument, which collects data relating to five key areas of early childhood development referred to as 'domains', these include:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge

The AEDC domains have been shown to predict later health, wellbeing, and academic success.[172]

There is considerable variation across the region with the proportion of children who are developmentally on track on all five domains, and their trends over time (Table 56). Buderim, Caloundra, Noosa and the Sunshine Coast hinterland had higher proportions on track than Queensland from 2009 to 2021. Whereas, Burnett and Maryborough have been consistently below the state over the same period.

It is important to note that the same region can have high proportions of children on track as well as high proportions of children with vulnerabilities on 2 or more domains (Table 56).

Indigenous Areas of Banana, Caloundra, Maroochy, Nanango – Kilkivan, Noosa and North Burnett all have higher proportions of Aboriginal and Torres Strait Islander children who are on track on all five domains compared with Queensland (Table 58).

Table 56: Proportion of children developmentally on track on all five domains, by SA3 (2009-2021)[173]

SA3	Developmentally on track on all five domains (%)				
	2009	2012	2015	2018	2021
Biloela*	**38.3**	**43.9**	51.3	**49.7**	59.8
Buderim	50.8	48.9	60.0	61.0	64.2
Bundaberg	**35.4**	46.5	**47.3**	**43.8**	**45.0**
Burnett*	**36.9**	**42.7**	**43.2**	**49.8**	**44.6**
Caloundra	46.4	56.2	57.8	54.6	59.9
Central Highlands	**39.6**	45.2	**49.0**	55.6	**46.9**
Gladstone	**40.2**	49.7	52.9	51.2	50.6
Gympie-Cooloola	**37.0**	**41.8**	**43.3**	47.9	**46.0**
Hervey Bay	**38.6**	48.3	**44.6**	**37.9**	**39.9**
Maroochy	45.9	45.5	52.4	51.2	56.9
Maryborough	**35.1**	**41.4**	**38.9**	**47.9**	**48.4**
Nambour	**40.3**	**40.6**	**47.0**	53.5	53.4
Noosa	45.9	55.0	61.5	74.2	64.2
Noosa Hinterland	46.6	47.9	**47.6**	58.7	57.1
Rockhampton	**38.9**	52.0	**43.1**	**47.9**	**39.8**
Sunshine Coast Hinterland	48.9	47.9	49.7	54.3	56.0
CCQ PHN					***50.9***
Queensland	***40.9***	***48.3***	***49.3***	***50.5***	***51.4***

*Not entire SA3 within PHN catchment (Biloela 93% and Burnett 31%)

Table 57: Proportion of children developmentally vulnerable on two or more domains (2009-2021)[173]

SA3	Developmentally vulnerable on two or more domains (%)				
	2009	2012	2015	2018	2021
Biloela*	**17.6**	**14.8**	**13.4**	10.6	8.6
Buderim	13.1	11.9	8.3	8.4	5.3
Bundaberg	**19.9**	**15.0**	**16.0**	**21.0**	**16.7**
Burnett*	**20.7**	**19.5**	**18.7**	**18.8**	**20.3**
Caloundra	11.3	11.5	13.4	12.2	9.7
Central Highlands	15.2	13.2	12.6	13.6	12.7
Gladstone	13.6	11.8	11.4	13.8	**13.9**
Gympie-Cooloola	**16.9**	**17.4**	**16.3**	**15.5**	13.0
Hervey Bay	**15.9**	**15.9**	**16.5**	**22.8**	**18.5**
Maroochy	10.5	11.6	11.8	**14.3**	8.1
Maryborough	**16.7**	**16.3**	**19.9**	**15.2**	**15.2**
Nambour	14.9	**15.3**	12.7	12.3	10.2
Noosa	14.6	9.8	9.0	5.5	7.1
Noosa Hinterland	12.1	9.5	**14.1**	**14.0**	10.0
Rockhampton	**16.0**	11.7	**16.4**	**15.8**	**19.0**
Sunshine Coast Hinterland	13.9	13.5	13.3	9.7	10.8
CCQ PHN					*13.0*
Queensland	***15.8***	***13.8***	***14.0***	***13.9***	***13.2***

*Not entire SA3 within PHN catchment (Biloela 93% and Burnett 31%)

Substantial numerical differences are shown in grey.

Table 58: Proportion of Aboriginal children on track and vulnerable in AEDC domains by number of domains and Indigenous Area (2021)[29]

Indigenous areas	Vulnerable one or more	Vulnerable in two or more	On track in all five
Banana	42.1	15.8	**42.1**
Bundaberg	38.3	24.3	32.2
Caloundra	33.3	24.7	**44.1**
Central Capricorn	48.9	24.4	25.6
Cooloola - Gympie	33.3	10.9	32.6
Fraser Coast	42.0	26.7	33.6
Gladstone	40.9	26.0	31.5
Maroochy	31.0	21.2	**45.0**
Nanango - Kilkivan	41.2	29.4	**41.2**
Noosa	38.5	30.8	**38.5**
North Burnett	39.3	28.6	**46.4**
Rockhampton - Yeppoon	47.9	31.8	26.5
Queensland	***42.1***	***26.9***	***33.8***
Australia	***42.3***	***26.5***	***34.3***

Access to childcare

Lack of access to childcare can impact child and family wellbeing. Quality childcare supports children's healthy development, allows parents to provide for their families, and strengthens the economy both by getting parents back to work in the short term and supporting children's success in the long term.[174] Additionally, children who attend preschool are generally better prepared to start primary school.[175]

A recent study revealed that across Australia, there are more than twice as many children as childcare places. Nearly 6 million Australians — that's close to one in four — live in a childcare desert, defined in the study as an area where three or more children compete for each childcare place. The figure includes more than 680,000 people living in areas with no access to childcare at all.

The CCQ region has a substantial number of SA2s in the top 20 areas with the worst access to childcare in Queensland (Table 59)[176] Some of these areas having had no change or worsening access from 2020 to 2024.[176]

Half of top 10 SA2s with the worst childcare access in the country are in the CCQ region (Mount Morgan #1; Rockhampton Surrounds – West #5; Maryborough Surrounds – South #6; Rockhampton Surrounds – East #8; and Bouldercombe #10).[176]

Bundaberg and Pialba - Eli Waters are the only two SA2s within the CCQ region in the top 20 areas with the best access to childcare in Queensland (0.953 and 0.863 respectively).[176]

Table 59: Worst childcare access in Queensland [176]

Rank*	SA2	Places per children	Trend
1	Mount Morgan	0	↓
2	Rockhampton Surrounds - West	0.001	-
3	Maryborough Surrounds - South	0.002	-
4	Rockhampton Surrounds - East	0.005	-
5	Bouldercombe	0.006	-
7	Booral - River Heads	0.019	↑
8	Rockhampton Surrounds - North	0.029	↑
10	Glenlee - Rockyview	0.033	↑
11	Craignish - Dundowran Beach	0.034	↑
14	Maroochy Hinterland	0.078	↑
16	Kilkivan	0.088	↓

* 1=Worst access

Mother's index

Australia consistently ranks in the top 10 places to be a mother world-wide.[177] Compared to most other countries, mothers in Australia have on average good healthcare, low risk of their child dying before their fifth birthday from preventable causes, high education attainment, and relatively high incomes.[178] However, national-level results mask major differences within Australia.[178]

The *Mothers Index* is used by Save the Children globally to measure overall maternal wellbeing. The Index includes five domains: Maternal health, child wellbeing, mothers' education status, mothers' economic status, and relative socio-economic disadvantage. For the purpose of the index, mothers are those who are biological mothers, stepmothers, divorced or separated mothers, mothers in same-sex relationships, and women caring for children through foster or kinship care, or as older sisters, grandmothers and other female relatives.[178]

At state level, **Queensland emerged as the toughest place to be a mother** in the latest Report (2016). While the state does not rank last on any individual indicator, **Queensland is consistently amongst the lowest rankings across all indicators**, bringing its total performance down to the bottom of the state-level ranking. Education status and economic status are behind most other states and territories, including the ACT, Western Australia, Victoria, New South Wales and the Northern Territory. Maternal and child mortality rates were also high relative to other parts of the country, with only the Northern Territory containing higher rates on these indicators. Similarly, Queensland's ranking on social disadvantage indicators was among the lowest in the country, well behind every state and territory bar the Northern Territory.[178]

At the local level, 74 Queensland LGAs were ranked based on their scores on the five domains. In Queensland, the top 10 places to be a mother were a mixture of cities and towns near resources deposits, including Central Highlands and Gladstone.[178] All of the lowest 10 were in remote areas of Queensland, including Woorabinda (Table 60)[178] Most had a relatively high population of Aboriginal and Torres Strait Islander people. These areas scored low due to most indicators performing lower, with children's developmental vulnerability on entry to school particularly low, as well as low scores on the educational qualifications of women.[178]

Table 60: Mother's Index rankings, by LGAs in Queensland[178]

Rank	LGA
Best	
4	Central Highlands
7	Gladstone (tied with Townsville)
13	Sunshine Coast
16	Rockhampton
20	Banana (tied with Scenic Rim, Maranoa and Western Downs)
44	Bundaberg (tied with Murweh)
48	Fraser Coast (tied with Lockhart River)
52	North Burnett (tied with Southern Downs)
56	Gympie
68	Woorabinda
Worst	

Digital inclusion

Digital inclusion is the ability to access and use digital technologies effectively.[179] Digital inclusion allows individuals to use digital technologies to manage their health, access education and services, participate in cultural activities, organise their finances, follow news and media, and connect with family, friends, and the wider world.[179]

The Australian Digital Inclusion Index is a relative measure of inclusion. Using a score of 0 to 100, it compares the degree to which individuals can be considered more or less digitally included than others based on three dimensions: Access, Affordability, and Digital Ability.

A score closer to 100 indicates higher inclusion while scores closer to 0 indicate greater exclusion.[179]

All LGAs in the CCQ region in 2021 and 2022 were below the national average, with Woorabinda (-16.0) and North Burnett (-9.9) considerably lower (Table 61).

This points to a range of issues related to access, affordability and digital literacy across the region.

Table 61: Digital inclusion index, by LGA (2020-2022)[179]

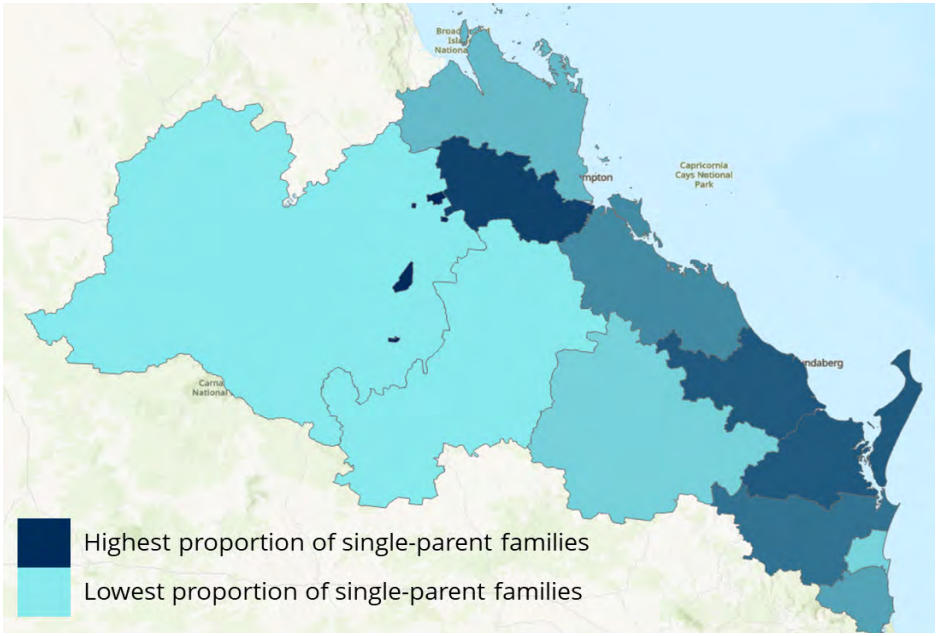
LGA	2020	2021	2022
Banana	**58.0**	**67.0**	**68.6**
Bundaberg	**61.0**	**64.0**	**65.2**
Central Highlands	**65.0**	**71.0**	**71.0**
Fraser Coast	**64.0**	**66.0**	**67.1**
Gladstone	69.0	**71.0**	**71.1**
Gympie	**62.0**	**61.0**	**67.9**
Livingstone	**63.0**	**68.0**	**70.8**
Noosa	**66.0**	**64.0**	**71.4**
North Burnett	**54.0**	**63.0**	**63.3**
Rockhampton	**63.0**	**67.0**	**70.6**
Sunshine Coast	69.0	**69.0**	**72.6**
Woorabinda	**58.0**	**63.0**	**57.2**
Queensland	***69.0***	***71.0***	***73.0***
AUSTRALIA	***67.5***	***71.1***	***73.2***

One parent families'

A one-parent family consists of a lone parent with at least one child (regardless of age) who is also usually resident in the household and who has no identified partner or child of his/her own. The family may also include any number of other related individuals.[180] The vast majority of single parents are women. Single parent families experience much higher rates of poverty and financial stress than couple parent families.[181]

On average in the CCQ region, 16.2% of families are one-parent families, which is similar to the Queensland average (16.8%) (Figure 34). However, there are substantial variations across LGAs. In Woorabinda, 62.5% of families are one-parent families, and 20.7% in Rockhampton.[12] The high proportion of one-parent families contradicts what we understand about multi-generational households in Woorabinda. Further highlighting a need for utilising Aboriginal and Torres Strait Islander informed data collection methods and indicators.

Figure 34: Rate of single parent families in the CCQ region, 2021[12]



Employment, income and wealth

More than half of the CCQ region's LGAs have higher proportions of low-income households that the state average, including Bundaberg, Fraser Coast, Gympie, North Burnett and Woorabinda (Table 62). Unemployment rates also tend to be higher in these areas. Income support payments are also higher in some of the same regions, including Bundaberg, Fraser Coast, Gladstone, Gympie, North Burnett, Rockhampton and Woorabinda (Table 62).

Table 62: Employment, income and wealth indicators

LGA	% low income households (household in bottom 40% of income distribution) (2021)[28]	Median personal income ($/year) (2021)[12]	Median family income ($/year)[12]	Percentage of low-income families (Less than $33,800 per year)[12]	Unemployment rate (%) March quarter 2024[12]
Banana	37.1	$44,512	$ 111,176	6.7%	2.9
Bundaberg	**56.8**	**$30,888**	**$ 74,204**	**9.9%**	**4.4**
Central Highlands	29.4	$52,572	$ 127,036	5.6%	3.8
Fraser Coast	**61.5**	**$27,716**	**$ 67,236**	**10.5%**	**5.2**
Gladstone	41.6	**$39,416**	$ 106,496	**8.1%**	**5.9**
Gympie	**60.0**	**$28,808**	**$ 70,668**	**10.1%**	**4.2**
Livingstone	42.0	**$39,780**	$ 104,416	6.8%	2.6
Noosa	44.6	**$37,544**	**$ 93,600**	**7.5%**	3.5
North Burnett	**59.8**	**$28,860**	**$ 68,484**	**11.6%**	**4.4**
Rockhampton	44.4	**$39,416**	**$ 98,176**	**7.5%**	**5.3**
Sunshine Coast	41.8	**$39,260**	**$ 99,840**	6.4%	3.6
Woorabinda	**86.6**	**$18,772**	**$ 36,764**	**37.1%**	**
CCQ	***47.4***	***$35,979***	***$90,543***	***7.9%***	-
Queensland	***40.0***	***$40,924***	***$105,248***	***6.9%***	***4.0***
AUSTRALIA	***39.8***	***-***	***-***	-	***-***

Total family income is the sum of the total personal incomes of each family member present in the household on 2021 Census Night

Bundaberg, Fraser Coast, Gympie and North Burnett LGAs have far lower private health insurance rates compared with Queensland and national rates (Table 63). This indicates a potentially far greater reliance on public health services in these areas. The current cost of living crisis may have affected these rates over the past 12-24 months, so figures are likely to be an overestimate.

Table 63: Proportion of people with private health insurance, aged 20 years and over (2019-20)[28]

LGA	% people with private health insurance
Banana	46.3
Bundaberg	**29.8**
Central Highlands	48.8
Fraser Coast	**22.1**
Gladstone	44.0
Gympie	**24.1**
Livingstone	39.7
Noosa	41.4
North Burnett	**28.4**
Rockhampton	38.9
Sunshine Coast	39.0
Woorabinda	44.4
CCQ	***35.7***
Queensland	***38.8***
AUSTRALIA	***42.6***

Table 64: Income support indicators, by LGA (%) (June 2023)[28]

LGA	Age pensioners	Female sole parent pensioners	People receiving an unemployment benefit (JobSeeker Payment or Youth Allowance (other)	People receiving a JobSeeker Payment	Young people receiving a Youth Allowance (other)	People receiving an unemployment benefit (aged 16-64 yrs)		Low income, welfare-dependent families (with children)	Children in low income, welfare-dependent families	Pensioner Concession Card holders	Health Care Card holders	Seniors Health Card holder
	over 65 years		aged 16-64 yrs	aged 22-64 yrs	aged 16-21 yrs	Short-term	Long-term		under 16 yrs	aged 15yrs+	aged 0-64yrs	aged 65 yrs+
Banana	48.4	4.5	5.2	5.4	3.6	1.0	4.2	**6.0**	**13.3**	17.9	4.8	**10.7**
Bundaberg	**69.2**	**6.3**	**10.3**	**10.3**	**9.8**	**1.9**	**8.4**	**6.5**	**18.0**	**36.9**	**8.6**	7.4
Central Highlands	49.5	**5.0**	5.1	5.2	4.3	1.0	4.0	**5.8**	10.6	14.0	4.4	6.7
Fraser Coast	**69.2**	**6.8**	**11.2**	**11.2**	**11.3**	**2.0**	**9.2**	**6.7**	**20.2**	**41.7**	**9.0**	6.5
Gladstone	**63.4**	**6.9**	**9.2**	**9.3**	**8.4**	**1.6**	**7.6**	**7.7**	**16.8**	24.1	**7.2**	8.8
Gympie	**65.9**	**5.9**	**9.5**	**9.5**	**9.1**	**1.8**	**7.6**	**6.5**	**17.5**	**37.2**	**8.0**	7.1
Livingstone	57.4	3.7	5.1	5.3	3.4	1.0	4.0	3.3	8.4	22.4	4.8	**10.6**
Noosa	50.1	2.6	5.3	5.6	3.1	1.1	4.2	3.1	8.8	23.8	4.7	**13.9**
North Burnett	61.3	**6.2**	**12.2**	**12.6**	**8.7**	**1.9**	**10.3**	**7.4**	**21.8**	**34.9**	**9.2**	8.5
Rockhampton	**64.7**	**6.8**	**8.3**	**8.3**	**7.9**	**1.7**	**6.6**	**7.6**	**18.0**	26.4	**7.6**	7.7
Sunshine Coast	57.9	2.9	4.7	4.9	3.5	1.0	3.8	3.4	8.3	22.9	5.1	**12.4**
Woorabinda	43.9	**30.5**	**50.6**	**50.8**	**49.6**	**11.8**	**39.6**	**58.2**	**74.8**	**39.4**	**30.9**	8.8
CCQ	***61.7%***	***4.7%***	***7.2%***	***7.3%***	***6.3%***	***1.4%***	***5.8%***	***5.2%***	***13.3%***	***28.0%***	***6.5%***	***9.8%***
Queensland	***58.9%***	***4.0%***	***6.0%***	***6.1%***	***5.1%***	***1.3%***	***4.7%***	***5.0%***	***12.2%***	***21.4%***	***6.1%***	***10.#%***
AUSTRALIA	***58.6%***	***3.1%***	***5.4%***	***5.5%***	***4.0%***	***1.1%***	***4.3%***	***4.4%***	***10.8%***	***20.2%***	***5.7%***	***11.3%***

Substantial numerical differences are shown in grey.

Financial resilience

Financial resilience is being able to bounce back from a financial shock and there are a number of things that help people's financial resilience, including income, savings, a willingness to seek financial advice, connections with family and friends, support from community and government organisations and access to appropriate banking products, such as credit and insurance.[182]

The Financial Resilience Barometer is an index that rates areas across Australia in terms of their level of financial security or vulnerability (Table 65). The indicators include: the percentage of people/population who can't afford a night out, can't access emergency funds, suffering mortgage or rental stress, government income support as main income source, wage and salary, bank interest, dividends from investments, banking services per 10,000 people, and volunteering.[183]

Table 65: Financial resilience barometer scoring[183]

Financial Resilience Category	Colour Code	Score Range	Percentile Range	Number of SA2s
Severe financial vulnerability		0-772	0-20	462
High financial vulnerability		773-1040	20-40	465
Mid-range		1041-1263	40-60	464
Low financial vulnerability		1264-1523	60-80	464
Financially resilient		> 1524	80-100	464

There were 29 SA2s that scored in the severe financial vulnerability category (Table 66). A majority are in the Wide Bay region. Caution should be taken for some locations that are located with higher scoring suburbs. For example, the Central Highlands – West was classified as Financially resilient, which corresponds with other socio-economic data; however, the Woorabinda LGA sits within this SA2 and is unlikely to classified as financially resilient according to other indicators.

Table 66: CCQ region SA2s with severe financial vulnerability[183]

SA2	Score
Svensson Heights – Norville	471.4
Cooloola	473.1
Bundaberg Surrounds - North	508
Gympie – South	508.3
Torquay – Scarness - Kawungan	513.6
Maryborough Surrounds - South	516.4
Burrum – Fraser	526.4
Booral – River Heads	630.7
Granville	546.9
Urangan – Wondunna	566.3
Gympie – North	567.2
Gin Gin	568.2
Walkervale – Avenell Heights	571.8
Point Vernon	576.8
Gympie Surrounds	583
Bundaberg North - Gooburrum	617.3
Maryborough	627.5
Ashfield – Kepnock	651.7
Bundaberg	677.6
Pialba – Eli Waters	696.5
Nambour	699.9
Bundaberg East - Kalkie	703.4
Millbank – Avoca	707.7
Lakes Creek	716.9
Meridan Plains – Little Mountain (North)	722.6
Caloundra West - Baringa	731.5
Glasshouse Mountains	734
Bundaberg Surrounds - South	751.4
Berserker	767.4

Stable and adequate housing

Stable (or secure) housing means that you aren't living in uncertainty about your housing situation and generally have a choice over when to move. The opposite of this – housing instability – can mean you're facing a number of different challenges, like struggling to pay rent, overcrowding in shelters, moving frequently, or spending most of your income on housing.

Adequate housing is safe, secure and affordable shelter with access to suitable facilities for daily living (such as washing, cooking and heating), and sufficient living space. Housing location and neighbourhood quality are also important.[184]

In the *My Healthy Community* survey, residents of the CCQ region across all geographies expressed very negative perceptions about the appropriateness of homes in their communities to meet their needs. Despite their strong affinity with the natural environment, they indicated that their built environment was lacking and adversely affecting their quality of life. This concern is not only about the aesthetic or design aspects but also relates to the fundamental adequacy and suitability of their housing.

It is worth noting that these negative perceptions could be closely linked to the overall perception that the cost of living is a significant factor affecting their quality of life. Particularly, rising rents and house prices are placing additional strain on residents, making it harder for them to find affordable and suitable homes. This financial pressure exacerbates the dissatisfaction with available housing options and their impact on daily living.

Moreover, the recent rental crises have highlighted several key issues faced by the residents of the CCQ region. The availability of housing remains a critical concern, with many struggling to find homes within their budget. The disrepair of cheaper rental properties further compounds the problem, as does the questionable quality of new builds. These factors collectively underscore the urgent need for improved housing policies and practices to ensure that all residents have access to safe, secure, and suitable living environments.

Defining Homelessness

There is no one definition of homelessness. The Australian Bureau of Statistics (ABS) offers a statistical definition of homelessness: 'when a person does not have suitable accommodation alternatives, they are considered as experiencing homelessness if their current living arrangement:

- is in a dwelling that is inadequate,
- has no tenure, or if their initial tenure is short and not extendable, or
- does not allow them to have control of, and access to space for social relations.

The definition has been constructed from a conceptual framework centred around the following elements: adequacy of the dwelling, security of tenure in the dwelling, and control of, and access to space for social relations.[185]

The Australian Housing and Urban Research Institute (AHURI) highlights **conceptualisation of homelessness in Australia do not align with how Aboriginal Australians may define homelessness**; for example, a person who is living in a crowded house with extended family may feel strongly that they are not homeless, even when statistics suggest otherwise.[186] The following tables should therefore be interpreted with this context in mind.

Aboriginal notions of "home" are often different from those of mainstream Australia. Australians strongly associate home with a house providing shelter from the elements, with walls enclosing their home - keeping the outside, outside. But for many Aboriginal cultures, home is a therapeutic space spanning inside and out.[187]

> *Before colonisation, there was no concept of "homelessness". Everyone had a place to call home, and home was with your kin, on country, practicing your ways. But today, many of us are homeless on our own land - at far higher rates than non-Aboriginal people*
>
> - Noongar Mia Mia 2022

The impact of homelessness on health

As one of the social determinants of health, access to stable accommodation has a profound impact on health and wellbeing.[188] People experiencing homelessness and those at risk of homelessness are among Australia's most socially and economically disadvantaged. Experiencing or being at risk of homelessness is associated with a higher risk of adverse health, social, and economic outcomes.[189]

Many people develop worsening health issues, including mental illness and increased or new substance abuse, during their experience of homelessness. Homelessness affects stability and social connectedness, which affect health and wellbeing outcomes. The absence of housing also affects personal safety and people's sense of control and mastery of their lives, influencing physical and mental health and wellbeing. Homelessness also affects living practices, such as the ability to access, store and prepare adequate food.[188]

Health problems can arise because of experiencing homelessness, including malnutrition and dental problems.[190,191] Homelessness can expose people to violence and victimisation, result in long-term unemployment and lead to the development of chronic ill health.[192] People experiencing homelessness have significantly higher rates of death and chronic illness when compared with the general population.[193]

People experiencing health issues while also experiencing homelessness may have difficulties managing their health conditions which can lead to the development and/or exacerbation of a chronic health issue. This in turn can reduce a person's ability to sustain wellbeing, employment, housing, and personal networks, further impacting their ability to sustain stable housing.

The evidence linking homelessness and unstable accommodation with health outcomes is compelling. A 15-year retrospective longitudinal cohort study in Australia reported that at least one episode of any level of homelessness was associated with premature mortality.[194] Homeless individuals had a younger median age of death (66.60 vs. 78.19 years) and significantly increased mortality risk ratios compared to the non-homeless individuals.[195]

Numbers experiencing homelessness

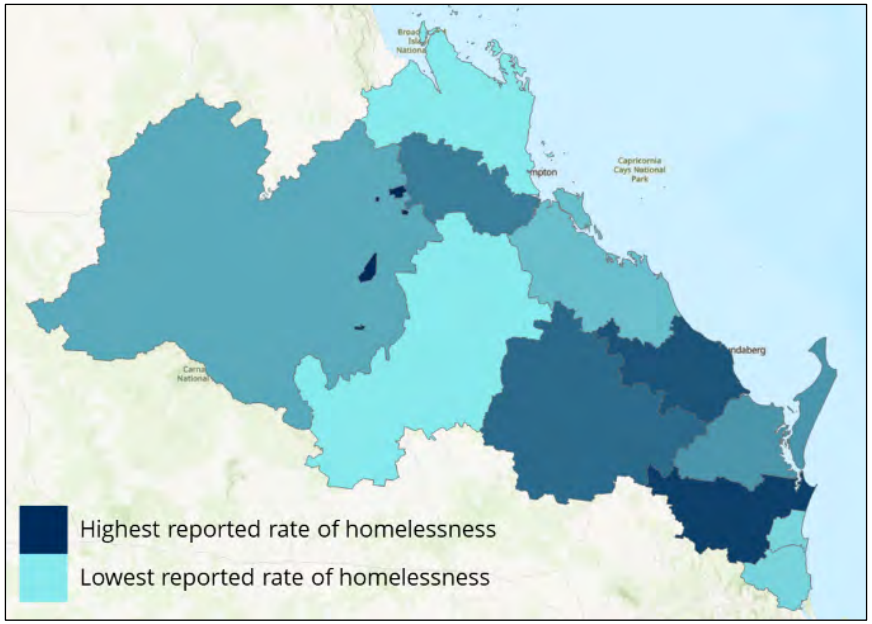
The ABS definition of homelessness is informed by an understanding of homelessness as 'home'lessness, not 'roof'lessness. It emphasises the core elements of 'home' including a sense of security, stability, privacy, safety, and the ability to control living space. Homelessness is therefore a lack of one or more of the elements that represent 'home'.[196]

The rate of homeless persons for the CCQ region in 2021 was 44.9 per 10,000 persons (Figure 35). Woorabinda LGA had the highest rate of homelessness (386.5 persons per 10,000 persons).[12] **Two-thirds of the CCQ region is experiencing rates of homelessness higher than that state average (43.2 per 10,000).**[12]

However, it is important to note that the measure categorises homelessness to include multi-generational homes that are commonly used in Indigenous communities and may not be an appropriate measure of homelessness in the local context of the population. It underlines the broader issue that using western measures are not always suitable for understanding Aboriginal people and their communities, as they often do not account for cultural and social differences.

It is also important to note that we do not have data post-COVID. We do not know the full extent of housing displacement and homelessness in our region, which has become a substantial issue across the country in recent years.

Figure 35: Rate of homelessness in the CCQ region, by LGA[12]



The ABS uses six operational groups for presenting estimates of the number of people experiencing homelessness on Census night. These groups are:

- people living in improvised dwellings, tents or sleeping out
- people living in supported accommodation for the homeless
- people staying temporarily with other households
- people living in boarding houses
- people in other temporary lodgings
- people living in 'severely' crowded dwellings (requires 4 or more extra bedrooms to accommodate the people who usually live there).

Numbers of people homeless on Census night in the CCQ region are presented in Table 67. The largest total numbers were in the Sunshine Coast LGA (1,205) followed by Bundaberg LGA (649) and Fraser Coast LGA (606).

Table 67: Estimating homelessness by LGA (2021)[185]

LGA	People living in improvised dwellings, tents, or sleeping out	People in supported accommodation for the homeless	People staying temporarily with other households	People living in boarding houses	People in other temporary lodgings	People living in 'severely' crowded dwellings	All homeless persons
Banana	5	16	10	0	0	0	34
Bundaberg	43	143	208	33	10	211	649
Central Highlands	33	20	62	0	10	36	161
Fraser Coast	68	138	190	27	12	176	606
Gladstone	38	55	76	42	7	72	290
Gympie	121	63	113	0	0	62	359
Livingstone	7	6	54	6	3	0	81
Noosa	17	26	68	20	8	43	175
North Burnett	0	0	30	0	0	25	59
Rockhampton	39	109	94	120	4	83	447
Sunshine Coast	204	262	354	61	32	287	1,205
Woorabinda	0	3	0	0	0	30	39

The ABS also compiles estimates from Census data for the following three groups of people who may be marginally housed but are not classified as homeless:

- people living in other crowded dwellings
- people in other improvised dwellings
- people marginally housed in caravan parks (Table 68).[197]

Table 68: Other marginal housing[197]

LGA	People living in other crowded dwellings	People in other improvised dwellings	People who are marginally housed in caravan parks
Banana	7	0	7
Bundaberg	312	25	215
Central Highlands	19	16	16
Fraser Coast	249	69	197
Gladstone	75	13	125
Gympie	143	174	27
Livingstone	75	33	33
Noosa	89	24	3
North Burnett	24	10	29
Rockhampton	255	4	44
Sunshine Coast	453	50	203
Woorabinda	71	0	0

For Aboriginal and Torres Strait Islander people the rate of person living in overcrowded dwellings was highest in the Indigenous Areas of Bundaberg, Central Capricorn, Gladstone, Maroochy, Nanango-Kilkivan and North Burnett (Table 69).

Table 69: Indicators of overcrowded housing[29]

Indigenous area	Aboriginal persons living in crowded dwellings (2021)		% dwellings with Aboriginal households requiring extra bedrooms
	%	Rate per 10,000	
Banana (part B)	9.4%	0.0	5.9%
Bundaberg	**17.5%**	**88.2**	**10.6%**
Caloundra	8.7%	38.0	6.5%
Central Capricorn	**21.1%**	**183.3**	**9.5%**
Cooloola - Gympie	11.7%	0.0	**8.6%**
Fraser Coast	14.5%	30.1	**9.2%**
Gladstone	12.6%	**46.7**	7.5%
Maroochy	10.0%	**51.2**	6.7%
Nanango - Kilkivan (part b)	13.0%	**99.3**	**8.9%**
Noosa	8.4%	0.0	5.4%
North Burnett	15.4%	**131.6**	**8.5%**
Rockhampton - Yeppoon	14.9%	31.5	**9.0%**
CCQ Region	***13.7%***	***49.6***	***8.4%***
Queensland	***17.4%***	112.1	**9.3%**
Australia	*17.2%*	197.6	8.9%

Substantial numerical differences are shown in grey.

Drivers of Homelessness

Why people experience homelessness is vast and complex and can be the result of an interplay between individual and structural factors. Individual factors are those relating to personal circumstances such as low educational attainment, employment status, experience of domestic family violence, ill health, or disability. Structural factors include the housing market (i.e. if there are access to, or availability of housing and rent at affordable rates) and the labour market (i.e. if there are employment opportunities to generate income to pay for housing and other life expenses).[198]

For Aboriginal and Torres Strait Islander people the drivers of homelessness, and the entry and exit points to accessing services are different and culturally distinct.[186]

Mainstream housing provision is based on European ideas focused on a nuclear family household, and they don't consider Aboriginal housing needs. From an Aboriginal perspective, homelessness is not only caused by the lack of houses: it can also stem from a lack of houses that are suitable for larger, multigenerational extended families.[187]

The impact of homelessness on service access and utilisation

There is a growing volume of research on the impact of insecure housing on the health of individuals and the associated costs to the health system.[199,200]

Meeting basic physical needs such as food, water and a place to sleep can be the most important day-to-day priority for people experiencing homelessness, especially those rough sleeping.

"Visiting a GP is not a priority for people when we are sleeping rough as we are too busy managing safety, food and sleep – we are too exhausted and don't have enough [phone] credit to make appointments" – Participant in Surviving the Streets Codesign project, 2019.

Subsequently health needs are often not considered until an emergency arises.[201] While rough sleeping is the least common form of homelessness in Australia,[202] the longer-term impacts of rough sleeping on health are profound due to issues, such as poor nutrition, living in harsh environments and high rates of injury.[203]

Severe overcrowding is the most common form of homelessness in Australia and is associated with different health impacts. For example, severe overcrowding places stress on the infrastructure of the dwelling, such as food preparation areas, bathrooms, laundry facilities and sewerage systems. It may lead to more rapid transmission of infectious disease (including COVID-19) and induce psychological stress.[204]

People experiencing homelessness typically require access to a wide range of mainstream services, including:

- Income support or welfare services**,**
- Housing—public and community housing services,
- Primary health care services,
- Clinical treatment services (including mental health and drug and alcohol services),
- Employment and training services,
- Education and early childhood services,
- Veterans' affairs services,
- Aged care services,
- Immigration services—including asylum seeker and refugee systems,
- Legal and Court service systems.[205]

Barriers to accessing mainstream and specialist homeless services (SHS) encountered by individuals who are at risk of homelessness or experiencing homelessness can be broadly classified into three categories: service system barriers, service model/practice barriers, and individual barriers. These barriers to access vary among different population groups experiencing or at risk of homelessness, with each having specific and distinct needs. Fragmentation and complexity is a key criticism in accessing both mainstream and specialist homeless services.[205]

Finally, broadly, service system barriers identified in the literature relate to eligibility barriers, structural barriers (e.g. transportation, discrimination, identification, and documentation requirements, system interaction breakdown), and capacity barriers (e.g. delayed availability, insufficient supply to meet demand). Few mainstream programs are required to collect information about the housing status of their clients, it is virtually impossible to find accurate data about the extent of their service usage by those experiencing homelessness.[205]

Groups more likely to experience or be vulnerable to homelessness

Some groups of Australians are more vulnerable to experiencing homelessness than the general population. Some people may be members of more than one group leading to additional intersectional challenges.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are over-represented among people experiencing homelessness and as users of SHS. National figures show that 20.4% of all Australians who experience homelessness are Aboriginal and Torres Strait Islander. Severe overcrowding as a form of homelessness is particularly prevalent for Aboriginal and Torres Strait Islander families. National figures estimate approximately 60% of Aboriginal and Torres Strait Islander people experiencing homelessness were living in severely crowded dwellings.[206] Aboriginal and Torres Strait Islander people made up about 29% of clients assisted by SHS in 2022-23.[207]

Young people

In 2021 nearly a quarter (23.0%) of all people experiencing homelessness in Australia were aged from 12 to 24 years (28,204 people).[197] Young people presenting alone were the fourth largest client group in 2022–23 supported by SHS, making up around 14% of all SHS clients.[207]

Older people

Homelessness is a growing problem for older Australians and will likely continue to increase over time due to an ageing population and declining rates of home ownership among older people. Very little information is available on elderly people who are homeless and live within the CCQ region. In 2021, there were 19,378 people aged 55 years and over were experiencing homelessness in Australia representing one in seven (15.8%). Older Australian females had a homelessness rate of 19 per 10,000 and compared to males were more likely to be in supported accommodation, staying temporarily with other households and living in severely crowded dwellings. Older Australian males had a homelessness rate of 34 per 100,00 and were more likely than females to live in improvised dwellings, tents or sleeping out and living in boarding houses.[197]

People leaving care

Young people leaving foster care arrangements are at risk of homelessness.[208] Around 1 in 3 (30%) young people leaving out-of-home care experience homelessness at some stage within their first year after leaving care (37% of these for 6 months or more).[209] People transitioning from health settings such as hospitals, psychiatric hospitals, rehabilitation and aged care facilities are also particularly vulnerable to homelessness.[202] People who have come into contact with these settings are often discharged into homelessness.

Women and children affected by family and domestic violence

Domestic and family violence is the main reason women and children leave home. SHS data for 2022-2023 shows that in Australia, clients presenting at risk of homelessness reported that the most common main reasons for seeking assistance were due to domestic and family violence (71%). 1 in 3 (35% or 90,100) clients were living as a single parent with one or more children when they sought SHS support.[207]

People living with a mental illness

People with mental health issues are especially vulnerable to experiencing homelessness. There is a complex bi-directional relationship between homelessness and mental health, whereby homelessness may act as a trigger for mental health issues and vice versa.[210] Approximately 31% of SHS clients in 2022-23 were clients with a mental health issue.[207]

Veterans

Veterans are over-represented in Australia's homeless population. Defence data estimates suggest that 5.3 per cent of the recently transitioned Australian Defence Force (ADF) population were homelessness in a 12-month period, representing 5,767 veterans.[211] SHS data shows that 55% of clients who are current or former members of the ADF were homeless at the start of support.[207]

People discharged from prison

People who have been in prison often face significant challenges in securing housing on release. Almost half (48%) of prison dischargees in Australia expect to be homeless once released, with 45% of prison dischargees planning to sleep in short-term or emergency accommodation and 2.8% expected to sleep rough on release from prison.[212]

Rental affordability

Rental affordability is a resident's capacity to pay for housing (rent). The Rental Affordability Index (RAI) is a price index for housing rental markets, and an indicator of rental affordability. The RAI uses the 30 per cent of income rule. Households paying 30 per cent of income on rent have a RAI score of 100, indicating these households are at the critical threshold level for housing stress. [213]

Figure 36 shows how RAI scores relate to the severity of housing unaffordability. Scores of 100 and less indicate that households spend 30 per cent or more of their income on rent. At this level, the cost of rent negatively impacts a household's ability to pay for other primary needs such as food, medical requirements, and education.[213]

Figure 36: Rental affordability index and severity of rental unaffordability[213]

Index score	Share of income spent on rent	Relative unaffordability
<50	60% or more	Extremely unaffordable rents
51-80	38-60%	Severely unaffordable rents
81-100	30-38%	Unaffordable rents
101-120	25-30%	Moderately unaffordable rents
121-150	20-25%	Acceptable rents
151-200	15% or less	Affordable rents
>200		Very Affordable rents

Source: SGS Economics and Planning, 2023

Rental affordability in regional QLD has been decreasing rapidly following a peak in June 2020 and reaching a historic low point that makes it the least affordable regional area in the country.[213] With a RAI score of 100, regional QLD now falls into the *Unaffordable* category (moving from *Acceptable* three years ago). The average rental household faces rent at 30 per cent of its total income, reaching the threshold of rental stress for the first time measured by the RAI.[213]

The **Sunshine coast** is entirely *Unaffordable* to *Severely Unaffordable*. Along Wurtulla beach, the RAI score has continued to fall further and is now *Severely Unaffordable*. Coolum Beach became *Severely Unaffordable* in 2022, with a RAI score of 80, but now the surrounding areas of Eumundi, Tewantin, Cooroy and Noosa Heads are all *Severely Unaffordable* too.[213]

In 2020, The Sunshine Coast region predominantly offered *Moderately Unaffordable* rents with some areas with *Acceptable* levels of affordability. The nearest suburb offering *Acceptable* rents now is Gympie.

Regional centres such as, **Bundaberg**, and **Rockhampton** all offered *Affordable* to *Very Affordable* rent prices for the average renter in 2020. In 2023, they have all fallen to *Acceptable*, and the surrounding regions are generally *Moderately Unaffordable* to *Unaffordable*. It indicates that even among those residents who would be priced out of the Greater Brisbane rental market would struggle to find affordable rental housing in other cities throughout Queensland.[213]Median rent estimates also highlight the higher cost of rentals in the Noosa and Sunshine Coast LGAs (Table 70). Both are considerably higher than the state average for family-sized homes.[12]

Table 70: Median rent estimates (12 months ending 30 June 2024)[12]

LGA	1 bedroom flat/unit	2 bedroom flat/unit	3 bedroom house	4 bedroom house
Banana	$180	$320	$380	$440
Bundaberg	$360	$370	$490	$580
Central Highlands	$300	$340	$380	$525
Fraser Coast	$300	$390	$490	$590
Gladstone	$260	$320	$440	$510
Gympie	$288	$355	$470	$575
Livingstone	$250	$450	$550	$620
Noosa	$450	**$650**	**$750**	**$950**
North Burnett	n/a	$230	$315	$350
Rockhampton	$245	$340	$450	$500
Sunshine Coast	$410	**$570**	**$660**	**$750**
Woorabinda	n/a	n/a	n/a	n/a
CCQ	***n/a***	***n/a***	***n/a***	***n/a***
Queensland	***$450***	***$560***	***$550***	***$640***

n/a = Not available

Social inclusion and cohesion

Social cohesion refers to positive social relationships – it is the bond or 'glue' that binds people. A socially cohesive society is one which works towards the wellbeing of all its members, fights exclusion and marginalisation, creates a sense of belonging, promotes trust and offers its members the opportunity of upward mobility.[214]

Australia has faced a series of challenges since 2019, including devastating bushfires, the COVID-19 pandemic, floods, and an ongoing cost-of-living crisis, all against a backdrop of global geopolitical tensions. These events, compounded by domestic issues like political division, climate change debates, and rising inequality, have significantly impacted the country's social cohesion. The debate over the Voice referendum and renewed conflict in the Middle East in 2023 have further tested national unity.

The 2023 Mapping Social Cohesion report reveals a concerning decline in Australia's social fabric.[215] The Scanlon-Monash Index of Social Cohesion dropped to its lowest score since the survey began in 2007, highlighting key areas of deterioration, including a weakened sense of national pride, increased financial strain, and growing feelings of exclusion and injustice. Economic inequality and diminishing trust in fairness have significantly contributed to this decline, with Australians increasingly pessimistic about the future.[216]

Further, according to the report a sense of belonging, worth and acceptance has deteriorated across various segments of society. Trust in others has decreased, especially among younger and financially disadvantaged Australians, and pessimism about the future has grown, particularly among conservative voters and those from lower socioeconomic backgrounds. Economic concerns, including housing affordability, remain top priorities for many Australians, while issues like climate change and geopolitical tensions continue to weigh on the national psyche.

Despite this, Australians continue to report high levels of belonging and cohesion at the neighbourhood level, which strengthened during the pandemic. While national pride has waned, these local connections provide a positive source of resilience, with many Australians feeling safe and engaged in their communities. The findings from the 2023 Mapping Social Cohesion study emphasise the importance of community and government efforts to improve economic conditions while leveraging the country's social diversity to build resilience and harmony in the future.

Currently, data on social cohesion is not publicly available at a local level in Australia, limiting our ability to fully understand how communities experience and respond to key social, economic and political challenges. Without localised data, we miss crucial insights into how different communities experience social inclusion, multicultural integration and economic and political conditions.

LGBTIQA+ communities

Compared with the general population, LGBTIQA+ people have historically faced discriminatory laws and policies and continue to encounter discrimination, social isolation and social stigma in various settings and at different times across their lives.

LGBTIQA+ refer to people who have identified themselves as lesbian, gay, bisexual, transgender, intersex, queer/questioning and/or asexual. Specific data on the health and wellbeing of the LGBTIQA+ community is still inconsistent, not routinely collected, and remains a gap in some of our most well-known sources (e.g. Census). Unfortunately, the 2021 Census did not adequately capture gender diversity within its question on sex despite the addition of "non-binary" as a response option. The ABS decided that the data collected on sex (non-binary) was not high quality enough to be used.[217]

LGBTIQA+ communities are diverse but are often grouped together because of a shared history of challenges and discrimination. LGBTIQA+ Australians may face discrimination and unique challenges to their health and wellbeing, as well as barriers to accessing health and support services.

The General Social Survey provides data on the social characteristics, wellbeing, and social experiences of people in Australia. In the 2020 edition, respondents were asked which of the following best describes how they think of themselves: straight (heterosexual); gay or lesbian; bisexual; or a different term to describe their sexual orientation. Data for people who described themselves as gay, lesbian, bisexual or a different term were combined into 'gay, lesbian or bisexual'.

In 2020, approximately 773,000, or 4%, of Australians described themselves as being gay, lesbian or bisexual, similar to 2019 (3%). This figure is higher among people younger than 25 in Australia: rising to 4% for male participants and around 7% for female.[218]

People who described themselves as gay, lesbian or bisexual were more likely to report experiencing discrimination than people who described themselves as heterosexual (30% compared to 13%) and more likely to have experienced at least one personal stressor in the last 12 months (76% compared to 58%).

People who described themselves as gay, lesbian or bisexual were less likely to agree with the follow statements than people who described themselves as heterosexual:

- most people can be trusted (51% compared to 63%)
- the healthcare system can be trusted (68% compared to 78%)
- the police can be trusted (56% compared to 82%)
- the justice system can be trusted (41% compared to 65%).[219]

Child social exclusion and poverty

Child Social Exclusion (CSE) is a multi-dimensional measure of child disadvantage. It extends the concept of child poverty by reflecting the extent to which children lack the opportunities and resources to participate fully in their communities and feel connected. The CSE Index is an area-based indicator of the risk of social exclusion for Australian children. The index uses a wider concept of disadvantage than one focussed purely on income at the Statistical Area 2 (SA2) small area level. Six domains were used: socio-economic, education, connectedness, access to housing, health and community, and environment.[220]

The CSE Index and Child poverty indicator is presented by splitting the 0-14 population into five groups with the same number of children (quintiles). The most excluded quintile (Q5) represents the 20 per cent of Australian children living in areas with the highest risk of social exclusion, experiencing disadvantage on multiple fronts. Similarly, child poverty ranges from a highest poverty quintile (the 20 per cent of Australian children living in the highest poverty areas) to a lowest poverty quintile (the 20 per cent of children living in the areas with the lowest poverty rates).

A child is deemed to be living in poverty if the household they live in falls below the poverty line. The poverty line is set at half the median equivalised household disposable income, adjusted for housing costs which was AUD $504 per week in 2021.

The most socially excluded SA2s (Decile 5) and high rates of child poverty (higher than Qld rate) within the CCQ region are presented in Table 71. **Overall, 43% of CCQ's SA2s fall within the most socially excluded decile and have child poverty rates above the national and state average (17%).** The most disadvantaged SA2s have rates over 30%, including Granville (35.1%), Gin Gin (34.7%), Nanango (33.7%), Kilkivan (31.2%), Bouldercombe (30.2%), and Cooloola (30.0%).

Table 71: The Child Social Exclusion Index and Child Poverty Data, by SA2

SA2	Child Poverty Rates 2021 (%)	Child Weighted Quintile of Child Poverty Rates 2021 (%)	Child Weighted Quintile of Child Social Exclusion 2021 (2021 variables)	Longitudinal analysis	
				Child Weighted Quintile of Child Social Exclusion 2016 (2016 variables)	Child Weighted Quintile of Child Social Exclusion 2021 (2016 variables)
Central Highlands LGA					
Central Highlands - East	29.5%	5	4	4	5
Rockhampton LGA					
Berserker	18.3%	4	5	5	5
Bouldercombe	30.2%	5	3	4	3
Emu Park	21.7%	4	5	5	4
Gracemere	20.7%	4	5	5	5
Lakes Creek	20.6%	4	5	5	5
Mount Morgan	24.2%	5	5	5	5
Park Avenue	19.6%	4	5	5	5
Parkhurst - Kawana	18.0%	4	4	4	4
Rockhampton - West	17.8%	4	4	5	4
Rockhampton City	19.1%	4	5	5	5
Gladstone LGA					

SA2	Child Poverty Rates 2021 (%)	Child Weighted Quintile of Child Poverty Rates 2021 (%)	Child Weighted Quintile of Child Social Exclusion 2021 (2021 variables)	Longitudinal analysis	
				Child Weighted Quintile of Child Social Exclusion 2016 (2016 variables)	Child Weighted Quintile of Child Social Exclusion 2021 (2016 variables)
Agnes Water - Miriam Vale	22.5%	5	4	4	4
West Gladstone	24.6%	5	5	4	4
Sunshine Coast					
Sippy Downs	18.1%	4	3	4	3
Caloundra - Kings Beach	26.8%	5	4	5	4
Tewantin	22.7%	5	3	4	3
Bundaberg LGA					
Ashfield – Kepnock	20.8%	4	4	5	5
Bundaberg	27.0%	5	5	5	5
Bundaberg North – Gooburrum	20.3%	4	5	5	5
Bundaberg Surrounds – North	27.0%	5	4	5	5
Bundaberg Surrounds – South	26.3%	5	5	5	5
Millbank – Avoca	18.9%	4	5	5	5
Svensson Heights - Norville	25.1%	5	5	5	5
Walkervale - Avenell Heights	27.4%	5	5	5	5
North Burnett LGA					
Gayndah – Mundubbera	22.6%	5	4	4	4
Gin Gin	34.7%	5	5	5	5
Monto – Eidsvold	25.8%	5	4	4	4
Nanango	33.7%	5	5	5	5
Gympie LGA					
Cooloola	30.0%	5	5	5	5
Gympie - North	24.2%	5	5	5	5
Gympie - South	22.2%	4	5	5	4
Gympie Surrounds	22.0%	4	4	5	4
Kilkivan	31.2%	5	5	5	5
Fraser Coast LGA					
Booral - River Heads	18.1%	4	-	5	-
Pialba - Eli Waters	18.8%	4	5	4	4
Point Vernon	28.0%	5	-	5	-
Torquay - Scarness – Kawungan	22.6%	5	5	5	5
Urangan - Wondunna	20.9%	4	5	5	5
Burrum - Fraser	26.1%	5	5	5	5
Granville	35.1%	5	5	5	5
Maryborough	26.4%	5	5	5	5
Maryborough Surrounds – South	21.9%	4	5	5	5
Tinana	25.4%	5	5	4	5
Queensland	***17.0%***	-	-	-	-
Australia	***17.0%***	-	-	-	-

Social Isolation and loneliness

Social isolation and loneliness can harm both mental and physical health and may affect life satisfaction. They are concerning issues in Australia due to the impact they have on peoples' lives and wellbeing.

Loneliness has been linked to premature death, poor physical and mental health, greater psychological distress and general dissatisfaction with life. Loneliness among Australians was already a concerning issue before the COVID-19 pandemic, to the extent that in 2022 it has been described as one of the most pressing public health priorities in Australia.

Social isolation has been linked to mental illness, emotional distress, suicide, the development of dementia, premature death and poor health behaviours (smoking, physical inactivity and poor sleep) – as well as biological effects, including high blood pressure and impaired immune function. Social isolation is also associated with psychological distress and sustained decreases in feelings of wellbeing. Conversely, more frequent social contact is associated with better overall health.

The difference between social isolation and loneliness

Social isolation means having objectively few social relationships or roles and infrequent social contact. It differs from loneliness, which is a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships. The two concepts may, but do not necessarily, coexist – a person may be socially isolated but not lonely, or socially connected but feel lonely.[221]

In 2022, almost 1 in 7 (15%) Australians (18% of males and 12% of females) were experiencing social isolation. Compared to just before the pandemic (2019) the proportion of young people aged 15–24 experiencing social isolation increased markedly over 2020 and 2021. During the later years of the pandemic (2021 to 2022) the proportion of young females (15–24 years) experiencing social isolation decreased (23% in 2021 down to 17% in 2022), while the proportion of young males continued to increase (from 22% to 25% over this time). The 35–44-year age group was the only one for whom social isolation continued to increase from 2021 (16% in 2021 to 17% in 2022).

In 2022, just over 1 in 6 (16%) Australians were experiencing loneliness. As of 2022, about 1 in 5 (17%) males and 1 in 6 (15%) females aged 15–24 were experiencing loneliness. An increasing number of people aged 15–24, have reported experiencing loneliness since 2012. In contrast, the frequency of people aged 65 and over reporting loneliness has been steadily declining since 2001.

Social isolation and loneliness disproportionally affect older people as they are more likely to face factors such as living alone, chronic diseases, hearing loss and the loss of family or friends.[222] Healthy social and emotional wellbeing in later life is significantly influenced by strong and positive relationships and networks, with studies showing social isolation and loneliness in older people leads to increased likelihood of premature death and conditions such as depression, anxiety, and dementia.[223]

Several risk factors have been identified as contributors to social isolation and loneliness amongst older people, including living alone and lack of access to transport to access social engagements.

