Gold Coast

Joint Regional Needs Assessment 2024-2026

Acknowledgement of Traditional Custodians

Jingeri. We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging.

Contributions

This document was developed in partnership between Gold Coast Hospital and Health Service, Gold Coast Primary Health Network, Kalwun Development Corporation, and Queensland Ambulance Service. Many organisations, groups, and individuals contributed their guidance, expertise, and lived experience to the development of the Gold Coast Joint Regional Needs Assessment. The authors acknowledge and extend gratitude for the time and effort spent contributing to this project, and the commitment to ensuring a shared understanding of our community's needs.

Suggested citation: Gold Coast Primary Health Network (2025). Gold Coast Joint Regional Needs Assessment 2024-2026. Gold Coast: GCPHN.

For further information, please contact: GCPHN Health Intelligence, Planning and Engagement Team via info@gcphn.com.au.

Disclaimer

The content presented in this publication is distributed by GPCHN as an information source only. GCPHN disclaims any and all liability for decisions made on the basis of the information in this report and recommends that independent research be undertaken prior to any decision making. GCPHN makes no statements, representations or warranties about the accuracy, currency, completeness or reliability of any information contained in this publication.

FOREWORD

The Gold Coast Joint Regional Needs Assessment 2024-2026 (JRNA) provides a comprehensive view of the evolving needs of our diverse Gold Coast community as it undergoes a period of unprecedented growth.

The JRNA builds on the previous Gold Coast Health Local Area Needs Assessment 2022-2025 and the Gold Coast Primary Health Network Health Needs Assessment 2023, by expanding the strong partnership between Gold Coast Health, Gold Coast Primary Health Network (GCPHN) and Kalwun Development Corporation (Kalwun) to include the Queensland Ambulance Service (QAS).

This expanded partnership creates an integrated system view of the health and service needs of our diverse and evolving Gold Coast community, enabling us to collectively plan for and prioritise the most pressing needs.

A commitment to collaborative, priority-driven planning has never been more important. Our health system continues to face significant pressures, including a growing and ageing population, workforce shortages, disparities in socioeconomic means and increasing complexity of health needs. By acknowledging these challenges and clearly defining the role and contributions of each partner organisation, we can provide care that is responsive, person-centred and aligned with our shared vision of achieving optimal health outcomes for the Gold Coast community.

We extend our sincere thanks to everyone, particularly our consumers and clinicians, who have been part of the development of the JRNA. Your insights and experiences have helped shape our priorities as we together support a healthy Gold Coast community.

Ron Calvert,
Chief Executive, Gold Coast Hospital and Health Service

Kieran Chilcott,
Chief Executive Officer, Kalwun Development Corporation

Matt Carrodus,
Chief Executive Officer, Gold Coast Primary Health Network

Andrew Hebbron,
Assistant Commissioner, Queensland Ambulance Service (Gold Coast)

Table of Contents

List of Acronyms

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACDC	Australian Early Development Census
ACG	Adjusted Clinical Groups
ACP	Advance Care Plan
ACT	Acute Care Treatment
ADHD	Attention Deficit Hyperactivity Disorder
AIHW	Australian Institute of Health and Welfare
ASD	Autism Spectrum Disorder
ASR	Age-Standardised Rate
BMI	Body Mass Index
CAC	Community Advisory Council
CAG	Consumer Advisory Group
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CRM	Client Relationship Management
CSU	Crisis Stabilisation Unit
CVD	Cardiovascular Disease
DoHAC	Department of Health and Aged Care
ED	Emergency Department
FASD	Foetal Alcohol Spectrum Disorder
GCHHS	Gold Coast Hospital and Health Service
GCPHN	Gold Coast Primary Health Network
HHS	Hospital and Health Service
JNAWG	Joint Needs Assessment Working Group
JRNA	Joint Regional Needs Assessments
LGA	Local Government Area
LGBTIQAP+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual and Pansexual, and other diverse sexual orientations and gender identities
MBS	Medicare Benefits Schedule
NBCSP	National Bowel Cancer Screening Program
NCSP	National Cervical Screening Program
NCSR	National Screening Cancer Register
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NLCSP	National Lung Cancer Screening Program
NMHSPF	National Mental Health Service Planning Framework
NSMHW	National Study of Mental Health and Wellbeing
PBS	Pharmaceutical Benefits Scheme
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
QAS	Queensland Ambulance Service
QPS	Queensland Police Service
RACGP	The Royal Australian College of General Practitioners
RACH	Residential Aged Care Homes
SA	Statistical Area Level
SPACE	Specialist Palliative Care in Aged Care
TWBSS	The Way Back Support Service

Chapter 1: BACKGROUND

1.1 INTRODUCTION

Queensland Health and PHNs share foundational principles, approaches, outputs, and organisational considerations for conducting health and service needs assessments. This alignment led to the establishment of the Queensland-Commonwealth Partnership in 2024. A key priority of this partnership is for Queensland HHSs and PHNs to deliver Joint Regional Needs Assessments (JRNA).

To achieve this, the Joint Needs Assessment Working Group (JNAWG) was established to develop a framework to guide the development of JRNAs. The JNAWG included representatives from the Department of Health and Aged Care (DoHAC), Queensland Health System Planning Branch, Mental Health Alcohol and Other Drugs Branch, Queensland Aboriginal and Islander Health Council (QAIHC), Queensland Ambulance Service (QAS), Hospital and Health Services (HHSs), and Queensland PHNs.

Queensland's transition to a single, overarching joint needs assessment process per region, with PHNs and HHSs working in partnership, is a national first.

Understanding and addressing the unique health needs of a region is crucial for effective healthcare planning and delivery. Recognising this, four local health organisations - Gold Coast Primary Health Network (GCPHN), Gold Coast Hospital and Health Service (GCHHS), Kalwun Develop Corp. (Kalwun) and Queensland Ambulance Service (QAS) - partnered to conduct a comprehensive place-based regional needs assessment for the region. This collaborative effort aimed to identify and prioritise health and service needs, based on comprehensive data analysis across multiple domains, and consideration of the existing service system and consultations, to ensure the diverse and evolving requirements of our community were jointly agreed.

Geographically, this JRNA focusses on the Gold Coast region which largely aligns with the boundaries of the Gold Coast GCPHN region, GCHHS region, and the Gold Coast Statistical Area Level 4 (SA4).

1.2 METHODOLOGY

The development process followed four key phases as outlined in the JRNA Framework:

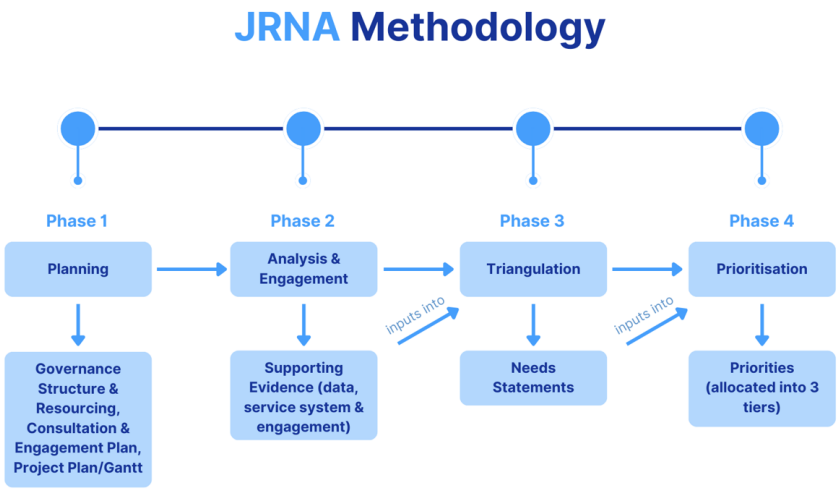
- Planning the process,
- Identifying and analysing regional health, wellbeing, and service-related information, including qualitative and quantitative data,
- Validation and triangulation, and
- Prioritising needs for the region.

1.2.1 Phase 1: Planning the process

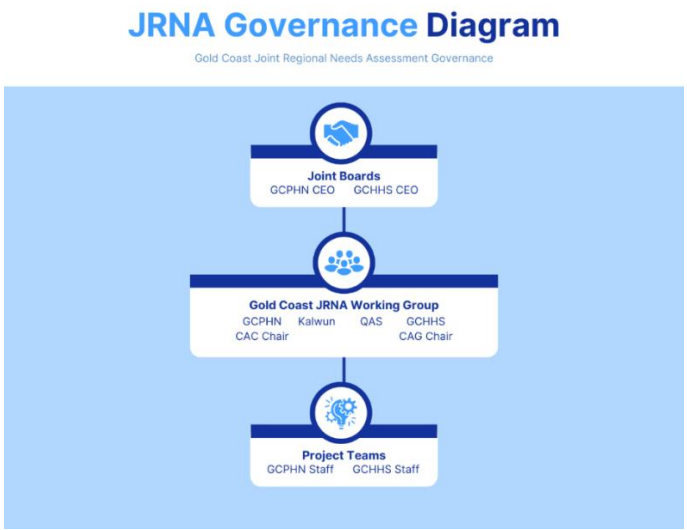
Conducting the JRNA required partnerships and collaboration, a whole system approach, and a clear plan to conduct the process. The phase involved:

1) Establishing governance and resourcing,
2) Preparing project plan documentation, and
3) Preparing a consultation and engagement plan.

In terms of governance, the development of the Gold Coast JRNA was overseen by the Gold Coast JRNA Working Group. This group provided leadership and oversight for the Gold Coast JRNA and included representatives from GCPHN, GCHHS, Kalwun, QAS, and members from both the GCPHN Community Advisory Council (CAC) and the GCHHS Consumer Advisory Group (CAG).



The Working Group and Project Teams worked to jointly agreed timelines set out in project documentation and met regularly to discuss progress and ensure milestones were being met.



1.2.2 Phase 2: Identifying and analysing regional health, wellbeing and service-related information

The JRNA was informed by a mix of both qualitative and quantitative evidence related to health and wellbeing, and consideration of the Gold Coast health service system. This included quantitative data from various sources, qualitative insights from stakeholder engagement, and other relevant existing documentation.

Quantitative data

The JRNA was developed using the collection of data from the following domains:

- Population data
- Social determinants of health
- Lifestyle factors
- Preventative health
- Mortality
- Managing health conditions
- Service mapping and utilisation
- Workforce

The Project Team reviewed existing topics from previous needs assessment iterations and examined data to identify any updates. The Project Team also scanned for new and emerging data sources at the state, national, and regional levels, and, where available, at the Statistical Area Level 3 (SA3). This analysis helps identify national and state health trends for comparison and allows for views of the different SA3s within the Gold Coast as distinct regions with unique issues and challenges.

The scope of the revision activity considered relevant time frames, knowledge of new data releases, and resource availability. Quantitative sources were reviewed based on their ability to add value and complement existing knowledge of health in the Gold Coast. Supplementary information included in the revision was sourced from a range of sources, including:

- Australian Childhood Immunisation Register,
- National Primary Health Network Secure Data Site, which included Medicare Benefits Schedule Data and Pharmaceutical Benefits Scheme Data,
- Australian Institute of Health and Welfare,
- Australian Bureau of Statistics,
- PHIDU Social Health Atlas of Australia,
- Queensland Government Statistician's Office,
- GCHHS data (Emergency Department presentations, hospital separations, wait times, etc.),
- Aggregated general practice data sourced through Primary Sense.

Service-related information

Service mapping was revised using the GCPHN and GCHHS Client Relationship Management (CRM) tools and internal data to identify changes in health service providers and workforce across the region. Additionally, information provided by external stakeholders through consultation was considered. A broad market scan was conducted to complement these activities and build a robust picture of the local service system, including service gaps and issues.

Stakeholder engagement and collaboration

Engagement and collaboration were essential in the JRNA process, ensuring consumers, carers, and partnered agencies worked together to develop a complete understanding of the health and wellbeing-related and service-related information of the Gold Coast community.

Adequate preparation and realistic expectations were provided to stakeholders ahead of engagement activities. Firstly, the results of recent engagement activities were reviewed to ensure we were building on information already provided, including extensive consultation with First Nations community. Where consultation was recently completed prior to the JRNA, it was assessed for relevance and where appropriate, included in evidence informing the JRNA.

The Project Team then conducted targeted engagement with several groups to provide deeper insight or fill gaps in available engagement outputs. The following groups were consulted in relation to specific topic areas to assist in the identification of health and service needs:

- Advisory councils,
- Clinicians and health sector providers,
- The broader community,
- Community service providers, including Gold Coast Homelessness and Multicultural service providers and their clients, and
- Staff of partnering organisations.

GCPHN and GCHHS also ensured stakeholders were aware of how their feedback was being considered as part of the wider JRNA process.

For a full list of consultation activities please refer to Appendix 1.

1.2.3 Phase 3: Validation and triangulation

The information gathered in Phase 2, comprising data, consultation and service mapping, was organised into chapters. The Project Team reviewed and analysed the information in each chapter and used a triangulation process to identify health and service needs across each chapter. By undertaking this process together, the Project Team ensured that issues were considered from a regional perspective rather than providing a single organisational view.

The Working Group progressively reviewed and approved the data identified in Phase 3 on a chapter-by-chapter basis, developing clear insights to enable the identification of health and service needs.

After undertaking this work, a validated list of health and service needs statements was drafted, workshopped, and agreed on by the Working Group for prioritisation in Phase 4.

1.2.4 Phase 4: Prioritising needs for the region

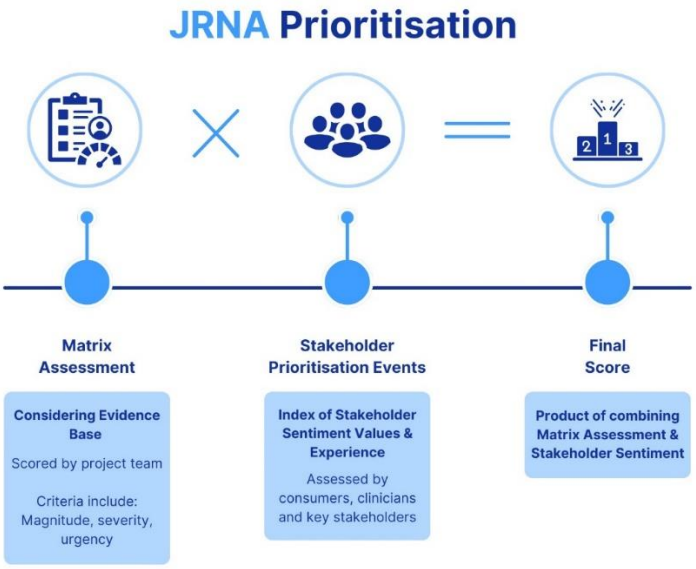
In Phase 4, the Working Group used a multi-stage process that considered both evidence and stakeholder sentiment to prioritise health and service needs identified in Phase 3.

The Project Team assessed each of the identified health needs and service issues against a matrix which included the following criteria:

- Magnitude of need,
- Consequence of unmet need (severity of impact), and
- Equity.

Following matrix-based scoring, relative priority according to stakeholder sentiment, values, and experience was determined by inviting key stakeholder groups (GCPHN Clinical Council and Community Advisory Council, GCHHS Community Advisory Group, GCHHS Senior Leadership Team, GCHHS Clinical Council, and GCPHN senior leadership team) to prioritise these health and service needs.

This component of the prioritisation process involved each member from the above groups receiving a pre-determined amount of 'JRNA bucks' to allocate towards the needs they prioritised. This method was used to enhance the sensitivity of the scoring process and allowed for greater differentiation between individual health and service needs, which was a learning from previous processes.



The Project Team then combined the outcomes of the matrix-based (objective) and sentiment-based (subjective) processes to deliver a final rating for each health and service need as set out below.

The Working Group reviewed the prioritised health and service needs and organised the grouping into four Tiers by levels of priority. The Working Group also identified the lead organisation(s) for each identified need.

This final output was reviewed and approved by the Senior Leadership of each partner organisation.

The list of all Needs statements, organised into four Tiers, and the lead organisations for each need, are show in Chapter 2: *Prioritised Needs*.

1.2.5 Market assessment

The triangulation of data, service mapping, and commissioning processes demonstrated that the Gold Coast region has a robust local market of health services, with a broad range of providers that offer services for the Gold Coast community and surrounding regions.

There is a strong public health service presence with 2 public hospitals, 7 community health service centres, 1 satellite hospital, and 2 Urgent Care Clinics. Additional facilities are currently being developed to include a hospital at Coomera. Public sector hospital services are currently at capacity with significant waiting lists for elective surgery and outpatient review.

In addition, there are 5 private hospitals and more than 15 private organisations that offer outpatient services with day surgery and overnight facilities.

In comparison to national averages, Gold Coast region has comparable or higher rates of population accessing services and available health workforce across most clinical professions (described in more detail in the *Primary Health Care Workforce* chapter).

As of September 2024, there were 880 GPs working across 212 general practices in the GCPHN region. The local university sector supports the growing demand for healthcare services with nursing and allied health programs being offered at three Gold Coast Universities and medicine at two of them.

Gold Coast mental health services across GCHHS, private psychologists, allied health, and non-government organisations (NGOs) are stretched and at capacity. Access for hard-to-reach groups has been negatively impacted by the increasing demands for services and the Government's changes to increase access to psychological services through Medicare Benefits Schedule (MBS). As a result, some private service providers prefer to offer services to MBS clients, which increases wait-times to access NGOs and GCPHN-funded psychological services.

The Gold Coast region has a strong presence of NGOs, particularly for mental health service delivery, with strong ongoing growth. However, NGOs are generally based in older and more established suburbs, particularly Southport. There is significant interest and a strong need for the expansion of NGOs in the northern Gold Coast where there is less of a presence and population continues to grow.

1.3 APPENDIX 1: CONSULTATION PLAN

Stakeholder group	Date	Topic	Method
First Nations	January 2022 – April 2024 and reviewed by JRNA committee April 2024	First Nations Health Equity and broad consultation	Series of facilitated meetings
General community and targeted cohorts (multicultural communities, homelessness service providers, young families)	July 2022 and reviewed by JRNA committee April 2024	Broad consultation, barriers to care, child and maternal health	Mix of face to face, online and survey
GCPHN Community Advisory Council and Gold Coast HHS Community Advisory Group	November 2023	Strategic Plan and Workforce	Face to face meeting
Gold Coast HHS Oral Health Service senior and clinical leadership	November 2023	Oral Health	Online meeting
General community	October - November 2023	Initial scoping	Online survey
General community	January - August 2024	Broad community and sector consultation opportunity via feedback on 2023 GCPHN HNA	Online survey
GCPHN Primary Care Partnership Council	March 2024	Chronic Disease and Older persons health and service needs	Face to face meeting
GCPHN project officers	February - March 2024	Unpack health and service needs across all topic areas	Face to face meeting and online
GCPHN funded providers	March - April 2024	PHN Project Officers asked providers about health and service needs	Provider meetings
Multicultural Communities Council Gold Coast	March 2024	Discuss health and service needs of multicultural populations	Face to face meeting
St John's Crisis Centre	March 2024	Discuss health and service needs of the homeless populations	Face to face meeting
Multicultural Families Organisation	March 2024	Discuss health and service needs of multicultural populations	Face to face meeting

Uniting Care Community	March 2024	Discuss health and service needs of the homeless populations	Face to face meeting
Gold Coast general practices	July 2023 to June 2024	Discuss workforce issues being experienced by general practices	Face to face meeting
GCPHN Community Advisory Council	April 2024	Homeless and multicultural populations	Face to face meeting
GCPHN Clinical Council	May 2024	Homeless and multicultural populations	Face to face meeting
St Johns Crisis Care, Uniting Care Community and Nerang Neighbourhood Centre - Client survey	April - May 2024	Survey with a sample of people experiencing homelessness about their healthcare experience	In person survey
Multicultural Communities Council Gold Coast – Client survey	April - May 2024	Survey with a sample of multicultural populations about their healthcare experience	In person survey
Mental health, Alcohol and Other Drug and Suicide prevention service providers, service users and broader sector	May 2024	220 sector partners at MH/AODS/SP Gold Coast Symposium	Menti survey
GCPHN Community Advisory Council	June 2024	Persistent Pain	Face to face meeting
Gold Coast HHS Community Advisory Group	July 2024	Health needs identification and validation	Online meeting
Gold Coast HHS executive and clinical leads	September 2024	Service needs identification and validation	Online meeting
Gold Coast HHS Oral Health Service dental van staff	November 2024	Oral Health	Online meeting

Chapter 2:
PRIORITISED NEEDS

The needs statements were prioritised into four Tiers based on the methodology described in the Background chapter. Tier 1 represents the highest priority items, while the following tiers (Tiers 2, 3, and 4) remain important but decrease in priority relative to Tier 1.

The below table also identify the lead organisation(s) for each health and service need.

TIER 1 **Needs Statement**	**Chapter**	GCHHS	GCPHN	Kalwun	QAS
Effective integrated care of complex chronic disease to optimise quality of life and avoid preventable hospitalisations.	CANCER AND CHRONIC DISEASE	○	○	○	○
Higher rates of chronic obstructive pulmonary disease and asthma diagnoses.	CANCER AND CHRONIC DISEASE	○	○	○	
Equitable access for integrated holistic multidisciplinary persistent pain management especially lower socio-economic groups.	CANCER AND CHRONIC DISEASE	○	○		○
Low rate of bowel cancer screening participation across Gold Coast, and across all national cancer screening programs in northern Gold Coast.	CANCER AND CHRONIC DISEASE	○	○		
There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.	CANCER AND CHRONIC DISEASE	○	○	○	○
Inadequate capacity to provide timely access to several specialist outpatient; procedural; and elective surgery specialties, including ENT, ophthalmology, gastroenterology; endoscopy and cardiac investigation/intervention; and orthopaedics and general surgery respectively.	DEMAND	○			
Insufficient service capacity to meet growing demand due to population growth, particularly in northern Gold Coast.	DEMAND	○	○	○	○
There are lower screening rates and increasing morbidity and mortality for cancers in the First Nations community.	FIRST NATIONS	○	○	○	
Worsening clinical workforce shortage in the primary, secondary, community and aged care sectors.	HEALTH WORKFORCE	○	○	○	○
High demand and limited availability of publicly funded AOD services, including after-hours options, acute detox and residential withdrawal services.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○	○	

Increasing acute demand requires improvement in early intervention, prevention and community support for mental health.	MENTAL HEALTH, AOD, SUICIDE PREVENTION		○	○	○
Delayed access to home care, social support and residential and community aged care services, leading to high rates of hospitalisation.	OLDER PEOPLE	○	○	○	
Limited, effective systems and models of care and support for increasing number of patients with dementia and their carers.	OLDER PEOPLE	○	○	○	○
Higher rates of mental ill health and mental health related ED presentations among people experiencing homelessness.	POPULATIONS EXPERIENCING INEQUITY	○	○		○
Limited resources, variable capability and unclear pathways for primary healthcare practitioners and paramedics to recognise and support patients experiencing family and domestic violence.	POPULATIONS EXPERIENCING INEQUITY		○		○
Need to actively eliminate racial discrimination, lateral violence and institutional racism.	FIRST NATIONS	○	○	○	○

TIER 2 **Needs Statement**	**Chapter**	**GCHHS**	**GCPHN**	**Kalwun**	**QAS**
Sufficient resources required to implement National Lung Cancer Screening Program and respond in a timely way to increased demand.	CANCER AND CHRONIC DISEASE	○	○	○	
Delayed diagnosis and limited dedicated primary care services for endometriosis and pelvic pain.	CANCER AND CHRONIC DISEASE		○		
QAS capacity is unable to meet demand and scheduling pressures for non-urgent patient transfer, including renal dialysis.	DEMAND	○			○
Constrained system capacity requires investment in alternate models of care, including digital opportunities to manage and mitigate demand.	DEMAND	○	○	○	○
Growing demand for hospital services and inadequate transition practices between paediatric and adult services requiring specialised, cohorted inpatient capacity to support safe and effective care.	DEMAND	○			
Constrained QAS system capacity requires investment in alternate models of care, including scaling sole, co-responder and digital options.	DEMAND				○

Growing numbers of people with socioeconomic disadvantage and associated higher need, especially in the northern Gold Coast.	DETERMINANTS, HEALTH BEHAVIOURS AND PREVENTION	INTERAGENCY			
Declining vaccination rates, including in children and in RACHs.	DETERMINANTS, HEALTH BEHAVIOURS AND PREVENTION	○	○		
Ongoing improvements are required in culturally safe service provision across the system to ensure equitable, effective access for First Nations people.	FIRST NATIONS	○	○		○
Low rates Indigenous specific health checks (MBS 715).	FIRST NATIONS		○	○	
Inadequate suicide prevention services and post event services for First Nations community.	FIRST NATIONS		○	○	
Systems and processes do not support consistent, effective clinical handover on discharge from the acute sector to primary and community services to support ongoing care.	GENERAL PRACTICE AND PRIMARY CARE	○			
Reduced bulk billing and reducing GP per capita rates leading to poorer access for some vulnerable people.	GENERAL PRACTICE AND PRIMARY CARE		○	○	
Insufficient capacity in sub-acute community based residential mental health services.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○			
Increasing rate of eating disorders, including severe cases requiring medical stabilisation and complex multi-specialty management.	DEMAND	○	○		
Inefficient system navigation leads to delayed connection of patients with suitable mental health, AOD and suicide prevention services.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○	○	○
Poorer mental health outcomes and higher suicidality for LGBTIQAP+ people.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○	○	○
Care coordination and information sharing by mental health, AOD and suicide prevention providers and services is often inefficient, particularly for transitions between acute or inpatient care to community-based services.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○		
Limited uptake and implementation of Advanced Care Plans, including end of life care provision in community.	PALLIATIVE CARE (END OF LIFE CARE)	○	○	○	○
Limited effective support in navigating complex community, aged care system and National Disability Insurance Scheme (NDIS).	OLDER PEOPLE		○		

		INTERAGENCY			
High levels of isolation and loneliness among older people.	OLDER PEOPLE				
Cost, transport and stigma limit the ability of people experiencing homelessness to access health care, including health checks, preventative and follow up care.	POPULATIONS EXPERIENCING INEQUITY	○	○	○	○
Large and growing Māori and Pasifika community with higher reported health needs and challenges accessing healthcare.	POPULATIONS EXPERIENCING INEQUITY	○	○		○
Out-of-pocket costs and safety concerns limit access to health services for people experiencing family and domestic violence.	POPULATIONS EXPERIENCING INEQUITY		○		
Gaps in cultural capability across service providers and clinicians, particularly relating to sensitive issues such as mental health, AOD and FDV.	POPULATIONS EXPERIENCING INEQUITY		○		○
Insufficient diagnostic and management service capacity for neurodevelopment exposure disorders (neonatal) neurodivergence and developmental delay.	PREGNANCY AND CHILDREN	○	○		
Prevalence of lifestyle and demographic maternal risk factors are increasing, including maternal smoking and high maternal age.	PREGNANCY AND CHILDREN	○	○	○	

TIER 3 **Needs Statement**	**Chapter**	GCHHS	GCPHN	Kalwun	QAS
Growing demand for acute care, specialised rehabilitation and ongoing care for GCHHS catchment residents with spinal cord injuries unable to secure timely access to current statewide service.	DEMAND	○			
Limited QAS fleet capacity to manage operations including surge periods including major events.	DEMAND				○
Low rates of people who identify as First Nations in health workforce, particularly for clinical roles.	FIRST NATIONS	○	○	○	○
Limited culturally informed holistic approaches to wellbeing and ill health prevention.	FIRST NATIONS	○	○	○	
Insufficient resources for some general practices and Residential Aged Care Homes (RACHs) to implement frequent reform and new initiatives.	GENERAL PRACTICE AND PRIMARY CARE		○		

Increasing risks of frontline staff experiencing psychosocial/psychological hazards.	HEALTH WORKFORCE				○
Limited availability of suitable service options to support older population.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○		○
Growing demand from RACHs for non-emergency situations due to issues around staffing constraints and policy requirements, even when Advance Care Plans in place.	OLDER PEOPLE	○	○	○	○
Limited culturally appropriate services for culturally and linguistically diverse older people.	OLDER PEOPLE	○	○		○
Access to public oral health services by eligible population is the lowest in Queensland.	ORAL HEALTH	○		○	
Lack of growth in public oral health workforce, including dentists, to meet the demand of growing population.	ORAL HEALTH	○			
Insufficient integration, funding mechanisms and capacity for the provision of community based palliative care.	PALLIATIVE CARE (END OF LIFE CARE)		○		
People from multicultural backgrounds have higher reported prevalence of diabetes, arthritis, and heart disease.	POPULATIONS EXPERIENCING INEQUITY	○	○		
Limited effective use of translation services in primary care and ambulance response services.	POPULATIONS EXPERIENCING INEQUITY		○		○
Growing numbers of children in out of home care, who typically have high health needs, and relatively high proportion of First Nations children in out of home care.	PREGNANCY AND CHILDREN	○	○	○	
First Nations women have a high prevalence of smoking during pregnancy, including passive smoking.	PREGNANCY AND CHILDREN	○	○	○	

TIER 4 **Needs Statement**	**Chapter**	GCHHS	GCPHN	Kalwun	QAS
High melanoma incidence rate.	CANCER AND CHRONIC DISEASE		○	○	
Prevalence of select chronic disease risk factors (low vegetable intake, high BMI, alcohol) is high and/or significantly increasing for adults in the Gold Coast region.	DETERMINANTS, HEALTH BEHAVIOURS AND PREVENTION	○	○	○	
Limited system partnerships addressing social determinants of health.	FIRST NATIONS	INTERAGENCY			
Challenges for general practices, primary care and RACHs in adopting digital health.	GENERAL PRACTICE AND PRIMARY CARE		○	○	
Some health practitioners have insufficient capability to support patients with complex needs, including mental ill health and social needs.	HEALTH WORKFORCE		○		
Insufficient resourcing to ensure supported, psychologically safe, meaningful engagement of people with lived experience in planning and service delivery.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○		
Reported high prevalence of vaping, particularly among young people.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	○	○	○	
Growing demand for psychological therapies.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	INTERAGENCY			
Stigma and shame associated with mental health, suicidality and AOD issues.	MENTAL HEALTH, AOD, SUICIDE PREVENTION	INTERAGENCY			
Absence of designated First Nations Residential Aged Care Homes.	OLDER PEOPLE	○	○	○	○
Slow adoption of digital health solutions by RACHs and poor integration with other clinical systems limits access to clinical information between service providers, including paramedics.	OLDER PEOPLE		○		
Migrants are often unfamiliar with the Australian health system and have lower health literacy.	POPULATIONS EXPERIENCING INEQUITY	○	○		○

Chapter 3: DEMAND

KEY FACTS:

- Gold Coast population grew by 23.1% from 2013 to 2023. This growth is concentrated in northern Gold Coast areas.
- The number of GPs per capita has fallen in recent years.
- Bulk billing options have sharply declined, contributing to a 65% increase in out-of-pocket costs for GP visits since 2008-09 to 2023-24 ($26 to $43).
- Residential aged care places in the Gold Coast region fell by 2.2% (124 places) from 2020 to 2023, while the population of those over 80 increased by nearly 12%.
- The ratio of aged care places per 100 people over 80 declined from 21.3 in 2020 to 18.7 in 2023, straining community support and hospital resources.
- Long delays in activating home care packages further complicate discharges from hospitals, with 8% beds occupied by long-stay sub-acute patients.
- ED presentations grew by 26.4% in the last 10 year.
- Elective surgery waitlists grew by 16.4% from 2021-22 to 2023-24.
- The highest volume of patients waiting for elective surgery from 2021-22 to 2023-24 specialties includes orthopaedics, gynaecology, and general surgery.
- The Gold Coast region has the lowest number of public hospital beds per capita (1.6 beds per 1,000 population), compared to other regions.

PRIORITISED NEEDS:

1) Insufficient service capacity to meet growing demand due to population growth, particularly in northern Gold Coast.
2) Inadequate capacity to provide timely access to several specialist outpatient; procedural; and elective surgery specialties, including ENT, ophthalmology, gastroenterology; endoscopy and cardiac investigation/intervention; and orthopaedics and general surgery.
3) Constrained system capacity requires investment in alternate models of care, including digital opportunities to manage and mitigate demand.
4) QAS capacity is unable to meet demand and scheduling pressures for non-urgent patient transfer, including renal dialysis.
5) Increasing rate of eating disorders, including severe cases requiring medical stabilisation and complex multi-specialty management.
6) Growing demand for hospital services and inadequate transition practices between paediatric and adult services requiring specialised, cohorted inpatient capacity to support safe and effective care.
7) Constrained QAS system capacity requires investment in alternate models of care, including scaling sole, co-responder and digital options.
8) Growing demand for acute care, specialised rehabilitation and ongoing care for GCHHS catchment residents with spinal cord injuries unable to secure timely access to current statewide service.
9) Limited QAS fleet capacity to manage surge periods including major events.

3.1 DEMOGRAPHIC CHANGE

The population of Gold Coast region is both growing and ageing, increasing the total demand for health care services. Demographic drivers of changing health care demand include:

- Population growth – additional people moving to the region that will require health care throughout their lifespan.
- Population ageing – although population growth is occurring across all age groups, the median age of Gold Coast residents is increasing in line with national trends. Older age groups have higher demand for health care services.
- Geographic locus of growth – population growth is concentrated to historically sparsely populated areas, such as the northern corridor of the Gold Coast, where the establishment of new services is required to provide access.

3.1.1 Population growth

- The estimated resident population for the Gold Coast SA4 region as of 30 June 2023 was 682,488.
- The Gold Coast population grew by 23.1% (or 127,921 people) from 2013 to 2023, which was above the Queensland rate of growth of 17.4% over the same period. Gold Coast was one of the fastest growing regions in Queensland, accounting for 15.8% of Queensland's total growth.
- Population growth occurred across all SA3 regions, however, was most concentrated in Ormeau-Oxenford SA3. This region grew by 62.5% (or 67,189 people), accounting for more than half of the total Gold Coast growth over the period.

TABLE 1: ESTIMATED RESIDENT POPULATION, GOLD COAST SA3 REGIONS, 2013 TO 2023

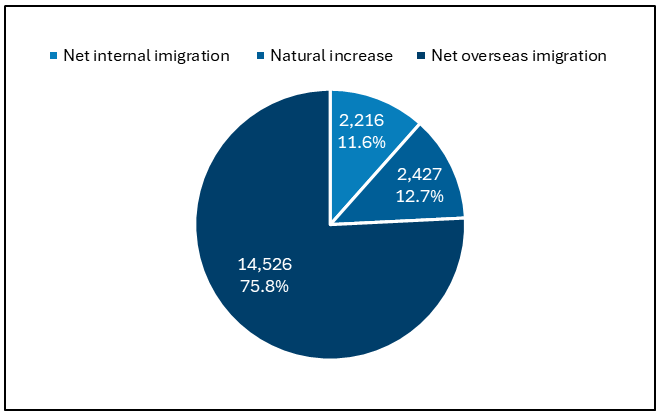
Region	2013	2018	2023	10-year growth %
Queensland	4,652,824	5,006,623	5,460,420	17.4%
Gold Coast	554,567	617,663	682,488	23.1%
Broadbeach – Burleigh	62,718	65,702	70,524	12.4%
Coolangatta	53,572	56,317	60,298	12.6%
Gold Coast – North	64,967	69,067	72,319	11.3%
Gold Coast Hinterland	18,046	19,602	20,966	16.2%
Mudgeeraba – Tallebudgera	33,079	35,440	37,482	13.3%
Nerang	67,378	70,509	72,380	7.4%
Ormeau – Oxenford	107,520	140,202	174,709	62.5%
Robina	49,041	53,215	56,582	15.4%
Southport	58,712	63,509	67,751	15.4%
Surfers Paradise	39,534	44,100	49,477	25.2%

Source: Australian Bureau of Statistics, Estimated Resident Population by SA4 and above (ASGS Edition 3), 2001 onwards.

3.1.2 Sources of population growth

In 2022-23, net overseas migration was the primary driver of population growth, accounting for over three-quarters of the total increase. While it's unclear if this surge was a short-term rebound following COVID-19 border re-openings, both internal and overseas migration surged in the Gold Coast region during the pandemic.

FIGURE 1: SOURCE OF POPULATION COMPONENT GROWTH, GOLD COAST, 2022-23



Source: Australian Bureau of Statistics, 2023, SA4.SA3, Population Components 2022-23.

3.1.3 Geographic variation

There was geographic variation in sources of population growth throughout the Gold Coast region, with internal migration and natural increase being the key drivers of Ormeau-Oxenford SA3 population growth, and the remainder of the regions being driven largely by net overseas migration.

TABLE 2: POPULATION COMPONENT GROWTH, GOLD COAST SA3 REGIONS, 2021-22 TO 2022-23

Population components of growth 2021-22 to 2022-23 (2 yrs combined)	Natural increase (Births - Deaths)	Net internal migration	Net overseas migration	Total increase 2021-22 to 2022-23	% of Population Growth
Gold Coast (SA4)	5667	7829	19501	32997	
Broadbeach - Burleigh	458	495	2329	3282	9.9%
Coolangatta	490	274	1348	2112	6.4%
Gold Coast - North	-193	378	2043	2228	6.8%
Gold Coast Hinterland	158	164	297	619	1.9%
Mudgeeraba - Tallebudgera	374	-61	665	978	3.0%
Nerang	874	-455	1274	1693	5.1%
Ormeau - Oxenford	3212	7265	3540	14017	42.5%
Robina	179	-212	1987	1954	5.9%
Southport	-28	-458	2846	2360	7.2%
Surfers Paradise	143	439	3172	3754	11%
% Component of Growth	17%	24%	59%		

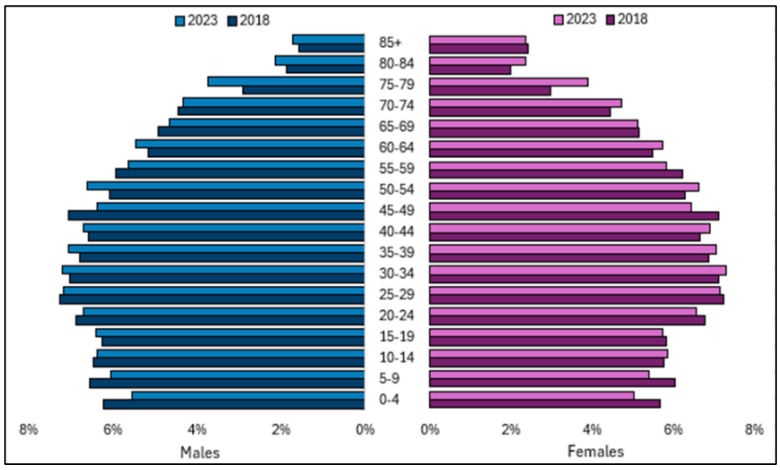
Source: Australian Bureau of Statistics, 2023, SA4.SA3, Population Components 2021-22 to 2022-23.

3.1.4 Age and sex profile

Between 2018 and 2023, the Gold Coast region has seen notable demographic shifts that impact healthcare services. Gold Coast has an older population that the Queensland average, with the median age at 39.5 years for 2020-2022, compared to 38.6 years for Queensland.

There was an increase in the proportion of Gold Coast residents aged 70+, consistent with broader trends of ageing populations across Australia. This will impact the type and intensity of healthcare service demand.

FIGURE 2: AGE AND SEX POPULATION PYRAMID, GOLD COAST, 2018 AND 2023



Source: Australian Bureau of Statistics ERP by Gold Coast SA2 (ASGS Edition 3), Age and Sex, 2017 and 2022.

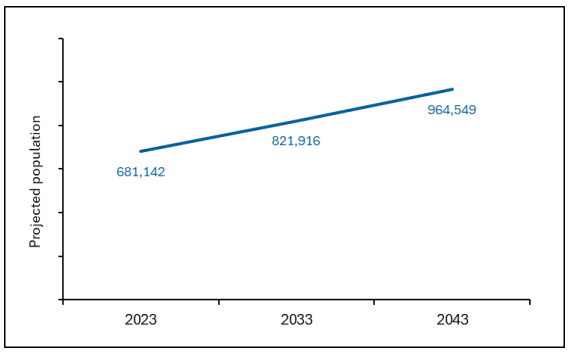
- There were a greater proportion of people aged 70- 84 in 2023 than in 2018.
- Between 2018 and 2023, the overall sex ratio remained stable, reflecting a distribution of 51.1% females to 48.8% males. However, the sex distribution within the 0-19 age cohort in 2023 shifted to majority male, with a ratio of 51.4% male to 48.6% female.

3.1.5 Projected population

The Gold Coast is experiencing significant demographic changes, characterised by a high population growth projection of 17-22% through to 2033.

- The Gold Coast population is projected to approach 1 million in 2043.
- The rate of growth in the Gold Coast region is estimated to be 4-5% above Queensland rate.

FIGURE 3: PROJECTED POPULATION OF GOLD COAST REGION, 2023 TO 2043



Source: QGSO 2023 Edition (update 16 Feb 2024). Projected population (B series) in Gold Coast Statistical Area SA4.

3.2 SERVICE UTILISATION

The utilisation of health services reflects the demand that is met by the current supply arrangements of the system and accommodated within existing capacity.

3.2.1 General practice

TABLE 3: GP ATTENDANCES, GOLD COAST SA3 REGIONS, 2022-23

Region	Number of services	Services per 100 people
National	166,234,507	629
Gold Coast SA4	4,698,338	709
Broadbeach–Burleigh	503,806	736
Coolangatta	399,324	679
Gold Coast–North	590,419	833
Gold Coast Hinterland	143,045	693
Mudgeeraba–Tallebudgera	237,498	643
Nerang	499,376	702
Ormeau–Oxenford	1,139,749	679
Robina	384,489	696
Southport	480,666	727
Surfers Paradise	320,976	681

Source: Australian Institute of Health and Welfare, Medicare-subsidised GP, allied health, and specialist healthcare across local areas, 2017-18 and 2022-23. Note: GP attendances include Enhanced Primary Care, After-hours GP attendances, Practice Incentive Program (PIP) services, and 'Other' GP services. These services are Medicare-subsidised patient/doctor encounters, such as visits and consultations, for which the patient has not been referred by another doctor.

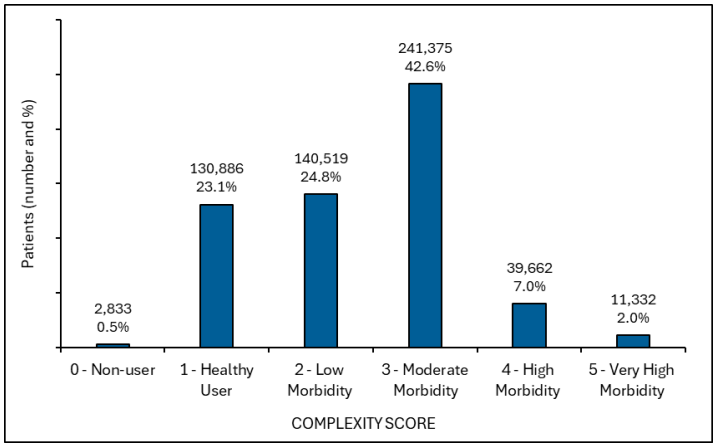
- In 2022-23, the rate of GP attendances in the Gold Coast region was above the national rate.
- Gold Coast-North SA3 had the highest rate of GP attendances per 100 people (833 per 100 people), while Ormeau Oxenford SA3 had the highest number of services (n=1,139,749).
- In 2022-23, the rate of after-hours GP attendances in the Gold Coast region was above the national rate (46.0 vs 30.5 per 100 people). The rate of after-hours attendances has decreased in recent years, in the Gold Coast region and nationally.

