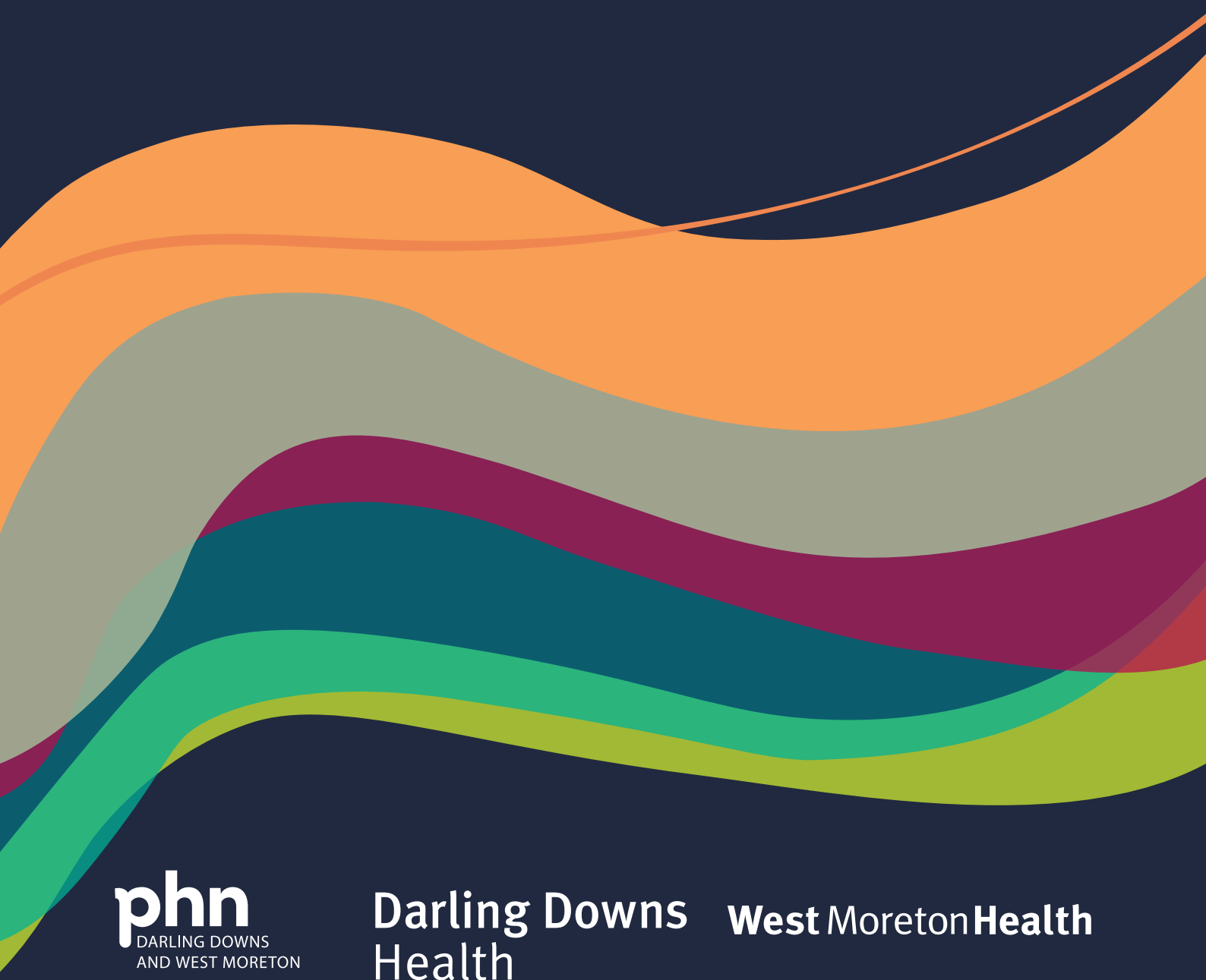
Darling Downs and West Moreton Joint Regional Needs Assessment

2025-28



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DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Darling Downs Health

West Moreton Health

We acknowledge Aboriginal and Torres Strait Islander peoples as the Custodians of this land. We pay our respect to Elders past, present and emerging, and commit to a future with reconciliation and renewal at its heart.

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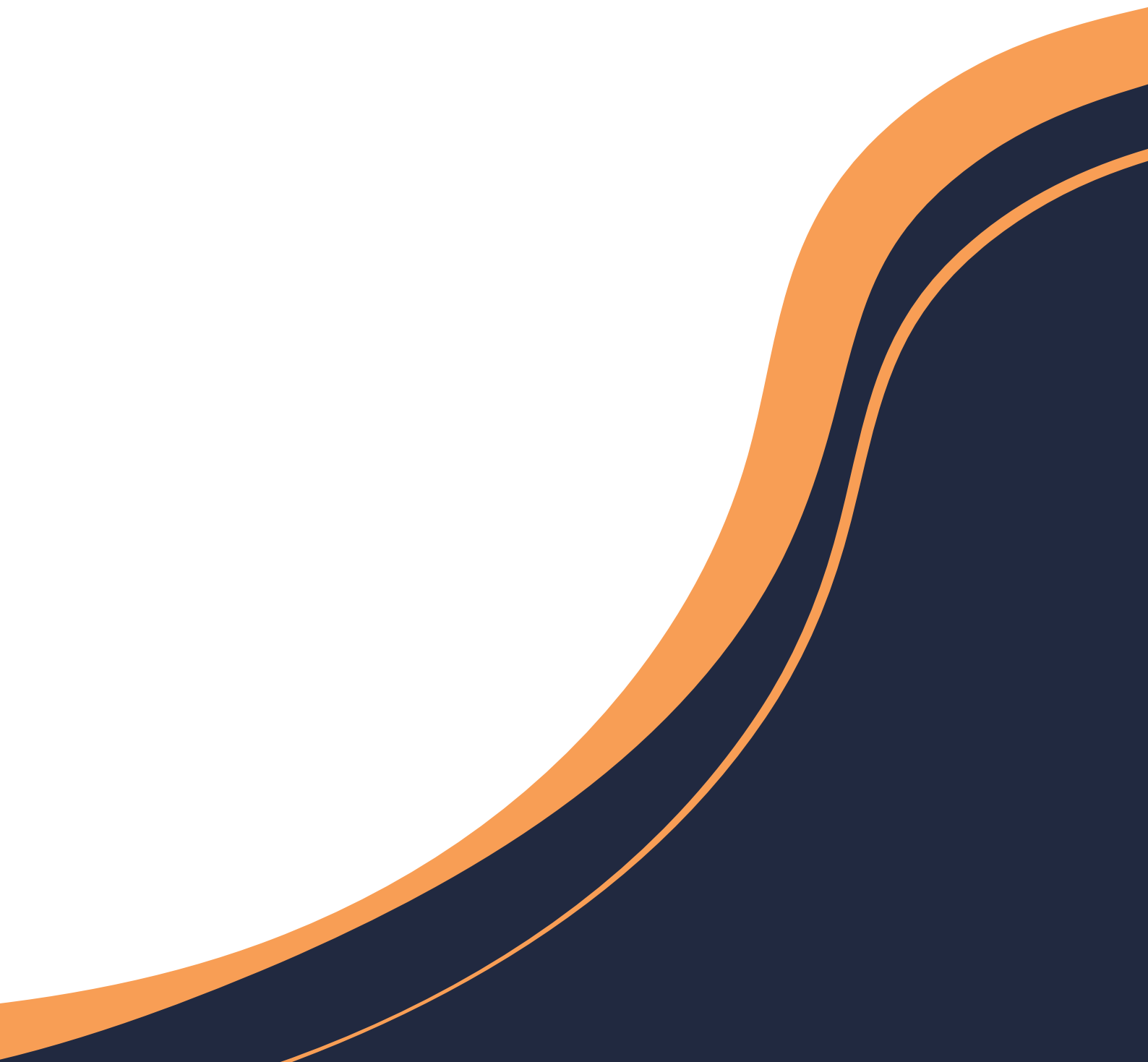


Executive summary

The inaugural Darling Downs and West Moreton Joint Regional Needs Assessment identifies the health and service priorities and opportunities for our region. Based on rigorous evidence, the assessment will allow us to improve the effectiveness and responsiveness of our models of care, within a rapidly changing health care environment. This joint assessment recognises that the coordination and collaboration of health providers and services are crucial, both to optimise the use of health resources and to provide the best possible care for patients, especially those most in need.

Table 1: Summary of Darling Downs and West Moreton Joint Regional Needs

Theme	Joint needs	
Care across the lifespan	Children and young persons	• Accessible and responsive services for children, families, and young people across the care continuum
	Older persons	• Accessible and responsive services to support patients with complex care needs associated with ageing • Older persons able to live well in their preferred place of residence
Priority populations	Aboriginal and Torres Strait Islander people	• Culturally safe, appropriate and accessible services that meet the needs of Aboriginal and Torres Strait Islander people across the lifespan
	Rural people	• Geographic equity in service access and availability for people living in rural areas
	Disadvantaged people	• Strategies to address complex health and social care needs caused by socio-economic disadvantage across the lifespan and care continuum
	People living with disability	• Person-centred, integrated care for people living with a disability
Priority health conditions	Chronic conditions and cancer care	• Person-centred, integrated care for people living with chronic conditions • Accessible and responsive cancer care and support services
	Preventative health	• Use of protective health behaviours to deliver positive health outcomes across the lifespan
Mental health and problematic substance use	Mental health and suicide prevention	• Accessible and responsive mental health services, including integrated services across the care continuum • Accessible and responsive suicide prevention, intervention, and postvention supports
	Minimisation of harm from alcohol and drugs	• Strategies to address prevalence and impact of problematic alcohol and drug use
Partnerships and integration	Service coordination and communication	• Effective referral pathways and transitions of care across the care continuum • Effective continuity and integration of care
Enablers	Human resources	• Appropriate workforce capacity, capability and stability
	Digital technology	• Effective use of digital health technology

Our regional priorities meet community needs for:

- Care across the lifespan
- Priority populations
- Priority health conditions
- Mental health and problematic substance use

and system needs for:

- Partnerships and integration
- Enablers

The joint assessment has been prepared in collaboration between Darling Downs Health (DDH), West Moreton Health (WMH), and the Darling Downs and West Moreton Primary Health Network (PHN).

Introduction

In this section we set the context and background of the joint regional needs assessment, including outlining the organisations involved and how it has been developed

Joint regional needs assessment

Regional health needs assessments identify the health needs of local populations, considering both disease prevention as well as diagnosis and treatment. Needs assessments also identify any gaps between health needs and service capability and supply, now and in the future.

Historically, assessments of health needs and service needs in Queensland have been prepared, based on organisational requirements, by Primary Health Networks and Hospital and Health Services.

By conducting joint regional needs assessments in collaboration, agencies within the health care system can align their efforts and deliver effective, efficient, and equitable services that meet the needs of the community. Joint regional needs assessments can reduce fragmentation in the health care system, increase the efficiency of resource use, and result in collective action and shared priorities across the care system (Figure 1). This comprehensive approach aims to improve overall health outcomes and enhance the wellbeing of the population.