Current aged care reforms in Australia include a focus on providing home and community-based care services to support older people to remain in their own homes.[223] The provision of these services recognises the importance of maintaining social engagement for older adults and supporting socially isolated individuals through a range of social care services.[224] Despite efforts to increase social engagement, aged care providers have found that 41% of older adults initially accessing services are lonely.[225]

Loneliness is a major health problem for older people and is associated with a range of negative health consequences including depression, dementia, cardiovascular disease, malnutrition, poor quality of life and mortality.[226,227]

"Lots of older people experiencing isolation or missing family support --> Older Persons Mental Health team can't see all of them (only for acute presentations). Hospital Avoidance Sub Acute (HASA) Team tries to set up social support but not every person in need agrees to this." (Capricorn Coast Hospital and Health Service – Yeppoon)

"People are presenting with anxiety & depression, isolation but don't get involved in the community or join groups, do not leave the house. These older people also won't discuss their loneliness/ mental health with GPs (a generation that does not discuss their troubles.)" (Capricorn Coast Hospital and Health Service – Yeppoon).

"Since the local Cafe and general store have been closed there is NO connection and the pub is so expensive with limited hours. The older community are struggling" (survey participant, Kin Kin)

Lone person households

Lone person households are projected to make up 26% to 28% of all Australian households in 2046.[228] Increase to between 3.4 and 4.0 million households by 2046 – up from 2.6 million in 2021. Under age 55, most people living alone were men (55% in 2021, down from 59% in 2001), but over age 55 most people living alone were women (62% in 2021, down from 68% in 2001). The increase in lone person households in Australia is driven by multiple factors – an ageing population and an increase in the number of people without children. Literature suggests that living in a lone person household does not always equate to social isolation or loneliness.

In the CCQ region, over a quarter of households are lone-person households in Banana, Bundaberg, Central Highlands, Fraser Coast, Gladstone, Gympie, North Burnett, Rockhampton and Woorabinda LGAs (Table 72).

Table 72: Lone person households (2021)[12] and living alone (2016)[229]

LGA	Lone person households	65+ years living alone
	%	%
Banana	**26.9%**	**23.1%**
Bundaberg	**27.7%**	**22.6%**
Central Highlands (Qld)	**25.6%**	20.2%
Fraser Coast	**27.6%**	**21.5%**
Gladstone	**25.6%**	**20.7%**
Gympie	**27.3%**	**23.1%**
Livingstone	22.7%	20.7%
Noosa	24.4%	20.2%
North Burnett	**31.4%**	**23.7%**
Rockhampton	**28.0%**	**27.8%**
Sunshine Coast	23.5%	22.6%
Woorabinda	**25.3%**	**24.1%**
CCQ	***25.5%***	***20.3%***
Queensland	***24.7%***	***23.5%***
AUSTRALIA		***24.8%***

Substantial numerical differences are shown in grey.

Triple and quadruple jeopardy

Triple and quadruple jeopardy is a method of identifying 65+ years population with increased potential need. Several LGAs have higher proportions of adults 65+ with increased potential need than Queensland, including Bundaberg and Rockhampton (Table 73). Both regions have greater rates of vulnerability across the three measures compared with Queensland and the CCQ region overall.

Table 73: Adults 65+ with increased potential need indicators (2016), by LGA[229]

LGA	Triple jeopardy (a) living alone; with disability; low income, 65+ years		Triple jeopardy (b) renters; disability; low income, 65+ years		Quadruple jeopardy renters; living alone; with disability; low income, 65+ years	
	Number	%	Number	%	Number	%
Banana	42	2.1	18	0.9	9	0.5
Bundaberg	**571**	**2.6**	**399**	**1.8**	**167**	**0.8**
Central Highlands	38	1.3	29	1.0	14	0.5
Fraser Coast	**664**	**2.5**	**485**	**1.8**	148	0.5
Gladstone	130	1.9	84	1.2	37	0.5
Gympie	**270**	**2.5**	**188**	**1.7**	66	0.6
Livingstone	151	2.2	83	1.2	40	0.6
Noosa	192	1.5	101	0.8	35	0.3
North Burnett	**69**	**2.7**	36	1.4	13	0.5
Rockhampton	**341**	**3.0**	**238**	**2.1**	**128**	**1.1**
Sunshine Coast	1,223	2.1	624	1.1	222	0.4
Woorabinda	0	0.0	**5**	**17.2**	0	0.0
CCQ	***3,694***	***2.0***	***2,334***	***1.3***	***886***	***0.5***
Queensland	***17,054***	***2.4***	***11,315***	***1.6***	***4,460***	***0.6***

Triple jeopardy (a) - people who live alone, on low income and with a disability as a percentage of the total population aged 65 years and over living in occupied private dwellings.

Triple jeopardy (b) - e people who rent, on low income and with a disability as a percentage of the total population aged 65 years and over living in occupied private dwellings.

Quadruple jeopardy - People who rent, live alone on low income and with a disability as a percentage of the total population aged 65 years and over living in occupied private dwellings.

Voluntary work

Volunteering offers a range of protective factors for health and wellbeing, including reducing stress levels, decreasing your risk of depression, and provides a sense of purpose. For those retired over 65 years, it's been found that those who volunteer live longer.[230]

In the Census, participants (aged 15 years and over) are asked 'In the last twelve months did the person spend any time doing unpaid voluntary work through an organisation or group?' In the CCQ region, 15.3% undertook voluntary work compared with 14.1% in Queensland. **Volunteering rates were the highest in more regional areas, including North Burnett LGA (22.5%), Banana LGA (20.9%) and Central Highlands LGA (18.4%)** (Table 74).

Table 74: Percentage of people who undertook voluntary work, by LGA (2021)[12]

LGA	%
Banana	**20.9**
Bundaberg	14.0
Central Highlands	**18.4**
Fraser Coast	13.1
Gladstone	**16.2**
Gympie	**16.0**
Livingstone	**15.5**
Noosa	**17.0**
North Burnett	**22.5**
Rockhampton	13.6
Sunshine Coast	**15.7**
Woorabinda	5.7
CCQ region	***15.3***
QLD	***14.1***

Health literacy

Health literacy refers, broadly, to the ability of individuals to “gain access to, understand and use information in ways which promote and maintain good health” for themselves, their families and their communities. While different definitions are used and health literacy is an evolving concept, there is agreement that health literacy means more than simply being able to "read pamphlets", "make appointments", "understand food labels" or "comply with prescribed actions" from a doctor.[231]

The Australian Commission on Safety and Quality in Health Care (the Commission) separates health literacy into two components: individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.

Health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services.[232]

Health literacy is also not just a personal resource; higher levels of health literacy within populations yield social benefits, too, for example by mobilizing communities to address the social, economic and environmental determinants of health. This understanding, in part, fuels the growing calls to ensure that health literacy not be framed as the sole responsibility of individuals, but that equal attention be given to ensure that governments and health systems present clear, accurate, appropriate and accessible information for diverse audiences.

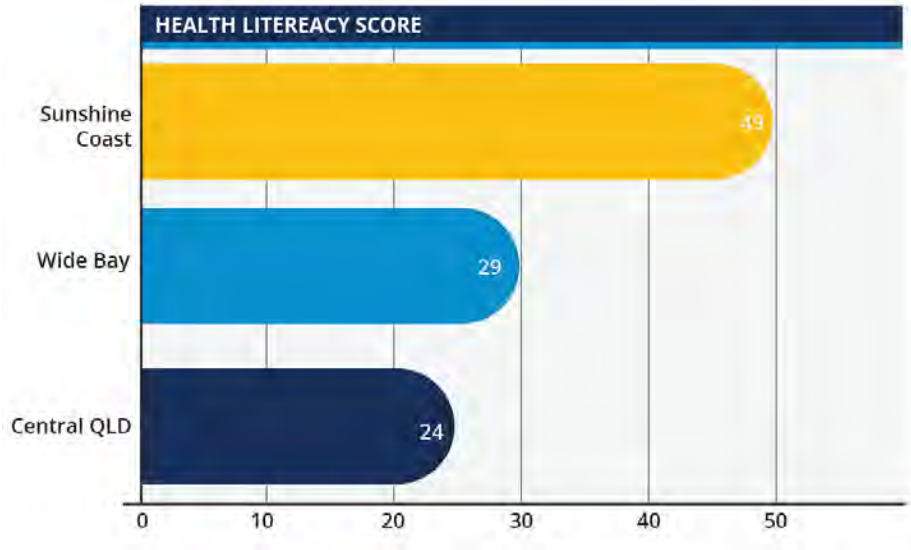
In Australia, only about 40 per cent of adults have the level of individual health literacy needed to meet the complex demands of everyday life.

Low individual health literacy is associated with higher rates of hospitalisation and emergency care, and with higher rates of adverse outcomes generally. Low health literacy is also associated with lower uptake of preventive approaches like mammography and the influenza vaccine. Low health literacy can significantly drain human and financial resources, and may be associated with extra costs of 3–5% to the health system. In older people, low individual health literacy is associated with a poorer health status and with a higher risk of premature death. These associations exist even after taking into account an individual’s age, gender, education, ethnicity and health status. However, the likelihood of a person experiencing barriers to health literacy may be increased where disadvantage and vulnerabilities connect, for example there may be greater barriers for people with lower educational attainment, who speak a language other than English or who have a disability.

Response to questions on Health Literacy in the *My Healthy Community* survey indicate that residents in the Sunshine Coast HHS generally have the highest health literacy rates in the CCQ region, followed by Wide Bay and then Central QLD (Figure 37). Three questions were asked about how easy or difficult it is to:

1. Make sure you find the right place to get the health care services you need
2. Discuss things with healthcare workers until you understand all you need to, and
3. Understand what healthcare workers are asking you to do.

Figure 37: Health literacy scores as calculated from the My Healthy Community survey



Defence force participation

A 'veteran' traditionally described former Australian Defence Force (ADF) personnel who were deployed to serve in war or war-like environments. Veterans are now considered people who have any experience in the ADF, including permanent, reserve, and former (ex-serving) personnel.[233]

ADF members have unique experiences as a result of their service in the military, which can influence their health and wellbeing relative to the rest of the Australian population. In general, ADF members are trained to be physically and mentally fit, receive regular medical assessments, and have access to comprehensive medical and dental treatment. In contrast to the general Australian population, ADF members can be subject to workplace stressors from exposure to combat, periodical geographical relocations, and lengthy separation from family. Military service also increases the likelihood of exposure to life threatening situations, which may result in physical and mental trauma and moral injury.[234]

The CCQ region has a high proportion of veterans living in the Bundaberg, Fraser Coast, Gympie and Sunshine Coast LGAs compared with Queensland (Table 75).

Table 75: Veteran population as at 28 June 2024 [235]

LGA	Total veteran card holders (2024)	Total ever served (2024)	Total ever served % of population (2024)
Banana	81	313	2.7%
Bundaberg	1,869	3,776	**4.6%**
Central Highlands	188	509	2.4%
Fraser Coast	2,847	5,206	**5.5%**
Gladstone	753	1,681	3.4%
Gympie	1,054	2,061	**4.6%**
Livingstone	525	1,209	3.7%
Noosa	798	1,706	3.6%
North Burnett	155	294	3.5%
Rockhampton	728	2,079	3.2%
Sunshine Coast	5,903	11,312	**4.0%**
Woorabinda	<5	7	1.1%
CCQ*	*~14,902*	*30,153*	***4.1%***
QLD	89,600	163,112	3.9%

* CCQ total calculated by summing LGAs and assuming a minimum of 1 for Woorabinda.

Includes currently serving in the regular service, currently serving in the reserves service and previously served in the Australian Defence Force.

Experience of violence and crime

Caution – this section contains information and statistics on DFV and sexual violence, which some people may find confronting or distressing.

Domestic, family and sexual violence

Family, domestic and sexual violence is a major health and welfare issue in Australia, occurring across all socioeconomic and demographic groups, but predominantly affecting women and children.

Social isolation is a well-recognised tactic of coercive control used by perpetrators to control their victims.[236] It ensures the victim does not hear other people's perspectives: perpetrators control the information the victim receives, reduce their help-seeking opportunities, and control the victim's ability to leave the abusive relationship.[237]

Domestic and family violence (DFV) involves abusive and violent behaviour towards a partner, former partner or family member. It extends beyond physical violence, and can involve actions that control, humiliate or scare the other person or people in the household.[238] Many victims of DVF never report their experience. With many incidents going unreported, prevalence of DFV may be much higher.[238]

DFV and sexual violence can occur at any life stage with immediate and long-term impacts. DFV and sexual violence can impact anyone, with changing risk factors depending on age and location; with young and middle-aged women living in metropolitan areas more likely to report experience of partner-abusive acts.

Adolescents, young women and Aboriginal and Torres Strait Islander women and girls are at particular risk. Sexual assault is most commonly reported for girls and young women aged 10 to 19 years. DFV and sexual violence impacts many health conditions that affect women and girls' ability to live well, work and contribute to the economy throughout their life. Pregnancy and birth are times of high risk for victims of DFV.

This is also a time when victims and perpetrators have increased contact with mainstream health providers, making this a significant intervention point.[140]

Indicators of DFV and sexual violence are presented in Table 76.

Table 76: Indicators of DFV and sexual violence, by SA4[239]

SA4	Sexual offences – all 2022-23		Rape and attempted rape		Other sexual offences		Stalking		Breach DV protection order	
	Rate per 100,000 persons	Change in rate (9 years)	Rate per 100,000 persons	Change in rate (9 years)	Rate per 100,000 persons	Change in rate (9 years)	Rate per 100,000 persons	Change in rate (9 years)	Rate per 100,000 persons	Change in rate (9 years)
Central Queensland	**254.0**	53.0%	**85.1**	70.1%	**168.9**	**45.6%**	**44.4**	139.1%	**1,977.5**	235.4%
Sunshine Coast	107.5	**60.8%**	35.6	85.2%	71.9	**51.0%**	23.7	110.4%	548.2	178.6%
Wide Bay	**199.5**	26.8%	**82.2**	**119.1%**	**117.3**	-2.1%	30.2	141.5%	**1,229.8**	232.2%
QLD	***187.0***	***57.3%***	***70.0***	***106.1%***	***117.1***	***37.8%***	***36.9***	***159.0%***	***1,105.4***	***255.2%***

Crime rates

The levels of crime victimisation in the community, as well as people's perceptions of their safety, are issues that impact directly or indirectly on the quality of people's lives. Those experiencing direct victimisation in particular, may suffer financially, physically or emotionally. Fear of crime can affect people by restricting community engagement, reducing levels of trust and impacting on social cohesion.

Police data is the most widely sourced administrative data used to produce crime statistics. It refers to those criminal offences that have been reported to or detected by police, and subsequently recorded by them. Police data is useful for compiling crime statistics because it represents an official record of crime.

However, police data has several limitations. Firstly, police data only provides information on those criminal offences that have come to the attention of police. Not all crimes committed are detected by the police, or, necessarily, the victims. Secondly, not all crimes committed are reported to the police. Several factors impact on a person's willingness to report crime to the police, including:

- Attitudes about the potential effectiveness of police in handling matters
- The people involved in an incident; and
- The possible implications for victims (including 'payback' and re-victimisation).

The data below should be interpreted with caution and examined with other available sources, if available.

Table 77: Reported offences per 100,000, by LGA (2022-23)[239]

LGA	Offences against a person	Offences against property	Other offences	Total offences
	Rate per 100,000			
Banana	**1,349**	4,141	**5,396**	**10,885**
Bundaberg	**1,306**	**4,528**	**4,305**	**10,140**
Central Highlands	**1,565**	3,310	**5,765**	**10,639**
Fraser Coast	**1,296**	**5,072**	**4,441**	**10,809**
Gladstone	**1,476**	4,018	**6,138**	**11,631**
Gympie	1,047	3,979	**4,176**	9,201
Livingstone	870	2,983	3,854	7,708
Noosa	620	2,672	3,276	6,568
North Burnett	1,108	2,857	3,693	7,658
Rockhampton	**2,576**	**9,334**	**7,471**	**19,381**
Sunshine Coast	727	3,091	2,668	6,487
Woorabinda	**14,100**	**15,677**	**49,814**	**79,592**
CCQ region	***1,151***	***4,172***	***4,118***	***9,441***
QLD	***1,472***	***5,299***	***4,228***	***10,999***

Elder abuse

While there is no agreed definition for elder abuse, the definition most commonly used in Australia is from the World Health Organization:

"Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person."[240]

A key aspect of the definition is that elder abuse occurs in relationships where there is 'an expectation of trust'. Such relationships include those with family members, friends, neighbours, and some professionals such as paid carers. In Australia, 'older people' are generally defined as those aged 65 and over. However, Aboriginal and Torres Strait Islander people are often included among 'older people' from the age of 50.

Until recently, we had a very limited understanding of elder abuse prevalence in Australia. The AIFS National Elder Abuse Prevalence Study estimated that, in Australian in 2020:

- around 1 in 6 (598,000 or 15%) older people living in the community had experienced elder abuse in the past year
- 471,300 (12%) had experienced psychological abuse in the past year
- 115,500 (2.9%) had experienced neglect in the past year
- 83,800 (2.1%) had experienced financial abuse in the past year
- 71,900 (1.8%) had experienced physical abuse in the past year
- 39,500 (1.0%) had experienced sexual abuse in the past year
- a slightly higher percentage of women than men had experienced any form of elder abuse in the past year. This pattern was also evident for psychological abuse and neglect.[241]

Occupational exposures and hazards

In 2018, 1.8% of the total burden in Australia was due to occupational exposures & hazards.[242]

These estimates reflect the amount of burden that could have been avoided if all people in Australia were not exposed to occupational exposures & hazards including injuries, loud noise, carcinogens, particulate matter, gas and fumes, asthmagens and ergonomic factors.

In 2018, occupational exposures & hazards was linked to 26 diseases and injuries including 11 types of cancer, 8 types of injury, hearing loss, back pain & problems, asthma, chronic obstructive pulmonary disease (COPD), silicosis, asbestosis and other pneumoconiosis. A list of occupational exposures/hazards and their linked diseases are presented in.

Occupational exposures and hazards were responsible for the entire burden from silicosis asbestosis and other pneumoconiosis, 65% of mesothelioma burden, 22% of burden from other unintentional injuries, 17% of back pain and problems burden, 12% of burden from fire, burns and scalds, 9% of burden from other land transport injuries, 9% of asthma burden and 8% of road traffic injuries of motor vehicle occupants burden.

Table 78: Type of occupational exposures and hazards and corresponding linked diseases as estimated in the Australian Burden of Disease Study 2018

Occupational exposure or hazard	Linked disease
Injury	Drowning, falls, fire, burns and scalds, homicide and violence, road traffic injuries—motor vehicle occupants, road traffic injuries—motorcyclists, other unintentional injuries, other land transport injuries
Benzene or formaldehyde	Acute myeloid leukaemia, Chronic myeloid leukaemia, Chronic lymphocytic leukaemia, Acute lymphoblastic leukaemia, Other leukaemias, nasopharyngeal cancer
Noise	Hearing loss
Arsenic, beryllium, cadmium chromium, diesel engine exhaust, polycyclic aromatic hydrocarbons, nickel, second-hand smoke, silica	Lung cancer
Sulfuric acid	Laryngeal cancer
Trichloroethylene	Kidney cancer
Particulate matter, gas and fumes	COPD
Asbestos	Laryngeal cancer, lung cancer, ovarian cancer mesothelioma
Asbestos, silicone and particulate matter	Silicosis, asbestosis and other pneumoconiosis
Asthmagens	Asthma
Ergonomic factors	Back pain & problems

Natural environment

The natural environment is a concept which encompasses climate, atmosphere, natural resources, water, land, ecosystems and biodiversity. A healthy natural environment is fundamental to quality of life and wellbeing.

Air and water quality

Air and water quality are critical factors influencing community health and well-being. Poor air quality, characterized by high levels of pollutants such as particulate matter and nitrogen dioxide, is linked to a range of health problems, including respiratory and cardiovascular diseases, and can exacerbate conditions like asthma. The CCQ region has generally high air quality – with the largest declines recorded during bushfire events where particulate matter has exceeded guideline amounts in the South Gladstone region.[243]

Similarly, access to clean, safe drinking water is essential for preventing waterborne diseases and maintaining overall health. The CCQ region has a high standard of drinking water quality throughout the region, with only sporadic public complaints linked to water aesthetic (e.g. particulate matter or taste considerations).[244,245] Data on air and water quality provides valuable insights into environmental conditions and helps identify areas at risk of pollution-related health issues. Effective monitoring and management of these resources are crucial for ensuring public safety and improving quality of life. By addressing air and water quality concerns through targeted interventions and policies, communities can enhance health outcomes, support sustainable living, and create environments that foster well-being for all residents.

A range of important gaps remain in the CCQ region that warrant further investigation and investment.

- While drinking water standards are high throughout the region, runoff and riverine water quality from agriculture and industrial processes is of importance and requires further attention. This is particularly the case for particulate matter and high nutrient loads that end up in waterways and catchments.
- In maintaining air quality, CCQ communities currently lack infrastructure for real-time local information during periods of poor air quality from industrial or bushfire-driven events. New networks of low-cost sensors are important to fill in the gaps between fixed-location monitoring stations.[246]
- According to the ABS, Queensland's population is predicted to double by 2056. Managing this growth will be one of Queensland's biggest ever challenges. As regional areas are the predominant regions for agriculture, more work is required to provide platforms that make rural and regional areas liveable and sustainable.[247]

Climate change and severe weather events

The World Health Organization (WHO) identifies climate change as the most pressing threat to human health. The impact of climate change poses significant health risks, including traumatic injuries, communicable diseases, and mental health challenges. The impacts of climate change will continue to increase over the coming decades due to past emissions of greenhouse gases.[248]

Since 1950, Australia has become warmer, with more extremely high temperatures and fewer extremely low temperatures. Rainfall has increased in the north-west and decreased in the south-west and east. Extreme daily rainfall intensity has generally increased. Sea levels have risen, oceans have warmed, and marine heatwaves have become more frequent. Increases in greenhouse gases have contributed to these changes.[249] Through altering the baseline and long-term atmospheric conditions, climate change is an unprecedented and dynamic change with potential to bring about both incremental and also acute disaster-driven impacts. Queensland's changing climatic conditions represent a rapidly evolving dynamic with important and varying implications.

The CCQ region straddles both northern tropical cyclone zones, and southern East Coast low weather systems with both weather complexes potentially increasing frequency, severity and impact. The list below shows the nature and timing of significant disaster events affecting CCQ LGAs over the past 10 years.

- Tropical Cyclone Kirrily, January – February 2024
- Southern Queensland Severe Storms and Rainfall, December 2023 – January 2024
- Southern Queensland Bushfires, September – November 2023

- Northern and Central Queensland Monsoon and Flooding, December 2022 – April 2023
- Southern Queensland Flooding, 6 - 20 May 2022
- South East Queensland floods, February – April 2022
- Ex Tropical Cyclone Seth, December 2021 – January 2022
- Central, Southern and Western Queensland rainfall and flooding, Nov-Dec 2021
- Halloween thunderstorm – giant hail, October 2020
- K'gari Bushfires, 2019-2020
- Black Summer Bushfires, Sept-Dec 2019
- Central Queensland Bushfires, 22 November - 6 December 2018
- Wide Bay-Burnett Severe Storms, 11 - 14 October 2018
- Gympie bushfires, 19 - 27 September 2018
- Central Coast Queensland Severe Weather, 16 - 19 October 2017
- Severe Tropical Cyclone Debbie & Associated Rainfall & Flooding, 28 March - 6 April 2017
- Central Queensland Severe Weather, 15 - 20 July 2016
- Central Queensland Surface Trough, 4 - 8 February 2016
- Severe Tropical Cyclone Marcia & South East Queensland Trough, 19 - 22 February 2015
- Central Eastern Queensland Heavy Rainfall & Flooding, 21 - 29 January 2015
- Central and Western Queensland Flooding & Rainfall, 18 - 28 February 2014
- Tropical Cyclone Dylan, 31 January 2014
- Central and Southern Queensland Low, 25 February - 5 March 2013
- Tropical Cyclone Oswald and Associated Rainfall and Flooding, 21 - 29 January 2013
- East Coast Low, 22 March 2012
- Heavy Rainfall & Flooding, Northern & Far Northern Queensland, 15 March 2012
- Western Queensland Tropical Low, 27 January 2012
- South East Queensland Heavy Rainfall and Flooding, 23 - 26 January 2012
- Queensland Bushfires, August - November 2011
- South West Flooding, April 2011
- Queensland Flooding and Tropical Cyclones Tasha and Anthony, November 2010 - February 2011
- South East Queensland Flooding, 9 - 12 October 2010

At their most acute, **climate change impacts are realised in the form of flooding events with centres of Rockhampton, Emerald, Bundaberg, Maryborough and Gympie all prone to increased occurrences of overland and riverine flooding events** which bring about associated public health and property damage impacts. For CCQ there are three factors that increase the risk of disaster related health issues:

1. Escalating disaster frequency and intensity,
2. Poor pre-existing health population health and strained healthcare resources
3. Low levels of disaster resilience to cope and adapt.

This combination of these factors means there is a significant risk to both the local population's health and the healthcare system, necessitating urgent attention.

Community health and climate change

Increasing incidents of extreme weather events bring about increased need for community preparation and resilience to cope with more, and more serious disasters that impact human populations. Yet, in circumstances of poor underlying social and environmental determinants, individuals with existing health issues are more susceptible to experiencing adverse health effects during and after a disaster. For example, when natural disasters impact communities already experiencing high levels

of chronic diseases and limited to access to health services, the impact can be devastating. For example, young children and the elderly represent two of Queensland's population groups most vulnerable to the negative impacts of a changing climate. These groups are among the first to suffer from the effects of prolonged or extreme heat. Together, the aged care and childcare sectors are large employers with significant infrastructure and facilities, providing care and support to vulnerable groups, which makes them an important component of Queensland's health system.

Social dynamics such as age and gender, social capital, education, and access to, and quality of public infrastructure, health and social services, also influence vulnerability to the health impacts of climate change. These impacts affect all populations, but those particularly vulnerable include children, women, disadvantaged and elderly people, as well as some geographically vulnerable communities (e.g. remote or isolated communities).

Many Aboriginal and Torres Strait Islander communities face multiple risks, including physical isolation, poor infrastructure and high underlying health disparities. Their deep cultural and spiritual connection to the land and sea also increases their potential for being emotionally affected by climate change.

Disaster resilience

In building resilience to climate change, human populations are required to undertake adaptation, whereby adaptation refers to adjustment in natural or human systems in response to actual or expected climatic stimuli or their effects, which moderates harm or exploits beneficial opportunities.[250] Disaster resilience is the capacity for communities to prepare for, absorb and recover from natural hazard events and to learn, adapt and transform in the face of future events. Across Australia, an overall measure of disaster resilience can be estimated through assessments of coping and adaptive capacities of LGAs. The Disaster Resilience Index values range from 0 to 1.[251]

Within CCQ various LGAs have different abilities to cope and adapt (Table 79).[251] Prior research by the Australian Institute of Disaster Resilience revealed that the great majority of LGAs in the region have low resilience and poor ability to respond and adapt to climate change driven disasters. These generally low capacities are reflective of a range of characteristics, from underlying socio-economic factors and environmental pre-conditions and high disaster risk (in particular flooding).

Low = 0.0000 to 0.4461

Communities in areas of low disaster resilience may be limited in their capacity to use available resources to cope with adverse events, and are limited in their capacity to adjust to change through learning, adaptation and transformation. Limitations to disaster resilience may be contributed by entrenched social and economic disadvantage, less access to or provision of resources and services, lower community cohesion and limited opportunities for adaptive learning and problem solving.

Moderate = 0.4462 – 0.6598

Communities in areas of moderate disaster resilience have some capacity to use available resources to cope with adverse events, and some capacity to adjust to change through learning, adaptation and transformation. Moderate disaster resilience is generally contributed by moderate levels of coping and adaptive capacity, which in turn are associated with moderate levels of economic capital, moderate provision of and access to services, moderate community cohesion and variable encouragement for adaptive learning and problem solving.

High = 0.6599 to 1.0000

Communities in areas of high disaster resilience have enhanced capacity to use available resources to cope with adverse events, and enhanced capacity to adjust to change through learning, adaptation and transformation. Factors contributing to high disaster resilience may include employment, education, income, good access to or provision of resources and services, strong community cohesion and ample opportunities for adaptive learning and problem solving.

Table 79: Disaster resilience factors, by SA2[251]

Group 1		Group 2	
Strengths:	**Barriers:**	**Strengths:**	**Barriers:**
Planning & the built environment	Social character	Planning & the built environment	Information access
Economic capital	Community capital	Economic capital	
Emergency services	Social and community engagement	Emergency services	
Information access		Governance and leadership	
Governance and leadership		Social character	
		Community capital	
		Social and community engagement	
Bundaberg LGA	**Rockhampton LGA**	**Sunshine Coast LGA**	**Rockhampton LGA**
Ashfield – Kepnock	Berserker	Caloundra Hinterland	Rockhampton Region - West
Bundaberg	Gracemere	Eumundi – Yandina	
Bundaberg East – Kalkie	Lakes Creek	Glass House Mountains	
Bundaberg North – Gooburrum	Park Avenue	Maroochy Hinterland	
Millbank – Avoca	Parkhurst – Kawana		
Svensson Heights – Norville	Rockhampton City	**Noosa LGA**	
Walkervale – Avenell Heights	The Range – Allenstown	Noosa Hinterland	
Sunshine Coast LGA			
Caloundra - Kings Beach	**Fraser Coast LGA**		
Maroochydore – Kuluin	Maryborough (Qld)		
Gympie LGA	Pialba - Eli Waters		
Gympie – North	Point Vernon		
Noosa LGA	Torquay - Scarness – Kawungan		
Noosaville	Urangan – Wondunna		
Terwantin			

Group 3		Group 4	
Strengths:	**Barriers:**	**Strengths:**	**No barriers**
Social character	Planning & the built environment	Planning & the built environment	
Community capital	Economic capital	Economic capital	
Social and community engagement	Emergency services	Emergency services	
	Information access	Information access	
	Governance and leadership	Governance and leadership	
		Social character	
		Community capital	
		Social and community engagement	
Bundaberg LGA	**Banana LGA**	**Sunshine Coast LGA**	**Bundaberg LGA**
Banana	Biloela	Aroona – Currimundi	Branyan – Kensington
Bargara - Burnett Heads	**Fraser Coast LGA**	Beerwah	
Bundaberg Region – North	Booral - River Heads	Bli Bli	**Fraser Coast LGA**
Bundaberg Region – South	Burrum – Fraser	Buddina – Minyama	Craignish – Dundowran Beach
Gin Gin	Granville	Buderim – North	
Central Highlands LGA	Maryborough Region – South	Buderim – South	**Gympie LGA**
Central Highlands – East	Tinana	Caloundra – West	Gympie – South
Central Highlands – West	**Gympie LGA**	Coolum Beach	
Emerald	Gympie Region	Diddillibah – Rosemount	**Noosa LGA**
Rockhampton LGA	Cooloola	Golden Beach – Pelican Waters	Peregian
Bouldercombe	Kilkivan	Landsborough	Sunshine Beach
Frenchville - Mount Archer	**Livingstone LGA**	Marcoola – Mudjimba	Noosa Heads
Mount Morgan	Emu Park	Moffat Beach - Battery Hill	
Norman Gardens	Glenlee – Rockyview	Mooloolaba – Alexandra Headland	
Rockhampton Region – East	Rockhampton Region – North	Mountain Creek	
Rockhampton – West	Yeppoon	Nambour	
	North Burnett LGA	Palmwoods	
	Gayndah – Mundubbera	Parrearra – Warana	
	Monto – Eidsvold	Wurtulla - Birtinya	
Group 5: Sippy Downs			

My Healthy Community survey respondents from the Central Queensland HHS region expressed the greatest perceived level of emergency preparedness (Figure 38). Within the results, CCQ residents expressed that they felt most prepared for Extreme Weather and Bush Fire emergencies; the most likely emergencies to occur in the CCQ region.

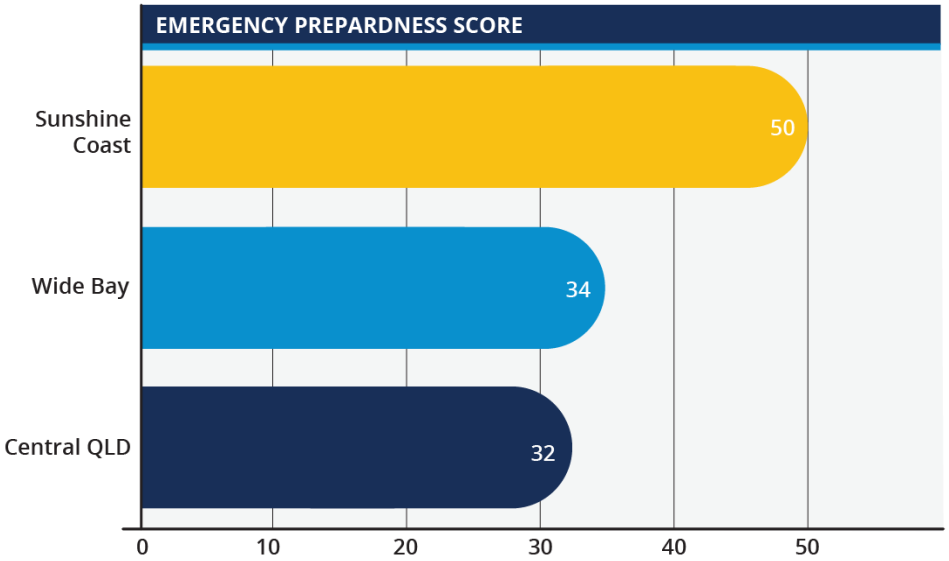
"Better communication about contingency plans if the community needs to be evacuated." (Peregian Beach)

"Household awareness, to ensure all members of your home, your street are well organized if a disaster or emergency event occurs." (Buderim)

"Not everyone can hear the siren in an emergency. Once you take hearing aids out at night you hear nothing." (Munduberra)

"Internet and phone signal is atrocious, access to solid connection is critical in times of emergency events to be warned, to get prepared and to evacuate." (Innes Park)

Figure 38: My Healthy Community results, indicating perceived levels of emergency preparedness across the CCQ region



Responses to the *My Healthy Community* survey highlighted several critical themes for emergency preparedness. A key theme, emphasised across multiple responses, was the need for better communication and information dissemination. Having reliable Internet and phone connections is essential for receiving timely warnings, preparing, and evacuating during emergencies. Additionally, there is a significant need for inclusive procedures to ensure that all community members, including those with hearing impairments, are aware of dangers in a timely manner.

The responses also underscore the necessity of educating new residents about emergency preparedness as a vital measure to ensure community-wide readiness, especially in the context of recent migration to the region from people who may not have lived in sub-tropical climates previously. Concerns about the reliability of telecommunications and the need for improved infrastructure were also prevalent, indicating that robust and accessible communication networks are fundamental to emergency resilience.

The voices of the community are integral to understanding the drivers behind feelings of preparedness or unpreparedness. It is key for us to further investigate these factors to develop appropriate strategies that enhance overall emergency resilience. There are varying capacities of residents in different local government areas (LGAs) to cope and adapt to climate change-driven disasters, as highlighted by the Australian Institute of Disaster Resilience, indicate a need for targeted resilience-building initiatives.

In conclusion, the community's insights reveal a multifaceted approach to improving emergency preparedness, emphasising communication, inclusivity, support for first responders, education, and infrastructure. By addressing these themes and understanding the underlying factors, we can enhance our strategies to better prepare and protect our communities in the face of emergencies.

Built environment

The built environment is the human-made surroundings where people gather to live, work and play. It encompasses both the physical structures where people do these activities and the supporting infrastructure, such as transport, water and energy networks.

The built environment is a determinant of health due to its ability to affect health outcomes through activity levels, access to nutritious food and clean water, the houses we live in, where we work, contact with nature and the spaces we have for social interactions.

It is important for built environments to be well planned, provide adequate housing and access to services, and support health and safety. These environments should be somewhere that people enjoy living and being, and should support positive social interaction and inclusion. Built environments have practical value, as well as heritage, social and aesthetic aspects which contribute to wellbeing.

Transportation

A well-functioning, affordable and reliable transportation system is a key enabler for a healthy built environment, enabling access to essential services like employment, healthcare and fresh food.[252] Transport can positively impact health by promoting active travel, such as walking or cycling, which reduces sedentary behaviour. However, it can also negatively affect health and the environment through traffic emissions and sedentary commuting habits.

In our recent survey using the Place Standard Tool, we received 2,054 responses covering 14 domains of community strengths. One clear trend emerged from the feedback: public transport was consistently identified as the area with the greatest room for improvement by participants across all three HHS regions.

"These services are available in neighbouring towns, however, there is no public transport to help residents get to those towns" (survey participant, Kin Kin)

This feedback underscores the critical role of transportation in shaping the quality of life and health outcomes in our communities. Enhanced public transport not only addresses the practical needs of commuting but also fosters greater social equity and environmental sustainability. By focusing on improving transportation infrastructure, we can significantly impact the wellbeing and connectedness of our community members, making strides towards a healthier and more accessible built environment.

In Australia, commuting patterns reveal a high dependence on private vehicles, with 86% of workers using cares according to the 2021 Census.[252] Public transport was used by only 7.2%, while 4.8% walked or cycled. Shorter commuting distances were linked with better health outcomes, such as lower obesity and higher physical activity levels. The shift towards working from home, accelerated by COVID-19, is also changing commuting behaviours, with a significant number of people continuing to work remotely post-pandemic.

Car dependence in Australia has multiple health and environmental consequences, including increased traffic congestion, pollution and poor air quality, which can affect respiratory and cardiovascular health. Electric vehicles, which made up 8.4% of new car sales in 2023, present a potential solution, though their adoption lags behind other countries. Care dependence disproportionately affects lower socioeconomic communities, which face higher transportation costs and vulnerability to fuel price fluctuations.

Promoting active travel, such as walking or cycling, has numerous benefits, including improved physical, mental and social health, as well as reduced emissions and traffic congestion. Active travel is more common in areas with accessible public transport and well-designed streets that ensure safety. As transport policies evolve, there is growing emphasis on encouraging active travel and the adoption of electric vehicles to enhance public health and environmental sustainability.

The *National Walking and Cycling Participation Survey*[253] provides a comprehensive look at walking and cycling habits across Australia, following on from the *National Cycling Participation Survey*[254] conducted biennially between 2011 and 2021.

Key findings from the 2023 survey include:

- 89.5% of Australians walk outside their homes for at least 10 minutes weekly, equating to about 23.69 million people. Australians typically walk 4.8 days per week, spending an average of 3.5 hours weekly walking.
- 15% of Australians ride a bicycle (including e-bikes) weekly, and 36.47% over the past year.
- Additionally, 2.1% of Australians ride electrically assisted devices (e.g., e-scooters) weekly.

The CCQ region has a slightly lower percentage of households without motor vehicles compared to Queensland (Table 80). CCQ also has a slightly higher proportion of households with two and three or more vehicles than the state average, suggesting a stronger reliance on private vehicles. **Public transport usage to travel to work in the CCQ region is notably low, mirroring the broader trend across regional areas.** Across LGAs, Woorabinda stands out with a high proportion of households without motor vehicles and a high proportion of people walking to work, although this may reflect the localised nature of the LGA and subsequently employment being close to home for many residents. In contrast, more developed LGAs such as the Sunshine Coast and Rockhampton have higher rates of car use, as do Noosa and Livingstone.

Table 80: Transportation Indicators

LGA	Number of motor vehicles per occupied private dwelling (2021)[255]								Mode of travel to work on the day of the Census, employed people aged 15 years and over (2021)[256]									
	No motor vehicles		1 motor vehicle		2 motor vehicles		3 or more motor vehicles		Walked only		Motorbike / scooter		Bicycle		By public transport^		By car as driver or passenger*	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Banana	224	4.5	1,331	26.6	1,854	37.1	1,458	29.2	405	5.7	28	0.4	43	0.6	59	0.8	4,606	65.3
Bundaberg	2,173	5.6	14,125	36.7	13,655	35.5	7,738	20.1	927	2.4	246	0.6	180	0.5	360	0.9	30,035	**77.4**
Central Highlands	316	3.4	2,838	30.6	3,467	37.3	2,454	26.4	695	4.9	62	0.4	76	0.5	703	5.0	9,543	**67.3**
Fraser Coast	2,540	**5.8**	17,080	38.9	15,341	34.9	8,143	18.5	952	2.5	258	0.7	286	0.8	261	0.7	27,937	**74.4**
Gladstone	966	4.2	7,545	32.5	9,092	39.2	5,186	22.4	690	2.4	234	0.8	138	0.5	842	2.9	21,677	**75.9**
Gympie	839	4.1	6,806	33.3	7,614	37.2	4,822	23.6	554	2.7	86	0.4	44	0.2	148	0.7	14,517	**71.3**
Livingstone	462	3.4	4,045	29.3	5,442	39.5	3,576	25.9	348	2.0	69	0.4	39	0.2	312	1.8	12,666	**71.9**
Noosa	769	3.5	7,554	34.6	8,584	39.3	4,618	21.1	649	2.7	199	0.8	196	0.8	282	1.2	14,975	61.8
North Burnett	176	4.5	1,280	32.8	1,317	33.7	1,003	25.7	330	7.8	14	0.3	15	0.4	61	1.4	2,669	62.8
Rockhampton	1,962	**6.6**	10,734	35.9	10,839	36.2	5,875	19.6	897	2.4	190	0.5	172	0.5	475	1.3	28,462	**77.0**
Sunshine Coast	4,972	3.9	44,461	34.8	50,224	39.3	26,582	20.8	3,171	2.0	730	0.5	1,190	0.7	2,087	1.3	107,865	**67.3**
Woorabinda	125	**45.8**	105	38.5	26	9.5	19	7.0	78	40.2	0	0.0	0	0.0	0	0.0	104	53.6
CCQ	***15,524***	***4.6***	***117,904***	***34.9***	***127,455***	***37.7***	***71,474***	***21.1***	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*
Queensland	***106,309***	***5.7***	***658,705***	***35.2***	***701,752***	***37.5***	***373,952***	***20.0***	***63,580***	***2.6***	***15,951***	***0.7***	***17,121***	***0.7***	***100,396***	***4.1***	***1,597,346***	***65.4***
AUSTRALIA	*-*	*-*	*-*	*-*	*-*	*-*	*-*	*-*	***306,045***	***2.5***	***49,683***	***0.4***	***79,089***	***0.7***	***554,711***	***4.6***	***6,961,762***	***57.8***

- data not reported; ^includes people who used public transport (train, bus, ferry, tram/light rail), as at least one of their methods of travel to work on Census day; *includes people who travelled by car (as a driver, or as a passenger), as at least one of their methods of travel to work on Census day. Substantial numerical differences are shown in grey.

Walkability

People who live in walkable communities are two times more likely to be physically active which in turn has physical and mental benefits and encourages social interaction. Walkable communities include feature that make walking convenient, comfortable and safe. These features include having: appealing neighbourhoods with trees, shade, points of interest and lit; paths, amenities to stop and rest and toilet facilities; and direct routes between homes, shops, workplaces and other places.[257]

Footpaths and cycle lanes are integral to promoting active transportation and improving overall community health. Well-designed networks of footpaths and cycle lanes facilitate safer and more convenient walking and biking, which encourages residents to engage in regular physical activity. This can lead to significant health benefits, including reduced risk of cardiovascular diseases, lower rates of obesity, and enhanced mental well-being. The extent, connectivity, and quality of these infrastructures helps in assessing how effectively a community supports active transportation. Communities with comprehensive footpath and cycle lane networks often report higher levels of physical activity and lower levels of traffic congestion, contributing to both environmental and public health improvements. Furthermore, urban planners and policymakers require ongoing support in identifying areas where infrastructure improvements are needed to ensure equitable access and encourage more sustainable transportation options.

Walk Score is a publicly available walkability indicator that measures the walkability of a location based on the distance to nearby places and pedestrian friendliness. Walk Score analyses hundreds of walking routes to nearby amenities. Points are awarded based on the distance to amenities in each category. Amenities within a 5-minute walk (.25 miles) are given maximum points. A decay function is used to give points to more distant amenities, with no points given after a 30-minute walk. Walk Score also measures pedestrian friendliness by analysing population density and road metrics such as block length and intersection density. Data sources include Google, Factual, Great Schools, Open Street Map, the U.S. Census, Localise, and places added by the Walk Score user community.

From a health perspective, walkable suburbs with access to public transport, better commutes, and proximity to the people and places you love are the key to a happier, healthier and more sustainable lifestyle.

Walk Scores are then categorised by their level of walkability as following.

90–100	**Walker's Paradise:** Daily errands do not require a car
70–89	**Very Walkable:** Most errands can be accomplished on foot
50–69	**Somewhat Walkable:** Some errands can be accomplished on foot
25–49	**Car-Dependent:** Most errands require a car
0–24	**Car-Dependent:** Almost all errands require a car

Some cities and suburbs in the CCQ region have Walk Score measures. These are provided below (Table 81).

Walkability was also identified as a theme in the *My Healthy Community* survey. Survey participants highlighted a lack of infrastructure enabling them to engage in physical activity.

"Walk on a continuous and well-maintained footpath, not the road, from my home to the surrounding park and corner shop" (survey participant, Bundaberg)

"Person with mobility issues and wheelie walker not being able to walk on a level and continuous footpath" (survey participant, Bundaberg)

Table 81: Walk score for CCQ suburbs[258]

City/suburb	Walk Score
Sunshine Coast, including Noosa	**44 car-dependent**
Caloundra	80 very walkable
Kings Beach	75
Moffat Beach	68 somewhat walkable
Mooloolaba	65
Buddina	64
Alexandra Headland	63
Maroochydore	62
Minyama	61
Shelly Beach	60
Dicky Beach	56
Noosaville	56
Noosa Heads	55
Golden Beach	52
Sunshine Beach	50
Coolum Beach	50
Pacific Paradise	49 car-dependent
Battery Hill	49
Currimundi	48
Parrearra	48
Wurtulla	47
Warana	46
Buderim	46
Kuluin	46
Nambour	46
Bokarina	44
Sunrise Beach	42
Mudjimba	40
Marcoola	40
Mountain Creek	39
Burnside	38
Sippy Downs	37
Aroona	36
Tewantin	35
Mount Coolum	35
Caloundra West	34
Pelican Waters	31
Peregian Springs	30
Yaroomba	29
Coes Creek	26
Twin Waters	25
Little Mountain	23
Peregian Beach	21
Bli Bli	20
Forest Glen	18
Meridan Plains	15
Castaways Beach	13
Diddillibah	11
Mons	9
Marcus Beach	7
Gympie	**40 car-dependent**
Gympie	53 somewhat walkable
Southside	26 car-dependent
Monkland	17
Victory Heights	15
Maryborough	**36 car-dependent**
Maryborough	39
Granville	27
Hervey Bay	**33 car-dependent**
Pialba	57 somewhat walkable
Scarness	50
Torquay	43 car-dependent
Urangan	37
Urraween	36
Point Vernon	31
Eli Waters	27
Kawungan	23
Craignish	11
Dundowran	11
Wondunna	10
Dundowran Beach	6
Bundaberg	**35 car-dependent**
Bundaberg West	67 somewhat walkable
Bundaberg South	59
Svensson Heights	52
Walkervale	47 car-dependent
Norville	46
Millbank	41
Kepnock	35
Bundaberg East	34
Avoca	34
Avenell Heights	29
Bundaberg North	28
Thabeban	16

City/suburb	Walk Score
Branyan	10
Gladstone	**38 car-dependent**
Gladstone Central	76 very walkable
Barney Point	62 somewhat walkable
West Gladstone	61
Kin Kora	48 car-dependent
South Gladstone	45
Sun Valley	39
Clinton	27
New Auckland	27
Telina	25
Toolooa	21
Glen Eden	7
Rockhampton	**43 car-dependent**
Rockhampton City	83 very walkable
Allenstown	67 somewhat walkable
Berserker	58
Park Avenue	54
The Range	52
Depot Hill	50
Wandal	47 car-dependent
Kawana	42
Frenchville	38
Norman Gardens	38
West Rockhampton	30
Koongal	29
Parkhurst	13
Yeppoon	**34 car-dependent**
Cooee Bay	56 somewhat walkable
Yeppoon	45
Taranganba	43
Lammermoor	11
Barmaryee	6
Barlows Hill	3
Pacific Heights	2
Gayndah (central location only)*	61 somewhat walkable
Emerald (central location only)*	38 car-dependent
Biloela (central location only)*	74 very walkable
Woorabinda (central location only)*	13 car-dependent
Biggenden (central location only)*	46 car-dependent
Tin Can Bay (central location only)*	44 car-dependent
Rainbow Beach (central location only)*	61 somewhat walkable

* Walk Score was only available for a central address and not at an overall suburb level.

Availability of green and blue spaces

Green open spaces, such as parks, forests, and community gardens, play a crucial role in enhancing community health and well-being. Access to these areas has been consistently linked to numerous physical and mental health benefits. Research shows that proximity to green spaces encourages physical activity, such as walking and jogging, which can reduce the risk of chronic diseases like obesity, diabetes, and cardiovascular conditions.

Moreover, green spaces provide essential opportunities for relaxation and stress relief, contributing to improved mental health by reducing anxiety, depression, and overall psychological distress. Communities with ample green spaces often experience lower crime rates and greater social cohesion, as these areas serve as communal gathering spots that foster social interactions and a sense of belonging. Therefore, data on the availability, accessibility, and quality of green open spaces is fundamental for designing healthier, more resilient communities.

In 2024, the CCQ region had 25,958.8 km^2 of protected areas – parks, forests and reserves. The largest protected area type was State Forests with 13,763.3 km^2. Within the region, Central Highlands LGA had the largest protected area with 7,357.8 km^2 (Table 82).

Table 82: Protected areas - parks, forests and reserves by LGA (2024)[12]

LGA	National park (a)	State Forest	Timber reserve	Forest reserve	Total
	Area (km2)				
Banana	1,504.9	3,235.8	96.1	0.0	4,836.9
Bundaberg	577.7	642.2	0.0	0.0	1,219.9
Central Highlands	3,485.4	3,872.4	0.0	0.0	7,357.8
Fraser Coast	1,947.6	1,481.2	0.0	0.0	3,428.9
Gladstone	1,400.0	458.4	0.0	0.0	1,858.4
Gympie	1,086.5	1,062.8	0.0	0.0	2,149.2
Livingstone	321.2	465.2	0.0	0.0	786.4
Noosa	234.8	33.9	0.0	0.0	268.7
North Burnett	769.7	2,200.6	25.4	0.0	2,995.6
Rockhampton	334.7	99.1	0.0	0.0	433.8
Sunshine Coast	410.2	211.6	0.0	1.2	623.1
Woorabinda	0.0	0.1	0.0	0.0	0.1
CCQ	**12,072.8**	**13,763.3**	**121.5**	**1.2**	**25,958.8**
Queensland	**98,432.8**	**31,018.9**	**662.6**	**501.0**	**130,615.4**

(a) Includes Conservation Parks, Resources Reserves and National Parks

Cities and Regions Wellbeing Index

The Cities and Regions Wellbeing Index (CRWI) examines socio-economic wellbeing on a local government area level. It presents GDP broken down into economic activity in the local regions, Gross Regional Product (GRP), alongside six other wellbeing domains - income and wealth, employment knowledge and skills, housing, health, equality and community, and the environment - to create a more nuanced understanding of how place shapes people's lives.

Each domain is calculated using a range of indicators, such as gender pay gap, income inequality, male-female work disparity ratio, index of environmental hazards, national park, reserve or protected land, rental affordability, life expectancy, income and education.

Many of the indicators below are presented separately through the report (Table 83). Perhaps not surprisingly, Noosa and Sunshine Coast LGAs score higher on the Index compared with other areas with higher levels of disadvantage, including Woorabinda and North Burnett.

Table 83: The seven dimensions of the CRWI framework[259]

LGA	Economy	Income & wealth	Employment, knowledge & skills	Housing	Health	Equality & Community	Environment	Headline CRWI#
Banana	4.10	3.22	4.64	6.99	3.51	4.50	4.17	4.44
Bundaberg	4.05	3.97	3.07	6.70	2.81	5.53	2.34	4.07
Central Highlands	3.98	2.83	5.96	7.04	4.10	4.26	5.74	4.84
Fraser Coast	3.98	4.33	1.98	6.70	2.23	5.68	4.98	4.27
Gladstone	4.33	2.95	5.12	6.82	4.39	4.53	5.07	4.71
Gympie	3.93	4.13	2.93	6.36	2.90	5.44	3.19	4.14
Livingstone	4.08	3.72	4.55	7.00	3.51	5.66	0.84	4.19
North Burnett	2.97	3.64	2.93	7.28	2.21	5.36	1.59	3.71
Noosa	4.74	4.55	4.64	6.47	6.15	5.92	8.21	5.81
Rockhampton	4.36	3.05	4.59	6.89	3.64	5.43	40.5	4.57
Sunshine Coast	5.25	3.77	5.53	6.59	6.19	5.84	4.11	5.33
Woorabinda	2.47	1.02	0.12	5.18	5.12	4.32	3.43	3.10

*Sub-index scores range from 0=10. With 0 being the poorest (relative to other LGAs) while 10 indicates the strongest performance.
#The Headline CRWI converts a region's performance across the seven dimensions of wellbeing into an overall wellbeing score.

Internet access

Data from 2022 suggests that 99% of Australian adults had been online (Jan to June 2022).[260] However, this does not acknowledge connectivity issues experienced by many rural and remote communities. Infrastructure Australia identified that ten of CCQ's local government areas[C] had experienced connectivity issues as well as mobile blackspots.[261]

Submissions from Bundaberg Regional Council and Fraser Coast Council to the 2021 Regional Telecommunications Review identified digital connectivity challenges. This included impacts to telehealth services in the regional Gin Gin Hospital and community raised concerns on intermittent services on K'gari (Fraser Island) during extreme weather events.[261] Poor and expensive internet connectivity in Central Queensland was identified as a challenge for the region, constraining access to education, government services and healthcare.[261]

[C] Banana, Bundaberg, Central Highlands, Fraser Coast, Gladstone, Gympie, Livingstone, North Burnett, Rockhampton, Woorabinda

Economic and political environment

The political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities. The political determinants of health create the social drivers - including poor environmental conditions, inadequate transportation, unsafe neighbourhoods, and lack of healthy food options - that affect all other dynamics of health.