Profile of general practice patients

The regional profile of patients who visited a GP in the Gold Coast region in 2023-24, using Primary Sense data from 164 general practices, is shown in Figure 4.

Primary Sense contains the Johns Hopkins University's Adjusted Clinical Groups (ACG)® risk stratification system, which stratifies patients in complexity levels ranging from 0-5: level 0 indicates a very low level of complexity with no known risks for poor health outcomes, while level 5 is the highest complexity.

FIGURE 4: ACG COMPLEXITY SCORES OF GENERAL PRACTICE PATIENTS, GOLD COAST, 2023-24



Source: GCPHN Primary Sense data.

Primary Sense recorded GP visits by 566,607 unique patients in 2023-24. Of those, 42.6% were categorised as ACG level 3, and 9.0% were categorised as having high or very high complexity, thus requiring often and complex interactions with all levels of the health system.

Data in Table 4 demonstrate that patients who visit the GP with levels 4 or 5 complexity are on average older, have more significant multi-morbidity, more frequent engagements with the primary health system, and higher risk of future hospitalisations.

TABLE 4: GENERAL PRACTICE PATIENTS' CHARACTERISTICS BY COMPLEXITY SCORE, GOLD COAST, 2023-24

	ACG 0	ACG 1-2	ACG 3	ACG 4-5
Average age (years)	33.8	31.4	48.6	66.1
Average number of chronic conditions	0.0	0.2	1.9	5.0
Number of visits to GP in the last 3 years	3.8	7.8	17.1	31.6
Hospitalisation risk in 12 months	1.0%	1.2%	4.3%	14.1%

Source: GCPHN Primary Sense data

3.2.2 After-hours general practice

The Gold Coast rate of after-hours service utilisation (46.0 per 100 population) was greater than the national rate (30.8 per 100 population) in 2022-23 and the preceding three years. There was some geographical variation in the utilisation of after-hours GP services, however, all regions of the Gold Coast had higher utilisation than the national average.

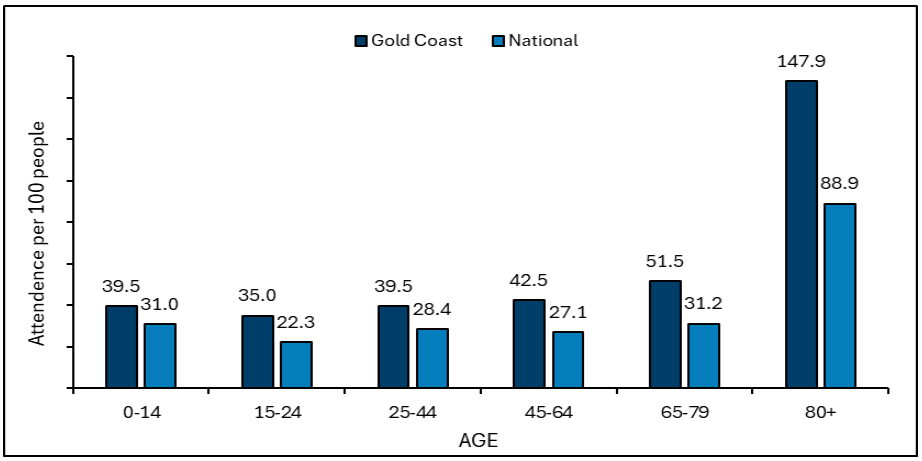
- Southport SA3 had the highest rate (56.8 per 100 population), while Ormeau – Oxenford SA3 had the highest number (n=45,317).
- Coolangatta had the lowest rate (32.5 per 100 population), while Gold Coast Hinterland SA3 had the lowest number (n=3,842) of after-hours GP attendances.

TABLE 5: AFTER HOURS GP ATTENDANCES, GOLD COAST SA3 REGIONS, 2019-20 TO 2022-23

Region	Rate per 100 population			
	2019-20	2020-21	2021-22	2022-23
National	42.5	33.5	30.7	30.8
Gold Coast (SA4)	55.1	46.5	47.3	46.0
Broadbeach – Burleigh	48.2	38.1	35.9	37.1
Coolangatta	42.8	35.6	33.8	32.5
Gold Coast – North	60.8	52.4	55.6	55.9
Gold Coast Hinterland	44.3	41.4	36.2	34.3
Mudgeeraba – Tallebudgera	43.4	35.3	34.9	34.0
Nerang	59.4	47.4	54.7	51.9
Ormeau – Oxenford	67.4	55.6	54.6	51.1
Robina	48.4	37.9	37.1	36.9
Southport	62.7	54.0	55.4	56.8
Surfers Paradise	51.9	42.6	46.8	43.5

Source: AIHW 2023, Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2019-20 to 2022-23.

FIGURE 5: GP AFTER-HOURS ATTENDANCES BY AGE, NATIONAL AND GOLD COAST, 2022-23



Source: AIHW 2023, Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2022-23.

- Rates of after-hours GP services were highest among people aged 80+ years for the Gold Coast region (147.9 per 100 people) and nationally (88.9 per 100 population).
- The lowest rates were recorded for age group 15-24 (35.0 per 100 population).

Urgent/non urgent after-hours GP attendance

Gold Coast residents utilised urgent and non-urgent after-hours GPs at a higher rate than the national average. In 2022-23, the rate of urgent after-hours services per 100 people in the Gold Coast region was 2.4 times the national rate (4.1 vs 1.7 per 100 people).

During the same period, the rate of non-urgent after-hours services in the Gold Coast region was 1.4 times the national rate (41.9 vs 29.1 per 100 people).

TABLE 6: URGENT AND NON-URGENT GP AFTER HOURS ATTENDANCES, GOLD COAST SA3 REGIONS, 2022-23

Region	Urgent attendances		Non-urgent attendances	
	Number	Rate per 100 people	Number	Rate per 100 people
National		1.7		29.1
Gold Coast (SA4)	19,071	4.1	141,171	41.9
Broadbeach - Burleigh	1,341	2.6	11,821	34.5
Coolangatta	681	1.6	9,230	31.0
Gold Coast - North	2,329	4.8	16,832	51.1
Gold Coast Hinterland	309	2.0	3,669	32.3
Mudgeeraba - Tallebudgera	647	2.2	5,874	31.8
Nerang	2,343	4.6	17,159	47.3
Ormeau - Oxenford	7,608	6.7	40,972	44.4
Robina	1,235	2.7	9,254	34.2
Southport	1,924	4.2	16,542	52.6
Surfers Paradise	654	1.8	9,858	41.8

Source: Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2022-2023

- Among Gold Coast SA3 regions, Ormeau-Oxenford had the highest rate and number (6.7 per 100 people, n=7,608) of urgent after-hours GP attendances, while Coolangatta had the lowest rate (1.6 per 100 people), and Gold Coast Hinterland had the lowest number (n=309).
- Southport had the highest rate of non-urgent GP after hours attendances (52.6 per 100 people), while Ormeau–Oxenford had the highest number (n=40,972). Coolangatta had the lowest rate (31.0 per 100 people), and Gold Coast Hinterland had the lowest number (n=3,669) of non-urgent after-hours attendances.

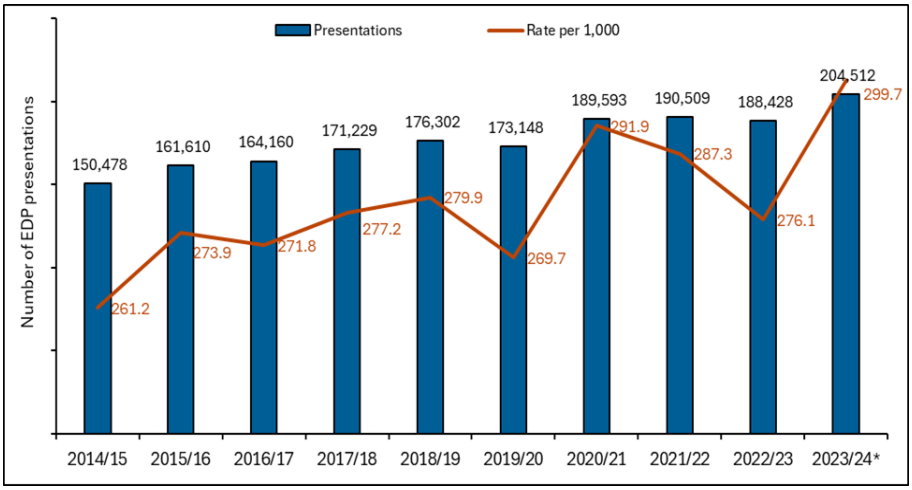
3.2.3 Emergency Departments (public hospital)

Overall growth

Emergency department activity in Gold Coast public hospitals has grown substantially over ten years, driven by both population growth and an increasing utilisation of services per population.

- The number of ED presentations grew by 26.4% over 10 years, reaching 204,512 in 2023-24.
- Over the same period, the rate at which Gold Coast residents attended ED grew by 14.9% to 300 per 1,000 population (not accounting for the change in population age structure over that period).

FIGURE 6: ED PRESENTATIONS, GOLD COAST HHS, 2014-15 TO 2023-24

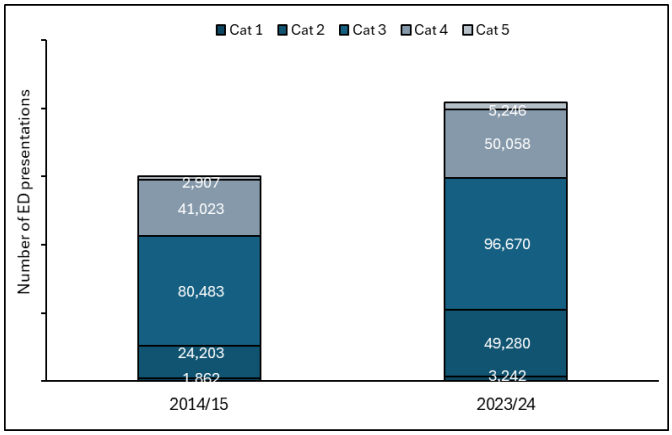


Source: Gold Coast Health and Hospital Service, Emergency Department Collection.

Change in urgency category

Despite high relative growth in triage categories 1 and 5, the overall growth in ED activity was driven by categories 2, 3 and 4, which range from 'potentially serious' to 'imminently life threatening'.

FIGURE 7: ED PRESENTATIONS BY TRIAGE CATEGORY, GOLD COAST, 2014-15 AND 2023-24



Source: Gold Coast Health and Hospital Service, Emergency Department Collection.

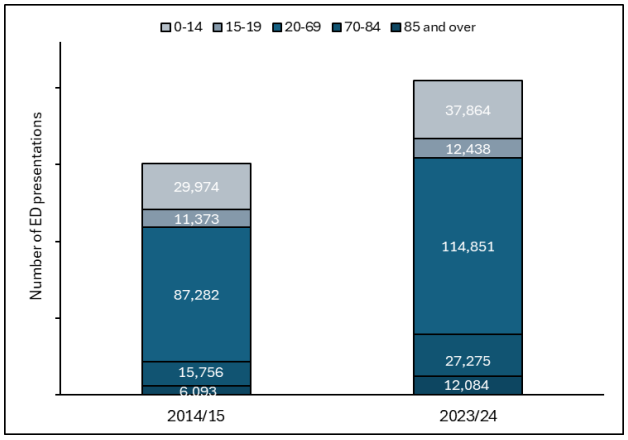
- Category 2 presentations grew by 50.9% between 2014-15 and 2023-24 and were a key contributor to overall ED activity growth over the period.

Age specific effect on demand

The number of ED presentations increased for all age groups between 2014-15 and 2023-24.

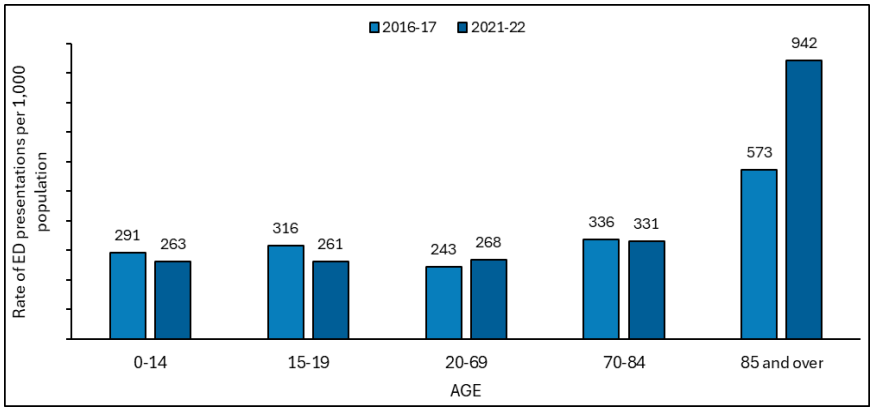
- Presentations for the 20–69-year age cohort grew by 24.0% between 2014-15 and 2023-24.
- The 20–69-year-old cohort accounted for 56.2% of all presentations in 2023-24.

FIGURE 8: ED PRESENTATIONS BY AGE GROUP, GOLD COAST, 2014-15 AND 2023-24



Source: Gold Coast Health and Hospital Service, Emergency Department Collection

FIGURE 9: ED PRESENTATION RATE, BY AGE, GOLD COAST, 2016-17 AND 2021-22



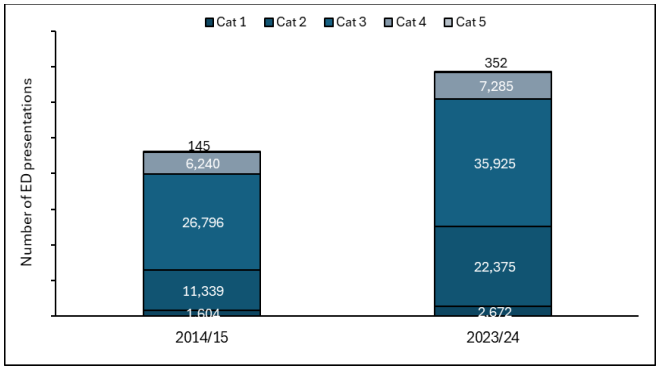
Source: Gold Coast Health and Hospital Service, Emergency Department Collection.

- Older people attended ED in 2021-22 at a much higher rate than in 2016-17, using ED at around triple the rate of any other age group and had the fastest growth rate of the age cohorts.
- The 85+ year old cohort utilised public EDs in 2021-22 at 1.6 times the rate of 2016-17.
- People aged 20-69 utilised ED in 2021-22 at 1.1 times the rate they did in 2016-17.
- Gold Coast people aged 0-14, 15-19 or 70-84 utilised ED at the same rate or less in 2021-22 than they did in 2016-17.

Ambulance arrivals

Ambulance arrivals to ED had an overall growth of 32.8% between 2014-15 and 2023-24, indicating an increasing utilisation of ambulance services that exceeded population growth. Ambulance arrivals increased across all urgency categories, however, growth in triage categories 2 and 3 were the most significant contributors to the overall increase.

FIGURE 10: ED PRESENTATIONS BY AMBULANCE, BY TRIAGE CATEGORY, GOLD COAST, 2014-15 AND 2023-24

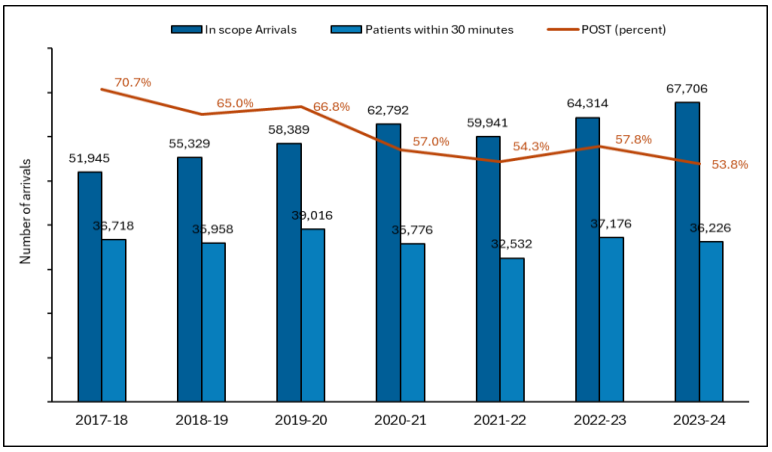


Source: Gold Coast Health and Hospital Service, Emergency Department Collection.

Patient Off Stretcher Time

Patient off stretcher time (POST) relates to the time it takes for patients to be transferred off stretchers into the care of ED. The target for transfer is 30 minutes following arrival; exceeding this time is known as 'ramping'. Ramping increases pressure on paramedic staff and vehicles, who must stay with patients until handover is completed.

FIGURE 11: POST 5-YEAR PERFORMANCE BY HOSPITAL, GOLD COAST, 2017-18 TO 2023-24



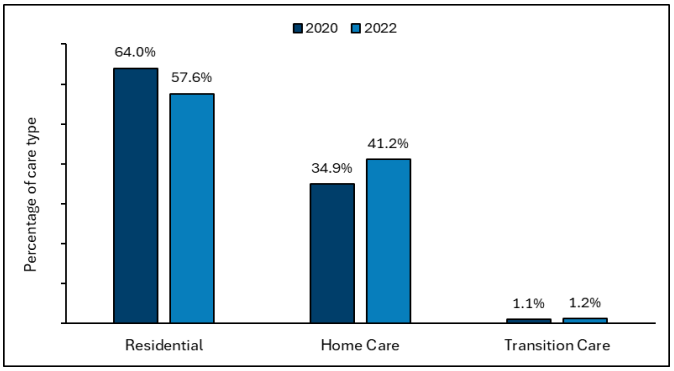
Source: Queensland Health, System Performance Reporting, Patient Off Stretcher KPI Dashboard.

- From 2017-18 to 2023-24, the combined POST performance of Gold Coast University Hospital and Robina Hospital declined from 70.7% to 53.8%; this means that only about half of ambulance arrivals were transferred off stretcher within 30 minutes of arrival.

3.2.4 Aged care

Aged care services in Australia are broadly categorised into three types: residential care, which provides 24-hour support in dedicated facilities; home care, which offers assistance for older individuals to remain independent in their own homes; and transition care, designed to help individuals recover and regain independence after a hospital stay.

FIGURE 4: TYPE OF AGED CARE SERVICES, SOUTH COAST AGED CARE PLANNING REGION, 2020 AND 2022



Source: GEN Aged Care Data, People Using Aged Care (2022): South Coast Aged Care Planning Region.

- Residential aged care was the most utilised care type in 2020 and 2022.
- There was a slight decline (6.4%) in the proportion of residential aged care users with a similar increase (6.3%) in the percentage of people using home care, transition care has remained stable between 2020 and 2022.

Residential Aged Care Home utilisation

Residential Aged Care Homes (RACHs) are utilised by older adults who can no longer live at home and need ongoing help with everyday task or health care. There were 3,485 people living in a RACH in the Gold Coast in 2020-21.

TABLE 7: NUMBER OF ADMISSIONS AND PEOPLE USING AGED CARE, SOUTH COAST AGED CARE PLANNING REGION, 2020-21

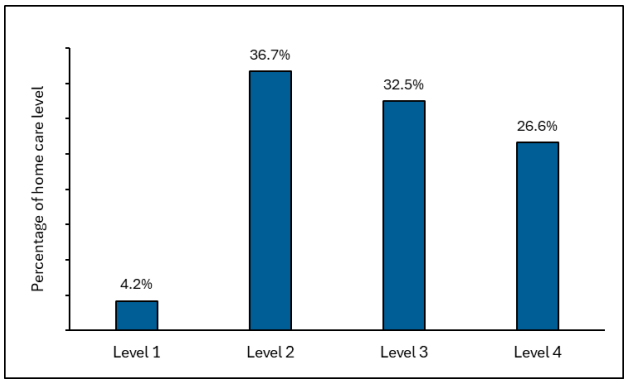
		Number of admissions	Number of people using aged care
Total		3,485	4,984
Age group	Under 65	30	90
	65-74	427	509
	75-84	1,199	3,144
	85+	1,829	2,811
Sex	Male	1,491	1,791
	Female	1,994	3,193
Indigenous status	Yes	15	24
	No	3,470	4,957

Source: GEN Aged Care Data, People Using Aged Care (2020-21).

Community aged care packages

The majority of Gold Coast residents utilising community aged care packages are on Level 3 and 4, which are provided for intermediate and high-level care needs.

FIGURE 5: HOME CARE SERVICES PACKAGES, BY LEVEL, SOUTH COAST AGED CARE PLANNING REGION, 2022



Source: GEN Aged Care Data, People Using Aged Care (2022): South Coast Aged Care Planning Region.

3.3 OTHER DEMAND DRIVERS

3.3.1 Decline in GP workforce coverage and bulk billing

The number of GPs per capita declined by 5.7% between 2020 and 2023, during which time the population growth exceeded workforce growth.

Although not a direct driver of demand, the reduced access to GPs exacerbates the impact of demand on general practice.

TABLE 8: GPs PER 1,000 POPULATION, GOLD COAST, 2020 TO 2023

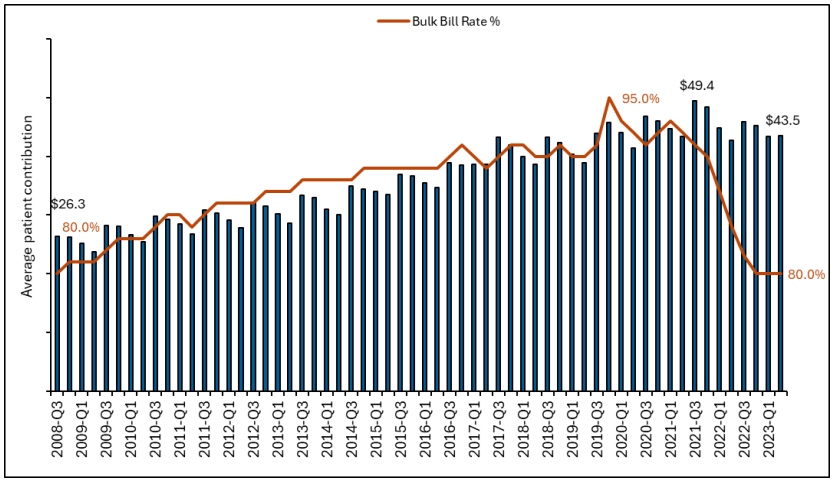
	2020	2021	2022	2023	2020 to 2023	
					Growth (n)	Growth (%)
GPs FTE	900.3	956.2	902.0	877.5	-22.8	-2.5%
Gold Coast population	642,046	649,491	663,216	685,084	43,038	6.7%
GPs FTE per 100,000	140.3	147.2	136.0	132.3	-8.0	-5.7%

Source: Commonwealth Department of Health and Aged Care HeaDS UPP Tool, extracted0 04/07/2024.

Visits to the GP are becoming less affordable for Gold Coast residents due to a reduction in bulk billing practices and an increase in patient contributions.

The proportion of GP visits that are bulk billed in the Gold Coast region has declined rapidly since 2021-22, while the average patient contribution grew from $26 in 2008-09 to $43 in 2023-24.

FIGURE 14: GP BULK BILLING RATE AND AVERAGE PATIENT CONTRIBUTION, GOLD COAST, 2008 TO 2023



Source: GCPHN annual report; MBS bulk bill data.

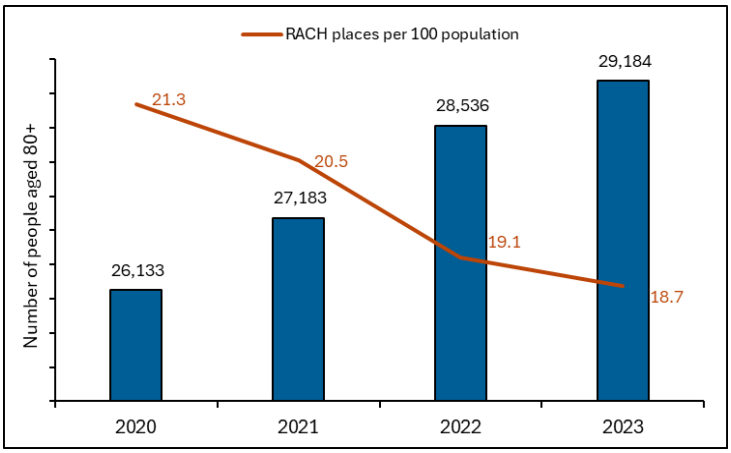
3.3.2 Declining aged care capacity and long waits

In 2023, approximately 8% of Gold Coast hospital beds were occupied by long-stay sub-acute patients, highlighting the urgent need for improved home care and RACH access to alleviate pressure on hospital resources.

Reducing residential aged care capacity

Gold Coast residential aged care place numbers are declining in real and per capita terms, with cascading effects on the hospital system where discharge to a RACH is delayed due to capacity constraints.

FIGURE 6: RESIDENTIAL AGED CARE HOME PLACES FOR PEOPLE AGED 80+, GOLD COAST, 2020 TO 2023



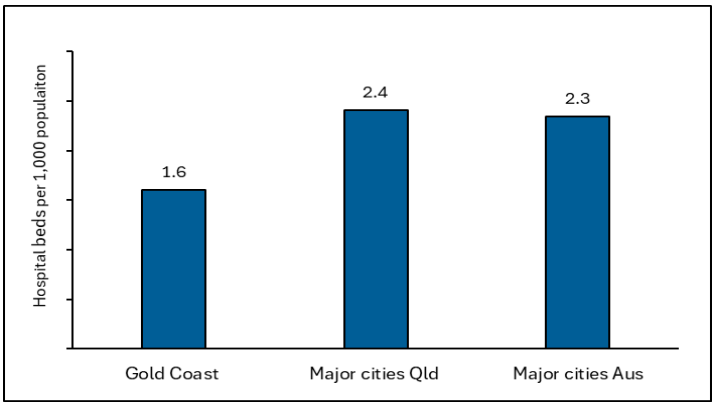
Source: GCPHN data; Infobank - GCHHS estimated resident population (QGSO derived).

- In 2023**,** the availability of residential aged care places declined by 2.2% -or 124 places-, compared to 2020.
- During this time, the number of Gold Coast residents aged over 80 years of age has increased by almost 12%.

Increasing hospital bed shortfall

Population growth has significantly outstripped the growth of public hospital infrastructure in the Gold Coast region.

FIGURE 16: PUBLIC HOSPITAL BEDS, GOLD COAST, 2023



Source: AIHW, Hospital Resources 2022-23; Queensland Health Monthly Activity Collection.

- The Gold Coast region has fewer public hospital beds per 1,000 population that the average for major cities of both Queensland and Australia, at 1.6 beds per 1,000.
- When compared with other Hospital and Health Services in Queensland, Gold Coast has the fewest beds, with rates in other regions ranging from 1.7 to 2.8 beds per 1,000 population.

3.3.3 Delayed access to community aged care packages

Delays in activating approved home care packages exacerbate discharge challenges for patients, increasing the risk of health deterioration at home and further straining the healthcare system. As of August 2023, in the Gold Coast region[1]:

- 541 people were waiting activation of an approved home care package.
- Wait times for a medium priority care plan (HCP 1-4) were 7-8 months.
- Wait times for all high priority care plans were 1 month.

The National Prioritisation Queue aims to connect people waiting for home care packages in order of priority and support level. Due to delays in receiving higher level packages, people can be offered lower-level care packages earlier as the wait times for lower-level packages are significantly shorter than for higher-level packages due to availability of providers.

[1] Australian Institute of Health and Welfare (AIHW) 2023. *Home Care Packages Program – Data Report 1st Quarter 2023-24*.

3.4 UNMET DEMAND

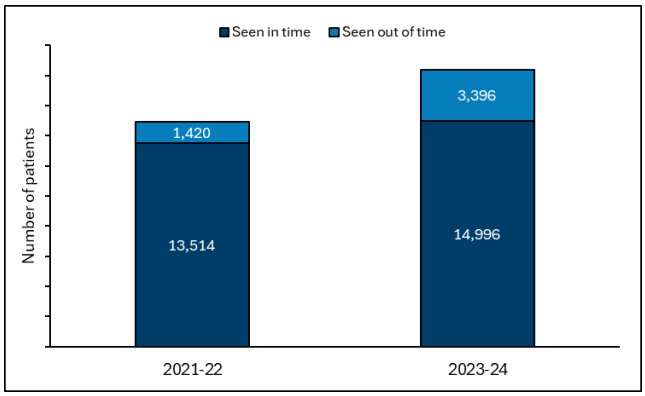
Unmet demand refers to the demand for services that is known and quantifiable through waitlists or other data collection methods. This does not include types of demand that are unmet and invisible to the system due to a lack of available data.

3.4.1 Elective Surgery (public)

Waitlists for elective surgery for the Gold Coast population have grown significantly over recent years, signalling a surge in demand that the health system is unable to accommodate within expected timeframes. Despite substantial efforts to improve performance and manage the backlog, the demand for timely access remained a pressing issue.

Throughput for elective surgeries increased by 23.16% between 2021-22 and 2023-24, with an additional 3,458 surgeries performed.

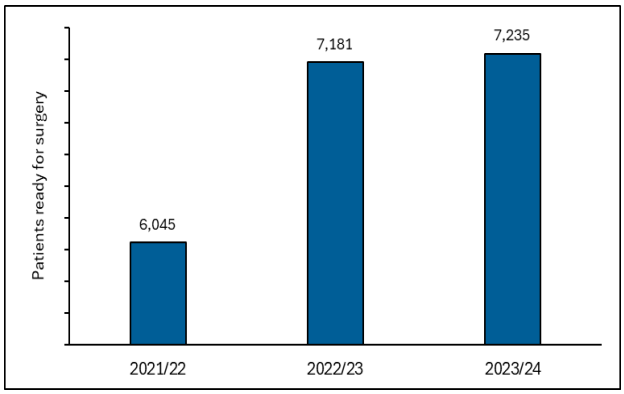
FIGURE 17: ELECTIVE SURGERY PATIENTS SEEN IN TIME/OUT OF TIME, GOLD COAST, 2021-22 AND 2023-24



Source: Queensland Health, SPR, Elective Surgery KPI Dashboard.

- The proportion of patients seen within clinically recommended time fell from 2021-22 to 2023-24, from 90.5% to 81.5% of total referrals treated.
- The total elective surgery waitlist (all urgency categories) grew substantially during this time.

FIGURE 18: ELECTIVE SURGERY TOTAL WAITLIST, GOLD COAST, 2021-22 TO 2023-24



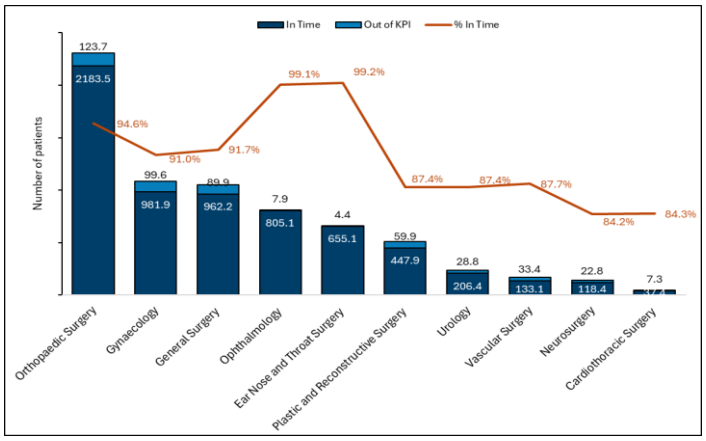
Source: Queensland Health, SPR, Elective Surgery KPI Dashboard

- Waitlists for patients ready for elective surgery increased by 19.7% from 2021-22 to 2023-24.

3.4.2 Elective surgery specialties

From July 2022 to June 2024, the Gold Coast community saw the highest demand for elective surgery in orthopaedics, which accounted for 33% of referrals, followed by gynaecology (16%), general surgery (15%), and ophthalmology (12%).

FIGURE 19: AVERAGE ELECTIVE SURGERY WAITLISTS BY SPECIALTY, GOLD COAST, 2022-23 TO 2023-24

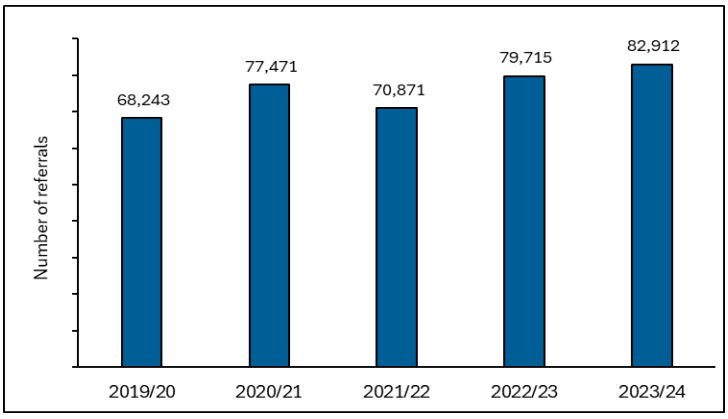


Source: Queensland Health, SPR, Elective Surgery KPI Dashboard. Note: In time= within clinically recommended time; Out of time=outside of clinically recommended time.

3.4.3 Specialist outpatients

The Gold Coast population had significant growth in referrals treated from waitlists in the specialty outpatient department, increasing by 21.5% between 2019-20 and 2023-24 (from 68,243 to 82,912).

FIGURE 20: SPECIALIST OUTPATIENT WAITLIST REFERRALS TREATED (ALL SPECIALTIES EXCLUDING GASTROINTESTINAL ENDOSCOPY), GOLD COAST, 2019-20 TO 2023-24

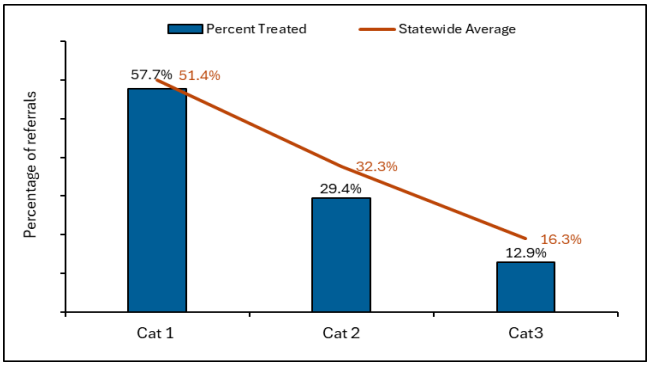


Source: Queensland Health, System Performance Reporting, SOPD KPI Dashboard.

- More than half (57.7%) of all waitlist referrals treated in 2023-24 were in category 1, compared to the statewide average of 51.4%.
- The specialties with the highest average number of patients waiting for specialist outpatient appointments between 2022-23 and 2023-24 were orthopaedics, ear, nose and throat, general surgery, ophthalmology and urology.

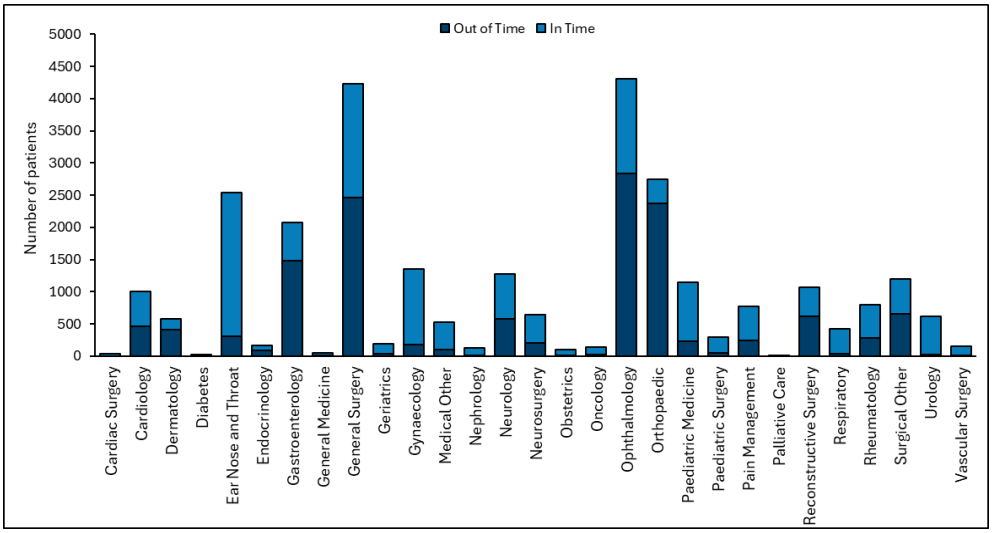
- Across all high demand clinics, there were a significant proportion of patients who had been waiting longer than the clinically recommended time.

FIGURE 21: REFERRALS TREATED BY CATEGORY (% OF TOTAL), QUEENSLAND AND GOLD COAST, 2023-24



Source: Queensland Health, System Performance Reporting, SOPD KPI Dashboard.

FIGURE 22: AVERAGE SPECIALIST OUTPATIENT SERVICES, IN/OUT OF TIME, GOLD COAST, 2022-23 TO 2023-24



Source: Queensland Health, System Performance Reporting, SOPD KPI Dashboard

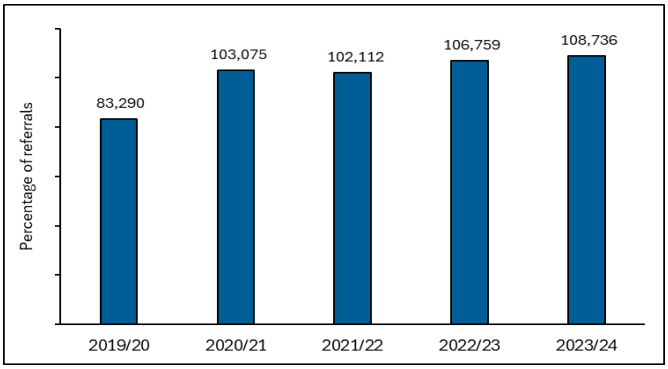
- The specialties with the most patients waiting longer than clinically recommended time were ear nose and throat (n=3,123), ophthalmology (n=2,839), general surgery (n=2,468), and orthopaedics (n=2,372).

Gastrointestinal endoscopy

The demand for Gastrointestinal Endoscopy services has surged significantly in recent years, with referrals treated increasing by 30.5% (from 83,290 in 2019-20 to 108,736 in 2023-24).

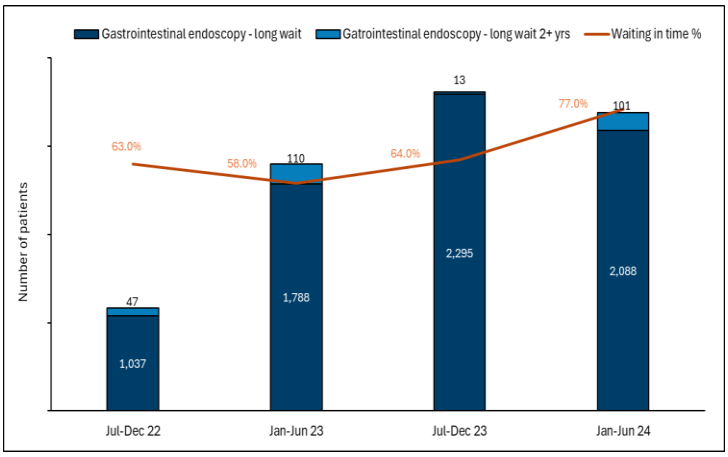
Despite improved performance on the volume of treated referrals for gastrointestinal endoscopies there has been a substantial surge in demand in 2022-23 to 2023-24, which has led to a significant number of people waiting longer than clinically recommended.

FIGURE 23: GASTROINTESTINAL ENDOSCOPY REFERRALS TREATED, GOLD COAST, 2019-20 TO 2023-24



Source: Queensland Health, System Performance Reporting GIE KPI Dashboard

FIGURE 24: GASTROINTESTINAL ENDOSCOPY LONG WAITS, GOLD COAST, 2022-23 TO 2023-24



Source: Queensland Health, System Performance Reporting GIE KPI Dashboard

- The number of long wait (including more than two years) patients grew by 102.3% between July-Dec 2022 and Jan-Jun 2024.
- The number of patients who have been waiting longer than two years increased by 112.3% between July-Dec 2022 and Jan-Jun 2024.

Chapter 4:
HEALTH WORKFORCE

KEY FACTS:

- Rising demand for healthcare is straining a workforce already hit by burnout and recruitment challenges.
- Almost three in ten GPs intend to retire from the workforce in the next five years.
- 71% of GPs reported feelings of burnout in 2023.
- Gold Coast housing is unaffordable for essential workers, including health professionals. Rental cost rates are unaffordable for most wage levels and sustained low vacancy rates pose a significant barrier to recruitment and retention of the health workforce.

PRIORITISED NEEDS:

1) Worsening clinical workforce shortage in the primary, secondary, community and aged care sectors.
2) Increasing risks of frontline staff experiencing psychosocial/psychological hazards.
3) Some health practitioners have insufficient capability to support patients with complex needs, including mental ill health and social needs.

4.1 CLINICAL WORKFORCE CHARACTERISTICS

4.1.1 National

The workforce is essential for delivering high-quality care to a growing and diverse community; therefore, understanding current workforce characteristics is key to addressing future healthcare needs. Between 2013 and 2022, Australia's health workforce saw notable shifts[2]:

- The workforce has become younger, with 33% of health professionals in 2022 aged 20-34, up from 28% in 2013.
- Medical practitioners now represent the largest share of health workers aged 65-74 (8% in 2022).
- FTE rates for professionals aged 20–34 and 35–44 increased by 47% and 31%, respectively, while FTE rates for those aged 45–64 slightly decreased.
- Nurses and midwives saw the largest increase in the 20–34 age group (53% growth), while allied health and dental practitioners had the highest FTE growth in the 35–44 age group (66% and 42%, respectively).

4.1.2 Gold Coast

The Gold Coast clinical workforce characteristics generally matched the Queensland average, with some variation in gender representation and average age in some professions.

TABLE 1: CLINICAL WORKFORCE, ALL SECTORS, QUEENSLAND AND GOLD COAST, 2020

Characteristics	Medical		Nursing & midwifery		Allied & oral health	
	Qld	Gold Coast	Qld	Gold Coast	Qld	Gold Coast
Headcount	23,681	2,917	87,671	11,168	38,442	4,587
FTE per 100,000 population	471.3	464.5	1,454.9	1,442.4	618.5	636.7
Average age	45.4	45.9	43.5	43.1	40.6	39.9
Average weekly hours worked	41.4	41.7	33.3	32.7	34.7	34.9
% Aged 55 & over	25.7%	27.0%	24.6%	23.5%	16.9%	14.7%
% Male	57.9%	61.8%	10.9%	10.4%	32.4%	36.5%
% First Nations	0.7%	0.7%	1.9%	1.8%	1.2%	1.2%

Source: Queensland Health, System Performance Reporting, Workforce Strategy Dashboard.

- In 2020, Gold Coast had a slightly lower medical workforce relative to population than the Queensland average (464.5 per 100,000 vs 471.3 per 100,000).
- The average age of clinicians within professions did not substantially differ between Gold Coast and Queensland.
- Males were over-represented in the Gold Coast medical workforce (61.8%), relative to Queensland (57.9%).

[2] Australian Institute of Health and Welfare (AIHW) 2024. Health Workforce.