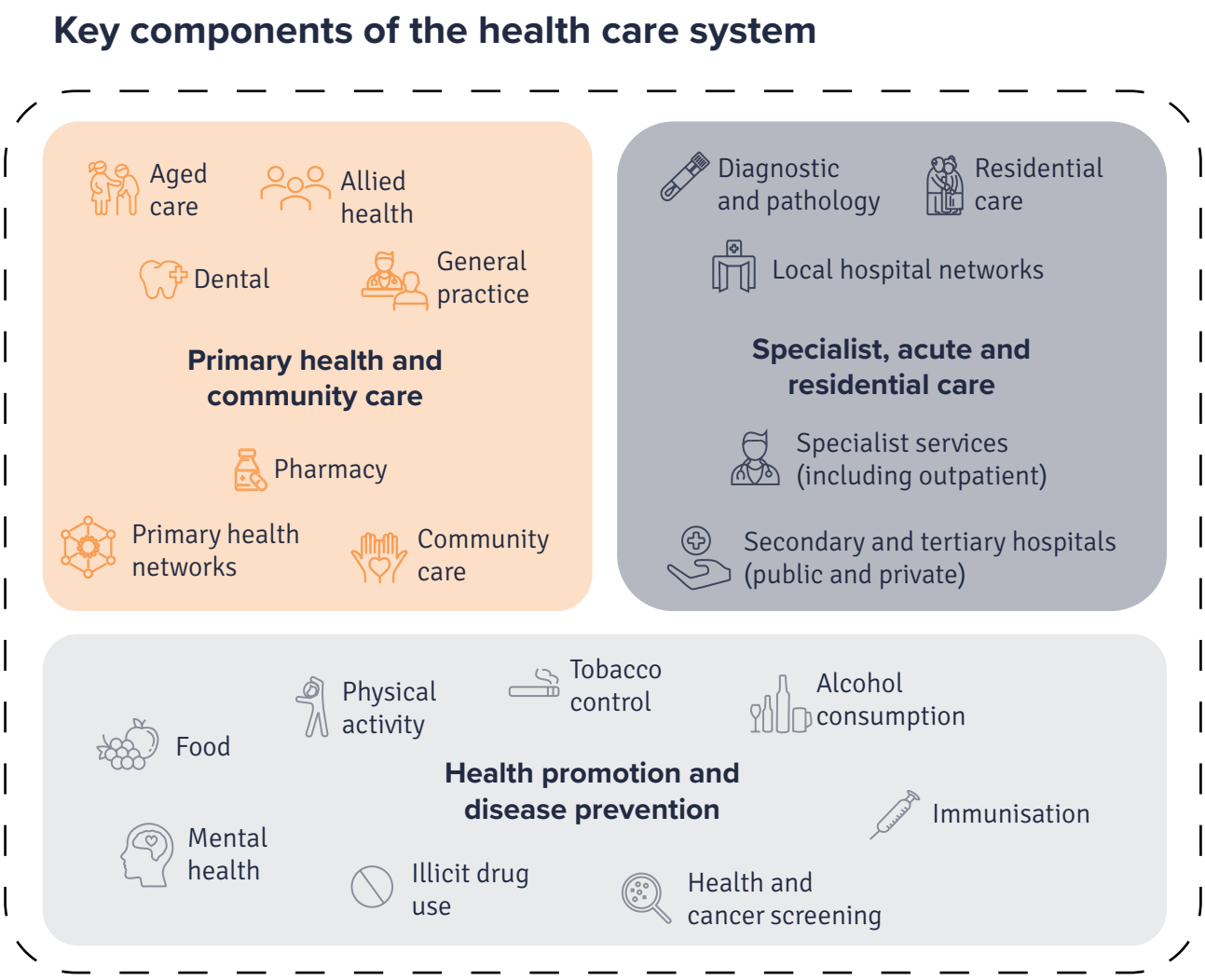


Figure 1: The health care system and key components involved

The inaugural Darling Downs and West Moreton Joint Regional Needs Assessment identifies the health and service priorities and opportunities for our region, and looks at priority health conditions, priority populations and service gaps. Joint regional needs assessments will be published every three years.

Methodology

The priorities in this joint regional needs assessment have been identified through a rigorous process of consultation and data analysis.

We worked together to develop a comprehensive profile of the region, based on detailed data from established sources including the Australian Institute of Health and Welfare, Social Health Atlas, Australian Bureau of Statistics and Queensland Department of Health. We also gathered community and professional input from consumer groups and health professionals.

We have developed a clear picture of the joint health and health care needs of people in our region using the **Joint Regional Area Needs Assessment Framework and Implementation Toolkit** from the Queensland Commonwealth Partnership (Queensland Primary Health Networks, Queensland Health System Planning Branch and Reform Office, Queensland Ambulance Service, Health Consumers Queensland, and Queensland Aboriginal and Islanders Health Council).

The Framework

Phase 1: Planning

- This includes establishing governance, identifying resources, and planning the approach. This planning process involved extensive joint planning and governance between the three key organisations, to support delivery of the joint needs assessment.

Phase 2: Identifying health and service information

- This includes:
  - using quantitative demographic and epidemiological data sources to understand community health status, including characteristics of specific populations or conditions
  - using service utilisation data to understand trends in service access, supply and demand
  - assessing the distribution of the workforce and services across the region, and the characteristics of specific locations and service types
  - collecting qualitative data from stakeholder and community engagement involving consumers, health service providers and partnered agencies and staff.

Phase 3: Validation and triangulation

- This process cross-verifies information from the multiple data sources used in Phase 2, to identify health and service needs.

Phase 4: Prioritising needs for the region

- Needs identified in Phase 3 undergo a collaborative prioritisation process with key stakeholders and representatives.

For our region, the process for Phase 1 involved extensive joint planning and governance between the three key organisations, to support delivery of the joint regional needs assessment.

In Phase 2, robust technical reports were delivered. They covered topics such as health behaviours, social determinants of health, health conditions, and service use of residents. A total of 374 internal staff members from Darling Downs Health and West Moreton Health were involved, including 234 responses to staff surveys. Consumers had a strong voice across multiple committees including the Steering Committee, West Moreton Youth Advisory Council, and West Moreton Community Advisory Council. More than 22 Kitchen Table Discussions were held; 351 community members and external stakeholders participated in the Darling Downs Health community survey including 92 Aboriginal and Torres Strait Islander people; and more than 600 responses to PHN online surveys were received.

A required output from this process was an individual needs assessment paper for each Hospital and Health Service – the Darling Downs Health and West Moreton Health communities. The PHN also maintained a Health Needs Assessment with a focus on primary health care and national health priorities.

In Phases 3 and 4, the 3 organisations participated in data analysis and prioritisation processes. A workshop involving a diverse group of people from across organisations and stakeholder groups was held to identify and discuss health- and service-need priorities common across the region. This workshop resulted in the joint health-and service-need priorities presented in this assessment.

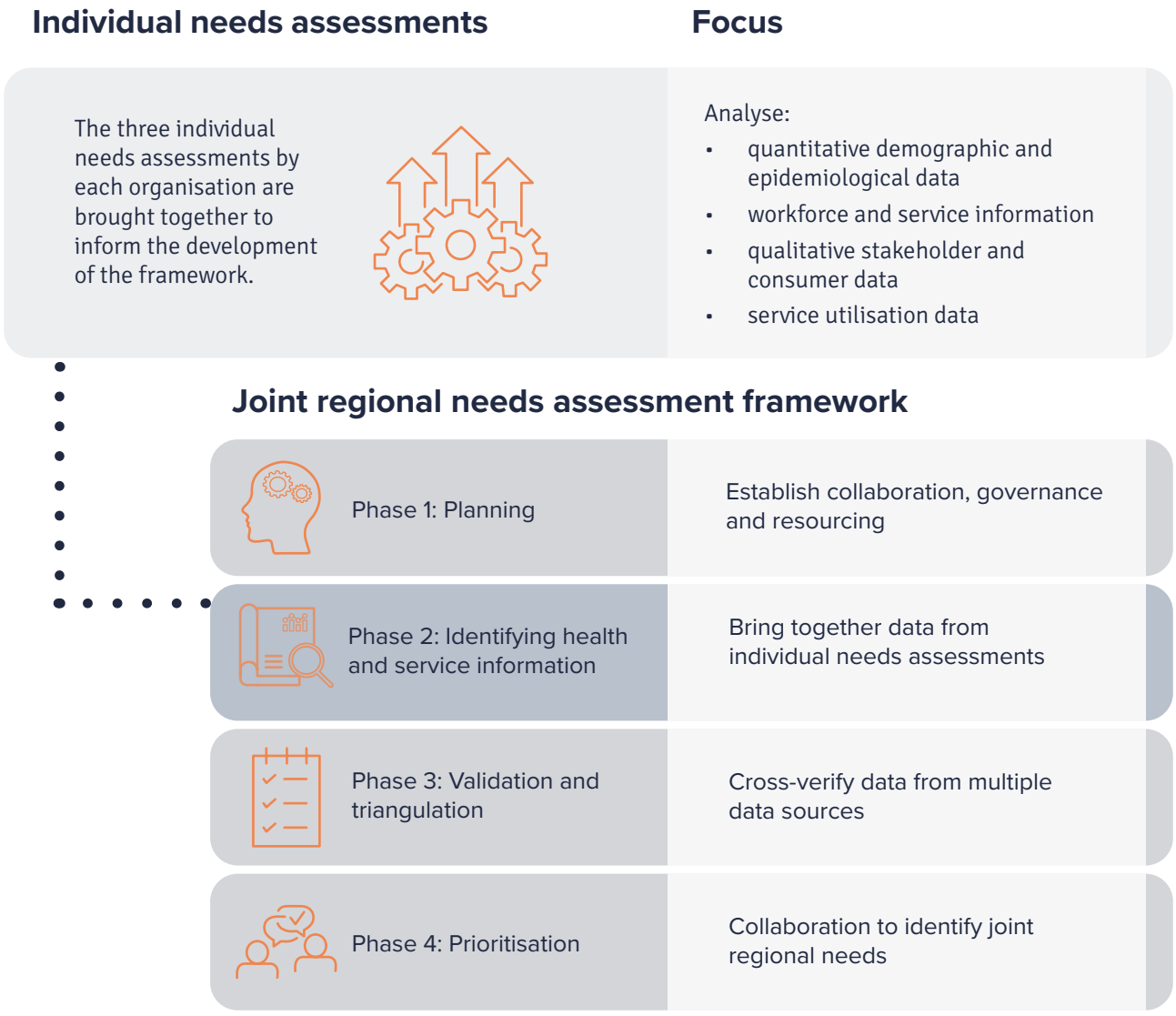


Figure 2: Development framework for the joint regional needs assessment

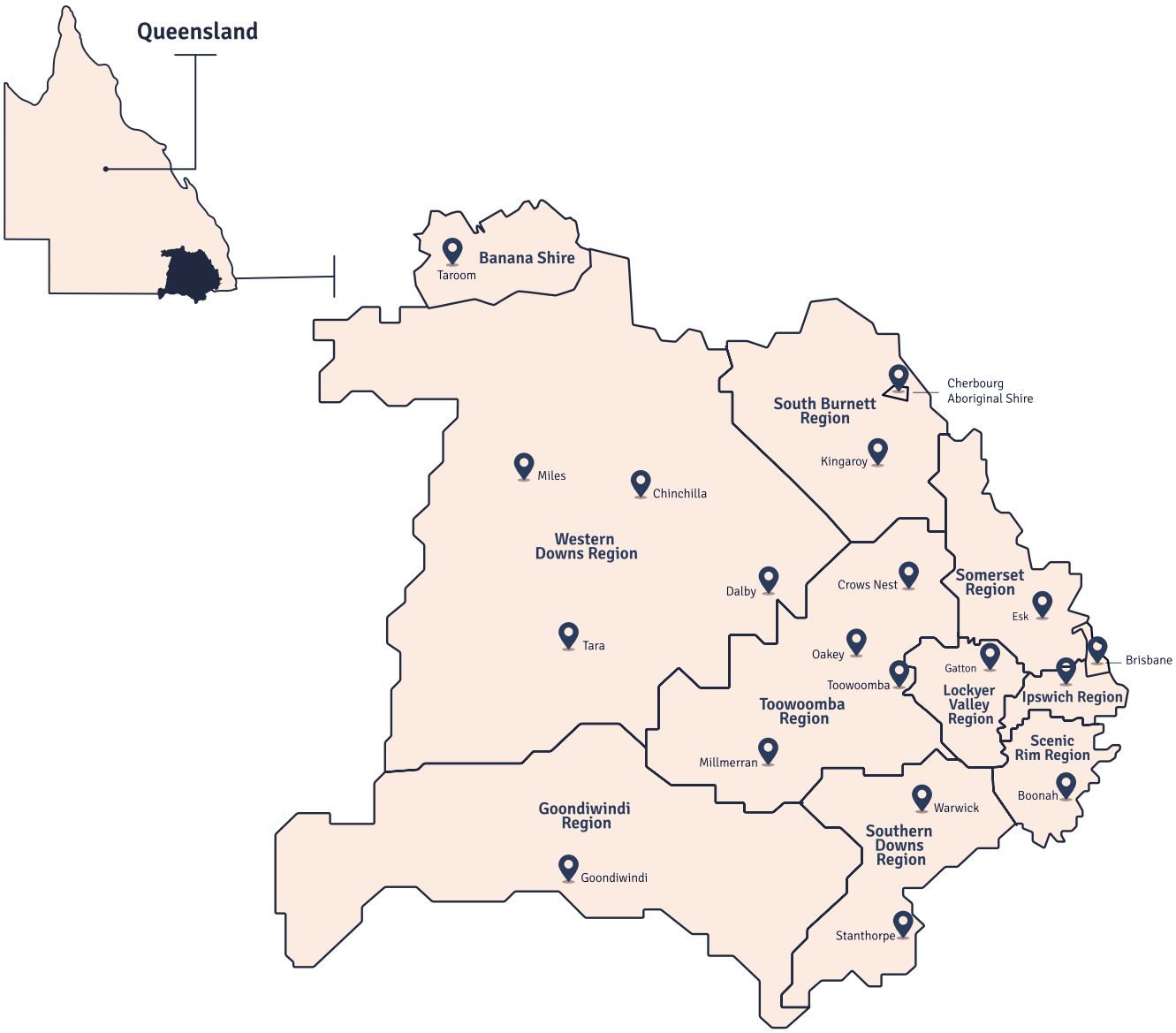
The publication of the joint needs is a milestone for the region, but it is not the end of the process. We are now continuing to find ways to embed and operationalise these priorities in our ongoing planning activities, programs and initiatives. We will also look to reflect and adjust in a continual cycle of improvement.