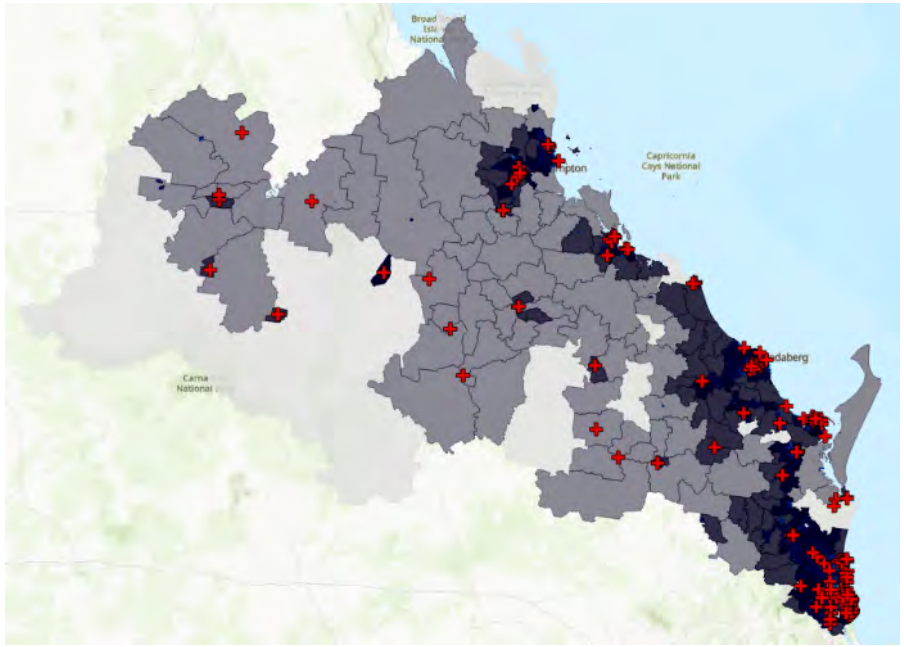
The economic determinants are intrinsically linked to the political environment of the day. Distribution of resources within a country and within communities are influenced by the political party in power and their political ideologies. In the health context, this can have significant impacts on health expenditure and allocation of those funds. Due to this connection between the political environment and allocation of health resourcing, indicators of CCQ's health service environment have been detailed below.

Healthcare profile

In the CCQ region, there are currently 276 services operating primarily in General Practice, including 2 Urgent Care Clinics, 5 specialist services and 8 Aboriginal Medical Services (Figure 39).

As these services operate as private businesses, they are subject to closures and openings that mean the exact number and locations of services is variable with time. Equally, GP practices are not a consistent measure of appropriate access; while the vast majority of the population in the CCQ region live within one hour of a GP practice, this does not account for wait times, workforce availability, cultural appropriateness, after hours access or a myriad other factors that contribute to the availability of quality health care.

Figure 39: GP practices in CCQ shown overlayed on population density map (source: Salesforce)



The National Health Services Directory estimates that there are 97 hospitals, 900 Allied Health services, 190 dental surgeries, 477 mental health and alcohol or other drug services, and 240 pharmacies in the CCQ region.

Healthcare access and quality

Access to healthcare is an individual's ability to obtain necessary healthcare services in the right place and right time. Primary care is often the first contact a person has with the health system and can be delivered in a range of settings, by a range of providers. It may be provided by general practitioners (GPs) within general practice or in an aged care or community setting, by public or private service providers. Nursing care, midwifery, pharmacy, dentistry, Aboriginal health services, and allied health care are also examples of primary care services.

Healthcare utilisation

From Medicare's inception in 1984 until 2022, the yearly GP services attendance rate has increased from 3.8 to 6.8 visits per person. The reasons for changes in rates of GP services over time are multifaceted and can include:

- the inclusion and cessation of additional telehealth and COVID-19 vaccination MBS items provided in response to the pandemic
- differing access to appropriate and affordable care for vulnerable population groups
- the availability of bulk billing to patients, such as increased bulk billing incentives for GPs during the COVID-19 pandemic.[262]

Table 84 displays the healthcare use by type of services for CCQ in 2022-23. GP attendances were the most common Medicare subsidised service in CCQ followed by diagnostic imaging in 2022-23. There were 558.9 GP attendances per 100 persons in 2022-23 across CCQ.

Table 84: Medicare-subsidised services, age standardised, by CCQ: 2022–23[263]

Service	CCQ Services per 100 people (age standardised)	National Services per 100 people (age standardised)
GP attendances (total)	558.9	596.8
Specialist attendances (total)	66.6	88.4
Allied Health attendances (total)	95.0	95.0
Diagnostic Imaging (total)	104.9	97.6
GP subtotal - After-hours	11.9	29.5

Table 85 displays the GP attendances in residential aged care facilities per patient for CCQ in 2022-23. Overall, each patient had approximately 14.2 GP visits in 2022-23.

Table 85: GP attendances in residential aged care facilities per patient who received at least one GP attendance in a facility, by CCQ: 2022–23[263]

	GP attendances per residential aged care patient	No. of GP residential aged care attendances	No. of GP residential aged care patients
CCQ	14.2	157,572	11,126
AUSTRALIA	17.4	4,871,165	279,260

Source: AIHW analysis of Department of Health, MBS Claims data.

Table 86 displays Medicare subsidised services, all persons for CCQ in 2022-23. 87.54 percent of CCQ had attended a GP in 2022-23, with 43.12 percent using a diagnostic imaging service and a further 42.13 percent using an allied health service.

Table 86: Medicare-subsidised services, all persons, by CCQ area: 2022–23[263]

Service	Percentage of people who had the service (%)	Services per 100 people	No. of patients	No. of services
Specialist attendances (total)	28.78%	80.67	267,359	749,373
GP attendances (total)	87.54%	644.46	813,206	5,986,673
Diagnostic Imaging (total)	43.12%	122.73	400,560	1,140,110
Nursing and Aboriginal Health Workers (total)	11.20%	23.34	104,027	216,841
Allied Health attendances (total)	42.13%	110.04	391,357	1,022,186
GP subtotal - After-hours	8.06%	13.96	74,876	129,651
GP subtotal - Enhanced Primary Care	27.48%	67.41	255,293	626,162
GP subtotal - Other	86.18%	549.88	800,524	5,108,073
GP subtotal - PIP	0.26%	0.26	2,421	2,431
Allied Health subtotal - Mental Health Care	4.97%	25.02	46,178	232,415
Allied Health subtotal - Optometry	34.82%	47.54	323,480	441,623
Allied Health subtotal - Other	6.09%	16.50	56,557	153,244
Allied Health subtotal - Physical Health Care	6.60%	20.93	61,296	194,472
Asthma Cycle of Care PIP	0.02%	0.02	198	198
Audiology	0.06%	0.16	583	1,488
Cervical Smear PIP	0.04%	0.04	330	330
Chiropractic Services	0.94%	3.28	8,726	30,427
Clinical Psychologist	1.77%	9.15	16,440	85,027
Diabetes Education	0.54%	0.90	5,016	8,329
Diabetes Mellitus Annual Cycle of Care PIP	0.20%	0.20	1,903	1,903
Dietetics	1.29%	2.48	12,022	23,012
Early Intervention Services for Children	0.04%	0.04	336	336
Exercise Physiology	1.02%	2.47	9,506	22,898
GP Acupuncture	0.20%	1.52	1,859	14,165
GP After-hours (non-urgent)	7.34%	12.83	68,209	119,149
GP After-hours (urgent)	0.90%	1.13	8,347	10,501
GP Chronic Disease Management Plan	18.21%	46.69	169,160	433,695
GP Focussed Psychological Strategies and Family Group Therapy	0.03%	0.07	309	627
GP Health Assessment	7.10%	7.19	65,914	66,798
GP Long (Level C)	38.29%	80.55	355,691	748,221
GP Mental Health	8.34%	12.79	77,511	118,826
GP Multidisciplinary Case Conference	0.12%	0.17	1,156	1,536
GP Pregnancy Support Counselling	0.06%	0.07	552	646
GP Prolonged (Level D)	4.83%	6.88	44,889	63,894
GP Prolonged - Imminent danger of death	0.04%	0.04	340	356
GP Short (Level A)	21.38%	35.58	198,617	330,474
GP Standard (Level B)	81.98%	410.64	761,542	3,814,570
Other GP Services	0.53%	0.83	4,961	7,726
Medication Management Review (domiciliary)	0.31%	0.31	2,877	2,892
Medication Management Review (residential)	0.35%	0.35	3,206	3,249
Midwifery	0.07%	0.66	688	6,094
Nurse Practitioners	2.35%	5.95	21,818	55,247
Occupational Therapy	0.19%	0.47	1,777	4,400
Osteopathy	0.38%	1.13	3,523	10,465
Other Allied Health	0.22%	0.34	2,047	3,144
Other Allied Mental Health	0.55%	2.46	5,137	22,853
Other Non-referred Medical Practitioner attendances	6.26%	12.21	58,126	113,398
Other Psychologist	2.88%	13.41	26,727	124,534
Physiotherapy	4.75%	14.07	44,116	130,682
Podiatry	4.28%	11.82	39,722	109,782
Practice Nurse/Aboriginal Health Worker	9.23%	16.74	85,745	155,501
Psychiatry	1.60%	5.81	14,856	54,016
Speech Pathology	0.13%	0.38	1,214	3,521

Sources: AIHW analysis of Department of Health, MBS claims data; and ABS, ERP. Notes: Includes non-hospital Medicare-subsidised services only. Non-hospital Medicare-subsidised services refers to services provided in non-inpatient settings. This excludes services delivered to patients admitted to hospital at the time of receiving the service or where the care was provided as part of an episode of hospital-substitute treatment where the patient received a benefit from a private health insurer. Medicare benefits associated with bulk-billing

incentives for non-hospital non-referred attendances are not included in the analysis. Therefore, the Medicare benefits paid, and the resulting provider fees are underestimated for GP and Practice Nurse/Aboriginal Health Worker services.

The *Patient Experience Survey* conducted in 2022-23 on health service use in adults showed that GPs continue to be the most common health professional seen in 2022-23. However, the proportion of people who saw a GP decreased to 82.3% in 2022-23, from 83.6% in 2021-22.[264]

Key statistics include:

- 45.6% of people who saw a GP for urgent medical care waited for 24 hours or more.
- 19.3% of people delayed or did not see a health professional for their own mental health when needed due to cost
- 52.3% of people saw a dental professional
- The proportion of people who could not see their preferred GP on one or more occasions increased to 36.3% in 2022-23, from 32.8% in 2021-22.[264]

The following people were more likely to wait for 24 hours or more to see a GP for urgent medical care:

- those living in areas of most socio-economic disadvantage than those living in areas of least disadvantage (52.0% compared to 42.2%)
- those living in outer regional, remote or very remote areas than those living in major cities (51.3% compared to 44.0%)
- those with a long-term health condition than those without a long-term health condition (48.5% compared to 36.5%).[264]

Healthcare accessibility

A comparison of 2022-23 and 2021-22 reported waiting times to see a GP for urgent medical care indicated:

- an increase in those who saw a GP for urgent medical care and waited for 24 hours or more (45.6% compared to 39.1%)
- a decrease in those who saw a GP for urgent medical care and were seen within 4 hours (41.5% compared to 49.7%)
- the proportion of those who saw a GP for urgent medical care and waited for 4 to 24 hours remained similar (12.7% compared to 10.9%).[264]

Public dental care is only available to a limited segment of the Australian population. Adults must generally have a healthcare card or Centrelink pensioner concession card to be eligible. The Child Dental Benefits Schedule (CDBS) provides basic dental services to eligible children aged 0-17 years. The proportion of people placed on public dentistry waiting lists in 2022-23 has remained similar to 2021-22 (4.7% compared to 4.2%). The following people were more likely to be placed on a public dentistry waiting list:

- those aged 85 years and over than those aged 15-24 years (13.4% compared to 3.3%)
- those living in areas of most socio-economic disadvantage than those living in areas of least disadvantage (11.4% compared to 1.1%)
- those with a long-term health condition than those without a long-term health condition (6.9% compared to 1.9%)
- those living in outer regional, remote or very remote areas than those living in major cities (6.8% compared to 3.8%)
- females than males (5.2% compared to 4.1%).[264]

How long people wait before they receive care (waiting time) can be used as a measure of the accessibility of care. Patients waiting outside clinically recommended times is indicative of delays to patient care. Waiting times for emergency care, specialist outpatients, elective surgery and dental are provided in Table 87.

Patients in the Wide Bay are waiting longer for emergency care compared with Central Queensland, Sunshine Coast and Queensland. Patients are waiting longer in Central Queensland for specialist outpatient appointments.

Table 87: Select health performance measures, CCQ (April to June 2024)[265]

SA4	**Emergency Care** % of patients seen within clinically recommended time (Total) April to June 2024	**Specialist Outpatient Waiting List** % of patients waiting to be seen for initial OPD appointment within clinically recommended time (Total) June 2024	**Planned Surgery – Ready for Surgery** - % of patients waiting within clinically recommended times (Total) April to June 2024	**Dental** – % of patients waiting within the clinically recommended times (waiting time for treatment-commencement within 2 years is desirable)
Central Queensland	76.0%	**47.4%**	70.4%	100%
Sunshine Coast	77.6%	69.4%	97.8%	100 %
Wide Bay	**66.4%**	69.4%	100.0%	100%
Queensland	**73.3%**	**61.4%**	**94.5%**	**99%**

Table 88: ED arrivals by urgency category, by HHSs (April to June 2024)[265]

	Central Queensland		**Sunshine Coast**		**Wide Bay**	
	Number of arrivals at ED	**% change from same period last year**	**Number of arrivals at ED**	**% change from same period last year**	**Number of arrivals at ED**	**% change from same period last year**
Category 1	178	7.2	343	8.2	157	**
Category 2	5,178	14.7	9,755	14.6	5,188	**
Category 3	14,802	3.3	23,120	7.5	14,035	**
Category 4	14,731	-3.1	19,636	1.3	11,812	**
Category 5	2,811	-17.1	4,972	22	2,016	**
Total	**37,700**	**0.3**	**57,826**	**7.5**	**33,208**	**

** not available

Table 88 displays the number of ED presentations across Central Queensland, Sunshine Coast and Wide Bay HHSs. Combined, there were 128,734 presentations to the ED for the April to June 2024 quarter. With the exception of Category 4 and 5 at Central Queensland, all categories have experienced growth in the number of ED presentations compared to the previous year.

Table 89 displays the outpatient activity across the HHSs. Across the HHSs, with the exception of the Sunshine Coast, compared to the same period last year, all HHS have experienced growth in the number of patients waiting on a specialist outpatient waiting list. Compared with the same period last year, Wide Bay encountered 8.1 per cent change in the number of patients on a specialist outpatient waiting list and a 34.8 per cent change in the number of specialist appointments held via virtual care.

Table 89: Specialist outpatient activity, by HHS (April to June 2024)[265]

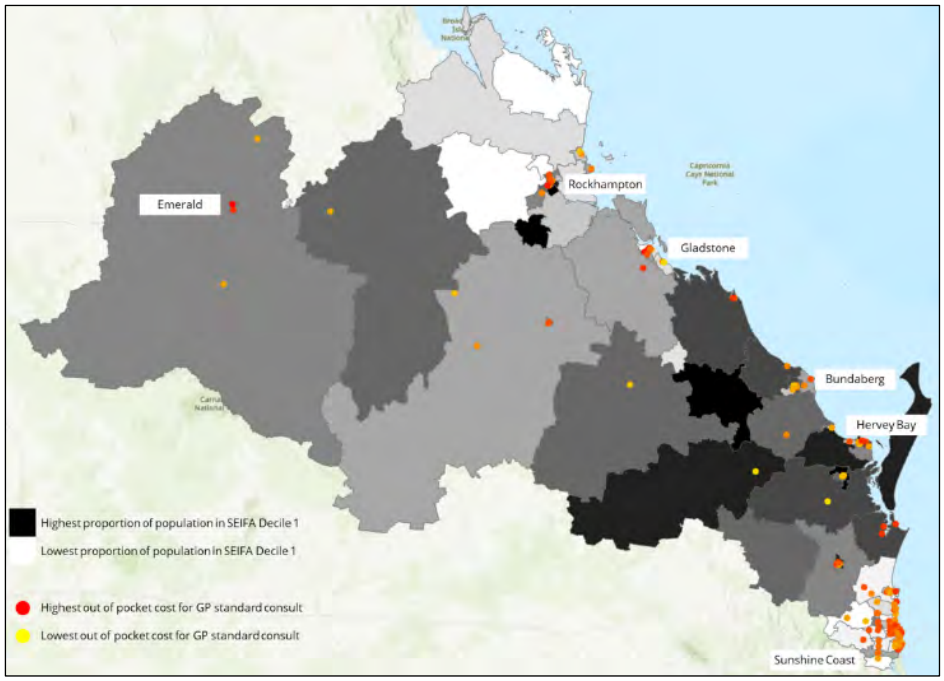
	Central QLD	**Compared with the same period last year**	**Sunshine Coast**	**Compared with the same period last year**	**Wide Bay**	**Compared with the same period last year**
Number of patients on a specialist OPD waiting list	13,276	3.3	19,561	-7.3	11,840	8.1
Number of initial specialist appointments held	7,865	31	17,495	14.8	6,821	11.2
Number of specialist appointments held via virtual care	5,135	9.9	3,939	1.1	2,501	34.8

The number and type of hospitals, and the beds available, are measures of access to healthcare services. Public hospitals in major cities are more likely to be larger and offer a broader range of services, whereas hospitals in more remote areas tend to be smaller and offer fewer services. This can affect the timeliness and availability of services for people living in more remote areas. The following bed and bed alternatives are displayed for CCQ as at June 2023 (Table 90). Overall CCQ, has 2,272 total available beds and bed alternatives, comprised of 1,901 available beds and 371 bed alternatives.

Table 90: Available bed and bed alternatives, as at June 2023, public acute hospitals, CCQ.[265]

HHS	Hospital	as at June 2023		
		Available Beds	Available bed alternatives	Total Available beds & Alternatives
Central Queensland	Baralaba	5	-	5
	Biloela	19	-	19
	Blackwater	10	-	10
	Emerald	34	3	37
	Gladstone	75	19	94
	Mount Morgan	10	-	10
	Moura	3	-	3
	Rockhampton	269	62	331
	Springsure	10	-	10
	Theodore	6	-	6
Sunshine Coast	Capricorn Coast (Yeppoon)	22	-	22
	Woorabinda	7	-	7
	Sunshine Coast University	645	74	719
	Caloundra	14	21	35
	Maleny	25	-	25
	Nambour	145	50	195
Wide Bay	Gympie	65	25	90
	Biggenden	7	-	7
	Bundaberg Base	200	61	261
	Childers	16	-	16
	Eidsvold	4	-	4
	Gayndah	10	-	10
	Gin Gin	6	-	6
	Hervey Bay	171	40	211
	Maryborough	105	16	121
	Monto	14	-	14
	Mundubbera	4	-	4
CCQ		**1,901**	**371**	**2,272**

Figure 40: Out of pocket expenses for GP standard consults overlayed with socioeconomic disadvantage



(Produced using data from Salesforce, ABS SEIFA, and CleanBill)

Figure 40 demonstrates that the cost of accessing GP services is not consistent across our region, which is consistent with the market of GP practices, which are small businesses with varying costs of doing business. You would expect that services are less expensive in lower socioeconomic areas, and this is the case in Maryborough and Bundaberg. In these regions, the cost of living is generally lower, which translates into lower operational costs for GP practices. Consequently, these savings can be passed on to patients in the form of more affordable consultations. Equally, costs of living and of doing business in higher socioeconomic areas such as Noosa and the Sunshine Coast might suggest that the costs to provide services are higher. This increased cost of business might be passed on to patients through higher out-of-pocket expenses, thereby creating a trend where health access becomes more expensive in affluent areas.

However, in some parts of Rockhampton, Gladstone, and the Cooloola coast area, this trend is not observed. Despite socioeconomic indicators suggesting that the population is less able to afford out-of-pocket expenses, the costs remain relatively high for the region. Possible explanations for this could include a lack of competition, higher fixed costs, or perhaps the presence of specialised services that are inherently more expensive to provide. However, it also demonstrates that there are communities of lower socioeconomic advantage that have more expensive GP consults, which is an indicator of inequity in the CCQ region. When individuals in these communities are required to pay higher out-of-pocket expenses, it can deter them from seeking necessary medical care, thereby exacerbating health disparities.

The *My Healthy Community* survey responses highlighted that the cost of living and the cost of accessing primary health services are key concerns among residents. The community has directly conveyed that the expense of accessing healthcare is a significant factor preventing them from addressing their health needs. Moreover, we understand that when health needs go unaddressed, their severity often escalates, leading to exponentially higher intervention costs for taxpayers over time.

Another factor to consider in a market made of many small businesses, like GP practices, is the impact of local competition on pricing. In the Sunshine Coast and Noosa, there are a large number of practices, which might be expected to lead to competition in the market that reduces prices. However, this effect would appear to be limited, based on these data. This suggests that competition in the market is not currently sufficient to be a key driver of consumer behaviour that would lead to a price correction. If improving accessibility to the market via intervention in pricing is considered, significant further investigation and consultation would be required to understand the drivers of local pricing variation.

While the cost of GP services across our region varies due to a variety of factors, including operational costs, local competition, and socioeconomic indicators, the presence of higher costs in lower socioeconomic areas is a significant concern. Addressing this inequity will require a multifaceted approach involving policy changes, increased funding for healthcare in disadvantaged areas, and perhaps incentives for practices to lower their fees in these communities. Only through such comprehensive measures can we hope to ensure equitable access to health services for all residents in our region.

Healthcare usage

People living in remote areas

People living in remote and very remote areas can face barriers to accessing and using health care, due to various challenges: geographic spread, low population density, limited infrastructure, and the higher costs of delivering rural and remote health care can limit the availability of services. The additional time and transportation costs to access health care services also means people in remote and very remote areas may delay access to preventive and primary health care and rely on hospital care to have their needs met.[266]

Australians living in rural, remote and very remote communities generally have poorer access to healthcare than people in regional centres and Metropolitan areas, and may need to travel long distances or relocate to attend health services or receive specialised treatment.[267]

Although the FTE rate for GPs increases with increasing remoteness, care should be taken in interpreting the data, as work arrangements in these areas are nuanced.[268] For example, there may be poor differentiation between general practice for on-call hours, activity for procedures and hospital work for GPs working in rural and remote areas, which affects the accuracy of statistics on GP supply and distribution.[269]

Feedback from CCQ Primary Health Coordinators in the Wide Bay region highlighted issues with accessing locum GPs in rural areas, including availability, rostering challenges, and reduced continuity of care for patients. There are also reported challenges with limited succession planning for retiring GPs in these areas. In the Central Queensland region, a range of issues were reported, including GPs not having the resourcing to focus on prevention and screening, higher volumes of patients requiring complex care, difficulties attracting and retaining staff (GPs and admin), and a limited range of professional development (CPD) opportunities for GPs, nurses and reception staff. These examples highlight the nuances in what "access" to primary health care means in rural and remote areas, and the need for more detailed consultation in this space.

After Hours

An in-depth internal analysis of primary care after hours service (AH) needs was undertaken for the CCQ region in 2022/23. Analyses of secondary data from administrative datasets for sub-regional AH service gaps identified deficiencies in AH primary care services across the CCQ region, with **all SA3s having lower AH primary care service provision and workforce rates than Australia**. Using composite scoring methodology developed by North Western Melbourne PHN, those regions identified were **Burnett, Biloela, Sunshine Coast Hinterland, Bundaberg, Hervey Bay, Gladstone and Nambour**. **Unmet AH service demand was highest in Maryborough, Gympie-Cooloola, Hervey Bay, Bundaberg, Gladstone and Nambour**.

Several need themes were identified in the analysis. These included the need for AH services to meet the needs of priority populations; increasing health literacy around AH services; enhancing locally-driven solutions to AH primary care provision and availability taking into account local contexts and workforce; enhancing the quality, appropriateness and responsiveness of AH services; increasing healthcare workforce availability, recruitment and retention to enhance access to services; advocating for and being leaders in system and policy change to support the provision of AH services; and increasing access to routine healthcare and care management (in hours).

Curbing the use of the ED for non-urgent care, barriers to accessing services such as means of transportation, and enhancement of care management of chronic and complex conditions in primary care, efficiencies and effectiveness in primary care delivery, and investment in more upstream measures to improve protective health factors, such as social support, resilience, and lifestyle factors to reduce the need for downstream healthcare system treatment services were also identified as areas of need.

Community consultation identified health literacy particularly related to the perceived urgency of care and use of AH healthcare services broadly, and the availability of AH services when needed, particularly in rural communities and where in-hours primary care services are not accessible as areas of need. Key barriers to accessing AH services included the availability of AH services, previous poor experiences with AH service quality, having no means of transportation, and service costs. The quality of the service was as important as the availability of the service. Poor experiences were described as a perceived lack of examination, long waiting times, and perceived lack of provider skills/knowledge.

Stakeholders identified an inadequacy in the provision of AH primary services to meet demand across the broad range of primary care service types, noting increases in demand for services across service types in most locations. Workforce issues such as staff burn out, workforce shortages, issues with the recruitment and retention of staff in rural communities, the lack of training and support for AH staff, insufficient Medicare funding models for the financial viability of AH service provision, and inadequate programs to support primary care workforce development were all identified as areas of need.

Identified areas of opportunity included greater local cooperation and shared workforce models, increasing medical deputising services and GP numbers (with funding), having rotating staff rosters, localised approaches to coordinate care in communities supported by PHN, telehealth options, outreach services including nurse-led clinics, minor trauma centres, and better service integration with the ED.

Perinatal care access

The perinatal period is defined as the period covering from conception to end of first postnatal year, but in some settings can cover up to 2-3 years postpartum.[64]

Antenatal care is a planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. Antenatal care is associated with positive maternal and child health outcomes – the likelihood of receiving effective health interventions is increased through attending antenatal care. It does not include visits where the sole purpose is to confirm the pregnancy.[270]

The proportion of women receiving antenatal care in the first trimester (before 14 weeks' gestational age) is the most widely reported indicator of antenatal care. Regular antenatal care in the first trimester is associated with better maternal health in pregnancy, fewer interventions in late pregnancy and positive child health outcomes.

The Australian Pregnancy Care Guidelines (Department of Health and Aged Care 2020) recommend that a woman has her first antenatal visit within the first 10 weeks of pregnancy. In 2021, 60% of women attended antenatal care within the first 10 weeks of pregnancy. Most women attend antenatal care in the first trimester, nationally (80%) and across all states and territories. In Queensland in 2021, 83.7% of women who gave birth in Queensland had their first antenatal care visit at less than 14 weeks gestation (52,247 of 62,425 women).[270]

In CCQ, 69.3% of mothers who lived in the region had at least one antenatal care visit in the first trimester (6,533 of 9,426 females who gave birth) (Table 91). This rate is substantially lower than state and national averages and further investigation is required to determine whether this is a reporting difference due to different models of care across the state or genuinely lower levels of access. In the Gladstone region, stakeholders have suggested that the cost to access a non-bulk billing GP is preventing women from accessing their first antenatal appointment in the first trimester (Gladstone Region Together project).

The Australian Pregnancy Care Guidelines also recommend that first-time mothers with an uncomplicated pregnancy have 10 antenatal care visits during pregnancy (7 visits for subsequent uncomplicated pregnancies).[271] In 2021, 94.8% of women who gave birth in Australia had 5 or more antenatal visits (Table 91).

In 2021, 96.6% of women who gave birth in Queensland, and 96.3% of women who lived in the CCQ region had 5 or more antenatal visits.

Nationally, some mothers were less likely to have an antenatal visit in the first trimester, including those who:

- had a parity of 4 or more (66%)
- were aged under 20 (69%)
- smoked during the first 20 weeks of pregnancy (73%) and after 20 weeks (70%)
- lived in Remote (73%) and Very remote areas (68%).[270]

Table 91: Antenatal indicators, by SA3 (2021)

SA3 (Indigenous area)	% women who had at least one antenatal care visit in the first trimester (2021)[270]	% women who had 5 or more antenatal care visits (2021)	% Aboriginal women who did not attend antenatal care within the first 10 weeks (2019-2021)[29]	Proportion of women who smoked at any time during pregnancy (2021)	Proportion of Aboriginal women who reported smoking during pregnancy (2019-2021)[29]
Biloela* (Banana)	**64.5%**	96.7%	**76.5%**	12.8%	**49.0%**
Buderim	75.3%	97.4%	-	6.2%	-
Bundaberg	77.2%	96.5%	**57.4%**	**15.2%**	40.8%
Burnett* (North Burnett)	**57.1%**	**93.6%**	**63.2%**	**25.0%**	44.7%
Caloundra	71.2%	96.7%	49.2%	7.0%	35.2%
Central Highlands (Central Capricorn)	**51.1%**	**93.6%**	**69.1%**	**19.3%**	**56.2%**
Gladstone	**61.8%**	96.6%	**80.2%**	**17.9%**	39.7%
Gympie-Cooloola (Nanango-Kilkivan)	75.1%	**95.1%**	44.5% **77.6%**	**16.5%**	41.3% **
Hervey Bay (Fraser Coast)	**65.2%**	97.5%	**61.0%**	**18.0%**	**47.5%**
Maroochy	75.2%	97.4%	49.5%	5.3%	31.3%
Maryborough	**64.4%**	97.4%	-	**22.3%**	-
Nambour	70.4%	97.2%	-	10.2%	-
Noosa	71.7%	96.4%	**54.2%**	3.1%	29.6%
Noosa Hinterland	**67.8%**	97.6%	-	9.4%	-
Rockhampton (Rockhampton-Yeppoon)	**66.8%**	96.0%	**57.8%**	**16.1%**	**46.5%**
Sunshine Coast Hinterland	72.0%	97.7%	-	9.9%	-
CCQ PHN	***69.3%***	***96.3%***	***60.5%***	***13.0%***	***43.5%***
Queensland	***83.7%***	***96.6%***	***49.9%***	***11.5%***	***43.5%***

*Not entire SA3 within PHN catchment (Biloela 93% and Burnett 31%)
** Not releasable

Postnatal care

The World Health Organization advocates that all women and newborns require a postnatal visit in the first six weeks following birth.[272] The postnatal period provides an opportune time for health promotion and prevention in primary care, including lactation and feeding problems, access to sexual and reproductive health, and identifying perinatal mental health disorders.[273]

Limited data is available on the quality and accessibility of postnatal care services, including follow-up visits and early interventions.

Access to traditional healing and medicine

Traditional medicine practice within Aboriginal and Torres Strait Islander cultures encompasses a holistic world view. This reflects that of the World Health Organization which defines health as 'physical, mental and social wellbeing and not merely the absence of disease or infirmity'. Most traditional health care practices believe that the mind and body are inseparable and that to prevent ill health there is a need to maintain a balance between the physical and spiritual selves.[274]

Prior to colonisation, traditional forms of healing such as the use of traditional healers, healing songs, and bush medicines were the only form of primary health care. For Aboriginal and Torres Strait Islander Australians the impact of colonisation and the removal and disconnection of people both from their land and from their traditional families has had a major effect on the use of traditional practices including traditional medicine. However, there are practices that continue today, that encourage spiritual and traditional healing.[274]

Although not asked in the *My Healthy Community* survey, we know from the **previous HNA consultation that 3 in 4 Aboriginal and Torres Strait Islander persons reported they would use traditional medicine if available**. Beyond this, we have a limited understanding of availability and desire to access traditional healing and medicine.

Aged care support services

The Australian aged care system offers a range of services to meet the needs of older adults. Services range from supports to remain living independently at home through to full-time care in a residential setting. There are 3 main types of services in the Australian aged care system:

- **Home support (Commonwealth Home Support Programme)**, which provides entry-level services focused on supporting individuals to undertake tasks of daily living to enable them to be more independent at home and in the community. Services available through home support include domestic assistance, personal care, social support, allied health and respite services.[275]
- **Home care (Home Care Packages Program)**, which is a more structured, more comprehensive package of home-based support, provided over 4 levels ranging from basic care (Level 1) to more intensive care (Level 4). It is targeted towards people with needs that go beyond what home support can provide. Ongoing services are available to keep people well and independent (such as nursing care), stay in their home (through help with cleaning, cooking and home maintenance) and remain connected to their community through transport and social support.[275]
- **Residential aged care**, which provides support and accommodation for people who have been assessed as needing higher levels of care than can be provided in the home, and the option for 24-hour nursing care. Residential care is provided on either a permanent, or a temporary (respite) basis.[275]

Home support (Commonwealth Home Support Program)

Clients receive a range of home support services across the region and at higher rates than Queensland for some LGAs (Table 92Of particular interest is the high rate of non-English speaking clients compared with Queensland. This reflects the proportion of Aboriginal and Torres Strait Islander people living in Woorabinda who may be speaking an Indigenous language only.

Home care (Home Care Packages Program)

To support people that want to remain living independently in their own homes, the Australian Government subsidises packages through the Home Care Packages Program (HCPP) to provide home-based care that can improve older Australians' quality of life and help them to remain active and connected to their communities. There are four levels of HCPs to help meet older Australians' different levels of care need, which is determined by the outcome of an independent aged care assessment.

Independent and qualified Aged Care Assessment Teams (ACATs) assess a person's needs and, when making an approval for care, can approve a person for a HCP, residential care, respite care, transitional care, and Commonwealth Home Support Programme (CHSP), depending on the person's circumstances. Therefore, based on care needs and choice, not everyone with a HCP approval and placed in the NPS will enter home care.[276] The largest number of people receiving the HCPP live in the Sunshine Coast aged care planning region, followed by Wide Bay and Fitzroy (Table 93).[276]

NOTE: Aged care data is provided by the Department of Health by Aged Care Planning Regions (ACPR). These regions consist of several SA2s. The CCQ region sits within three planning regions: *Fitzroy* (Banana up to Shoalwater Bay and out to Central Highlands – West), *Sunshine Coast* (Glasshouse Mountains up to Cooloola and out to Gympie), and *Wide Bay* (includes four SA2s not in our catchment: Nanango, Kingaroy Region-South/North, and Kingaroy).

Table 92: Commonwealth Home Support Programme (CHSP) clients, by LGA (2022/23), ASR per 1,000[28]

LGA	Indigenous clients (% of total clients)	Non-English-speaking clients (% of total clients)	Total clients (ASR per 1000)	Allied health therapy clients	Domestic assistance clients	Flexible respite clients	Goods and equipment clients	Home maintenance clients	Home modification clients	Meals clients	Nursing clients	Personal care clients	Social support (group) clients	Social support (individual) clients	Specialised support services clients	Transport clients
Banana	6.3	1.6	26.1	5.0	15.9	3.0	1.2	9.5	0.7	6.5	12.5	3.4	6.5	12.2	1.1	9.2
Bundaberg	1.9	14.6	35.7	8.4	18.4	0.9	1.0	6.2	3.8	6.9	3.9	3.3	1.7	4.8	0.9	6.6
Central Highlands	8.5	32.5	26.4	6.4	15.3	**	**	1.3	0.5	7.0	8.4	4.6	4.4	9.1	0.9	5.2
Fraser Coast	2.9	8.8	38.3	6.1	22.1	1.0	1.6	11.0	2.8	5.2	4.4	2.7	1.2	8.5	1.4	6.8
Gladstone	4.7	18.2	34.1	6.9	19.7	1.1	0.7	10.8	1.5	4.9	3.4	3.8	2.1	5.3	2.0	5.4
Gympie	2.6	3.2	29.9	6.7	13.0	1.6	0.9	7.8	2.6	2.9	4.7	1.9	2.0	7.6	1.3	4.3
Livingstone	2.0	18.1	34.3	5.4	16.3	0.8	0.5	14.6	2.5	4.1	3.3	2.1	0.9	4.7	1.5	4.8
Noosa	0.9	2.6	27.0	6.1	10.1	0.7	0.4	6.7	1.1	3.6	3.3	1.6	5.0	3.6	1.2	4.5
North Burnett	6.4	8.1	26.9	2.9	14.6	1.2	1.1	5.7	1.2	5.3	5.9	3.3	3.7	4.5	0.7	3.9
Rockhampton	4.3	19.1	34.4	9.0	13.1	0.7	0.6	14.8	2.8	4.1	3.4	2.4	1.4	4.7	1.4	5.5
Sunshine Coast	1.0	3.1	35.4	7.1	14.4	0.9	0.6	15.9	3.8	4.0	3.4	1.4	2.9	5.8	1.7	7.1
Woorabinda	**	34.1	94.0	19.5	55.3	**	**	**	**	24.5	30.1	**	**	31.5	**	19.5
CCQ	**2.1**	**8.3**	**34.4**	**7.0**	**16.0**	**0.9**	**0.8**	**11.9**	**3.0**	**4.6**	**3.9**	**2.2**	**2.5**	**6.0**	**1.5**	**6.4**
Queensland	**3.6**	***8.1***	***36.3***	***9.3***	***16.1***	***1.2***	***1.1***	***9.7***	***2.7***	***4.3***	***4.4***	***2.8***	***3.0***	***6.4***	***2.3***	***8.2***
AUSTRALIA	***2.8***	***13.3***	***31.4***	***9.4***	***12.1***	***1.2***	***0.8***	***5.9***	***1.9***	***3.9***	***4.2***	***2.6***	***3.3***	***4.8***	***2.2***	***6.0***

** Not available Substantial numerical differences are shown in grey.

Table 93: Number of people in a Home Care Packages Program (HCP) at 31 March 2024, by ACPR[276]

Aged care planning region	Level 1 Basic care needs	Level 2 Low-level care needs	Level 3 Intermediate care needs	Level 4 High-level care needs	Total
Fitzroy	69	1,132	1,351	455	3,007
Sunshine Coast	183	2,865	2,990	3,072	9,110
Wide Bay	396	2,101	1,441	769	4,707
Queensland	***2,393***	***20,821***	***17,655***	***11,421***	***52,290***

The current estimated wait time for someone with a HCP level 4 HCP (high-level care needs) can expect to wait 6-9 months to receive their first HCP. The wait is 9-12 months for level 3, 3-6 months for Level 2 and less than a month for level 1.[276]

In Queensland, there were 842 people waiting for level 4 HCP as at 31 March 2024 (Table 94).[276]

The number of Aboriginal and Torres Strait Islander people receiving a HCP or waiting for a HCP is proportionately less for their population size relative to the rest of the population. This is attributed to First Nations peoples accessing alternative programs such as the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Multi-Purpose Services for in-home care support.[276]

Table 94: Number of people waiting on a HCP at their approved level at 31 March 2024, who are not in an interim level HCP, by ACPR[276]

Aged care planning region	Level 1 Basic care needs	Level 2 Low-level care needs	Level 3 Intermediate care needs	Level 4 High-level care needs	Total
Fitzroy	-	134	226	34	394
Sunshine Coast	1	457	774	172	1,404
Wide Bay	5	298	284	38	625
Queensland	***22***	***3,037***	***4,505***	***842***	***8,406***

Residential Aged Care Homes (RACH)

An aged care home (sometimes known as a nursing home or residential aged care facility) is for older people who can no longer live at home and need ongoing help with everyday tasks or health care. Residential aged care provides accommodation and care at a facility on a permanent or respite (temporary) basis. Permanent care is intended for those who can no longer live at home due to increased care needs, while respite provides a break from normal living arrangements.[275] In the CCQ region, there were 99 RACHs as at 30 June 2024 with a total of 4,170 places (Table 95). Table 96 highlights characteristics of those who may require aged care services.

Table 95: Aged care service list, by LGA as at 30 June 2024[277]

LGA	Residential aged care homes (RACH)	Residential places
Banana	1	65
Bundaberg	10	911
Central Highlands	1	60
Fraser Coast	14	1,424
Gladstone	3	220
Gympie	5	445
Livingstone	3	252
Noosa	6	768
North Burnett	3	88
Rockhampton	10	831
Sunshine Coast	43	4,170
Woorabinda	0	0
CCQ	**99**	**9,234**

Table 96: Indicators for aged care services

Aged care region	Older people (who might need aged care services) by selected characteristics (2021)					Number of aged care services and outlets			Occupancy rates in residential care (30 June 2023)	Number of places in residential care per 1,000 target population (70 years and over) (2017-2023)	People per 1,000 target population (aged 65 and over) using aged care, by care type (30 June 2023)		
	People aged 50 and over by Indigenous status	People aged 55 and over by need for assistance with core activities (Requires assistance)	People aged 65 and over by country of birth (Born overseas)	People aged 65 and over by language used at home (language other than English)	People aged 65 and over by relationship in household (lives alone)	Residential care	Home care	Home support			Permanent residential care	Home care	Home support
Fitzroy	**3.3%**	12.3%	13.5%	2.1%	**22.9%**	21	33	47	87.3%	74.3	34.7	56.8	181.5
Sunshine Coast	1.2%	11.9%	26.1%	3.1%	20.7%	52	52	49	**86.4%**	68.6	40.3	**64.5**	195.5
Wide Bay	**2.5%**	**15.9%**	19.7%	2.5%	21.4%	36	38	55	87.9%	**57.2**	33.9	36.9	**206.3**
CCQ	***1.9%***	***13.2%***	***22.2%***	***2.9%***	***21.3%***	***102***	***116***	***138***	***86.8%***	***65.4***	***37.2***	***53.8***	***198.0***
Queensland	***2.3%***	***13.0%***	***27.1%***	***7.6%***	***22.0%***	*-*	*-*	*-*	*-*	*-*	***41.5***	***59.5***	***206.0***
AUSTRALIA	***1.7%***	***13.0%***	***34.6%***	***16.5%***	***22.7%***	*-*	*-*	*-*	*-*	*-*	***40.7***	***57.1***	***179.3***

Bold indicates higher rates than Queensland

Aged Care Assessment Teams (ACAT)

To access government-funded aged care services, people undergo an assessment of need. These processes assess people's circumstances and care needs and, where appropriate, approve them for aged care services. Aged Care Assessment Teams (ACATs) conduct comprehensive assessments and approve people for entry into residential aged care (permanent or respite), home care and transition care programs.

- In 2021–22, 41% of new entrants to permanent residential care entered permanent care within 3 months of their ACAT assessment.
- Older people are waiting 24% longer to receive an ACAT (Aged Care Assessment Team) assessment from the time of referral this financial year, according to the latest data from the Department of Health and Aged Care (March 2024).
- Nationally, median wait times for an ACAT assessment increased from 17 days in the 2022-23 financial year, to 21 days in the first six months of 2023-24.
- In Central Queensland, the wait time is 8-9 months for an ACAT assessment and lengthy OT waiting times.
- Since 30 June 2023, wait times for Home Care Packages have also increased for Levels 2, 3 and 4 packages. However, wait times have fallen for Level 1 packages.
- Wait times for Level 3 packages have blown out to up to 12 months.

"Getting access to an Aged Care Package in a timely manner (not 6 months after application) is crucial" (survey participant, Kawungan)

Palliative and End of Life Care

Palliative care is an approach to treatment that improves the quality of life of patients and their families who are facing the problems associated with life-limiting illness.[278] Palliative care can be delivered by a wide range of health and community providers, is not limited to any specific condition, can be delivered at any stage of illness, and can accompany curative treatments.[279]

This philosophical approach to palliative care is distinct from the services delivering palliative care in Australia. The term 'specialist palliative care' refers to both clinicians with specialised expertise in palliative care, and services that make up the designated specialist palliative care sector. These clinicians and services are defined by set criteria and are funded to deliver specialist care.

The term 'end-of-life care' shares many of the same components of palliative care; including physical, spiritual and psychosocial assessment and treatment. While the terms are sometimes used interchangeably, 'end-of-life care' refers to the care provided to people who are likely to die within the next 12 months. It is provided to those with advanced or incurable conditions, frailty and old age, and life-threatening acute conditions.[280] End-of-life care is for people of any age. Recent survey data reveals that 60%–70% of Australians would prefer to die at home, which echoes the emerging trend of older Australian's preferring to age in place.[281]

In Australia, there is an increasing demand for palliative care services as a result of an aging population and an increase in the prevalence of cancer and chronic disease.[282] This has led to palliative care being provided in almost all health care settings within the Australian health care system, including hospital intensive care units, inpatient services, outpatient services, general practices, ambulatory services, pharmacies, and residential aged care facilities.[283] As a result, in Australia palliative care has become highly institutionalised.[284]

In 2022-23, 10.5% (n = 1,998) of MBS-subsidised palliative medicine attendance and case conference services in QLD occurred in the CCQ region.[283]

Key challenges and opportunities to progress palliative care and end-of-life care, include:

Building national data infrastructure: Comprehensive national data on palliative care and end-of-life care has substantial gaps, including care delivered in community, residential care, and primary care settings, either by governments or private providers, along with information about the number and cost of the establishments delivering specialist palliative care services.

Identifying patient pathways through the system: A major challenge is identifying palliative care and end-of-life care within the various health settings and patient pathways through the system. While activity that occurs in a specialist palliative care service can be readily identified as being 'palliative care' in nature, a large volume of palliative care and end-of-life care-related activity occurs outside of specialised palliative care settings. For example, activity could occur in a range of settings including primary care, oncology wards, geriatric wards, intensive care units, within the home,

and residential aged care facilities. Capturing palliative care-related activity across the diverse service settings is a key challenge.

Developing national data about person and family-centred care: Palliative care is provided to people with a life-limiting illness; however, it is also intended to support the families of people with a life-limiting illness. Little data is available to facilitate insight into the supports provided pre and post-death to families and carers.

Collecting information on social and spiritual support: The provision of psychological, spiritual, and social support is integral to managing suffering and distress of people with a life-limiting illness and their families, and managing problems related to the person's social and living circumstances, such as access to formal carers and maintenance of independence. Collecting information at a national level about these important aspects of care will be a key challenge.

Community capacity to support healthy approaches to death, dying and bereavement: Community capacity to support people approaching the end of life, their families, and informal carers adds an important dimension to the support that can be provided by health services. This includes understanding when a person with a life-limiting illness is approaching the end of life to ensure appropriate planning and care provision. A public health approach to death and dying, such as the international 'Compassionate Communities' movement could potentially build this capacity.[279]

Families have a lack of knowledge on acute deterioration, palliative and end-of-life care, and Enduring Power of Attorneys. They are sometimes indecisive and won't honor current Statement of Choices and will request a hospital transfer. Clinicians do not have the time to educate the residents and families about acute deterioration, palliative and end-of-life care (Wide Bay RACH stakeholder feedback)

At the national level, a range of information/data gaps have been identified:[279]

People with a life-limiting illness	• Patient-reported experience measures (PREMS) • Patient-reported outcome measures (PROMS) • Identifying and supporting people without carers • Conversations people are having and how they are planning for their future care
Families and carers	• Identifying who is providing care to Australians at their end of life • Identifying the needs of carers • Finding opportunities to understand carer experience
Workforce	• Complexity and capacity of the workforce supporting end-of-life care • Capacity across the workforce to deliver high-quality and person-centred care • Planning for future workforce requirements
Service and system planning and design	• Unmet need and demand for palliative care and end-of-life care to support system and service planning • Vulnerable populations • People's preferences and actual place of care and death
Service delivery and integration	• Data capture on care at home and in the community • Ease of access, coordination and transition between services • Data sharing for appropriate and coherent care across services and care settings
Performance and public reporting	• Improve the quality of existing data • Identify the characteristics of people at the end of life • Monitor the quality and provision of palliative care in the system overall
Understanding and awareness of palliative care	• Data is easily understood and accessible to improve understanding • Data supports meaningful discussions and informed and shared decision making • Data is appropriately shared

Access to culturally appropriate palliative and end of life care

It is important to understand the cultural and spiritual considerations of Aboriginal and Torres Strait Islander people and their families when providing person-centred palliative care.[285] A set of specific principles assist in the delivery of culturally appropriate palliative care for Aboriginal and Torres Strait Islander people, including:

- equity of access (i.e. equal opportunity for accessing care)
- empowerment and autonomy (i.e. individual choices and shared decision making)
- trust (i.e. trusting relationships can be developed by acknowledging and demonstrating a person's spiritual and cultural beliefs)
- cultural respect.[285]

There are many Aboriginal and Torres Strait Islander language groups in Australia and healthcare providers should recognise that cultural and spiritual practices and individual choices may vary across these groups. Such practices to consider when providing palliative care to Aboriginal and Torres Strait Islander people include, but are not limited to:

- Kinship – recognise that Aboriginal and Torres Strait Islander kinship systems extend beyond immediate family members
- Communication – be mindful of verbal and non-verbal communication styles and that plain language explanations are often preferable to medical jargon
- Country – understand that some Aboriginal and Torres Strait Islander people approaching end-of-life may wish to pass away on Country
- Sorry Business – a period after the loss of a person where many Aboriginal and Torres Strait Islander people follow traditional practices and/or ceremonies.[285]

Culturally appropriate palliative care applies to other culturally and linguistically diverse communities within the CCQ region. In Australia, over 300 languages are spoken, more than 100 religions and beliefs are practised and many of the world's ethnic groups are represented from over 230 different countries.[286]

Further, Australia's ageing culturally and linguistically diverse population is experiencing more rapid growth than the general population and by 2011 it is estimated that over 1 million Australians over 65 will be from culturally and linguistically backgrounds.[286] Differences in beliefs, values, and traditional health care practices are of particular relevance at the end of life. Even for people who do not usually follow traditional practices, is particularly important in shaping attitudes about dying, death, and preference for end-of-life care.[286]

Advanced care planning

Advance care planning is a 'process of reflection, discussion and communication that enables a person to plan (in advance) for their future medical treatment and other care, for a time when they are not competent to make, or communicate, decisions for themselves'.[287]

As at Jul 2024, a total of 8,383 Statement of Choices (SoC) documents has been uploaded, by the Statewide Office of Advance Care Planning (ACP) for residents of CCQ PHN. Of these: 48% are Form A, 52% are Form B, 42% are for males (mean age 81 years), 58% are for females (mean age 83 years), 73% do not want CPR, 77% do not want life prolonging treatment, 44% prefer to die in an RACF.[288] In July 2024, approximately 6,000 people aged 70-79 had completed an enduring Advanced Care plan document the CCQ region.

Voluntary assisted dying

The Voluntary Assisted Dying Act 2021 (the Act) was passed in September 2021. It became available to eligible Queenslanders on 1 January 2023.[289]

Voluntary assisted dying is an additional end-of-life choice that gives eligible people who are suffering and dying the option of asking for medical assistance to end their lives. There are strict eligibility criteria for accessing voluntary assisted dying.

In the first six months of voluntary assisted dying in Queensland (1 Jan – 30 June 2023), 591 people commenced the process and 245 people died from administration of a voluntary assisted dying substance, as their end-of-life choice (Table 97).[290] There were 318 authorised practitioners as at 30 June 2023 (Table 98).

Table 97: Overview of voluntary assisted dying in Queensland from 1 January – 30 June 2023[290]

Stage in the process		1 January – 30 June 2023
Completed first assessments	Eligible	562
	Ineligible	29
	Gender	Male: 331 Female: 260 X or non-binary: 0
	Aboriginal and Torres Strait Islander peoples	Aboriginal: 7 Torres Strait Islander: 0 Both Aboriginal and Torres Strait Islander: 1
	Median age	73
	Region	Metropolitan: 296 Regional, rural or remote: 295
	Accessing palliative care	459
Deaths	Self-administration	106
	Practitioner administration	139
	Substance not administered	130
Withdrawn requests		30

Table 98: Authorised practitioners at 30 June 2023[290]

Type of healthcare worker	30 June 2023
Medical practitioners	155
Nurse practitioners	19
Registered nurses	144

Appropriateness

Appropriateness in health care can be defined by the effectiveness (based on evidence) and efficiency (cost-effectiveness) of care provided. Arguably, the most important aspect is how consistent the care is with the ethical principles, values and preferences of relevant individuals, communities or society. For Aboriginal and Torres Strait Islander people, cultural safety is an important indicator of the appropriateness of the care they receive.

Cultural safety in health care for Aboriginal and Torres Strait Islander people

Cultural safety aims to enhance the delivery of health services and programs by identifying the power relationship between the healthcare professional and the person receiving care, and empowering the service user to take full advantage of the health care service offered. **Cultural safety is based on the experience of the recipient of care, and involves the effective care of a person or family from another culture by a healthcare professional who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their own practice.**[291]

Cultural safety on a continuum of care with cultural awareness being the first step in the learning process (which involves understanding difference), cultural sensitivity being a next step (where self-exploration occurs), cultural competence, and cultural safety being the final outcome of this process. This is a dynamic and multidimensional process where an individual's place in the continuum can change depending on the setting or community.[291]

Cultural awareness → ***Cultural sensitivity*** → ***Cultural competency*** → ***Cultural safety***

Improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system that respects Aboriginal and Torres Strait Islander cultural values, strengths and differences, and also addresses racism and inequity.

Direct consultation with the Woorabinda community or other Aboriginal and Torres Strait Islander communities was not undertaken as part of this stage of the HNA. However, submissions to an inquiry into service delivery in remote and discrete Aboriginal and Torres Strait Islander communities by the Queensland Productivity Commission suggest there may be opportunities for improvement.