4.1.3 General practice workforce

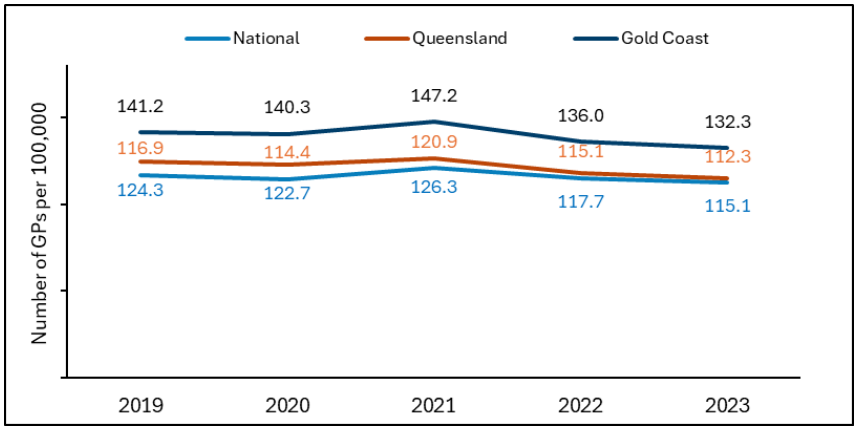
TABLE 2: NUMBER OF GENERAL PRACTICES AND GPs, GOLD COAST SA3 REGIONS, SEPTEMBER 2024

Region	Number of general practices	Number of GPs
Broadbeach-Burleigh	28	143
Coolangatta	20	91
Gold Coast-North	24	82
Gold Coast Hinterland	6	35
Mudgeeraba-Tallebudgera	6	22
Nerang	15	73
Ormeau-Oxenford	41	188
Robina	24	118
Southport	28	128
Surfers Paradise	20	75
TOTAL	212	880

Source: GCPHN Client Relationship Management System. This data set is a component of the minimum data set. Note: the number of GPs listed includes GPs who may work at more than one general practice. Data extracted 12/09/2024

- As at September 2024, there were 880 GPs working across 212 general practices in the Gold Coast region.
- Ormeau Oxenford SA3 region had the highest number of general practices and GPs, while Gold Coast Hinterland had the lowest number of general practices and GPs. This distribution of general practices and GPs is reflective of the population size in these regions.

FIGURE 1: GP FTE PER 100,000 PEOPLE, NATIONAL, QUEENSLAND AND GOLD COAST, 2019 TO 2023

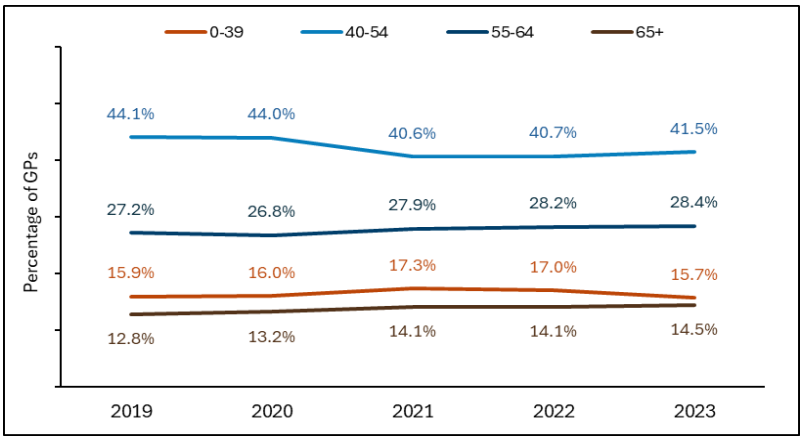


Source: Commonwealth Department of Health and Aged Care HeaDS UPP Tool, extracted0 04/07/2024.

- Significant population growth is outstripping growth in the GP workforce, reducing the number of GPs relative to population.
- In 2023, there were 132.3 GP Full Time Equivalents (GP FTE) per 100,000 residents, surpassing the national (112.3 per 100,000) and Queensland (115.1 per 100,000) rates.
- There was a decline of 3.7 GP FTE per 100,000 in the Gold Coast region from 2022 to 2023, a trend that was mirrored to a lesser extent nationally (2.8 FTE decrease) and in Queensland (2.6 FTE decrease).

GPs by age group

FIGURE 2: GPs BY AGE GROUP, GOLD COAST, 2019 TO 2023

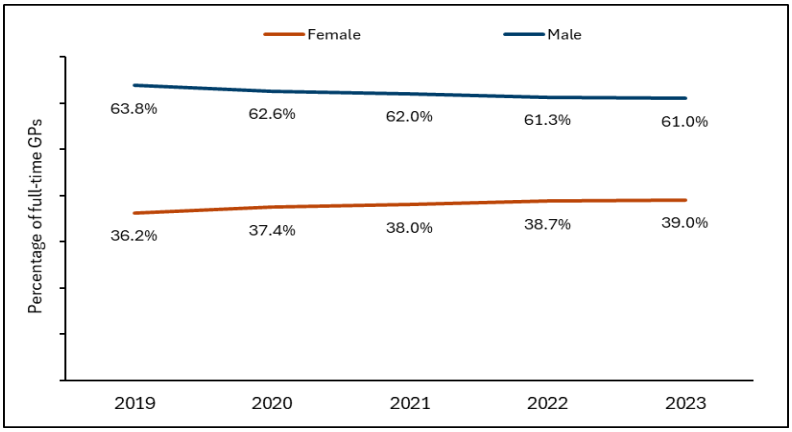


Source: Commonwealth Department of Health and Aged Care HeaDS UPP Tool, (Needs Assessment), extracted 04/07/2024

- From 2019 to 2023, most GPs in the Gold Coast were aged between 40 and 54 years.
- In recent years, there has been a rise in the proportion of GPs aged 65 years and older, suggesting an increase in those nearing retirement from 12.8% in 2019 to 14.5% in 2023.

GPs by gender

FIGURE 3: GPs BY SEX, GOLD COAST, 2019 TO 2023



Source: Commonwealth Department of Health and Aged Care HeaDS UPP Tool, (Needs Assessment), extracted 04/07/2024.

- The number of male GPs has been higher than female GPs for a number of years.
- However, the proportion of the female GPs is increasing, from 36.2% in 2019 to 39.0% in 2023.

Nurses in general practice

In the Gold Coast region, 83.8% of general practices employ at least one nurse, accounting for a total of 446 nurses (though some may work across more than one general practice).

TABLE 3: GENERAL PRACTICES WITH ONE OR MORE NURSES, GOLD COAST SA3 REGIONS, 2023

Region	Number of general practices	Number of nurses
Broadbeach-Burleigh	29	66
Coolangatta	20	47
Gold Coast-North	22	50
Gold Coast Hinterland	6	19
Mudgeeraba-Tallebudgera	7	16
Nerang	15	34
Ormeau-Oxenford	41	95
Robina	23	48
Southport	28	59
Surfers Paradise	19	32
Total	210	446

Source: GCPHN Client Relationship Management System.

4.2 WORKFORCE CHALLENGES

4.2.1 Retirements and ageing

Australia's health workforce is under growing pressure due to an ageing population and workforce. By 2050, those aged 65+ will make up 22% of the Australian population, increasing demand for healthcare[3]. Meanwhile, a significant portion of the workforce is nearing retirement within the next decade, worsening shortages and placing additional strain on the system through attrition.

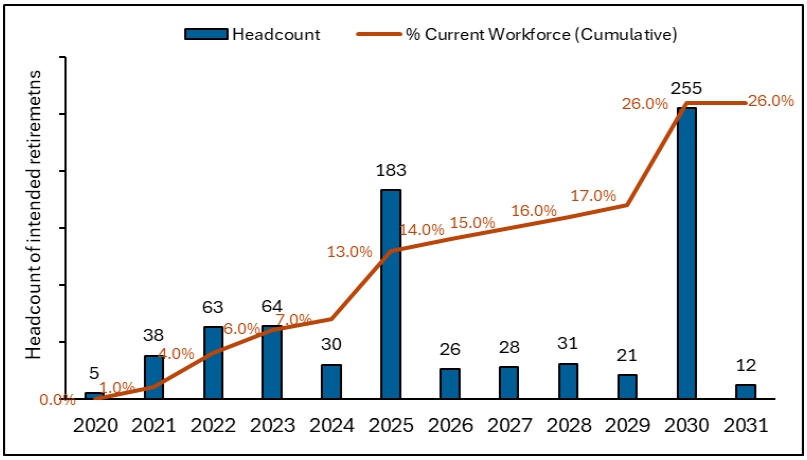
4.2.2 Gold Coast clinical workforce

A large segment of the clinical Gold Coast clinical workforce (all sectors) is expected to retire by 2030. The percentage of the current workforce expected to retire by 2030 is:

- Medical: 26%
- Nursing and midwifery: 29%
- Allied health and oral health: 29%

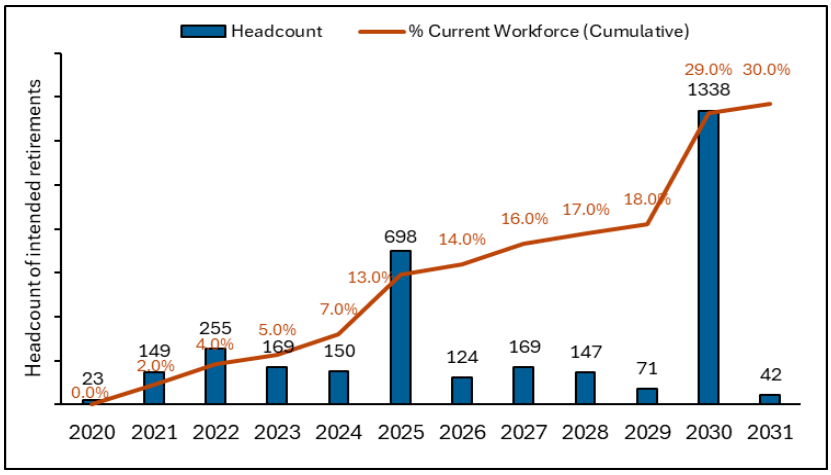
[3] Australian Institute of Health and Welfare (AIHW) 2024, *Health workforce*.

FIGURE 4: EXPECTED RETIREMENTS AMONG MEDICAL PROFESSIONALS, GOLD COAST, 2020 TO 2031



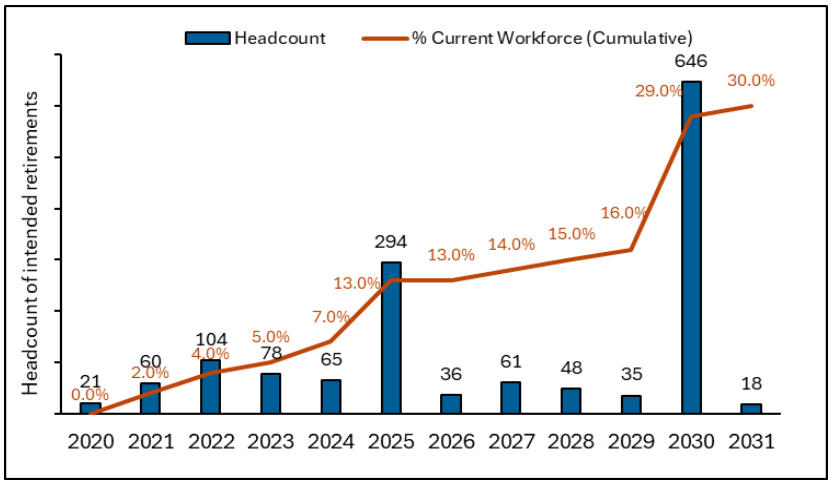
Source: Queensland Health, SPR, Workforce Strategy, Whole of Industry, Gold Coast HHS boundary.

FIGURE 5: EXPECTED RETIREMENTS AMONG NURSING AND MIDWIFERY, GOLD COAST, 2020 TO 2031



Source: Queensland Health, SPR, Workforce Strategy, Whole of Industry, Gold Coast HHS boundary

FIGURE 5: EXPECTED RETIREMENTS AMONG ALLIED HEALTH, GOLD COAST, 2020 TO 2031



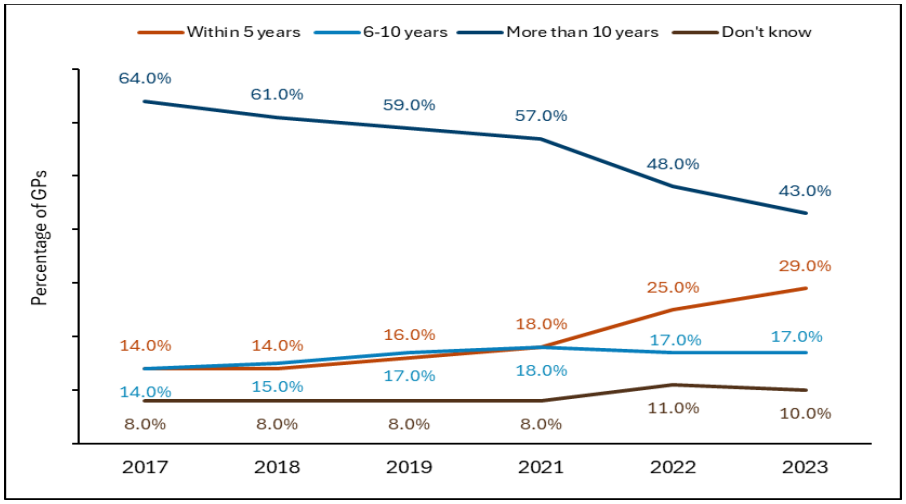
Source: Queensland Health, SPR, Workforce Strategy, Whole of Industry, Gold Coast HHS boundary

General practice

The report *General Practice Health of the Nation*, published by the Royal Australian College of General Practitioners in 2023, surveyed 2,048 practicing GPs. The report found that 29% reported intentions to retire within the next five years (an increase from 25%), and fewer than half of GPs (43%) intend to still be practicing in 10 years' time.

The declining interest in becoming a GP, in combination with this significant percentage of experienced GPs who may leave the profession in the near future, raises serious concerns when considered in combination with the time it takes (between 8-10 years) to become a GP[4].

FIGURE 7: GPs AND WHEN THEY PLAN TO RETIRE FROM PRACTISING, AUSTRALIA, 2017 TO 2023



Source: Royal Australian College of General Practitioner (2023). General Practice: Health of the Nation 2023.

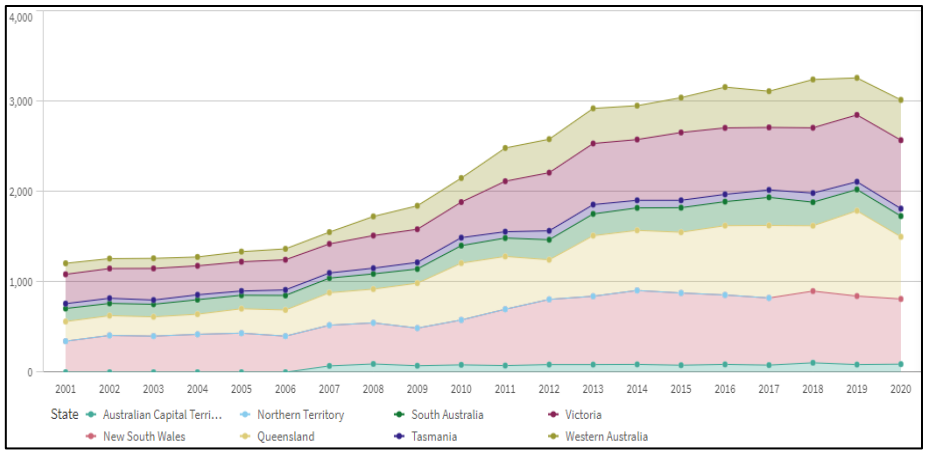
4.2.3 Recruitment and training

The number of graduates entering the workforce has increased significantly over the last two decades, however, the growth in number of medical graduates has tapered in recent years.

- Queensland has been a key contributor to Australia's medical graduate pool, with a consistent increase in the number of graduates, peaking in 2019.
- Queensland had the highest number of medical graduates in 2019 (n=945), surpassing New South Wales (n=759) and Victoria (n=741).
- From 2012 onwards, Queensland consistently had over 2,000 nurses graduate per year, with 2020 being the highest year on record at 3,008.

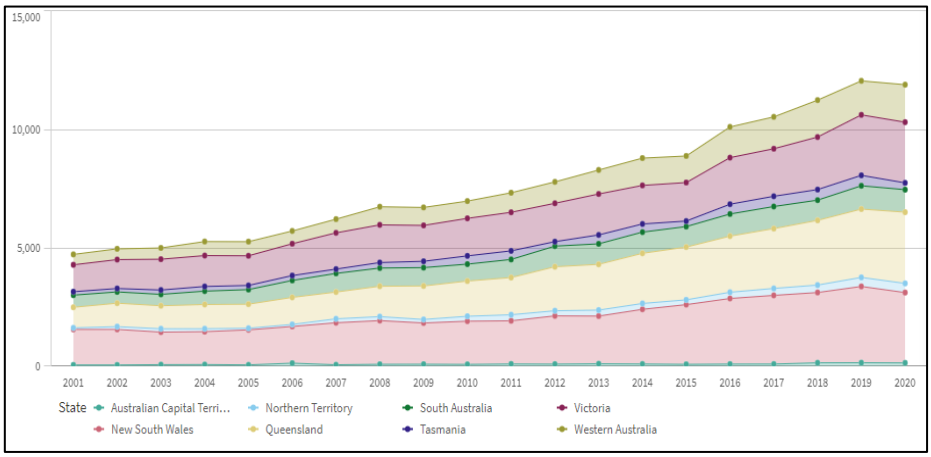
[4] Australian Institute of Health and Welfare (AIHW) 2024, *Health* workforce.

FIGURE 8: MEDICAL GRADUATES, AUSTRALIAN STATES AND TERRITORIES, 2001 TO 2020



Source: Queensland Health, SPR, Workforce Strategy, National comparison – Graduates

FIGURE 9: NURSING GRADUATES, AUSTRALIAN STATES AND TERRITORIES, 2001 TO 2020



Source: Queensland Health, SPR, Workforce Strategy, National comparison – Graduates

General practice

The declining interest by junior doctors to enter the specialty of general practice is a significant issue for the future supply of GPs. The National Health Workforce dataset shows that a higher proportion of junior doctors are continuing to choose non-GP specialty training, resulting in the number of non-GP specialists growing faster than GP specialists[5].

There has been an overall decline in the number of medical students expressing interest in a general practice career at graduation. The peak body representing medical education, training and research in Australia and New Zealand, Medical Deans Australia and New Zealand, conducts an annual survey of final year medical students from all medical schools across Australia. In 2015, the Medical Deans survey found that 17.8% of medical students identified general practice as their preferred specialty, compared to 13.8% in 2022[6].

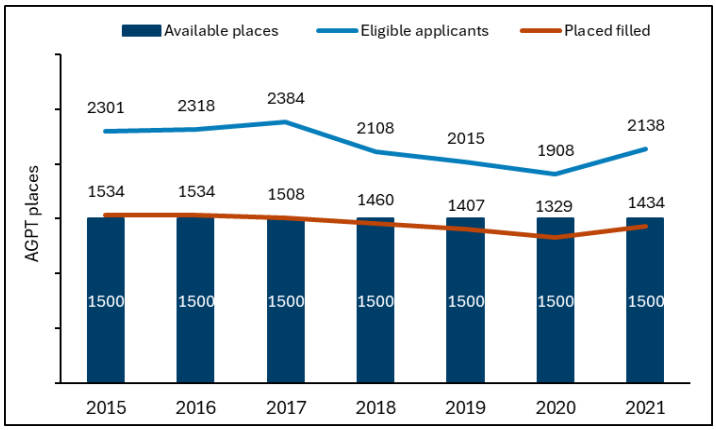
[5] National Health Workforce Dataset, Department of Health and Aged Care.
[6] Medical Deans Australia and New Zealand 2020. *National Data Report 2020: 2015–2019.*

Australian General Practice Training Program

The Australian General Practice Training Program trains medical registrars in general practice. Registrars who achieve their fellowship under the program can work as GPs anywhere in Australia.

The program's 1,500 training places have not been filled since 2017. In 2022, the number of unfilled positions increased to 252[7]. The declining interest among medical students and postgraduate doctors is a significant concern for the future supply of the GP workforce.

FIGURE 10: GP TRAINING PLACES, ELIGIBLE APPLICANTS AND POSITIONS FILLED, AUSTRALIA, 2015 TO 2021



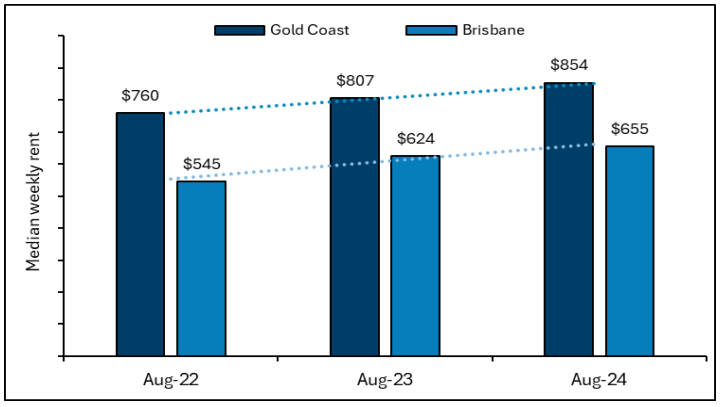
Source: The Royal Australian College of General Practitioners (2021). General Practice Health of the Nation. Retrieved 29/01/2024.

4.2.4 Housing affordability

Housing availability and affordability is a significant factor in attracting and retaining both clinical and non-clinical workforce. Gold Coast housing affordability has declined in recent years, with housing cost inflation outstripping wage growth.

Between August 2022 and August 2024, combined weekly rents for houses and units in the Gold Coast region increased by 12.7%, from $760 to $854, driven by a vacancy rate of just 1.4% in 2023-24. In comparison, Brisbane's median rent is 30% lower at $655 per week.

FIGURE 11: GOLD COAST MEDIAN WEEKLY RENT GROWTH, AUG 2022 TO AUG 2024



Source: SQM Research - Property - Weekly Rents - Gold Coast and Brisbane, extracted 2 Sep 2024.

[7] RACGP training data (unpublished).

Housing stress occurs when a household spends over 30% of its disposable income on housing costs, such as mortgage repayments or rent. Similarly, rental affordability measures if rent payments remain within 30% of household income.

No wage level within Queensland Health wage structure meets affordability criteria against Gold Coast median rents (Table 12). This poses a significant challenge for workforce attraction in nursing, allied health, administrative, and operational streams.

TABLE 12: QLD HEALTH WAGES AND MEDIAN RENT, GOLD COAST AND BRISBANE, AUGUST 2024

Occupation (level)	Weekly Net Pay	% Median rent Gold Coast	% Median rent Brisbane
Admin (A02)	$940.62	91%	70%
Admin (A04)	$1,293.90	66%	51%
Admin (A06)	$1,666.85	51%	39%
Admin (A08)	$2,005.50	43%	33%
Operational (002)	$940.62	94%	70%
Operational (004)	$1,081.90	79%	61%
Operational (006)	$1,343.31	64%	49%
Operational (008)	$1,549.85	55%	42%
Nursing (NG1)	$1,011.92	84%	65%
Nursing (NG3)	$1,079.88	79%	61%
Nursing (NG5)	$1,178.35	72%	56%
Nursing (NG7)	$1,841.27	46%	36%
Health Practitioner (HP1)	$933.12	92%	70%
Health Practitioner (HP3)	$1,149.90	74%	57%
Health Practitioner (HP5)	$1,937.06	44%	34%
Health Practitioner (HP7)	$2,382.75	36%	27%

Source: Qld Health wage rates, 2023-24

4.2.5 Burnout and psychological distress

A 2018 study found Australian doctors have higher rates of psychological distress and suicidal thoughts compared to the Australian general population and other Australian professionals. In particular, very high psychological distress was found to be much higher in doctors aged 30 years and below than in individuals aged 30 years and under in the Australian general population and other professions (5.9% vs. 2.5% vs. 0.5%)[8].

Physician burnout is an under-recognised and under-reported problem, characterised by mental exhaustion, depersonalisation, and a decreased sense of personal accomplishment[9].

While doctors and medical students have a good understanding of the health system and have access to services, they may experience barriers to seeking treatment for mental health problems, including:

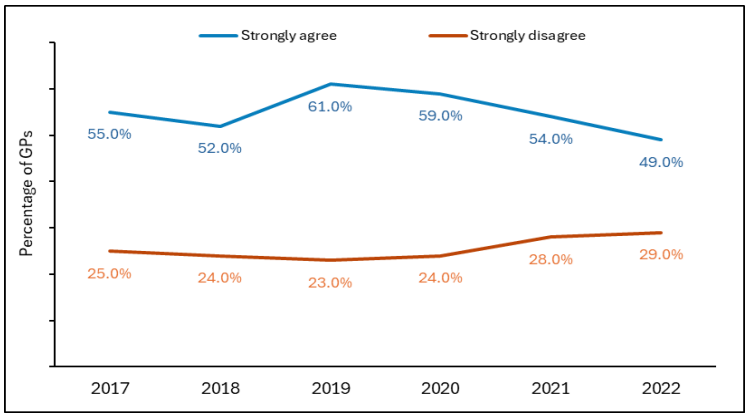
[8] Beyond Blue 2023, *National Mental Health Survey of Doctors and Medical Students*.
[9] Lacy, B.E. and Chan, J.L., 2018. Physician burnout: the hidden health care crisis. *Clinical Gastroenterology and Hepatology, 16*(3), pp.311-317.

- Stigmatising attitudes regarding medical professionals with mental health conditions.
- Lack of availability, confidentiality and privacy.
- Concerns about career progression and potential impacts on patients and colleagues.
- Concerns regarding professional integrity[10].

4.2.6 General practitioners

Maintaining a healthy work–life balance is important for GPs' wellbeing, and to encourage continuing engagement in the profession. Burnout and poor work–life balance appears to be linked to earlier exit from the profession. GPs who indicated intention to retire early are significantly more likely to report experiencing burnout in the previous 12 months, and more likely to report that they are unable to maintain a good work–life balance[11].

FIGURE 13: GP RESPONSES TO QUESTION, 'I AM ABLE TO MAINTAIN A GOOD WORK–LIFE BALANCE', AUSTRALIA, 2017 TO 2022



Source: The Navigators, RACGP Health of the Nation survey April/May 2022.

- GP work–life balance has declined annually since 2019, and for the first time since the survey began, in 2022, fewer than half of GPs reported having a good work-life balance.

4.2.7 Nurses in primary care

The 2021 Australian Primary Health Care Nurses Association (APNA) Workforce survey with 1,062 respondents found[12]:

- Many nurses are experiencing burnout, with 42% saying they experience burnout sometimes, 27% saying they feel burnt out very often and 10% saying they always feel burnt out.
- Between 2018 to 2021, there has been a 10% increase in the number of nurses planning to leave primary health care settings in the next 12 months.
- In 2021, 29% of nurses reported planning to leave primary health care in the next 2 to 5 years.
- In addition to low wages, the most common reasons for the intention to leave is burnout, stress, lack of appreciation and unsupportive or poor management.

[10] Beyond Blue 2023, *National Mental Health Survey of Doctors and Medical Students*.
[11] The Navigators 2022, *RACGP Health of the Nation survey April/May 2022*.
[12] Australian Primary Health Care Nurses Association (APNA), *2021 APNA Workforce Survey summary.*.

4.2.8 Areas with workforce shortage

Distribution Priority Area (DPA) areas

The DPA classification system identifies areas with lower levels of GP services, compared with a benchmark level. Initiatives to increase the supply of GPs are then implemented in these areas.

Table 13 displays the DPA classification for the year 2022 as assessed by DoHAC for international medical graduates and Bonded Medical Places. A "Yes" indicates the entire catchment falls under the DPA classification, "No" indicates that no part of the catchment is categorised as DPA, and "Partial" signifies that some areas of the catchment are classified as DPA, and others are classified as non-DPA.

TABLE 13: DPA CLASSIFICATIONS FOR GENERAL PRACTITIONERS, GOLD COAST, 2022

GP catchment	DPA 2022 international medical graduates	DPA 2022 Bonded Medical Places
Broadbeach - Burleigh	No	No
Coolangatta	No	No
Gold Coast - North	No	No
Guanaba - Springbrook	Yes	Yes
Mudgeeraba - Tallebudgera	Partial	Partial
Nerang	No	No
Ormeau - Oxenford	Partial	Partial
Robina	No	No
Southport	No	No
Surfers Paradise	No	No
Tamborine - Canungra	Partial	Partial

Source: https://www.health.gov.au/resources/publications/dpa-classifications-for-gps-2022.

DPA region designated in the Gold Coast region is Guanaba – Springbrook.

DPA regions partially designated in the Gold Coast region are Mudgeeraba–Tallebudgera, Ormeau –Oxenford, and Tamborine–Canungra.

4.2.9 Workforce capability

Need for continuous learning

Medical practice and health policy are changing rapidly. While the adoption of changes is not new for primary care staff, the pace of change in standards of care, marked by medical advances has accelerated over the past 20 years. GPs and nurses must simultaneously absorb new processes in the healthcare system, while also staying up to date with the latest research to offer the best care to their patients.

The rapid advancements in medical information have resulted in exponential growth of medical knowledge, increased complexity of medical practice and greater medical specialisation. The role of GPs is increasing each year, and their level of knowledge is expected to be very high in numerous different domains.

In recent years, there has been an increase in the number of consultations with GPs for mental health, alcohol and other drugs and family and domestic violence, highlighting the need for GPs and other general practice staff and other health professionals for continuous learning.

Upskilling the mental health and suicide prevention workforce

The Productivity Commission on Mental Health Inquiry report identified numerous issues with the mental health and suicide prevention workforce including[13]:

- Lack of nurses, psychologists and allied health practitioners in mental health settings,
- Low number of psychiatrists actively working in Australia,
- Underrepresentation of First Nations people in the mental health workforce,
- Need to boost mental health peer workforce, and
- Additional mental health training for GPs working in aged care.

4.3 CONSULTATIONS

Key issues identified by GCPHN commissioned service providers are:

- With increased employment opportunities in Gold Coast Hospital and Health Service (GCHHS), providers are seeing their staff move over to GCHHS. From this, the providers are seeing a much younger workforce across the NGO sector.
- Differences in remuneration across the sectors contributes to the shift.
- Access to affordable psychologists is consistently a service gap for clients.
- Difficulty in recruiting occupational therapists whose preference is to work for NDIS – due to better rates of reimbursement.
- One provider who utilses a provisional psychologist workforce has major concerns and is liaising with the local universities to optimise student pathways.

Additional issues identified in previous consultations include:

- Nurses moving to higher paying jobs outside of general practice.
- Practice staff at capacity, this increased workload means increased pressures and stresses for staff with a significant number considering retiring/changing career.
- Lack of formal training for Practice Managers.
- General practices are experiencing low recruitment of nurse graduates.
- Nurse graduates entering general practice have limited experience in primary care and receive insufficient training and mentorship in general practice settings.
- Limited number of Registrars choosing general practice and getting one is very difficult/impossible. Some practices have stopped trying.
- Practices are reporting GPs leaving practices that bulk bill and moving to practices that mix bill or private bill service users.

[13] Productivity Commission, 2022. *Mental health report no. 95, Canberra. 2020*.

4.4 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Distribution	Information
Royal Australian College of General Practitioners (RACGP) GP Support Program	Online	• RACGP is the professional body for GPs in Australia and is responsible for maintaining standards for quality clinical practice, education and training, and research. • RACGP offers free, confidential specialist advice to help cope with professional and personal stressors impacting mental health and wellbeing, work performance and personal relationships.
DRS4DRS	Online	• Independent program providing confidential support and resources to doctors and medical students across Australia. • The DRS4DRS website provides coordinated access to mental health and wellbeing resources, training on becoming a doctor for doctors.
Lifeline	Online	• Lifeline provides all Australians experiencing a personal crisis with access to 24-hour crisis support and suicide prevention services.
Beyondblue	Online	• Beyondblue's support service is available 24 hours/7 days a week.

Chapter 5:
GENERAL PRACTICE AND PRIMARY CARE

KEY FACTS:

- As of September 2024, there were 212 general practices and 880 GPs in the Gold Coast region.
- 95% of Gold Coast general practices that are eligible (accredited or in process of being accredited) are registered for the PIP QI.
- The rate of GP attendances in the Gold Coast region is above the national rate (709 vs 629 per 100 people, respectively).
- In 2019-2020, private health insurance coverage in the Gold Coast region was below the national rate (48.4% vs 56.5%, respectively).

PRIORITISED NEEDS:

1) Systems and processes do not support consistent, effective clinical handover on discharge from the acute sector to primary and community services to support ongoing care.
2) Reduced bulk billing and reducing GP per capita rates leading to poorer access for some vulnerable people.
3) Insufficient resources for some general practices and Residential Aged Care Homes (RACHs) to implement frequent reform and new initiatives.
4) Challenges for general practices, primary care and RACHs in adopting digital health.

5.1 RATE OF GP ATTENDANCES

In 2022-23, the rate of GP attendances in the Gold Coast region was above the national rate (709 vs 629 per 100 people).

TABLE 1: GP ATTENDANCES, GOLD COAST SA3 REGIONS, 2022-23

Region	Number of services	Services per 100 people
National	166,234,507	629
Gold Coast SA4	4,698,338	709
Broadbeach–Burleigh	503,806	736
Coolangatta	399,324	679
Gold Coast–North	590,419	833
Gold Coast Hinterland	143,045	693
Mudgeeraba–Tallebudgera	237,498	643
Nerang	499,376	702
Ormeau–Oxenford	1,139,749	679
Robina	384,489	696
Southport	480,666	727
Surfers Paradise	320,976	681

Source: AIHW, Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2022-23. Note: GP attendances include Enhanced Primary Care, After-hours GP attendances, Practice Incentive Program (PIP) services, and 'Other' GP services. These services are Medicare-subsidised patient/doctor encounters, such as visits and consultations, for which the patient has not been referred by another doctor.

- Gold Coast-North had the highest rate of GP attendances per 100 people (833 per 100 people), while Ormeau-Oxenford had the highest number of services with 1,139,749. This is due to the large population of Ormeau-Oxenford (n=174,709).
- Ormeau - Oxenford also has an anticipated average annual growth rate of 2.3% between 2021 to 2046, surpassing both the Queensland (1.4%) and Gold Coast (1.7%) rate; this is anticipated to put further demand on GP services in this region[14].
- In 2022–23, the total number of GP attendances declined compared to the previous year, with decreases of 13.1% in the Gold Coast region and 11.9% nationally. Possible factors for this trend include delays in seeking care due to cost, reducing GP per capita rates, and higher rates of GP visits in prior years driven by COVID-1915.
- In 2023, the total number of GP services increased compared to pre-COVID levels both nationally and within the GCPHN region. The per capita rate of GP services is returning to levels similar to those seen before COVID, with close monitoring planned for future trends[15].

[14] Queensland Government 2023, *Population projections: 2023 edition*.
[15] AIHW 2024, *Medicare-subsidised GP, allied health, and specialist healthcare across local areas: 2017–18 to 2022–23*.

5.2 ISSUES FACED BY GPs

The Health of the Nation 2023 report surveyed 2,048 practising GPs. Top responses to the question "What are the main issues you face as a GP?" are listed in Table 2. Although we lack extensive local data, it is reasonable to assume that the challenges identified in the national data below are also present in our local context.

TABLE 2: ISSUES FACING GPs, AUSTRALIA, 2023

Issue	Proportion
Managing workload	65%
Understanding and adhering to regulatory and policy challenges	65%
Patient access to other medical specialist	60%
Maintaining income	52%
Ensuring high–quality care is accessible for patients from disadvantaged backgrounds	52%
Patient access to allied health professionals	37%
Care coordination and communication with external health providers	37%
Meeting CPD requirements	37%
Addressing misinformation in the community	34%
Awareness of community supports available to patients	27%
Role encroachment by other health professionals	25%
Practicing amid challenges of disaster/pandemic response and recovery	20%
Conflicts or disputes with patients	10%
Ensuring care provided is culturally safe and responsive	10%
Networking with local GPs	8%
Other	8%

Source: The Royal Australian College of General Practitioners. General Practice: health of the Nation 2023. East Melbourne, Vic: RACGP, 2023

5.2.1 Change management and cultural change

Consistent evolution in primary health care, with the introduction of new incentives, systems, digital health tools, and policies, can pose challenges for primary healthcare staff due to:

- lack of time to stay up to date,
- lack time to prepare for new incentives (e.g., MyMedicare and General Practice in Aged Care Incentive),
- new systems are introduced that disrupt existing systems,
- lack of resources, guidance, and education, and
- when staff members depart a practice, their knowledge also departs.

5.3 QUALITY OF CARE

5.3.1 PIP QI Incentive

Under the Australian Government's Practice Incentive Program Quality Improvement (PIP QI) Incentive, general practices work with their local PHN to undertake continuous quality improvement (CQI) activities through the collection of general practice data on selected improvement measures.

As of September 2024, 95% of general practices in the Gold Coast region that were accredited or in the process of accreditation were enrolled in the PIP QI Incentive. These general practices are participating in continuous quality improvement activities in their general practice and submitting PIP eligible data sets at least once every quarter to the Gold Coast PHN.

The improvement measures support a regional and national understanding of chronic disease management in areas of high need, and future iterations will respond to emerging evidence on areas of high need.

In July 2024, the Gold Coast region was above the national rate in three of the ten PIP QI measures.

TABLE 3: QUALITY IMPROVEMENT MEASURES, NATIONAL AND GOLD COAST, JULY 2024

Quality Improvement Measure		Gold Coast	National
QIM 1	Patients who have Type 1 diabetes and who have had an HbA1c measurement result recorded	44.2%	56.9%
	Patients who have Type 2 diabetes and who have had an HbA1c measurement result recorded	65.3%	71.8%
	Patients who have unspecified, generic, or general diabetes diagnosis and who have had an HbA1c measurement result recorded	60.3%	65.4%
QIM 2	Patients with a smoking status	72.8%	68.7%
QIM 3	Patients with a weight classification	26.1%	24.4%
QIM 4	Patients aged 65 and over who were immunised against influenza	49.1%	55.9%
QIM 5	Patients with diabetes who were immunised against influenza	45.6%	48.4%
QIM 6	Patients with COPD who were immunised against influenza	57.8%	58.4%
QIM 7	Patients with an alcohol consumption status	81.1%	68.3%
QIM 8	Patients with the necessary risk factors assessed to enable CVD assessment	56.3%	58.8%
QIM 9	Female patients with an up-to-date cervical screening	35.8%	40.0%
QIM 10	Patients with diabetes with a blood pressure result	54.9%	57.8%

Source: Practice Incentives Program Quality Improvement Measures: Data update 2023-2024.

Feedback from general practices on barriers for completing CQI activities include:

- perceived lack of capacity of staff to focus on CQI activities,
- low priority compared to other work, especially disaster recovery and policy changes, and
- change of staff resulting in loss of knowledge around CQI and data extraction.

5.3.2 Patient experiences

Australian Bureau of Statistics' *Patient Experience Survey 2019–20* captures people's experiences with the health system at a local level; results are shown in Table 4.

TABLE 4: PATIENT EXPERIENCE SURVEY, AUSTRALIA AND GOLD COAST, 2019-2020

Indicator: Adults who…	Gold Coast	National
reported excellent, very good or good health	88.1%	87.5%
reported having a long–term health condition	49.8%	51.6%
saw a GP in the preceding 12 months	80.5%	83.5%
saw a GP 12 or more times in the preceding 12 months	14.0%	10.5%
saw a GP for urgent medical care in the preceding 12 months	9.4%	10.0%
saw a dentist, hygienist, or dental specialist in the preceding 12 months	48.9%	48.9%
saw a medical specialist in the preceding 12 months	35.6%	36.5%
were admitted to any hospital in the preceding 12 months	13.0%	12.6%
went to any hospital ED for their own health in the preceding 12 month	13.2%	14.3%
had a preferred GP in the preceding 12 months	78.9%	76.6%
could not access their preferred GP in the preceding 12 months	20.6%	28.0%
felt they waited longer than acceptable to get an appointment with a GP	12.9%	18.6%
felt their GP always or often listened carefully in the preceding 12 months	90.6%	92.3%
felt their GP always or often showed respect for what they had to say	93.1%	94.6%
felt their GP always or often spent enough time in the preceding 12 months	89.2%	90.9%
did not see or delayed seeing a GP due to cost in the preceding 12 months	2.3%	3.8%
delayed or avoided filling a prescription due to cost in the preceding 12 months	9.3%	6.6%
did not see or delayed seeing a dentist, hygienist or dental specialist due to cost	19.8%	19.1%
saw three or more health professionals for the same condition	17.4%	16.8%
needed to see a GP but did not in the preceding 12 months	13.2%	13.2%
saw a GP after hours in the preceding 12 months	8.4%	7.2%
were covered by private health insurance in the preceding 12 months	48.4%	56.5%
referred to a specialist who waited longer than acceptable to get an appointment	26.9%	23.2%

Source: Patient experiences in Australia by small geographic areas in 2017-18, Australian Institute of Health and Welfare, 2019-20

- In the Gold Coast region, 14.0% of respondents had seen a GP in the preceding 12 months, which was slightly above the national rate of 10.5%.
- However, various quality indicators were just below the national rate, with 90.6% of Gold Coast respondents stating they felt listened to by their GP, in comparison to the national rate of 92.3%.
- Notably, only 48.4% of patients in the Gold Coast region were covered by private health insurance in the preceding 12 months, in contrast to 56.5% of patients nationally.
- Aside from this, residents in the Gold Coast region generally have comparable experiences with the local primary healthcare system, when compared to national results.

5.3.3 Shared care

Shared Care is a joint responsibility for planned care that is agreed between healthcare providers, the patient, and any carers they would like to engage. The shared care model provides improved quality and continuity between services. They are in place in aspects of healthcare where non-GP specialists and GPs need to work together. Effective and efficient long-term management of complex, chronic diseases is one of the greatest health-related challenges facing patients and health professionals[16].

Barriers to the shared care model include:

- poor communication and lack of clarity around healthcare provider roles[17],
- limited opportunities for information sharing (while My Health Record is a tool that aims to streamline sharing of patient health information, it is not a communication tool for direct communication between healthcare providers)[18],
- health professionals are unclear about the capacity of other providers,
- practice nurses are well positioned to assist in coordination of shared care, but their services are currently underfunded via Medicare Benefits Schedule.

5.4 WOUND MANAGEMENT

The prevalence of wounds is increasing due to an aging population, rising incidences of diabetes and respiratory diseases, and poor nutrition[19].

In Australia, approximately 500,000 people have an unhealed wound at any given time, with an annual financial impact exceeding $3 billion[20]. These costs are both direct, related to wound treatment, and indirect, affecting the ability of individuals with wounds to work. Chronic wounds present a significant health and economic burden to the healthcare system and health providers.

Reported challenges in wound management in general practice include:

- high costs associated with providing evidence-based care,
- inadequate funding for general practices to offer wound management,
- lack of subsidies for wound care consumables,
- insufficient formal education and training, and
- challenges in assessing and managing wounds remotely with increasing use of telehealth.