About our region

In this section we provide an overall regional population and health snapshot, and profiles of the key population and health features of each of the Local Government Areas (LGAs) within our region.

Darling Downs and West Moreton regional snapshot

Our region spans around 99,000 km^2 and encompasses twelve Local Government Areas. The largest communities in our region are Ipswich and Toowoomba, plus the surrounding communities located in the Lockyer Valley, Scenic Rim, Somerset, South Burnett, Cherbourg, Southern Downs, Goondiwindi and Western Downs LGAs. Our region also includes communities located within smaller areas of the Banana Shire and Brisbane LGA.

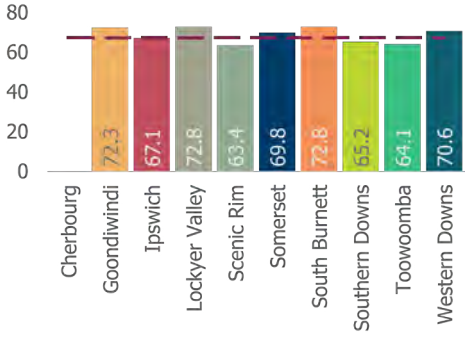


Our community

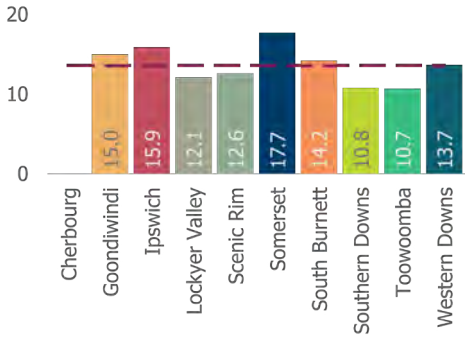
Our region includes urban, regional, rural and remote settings, and has a diverse population of around 632,000 people in 2023. The region is one of the fastest growing areas in Australia, with the population predicted to increase 40% by 2041, from 632,005 people in 2023 to 885,217 in 2041.

A summary of the regional health and service data collected for this joint assessment presents a clear line of sight to the health needs we have identified. These needs most strongly affect our children, youth and adolescent, and older people, as well as people with high care needs, and those who are most disadvantaged. Better coordination, collaboration and integration within our healthcare system, and better use of available technology, will help us to meet our community's needs, both now and into the future.

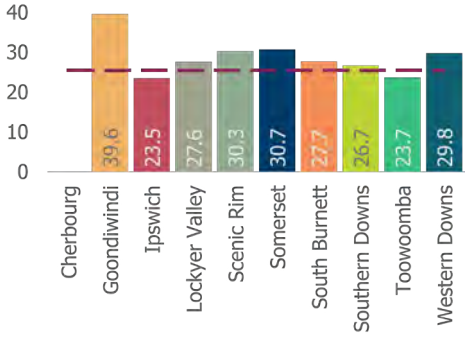
Behavioural risk factors



67.3% adults have overweight or obesity (2021–22)

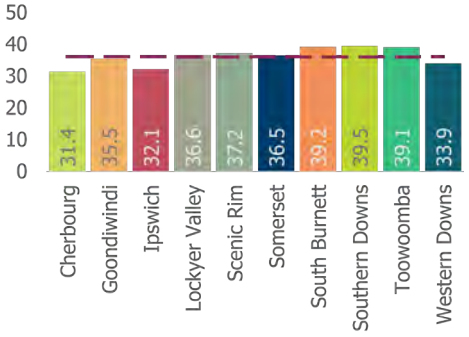


13.6% of adults are daily smokers (2021–22)

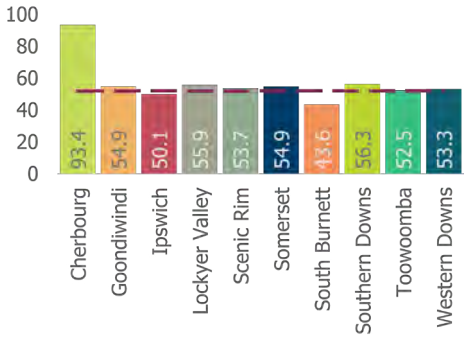


25.5% of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

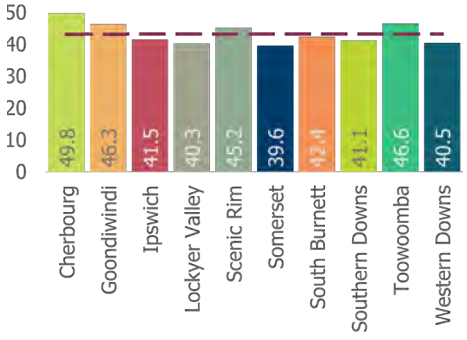
Cancer screening



36.1% of the target population participate in the National Bowel Cancer Screening Program (2020–21)

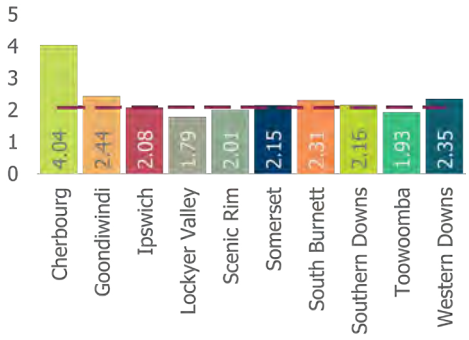


52.1% of females aged 50–74 participate in the national breast cancer screening program (2019–20)

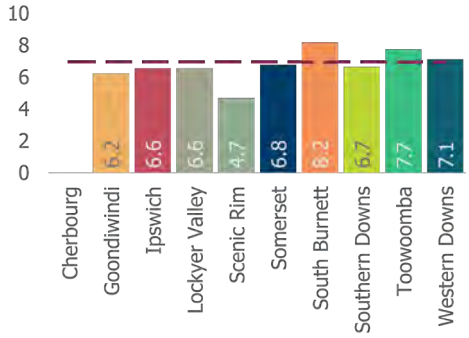


43.2% of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

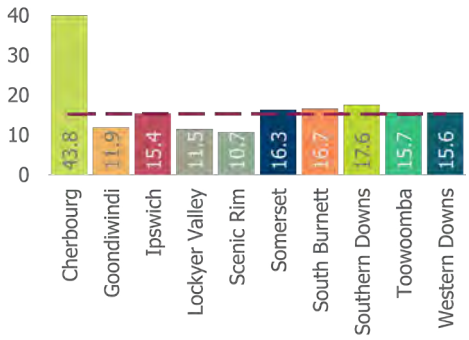
Children and young persons



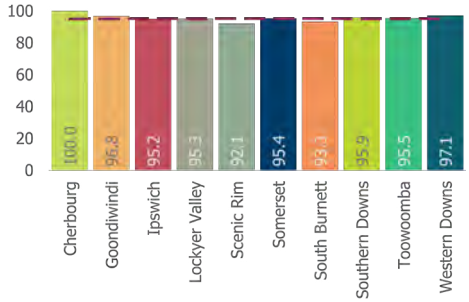
The total fertility rate is 2.09 live births per woman (2022)



7.0% of babies are low birth weight (2019–21)

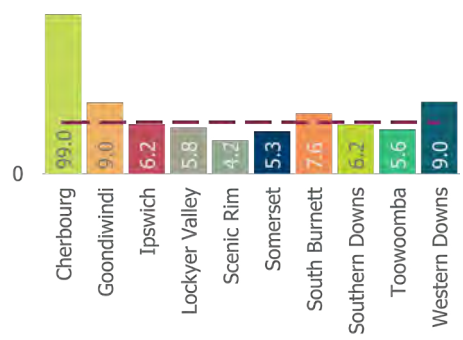


15.3% of children are developmentally vulnerable on 2 or more domains (2021)

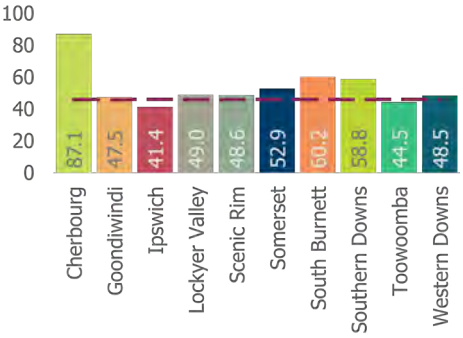


95.3% of children are fully immunised at age 5 (2021)

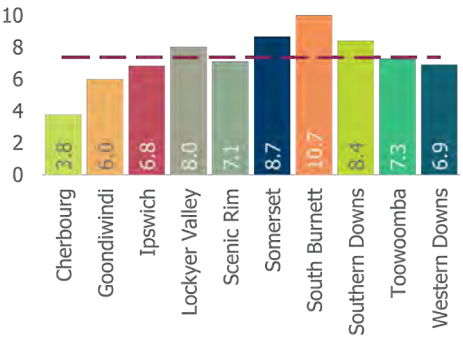
Priority populations



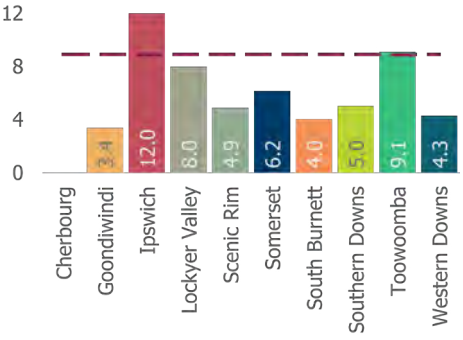
6.5% of residents are Aboriginal and/or Torres Strait Islander (2021)



46.1% of households are low income (2021)



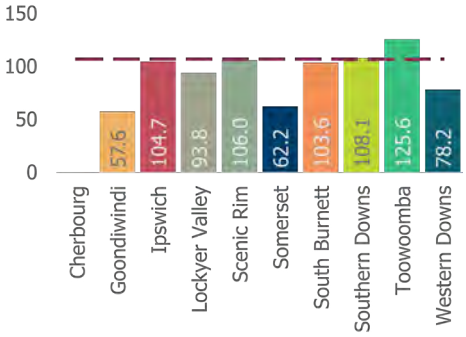
7.4% of residents have a profound or severe disability (2021)