"Woorabinda community members need to be considered best placed to drive change in their community. This requires a bottom-up approach to accommodate not only meaningful engagement but more importantly, community ownership. Local decision making, program design, the ability of community to participate in problem solving, and respect and understanding for local cultural constraints are critical aspects of the process. (The

Woorabinda Aboriginal and Torres Strait Islander Corporation for Social and Emotional Wellbeing and Health submission. 5, p. 2)"[292]

Healthcare workforce

The health workforce in Australia is large and diverse and includes a wide range of professionals and support staff working to provide healthcare services to the population. These include health practitioners registered with the Australian Health Practitioner Regulation Agency as well as other health professionals and health support workers. The AIHW estimates the health workforce represented 5.0 per cent of the total employed workforce in Australia with nurses accounting for 54 per cent of total healthy industry employment (around 372,000 registered nurses in 2022).[267]

Between 2013-2022, the number of registered healthcare professionals actively working in their field in Australia increased by 37 per cent (184,000 professionals). Allied Health professions had the highest total growth (67%) followed by Medical Practitioners (41%), Dental practitioners (29%) and Nurses and Midwives (26%). Over the same period, the Health Care and Social Industry grew by almost 50 percent to almost 2.1 million people in 2022 (Table 99).[267]

Table 99: Full time equivalent rate (per 100,000 people), by profession, 2013 and 2022

Health professional group	2013	2022
Allied health	426	652
Dental Practitioners	72	81
Medical Practitioners*	382	442
Nurses and Midwives	1155	1307
All professions	2035	2482

Source: Department of Health and Aged Care 2023a. *excludes GPs.

Table 100 displays select health workforce information by profession. Compared to Queensland and Australia, in 2022, CCQ has a smaller workforce per 100,000 persons with the exception of enrolled nurses, with a rate of 242.5 per 100,000 population compared to the Queensland rate of 216.6 per 100,00 persons. There is great disparity within the LGAs when comparing the health workforce data per 100,00 persons.

Table 100: Health workforce data, by CCQ, 2022[28]

LGA	Hospital Practitioners non-specialist (2022)	Specialist Practitioners (2022)	Specialist Practitioners in training (2022)	Registered Nurse only (2022)	Registered Nurses who are also midwifes (2022)	Enrolled Nurses (2022)	Dentists (2022)
	Rate per 100,000 persons						
Banana - part B	20.3	0.0	33.8	703.7	54.1	250.4	33.8
Bundaberg	65.6	115.6	92.1	1,157.0	76.4	285.1	43.1
Central Highlands (Qld)	17.5	31.5	35.1	452.2	80.6	133.2	45.6
Fraser Coast	61.7	102.5	76.5	1,066.2	60.8	225.1	53.0
Gladstone	30.6	50.5	19.9	580.4	38.3	170.0	30.6
Gympie	23.6	39.9	38.1	642.3	58.1	177.8	56.2
Livingstone	14.7	9.8	36.7	396.0	41.6	154.0	26.9
Noosa	15.7	92.4	26.2	750.1	31.4	190.1	108.1
North Burnett	0.0	29.4	29.4	626.5	127.3	323.0	0.0
Rockhampton	74.2	193.8	89.7	1,565.7	139.9	406.7	61.0
Sunshine Coast	67.7	180.1	80.6	1,325.7	90.5	247.0	75.9
Woorabinda	0.0	0.0	0.0	1,133.1	283.3	472.1	0.0
CCQ	***53.5***	***125.1***	***67.1***	***1081.0***	***78.4***	***242.5***	***61.1***
Queensland	***56.0***	***159.7***	***76.3***	***1180.8***	***78.5***	***216.6***	***69.6***
AUSTRALIA	***55.5***	***160.2***	***73.1***	***1129.1***	***76.7***	***206.5***	***66.3***

General Practice workforce

A strong and sustainable general practice sector is vital for the health of Australia. With almost 9 in 10 Australians visiting a GP each year, it is important to understand current and emerging workforce trends to identify areas for improvement.

In Australia, there were a total of 39,449 primary care GPs in 2023 compared to 36,916 GPs in 2018, an annual rate of growth of 1.3 per cent over the five-year period. Interestingly, the number of GP FTE per 100,000 population has decreased 0.4 per cent per annum over the five-year period, from a rate of 114.4 GPs to 112.3 per 100,000 population in 2018 and 2023 respectively.[293]

In 2023, there were 31,885 (81%) of GPs that were VR, 1,562 (4%) that were NONVR and a further 6,002 (15%) that were GP trainees. 38 per cent of GPs in 2023 were aged between 40-54, 26 per cent aged between 0-39, 21 per cent aged between 55-64 and 16 per cent aged over 65 years. Nationally, 57 per cent of GPs in 2023 obtained their initial medical qualification in Australia versus 43 per cent overseas.

In Queensland, there were a total of 6,124.6 GP FTEs in 2023. This FTE has remained steady over the five years from 2018 to 2023. In 2023, 84 per cent of these were VR GPs, 2 per cent NONVR and 13 per cent were GP trainees. 58 per cent of GPs were male and the 48 per cent were females in 2023. 44 per cent of the workforce were aged between 40-54, 25 per cent aged between 54 and 64 and 19 per cent aged 0-39 and the remaining 13 per cent aged over 65 years.

Table 101 displays the GP information for CCQ in 2023. In 2023, there were 224 Active General Practice Trainees Program trainees in the CCQ region with 132.7 of these FTE positions. Biloela, Buderim, Central Highlands, Gympie-Cooloola, Nambour and Noosa and the Sunshine Coast Hinterlands had no GP trainee positions in 2023.

Table 101: Number and FTE type of GP trainees (2023)[293]

Local Government Area	Number of active AGPT	AGPT Trainees FTE	Number of GP Trainee	GP Trainee FTE	Number of Non VR GPs	Non VR GPs FTE	Number of VR GPs	VR GPs FTE
Biloela	3	1.8	-	4.5	-	1.6	34	10.5
Buderim	10	6.4	-	5.5	-	0.3	163	64.5
Bundaberg	29	19.3	57	39.2	9	3.2	122	80.4
Burnett	14	7.6	28	11.9	7	0.8	140	35.6
Caloundra	23	11.4	15	7.1	4	1.4	242	124.7
Central Highlands	10	7.8	-	8.2	-	0.8	47	10.7
Gladstone	10	5.2	26	20.7	8	3.0	70	33.8
Gympie - Cooloola	17	10.7	-	26.0	-	0.3	93	40.5
Hervey Bay	35	21.1	51	36.3	14	6.4	94	69.6
Maroochy	7	4.4	7	3.3	-	-	162	85.9
Maryborough	4	2.3	25	19.6	12	7.0	43	28.1
Nambour	15	7.7	-	8.0	-	1.4	84	42.0
Noosa	5	2.7	9	2.4	-	-	125	66.2
Noosa Hinterland	5	1.6	-	6.9	-	0.1	28	13.0
Rockhampton	30	19.9	42	23.6	10	4.0	143	96.4
Sunshine Coast Hinterland	7	2.8	-	19.9	-	0.9	81	41.8
CCQ	**224.0**	**132.7**	**260.0**	**243.1**	**64.0**	**31.2**	**1,671.0**	**843.7**
Queensland	**..**	**..**	**..**	**820.3**	**..**	**130.7**	**..**	**5173.6**
Australia								

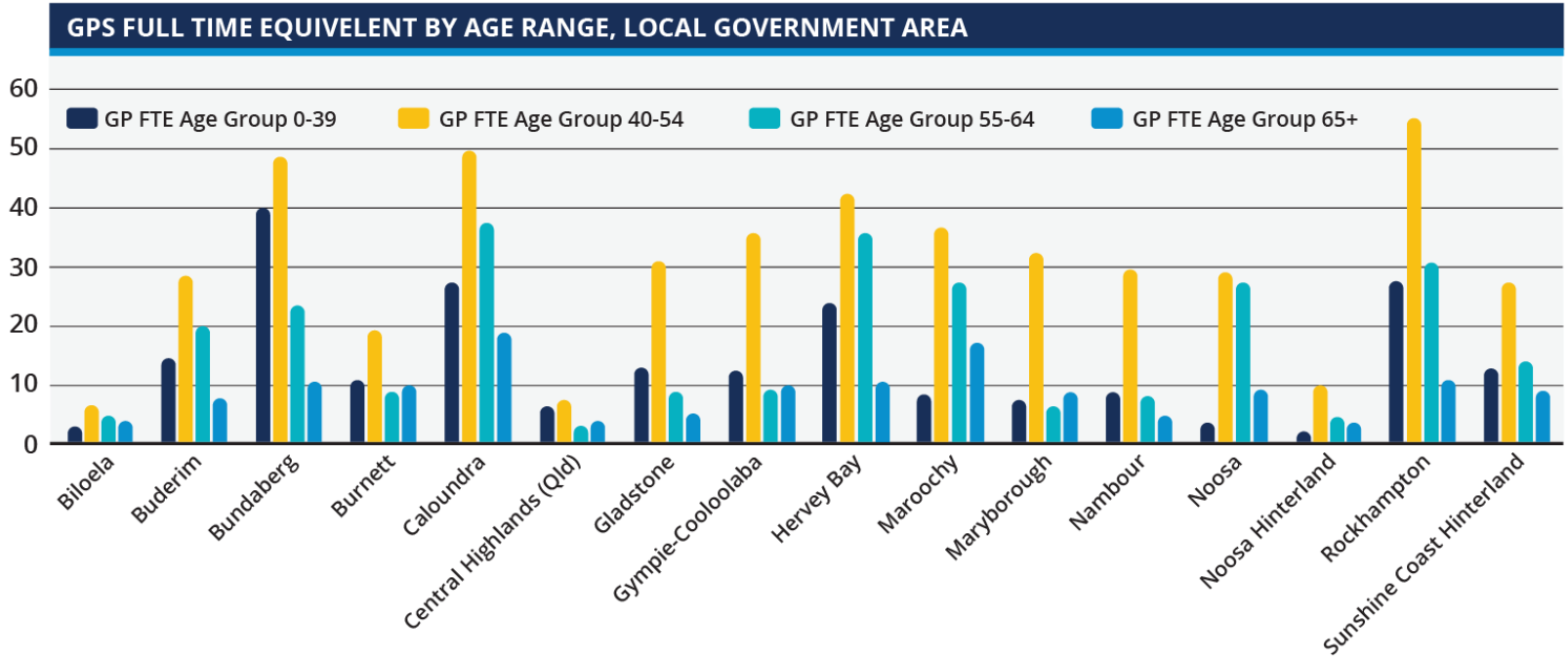
In 2023, there were 432.5 FTE (38%) female GPs compared to 685.3 (62%) male GPs in the CCQ region (Table 102).

Table 102: GPs FTE by Gender (2023)[293]

SA3_Name	GP FTE Female	GP FTE Male
Biloela	5.4	11.3
Buderim	31.8	38.5
Bundaberg	46.1	76.7
Burnett	18.3	30
Caloundra	46.8	86.5
Central Highlands	6	13.7
Gladstone	25.6	31.8
Gympie - Cooloola	25.5	41.3
Hervey Bay	44.9	67.4
Maroochy	26.5	62.6
Maryborough	13.9	40.8
Nambour	18	33.4
Noosa	26.3	42.2
Noosa Hinterland	11.2	8.8
Rockhampton	57.2	66.8
Sunshine Coast Hinterland	29	33.5
CCQ	**432.5**	**685.3**
Queensland	**3,578.8**	**2,545.8**
Australia	**12,387.3**	**16,827.7**

CCQ have trends similar to Queensland with the GPS aged between 40-54 accounting for 44 per cent of the GP FTE workforce in 2023, followed by persons aged between 55-64 (24%). Figure 41 displays the distribution of GP FTE across the CCQ LGAs.

Figure 41: Number of FTE GPs by age range, by SA3[293]



Across CCQ, the GP FTE per 100,000 residents varies with Hervey Bay, Noosa and Maroochy having the greatest FTE across the region compared to Central Highlands and Noosa Hinterland having lower GPs FTE per 100,000 population compared to the rest of CCQ (Table 103Table 103).

Table 103: Number and FTE of GPs (2024)[293]

SA3_Name	GP FTE per 100,000 residents (ERP)	GP Full-time Equivalent (GP FTE)	Number of GPs	Ratio of GP FTE to Number of GPs
Biloela	112.5	16.6	42	0.4
Buderim	115.8	70.2	178	0.4
Bundaberg	127.2	122.8	188	0.7
Burnett	95	48.2	175	0.3
Caloundra	133.1	133.3	261	0.5
Central Highlands (Qld)	66.8	19.8	67	0.3
Gladstone	87.9	57.4	104	0.6
Gympie - Cooloola	121.4	66.8	134	0.5
Hervey Bay	170.1	112.3	159	0.7
Maroochy	136.3	89.2	169	0.5
Maryborough	111.4	54.7	80	0.7
Nambour	98.8	51.4	107	0.5
Noosa	144.1	68.6	134	0.5
Noosa Hinterland	79.9	20	41	0.5
Rockhampton	99.6	124	195	0.6
Sunshine Coast Hinterland	100.4	62.6	118	0.5
CCQ	**112.5**	**1,117.9**	**2,152**	**8.2**
Queensland (2023)	**115.1**	**6,124.6**	**17,920***	
Australia (2022)	**114**	**29,626**	**32,635**	

Aged care workforce

Australia is facing a shortage of at least 110,000 direct aged-care workers within the next decade unless urgent action is taken to boost the workforce.[294] At least 18 aged-care homes across the country have closed or were due to close in 2023 – at least half of which have directly noted staff shortages as the reason for closing.

The aged care sector faces several workforce challenges driven by low retention, a lack of available training, and a shortfall in specialist staff to support complex patients.[295] Job vacancies in health care and social services remain the highest of any industry – showing the widespread demand for workers.

Feedback from stakeholders in the Central Queensland region reported:

- Aged care services are at capacity and patients can't be discharged
- Rockhampton Hospital over capacity and patients can't be transferred
- RACH closing secure units due to changes in government policies (restrictive practice)

Feedback from stakeholders in the Wide Bay region reported:

- Clinicians lack the skills, confidence, tools, adequate staffing to manage acute deterioration or predisposing factors to acute illness in RACH.
- Quick staffing turnover resulting in prevalent hiring of Agency workers in the RACH. Most of them have limited accountability, familiarity, and clinical experience. Some of them present as new graduates.
- RACH staff shortages and burnout thus, residents are not being cared for in a timely and adequate manner.

Food environment

Diet is a factor that can be modified, and aspects of a person's diet can influence the extent to which they are at risk of, or protected against, a range of chronic conditions as well as overweight or obesity. The food environment plays a role in the food and drinks we choose to buy and consume through factors such as availability, accessibility, affordability and marketing of healthy and unhealthy food options. Additional factors within the food environment including living in areas of greater socioeconomic disadvantage or living in rural and remote areas, are also associated with more limited access to healthy food options.[296]

In Australia, consumption of unhealthy, processed foods is a major contributor to excess population intake of energy, sodium, added sugar and saturated fat, which in turn contributes to excess weight, ill health and premature death. A range of studies have investigated the healthiness of food and drinks available in Australian supermarkets and fast-food outlets.

At a national level, the Australia's Food Environment Dashboard provides an overall picture of the healthiness of Australia's food environments. The measures include: Food composition, Food labelling, Food prices and affordability, Food promotion, Food in settings, Food retail, Supermarkets, Fast food, Food manufacturers, Government policies, and Equity.[296]

Key national findings:

- **For people on low income living in rural or remote areas, a healthy diet is simply unaffordable** (diet costs more than 30% of household income).
- **Community sports clubs located in regional areas are more likely to be affiliated with an unhealthy food sponsor** compared to community sports clubs in metro areas.
- **The proportion of shelf space allocated to unhealthy food compared to healthy items, was found to be almost 10% higher in the most disadvantaged areas** (compared with the least disadvantaged areas).
- Households in all socioeconomic and geographical areas are driven by the current food environment to spend the majority of their food budget (around 60%) on unhealthy food and drinks.
- The **average 'combination deal' (usually consisting of a main, side and drink) contains more than half the average daily recommended energy intake for an Australian adult**, with some combination deals providing nearly 90% of recommended daily kilojoules.
- Several studies have documented how **food companies in Australia engage in diverse and extensive practices**, such as political donations, involvement in scientific research, and corporate philanthropy, that are **designed to avoid, weaken or delay policy actions that would improve public health**.
- **Most supermarket chains (except ALDI) dedicate more promotional space to unhealthy than healthy products**. Of all discounted food and drinks, there are 7.5 times more unhealthy than healthy items at checkouts, and two times more unhealthy than healthy items at end-of aisle displays. ALDI has no price promotions on unhealthy food or drinks at checkouts and almost none at end-of-aisle displays.
- **On any given week, children could be exposed to almost 100 food promotions on their mobile devices**, including almost 34 promotions per week for fast food restaurants or delivery services related to unhealthy food, 13 promotions for sugar-sweetened beverages and 12 promotions for chocolate and confectionery.
- There were a number areas where **Australia was identified as lagging substantially behind other countries in their efforts to address unhealthy diets and obesity** including: Restricting promotion of unhealthy foods online, in retail outlets and related to sport, as well as restricting elements that appeal to children on unhealthy food packaging.[296]

A well-developed food environment includes a variety of fresh fruits, vegetables, whole grains, and lean proteins, which are essential for balanced nutrition and disease prevention. In contrast, limited access to healthy food options, often referred to as "food deserts," can lead to poor dietary choices and higher rates of obesity, diabetes, and other diet-related health issues. The CCQ community of Woorabinda demonstrates more than double the Australian average of incidences of diabetes (11.7% vs 4.7% of the population)[297] due to such environmental circumstances. **On average, Central and North Queensland have a 20 per cent higher likelihood of food insecurity than the rest of the state, with areas such as Mt Morgan (west of Rockhampton) experiencing food insecurity levels more than double than southeast Queensland**.[298] The presence of local markets, community gardens, and educational programs about nutrition can empower individuals to make healthier food choices and improve their overall quality of life.

Commercial determinants of health

Commercial determinants of health are the activities undertaken by commercial organisations that affect people's health, directly or indirectly, positively or negatively.[299] An example of a commercial organisation is tobacco companies. Commercial determinants include the systems, practices and pathways through which these organisations affect health and equity.[300]

The commercial determinants of health are listed in the National Preventative Health Strategy (2021-2030) as one of the root causes of poor health.[15] While private sector commercial organisations can have a positive effect on health (for example, green grocers and gyms), there is a large body of evidence of an increasingly negative effect, particularly linked to multi- and trans-national corporations.[299] Problems can arise when the profit motive conflicts with good health outcomes.

Most focus has been on specific unhealthy products with direct health effects – such as tobacco, alcohol, and discretionary foods – and the large commercial organisations behind them.[301] However, commercial organisations are diverse, and there is increasing attention being paid to the wider, and more indirect effects. Examples include social media's effect on mental health and the fossil fuel industry's contribution to pollution and climate change which in turn harms health.[301]

Changes in the way that people, corporations and governments interact at the international level in recent decades have been identified as enabling health-harming commercial practices. These include:

- The transfer of some public assets to the private sector.
- The rise of transnational corporations which may not be accountable to any one government and can settle in whichever country serves their interest.
- Available policy options not being used.
- Reductions in government regulations (deregulation) which can remove safeguards against harm.
- The spectrum of activities commercial organisations engage in ranges from legal and healthy, legal and neutral, legal and harmful, to illegal.[302]

How do commercial actions affect health?

Commercial organisations can influence health directly or through the broad features of society – by influencing the social, physical and cultural environments. Harms to health are often hidden and indirect, and the many pathways are inter-related. Commercial determinants can influence health either positively or negatively. The negative impacts causing harm that need to be addressed include:

- product design, packaging and marketing – e.g. misleading packaging, inappropriate marketing to children
- supply chains – e.g. harm to local communities and the environment during production
- labour and employment – such as low pay levels and dangerous work environments
- reputational management – such as enhancing credibility and corporate image through donating to charity, greenwashing
- research funding and shaping the knowledge environment – for example, influencing the direction and volume of research, spreading unjustified doubt, spreading misinformation and disinformation
- lobbying and donations to influence the political and economic environment – for example, to block or delay regulation that aims to limit harms
- financial practices – including investment in products harmful to health, or tax avoidance
- preference and norms shaping so that their needs are seen as a higher priority than social goods including health – for example, seeking to shape ideas, beliefs and values, funding front groups and think tanks to seed doubt, having supportive media.[302]

What do we know about the consequences?

The activities of commercial organisations affect many risk factors and health outcomes.[303,304] Risk factors include smoking and e-cigarette use, diet, alcohol use, obesity, physical inactivity and air pollution. Health outcomes include acute, chronic and infectious diseases as well as injuries. All groups of society are affected, but the young are particularly vulnerable including through advertising. Aboriginal and Torres Strait Islander people may be disproportionately affected.[305] Existing health inequalities are also worsened.

Given the complexity in how commercial determinants can affect health, it is difficult to measure their impact. Using Global Burden of Disease data, it is estimated that 4 commercial products – tobacco, alcohol, ultra-processed food, and fossil fuels – accounted for 19 million global deaths in 2019, which is 34% of all deaths and 41% of non-communicable disease deaths.[305]

Digital media use

The increasing use of digital media and devices by children has led to growing concerns that spending time online without sufficient guarding is having negative effects on their health and wellbeing.[306] Holly et al (2024) argue that **children's use of digital technologies and engagement in digital environments should be recognised as important determinants of their health and that a public health approach is required to protect children from digital harms**.[306]

The digital determinants of health offer a helpful framing to consider the range of direct and indirect ways in which digital transformations, both within and beyond the health sector, can both boost or undermine health and wellbeing. Understanding the effects of the digital determinants of health on children's health and wellbeing is important because younger population groups spend a substantial amount of time online, particularly on social media and playing online games. Childhood, especially early childhood and adolescence are crucial windows for brain development and there is growing evidence that use of digital technologies can change brain function and structure. Public health interventions in childhood can prevent health issues and promote wellbeing throughout the entire life course and help break cycles of intergenerational health inequalities.

Research on the relationship between digital media use and child health outcomes is still emerging, with only a few studies done outside of high-income countries. However, **existing literature suggests that allowing children—defined as being younger than 18 years—to roam the digital world without sufficient guarding can be detrimental to their mental and physical health, and cognitive development**. One important factor is the reduced time that digitally connected children spend on real-life interactions with friends and family. It is also becoming clearer to policy makers that the benefits and risks of digital transformations are not being distributed evenly.

By treating children's use of digital media and engagement in digital environments as everyday determinants of their health, interventions can be designed to ensure that children can enjoy the benefits of digitalisation without putting their development, health, and wellbeing at risk.

Australia's national screen time guidelines:

- no screen time for children younger than two years
- no more than one hour per day for children aged 2–5 years
- no more than two hours of sedentary recreational screen time per day for children and young people aged 5–17 years (not including schoolwork).[307]

Most Australian children spend more time on screens than is recommended. Estimates from primary research suggest only 17–23% of preschoolers and 15% of 5–12-year-olds meet screen-time guidelines.[308-310] Screen time has also been shown to increase between the ages of 10 and 14, especially among boys. The types of screen-time that increased was electronic gaming for boys and TV, computer use and social networking for girls.[311]

Key facts

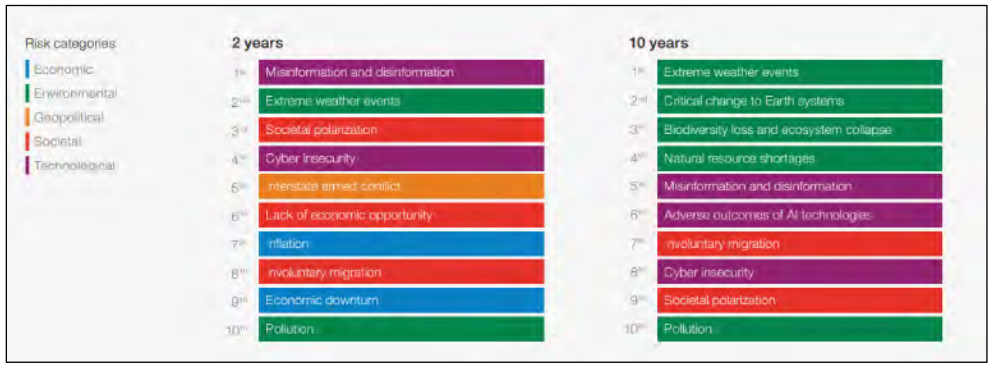
The Australian Growing Up Digital project identified:

- More than four in five children own at least one screen-based device that belongs to them. The average is 3.3 devices owned by each child.
- Personal ownership of gadgets starts as young as four years old.
- Less than half (46%) of parents felt that their child spends a day without digital technology.
- Lower-income parents and lower-achieving students are most at risk of problematic interactive media use. This is compounded by these same groups of parents being less likely to act as positive role models and implement monitoring strategies at home
- 30% of families allow their children to use their devices in their bedrooms after bedtime every single day. This climbs to 47% when families are in the lowest income bracket, and 59% when their child is experiencing educational struggles.[312]

Socio-political environment

It is well established that health and wellbeing are created by conditions outside the health system. Policy and regulatory activities involve the application of legislative and financial frameworks that create or enhance opportunities for health living. These activities are developed at the international, national and local levels.

At the international level, there are also risks that pose significant implications for health and wellbeing and the delivery of healthcare in the future. The 19th Edition of the Global Risks Report identified the top risks over the next 2 years and emerging risks (10 years).



Individual characteristics

Individual characteristics are those factors that are intrinsic to a person and directly influence their health status. These include age, sex and genetic factors. Age and sex are fundamental biological variables that can affect the prevalence and severity of various health conditions. For example, certain diseases may be more common or manifest differently in men compared to women, and health risks generally change with age, such as the increased risk of chronic diseases in older adults.

While these intrinsic factors are beyond an individual's control, understanding them is important for recognising priority populations and tailoring health interventions to address the unique needs of different demographic groups.

Genetics and biomarkers

Genetic factors refer to the inherited characteristics passed down from parents to offspring that influence an individual's health and susceptibility to various diseases. These genetic factors are part of the individual's innate biology and can include predispositions to certain conditions such as cardiovascular disease, diabetes, some types of cancer and other hereditary disorders.

Genetic factors can also determine physical attributes such as height, body composition and skin colour, which may indirectly impact health by influencing susceptibility to environmental exposers or lifestyle behaviours. Understanding genetic factors plays an important role in the context of personalised medicine and public health, as it helps in identifying priority individuals and populations, leading to more targeted and effective interventions.

Biomarkers, also often referred to as biomedical risk factors, are physical conditions or physiological states that can increase an individual's susceptibility to various diseases and health issues. They are measurable aspects of a person's biology that may predispose them to developing chronic conditions over time.

According to the National Preventive Health Strategy 2021-2030, key biomarkers include:

- High or low blood pressure
- Elevated blood glucose levels
- Overweight, obesity or underweight
- High blood cholesterol
- Genetics, epigenetics and telomere biology.[15]

These biomarkers are closely linked to behavioural risk factors such as smoking and diet. They are also influenced by broader health determinants, including social, commercial and environmental factors.

Blood pressure

High blood pressure, or hypertension, is a notable risk factor for chronic conditions such as stroke, coronary heart disease, dementia and chronic kidney disease. It is defined as a systolic blood pressure of 140 mmHg or higher, and/or a diastolic blood pressure of 90 mmHg or higher.[313] Persistent high readings indicate the need for medical follow-up and potential diagnosis of hypertension.

Treatment typically involves lifestyle changes like a healthy diet, regular physical activity, avoiding smoking, and medication. Controlled high blood pressure is defined as having measurements below 130/80 mmHg. A doctor will determine the ideal blood pressure target based on individual medical history.[313]

In Australia, high blood pressure was the fourth leading risk factor for ill health and premature death in 2018, contributing to 5.1% of the total burden.[313] It was responsible for significant proportions of the burden from hypertensive heart disease, coronary heart disease, stroke, chronic kidney disease, and atrial fibrillation.

In 2022, 14.9% of adults across Australia self-reported having high blood pressure, similar to previous years. However, measured data showed that 23.3% of adults had high blood pressure, with rates increasing with age. Self-reported data often underestimates the prevalence of high blood pressure, as many people with elevated levels are unaware of their condition.[313]

Efforts to control high blood pressure include the National Hypertension Taskforce, which aims to improve the proportion of people with controlled blood pressure to 70% by 2030.[314]

The overall ASR of high blood pressure in the CCQ region is slightly higher than the rates for both Queensland and Australia (Table 104Table 104). Fraser Coast and Gympie LGAs have notably higher rates compared to the overall CCQ catchment. Conversely, Banana LGA has the lowest rate and is notably lower than CCQ, Queensland and national regions. These variations highlight disparities within the CCQ region, with some LGAs experiencing higher burdens of blood pressure than others.

Table 104: Estimated number of people aged 18 years and over who had high blood pressure (2017-18)[28]

LGA	Number	ASR per 100
Banana	457	9.0
Bundaberg	4,261	**12.0**
Central Highlands	1,061	10.2
Fraser Coast	5,355	**13.8**
Gladstone	2,823	11.9
Gympie	2,708	**13.9**
Livingstone	1,609	11.4
Noosa	2,256	10.9
North Burnett	543	**12.9**
Rockhampton	3,658	**12.3**
Sunshine Coast	12,873	11.3
Woorabinda	^	-
CCQ	***37,642***	***11.9***
QLD	***207,354***	***11.4***
AUSTRALIA	***1,035,100***	***11.3***

^data not releasable; - data not reported

New data for controlled high blood pressure in Australia will be available later in 2024.

Blood lipids (cholesterol and triglycerides)

Blood lipids, including cholesterol and triglycerides, are essential fats in the bloodstream. Cholesterol, produced by the liver, helps build cell walls and produce hormones, while triglycerides serve as an energy source and assist in transferring dietary fat throughout the body. When these lipids are not within the healthy range it is termed dyslipidaemia, which can lead to atherosclerosis – an accumulation of fatty deposits in blood vessels, increasing the risk of cardiovascular diseases.[313]

Blood tests are commonly used to assess blood lipid levels, measuring total cholesterol, low-density lipoprotein (LDL or "bad" cholesterol), high-density lipoprotein (HDL or "good" cholesterol), and triglycerides. High cholesterol was a significant concern in Australia, ranked as the eighth leading risk factor for ill health and premature death in 2018, contributing to 37% of coronary heart disease and 16% of stroke burden.[313]

In 2022, 10.7% of Australian adults reported having high cholesterol, up from 7.8% in 2017-18. The prevalence of high cholesterol increased with age, affecting 1.1% of those aged 18-34 and 29.0% of those aged 75 and over.

Data for blood lipids is not currently publicly available at a regional level.

Healthy weight

Achieving and maintaining a healthy body weight is important to living longer and healthier lives. Being a healthy weight can reduce the risk of ill-health, support management of chronic conditions and helps to improve mental health. A healthy weight is the appropriate body weight for an individual and varies for everyone and is dependent on factors such as gender, age, height, muscle mass and biological and genetic factors including ethnic background.[315] Supportive environments are needed to make the healthy choice, the easy choice. In Queensland, there has been a significant step in supporting Queenslanders of all ages and backgrounds to support maintain a healthy weight. Health and Wellbeing Queensland have released the Making Healthy Happen 2032, a strategy and a series of three-year action plans for obesity prevention in Queensland.

Nationally, 66.0 per cent of adults and 26 per cent of children and adolescents were overweight or obese in 2022.[316] In Queensland, the prevalence of overweight and obesity in the adult Queensland population is high. In 2020, it was estimated 220,000 (24.6%) children and 2.6 million (65.9%) adults were overweight or obese. 140,000 (15.9%) children and 1.3 million (33.5%) adults were overweight, 70,000 (8.3%) children and 1.3 million (32.4%) adults were classified as obese.

Within CCQ in 2021-22, the proportion of adults (over 18) and children (5 to 17) that were under/healthy weight was 36 per cent and 30.9 per cent respectively in 2021-22 (Table 105). The LGAs that had the greatest proportion of under/healthy weight for persons aged 18 years and over included Noosa (50.9 %) and the Sunshine Coast (40.1%). The LGAs with the lowest proportion of under/healthy weight included Central Highlands (26.5%) and Gladstone (26.4%).

For CCQ, the Queensland Health Chief Health Officers report suggests a significant worsening in trends with lifestyle behaviours with self-reported status for overweight /obese and obesity. Self-reported obesity increased by 41.3 per cent between 2004 and 2022 in Queensland's adult population.[317]

Table 105: Proportion of under/healthy weight adults and young people, by 2021-22 by LGA[34]

LGA	BMI (under/healthy weight) young people aged 18-29 years	BMI (under/healthy weight) persons aged 18 years+	BMI (under/healthy weight) persons aged 30-44 years	BMI (under/healthy weight) persons aged 45-64 years	BMI (under/healthy weight) persons aged 65+ years
	2021-22	2021-22	2021-22	2021-22	2021-22
Banana	**	30.1%	32.5%	24.3%	25.0%
Bundaberg	51.4%	33.2%	41.5%	23.7%	28.9%
Central Highlands	34.7%	26.5%	27.7%	20.9%	26.9%
Fraser Coast	**	31.6%	26.3%	30.8%	31.3%
Gladstone	34.2%	26.4%	25.7%	24.7%	21.3%
Gympie	**	32.3%	**	31.9%	34.6%
Livingstone	**	34.9%	34.8%	32.6%	30.6%
Noosa	**	50.9%	**	49.6%	42.7%
North Burnett	**	31.5%	**	20.7%	25.1%
Rockhampton	**	32.3%	32.7%	19.3%	33.5%
Sunshine Coast	61.7%	40.1%	45.2%	29.4%	37.0%
Woorabinda	**	**	**	**	**
CCQ Region	52.9%	36%	37.9%	29.2%	33.8%

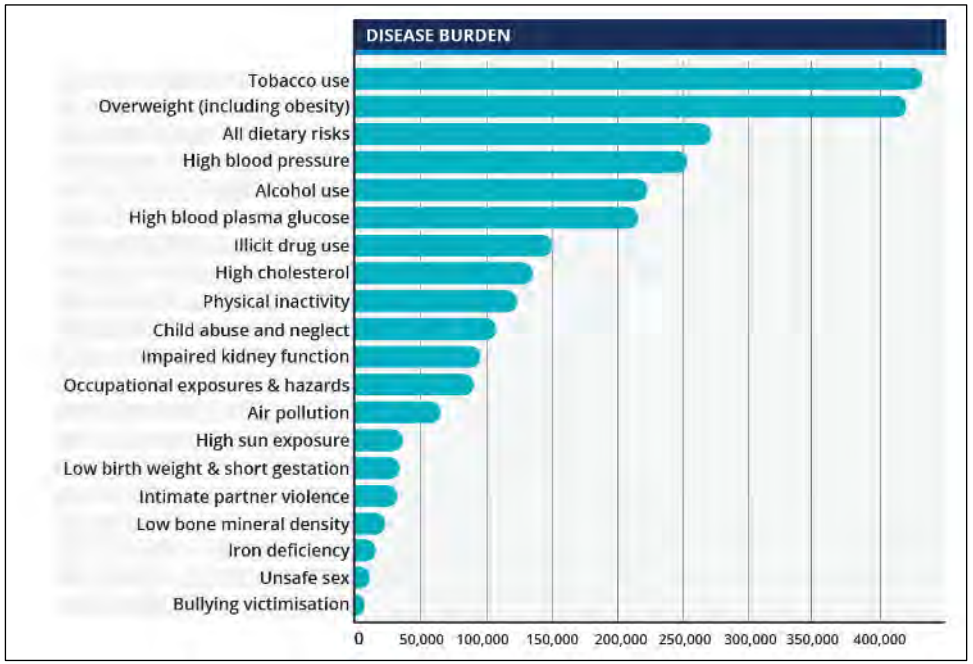
Table 106: Proportion of children (aged 5-17 years) by selected indicators[34]

LGA	BMI (under/healthy weight) children aged 5-17	BMI (under/healthy weight) children aged 8-11	BMI (under/healthy weight) children aged 12-15	BMI (under/healthy weight) children aged 16-17
	2021-22	2021-22	2021-22	2021-22
CCQ Region	30.9	29.6	22.1	32.4

Health behaviours

A person's health and wellbeing are influenced by their behaviours. Around 38 per cent of the burden of disease in Australia in 2018 could have been prevented by reducing exposure to modifiable risk factors. The leading five risk factors of the burden of disease were: tobacco use, overweight (including obesity), all dietary risks, high blood pressure and alcohol use (Figure 42).

Figure 42: Leading risk factors contributing to disease burden in Australia (2018), age-standardised attributable disability adjusted life years, all persons[88]



The burden attributable to most (14 out of 20) risk factors was higher in males than in females; with the exception of bullying victimisation, child abuse and neglect, low bone mineral density, unsafe sex, iron deficiency and intimate partner violence (only estimated in females).

Tobacco use, overweight (including obesity), all dietary risks and high blood pressure were consistently the leading four risk factors since 2003. High blood pressure decreased from the 2nd highest risk factor in 2003 to the 4th highest in 2018, whereas the reverse was seen in overweight (including obesity) rankings— moving from the 4th highest risk factor in 2003 to the 2nd highest risk factor in 2018. There were decreases in the age-standardised rate of total burden attributable to risk factors for high cholesterol by 53%, high blood pressure by 49%, dietary risks by 42%, physical inactivity by 34%, and tobacco use by 32%. Decreases in burden from cardiovascular diseases linked to these risk factors contributed to the decrease in rate of attributable burden.

In females, child abuse and neglect ranked high (6th in 2018) compared with males (not in the 10 leading risk factors in 2018). Conversely, occupational exposures and hazards ranked higher in males compared with females (ranked 9th and not in the 10 leading risk factors in 2018, respectively).

Behaviours are presented below in order of burden of disease.

Tobacco and e-cigarette use

Smoking is the leading cause of burden of disease in Australia. There has been a long-term downward trend in daily smoking since 1991, with an increase in the number of people choosing to never take up smoking (65% in 2022/23 from 49% in 1991). However, lifetime use of e-cigarettes increased significantly nationally between 2019 (11.3%) and 2022/23 (19.8%), and around 1 in 5 people living in remote and very remote and the most disadvantaged areas of Australia are still daily smokers. People aged 50-59 years are the most likely to smoke daily, and males.[318]

Many public health control measures have contributed to these trends, including prohibiting tobacco advertising including at the point of sale (and introduction of plain packaging), banning smoking in public spaces such as restaurants, bars and clubs, in cars, children's play equipment, swimming pools, public transport, and around public buildings, retailing laws regulating the advertising, promotion and display of tobacco products, e-cigarettes and accessories, non-tobacco smoking products and age requirements for purchase. Although AOD treatment services exist for treatment,

nicotine features low in closed treatment episodes across Australia. This is thought due to widespread availability of support and treatment for nicotine use in the community, including general practitioners, pharmacies, helplines, and web services.[318]

Although like national rates, the daily smoking rate in CCQ continues to decline, **smoking prevalence in CCQ remains significantly higher than in some LGAs compared with Queensland, including in Gladstone, Fraser Coast, Central Highlands and Bundaberg**. For Aboriginal and Torres Strait Islander people in CCQ, smoking rates continue to be high, with Indigenous Areas reporting higher rates than Australia, such as Central Capricorn, Fraser Coast, Bundaberg, Nanango-Kilkivan and Rockhampton-Yeppoon (Table 107).

Smoking continues to be an issue across communities in CCQ. Smoking remains the risk factor for burden of disease and many of the high rates of chronic disease PPHs in the region. Continued prevention and quit smoking programs are needed, particularly in areas where rates are high. Effectiveness of existing strategies should be evaluated.

Tobacco smoking during pregnancy is a preventable risk factor for pregnancy complications, and support to stop smoking is widely available through antenatal clinics. Smoking is associated with poorer perinatal outcomes, including low birth weight, being small for gestational age, pre-term birth and perinatal death. Nationally, the proportion of mothers who smoke during pregnancy has fallen over the last decade (13.2% to 8.7%). These decreases have been seen for Aboriginal and Torres Strait Islander mothers as well as non-Indigenous mothers.

Inhalation of other people's tobacco smoke can be harmful to health. Second-hand smoke causes coronary heart disease and lung cancer in non-smoking adults, and induces and exacerbates a range of mild to severe respiratory effects in infants, children and adults. Second-hand smoke is a cause of sudden infant death syndrome (SIDS) and a range of other serious health outcomes in young children. There is increasing evidence that second-hand smoke exposure is associated with psychological distress. Australian data shows that parents and guardians are choosing to reduce their children's exposure to tobacco smoke at home with the proportion of households with children aged where someone smoked inside having fallen from 31% to 2% over the last 25 years. However, nationally, over half (63%) of young Indigenous people aged 15–24 reported having a daily smoker in their household.

Electronic cigarettes (e-cigarettes) or vaping use continues to rise in popularity, particularly among younger people, while the evidence of potential harms continues to grow. In a 2022 Australian review, there was limited evidence that vaping was effective for smoking cessation and when used for this purpose, led to longer nicotine exposure than other cessation methods. It may also be associated with relapse in ex-smokers. Risks of vaping include lung damage, injuries and burns, acute nicotine toxicity, poisoning, and environmental waste. Use has been associated with cardiovascular health markers such as blood pressure and heart rate, lung function, and adolescent brain development.[318]

Nationally, between 2019 and 2022–23, current vaping almost tripled among the population 14 years and over, with an almost four-fold increase among those aged 18–24. One in five 18-24-year-olds reported currently vaping in 2022–23, up from one in 20 in 2019. Nationally, almost 60 per cent of current vapers were aged under 30 in 2022-23.[319]

In 2022, 19.7 per cent of Queensland adults had tried an e-cigarette in their lifetime—5.0 per cent were currently vaping and 1.9 per cent were vaping daily. Adults who currently vaped are more likely to be male, younger, current tobacco smokers. Prevalence of current vaping for Queensland adults increased from 2.1 per cent in 2018 to 5.0 per cent in 2022 and the largest increase in vaping was for young people aged 18 to 29. The increase in vaping over this period was similar for males and females.[319]

Table 107: Indicators of tobacco use

LGA (Indigenous Area)	Non-smokers and non-daily smokers, all adults 18+ years % (2021-22)[32]	Estimated number (ASR per 100) of daily smokers, Aboriginal people aged 18 years and over (2018-19)[29]	Proportion of young people (aged 18-29 years) who are non-smokers and non-daily smokers (2021-22)[32]
Banana	89.3%	38.2%	**
Bundaberg	**84.0%**	40.3%	**72.4%**
Central Highlands (Central Capricorn)	**84.5%**	**50.2%**	**75.5%**
Fraser Coast	**85.2%**	**41.3%**	**
Gladstone	**86.0%**	33.2%	**
Gympie (Cooloola-Gympie; Nanango-Kilkivan)	**86.2%**	**40.9%; 40.9%**	**
Livingstone (Rockhampton-Yeppoon)	**88.8%**	**40.8%**	**
Noosa	94.3%	32.5%	**
North Burnett	**87.7%**	38.2%	**
Rockhampton (Rockhampton-Yeppoon)	**87.4%**	**40.8%**	**
Sunshine Coast (Maroochy; Caloundra)	92.6%	26.8%; 28.4%	**
Woorabinda (Central Capricorn)	**	**50.2%**	**
CCQ	***89.0%***	*--*	**86.2%**
Queensland	***89.6%***	***40.3%***	***90.5%***
AUSTRALIA	*--*	***37.5%***	*-*

**Not releasable

Healthy eating

Food and beverage consumption plays an important role in overall health and wellbeing and is associated with many chronic diseases. Guidelines for healthy eating suggest consuming plenty of vegetables, grains, lean meats and alternatives, dairy and drinking plenty of water. Over 1 in 2 Australian adults do not meet the recommended daily fruit intake and over 1 in 9 do not meet the daily vegetable intake. One-third of Australian's energy is from discretionary foods. Adults living in the most disadvantaged areas. Nationally, adults not eating recommended services of fruit has remained about the same over the last 15 years, with it increasing from 2017/18, while adults meeting recommended serves of vegetables has remained about the same. People living in the most disadvantaged areas are more at risk of not meeting the recommended services of fruit and vegetables.

Prevalence of adults meeting healthy eating guidelines in CCQ is similar to Queensland (Table 108). The proportion of sufficient daily vegetable consumption for all adults in CCQ is 10 per cent, which is slightly higher than Queensland (8.7%).

Over 3 in 10 Australian children aged 2-17 years do not meet the recommended daily fruit intake and over 1 in 9 do not meet the daily vegetable intake. Forty-one percent of teenager's energy is from discretionary foods. In CCQ, sufficient daily vegetable and fruit consumption is similar to Queensland (Table 108).

NHMRC guidelines recommends individuals limit intake of foods and drinks containing added sugars such as confectionary, sugar sweetened soft drinks and cordials, fruit drinks, vitamin waters, energy and sport drinks. In 2021-22, of people aged 18 years and over 6.4 per cent consumed sugar sweetened drinks daily, 7.1 per cent consumed diet drinks daily and six in ten (59.7 per cent) did not usually consume either sugar sweetened or diet drinks. In children aged 2 to 17 years, most did not consume sugar sweetened (79.4%) or diet drinks (90.4%) at all, 3.4 per cent consumed sugar sweetened drinks daily and 1.2 per cent consumed diet drinks daily. Younger children aged 2-3 years were more likely to not consume either sugar sweetened, or diet drinks compared to older children aged 14-17 years (94.6 % compared to 54.6%).[320]

Guidelines recommend that infants be exclusively breastfed until around six months of age when solid foods are introduced. In Queensland, approximately 34.9% of children aged six months and over were exclusively breastfed milk to six months.[321]

Food insecurity is an issue for multiple reasons including the impacts of the COVID-19 pandemic and the cost of living crisis with rises in the prices of fresh produce. For Queensland, the McKell Institute's Food Insecurity Index shows Central and North Queensland have a food insecurity score 60 per cent higher than inner Brisbane and the problem exacerbated for Aboriginal and Torres Strait Islander Australians living in remote communities. There has been effort at a system level with Health and Wellbeing Queensland, leading the development of the Remote Food Security Action Plan. Improving food security is reliant on a coordinated response from multiple sectors.

Table 108: Healthy eating indicators[32]

LGA	Sufficient daily fruit consumption, all adults (%)	Sufficient daily vegetable consumption, all adults (%)	Sufficient daily fruit consumption, children 5-17 (%)	Sufficient daily vegetable consumption, children 5-17 (%)	Sufficient daily fruit consumption young people (aged 18-29 years) (%)	Sufficient daily vegetable consumption young people (aged 18-29years) (%)
	2017-18	2017-18	2021-22	2021-22	**2017-18**	**2017-18**
Banana	50.7	5.8	-	-	**	**
Bundaberg	51.9	9.7	-	-	29.5	**
Central Highlands	56.9	6.6	-	-	**	**
Fraser Coast	53.0	8.2	-	-	**	**
Gladstone	50.1	8.3	-	-	53.0	**
Gympie	54.7	11.0	-	-	**	**
Livingstone	56.0	6.2	-	-	**	**
Noosa	61.5	15.6	-	-	**	**
North Burnett	50.0	9.0	-	-	**	**
Rockhampton	50.6	8.1	-	-	41.4	**
Sunshine Coast	56.3	11.2	-	-	52.7	**
Woorabinda	**	**	-	-	**	**
CCQ Region	***54.5***	***10.0***	***67.8***	***3.0***	**47.7%**	**6.4%***
Queensland	***53.5***	***8.7***	***69.1***	***3.2***		

* Interpret with caution (RSE between 25% and 50%) **Not releasable *Sufficient* according to Australian Guidelines[96]

In CCQ, three or more serves of vegetables per day is achieved in 41.9 per cent of adults aged over 18 in 2017-18. Only 36.4 per cent of persons aged between 18-29 attain three or more services of vegetables per day (Table 109). Daily consumption of fruit and vegetables is lowest in the Sunshine Coast HHS for children aged 5-17 years (Table 110).

Table 109: Preventative health indicators, 2017-18[32]

LGA	Three serves of vegetables or more per day, persons aged over 18 years	Three serves of vegetables or more per day, persons aged over 18 -29 years	Three serves of vegetables or more per day, persons aged over 30-34 years	Three serves of vegetables or more per day, persons aged over 45-64 years	Three serves of vegetables or more per day, persons aged over 65 + years
	2017-18	2017-18	2017-18	2017-18	2017-18
Banana	46.7%	**	**	49.8%	48.3%
Bundaberg	41.4%	34.5%	46.2%	41.9%	39.8%
Central Highlands	43.4%	**	41.3%	41.3%	44.8%
Fraser Coast	43.6%	**	47.2%	44.9%	42.6%
Gladstone	39.1%	35.1%	46.2%	33.2%	43.9%
Gympie	39.3%	**	**	45.3%	36.9%
Livingstone	36.5%	**	34.5%	44.6%	33.8%
Noosa	45.9%	**	**	44.4%	51.4%
North Burnett	38.3%	**	**	39.0%	45.1%
Rockhampton	41.3%	38.1%	48.7%	33.6%	47.3%
Sunshine Coast	42.7%	36.9%	40.9%	46.4%	43.1%
Woorabinda	**	**	**	**	**
CCQ Region	**41.9%**	**36.4%**	***42.8%***	***42.9%***	***42.7%***

* Interpret with caution (RSE between 25% and 50%) **Not releasable

Table 110: Proportion of children (aged 5-17 years) by selected indicators, by HHS[32]

LGA	Sufficient daily fruit consumption	Sufficient daily vegetable consumption	Three serves of vegetables or more per day
	2021-22	2021-22	2021-22
Central Queensland HHS	67.9%	3.1%*	21.7%
Sunshine Coast HHS	66.9%	2.5%*	22.8%
Wide Bay HHS	69.5%	**	24.3%
CCQ Region	***67.8%***	***3.0%***	***22.8%***

* Interpret with caution (RSE between 25% and 50%) ** Not releasable. *Sufficient* according to Australian Guidelines

Alcohol consumption

Alcohol consumption is associated with many social and cultural activities in Australia. The majority of Australians aged 14 and older have consumed alcohol in their lifetime, with over 2 in 3 people having had consumed alcohol in the previous 12 months. When consumed, alcohol produces various central nervous system depressant effects. Long term effects of risky drinking include some cancers (e.g. oral, throat and breast), liver cirrhosis, brain damage and dementia, and some forms of heart disease and stroke. "Drinking at risky levels" or "risky drinking" is defined according to the Australian guidelines to reduce health risks from drinking alcohol. The guidelines state:

- **Guideline 1**: To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.
- **Guideline 2**: To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.
- **Guideline 3**: To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol.

Alcohol consumption during pregnancy can lead to poorer perinatal outcomes including low birthweight, pre-term birth and foetal alcohol spectrum disorder. Women who are planning a pregnancy, or are pregnant, are advised not drink alcohol. One in four pregnant women nationally report consuming alcohol at some stage during their pregnancy. Mothers living in remote and very remote areas, under 20 years and identifying as Aboriginal and Torres Strait Islander are more at risk of consuming

alcohol in the first 20 weeks of pregnancy nationally. For women who are breastfeeding, not drinking alcohol is safest for their baby.

Risky drinking levels overall have decreased over the last 20 years, particularly for young people. Nationally, 1 in 3 people aged 14 years and over consumed alcohol at risky levels, with males, younger people (14-17 years), people living in the most disadvantaged and remote, very remote and outer regional areas, and people born in Australia most at risk.

Nationally, the highest number and rate of ambulance attendances continues to be alcohol intoxication-related.

Drug-related hospitalisations are defined as hospitalisations with a principal diagnosis relating to a substance use disorder or direct harm relating to use of selected substances. Alcohol accounted for more than half of drug-related hospitalisations in 2021/22 and has remained the most common drug recorded in drug-related hospitalisations over the 7 years nationally.

Alcohol-induced deaths are defined as those that can be directly attributable to alcohol use (that is, where an alcohol-related condition is recorded as the underlying cause of death), as determined by toxicology and pathology reports. Alcohol-related deaths include deaths directly attributable to alcohol use and deaths where alcohol was listed as an associated cause of death. Nationally in 2022:

- there were 1,742 alcohol-induced deaths (1,245 males and 497 females).
- there was a 9.1% increase in the alcohol-induced death rate, with 164 additional deaths since 2021.
- the age-standardised rate for alcohol-induced deaths was 8.7 for males and 3.4 for females, representing the highest rates per 100,000 people in the 10-year time series.
- the rate increase is largely due to complications associated with chronic alcohol use including liver cirrhosis and liver failure.
- the largest numerical increase in alcohol-induced deaths from 2021 was in females aged 45-64 years (55 more deaths) and males aged 65-84 years (47 more deaths).[322]

Nationally, more than half (54%) of Aboriginal and Torres Strait Islander adult persons had exceeded the single occasion risk guideline (more than four standard drinks on one occasion in the last 12 months).[323] In Queensland, it is estimated, 72 per cent of adult Aboriginal and Torres Strait Islander persons exceeded the single occasion risk guidelines.[323]

Prevalence of risky alcohol consumption in CCQ is similar to Queensland, except for the Central Highlands LGA, where it is significantly higher. Of note, is the risky alcohol consumption in young people aged 18-29 in the Central Highlands and Sunshine Coast LGAs (Table 111).

In CCQ, adults that consume alcohol within NHMRC guideline one recommendations is highest for LGAs Noosa and Sunshine Coast. The LGAs that consume alcohol above these limits is greatest in Livingstone (Rockhampton-Yeppoon) at 37.8 per cent and North Burnett at 38.2 per cent (Table 111).

There are several options available to clients for treatment of alcoholism that are available through government and non-government organisations alcohol and other drug (AOD) services. Counselling was the most common main treatment type in 2022-23 accounting for one in three episodes. Other treatment types include alcohol cessation medicines, which are designed to help people stop alcohol consumption or maintain abstinence from alcohol. Pharmacotherapy is recommended for all people experiencing moderate to severe alcohol use disorder in conjunction with psychosocial support. Some population groups are at greater risk of problematic consumption including Aboriginal and Torres Strait Islander peoples, older people, people with mental health conditions and younger people.[324]

Table 111: Alcohol consumption indicators[32]

LGA	Alcohol consumption (drinks below guideline 1)				
	Persons 18+ years	People aged 18-29	People aged 30-34	People aged 45-64	People aged 65+
	2021-22				
Banana	44.0%	**	55.0%	46.3%	36.8%
Bundaberg	41.7%	42.9%	46.2%	42.4%	37.5%
Central Highlands	39.6%	22.3%*	45.0%	43.9%	38.9%
Fraser Coast	44.0%	**	51.2%	43.1%	41.6%
Gladstone	42.3%	40.1%	44.6%	41.4%	43.6%
Gympie	44.8%	**	**	45.2%	43.9%
Livingstone	37.8%	**	40.2%	40.7%	37.4%
Noosa	48.2%	**	**	44.9%	42.8%
North Burnett	38.2%	**	**	41.1%	36.1%
Rockhampton	42.4%	48.3%	43.6%	41.3%	36.8%
Sunshine Coast	46.7%	29.0%	52.8%	50.9%	45.9%
Woorabinda	**	**	**	**	**
CCQ	***44.4%***	***36.4%***	***49.9%***	***45.9%***	***42.3%***

* Interpret with caution (RSE between 25% and 50%)
**Not releasable
NHMRC Guideline 1 – To reduce risk of harm from alcohol, adults should drink no more than 10 standard drinks per week and no more than four standard drinks on any one day

Illicit drug use

Illicit drug use is a major cause of preventable disease and is associated with risks to people who use drugs, their family and friends and the community. Illicit drugs cover the use of a broad range of substances. Some of these drugs are more commonly used than others and some can be obtained legally while others can only be obtained illegally. Types include illegal drugs, pharmaceuticals, and other psychoactive substances.