Chronic wounds also represent a major health burden in Residential Aged Care Homes (RACHs), with many residents entering with one or more chronic conditions and complex wounds. The

[16] Australian Bureau of Statistics 2018, *Chronic conditions*.
[17] Trankle, S.A., Usherwood, T., et al. 2019. Integrating health care in Australia: a qualitative evaluation. *BMC health services research, 19,* pp.1-12.
[18] Mitchell, G.K., Young, C.E., Janamian, T., et al. 2020. *Factors affecting the embedding of integrated primary–secondary care into a health district. Australian Journal of Primary Health, 26*(3), pp.216-221.
[19] Pacella, R.E., Tulleners, R., Cheng, Q., et al. 2018. Solutions to the chronic wounds problem in Australia: a call to action. *Wound Practice & Research: Journal of the Australian Wound Management Association, 26*(2), pp.84-98.
[20] Vu, T., Harris, A., Duncan, G. and Sussman, G., 2007. Cost-effectiveness of multidisciplinary wound care in nursing homes: a pseudo-randomized pragmatic cluster trial. *Family Practice, 24*(4), pp.372-379.

elderly are at increased risk of impaired skin integrity due to age-related changes to the skin, frailty, malnutrition, incontinence, immobility, and impaired cognition.

5.5 BULK BILLING

An increasing number of general practices across Australia are opting to charge a fee instead of bulk billing their patients which may deter patients from accessing needed medical care. In 2022-23, the national GP non-referred attendances bulk billing rate was 80.2%, and the Gold Coast rate was 83.5%.

Gold Coast data indicate that in May 2024:

- 28.8% general practices (n=60) were bulk billing; a decrease from 73 in May 2023.
- 59.6% general practices (n=124) used mixed billing; an increase from 113 in May 2023.
- 11.5% general practices (n=24) were private billing; an increase from 22 in May 2023[21].

While the Australian Government's tripling of bulk billing incentives has helped more GPs bulk bill specific groups of patients, including children, pensioners and health care card holders, more needs to be done to ensure care is affordable for the rest of the population.

Recent national data from Australian Bureau of Statistics revealed that in 2022-23, 7% of people who needed to see a GP delayed or did not see a GP when needed due to cost. This was double the number compared to 2020-21, when 3.5% of people put off or did not see a GP when they needed because of cost[22]. Delaying seeing a GP can exacerbate health conditions, potentially leading to more serious consequences and complicating treatment.

5.6 TRANSLATING AND INTERPRETING SERVICE

Gold Coast has 10,361 residents who did not speak English at home well or not at all in 2021[23].

The Translating and Interpreting Service (TIS) is an interpreting service provided by the Department of Home Affairs for people who do not speak English, and for agencies and business that need to communicate with their non-English speaking clients. The interpreting service aims to provide equitable access to key services for people with limited or no English language proficiency.

Medical Practitioners (GPs, nurse practitioners, and approved medical specialist) are eligible for the free interpreting service and access to the Medical Practitioner line when providing services that are:

- Medicare-rebatable,
- delivered in private practice, and
- provided to non-English speakers who are eligible for Medicare.

[21] GCPHN CRM extracted 14/05/2024.
[22] Australian Bureau of Statistics 2023, *Patient Experiences*.
[23] Australian Bureau of Statistics 2021, *Census of Population and Housing, General Community Profile - G1*.

Table 5 below identifies the use of Translating and Interpreting services within the Gold Coast region in 2022 and 2023, showing an increase of 43 services (8.4%) from 2022 to 2023.

TABLE 5: USE OF TRANSLATING AND INTERPRETING SERVICE, GOLD COAST, 2022 AND 2023

Provider	2022	2023	Change 2022 to 2023	
			N	%
General Practitioner	354	421	67	18.9%
Specialist	156	131	-25	-16.0%
Pharmacy	3	4	1	33.3%
Total	513	556	43	8.4%

Source: Translating and Interpreting Service (TIS National), Department of Home Affairs was extracted from Department systems as at 15/02/2024.

The area with the greatest utilisation of GP translation and interpreting services in 2023 was postcode 4215 (encompassing Chirn Park, Labrador, and Southport) with a total of 155 services. Postcode 4218 (comprising Broadbeach and Mermaid) followed with a total of 46 services.

In 2023, translation and interpretation services involved a total of 37 languages among GPs. Mandarin emerged as the predominant language, accounting for 82 instances or 19.5%, followed by Tigrinya with 47 instances or 11.2%, and Japanese with 33 instances or 7.8%.

It has been suggested that interpreter services remain underused and frequently misunderstood, reasons appear to be related to:

- faith in 'in house' bilingual staff[24],
- beliefs about the preference of patients for family members to interpret, and a lack of practice systems to facilitate interpreters[25],
- interpreters can be cumbersome to access and challenging to use in day-to-day practice[26].

5.7 DIGITAL HEALTH

The Strengthening Medicare Taskforce recommends the modernisation of digital systems and significant improvements in the way patients' information is accessed and shared across the health system. Several systems are integrated in general practice software and workflows which brings additional training for healthcare staff and potential Interoperability concerns with other systems.

Pain points that have been raised to GCPHN by healthcare providers include:

- limited up-to-date, simple and meaningful training in digital health,
- no single point login for clinical IT systems,
- a heavy promotion to utilise My health Record from every health facility is required,
- cost of implementing and updating IT systems to meet digital system requirements, and

[24] Huang, Y.T. and Phillips, C., 2009. Telephone interpreters in general practice: Bridging the barriers to their use. *Australian Family Physician, 38*(6), pp.443-446.
[25] Atkin, N., 2008. Getting the message across: Professional interpreters in general practice. *Australian Family Physician, 37*(3).
[26] Centre for Culture Ethnicity and Health, Health Sector Development 2024. *Working effectively with professional interpreters in private general practice*.

- getting the time in front of a healthcare professionals to demonstrate the value/ timesaving/benefits a new system/tool is a barrier to adoption to use.

5.7.1 My Health Record

My Health Record is a secure online summary of an individual's health information. Healthcare providers authorised by a registered healthcare organisation can access My Health Record to view and add patient health information while patients can view their health information on My Health Record at any time.

The My Health Record system provides access to timely information to healthcare providers about their patients such as discharge summaries, event summaries, prescription and dispense records and immunisation information. In the Gold Coast region, 100% of general practices are aware of My Health Record, and 95.7% are registered for My Health Record.

Barriers to the adoption of My Health Record by healthcare providers include:

- interoperability of systems/conformant software and therefore usability,
- costs and resource constraints associated with staff training, system upgrades, and support,
- resistance to change due to fear of disruption to established workflows leading to decreased productivity,
- minimal regulatory requirements,
- ready availability of appropriate training[27].

5.7.2 Telehealth services

Many GPs, specialists and other healthcare providers now offer a telehealth consultation when a physical examination isn't necessary. These are not intended to replace essential visits to the healthcare provider but rather provide a convenient solution when consumers can't see a healthcare provider face to face.

Two consultation options are:

- Phone – Consumers can talk to healthcare provider using mobile or landline phone.
- Video – Consumers can have a video call with their healthcare provider using a device that has a video platform (smartphone, computer, tablet etc.).

Feedback from the GCPHN Primary Healthcare Improvement Committee and Clinical Council regarding the use of telehealth identified that it has been a positive experience. Both groups noted it has reduced previous patient transport barriers to access services and resulted in less patient cancellations. Both groups agreed that telehealth compliments face-to-face GP visits, however there will always be a need for face-to-face visits with a GP.

In 2022, telehealth accounted for roughly 23% of all GP consultations in Australia, with most occurring over the telephone[28]. Analysis of consultations and data revealed that GPs tend to

[27] Department of Health and Aged Care 2023, Allied Health Digital Readiness- Issues paper, *Allied Health Digital Readiness Issues Paper – 2 June 2023*.
[28] Australian Government 2024, *MBS online - Medicare Benefits Schedule*.

prefer utilising technology they are familiar with for their telehealth requirements. This explains the higher adoption rate of phone usage for telehealth compared to video.

Barriers for GPs to undertake video consultations include:

- negative attitudes and unfamiliarity with video technology,
- view that the time taken to set up a video consultation will interfere with consultation time,
- interruption and/or disruption to workflows in the general practice,
- low confidence with the technology, equipment, and software,
- patient preference for telephone versus video call,
- outdated digital assets (computers, cameras, microphones).

Barriers to patients' use of video consultations include:

- negative attitudes and unfamiliarity with video technology,
- GP does not provide and/or advocate for the use of video for consultations,
- lack of familiarity, competence, and/or confidence with technology,
- availability/cost of equipment.

5.7.3 Secure messaging

Secure messaging is a core foundational capability required to enable interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers.

Secure messaging supports the delivery of messages containing clinical documents and/or other information between healthcare organisations, sent either directly or through one or more secure messaging providers. In the Gold Coast region, 92% of general practices are connected to use secure messaging.

A 2019 review by Australian Digital Health Agency *Secure Messaging National Scaling Final Report*[29] on the safety and quality benefits of secure messaging found that the barriers to the expansion/use of secure messaging can be divided into three main categories:

- Policy and governance
  - inadequate governance over the secure messaging ecosystem,
  - inconsistent uptake of industry offers leading to misalignment on standardisation requirements,
- Functional and technical
  - challenges in messaging acknowledgements and accurate addressing to end points,
  - negative impacts on clinical workflows and patient care delivery,
  - lack of standardisation in adherence to technical standards for payloads,
- Adoption and usability
  - misalignment in secure messaging value proposition across the healthcare industry,
  - challenges in the usability and inconsistent support mechanisms[29].

[29] Australian Digital Health Agency 2019, *Secure Messaging National Scaling Final Report*.

5.7.4 Electronic prescribing

An electronic prescription is a digital version of a paper prescription. Individuals can choose to receive an electronic prescription from their healthcare provider when a prescription is needed. Most pharmacies are set up to dispense medicines using an electronic prescription.

Issues identified in uptake of electronic prescription from general practices, pharmacies and consumers include:

- pharmacies and general practices to have the technological infrastructure established to receive and send electronic prescriptions,
- training of healthcare professionals on electronic prescriptions,
- the electronic transmission of sensitive health information raises concerns about data security and patient privacy among consumers,
- ensuring both general practice and pharmacy have the correct patient contact details (mobile number) to deliver the prescription,
- pharmacies need to change their script in workflow with electronic prescriptions and perhaps the use of software that can create virtual queue system, so the electronic prescription does not get lost in the queue among the paper scripts, and
- consumers may face challenges accessing the technology required for e-prescriptions such as smartphones and internet connection.

5.7.5 Hospital discharge summaries

A discharge summary can be shared between healthcare providers, including specialists, GPs, and structured clinical handovers reduce communication errors between health service organisations and improve patient safety and care[30]. Timely access to quality discharge summaries from private and public hospitals has been identified as a major issue for both general practices and RACHs in the Gold Coast region.

Key barriers to timely access to discharge summaries from hospital include:

- lack of efficient interoperable secure electronic communication systems,
- electronic hospital medical record unable to send messages to GP,
- communication by phone challenging due to clinical duties,
- lack of time for hospital clinician to write clinical handover, and
- difficult for GPs and RACH to ask questions to the hospital clinician.

GCHHS has initiated automated reporting for endoscopy procedures with digital reports delivered directly to named GPs. This has reduced delivery of endoscopy reports from an average 7 days to less than 24 hours. This initiative is now being scaled to other areas of Gold Coast Health to improve communications at the point of transition between acute and primary care.

[30] Australian Commission on Safety and Quality (ACSQH) 2017, *Communicating for Safety Standard: The NSQHS Standards*.

5.8 CONSULTATIONS

Primary Health Care staff in the Gold Coast region provided feedback to Gold Coast PHN during 2023-24. Their responses have been summarised across three key questions:

What are the challenges facing general practices?

Staffing

- GP, nurse and practice managers recruitment and retention.
- Understaffing of practice staff.
- Nurses moving to higher paying jobs outside of general practice.
- Limited handover from one staff member to the next.
- Practice staff at capacity, this increased workload means increased pressures and stresses for staff with a significant number considering retiring/changing career.
- Lack of formal training for Practice Managers.
- General practices are experiencing low recruitment of nurse graduates.
- Nurse graduates entering general practice have limited experience in Primary Care and receive insufficient training and mentorship in general practice settings.
- Limited number of Registrars choosing general practice and getting one is very difficult/ impossible. Some practices have stopped trying.
- Practices are reporting GPs leaving practices that bulk bill and moving to practices that mix bill or private bill service users.

Government incentives

- Keeping up with policy changes, standards, regulations
- Changes to MBS items and new MyMedicare Incentives which can be difficult for practices to stay updated on.
- Insufficient MBS items available for practice nurses to allow nurses to work to the top of their scope without GP involvement (such as Wound Care).
- Insufficient MBS items and Workforce Incentive Program (WIP) payment options available for Non-Dispensing Pharmacists, nurses, Social Workers and Care Co-ordinators. This means establishing and keeping these professions in general practice is often not financially viable.

Digital health

- Limited up-to-date, simple and meaningful training in digital health (My Health Record, secure messaging, health pathways, telehealth videoconferencing software, referrals etc).
- More information and clarification to healthcare providers is needed about how each digital health system interacts with each other such as My Health Record, secure messaging, and The Queensland Viewer.
- The need to use different state and federal systems for the same purpose – The Viewer vs My Health Record.

- No single point login for digital health tools (clinical software, My Health Record, secure messaging, health pathways, telehealth videoconferencing software, referrals etc).
- Multi-factor authentication now needed for many tools which is time consuming for practice staff and need to be entered many times.
- Telehealth platform usage (which one to use and how to use it).
- Continued promotion of privacy and security information required in telehealth.
- A heavy promotion to utilise My health Record from every health facility is required, supported by private and public bodies working together and driven by patient demand.
- My Health Record in aged care – training and support is underway but there is still limited meaningful use or conformant software.
- Limited use of My Health Record within Allied Health organisations.
- Limited training on digital health tools in university/TAFE settings to educate practice staff (GPs and nurses) on the significance of these systems and their proper utilisation.
- Lack of Healthdirect (symptom checker, service finder and telehealth platform) usage by both practices and consumers.
- Support for local pharmacies transitioning to use digital health platforms such as AIR and PRODA is needed. This is highlighted through incoming phone calls requesting of support and stakeholder engagement.
- Lack of knowledge and confidence to use digital platforms efficiently.
- Outdated digital assets (e.g. computers, cameras) for telehealth delivery.
- Old templates in Practice Management software to support practices.
- Interoperability of systems
- Interconnectivity issues and meaningful use of digital health tools; systems do not communicate with each other.
- Managing MyMedicare patient registrations and lack of integrations with Practice Management Software.
- Need for workflows to be introduced on how new systems integrate with other systems and when they should be used (Consistency across PHNs).

Miscellaneous

- Natural disasters/events more frequent.
- Financial sustainability of general practices is threatened.
- Risk of digital attacks.
- Changes to funding affecting payroll tax and business models.
- Practice managers are reporting frequently turning multiple patients away each day as they do not have capacity. This is most common in the Northern corridor but happens in all SA3s.
- Many practices are struggling to stay financially viable.

What are the most difficult services for practices to obtain?

- Reports of long wait times for some hospital services, for example paediatricians and geriatricians.
- Reports of a low number of Geriatrician's in the Gold Coast region.
- Reports of low number of private primary care services for reproductive health and antenatal care can be limited.

What are the barriers for practices completing Continued Quality Improvement?

- General practice staff report a lack of capacity to focus on CQI activities.
- There is a need for development of consistent and appropriate general practice orientation training packages which will support a national standard of training across the sector.
- Low priority compared to other work, such as disaster recovery, policy changes, etc.
- Changes to staff resulting in loss of knowledge around CQI and data extraction tool.
- Some staff reported they would like to increase the number of some MBS items being billed, for example health assessments, as a CQI activity which would also support business sustainability but are concerned of being audited.
- See it as separate to everyday business.
- Uptake by patients to undertake preventive healthcare and cost to attend appointment (increase in the number of privately billed general practices).

5.9 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information
General practice	212	Across Gold Coast region	• 880 GPs in the Gold Coast region. • 446 nurses in the Gold Coast region. • 36 general practices deliver speciality services (e.g., skin checks). • 81.6% of general practices are accredited or working towards it. • Many practices operate extended hours, but this is an individual decision and subject to change.
Urgent non-life-threatening care	2	2 Urgent Care Clinic (UCC) – Oxenford and Southport	• Patients can access a UCC when they need same-day medical attention for a minor illness/infection or injury that can be managed without a trip to the emergency department but cannot wait for an appointment with GP.
	1	The Minor Injury and Illness Clinic (Satellite Hospital Tugun)	• The Satellite Hospital can be accessed for walk-in, urgent care for illnesses and injuries not life-threatening in nature, such as simple fractures, simple infections, toothache, minor burns and eye issues. • It is open 8am to 10pm, 7 days a week.
Medical deputising services	6	Available across most Gold Coast, though some areas (e.g. the hinterland) are less well serviced	• In-home and after-hour visits from a doctor. • All consultations are bulk billed for Medicare and DVA card holders. • Appointments can be requested by phone or online.
Pharmacy	132	Across Gold Coast region	• Pharmacies provide a variety of services: • Medication dispensing • Medication reviews

			• Medication management • Some screening and health checks • Some vaccinations • Some have extended hours into the evening and weekends.
Emergency departments	6	Southport and Robina (public); Tugun, Southport and Benowa (private); Robina (WiSE Specialist Emergency Clinic)	• Private health insurance is required to access private EDs, a gap payment may also be incurred. Limited integration with general practice data. • Residents near borders may also use nearby hospitals such as Tweed, Logan, and Beaudesert.

Online and phone support		Phone or online	• There are several telephone and online services that provide health information and advice, including:
			  ○ Healthdirect
			  ○ 13 HEALTH – health information and advice
			  ○ Mental Health: Head to Health website and 1300MHCALL
			  ○ Lifeline crisis support service
			  ○ Pregnancy Birth and Baby
			  ○ PalAssist – 24-hour palliative care support and advice line

Allied health services	428 services; 1,260 staff	Across Gold Coast region	• Many different allied health groups contribute to the care of people in the Gold Coast region both individually and as part of multidisciplinary care teams.

Chapter 6:
DETERMINANTS, HEALTH BEHAVIOURS, AND PREVENTION

KEY FACTS:

- The Gold Coast has the least affordable housing for front line workers in Australia and housing stress is significantly higher than the state average.
- Childhood immunisation rates in the Gold Coast region are below national targets and are declining, with increasing incidence of vaccine preventable outbreaks.
- COVID-19 and influenza vaccination rates are lagging, with lower uptake among residential aged care home residents and other high-risk groups.
- 56.8% of Gold Coast residents were overweight or obese in 2021-22, an increase since 2013-14.
- 38.3% of Gold Coast adults exceeded alcohol use guidelines in 2021-22, higher than the Queensland rate of 36.4%.

PRIORITISED NEEDS:

1) Growing numbers of people with socioeconomic disadvantage and associated higher need, especially in the northern Gold Coast.
2) Declining vaccination rates, including in children and in RACHs.
3) Prevalence of select chronic disease risk factors (low vegetable intake, high BMI, alcohol) is high and/or significantly increasing for adults in the Gold Coast region.

6.1 DETERMINANTS OF HEALTH

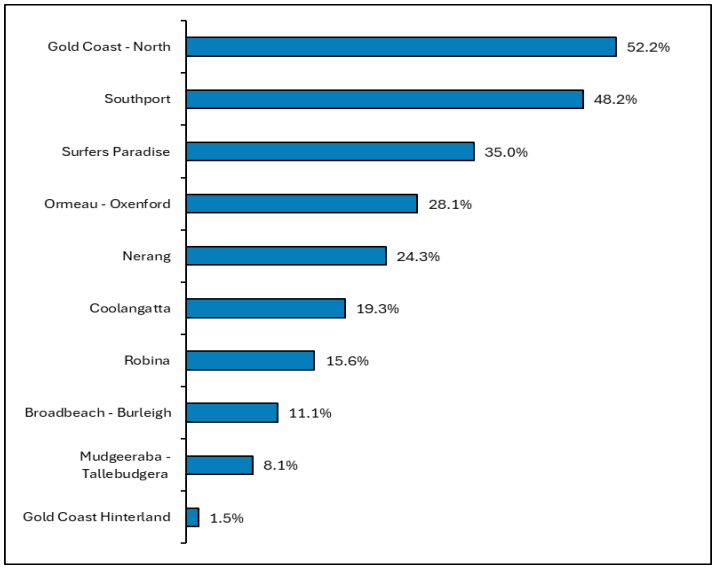
The social, economic, and environmental determinants of health refer to the conditions in which people are born, live, work, and age, as well as the broader structural influences that shape these conditions. Social determinants encompass factors such as education, income, and social support networks; economic determinants include employment, financial security, and resource distribution; and environmental determinants involve access to clean air, water, and safe living spaces. These factors are the basis for downstream health outcomes and influence the more proximal determinants, such as health behaviours.

- *Socioeconomic determinants:* Disadvantaged groups experience higher rates of chronic illness and mental health issues, leading to increased use of public health services.
- *Environmental determinants:* Poor environmental conditions (e.g., air quality, housing) contribute to diseases like asthma and heart disease, raising healthcare demands.

6.1.1 Socioeconomic disadvantage

Socio-Economic Indexes for Areas (SEIFA) scores by the Australian Bureau of Statistics measure disadvantage based on income, education, and employment, comparing areas across Australia.

FIGURE 1: POPULATION IN SEIFA QUINTILE 1 OR 2, GOLD COAST SA3 REGIONS, 2021



Source: ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2021.

- At a regional level, the Gold Coast population appears relatively advantaged compared to the state distribution of socioeconomic advantage and disadvantage; 27.2% of Gold Coast residents live in areas of SEIFA quintiles 1 or 2.
- However, there are some regions of the Gold Coast with significant disadvantage. This includes a level of "invisible" disadvantage that is not reflected in SEIFA, due to the close geographical proximity of extremely advantaged and disadvantaged households in small geographical areas, obscuring a population level view.
- Approximately half of Gold Coast North SA3 (52%) and Southport SA3 (48%) residents were in the most disadvantaged two SEIFA quintiles.

TABLE 1: POPULATION BY SEIFA QUINTILES, GOLD COAST SA3 REGIONS, 2021

Region	Quintile 1 (most disadvantaged)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (least disadvantaged)
Queensland	20.0%	20.0%	20.0%	20.0%	20.0%
Gold Coast SA4	7.4%	19.8%	26.1%	29.3%	17.4%
Broadbeach-Burleigh	1.3%	9.8%	21.2%	39.2%	28.5%
Coolangatta	1.6%	17.7%	25.3%	41.9%	13.5%
Gold Coast-North	19.4%	32.8%	21.6%	16.2%	10.1%
Gold Coast Hinterland	0.0%	1.5%	36.0%	43.6%	19.0%
Mudgeeraba-Tallebudgera	1.2%	6.9%	19.6%	29.8%	42.6%
Nerang	6.7%	17.6%	29.0%	32.3%	14.4%
Ormeau-Oxenford	5.5%	22.6%	22.4%	30.3%	19.2%
Robina	3.2%	12.4%	39.2%	31.9%	13.3%
Southport	21.8%	26.4%	31.6%	17.9%	2.2%
Surfers Paradise	6.7%	28.3%	27.2%	16.5%	21.4%

Source ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2021.

6.1.2 Income

In 2021, the median total person income in the Gold Coast region was $40,820 per year, which was comparable to the total Queensland income of $40,924.

- Broadbeach-Burleigh SA3 region had the highest median total personal income $45,500.
- Southport had the lowest median total personal income with $35,932 per year.

TABLE 2: MEDIAN ANNUAL INCOME, QUEENSLAND, GOLD COAST SA3 REGIONS, 2021

Region	Median annual income
Gold Coast SA4	$40,820
Broadbeach-Burleigh	$45,500
Ormeau-Oxenford	$43,888
Mudgeeraba-Tallebudgera	$42,016
Coolangatta	$41,704
Surfers Paradise	$41,340
Robina	$40,352
Nerang	$40,196
Gold Coast Hinterland	$38,324
Gold Coast-North	$36,140
Southport	$35,932

Source: ABS, Census of Population and Housing, 2021, General Community Profile - G02 and G17 and Queensland Treasury estimates

6.1.3 Education

TABLE 3: HIGHEST LEVEL OF SCHOOLING, GOLD COAST SA3 REGIONS, 2021

Region	Did not go to school or Year 8 or below		Year 9 or 10 or equivalent		Year 11 or 12 or equivalent	
	Number	%	Number	%	Number	%
Queensland	178,101	4.4%	989,350	24.63%	2,554,330	63.58%
Gold Coast SA4	14,252	2.8%	118,240	23.32%	337,508	66.58%
Broadbeach-Burleigh	1,373	2.5%	11,217	20.4%	38141	69.3%
Coolangatta	1,235	2.7%	12,085	26.0%	29,911	64.5%
Gold Coast-North	2,343	4.0%	15,509	26.5%	35,843	61.3%
Gold Coast Hinterland	379	2.4%	4,200	26.3%	10,267	64.3%
Mudgeeraba-Tallebudgera	620	2.3%	6,261	23.7%	18,145	68.6%
Nerang	1,589	3.0%	14,256	26.6%	34,686	64.8%
Ormeau-Oxenford	2,989	2.6%	28,612	24.7%	77,113	66.7%
Robina	1,153	2.7%	8,480	19.8%	30,443	71.2%
Southport	1,685	3.1%	10,608	19.8%	36,334	67.9%
Surfers Paradise	899	2.3%	7,031	18.0%	26,629	68.1%

Source: ABS, Census of Population and Housing, 2021, General Community Profile - G16.

- In 2021, there were 337,508 people (66.6%) in the Gold Coast region with the highest level of schooling year 11 or 12.
- Robina SA3 region had the largest percentage of people whose highest level of schooling was year 11 or 12 (71.2%) equivalent
- In comparison Gold Coast-North SA3 region had the largest percentage whose highest level of schooling was year 8 or below (or did not go to school) with 4%.

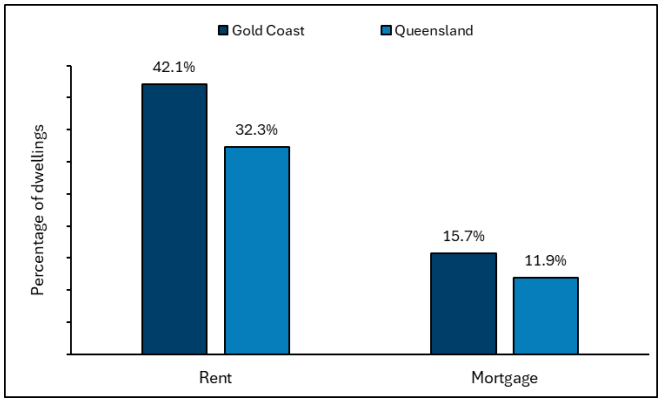
6.1.4 Housing affordability

Affordable housing supply is significant social and economic issue for Australia and is especially relevant for Gold Coast where housing affordability is low for both renters and mortgage holders.

Low housing affordability impacts financial security, access to essential goods and services and can lead to environmental health risks through overcrowded dwellings.

- The proportion of rented dwellings where housing payments exceeded 30% of household income was high for the Gold Coast (42.1%), compared to the state average (32.3%).
- There was a greater proportion of Gold Coast dwellings (15.7%) where housing payments exceeded 30% of household income, compared to Queensland average (11.9%).
- Although recent regional data is unavailable, it is likely that housing stress has increased in recent years, underpinned by extended periods of low vacancy rates, higher rents, and increased finance costs.

FIGURE 2: OCCUPIED DWELLINGS WHERE HOUSING PAYMENTS EXCEED 30% INCOME, GOLD COAST, 2021



Source: ABS, Census of Population and Housing, 2021, General Community Profile

6.1.5 Unemployment

TABLE 4: UNEMPLOYMENT RATE, GOLD COAST SA3 REGIONS, JUNE QUARTER 2023

Region	Number	Percent
Queensland	107,832	3.7%
Gold Coast SA4	10,295	2.8%
Gold Coast-North	1,357	3.6%
Southport	1,416	3.8%
Nerang	1,235	3.0%
Coolangatta	823	2.5%
Gold Coast Hinterland	328	2.9%
Ormeau-Oxenford	2,385	2.6%
Surfers Paradise	708	2.5%
Robina	741	2.4%
Broadbeach-Burleigh	875	2.2%
Mudgeeraba-Tallebudgera	427	2.0%

Source Australian Government Department of Education, Skills and Employment, Small Area Labour Markets Australia, various editions.

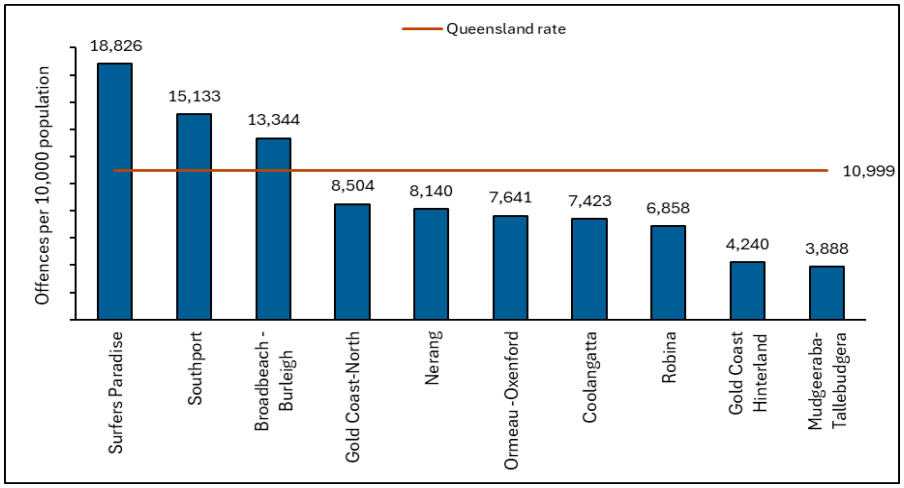
- As of June 2023, 10,295 people (2.8%) in the Gold Coast region were unemployed, below the Queensland average of 3.7%.
- Southport had the highest unemployment rate in the region at 3.8%, and Mudgeeraba-Tallebudgera had the lowest unemployment rate at 2.0%.

6.1.6 Crime

Lack of community safety and fear of crime are associated with poorer mental health outcomes and limitations in physical functioning, including engaging in healthy behaviours[31].

[31] Stafford, M., Chandola, T. and Marmot, M., 2007. Association between fear of crime and mental health and physical functioning. *American Journal of Public Health, 97*(11), pp.2076-2081

FIGURE 3: REPORTED OFFENCES, GOLD COAST SA3 REGIONS, 2022-23



Source: QLD Police Service 2023.

- The Gold Coast region, on average, had lower rate of reported crime than the Queensland average, with 64,443 offences recorded and a rate of 9,520 per 10,000 (Queensland rate was 10,999 per 10,000 people).
- The highest rates of crime in the region were observed in Surfers Paradise, Southport, and Broadbeach-Burleigh.

6.1.7 Risk and protective factors

Risk and protective factors significantly influence the disease burden of a population. The 2018 Australian Burden of Disease Study[32] estimated that 37.5% of the total disease and injury burden were attributable to joint risk factors. The leading risk factors identified were:

- Tobacco use (8.6%)
- High body mass (8.4%)
- Dietary pattern (5.4%)
- High blood pressure (5.1%)
- Alcohol use (4.5%)

Tobacco use

Tobacco use is the leading preventable cause of morbidity and mortality in Australia and was responsible for 8.6% of the total disease burden, 76.5% of lung cancer, and 73.2% of COPD in 2018[33]. Tobacco use in the Gold Coast is comparatively low and has declined steadily. Gold Coast daily smoking rate (8.4%) is lower than Queensland's (10.4%)[33] and declined since 2009-10.

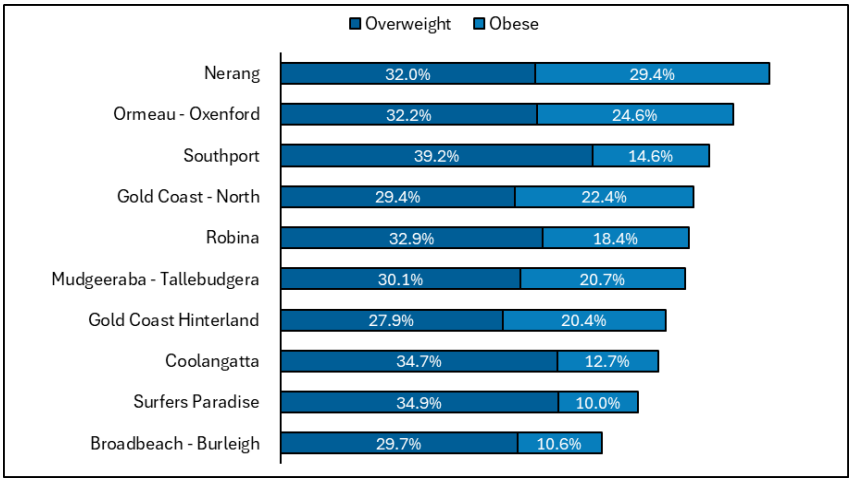
The impact of increasing utilisation of vapes on tobacco use is unclear, however, as vape usage and epidemiological data are improved, the relationship between vaping, tobacco use, and respiratory disease will be further explored.

[32] Australian Government Department of Health and Aged Care, 2022. *Data strategy 2022–2025: Harnessing the power of data for better health, aged care and wellbeing*.
[33] Queensland Health 2023. *The health of Queenslanders - Report of the Chief Health Officer Queensland. Queensland Government.*

High body mass

High body mass is a major risk factor for chronic diseases, such as Type 2 diabetes and heart disease[33].

FIGURE 4: OVERWEIGHT/OBESE POPULATION, GOLD COAST, 2021-22



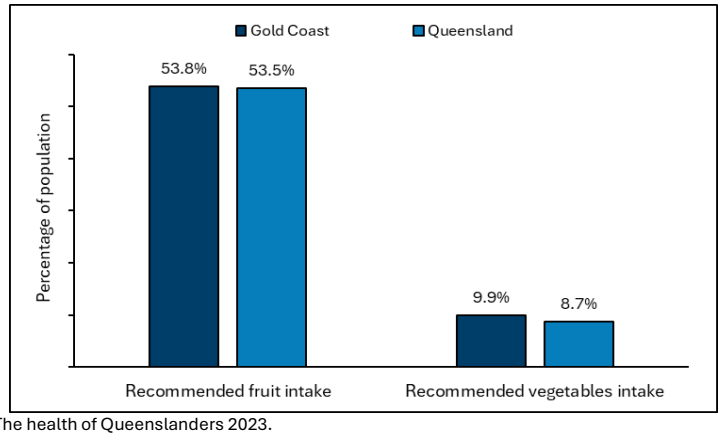
Source: Queensland Preventive Health Survey 2019-20

- In 2021-22, 56.8% of Gold Coast residents were overweight or obese; slightly up from 55.7% in 2013-14 but remaining below Queensland's rate (61.9%).
- High prevalence of overweight or obese residents is seen in northern Gold Coast, especially Nerang (61.4%) and Ormeau-Oxenford (56.9%).

Dietary pattern

A balanced diet, including meeting the recommended fruit and vegetable intake, reduces chronic disease risk, including heart disease and cancer.

FIGURE 5: ADULTS MEETING RECOMMENDED INTAKE OF FRUIT AND VEGETABLES, GOLD COAST, 2017-18



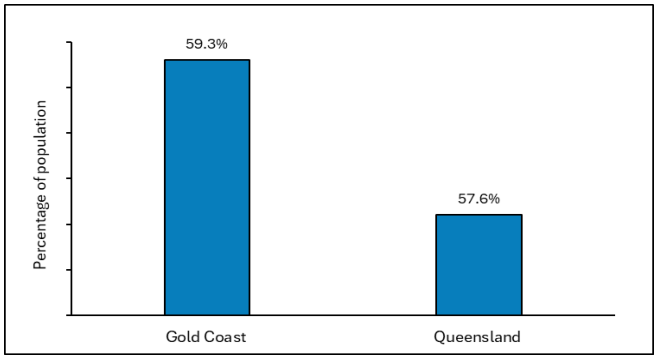
Source: Queensland Health. The health of Queenslanders 2023.

- In 2017-18, 53.8% of Gold Coast adults met fruit intake guidelines (2+ serves), however, only 9.9% met the vegetable intake guidelines (5-6+ serves).

Physical activity

Physical activity is a protective factor against chronic disease, mental health, and well-being. In 2018, physical inactivity contributed to 2.5% of the disease burden in Australia[33].

FIGURE 6: ACTIVITY STATUS AMONG GOLD COAST AND QUEENSLAND RESIDENTS, 2020-11



Source: Queensland Health. The health of Queenslanders 2023.

- In 2020-21, 59.3% of Gold Coast adults met physical activity guidelines, which was higher than for total Queensland's (57.6%).

Alcohol use

Alcohol was the fifth highest contributing risk factor to the burden of disease in Australia in 2018.

NHMRC guidelines recommend no more than 10 standard drinks per week and 4 per day; in 2021-22, 38.3% of Gold Coast adults exceeded these guidelines, above Queensland's 36.4%.

6.2 IMMUNISATION AND COMMUNICABLE DISEASES

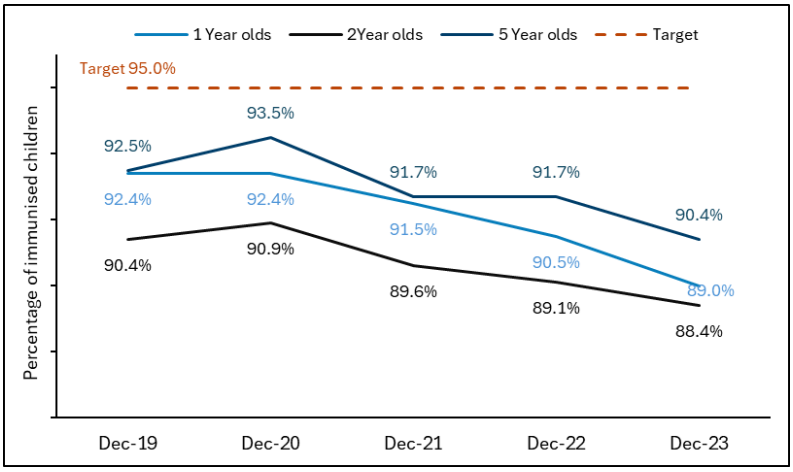
Immunisation is one of the most effective and cost-efficient public health interventions, preventing significant disease burden due to communicable diseases. Effective vaccine programs with high levels of coverage in the community safeguard not only those who are vaccinated, but also people who are unable to be vaccinated or for whom a vaccine is ineffective.

6.2.1 Fully immunised children

The childhood immunisation schedule includes vaccines for pertussis, measles, mumps, rubella, varicella, diphtheria, and hepatitis B, among others. Australia's target is 95% childhood immunisation to prevent disease outbreaks and protect vulnerable groups.

Immunisation coverage has been falling for children, with several outbreaks of vaccine preventable diseases in recent years. For example, between 1 January and 17 November 2024, Gold Coast HHS Public Health Unit recorded 1,997 cases of pertussis (across all ages), which is 31.5-times higher than the 5-year average.

FIGURE 7: FULLY IMMUNISED CHILDREN, GOLD COAST, 2019 TO 2023



Source: Australian Immunisation Register

Gold Coast childhood immunisation coverage declined across all age groups between 2019 and 2023 and has remained below the national target of 95%. Contributing factors to this decrease in childhood immunisation rates may include:

- Vaccine hesitancy: Misinformation or mistrust in vaccines influences parents/caregivers' decisions to vaccinate children[34].
- Complacency: Parents/caregivers may underestimate the importance of vaccinations[35].
- Access barriers: Limited clinic availability and timing issues for families[36].
- Lack of awareness: Parents/caregivers may be unaware their child has missed vaccinations.

TABLE 5: FULLY IMMUNISED 1-, 2- AND 5-YEAR-OLDS, GOLD COAST SA3 REGION, SEPTEMBER 2023

Region	1 years	2 years	5 years
National	93.3%	91.2%	94.0%
Gold Coast (SA4)	90.0%	89.7%	91.0%
Broadbeach-Burleigh	87.6%	85.9%	88.6%
Coolangatta	88.1%	84.3%	87.1%
Gold Coast-North	90.9%	87.4%	91.7%
Gold Coast Hinterland	81.9%	80.6%	79.8%
Mudgeeraba-Tallebudgera	87.8%	86.1%	92.7%
Nerang	92.7%	89.5%	92.3%
Ormeau-Oxenford	91.3%	92.1%	92.8%
Robina	89.1%	90.1%	91.3%
Southport	89.8%	90.1%	89.8%
Surfers Paradise	89.6%	83.4%	90.9%

Source: QLD Childhood immunisation coverage data, Department of Health and Aged Care

[34] Nuwarda, R.F., Ramzan, I., Weekes, L. et al. 2022. Vaccine hesitancy: contemporary issues and historical background. *Vaccines, 10*(10), p.1595.
[35] Robinson, R., Nguyen, E., Wright, M., Holmes, J., Oliphant, C., Cleveland, K. and Nies, M.A., 2022. Factors contributing to vaccine hesitancy and reduced vaccine confidence in rural underserved populations. *Humanities and Social Sciences Communications, 9*(1), pp.1-8.
[36] McCready, J.L., Nichol, B., Steen, M., Unsworth, J., Comparcini, D. and Tomietto, M., 2023. Understanding the barriers and facilitators of vaccine hesitancy towards the COVID-19 vaccine in healthcare workers and healthcare students worldwide: An Umbrella Review. *PLoS One, 18*(4), p.e0280439.

There is regional variation of immunisation coverage across Gold Coast SA3 regions:

- Ormeau-Oxenford SA3 had the highest 2- and 5- year vaccination coverage, however, also had the highest numbers of unvaccinated children across all age groups (due to a large population size).
- Gold Coast Hinterland SA3 had lower immunisation coverage across all age groups, but fewer unvaccinated children due to a comparatively small population.

6.2.2 *Influenza*

- Lab-confirmed cases of influenza have increased in recent years; there were 9,371 cases between 1 January and 17 November 2024, which is 2.3-times the 5-year average of 4,073[37].
- In July 2024, Gold Coast influenza vaccination rates were below Queensland and national averages for all age groups (Table 6).

TABLE 6: PEOPLE VACCINATED WITH INFLUENZA VACCINE BY AGE GROUP, 1 MARCH 2024 – 6 JULY 2024

	6mo-<5yrs	5yrs<15yrs	15yrs<50yrs	50yrs<65yrs	≥65yrs
Gold Coast	12.3%	8.4%	12.2%	23.5%	53.9%
Queensland	18.4%	12.4%	17.1%	30.5%	58.9%
Australia	21.9%	12.8%	18.9%	31.0%	58.9%

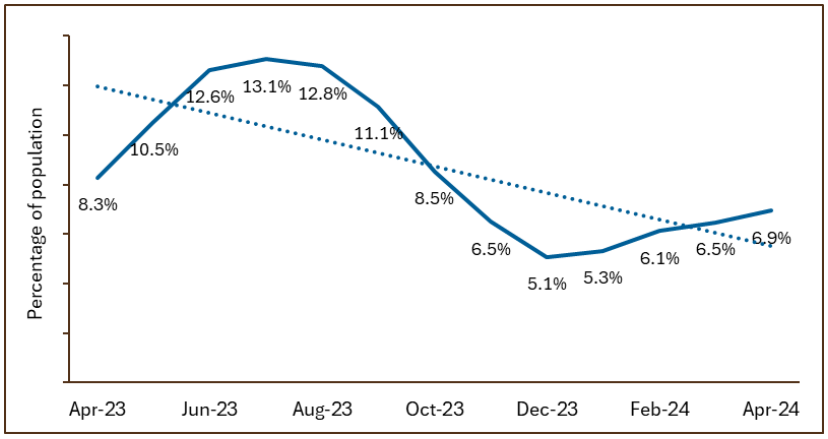
Source: Australian Immunisation Register

6.2.3 *COVID-19*

Although the World Health Organization (WHO) no longer deems the spread of COVID-19 a global health emergency, the number of cases remains elevated. Regular COVID-19 vaccinations (boosters) maintain protection against severe illness, hospitalisation and deaths from COVID-19.