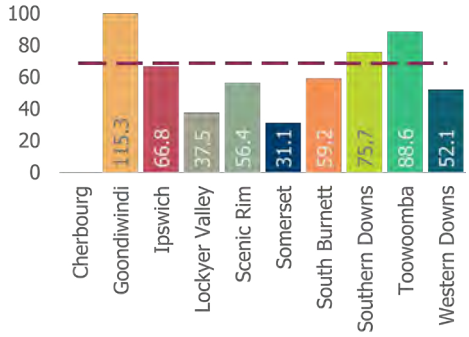
8.9% of residents were born in non-English-speaking countries (2021)

Health workforce

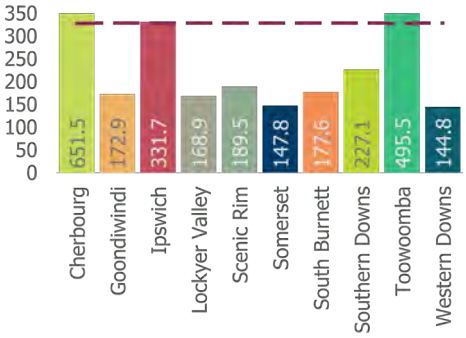
For every 100,000 residents, there are:



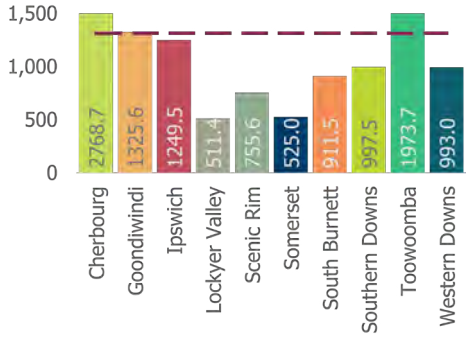
106.9 general medical practitioners (2022)



68.7 dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

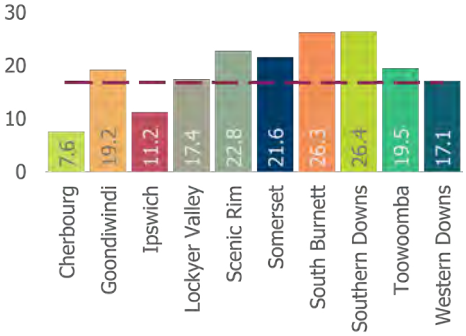


328.8 total medical practitioners (2022)



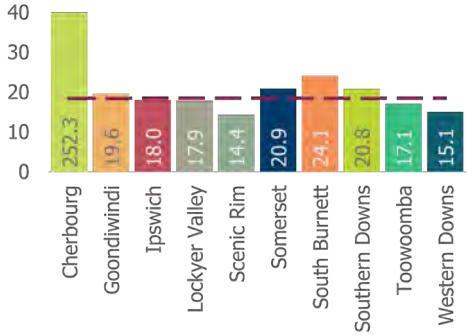
1,314.6 total nurses (registered nurses, enrolled nurses and midwives) (2022)

Older persons



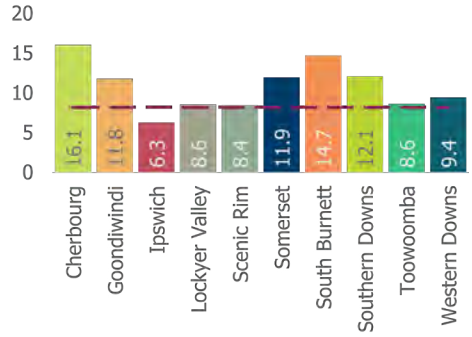
16.8% of residents are aged 65 years or older (2022)

Suicide



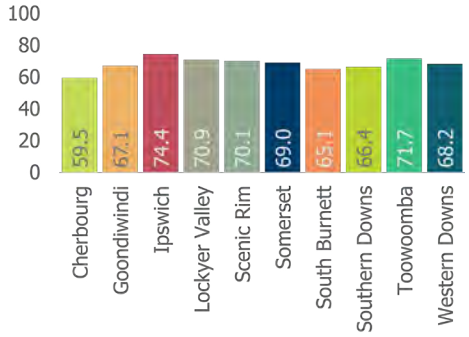
18.5 people per 100,000 residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions



8.2% of general practice patients have 3 or more chronic conditions, additionally 37.4% have 1 or 2 chronic conditions and 54.4% have none (2024)

Digital inclusion



The Australian Digital Inclusion Index scores digital inclusion out of 100. Scores on the Index varied across the region from 59.5 to 71.7, with communities having varying access, capacity to afford, and ability to use digital technologies (2022)

Local Government Area profiles

Cherbourg

In 2023, 1,264 people lived in Cherbourg, by 2041 population predicted to increase 5%. Cherbourg has a predominantly Aboriginal and Torres Strait Islander population and of the LGAs in our region has the highest proportion of children fully immunised at age five. It also has the highest rates of participation in the national breast cancer screening program and the National Cervical Screening Program. However, Cherbourg also faces the highest proportion of children who are developmentally vulnerable on 2 or more domains and the highest rate of death by suicide of the LGAs in our region. Close to 9 in 10 households in Cherbourg are low income.

Children and young persons

4.04

The total fertility rate is 4.04 live births per woman (2022)

Low-birthweight data are not available for Cherbourg

43.8%

of children are developmentally vulnerable on 2 or more domains (2021)

100%

of children are fully immunised at age 5 (2021)

Priority populations

99.0%

of residents are Aboriginal and/or Torres Strait Islander (2021)

87.1%

of households are low income (2021)

3.8%

of residents have a profound or severe disability (2021)

Sample size of residents who were born in non-English-speaking countries (2021) is too small to identify

Behavioural risk factors

Data are not available for Cherbourg (data are available at an SA2 level; Cherbourg is part of Kingaroy Surrounds – North)

Cancer screening

31.4%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

93.4%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

49.8%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

651.5*
total medical practitioners (2022)

2768.7*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

There are also:

< 5
general medical practitioners (2022)

< 5
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

7.6%
of residents are aged 65 years or older (2022)

Suicide

252.3* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

25.0% | 16.1% | 58.9%

25.0% of general practice patients have 1 or 2 chronic conditions, 16.1% have 3 or more and 58.9% have none (2024)

Digital inclusion

59.5
The Australian Digital Inclusion Index scores digital inclusion out of 100. Cherbourg scores 59.5 on the Index (54.2 for access, 88.1 for affordability and 56.6 for digital ability) (2022)

Goondiwindi

In 2023, 10,402 people lived in Goondiwindi, by 2041 the population is predicted to decrease 9%. Around 1 in 10 residents of Goondiwindi are Aboriginal and/or Torres Strait Islander. Compared with other LGAs in the region, Goondiwindi generally has fewer general medical practitioners and medical practitioners per 100,000 residents. Almost 4 in 10 adult residents of Goondiwindi have an average weekly alcohol consumption of more than 10 standard drinks, one of the highest proportions of the LGAs in our region.

Children and young persons

2.44
The total fertility rate is 2.44 live births per woman (2022)

6.2%
of babies are low birthweight (2019–21)

11.9%
of children are developmentally vulnerable on 2 or more domains (2021)

96.8%
of children are fully immunised at age 5 (2021)

Priority populations

9.0%
of residents are Aboriginal and/or Torres Strait Islander (2021)

47.5%
of households are low income (2021)

6.0%
of residents have a profound or severe disability (2021)

3.4%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

72.3%
adults have overweight or obesity (2021–22)

15.0%
of adults are daily smokers (2021–22)

39.6%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

35.5%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

54.9%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

46.3%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

57.6*
general medical practitioners (2022)

172.9*
total medical practitioners (2022)

1325.6*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

115.3*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

19.2%
of residents are aged 65 years or older (2022)

Suicide

19.6* per 100,000
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

40.2% | 11.8% | 48.0%

40.2% of general practice patients have 1 or 2 chronic conditions, 11.8% have 3 or more and 48.0% have none (2024)

Digital inclusion

67.1

The Australian Digital Inclusion Index scores digital inclusion out of 100. Goondiwindi scores 67.1 on the Index (66.4 for access, 94.1 for affordability and 56.2 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Ipswich

In 2023, 251,284 people lived in Ipswich, making it the most populous of the LGAs in our region. The population is predicted to nearly double by 2041. Of the LGAs in our region, Ipswich has the highest proportion of residents born in non-English-speaking countries and the lowest proportion of residents aged 65 years or older. Ipswich has one of the lowest rates of participation in the National Bowel Cancer Screening Program of the LGAs in our region and one of the lowest rates of participation in the national breast cancer screening program.

Children and young persons

2.08
The total fertility rate is 2.08 live births per woman (2022)

6.6%
of babies are low birthweight (2019–21)

15.4%
of children are developmentally vulnerable on 2 or more domains (2021)

95.2%
of children are fully immunised at age 5 (2021)

Priority populations

6.2%
of residents are Aboriginal and/or Torres Strait Islander (2021)

41.4%
of households are low income (2021)

6.8%
of residents have a profound or severe disability (2021)

12.0%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

67.1%
adults have overweight or obesity (2021–22)

15.9%
of adults are daily smokers (2021–22)

23.5%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

32.1%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

50.1%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

41.5%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

104.7
general medical practitioners (2022)

331.7
total medical practitioners (2022)

1249.5
total nurses (registered nurses, enrolled nurses and midwives) (2022)

66.8
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

11.2%
of residents are aged 65 years or older (2022)

Suicide

18.0 per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

34.6% | 6.3% | 59.1%
34.6% of general practice patients have 1 or 2 chronic conditions, 6.3% have 3 or more and 59.1% have none (2024)

Digital inclusion

74.4
The Australian Digital Inclusion Index scores digital inclusion out of 100. Ipswich scores 74.4 on the Index (73.5 for access, 95.3 for affordability and 66.9 for digital ability) (2022)

Lockyer Valley

In 2023, 43,853 people lived in Lockyer Valley, with more than 1 in 5 aged 65 years or older. The population is predicted to increase 23% by 2041. Lockyer Valley has one of the lowest rates of participation in the National Cervical Screening Program of the LGAs in our region. Compared with other LGAs in the region, it generally has fewer general medical practitioners, medical practitioners, nurses and dental practitioners per 100,000 residents.

Children and young persons

1.79
The total fertility rate is 1.79 live births per woman (2022)

6.6%
of babies are low birthweight (2019–21)

11.5%
of children are developmentally vulnerable on 2 or more domains (2021)

95.3%
of children are fully immunised at age 5 (2021)

Priority populations

5.8%
of residents are Aboriginal and/or Torres Strait Islander (2021)

49.0%
of households are low income (2021)

8.0%
of residents have a profound or severe disability (2021)

8.0%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

72.8%
adults have overweight or obesity (2021–22)

12.1%
of adults are daily smokers (2021–22)

27.6%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

36.6%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

55.9%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

40.3%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

93.8*
general medical practitioners (2022)

168.9*
total medical practitioners (2022)

511.4*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

37.5*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

17.4%
of residents are aged 65 years or older (2022)

Suicide

17.9* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

39.8% | 8.6% | 51.7%
39.8% of general practice patients have 1 or 2 chronic conditions, 8.6% have 3 or more and 51.7% have none (2024)

Digital inclusion

70.9
The Australian Digital Inclusion Index scores digital inclusion out of 100. Lockyer Valley scores 70.9 on the Index (70.1 for access, 94.5 for affordability and 62.3 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Scenic Rim

The Local Government Area of Scenic Rim reports 29.30% within West Moreton Health catchment.

In 2023, 13,175 people lived in Scenic Rim, with nearly 1 in 4 aged 65 years or older. The population is predicted to increase 19% by 2041. Close to 1 in 2 households in the LGA are low income, potentially reflecting the area's older population. Ninety-two percent of children are fully immunised at age five, the lowest proportion of the LGAs in our region. Compared with other LGAs in the region, it generally has fewer nurses per 100,000 residents.