There are some commonalities across most illicit drugs that can lead to social harms such as violence, crime and contact with the criminal justice system, health harms from intoxication and overdose and death and economic impacts such as the cost of health care and law enforcement. Regularly monitoring of use of illicit substances is important to identify trends and populations at particular risk from use of illicit drugs.[325]

Some population groups are at greater risk of experiencing disproportionate harms associated with illicit drug use, including young people, people with mental health conditions and people who are gay, lesbian, bisexual, transgender or intersex.[326]

Almost 1 in 5 people in Australia (17.9%) had used an illicit drug in the previous 12 months in 2022–23 which equates to about 3.9 million people, an increase from 2019 when 3.4 million had used an illicit drug. Notable findings from the *National Drug Strategy Household Survey 2022-23* indicate:

- a rise in the use of hallucinogens - becoming the third most used illicit drug in 2022-23
- cannabis remains the most commonly used illicit drug
- declining use of ecstasy since 2019, although it showed signs of rebounding in 2023
- people that used methamphetamine and amphetamine had mainly used crystal/ice
- non-medical use of pain relievers continues to decline since 2016
- ketamine use grew in 2022-23 and was recently used by around 300,000 people in Australia.

The *Australian Needle Syringe Program Survey* (ANSPS) conducted annually provides serial point prevalence estimates of human immunodeficiency virus (HIV) and hepatitis C virus (HCV) antibody prevalence, HCV ribonucleic acid (RNA) prevalence and sexual

and injecting risk behaviour among people who inject drugs (PWID) in Australia. Over the 2019-2023 period:

- the proportion of respondents from an Aboriginal and Torres Strait Islander background increased significantly from 22% to 29%
- the median age at survey completion ranged from 42 to 45 years
- The proportion of respondents reporting incarceration in the 12 months prior to survey completion decreased significantly, from 13% to 11% over the five-year period
- Methamphetamine was the most commonly reported drug last injected nationally in all years, followed by heroin in 2023 and performance and image enhancing drugs (PIIEDS) over the five-year timeframe
- Engagement with drug treatment services was high with two thirds (67%) of respondents in 2023 reporting a lifetime history of drug treatment
- HIV antibody prevalence was low and stable nationally over the period 2019 to 2023. Nationally, HIV antibody prevalence was consistently higher among homosexual male respondents than among bisexual and heterosexual male or female respondents in all years. In 2023, the median age of respondents living with HIV was 50 years. In 2023, comparable to previous years, 77% of respondents living with HIV reported they were on HIV antiretroviral treatment. Prevalence of HIV infection among Aboriginal and Torres Strait Islander respondents remained stable between 2019 and 20223
- HCV antibody prevalence nationally declined significantly from 45.5% in 2019 to 44.8% in 2023. There was a decline in HCV antibody prevalence was observed in Queensland over the five years.

Drug-induced deaths are those which are directly attributable to drug use. They include deaths due to acute drug toxicity (e.g., overdose) and chronic drug use (e.g., drug-induced cardiac conditions). On average, 97 per cent of drug induced deaths are certified by a coroner. Multiple complex factors must be considered with a death is certified as drug induced, requiring multiple revision processes to the certification process and therefore data should be interpreted with caution.

Nationally, in 2022, there were 1,693 drug-induced deaths (1,082 males and 611 females). This compares to 1,788 deaths in 2021 (1,120 males and 668 females). The sex ratio for drug-induced deaths was 1.9 (male to female). The median age at death was 47.4 years. For males the median age at death was 45.4 years and for females 50.0 years. Opioids were the most common drug class identified in toxicology for drug-induced deaths.

Table 112 displays select health indicators for Aboriginal and Torres Strait Islanders. The percentage of persons that smoke daily and are overweight and obesity is higher compared to the CCQ region.

Table 112: Proportion of Aboriginal and Torres Strait Islander adults aged 15 years+ by selected health indicators, by CCQ region (2018-19)[323]

Sex	Current daily smoker %	BMI (overweight/obese)	Alcohol consumption (long-term/lifetime risk)	Alcohol consumption (short-term/single-occasion risk)	Has used substances
Male	**38.8%**	**72.4%**	-		-
Female	**35.6%**	**73.2%**	-		-
Persons	**37.1%**	**72.9%**	21.0%	**51.1%**	28.0%
CCQ Region (2021-22)	***11.0%***	***64.0%***	***-***	***38.6%***	***-***

Exceeds 2009 NHMRC guidelines (long-term/lifetime risk)

Physical activity

Physical activity is important across all ages and contributes to health, growth and development. The benefits of regular physical activity include prevention and management of health conditions such as heart disease, stroke, Type 2 diabetes and high blood pressure. Physical activity is also an important contributor for achieving and maintaining a healthy lifestyle.

Australia's physical activity and sedentary behaviour guidelines include recommendations for time spent on physical activity, and muscle-strengthening activities for different age groups as well as screen-based activity in children (Table 113). Nationally, over 1 in 3 adults do not meet the physical activity guidelines, and almost 3 in 4 not doing enough muscle-strengthening activities for health gains. Nationally, there has been a large decrease in the proportion of adults who did not

meet the physical activity guidelines to 46% in 2022, from 65% in 2017–18. This follows from the slight decreasing trend observed since 2007/08. People living in outer regional and remote, and the most disadvantaged areas are most at risk of not meeting the guidelines.

Australia is one of few countries globally that does not have a national physical activity action plan, and rates low of global physical activity scorecards, particularly for children and adolescents[92]. In 2018, insufficient physical activity accounted for 2.5 per cent of the total disease burden nationally.[327]

Participation of children and youth in sport are crucial in establishing positive lifelong behaviours. Playing sport during these years can provide lifelong benefits to physical, mental, social, and economic wellbeing. Children and youth who grow up playing sport are more likely to remain active as adults and to have improved resilience and social connectedness. An estimated 2,347,000 (47%) of children aged 0-14 participated in organised outside-of-school hours sport-related activity at least once a week in 2022. An estimated 1,831,000 (54%) of individuals aged 15-24 participated in a sport-related activity at least once a week in 2022.[328]

On average, children aged 5–14 spent more than 2 hours (123 minutes) each day sitting or lying down for screen-based activities. Children aged 2–4 spent 83 minutes a day on average in front of screens.[329]

The three main modes of transport Australians used to commute to work in 2021 during the COVID pandemic included, car, as driver', 'worked at home' and 'did no go to work' compared to 2016 census snapshot where 'car, as driver' was the most common followed by 'did not go to work', then 'walked only'.

Table 113: Physical activity and sedentary behaviour guidelines

	2-4 who are not in school	5–17	18–64	65 years and older
Physical activity	At least 180 minutes a day of physical activity including energetic play	60 minutes of moderate to vigorous physical activity per day	150–300 minutes per week of moderate physical activity, OR 75–150 minutes per week of vigorous physical activity, OR an equivalent combination of both per week	30 minutes or more of physical activity on most, preferably all, days(a)
Strength and toning		Three days or more per week	Two days of more per week	No specific guidelines
Screen based activity	no more than 60 minutes a day engaged in screen-based activity	no more than 2 hours a day of screen-based activity for entertainment (for example, television, seated electronic games and computer use).		

a) For this analysis, this has been interpreted as completing 30 minutes or more of physical activity five days in a week and having completed any physical activity on seven days. Notes: sedentary behaviour is defined as sitting or lying down for activities.

In Queensland, 24.7 per cent of persons aged 15 years and over met the recommended physical activity guidelines.[321]

Across CCQ in 2019-20:

- 49.4 percent of children were active for 60 minutes or more daily in the past week in 2021-22, which is slightly higher than the Queensland at 46.9 percent (Table 114).
- Physical activity levels are similar to Queensland, except for in the LGAs Gympie, North Burnett, Banana and Gladstone (Table 115).
- Adults aged between 18-29 had the greatest physical activity of all age groups in 2019-20 with the least physical activity apparent in children aged 5-17 in 2021-22 (Table 115).

Table 114: Proportion of children (aged 5-17 years) by selected indicators, by HHS[32]

Hospital and Health Service	Active 60 mins or more daily (past week)
	2021-22
Central Queensland HHS	49.1%
Sunshine Coast HHS	48.0%
Wide Bay HHS	52.7%
CCQ Region	***49.4%***
Queensland	***46.9%***

Table 115: Physical activity indicators[32]

LGA	Sufficient physical activity, all adults 18+ years	Past week physical activity ^ children 5-17 years	Sufficient physical activity, young adults 18-29 years	Sufficient physical activity, persons 30-34 years	Sufficient physical activity, persons 45-64 years	Sufficient physical activity, persons 65+ years
	2019-20	2021-22	2019-20	2019-20	2019-20	2019-20
Banana	49.4%	-	**	67.5%	36.5%	40.6%
Bundaberg	52.6%	-	**	63.0%	48.4%	45.1%
Central Highlands	52.8%	-	65.6%	52.5%	49.3%	37.3%
Fraser Coast	55.8%	-	**	63.6%	54.7%	49.5%
Gladstone	51.4%	-	57.2%	56.4%	45.9%	46.4%
Gympie	47.5%	-	**	**	44.6%	50.0%
Livingstone	53.7%	-	**	52.8%	57.1%	45.2%
Noosa	66.3%	-	**	**	67.7%	72.0%
North Burnett	48.1%	-	**	**	46.6%	28.6%
Rockhampton	52.5%	-	57.0%	58.2%	47.8%	45.5%
Sunshine Coast	65.3%	-	**	60.5%	65.4%	61.0%
Woorabinda	**	-	**	**	**	**
CCQ Region	***58.2%***	***49.4%***	***65.3%***	***59.2%***	***56.6%***	***53.7%***
Queensland	***58.3%***	***46.9%***	-	-	-	-

* Interpret with caution (RSE between 25% and 50%). **Not releasable. ^ active 600 minutes or more daily

Sexual practices

Good sexual health is fundamental to overall health and wellbeing across every stage of life. It can affect and be affected by other aspects of health, including physical, mental and emotional health. Sexual health includes:

- respect for the right to healthy relationships, equality and safety
- safety to express individual sexuality, sexual orientation and gender identity
- freedom from coercion, discrimination, violence and stigma
- access to information and health care
- protection from, and treatment of, STI.

Maintaining good sexual health is important, and requires:

- access to accurate and comprehensive information
- knowledge about risks and consequences of unprotected sexual activity, such as STI and unwanted pregnancies
- practising safe sex to avoid STI or unwanted pregnancies, including by wearing a condom
- access to inclusive and safe sexual health care.

In Australia, about 16 per cent of Australians have had an STI in their lifetime. In 2020, there were about 57,500 new cases of notifiable STI among females and 67,400 among males. Between 2015-2019, STI notification rates increased by: 17 per cent for chlamydia, nearly 79 per cent for gonorrhoea and 95 per cent for infectious syphilis.

The prevalence of sexually transmitted infections is higher in Queensland women than in Australian women. Chlamydia is the most common sexually transmitted infection among Queensland women, followed by gonorrhoea and syphilis.

Queensland regularly reports notifiable conditions by Hospital and Health Service. displays annual trends in notifiable conditions for select sexually transmitted infections for the CCQ. In Queensland, notifications for syphilis improved slightly in 2020, reflecting similar national trends, with 1054 cases in 2021 (20.3 per 100,000 persons). In 2020-21, the number of reported cases in pregnant women and their babies was 65 for infectious syphilis, 30 for late latent syphilis and 8 for congenital syphilis.[330]

The most common sexually transmitted infection in CCQ was chlamydia with the highest number of infections in the Sunshine Coast HHS. There has also been an increase in the notification of syphilis (infectious) between 2019 and 2023 in Central Queensland (Table 116).

Overall, Aboriginal and Torres Strait Islander people in Queensland experience a disproportionately high burden of BBV/STIs.

- In 2018, Aboriginal and Torres Strait Islander people in Queensland accounted for 12 per cent of hepatitis B, 17 per cent of hepatitis C, seven per cent of HIV, 14 per cent of chlamydia, 20 per cent of gonorrhoea, and 25 per cent of infectious syphilis notifications, despite only making up four per cent of the total population in Queensland.
- There has been an ongoing outbreak of infectious syphilis in Aboriginal and Torres Strait Islander peoples which was first declared in January 2011. The outbreak affects Central Queensland HHS and other far north Queensland HHSs.
- Gonorrhoea notifications increased by 43 per cent in Aboriginal and Torres Strait Islander people between 2014 and 2018.
- Between 2014 and 2018 HIV and hepatitis C notifications in Aboriginal and Torres Strait Islander people increased with peaks in 2016, followed by declines in 2017 and 2018.
- There was a 19 per cent decrease in hepatitis B notifications amongst Aboriginal and Torres Strait Islander people between 2014 and 2018.[331]

Condoms are an important component of Sexually Transmitted Infections and Blood Borne Viruses prevention strategies. Nationally, approximately one quarter (26%) of Aboriginal and Torres Strait Islander young people who had vaginal or anal sex in the last year reported always using a condom, 44 per cent used condoms sometimes and 31 per cent never used them.[332]

Table 116: Notifiable conditions, annual totals

Annual Totals of sexually transmissible infections by HHS	Central QLD					Wide Bay					Sunshine Coast				
	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
Chancroid	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chlamydia*	984	898	1069	1086	1087	643	573	607	585	569	1535	1395	1461	1497	1588
Donovanosis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gonorrhoea*	228	316	237	166	198	133	132	112	117	170	245	305	263	281	333
Lymphogranuloma venereum (LGV)	0	0	0	0	0	1	0	0	0	0	0	2	0	0	0
Syphilis (infectious)	33	35	56	87	89	12	13	8	15	29	40	31	17	32	49
Syphilis (late)	11	3	12	24	190	9	5	6	8	8	18	5	10	7	17
Syphilis (congenital)	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0

*Notes for Gonorrhoea and Chlamydia: From 1 January 2018 notifications represent discrete individuals whereas prior to that date notifications represent infection site-specific positive results and may include more than one notification per individual. From 29 January 2018 notifications of sexually transmitted infections (STI) and non-sexually transmitted infections (non-STI) are reported separately.

Teenage pregnancies

Motherhood for women under the age of 20 can be a positive and maturing experience. For many young people, becoming a parent can have a transformative impact, particularly with changing unhealthy behaviours and relationships. Mothers who give birth under 20 years of age are also a vulnerable population group who may experience lower education and reduced employment. This may increase the risk of socioeconomic disadvantage for both child and mother. Children of vulnerable young parents are also at risk of becoming teenage parents themselves. Nationally, in 2017, around 6,600 babies were live-born to teenage mothers—a rate of 9.2 live births per 1,000 females aged 15–19. Births to teenage mothers made up 2.2% of all live births. Births to teenage mothers decreased by more than 40% between 2006 and 2017 from17.6 to 9.2 per 1,000 females aged 15–19.

Gambling

Gambling is a major public policy issue in Australia, affecting the health and wellbeing of many individuals and families in a range of ways. The social costs of gambling can include adverse financial impacts, emotional and psychological costs, relationship and family impacts, and productivity loss and work impacts. There has been a gradual transition from land-based gambling (i.e. poker machines or pokies) to gambling online on sports and race betting which has grown substantially in recent years, and related harms are of increasing concern. In a survey, almost half (46%) of Australians who gambled were classified as being at some risk of gambling harm. Men are greatest gambling risk with a tendency to gamble more frequently, spend more money.[333]

The National Gambling Trends Study identified the following emerging gambling trends in 2022:

- An increase in exposure to gambling marketing including promotions and incentives
- An increase in online gambling and concern about the potential harms due to factors such as the widespread availability and ease of access
- Increased spending on poker machines post COVID-19 restrictions
- Convergence of video gaming and gambling through products that are appealing to young people
- An overall increase in gambling related harm in Australia and concerns about the normalisation of gambling for youth, increases in youth gambling and risk of harm.[334]

Risk taking behaviours during pregnancy

Proportion of mothers who smoked tobacco during pregnancy

Smoking during pregnancy is an important preventable risk factor for pregnancy complications. Supporting women to stop smoking during pregnancy can reduce the risk of adverse outcomes for mothers and their babies. Smoking is associated with poorer perinatal outcomes, including low birthweight, being small for gestational age, pre-term birth and perinatal death.[335]

Nationally, in 2021, almost 1 in 10 mothers (8.7%) reported smoking at any time during pregnancy, a rate that has been gradually falling since 2011 (13%). Higher smoking rates were observed among Aboriginal and Torres Strait Islander mothers (42%), teenage mothers (aged under 20) (33%) and mothers aged 20-24 (21%). Rates of mothers reporting that they smoked during their pregnancy were higher in Queensland (11.5%) and in the CCQ region (13.0%). Rates were higher still in all SA3s within the CCQ region that cover Central Queensland and Wide Bay.[335]

Alcohol consumption during pregnancy

Alcohol consumption in pregnancy can lead to poorer perinatal outcomes including low birthweight, being small for gestational age, pre-term birth and fetal alcohol spectrum disorder (FASD).[336] FASD refers to a range of adverse physical, learning, and behavioural effects after exposure to alcohol during pregnancy, with issues occurring into childhood and adult life. The National Health and Medical Research Council (NHMRC) advises that women who are pregnant or planning a pregnancy should not drink alcohol.[336]

Data on maternal consumption of alcohol during pregnancy were available for the first time in 2019. In Australian in 2021, over 97% of women did not consume alcohol in the first 20 weeks of pregnancy. The proportion of Queensland women who consumed alcohol in the first 20 weeks decreased after 20 weeks of pregnancy (from 5.9% in the first 20 weeks, down to 0.9% after 20 weeks).[337]

Women were more likely to consume alcohol in the first 20 weeks of pregnancy if they:

- lived in Remote (4.6%) or very remote (7.1%) areas
- were teenage mothers (aged under 20) (4.6%).[337]

However, women from these population groups showed a decline in alcohol consumption after 20 weeks of pregnancy with:

- 1.6% of women who lived in Remote areas and 3.3% women who lived in Very remote areas consuming alcohol
- 0.8% of teenage mothers (aged under 20).[337]

Breastfeeding

Breastfeeding promotes the healthy growth and development of infants and young children. In Australia, The National Health and Medical Research Council (NHMRC) publishes infant feeding guidelines recommending that infants be exclusively breastfed until around 6 months of age when solid food are introduced. The guidelines also recommend that breastfeeding be continued until 12 months of age and beyond, 'for as long as the mother and child desire'. [338]

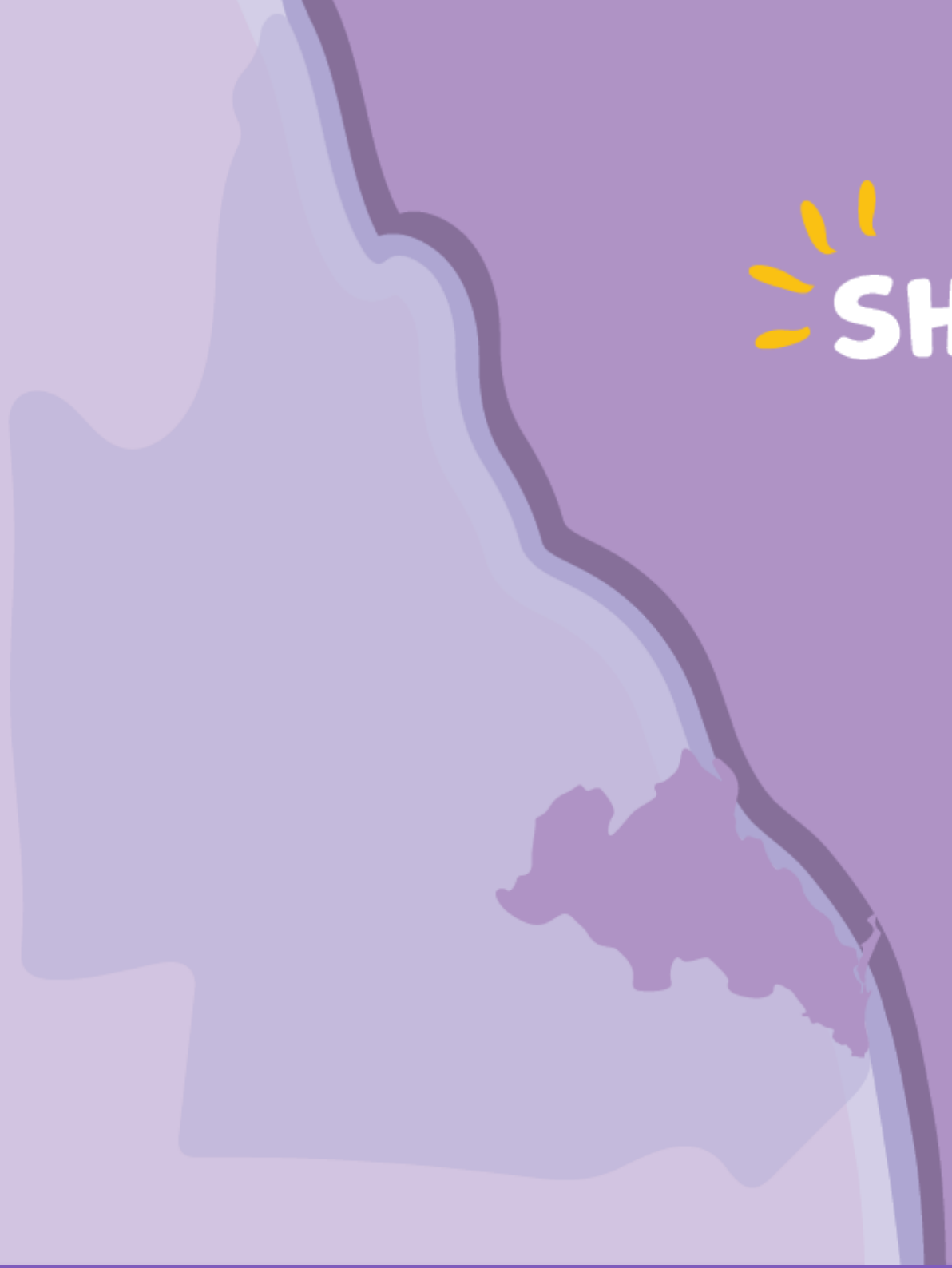
Breastfeeding provides many benefits for both mother and child. Breastfeeding promotes the healthy growth and development of infants and young children, with benefits extending into adult life.[338]

Breastfeeding provides infants with a nutrition source that is easy for their digestive systems to absorb, and changes composition over months and years to meet the child's nutritional, immunological and developmental needs. In infants, breastfeeding is also reported as being protective against infections of the ear, respiratory tract and gastrointestinal system, sudden infant death syndrome (SIDS) and malocclusion in baby teeth.[339-342]

Higher breastfeeding rates lead to lower healthcare costs as breastfeeding protects against a range of diseases.

According to a 2002 study, early weaning was estimated to add around $60 million to $120 million to annual hospitalisation costs for gastrointestinal illnesses, respiratory and ear infection, eczema, and neonatal necrotising enterocolitis in Australian hospitals.[343]

In 2020-21, 34.5% of infants aged 0-3 years who lived in Queensland were exclusively breastfed for at least 6 months.[338] Rates were far lower for Aboriginal and Torres Strait Islander women, with only 15.4% exclusively breastfeeding for 6 months.[338]



SHORT-LISTED PRIORITIES

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Short-listed priorities

This section identifies and summarises evidence for key need themes determined in the HNA, for health needs and service needs separately. Furthermore, in-depth analysis of themes will be undertaken to take these priority health needs into regional prioritisation. Broad options based on evidence-based practice have been described as options to address these needs. However, greater in-depth analysis of the local contextual factors influencing these each need with communities and stakeholders is required as part of the planning process to determine the most appropriate ways to address needs, in partnership with communities as part of a good planning process.

	Short-listed health needs	Priority area	Priority sub-category
1	Healthy communities with spaces and opportunities to safely engage with nature, play and be active	Healthy communities	Community design
2	Getting around in communities	Healthy communities	Transportation
3	Alcohol and drug use	Social determinants	AOD
4	Child development/school readiness/access to quality childcare	Population Health	Early intervention
5	Chronic disease /lifestyle risk factors	Population Health	Chronic conditions
6	Chronic disease morbidity/ mortality	Population Health	Chronic conditions
7	Community safety	Healthy communities	Safety
8	Dementia/Alzheimer's	Aged care	Chronic conditions
9	Disaster resilience and readiness	Climate change	Disaster resilience
10	Domestic and family violence (prevalence and access to services)	Social determinants	DFV
11	Injury and poisoning	Population Health	Injury and poisoning
12	Health literacy	Social determinants	Health literacy
13	Housing/ homelessness/community displacement	Social determinants	Housing security
14	Immunisation	Population Health	Immunisation
15	Income/ education/employment	Social determinants	Service integration; advocacy
16	Perinatal health	Population Health	Early intervention
17	Mental health morbidity/ mortality, including suicide and self-harm	Mental Health	Access; safety and quality; appropriate care
18	Sexual health	Population Health	Sexual health
19	Individual social and emotional wellbeing, support and resilience	Healthy communities	Service integration; advocacy
20	Community social cohesion, inclusivity and capital	Healthy communities	Service integration; advocacy
21	Supporting healthy ageing	Healthy communities	Ageing
22	Women's health	Population Health	Women's health
23	Palliative and End of life care	Healthy communities	Palliative and End of life care

	Short-listed health service needs	Priority area	Priority sub-category
1	Access to primary healthcare, including affordable, quality, timely and during the after hours	Access	Safety and quality of care; After Hours; System integration
2	Appropriate and safe primary healthcare for priority populations, including persons identifying as CALD, with a disability, LGBTIQ+, Aboriginal and Torres Strait Islander, experiencing homelessness	Appropriate care	Safety and quality of care
3	Health promotion/ prevention services	Population Health	Health promotion
4	Workforce shortages, maldistribution and models of care	Health workforce	Workforce

Priority health need summaries

Health issue	Description
Healthy communities with spaces and opportunities to safely engage with nature, play and be active	***Background*** Local communities that are designed and provide spaces and opportunities for people to engage in their local neighbourhoods to safely play, be physically active and out in the community, and more broadly just "be" in healthy and natural spaces, was a prominent theme due to the frequency it was noted in the *My Healthy Community* survey as both an enabler and key area for health improvement. In particular, nature was the top ranked asset of communities, and child-friendly communities the number one theme for improving the quality of life for children; and healthy lifestyle behaviours, including independent "age-friendly" living in community, was important for people over 65 years. It was also a key driver of barriers to doing things community members identified for their health and wellbeing. Extensive research has consistently shown that the design of local neighbourhoods is an important influence of physical activity, physical and mental health outcomes, social interaction and connectedness, and sustainability. This includes having access to safe places to play and walk, such as parks, safe streets, trails, and greenways, and being able to safely and easily walk, bike, or take transit to everyday destinations such as homes, workplaces, schools, parks, health care, and food outlets. Walkable streets and neighbourhoods provide access to active transportation, as well as determine how often people take walks or go outside, how connected we feel to nature, how much we feel engaged and involved with others, how likely we are to volunteer, and influence many other positive health indicators. Healthy safe communities also support children to develop independence and for older people to live independently in completing their daily chores and staying connected. ***Bradshaw's typology of need*** Felt/expressed need – community member identified enabler and barrier of health; place standard tool showed areas for improvement across CCQ Normative – limited data; walkability scores show car-dependent communities across CCQ Comparative need – limited data; walkability scores are comparably lower in many communities across CCQ ***Burden (severity of issue)*** Health is influenced as much by design of communities as it is by medical care. The environment has a role in disease dynamics and determining the health of people. It has a large impact on the prevention of chronic disease. For instance, physical activity levels can be increased by as much as 160% by providing supportive community environments in the absence of other strategies. ***Options to address*** *Alignment with SDGs* • SDG 3: Good health and well-being– Recognising the link between neighbourhood design and health and wellbeing • SDG 10: Reduced inequalities • SDG 11: Sustainable Cities and Communities – Provision of universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities. ***CCQ Role*** CCQ can facilitate upstream approaches that address policy, environmental and program factors impacting health. Within its PHN functions, CCQ can advocate and provide evidence and support to create or improve community environments that promote active, healthy, safe and independent living, which is essential for improving population health outcomes and reduce inequities. ***Opportunities*** Physical changes to the community environment require upstream approaches and PHC has a role in advocating and providing input and partnering in such initiatives. Community based opportunities for physical activity can be acquired through partnerships with communities and local governments. PHC providers can also support through their engagement with clients using more traditional interventions of motivational interviewing and counselling, and referral programs. CCQ can also advocate

Health issue	Description
	for and support the development of community infrastructure that promotes people being out in their community, such as in open spaces, parks and walking paths. Policy approaches to planning and transport schemes and social / community development and recreation plans of local government in providing programs to get people engaging in their community. It also includes housing, transport and planning policies of state government.
Getting around in communities	***Background*** Getting to places, including health services, was a key theme in community and stakeholder consultation. However, local secondary data are limited for this issue. This gap in data underscores the need for more comprehensive and targeted research to better understand transportation barriers and their impact on health and wellbeing, and access to services across the CCQ catchment. Public transport was specifically identified in the *My Healthy Community* survey as an area requiring large improvement in communities. This result was consistently negative across the whole CCQ region. Transportation is a critical social determinant of health affecting other determinants of health. Transportation impacts physical and mental health, overall wellbeing of individuals and communities, and access to essential services such as healthcare and social services, educational and employment opportunities. It also has key roles in independent ageing and rural communities. ***Bradshaw's typology of need*** Felt/expressed need – community members identified barrier of health; place standard tool showed areas for improvement across CCQ Normative – limited data Comparative need – limited data; travel to work showed high car dependence compared to state and nation ***Burden (severity of issue)*** Transportation is a social determinant of health that affects equity community members in multiple ways. Transportation can affect access to healthcare services, social services, employment, educational opportunities, and daily chores such as accessing food as well as social contact and independence. As an indicator of socioeconomic status, burden of disease may be assumed to be similar, i.e., 1.5 times as high as the rate for people in the highest socioeconomic areas, but much higher for some diseases. The lack of reliable transportation, particularly in rural and remote areas, contributes to health disparities and challenges in achieving equitable healthcare outcomes. ***Options to address*** *Alignment with SDGs* • SDG 11: Sustainable Cities and Communities – highlighting the need for improved infrastructure and mobility solutions. Addressing transportation challenges contributes to creating inclusive, safe, and sustainable urban and rural environments, ensuring that all individuals, including those in underserved areas, can access essential services like healthcare. • SDG 3: Good health and well-being– recognising the challenges faced by people with limited transport options being able to access services and other opportunities, including employment and social interaction. • SDG 10: Reduced inequalities ***CCQ role*** CCQ is well-positioned to identify local barriers, coordinate with stakeholders, and implement targeted solutions to improve access to healthcare services. CCQ's involvement in this space can ensure that transportation challenges are integrated into broader health service planning and delivery, enhancing overall health outcomes and equity. Advocating for transport as a social determinants of health in local and regional planning and policy. There is a need for transportation and public health policies to implement interventions to overcome transportation barriers, improve existing infrastructures and promote the understanding of population health and equity outcomes related to transport options.

Health issue	Description
	Opportunities CCQ can leverage their role in coordinating and integrating health services to address transportation needs by developing partnerships with local transportation providers and community organisations. Additionally, CCQ can use their data and insights to identify areas of greater need and prioritise action that improve access to healthcare services. Interventions to address transportation within the community domain require upstream approaches which PHC can partner and support. PHC may also be also to support those impacted through promoting travel subsidy schemes, providing transport and ensuring services are accessible. PHC can also support by ensuring services allocate funding for outreach vehicles to ensure those who have trouble accessing transport can still receive health care.
Alcohol and drug use	***Background*** Alcohol and drug use is a Department of Health and Ageing key priority area for PHNs. Alcohol consumption is ingrained in many social and cultural activities in Australia. The majority of Australians have consumed alcohol in their lifetime, and many continue to drink regularly. Long term and excessive use of alcohol can cause extreme harm to the physical and mental health of individuals, families and communities and is strongly associated with liver disease, stroke, numerous types of cancer and depression. Excessive alcohol abuse can also lead to injury and death through accident, suicide and violence and is often connected to family violence, assault and homicide. These physical and social costs increase the burden of preventable disease on Australia's health care system. ***Bradshaw's typology of need*** Felt/expressed need – community members identified as barrier of health Normative – risky alcohol consumption rates across Australia are high Comparative need – some communities in CCQ had comparatively higher risky alcohol consumption than state and nation. ***Burden (severity of issue)*** Alcohol use is the 5th leading risk factor in disease burden, illicit drug use is the 7th. This is an increase in the ranking over recent years. Risky alcohol consumption remains a significant public health issue in Australia. Despite some progress, a substantial portion of the population continues to exceed recommended drinking guidelines, leading to adverse health outcomes. High-risk groups, including young people, males, those in disadvantaged areas, and Aboriginal and Torres Strait Islander people, are particularly vulnerable. Alcohol-related hospitalisations and deaths are on the rise, highlighting the severity of the problem. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – reducing alcohol-related harm contributes to improved health and wellbeing. • SDG 10: Reduced inequalities ***CCQ role*** CCQ can play an important role in addressing risky alcohol consumption and develop and implement strategies to reduce alcohol-related harm within communities. PHNs also fund and support AOD treatment services, collaborate with other stakeholders and advocate for policies that promote healthy alcohol consumption. ***Opportunities*** Addressing risky alcohol consumption requires a multifaceted approach. Public health campaigns can raise awareness about the risks and promote healthy drinking habits. Accessible and culturally appropriate AOD treatment services are essential for those struggling with alcohol dependence. Early intervention programs can target young people at risk of developing problematic drinking patterns. Regulatory measures, such as restrictions on alcohol marketing and availability, can also play a role. Digital technologies offer new opportunities for delivering health messages and interventions. Engaging with community organisations can help reach high-risk groups. Telehealth can expand access to AOD treatment services. Addressing underlying social determinants of health, such as poverty and unemployment, is foundational for long-term success in reducing risky alcohol consumption.

Health issue	Description
Child development/school readiness/access to quality childcare	***Background*** The first 2,000 days is an important time for healthy development and learning, and for establishing the foundation blocks of future wellbeing, but it is also a time of vulnerability. While a positive start in life helps children to reach their full potential, a poor start increases the chances of adverse outcomes for the individual, society and possibly future generations. Early childhood years is a time when children begin to learn to communicate and get along with others, as well as adapt their behaviour, emotions and attention. These developmental skills play an important role when a child transitions to primary school and establish the foundations for academic and life success, including longer term job prospects, and participation in, and connection with the wider community. Child development and learning has been identified as a separate health need to perinatal health given the determinants underpinning it are potentially different. AEDC is a nationwide data collection of early childhood development at the time children commence their first year of fulltime school. It includes developmental domains: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills and community kills and general knowledge. The AEDC domains have been shown to predict later health, wellbeing and academic success. ***Bradshaw's typology of need*** Felt/expressed need – community members identified as barrier of health Normative – AEDC scores show high vulnerability in many communities and domains across CCQ Comparative need – some communities in CCQ had comparatively higher AEDC and lower childcare access than state and nation for both non-Indigenous and Aboriginal and Torres Strait Islander children. **Burden (severity of issue)** Australian Early Development Census (AEDC) data highlight the region as having lower childhood development scores than state averages. Economic costs to society by providing late intervention through health, child protection, policing and welfare etc. is said to be an additional $15.2 billion per year, and investing early (in first 2000 days) return on investment of $13 for every $1 invested. (The earlier the investment i.e. prenatal) the greater the return.). The Child Social Exclusion Index showed a large number of CCQ's SA2s falling within the most social excluded decile and having child poverty rates above the national and state average. Data also highlights several childcare deserts in the region where access to childcare is challenging or non-existent. For children from disadvantaged areas or with unhealthy home environments, access to quality early childhood education can have significant positive impacts on their development and the detection of potential developmental delays. ***Options to address*** *Alignment with SDGs* • SDG 3: Good health and well-being - Developmental delays have been shown to predict later health, wellbeing and academic outcomes. • SDG 4: Quality Education – specifically target 4.2 that states by 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education. A strong foundation in early childhood development contributes to a child's overall wellbeing, future learning, and potential to contribute to a sustainable society. • SDG 10: Reduced inequities - recognising that children have the right to access quality early childhood education and early intervention services for developmental vulnerabilities.

Health issue	Description
	CCQ role CCQ can promote childhood development by coordinating healthcare and social services, improving access to early intervention programs, and supporting families and communities in need. CCQ can work closely with local communities to identify and address specific development needs, ensuring that children receive the necessary care and support to reach their full potential. ***Opportunities*** Childhood development action requires an upstream and whole of community approach in which PHC has a role. More traditional health service roles may also include ensuring parents are provided support needed in caring for their family, early identification of problems and providing support mechanisms and appropriate care for those impacted through person-centred and integrated care models.
Chronic disease / lifestyle risk factors	***Background*** Chronic disease prevention has been separated from chronic disease management given traditionally in healthcare systems, upstream and systems approaches to health promotion and prevention are overlooked for early intervention and treatment models of care. Risk factors for chronic diseases include obesity, blood pressure, diabetes, diet, physical activity, smoking, and social determinants of health. Lifestyle factors were raised in both community consultations. The region also has higher than state average of lifestyle-related avoidable hospitalisations. ***Bradshaw's typology of need*** Felt/expressed need – community members identified as barrier of health Normative – many chronic disease risk factors are classified as being in the unhealthy range Comparative need – some communities in CCQ had comparatively higher prevalence of risk factors and preventable hospitalisations compared with state and nation ***Burden (severity of issue)*** About 40% of burden of disease could be prevented by reducing modifiable risk factors. The leading five risk factors contributing to total burden were: tobacco use, overweight/ obesity, diet, high blood pressure and alcohol use. Tobacco use, overweight (including obesity), all dietary risks and high blood pressure were consistently the leading four risk factors since 2003. High blood pressure decreased from the 2nd highest risk factor in 2003 to the 4th highest in 2018, whereas the reverse was seen in overweight (including obesity) rankings— moving from the 4th highest risk factor in 2003 to the 2nd highest risk factor in 2018. There were decreases in the age-standardised rate of total burden attributable to risk factors for high cholesterol by 53%, high blood pressure by 49%, dietary risks by 42%, physical inactivity by 34%, and tobacco use by 32%. Decreases in burden from cardiovascular diseases linked to these risk factors contributed to the decrease in rate of attributable burden. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – specifically target 3.4, which focuses on reducing premature mortality from non-communicable diseases through prevention and treatment. Addressing lifestyle-related risk factors and improving chronic disease management are key components of this goal. • SDG 10: Reduce inequalities ***CCQ role*** CCQ can play an important role in chronic disease prevention by promoting traditional approaches to prevention and early intervention, as well as addressing the social determinants of health. CCQ's ability to engage with communities and stakeholders allows for tailored health promotion and prevention programs to address local needs, reducing hospitalisations and improving health outcomes through targeted, evidence-based action. ***Opportunities*** Environmental and behavioral strategies in communities and PHC have been shown effective in addressing risk factors associated with chronic disease. Promoting healthy practices early in life (and across the life course) is critical. Strategies could include co-designing more behavioural strategies within communities, such as

Health issue	Description
	seeking out already existing health promotion services that promote healthy practices early in life such as i.e. healthy Harrold van within schools; promotion of self-management strategies-typically requiring behavioural changes involving diet, rehabilitation, and exercise; GP education around the correct use of prescription medications; education on mitigation and/ or elimination of risk factors such as smoking, stress, and risky behaviours such as unprotected sex, drink driving, drug, and alcohol use; and partnering with/ co-commission services that deliver/ have a focus on behavioural strategies (smoking cessation, Diabetes Prevention, sun care, Heart, lungs and stoke, nutrition and stress). Policy and environmental approaches to addressing these needs is going to be important for sustainable change.
Chronic disease morbidity/ mortality	***Background*** Chronic disease is a national health priority area. Chronic diseases include arthritis, back pain, cancer, diabetes, heart disease, asthma. These conditions often result from a combination of genetic, environmental, and lifestyle factors, and they account for a significant portion of Australia's healthcare burden. Preventing and managing chronic diseases is essential to improving quality of life, reducing healthcare costs, and lowering the incidence of avoidable hospitalisations. **Bradshaw's typology of need** Felt/expressed need – management of health conditions was not raised in community member consultation; access to services however was Normative – high rates or preventable chronic disease hospitalisations Comparative need – many communities in CCQ had comparatively higher chronic disease prevalence and mortality rates than state and nation ***Burden (severity of issue)*** Chronic diseases as a group is the leading burden of disease in Australia, specifically cancer (17%), musculoskeletal conditions (13%) and cardiovascular diseases (12%). Back pain and problems has increased in contribution since 2003 (now third highest ranking disease). Back pain and problems emerged as the second leading cause of burden for adults aged 25–44 and 45–64. Coronary heart disease was the leading cause of burden in adults aged 45–64. CCQ has significantly higher self-reported prevalence of long-term health conditions compared with Australia for all persons including children and young people. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – specifically target 3.4, which focuses on reducing premature mortality from non-communicable diseases through prevention and treatment. It also supports target 3.8, which emphasises achieving universal health coverage, including access to essential healthcare services for managing chronic diseases. Addressing lifestyle-related risk factors and improving chronic disease management are key components of this goal. • SDG 10: Reduced inequalities ***CCQ role*** PHNs play an important role in chronic disease management and prevention as they work to improve the coordination and delivery of primary healthcare services. ***Opportunities*** Preventive strategies have been shown to be effective in both community and healthcare settings, as well as early in life. Better and integrated healthcare teams, health literacy and self-management, clinician connection, and risk factor modification have also shown to be effective. Strategies may include: workforce development (upskilling current workforce on duel diagnosis and comorbidities); improving health literacy; focusing on environmental approaches such as; education around poor lifestyle choices and their outcomes (i.e. flavoured cigarettes, smoking), encouraging communities to walk or bike to work/ school; supporting children and young people in learning about the importance of physical activity and being physically active in child care and schools.
Community safety	***Background*** Community safety refers to the measures and conditions that ensure the physical and emotional security of individuals within a community, encompassing crime prevention, emergency preparedness, and fostering social cohesion. It involves creating environments where individuals feel safe to participate in community life and access resources without fear of violence or harm. Ensuring community safety is crucial for health, as safe environments promote mental wellbeing, encourage physical activity, and reduce stress-related health issues. The chronic stress associated with living in unsafe neighborhoods can accelerate ageing and harm health. Unsafe

Health issue	Description
Community safety	neighborhoods can cause anxiety, depression, and stress, and are linked to higher rates of pre-term births and low birthweight babies, even when income is accounted for. Fear of violence can keep people indoors, away from neighbours, physical activity, and healthy foods. Additionally, communities that prioritise safety can better support key populations, ultimately leading to improved population health outcomes, reduced inequalities and a higher quality of life for all residents. ***Bradshaw's typology of need*** Felt/expressed need – safety was a community member barrier to health in some communities across CCQ Normative – limited data available Comparative need – limited data available ***Burden (severity of issue)*** Greater neighborhood safety concerns are associated with higher negative affect and more physical symptoms. Moreover, lower perceived neighborhood safety is related to greater increases in negative affect and physical symptoms on days with no stressors. Exposure to neighborhoods perceived as unsafe is associated with poorer daily well-being and exacerbated responses to daily stressors, contributing to poorer health among people living in neighbourhoods perceived as unsafe. ***Options to address*** *Alignment with SDG* • SDG 5: Gender Equality – this goal emphasises the need to end all forms of discrimination and violence against women and girls in public and private spheres, including domestic violence and sexual violence. • SDG 3: Good Health and Wellbeing – this goal aims to ensure healthy lives and promote wellbeing for all individuals, including addressing the health impacts of domestic and sexual violence. • SDG 16: Peace, Justice and Strong Institutions – focuses on promoting peaceful and inclusive societies, ensuring access to justice for all, and building effective, accountable institutions. Addressing domestic violence and elder abuse contributes to a safer, more just society. ***CCQ role*** CCQ provides connectors between health services, community organisations, and law enforcement. They can enhance the capacity of healthcare providers to recognise and respond to signs of abuse, ensuring that victims receive timely and appropriate support. By promoting awareness and fostering collaboration among various sectors, CCQ can play a vital role in creating safer communities and improving health outcomes for vulnerable populations. ***Opportunities*** There are opportunities within CCQ and PHC functions to enhance training for healthcare providers on identifying and responding to community safety needs. By developing targeted outreach programs during critical life stages, CCQ can ensure that at-risk individuals receive timely support. Additionally, leveraging technology for secure reporting and resource access can improve communication and service delivery to key populations, fostering a more integrated approach to addressing these pressing issues. Understanding the physical spaces and social structures and other social and economic drivers of safety and effective actions, including targeted investments in community through multisectoral partnerships. This will include community-driven, place-based approaches that promote community safety by interrupting the cycle that produces unsafe communities.
	Background Dementia is a serious condition that causes a decline in brain function, impacting memory, thinking, behaviour, and daily activities. It's a growing concern, especially for older adults. It is important to note that dementia is not a normal part of aging. While there is no cure, treatments can help manage symptoms and improve quality of life for those impacted. The physical, emotional and economic impact of dementia extends to families and caregivers of the individual suffering from dementia. With an ageing and growing population, it is predicted that the number of people with dementia will more than double by 2058. ***Bradshaw's typology of need*** Felt/expressed need – was not raised by community members

Health issue	Description
Dementia/Alzheimer's	Normative – limited data available Comparative need – limited data available; prevalence data suggests similar rates to and psychogeriatric hospitalisations higher rates than state and nation ***Burden (severity of issue)*** Dementia is the second leading individual disease causing burden in Australia and overall, it ranks as the 2nd highest ranking disease (contributing 9% overall) to total burden of disease. The ranking has increased from 12th to 2nd place since 2003. Dementia is the leading cause of disease burden for females and ranked 4th for males. The CCQ region has in ageing population which is also increasing. Health administration data show psychogeriatric hospitalisations to be higher than the national average. Dementia and Alzheimer's disease are the second leading cause of death in the CCQ region, responsible for 7.2% of deaths in the 2013-2017 period. Our understanding of the prevalence of dementia in the Aboriginal and Torres Strait islander community is limited with no local level data available. ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – Dementia and Alzheimer's disease significantly impact health and quality of life. ***CCQ role*** PHNs act as a bridge between GPs, specialists, and community-based services, and can support a coordinated approach to care. ***Opportunities*** There are treatments available in the management of dementia, including pharmacological and other psychological, memory, physical activity activities. Prevention of dementia remains unclear. Modifiable lifestyle risk factors are thought to reduce risk of dementia such as those associated with heart health, physical health, and mental exercise and health. Opportunities arise in supporting community education, coordination of services, caregiver support interventions and quality improvement initiatives. There is a lack of understanding of the needs of home carers of people with dementia and how best to support them. Dementia-friendly communities is also an opportunity for investment.
Disaster resilience and readiness	***Background*** Climate change is recognised by the World Health Organization as the foremost threat to human health, with its impacts leading to traumatic injuries, communicable diseases, and mental health issues. Since 1950, Australia has experienced significant climatic changes, including increased temperatures, altered rainfall patterns, and rising sea levels. Queensland and the CCQ region, is especially vulnerable to the increasing frequency and intensity of extreme weather events, such as flooding, which pose substantial risks to public health and the healthcare system. ***Bradshaw's typology of needs*** Felt/expressed need – was not raised as an independent need by community members; however, areas of need were identified when prompted Normative –communities vulnerable to climate change have been identified across CCQ Comparative need – disaster risk is higher for many communities compared with state and nation ***Burden (severity of issue)*** The escalating severity of climate change impacts is evidenced by a rise in natural disasters, exacerbated by a population with pre-existing health issues and limited healthcare resources. Communities facing high levels of chronic disease are particularly susceptible to adverse health effects during extreme weather events. Certain groups, such as young children, the elderly, and Aboriginal and Torres Strait Islander communities, face heightened risks due to their social and geographical conditions. This confluence of factors underscores the urgent need for effective public health strategies to mitigate the health impacts of climate change. ***Options to address*** *Alignment with SDG*

Health issue	Description
	• SDG 13: Climate Action – urgent action to combat climate change and its impacts. This includes enhancing resilience and adaptive capacity to climate-related hazards and natural disasters. • SDG 11: Sustainable Cities and Communities – focuses on making cities inclusive, safe, resilient, and sustainable, emphasising the importance of disaster resilience in urban planning and community development. ***CCQ role*** CCQ plays an important role in enhancing community resilience to climate change by facilitating preparedness and response strategies. Additionally, PHNs are placed to collaborate with local government and community organisations to strengthen infrastructure and communication systems, ensuring that timely information reaches all residents during emergencies. ***Opportunities*** Addressing climate change impacts presents significant opportunities for enhancing community health resilience. By investing in disaster preparedness initiatives and improving healthcare access, PHNs can mitigate the health risks associated with extreme weather events. Engaging communities in resilience-building activities, fostering partnerships with local organisations, and leveraging technology for effective communication can further enhance the capacity of communities to respond to and recover from climate-related disasters. Additionally, prioritizing the needs of key populations in health policy can lead to more equitable and effective responses to the challenges posed by climate change.
Domestic and family violence (prevalence and access to services)	***Background*** Domestic and family violence (DFV) and sexual violence are critical issues affecting various demographic groups, with a pronounced impact on women and children, and the elderly through elder abuse. DFV encompasses a range of abusive behaviours, including physical violence, control, humiliation, and intimidation. Adolescents, young women, people with a disability, elderly people and Aboriginal and Torres Strait Islander women and girls are at heightened risk. Family, domestic and sexual violence can lead to long-lasting impacts on individuals and communities. Women and girls, particularly young, Aboriginal and Torres Strait islander women, face higher risks of violence, with rates of sexual assault notably high in adolescents. Data shows increasing rates of sexual offenses and breaches of domestic violence orders, particularly in region and rural areas. Additionally, approximately 1 in 6 Australians living in the community experiences elder abuse in the past year, with psychological abuse being the most prevalent, followed by neglect and financial abuse. The effects of violence and elder abuse permeate health, economic participation, and social wellbeing. ***Background*** Domestic and family violence (DFV) and sexual violence are critical issues affecting various demographic groups, with a pronounced impact on women and children, and the elderly through elder abuse. DFV encompasses a range of abusive behaviours, including physical violence, control, humiliation, and intimidation. Adolescents, young women, people with a disability, elderly people and Aboriginal and Torres Strait Islander women and girls are at heightened risk. ***Bradshaw's typology of needs*** Felt/expressed need – community members identified as barrier to health, stakeholders identified limited access to service for Aboriginal and Torres Strait Islander men in Woorabinda (perpetrators and victim/survivors). Normative – limited data available Comparative need – limited data available; crime data suggests some communities across CCQ with higher rates of DFV crime compared with state and nation ***Burden (severity of issue)*** Family and domestic violence is a major health and welfare issue occurring across all socioeconomic and demographic groups, but predominantly affecting women and children. The impacts of family and domestic violence can be serious and long-lasting, affecting health, wellbeing, education, relationships and housing outcomes. During the pandemic (and other crises), the risk of family and domestic violence is known to increase. Child abuse and neglect is the 10th leading risk factor contributing to disease burden, ranking has remained the same since 2003. Partner violence is linked with increased: depressive disorders; anxiety disorders; alcohol use disorders;

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	early pregnancy loss; homicide and violence (injuries due to violence); and suicide and self-inflicted injuries. It contributes to 1.6% of the burden of disease and injury and was ranked as the third leading risk factor contributing to total disease burden for women aged 25–44. Between 2-14% of older people are thought to experience elder abuse with any given year. ***Options to address*** *Alignment with SDGs* • SDG 5: Gender Equality – specifically, it addresses the target to "eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation". ***CCQ role*** Supporting people experiencing DFV and sexual violence is a crucial role that CCQ can contribute to and support. Additionally, CCQ can advocate for and contribute to community awareness and prevention initiatives to address and reduce DFV and sexual violence. ***Opportunities*** Action to address domestic and family violence require a whole of community approach which PHC can partner and support. PHC can play a role in identifying and providing support for those impacted through person-centred care. PHC can also promote partnering with local DFV groups to upskill PHC providers on relevant referral pathways and promoting DFV counselling and psychological therapies available within the community to build confidence among providers. Understanding the physical spaces and social structures and other social and economic drivers of safety and effective actions, including targeted investments in community through multisectoral partnerships. This will include community-driven, place-based approaches that promote community safety by interrupting the cycle that produces unsafe communities.
Injury and poisoning	**Background** Injuries and poisoning were identified as a need theme due to their prominence in secondary data when comparing indicators with state/national averages. Rates were particularly dominant in more rural areas. Injuries and poisoning include road transport accidents, accidental poisoning, falls, (and will often include self-inflicted injuries; however, self-inflicted injuries has been included in mental health). **Bradshaw's typology of need** Felt/expressed need – not raised by community members Normative – high preventable hospitalisation rates and deaths Comparative need – many communities across CCQ with higher preventable hospitalisation rates and deaths compared with state and nation **Burden (severity of issue)** Injuries is the 5th leading cause of disease burden (9%) and 7% of the long-term health conditions. It is the greatest cause of death between the ages of 1 and 44 years and leaves many with serious disabilities or long-term conditions. The leading causes of injury and injury deaths in Australia include unintentional falls, transport crashes and intentional self-harm and suicide. Other causes of injury and injury deaths include exposure to animate and inanimate mechanical forces, assault, poisoning, thermal causes, and drownings and submersions. Falls are common among people 65+ years, with around 30% of adults over 65 experiencing at least one fall per year. Injuries resulting from falls are the major cause of death, hospitalisation and emergency department presentations among the elderly population. Rates of falls are significantly higher in Caloundra, Central Capricorn, Cooloola-Gympie, Gladstone and Noosa Indigenous Areas for Aboriginal and Torres Strait Islander people compared with national rates. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – Injuries can lead to long-term disabilities or conditions, or death. Indicator 3.6 specifically notes a reduction in injuries from road traffic accidents.