Depending on the age and risk factors for individuals, they may be eligible for one or two COVID-19 booster doses in the last 12 months. National data has identified that booster rates are lagging, with millions of Australians not keeping up with vaccine recommendations.

FIGURE 8: ADULTS WHO RECEIVED COVID-19 BOOSTER IN LAST 6 MONTHS, GOLD COAST, 2023 TO 2024



Source: COVID-19 vaccination – Geographic vaccination rates – LGA | Australian Government Department of Health and Aged Care

[37] Queensland Health 2024, *Notifiable conditions weekly totals: Gold Coast*.

Stakeholders engaged in consultations identified several factors contributing to low uptake of COVID-19 boosters in Australia:

- As additional booster doses have come out, recommendations have changed, making it difficult for people to track what is recommended for them.
- Perceived risk of the virus is not as high as it was earlier in the pandemic due to base-level immunity through earlier vaccines and infection.
- Discussions occurring in the community about rare but serious side effects associated with the vaccines, that are viewed as being of greater concerns that contracting COVID-19.

COVID-19 vaccinations in aged care

While those in aged care have been among those worst affected by COVID-19, only few eligible residents living in aged care have received a booster dose in the last 6 months.[38]

Recent data* reveals that in 2023, the majority of 56 RACHs in the Gold Coast region had a COVID-19 vaccination rate of 50-60% or below (n=33) and 7 RACHs had a vaccination rate of 10-20% or below. Only 5 of 56 RACHs had a vaccination rate of 80-90%[39].

Stakeholders identified these factors contributing to low uptake in COVID-19 boosters in RACHs:

- Lack of awareness of residents' progress in receiving booster vaccinations.
- Primary responsibility for tracking resident's booster status lies with their GPs.
- Coordinating large vaccination groups is challenging due to multiple GPs within RACH.
- Discrepancies in AIR data arise from delays in entering information into the system.
- Changes in RACH management/staff create difficulties in coordinating booster vaccinations.
- Securing consent from residents/families can be time-consuming.
- Residents and families lack understanding of the required number of COVID vaccinations and may be hesitant without proper guidance.

Human papillomavirus (HPV) vaccine

The HPV vaccine is provided free to individuals aged 12-13 through schools via the National Immunisation Programs. Vaccination is rrecommended for people aged 9-25, those with immunocompromising conditions, and men who have sex with men.

TABLE 7: CHILDREN AGED 15 YEARS WHO RECEIVED HPV SINGLE-DOSE VACCINE, 2023

	Queensland	Australia
Females	83.2%	85.9%
Males	80.9%	83.4%

Source: Australian Immunisation Register.

- Queensland's HPV vaccination rates for 15-year-olds are below national averages for males and females.

[38] Department of Health and Aged Care 2024, *COVID-19 vaccination rollout update*.
[39] Department of Health 2024, Australian Immunisation Register Immunisation *residential aged care residents COVID-19 vaccination rates*. *Data only includes residents who have linked vaccination records (98.3%), data for facilities with fewer than 5 residents are excluded.

Vaccine potentially preventable hospitalisations

In 2020-21, rates of hospitalisations for vaccine preventable conditions were lower in the Gold Coast region, in comparison to the Queensland[40]:

- Gold Coast region had 45 preventable admissions for pneumonia/influenza (ASR 7.6 per 100,000), lower than Queensland's rate (ASR 12.0 per 100,000).
- Total vaccine-preventable admission rate was also lower for Gold Coast (57 per 100,000), compared to Queensland rate (84.4 per 100,000).

6.3 CONSULTATIONS

The information presented herein has been collated from GCPHN Community Advisory Council, GCPHN Clinical Council, and community consultations. Main findings include:

- Lack of availability of public and social/community housing.
- Homelessness has increased in recent years and will no doubt continue to with the impacts of COVID-19 still worsening for many.
- Ormeau-Oxenford region has the largest population in the Gold Coast region yet have low number of water fountains and community fitness equipment for the community to utilise.
- Those who identify as aged or having a disability continue to have access issues to health providers, a lot do not drive and if they do, cannot afford parking or unable to walk the distance required, Telehealth can only do so much in this space.
- Language barrier can be a concern for patients who do not speak English, having a translator must be arranged prior to consultation.
- Difficult to know of local GPs in the area who speak other languages other than English who a GP could refer a patient to.
- Telehealth has improved access to care during COVID-19 which is often a determinant to health.
- Less cancellations of patients using telehealth has been noted during COVID-19.
- There is still a need for face-to-face consultations as some things can be missed on a telehealth consultation (skin checks etc) and digital divide (low social economic and literacy).
- Identified specific health needs and service issues for people with a disability:
    - Access to adequate housing (many people with disabilities are inappropriately housed in aged care homes),
    - Accessibility,
    - Timely access to & effective health services, and
    - Employment.

[40] PHIDU 2024. *Social Health Atlas of Australia Primary Health Networks*. Potentially Preventable Hospitalizations Vaccine Preventable Conditions.

6.4 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information
General practices	212	Across Gold Coast region 81% of general practices have a nurse who can assist in immunisation.	• Childhood immunisations are free due to funding by the Government, but the consultation fee may differ between general practices. • Immunisation education events are well attended. • General practices require support from Gold Coast regarding data recording on Australian Immunisation Register.
Community immunisation clinics, GCHHS	Various	Clinics at various locations and times	• See website Free Community Immunisation Clinics. • Vaccines on the National Immunisation Program Schedule Queensland. • Some vaccines not on the Immunisation Schedule Queensland are available for purchase.
Online Chlamydia and Gonorrhoea test request	Online	Online	• 13 HEALTH Webtest is a free urine test for chlamydia and gonorrhoea that can be ordered online. The test is available to all Queenslanders aged 16+. • Queenslanders can order the test online and receive the results through 13 HEALTH. It is confidential and available without a Medicare Card.
Schools	116	Public and private schools across the Gold Coast region	• GCHHS provides a free scheduled immunisation service for School/Adolescent Immunisation program including HPV, Meningococcal tetanus, and whooping cough.

Services	Number	Distribution	Information
Gold Coast Hospital Maternity and Antenatal Clinic	1	Southport	• Pregnant women can access immunisations including whooping cough and influenza.
Pharmacy	132	Across Gold Coast region	• Pharmacist must undertake additional training to administer vaccines and pharmacies must implement additional processes (e.g. cold chain).
Mobile services for vaccines	Multiple	Various locations	• Onsite service for efficient administration of flu shots at aged care facilities, workplaces and schools. • Specialist immunisation nurses with vast experience. • Up to date flu vaccines recommended by the WHO.
Gold Coast Sexual Health Service	1	Southport	• The Gold Coast Sexual Health Service provides testing and treatment for STIs and HIV management including PEP (Post Exposure Prophylaxis), and vaccinations for Hepatitis B. • Sexual health counselling, information, education, advice. • Free confidential walk-in and appointment-based service.
Griffith University Health and Medical Service	1	Southport	• Vaccinations for Griffith University students attending clinical placement (travel and influenza vaccinations are offered).
Bond Medical Clinic	1	Varsity Lakes	• The medical clinic is a facility for currently enrolled students and staff members of Bond University.
Active and Healthy Lifestyle, Gold Coast City Council	Multiple	Across Gold Coast region	• Promotes physical activity and healthy eating with free/low-cost activities at parks, libraries, community centres, and aquatic centres.

Chapter 7:
FIRST NATIONS PEOPLE

KEY FACTS:

- In 2021, 2.2% of total Gold Coast population identified as First Nations.
- Over half (58.7%) of the increase in all-cause mortality between 2012–2016 and 2018–2022 for the First Nations Gold Coast population was driven by cancers, cardiovascular, endocrine (including diabetes), and respiratory diseases.
- Cancers contributed 40.0% of the rise in all-cause mortality between 2013–2017 and 2018–2022.
- Uptake of Indigenous specific health checks is below the Queensland average and has decreased from 22.3% in 2016–17 to 18.7% in 2021–22.
- The proportion of First Nations babies born with a healthy birth weight has increased in recent years.

PRIORITISED NEEDS:

1) There are lower screening rates and increasing morbidity and mortality for cancers in the First Nations community.
2) Need to actively eliminate racial discrimination, lateral violence and institutional racism.
3) Ongoing improvements are required in culturally safe service provision across the system to ensure equitable, effective access for First Nations people.
4) Low rates Indigenous specific health checks (MBS 715).
5) Inadequate suicide prevention services and post event services for First Nations community.
6) Low rates of people who identify as First Nations in health workforce, particularly for clinical roles.
7) Limited culturally informed holistic approaches to wellbeing and ill health prevention.
8) Limited system partnerships addressing social determinants of health.

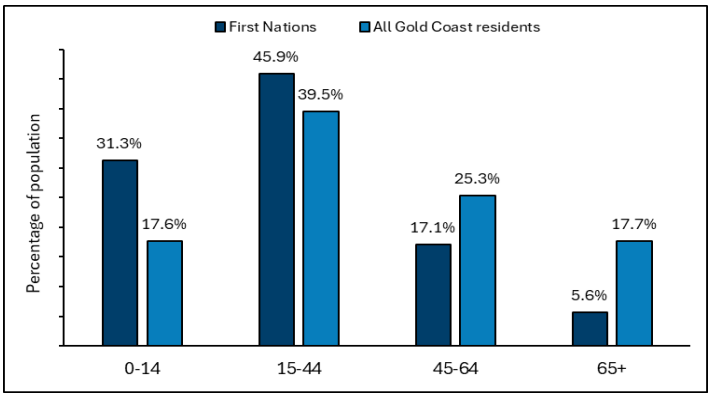
7.1 DEMOGRAPHIC SNAPSHOT

The First Nations population of the Gold Coast region is growing in both absolute terms and as a proportion of the total Gold Coast population.

There were 13,901 First Nations people living in the Gold Coast region in 2021, an increase of 46.3% from 9,501 in 2016. The proportion of the total population who identified as First Nations increased from 1.7% in 2016 to 2.2% in 2021[41,42].

The age profile of the First Nations Gold Coast population is comparatively young, with a median age of 24.0 years[44].

FIGURE 1: POPULATION AGE DISTRIBUTION BY FIRST NATIONS STATUS, GOLD COAST, 2021



Source: Australian Bureau of Statistics, 2021 Census of Population and Housing

7.1.1 Population by region

In 2021, more than half of the Gold Coast First Nations population lived in either Ormeau-Oxenford SA3 (31.4%), Gold Coast-North SA3 (9.3%) or Nerang (12.7%).

TABLE 1: FIRST NATIONS POPULATION, GOLD COAST SA3 REGIONS, 2021

Region	Number	% of Gold Coast First Nations population
Broadbeach-Burleigh	1,013	7.3%
Coolangatta	1,429	10.3%
Gold Coast-North	1,292	9.3%
Gold Coast Hinterland	432	3.1%
Mudgeeraba-Tallebudgera	750	5.4%
Nerang	1,759	12.7%
Ormeau-Oxenford	4,359	31.4%
Robina	919	6.6%
Southport	1,419	10.2%
Surfers Paradise	528	3.8%

Source: Australian Bureau of Statistics, 2021 Census of Population and Housing

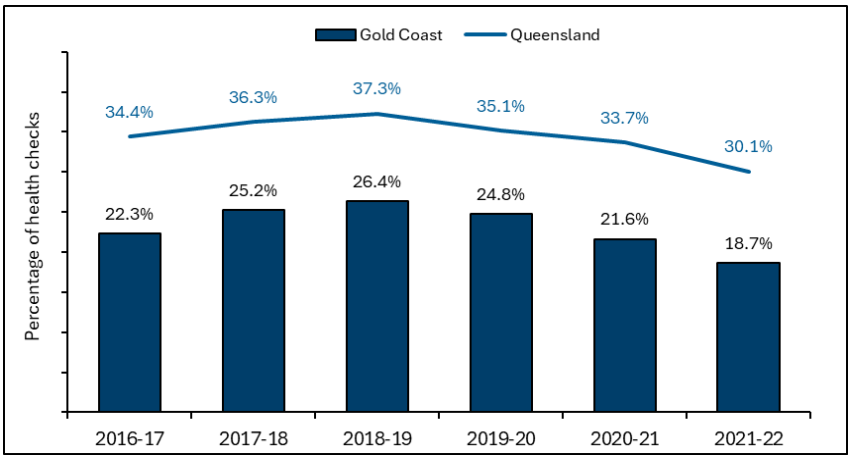
[41] Australian Bureau of Statistics 2021, *Census of Population and Housing*.
[42] Australian Bureau of Statistics 2016, *Census of Population and Housing*.

7.2 PRIMARY CARE AND PREVENTION

First Nations people are eligible for an annual health check funded through Medicare. The 'Indigenous-specific health check' was introduced in recognition that First Nations people experience higher risk of ill health, and to encourage early detection and treatment of common conditions.

The uptake of Indigenous-specific health checks among First Nations Gold Coast residents is lower than Queensland and national rates and declining. It's likely that this is an underestimate of First Nations people engaged in primary care, who may not identify during a general practice consult.

FIGURE 2: INDIGENOUS-SPECIFIC HEALTH CHECKS, GOLD COAST AND QUEENSLAND, 2016-17 TO 2021-22



Source: AIHW analysis of MBS data. 'Indigenous-specific health checks include MBS items: 715, 228, 92004, 92011, 92016, 92023.

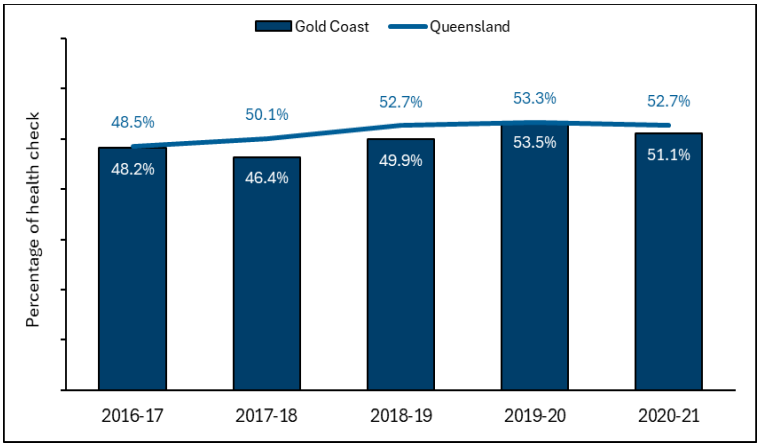
- In 2021-22, Gold Coast region had a lower rate of completed Indigenous specific health checks (18.7%), compared to the Queensland rate (30.1%).
- The rate of uptake of Indigenous-specific health checks by First Nations Gold Coast residents declined from 2016-17 (22.3%) to 2021-22 (18.7%).

7.2.1 Health check follow up care

Indigenous-specific health checks are important for early detection of health concerns, however, improving health outcomes also requires appropriate follow-up of any issues identified[43]. Based on the needs identified during a health check, First Nations people can access Indigenous-specific follow up services from allied health workers, general practice nurses or First Nations health practitioners.

[43] Bailie, J., Schierhout, G.H., Kelaher, M.A., et al.., 2014. Follow-up of Indigenous-specific health assessments-a socioecological analysis. *Medical Journal of Australia, 200(*11), pp.653-657.

FIGURE 3: PATIENTS WHO RECEIVED A FOLLOW-UP SERVICE WITHIN 12 MONTHS FROM INDIGENOUS-SPECIFIC HEALTH CHECK, GOLD COAST AND QUEENSLAND, 2020-21



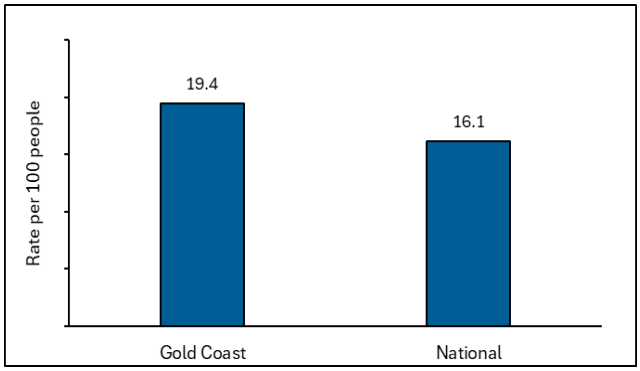
Source: AIHW analysis of MBS data. NOTE: Indigenous-specific health check has MBS item 715.

- In 2020-21, percentage of patients with follow-up to Indigenous-specific health check in the Gold Coast region was higher than the national rate (46.1%) and similar to the Queensland rate (51.1%).
- The rate of Indigenous-specific health check follow-ups increased between 2016-17 (48.2%) and 2020-21 (51.1.%).

7.2.2 Nursing and Aboriginal Health Worker services

First Nations Gold Coast residents utilise community nursing and Aboriginal Health Worker services at a higher rate than the national average.

FIGURE 4: NURSING AND ABORIGINAL HEALTH WORKER APPOINTMENTS FOR FIRST NATIONS PEOPLE, GOLD COAST AND NATIONAL, 2020-21



Source: Australian Institute of Health and Welfare, Medicare-subsidised GP, allied health and specialist care across local areas: 2021-22

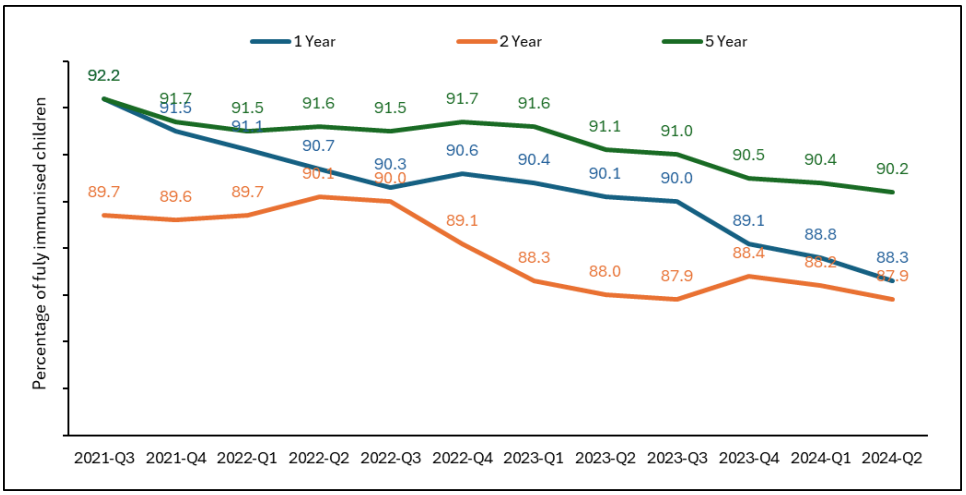
There were 125,843 nursing and Aboriginal Health Worker services provided to First Nations Gold Coast residents in 2021-22 (19.4 per 100 people). In comparison, national rate was 16.1 per 100.

7.2.3 Childhood immunisation

Immunisation coverage of First Nations children has historically been high but declined over the last three years for 1- and 5-year-olds, in line with childhood immunisation trends across the broader population.

The rate of immunisation coverage for 2- and 5-year-old First Nations children remains higher than the Gold Coast average despite the declining coverage trend.

FIGURE 5: FULLY IMMUNISED FIRST NATIONS CHILDREN, GOLD COAST, 2021 TO 2024



Source: Australian Immunisation Register

Over the three-year period of 2021 to 2024, Gold Coast immunisation coverage:

- Declined for 1-year-old First Nations children, from 95.8% to 86.9%.
- Remained approximately stable for 2-year-old First Nations children (91.3% in Q2 2024).
- Declined for First Nations 5-year-olds from 96.7 %to 93.9%

7.2.4 Cancer screening

There are several factors that impact access to cancer screening for First Nations people, including a lack of cultural safety in mainstream services, experiences of racism and discrimination, and attitudes surrounding screening activities, such as shame, stigma and fear.

Regional cancer screening data is unavailable for First Nations population of the Gold Coast; however, national data shows that participation in cancer screening programs remains low.

TABLE 2: PARTICIPATION IN CANCER SCREENING PROGRAMS, AUSTRALIA, 2019-2021

Screening program	% eligible First Nations population screened
Women screened for breast cancer, 2020-21*	49.1%
National Bowel Screening Program, people aged 50-74, 2019-20**	35.0%
National Cervical Screening Program, people aged 20-69, 2019-20**	50.0%

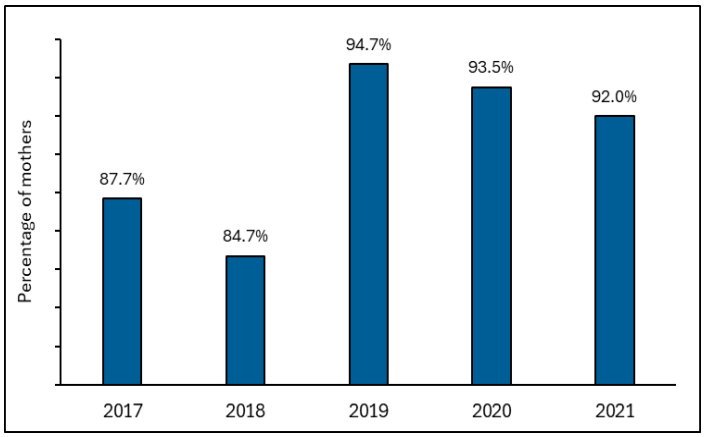
* Source: IUIH 2024: SEQ First Nations Health Equity Strategy. Data for First Nations women in 2020-21 are estimates only and are likely an overestimate.
**AIHW & National Indigenous Australians Agency. (2023). Measure 3.04 Early detection and early treatment, Aboriginal and Torres Strait Islander Health Performance Framework website.

7.3 MATERNAL AND NEWBORN HEALTH

7.3.1 Antenatal care

First Nations women living in the Gold Coast region have high engagement with antenatal care, with more than 9 in 10 pregnant First Nations women attending 5 or more antenatal appointments. This is enabled via a First Nations specific birthing on country service, Waijungbah Jarjums.

FIGURE 6: FIRST NATIONS MOTHERS WHO ATTENDED 5 OR MORE ANTENATAL VISITS, GOLD COAST, 2021

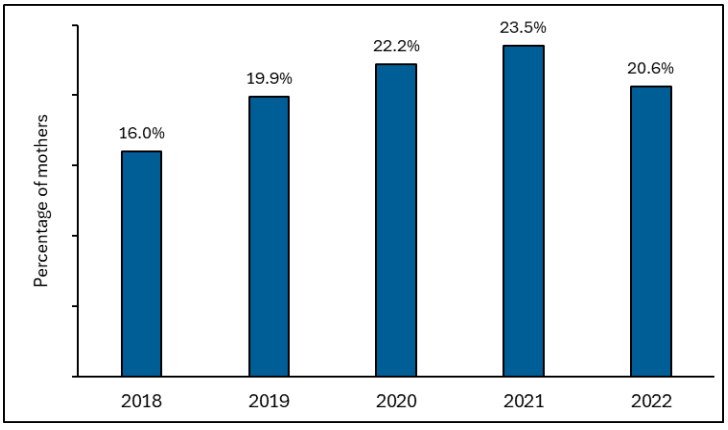


Source: Queensland Perinatal Data Collection

- The proportion of First Nations women attending five or more antenatal visits increased from 87.7% in 2017 to 92% in 2021.

7.3.2 Smoking during pregnancy

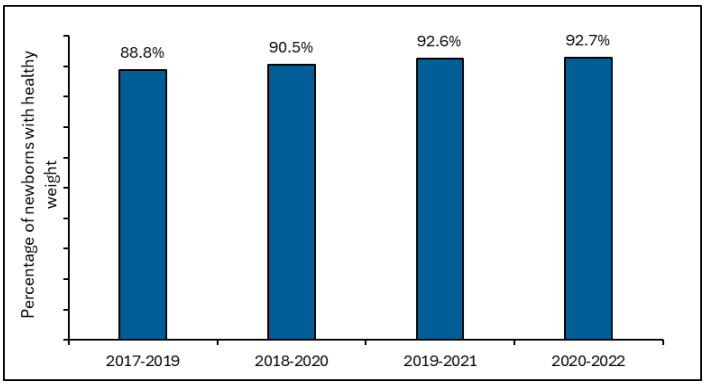
FIGURE 7: FIRST NATIONS WOMEN WHO SMOKED DURING PREGNANCY, GOLD COAST, 2018 TO 2022



- While most First Nations women do not smoke during pregnancy, the rate of maternal smoking for First Nations women has been increasing from 2018, reaching 20.6% on 2022.
- Maternal smoking for First Nations women follows a similar trend to the broader population from 2019 to 2020, where higher rates were observed in 2020 and 2021, followed by a reduction in 2022.

7.3.3 Healthy birth weight

FIGURE 8: FIRST NATIONS BABIES BORN WITH HEALTHY BIRTH WEIGHT, GOLD COAST, 2017-19 TO 2020-21



Source: Queensland Perinatal Data Collection

- The vast majority of First Nations babies are born with a healthy birth weight (2,500-4,499g) and there has been substantial improvements year on year since 2017-2019. This change represents significant progress in newborn health for First Nations babies in the Gold Coast region.
- The proportion of First Nations babies born with healthy birth weight increased between 2017-2019 and 2020-2022, from 88.8% to 92.7%.

7.4 HEALTH OUTCOMES

7.4.1 Potentially preventable hospitalisations

Between July 2022 and June 2023, there were 526 potentially preventable hospitalisations (PPHs) for First Nations people in the Gold Coast region. Of those, 255 were for acute conditions, 248 for chronic conditions and 28 for vaccine-preventable conditions.

The five leading types of PPH admissions amongst First Nations people during this period were:

- Diabetes complications: 99 hospitalisations
- Convulsions and epilepsy: 56 hospitalisations
- Urinary tract infections: 51 hospitalisations
- Iron deficiency anaemia: 53 hospitalisations
- Cellulitis: 39 hospitalisations

Between 2020-21 and 2022-23, rates of PPHs for First Nations patients living in Gold Coast remained relatively stable[16].

7.4.2 Life expectancy and mortality

Life expectancy for First Nations people living in Queensland increased between 2015-2017 and 2020-2022, by 0.9 years for males (LE: 72.9) and 0.2 years for females (LE: 76.6).

However, significant disparities in life expectancy remain prevalent between First Nations people and non-Indigenous people. Between 2020 and 2022, the life expectancy for First Nations males

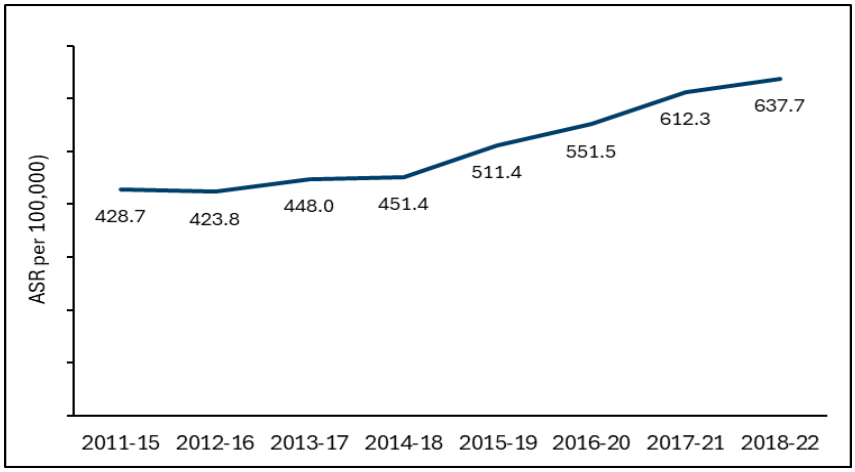
in Queensland was 7.4 years less than for non-Indigenous males (72.9 vs 80.2 years), and the life expectancy for First Nations females was 7.0 years less than for non-Indigenous females (76.6 vs 83.5 years)[44].

Official life expectancy estimates for First Nations people are not available for the Gold Coast, but other indicators, outlined below, can provide insight into the patterns of mortality experienced by First Nations people.

7.4.3 Mortality

The rate of all-cause mortality experienced by First Nations people living in the Gold Coast region increased by 50.5% between 2012-2016 and 2018-2022. Although statistically significant, this change should be interpreted with caution. The 2012-2016 period and adjacent years had comparatively low rates of mortality (0.8 times the total Queensland rate), which amplifies the change over time. All-cause mortality for First Nations people living in the Gold Coast region was 1.2-times the total Queensland rate in 2018-2022, after adjusting for differences in population age structures.

FIGURE 9: ALL-CAUSE MORTALITY IN FIRST NATIONS PEOPLE, GOLD COAST, 2011-2015 TO 2018-2022



Source: Cause of Death Files, Australian Coordinating Registry

Causes for increased mortality

Mortality in First Nations people aged over 65 increased substantially over the period and was the age cohort primarily affected by the change in mortality rate.

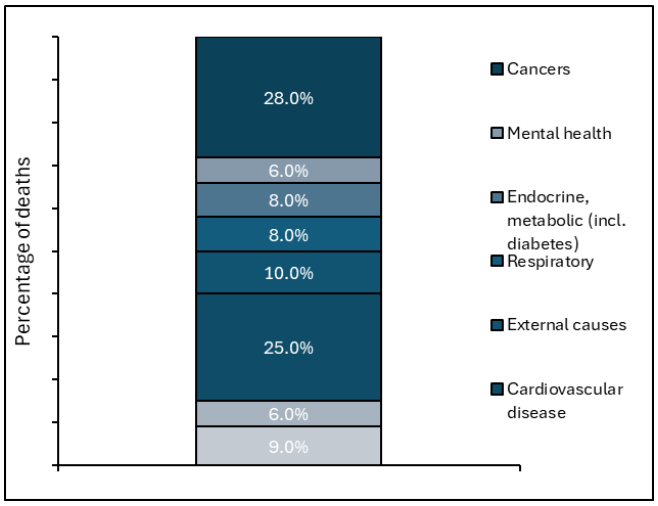
More than half (58.7%) of the increase in all-cause mortality between 2012-2016 and 2018-2022 was attributable to cancers, cardiovascular, endocrine (including diabetes) and respiratory diseases. Cancers alone contributed 40.0% of the increase in all-cause mortality rate between 2013-2017 and 2018-2022.

[44] Australian Bureau of Statistics 2020-2022, *Aboriginal and Torres Strait Islander life expectancy.*

Leading causes of death

The leading causes of death for First Nations people in the Gold Coast region in 2018-2022 were cancers (26.7%), cardiovascular disease (22.2%) and external causes (13.3%). The three leading causes of mortality have remained unchanged since 2013-2017.

FIGURE 10: LEADING CAUSES OF MORTALITY FOR FIRST NATIONS PEOPLE, GOLD COAST REGION, 2018-2022



Source: Cause of Death Files, Australian Coordinating Registry

Cancers

Cancer is the leading cause of death for First Nations people living in the Gold Coast region. Between 2013-2017 and 2018-2022, the rate of cancer mortality for First Nations people living in the Gold Coast region increased by 47.4%[45,46].

Lung cancer was a leading contributor to cancer deaths for First Nations people living in the Gold Coast region in 2013-2022, accounting for 24.3% of all cancer mortality[46].

Cardiovascular disease

Cardiovascular disease is the second leading cause of death for First Nations people living in the Gold Coast region, accounting for 20.8% of deaths in 2018-2022.

The rate of age standardised cardiovascular disease mortality increased by 14.2%[49] between 2012-2016 and 2018-2022.

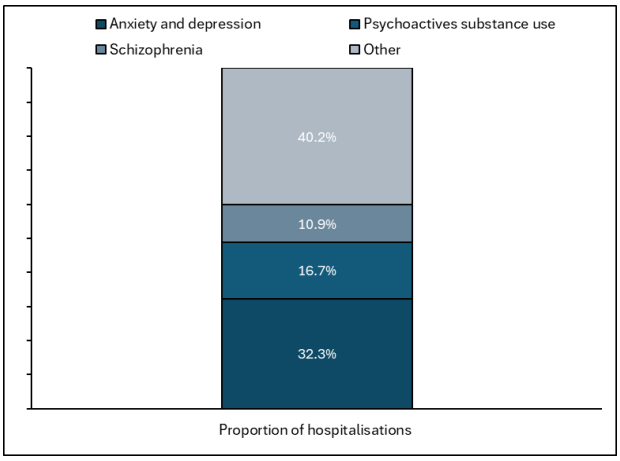
7.5 SOCIAL AND EMOTIONAL WELLBEING

Mental health and substance use are two of the leading causes of burden of disease for First Nations people in Queensland. Disparities in mental health outcomes are experienced by First Nations people living in the Gold Coast, with high rates of hospitalisation for mental health disorders, including anxiety, depression, psychoactive substance use and self-harm.

[45] Not significant at 95% CI; directly age standardised to 2001 Australian population; Cause of Death Unit Record File, Australian Coordinating Registry.
[46] Cause of Death Unit Record File, Australian Coordinating Registry.

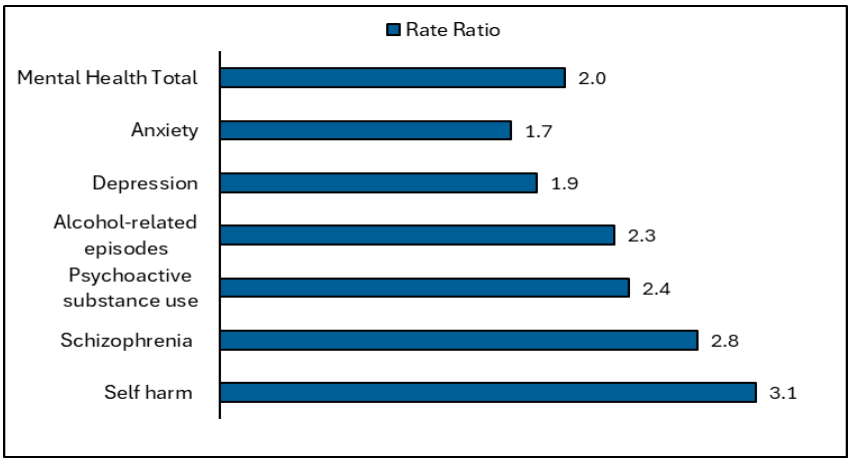
- In 2020-21 to 2022-23, anxiety and depression accounted for almost a third (32.3%) of all mental health hospitalisations for First Nations people.
- Psychoactive substance use accounted for 16.7% of all mental health hospitalisations.
- First Nations people living in the Gold Coast region had 2.0-times the rate of hospitalisation due to mental health disorders, relative to the total Gold Coast population.

FIGURE 11: MENTAL HEALTH RELATED HOSPITALISATIONS, FIRST NATIONS PEOPLES, GOLD COAST, 2020-21 TO 2022-23



Source: Queensland Health Admitted Patient Data Collection

FIGURE 12: RATE RATIO OF HOSPITALISATION RATES FOR SELECT CAUSES, FIRST NATIONS AND TOTAL GOLD COAST POPULATION, 2020-21 TO 2022-23



Source: Queensland Health Admitted Patient Data Collection

Compared to the total Gold Coast population, in 2020-21 to 2022-23 First Nations people had:

- 3.1-times the rate of hospitalisations for self-harm,
- 2.8-times the rate of hospitalisations for schizophrenia,
- 2.4-times the rate of hospitalisations for psychoactive substance use,
- 2.3-times the rate of hospitalisations for alcohol use,
- 1.9-times the rate of hospitalisations for depression, and
- 1.7-times the rate of hospitalisations for anxiety.

7.6 CONSULTATIONS

Various consultation activities were undertaken across the Gold Coast community, clinicians and service providers to inform the identification of First Nation's specific health needs and service issues. Mechanisms included broad scale community briefing, consumer journey mapping, interviews, industry presentations, and working groups.

Some of the information contained herein has been collated in preparation for previous iterations of GCPHN's Health Needs Assessment and GCH's Local Area Needs Assessment. Much of the input provided by stakeholders (such as Karulbo First Nation Partnership Council, GCPHN Community Advisory Council, and a variety of service providers and service users that participated in the planning for Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services) remains relevant for 2024 Regional Needs Assessment and is therefore summarised below.

- The limited presence of First Nation workers in the region was a key point throughout the consultation. Particular gap was identified for First Nation workers skilled in suicide prevention, and male workers for mental health and alcohol and other drugs. There is a limited pool of workers and recruitment to new positions is challenging.
- Gold Coast First Nation community are more likely to access services if they are provided by a First Nation health professional. When not available, cultural competence of mainstream service providers across all areas of healthcare is very important.
- Mainstream services lack confidence delivering culturally competent First Nation services.
- Holistic approach with First Nation workers supporting mainstream services has been identified as essential element of equitable and effective service delivery and improved outcomes for First Nation people.
- Coordination of holistic care was very important with information sharing and collaboration being seen as key elements. Barriers to coordinated care include limited knowledge of roles and responsibilities, funding and red tape, lack of culturally specific roles in available programs, transport, limited outside of work hours service, and limited access to specialists.
- Gaps in service exist in coordination of medication across Gold Coast Health and primary and secondary heath care, supporting First Nations clients in transitioning to NDIS or young people transitioning out of Department of Child Safety care.
- Service user satisfaction and engagement in care could be improved through increasing the coordination of services by using established, well-developed, and trusted pathways to support client referrals into culturally appropriate services.
- The link between racism and poor health outcomes is well established, and a high proportion of First Nation peoples experience high levels of direct and indirect racism on a daily basis.
- Many models of care, including First Nation health checks in primary care, do not include social and emotional wellbeing screenings.
- The most common issues affecting access to Indigenous specific services is related to transport, including access to brokerage funds to cover expenses such as go cards, phone credit and fuel. IUIH Moblink (transportation service) is sometimes overloaded which impacts the accessibility of services for those who rely upon the service for transportation.

- First Nations patients are increasingly presenting to mental health services with complex concerns, which require a longer and more coordinated response. Care coordination for this setting would enhance opportunity to engage in a multidisciplinary wrap-around care.
- Service users have indicated limited after-hours services at Kalwun medical services. It is particularly difficult to get consultation for a child outside of school hours.

'Lets Yarn Health Equity' Consultations

GCHHS commenced the Let's Yarn Health Equity campaign in January 2022 as part of the First Nations Health Equity Strategy co-design process. Extensive consultations were held with various groups of stakeholders through face-to-face forums, online surveys, and phone calls. Main themes identified through these consultations are summarised below; for more details, please refer to the original sources.

Consultation with 41 stakeholders - including First Nations community members, First Nations health staff and representatives from other community organisations that were either residents of the Gold Coast or worked in the Gold Coast region – revealed the following main themes:

- Community care is instrumental for First Nation people's health as it minimises the risk of receiving culturally unsafe care in a clinical setting. When community care is not an option, the presence of First Nation workers allows for 'the community to be present' through the workforce.
- As many First Nation families choose to care for their family members within the home, there is a need for improved support for carers, e.g., through training options and remuneration.
- Establishing a connection with GPs encourages improved continuity of care.
- Fragmented data sharing between the public and private sector and acute and primary care services is a barrier to continuity of care as this requires community members to repeat their concerns, which can lead to feelings of being undervalued.
- 'Deficit narrative' around health equity shifts blame onto the community rather than recognising underlying causes tied to colonisation and the effects of historical trauma. Strengths based language should be used instead, as it recognises the strengths of the community and champions community members.
- Physical health of First Nations peoples (cancer, diabetes, heart, lung and kidney disease) was recognised as an area of great concern, followed by social and emotional wellbeing (anxiety, depression and self-harm).
- Community health checks are accessed by some members of the community; however, they are less frequently accessed by younger First Nations people.
- Several barriers affect the accessibility of health care, such as: availability of GP appointments, time (wait times, lack of time of work), competing priorities (caring family/working), lack of trust in the service, culturally unsafe care, and difficulties navigating the system.

Two online forums were held with 14 First Nations staff employed by Gold Coast Health and Kalwun Development. Participants identified the following most important strategies for improving healthcare system for First Nations included:

- Accessible services without any perceived or physical barriers,
- Continuity of care including appropriate referrals and follow-up,
- Collaboration between all healthcare services,
- Workforce development – increased First Nations staff across all streams,
- Welcoming environment,
- Information in plain language,
- Access to existing supports for patients / GPs / hospital staff and clinicians,
- Systems to share data to improve patient care and evaluate service initiatives, and
- Staff education.

7.7 FIRST NATIONS SERVICE SYSTEM IN THE GOLD COAST REGION

First Nations people require access to services that are integrated, culturally appropriate, safe, and designed to holistically meet their social and emotional wellbeing needs of the community.

These needs and responses must be culturally informed, and community led, including healing initiatives to more sustainably address the ongoing effects of colonisation, dispossession, racism and forced removal policies. Services need to complement and link with other closely connected activities, such as social and emotional wellbeing services, mental health services, suicide prevention approaches, alcohol and other drug services.

Culturally appropriate health service providers facilitate more effective mental health service delivery and improved mental health outcomes for First Nations people. This requires cultural awareness, cultural respect, cultural safety, an understanding of the broader social and cultural determinants of health and wellbeing.

While many service providers identify First Nations peoples as a target group within their broader programs, only the following offer specific First Nations health services:

- Kalwun - Gold Coast Aboriginal Medical Service (Kalwun);
- Krurungal First Nations Corporation for Welfare, Resource and Housing (Krurungal);
- Aboriginal and Torres Strait Islander Health Service - GCHHS.

The Karulbo partnership brings together these three key partners to improve collaboration between services and provide a platform for community and other services to come together to collaboratively progress the health and wellbeing of the First Nations community.

Services	Number	Distribution	Information
General practices	212	Across Gold Coast region	• Health Workforce data suggests around 1% of GPs in the Gold Coast region identify as First Nations. • Some First Nations GPs do not self-identify due to professional, cultural and privacy preferences. • Almost 70% of Gold Coast general practices are registered for the Closing the Gap Practice incentive program which assists them to provide better health care to First Nations patients.
Kalwun Development Corporation, including the Kalwun Health Service	1	• 3 Aboriginal Medical Service locations (Bilinga, Miami, Coomera) • 1 community care service for frail aged or disability (Bonogin) • 1 dental and allied health (Miami) • 2 family wellbeing services (Burleigh and Coomera)	• While services target First Nation patients, most services are open to all patients. • Kalwun health clinic's provide health assessments for all First Nations people. • Kalwun also provide support and programs for Indigenous people with chronic conditions. • Kalwun's Social and Emotional Wellbeing Program, funded by GCPHN, offers comprehensive support for First Nations people struggling with their mental health or alcohol and other drugs. The program works within a social and emotional wellbeing framework and provides clinical and non-clinical treatment and a range of psychotherapeutic interventions. • Kalwun also supports mainstream general practice to deliver culturally safe care and support patients to access mainstream care they require.
Krurungal; Aboriginal & Torres Strait Islander Corporation for Welfare, Housing & Resource	1	1 located at Coolangatta Airport, Bilinga	• Krurungal are GCPHN funded for the Community Pathway Connector program. • This is a non-clinical service for First Nations people within the Gold Coast region, aimed at connecting people to appropriate health and support services.