Children and young persons

2.01
The total fertility rate is 2.01 live births per woman (2022)

4.7%
of babies are low birthweight (2019–21)

10.7%
of children are developmentally vulnerable on 2 or more domains (2021)

92.1%
of children are fully immunised at age 5 (2021)

Priority populations

4.2%
of residents are Aboriginal and/or Torres Strait Islander (2021)

48.6%
of households are low income (2021)

7.1%
of residents have a profound or severe disability (2021)

4.9%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

63.4%
adults have overweight or obesity (2021–22)

12.6%
of adults are daily smokers (2021–22)

30.3%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

37.2%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

53.7%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

45.2%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

106.0*
general medical practitioners (2022)

189.5*
total medical practitioners (2022)

755.6*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

56.4*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

22.8%
of residents are aged 65 years or older (2022)

Suicide

14.4* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

40.2% | 8.4% | 51.4%
40.2% of general practice patients have 1 or 2 chronic conditions, 8.4% have 3 or more and 51.4% have none (2024)

Digital inclusion

70.1
The Australian Digital Inclusion Index scores digital inclusion out of 100. Scenic Rim scores 70.1 on the Index (67.9 for access, 94.6 for affordability and 60.6 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Somerset

The Local Government Area of Somerset reports 81.81% within West Moreton Health catchment.

In 2023, 21,131 people lived in Somerset, and the population is predicted to increase 24% by 2041. Nearly 1 in 5 adult residents of Somerset smoke daily, one of the highest proportions of the LGAs in our region. Somerset has one of the lowest rates of participation in the National Cervical Screening Program of the LGAs in our region. Compared with other LGAs in the region, it generally has fewer general medical practitioners, medical practitioners, nurses and dental practitioners per 100,000 residents.

Children and young persons

2.15
The total fertility rate is 2.15 live births per woman (2022)

6.8%
of babies are low birthweight (2019–21)

16.3%
of children are developmentally vulnerable on 2 or more domains (2021)

95.4%
of children are fully immunised at age 5 (2021)

Priority populations

5.3%
of residents are Aboriginal and/or Torres Strait Islander (2021)

52.9%
of households are low income (2021)

8.7%
of residents have a profound or severe disability (2021)

6.2%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

69.8%
adults have overweight or obesity (2021–22)

17.7%
of adults are daily smokers (2021–22)

30.7%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

36.5%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

54.9%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

39.6%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

62.2*
general medical practitioners (2022)

147.8*
total medical practitioners (2022)

525.0*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

31.1*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

21.6%
of residents are aged 65 years or older (2022)

Suicide

20.9* per 100,000
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

40.3% | 11.9% | 47.8%
40.2% of general practice patients have 1 or 2 chronic conditions, 11.9% have 3 or more and 47.8% have none (2024)

Digital inclusion

69.0
The Australian Digital Inclusion Index scores digital inclusion out of 100. Somerset scores 69.0 on the Index (67.8 for access, 94.3 for affordability and 59.7 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

South Burnett

In 2023, 35,026 people lived in South Burnett, with more than 1 in 4 aged 65 years or older. The population is predicted to increase 7% by 2041. Close to 6 in 10 households in the LGA are low income, potentially reflecting the area's older population. South Burnett has the lowest rate of participation in the national breast cancer screening program of the LGAs in our region and one of the higher rates of death by suicide. The area has the highest proportion of residents with a profound or severe disability.

Children and young persons

2.31
The total fertility rate is 2.31 live births per woman (2022)

8.2%
of babies are low birthweight (2019–21)

16.7%
of children are developmentally vulnerable on 2 or more domains (2021)

93.3%
of children are fully immunised at age 5 (2021)

Priority populations

7.6%
of residents are Aboriginal and/or Torres Strait Islander (2021)

60.2%
of households are low income (2021)

10.7%
of residents have a profound or severe disability (2021)

4.0%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

72.8%
adults have overweight or obesity (2021–22)

14.2%
of adults are daily smokers (2021–22)

27.7%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

39.2%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

43.6%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

45.4%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

103.6*
general medical practitioners (2022)

177.6*
total medical practitioners (2022)

911.5*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

59.2*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

26.3%
of residents are aged 65 years or older (2022)

Suicide

24.1* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

43.7% | 14.7% | 41.6%
43.7% of general practice patients have 1 or 2 chronic conditions, 14.7% have 3 or more and 41.6% have none (2024)

Digital inclusion

65.1
The Australian Digital Inclusion Index scores digital inclusion out of 100. South Burnett scores 65.1 on the Index (64.3 for access, 93.5 for affordability and 53.5 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Southern Downs

In 2023, 37,141 people lived in Southern Downs, with more than 1 in 4 aged 65 years or older. The population is predicted to increase 5% by 2041. Close to 6 in 10 households in the LGA are low income, potentially reflecting the area's older population. Around 1 in 6 children in Southern Downs are developmentally vulnerable on 2 or more domains, one of the highest proportions of the LGAs in our region.

Children and young persons

2.16
The total fertility rate is 2.16 live births per woman (2022)

6.7%
of babies are low birthweight (2019–21)

17.6%
of children are developmentally vulnerable on 2 or more domains (2021)

95.9%
of children are fully immunised at age 5 (2021)

Priority populations

6.2%
of residents are Aboriginal and/or Torres Strait Islander (2021)

58.8%
of households are low income (2021)

8.4%
of residents have a profound or severe disability (2021)

5.0%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

65.2%
adults have overweight or obesity (2021–22)

10.8%
of adults are daily smokers (2021–22)

26.7%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

39.5%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

56.3%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

41.1%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

108.1*
general medical practitioners (2022)

227.1*
total medical practitioners (2022)

997.5*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

75.7*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

26.4%
of residents are aged 65 years or older (2022)

Suicide

20.8* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

42.4%, 12.1%, 45.6%

42.4% of general practice patients have 1 or 2 chronic conditions, 12.1% have 3 or more and 45.6% have none (2024)

Digital inclusion

66.4

The Australian Digital Inclusion Index scores digital inclusion out of 100. Southern Downs scores 66.4 on the Index (65.3 for access, 93.6 for affordability and 55.1 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Toowoomba

In 2023, 178,278 people lived in Toowoomba, making it the second-most populous of the LGAs in our region. The population is predicted to increase 15% by 2041. Around 1 in 11 residents of Toowoomba were born in non-English-speaking countries. Toowoomba has one of the lowest rates of participation in the national breast cancer screening program of the LGAs in our region and one of the highest proportions of low birthweight babies.

Children and young persons

1.93
The total fertility rate is 1.93 live births per woman (2022)

7.7%
of babies are low birthweight (2019–21)

15.7%
of children are developmentally vulnerable on 2 or more domains (2021)

95.5%
of children are fully immunised at age 5 (2021)

Priority populations

5.6%
of residents are Aboriginal and/or Torres Strait Islander (2021)

44.5%
of households are low income (2021)

7.3%
of residents have a profound or severe disability (2021)

9.1%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

64.1%
adults have overweight or obesity (2021–22)

10.7%
of adults are daily smokers (2021–22)

23.7%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

39.1%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

52.5%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

46.6%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

125.6
general medical practitioners (2022)

495.5
total medical practitioners (2022)

1973.7
total nurses (registered nurses, enrolled nurses and midwives) (2022)

88.6
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

19.5%
of residents are aged 65 years or older (2022)

Suicide

17.1 per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

37.9% | 8.6% | 53.5%
37.9% of general practice patients have 1 or 2 chronic conditions, 8.6% have 3 or more and 53.5% have none (2024)

Digital inclusion

71.7
The Australian Digital Inclusion Index scores digital inclusion out of 100. Toowoomba scores 71.7 on the Index (71.2 for access, 94.6 for affordability and 63.1 for digital ability) (2022)

Western Downs

In 2023, 34,524 people lived in Western Downs, and the population is predicted to increase 5% by 2041. Around 1 in 10 residents of Western Downs are Aboriginal and Torres Strait Islander. More than 97% of children in Western Downs are fully immunised at age five, one of the highest proportions of the LGAs in our region. However, Western Downs also has one of the lowest rates of participation in the National Cervical Screening Program of the LGAs in our region.

Children and young persons

2.35
The total fertility rate is 2.35 live births per woman (2022)

7.1%
of babies are low birthweight (2019–21)

15.6%
of children are developmentally vulnerable on 2 or more domains (2021)

97.1%
of children are fully immunised at age 5 (2021)

Priority populations

9.0%
of residents are Aboriginal and/or Torres Strait Islander (2021)

48.5%
of households are low income (2021)

6.9%
of residents have a profound or severe disability (2021)

4.3%
of residents were born in non-English-speaking countries (2021)

Behavioural risk factors

70.6%
adults have overweight or obesity (2021–22)

13.7%
of adults are daily smokers (2021–22)

29.8%
of adults have an average weekly alcohol consumption of more than 10 standard drinks (2021–22)

Cancer screening

33.9%
of the target population participate in the National Bowel Cancer Screening Program (2020–21)

53.3%
of females aged 50–74 participate in the national breast cancer screening program (2019–20)

40.5%
of females aged 25–74 participate in the National Cervical Screening Program (2018–20)

Health workforce

For every 100,000 residents, there are:

78.3*
general medical practitioners (2022)

144.8*
total medical practitioners (2022)

993.0*
total nurses (registered nurses, enrolled nurses and midwives) (2022)

52.1*
dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022)

Older persons

17.1%
of residents are aged 65 years or older (2022)

Suicide

15.1* per **100,000**
residents aged 0–74 die by suicide and self-inflicted injuries per year (2018–22)

Chronic conditions

41.2%, 9.4%, 49.3%
41.2% of general practice patients have 1 or 2 chronic conditions, 9.4% have 3 or more and 49.3% have none (2024)

Digital inclusion

68.2
The Australian Digital Inclusion Index scores digital inclusion out of 100. Western Downs scores 68.2 on the Index (64.8 for access, 94.1 for affordability and 59.0 for digital ability) (2022)

*Low residential population has an effect on the health and demographic indicators when the denominator is 100,000 residents. Where this occurs, figures may look inflated and should only be taken as a guide.

Other Local Government Areas

Our region also includes communities located in the Banana Shire and Brisbane LGA. These communities include people and health care services that are delivered within our catchment area, however the majority of the LGA population and profile information falls outside of our catchment area.

Banana Shire

In 2023, 989 people lived in communities in Banana Shire that are within the Darling Downs Health area, including Taroom (11% of entire Banana Shire). The population is predicted to decrease by 8% by 2041. Fewer than 4 in 10 households in Banana Shire are low income, the lowest proportion of the LGAs in our region. More than 1 in 3 adult residents of Banana Shire have an average weekly alcohol consumption of more than 10 standard drinks, one of the highest proportions of the LGAs in our region. Compared with other LGAs in the region, it generally has fewer general medical practitioners and medical practitioners per 100,000 residents.

Brisbane

In 2023, 6,192 people lived in communities in Brisbane that are within the West Moreton Health area, including Karana Downs (Fewer than 1% of the entire Brisbane City Council area). The population is predicted to decrease by 4% by 2041. Brisbane has the lowest proportion of adults who are daily smokers and the lowest proportion of adults who have overweight or obesity of the LGAs in our region.

Our regional priorities

In this section we present the joint regional priorities that have been developed through cross-sectoral collaboration. For each priority, supporting evidence has been included.

We also include a summary of the priorities that were developed separately by each organisation, and show how these map to the joint priorities.

Joint regional priorities

By identifying joint regional health priorities, we ensure that we are meeting the needs of our communities and services across the region.

Theme - Care across the lifespan

Children and young persons

Health begins before birth, and many children in our region are at risk of poor health and wellbeing outcomes. Our region has unacceptably high infant and child mortality rates.

Joint need

Accessible and responsive services for children, families and young people across the care continuum

Evidence

- Queensland has the highest overall infant mortality rate.
- The rate of infant mortality in the region was 4.4 per 1,000 live births during 2018–22, with rates especially high in the Lockyer Valley, Somerset and Southern Downs regional areas (PHIDU 2024).
- Risk factors associated with infant mortality in the region include prematurity, low birth weight, maternal smoking, high maternal body mass index, socio-economic disadvantage, remoteness, and attending fewer than the recommended number of antenatal visits (Queensland Health 2015).