Health issue	Description
	• SDG 10: Reduced inequalities ***CCQ role*** PHNs play a vital role in reducing injuries and poisoning by educating communities, supporting healthcare providers, advocating for appropriate policies, and coordinating services. ***Opportunities*** Most injuries, whether unintentional or intentional, are preventable and there are effective interventions available such as Kidsafe, education, environmental modification, road safety, falls prevention, sports injury. It is a community wide responsibility. PHC providers have been shown to have a prevention role.
Health literacy	***Background*** Health literacy was consistently identified as a need by community and stakeholders. It is also reported in AIHW and in PHN's Performance Quality Framework as an outcome indicator that PHNs are assessed against. Health literacy relates to how people access, understand and use health information in ways that benefit their health. There are 2 main components to health literacy: • Individual health literacy - these are individual skills, such as the ability to find, understand and use health information, e.g., complete health care forms, understand and use the health care system. • Health literacy environment - these are the health system-based elements, such as policies, processes, and materials, which affect the way the individual engages with the health system ***Bradshaw's typology of needs*** Felt/expressed need – community members identified as barrier to health Normative – low health literacy levels in communities Comparative need – limited data available ***Burden (severity of issue)*** In Australia, about 40% of adults lack sufficient health literacy, which is linked to higher rates of hospitalisation, lower preventative care uptake, and increased strain on health resources. People with low health literacy are at higher risk of worse health outcomes and poorer health behaviours, such as: lower engagement with health services, including preventive services, higher hospital re-admission rates, poorer understanding of medication instructions, and lower ability to self-manage care. Low health literacy is a major source of economic inefficiency in healthcare systems. US studies have shown that by moving people from the lowest levels of health illiteracy could save the health sector conservatively $106 billion per year. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – health literacy directly impacts individual's ability to make informed health decisions and access appropriate care, contributing to better health outcomes and overall wellbeing. • SDG 4: Quality Education – enhancing health literacy requires educational efforts, which aligns with the goal of ensuring inclusive and equitable quality education and promoting lifelong learning opportunities for all. • SDG 10: Reduced Inequalities – improving health literacy can help address health disparities and reduce inequalities by empowering individuals in marginalised communities to better navigate health systems and access necessary services. ***CCQ role***

Health issue	Description
	PHNs have been named as having a key role within the health system to improve health literacy levels in designing and implementing locally appropriate health literacy interventions. ***Opportunities*** CCQ could develop locally appropriate health literacy action that both develop community capacity and organisational practice by developing information resources designed for a particular target audience (plain language consumer information), systems and resources to drive and support change, health literacy champions (GP's), CCQ staff, including health literacy KPI within contracts, patient information portals (my health record, health pathways, service navigation tools) GP educational events on "increasing health literacy with patients".
Housing/ homelessness/ community displacement	***Background*** Housing has remained a prominent theme in community and stakeholder consultation since the previous HNA was conducted and continues to gain greater focus since the pandemic (with rising house prices, lack of property availability and people being displaced from their homes). Anecdotally, homelessness and displacement are being seen further north and inland with housing insecurity spreading beyond major urban centres. Areas that were once considered more affordable are now facing increased demand, driving up prices and reducing availability. As a result, smaller regional towns and communities are reporting higher rates of homelessness, with limited resources to support those affected. The ongoing displacement is also exacerbating social and health inequalities, placing additional strain on local services, which are already struggling to meet the needs of the growing population. ***Bradshaw's typology of need*** Felt/expressed need – community members identified as barrier to health Normative – inappropriate housing across CCQ region Comparative need – limited current data available; appears there are communities across CCQ with higher homelessness rates than state and nation ***Burden (severity of issue)*** The role of housing as a social determinant of health is well-established. Access to appropriate, affordable and secure housing can limit the physical and mental health risks presented by factors such as homelessness and overcrowding. Evidence also supports a direct association between poor-quality housing and poor physical and mental health. Housing service provision, tenants' experience of property quality and aspects of neighbourhood are all demonstrated to be significantly correlated with measures of health and wellbeing. For low-income, vulnerable households there are particular challenges in creating a sense of home in a new tenancy which may have substantial effects on health and wellbeing. Being homeless increases an individual's risk of many health problems and is known to reduce life expectancy by 30 years. ***Options to address*** Alignment with SDGs • SDG 11: Sustainable Cities and Communities – specifically the target to ensure access to adequate, safe and affordable housing for all by 2030. SDG 11 focuses on making cities and human settlements inclusive, safe, resilient, and sustainable, and housing stability and homelessness are central issues addressed within this goal. • SDG 3: Good health and well-being - Access to appropriate, affordable and secure housing can limit the physical and mental health risks presented by factors such as homelessness and overcrowding. • SDG 10: Reducing inequalities ***CCQ role*** Stable housing is a critical social determinant of health, directly impacting individuals' physical and mental wellbeing. By addressing housing instability, PHNs can reduce health inequalities, prevent chronic conditions, and improve access to healthcare for priority populations.

Health issue	Description
	Opportunities CCQ has an opportunity to address homelessness through their role in care coordination, linking vulnerable individuals to health, housing, and social services. CCQ can also support integrated care models, partnering with housing providers, mental health, and social services to ensure holistic support for people experiencing homelessness. Additionally, CCQ can use their population health planning and data analysis functions to identify priority populations, advocate for policy changes, and target interventions where they are most needed. PHC may also be also to support those impacted by homelessness or housing crises by specifically reaching out to those affected and/or providing psychosocial support/referral to clients. There are also roles in supporting service navigation education to local services and local community groups/stakeholder groups etc. to ensure those asking for help are supported correctly.
Vaccine preventable conditions - Immunisation	***Background*** Vaccines are important for preventing infectious diseases. Vaccine-preventable diseases are illnesses that can be prevented or mitigated through immunisation. While vaccines have been highly successful, vaccine hesitancy remains a challenge. Australia aims for high vaccination rates, and the Queensland government has set specific targets for children and adolescents. The National Immunisation Program offers free vaccines, and catch-up programs are available. Childhood immunisation at 5 years is an outcome indicator in the Quality Performance Framework on which PHNs are assessed against. ***Bradshaw's typology of need*** Felt/expressed need – not raised by community members Normative – low herd immunity rates across CCQ Comparative need – low immunisation rates compared with state and nation; however, immunisation preventable hospitalisation rates are lower ***Burden (severity of issue)*** The rate of burden of vaccine preventable diseases has decreased by nearly a third in the last decade. Whilst the CCQ region reports a lower rate of public hospital admissions due to vaccine-preventable conditions, the proportion of children fully immunised at 1, 2 and 5 years of age has decreased over the last two years and sits below the national target of 95%. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing. Indicator 3.3 specifically relates to ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. ***CCQ role*** PHNs play a vital role in improving vaccination rates by educating communities, tracking vaccination data, supporting healthcare providers, advocating for vaccination policies, and coordinating services. ***Opportunities*** Health literacy is one area of intervention for addressing immunisation. Other actions have also been shown to be effective. Policy interventions by governments have been effective in increasing vaccination rates. Opportunities exist in partnering with community organisations to build trust and reach underserved populations. Assisting with the procurement of vaccinations and supplies efficiently also ensures availability and affordability. Combined efforts can improve vaccination rates and address health disparities.
	Background Access to jobs and money and cost of living generally were prominent themes across all sources of data. A person's socioeconomic status (SES) encompasses not just income but also educational attainment, financial security, and subjective perceptions of social status and social class. The rising cost of living in Australia is significantly impacting people's health and wellbeing, particularly among low- to middle-income households. As housing, utilities, food, and healthcare costs continue to soar, many Australians are facing increased financial stress and uncertainty. This economic pressure often forces individuals to make difficult choices, such as sacrificing nutritious

Health issue	Description
Income/education/ employment	food, delaying medical care, or foregoing essential services to meet basic living needs. Mental health is also affected, with growing rates of anxiety, depression, and stress-related illnesses linked to financial hardship. For vulnerable populations, including older adults, single-parent families, and those with pre-existing health conditions, the cost of living crisis further exacerbates health inequalities, creating barriers to accessing care and maintaining a healthy lifestyle. ***Burden (severity of issue)*** SES impacts quality of life attributes as well as the opportunities and privileges afforded to people within society. Low SES is characterised by multiple physical and psychosocial stressors and is a consistent and reliable predictor of a vast array of outcomes across the life span, including physical and psychological health. The overall disease burden rate for people in the lowest socioeconomic areas was 1.5 times as high as the rate for people in the highest socioeconomic areas, with the prevalence of chronic conditions such as diabetes and cardiovascular disease being markedly higher in disadvantaged communities, reflecting the severe impacts of socio-economic inequality on overall health outcomes. ***Bradshaw's typology of need*** Felt/expressed need – community members identified as barrier to health Normative – costs of living measures are high Comparative need – lower SES rates compared with state and nation ***Options to address*** Alignment with SDGs • SDG 1: No Poverty – rising living costs exacerbate financial hardship and health disparities, making it crucial to address economic inequalities and ensure equitable access to healthcare and essential services to promote overall wellbeing. • SDG 8: Decent Work and Economic Growth – promoting sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all. • SDG 3: Good health and well-being – Recognising the impact of socio-economic inequality on health outcomes • SDG 10: Reduced inequalities ***CCQ role*** CCQ is well-positioned to integrate and coordinate healthcare services, identify community needs, and advocate for resources. Our involvement can lead to more comprehensive and effective strategies for mitigating the impact of economic pressures on priority populations. ***Opportunities*** CCQ can leverage their role in service planning and coordination to integrate social support services with healthcare, ensuring that financial assistance, housing support, and health services are more accessible to those in need. Additionally, CCQ can use their data and community insights to advocate for policy changes and funding that address the root causes of financial strait and its impact on health, ultimately driving more holistic and effective solutions. Actions to address access to jobs and money require upstream approaches which PHC can partner and support. PHC may also be also to support those impacted through ensuring services are accessible and affordable, and providing person-centred approaches to health including psychosocial support and referral processes, for instance, to alleviate stresses.
	Background The perinatal period covers from conception to end of the first postnatal year, but in some settings can cover up to 2-3 years postpartum. Perinatal health covers both the mother and child and indicators, include receiving appropriate and timely antenatal care, birthweight, infant mortality rates, and the mother's mental health. Antenatal care is associated with positive maternal and child health outcomes.

Health issue	Description
Perinatal health, including antenatal care, low birthweight babies, infant mortality, perinatal mental illness	***Burden (severity of issue)*** In some SA3s, women are not accessing antenatal care in the first trimester for both non-Indigenous and Aboriginal and Torres Strait Islander mothers. Low birthweight and infant mortality rates are also higher in some areas compared with state and national rates. Rates of perinatal mental illness are also unknown at a local level; however, national data suggests 1 in 5 women experience perinatal anxiety, and around 15-22% of women experience depression during pregnancy and/or following the birth of their baby. ***Bradshaw's typology of need*** Felt/expressed need – community members identified support for families as barrier to health Normative – limited data Comparative need – some communities in CCQ have higher rates of indicators than state and nation ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – supporting mothers during and after pregnancy is vital for both the health and wellbeing of the mother and child. • SDG 10: Reduce inequalities ***CCQ role*** CCQ can work with healthcare providers to ensure women receive integrated, and timely access to antenatal care. This may also include addressing gaps in care for priority populations, such as Aboriginal and Torres Strait Islander people and young mothers. ***Opportunities*** To appropriately address lower rates of antenatal care access, we first need to understand why women are not accessing care within the first trimester but go onto have the five recommended visits. Antenatal care within the first trimester is vital for preventative health interventions, including screening for mental illness, smoking and alcohol consumption during pregnancy, and identifying whether the mother may require additional support during her pregnancy.
Mental health morbidity/ mortality, including suicide and self-harm	***Background*** Mental health is a key priority of the Department for PHNs and has a high prevalence in the region according to secondary health data. The pandemic crisis and other natural disasters have further intensified the spotlight on mental health challenges, underscoring the pressing need for comprehensive and coordinated interventions. Long before the COVID-19 pandemic, substantial evidence indicated that young people were facing rising rates of mental ill health, including anxiety, depressive symptoms, psychological distress, self-harm, and suicide. The increasing demand for mental health services by all age-groups, coupled with the complex interplay of socio-economic factors, necessitates a multifaceted approach to address both immediate and long-term needs effectively. ***Bradshaw's typology of need*** Felt/expressed need – community members identified mental wellbeing as barrier to health Normative – rising prevalence of mental ill health Comparative need – prevalence of mental health conditions are higher than state and nation ***Burden (severity of issue)*** Mental and substance use disorders are overall the 2nd leading disease group causing burden of disease, responsible for 15% the total burden. In terms of ranking against other diseases, dementia (highest ranking mental disorder) and anxiety disorders (the second) have increased since 2003, as have suicide and self-inflicted injuries and depressive disorders. Across the board, people in the CCQ region experience greater prevalence of all mental health and substance-use disorders across

Health issue	Description
	most age groups compared with Queensland averages. This was also the case for people with comorbidity of any 12-month mental disorder and a physical condition. Mental health status has a social gradient, with higher rates of mental illnesses among the most socio-economically disadvantaged populations. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – addressing mental health challenges is crucial for achieving overall health and wellbeing and is a key component in building resilient communities. • SDG 10: Reduced inequalities ***CCQ role*** CCQ is vital in addressing mental health conditions as they serve as a bridge between the community and the health system, facilitating tailored, local responses to mental health needs. By coordinating services, integrating care, and addressing gaps in service delivery, PHNs ensure that mental health support is accessible, effective and aligned with the specific needs of the population. There is a need for a more health promotion and prevention focus on mental health and support in settings outside traditional health services. ***Opportunities*** In sustainably addressing mental health, attention is needed to the underlying determinants of mental health as well as focusing on populations that are more at risk such as homelessness, social isolation, family background, disability and socioeconomic. Many mental illnesses are preventable and can be reduced through prevention strategies implemented with at-risk populations. Programs across the continuum of care are required, as well as improving/ having access to needed mental health resources like therapy, peer services, supported education, case management, integrated school, and community care and/ or medication, is crucial in preventing mental illness from progressing/ getting worse; addressing the determinants of good mental health more holistically (access to green space, housing, education, social and physical health, access to fresh food and water) sense of belonging); early childhood interventions (e.g., home visits for pregnant women, pre-school psychosocial activities); -providing support for children (e.g., skills-building programs, child and youth development programs); -programs targeted at vulnerable groups, including minorities, indigenous people, migrants, and people affected by conflicts and disasters (e.g., psychosocial interventions after disasters); incorporating mental health promotional activities in schools (e.g., programs supporting ecological changes in schools and child-friendly schools); violence prevention programs, and community development programs. Suicide prevention strategies could include: identifying and making use of data sources such as social media, using data science tools, methods and techniques to track trends, to better commission areas/ services in need; partnering with local and state groups/networks/services to better track and monitor suicide-related outcomes to inform prevention methods; upskilling the current MHAOD workforce; services providing suicide prevention/ first aid within communities.
Sexual health	***Background*** Sexual health is vital for overall wellbeing at every life stage. It encompasses physical, mental, and emotional aspects. Good sexual health includes respecting rights, expressing identity safely, and being free from coercion, discrimination, violence, and stigma. It also involves access to information, healthcare, and STI prevention and treatment. Maintaining good sexual health requires accurate information, understanding risks, practicing safe sex, and accessing inclusive sexual healthcare. ***Bradshaw's typology of need*** Felt/expressed need – not raised by community members Normative – limited data Comparative need – some communities across CCQ with higher rates of some indicators compared with state and nation ***Burden (severity of issue)*** STIs continue to be the most frequently reported condition to the Australian National Notifiable Diseases Surveillance System. About 16% of Australians will have an STI in their lifetime. There has been an ongoing rise of chlamydia, gonorrhoea, and syphilis over the last five years, which has a disproportionate burden of disease in the

Health issue	Description
	young and minority populations. Untreated STI can cause major health problems, like infertility, ectopic pregnancy, preterm birth, neonatal death, and pelvic inflammatory disease. The most common STI in CCQ is chlamydia. ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – sexual health is important for overall health, encompassing physical, mental, and emotional wellbeing. • SDG 10: Reduced inequalities ***CCQ role*** PHNs can help to advocate for sexual health through the coordination of services, advocating for policies, education and building partnerships. CCQ can work with healthcare providers to ensure the community receives integrated, culturally appropriate services, while also addressing gaps in care for priority populations such as youth, Aboriginal and Torres Strait Islander people, and LGBTQIA+ individuals. ***Opportunities*** Management varies across STI, but most STIs are treatable. Early detection and treatment is important in the management of all STI. There are a broad range of effective preventative strategies for STI. These include sexual health education, including peer education; condoms, water-based lubricants, and other barrier methods; and early detection and treatment, including as part of antenatal care. It also involves having access to accurate and comprehensive information, knowledge about risks and consequences of unprotected sexual activity, such as STI and unwanted pregnancies, practicing safe sex to avoid STI or unwanted pregnancies, including by wearing a condom, and access to inclusive and safe sexual health care.
Individual social and emotional wellbeing, support and resilience	***Background*** Social and emotional wellbeing is recognised in the Performance Quality Framework on which PHNs are assessed. It also emerged as a specific health issue in community and stakeholder consultations and is continuing to be a building issue since the pandemic. Social wellbeing is a sense of belonging to a community, making a contribution to society and feeling like you have access to support in times of need. Emotional wellbeing is about feeling good, being happy, experiencing positive emotions like love, joy or compassion, and feeling generally satisfied with life. ***Bradshaw's typology of need*** Felt/expressed need – community members raised as enabler and barrier of health; stakeholders and CCQ staff identified issue within older populations Normative – limited data Comparative need – limited data ***Burden (severity of issue)*** Social connection and emotional support are associated with cardiovascular, autoimmune, neurocognitive and mental health problems. In turn, depression and anxiety has also been shown to increase social disconnectedness heightening the issue. Social connectedness is known to be one of the strongest predictors of mortality, mental and physical health, and access to health services. It can be assumed that burden of disease for social and emotional wellbeing may be similar to that of mental health, as a major risk factor, overall the 4th leading disease group, responsible for 12% the total burden. ***Options to address*** *Alignment with SDGs* • SDG 3: Good Health and Wellbeing – social and emotional wellbeing is a critical aspect of overall health and quality of life, making it integral to achieving this SDG. • SDG 10: Reduced inequalities

Health issue	Description
	CCQ role By coordinating care and integrating services across various sectors, PHNs can ensure a holistic approach to health that supports both social and emotional wellbeing. ***Opportunities*** Preventive interventions in clinical contexts, welfare and social spaces have been shown to improve meaningful connections with others. Behavioural cognitive skills to enable people to assess their social support networks and how they fulfill the need for friendships and a sense of belonging delivered online or in-person, have been shown to alleviate depression and anxiety symptoms while simultaneously decreasing loneliness. Action-based strategies, such as establishing more frequent social contact with significant others or repairing strained relationships, community volunteer outreach for adults who are less mobile or more secluded and raising awareness of PHC providers of the potentially scarring effects of untreated depressive and anxiety disorders particularly in middle and late adulthood have also been found to be effective. Access to ageing or retirement communities that provide a sense of belonging and security is also important for the mental health care to older adults.
Community social cohesion, inclusivity and capital	***Background*** Social cohesion refers to the social bonds that foster positive relationships within a society, promote wellbeing, trust, and inclusion. A cohesive society is also one that is richly endowed with stocks of social capital, that is, social structure features including interpersonal trust and norms of reciprocity and mutual aid, which act as resources for individuals and facilitate collective action. People living in areas characterised by high levels of social capital are more likely to trust fellow citizens and to value solidarity and equality. Social capital has been linked with norms and attitudes that influence health behaviours, psychosocial networks that increase access to health care and self-esteem. Since 2019, Australia has faced multiple crises, including bushfires, the COVID-19 pandemic, and rising inequality, leading to a decline in national social cohesion. ***Bradshaw's typology of need*** Felt/expressed need – community members raised as enabler and barrier of health Normative – limited data; national decline in social cohesion Comparative need – limited data; some communities across CCQ with lower rates of some indicators compared with state and nation ***Burden (severity of issue)*** The 2023 Mapping Social Cohesion report shows the lowest score since 2007, with concerns over economic inequality, diminished national pride, and decreased trust in others. While local communities have remained resilient, the lack of localised data on social cohesion hinders a deeper understanding of how different communities navigate these challenges. ***Options to address*** *Alignment with SDGs* • SDG 10: Reduced Inequality – focuses on reducing inequality within and among countries, addressing social, economic, and political disparities, and promoting inclusion and fairness for all. • SDG 3: Good health and well-being • SDG 11: Sustainable cities and communities ***CCQ role*** CCQ can undertake activities aimed to support and enhance social cohesion, particularly for key populations and communities. PHNs work to reduce health inequalities by supporting integrated care, promoting mental health and fostering community engagement.

Health issue	Description
	Opportunities PHNs can enhance social cohesion through their core functions of procure, provide, and partner. By commissioning health services that target underserved populations and address social determinants of health, they reduce inequalities and promote inclusion. Delivering community health programs focused on mental health and wellbeing can strengthen social bonds and mitigate exclusion. Additionally, partnering with local governments and community organisations fosters trust, improves access to care, and supports diverse and multicultural communities, contributing to greater social cohesion. Social infrastructure, programs and community development, addressing social supports across the lifespan provides essential societal resources that support wellbeing. Social infrastructure includes community and individual support services and resources such as health, education, early childhood, community support, community development, culture, sport and recreation, parks and emergency services. The provision of well-planned social infrastructure supports the liveability of communities by promoting community social interaction. Similarly, it is associated with people's improved physical and mental health and their increased satisfaction with the area in which they live.
Supporting healthy ageing	***Background*** Healthy aging aims to ensure that everyone, regardless of where they live, has the chance to enjoy a long and healthy life. If focuses on creating environments that promote wellbeing, allowing people to engage in valued activities throughout their lives. While being free from disease is not a prerequisite for healthy aging, managing health conditions effectively is important for maintaining quality of life. Older adults have expressed a need for affordable and quality health care, as highlighted in the *My Healthy Community* survey. This demographic, particularly those aged 65 and over, and over 50 in the Aboriginal and Torres Strait Islander community, is increasingly important in Australia, with their numbers projected to continue increasing. Addressing the specific health needs and functional abilities of older Australians is crucial for promoting their overall wellbeing and healthy ageing. There is a need to support people with frailty, those experiencing social isolation and loneliness, and to better understand the needs of carers. ***Bradshaw's typology of need*** Felt/expressed need – community members important aspects of healthy independent ageing Normative – ageing population Comparative need –communities across CCQ with higher rates of some indicators compared with state and nation ***Burden (severity of issue)*** The challenges faced by older adults are compounded by a growing financial burden associated with maintaining stable living environments. Many desire to lead independent lives, yet the survey results indicate that without adequate preventative health and support measures, the risk increased reliance on health care systems. Additionally, regions across CCQ show higher proportions of older adults with multiple vulnerabilities, such as living alone, having disabilities, and low income, highlighting the severity of the issue across various LGAs. Data also shows higher risk of suicide amongst elderly people accessing home care services and higher rates of mental illness in those entering RACH. ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – focuses on ensuring healthy lives and promoting wellbeing for all at all ages, which directly correlates with the needs expressed by older adults for affordable and quality health care, preventative measures and health ageing. • SDG 10: Reduce Inequality – addresses the vulnerabilities faced by older adults, particularly those in lower-income situations or with disabilities. • SDG 11: Sustainable Cities and Communities – emphasising the importance of creating environments that support the wellbeing and independence of older adults.

Health issue	Description
	CCQ role CCQ can lead initiatives focused on preventative health strategies, promote healthy lifestyle choices, and enhance support systems that encourage independence among older adults. By working with local communities, CCQ can identify and prioritise the unique needs of older populations, particularly in areas with higher rates of vulnerability. ***Opportunities*** There are opportunities for improving the health and quality of life for older adults through targeted actions. By prioritising preventative health measures and creating supportive environments that enhance functional ability, PHNs can help older adults maintain their independence for longer. Collaborative efforts with community organisations and stakeholders can also foster healthy ageing and address the inequities faced by older populations, ensuring that all individuals can contribute meaningfully to society as they age. Ensuring age-friendly communities and environments are highly influential on healthy ageing, exposure to health risks (for example, air pollution or violence), our access to quality health and social care and the opportunities that ageing brings. Better understanding the home carer roles in healthy ageing will also be important.
Women's health	***Background*** Traditionally, women's health has focused solely on sexual and reproductive health, however this paints an incomplete picture of women's health needs. Women experience a wider range of health issues, with over half impacting them during their prime working years. These conditions can be specific to women, such as endometriosis and menopause. Women's health has been separated from sexual and reproductive health and maternal and postnatal health as the determinants are often different. ***Bradshaw's typology of need*** Felt/expressed need – not raised by community members Normative – women's health issues are being more fully recognised Comparative need – limited data available ***Burden (severity of issue)*** Endometriosis, a condition causing pelvic pain and impacting fertility, affects 1 in 9 Australian women by age 44. However, diagnosis often takes a staggering 7 years. A higher proportion of Queensland women (17%) specifically are reported as having endometriosis compared to the national average (11%) by their early 40s. Menopause typically occurs around 50-51 years of age for women in Queensland, with nearly half of women aged 43-48 experiencing hot flashes and night sweats. Despite this, only a quarter of these women report seeking help. ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – access to appropriate and timely healthcare • SDG 5: Gender equality – recognising the health burden of sex-specific conditions often affects women in their working years, impacting their ability to earn money. ***CCQ role*** CCQ can help to coordinate PHC services, including those related to women's health, and advocate for greater investment in service provision and research. ***Opportunities*** Addressing women's health requires a comprehensive approach that includes raising awareness, improving access to care, investing in research, advocating for supportive policies, and providing community-based support. A multifaceted approach can improve women's health outcomes and quality of life.

Health issue	Description
Palliative and end of life care	***Background*** Palliative care is an approach to treatment that improves the quality of life of patients and their families who are facing the problems associated with life-limiting illness. In Australia, there is an increasing demand for palliative care services as a result of an ageing population and an increase in the prevalence of cancer and chronic disease. Palliative care is not limited to older populations and is for everyone across the life-course. ***Bradshaw's typology of need*** Felt/expressed need – not raised by community members Normative – expectation of appropriate care at end of life Comparative need – limited data ***Burden (severity of issue)*** In Australia, palliative care is being provided in almost all health care settings within the health care system, including hospital intensive care units, inpatient services, outpatient services, general practices, ambulatory services, pharmacies, and residential aged care homes. As a result, palliative care has become highly institutionalised. A range of data gaps has also been identified at a national level, including patient experiences of care, who is providing care and their health needs, workforce capacity, and levels of awareness and understanding of palliative care in the community. ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – people have the right to experience good quality of life at end-of-life. ***CCQ role*** Support our understanding of demand and capacity to deliver appropriate and quality palliative care services across the region, as well as the extent to which Aboriginal and Torres Strait Islander people are receiving culturally safe care. ***Opportunities*** There are opportunities to identify patient pathways through the system in the CCQ region and support integrated care for those at end-of-life. Building community capacity to support people approaching the end of life, their families, and informal carers adds an important dimension to the support that can be provided by health services.

Priority health service issue summaries

Health service issue	Description
Access to primary healthcare, including affordable, quality, timely and during the after hours	***Background*** Access to healthcare was an issue identified across all data sources in the HNA. This included timely access to ACAT for older people (extensive wait times for assessment), access to affordable PHC (high out-of-pocket costs for GPs in low socio-economic areas), access to specialists and allied health professionals close to home (current need to travel to Brisbane or Sunshine Coast), access to after-hours services, and continuity of care (only having access to locum GPs). ***Bradshaw's typology of need*** Felt/expressed need – community members identified gaps in health services Normative – service gaps Comparative need – service rates lower for some communities across CCQ compared with state and nation ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – people have access to universal, comprehensive primary health care ***Opportunities*** The National PHC Plan recognises that an increasing population means there will be a higher need for services across the life-course. The need for bulk billing services to overcome cost barriers in low SES areas is also highlighted. There is a focus on after hours PHC services to ensure access to appropriate care and reduce demand on public hospital emergency departments, with commitment to extend programs, and focus on care pathways and joint and collaborative planning across health sectors. For aged care, there is a focus on helping slow the decline of older Australians into frailty, and the need for home care supports and residential care, and to reduce unnecessary emergency department attendances and hospital admissions by providing more effective PHC in the community.
Appropriate and safe primary healthcare for priority populations, including persons identifying as CALD, with a disability, LGBTIQ+, Aboriginal and Torres Strait Islander, experiencing homelessness	***Background*** Cultural safety requires practitioners to be aware of their own cultural values, beliefs, attitudes and outlooks that consciously or unconsciously affect their behaviours. Certain behaviours can intentionally or unintentionally cause clients to feel accepted and safe, or rejected and unsafe. Additionally cultural safety is a systemic outcome that requires organisations to review and reflect on their own policies, procedures, and practices in order to remove barriers to appropriate care. In Australia, there has been increasing recognition that improving cultural safety for Aboriginal and Torres Strait Islander health care users can improve access to, and the quality of health care. This means a health system where Indigenous cultural values, strengths and differences are respected; and racism and inequity are addressed. ***Bradshaw's typology of need*** Felt/expressed need – community members identified aspects of service quality as areas for improvement Normative – expectation to receive quality and safe service provision Comparative need – limited data available ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – people have access to culturally safe and quality primary health care ***Opportunities***

	The National PHC Plan focuses on all priority populations in achieving equitable access to healthcare. It has a focus on access to quality person-centred, integrated and culturally appropriate care. Funding arrangements, incorporating digital health, working in partnership with communities, multidisciplinary team-based care, strengthening community-controlled sector, community-led commissioning, and access to PHC, navigation between health and other social systems, telehealth, digital health and data sharing, workforce. It also specifically highlights the need for PHNs to engage with priority populations in joint planning and collaborative commissioning and empowering people to stay healthy and manage their own health care.
Health promotion/ prevention services	***Background*** Health promotion and prevention are essential part of an effective PHC system and are required if sustainable and effective/efficient health care systems are to be realised. Health promotion is described as the process of enabling people to increase control over, and to improve, their health. It has a focus more toward social and environmental interventions that impact populations rather than individuals, such as creating healthy environments to make the healthy choice the easy choice, health literacy, health in non-traditional health setting. Prevention is about keeping healthy and well, for example eating well, getting vaccinated, avoiding risky behaviours. It can also have a broader lens beyond focusing on changing individual behaviours. ***Bradshaw's typology of need*** Felt/expressed need – community members identified prevention as a barrier to health Normative – expectation to provide health promotion and prevention in health systems Comparative need – limited data available ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – people have access to universal, comprehensive primary health care ranging from prevention through to treatment/rehab. ***Opportunities*** The National PHC Plan recognises the role of health promotion in the continuum of PHC and as part of the shift in PHC focus, refers to wellbeing (rather than illness) and health promotion and prevention (rather than treatment and care).
Workforce shortages, maldistribution and models of care	***Background*** Workforce is a priority area for PHNs and an outcome indicator in the Quality Performance Framework that PHNs are assessed against. It also features strongly in the National PHC Plan where a highly skilled workforce reported as being needed to deliver high-value PHC services. There is also a focus on access to rural health care, person-centred PHC in such areas, workforce shortages, quality issues and maldistribution, an emphasis on community-led approaches, telehealth, financial incentives, training and professional development. Our data frequently reports deficiencies in healthcare in rural areas and in workforce across the range of PHC provider types. CCQ has large proportions of the population living in rural and remote areas. People living in rural and remote areas have inequities of access to health services and poorer health outcomes. Challenges such as lack of stable workforce, limited access to specialist services and other allied health care are issues, as are people seeking treatment late and showing advanced disease due to the delays in diagnosis. Subsequently, there are higher avoidable mortality due to chronic conditions. People from rural/ remote areas also have higher undiagnosed risk factors. Workforce shortages were identified across multiple data sources. In particular, shortages of mental health workers in the Wide Bay and Central Queensland regions, access to ACAT, turn-over of staff within RACHs, AHP in RACHs, and limited is any access to specific specialists and AHPs in Wide Bay and Central Queensland. Issues with existing models of care were also reported, including issues with locums being able to provide continuity of care, GP attraction and retention, and access to and awareness of telehealth, where appropriate. ***Bradshaw's typology of need*** Comparative need – comparatively higher than state and national averages

	Expressed need Felt/expressed need – community members identified workforce shortages and gaps in rural services Normative – workforce shortages and rural service gaps national priority Comparative need – communities across CCQ with lower rates of workforce compared with state and nation–Stakeholders identified this as a need during consultation ***Options to address*** *Alignment with SDG* • SDG 3: Good Health and Wellbeing – support recruitment, development, training and retention of the health workforce ***Opportunities*** There are opportunities to research and pilot new models of care for delivering health services and programs, particularly in more rural and remote areas, and investigating programs to support workforce retention in rural and remote areas.

APPENDIX A: HNA METHODOLOGY

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Appendix A: HNA Methodology

HNA framework

A HNA project team was established in early 2024 consisting of the Director Commissioning, Senior Manager Service Planning, and Analyst Service Planning. A governance structure (Figure 43), Project Plan and Stakeholder Engagement Plan were developed and approved in March 2024.The Plans outlined the overall scope of the HNA project, including budget, timelines and deliverables. Key inputs and project stages are outlined in Figure 44. Governance group membership is detailed in Figure 45.

Figure 43: HNA Governance structure

Figure 44: HNA framework

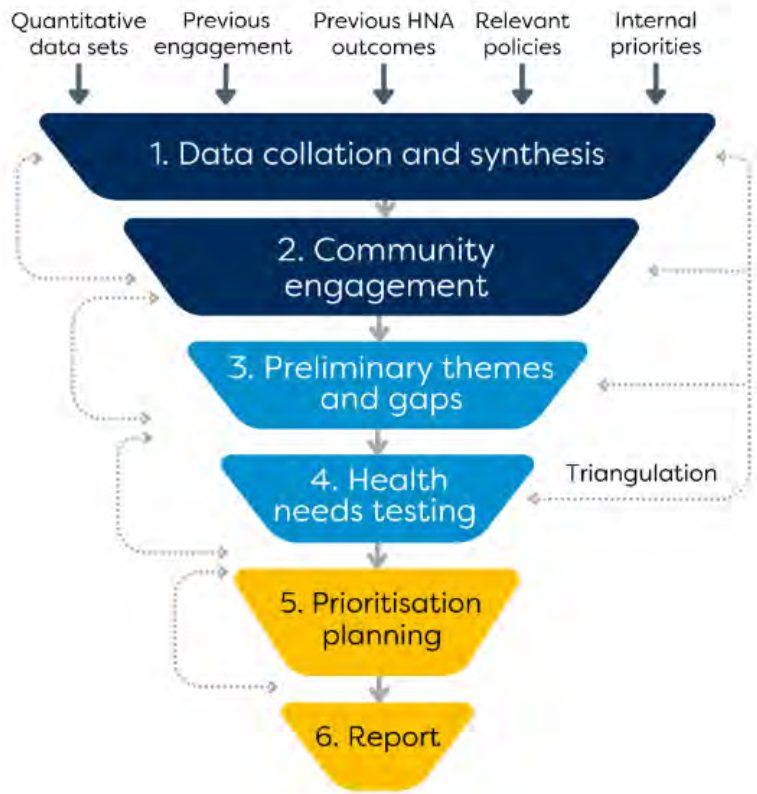
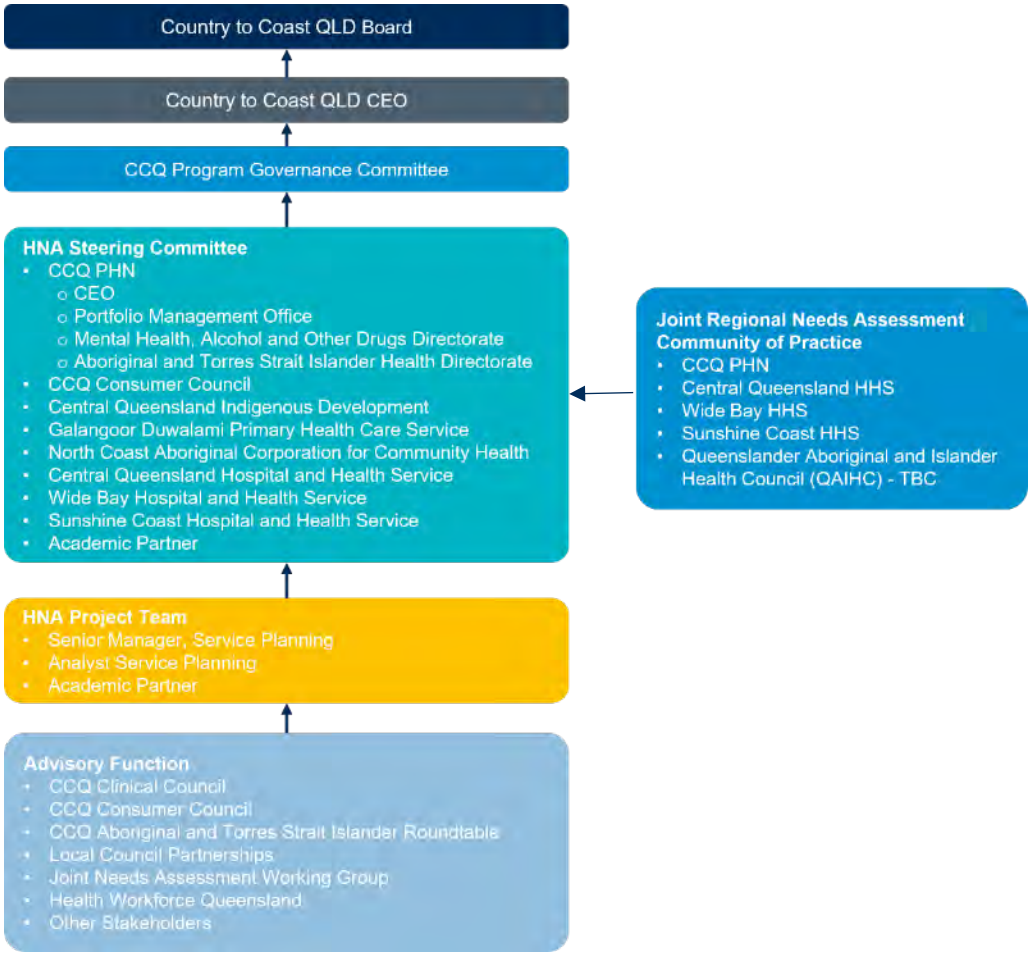


Figure 45: Governance membership



Project stages

Stage 1: Data collation and synthesis

A comprehensive health and wellbeing indicator framework based on holistic and ecological views was developed, which provided a framework for data collection and assessment for the HNA.

Key secondary data sources included:

- Australian Bureau of Statistics (ABS)
- Australian Early Development Census (AEDC)
- Australian Immunisation Register (AIR)
- Australian Institute of Health and Welfare (AIHW)
- National Aboriginal and Torres Strait Islander Health Survey
- National Disability Insurance Scheme (NDIS)
- Public Health Information Development Unit (PHIDU)
- Queensland Government Statistician's Office (QGSO)
- Queensland Health Preventive Health Survey

Stage 2: Community engagement

A Consumer and Stakeholder engagement plan was developed and approved in March 2024 to ensure broad and strategic consultation occurred. Table 117 lists the stakeholder engagement activities undertaken between November 2023 and September 2024. The engagement plan also included strategies for internal CCQ HNA Socialisation and recruitment for the *My Healthy Community* survey.

Table 117: Stakeholder engagement activities

Stakeholder	Brief description of engagement	Date
Aboriginal and Torres Strait Islander Roundtable	Presentation delivered to the Roundtable informing the group the HNA project was commencing. Focus was on what data they could share to inform the HNA and any insights/learnings the project team could adopt following the last HNA.	November 2023
CCQ Clinical Council	Presentation delivered to council members introducing the HNA Project, including vision, proposed methodology and engagement, governance structure, timeline, and next steps.	February 2024
CCQ Primary Health Coordinators	Group interviews undertaken with Primary Health Coordinators working across the Sunshine Coast and Central Queensland region. Purpose of the interviews were to gain insights from their engagement with general practices, and health service and system challenges.	April 2024
All CCQ staff	OneTeam presentation introducing the HNA to all staff, including the vision, methodology and invitation to get in touch to share data or insights.	April 2024
CCQ Clinical Council	Presentation delivered to council members on project progress, including deliverables and engagement undertaken to date, the Joint Regional Needs Assessment Framework, and the launch of the *My Healthy Community* survey.	May 2024
Local councils	All twelve local councils were invited to a presentation introducing CCQ and the HNA. The presentation also covered the *My Healthy Community* survey and how councils could support survey recruitment. Following the presentation, all councils were contacted individually to develop region specific survey recruitment strategies.	May 2024
HNA Steering Committee	Monthly Steering Committee meetings were held to provide the committee with regular project updates and opportunities to provide input into key project stages. The group also provided opportunities for discussion on implementation of the Joint Regional Needs Assessment Framework.	May to October 2024
CCQ Consumer Advisory Council	Presentation delivered to council members introducing the HNA Project and project update, including deliverables and engagement undertaken to date, the Joint Regional Needs Assessment Framework, and the launch of the *My Healthy Community* survey.	June 2024
All community members	*My Healthy community* survey – comprehensive community health and wellbeing survey distributed throughout the region. An extensive recruitment strategy covering numerous distribution channels was employed to maximise response rates.	10th June – 14th July 2024
CCQ Consumer Advisory Council	Brief provided to update council members on project progress and preliminary survey numbers.	August 2024
CCQ Clinical Council	Brief provided to update council members on project progress and preliminary survey numbers.	August 2024
Subject matter expert consultation (CCQ, stakeholders, academic partner)	Subject-matter experts from CCQ were invited to contribute to a triangulation workshop. A series of subject/topics were discussed throughout the day, including immunisation, natural environment (climate change, disaster preparedness), primary care access, healthy ageing, palliative care, education, Aboriginal and Torres Strait Islander health and developmental delays.	September 2024

My Healthy Community survey

The *My Healthy Community* survey 2024 was a key consultation piece and data source used to inform the HNA. Extensive work was undertaken to develop the survey and its branding, so it can be replicated in three-years. Ethics approval was granted by the Human Research Ethics Committee at the University of the Sunshine Coast (A242114).

Community members' views and perspectives on health needs and assets are known as felt needs and are considered an important source of evidence in determining the health priorities of a community. The *My Healthy Community* survey was designed to build on existing evidence from previous HNAs and start exploring emerging health priorities for communities across the region. The themes, questions and response options were developed using findings from previous HNAs and other consultation processes, policy directions, literature (and validated health and wellbeing indices), and input from key CCQ staff and external HNA partners.

The aims of the *My Healthy Community* survey were to:

1. Gain insight into community members' perspectives on the health and wellbeing priorities for their community, and
2. Start an ongoing dialogue with community members about their health and wellbeing.

The *My Healthy Community* survey was designed as an "opinion survey" asking community members for their perspectives on the health and wellbeing of their community, rather than a "prevalence survey" that measures individual health-related factors. Where possible and appropriate, survey questions intentionally asked participants about the health and wellbeing of community rather than their personal health and wellbeing.

Objectives:

1. To understand health and wellbeing assets and strengths of communities
2. To understand the priority community health and wellbeing areas of need of communities, generally and for children and older adults as key populations within communities
3. To understand the health care knowledge, preferences, assets/ strengths and priority unmet needs of communities generally and for mental health care specifically as a growing area of health systems
4. To understand priority disaster preparedness and community resilience areas of need
5. To assess and map health equity and broader environmental determinants influencing health and wellbeing across communities in CCQ. This will position CCQ to advocate for and establish partnerships to address the social determinants of health and wellbeing and determine priority communities for further HNA deep dives.

Stage 3: Identification of preliminary themes and gaps

Interpretation of the data was an iterative, in-depth manual process of the project team immersing themselves in the data. The process of collating the secondary data and synthesising it into tables, graphs and narrative allowed the project team to identify potential needs and data gaps. This process resulted in a preliminary list of priority areas that were sense-checked and further explored in a workshop in early September 2024. The workshop included attendance by subject-matter experts covering immunisation, healthcare access, climate change and disaster resilience, healthy ageing, palliative care, and Aboriginal and Torres Strait Islander health and wellbeing.

Stage 4: Health needs sense-checking

A finalised list of preliminary themes and gaps was presented to the HNA Steering Committee and CCQ Executive Leadership Team (ELT) for sense-checking and feedback during the report review process. Additional sense-checking processes will occur as part of the Joint Prioritisation workshop.

Stage 5: Prioritisation planning

Synthesis of the short-listed needs and triangulation will occur as part of the preparation for the prioritisation process. A prioritisation process was developed by

CCQ and shared with the HNA Steering Committee, CCQ ELT, and Joint Regional Needs Assessment Community of Practice for review and feedback. The process will be implemented in late 2024 to leverage the establishment of Joint Regional Governance arrangements and subsequent joint planning and investment potential.

Stage 6: Reporting

The HNA Report was submitted to the Department of Health and Ageing in November 2024. Subsequent reports will be prepared in early 2025 covering the *My Healthy Community* survey findings, local government fact sheets, and summaries of the final joint priority areas.

Data limitations and gaps

There are still substantial limitations and gaps in available data. The key gaps, include:

- Regional LGBTIQA+ numbers and health and wellbeing status
- Regional quality of life indicators
- Data on multiple indicators for Woorabinda (e.g. disability, health conditions and behaviours)
- Self-rated health data specific to school-aged children, young people and working adults
- Disability Employment Services participation at a regional level
- No nationally consistent data collection to monitor provision of care by GPs for a range of health conditions (e.g. musculoskeletal, dementia, respiratory, cardiovascular)
- Data on indicators related to respiratory condition treatment, GP care plans for COPD, health checks related behavioural factors are not available.
- Data on dementia, including hospitalisation and emergency data on dementia, aged care services data, PBS data
- Health and wellbeing needs of carers
- Localised data on proportion of children exposed to alcohol in utero and young mothers (<20 yrs) who smoked during pregnancy
- Localised data on young Aboriginal and Torres Strait Islander mothers with low-birth-weight babies, birth rates for Aboriginal and Torres Strait Islander mothers, and Infant mortality rates for Aboriginal and Torres Strait Islander babies.
- Data on local community determinants of health and wellbeing
- Local health literacy data
- Access to traditional healing and medicine
- A range of palliative care indicators for patients and their carers and families.

HNA evaluation

An academic partner was engaged to evaluate the HNA process and inform ongoing processes for the HNA program. A preliminary evaluation framework was developed and included within the HNA Project Plan. This will be reviewed and revised, if necessary, with implementation scheduled for early 2025. Limitations of the HNA will be captured in the evaluation process.

APPENDIX B: POLICY REVIEW SUMMARY

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Appendix B: Policy review summary

Purpose

This high-level rapid policy review was undertaken to understand the population health global, national, state and local policy contexts to inform the scope and analyses of the 2025-28 HNA. Attention was placed on general population health and primary health care policies, and other key policy documents identified by stakeholders as relevant. Focus areas of the review include the role of primary health care, use of data in informing primary health care action, and general population health, specific health topics and health service elements.

The role of primary health care

Primary health care (PHC) is described as being a whole-of-society approach that aims at ensuring the highest possible level of health and wellbeing by focusing on people's needs as early as possible along the continuum, from health promotion (i.e. upstream actions on determinants of health) and disease prevention to treatment, rehabilitation and palliative care. It is focused strongly on equity with the aim of providing services as close as possible to people's everyday environment.

PHC uses universal health coverage and "systems approaches" (i.e. multi-sectoral / community / government policies and actions) to address the upstream and wider determinants of health, and the provision of comprehensive integrated services designed with people, and for people; rather than centring action on diseases and institutions. Community participation and empowerment underpins all PHC and is used in identifying health priorities and innovative responsive actions to community resources. PHC covers the entire life-course and whole person, including the comprehensive and inter-related aspects of physical, mental and social health and wellbeing.

PHC authorities are considered to have roles in leading, coordinating and facilitating these functions in society and communities, using good practice health needs assessment and planning and evidence-informed decisions strongly situated in community engagement and empowerment processes.

Australian national primary health care policies still have a primary health care "services" focus rather than comprehensive primary health care approach as described above.

Use of data

Across policy levels and health sectors (and beyond), there is a strong focus on evidence-informed activity that includes administrative data and the voices of community and stakeholders; as well as better use and integration of reliable data and linked data systems. Policies focus on the use of data and evidence for future thinking and innovations, scaling up innovations, and research in the application of data and planning processes, solution-generation using place-based and other local approaches, and models of care. Enhancing health data literacy with commonly understood meaning is also a key policy focus area.

Key policy focus areas

There are several areas of direction and focus across policy levels globally and nationally. These are summarised below.