			• This culturally safe connection point and referral service supports individuals and families who are seeking support for a variety of needs, including mental health, suicide prevention, alcohol, and other drug concerns. • Additional services provided include transport assistance, Emergency Relief program, Children and Schooling Program and Cultural Awareness Training.
Mungulli Wellness Clinic, Gold Coast HHS	1	Robina Outreach clinics also available	• A culturally safe chronic disease management program for people who identify as First Nations and have complex needs relating to respiratory, kidney disease, heart failure or diabetes. • First Nation Health Worker is the first point of contact for clients.
Aboriginal and Torres Strait Islander Health Service, Gold Coast HHS	1	Gold Coast University Hospital (Southport) and Robina Hospital	• This service is a member of the Karulbo First Nation Health Partnership and provides service navigation support to First Nations patients.
Yan-Coorara, Gold Coast HHS	1	Palm Beach	• Program aimed to support social and emotional health, advocacy and cultural support to assist the First Nations community to access services.
COACH Indigenous-specific stream, Queensland Health	State-wide	Phone service	• Free phone coaching service is available to support Indigenous people with chronic disease self-management. • Very low awareness of Indigenous specific stream of COACH and low referrals to program.
Kirrawe Indigenous Mentoring Service	1	Labrador	• Mentoring program to improve the social and emotional wellbeing of First Nation young people. • Provides individual support, advice and guidance and help in practical ways at important transition points in their life.
Institute for Urban Indigenous Health	1	Kalwun clinic at Bilinga, Miami and Oxenford	• A community Controlled Health Service that leads planning, development and delivery of health, family wellbeing and social support services for SE Queensland.

			• Kalwun is a member of IUHI.
Deadly tracks program, Strong and Deadly wellness program, Closer to country Cardiac and Renal Programs Better Cardiac Care		Gold Coast HHS	• Provides cultural support in a variety of chronic disease programs, e.g. community based cardiac care and rehabilitation, and renal dialysis via the Big Red bus. • MDT inpatient to community service to reduce mortality and morbidity from cardiac conditions by increasing access to services, better managing risk factors, and improving care coordination.
e-mental health services			• Online Services: AIMhi Stay Strong App • Public and health professional knowledge of these services would drive uptake/demand.
Waijungbah Jarjums	1	Gold Coast HHS	• Provides culturally safe care tailored for Aboriginal and Torres Strait Islander mothers and families throughout pregnancy, birth and as their child develops, grows (first 2000 days). • Cultural connection and wellbeing are central to the ethos of care.

Chapter 8:
POPULATIONS EXPERIENCING INEQUITY

KEY FACTS:

- People experiencing homelessness suffer from significantly higher rates of mental health issues and substance use than the general population.
- Overseas-born residents of the Gold Coast have a higher prevalence of long-term health conditions, including diabetes and heart disease.
- Despite 1.6% of the Gold Coast population not speaking English well or at all, interpreter services remain underutilised in primary care and paramedicine, with a heavy reliance on bilingual staff and family members.
- Family, domestic, and sexual violence are significant public health and welfare issues that disproportionately impact vulnerable populations.

PRIORITISED NEEDS:

1) Higher rates of mental ill health and mental health related ED presentations among people experiencing homelessness.
2) Limited resources, variable capability and unclear pathways for primary healthcare practitioners and paramedics to recognise and support patients experiencing family and domestic violence.
3) Cost, transport and stigma limit the ability of people experiencing homelessness to access health care, including health checks, preventative and follow up care.
4) Large and growing Māori and Pasifika community with higher reported health needs and challenges accessing healthcare.
5) Out-of-pocket costs and safety concerns limit access to health services for people experiencing family and domestic violence.
6) Gaps in cultural capability across service providers and clinicians, particularly relating to sensitive issues such as mental health, AOD and FDV.
7) People from multicultural backgrounds have higher reported prevalence of diabetes, arthritis, and heart disease.
8) Limited effective use of translation services in primary care and ambulance response services.
9) Migrants are often unfamiliar with the Australian health system and have lower health literacy.

8.1 BACKGROUND

Health inequity continues to be a significant issue in Australia, including the Gold Coast region, and is especially pronounced among diverse communities who face considerable barriers to achieving equitable health outcomes. Addressing these disparities is essential to ensuring fair and inclusive health outcomes for all.

Inequitable health outcomes are experienced by a range of population groups; however, this chapter will only focus on a selection of communities. These diverse communities encompass individuals experiencing homelessness, multicultural groups (including Pasifika communities and refugees), people with a disability, victims of family and domestic violence, and members of the LGBTIQA+ community.

First Nations health equity is not included herein and is instead discussed in the First Nations chapter.

8.2 HOMELESSNESS

Individuals experiencing homelessness suffer from higher rates of mental health disorders, substance use, and chronic disease, as well as a multitude of barriers to accessing healthcare.

There is an emerging group of people experiencing homelessness or near homelessness due to increasing financial stress and pressure on housing affordability and availability. This shift has led to a new cohort of individuals who have previously not accessed social services for housing support, which includes a growing number of families, younger people, and people with low incomes who are sleeping in cars, couch/spare room ‘surfing’, or residing in overcrowded dwellings.

8.2.1 Definition

There is no single definition of homelessness. The Australian Bureau Statistics (ABS) defines homelessness as when a person does not have suitable accommodation, or if their current living arrangement:

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

Although the experience of homelessness can take many forms, including rough sleeping, couch surfing, and other unstable housing situations (including those at risk of homelessness), this chapter will used the term *people experiencing homelessness* to encompass these diverse situations, unless otherwise specified.

8.2.2 Prevalence

Estimates of the number and demographic characteristics of people experiencing homelessness vary significantly, due to insufficient data collection, fluctuations in cohort size and the psychosocial, financial and health factors that can co-occur with people experiencing homelessness.

On the night of the 2021 Census, 1,828 people in the Gold Coast PHN region were estimated to be experiencing homelessness[47]. This marks an increase by 113 individuals or 6.6% since the 2016 Census.

This number is likely an underestimate, as it does not include those not accounted for on Census night (hidden homelessness) or those who became homeless since the Census was conducted.

TABLE 1: NUMBER OF PEOPLE EXPERIENCING HOMELESSNESS, GOLD COAST AND QUEENSLAND, 2021

Living circumstances	Gold Coast	Queensland
People living in improvised dwellings, tents, or sleeping out	181	2,051
People in supported accommodation for the homeless	279	4,125
People staying temporarily with other households	496	4,981
People living in boarding houses	319	2,972
People in other temporary lodgings	71	488
People living in 'severely' crowded dwellings	476	7,839
All homeless persons	1,828	22,444
Rate per 10,000 population	28.4	43.2

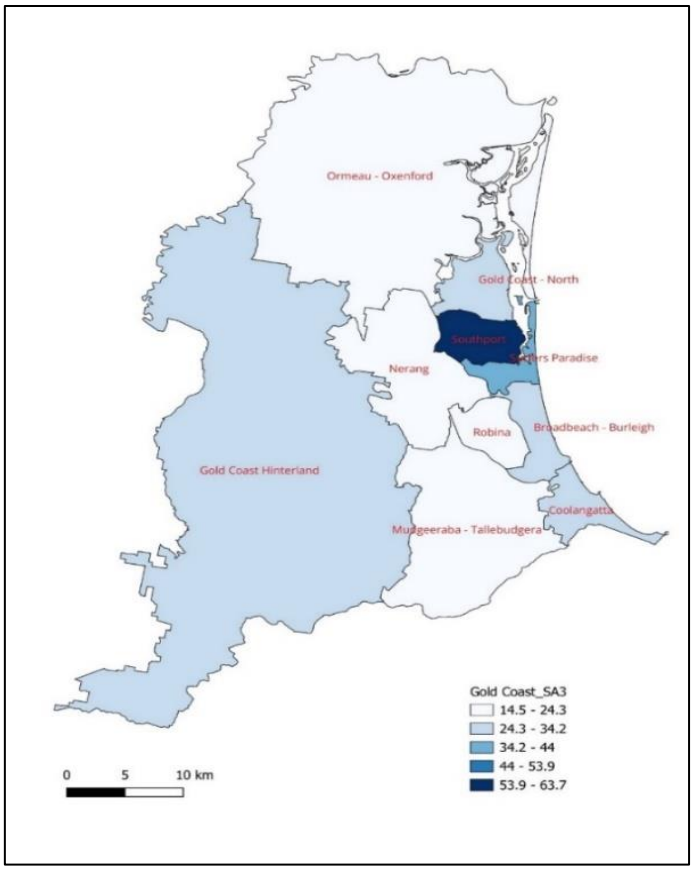
Source: Estimating homelessness: Census, 2021. The homelessness estimates reflect the unique accommodation circumstances of those experiencing homelessness at the time of the Census during COVID-19. The high proportion of people living in 'severely' crowded dwellings (26.0%) may be partly associated with measures put in place by local and state governments in response to COVID-19.

Rates of homelessness vary regionally in the Gold Coast region:

- The highest rate of homelessness is seen in Southport SA3.
- Ormeau-Oxenford SA3 had a lower rate of homelessness (18.5 per 10,000 persons), compared to other areas, however, due to the larger population it ranks second in terms of the total number of individuals experiencing homelessness among Gold Coast SA3 regions (n=290).

[47] Australian Bureau of Statistics 2021, Estimating Homelessness: Census.

FIGURE 1: RATE OF HOMELESSNESS BY GOLD COAST SA3 REGIONS, 2021



Source: Estimating homelessness: Census, 2021

Age

Local data for the Gold Coast region from the 2021 Census is unavailable. National data reveals that out of the highest rates of homelessness in 2021 were observed in the 19–24-year age group (91 people per 10,000) and 25-34 years (70 people 10,000). There were 48 per 10,000 children under the age of 12 years old experiencing homelessness.

TABLE 2: AGE-SPECIFIC RATE OF HOMELESSNESS, AUSTRALIA, 2016 AND 2021

	Rate per 10,000	
Age group	2016	2021
Under 12	45	48
12–18	51	53
19–24	95	91
25–34	72	70
35–44	50	49
45–54	46	45
55–64	39	36
65–74	27	25
75 and over	14	12

Source: Census of Population and Housing 2016, 2021.

First Nations

Local data is not available for the Gold Coast region from the 2021 Census, however, national data from 2021 reveals that an estimated 24,930 First Nations people in Australia were experiencing homelessness, marking a 6.4% increase from 23,437 in 2016.

Among the First Nations people experiencing homelessness during the 2021 Census:

- 60.0% were residing in 'severely' crowded dwellings.
- 19.1% were in supported accommodation for the homeless.
- 9.3% were living in improvised dwellings, tents, or sleeping outdoors.

Specialist Homelessness Services activity

Specialist Homelessness Services (SHS) receive government funding to provide assistance to people experiencing homelessness. The services are aimed at prevention, early intervention, crisis and post-crisis assistance, and include accommodation-related and personal services.

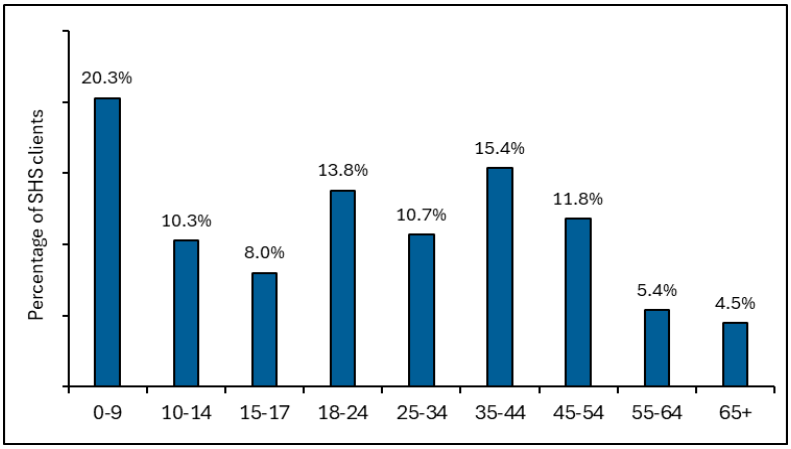
In 2022-23, 2,865 clients were assisted in the Gold Coast region (43.2 per 10,000 population). This number is higher than the number of people identified as experiencing homelessness in the 2021 Census (n=1,037). This may be due to different definitions of homelessness and including people who were at risk of homelessness.

Of the 2,865 clients assisted in the Gold Coast region:

- 1,610 (56.2%) were women,
- 50.6% (n=1,430) were currently homeless, and
- 49.4% (n=1,394) were at risk of homelessness.

Figure 2 shows that 38.6% (n=1,106) of SHS clients were under the age of 18, while individuals aged 35 to 44 were the second highest contact group, accounting for 15.4% (n=441) of clients.

FIGURE 2: SPECIALIST HOMELESSNESS SERVICES CLIENTS BY AGE GROUP, GOLD COAST, 2022-23



Source: Specialist homelessness services annual report 2022-23, Australian Institute of Health and Welfare

8.2.3 Housing vacancy rates

The Gold Coast rental market is currently experiencing a significant shortage, as indicated by its vacancy rates standing at 0.9% as of March 2024, below the national average of 1.1%[48].

Declining vacancy increases competition for rental properties and applies pressure to rental prices. Consequently, rents are on the rise, with the median total personal income in the Gold Coast region at $785 per week, while the weekly median rent for a one-bedroom flat or unit is $520 per week. This figure is $80 higher than the Queensland median weekly rent for a comparable one-bedroom unit, which stands at $440[49].

8.2.4 Health needs of people experiencing homelessness

Self-assessed health status

People experiencing homelessness represent some of Australia's most socially and economically disadvantaged populations.

In 2022–23, 27% (n=31,600) SHS clients in Australia identified health-related reasons for seeking support, specifically:

- 23,700 clients identified mental health needs.
- 11,400 clients identified medical issues.
- 8,300 clients identified problematic drug or substance use.
- 3,900 clients identified problematic alcohol use.

Mortality

Mortality for people experiencing homelessness in the Gold Coast region is not currently reported, however, small studies of other major cities in Australia may provide some indication. Deaths among people experiencing homelessness in Australia remain largely 'invisible', as housing characteristics do not appear in routinely reported national mortality data sets.

Since 2017, the University of Western Australia's Home2Health team have been documenting deaths among the Perth homeless population that have been recorded by health services. During 2020, there were 56 known deaths among people experiencing homelessness in Perth. This is equivalent to 1.1 deaths every week in the Perth homeless population alone. Among these individuals, the average age at death was 47.9 years[50].

Mental health

Mental health disorders are more prevalent among those experiencing homelessness than the general population. Clients with a current mental health issue were the second largest SHS client group in 2022-23, making up 31% (85,300) of all SHS clients. Since data collection began in July 2011, the number of SHS clients with a current mental health disorder has increased faster than most other client groups, accounting for 19% of all SHS clients in 2011-12 to 31% in 2022-23[51].

[48] SQM Research March 2024.
[49] Residential Tenancies Authority, Rental Bonds data (Queensland Government Statistician's Office derived).
[50] Wood, L. and Vallesi, S., 2021. Deaths among people experiencing homelessness: each one, a life. *Parity, 34*(7), pp.31-34.
[51] Australian Institute of Health and Welfare 2024, *Specialist Homelessness Services Collection data cubes 2011–12 to 2022–23*.

Nationally, in 2020–2022, 39% of people aged 16–85 with a history of homelessness experienced a mental health condition within the past year, almost twice as high as the general Australian population (21%)[52]. While the environmental stressors of homelessness can contribute to mental health issues, mental health issues can also contribute to the risk of experiencing homelessness[53]. Local consultation with services providers identified mental ill health is often present among the homeless.

Cancer screening

Local data isn't available relating to cancer screening rates or the incidence of people experiencing homelessness. It's been observed in homeless populations in other high-income countries that cancer-related deaths among adults experiencing homelessness can be twice the rate of those who are not homeless [54]. Disparities in cancer screening rates persist among individuals facing homelessness, with lower rates identified compared to those who are not homeless[55]. Various obstacles contribute to the reduced rates of cancer screening within this demographic, including:

- Limited access to services due to financial constraints and a lack of transportation.
- Prioritisation of immediate needs: Homeless individuals often prioritise immediate necessities such as food, shelter, and safety over preventive healthcare measures.

Vaccination

International studies show that individuals facing homelessness encounter elevated rates of vaccine-preventable diseases[56]. People experiencing homelessness who are diagnosed with COVID-19 have more than 20-times higher hospitalisation risk, more than 10-times higher need for intensive care, and a mortality risk exceeding five times compared to the general population[57].

Although data on vaccination rates among the homeless in the Gold Coast region is limited, consultation indicates lower vaccination rates in this group compared to the general population.

However, administering vaccines to homeless individuals poses distinct challenges, including:

- Limited access to services: such as financial constraints and a lack of transportation.
- Preventable diseases: homeless individuals often lack accurate information on vaccinations.
- Healthcare access: reluctance to trust to healthcare professionals, and unwillingness to actively seek out clinics are additional barriers.

[52] Australian Bureau of Statistics 2020-2022, *National Study of Mental Health and Wellbeing*.
[53] Moschion, J. and van Ours, J.C., 2021. Do transitions in and out of homelessness relate to mental health episodes? A longitudinal analysis in an extremely disadvantaged population. *Social Science & Medicine, 279*, p.113667.
[54] Asgary, R., 2018. Cancer screening in the homeless population. *The Lancet Oncology, 19*(7), pp. e344-e350.
[55] Drescher, N.R. and Oladeru, O.T., 2023. Cancer screening, treatment, and outcomes in persons experiencing homelessness: shifting the lens to an understudied population. *JCO Oncology Practice, 19*(3), pp.103-105.
[56] Peak, C.M., Stous, S.S., Healy, J.M., Hofmeister, M.G., Lin, Y., Ramachandran, S., Foster, M.A., Kao, A. and McDonald, E.C., 2020. Homelessness and hepatitis A—san diego county, 2016–2018. *Clinical infectious diseases, 71(*1), pp.14-21.
[57] Richard, L., Booth, R., Rayner, J., et al. 2021. Testing, infection and complication rates of COVID-19 among people with a recent history of homelessness in Ontario, Canada: a retrospective cohort study. *Canadian Medical Association Open Access Journal, 9*(1), pp. E1-E9.

Alcohol, tobacco, and other drugs

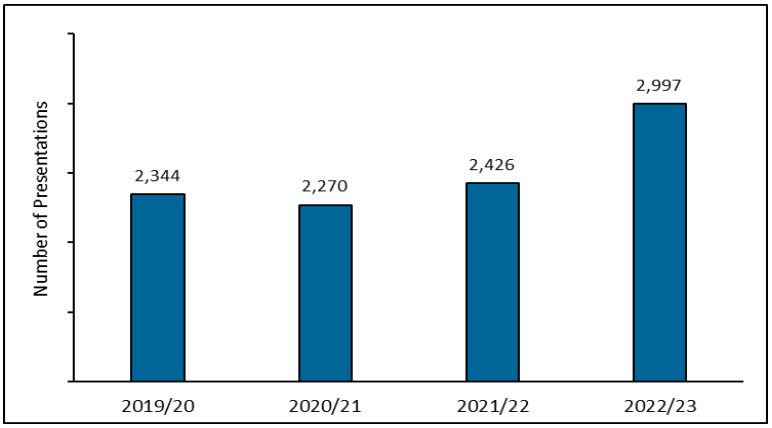
The Journeys Home project (a longitudinal survey of Australians) found that people who had experienced housing instability or homelessness reported high rates of risky use of substance use in the previous 6-12 months, such as alcohol (57%), illicit drug use (39%) and injection of drugs (14%)[58].

The annual Illicit Drug Reporting System survey of people across Australia who regularly inject illicit drugs found that of the 820 participants surveyed, over one-quarter (27%) reported as being homeless.

Emergency Department Presentations

The number of presentations to public Emergency Departments (ED) at Gold Coast University Hospital and Robina Hospital where the patient has no fixed address has increased by 33.6% from 2,023 in 2019-20 to 2,702 in 2022-23[59]. An increase in the average number of ED visits per patient, per year, has also been noted in this cohort, from 3.4 in 2019-20 to 3.9 in 2022-23.

FIGURE 3: ED PRESENTATIONS BY PERSONS WITH NO FIXED ADDRESS, GOLD COAST, 2019-20 TO 2022-23



Source: GCHHS – FirstNet; ED presentations

- In 2022-23, people aged 30-44 without a fixed address had the highest frequency of ED presentations, with those aged 45-59 showing considerable increase in recent years.
- The leading reasons for ED presentation for individuals with no fixed address in 2022-23 were suicidal ideation (7.4% of total presentation) and mental and behavioural disorders due to use of alcohol or acute intoxication (5.5% of all presentations).

8.2.5 Consultation

Due to limited localised homelessness data, qualitative data was sourced via extensive consultation with the Gold Coast Homelessness Network and a range of support providers to gain an insight into the health needs of this vulnerable community.

[58] Sutherland, R., Uporova, J., King, C., Chandrasena, U., Karlsson, A., Jones, F., Gibbs, D., Price, O., Dietze, P., Lenton, S. and Salom, C., 2023. *Australian drug trends 2023: key findings from the National Illicit Drug Reporting System (IDRS) interviews.*
[59] Queensland Health 2023, *Emergency Department Collection*.

Gold Coast Health Homelessness Network (2023):

- Rough sleeping isn't just in Southport anymore.
- Service providers are seeing more older people becoming homeless, forced out of homes they've been in for more than 20 years due to rent rises or the owner selling, and they can't find anywhere affordable to go.
- Stakeholders report growth in homelessness, overcrowded housing and at-risk populations due to financial stress, low housing affordability and availability.
- GPs in Mermaid and Surfers Paradise have reported increase of patients who are either experiencing or at risk of homelessness and unsure what services to refer to.

Gold Coast Homeless Symposium (March 2024):

- Single (including widowed or divorced) women aged 55 or more are now considered the most vulnerable population in relation to homelessness.
- Homelessness and rising cost of living are the largest contributors to situational stress.
- People are spending up to 110% (using savings) of income on their weekly rent.
- Noted barriers to healthcare include affordability, identification (no Medicare card/ID), stigma and difficulties accessing transport.

Gold Coast Mental Health Symposium (April 2024):

- *Lack of resources*: A lack of resources was highlighted several times and included: temporary accommodation, housing, emergency housing, specialised support, mental health support, drug and alcohol support and homeless services with beds.
- *Accessibility:* Issues relating to the accessibility of resources include accessibility of housing, hygiene facilities (washing, clean clothes), as well as medical care as financial barriers may impact the individual's ability to purchase medications.
- *Vulnerable populations:* Several vulnerable populations at risk of poor mental health were identified in responses, including women over 50, LGBTIQ and young people. It was noted that the issue of homelessness necessitates services catered to young people who are in a time of transition and may be escaping dysfunctional family environments.
- *Mental health:* There was an identified need for flexible mental health appointments and outreach services. Additionally, the criteria for some mental health services may exclude individuals experiencing homelessness.

St Johns Crisis Centre (March 2024):

- While most clients have Medicare cards, clients from New Zealand may not necessarily hold Medicare or Centrelink cards although may be eligible to have these cards.
- Most clients have a usual GP, although not all clients are homeless who access services. Rather they may be facing financial challenges and seeking assistance.
- Initial cost to see a GP and stigma when presenting to a general practice or Hospital acts as a significant barrier for many clients.
- Several clients have reported experiencing differential treatment, often associated with negative stigma, when visiting general practices or Hospitals.

- Common health issues among clients include mental health, addiction to substances such as alcohol and drugs, as well as wounds and minor injuries.
- Initially, clients are attended to by the nurse at the centre, who then refers them to the appropriate agency.
- The nurse has established a close relationship with a nearby GP, whom clients are frequently referred to.
- Additionally, the centre has developed a partnership with a local pharmacy.
- GCHHS Mental Health outreach teams visit the centre one or two times weekly during lunch breaks.
- The Mental Health Outreach Team doesn't directly approach clients but instead clients are encouraged to approach them.
- However, very few clients do approach the Mental Health Outreach Team, as many of those in need are hesitant to seek help in a peer-filled environment.
- Various organisations visit the centre to administer vaccinations, with ongoing discussions aimed at providing flu shots, among others. Efforts are underway to establish specific times for these organisations to ensure maximum client awareness.
- There is a pressing need for support tailored to women over 55 years old.
- This demographic often presents with a high prevalence of chronic diseases and may be experiencing menopause.
- Health deterioration occurs rapidly upon clients experiencing homelessness, often compounded by relationship breakdowns, lack of superannuation, and limited employable skills.
- Employment opportunities are scarce for older women in general, exacerbating the challenges faced by this specific cohort.

Uniting Care (March 2024):

- While most clients hold Medicare cards, accessibility to primary care remains a significant challenge due to cost, compounded by a decrease in the number of bulk billing GP services, which serves as a major barrier.
- Uniting Care collaborates with the City of Gold Coast to mitigate move-on orders for rough sleepers, which sometimes result in the loss of personal belongings, including Medicare cards.
- Prevention measures are often overlooked by clients in primary care settings, leading them to seek ED services instead.
- The largest demographic of clients includes single individuals, although there's a growing number of families, likely attributed to financial constraints, lost rentals etc.
- The Ormeau-Oxenford region has seen an increase in makeshift shelters and groups of families, with early morning outreach efforts targeting clients sleeping in cars and tents. Feedback suggests clients feel safer in this area and less exposed.
- A notable rise in homelessness is observed among older women (55+), often stemming from relationship breakdowns and housing loss.

- Likewise, there's a surge in homelessness among young people, particularly those transitioning out of home care.
- Challenges arise when patients are admitted and discharged from the ED or crisis stabilisation units without proper handover to case managers.
- Some rough sleepers suffer from chronic conditions, posing difficulties in managing these conditions in primary care and often resulting in ED visits or hospitalisations if left untreated.
- Alcohol and drug use contribute to numerous physical illnesses, with intravenous drug use increasing the risk of infection and cellulitis.
- Clients frequently access Primary Care Community Services' (PCCS) after-hours safe spaces in Mermaid and Southport, with nightly visits from Uniting Care's after-hours outreach team to locate and engage with homeless clients.

GCPHN Community Advisory Council (April 2024):

What are major health issues that are NOT currently being addressed in the Gold Coast region?

- Access – including the ability to make an appointment, transport to get to appointment, cost of appointment and stigma associated once they arrive at appointment.
- Limited drug and alcohol rehabilitation services plus limited housing while in rehabilitation.
- Outreach medical services should be available with organisations already providing services to homeless people.

Are there any access issues for health services or regions in the Gold Coast region that lack health services?

- Access – would be better if medical care was available with other homeless services such as food, laundry etc.
- "No one tells you what services you need when you are homeless" – you are expected to just know what's available and what you are eligible for.

GCPHN Clinical Council (May 2024):

What are major health issues that are NOT currently being addressed in the Gold Coast region?

- Chronic disease management: challenges in maintaining appropriate diet; and cost of medications can be expensive and impacts the follow up care after an acute episode.
- Continuity of care - contacting and scheduling patient appointments without phone or internet access.

Are there any access issues for health services or regions in the Gold Coast region that lack health services?

- Cost of transport, service and medications.
- Unaware of available services and how to access them.
- Digital access to book appointments and access telehealth.

Consultation summary: people experiencing homelessness

Rising homelessness across diverse groups

- Homelessness is expanding beyond historically prevalent areas (e.g., beyond Southport) and affecting more populations, e.g. older people forced out due to rising rents or property sales.
- Increased homelessness among older single women (55+), young people, families, and those facing relationship breakdowns, financial pressures, or transitioning from care.
- Significant barriers to accessing healthcare, including high costs, limited bulk-billing, lack of ID (Medicare), transportation issues, and stigma at healthcare facilities.
- Accessibility issues also impact medication affordability, follow-up care, and resources like mental health and drug rehabilitation services.
- Limited outreach services and gaps in the continuity of care.
- Mental Health and Substance Use Challenges
- High demand for mental health resources and flexible, stigma-free outreach services.
- Substance use is common among homeless individuals, often exacerbating health conditions and increasing reliance on emergency care.
- Barriers in service eligibility exclude some homeless individuals from mental health care.

Financial stress and cost of living

- Rising costs of living force many to spend more than they earn on rent, sometimes relying on savings to cover basic needs, pushing more people towards homelessness.
- Financial stress is contributing to overcrowded housing and situational stress, especially as people struggle to afford daily expenses, housing, and healthcare.
- Community and Support Services Coordination
- Homeless individuals are often unaware of available services and eligibility, creating a need for better information sharing and coordinated support.
- Local collaborations (e.g., St Johns Crisis Centre with GPs and pharmacies) provide critical support, but more partnerships with primary care and outreach are needed to close gaps.
- Calls for co-located services (e.g., healthcare with food, hygiene, and shelter services) to improve accessibility and reduce logistical barriers.

Vulnerable Populations and Tailored Support

- Older women and young people are at higher risk, often due to issues like chronic disease, lack of superannuation, and limited employability.
- Tailored health services for women over 55 and youth facing transitional challenges are necessary to address unique vulnerabilities.

Continuity and accessibility of care

- Limited access to chronic disease management, continuity of care post-ED, and access to necessary follow-up care due to logistical, digital, and financial constraints.

- Difficulty in maintaining appropriate care (e.g., diet, medication) due to financial and accessibility barriers.

Healthcare access and utilisation

- Difficulty accessing GPs and telehealth services.
- Financial barriers to accessing and following up on healthcare.
- Predominantly physical health issues.
- Significant mental health concerns due to the stress of homelessness.
- Healthcare is a lower priority compared to housing, food, and funding needs.
- Healthcare accessibility and quality are inconsistent, often depending on the practitioner.
- Additional barriers include stigma and limited transport options.
- Healthcare Experiences and Attitudes
- Mixed experiences with healthcare services, with some positive feedback about health providers' professionalism and interventions.
- Low engagement with regular primary care services.
- Recognition of the need for mental healthcare but limited proactive support.
- High reliance on emergency health departments and hospital services.

8.3 MULTICULTURAL COMMUNITIES

Australia is a multicultural society with increasing cultural, linguistic, and religious diversity of its population. A suite of cultural diversity questions collected by the ABS through Census capture the increasing complexity and growing ethnic diversity in Australia, including ancestry, country of birth, English proficiency, language spoken and religious affiliation[60].

Multicultural communities, including Pasifika populations and refugees, face obstacles such as language barriers, limited health literacy, and a lack of culturally responsive services, all of which exacerbate health disparities.

8.3.1 Definition

Different terms are used to describe multicultural communities in Australia. One of the more common ones is Culturally and Linguistically Diverse (CALD) populations. AIHW defines CALD population as "people living in Australia who were born overseas, or people living in Australia who have parent(s) or grandparent(s) born overseas and are predominately from non-English speaking or non-Western countries"[61].

[60]Australian Bureau of Statistics 2022, *Cultural diversity of Australia*.
[61] Australian Institute of Health and Welfare (AIHW), 2018. Australia's health 2018. *Australia's health series no. 16*. AUS 221. Canberra: AIHW.

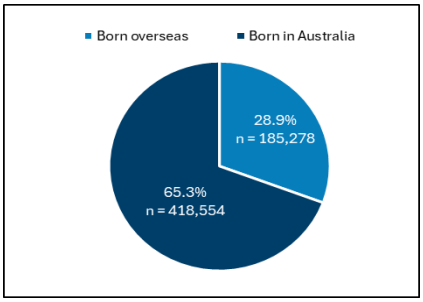
Refugees are defined as a subset of CALD populations and include people who have fled their country to escape persecution based, for example, on their race, nationality, religion[62].

The PHN Multicultural Framework[63], released in February 2024, notes that the term 'multicultural' is generally preferred by communities, and will therefore also be used in this document. It needs to be noted, however, that the PHN Multicultural Framework includes the First Nations populations of Australia, whereas in this document, First Nation people's distinct health needs and service issues are described in a separate chapter.

8.3.2 Country of birth

The Gold Coast region has a very culturally diverse population with almost one third of residents born overseas and almost half of the population with at least one parent born overseas.

FIGURE 4: GOLD COAST RESIDENTS BORN IN AUSTRALIA AND OVERSEAS, 2021



Source: ABS, Census of Population and Housing, 2021.

TABLE 3: BY RESIDENTS COUNTRY OF BIRTH, GOLD COAST SA3 REGIONS, 2021

Region	Born in Australia		Born Overseas					
			English speaking countries		Non-English speaking countries*		Total***	
	Number	%	Number	%	Number	%	Number	%
Queensland	3,679,899	71.4%	518,523	10.1%	651,810	12.6%	1,170,333	22.7%
Gold Coast SA4	418,554	65.3%	96,634	15.1%	88,644	13.8%	185,278	28.9%
Broadbeach-Burleigh	44,825	67.5%	8,840	13.3%	8,508	12.8%	17,348	26.1%
Coolangatta	43,962	76.4%	6,402	11.1%	4,115	7.2%	10,517	18.3%
Gold Coast-North	42,463	61.2%	11,267	16.2%	11,373	16.4%	22,640	32.6%
Gold Coast Hinterland	14,502	72.1%	2,999	14.9%	1,395	6.9%	4,394	21.8%
Mudgeeraba-Tallebudgera	25,854	71.8%	5,541	15.4%	3,195	8.9%	8,736	24.2%
Nerang	47,971	68.8%	10,762	15.4%	7,932	11.4%	18,694	26.8%
Ormeau-Oxenford	104,635	66.2%	28,185	17.8%	17,311	11.0%	45,496	28.8%
Robina	33,449	62.1%	8,282	15.4%	9,797	18.2%	18,079	33.5%
Southport	37,082	57.5%	8,431	13.1%	14,206	22.0%	22,637	35.1%
Surfers Paradise	23,882	52.7%	5,912	13.1%	10,782	23.8%	16,694	36.9%

Source: ABS, Census of Population and Housing, 2021, General Community Profile - G01 and G09c. *NESB: Includes countries not identified individually, Inadequately described' and 'At sea' responses. ** Includes not stated responses.

[62] The UN Refugee Agency 2024, *What is a Refugee?*.
[63] Brisbane South Primary Health Network 2024, *PHN Multicultural Health Framework*.

- In 2021, the percentage of Gold Coast population born overseas (28.9%) was significantly higher than the Queensland total (22.7%).
- Ormeau-Oxenford, as the most populated SA3 region, had the most persons born overseas.
- The Gold Coast SA3s regions with the largest proportion of residents born overseas were Surfers Paradise (36.9%), followed by Southport (35.1%), Robina (33.5%) and Gold Coast North (32.6%). Only two SA3 regions, Coolangatta (18.3%) and Gold Coast Hinterland (21.8%), had a higher percentage of residents born overseas than the state average (22.7%).

8.3.3 Multicultural communities' health status

Multicultural communities may experience disadvantages on several social and cultural determinants of health, such as language barriers, lower socio-economic status, lower education, and lower levels of health literacy. They may also experience difficulties navigating the Australian health care system, all of which may contribute to poorer health and mental health outcomes[64]. People with lower levels of English proficiency have worse health outcomes than those who speak English well[64].

In the early years following migration, some migrants report better health outcomes than the Australian-born population; this is known as the *healthy migrant effect*[65]. This can be explained by health screening and eligibility criteria required prior to entry into Australia, however, it can differ among groups of migrants depending on the eligibility requirements for different visas[65].

It is also important to note that the healthy migrant effect can disappear over time. According to AIHW, the prevalence of one or more long-term health conditions was 15% higher for people who arrived in Australia within the 5 years prior to the 2021 census, this number increased to 30% for those who arrived more than 15 years prior to the census. Notably, mental health conditions were 4-times as high in those who had lived in Australia for more than 15 years when compared to those who had arrived within the last 5 years.

Another study found that immigrant groups from non-English speaking countries who have been in Australia for more than ten years, self-asses their physical and mental health as worse than Australian born individuals[66].

Long-term health conditions

According to AIHW, the national prevalence of dementia, heart disease, stroke, diabetes, and kidney disease are higher in some over-seas born populations, compared to those born in Australia. This is particularly true for people born in countries from regions such as Polynesia, South Asia and the Middle East[67].

The Gold Coast region reflects similar health disparities in long-term health conditions between the population born overseas and the Australian born population (Table 4).

[64] Australian Institute of Health and Welfare 2023, *Culturally and linguistically divers Australians*.
[65] Australian Institute of Health and Welfare 2022, *Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper*.
[66] Jatrana, S., Richardson, K. and Pasupuleti, S.S.R., 2018. Investigating the dynamics of migration and health in Australia: a longitudinal study. *European Journal of Population, 34*(4), pp.519-565.
[67] Australian Institute of Health and Welfare 2023, *Chronic health conditions among culturally and linguistically diverse Australians*.

It should be noted that the following data includes people born overseas in English-speaking countries, and the presence of specific conditions is based on self-assessment rather than confirmed medical diagnosis.

TABLE 4: CHRONIC CONDITIONS AMONG AUSTRALIA-BORN RESIDENTS AND THOSE BORN OVERSEAS, GOLD COAST, 2021

Region	Diabetes		Heart disease		Arthritis		Mental Health	
	Born Overseas	Born in Australia	Born Overseas	Born in Australia	Born Overseas	Born in Australia	Born Overseas	Born in Australia
Gold Coast	4.8%	3.3%	4.5%	3.7%	9.2%	8.5%	6.2%	10.0%
Broadbeach-Burleigh	4.0%	2.6%	4.4%	3.7%	8.9%	7.9%	5.4%	8.2%
Coolangatta	3.9%	3.1%	4.6%	4.1%	9.9%	9.1%	6.7%	9.0%
Gold Coast-North	6.1%	4.6%	5.9%	5.5%	12.4%	12.4%	7.3%	11.4%
Gold Coast Hinterland	4.6%	3.1%	5.9%	4.0%	12.1%	9.6%	8.1%	9.4%
Mudgeeraba-Tallebudgera	4.1%	2.6%	4.4%	2.8%	9.0%	7.0%	6.2%	8.2%
Nerang	5.6%	3.4%	5.0%	3.5%	10.7%	8.3%	6.7%	10.3%
Ormeau-Oxenford	4.9%	3.1%	3.9%	2.8%	8.3%	6.9%	6.4%	10.5%
Robina	4.6%	3.1%	4.4%	3.4%	8.3%	7.8%	5.9%	9.9%
Southport	5.0%	3.8%	4.2%	4.2%	8.2%	9.5%	6.3%	12.1%
Surfers Paradise	3.8%	3.3%	3.8%	4.4%	7.2%	9.7%	4.5%	9.1%

Source: ABS, Census of Population and Housing, 2021, General Community Profile.

- Compared to Australian-born, Gold Coast residents born overseas had a higher prevalence of diabetes (4.8% vs 3.3%), heart disease (4.5% vs 3.7%), and arthritis (9.2% vs 8.5%).
- Distribution of above conditions across SA3 region shows particularly high prevalences of among overseas-born population in Gold Coast-North, Gold Coast Hinterland and Nerang.
- In contrast, the prevalence of self-reported mental health conditions was lower among overseas-born population than Australian-born residents (6.2% vs 10.0%). Gold Coast Hinterland (8.1%) has the highest proportion of overseas born residents with a mental health condition.

It needs to be acknowledged that there are major gaps in data and information surrounding the mental health status of multicultural communities due to many services not having systems that are equipped to collect data on cultural backgrounds and language proficiency. This can lead to an under-representation of mental health issues faced by multicultural communities in the Gold Coast region.

8.3.4 Māori and Pasifika communities

Māori and Pasifika populations in Australia have increased in recent years, with growth continuing in both absolute terms and in proportion to the total population. Despite this, it is difficult to determine accurate figures on the numbers of people with Māori and/or Pasifika heritage,

underreporting is likely as many people are documented as New Zealand citizens[68]. As of 2021, 13,843 people in the Gold Coast region reported Māori ancestry, 2,895 people reported Samoan ancestry whilst 932 reported a Tongan ancestry*[69].

Māori and Pasifika community health status

Although there is little data available concerning the health of Pasifika communities, literature suggests that health inequities may be apparent due to difficulties surrounding healthcare access. Residency and citizenship requirements potentially limit engagement with preventative primary health services[23].

Consultations

Gold Coast region is home to the largest New Zealand born population in Queensland, many of whom identify as Māori. As the first people of New Zealand/Aotearoa, many Māori people experience similar inequities as First Nations people in Australia due to colonisation, dispossession, and racism. However, following migration to the Gold Coast there are no mechanisms to record Māori cultural identity in hospital data sets, which makes this population invisible for the purposes of planning and service design.

Qualitative findings from the 2022 GCHHS Local Area Health Needs Assessment highlight healthcare accessibility challenges among Māori and Pasifika communities in the Gold Coast region. Community members identified visa and citizenship status as barriers to accessing healthcare, along with cultural barriers.

Ongoing engagement with these communities will aid in developing culturally informed services, navigation pathways within the healthcare system, and digitally supported access to care until improved datasets provide a clearer picture of the overall needs.

8.3.5 Refugees and humanitarian entrants

Australia's Refugee and Humanitarian Program helps people in humanitarian need who are:

- outside Australia (offshore) and need to resettle to Australia when they do not have any other durable solution available or
- already in Australia (onshore) and who want to seek protection after arriving in Australia.

In 2018-19, 3,037 people arrived in Queensland as part of the Australian Humanitarian Settlement program, representing 18% of Australia's humanitarian intake[70]. During the 2020-21 period there were fewer arrivals due to the pandemic and restrictions. However, the program has since resumed and an increased intake of people from refugee backgrounds in Queensland is anticipated over the next four years[71].

*This variable indicates how a person identifies their ancestry. Respondents were able to provide up to two responses. These responses were combined and output into Ancestry multi response (ANCP).

[68] Durham, J., Fa'avale, N., Fa'avale, A., Ziesman, C., Malama, E., Tafa, S., Taito, T., Etuale, J., Yaranamua, M., Utai, U. and Schubert, L., 2019. The impact and importance of place on health for young people of Pasifika descent in Queensland, Australia: a qualitative study towards developing meaningful health equity indicators. *International Journal for Equity in Health, 18*, pp.1-16.

[69] Australian Bureau of Statistics 2021, *Microdata and TableBuilder: Census of Population and Housing*.

[70] Queensland Health 2023, *The health of Queenslanders 2020*.

[71] Queensland Health 2022, *Refugee Health and Wellbeing Policy and Action Plan 2022-2027*.

Humanitarian settlement of refugees is happening in the Gold Coast region, though numbers are quite low, and limited data is available.

Refugee health status

Refugees are faced with a complex interplay of social issues which may contribute to a lack of accessible health services, potentially resulting in health inequities.

The social determinants of mental health in refugee populations include safe environments with adequate housing and food, income, access to health care and healthy social policies. However, exposure to trauma, social exclusion and psychological stress related to migration further confound the risk factors of poor physical and mental health[72].

In addition, legal and socio-economic barriers, language barriers and a lack of migrant sensitive care have been noted to impact the accessibility of health services[73]. Even when health services are available, social stigma persists as a barrier to receiving treatment, particularly in the mental health field[74].

Data pertaining to the health of refugees in Australia is limited. AIHW report found that as of 2021, refugees in Australia reported higher rates of certain long-term health conditions, including diabetes, kidney disease, stroke, heart disease and dementia. The prevalence of diabetes in male refugees was 7.3% (compared to 5.3% in male permanent migrants and 4.8% in remaining male population), and 7.8% in female refugees (compared to 3.9% in female permanent migrants and 3.7% in remaining female population)[75].

The prevalence of reported mental health conditions varies significantly across sex and age groups, with rates ranging between 0.4% to 13.5%. However, these numbers do not reflect the actual prevalence of mental health conditions in this population; factors that impact the accuracy of these data include cultural sensitivities that prevent self-reporting, refugee specific mental services which do not require a referral, poor mental health literacy and the use of religious or community groups to seek mental health support[18].