- Deaths among people aged 15–24 years were higher (36.9 per 100,000 young people) than the national average (26.8) and the Queensland average (31.3) during 2018–22.
- The rates were highest in the Goondiwindi, South Burnett and Western Downs regional areas. The community of Cherbourg also recorded high rates, for a small population (PHIDU 2024).

- Immunisation rates for our region are similar to national rates.
- By the age of five, 95% of all children in the region – and 97% of Aboriginal and Torres Strait Islander children in the region – were fully immunised in 2020.
- This rate was slightly above the Queensland average of 94% for all children (Department of Health and Aged Care 2020a). However, regional hospitals are still seeing a high incidence of vaccine-preventable diseases, suggesting that more can be done.

Theme - Care across the lifespan

Older persons

Australia's population is ageing, with subsequent increases in the pressure on health care. Coordinated and strategic support will help older Australians enjoy a better quality of life and reduce demand for acute and residential care.

Joint need

Accessible and responsive services to support patients with complex care needs associated with ageing.

Older persons able to live well in their preferred place of residence

Evidence

- Our region has a similar proportion of older people to the rest of Queensland and Australia, but this proportion is growing at a very fast rate.
- There are more than 90,000 older Australians (aged 65 years and over) living in the region.
- The number is expected to double by 2036 (Queensland Government Statisticians' Office 2021).
- Regional areas that have a high proportion of older Australians are Southern Downs (24.9% of the population), South Burnett (24.7%) and Somerset (21.4%) (Queensland Government Statisticians' Office 2021).

- We have a lower number of residential aged care places available than the rest of Queensland and Australia.
- In 2020–21, the region had 68 residential aged care facilities, with an average occupancy rate of around 87%.
- There were 73 home care services providing around 47 places per 1000 older Australians, compared with 48 per 1000 nationally and 46 per 1000 across Queensland.
- There were also around 104 home support services providing 307 places per 1000 older Australians, compared with 290 per 1000 nationally and 340 per 1000 across Queensland (AIHW 2021c).

- Our region has a growing population of older people who will require support to continue living at home.
- Appropriate end-of-life planning and palliative care are also required.
- By 2026–27, demand for specialist palliative care is expected to increase by 44% in the Darling Downs region, and by 52% in the West Moreton region (Queensland Health 2019).

- A high proportion of older Australians in our region have one or two chronic conditions.
- The proportion ranges between 59% and 68% across our communities, (PHN, 2022).
- The region has an increasing number of people living with dementia, including those with early onset dementia, but appropriate services and workforce are limited.
- Nearly 1 in 5 (19%) older Australians in our region had a profound disability (PHIDU, 2022).

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people generally have poorer health outcomes and lower life expectancies than non-Indigenous people. Culturally safe services and collaboration can help to improve these outcomes.

Joint need

Culturally safe, appropriate and accessible services that meet the needs of Aboriginal and Torres Strait Islander People across the lifespan

Evidence

- The region has a larger proportion of Aboriginal and Torres Strait Islander people than the Queensland and Australian averages.
- Aboriginal and Torres Strait Islander peoples represent 5.5% of the region's population, compared with 4.7% for Queensland (Queensland Health, 2020).
- Aboriginal and Torres Strait Islander children (aged 0–14) make up 8.3% of children in our region.

- There is an 11.8-year gap in health-adjusted life expectancy for Aboriginal and Torres Strait Islander residents in the Darling Downs region, and an 8.3-year gap for Aboriginal and Torres Strait Islander residents in the West Moreton region, compared with other residents (Queensland Health 2017).
- The most significant contributors to the gap in the Darling Downs region are cardiovascular disease (2.9 years), mental health (1.2 years), cancer (2.1 years) and diabetes (1.5 years), and in the West Moreton region are cardiovascular disease (2.4 years), diabetes (1.5 years) and mental health (1.4 years).

- Mental health conditions, as an underlying cause of death in Australia, rank higher with Aboriginal and Torres Strait Islander people than with other people in the community.
- The suicide rate for Aboriginal and Torres Strait Islander people in the region is more than 2.5 times the national average (AIHW 2020, Upton et al. 2021).
- As of September 2024, around 2 in 5 Aboriginal and Torres Strait Islander people who regularly attend a general practice in the region had a mental health concern recorded (PHN 2024).
- Depression and anxiety disorders are the most commonly diagnosed conditions. Aboriginal and Torres Strait Islander peoples represented 1 in 4 (24%) of all consumers accessing a PHN-funded primary mental health care service in 2024, which was an increase from 21% in 2020.

- Culturally safe and accessible health care helps to close the gap in outcomes for Aboriginal and Torres Strait Islander peoples and improves their social and emotional wellbeing.
- In the region, our First Nations Strategy and local Health Equity Strategy aim to actively eliminate racial discrimination and institutional racism, and influence the social, cultural and economic determinants of health by working with Aboriginal and Torres Strait Islander organisations, health services, communities, consumers and Traditional Owners to design, deliver, monitor and review health care services.

Theme - Priority populations

Rural people

The region has many rural areas, which generally have poorer access to health care services than urban settings do. Collaboration and creative approaches to service delivery can help to ensure all residents have equal access to care.

Joint need

Geographic equity in service access and availability for people living in rural areas

Evidence

- The region has continued to experience challenges in service availability and access since 2022 (Thomas et al. 2024).
- Kingaroy Region, Millmerran, Tara, Esk and Crows Nest – Rosalie, Chinchilla, Nanango, Inglewood – Waggamba, Lockyer Valley – East and Southern Downs (SA2) areas were identified as having higher workforce and service needs (Health Workforce Queensland 2022).

- Residents in our region said they are experiencing (Health Consumers Queensland 2022):
    - long travel distances because necessary services are not locally available
    - long wait times to get an appointment; no same-day appointments offered locally, when needed
    - not enough time during their appointment to discuss all details they felt were relevant to their care.

- Residents told us that when it comes to service availability and access, they would like to see (Health Consumers Queensland 2022):
    - more local services, especially bulk-billing services, in the region; they also noted that some existing general practices have full patient lists
    - primary care services available after hours, including general practice and pharmacy; this can help reduce use of hospital emergency departments for lower-urgency care
    - increased access to transport and telehealth options to obtain health care, especially for vulnerable persons in regional and rural areas
    - more promotion and information about available services, and health promotion campaigns with improved consumer engagement
    - increased primary, specialised, and allied health services, especially in rural areas
    - more affordable allied health and disability support services, such as more bulk billing, and options to obtain repeat referrals.

Disadvantaged people

Socio-economic disadvantage can limit access to health care and lead to poor health and development outcomes. Our region has a high proportion of low-income families. On average, our region has some socio-economic disadvantage compared with the rest of the state, and more in regional areas.

Joint need

Strategies to address complex health and social care needs caused by socioeconomic disadvantage across the lifespan and care continuum

Evidence

- The region's relative socio-economic disadvantage in 2021 was an index value of 960, compared with 996 for Queensland.
- A low score indicates relatively greater disadvantage in general, and a higher score a relative lack of disadvantage – 1,000 is the average score for Australia (PHIDU 2024). Cherbourg (99%), the South Burnett (60%) and Somerset (46%) regional areas have higher proportions of people experiencing relative disadvantage.
- These areas are likely to have a high proportion of households with low income or who are experiencing unemployment, lower levels of education and limited access internet, and who are likely to have increased health care needs (Queensland Government Statistician's Office 2021).

- The region has the highest proportion in Australia of families in which there is no parent in employment.
- In 2021, the rate was 14.7% – higher than the Queensland average (11.4%) and the national average (11.4%) (PHIDU 2024).
- Children in the region are on average more developmentally vulnerable than children across Queensland for all 5 early childhood development domains.
- In 2021, around 87% of children were on track with their physical health and wellbeing when they commenced school. This rate is slightly below the Queensland average (88%) and the national average (90%) (PHIDU 2024).

- Vulnerable populations can benefit from additional support to access the health care they need, including primary and preventive health care programs.
- Vulnerable populations – including those with socio-economic disadvantage or with a diverse cultural or linguistic background – are at significant risk of poor health and poor access to health care, and are more likely to experience significant disparities in life expectancy and socio-economic status (Rukmana 2014).

Theme - Priority populations

People living with a disability

People living with a disability have specific and complex needs that can change across the lifespan. Appropriate support as well as responsive person-centred health care can help to ensure their wellbeing and quality of life.

Joint need

Person-centred, integrated care for people living with a disability

Evidence

- The region has a high proportion of people living with a profound or severe disability.
- 6.4% compared with 5.4% for Queensland and Australia in 2016.
- Some regional areas have higher proportions: 9.9% for South Burnett, 7.9% for Somerset and 7.5% for Southern Downs (PHIDU 2021).

- The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability notes that **'Quality health care is an essential service and human right in itself.'**

- The Australian Institute of Health and Welfare (2022) notes that people with disability have greater exposure to health risk factors than Australians without disability:
    - 24% of people with disability self-report 'excellent or very good' health, compared to 65% of people without disability
    - 32% of people with disability self-report 'high or very high' psychological distress, compared to 8% of people without disability
    - 18% of people with disability are daily smokers, which is higher than for those living without disability (12%)
    - 54% of people with disability were reported to have high blood pressure, considerably more than people without disability (27%)
    - nearly three-quarters (72%) of people with disability had overweight or obesity, compared to 55% of people without disability.

Chronic conditions and cancer care

Long-term conditions often require complex care, which should be focused on the needs and goals of the person and their family. Our region has high rates of chronic conditions and cancer, and limited oncology services in some regions.

Joint need

Person-centred, integrated care for people living with chronic conditions

Accessible and responsive cancer care and support services

Evidence

- Our region has high rates of premature death from diabetes, circulatory and respiratory system diseases (AIHW 2021f).
- In 2021, 61% of adults in the region reported having a long-term health condition, compared with 52% nationally (AIHW 2021f, ABS 2021).
- Higher rates of chronic disease were experienced in the Banana, Goondiwindi, Somerset, South Burnett and Western Downs regional areas. The community of Cherbourg also experienced very high rates, for a small population (PHIDU 2021).
- Overall, participation in each of the three national cancer screening programs was lower in the region than the national average rates.
- The long-term effects of delayed screening during the COVID-19 restrictions cannot be quantified using existing data; however, it will monitored when data become available (AIHW 2021).

Theme - Priority health conditions

Preventative health

Information and support can encourage healthier lifestyles, reduce the risk of chronic disease and increase wellbeing. With a high level of chronic disease in the region, this is a critical area of need. Another area of need for wellbeing is oral health, in which there are large service gaps in the region.

Joint need

Use of protective health behaviours to deliver positive health outcomes across the lifespan

Evidence

- Many diseases share risk factors. These risk factors include obesity, smoking, high alcohol consumption, low exercise rates and poor nutrition, as well as the physical and socio-economic environment. Addressing the underlying risks can improve health outcomes for both the individual and the community. Information and support for health care providers and the community can encourage healthier lifestyles and reduce disease.
- Our region has very high rates of obesity in both adults and children, and very low rates of physical activity in adults. In the 2019–20 Queensland preventive health survey, 1 in 2 (52%) adults in the region indicated they had sufficient physical activity in the past week (150 minutes of activity over 5 or more sessions). Similarly, 53% of children in the region were active for 60 minutes or more each day in the past week (Queensland Health 2020). Although our children are more physically active than those in many other regions (53% are active every day, compared with 46% across Queensland), a high percentage remain overweight or obese (12% obese, compared with 9% across Queensland) (Queensland Health 2020).
- Although smoking rates are moderate on average across the region, in some regional areas these rates are very high. In 2020, 11.5% of people in the region were daily smokers, compared with 10.3% across Queensland. Smoking rates were higher in the Western Downs (15.2%), Southern Downs (12.2%), Ipswich (11.9%) and Goondiwindi (11.6%) regional areas (Queensland Health 2020).
- Oral health is a key indicator of overall health, wellbeing and quality of life. In the region:
    - estimated proportion of adult patients with inadequate dentition (less than 10 natural teeth) – Darling Downs region 19% and West Moreton 17.5%
    - estimated proportion of adult patients with at least one decayed tooth – Darling Downs region 67% and West Moreton 78%
    - estimated proportion of child patients with experience of tooth decay – Darling Downs region 55% and West Moreton 59%.
- There are lengthy wait times for oral health care; there are 68.7 dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) per 100,000 people compared with 90.3 for Queensland (2022).