General policy focus areas

- Integrated, collaborative and coordination forums, joint planning and communication
- Prevention and multi-sectoral action on determinants of health
- Equity, including priority populations and gender equality
- Engagement of communities and civil societies
- Digital health and innovations (telehealth and virtual care, digital integration, health technology, precision medicine)
- Accountability, including assessing impact and tracking progress
- Close the Gap (community-controlled sector); cultural respect; reconciliation (partnerships and shared decision-making; workforce; health promotion and early intervention; social and emotional wellbeing and trauma-area, healing informed approaches; healthy environments; racism; person/ family centred; mental health and suicide; culturally informed and evidence-based; local data); preventive health (health checks, antenatal checks, diabetes in children and young people); rheumatic heart disease eradication; avoidable blindness

- Medical research (patients, researchers, translation and mission; new fields of medicine (robotics, genomics, stem cells, immunotherapy); clinical trials; cancers and diseases; precision medicines)

Topic-specific policy focus areas

- Health and wellbeing at every life stage - maternal and early years, children and adolescents, adults of working age, older adults (ageing well across all life stages; service coordination; living independently in older age; aged care quality and safety)
- Hospital avoidance
- Chronic diseases (diabetes, asthma, arthritis, childhood heart disease, heart disease and stroke, inflammatory bowel disease, kidney disease, lung conditions, pain management, cancer (skin))
- Mental health and suicide (dementia, social and emotional wellbeing and prevention, resilience, crisis response)
- Protective and risk behaviours and biomarkers (tobacco use and nicotine addiction; access to and the consumption of a healthy diet and breastfeeding; physical activity sport and Olympics 2032; obesity; cancer screening and prevention; immunisation; alcohol and fetal alcohol spectrum disorder; drugs (methamphetamine); health information/ literacy)
- Maternal, sexual and reproductive health (endometriosis, still birth, perinatal and pregnancy care)
- Injuries and risk taking (road safety)
- Oral health
- Eye health (avoidable blindness and vision loss; macular disease)
- Communicable disease control (influenza, HIV, hepatitis B, STIs, syphilis, blood borne viruses; rebuilding from COVID-19; and preparing for, responding to and recovering from crises)
- Rare diseases
- Violence (against women and girls, elder abuse)
- Climate change resilience, adaption, mitigation; natural disasters and extreme weather events
- Cost of living and economy
- Disability
- Women's equity (economic security)
- Social cohesion and polarisation
- Control over life decisions, having a voice, particularly for Aboriginal and Torres Strait Islander persons
- Community connectedness, inclusion, safety, culture
- Natural environment (air, waterways, conservation, waste)
- Community identity, vibrancy, heritage, sense of place
- Environmental determinants of health (liveability, community design, infrastructure, transport, housing, facilities, services, spaces for living, working, learning and sport and recreation)
- Digital literacy

Services

- Accessible, used (by people at risk of poorer health outcomes), affordable and quality health services
- Comprehensive integrated services, person-centred care, multidisciplinary team-based care
- Cultural safety (culturally safe workforce)
- Consumer safety and quality
- Services across the continuum of care (investing in prevention and early intervention)
- Health and care workforce (attract and train; support and retain; maximise, distribute and connect; aged care; First Nations; participation and economic security of women; equity, diversity and inclusive)
- Doctors / nurses in rural/regional areas (rural generalist pathways)
- Nurses / pharmacists in PHC
- Private health insurance reform
- Infrastructure improvements
- Innovation
- Access to PHC in rural areas
- Empowering wellbeing and self-management of health
- Workforce development (digital technologies; pain management)
- Health data, security and use AI
- Health services (First Nations, child and family, palliative care and end of life, rural and remote, maternal, priority populations)
- Quality use of medicines
- Wait times
- Green health care (waste reduction; recycling; global green and healthy hospitals)

Detailed review of key policies

Global policies and direction

Policy	Focus areas
Sustainable Development Goal 3 (SDG3): Global Action Plan for Healthy Lives and Well-being for All (2019)	Goal: accelerate progress toward health-related SDGs, leaving no one behind, including the context of countries' efforts to recover and rebuild from COVID-19 **Outcome 1:** more coordinated and efficient country support – performance; collaboration incentivised and institutionalised; collaborative forums; joint progress reports and communisations **Outcome 2:** more equitable PHC through sustainably financed health plans – essential PHC improved and more equitable and public health functions strengthened; health financing strengthened; essential PHC and public health functions strengthened in fragile settings and during outbreaks **Outcome 3:** More equitable and inclusive progress towards health-related SDGs – engagement of communities and civil societies; multisectoral action on determinants of health; equity, gender equality and responsiveness **Outcome 4:** Improved PHC through innovations and reliable health data – health innovations are scaled; health data systems improved **Accelerator 2: Frontline health/ Primary health care - Problem/Opportunity Statement**: Reaching SDG 3 will require health services to be accessible, used, affordable and of sufficient quality. Moreover, other sectors than health need to be engaged and citizens and communities empowered to both produce health at home and demand good services. However, the present situation is characterized by inequities between and within countries on all these accounts; this will preclude reaching aggregate SDG3 targets. Including, and starting from, marginalized communities such as rural remote, urban poor, migrants and displaced, and minority populations, the PHC accelerator will assist governments to identify bottlenecks and strengthen rate-limiting systems "levers", to build and expand service delivery models that include the most vulnerable groups
World Health Organisation Primary Health Care description and scope **(cont)**	*Definition: "Primary health care is a **whole-of-society approach** to health that aims at ensuring the highest possible level of health and well-being and their **equitable distribution** by focusing on people's **needs** and as **early as possible** along the continuum from **health promotion** and disease prevention to treatment, rehabilitation and palliative care, and as **close as feasible to people's everyday environment**."* WHO and UNICEF. A vision for primary health care in the 21st century: Towards UHC and the SDGs. Three inter-related and synergistic components, including: 1. comprehensive **integrated health services** that embrace primary care as well as **public health goods and functions** as central pieces; 2. **multi-sectoral policies and actions** to address the **upstream and wider determinants of health**; and

Policy	Focus areas
	3. **engaging and empowering individuals, families, and communities** for increased social participation and enhanced self-care and self-reliance in health. PHC is rooted in a commitment to **social justice, equity, solidarity and participation**. It is based on the recognition that the enjoyment of the highest attainable standard of health is one of the fundamental **rights** of every human being without distinction. For **universal health coverage** (UHC) to be truly universal, a shift is needed from health systems designed around diseases and institutions towards health systems designed for people, with people. PHC requires governments at all levels to underscore the importance of **action beyond the health sector** in order to pursue a whole-of government approach to health, including health-in-all-policies, a strong focus on equity and interventions that encompass the entire **life-course**. PHC addresses the **broader determinants of health** and focuses on the comprehensive and interrelated aspects of **physical, mental and social health and wellbeing**. It provides **whole-person care** for health needs throughout the lifespan, not just for a set of specific diseases. • PHC is widely regarded as the most inclusive, equitable and cost-effective way to achieve **universal health coverage**. It is also key to strengthening the **resilience** of health systems to prepare for, respond to and recover from **shocks and crises**. Universal health coverage will only be possible when everyone, everywhere can access the health services they need. **Communities should be empowered to identify their health priorities and contribute to finding responsive solutions.** Heath care and other sectors need to work together to ensure all decisions affecting health are addressed in an integrated way. This includes promoting policies to protect and improve people's health and well-being; providing information, services and infrastructure for improved water and sanitation and other environmental determinants of health; prevention of noncommunicable diseases; preparing for and responding to health emergencies; providing services for pregnant women, routine vaccination for children and sexual and reproductive health services; mental health support; platforms for community consultation and many others.
Back to the future: Harnessing the power of primary health care to transform our health	• 70 countries convened to step up primary health care investments by 2030 • Participants called for **greater investments in PHC**, making the most of **digital innovations**, ensuring protection from catastrophic out-of-pocket **health costs**, and investing in the **health and care workforce** to address the projected 10 million health worker shortage by 2030. • WHO Special Programme on PHC's objective is to support countries in **reorienting their health systems towards PHC** and to ensure robust normative guidance to **track progress** for accountability and impact, through prioritising action and investments into a primary

<table>
<tr><th>Policy</th><th>Focus areas</th></tr>
<tr><td>systems conference, October 2023</td><td>health care approach. Implementing PHC requires enhanced collaboration to increase and improve political commitment, governance, financing and engagement. It also requires a paradigm shift, from building health systems that focus on treating diseases to co-creating systems that look after the totality of health and well-being of people, so that communities can be healthier and better protected from diseases.</td></tr>
<tr><td>Global Risks Report, World Economic Forum</td><td>
<table>
<tr><th>2-year ranking of risk by impact (severity)</th><th>10-year risks ranking of risk by impact (severity)</th></tr>
<tr><td>1. Cost of living
2. Natural disasters and extreme weather events
3. Geoeconomic confrontation
4. Failure to mitigate climate change
5. Erosion of social cohesion and social polarisation
6. Large-scale environmental damage incidents
7. Failure of climate-change adaption
8. Widespread cybercrime and cyber insecurity
9. Natural resource crises
10. Large-scale involuntary migration</td><td>1. Failure to mitigate climate change
2. Failure of climate-change adaption
3. Natural disasters and extreme weather events
4. Biodiversity loss and ecosystem collapse
5. Large-scale involuntary migration
6. Natural resource crises
7. Erosion of social cohesion and social polarisation
8. Widespread cybercrime and cyber insecurity
9. Geoeconomic confrontation
10. Large-scale environmental damage incidents</td></tr>
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National policies and direction

Health system challenges:

- ageing population and increasing demand on health services
- increasing rates of chronic disease
- costs of medical research and innovations
- making the best use of emerging health technologies
- making better use of health data

Policy	Focus areas
Australia's Long Term National Health Plan to build the world's best health system, 2019	• Guaranteeing Medicare, stronger primary care and improving access to medicines through the PBS – 10-Year Plan for Primary Care; nurses and pharmacists in PHC; access to new medicines; doctors and nurses in rural/regional areas; end avoidable blindness in Indigenous communities; rheumatic heart disease eradication; National Rural Generalist Pathway • Supporting our public and private hospitals, including improvements to private health insurance – National Health Reform Agreement (PPHs); private health insurance reform; new health innovation and treatment projects; new centres and upgrades • Mental health and preventive health – Vision 2030 (see below); Intergenerational Health and Mental Health study; Youth and Indigenous Mental Health and Suicide Prevention Plan; Million Minds Mental Health Research Mission (eating disorders, children and young people, First Nations); National Mental Health Partnership with states; 10-year National Preventive Health Strategy; smoking; Indigenous Preventive Health Plan (health checks, antenatal check, diabetes in children and young people); physical activity; sport; 2023 Olympics • Medical research to save lives and boost our economy – Medical Research Future Fund -year plan; focus on patients, researchers, translation and mission; Frontier Health and Medical Research program; new fields of medicine (robotics, genomics, stem cells, immunotherapy); -year plan for global centre for clinical trials; research on are cancers and diseases; precision medicines • Ageing well and aged care – Budget package, More Choices for a Longer Life (coordination of services across government at every stage of life); living independently; aged care quality and safety;
Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032	• Future focused health care – telehealth and virtual care; data-driven insights and digital integration; health care technologies and precision medicine • Person-centred PHC supported by funding reform – incentivised person-centred care; multidisciplinary team-based care; Close the Gap through community-controlled sector; access to PHC in rural areas; access to care for people at risk of poorer health outcomes; empowering wellbeing and self-management of health • Integrated care, locally driven – joint and collaborative commissioning; research and evaluation to scale up what works; cross-sectoral leadership

Policy	Focus areas
National Preventive Health Strategy 2021–2030	• Tobacco use and nicotine addiction • Access to and the consumption of a healthy diet • Physical activity • Cancer screening and prevention • Immunisation • Alcohol and other drug harm • Mental health
National Digital Health Strategy **(cont)**	• Health information availability • Secure information exchange • High-quality data with a commonly understood meaning • Availability and access to prescriptions and medicines information • Digitally-enabled models of care • Confident workforce in using digital technologies • Digital health industry delivering world-class innovation
Vision 2030: Blueprint for Mental Health and Suicide Prevention	• Local community solutions – co-deign at community level; services across continuum of care; prioritising care for acute episodes and low intensity primary care; community hubs ad home-based care • Connected and integrated system of care – incentivising cross sector care; local care planning and coordination; multiple points of engagement across continuum; integration with tertiary health settings • Investing in prevention and early intervention – early identification and intervention; access to self-guided programs developing coping capabilities and problem-solving linked with other services as needed
National Mental Health Workforce Strategy 2022-2032	• Attract and train • Maximise, distribute and connect • Support and retain • Data, planning, evaluation and technology
National Children's Mental Health and Wellbeing Strategy	• Family and community – parenting programs, antenatal and parenting emotional wellbeing courses, resources, place-based approaches • Service system – integrated child and family care service models 0-12 years, innovative service delivery, co-design, carte coordination for complex needs, state care reporting, Medicare item amendments for case conferencing, consultation with parents and carers, communication with educators and other services providers about care • Education settings – comprehensive wellbeing plan for students; school programs; wellbeing staff members art all early childhood learning services and primary schools

Policy	Focus areas
	• Evidence and evaluation – Inter-departmental committees on data sharing, program evaluation, MH research funding
National Stigma and Discrimination Reduction Strategy (under development)	• Self-stigma amongst those who experience mental health issues and those who support them • Public stigma by changing attitudes and behaviours towards people with personal lived experience and carers, families and support people • Take steps towards eliminating structural stigma and discrimination towards those affected by mental health issues in identified settings (Mental Health System; Health System; Financial Services, Insurance and Law; Education and Training; Employment; Social Services, Disability, Income Support and Housing)
National Disaster Mental Health and Wellbeing Framework: Supporting Australians' mental health through disaster	• Responding to need – components of care (specialised services, focused non-specialised support, community and family support, practical support and advocacy; psycho-social prevention and preparedness (mental health literacy, community level planning, support for front line workers) • Stepped carte and the UN IASC guideline - three-tiered matrix of psychological intervention and skills • Roles of PHNs in regional planning and coordination – Joint Regional MH Plans include disaster management; Recovery Committees and emergency response planning; integrated PHC response plan for emergencies; regional disaster MH coordination; collaborative plan on community upskilling in MH awareness; disaster mental health workforce plan; regional mental health-related intelligence from multiple sources • Enablers – service coordination; navigation and connection assistance; coordinated information and data sharing; workforce planning, development and support; MH and wellbeing service mapping; delivery considerations (assessment and screening, digital services, proactive outreach, provision of disaster MH support and information, school and workplace delivery, tracking mobile populations, trauma-informed service provision
National Drug Strategy, 2017-2026	• access to evidence-informed, effective and affordable treatment services and support – pharmacotherapy; outpatient, inpatient and community-based treatment and post treatment; assessment and brief intervention; subsidised medications • develop and share data and research, measure performance and evaluate outcomes – data collection and analysis; monitor emerging drug issues; drug supply markets; evaluation • develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems – community knowledge; treatment planning across government; price mechanism interventions; early detection through schools • supporting community engagement in identifying and responding to alcohol, tobacco and other drug issues – prevention programs; information; local community partnerships; engagement • adverse health, social and economic consequences – high-risk group interventions; programs during times of increased risk; diversion into health interventions from criminal justice; evidence-based strategies • addressing availability – work with those at point of supply; consistent national legislation; restricting promotion • improve national coordination – reporting; governance; engagement; national guidelines and approaches

Policy	Focus areas
National Men's Health Strategy, 2020-2023	• Mental health • Chronic conditions • Sexual and reproductive health and conditions where men are over-represented • Injuries and risk taking • Healthy ageing
National Women's Health Strategy, 2021-2030	• maternal, sexual and reproductive health • healthy ageing • chronic conditions and preventive health • mental health • violence against women and girls
Department of Health Strategic Plan 2021–2025	• Reform (see Strategy below) • First Nations (see Strategy below) • Health services – co-design delivery and models of care with priority populations; networked services; use of data and AI • Workforce – mobility initiatives for rural and remote employees; leadership development programs and cultural enhancement initiatives; attraction approaches to address supply • Public policy – policy maturity; strengthening connections; service needs analysis sexual assault • Research – generation of research questions; research education and training; recognition of research excellence; research collaborations • Consumer safety and quality – patient safety culture protocol; education package and training; QH clinical governance framework
Australian National Diabetes Strategy: 2021-2030	• Prevent type 2 diabetes – modifiable risk factors in general population; identify high-risk individuals • Promote awareness and earlier detection – symptom education; population and opportunistic screening; early detection capacity; risk assessment and health checks • Reduce the burden and complications and improve quality of life – clinical guidelines, local care pathways, complications prevention programs; consumer engagement and self-management; quality improvement processes; care during times of disaster; information and communication technology; affordable medications and devices; workforce capacity and capability; funding mechanisms; mental health care; quality hospital care • Impact of pre-existing diabetes and gestational diabetes in pregnancy – programs pre- and post-pregnancy and testing; paediatric follow up of at-risk children • Impact of diabetes among Aboriginal and Torres Strait Islander peoples – programs; workforce upskilling; community-wide interventions; specialist support; referral pathways; retinopathy assessment; data • Impact of diabetes among other priority groups – CALD, older Australians, children and young people, rural and remote, people with a disability, people with a mental health disorder

Policy	Focus areas
	• Prevention and care through research, evidence and data – national research agenda; data linkage
The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025	• Cultural safety – culturally safe workforce • Participation – in workforce • Access – to services • Influence
The National Aboriginal and Torres Strait Islander Health Plan 2021-2031	• Genuine shared decision making and partnerships • Aboriginal and Torres Strait Islander community controlled comprehensive primary health care • Workforce • Health promotion • Early intervention • Social and emotional wellbeing and trauma-aware, healing-informed approaches • Healthy environments, sustainability and preparedness • Identify and eliminate racism • Access to person-centred and family-centred care • Mental health and suicide prevention • Culturally informed and evidence-based evaluation, research and practice • Shared access to data and information at a regional level
National Health and Climate Strategy	**Objectives:** • Health system resilience: build a climate-resilient health system and enhance its capacity to protect health and wellbeing from the impacts of climate change. • Health system decarbonisation: build a sustainable, high quality, net zero health system. • International collaboration: collaborate internationally to build sustainable, climate-resilient health systems and communities. • Health in all policies: support healthy, climate-resilient and sustainable communities through whole-of-government action which recognises the relationship between health and climate outcomes. **Actions:** • workforce, leadership and training • research and innovation

Policy	Focus areas
	• communication and engagement • collaboration and governance

Overarching national strategies

- A matter of Care: Australia's Aged Care Workforce Strategy
- Australia's National Action Plan for Health Security 2019-2023
- Department of Health and Aged Care data Strategy 2022-25
- Fifth National Mental Health and Suicide Prevention Plan (2017) and Implementation Plan (2017)
- Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health (2015)
- My Aged Care Workforce learning Strategy 2023
- National Aboriginal and Torres Strait Islander Health Plan and Implementation Plan (2013-2023)
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-31
- **National Action Plan for the Health of Children and Young People 2020-2030**
- National Children's Mental Health and Wellbeing Strategy
- National Climate Resilience and Adaptation Strategy 2021-2025
- National Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026
- National Digital Health Strategy (2018)
- National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (2016)
- National Framework for Universal Child and Family Health Services (2011)
- National Health Genomics Policy Framework 2018-2021
- National Medical Workforce Strategy 2021-2031
- National Medicines Policy (2000)
- National Palliative Care Strategy (2010)
- National Preventive Health Strategy 2021–2030
- National Stigma and Discrimination Reduction Strategy (under development)
- National Statement on Health Literacy and Australian Charter of Healthcare Rights (through ACSQHC)
- National Strategic Framework for Rural and Remote Health (2011)
- National Strategy for Quality Use of Medicines
- Reconciliation Action Plan 2021-2023
- **Vision 2030: Blueprint for Mental Health and Suicide Prevention**
- **National Health and Climate Strategy 2023-2028**

Condition-specific national policies and strategies

- **Australia Health Management Plan for Pandemic Influenza (2019)**
- **Australian National Breastfeeding Strategy: 2019 and Beyond**
- Australian National Diabetes Strategy 2021-2030
- Draft National Strategy for Radiation Safety and Implementation Plan (2021)
- Eighth National HIV Strategy 2018-2022
- Fifth National Mental Health and Suicide Prevention Plan (2017) and Implementation Plan (2017)
- Fourth National Hepatitis B Strategy 2023-2030
- Fourth National Sexually Transmitted Infections Strategy 2018-2022
- Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2015-2024
- National Action Plan for Endometriosis (2018)
- **National Alcohol Strategy 2019-2028**
- National Asthma Strategy (2018)
- National Blood Borne Viruses and Sexually Transmissible Infections Strategies 2018-2022
- National Disaster Mental Health and Wellbeing Framework: Supporting Australians' mental health through disaster
- National Drug Strategy 2017-2026
- National Fetal Alcohol Spectrum Disorder Action Plan 2018-2028
- National Framework for Action on Dementia 2015-2019
- National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss and Third Progress Report
- National Framework for Communicable Disease Control (2014)
- **National Immunisation Strategy for Australia 2019 to 2024**
- **National Injury Prevention Strategy (2023)**
- National Mental Health Workforce Strategy 2022-2032
- National Obesity Strategy 2022-2032
- National Palliative Care Strategy 2018
- National Strategic Action Plan for Arthritis (2019)
- National Strategic Action Plan for Childhood Heart Disease (2019)
- National Strategic Action Plan for Heart Disease and Stroke (2021)
- National Strategic Action Plan for Inflammatory Bowel Disease (2019)
- National Strategic Action Plan for Kidney Disease (2020)
- National Strategic Action Plan for Lung Conditions (2019)
- National Strategic Action Plan for Macular Disease (2019)
- National Strategic Action Plan for Osteoporosis (2019)
- National Strategic Action Plan for Pain Management (2021)

- National Strategic Action Plan for Rare Diseases (2020)
- National Strategic Approach for responding to rising rates of syphilis in Australia 2021
- National Strategic Approach to Maternity Services
- National Strategic Framework for Chronic Conditions (2017)
- National Strategy for Health Practitioner Pain Management Education
- National Still Birth Action and Implementation Plan 2022-2030
- National Tobacco Strategy 2023-2030
- Range of clinical practice guidelines such as: National Mental Health Care in the Perinatal Period (2017) and Pregnancy Care Guidelines
- Range of national cancer frameworks (through Cancer Australia)
- Sixth National Hepatitis C Strategy 2023-2030
- Sports Diplomacy: Sport 2030 - National Sport Plan
- Strategic National Action Plan for Macular Disease
- Women-centred care: Strategic directions for Australian maternity services

Gender-specific policies and strategies

- National Women's Health Policy 2010-2030
- National Men's Health Strategy 2020-2030

Related cross-sector policies and strategies

- Australian Work Health and Safety Strategy 2012-2022
- Defence Mental Health and Wellbeing Strategy 2018-2023
- National Ageing and Aged Care Strategy for people from culturally and linguistically diverse (CALD) backgrounds (2015)
- National Alcohol Strategy 2018-2026 (draft)
- National Disability Strategy 2010-2020
- National Plan to Address Elder Abuse
- National Plan to Reduce Violence against Women and their Children 2010-2022
- National Plan to Reduce Violence against Women and their Children: Fourth Action Plan 2019-2022
- National Road Safety Action Plan 2018-2020
- Social Health Strategy 2015-2023 for the Veteran and Ex-service Community
- Towards 2025: An Australian Government Strategy to Boost Women's Workforce Participation
- Veteran Mental Health Strategy 2013-2023
- Women's Economic Security Statement

State policies and direction

Health system challenges:

- increasing population
- growth in an ageing population
- longer life expectancies
- increasing burden of disease in conditions, such as cardiovascular disease, cancers and diabetes
- the challenge of providing equity of health service provision in regional, rural and remote communities

Policy	Focus areas
Department of Health strategic plan, 2021-2025 **HEALTHQ32: A vision for Queensland's health system**	• Reform (connected, equitable, sustainable, integrated healthcare) • First Nations (centre healthcare design and delivery) • Workforce (responsive, skilled and valued; feel supported) • Consumer safety and quality (safe and quality healthcare; performance) • Health services (sustainable, personalised healthcare; patient- and community-centred outcomes) • Public policy (quality advice to government; agile, future focused health policy) • Research (research and innovation encouraged, supported and enabled)
Queensland Women and Girl's Health Strategy, 2022-2027	• Women's economic security • safety, health and wellbeing (including violence against women) • elevating First Nations women (control of life decisions and for voices to be heard) • women with diverse backgrounds and experiences (disability, CALD, sexuality, poverty; older women; regional, remote and rural) • empowerment and recognition (supporting and empowering women into leadership roles; recognise, celebrate and inspire women)
Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027	• Strengthening service capacity and the built environment • Responding to mental health crisis and suicidality • Delivering improved services with First Nations peoples • Strengthening quality to reduce harm and improve outcomes • Improving workforce capability and sustainability • Delivering digital capability and digitally enabled treatment, care, and support

Policy	Focus areas
Health Workforce Strategy for Queensland to 2032	• Supporting and retaining our current workforce • Building new pipelines of talent • Adapting and innovating new ways to deliver
eHealth Investment Strategy	• new ICT infrastructure utility to provide contemporary network and data centre foundations that support contemporary systems and increase the mobility of the workforce • a contemporary desktop environment to support a consistent user experience, and access to common systems and tools across the health system • establishing a secure environment to share information and images, and consult with others through an information interoperability platform • renewing enterprise systems, including those for patient administration, finance and laboratories • investing statewide in electronic medical records and enabling digital hospitals
Prevention Strategic Framework, 2017-2026	• Healthy weight • Smoking prevention • Skin cancer prevention
Aboriginal and Torres Strait Islander Health Workforce Strategic Framework, 2016-2026	• Growth (representation of Aboriginal and Torres Strait Islander people employed by Queensland Health) • Collaboration (representation of Aboriginal and Torres Strait Islander people working in all health professions) • Partnerships (partnerships between the health and education sectors to deliver real change for Aboriginal and Torres Strait Islander people wanting to enter the health workforce and improve career pathways for existing employees) • Leadership and planning (leadership and planning in Aboriginal and Torres Strait Islander workforce development) • University health graduates (actively target attraction and recruitment efforts at the increasing pool of Aboriginal and Torres Strait Islander university students and graduates undertaking health and health-related courses) • Culturally safe and competent health services (build a Queensland Health workforce that 'closes the gap' in health outcomes between Aboriginal and Torres Strait Islander people and non-Indigenous people by providing culturally safe and competent health services)
Healthy Ageing: A strategy for older Queenslanders	• Staying in good health for longer (influence the social and environmental determinants of health and understand the needs of older people within this broader context) • Person-centred care for older Queenslanders (development of care pathways and collaborative service arrangements that span the health care continuum and extend to other community and aged care service providers) • Integrating health and other support services (work in partnership with other providers to ensure older Queenslanders have a 'no wrong door' experience as they transition between the public health system, aged care services and community-based support services)

Policy	Focus areas
Queensland Health Climate Risk Strategy, 2021-2026	• Leadership and Governance (Integrate climate risk into existing governance arrangements and organisational business as usual; establish executive level sponsors to drive the Climate Risk Strategy) • Our People (Create a climate ready workforce culture; enable a resilient and adaptable workforce) • Emission Reduction (reduce greenhouse gas emissions from Queensland Health's Infrastructure and Operations; report on emissions against agreed targets) • Resilient Infrastructure (Adapt existing infrastructure and assets to ensure their climate resilience; consider climate change in future infrastructure delivery, serviceability and whole of lifecycle emissions) • Sustainable Procurement (Establish green and ethical procurement policies to source sustainably produced products and services whilst ensuring resilience of supply and reduction of whole-of-life cycle impacts) • Health System Planning (Ensure the reliability of health care services through integrated planning for climate impacts) • Research and innovation (Promote research to better inform health system responses, including for infrastructure design, heat impacts and community resilience; utilise established predictive modelling tools to understand climate impacts on community health and on the delivery of future health services) • Public Health - Advocacy and Support (Advocate for climate smart environments across all state policy, industry sectors, and national jurisdictions; inform and promote community capacity to better address physical and mental health impacts from climate change)
Rural and Remote Health and Wellbeing Strategy, 2022-2027	• Equity of Health Outcomes (requires both immediate health and wellbeing, and the factors that impact health and wellbeing, to be met; such as housing, literacy, employment and isolation) • Integrated Person-Centred Care (integration across healthcare and other settings through the delivery of comprehensive care, coordinated and aligned to an individual's preferences for their health and wellbeing; planning across organisational boundaries, innovation and high-quality leadership) • Strong Partnerships (cross sector approach to respond to both health needs and its determinants; system alignment of goals, forge strong partnerships, connect with communities, and share accountabilities) • Sustainable, Skilled and Supported Workforce (workforce that represents and responds effectively to the varied and diverse needs of people across a lifetime, matter; right professional and personal supports, and prioritising wellbeing) • First Nations Health Equity (renewed and shared agenda to improve First Nations peoples health outcomes, experiences and access to care across the health system; reform; across the system, have First Nations' voices in the system, and design a better coordinated system) • Digitally Enabled (equity of access to healthcare by digitally enabling health services, empowering health consumers to own health outcomes, and supporting local care through wearable devices, augmented reality and high-quality home monitoring)
Digital Health 2031: A digital vision for Queensland's health system	• Empowered consumers (manage and optimise their healthcare throughout the course of their lives)

Policy	Focus areas
	• Digitally-enabled population health (deliver equitable and accessible care closer to home for our First Nations people and other diverse communities) • Connected and insight-enabled workforce (connected workforce with greater access to meaningful insights and tools to enable smarter, safer and higher quality care delivery across the continuum of care) • Health service modernisation for sustainability (robust health system that that is value-based and can sustainably meet the needs of our population)

Overarching strategies

- Department of Health strategic plan
- HHS strategic plans
- HEALTHQ32: A vision for Queensland's health system
- Queensland Women and Girl's Health Strategy, 2022-2027
- Better Care Together (MHAOD)
- Health service planning (strategies and guides by service type)
- Unleashing the potential: An open and equitable health system (reform planning roadmap from COVID-19)
- Health Workforce Strategy for Queensland to 2032: Consultation paper (Strategic health workforce planning framework; Health Workforce Strategy feedback; Advancing health service delivery through workforce: A strategy for Queensland 2017-2026)
- eHealth Investment Strategy
- Prevention Strategic Framework, 2017-2026
- Aboriginal and Torres Strait Islander Health Workforce Strategic Framework, 2016-2026
- Department of Health Disability Service Plan, 2022-2024
- Medical Practitioner Workforce Plan for Queensland
- Domestic and family violence is a workplace issue (internal commitment to providing a safe, secure and supportive workplace)
- Queensland Health Equity, Diversity and Inclusion Statement of Commitment (internal commitment to equity, diversity and inclusion)
- Waste Reduction and Recycling Plan (internal commitment to reducing waste)
- Healthy Ageing: A strategy for older Queenslanders
- Cancer Screening Strategic Framework, 2019-2026
- Queensland Newborn Bloodspot Screening Strategic Framework
- Action on ice
- Climate change and a sustainable public health system (Climate Risk Strategy and Adaptation Planning Guidelines; Global Green and Healthy Hospitals)
- Rural and Remote Health and Wellbeing Strategy, 2022-2027
- Ending Rheumatic Heart Disease: Queensland's First Nations Strategy, 2021-2024
- Digital Health 2031: A digital vision for Queensland's health system
- Palliative and End-of-Life Care Strategy

Local policies and direction

Policy	Focus areas
SCHHS Strategic Plan, 2022-2026	• Our care (high-quality, equitable, accessible, person-centred care; safety; consumer co-design and experience; equity of Aboriginal and Torres Strait Islanders; people with a disability, special needs and carers; partnerships with PHC and community care; pandemic and disaster preparedness and response; wellbeing and disease prevention) • Our people (value and support our people; values-based organisational culture; employee safety and health and wellbeing; capability and accountability of leaders; attract, retain, empower and develop a capable diverse and inclusive workforce; support people to work to their full scope of practice) • Our sustainability (finances, physical and environmental resources; optimise services, facilities and models of care; transform non-admitted care to improve patient outcomes; engage our people to identify and drive cost-effectiveness; optimise our organisational structure, processes and governance to maximise efficiencies and manage risk; maximise revenue and invest wisely; minimise our impact on the environment) • Our future (improve and prepare for the future through research, education and innovation; strong, sustainable research culture; integrate research, education and clinical care in collaboration with Sunshine Coast Health Institute and other partners; virtual care and digital health capability; foster innovation)
WBHHS Strategic Plan, 2022-2026	• Optimise and transform (enhance and transform the health services to improve patient outcomes; patient flow; wait times; indicators; collaboration between facilities; infrastructure; financial sustainability) • Equity and access (ensure the services delivered are equitable and accessible to the community; engagement about service delivery models; accreditation with safety and quality standards; subspecialty services; scale up alternative models of care; services for First Nations and people with a disability) • Embed technology (increase access to virtual care through embedded technology; care; performance and decision-making; access to business information systems at service delivery points; virtual care) • Foster partnerships (partner with diverse stakeholders to better serve the community; collaborative, community-based services; co-design; partnerships with private, PHN, non-government sectors; health literacy; partnerships to build capacity in clinical services, education, training and research) • Nurture and future-proof the workforce (strengthen our workforce to ensure care, connection and compassion for all; culturally safe and responsive; workforce capabilities; continuous improvement and learning; Regional Medical Pathways; graduate intakes and succession planning)
CQHHS Strategic Plan, 2023-2027	• Great Care, Great Experience (safe, compassionate care, delivered to the highest standards, close to home, with consumers at the heart of all we do; service improvements to meet patient needs; safe services close to home; hospital avoidance; rural and remote health inequities; patient experience of communities with special needs) • Great People, Great Place to Work (great staff working in great teams with a culture of supporting and investing in our people's future; attract and retain; healthy and safe work environments; engaged and valued workforce; agility; staff reach best potential)

Policy	Focus areas
	• Great Partnerships (working collaboratively with our partners to deliver great care and improve the health of Central Queenslanders; PHC partnerships to reduce non-acute attendances; coordinated and support health services; co-design with Aboriginal and Torres Strait Islanders; health equity; innovative and sustainable models of public-private healthcare) • Sustainable Future (securing the future of great healthcare with efficient, effective, affordable and sustainable services; sustainability initiatives; infrastructure projects; executive and health service structure)
Sunshine Coast Council	**Goals:** • Our Strong Community - our communities are connected and thriving places where people are included, treated with respect and opportunities are available for all • Our Environment and Liveability - our natural assets, healthy environment and liveability credentials are maintained and enhanced • Our Resilient Economy - our resilient, high-value economy of choice drives business performance, investment and enduring employment • Our Service Excellence - our services are inclusive and responsive to the needs of our community and deliver positive experiences for our customers • Our Outstanding Organisation - our organisation lives its values and is high performing, sustainable, innovative and community focused, marked by great people, good governance and regional leadership.
Noosa Shire Council	**Key themes:** • Environment - natural environment, built environment, waterways and coasts and conservation and heritage • Liveability - housing, facilities and services, transport, health and wellbeing to enable an inclusive, connected and vibrant community • Prosperity - economic development, local business, innovation, arts and culture, waste and a circular economy • Future - our future, strengthening our relationship with First Nations peoples and to ensure our community is prepared and resilient to change. A focus on youth, climate resilience and adaptation, sense of place and destination management • Excellence - customer experience, financial sustainability, innovation and technology, levels of service, governance, our employees and volunteers, funding streams and asset management practices.
Gympie Regional Council	**Key response areas:** • Community and Environment - Our communities have infrastructure and spaces for living, working, learning, sport and recreation that supports and caters for growth and enables the community to be inclusive, connected and safe. Natural ecosystems are conserved and enhanced and our built environment embraces biodiversity, sustainability and heritage • Infrastructure and Economic Opportunity - Our planning and infrastructure seeks to meet foreseeable future needs to support economic development, community enhancement and residents' wellbeing • Organisation - Gympie Regional Council is an organisation that understands the community, and delivers services efficiently and effectively through highly engaged staff.

Policy	Focus areas
North Burnett Regional Council	• Essential service delivery - getting the basics right • Sustainable communities - to retain population and attract investment • Prosperous future - to ensure economic growth for future generations
Fraser Coast Regional Council	**Focus areas:** • Connected, Inclusive Communities and Spaces - To embrace the Fraser Coast way of life and create connected communities through our places, spaces and people. • Resilient and Environmentally Responsible Region - To shape a healthy future for the Fraser Coast region and create a destination for future generations to come • Focused Service Delivery - To provide positive customer experiences, deliver services and infrastructure to meet the unique needs of our growing community • Focused Organisation and Leadership - To be a leader in local government, instilling confidence in the community we serve and the stakeholders we partner with • Engaged and Agile Workforce - To attract, engage and retain the best people, empowering our capable workforce and volunteers to serve and support our community now and into the future
Bundaberg Regional Council	**Game changers, 5 year outcomes:** • Advocacy and investment attraction • Connected and leveraged infrastructure • Intelligent and liveable communities • High performing council
Gladstone Regional Council	**Goals:** • Connecting - Communities We work with you and for you, supporting the success of our communities • Delivering - Value We work efficiently to deliver value for your rates • Resilient - Economy We play our part in supporting the success of our region • Our People - We look after our people, so they look after you • Accountable - Council We are providing good stewardship built on a foundation of trust
Livingstone Shire Council	**Themes:** • Liveable Livingstone - A 'Liveable Livingstone' will support and advocate for services for the wellbeing of the people of Livingstone at any age and with any ability

Policy	Focus areas
	• Thriving Livingstone - Prioritise the Traditional Owners and the importance of the place and country of Indigenous people; offer a diverse range of cultural activities and events; and develop and sustain a diverse economy • Natural Livingstone - Protect, sustainably manage and enhance the natural beauty, landscapes and resources of the country of the Darumbal and Woppaburra people in order to safeguard the sustainability and environmental resilience of the region into the future • Leading Livingstone - Provide transparent, accountable leadership which listens to the needs of the Livingstone community and advocates strongly for Livingstone's interests to State and Federal Governments • Future Livingstone - Become a resilient community prepared for future economic, social, environmental and infrastructure challenges to ensure Livingstone retains its unique character and thrives into the future •
Rockhampton Regional Council	**Our commitment:** • Our Council - We will prioritise our projects, programs and services in a rigorously planned and financially sustainable way. We will consult with the community and advocate on their behalf. We will value the contributions of our staff and ensure that their wellbeing and safety is a priority • Our Community - We will engage with the community to provide facilities that meet their needs, and have Service Delivery Standards and measures for key areas • Our Economy - We will deliver and implement economic development strategies and plans to support future growth opportunities. We will have Performance Plans for our commercial businesses, and plans for all major areas of Council and monitor our progress. • Our Environment - We will deliver environmental sustainability strategies and plans • Our Infrastructure - We will undertake asset management and planning, and will work within our projects priorities to provide infrastructure to support the community
Banana Shire Council	**Themes and goals:** • Communities - To develop strong and vibrant communities across Banana Shire with equitable access to services and a strong sense of place • Environment - To manage operations in a way that maintains the quality of our local environment for future generations • Economy - To develop a diverse and sustainable environment that provides a secure future for all members of our community • Infrastructure - To provide a suite of infrastructure that meets the needs of the community that is sustainable; Organisation and Customer Service
Central Highlands Regional Council	**Goals:** • Deliver, enable and advocate for reliable services to our community • Protect and grow a diverse and prosperous economy • Support and enhance resilient, safe, vibrant and inclusive communities • Drive our council and the region towards a digital future • Develop a future-focused workforce to support council and our region

Policy	Focus areas
	• Responsibly manage our natural environment • Prepare for a low carbon future and adapt to a changing climate
Woorabinda Aboriginal Shire Council	**Theme and goal:** • Governance - Open, inclusive, and accountable representation • Infrastructure - Effective town planning and infrastructure designed to support the communities needs with a focus on visionary planning to suit changing needs into the future • Industry - Develop sustainable economic activity to contribute to a prosperous local economy and improve opportunities and living standards for all • Environment - To enhance, protect and sustain the local environment • Community - A vibrant community that is safe, healthy, educated and proud of their culture and traditions and embraces diversity

APPENDIX C: NOTES ON GEOGRAPHY

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government initiative

Appendix C: Notes on geography

Rules applied in HNA

Data is not always available at the desired geographic levels, including by PHN, LGA, SA2, SA3, SA4 and HHS regions. Boundaries also do not align perfectly between geographic levels. The rules applied in this HNA are outlined below.

Hospital and Health Service (HHS) regions

- HHS service regions do not align with the three SA4 areas within the CCQ region (i.e. Central Queensland, Sunshine Coast and Wide Bay SA4s do not align with the three HHS boundaries of the same name).
- HHS service regions align with combinations of SA2s. This is the level at which HHSs' have reported to in their LANAs in many instances.
- There are 99 SA2s in the CCQ region with Banana SA2 being the only area with its boundary crossing into the Western Queensland PHN. Overall, 89% of Banana SA2 is within the CCQ region.
- The CCQ region aligns with the boundaries of the Central Queensland, Sunshine Coast and Wide Bay HHS service region boundaries.

SA2s within HHS – PHN place names concordance 2023

Central QLD SA2s	Sunshine Coast SA2s	Wide Bay SA2s
1. Banana	1. Aroona - Currimundi	1. Agnes Water - Miriam Vale
2. Berserker	2. Beerwah	2. Ashfield – Kepnock
3. Biloela	3. Bli Bli	3. Bargara – Burnett Heads
4. Bouldercombe	4. Buddina-Minyama	4. Booral – River Heads
5. Boyne Island – Tannum Sands	5. Buderim – North	5. Branyan - Kensington
6. Callemondah	6. Buderim - South	6. Bundaberg
7. Central Highlands – East	7. Caloundra Hinterland	7. Bundaberg East – Kalkie
8. Central Highlands – West	8. Caloundra - Kings Beach	8. Bundaberg North – Gooburrum
9. Clinton – New Auckland	9. Caloundra West - Baringa	9. Bundaberg Region – North
10. Emerald	10. Cooloola	10. Bundaberg Region – South
11. Emu Park	11. Coolum Beach	11. Burrum – Fraser
12. Frenchville – Mount Archer	12. Diddillibah - Rosemount	12. Craignish – Dundowran Beach
13. Gladstone	13. Eumundi – Yandina	13. Gayndah – Mundubbera
14. Gladstone Hinterland	14. Glasshouse Mountains	14. Gin Gin
15. Glenlee - Rockyview	15. Golden Beach – Pelican Waters	15. Granville
16. Gracemere	16. Gympie Surrounds	16. Maryborough
17. Kin Kora – Sun Valley	17. Gympie – North	17. Maryborough Region – South
18. Lakes Creek	18. Gympie – South	18. Millbank – Avoca
19. Mount Morgan	19. Kilkivan	19. Monto – Eidsvold
20. Norman Gardens	20. Landsborough	20. North Burnett
21. Park Avenue	21. Maroochydore – Kuluin	21. Pialba - Eli Waters
22. Parkhurst-Kawana	22. Maroochy Hinterland	22. Point Vernon
23. Rockhampton City	23. Marcoola - Mudjimba	23. Svensson Heights – Norville
24. Rockhampton West	24. Meridan Plains – Little Mountain (North)	24. Tinana
25. Rockhampton Region – East	25. Moffat Beach – Battery Hill	25. Torquay - Scarness – Kawungan
26. Rockhampton Region - North	26. Mooloolaba – Alexandra Headland	26. Urangan - Wondunna
27. Rockhampton Region - West	27. Mountain Creek	27. Walkervale - Avenell Heights
28. Shoalwater Bay	28. Nambour	
29. South Trees	29. Noosa Heads	
30. Telina - Tooloola	30. Noosa Hinterland	
31. The Range - Allenstown	31. Noosaville	
32. West Gladstone	32. Palmwoods	
33. Yeppoon	33. Parreara - Warana	
	34. Peregian Beach-Marcus Beach	
	35. Peregian Springs	
	36. Sippy Downs	
	37. Sunshine Beach	
	38. Tewantin	
	39. Wurtulla – Birtinya	

Indigenous Areas

There are 12 Indigenous Areas within the CCQ catchment: Banana (part b); Bundaberg; Caloundra; Central Capricorn; Cooloola – Gympie; Fraser Coast; Gladstone; Maroochy; Nanango - Kilkivan (part b); Noosa; North Burnett and Rockhampton – Yeppoon.

Statistical Area Level 3 (SA3)

There are 16 SA3s within the CCQ region boundaries. Three of these also cross over the Darling Down and West Moreton PHN boundary of which two are negligible in regard to the HNA (i.e. Biloela and Gympie are predominantly within CCQ boundaries (93% and 99% respectively). The Burnett SA3 has less than a third within the CCQ boundary, so data for this area should be interpreted with caution with regard to CCQ's capacity to respond to needs in that area without partnering with Darling Downs and West Moreton PHN.

PHN to SA3 concordance

SA3_NAME_2021	RATIO_FROM_TO
Central Highlands (Qld)	1
Rockhampton	1
Biloela	0.934918
Gladstone	1
Buderim	1
Caloundra	1
Maroochy	1
Noosa	1
Sunshine Coast Hinterland	1
Nambour	1
Noosa Hinterland	1
Bundaberg	1
Burnett	0.311998
Gympie - Cooloola	0.999684
Hervey Bay	1
Maryborough	1

Local government areas (LGA)

There are 12 LGAs within the CCQ region. Only a very small proportion of Banana and Gympie LGAs sit outside of the CCQ region boundaries. In most instances, this is the preferred level to report on within the HNA.

PHN to LGA concordance

LGA_NAME_2021	RATIO_FROM_TO
Banana	0.934918
Bundaberg	1
Central Highlands (Qld)	1
Fraser Coast	1
Gladstone	1
Gympie	0.999685
Livingstone	1
Noosa	1
North Burnett	1
Rockhampton	1
Sunshine Coast	1
Woorabinda	1

LGA to Postcode

Postcode	LGA_Name	SA2_Name	SA3_Name	HHS	Zone Rating
4420	Banana (S)	Banana	Biloela	CQ	Rural
4517	Sunshine Coast (R)	Glass House Mountains	Sunshine Coast Hinterland	SC	Rural
4518	Sunshine Coast (R)	Glass House Mountains	Sunshine Coast Hinterland	SC	Rural
4519	Sunshine Coast (R)	Beerwah	Sunshine Coast Hinterland	SC	Rural
4550	Sunshine Coast (R)	Landsborough	Sunshine Coast Hinterland	SC	Rural
4551	Sunshine Coast (R)	Caloundra - West	Caloundra	SC	Urban
4552	Sunshine Coast (R)	Caloundra Hinterland	Sunshine Coast Hinterland	SC	Rural
4553	Sunshine Coast (R)	Landsborough	Sunshine Coast Hinterland	SC	Rural
4554	Sunshine Coast (R)	Palmwoods	Sunshine Coast Hinterland	SC	Rural
4555	Sunshine Coast (R)	Palmwoods	Sunshine Coast Hinterland	SC	Rural
4556	Sunshine Coast (R)	Buderim - North	Buderim	SC	Urban
4557	Sunshine Coast (R)	Mountain Creek	Buderim	SC	Urban
4558	Sunshine Coast (R)	Maroochydore - Kuluin	Maroochy	SC	Urban
4559	Sunshine Coast (R)	Nambour	Nambour	SC	Rural
4560	Sunshine Coast (R)	Nambour	Nambour	SC	Rural
4561	Sunshine Coast (R)	Eumundi - Yandina	Nambour	SC	Rural
4562	Sunshine Coast (R)	Noosa Hinterland	Noosa Hinterland	SC	Rural
4563	Noosa (S)	Noosa Hinterland	Noosa Hinterland	SC	Rural
4564	Sunshine Coast (R)	Marcoola - Mudjimba	Maroochy	SC	Urban
4565	Noosa (S)	Tewantin	Noosa	SC	Urban
4566	Noosa (S)	Noosaville	Noosa	SC	Urban
4567	Noosa (S)	Sunshine Beach	Noosa	SC	Urban
4568	Noosa (S)	Noosa Hinterland	Noosa Hinterland	SC	Rural
4569	Noosa (S)	Noosa Hinterland	Noosa Hinterland	SC	Rural
4570	Gympie (R)	Gympie Region	Gympie - Cooloola	SC	Urban
4571	Noosa (S)	Noosa Hinterland	Noosa Hinterland	SC	Rural
4572	Sunshine Coast (R)	Mooloolaba - Alexandra Headland	Maroochy	SC	Urban
4573	Sunshine Coast (R)	Coolum Beach	Maroochy	SC	Urban
4574	Sunshine Coast (R)	Maroochy Hinterland	Sunshine Coast Hinterland	SC	Rural
4575	Sunshine Coast (R)	Parrearra - Warana	Caloundra	SC	Urban
4580	Gympie (R)	Cooloola	Gympie - Cooloola	SC	Rural
4581	Gympie (R)	Cooloola	Gympie - Cooloola	SC	Rural
4600	Gympie (R)	Kilkivan	Gympie - Cooloola	SC	Rural
4601	Gympie (R)	Kilkivan	Gympie - Cooloola	SC	Rural
4620	Fraser Coast (R)	Maryborough Region - South	Maryborough	WB	Rural
4621	North Burnett (R)	Gayndah - Mundubbera	Burnett	WB	Rural

Postcode	LGA_Name	SA2_Name	SA3_Name	HHS	Zone Rating
4625	North Burnett (R)	Gayndah - Mundubbera	Burnett	WB	Rural
4626	North Burnett (R)	Gayndah - Mundubbera	Burnett	WB	Rural
4627	North Burnett (R)	Monto - Eidsvold	Burnett	WB	Rural
4630	North Burnett (R)	Monto - Eidsvold	Burnett	WB	Rural
4650	Fraser Coast (R)	Maryborough (Qld)	Maryborough	WB	Urban
4655	Fraser Coast (R)	Torquay - Scarness - Kawungan	Hervey Bay	WB	Urban
4659	Fraser Coast (R)	Burrum - Fraser	Maryborough	WB	Rural
4660	Bundaberg (R)	Bundaberg Region - South	Bundaberg	WB	Rural
4662	Fraser Coast (R)	Burrum - Fraser	Maryborough	WB	Rural
4670	Bundaberg (R)	Bargara - Burnett Heads	Bundaberg	WB	Urban
4671	Bundaberg (R)	Gin Gin	Burnett	WB	Rural
4673	Bundaberg (R)	Bundaberg Region - North	Bundaberg	WB	Rural
4674	Gladstone (R)	Agnes Water - Miriam Vale	Gladstone	CQ	Rural
4676	Gladstone (R)	Agnes Water - Miriam Vale	Gladstone	CQ	Rural
4677	Gladstone (R)	Agnes Water - Miriam Vale	Gladstone	CQ	Rural
4678	Gladstone (R)	Agnes Water - Miriam Vale	Gladstone	CQ	Rural
4680	Gladstone (R)	Clinton - New Auckland	Gladstone	CQ	Urban
4694	Gladstone (R)	Gladstone Hinterland	Gladstone	CQ	Rural
4695	Gladstone (R)	Gladstone Hinterland	Gladstone	CQ	Rural

Postcode	LGA_Name	SA2_Name	SA3_Name	HHS	Zone Rating
4697	Gladstone (R)	Gladstone Hinterland	Gladstone	CQ	Rural
4699	Rockhampton (R)	Bouldercombe	Rockhampton	CQ	Rural
4700	Rockhampton (R)	The Range - Allenstown	Rockhampton	CQ	Urban
4701	Rockhampton (R)	Norman Gardens	Rockhampton	CQ	Urban
4702*	Rockhampton (R)	Gracemere	Rockhampton	CQ	Rural
4703	Livingstone (S)	Yeppoon	Rockhampton	CQ	Rural
4704	Livingstone (S)	Rockhampton Region - North	Rockhampton	CQ	Rural
4705	Livingstone (S)	Rockhampton Region - North	Rockhampton	CQ	Rural
4706	Livingstone (S)	Rockhampton Region - North	Rockhampton	CQ	Rural
4709	Central Highlands (R) (Qld)	Central Highlands - West	Central Highlands (Qld)	CQ	Rural
4710	Livingstone (S)	Emu Park	Rockhampton	CQ	Rural
4711	Livingstone (S)	Glenlee - Rockyview	Rockhampton	CQ	Rural
4712	Central Highlands (R) (Qld)	Central Highlands - East	Central Highlands (Qld)	CQ	Rural
4713	Woorabinda (S)	Central Highlands - East	Central Highlands (Qld)	CQ	Rural
4714	Rockhampton (R)	Mount Morgan	Rockhampton	CQ	Rural
4715	Banana (S)	Biloela	Biloela	CQ	Rural
4716	Banana (S)	Banana	Biloela	CQ	Rural
4717	Central Highlands (R) (Qld)	Central Highlands - East	Central Highlands (Qld)	CQ	Rural
4718	Banana (S)	Banana	Biloela	CQ	Rural

Postcode	LGA_Name	SA2_Name	SA3_Name	HHS	Zone Rating
4719	Banana (S)	Banana	Biloela	CQ	Rural
4720	Central Highlands (R) (Qld)	Emerald	Central Highlands (Qld)	CQ	Urban
4722	Central Highlands (R) (Qld)	Central Highlands - West	Central Highlands (Qld)	CQ	Rural
4723	Central Highlands (R) (Qld)	Central Highlands - West	Central Highlands (Qld)	CQ	Rural

***4702 reaches across four LGAs – Rockhampton, Livingstone, Gladstone and Central Highlands.**

REFERENCES

CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

phn
CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

References

1. Taylor J, O'Hara L, Talbot L, Verrinder G. *Promoting Health: The Primary Health Care Approach 7E*. 2021. https://books.google.com.au/books?id=NT0QEAAAQBAJ&printsec=frontcover&source=gbs_ge_summary_r&cad=0#v=onepage&q&f=false

2. Kukutai T, Taylor J. *Indigenous data sovereignty: Toward an agenda*. ANU press; 2016.

3. Australian Institute of Health and Welfare (AIHW). Discrete Indigenous community—Indigenous community identifier. 2001.

4. Country To Coast QLD (CCQ). *Commissioning framework*. June 2024. https://c2coast.org.au/wp-content/uploads/200811_Commissioning-Framework._Updated_-V2.0docx.pdf

5. Queensland Health. *Joint regional needs assessment framework*. 2024. 2 Apr 2024. https://www.health.qld.gov.au/__data/assets/pdf_file/0028/1351549/Joint-Regional-Needs-Assessment-Framework.pdf

6. World Health Organization (WHO). Primary Care. https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

7. World Health Organization (WHO). Primary Health Care. https://www.who.int/news-room/fact-sheets/detail/primary-health-care

8. Rajan D, Rouleau K, Winkelmann J, Jakab M, Kringos D, Khalid F. *Implementing the primary health care approach: a primer*. 2024.

9. United Nations. Sustainable Development Goals. https://www.un.org/sustainabledevelopment/

10. Australian Bureau of Statistics (ABS). Remoteness Structure. 20/07/2021, https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure

11. Department of Health and Aged Care (DHAC). Department of Health and Aged Care Modified Monash Model. https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

12. Queensland Government Statistician's Office (QGSO). Queensland Regional Profiles: Resident Profile for Local Government Areas. Queensland Treasury; 2024.

13. Queensland Government Statistician's Office (QGSO). Queensland Government population projections, 2023 edition. Queensland Treasury. 2023, https://www.qgso.qld.gov.au/issues/2671/qld-government-population-projections-2023-edn.pdf

14. Australian Institute of Health and Welfare (AIHW). Older People: Older Australians. Updated 2 Jul 2024. https://www.aihw.gov.au/reports/older-people/older-australians/contents/demographic-profile

15. Department of Health. *National Preventative Health Strategy 2021-2030*. 2021. 2021. Accessed February 2024. https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf

16. Improvement and Development Agency (I&DEA). *A glass half-full: how an asset approach can improve community health and well-being*. 2010. March 2010. https://www.local.gov.uk/sites/default/files/documents/glass-half-full-how-asset-3db.pdf

17. Burns JC, Paul DP. Participatory Asset Mapping: A Community Research Lab Toolkit. April 2012.

18. Burns JC, Cooke DY, Schweidler C. A Short Guide to Community Based Participatory Action Research: A Community Research Lab Guide. December 2011.

19. World Health Organization (WHO). Governance: Constitution. 2024, https://www.who.int/about/governance/constitution

20. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Aboriginal and Torres Strait Islander social and emotional wellbeing. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. 2014;2:55-68.

21. Department of Health and Ageing. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. 2013.

22. World Health Organization (WHO). WHOQOL: Measuring Quality of Life. https://www.who.int/tools/whoqol

23. UNICEF. Child friendly cities initiative. https://www.childfriendlycities.org/

24. Australian Institute of Family Studies (AIFS). Deaths in Australia: Life expectancy. Updated 6 June 2024. https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/life-expectancy

25. Galvani-Townsend S, Martinez I, Pandey A. Is life expectancy higher in countries and territories with publicly funded health care? Global analysis of health

care access and the social determinants of health. *Journal of Global Health*. 2022;12

26. Australian Bureau of Statistics (ABS). Life expectancy estimates for Aboriginal and Torres Strait Islander Australians, age groups and sex by selected states and territory and Australia—2020–2022. 29/11/2023, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy/latest-release

27. Australian Bureau of Statistics (ABS). Life expectancy. 8/11/2023, https://www.abs.gov.au/statistics/people/population/life-expectancy/latest-release

28. Public Health Information Development Unit (PHIDU). PHN data - with component LGAs. June 2024, https://phidu.torrens.edu.au/social-health-atlases/data

29. Public Health Information Development Unit (PHIDU). Social Health Atlas - Data by Primary Health Network (Incl. Indigenous Areas). Torrens University. July 2021, https://phidu.torrens.edu.au/social-health-atlases/indicators-and-notes-on-the-data/indigenous-social-health-atlas-of-australia-contents

30. Australian Institute of Health and Welfare (AIHW). Australia's Health 2018. 20 Jun 2018, https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/indicators-of-australias-health/self-assessed-health-status

31. Australian Institute of Health and Welfare (AIHW). Australia's health performance framework: Health status: Wellbeing. Updated 03/06/2024. https://www.aihw.gov.au/reports-data/australias-health-performance/australias-health-performance-framework/national/all-australia/wellbeing/wellbeing/3_3_2

32. Queensland Health. *Queensland Survey Analytic System: regional detailed*. 2022. 2022. https://public.tableau.com/views/QSAS_Regional_By_Indicator/Adult?:embed=y&:display_count=no&:showShareOptions=false&:showVizHome=no

33. Australian Institute of Health and Welfare (AIHW). Australian Burden of Disease Report 2023,. 14 December 2023, https://www.aihw.gov.au/getmedia/64e9a67b-6ad5-470b-bac1-119459072021/aihw-bod-39-infocus.pdf

34. Australian Institute of Health and Welfare (AIHW). Disability: Overview. Updated 15/08/2023. https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/disability/overview

35. Australian Federation of Disability Organisations. Social model of disability. 2024, https://www.afdo.org.au/social-model-of-disability/

36. People with a disability Australia. About disability. https://pwd.org.au/about-us/about-disability/

37. Australian Government. *Australia's Disability Strategy 2021-2031*. 2022. https://www.disabilitygateway.gov.au/sites/default/files/documents/2021-11/1786-australias-disability.pdf

38. Australian Bureau of Statistics (ABS). Health and Disability, Local government area. 2011, 2016, 2018, 2021. https://dbr.abs.gov.au/region.html?lyr=lga&rgn=30370

39. Australian Bureau of Statistics (ABS). People with a disability in Australia. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/people-with-disability/prevalence-of-disability

40. National Disability Insurance Scheme (NDIS). What is the NDIS? https://www.ndis.gov.au/understanding/what-ndis

41. Australian Institute of Health and Welfare (AIHW). Specialised supports for people with disability. https://www.aihw.gov.au/reports/australias-welfare/supporting-people-with-disability

42. National Disability Insurance Scheme (NDIS). Explore Data. 4 June 2024.

43. Job Access. About DES. Australian Government. https://www.jobaccess.gov.au/people-with-disability/about-des

44. Australian Institute of Health and Welfare (AIHW). Australia's health: Chronic conditions. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/australias-health/chronic-conditions

45. Australian Institute of Health and Welfare (AIHW). Australia's Health: Cancer. 2 Jul 2024, https://www.aihw.gov.au/reports/australias-health/cancer

46. Australian Institute of Health and Welfare (AIHW). Australia's Health: Cancer screening. 13 Jun 2024, https://www.aihw.gov.au/reports/australias-health/cancer-screening-and-treatment

47. Australian Institute of Health and Welfare. Cancer screening programs: quarterly data. https://www.aihw.gov.au/reports/cancer-screening/national-cancer-screening-programs-participation/data

48. Australian Institute of Health and Welfare (AIHW). Mental Health: Prevalence and impact of mental illness. Updated 17/07/2024. https://www.aihw.gov.au/mental-health/overview/prevalence-and-impact-of-mental-illness

49. Australian Institute of Health and Welfare (AIHW). Mental Health: Overview. 30/04/2024, https://www.aihw.gov.au/mental-health/overview

50. Australian Bureau of Statistics (ABS). National Study of Mental Health and Wellbeing: Prevalence of mental disorders. 5/10/2023, https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#prevalence-of-mental-disorders

51. Chesney E, Goodwin GM, Fazel S. Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World psychiatry*. 2014;13(2):153-160.