8.3.6 Utilisation of health care services among multicultural communities

Multicultural communities in the Gold Coast region face multiple challenges when interacting with the Australian health care system. The main barriers impacting the multicultural communities' access to health care at an individual, family, and community level include language proficiency, inadequate translation services, services with poor cultural competencies, and low levels of health literacy[76].

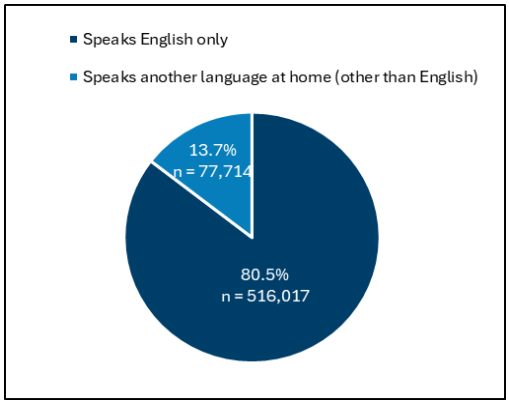
There are also major gaps in available data on the use of health services by multicultural communities as many services do not collect data on patients' country of birth, cultural background, or language proficiency.

[72] Hynie, M., 2018. The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry, 63*(5), pp.297-303.
[73] McMichael, C., 2019. *The health of migrants and refugees. Public health: Local and global perspectives*, pp.352-370.
[74] Silove, D., Ventevogel, P., Rees, S., 2017. The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry, 16*(2),.130-139.
[75] Australian Institute of Health and Welfare 2023, *Health of refugees and humanitarian entrants in Australia*.
[76] Khatri, R.B. and Assefa, Y., 2022. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. *BMC public health, 22*(1), p.880.

8.3.7 Language proficiency

Language proficiency in multicultural communities is an important determinant of health that can impact the accessibility and use of health services[77]. Difficulties in speaking English when interacting with the health care system can lead to difficulties in sourcing, understanding and interpreting health information[78]. It is acknowledged that the Australian health system does not adequately cater for those accessing primary health care with low English proficiency levels, and this can lead to negative health outcomes[79].

FIGURE 5: LANGUAGE SPOKEN AT HOME, GOLD COAST, 2021



Source: ABS, Census of Population and Housing, 2021, General Community Profile.

TABLE 5: LANGUAGES SPOKEN AND LEVEL OF PROFICIENCY IN SPOKEN ENGLISH, GOLD COAST, 2021

Region	Speak English only		Speak other language at home					
			Speak English very well or well		Speak English not well or not at all		Total*	
	Number	%	Number	%	Number	%	Number	%
Gold Coast SA4	516,017	80.5	77,714	12.1	10,361	1.6	88,076	13.7
Broadbeach-Burleigh	54,438	82.0	6,889	10.4	889	1.3	7,775	11.7
Coolangatta	50,773	88.3	3,455	6.0%	291	0.5	3,745	6.5
Gold Coast-North	54,235	78.2	9,454	13.6%	1,529	2.2	10,982	15.8
Gold Coast Hinterland	17,889	88.9	936	4.7%	53	0.3	996	5.0
Mudgeeraba-Tallebudgera	31,511	87.5	2,818	7.8%	266	0.7	3,080	8.5
Nerang	58,770	84.3	7,148	10.3%	865	1.2	8,006	11.5
Ormeau-Oxenford	131,028	82.9	16,702	10.6%	2,056	1.3	18,764	11.9
Robina	41,241	76.5	8,998	16.7%	1,319	2.4	10,317	19.1
Southport	45,845	71.1	12,126	18.8%	1,958	3.0	14,086	21.8
Surfers Paradise	30,284	67.0	9,195.0	20.3%	1,130	2.5	10,328	22.9

*Source: ABS, Census of Population and Housing, 2021, General Community Profile - G13. *This data set includes the categories 'Proficiency in English not stated' and 'Language and proficiency in English not stated'.*

[77] Pandey, M., Maina, R.G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C.R. and Maroof, R., 2021. Impacts of English language proficiency on healthcare access, use, and outcomes among immigrants: a qualitative study. *BMC Health Services Research, 21*, pp.1-13.
[78] Australian Institute of Health and Welfare 2022, *Reporting on the health of culturally and linguistically diverse populations in Australia: An exploratory paper*.

Across the Gold Coast, 13.7% of people speak a language other than English at home. Of those, 12.1% speak English well or very well, and 1.6% speak English not well or not at all (Table 5).

- Across the Gold Coast region, Surfers Paradise SA3 had the highest proportion of the population who do not speak English well or not at all at 22.9%.
- Ormeau–Oxenford SA3, which has the highest population, also had the highest number of people who do not speak English well or not at all (18,764).

The top five countries of origin among Gold Coast residents of English and non-English speaking backgrounds are:

English speaking:	**Non-English speaking:**
New Zealand (7.9%)	China excludes SARs and Taiwan (1.2%)
England (5.2%)	Japan (0.7%)
South Africa (1.2%)	India (0.7%)
Scotland (0.6%)	Philippines (0.7%)
United States of America (0.5%)	South Korea (0.6%)

8.3.8 Translating and Interpreting service

The use of a patient's primary language has been shown to improve the utilisation of health services for people from multicultural backgrounds. Medical interpreters allow for better communication between care providers and patients with varying levels of English proficiency[79].

The Translating and Interpreting Service (TIS) is provided by the Department of Home Affairs for people who do not speak English, and for agencies that need to communicate with non-English speaking clients. TIS provides services on the phone, in person, or through video[80].

Medical Practitioners (GPs, nurse practitioners and approved medical specialist) and patients are eligible for the free interpreting service when the health services provided are Medicare-rebatable and delivered in private practice or provided to non-English speakers eligible for Medicare.

TABLE 6: USE OF TRANSLATING AND INTERPRETING SERVICE, GOLD COAST, 2022 AND 2023

	2022	2023	Change 2022 to 2023
General Practitioner	354	421	18.9%
Specialist	156	131	-16.0%
Pharmacy	3	4	33.3%
Total	513	556	8.4%

Source: Translating and Interpreting Service (TIS National), Department of Home Affairs was extracted from Department systems as at 15/02/2024.

- There has been an increase in the use of TIS services by 8.4% between 2022 and 2023; the increase is seen among pharmacists and GPs, while the use among specialists declined.
- GPs used the largest proportion of TIS services (75.7% in 2023).

[79] Attard, M., McArthur, A., Riitano, D., Aromataris, E., Bollen, C. and Pearson, A., 2015. Improving communication between health-care professionals and patients with limited English proficiency in the general practice setting. *Australian Journal of Primary Health, 21*(1), pp.96-101.
[80] Department of Home Affairs 2024, *Translating and interpreting service*.

Interpreter services remain underused, with some of the reasons including:

- Confidence in 'in house' bilingual staff[81].
- Beliefs about the preference of patients for family members to interpret, and a lack of practice systems to facilitate interpreters[82].
- Interpreters can be cumbersome to access and challenging to use in day-to-day practice[83].

In 2023, translation and interpretation services used by GPs involved a total of 37 languages. Mandarin was the most requested language (accounting for 82 instances or 19.5%), followed by Tigrinya with (47 instances or 11.2%), and Japanese (33 instances or 7.8%).

The area with the greatest utilisation of General Practitioner translation and interpreting services by GPs in 2023 was identified by postcode 4215 (encompassing suburbs Chirn Park, Labrador, Southport), with a total of 155 services. Postcode 4218 (comprising Broadbeach and Mermaid) followed with 46 services.

8.3.9 Consultations

The Gold Coast PHN has consulted with multiple multicultural community agencies to better understand challenges these communities face in accessing appropriate healthcare services. One agency conducted extensive consultations with multicultural agencies in the Gold Coast region.

This consultation indicates these communities are more likely to be impacted by social determinants of health compared to Australian-born residents, and service models need to be more culturally diverse to meet the varied needs of the population. Language barriers remain a significant challenge, with a strong demand for better access to interpreters and translation services.

Suggestions for improvement include reducing waiting times, providing more affordable healthcare options for migrants, improving website accessibility for different language groups, and offering language support services. There is also a need for healthcare providers to better engage with community leaders to address myths about healthcare services and improve trust in the system.

Addressing these barriers requires a multifaceted approach, including enhanced language support, culturally sensitive healthcare models, and improved accessibility to mental health services and preventative care.

Multicultural Communities Council Gold Coast (MCCGC) (February 2024)

- Multicultural communities in the Gold Coast region are more likely to be impacted by social determinants of health that Australian born residents.
- Having a language barrier is the most common issue for the multicultural communities to access appropriate services, including written materials.

[81] Huang, Y.T. and Phillips, C., 2009. *Telephone interpreters in general practice: Bridging the barriers to use. Australian Family Physician, 38*(6), 443-446.
[82] Atkin, N., 2008. Getting the message across: Professional interpreters in general practice. *Australian Family Physician, 37*(3).
[83] Centre for Culture Ethnicity and Health – Health Sector Development 2024, *Working effectively with professional interpreters in private general practice*.

- There is a lack of appropriateness for translation services and use of interpreters.
- Use of interpreters in consultations can be disjointed leading to the patient not being able to completely communicate their health concerns or understand diagnosis.
- There is a lack of utilisation of Translating and Interpreting Service (TIS) in GP consults and other service providers.
- Having an interpreter or using a translation service during regular GP style appointments is complex and more time intensive.
- Health issues often do not translate directly from language to language, for example with many mental health conditions, these are described and explained differently across cultures.
- Service models require major levels of diversity due to how many different backgrounds and cultures there are in the Gold Coast region.
- There are low levels of health literacy across the multicultural communities, and a need to build health literacy across the individual communities.
- Refugees living in the Gold Coast often have highly complex health concerns with lack of services to appropriately address these. Services for refugees are only available outside of Gold Coast and have long waitlists.

Thriving Multicultural Communities (March 2024)

- The main health needs of clients presenting to the Thriving Multicultural services are around domestic violence support, housing, and mental health.
- There is limited access to mental health professionals that can provide appropriate support to multicultural communities for things such as domestic violence.
- Majority of the clients that come through this service have a preferred or usual GP that speaks their language or can provide a culturally appropriate service.
- Transport to services can be a major barrier to the multicultural communities in the Gold Coast region; a large component of the population is in the northern corridor of the Gold Coast region where there is a lack of public transport services.
- Multicultural communities prefer face to face consultations over online or phone calls.

Community Advisory Council (March 2024)

What are major health issues NOT currently being addressed in the Gold Coast region?

- Mental health – afraid or don't know how to get help.
- Domestic violence.
- Delaying preventative healthcare such as cancer screenings (delays should not occur because of limited translation).

Are there any access issues for health services or regions in the Gold Coast region that lack health services?

- Tend to navigate towards a physician who speaks their language, if this isn't their local community, they may have a delay in getting care, e-translation isn't always culturally appropriate. Finding a translator for a small language group is difficult.
- Limited digital literacy, some cultures have a hesitation to use devices over face-to-face interactions.
- Medicare eligibility.

MCCGC/GCPHN/GCHHS Consultation Project (May 2024)

- MCCGC coordinated a community consultation project with 120 multicultural community members from a variety of diverse language groups (including Portuguese, Cantonese and Mandarin, Spanish, Indian community, Tagalog, Farsi, Korean, Tigrinya, Japanese, Pasifika and Amharic) to gather feedback and insights about their experiences with the Gold Coast healthcare system.
- Language barriers are a significant challenge for specific communities when accessing healthcare services, impacting their ability to understand diagnoses and communicate effectively with healthcare professionals.
- Long waiting times for appointments and surgeries are a common concern, contributing to delays in receiving necessary care.
- Those who have utilised healthcare services in Gold Coast public hospitals have had a positive overall experience, though some reported issues include high costs and a perception of rushed care.
- Some communities, particularly those speaking Chinese and Tigrinya, face difficulties finding the right provider and receiving adequate care due to language barriers and extended waiting times.
- Suggestions for improvement include language support services, reducing waiting times, and ensuring affordable access to healthcare for migrants and visa holders.
- There is a need to approach healthcare providers and community leaders to address myths and misconceptions about healthcare services in Australia.
- User-friendly interfaces for healthcare information websites are essential for facilitating access to relevant information for diverse language groups.
- Access to mental health services appears limited for certain visa holders, indicating a need for broader accessibility and support in this area.
- Accessing interpreter services is a challenge.
- Some interpreters often lack adequate training in medical terminology, leading to inaccuracies in translation and potentially compromising the quality of care.
- Word of mouth recommendations play a significant role within communities in identifying suitable GPs, highlighting the importance of community networks in healthcare decision-making.

- Chinese and Korean participants prefer seeking treatment in their home countries, indicating a perception of better accessibility or quality of care abroad.

Gold Coast Primary Health Network Clinical Council (May 2024):

Major health issues not currently being addressed in the Gold Coast region:

- Locating and accessing medical records often in other languages.
- Delays to health care due to family dynamics such as husband may not be able to accompany wife to appointment.
- Access to health services and issues:
- Finding a GP that is culturally sensitive and speaks the same language.
- Navigating the Medicare/international health insurance and associated entitlements.
- Immunisations - accessing and understanding immunisation records from other countries.
- Dietary considerations to support wellbeing aligning with cultural diets.

Summary of key findings:

Language barriers

- Limited access to interpreters and translation services, with some interpreters lacking medical training.
- Disjointed consultations, where patients struggle to express their concerns and understand diagnoses.
- Health issues, especially mental health conditions, often do not translate well across languages or cultures, complicating diagnosis and treatment.

Access to services

- Some multicultural groups struggle to navigate Medicare and international health insurance systems, including understanding their entitlements and immunisation records from other countries.
- A shortage of culturally sensitive GPs and specialists who can communicate in the patient's language remains a major barrier to care.
- Many community members rely on word-of-mouth recommendations for identifying suitable healthcare providers, underscoring the importance of community networks in healthcare decision-making.
- Refugees often face complex health issues, with insufficient services available in the Gold Coast region, leading to long waitlists or the need to travel outside the region for care.
- Health literacy is low across many multicultural communities, making it harder for individuals to navigate the healthcare system or understand medical advice.
- There is limited access to mental health support and domestic violence services, particularly for multicultural populations.
- Transport to services is a barrier, especially for those in areas with poor public transport access, such as the northern corridor.

Cultural sensitivity and health service models

- Many individuals prefer healthcare providers who speak their language or offer culturally appropriate services, but finding these providers can be challenging.
- Multicultural communities often prefer face-to-face consultations over phone or online appointments due to cultural norms and limited digital literacy.
- There is a need for services that cater to the specific health beliefs and needs of diverse cultural groups, including dietary preferences and health practices.

Healthcare delivery challenges

- Long waiting times for appointments and surgeries are a common complaint.
- Some communities face difficulties finding appropriate providers, especially those speaking specific languages like Mandarin, Cantonese, Tigrinya, or Korean.
- High costs of healthcare, along with perceptions of rushed care, are concerns for those accessing public hospitals.
- A lack of understanding about healthcare systems in Australia leads to misconceptions and delays in seeking care, particularly for migrants and visa holders.

Unmet health needs

- Mental health services, particularly for those dealing with domestic violence, remain underfunded and under-resourced.
- Domestic violence support is a major need, but there is limited access to culturally sensitive services.
- Preventative healthcare, such as cancer screenings, is often delayed due to language barriers and lack of understanding of available services.

8.4 PEOPLE OF DIVERSE SEXUALITIES AND GENDERS (LGBTIQAP+)

8.4.1 Definition

The acronym LGBTIQAP+ represents individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual, and other gender or sexuality diverse identities.

LGBTIQAP+ Australians can face unique challenges related to social exclusion, discrimination, and limited access to healthcare and, as a result, may experience health and wellbeing disparities in comparison to bisexual and heterosexual residents.

There is little data available specific to LGBTIQAP+ communities in the Gold Coast region, however, national and Queensland data can provide some insight into the broader LGBTIQAP+ community's health and wellbeing.

8.4.2 LGBTIQAP+ health

LGBTIQAP+ people in Australia experience inequitable health outcomes, including higher rates of mental health issues, substance use disorders, chronic diseases and poorer sexual health compared to the general population.

According to the 2022 National Health survey, approximately 231,000 gay or lesbian Queensland survey participants (74.8%) reported a selected health condition, which was more than double the rate of bisexual and heterosexual participants (34.6% or 25,500 and 30.8% or 1,125,800)[84,85].

8.4.3 Screening participation

LGBTIQAP+ individuals face higher discrimination and health risks, including lower participation in cervical screening, especially those who haven't had sex with men or are transgender men with a cervix. Barriers include misconceptions about cancer risk, discrimination, stigma, fear of judgment from providers, and discomfort during exams. Transgender men often face unique challenges, such as inadequate provider understanding and painful exams. Addressing these issues can help improve screening rates and health outcomes for these communities[86].

8.4.4 Mental health

Insufficient data collection and publication at regional levels means Gold Coast level estimates of mental health burden among LGBTIQAP+ people are unavailable. At a national level, larger population-based surveys, such as the National Study of Mental Health and Wellbeing 2020-2022, find that LGBTIQAP+ people experience higher rates of rates of mental health disorders, suicidal ideation and self-harm.

8.4.5 Sexual health

LGBTIQAP+ people are at higher risk of sexually transmitted infections, particularly men who have sex with men. There were 159 infectious syphilis notifications in the Gold Coast region in 2023, 47.2% more than in 2019[87]. National syphilis surveillance data showed that men who exclusively have sex with men accounted for 55% of syphilis cases on average[88].

8.4.6 Substance use

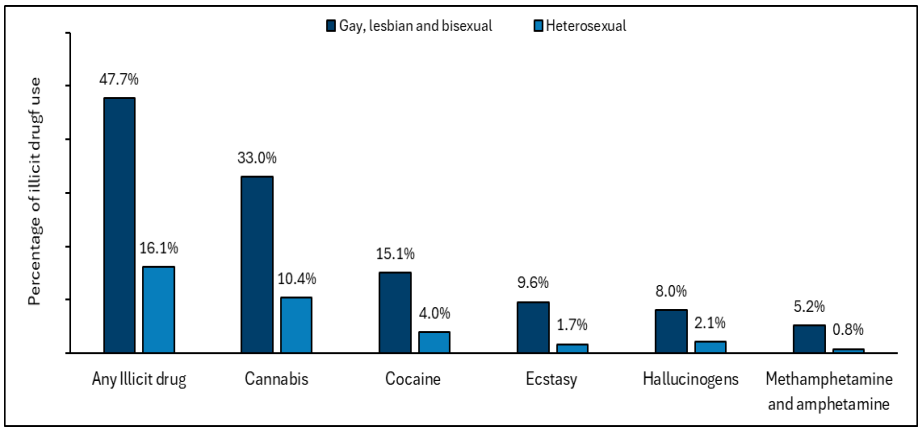
Estimates of substance use for LGBTQI+ people in the Gold Coast region are unavailable, however, national trends observed in the National Drug Strategy Household Survey 2022-2023 show higher rates of substance use than the general population[89].

- Risky alcohol consumption declined among gay, lesbian, and bisexual people between 2010 and 2022-23, from 50.3% to 39.8%. This group still consumes alcohol at risky levels at 1.2 times the rate of other people, however, the gap has narrowed since 2019.

[84] The data used in these estimates have a relative standard error above 25% and should be interpreted with caution.
[85] Australian Bureau of Statistics 2022, *National Health Survey*.
[86] Department of Health and Aged Care 2022, *People of diverse sexualities and genders (LGBTQI+).*
[87] Queensland Health 2024, *Notifiable conditions annual reporting - Data for 2023*.
[88] Australian Centre for Disease Control 2024, *National Syphilis Surveillance Quarterly Report: Quarter 1*.
[89] Australian Institute of Health and Welfare 2024, *National Drug Strategy Household Survey 2022–2023*.

- Significant increase in the rate of recent illicit drug use among gay, lesbian and bisexual individuals between 2019 (40.1%) and 2022–2023 (47.4%), particularly recent cocaine use, which increased from 10.5% to 15.1% over the same period.
- In the past 12 months, in comparison to heterosexual people, gay, lesbian and bisexual people were 12.2-times as likely to have use inhalants, 6.5-times as likely to have used methamphetamine/amphetamine, and 5.6-times as likely to have used MDMA.

FIGURE 7: ILLICIT DRUG USE BY SEXUAL ORIENTATION, AUSTRALIA, 2022-23



Source: National Drug Strategy Household Survey 2022–2023, Table 10.5.Disability

8.4.7 Definition

The term 'disability' broadly acknowledges a person's limitation, restriction or impairment which restricts everyday activities and has lasted or is likely to last at least six months. People experience varying degrees of disability resulting in different needs for everyone, this may also depend on the type of disability the person has which can include sensory, intellectual, physical, psychosocial, head injury or stroke.

Persons with a profound or severe disability are defined as needing help or assistance in one or more of the three core activity areas of self-care, mobility and communication because of long-term health condition, disability, or old age.

8.4.8 Prevalence of disabilities

In 2021 Census, 35,066 Gold Coast residents (5.5%) reported having a severe or profound disability.

This included 4,230 (3.8%) children aged 0-14 and 2,264 (2.9%) people aged 15-24 who had a reported need for assistance with core activities in the Gold Coast region. There were 19,113 people aged 65 and over (16.7%) who required assistance with core activities.

- In 2021, the Gold Coast region's rate of people with a disability who require assistance was below the Queensland rate (5.5% vs 6.0%).
- The SA3s regions that were above the Queensland average rate were Gold Coast-North and Southport, while Surfers Paradise had the lowest rate (4.1%).

TABLE 7: NEED FOR ASSISTANCE FOR PROFOUND OR SEVERE DISABILITY, GOLD COAST SA3 REGIONS, 2021

Region	Number	%
Queensland	309,366	6.0%
Gold Coast SA4	35,066	5.5%
Gold Coast-North	5,207	7.5%
Southport	4,259	6.6%
Nerang	3,989	5.7%
Robina	3,008	5.6%
Coolangatta	3,026	5.3%
Gold Coast Hinterland	1,036	5.1%
Ormeau-Oxenford	8,040	5.1%
Mudgeeraba-Tallebudgera	1,665	4.6%
Broadbeach-Burleigh	2,960	4.5%
Surfers Paradise	1,871	4.1%

Source ABS, Census of Population and Housing, 2021.

National Disability Insurance Scheme participation

The National Disability Insurance Scheme (NDIS) supports eligible Australians who were either born with or acquire a permanent and significant disability. The NDIS funds reasonable and necessary supports and services that relate to a person's disability to help them achieve their goals. 'Reasonable' means the support is most appropriately funded or provided through the NDIS, and 'necessary' means something a person needs that is related to their disability.

The number of NDIS participants in the Gold Coast region increased by 36.2% from 2021 (n=10,729) to 2023 (n=14,618). Autism and intellectual disabilities were the most prevalent disabilities among NDIS participants.

TABLE 8: NUMBER OF NDIS PARTICIPANTS, GOLD COAST SA3 REGIONS, 2021 TO 2023

Region	Number of NDIS Participants		
	2021	2022	2023
Gold Coast	10,729	12,858	14,618
Broadbeach - Burleigh	790	926	1,082
Coolangatta	796	962	1063
Gold Coast - North	1,204	1,411	1,587
Gold Coast Hinterland	324	387	462
Mudgeeraba - Tallebudgera	624	765	881
Nerang	1,298	1,574	1,832
Ormeau - Oxenford	3,212	3,928	4,529
Robina	847	976	1,084
Southport	1,203	1,418	1,557
Surfers Paradise	431	511	541

NDIS, participant datasets, SA3 & SA4 regions, December 2021-2023.

TABLE 9: DISABILITIES AMONGST PARTICIPANTS WITH NDIS PLAN, GOLD COAST AND QUEENSLAND, 2021

Primary disability	Gold Coast	Queensland
Autism	37%	34%
Developmental delay and global developmental delay	10%	10%
Intellectual disability and down syndrome	15%	17%
Psychosocial disability	10%	10%
Other disabilities	28%	29%
Total	100%	100%

Source: NDIS, Market monitoring regional datasets, LGA, 2021

TABLE 10: AGE DISTRIBUTION OF PARTICIPANTS WITH NDIS PLAN, GOLD COAST AND QUEENSLAND, 2021

Age group	Gold Coast %	Queensland %
0 to 6 years	17%	16%
7 to 14 years	28%	26%
15 to 18 years	8%	8%
19 to 24 years	7%	8%
25 to 34 years	8%	9%
35 to 44 years	7%	8%
45 to 54 years	10%	10%
55 to 64 years	11%	12%
65+ years	3%	3%

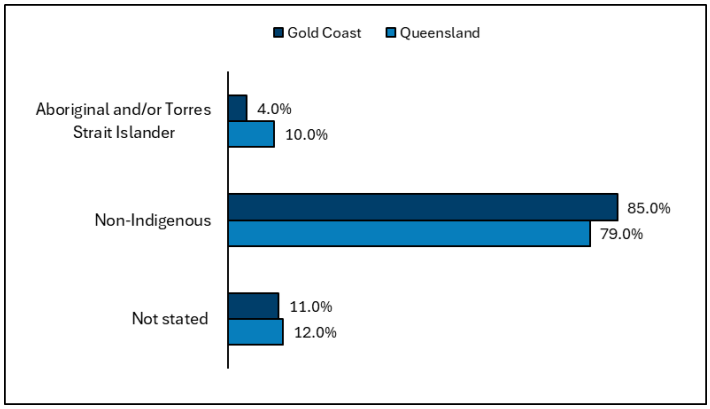
NDIS, Market monitoring regional datasets, LGA, 2021

First Nations people with disability

In the Gold Coast region, 1,168 (8.4%) of First Nations people had a profound or severe disability, compared to the 5.5% of the total Gold Coast population.

First Nations people in the Gold Coast region are more likely to provide unpaid assistance to a person with a disability. In 2021, 13.4% (n=1,279) of First Nations people aged 15 years and over were providing unpaid assistance to persons with a disability in the Gold Coast region; in comparison, 10.6% (n=56,085) of the total Gold Coast population provided unpaid assistance.

FIGURE 8: FIRST NATIONS PARTICIPANTS WITH NDIS PLAN, GOLD COAST AND QUEENSLAND, 2021



Source: NDIS, Market monitoring regional datasets, LGA, 2021

8.5 FAMILY, DOMESTIC, AND SEXUAL VIOLENCE

8.5.1 Definitions

Family violence refers to violence between family members, typically where the offender uses power and control over another person. The most common and widespread cases occur in intimate (current or previous) partner relationships and are usually referred to as domestic violence.

Sexual violence refers to behaviours of a sexual nature carried out against a person's will. It can be committed by a current or previous partner, other people known to the victim, or strangers.

8.5.2 Vulnerable groups

Family, domestic, and sexual violence affects people of all ages and from all backgrounds, but primarily women and children. Victims often display including behavioural, emotional, and cognitive-functioning problems as a result.

Some groups of people are more vulnerable[90]:

- children,
- young women,
- older people,
- persons with disability,
- people from culturally and linguistically diverse backgrounds,
- LGBTIQAP+ people,
- people in rural and remote Australia, and
- people from socioeconomically disadvantaged areas.

8.5.3 Contributing factors

Many factors contribute to and influence family, domestic and sexual violence[91]. These elements relate to victims and offenders and include relationship dynamics, families and communities and geographic and political environments[92]. Contributing factors include:

- Cultural values and beliefs: masculinity linked to dominance and toughness, and strict gender roles.
- Social factors: unemployment, socioeconomic status, social and geographic isolation.
- Situational factors: male dominance in the family, intimate partner conflict, alcohol and other substance use.
- Personal history: witnessing intimate partner violence as a child, being abused during childhood or witnessing domestic violence[93].

[90] Australian Institute of Health and Welfare 2024, *Family, domestic and sexual violence*.
[91] Eurobarometer, S., 2010. *Domestic violence against women report. Special Eurobarometer 344.*
[92] Australian Bureau of Statistics 2013, *Defining the Data Challenge for Family, Domestic and Sexual Violence.*
[93] Edleson, J.L., 1999. Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), pp.839-870.

8.5.4 Prevalence

Australia

The Australian Bureau of Statistics' *2021-22 Personal Safety Survey* estimated that 3.8 million Australians adults have been victims of physical and/or sexual violence from a partner of family member[94]. Furthermore, it was estimated that 4.2 million (21%) have experienced cohabiting partner violence, emotional abuse and economic abuse; these rates increase to 27% for Australian women.

Queensland

In Queensland, rates for cohabiting partner, violence, emotional and economic abuse are estimated at 29% for women (579,300) with 20% having experienced physical and/or sexual partner violence since the age of 15[95].

As a crude estimate, applying Queensland prevalence to the Gold Coast population indicates 79,724 women may have experienced cohabiting partner, violence, emotional and economic abuse, and 54,982 women may have experienced sexual and/or physical partner violence.

8.5.5 Hospitalisations for assault

In 2021-22, 6,500 (32%) assault hospitalisations in Australia were due to family and domestic violence (FDV), the rate of FDV hospitalisations for females was almost 3-times the rate of males. Some additional facts regarding FDV hospitalisations include:

- Almost 9 in 10 (87%) FDV injuries caused by a partner were for females.
- Of all FDV hospitalisations, 73% were for females (4,700) and 27% (1,700) were for males.
- 63% (n=4,100) reported the perpetrator was spouse or domestic partner.
- 37% (n=2,400) reported the perpetrator was a parent or family member51.
- Over half (59%) of FDV hospitalisations for males aged 15 and over were caused by a family member rather than spouse.

Health services play an instrumental role in a multisector response to domestic violence[95]. Findings from the ABS Personal Safety survey revealed that an estimated 1 in 5 women who experienced violence from a current partner sought help from a GP or other health professional[94].

8.5.6 Burden of disease

The 2018 Australian Burden of Disease study estimated that intimate partner violence contributed to 1.4% of the total burden of disease in Australian women. The study ranked intimate partner violence as the fourth leading risk factor for the total burden of disease in females aged 15-44. The impact of this risk factor was estimated only for women, as the evidence in past

[94] Australian Bureau of Statistics 2023, *Personal Safety, Australia, 2021- 22*.
[95] Australian institute of Health and Welfare 2024, *Family, domestic and sexual violence*.

literature to identify the causally linked diseases and the amount of increased risk was available only for women[96,97].

Six diseases were causally linked to exposure to partner violence[98]:

- depressive disorder,
- anxiety conditions,
- alcohol use disorders,
- early pregnancy loss,
- homicide and violence (injuries due to violence), and
- suicide & self-inflicted injuries.

8.5.7 Domestic violence among LGBTIQAP+

LGBTIQAP+ people are recognised as a group that experiences health and wellbeing disparities. Research suggests that most people from this community experience intimate and/or family violence at some point in their life[100]. Stigma, prejudice, and discrimination compound the profound effects of family and domestic violence for members of this community.

There is limited data acknowledging gender, sexual orientation and variations of sex characteristics, which hinder the reporting of health and wellbeing for LGBTIQAP+ people. 'Privates Lives' conducts Australia's largest survey of the health and wellbeing of LGBTIQ+ people; findings from the 2021 survey indicate:

- 6 in 10 (61.1%) participants had experienced intimate partner violence, including emotional abuse (48.1%), verbal abuse (43.3%), physical violence (25.0%), and sexual assault (21.4%).
- 63.9% had experienced family violence, including verbal abuse (40.5%), LGBTIQ+ related abuse (49.4%), emotional abuse (38.1%), physical violence (25.0%), and sexual assault (9.4%)[99].

8.5.8 Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, sexual abuse, and often a combination of these. Elder abuse differs from other types of family and domestic violence as adult children are often involved in the abuse of parents[100].

There is an absence of data available to measure the prevalence of elder abuse at the regional level. The National Elder Abuse Prevalence survey estimated that in 2020, 15% (n=598,000) of older people living in the community had experienced elder abuse within the last 12 months. Furthermore, 2.9% (n=115,000) had experienced neglect, 2.1% (n=83,800) had experienced financial abuse, 1.8% (n=71,900) experienced physical abuse, and 1.0% (n=39,500) had

[96] Ayre, J., On, M.L., Webster, K., Gourley, M. and Moon, L., 2016. *Examination of the burden of disease of intimate partner violence against women in 2011*. Australia's National Research Organisation for Women's Safety.
[97] GBD 2016 Risk Factors Collaborators, 2017. Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet 390*(10100), p.1345.
[98] Australian institute of Health and Welfare 2021, *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018*.
[99] La Trobe University 2021, *Private Lives 3*,. https://www.latrobe.edu.au/arcshs/work/private-lives-3
[100] Australian institute of Health and Welfare 2024, *Family, domestic and sexual violence*.

experienced sexual abuse. Slightly higher rates of elder abuse were evident for women, this was also the case for psychological abuse and neglect[100].

In Queensland, calls to the Elder Abuse Prevention Unit (EAPU) have increased in recent years, from just over 200 in 2000-01 to nearly 1,300 in 2014-15[101]. The calls were mostly in relation to female victims (68% female, 31% male and 1% unknown). Perpetrators were males in 50% of calls and females in 45% (unknown 5%). Children were the largest groups of perpetrators reported (31% sons, 29% daughters), with 10% of cases perpetrated by other relatives. In 2014-15, the most reported type of abuse to the EAPU helpline was financial abuse, accounting for 40% of cases. In 2012-13, the most common type of reported abuse was psychological abuse.

8.5.9 Reported offences

The below tables and figures highlight the number of reported domestic violence cases reported to Queensland Police through police officers and private domestic violence orders; however, it is acknowledged that these figures are an under-representation as not all incidents are reported.

In 2019, there were 2,976 reported domestic violence applications, including 2,260 from police and 716 through private applications.

TABLE 11: DOMESTIC VIOLENCE OFFENCES BY TYPE, GOLD COAST, 2019

Type of offence	Rate per 100,000
Assault	284
Grievous assault	<5
Serious assault	119
Serious assault (other)	24
Common assault	138
Sexual offences	11
Rape and attempted rape	7
Other sexual offences	<5
Other offences against the person	51
Kidnapping and abduction	<5
Stalking	6
Life endangering acts	39

Source: Queensland Police Service.

Domestic violence – police and private applications

Police can apply for a Domestic Violence Order (DVO) where they reasonably believe that there is sufficient reason to act and there is sufficient evidence to determine that the aggrieved person requires protection.

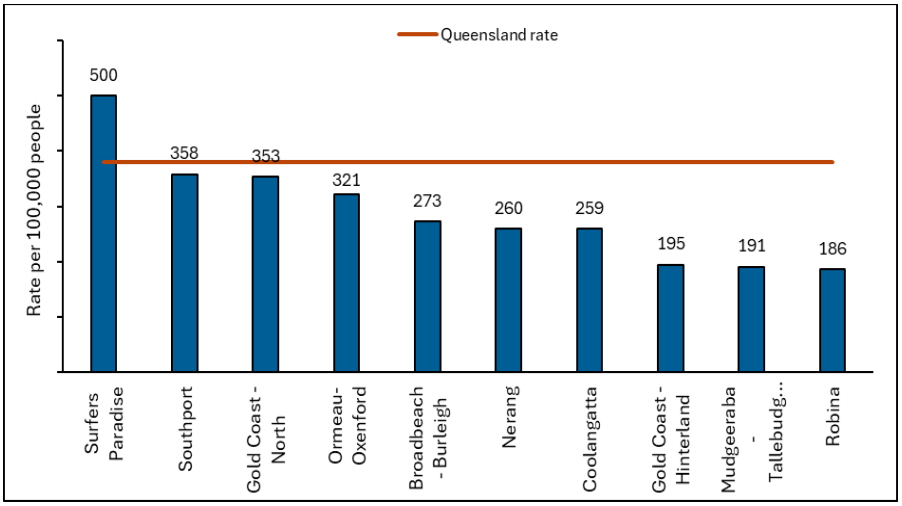
A private application for a DVO can be made by any member of the public who considers themselves to be at risk within their relationship and feels that their current situation warrants this type of protection.

[101] Spike, C. and Unit, E.A.P., 2015. *The EAPU Helpline: Results of an investigation of five years of call data*. Elder Abuse Prevention Unit, UnitingCare Community.

In 2020, there were 1,973 police applications and 689 private applications for DVOs:

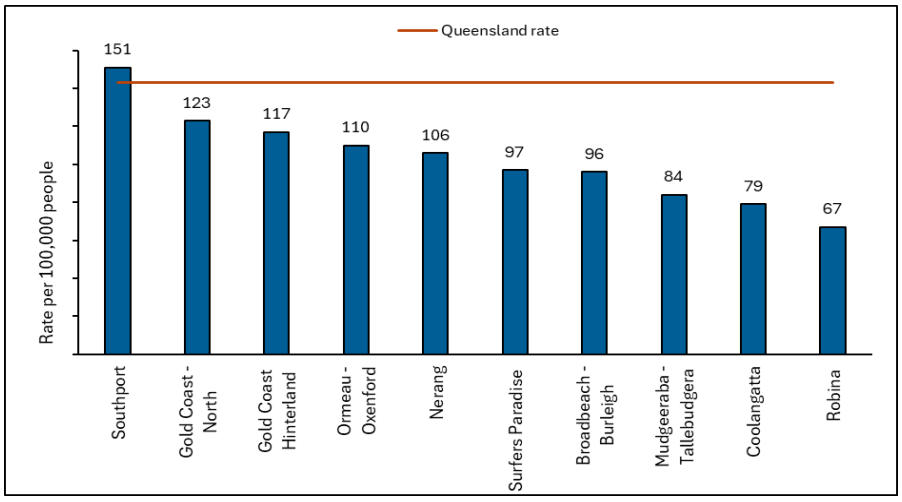
- The rate of police and private DVOs in Gold Coast SA3s were generally lower than the Queensland average, apart from Surfer Paradise (police DVO; 500 per 100,000) and Southport (private DVO: 151 per 100,000).
- The number and rate of DVOs do not capture the extent of family and domestic violence, due to the significant amount that is unreported and does not result in a DVO.

FIGURE 9: DOMESTIC VIOLENCE ORDERS – POLICE APPLICATIONS, GOLD COAST, 2020



Source: Queensland Police Service.

FIGURE 10. DOMESTIC VIOLENCE ORDERS – PRIVATE APPLICATIONS, GOLD COAST, 2020



Source: Queensland Police Service.

8.5.10 Consultations

Consultations with local GPs and the Domestic Violence Integrated Response (DVIR) identified a need for increased funding, enhanced support services, and more tailored intervention strategies to address rising domestic violence cases in the Gold Coast region, supporting both victims and perpetrators.

Gold Coast Local Level Alliance

- Local GPs are advocating for funding in the northern corridor for DV. GPs indicated they have had a large client base seeking psychological support for DV given many recent tragedies.
- Some GCPHN commissioned providers have indicated they have seen an increase of clients with family and/or domestic violence presentations to services.
- Noticeable increase in crisis calls and walk-ins specifically pertaining to women fleeing DV situations, seeking immediate support.
- Lack of safe accommodation for women, children's and their pets which is often a factor influencing someone to stay in this situation.
- Not often crisis housing will facilitate a pet to stay.
- Impact of COVID-19 on increasing DV presentations needs to be considered.

GCPHN Community Advisory Council

What are major health issues that relate to domestic violence that are not currently being addressed in the Gold Coast region?

- A lot of DV is from kids to parents, as these kids are under 18 there is no reporting due to parents not wanting to have the family engaged in child protection services. Kids seem to be repeating these behaviours as this is all they have ever known, and it is considered normal. Early intervention with children should be implemented when families visit their local doctor or service to help:
    - avoid children adopting violent tendencies,
    - avoid children self-harming and development of mental health issues,
    - avoid emergency department admissions.
- Lack of accommodation/safe spaces for women and children.
- The psychosocial support needs of those experiencing domestic and family are currently under-supported due to limitations of GP Mental healthcare plans and similar programs, particularly for those with limited financial capacity to pay for out-of-pocket cost.
- Low-income families experience more domestic violence, and this seems to be a snowball effect from limited earnings, time poor from working for low wages creates fatigue and the feelings of no progression, leading to frustration and aggression.
- More education and early intervention are necessary to avoid ED admissions.
- The impacts of domestic violence on child development and the early onset of chronic disease, mental health issues and self-harming.
- Data show women are the most affected, however men also require safe spaces.

Are there any access issues to services or regions in the Gold Coast region that lack services?

- There is a need for more men’s behaviour change groups.
- Community attitudes need to change for change to occur on an individual basis and this is something to which more attention should be paid too.

- Adverse childhood experiences and their impacts are still under-acknowledged in the way we design and deliver services, and this area requires more attention due to the multitude of ways in which it impacts children in later life if they're subjected to adversities.
- Women and children need to be moved to safety houses if they suspect men can be dangerous.
- Holistic care to all members of domestic violence.
- Early intervention and empowering men and women at a young age may encourage respect and equality.
- Culturally and linguistically diverse and Aboriginal and Torres Strait Islander people need focus.

Domestic Violence Integrated Response

Domestic Violence Integrated Response (DVIR) is a collection of about 16 organisations that primarily work in the DFV 'system', these are Police, Queensland Corrective Services, DJAG, Youth Justice, Child Safety, Centrelink, Department of Housing, Refuges, Queensland Health, Department of Education, Legal Aid, Multicultural Families Organisation, and domestic violence prevention centre. As a group they meet monthly and largely look at improving the coordination of system responses.

- Based on evidence and research[102] , DVIR is focused on perpetrator interventions and looks to create doorways for men into services. Healthcare services are one of the limited number of points that could be a door for response required.
- Women tend to use GP and health services more than men. Often health services become aware and get involved in DV situations when there is a crisis. It would be better if DV could be identified earlier or outside of a crisis through proactive response.
- One thing any services who are supporting people in this area need to be aware of is unintended consequences. For example, if a person presents GCHHS for DV related injuries, would this information in a discharge summary to GP assist or cause more issues?
- DVIR members noted several issues with private psychologists:
    - Many do not understand the complexity of DV, and many may see it as "marriage counselling" which it is not.
    - If domestic violence is pathologised, it does not make women safer; in fact, it can provide "reasons/excuses". It is important to remember a lot of people drink/take drugs/have anxiety, yet not all of them commit DV. These are escalating factors, not the whole problem.
    - GPs and private psychologists can become unconscious allies for perpetrators because they focus on treating the individual.
- Also need to consider other general practice staff e.g., nurse and even reception staff. They are often placed to pick up on issues.

[102] RMIT University. Centre for Innovative Justice, 2016. *Pathways Towards Accountability: Mapping the Journeys of Perpetrators of Family Violence-Phase 1*. Centre for Innovative Justice, RMIT University.

- GPs do not always book interpreters when they need to. Some doctors who speak other languages and have patients from those countries will refer women to multicultural support services.
- 'Bomb drop training' is not helpful – it should be integrated into the work they do.
- Telehealth consults has provided some insights into family life not otherwise seen, with things going on in the background that flag potential DV situations.

GCPHN Clinical Council

- GPs screen for domestic violence, and it can be a safe place for victims. There are resources available for GPs (White book).
- GPs will ask questions to their patients regarding domestic violence as part of their continued care, it's a longitude relationship with GPs.
- It builds the GP's confidence having conversations with their patient regarding family and domestic violence.
- Unclear health pathways within Primary Care for DV victims and perpetrators, what is the next step to take for a client who is a victim of domestic violence from their GP.
- Some GPs in the group use DV connect as a referral source, challenging to find support and in particular legal support.
- GPs in the group have no preferred psychologists that they would refer victims and perpetrators to. It is difficult to search for psychologists with a special interest.
- Gap fees are a barrier for victims to seek psychologists.
- When a patient is referred to a psychologist, the psychologists need to deal with the risk and safety work alongside domestic violence services to focus on safety and not just psychological strategies.
- Pharmacists can give current medications for emergency medications, but they are unaware of where to refer to next.
- The white book is a great source for information for GPs although not reviewed as often due to time constraints, non-GPs in the group interested in the white book and how it can be of assistance.
- Often an issue can be emergency accommodation if victims of DV move out with kids, churches can be a safe place although they can be difficult for families.