Mental health and suicide prevention

Our region has high levels of mental health concerns, including anxiety, depression and suicide attempts. Regional areas with socio-economic disadvantage are particularly affected.

Joint need

Accessible and responsive mental health services, including integrated services across the care continuum

Accessible and responsive suicide prevention, intervention, and postvention supports

Evidence

- As of February 2022, more than 110,000 people (1 in 5) had discussed a mental health concern with their general practitioner. A diagnosis of anxiety was recorded for around half (53%), and a diagnosis of depression for 62% (PHN 2021a). During 2018–19, more than 4% of hospitalisations of people in the region were for a mental health or behavioural disorder. This is a rate of 2,066 hospitalisations per 100,000 residents, below the Queensland average of 2,658 per 100,000 residents (Queensland Health 2020).
- During 2017–18, around 1 in 7 adults in the region experienced high or very high psychological distress, which was higher than the Queensland and national averages (PHIDU 2021). It is estimated that around 13% of people aged 15–24 in the region have a mental health concern, 34% of those aged 25–44, and 22% of those aged 45 years and older (PHN 2024).
- During 2022, the deaths of 92 people in the region were recorded as suspected suicides. This was a rate of 145.5 per 100,000 residents, higher than the Queensland average rate of 12.3 per 100,000 people per year (AIHW 2023). Within the region, Cherbourg (252 per 100,000), South Burnett (24 per 100,000) and Somerset (21 per 100,000) regional areas reported the highest rate of suicide deaths from 2018 to 2022 (PHIDU 2024). In 2020–23, 119 people per 100,000 residents in the region were admitted to hospitals due to intentional self-harm, higher than the national rate of 100 people per 100,000 (AIHW 2023).
- Early support and mental health care services matched to individual needs can improve the wellbeing of people at risk. Because of high rates of anxiety and depression, and deaths from suicide, appropriate support and care is a high priority for the region. Early intervention and support can help prevent mental health concerns and decrease presentations to emergency departments for mental health as well as suicide and self-harm. People seeking to address their substance use can benefit from evidence-based treatments that help them to achieve their goals and change their lives.

Theme - Mental health and problematic substance abuse

Minimisation of harm from alcohol and drugs

Rates of alcohol and drug consumption are very high in some of our regional areas, though moderate in the region as a whole.

Joint need

Strategies to address the prevalence and impact of problematic alcohol and other drug use

Evidence

- Around 33% of adults in the region were risky alcohol drinkers, meaning they exceed guidelines about the regular consumption of alcohol. This was below the Queensland average of 38%. Rates were higher in the Goondiwindi (44%), Scenic Rim (41%) and Western Downs (40%) regional areas (Queensland Health 2020).
- When people in the region sought treatment for use of illicit drugs during 2019–20, they most often sought treatment for use of amphetamines (34%), cannabis (28%), alcohol (19%) and heroin (5%) (AIHW 2021e).

Service coordination and communication

Coordination and collaboration is critical to ensure residents experience the best possible care across the care continuum. It is also critical to optimise the effective use of health care resources and budgets.

Joint need

Effective referral pathways and transitions of care across the care continuum

Effective continuity and integration of care

Evidence

- Improved coordination and communication between health care providers improves the health care delivered in our region. Strong relationships between hospitals and the broader health system, including primary and community services and general practices, can help to deliver services in partnership or outside the acute health care system, reduce wait times for services and decrease lower-urgency care presentations to emergency departments.
- The proportion of adults in our region who were referred to a medical specialist and waited longer than they felt was acceptable to get an appointment increased from 16.5% in 2017–18 to 17.2% in 2019–20. This number has increased nationally from 21.7% in 2020–21, to 27.9% in 2022–23 (ABS 2023).
- Residents in our region identified a key theme – namely, that both the cost of medical services and the lengthy wait times are critical barriers to receiving care (Health Consumers Queensland 2023b).

Theme - Enablers

Human resources

Our workforce is the backbone of an effective health care system. Our region has lower levels of health care personnel than the Queensland average. Regional communities can benefit from innovative recruitment, retention and training strategies for health care staff.

Joint need

Appropriate workforce capacity, capability and stability

Evidence

- For every 100,000 residents, there are:
    - 106.9 general medical practitioners (2022), compared with 127.8 for Queensland
    - 328.8 total medical practitioners (2022), compared with 434.5 for Queensland
    - 1,314.6 total nurses (registered nurses, enrolled nurses and midwives) (2022) compared with 1,500.9 for Queensland
    - 68.7 dental practitioners (dentists, oral health therapists, dental hygienists, dental therapists and dental prosthetists) (2022) compared with 90.3 for Queensland
- Health workforce gaps in 2022 were largest in psychology, speech pathology, social work, occupational therapy and general practice.
- Services with the most need included community-based rehabilitation, mental health, alcohol and other drugs, social support, and health prevention and promotion health (Health Workforce Queensland 2022).
- Kingaroy Region, Millmerran, Tara, Esk and Crows Nest – Rosalie, Chinchilla, Nanango, Inglewood – Waggamba, Lockyer Valley – East and Southern Downs (SA2) areas were identified as having higher workforce and service needs than other areas (Health Workforce Queensland 2022).

Technological support

Digital health options can improve access to health care in many regional areas, and can optimise the effective use of limited health care resources.

Joint need

Effective use of digital health technologies

Evidence

- The Australian Digital Inclusion Index scores digital inclusion out of 100.
- The Digital Inclusion Index for our region was 69.0, which is 4.2 units below the national average of 73.2.
- The gap is largest in Cherbourg (59.5), South Burnett (65.1), Southern Downs (66.4), and Goondiwindi (67.1) areas (Digital Inclusion Index 2022) (Thomas et al. 2024).
- Medical workers stated that a lack of locally available services increases reliance on digital and telehealth options (Health Workforce Queensland 2023).

Darling Downs Health priorities

In 2022, Darling Downs Health completed a Local Area Needs Assessment to identify the community's health needs, service needs, gaps and priorities. The assessment was based on data analysis across multiple domains, and consultations with stakeholders including staff, consumers and other health care organisations. This assessment was reviewed in 2023, confirming that the priorities remained the same.

Following the introduction of the joint regional needs assessment in 2024, Darling Downs Health has again assessed the needs of our region as part of the regional planning process. Needs have been assessed using quantitative and qualitative data. Existing documented needs were validated with recent data releases.

Following the identification of health needs, a triangulation process was undertaken, followed by a prioritisation process using a modified Delphi method to determine and tier the highest-level needs – those that have the greatest impact on the health of our region.

Darling Downs Health identified five priority themes for the region in 2024. Several priorities were identified as specific to the organisation and region (Table 2). Most of the priorities map to the joint needs identified in this assessment (Table 3).

Table 2: Darling Downs Health-specific themes and priorities

Theme	Priority
Preventative health	• An identified need for improved access to available and affordable housing across the Darling Downs Health region
	• An identified need for improved rates of high school completion to influence improvement in health literacy for both First Nations and non-First Nations populations, particularly in Nanango, Kingaroy surrounds, Tara, Millmerran, Inglewood-Waggamba, Crows Nest - Rosalie, Southern Downs – West
Population subgroups	• Better understand and ensure services are safe, appropriate and accessible for our refugee and multicultural community
	• Better understand and ensure services are safe, appropriate and accessible for gender and sexuality diverse people health needs
Enablers	• A need to continually ensure support systems address the increasing complexity of patient behaviours to improve the safety and wellbeing of Darling Downs Health employees

Table 3: Darling Downs Health- mapped to joint needs

Darling Downs Health priority	Maps to joint need
Health conditions • Reduce the prevalence and/or impact of diabetes, arthritis, cardiovascular disease and respiratory conditions • Reduce the prevalence and/or impact of mental health disorders and substance misuse disorders • Reduce the prevalence and/or impact of cancer – particularly breast and prostate cancer across the region, and also colorectal cancer • Reduce the incidence and/or impact of suicide and self-harm • Reduce the prevalence and/or impact of oral disease on children and adults	**Priority health conditions** **Mental health, suicide prevention, and alcohol and other drugs**
Preventative health • Reduce obesity and overweight, including during pregnancy, to reduce the risk of developing preventable chronic conditions such as some types of cancers, heart diseases and diabetes • In the Darling Downs Health region, impacts of vulnerability contribute to poorer health outcomes, particularly in the regions of Kingaroy – North, Nanango, Tara, Stanthorpe, Inglewood • Decrease the likelihood of low birthweight live births and preterm births • Transport is identified as a barrier to receiving health care, particularly for young people, older people, multicultural and homeless communities residing in geographically dispersed rural and remote locations • There is a high health burden without reduction and prevention of the use of tobacco-related products generally, and particularly use by pregnant women and young people • Health and emotional wellbeing are impacted by high rates of early childhood developmental delay, particularly in Southern Downs - East, Wilsonton, Toowoomba Central, Kingaroy, Kingaroy Surrounds - North, Newtown, Drayton-Harristown • An identified need to reduce the use of drugs and illicit substances in the Darling Downs communities • Enduring socioeconomic disadvantage in the Darling Downs contributes to complex health care needs, particularly in Nanango, Stanthorpe, Tara, Kingaroy Region – North, Newtown, Wilsonton and Inglewood – Waggamba • There are recognised financial constraints on the ability to access care and follow up on treatment	**Care across the lifespan** **Priority populations** **Priority health conditions** **Mental health, suicide prevention, and alcohol and other drugs**

Table 3 continued: Darling Downs Health-mapped to joint needs

Darling Downs Health priority	Maps to joint need
Population subgroups • Ensure services are safe, appropriate, accessible and meet the needs for Aboriginal and Torres Strait Islander people within the Darling Downs Health region • Minimise the impact of our large proportions of older people and people with a severe or profound disability on length of stay and demand for sub-acute beds • Better understand and ensure services are safe, appropriate and accessible for young people in our community	**Care across the lifespan** **Priority populations**
Service usage • Increase access to mental health and drug and alcohol services • Increase access to primary care through general practices across the entire region, including access to tests and scans • Increase access to allied health services within all rural locations within the Darling Downs Health region • Increase access to specialist medical services within all rural locations within the Darling Downs Health region • Reduce wait times, particularly emergency departments • Increase access to aged care services	**Integration and partnerships**
Enablers • Address health workforce shortages and improve workforce capability and stability • Improve support and delivery of digital health care throughout the Darling Downs, particularly in rural and remote locations where there is a shortage of primary care, allied health and specialists • Improve referral pathways, including expanding the scope of practitioners eligible to refer	**Enablers**

West Moreton Health priorities

The West Moreton Health Regional Area Needs Assessment has been developed as a key foundation for integrated planning across and within West Moreton Health. The 2025–28 assessment builds on the foundational West Moreton Health Local Area Needs Assessment 2022–25, including the 2023 refresh.

The assessment was systematically developed in five phases:

Phase 1: Establishment- Initiation of project, including scope and governance.

Phase 2: Assess population health and service needs, including

- development of the WMH Regional Area Needs Assessment 2025–28 Data Analysis Plan to guide quantitative and qualitative data collection and analysis
- identification of, access to and analysis of quantitative data sources, documented in the WMH Regional Area Needs Assessment 2025–28 Technical Data Report
- consultation with key stakeholders and qualitative analyses, documented in the WMH Regional Area Needs Assessment 2025–28 Engagement Report.

Phase 3: Synthesis and triangulation -Triangulation of both qualitative and quantitative data insights to develop need statements. Statements and supporting evidence were documented in the WMH Regional Area Needs Assessment 2025–28 Triangulation Report.