52. Butterfly Foundation. The reality of eating disorders in Australia. Butterfly Foundation. https://butterfly.org.au/wp-content/uploads/2020/06/FULL-REPORT-Butterfly-Foundation-Investing-in-Need-cost-effective-interventions-for-eating-disorders-report.pdf

53. Arcelus J, Mitchell AJ, Wales J, Nielsen S. Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of general psychiatry*. 2011;68(7):724-731.

54. Gaudiani JL. *Sick enough: A guide to the medical complications of eating disorders*. Routledge; 2018.

55. Gibson D, Workman C, Mehler PS. Medical complications of anorexia nervosa and bulimia nervosa. *Psychiatric Clinics*. 2019;42(2):263-274.

56. Mehler PS, Brown C. Anorexia nervosa–medical complications. *Journal of eating disorders*. 2015;3:1-8.

57. Wassenaar E, Friedman J, Mehler PS. Medical complications of binge eating disorder. *Psychiatric Clinics*. 2019;42(2):275-286.

58. Hay P, Aouad P, Le A, et al. Epidemiology of eating disorders: population, prevalence, disease burden and quality of life informing public policy in Australia—a rapid review. *Journal of Eating Disorders*. 2023;11(1):23.

59. Calzo JP, Blashill AJ, Brown TA, Argenal RL. Eating disorders and disordered weight and shape control behaviors in sexual minority populations. *Current psychiatry reports*. 2017;19:1-10.

60. Meneguzzo P, Collantoni E, Gallicchio D, et al. Eating disorders symptoms in sexual minority women: A systematic review. *European Eating Disorders Review*. 2018;26(4):275-292.

61. Simone M, Hazzard VM, Askew AJ, Tebbe EA, Lipson SK, Pisetsky EM. Variability in eating disorder risk and diagnosis in transgender and gender diverse college students. *Annals of epidemiology*. 2022;70:53-60.

62. Deloitte Access Economics. Prevalence of eating disorders by Primary Health Network. https://www.nedc.com.au/assets/PHN/Deloitte-Access-Economics-2019-Eating-Disorders-and-PHNs.pdf?vid=10 2019.

63. Post and Antenatal Depression Association (PANDA). How common are mental health issues in the Perinatal Period? 2024, https://panda.org.au/articles/how-common-are-mental-health-issues-in-the-perinatal-period/

64. Highet N, Group EW, Subcommittees E. *Mental Health Care in the Perinatal Period*. April 2023. https://www.cope.org.au/wp-content/uploads/2023/06/COPE_2023_Perinatal_Mental_Health_Practice_Guideline.pdf

65. Bryson H, Perlen S, Price A, et al. Patterns of maternal depression, anxiety, and stress symptoms from pregnancy to 5 years postpartum in an Australian cohort experiencing adversity. *Archives of women's mental health*. 2021;24(6):987-997.

66. Dennis C-L, Falah-Hassani K, Shiri R. Prevalence of antenatal and postnatal anxiety: systematic review and meta-analysis. *The British Journal of Psychiatry*. 2017;210(5):315-323.

67. Leach LS, Poyser C, Fairweather-Schmidt K. Maternal perinatal anxiety: A review of prevalence and correlates. *Clinical Psychologist*. 2017;21(1):4-19.

68. Falah-Hassani K, Shiri R, Dennis C-L. The prevalence of antenatal and postnatal co-morbid anxiety and depression: a meta-analysis. *Psychological medicine*. 2017;47(12):2041-2053.

69. VanderKruik R, Barreix M, Chou D, Allen T, Say L, Cohen LS. The global prevalence of postpartum psychosis: a systematic review. *BMC psychiatry*. 2017;17:1-9.

70. Cook N, Ayers S, Horsch A. Maternal posttraumatic stress disorder during the perinatal period and child outcomes: A systematic review. *Journal of affective disorders*. 2018;225:18-31.

71. Sharma V, Sharma P, Sharma S. Managing bipolar disorder during pregnancy and the postpartum period: a critical review of current practice. *Expert review of neurotherapeutics*. 2020;20(4):373-383.

72. Davies C, Segre G, Estradé A, et al. Prenatal and perinatal risk and protective factors for psychosis: a systematic review and meta-analysis. *The Lancet Psychiatry*. 2020;7(5):399-410.

73. Howard LM, Khalifeh H. Perinatal mental health: a review of progress and challenges. *World Psychiatry*. 2020;19(3):313-327.

74. Giallo R, D'Esposito F, Christensen D, et al. Father mental health during the early parenting period:

results of an Australian population based longitudinal study. *Social psychiatry and psychiatric epidemiology*. 2012;47:1907-1916.

75. Chhabra J, McDermott B, Li W. Risk factors for paternal perinatal depression and anxiety: A systematic review and meta-analysis. *Psychology of Men & Masculinities*. 2020;21(4):593.

76. Leiferman JA, Farewell CV, Jewell J, et al. Anxiety among fathers during the prenatal and postpartum period: a meta-analysis. *Journal of Psychosomatic Obstetrics & Gynecology*. 2021;42(2):152-161.

77. Philpott LF, Savage E, FitzGerald S, Leahy-Warren P. Anxiety in fathers in the perinatal period: A systematic review. *Midwifery*. 2019;76:54-101.

78. Kirubarajan A, Barker LC, Leung S, et al. LGBTQ2S+ childbearing individuals and perinatal mental health: a systematic review. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2022;129(10):1630-1643.

79. Bhat SK, Marriott R, Galbally M, Shepherd CC. Psychosocial disadvantage and residential remoteness is associated with Aboriginal women's mental health prior to childbirth. *International journal of population data science*. 2020;5(1)

80. Sullivan C, Vaughan C, Wright J. Migrant and refugee women's mental health in Australia: a literature review. *School of Population and Global Health, University of Melbourne: Melbourne, Australia*. 2020;

81. Australian Institute of Health and Welfare (AIHW). Mental health in aged care. Australian Government. https://www.aihw.gov.au/reports/aged-care/mental-health-in-aged-care/contents/conclusions-and-future-directions

82. Slade T, Grove R, Burgess P. Kessler psychological distress scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry*. 2011;45(4):308-316.

83. Australian Bureau of Statistics (ABS). First insights from the National Study of Mental Health and Wellbeing, 2020-21. 8/12/2021, https://www.abs.gov.au/articles/first-insights-national-study-mental-health-and-wellbeing-2020-21

84. Cleary A, Thomas N, Boyle F. *National Mental Health Workforce Strategy-A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*. *Institute for Social Science Research, University of Queensland*. 2020. https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf

85. Australian Institute of Health and Welfare (AIHW). Mental Health: Mental health workforce. 09/07/2024, https://www.aihw.gov.au/mental-health/topic-areas/workforce

86. Australian Institute of Health and Welfare (AIHW). Mental health-related prescriptions. https://www.aihw.gov.au/mental-health/topic-areas/mental-health-prescriptions#Key-points

87. McGorry PD, Mei C, Dalal N, et al. The Lancet Psychiatry Commission on youth mental health. *The Lancet Psychiatry*. 2024;11(9):731-774.

88. Australian Institute of Health and Welfare (AIHW). Chronic musculoskeletal conditions: Summary. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/musculoskeletal-conditions/contents/summary

89. Australian Institute of Health and Welfare (AIHW). Chronic musculoskeletal conditions: All arthritis. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/musculoskeletal-conditions/contents/arthritis

90. Australian Institute of Health and Welfare (AIHW). Osteoporosis and minimal trauma fractures: Data. 17/06/2024, Updated 17 Jun 2024. https://www.aihw.gov.au/reports/chronic-musculoskeletal-conditions/osteoporosis/data

91. Australian Institute of Health and Welfare (AIHW). Heart, stroke and vascular disease: Australian facts: Coronary heart disease. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/all-heart-stroke-and-vascular-disease/coronary-heart-disease

92. Australian Institute of Health and Welfare (AIHW). Heart, stroke and vascular disease: Australian facts: Stroke. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/hsvd-facts/contents/all-heart-stroke-and-vascular-disease/stroke

93. Australian Institute of Health and Welfare (AIHW). Dementia: Overview. 15/08/2023, https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/dementia/overview

94. Australian Institute of Health and Welfare (AIHW). Dementia in Australia. https://www.aihw.gov.au/reports/dementia/dementia-in-aus/data

95. Australian Institute of Health and Welfare (AIHW). GEN Aged Care data: My aged care region. Australian Government. https://www.gen-agedcaredata.gov.au/my-aged-care-region

96. Dementia Australia. Dementia Prevalence Data 2024-2054, commissioned research undertaken by the Australian Institute of Health and Welfare. www.dementia.org.au/information/statistics/prevalence-data

97. Australian Institute of Health and Welfare (AIHW). GEN data: Dashboard supplementary tables. Australian Government. https://www.gen-agedcaredata.gov.au/resources/access-data/2024/august/gen-data-dashboard-supplementary-tables

98. Australian Institute of Health and Welfare (AIHW). Chronic respiratory conditions: Summary. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/chronic-respiratory-conditions/chronic-respiratory-conditions/contents/summary

99. Australian Institute of Health and Welfare (AIHW). Chronic respiratory conditions: Asthma. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/chronic-respiratory-conditions/asthma

100. Australian Institute of Health and Welfare (AIHW). Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23. Updated 7 Mar 2024. https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/contents/about

101. Australian Institute of Health and Welfare (AIHW). Australia's health: Injury in Australia: Summary. Updated 21 Jun 2024. https://www.aihw.gov.au/reports/injury/injury-in-australia/contents/summary

102. National Road Safety Strategy. National Road Safety Strategy. https://www.roadsafety.gov.au/

103. Australian Institute of Health and Welfare (AIHW). Injury in Australia: Falls. Updated 6 Jul 2023. https://www.aihw.gov.au/reports/injury/falls

104. Australian and New Zealand Falls Prevention Society. The problem and prevalence of falls. https://www.anzfallsprevention.org/info/

105. Mindframe. Suicide: Communicating about suicide. Accessed: 10/4/24, https://mindframe.org.au/suicide/communicating-about-suicide

106. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Suicide & self-harm monitoring data. Updated 31/05/2024. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suicide-self-harm-monitoring-data

107. US Centers for Disease Control and Prevention (CDC). Risk and Protective Factors for suicide. https://www.cdc.gov/suicide/risk-factors/index.html

108. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Data: Deaths by suicide, by Primary Health Network areas. Updated 24/10/2023. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/suicide-by-phn-areas

109. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Data: Deaths by suicide, by local areas. Updated 07/11/2023. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/suicide-by-local-areas

110. Australian Institute of Health and Welfare (AIHW). Map: Deaths by suicide, Australia: 2014-2022.

111. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Data from suicide registers. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/suspected-deaths-by-suicide/data-from-suicide-registers

112. Demesmaeker A, Chazard E, Hoang A, Vaiva G, Amad A. Suicide mortality after a nonfatal suicide attempt: A systematic review and meta-analysis. *Australian & New Zealand Journal of Psychiatry*. 2022;56(6):603-616.

113. Mendez-Bustos P, de Leon-Martinez V, Miret M, Baca-Garcia E, Lopez-Castroman J. Suicide reattempters: a systematic review. *Harvard Review of Psychiatry*. 2013;21(6):281-295. doi:10.1097/HRP.0000000000000001

114. Queensland Health. Emergency department overview: Presentations by diagnosis, Queensland. 2024.

115. Australian Bureau of Statistics (ABS). National Study of Mental Health and Wellbeing. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#data-downloads

116. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Suicide & self-harm monitoring: Intentional self-harm hospitalisations. Updated 25/03/2024. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/intentional-self-harm-hospitalisations

117. Australian Institute of Health and Welfare (AIHW). Injury in Australia: Intentional self-harm and suicide. Updated 6 Jul 2023. https://www.aihw.gov.au/reports/injury/intentional-self-harm-and-suicide

118. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Ambulance attendances: suicidal and self-harm behaviours. Updated 06/05/2024. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/ambulance-attendances

119. Clapperton A, Dwyer J, Millar C, Tolhurst P, Berecki-Gisolf J. Sociodemographic characteristics associated with hospital contact in the year prior to suicide: a data linkage cohort study in Victoria, Australia. *PLoS One*. 2021;16(6):e0252682.

120. Australian Institute of Health and Welfare (AIHW). Suicide & self-harm monitoring: Health service use in the last year of life. 2022, https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/health-service-use-in-the-last-year-of-life

121. Australian Institute of Health and Welfare (AIHW). Suicide and self-harm monitoring: Patterns of health service use in the last year of life among those who died by suicide. Updated 17/08/2023. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/health-service-use-in-the-last-year-of-life

122. Australian Institute of Health and Welfare (AIHW). Diabetes: Australian facts: Summary. Updated 17 Jun 2024. https://www.aihw.gov.au/reports/diabetes/diabetes/contents/summary

123. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Maternal medical conditions. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/pre-existing-medical-conditions

124. healthdirect. Hearing Loss. https://www.healthdirect.gov.au/hearing-loss

125. Department of Health and Aged Care (DHAC). About ear health. https://www.health.gov.au/topics/ear-health/about

126. Australian Institute of Health and Welfare (AIHW). *Ear and hearing health of Aboriginal and Torres Strait Islander people 2023*. 2023. https://www.aihw.gov.au/getmedia/e9e18ae2-e282-4f61-8f61-3cb33256e5eb/aihw-ihw-282.pdf?v=20231128163049&inline=true

127. Australian Institute of Health and Welfare (AIHW). Regional Insights for Indigenous communities. Australian Government. https://www.rific.gov.au/regional-overview?app=rific&code=overview&release=r2&latitude=-26.530623433925033&longitude=152.91857719290425&region=CK_AUS

128. Australian Institute of Health and Welfare (AIHW). Australia's health: Infectious and communicable diseases. 2 Jul 2024, https://www.aihw.gov.au/reports/australias-health/infectious-and-communicable-diseases

129. Queensland Health. *Notifiable conditions annual reporting*. Extracted: 5/8/24. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/notifiable/annual

130. World Health Organization (WHO). Vaccines and immunization. https://www.who.int/health-topics/vaccines-and-immunization#tab=tab_1

131. Queensland Health. *Queensland Immunisation Strategy and Action Plan 2024-2029 (Consultation Draft)*. 2024.

132. Department of Health and Aged Care (DHAC). Childhood immunisation coverage data (PHN and SA3): Collection description. https://www.health.gov.au/resources/collections/childhood-immunisation-coverage-data-phn-and-sa3

133. NHMRC Centre of Research Excellence in Cervical Cancer Control. Vaccine Coverage Indicators. https://report.cervicalcancercontrol.org.au/vaccine-coverage-indicators/

134. Australian Institute of Health and Welfare (AIHW). Oral health and dental care in Australia. Updated 21 Nov 2023. https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/about

135. Australian Institute of Health and Welfare (AIHW). Chronic pain in Australia. https://www.aihw.gov.au/reports/chronic-disease/chronic-pain-in-australia/summary

136. Moilanen T, Kangasniemi M, Papinaho O, et al. Older people's perceived autonomy in residential care: An integrative review. *Nursing ethics*. 2021;28(3):414-434.

137. Department of Health. Frailty. Victoria State Government. https://www.health.vic.gov.au/older-people-in-hospital/frailty

138. Zhang X-M, Jiao J, Cao J, et al. Frailty as a predictor of mortality among patients with COVID-19: a systematic review and meta-analysis. *BMC geriatrics*. 2021;21:1-11.

139. Ellingrud K, Pérez L, Petersen A, Sartori V. Closing the women's health gap: a $1 trillion opportunity to improve lives and economies. *McKinsey Health Institute Retrieved June*. 2024;11:2024.

140. Queensland Health. *Queensland Women and Girls' Health Strategy 2032*. March 2024.

141. Mishra G, Chan H-W, Hockey R, Chung H-F, Wilson L, Dobson A. *Evidence review: Queensland women and girls' health*. 2023. https://www.health.qld.gov.au/__data/assets/pdf_file/00

21/1245702/womens-health-strategy-evidence-review.pdf

142. Rowlands I, Abbott J, Montgomery G, Hockey R, Rogers P, Mishra G. Prevalence and incidence of endometriosis in Australian women: a data linkage cohort study. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2021;128(4):657-665.

143. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Maternal body mass index. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/maternal-body-mass-index

144. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Birthweight. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/baby-outcomes/birthweight

145. Australian Bureau of Statistics (ABS). Births, Australia. 18/10/2023, https://www.abs.gov.au/statistics/people/population/births/australia/latest-release

146. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Gestational age. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/baby-outcomes/gestational-age

147. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Stillbirths and neonatal deaths in Australia. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/stillbirths-neonatal-deaths/stillbirths-and-neonatal-deaths-in-australia

148. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Maternal deaths. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/maternal-deaths

149. Commonwealth of Australia. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet; 2017.

150. Dudgeon P, Wright M, Paradies Y, Garvey D, Walker I. Aboriginal social, cultural and historical contexts. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*. Commonwealth Department of Health; 2014. https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf

151. Elias A, Mansouri F, Paradies Y. *Racism in Australia today*. Springer; 2021.

152. National Aboriginal Community Controlled Health Organisation. Aboriginal Community Controlled Health Organisations (ACCHOs): what is the definition of Aboriginal health? https://www.naccho.org.au/acchos

153. Dudgeon P, Derry KL, Mascall C, Ryder A. Understanding Aboriginal models of selfhood: The National Empowerment Project's cultural, social, and emotional wellbeing program in Western Australia. *International journal of environmental research and public health*. 2022;19(7):4078.

154. Verbunt E, Luke J, Paradies Y, et al. Cultural determinants of health for Aboriginal and Torres Strait Islander people–a narrative overview of reviews. *International Journal for Equity in Health*. 2021;20:1-9.

155. Butler TL, Anderson K, Garvey G, et al. Aboriginal and Torres Strait Islander people's domains of wellbeing: A comprehensive literature review. *Social science & medicine*. 2019;233:138-157.

156. Lovett R, Brinckley M-M, Phillips B, et al. Marrathalpu mayingku ngiya kiyi. Minyawaa ngiyani yata punmalaka; wangaaypu kirrampili kara [Ngiyampaa title]; In the beginning it was our people's law. What makes us well; to never be sick. Cohort profile of Mayi Kuwayu: The National Study of Aboriginal and Torres Strait Islander Wellbeing [English title]. *Australian Aboriginal Studies*. 2020;(2):8-30.

157. Lovett R, Jones R, Maher B. The intersection of indigenous data sovereignty and closing the gap policy in Australia. *Indigenous data sovereignty and policy*. Routledge; 2020. https://www.researchgate.net/publication/345212416_The_Intersection_of_Indigenous_Data_Sovereignty_and_Closing_the_Gap_policy_in_Australia

158. Griffiths K, Coleman C, Al-Yaman F, et al. The identification of Aboriginal and Torres Strait Islander people in official statistics and other data: Critical issues of international significance. *Statistical Journal of the IAOS*. 2019;35(1):91-106.

159. Australian Bureau of Statistics (ABS). Estimates of Aboriginal and Torres Strait Islander Australians. Local Government Areas, States and Territories. 31/08/2023, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release

160. PHN Cooperative. *PHN Multicultural Health Framework*. February 2024. https://wentwest.com.au/wp-content/uploads/planning_resources/2024_04_02_MulticulturalHealthFramework_A4_Final_Digital_1.1.pdf

161. Department of Health. WA Aboriginal Health and Wellbeing Framework 2015–2030. Government of Western Australia. https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/Aboriginal-health/PDF/12853_WA_Aboriginal_Health_and_Wellbeing_Framework.pdf

162. Australian Institute of Health and Welfare (AIHW). Health and wellbeing of First Nations people. https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing

163. Australian Institute of Health and Welfare (AIHW). Aboriginal and Torres Strait Islander Stolen Generations aged 50 and over: updated analyses for 2018–19. Australian Government; 2021.

164. Drew N, Durbin M, Parnell A, Potter C, Poynton M, Tarrant H. *Overview of Aboriginal and Torres Strait Islander health status, 2023*. 2024. https://healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=706475&title=Overview+of+Aboriginal+and+Torres+Strait+Islander+health+status+2023&contentid=48279_1

165. Australian Bureau of Statistics (ABS). Language Statistics for Aboriginal and Torres Strait Islander Peoples, Census 2021. 25/10/2022, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/language-statistics-aboriginal-and-torres-strait-islander-peoples/latest-release

166. Fran Baum A. People's health and the social determinants of health. *Health Promotion Journal of Australia*. 2018;29(1):8-9.

167. World Health Organization (WHO). Determinants of health. 3 February 2017, https://www.who.int/news-room/questions-and-answers/item/determinants-of-health

168. Australian Bureau of Statistics (ABS). Socio-Economic Indexes for Areas (SEIFA), Australia. 27/04/2023, Accessed Accessed March 2024, https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

169. Raghupathi V, Raghupathi W. The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015. *Archives of Public Health*. 2020;78:1-18.

170. Australian Government. Literacy and access. https://www.stylemanual.gov.au/accessible-and-inclusive-content/literacy-and-access#:~:text=In%20Australia%3A,5%20(the%20highest%20level

171. Raising Children Network. Developmental delays. Australian Government. https://raisingchildren.net.au/guides/a-z-health-reference/developmental-delay

172. Australian Early Development Census (AEDC). About The AEDC. Australian Government. Accessed: February 2024, https://www.aedc.gov.au/about-the-aedc

173. Australian Early Development Census (AEDC). Data explorer. https://www.aedc.gov.au/data-explorer/

174. Lieberman A. Lack of Access to Child Care Impacts Child Well-Being. First Five Years Fund. https://www.ffyf.org/resources/2023/08/lack-of-access-to-child-care-impacts-child-well-being/

175. Department of Education. About early childhood education and care in Australia. https://www.education.gov.au/early-childhood/about-early-childhood-education-and-care-australia#toc-why-is-early-childhood-education-and-care-so-important-

176. Ting I, Chwasta M, Brettell T, B. S. Australia's childcare divide is growing. Here are the suburbs getting left behind. https://www.abc.net.au/news/2024-08-20/mapping-australia-s-growing-childcare-divide/104243302

177. Save the Children. The Urban Disadvantage: State of World's Mothers. US: Save the Children; 2015.

178. Harris J, Wells M. State of Australia's Mothers. Save the Children Australia. https://apo.org.au/sites/default/files/resource-files/2016-05/apo-nid63692.pdf

179. Thomas J, McCosker A, Parkinson S, et al. *Australian Digital Inclusion Index: 2023*. 2023. 2023. https://www.digitalinclusionindex.org.au/the-adii/

180. Australian Bureau of Statistics (ABS). Census Dictionary: One-part family. 15/10/2021, https://www.abs.gov.au/census/guide-census-data/census-dictionary/2021/glossary/o#one-parent-family

181. Gray M, Phillips B. *Analysis of the impact increasing the rate and extending eligibility of Parenting Payment Single on financial living standards*. 2023. https://csrm.cass.anu.edu.au/research/publications/analysis-impact-increasing-rate-and-extending-eligibility-parenting-payment

182. Centre for Social Impact. Financial Resilience in Australia. University of New South Wales. https://www.csi.edu.au/research/financial-resilience-in-australia/

183. Centre for Full Employment and Equity. Financial Resilience Barometer Index - Queensland. https://www.fullemployment.net/frb/frbmaps.php?state=QLD

184. Foster G, Gronda H, Mallett S, Bentley R. Precarious housing and health: research synthesis.

Australian Housing and Urban Research Institute, Hanover Welfare Services, University of Melbourne, University of Adelaide & Melbourne City mission, Australia. www.vichealth.vic.gov.au/publications/health-inequalities

185. Australian Bureau of Statistics (ABS). Estimating Homelessness: Census methodology. 22/03/2023, https://www.abs.gov.au/methodologies/estimating-homelessness-census-methodology/2021

186. Tually S, Tedmanson D, Habibis D, et al. *Urban Indigenous homelessness: much more than housing*. 2022. 10 Aug 2022. https://www.ahuri.edu.au/sites/default/files/documents/2022-08/AHURI-Final-Report-383-Urban-Indigenous-homelessness-much-more-than-housing_1.pdf

187. Noongar Mia Mia. *Why Aboriginal Homelessness Needs A Cultural Approach*. August 2021. https://noongarmiamia.com.au/wp-content/uploads/2022/02/Why-Aboriginal-Homelessness-Needs-A-Cultural-Approach.pdf

188. VicHealth. Housing and Health Research summary - Addressing the social and economic determinants of mental and physical health. Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/sites/default/files/Housing_and-_Health_Research-Summary_web.pdf

189. Fitzpatrick S, Bramley G, Johnsen S. Pathways into multiple exclusion homelessness in seven UK cities. *Urban studies*. 2013;50(1):148-168.

190. Goode J, Hoang H, Crocombe L. Homeless adults' access to dental services and strategies to improve their oral health: a systematic literature review. *Australian Journal of Primary Health*. 2018;24(4):287-298.

191. Huang C, Foster H, Paudyal V, Ward M, Lowrie R. A systematic review of the nutritional status of adults experiencing homelessness. *Public health*. 2022;208:59-67.

192. Larney S, Conroy E, Mills KL, Burns L, Teesson M. Factors associated with violent victimisation among homeless adults in Sydney, Australia. *Australian and New Zealand journal of public health*. 2009;33(4):347-351.

193. Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *International journal of epidemiology*. 2009;38(3):877-883.

194. Seastres RJ, Hutton J, Zordan R, et al. Long-term effects of homelessness on mortality: A 15-year Australian cohort study. *Australian and New Zealand Journal of Public Health*. 2020;44(6):476-481.

195. Zordan R, Mackelprang JL, Hutton J, Moore G, Sundararajan V. Premature mortality 16 years after emergency department presentation among homeless and at risk of homelessness adults: a retrospective longitudinal cohort study. *International Journal of Epidemiology*. 2023;52(2):501-511.

196. Homelessness Australia. Definitions of homelessness Fact Sheet. 2001.

197. Australian Bureau of Statistics (ABS). Estimating Homelessness: Census. 22/03/2023, https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/2021

198. Australian Institute of Health and Welfare (AIHW). Homelessness and homelessness services. 27 Feb 2024, https://www.aihw.gov.au/reports/australias-welfare/homelessness-and-homelessness-services

199. Davies A, Wood LJ. Homeless health care: meeting the challenges of providing primary care. *Med J Aust*. 2018;209(5):230-234.

200. Zaretzky K, Flatau P. *The cost of homelessness and the net benefit of homelessness programs: a national study*. December 2013. https://www.ahuri.edu.au/sites/default/files/migration/documents/AHURI_Final_Report_No218_The-cost-of-homelessness-and-the-net-benefit-of-homelessness-programs-a-national-study.pdf

201. Wise C, Phillips K. Hearing the silent voices: narratives of health care and homelessness. *Issues in mental health nursing*. 2013;34(5):359-367.

202. Australian Institute of Health and Welfare (AIHW). Health of people experiencing homelessness. 27 June 2024, https://www.aihw.gov.au/reports/australias-health/health-of-people-experiencing-homelessness

203. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*. 2014;384(9953):1529-1540.

204. Buckle C, Gurran N, Phibbs P, Harris P, Lea T, Shrivastava R. *Marginal housing during COVID-19*. December 2020. https://www.ahuri.edu.au/sites/default/files/migration/documents/AHURI-Final-Report-348-Marginal-housing-during-COVID-19.pdf

205. Black C, Gronda H. *Evidence for improving access to homelessness services*. July 2011. https://www.ahuri.edu.au/sites/default/files/migration/documents/SYN059_Evidence_for_improving_access_to_homelessness_services.pdf

206. Australian Bureau of Statistics (ABS). Aboriginal and Torres Strait Islander peoples experiencing homelessness - key statistics. 27/06/2023, https://www.abs.gov.au/articles/aboriginal-and-torres-strait-islander-peoples-experiencing-homelessness

207. Australian Institute of Health and Welfare (AIHW). Specialist homelessness services annual report 2022–23. Updated 13 Feb 2024. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/about

208. Australian Housing and Urban Research Institute (AHURI). The risk of homelessness for young people with exiting foster care. 27 June 2018, https://www.ahuri.edu.au/analysis/brief/risk-homelessness-young-people-exiting-foster-care

209. McDowall J. *Transitioning to adulthood from out-of-home care: Independence or interdependence*. 2020. 2020. https://create.org.au/wp-content/uploads/2021/05/CREATE-Post-Care-Report-2021-LR.pdf

210. Brackertz N, Wilkinson A, Davison J. *Housing, homelessness and mental health: towards systems change*. *AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne*. 2018. https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/housing-homelessness-mental-health-towards-systems-change.pdf

211. Hilferty F, Katz I, Van Hooff M, et al. *Homelessness amongst Australian veterans: summary of project findings*. May 2019. https://www.ahuri.edu.au/sites/default/files/migration/documents/AHURI-Report_Homelessness-Amongst-Australian-contemporary-veterans_Final-Report.pdf

212. Australian Institute of Health and Welfare (AIHW). Specialist homelessness services annual report 2022-2023 - Clients exiting custodial arrangements. Updated 13 Feb 2024. https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-exiting-custodial-arrangements

213. SGS Economics and Planning. *Rental Affordability Index*. 2023. November 2023. https://sgsep.com.au/assets/main/SGS-Economics-and-Planning_RAI2023-Website.pdf

214. Australian Human Rights Commission. Building social cohesion in our communities: A summary of the online resource for local government. https://humanrights.gov.au/sites/default/files/document/publication/WEB_Building_social_cohesion_A4_brochure.pdf

215. O'Donnell J. Mapping Social Cohesion. https://scanloninstitute.org.au/sites/default/files/2023-11/2023%20Mapping%20Social%20Cohesion%20Report.pdf

216. Scanlon Foundation Research Institute. Scanlon-Monash Index. https://scanloninstitute.org.au/research/scanlon-monash-index

217. Australian Bureau of Statistics (ABS). Analysis of non-binary sex responses. 27/09/2022, https://www.abs.gov.au/articles/analysis-non-binary-sex-responses?fbclid=IwAR2aVhb_bYkbBrOEgcvTk9a4laHCw_5LHymFNotZhQKVFS_BZE8IkIFeo8Q

218. Carman M, Farrugia C, Bourne A, Power J, Rosenberg S. Research Matters: How many people are LGBTIQ? A fact sheet by Rainbow Health Victoria. Rainbow Health Victoria. https://www.rainbowhealthvic.org.au/media/pages/research-resources/research-matters-how-many-people-are-lgbtiq/4170611962-1612761890/researchmatters-numbers-lgbtiq.pdf

219. Australian Bureau of Statistics (ABS). General Social Survey: Summary Results, Australia, 2020. https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2020

220. Miranti R, Freyens B, Vidyattama Y, Tanton R, Shakir GR. *Child Social Exclusion Index - Nurturing Inclusion: Paving the Way to Improved Child Wellbeing. The Canberra School of Politics, Economics and Society (SchoPES), Faculty of Business, Government and Law (BGL), University of Canberra, 2024. 99 p.* 2024. https://unitingcare.org.au/submission/child-social-exclusion-report-index/

221. Australian Institute of Health and Welfare (AIHW). Social isolation and loneliness. Australian Government. https://www.aihw.gov.au/mental-health/topic-areas/social-isolation-and-loneliness

222. Centre for Disease Control and Prevention (CDC). Loneliness and Social Isolation Linked to Serious Health Conditions. https://www.cdc.gov/social-connectedness/risk-factors/index.html#:~:text=Health%20impacts,Depression%20and%20anxiety.

223. Jorgensen M, Haddock R. The impact of the home care reforms on the older person, the aged care workforce and the wider Health System. Deeble Institute for Health Policy Research. https://ahha.asn.au/resource/the-impact-of-the-home-care-reforms-on-the-older-person-the-aged-care-workforce-and-the-wider-health-system/

224. Jorgensen M, Siette J, Georgiou A, Warland A, Westbrook J. Modeling the Association Between Home Care Service Use and Entry Into Residential Aged Care: A Cohort Study Using Routinely Collected Data. *Journal of the American Medical Directors Association*. 2018;19(2):117-121.e3. doi:10.1016/j.jamda.2017.08.004

225. Social Policy Research Centre. Research to Practice.

https://www.sprc.unsw.edu.au/media/SPRCFile/8_Report_BenSoc_ResearchtoPractice2.pdf

226. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspectives on psychological science*. 2015;10(2):227-237.

227. Gardiner C, Laud P, Heaton T, Gott M. What is the prevalence of loneliness amongst older people living in residential and nursing care homes? A systematic review and meta-analysis. *Age and ageing*. 2020;49(5):748-757.

228. Australian Bureau of Statistics (ABS). Houshold and Family Projections, Australia. 28/06/2024, https://www.abs.gov.au/statistics/people/population/household-and-family-projections-australia/latest-release

229. Public Health Information Development Unit (PHIDU). Social Health Atlases - Older adults. Torrens University. https://phidu.torrens.edu.au/social-health-atlases

230. Volunteer Benefits. Queensland Government; https://metronorth.health.qld.gov.au/community/wp-content/uploads/sites/7/2017/11/volunteer-benefits.pdf

231. World Health Organization (WHO). Health Promotion, Health Literacy. https://www.who.int/teams/health-promotion/enhanced-wellbeing/ninth-global-conference/health-literacy

232. Australian Commission on Safety and Quality in Health Care (ACSQHC). *National Statement on Health Literacy: Taking action to improve safety and quality*. 2014. https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-National-Statement.pdf

233. Australian Institute of Health and Welfare (AIHW). Who is a veteran. Updated 14/11/2023. https://www.aihw.gov.au/reports-data/population-groups/veterans/who-is-a-veteran

234. Jones K, Varker T, Stone C, et al. *Defence force and veteran suicides: literature review. Report prepared for the Australian Commission on Safety and Quality in Health Care. Melbourne, Australia: Phoenix Australia–Centre for Posttraumatic Mental Health*. 2020. 2020. https://defenceveteransuicide.royalcommission.gov.au/system/files/exhibit/EXHIBIT%2008-06.17%20-%20EXP.0001.0015.0004%20-%20Phoenix%20Australia%20-%20Defence%20Force%20and%20Veteran%20Suicide%20Lit%20Review%20%2831.7.2020%29.pdf

235. Department of Veterans' Affairs. Statistics about the veteran population. https://www.dva.gov.au/get-support/providers/training-research/research/statistics-about-veteran-population

236. Boxall H, Morgan A. *Experiences of coercive control among Australian women*. Australian Institute of Criminology; 2021.

237. Stark E. *Coercive control: How men entrap women in personal life*. Oxford University Press; 2007.

238. Mission Australia. Domestic and Family Violence statistics. https://www.missionaustralia.com.au/domestic-and-family-violence-statistics

239. Queensland Government Statistician's Office (QGSO). Crime Report 2022-23. https://www.qgso.qld.gov.au/issues/7856/crime-report-qld-2022-23.pdf

240. World Health Organization (WHO). Abuse of older people. https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people

241. Qu L, Kaspiew R, Carson R, et al. National elder abuse prevalence study final report. AIFS research report. https://apo.org.au/sites/default/files/resource-files/2023-02/apo-nid321557.pdf

242. Australian Institute of Health and Welfare (AIHW). Australian Burden of Disease Study 2018: Interactive data on risk factor burden. https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-risk-factors/contents/occupational-exposures-and-hazards

243. Queensland Government. Queensland air monitoring 2023 National Environment Protection(Ambient Air Quality) Measure. https://www.qld.gov.au/__data/assets/pdf_file/0032/68657/air-monitoring-report-2023.pdf

244. Council CHR. Drinking Water Quality Management Plan (DWQMP) Annual Report. https://www.chrc.qld.gov.au/wp-content/uploads/2022/12/2021-2022-DWQMP-Annual-Report.pdf

245. seq water. Water Quality Report. https://www.seqwater.com.au/water-quality-report

246. Australian Government. Australia State of the Environment: Air quality. https://soe.dcceew.gov.au/air-quality/key-findings

247. Department of Employment EDaI. Food for a growing economy: An economic development framework for the Queensland food industry. https://cabinet.qld.gov.au/documents/2011/Jun/Food%20for%20a%20Growing%20Economy/Attachments/Report.pdf

248. Department of Climate Change and Energy and the Environment and Water (DCCEEW). Climate adaptation in Australia. Accessed: 12/4/24, https://www.dcceew.gov.au/climate-change/policy/adaptation

249. Commonwealth Scientific and Industrial Research (CSIRO). Climate projections for Australia. https://www.csiro.au/en/research/environmental-impacts/climate-change/climate-change-information

250. Intergovernmental Panel on Climate Change (IPCC). Fourth Assessment Report of the Intergovernmental Panel on Climate Change. https://www.ipcc.ch/

251. Natural Hazards Research Australia. Australian Disaster Resilience Index.

252. Australian Institute of Health and Welfare (AIHW). Built environment and health. https://www.aihw.gov.au/reports/australias-health/built-environment-and-health

253. Cycling and Walking Australia and New Zealand (CWANZ). National Walking and Cycling Participation Survey 2023. https://www.cwanz.com.au/national-walking-and-cycling-participation-survey-2023/

254. Austroads. Cycling participation. https://austroads.com.au/network-operations/active-travel/cycling-participation

255. Australian Bureau of Statistics (ABS). 2021 Census Community Profiles - Number of registered motor vehicles. 2021;

256. Australian Bureau of Statistics (ABS). 2021 Census Community Profiles - Method of travel to work. https://www.abs.gov.au/census/find-census-data/search-by-area

257. Heart Foundation. Community Walkability Checklist. https://walking.heartfoundation.org.au/resources/community-walkability-checklist

258. Walk Score. www.walkscore.com

259. SGS Economics and Planning. *Cities and Regions Wellbeing Index*. 2023. 2024. https://sgsep.com.au/projects/sgs-wellbeing-index

260. Australian Communications and Media Authority (ACMA). *Communications and media in Australia: How we use the internet - Executive Summary and key findings*. December 2023. https://www.acma.gov.au/sites/default/files/2023-12/ACMA_How%20we%20use%20the%20internet_Executive%20summary%20and%20key%20findings.pdf

261. Infrastructure Australia. *Regional Strengths and Infrastructure Gaps - Regional Analysis: Queensland*. 2022. March 2022. https://www.infrastructureaustralia.gov.au/sites/default/files/2022-03/5_RSIG_Regional%20Analysis_QLD.pdf

262. Australian Institute of Health and Welfare (AIHW). General practice, allied health and other primary care services. Australian Government. https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care

263. Australian Institute of Health and Welfare (AIHW). Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23. https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data

264. Australian Bureau of Statistics (ABS). Patient experiences 2022-23. https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release

265. Queensland Government. Our Performance, Queensland Health https://www.performance.health.qld.gov.au/

266. National Rural Health Alliance (NRHA). *Evidence base for additional investment in rural health in Australia*. 23 June 2023. https://www.ruralhealth.org.au/document/evidence-base-additional-investment-rural-health-australia

267. Australian Institute of Health and Welfare (AIHW). Health workforce. Updated 2 Jul 2024. https://www.aihw.gov.au/reports/workforce/health-workforce

268. National Rural Health Alliance (NRHA). *Medical practitioners in rural, regional and remote Australia*. November 2019. https://www.ruralhealth.org.au/factsheets/list

269. Walters LK, McGrail MR, Carson DB, et al. Where to next for rural general practice policy and research in Australia? *The Medical Journal of Australia*. 2017;207(2):56-58.

270. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Antenatal care. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/antenatal-visits

271. Department of Health and Aged Care (DHAC). Clinical practice guidelines: pregnancy care. Australian Government; 2020.

272. World Health Organization (WHO). Raising the importance of postnatal care. 2024, https://www.who.int/activities/raising-the-importance-of-postnatal-care

273. Frayne J. The postnatal period. *Australian Journal of General Practice*. 2022;51(3):101-102.

274. Australian Indigenous HealthInfoNet. Traditional healing and medicine. https://healthinfonet.ecu.edu.au/learn/cultural-ways/traditional-healing-and-medicine/

275. Australian Institute of Health and Welfare (AIHW). Older Australians. https://www.aihw.gov.au/reports/older-people/older-australians/contents/aged-care

276. Department of Health and Aged Care (DHAC). Home Care Packages Program Data Report 3rd Quarter 2023-24 (1 January – 31 March 2024). Australian Government. https://www.gen-agedcaredata.gov.au/getmedia/447b425c-63d6-4b96-a1fc-4dac805066ba/Home-Care-Packages-Program-data-report-1-January-%E2%80%93-31-March-2024

277. Australian Institute of Health and Welfare (AIHW). GEN Aged Care data: Aged care service list: 30 June 2024. Australian Government. https://www.gen-agedcaredata.gov.au/resources/access-data/2024/september/aged-care-service-list-30-june-2024

278. World Health Assembly. Strengthening of palliative care as a component of comprehensive care throughout the life course. https://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r19-en.pdf

279. Australian Institute of Health and Welfare (AIHW). National Palliative Care and End-of-Life Care Information Priorities. https://www.aihw.gov.au/getmedia/17b82c56-83ff-45dc-be93-392bc5669fab/national-palliative-care-and-end-of-life-care-information-priorities.pdf.aspx

280. Australian Commission on Safety and Quality in Health Care (ACSQHC). National Consensus Statement: Essential elements for safe and high-quality end-of-life care. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-consensus-statement-essential-elements-safe-and-high-quality-end-life-care

281. Foreman LM, Hunt RW, Luke CG, Roder DM. Factors predictive of preferred place of death in the general population of South Australia. *Palliative Medicine*. 2006/06/01 2006;20(4):447-453. doi:10.1191/0269216306pm1149oa

282. Worldwide Palliative Care Alliance. Global Atlas of Palliative Care at the End of Life. https://www.iccp-portal.org/system/files/resources/Global_Atlas_of_Palliative_Care.pdf

283. Australian Institute of Health and Welfare (AIHW). Palliative care services in Australia. https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/about

284. van Gaans D, Erny-Albrecht K, Tieman J. Palliative care within the primary health care setting in Australia: A scoping review. *Public Health Reviews*. 2022;43:1604856.

285. HealthInfoNet. Culturally appropriate palliative care and end-of-life care. https://healthinfonet.ecu.edu.au/learn/health-system/palliative-care/culturally-appropriate/

286. Palliative Care Australia. Position Statement: Palliative Care and Culturally and Linguistically Diverse Communities. https://palliativecare.org.au/wp-content/uploads/2015/08/PCA-Culturally-and-Linguistically-Diverse-Communities-and-Palliative-Care-Position-Statement.pdf

287. RACGP. Advance care planning. https://www.racgp.org.au/running-a-practice/practice-resources/practice-tools/advance-care-planning

288. ADVAnce care planning Reporting Console. https://www.qld.gov.au/__data/assets/pdf_file/0026/506087/office-acp-data-access-request.pdf.

289. Queensland Health. Implementation of voluntary assisted dying. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/voluntary-assisted-dying/explained/overview

290. Queensland Government. The Queensland Voluntary Assisted Dying Review Board Annual Report 2022–2023. https://www.health.qld.gov.au/__data/assets/pdf_file/0024/1261185/vad-annual-report-2022-23.pdf

291. National Aboriginal and Torres Strait Islander Health Workers Association. *Cultural Safety Framework*. 2016.

292. Queensland Productivity Commission. *Final Report: Service delivery in remote and discrete Aboriginal and Torres Strait Islander communities*. 2017.

293. Department of Health and Aged Care (DHAC). General Practice Workforce 2018-2023 Calendar. https://hwd.health.gov.au/resources/data/gp-primarycare.html

294. Committee for Economic Development of Australia (CEDA). Duty of care: Aged-care sector running on empty. https://cedakenticomedia.blob.core.windows.net/cedamediatest/kentico/media/attachments/ceda-duty-of-care-3-final.pdf

295. Country to Coast QLD & Consortium partners. Integrated Care Oasis Central Queensland's systems approach to healthy ageing. Country to Coast QLD: Country to Coast QLD; 2024.

296. Australian Government. Australia's Food Environment Dashboard. How healthy are Australia's food environments? https://foodenvironmentdashboard.com.au/

297. Australian Bureau of Statistics (ABS). Woorabinda 2021 Census All persons QuickStats. https://abs.gov.au/census/find-census-data/quickstats/2021/LGA37550

298. McKell Institute Queensland. Mapping food insecurity: An Index for Central and North Queensland. https://mckellinstitute.org.au/wp-content/uploads/2022/02/200713-McKell_QLD_Food-bank_V61.pdf

299. World Health Organization (WHO). Commercial determinants of health. https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health

300. Gilmore AB, Fabbri A, Baum F, et al. Defining and conceptualising the commercial determinants of health. *The Lancet*. 2023;401(10383):1194-1213.

301. Lacy-Nichols J, Nandi S, Mialon M, et al. Conceptualising commercial entities in public health: beyond unhealthy commodities and transnational corporations. *The Lancet*. 2023;401(10383):1214-1228.

302. Friel S, Collin J, Daube M, et al. Commercial determinants of health: future directions. *The Lancet*. 2023;401(10383):1229-1240.

303. Chung A, Westerman L, Martin J, Friel S. The commercial determinants of unhealthy diets. *Public Health Research & Practice*. 2022;32(3)

304. UNICEF. The State of the World's Children 2019. Children, Food and Nutrition: Growing well in a changing world. UNICEF; 2019.

305. Maddox R, Kennedy M, Waa A, et al. Clearing the air: conflicts of interest and the tobacco industry's impact on indigenous peoples. *Nicotine and Tobacco Research*. 2022;24(6):933-936.

306. Holly L, Demaio S, Kickbusch I. Public health interventions to address digital determinants of children's health and wellbeing. *The Lancet Public Health*. 2024;9(9):e700-e704.

307. Department of Health and Aged Care (DHAC). Physical activity and exercise guidelines for all Australians. https://www.health.gov.au/topics/physical-activity-and-exercise/physical-activity-and-exercise-guidelines-for-all-australians

308. Cliff DP, McNeill J, Vella SA, et al. Adherence to 24-hour movement guidelines for the early years and associations with social-cognitive development among Australian preschool children. *BMC public health*. 2017;17:207-215.

309. Hinkley T, Timperio A, Watson A, et al. Prospective associations with physiological, psychosocial and educational outcomes of meeting Australian 24-Hour Movement Guidelines for the Early Years. *International Journal of Behavioral Nutrition and Physical Activity*. 2020;17:1-12.

310. Howie EK, Joosten J, Harris CJ, Straker LM. Associations between meeting sleep, physical activity or screen time behaviour guidelines and academic performance in Australian school children. *BMC public health*. 2020;20:1-10.

311. Thomas G, Bennie JA, De Cocker K, Ireland MJ, Biddle SJ. Screen-based behaviors in Australian adolescents: Longitudinal trends from a 4-year follow-up study. *Preventive Medicine*. 2020;141:106258.

312. Graham A, Sahlberg P. Growing Up Digital Australia: Phase 2 technical report. Gonski Institute for Education. UNSW. https://www.gie.unsw.edu.au/sites/default/files/documents/GONS5000%20Growing%20Up%20Digital%20Report_FINAL.pdf

313. Australian Institute of Health and Welfare (AIHW). Biomedical risk factors. https://www.aihw.gov.au/reports/australias-health/biomedical-risk-factors

314. Hypertension Australia. National Hypertension Taskforce. https://www.hypertension.org.au/the-national-hypertension-taskforce/

315. Department of Health and Aged Care (DHAC). About overweight and obesity. https://www.health.gov.au/topics/overweight-and-obesity/about

316. Australian Institute of Health and Welfare (AIHW). Overweight and Obesity. https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/overweight-and-obesity#how_common_overweight

317. Queensland Government. The health of Queenslanders: Report of the Chief Health Officer Queensland - Weight. 2023;

318. Queensland Government. The health of Queenslanders: Report of the Chief Health Officer Queensland - Electronic cigarettes. https://www.choreport.health.qld.gov.au/our-lifestyle/electronic-cigarettes#:~:text=In%202022%2C%2019.7%25%20Queensland%20adults,in%20the%20previous%2012%20months.

319. Cancer Council. Prevalence of e-cigarette use. https://www.tobaccoinaustralia.org.au/chapter-18-e-cigarettes/18-3-legal

320. Australian Bureau of Statistics (ABS). Dietary behaviour. https://www.abs.gov.au/statistics/health/health-conditions-and-risks/dietary-behaviour/latest-release

321. Australian Bureau of Statistics (ABS). National Health Survey 2022. 15/12/2023, https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey/latest-release

322. Australian Bureau of Statistics (ABS). Causes of Death, Australia. 27/09/2023, Updated 27/09/2023. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release

323. Australian Bureau of Statistics (ABS). National Aboriginal and Torres Strait Islander Health Survey: Statistics about long term health conditions, disability, lifestyle factors, physical harm and use of health services. 2018-19. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/national-aboriginal-and-torres-strait-islander-health-survey/latest-release#alcohol-consumption

324. Australian Institute of Health and Welfare (AIHW). Alcohol tobacco & other drugs in Australia. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/alcohol#treatment

325. Australian Institute of Health and Welfare (AIHW). National Drug Strategy Household Survey 2022-23. Updated 08/04/2024. https://www.aihw.gov.au/about-our-data/our-data-collections/national-drug-strategy-household-survey

326. Australian Institute of Health and Welfare (AIHW). Illicit drug use. https://www.aihw.gov.au/reports/illicit-use-of-drugs/illicit-drug-use

327. Queensland Government. The health of Queenslanders: Report of the Chief Health Officer Queensland - Physical activity. 2023;

328. Clearinghouse for Sport. Children and youth in sport. https://www.clearinghouseforsport.gov.au/kb/children-and-youth-in-sport

329. Australian Institute of Health and Welfare (AIHW). *Australia's children: The health of Australia's children*. 25 Feb 2022. https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/health-australias-children

330. Queensland Government. The health of Queenslanders: Report of the Chief Health Officer Queensland - Bacterial communicable diseases. https://www.choreport.health.qld.gov.au/our-health/communicable-diseases/bacterial-communicable-diseases

331. Queensland Health. Queensland Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Action Plan 2019–2022. 2019;

332. Ward J, Elliott S, Bryant J, et al. *The Goanna Survey 2: Results of the second Australian survey of knowledge, relationships, behaviour and health service access relating to sexually transmissible infections (STIs) and blood borne viruses (BBVs) among Aboriginal and Torres Strait Islander young people*. 2020. 2020. https://youngdeadlyfree.org.au/wp-content/uploads/2020/11/SAHRMI_goannaSurvey_online_20201103r.pdf

333. Australian Institute of Family Studies, Australian Gambling Research Centre. Gambling participation, experience of harm and community views. An overview. https://aifs.gov.au/sites/default/files/2023-03/2302-overview_gambling-participation-harm-views.pdf

334. Australian Institute of Health and Welfare (AIHW). Gambling in Australia. https://www.aihw.gov.au/reports/australias-welfare/gambling

335. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Smoking during pregnancy. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/smoking

336. National Health and Medical Research Council (NHMRC). *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. 2020. https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol

337. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Alcohol consumption during pregnancy. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/antenatal-period/alcohol

338. Australian Institute of Health and Welfare (AIHW). Australia's mothers and babies: Breastfeeding. Updated 30 Jul 2024. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/breastfeeding-practices

339. Bowatte G, Tham R, Allen K, et al. Breastfeeding and childhood acute otitis media: a systematic review and meta-analysis. *Acta Paediatrica*. 2015;104:85-95.

340. Horta BL, Victora CG, Organization WH. Short-term effects of breastfeeding: a systematic review on the benefits of breastfeeding on diarrhoea and pneumonia mortality. 2013;

341. Hauck FR, Thompson JM, Tanabe KO, Moon RY, Vennemann MM. Breastfeeding and reduced risk of

sudden infant death syndrome: a meta-analysis. *Pediatrics*. 2011;128(1):103-110.

342. Tham R, Bowatte G, Dharmage SC, et al. Breastfeeding and the risk of dental caries: a systematic review and meta-analysis. *Acta paediatrica*. 2015;104:62-84.

343. Smith JP, Thompson JF, Ellwood DA. Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory. *Australian and New Zealand journal of public health*. 2002;26(6):543-551.