Phase 4: Prioritisation and validation - A modified Delphi technique was applied to facilitate the prioritisation process. Two rounds of scoring were completed, with results of each round of scoring fed back for validation. The methodology and results were documented in the WMH Regional Area Needs Assessment 2025–28 Prioritisation Report.

Phase 5: Finalisation and dissemination.

West Moreton Health identified eight priority themes for the region in 2024. Several priorities were identified as specific to the organisation and region (Table 4). Most of the priorities map to the joint needs identified in this assessment (Table 5).

Table 4: West Moreton Health-specific themes and priorities

Theme	Priority
Priority populations	Supporting people under the care of Corrections and Youth Detention to access high-quality, equal, safe, and timely healthcare services that maintain dignity across the care continuum
Chronic conditions	Optimising and enhancing capacity, access, and integration of care for people living with chronic kidney disease across the region and care continuum
Promoting health across the care continuum	Continued need for empathetic and high-quality end-of-life planning and palliative care to support West Moreton residents
Integration and partnerships	Actively planning for service growth and innovation that is future-proofed and commensurate with current service use and projected population increases
	Transform services and work with cross-sectoral partners to strengthen the local health system, to bring care closer to home for West Moreton residents

Table 5: West Moreton Health themes and priorities mapped to joint needs

West Moreton Health priority	Maps to joint need
Care across the lifespan • Optimising and enhancing pregnancy care and supports for expectant parents in the West Moreton region • Enhancing the availability, accessibility, and coordination of high-quality services across the whole West Moreton region, to engage and support children and families (including guardians and other carers) in the first 2000 days of life • Supporting the health and wellbeing of West Moreton's children and young people (5–17 years), and their families and supports across the care continuum (health promotion to acute care) • Working with cross-sectoral partners and carers to promote the health and wellbeing of West Moreton's diverse and growing older persons population to live well in their preferred place of residence • Transformation and growth of older persons care services across the whole of the West Moreton region, to respond to the growing needs of the population • Work with cross-sectoral partners to optimise transitions of care for older persons across West Moreton Health services, the community, primary, and aged care sectors for older persons	**Care across the lifespan**
Priority populations • Address geographic inequities in access through transformation and growth of West Moreton Health services and workforce, across the health care continuum • Enhance cross-sectoral partnerships to strengthen referral pathways to existing services, growing the wider health and social care system, and supporting people to access care in rural communities • Persistent socioeconomic disadvantage contributes to complex health and social care needs across the lifespan and continuum of health, requiring a multi-sectoral approach to address. This particularly affects the SA2s of Leichhardt - One Mile, Gatton, Riverview, Goodna, and Redbank Plains.	**Priority populations**
First Nations peoples • Supporting First Nations families and communities to have the healthiest start to life possible and continue to thrive throughout childhood • Supporting mainstream health care services to address systemic barriers to health care access and engagement for First Nations peoples • Working with First Nations communities and services to build on their strengths and support optimal health and social and emotional wellbeing	

Table 5 continued: West Moreton Health themes and priorities mapped to joint needs

West Moreton Health priority	Maps to joint need
Chronic conditions • Supporting West Moreton residents living with multiple chronic conditions through the provision of integrated, person-centred care • Optimising and enhancing capacity, access, and integration of care for people living with chronic cardiac conditions across the region and care continuum • Optimising and enhancing capacity, access, and integration of care for people living with diabetes across the region and care continuum • Optimising and enhancing capacity, access, and integration of care for people living with chronic respiratory conditions (such as asthma and chronic obstructive pulmonary disease) across the region and care continuum • Improve access to, and uptake of, cancer prevention and screening services; including human papillomavirus vaccination and bowel, breast, and cervical cancer screening • Transform and grow cancer care and support services across the region to provide care closer to home	**Priority health conditions**
Promoting health across the care continuum • A multi-sector approach focused on preventive health to support and enhance protective health behaviours and positive health outcomes across the lifespan • Working with cross-sectoral partners to enhance the individual health literacy of West Moreton residents, support health service navigation, and improve the health literacy environment of West Moreton Health services • Timely and regular access to oral health care services is outpaced by demand across the region, lifespan, and care continuum	
Mental health, suicide prevention and intervention, and alcohol and other drugs • Grow and transform acute drug and alcohol treatment services to respond to the varying and growing needs of the community across the lifespan • There is continued need for suicide prevention, intervention, and post-vention supports for the West Moreton community; particularly First Nations peoples, men, and ex-service Australian Defence Force members. • Support the mental health and wellbeing of children, young people, and young adults through growth and optimisation of mental health services • Continue to develop and optimise mental health services, and enhancing integration of services across the region avnd the stepped care continuum	**Mental health, suicide prevention, and alcohol and other drugs**

Table 5 continued: West Moreton Health themes and priorities mapped to joint needs

West Moreton Health priority	Maps to joint need
Integration and partnerships • Working with cross-sectoral partners to optimise referral, continuity of care, and transitions of care between primary care, secondary care, and community-based supports • The local health care system (including primary care, public and private hospital services, aged care, and disability support) are under increasing strain. These may have downstream effects to each other, including impacting patient flow into and within West Moreton Health services	**Integration and partnerships**
Enablers to health care provision • Virtual health care technologies and improved uptake are needed to better support care closer to home for West Moreton residents • Introducing digital technologies is important to support clinical and non-clinical processes and workflows, enhance efficiencies, and support data-driven decision-making • Strategic and innovative approaches are needed to attract, retain, and support a workforce to alleviate current workload pressures and meet the growing needs of West Moreton communities into the future • Continue to build a workforce that challenges stigma, and values diversity, equity, and inclusion of health care consumers and staff	**Enablers**

Darling Downs and West Moreton PHN priorities

Darling Downs and West Moreton PHN priorities

The Darling Downs and West Moreton PHN Health Needs Assessment was developed through a rigorous process of research and consultation, focused around the 7 national PHN priority areas: Aboriginal and Torres Strait Islander health, aged care, alcohol and other drugs, digital health, health workforce, mental health and population health.

We use trusted approaches to understand health needs and define our priorities. These include:

- reviewing available evidence using a scoping review method (Peters et al. 2015)
- developing community health assessment and improvement planning using the Mobilising for Action through Planning and Partnerships framework
- determining priority needs using a matrix approach in collaboration with our health partners (NACCHO 2015).

The current PHN Health Needs Assessment covers 2022–25. We update our assessment every quarter with new data and analysis and information gained from engagement with our stakeholders, services and the community. When possible, we monitor trends over time and compare with other PHNs in Queensland and across Australia. Based on this input, we review and revise our priorities as needed.

The PHN identified 10 priority themes for the region in 2024. Several priorities were identified as specific to the organisation and region (Table 6). Most of the priorities map to the joint needs (Table 7).

Table 6: PHN-specific themes and priorities

Theme	Priority
Improving the health of older Australians	• Increased support for regional palliative care services
Improving the health of vulnerable groups	• Language support services attached to health services in areas with high levels of culturally and linguistically diverse residents
	• Health services at the community level and in different languages

Table 7: PHN themes and priorities mapped to joint needs

PHN priority	Maps to joint need
Supporting healthy mothers and children Focus areas include: • prenatal and antenatal services, including holistic support services to improve the health and wellbeing of expecting mothers, especially in rural areas • paediatric services, especially in rural areas • school-based youth health nurses and paediatric nurses to provide early-intervention care to prevent social and wellbeing issues, especially in rural areas • paediatric training in the workforce to improve skills and capabilities • culturally safe health approaches and practice frameworks for service providers working with Aboriginal and Torres Strait Islander children.	**Care across the lifespan**
Improving the health of older Australians Focus areas include: • resources and training for regional staff, to help them better understand dementia and its symptoms, and to more effectively work with people with dementia and their carers • culturally appropriate resources for end-of-life planning for Aboriginal and Torres Strait Islander people • information about carer supports and how they can be accessed • an aged care strategy for the region • collaborating with key peak bodies to identify gaps that the PHN could fill.	
Improving the health of vulnerable groups Focus areas include: • health centres and local community mentors, social workers and coordinators • holistic collaboration between health and other social services – for example, between health and education services • outreach health and education services for vulnerable groups in regional areas • health transport from rural regional areas to centres for specialised health services.	**Priority populations**
Improving the health of Aboriginal and Torres Strait Islander peoples Focus areas include: • community education around healthy lifestyles, risky behaviours and available health services • education to help mainstream services provide accessible and appropriate health care for Aboriginal and Torres Strait Islander peoples • ways to attract, support and retain Aboriginal health workers • transport from rural communities to health services	

Table 7 continued: PHN themes and priorities mapped to joint needs

PHN priority	Maps to joint need
Preventing and managing chronic conditions Focus areas include: • developing further understanding of mechanisms to decrease risk and prevent chronic conditions or further complexity of care needs • regional partnerships for innovative action, guided by the Global Obesity Centre • regional education and initiatives to reduce alcohol consumption and smoking.	**Priority health conditions**
Promoting health and preventing disease Focus areas include: • health promotion, including diet and exercise – for example, through the My Health for Life program • prevention and intervention strategies to minimise the incidence of obesity • immunisation and cancer screening services and schedules • mobile clinics and transport options to support screening and vaccination services • social prescribing to improve patient self-management behaviours and empower people to play a more active role in their health care.	
Treating alcohol and drug use Focus areas include: • education and prevention activities focused on young people • alcohol and drug training for health service staff, including general practitioners • peer support programs for health service staff • Aboriginal and Torres Strait Islander workers trained in alcohol and drug care, especially in rural and remote regional areas • educational resources for allied professions such as police, youth workers and teachers • integration between mental health, alcohol and other drug services, and other providers in the primary health care system • Local Drug Action Teams • transport options and mobile treatment services for rural areas • after-hours treatment options for alcohol and drug cases • day and residential rehabilitation services • prescribers and pharmacies involved in opioid replacement therapy.	**Mental health, suicide prevention, and alcohol and other drugs**

Table 7 continued: PHN themes and priorities mapped to joint needs

PHN priority	Maps to joint need
Providing primary mental health care Focus areas include: • counselling and referrals to PHN services and other support, such as financial assistance • promotion of help-seeking, such as regional community engagement events • linkages and support programs for young people at risk • localised mental health responses for communities with high rates of suicide • stepped care to allow improved referral options across the region, with e-referral and health service navigators enabling closer monitoring of wait times while ensuring appropriate priority for referrals.	**Mental health, suicide prevention, and alcohol and other drugs**
Increasing access and coordination of care Focus areas include: • collaborative arrangements between community services and health care services • clear communication protocols between services and during care handover • HealthPathways • attraction of key specialist services to the region • travel support for rural residents to access specialist services • increased use of digital health systems to improve patient care, patient and medicines safety, and communication between providers • increased uptake of digital health tools such as secure messaging, e-ordering, Smart Referrals, The Viewer, electronic prescriptions and My Health Record • use of Project ECHO, in which clinicians are partnered with specialist mentors at academic medical centres or hubs, to better support primary health care professionals to treat patients with complex conditions in their own community.	**Integration and partnerships**
Increasing workforce capacity and wellbeing Focus areas include: • formal rotation training programs to improve skills and relationships between hospitals and rural facilities • incentives to encourage uptake of rural positions and the rural generalist program • supporting the Aboriginal and Torres Strait Islander health workforce • peer networks to support health practitioners • education to increase digital literacy of both consumers and health care providers • online education courses and workshops.	**Enablers**

Conclusion

The Joint Regional Needs Assessment has been developed to play a key role in informing policy, planning, and funding decisions at the local level and across the health care system. The priority health and service needs that have been identified, will be used to guide strategic planning and optimising resources to address the most pressing needs in the community.

Darling Downs Health, West Moreton Health and the PHN agree that collaboration is important when planning health services and making investment decisions. We seek to share information, collaborate on our common priorities, seize opportunities for joint investment and action, as well as to help reorient the health system to improve patient outcomes and experiences.

The Joint Regional Needs Assessment will undergo a review annually to ensure needs remain contemporary, and a full refresh every three years to reassess and reprioritise needs.

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