Summary of key findings:

Increased funding and support needs

- Stakeholders, including GPs and the Domestic Violence Integrated Response (DVIR), identified a critical need for more funding and enhanced support services.

Barriers to access

- Lack of safe accommodation for women, children, and pets is a major barrier for those fleeing abusive situations.
- High gap fees for legal aid and psychological services pose significant barriers for victims accessing support.

- A shortage of specialized domestic violence support services and clear health pathways complicates care for both victims and perpetrators.

Prevalence and contributing factors

- GPs are seeing an increase in patients seeking psychological help after recent domestic violence incidents.
- Domestic violence is prevalent in low-income households, often linked to financial stress and exhaustion, which can contribute to aggressive behaviours.
- Earlier intervention for children exposed to domestic violence is essential to prevent violent behaviours and related mental health issues.
- Perpetrator interventions and support
- DVIR emphasised the need for intervention with perpetrators and accessible pathways for men to access tailored services.

Need for improved systems and workforce capability

- Stakeholders advocate for better training for healthcare professionals to address domestic violence complexities effectively.
- There are capability issues among some private psychologists who sometimes offer inappropriate "marriage counselling" in situations where domestic violence is a factor, which can inadvertently support perpetrators.
- There is a need for more integrated and coordinated services, improved referral systems, and strategies to support the psychological and safety needs of affected individuals.

8.6 SERVICE SYSTEM IN THE GOLD COAST REGION

8.6.1 Homelessness

Services	Number	Distribution	Information

Gold Coast Homelessness Service – Uniting Care	3	Various locations	• Multiple services across the Gold Coast region providing:
			  ○ Emergency accommodation for those over 18 years
			  ○ Support and referral for young people
			  ○ Crisis intervention, counselling and emotional support
			  ○ Training on living skills, budgeting skills and financial management
			  ○ Practical assistance and advocacy

Homeless Hotline	Phone	Queensland wide	• Homeless Hotline is a 24/7 phone information and referral service for people who are experiencing or are at risk of homelessness. • Service provides information about where individuals can find support, accommodation, meals, or showers.
Gold Coast Youth Service	1	Miami	• Not for profit, specialist youth support & homelessness organisation. • Supports young people (aged 16 to 25) and their families in Gold Coast region who may be marginalised, disadvantaged, and homeless or at risk of homelessness.
Homeless Health Outreach Team – GCHHS	3	Southport x2 and Robina	• HHOT service provides comprehensive assessments, care co-ordination and clinical interventions for homeless person in the community who are experiencing mental illness.
Nerang Neighbourhood Centre	1	Nerang	• Services to support people who are homeless and at risk of homelessness, with an onsite nurse practitioner available 2 days a week.

Services	Number	Distribution	Information
St John's Crisis Centre	1	Surfers Paradise	• Provides food, clothing and other essential services for Gold Coasters in their time of crisis. • Counselling to those who need safe and affordable shelter and food to those in urgent need.
PCCS After Hours Mental Health Safe Space (GCPHN funded)	2	Mermaid Beach, Southport	• After Hours Safe Space is a confidential, low intensity, after-hours mental health service for people experiencing mental health distress. • Services are delivered by clinical and lived experience staff. No referral/ appointment is needed.
Gold Coast Public Health Unit	1	Carrara	• GCPHU Community Immunisation Team provide a pop-up immunisation clinic at the 9 locations across Gold Coast (locations are spread across Gold Coast in locations where people who may be expiring homelessness already attend). • Immunisation clinics provide Influenza vaccine usually scheduled in April – May. • Opportunistic immunisation is also offered to ensure clients are 'up to date' with National Immunisation Program vaccines.
Gold Coast Homelessness Network	1	Gold Coast	• Well–integrated, multi–agency network of over 20 services addressing issues of homelessness, particularly the lack of emergency and short–term housing. • It has proven to be an extremely effective hub for linking public and private housing and support services, raising awareness of homelessness issues, and advocating for improved support for homeless people in the Gold Coast region.

8.6.2 Multicultural communities

Services	Number	Distribution	Information
Multicultural Communities Council Gold Coast - Cura Community Pathway Connector (GCPHN funded)	1	Southport	• Provides service navigation for multicultural families to access culturally appropriate care.
Thriving Multicultural Communities	1	Southport, mobile service working out of community centers in the Northern Corridor	• Services span vital areas such as training and employment, settlement services, community engagement and development, youth programs, domestic family violence, and senior support.
Multicultural Families Organsisation (MFO)	1	Southport	• MFO is a not-for-profit organisation that has been supporting multicultural families and communities on the Gold Coast since 1996. • Services include settlement support, domestic and family violence support, training and employment, women's programs, community development, youth development and arts and cultural programs.

8.6.3 Family and domestic violence

Services	Number	Distribution	Information
Domestic Violence Prevention Centre (DVPC) Gold Coast	1	Gold Coast	• The DVPC provides a wide range of programs to support women and their children affected by domestic violence and family violence and work with men who perpetrate domestic and family violence.
Kalwun Family and Domestic Violence Support Program	1	Kalwun Medical Centres	• Kalwun family and domestic violence program supports and empowers families escaping and recovering from violence and abuse. • Women and children escaping family and domestic violence are eligible.
Gold Coast Centre against sexual violence	1	Gold Coast	• Not for profit, charitable organisation providing free counselling, advocacy, information and practical support, as well as therapeutic and educational groups for women who have experienced sexual violence at any time in their lives.
Support Assessment Referral Advocacy	1	Gold Coast	• Supports women and their children from culturally and linguistically diverse backgrounds affected by domestic and family violence.
Telephone hotlines	Phone	Australia wide	• There are a wide range of telephone hotlines accessible to anyone, including: DV Connect Womensline, Elder Abuse Helpline (Qld), 1800RESPECT, Men's Referral Service, Mensline Australia, Kids Help Line, Aboriginal Family Domestic Violence Hotline, and Safe Haven Community.

Chapter 9:
PREGNANCY AND CHILDREN

KEY FACTS:

- The annual number of births increased over 5 years for Gold Coast residents despite a declining birth rate, driving demand for antenatal, birthing and postnatal services.
- Ormeau-Oxenford SA3 region has the highest rate of births (63.3 per 1,000 maternal aged women).
- A high proportion (85.5%) of expectant mothers living in the Gold Coast region engaged with antenatal care in the first trimester.
- The proportion of mothers who smoke while pregnant increased between 2018 (4.2%) and 2022 (6.4%), and particularly for First Nations women (from 16.0% to 20.6%).
- The rate of foetal deaths (stillbirths) for the Gold Coast region is 5.4 per 1,000 births, which is lower than the Queensland and national rates.
- The vast majority (92.8%) of Gold Coast babies are born with healthy birth weight, with no difference between First Nations and other women.
- Gold Coast has significant demand for services for young people with autism; almost half of all NDIS participants have a primary disability of autism or developmental delay.

PRIORITISED NEEDS:

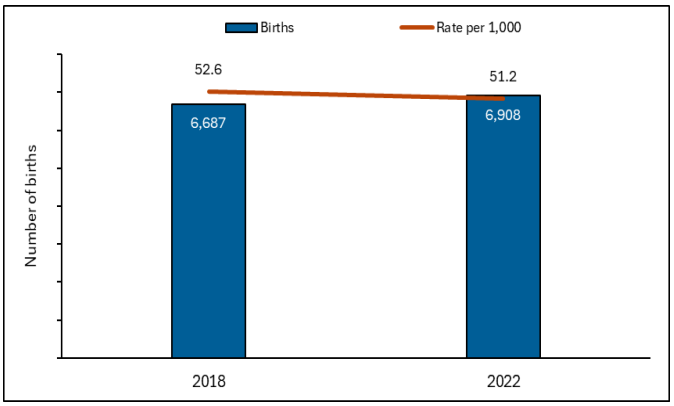
1) Growing numbers of children in out of home care, who typically have high health needs, and relatively high proportion of First Nations children in out of home care.
2) First Nations women have a high prevalence of smoking during pregnancy, including passive smoking.
3) Insufficient diagnostic and management service capacity for neurodevelopment exposure disorders (neonatal) neurodivergence and developmental delay.
4) Prevalence of lifestyle and demographic maternal risk factors are increasing, including maternal smoking and high maternal age.

9.1 MATERNITY SNAPSHOT

9.1.1 Birth and birth rate

The annual number of births increased over 5 years for Gold Coast residents despite a declining birth rate; this has driven the demand for antenatal, birthing and postnatal services.

FIGURE 1: LIVE BIRTHS, GOLD COAST, 2018 AND 2022

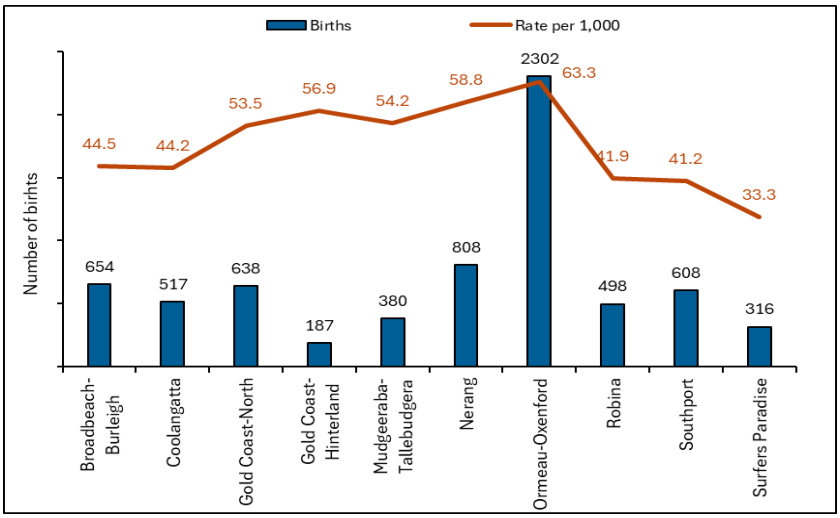


Source: Queensland Perinatal Data Collection

- The number of live births to Gold Coast residents grew by 3.3.% between 2018 and 2022, which was an additional 221 babies born annually, compared to five years earlier.
- Babies were born at a 2.6% lower rate in 2022 compared to 2018, with 51.2 babies born per 1,000 maternal aged women (15-44 years), compared to 52.6 five years earlier.

Demand for maternity services varied across the region, with a comparatively high number of births to residents in northern areas of the Gold Coast.

FIGURE 2: NUMBER AND RATE OF LIVE BIRTHS, GOLD COAST SA3 REGIONS, 2022



Source: Queensland Perinatal Data Collection

- A third (33.3%) of all babies born to Gold Coast residents were from Ormeau-Oxenford SA3, which also had the highest rate of births per 1,000 maternal aged women (63.3 per 1,000).

9.2 ANTENATAL PERIOD

9.2.1 Antenatal care

Maternal, foetal and family health and wellbeing are supported through regular antenatal check-ups with a GP, midwife or obstetrician. Effective antenatal care allows health professionals to detect and manage risks and potential complications throughout pregnancy, as well as engage in health promotion[103,104].

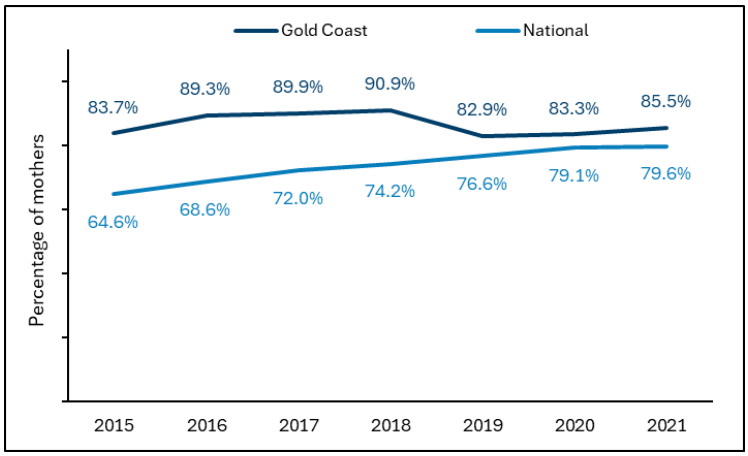
The 2020 Australian Pregnancy Guidelines recommend the first antenatal visit occurs within 10 weeks gestation and that 7 or more antenatal visits are made throughout the pregnancy.

First trimester antenatal visits

A high proportion (85.5%) of expectant mothers living in the Gold Coast region engaged with antenatal care in the first trimester in 2021. Early engagement with antenatal care was consistently high between 2015 and 2021 and remained higher than the national rate over the same period.

The COVID-19 pandemic impacted early attendance of antenatal services for expectant mothers in the Gold Coast region for 2019 and 2021, due to increased personal safety concerns and the ability for women to attend a face-to-face service[108].

FIGURE 3: WOMEN WITH AT LEAST ONE ANTENATAL VISIT IN THE FIRST TRIMESTER, NATIONAL AND GOLD COAST, 2015 TO 2021



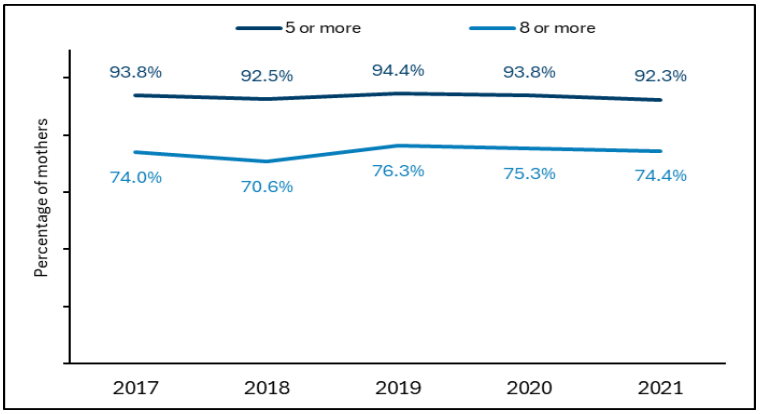
Source: Australian Institute of Health and Welfare 2023. National Core Maternity Indicators

Total antenatal visits

- Expectant mothers living in the Gold Coast region had high engagement with antenatal care throughout pregnancy; in 2021, 74.4% attended 8 or more antenatal appointments, and 92.3% attended 5 or more.
- Attendance of 5+ antenatal visits for Gold Coast was below the state average of 96.1%[105].

[103] Australian Institute of Health and Welfare 2023, *Mothers and Babies*,.
[104] UNICEF 2024, *Antenatal Care*.
[105] Australian Institute of Health and Welfare 2023, National perinatal data collection annual update- 2022.

FIGURE 4. WOMEN WHO ATTENDED 5+ OR 8+ ANTENATAL VISITS, GOLD COAST, 2017 TO 2021



Source: Queensland Perinatal Data Collection

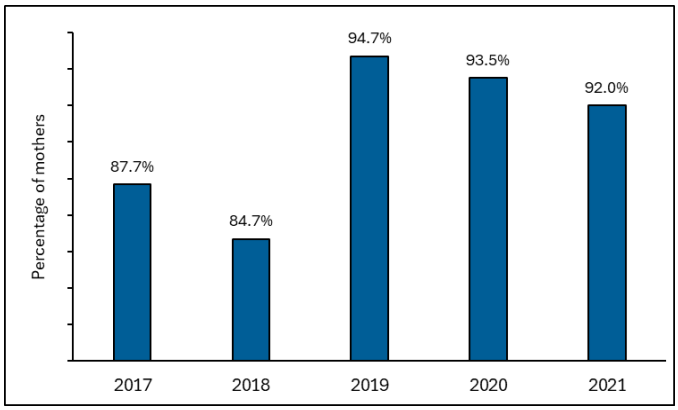
Geographical differentials

Antenatal care coverage is relatively consistent across the Gold Coast region, with only small geographical differentials.

In 2021, Coolangatta had the highest proportion (94.0%) of women who attended antenatal visits five or more times. Surfers Paradise (91.0%), Ormeau-Oxenford (91.6%) and Gold Coast North (91.9%) had the lowest proportion of women attending 5+ antenatal appointments.

First Nations mothers

FIGURE 5: FIRST NATIONS MOTHERS WHO ATTENDED 5+ OR 8+ ANTENATAL VISITS, GOLD COAST, 2017 TO 2021



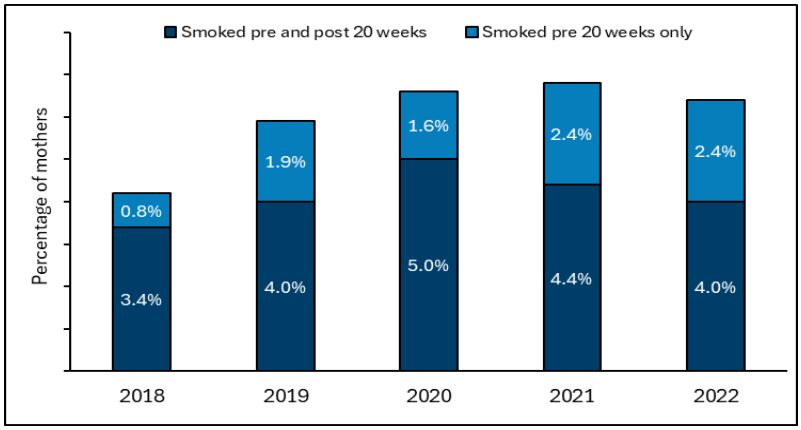
Source: Queensland Perinatal Data Collection

- First Nations women living in the Gold Coast region had high engagement with antenatal care in 2021, with 92.0% attending 5 or more antenatal visits.
- The proportion of women attending 5 or more visits increased since 2017 (87.7%)

9.3 SMOKING DURING PREGNANCY

Smoking during pregnancy exposes the mother and their unborn child to an increased risk of health problems, including low birth weight and pre-term birth[106].

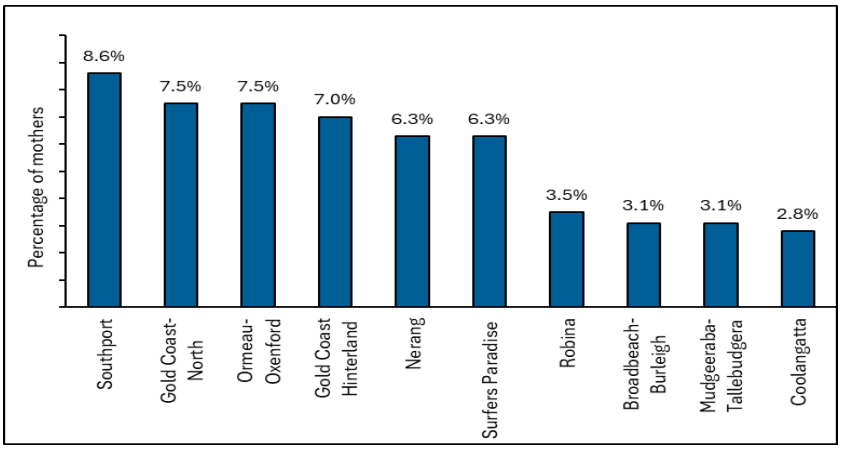
FIGURE 6: MATERNAL SMOKING PRE- AND POST 20 WEEKS GESTATION, GOLD COAST, 2018 TO 2022



Source: Queensland Perinatal Data Collection

- The majority of mothers living in the Gold Coast region do not smoke at all during pregnancy, however, the proportion of mothers who did smoke while pregnant increased between 2018 (4.2%) and 2022 (6.4%).
- Maternal smoking rates post 20 weeks gestation in 2022 decreased to the same level as 2019 (4.0%), which shows that although a higher proportion of women are smoking during their pregnancy than five years prior (2018: 3.4%), the proportion of women who stopped smoking while pregnant improved over four years.
- Maternal smoking rates varied between regions, with residents of Southport (8.6%), Ormeau-Oxenford (7.5%) and Gold Coast-North (7.5%) SA3s having the highest maternal smoking rates.

FIGURE 7: WOMEN WHO SMOKED AT ALL DURING PREGNANCY, GOLD COAST SA3 REGIONS, 2018 TO 2022

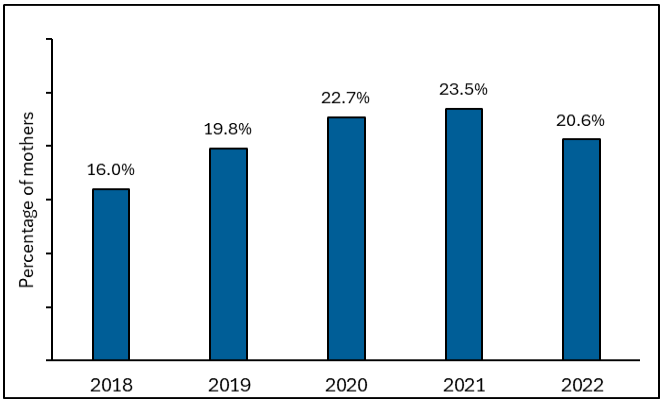


Source: Queensland Perinatal Data Collection

[106] Australian Institute of Health and Welfare 2023, *Smoking During Pregnancy*.

9.3.1 First Nations

FIGURE 8: FIRST NATIONS WOMEN WHO SMOKED AT ALL DURING PREGNANCY, GOLD COAST, 2018 TO 2022



Source: Queensland Perinatal Data Collection

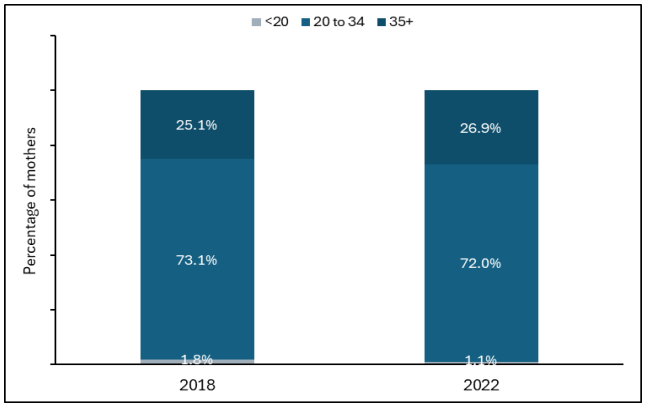
- Most First Nations women do not smoke at all during pregnancy, however, the rate of maternal smoking for First Nations women increased from 2018 (16.0%) to 2022 (20.6%).
- Maternal smoking for First Nations women follows a similar trend to the broader population, where higher rates were observed in 2020 and 2021, followed by a reduction in 2022.

9.4 MATERNAL AGE

The age of the mother during pregnancy is a predictor of risk factors and birth and postnatal outcomes. Lower maternal age (<20 years) is associated with behavioural risk factors (such as maternal smoking), low baby birth weight, and broader disadvantage[107]. Younger mothers are also less likely to breastfeed exclusively and more likely to use instant formula compared to mothers aged 20 or more[108].

Mothers with higher maternal age (35+ years) have increased risk of maternal complications, such as developing gestational diabetes mellitus, and pre-term birth[109].

FIGURE 9: MATERNAL AGE AT BIRTH, GOLD COAST, 2018 AND 2022



Source: Queensland Perinatal Data Collection

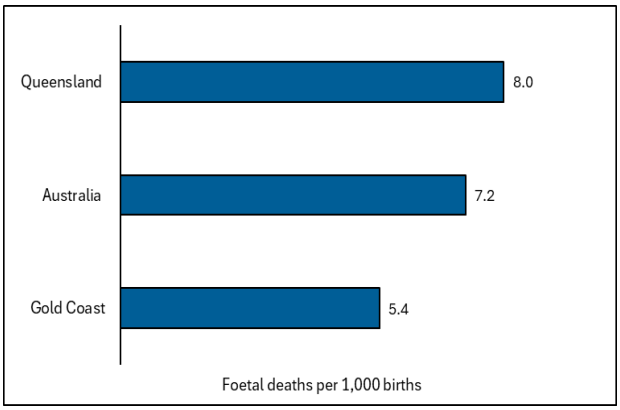
[107] Australian Institute of Health and Welfare 2018, *Teenage mothers in Australia 2015*.
[108] Department of Health 2016, *Queensland infant feeding survey 2014: current results, sociodemographic factors, and trends*.
[109] Australian Institute of Health and Welfare 2023, *Mothers and Babies*.

- The proportion of mothers aged under 20 years in the Gold Coast region decreased over the last five years, from 1.8% in 2018 to 1.1% in 2022, following a broader trend of increasing maternal age.
- More than a quarter (26.9%) of Gold Coast mothers were 35 or older at birth, a proportion which has grown since 2018 (25.1%).

9.5 BIRTH OUTCOMES

9.5.1 Still births

FIGURE 10: STILL BIRTH RATE, GOLD COAST, QUEENSLAND AND AUSTRALIA, 2021



Source: Queensland Perinatal Data Collection; Cause of Death Unit Record File; National Perinatal Data Collection

- The rate of foetal deaths (stillbirths) for the Gold Coast region was lower than both the Queensland (RR: 0.7x) and national rates (RR: 0.7x) in 2021, at 5.4 per 1,000 births.

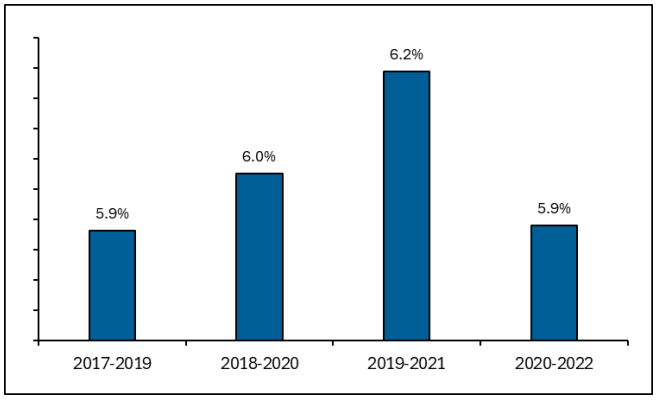
9.5.2 Neonatal birth weight

Low birthweight newborns are at greater risk of poor health, disability, and death compared to babies of healthy weight[110]. Factors that affect low birthweight include maternal age, illness during pregnancy, the level of relative advantage/disadvantage, harmful behaviours such as smoking or excessive alcohol consumption, poor nutrition during pregnancy, and poor antenatal care[111].

The vast majority (92.8%) of Gold Coast babies were born with healthy birth weight (2,500-4,499g) in the three years 2020 to 2022. There was a small, but not significant, decrease in the proportion of low-birth-weight babies born between 2019-2021 and 2020-2022, from 6.2% to 5.9%, but the overall trend remained stable.

[110] Australian Institute of Health and Welfare 2023, *Birthweight*.
[111] Goldenberg, R.L. and Culhane, J.F., 2007. Low birth weight in the United States. *The American Journal of Clinical Nutrition, 85*(2), pp.584S-590S.

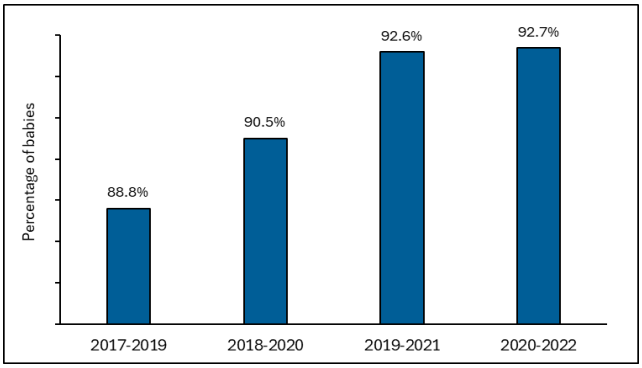
FIGURE 11: BABIES BORN WITH LOW BIRTH WEIGHT, GOLD COAST, 2017-2019 TO 2020-2022



Source: Queensland Perinatal Data Collection

9.5.3 First Nations

FIGURE 12: FIRST NATIONS BABIES WITH HEALTHY BIRTH WEIGHT, GOLD COAST, 2017-19 TO 2020-22



Source: Queensland Perinatal Data Collection

- The proportion of First Nations babies born with healthy birth weight (2,500-4,499g) increased between 2017-2019 and 2020-2022, from 88.8% to 92.7%.
- This change was driven largely by a reduction in the number of babies born with low birth weight, which represents a significant progress in child and maternal health for First Nations women living in the Gold Coast.

9.6 PERINATAL PERIOD

9.6.1 Infant mortality

Death of an infant within the first year of life can be an indicator of underlying risks associated with socio demographic and environmental factors, as well as the effectiveness of antenatal and perinatal care. Deaths can result from congenital abnormalities, complications arising in the antenatal period or peripartum, foetal growth restriction, sudden infant death syndrome, accidents, among other causes.

In 2017-2021, the infant mortality rate was lower than the national rate for the Gold Coast region, at 2.4 per 1,000 live births, compared to the national rate of 3.2 per 1,000 live births[112].

[112] PHIDU 2024, *Social Health Atlas of Australia Primary Health Networks*.

9.6.2 Immunisation

Immunisation is an effective and safe way to protect infants, children and families from harmful infectious diseases.

TABLE 1: PERCENTAGE OF FULLY IMMUNISED 1-, 2- AND 5-YEAR-OLDS, GOLD COAST, DECEMBER 2023

	1 Year	2 Years	5 Years
Gold Coast	89.0%	88.4%	90.4%

Source: PHN Childhood immunisation coverage data, Department of Health and Aged Care

- As of December 2023, the percentage of fully vaccinated children in the Gold Coast region was below the national target of 95%, and below the national average for all age groups.
- Immunisation rates have decreased in since 2020 for all age groups: 3.4% decline for children aged 1, 2.5% decline for children aged 2, and 3.1% decline for children aged 5 years.

9.6.3 Developmental vulnerability and neurodivergence

The Australian Early Development Census (AEDC) provides a national measurement to monitor Australian children's development across five domains:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive
- communication skills and general knowledge

In 2021, 6,910 children participated in the AEDC in the Gold Coast region, of which 20.4% were developmentally vulnerable in one or two domains, and 10.3% were vulnerable in two or more domains. These percentages were below the Queensland rates (24.7% and 13.2%, respectively).

TABLE 2: DEVELOPMENTALLY VULNERABLE CHILDREN, GOLD COAST SA3 REGIONS, 2021

Region	One or two domains	Two or more domains
Queensland	24.7%	13.2%
Gold Coast SA4	20.4%	10.3%
Broadbeach-Burleigh	16.3%	6.6%
Coolangatta	16.7%	8.0%
Gold Coast North	23.6%	11.4%
Gold Coast Hinterland	14.7%	4.0%
Mudgeeraba-Tallebudgera	18.2%	8.3%
Nerang	24.3%	13.5%
Ormeau-Oxenford	22.1%	11.8%
Robina	13.9%	8.1%
Southport	22.4%	10.8%
Surfers Paradise	24.9%	13.2%

Source: Australian Early Development Census, Public table by statistical Area Level (SA3), 2009-2021

Autism

Gold Coast has significant demand for services to diagnose and support young people with autism. Almost half (46.8%) of NDIS participants of all ages living in the Gold Coast region in 2021 had a primary disability of autism or developmental delay/global development delay, which is higher than the state average of 42.7%[113]. Autism was the most common (37.0%) disability for NDIS participants living in the Gold Coast region.

Nationally, the National Disability Insurance Agency reported that 78% of NDIS participants with a primary diagnosis of autism were under the age of 18. It's expected that the number of NDIS participants whose primary disability was autism has grown over recent years.

Local data is unavailable, however, nationally, this cohort of NDIS participants grew by 21% in 2021-22 and 18% in 2022-23[114].

[113] National Disability Insurance Scheme 2021, *Market Monitoring Report*.
[114] National Disability Insurance Scheme 2021, *Autism*.

9.7 CONSULTATIONS

The following key findings emerged through the consultation process with service providers, community members and people working closing with service providers in the Gold Coast region who work with mothers and young children.

Major issues identified included:

- Incidence of postnatal depression.
- Immunisation rates in the Gold Coast region.
- Gold Coast region has limited services for mothers and their children.
- Lack of services near public transport.
- Families frequently do not have a regular GP or a regular general practice which they attend.
- Extreme and excessive behaviours from a much earlier age in a preschool/school setting
- Long wait times into child related neurodevelopment diagnosis and support services (including developmental delay, neurodevelopment exposure disorder, foetal alcohol spectrum disorder and neurodiversity).
- Provision of services targeted at mums living with a mental health issue/illness.
- Low general practice referral to Early Childhood Early Intervention (ECEI), children being missed for early intervention as once in school it's too late.
- The GP may be the only services that picks up on development delay if child is not attending preschool.
- Parents' concerns on labelling their children may impact on their accessing NDIS partner ECEI.

Specific services that are missing or needs that are not met:

- Services that support parents with before and after school care.
- Service providers need education on what other services are available to possibly refer to lack of wrap around support.
- Affordable assessments for autism diagnosis to apply for NDIS continues to be a big gap affecting families and children with long term access to NDIS packages. A diagnosis is required for an application, but many families cannot afford those.
- Carers further report lack of information sharing from health professionals, for example, appointment letter and text reminder sent to the Child Safety Officer not the carer.
- Access to low-cost cognitive assessments is extremely limited. 1year+ waitlist for university clinics. Schools occasionally will support but they do not accept GP referral, only teacher referrals based on learning needs. Private fees are $2000-3000. Some services such as the public funded Child Protection Unit have requested that the child has a cognitive assessment before receiving paediatric assessment by the unit.
- Service gaps that prevent children receiving timely services e.g., lack of publicly funded speech pathology.

- Fetal alcohol spectrum disorder (FASD) assessments for 7-10-year-olds have a 2-year waitlist.
- Griffith University Health clinics have the potential to move towards a multidisciplinary team care-based student clinic.
- Medicare funded services (mental health treatment plan) do not cover assessment cost.
- Allied health is not remunerated by Medicare for participation in case conferencing reducing opportunities for multidisciplinary approaches to complex care.
- Misdiagnosis of trauma as ADHD and ASD.
- Specific groups of mothers and children up to 6 years that have issues accessing services in the Gold Coast region include:
    - low socioeconomic groups,
    - those with limited access to transport, and
    - instances where mother and child both have mental delays and/or complex needs.

9.8 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information
General Practices (Antenatal visits)	212	Across the Gold Coast	• Confirmation of pregnancy. • Immunisation against infections that may affect the baby. • Urine test (for evidence of diabetes or pre-eclampsia). • Monitoring progress of the baby and mother. • Monthly antenatal visits until week 28, fortnightly from week 30 to 36, and weekly thereafter. • Hospital visits usually for an initial assessment and weeks 32 and 41.
Paediatricians	57	Across the Gold Coast	• Manage physical, behavioural, and mental health issues of children. • Trained to diagnose and treat childhood illness, from minor health problems to serious disease.
Early Childhood Education Centres	347	Across the Gold Coast	• Provides professional care for children aged 6 weeks to 5 years. • Some long day care centres offer Kindergarten or preschool programs.
School interventions	78	State schools through Gold Coast	• State schools offer support for children in state schools.
Antenatal clinics at hospitals	4	2 in Southport, 1 in Tugun, 1 in Benowa	• Both public and private antenatal clinics.
Gold Coast HHS perinatal services	Multiple	Various services across multiple locations	• Providing services related to childbirth parenting classes; pregnancy and process of birth; pain relief and induction of labor; assisted birth and caesarean section and parenting the first few weeks. • Child and Family Health Service:

			○ health and developmental checks. ○ feeding and nutritional support/information. ○ education and support groups. ○ parenting interventions to enhance parenting. ○ hearing assessment and referral (four years and over). ○ information and advice for parents for healthcare referrals. • Lavender Mother and baby unit: ○ Four bed specialist state-wide acute service. ○ Specialist care for women who require admission to hospital for mental health difficulties in the first year following childbirth. ○ GPs, obstetricians, paediatricians, psychiatrists and mental health services can refer patients to the unit. • GCHHS Child Development Service (CDS): ○ Community based, multidisciplinary service involved in the assessment and management of children aged 0-10 years referred with developmental problems, such as communication, movement, emotions, behaviour or socialisation. • GCHHS Neurodevelopment Exposure Disorder Service (FASD) clinic: ○ Diagnosis of FASD caused by fetal alcohol exposure. ○ Health professionals at the clinic include paediatricians, psychologists, speech language pathologists, physiotherapists, OTs, social workers, and nurse navigators. ○ Referral to the service can be made by GPs, paediatricians, other medical specialist, psychologists, allied health professionals, Child protection service, Education and Justice Departments.

Birth Suites	4	2 in Southport (1 public at GCUH), 1 in Benowa and 1 in Tugun	• Collaborative multidisciplinary approach to provide midwifery to all women with both low risk and high-risk pregnancies. • The facilities enable early discharge home for women and babies who have an uncomplicated birth, allowing a family centred approach. • Home visiting team provide ongoing support.
Kalwun perinatal services	5	Kalwun and Burleigh locations	• Early learning Program: Central community point for those with young children to build relationships, support each other, and access child and parent related information with a strong cultural connection. • The Family Participation Program assists First Nations families with children < 18 years with child protection and safety matters. • Kalwun's Family Wellbeing Service delivers timely, effective support to Gold Coast families with children and young people aged under 18. • The Kalwun Foster and Kinship Care Service recruits, trains and assesses Aboriginal and Torres Strait Islander carers. • Jarjums playgroup supports and enhances learning in young children with a strong emphasis on play-based learning. It is open for parents/carers of First Nations children aged 0–5 years.
Uniting Care (ECEI)	1	Carrara	• Identify information, community-based and mainstream supports that can be used to support child. • If required, can help request NDIS access, and help with the implementation of the plan.
Parenting programs for behaviour management	Across Gold Coast region	Around 10 providers of varying programs + One online program	• Times may vary, often some are limited to the clients of the service.

Chapter 10: OLDER PEOPLE

KEY FACTS:

- Older adults on Gold Coast visit GPs more frequently than the national average.
- 10,353 Gold Coast residents reported having dementia.
- 3,044 older people in Gold Coast were using home care packages.
- 9,278 potentially preventable hospitalisations for people aged 65 years and over per year.
- Three most common reasons for people aged 65 years and over presenting to ED continue to be the tendency to fall, chest pain, and abdominal pain.

PRIORITISED NEEDS:

1) Absence of designated First Nations Residential Aged Care Homes.
2) Limited, effective systems and models of care and support for increasing number of patients with dementia and their carers.
3) Delayed access to home care, social support and residential and community aged care services, leading to high rates of hospitalisation.
4) Limited effective support in navigating complex community, aged care system and National Disability Insurance Scheme (NDIS).
5) High levels of isolation and loneliness among older people.
6) Growing demand from RACHs for non-emergency situations due to issues around staffing constraints and policy requirements, even when Advance Care Plans in place.
7) Limited culturally appropriate services for culturally and linguistically diverse older people.
8) Slow adoption of digital health solutions by RACHs and poor integration with other clinical systems limits access to clinical information between service providers, including paramedics.

10.1 DEMOGRAPHICS

According to the 2021 Census, the population of the Gold Coast residents aged 65 years and over (referred hereafter as 'older adults') was 114,354 people or 17.8% of total population.

Table 1 provides a breakdown of the older adult population by age group.

TABLE 1: POPULATION OF OLDER ADULTS BY AGE GROUP, GOLD COAST SA3 REGIONS, 2021

Region	65-74		75-84		85 or more		65 or more	
	N	%	N	%	N	%	N	%
Queensland	503,467	9.8%	274,996	5.3%	97,135	1.9%	875,598	17.0%
Gold Coast	64,281	10.0%	37,005	5.8%	13,068	2.0%	114,354	17.8%
Broadbeach - Burleigh	7,197	10.8%	4,214	6.3%	1,645	2.5%	13,056	19.7%
Coolangatta	6,512	11.3%	3,550	6.2%	1,602	2.8%	11,664	20.3%
Gold Coast-North	9,736	14.0%	6,397	9.2%	2,197	3.2%	18,330	26.4%
Gold Coast Hinterland	2,584	12.8%	1,275	6.3%	297	1.5%	4,156	20.7%
Mudgeeraba-Tallebudgera	3,181	8.8%	1,564	4.3%	499	1.4%	5,244	14.6%
Nerang	6,493	9.3%	3,737	5.4%	1,206	1.7%	11,436	16.4%
Ormeau-Oxenford	11,568	7.3%	5,602	3.5%	1,519	1.0%	18,689	11.8%
Robina	5,168	9.6%	3,290	6.1%	1,433	2.7%	9,891	18.3%
Southport	6,032	9.4%	4,047	6.3%	1,840	2.9%	11,919	18.5%
Surfers Paradise	5,809	12.9%	3,336	7.4%	852	1.9%	9,997	22.1%

Source: Australian Bureau of Statistics (ABS) community profiles G01

- 53.4% of the older adult population were female, compared to 46.6% of the all-age population, which is likely due to a higher life expectancy for females.
- According to national trends, the Gold Coast population is aging, with the number of senior residents projected to be 195,734 or 20.7% of the city's population by 2041[115].

10.1.1 First Nations older adults

In 2021, there were 2,431 people in the Gold Coast region identifying as First Nations aged 50 years and over (the age of eligibility for First Nations people to enter the public-funded aged care system). This accounts for 1.0% of all people aged 50 years, compared to the Queensland rate of 2.3%.

Over one quarter (28.2%) of the First Nations population living in Surfers Paradise were aged 50 years and over. The largest population of First Nations peopled aged 50 years and over resided in Ormeau-Oxenford (507 people).

[115] City of Gold Coast 2024, *Statistics for seniors.*.

TABLE 2: FIRST NATION PEOPLE AGED 50 YEARS+, GOLD COAST SA3 REGIONS, 2021

Region	First Nations people aged 50+	
	N	% of First Nations population
Queensland	41,925	17.7%
Gold Coast SA4	2,431	17.5%
Broadbeach - Burleigh	204	20.1%
Coolangatta	323	22.6%
Gold Coast North	296	22.9%
Gold Coast Hinterland	79	18.3%
Mudgeeraba - Tallebudgera	118	15.7%
Nerang	321	18.2%
Ormeau - Oxenford	507	11.6%
Robina	157	17.1%
Southport	277	19.5%
Surfers Paradise	149	28.2%

Source: Australian Bureau of Statistics 2021 Census of Population and Housing (G07)

10.1.2 Multicultural populations

Gold Coast's 5-year net migration from interstate and overseas was 26,034 in 2021; 13.4% of this population were aged 65 years and over[116].

A total of 6,572 adults aged 65+ years in the Gold Coast region migrated from interstate or overseas within the last 5 years, representing 7% of the older adult population. Of those, over 30% migrated within the last 12 months.

These numbers suggest there is a portion of older adults who lack strong support networks, living away from family and friends may impact the availability of informal caring in this population.

10.1.3 Age pension

The proportion of people aged 65+ receiving a government age pension provides an indication of the socioeconomic status and financial vulnerability of older adults.

As of June 2021, 66,893 Gold Coast residents aged 65+ were receiving an age pension. This accounts for 60.5% of the older population, which is slightly lower than the national level of 61.8%. This finding aligns with the lower levels of socio-economic disadvantage observed within the wider Gold Coast population relative to other regions.

Table 3 outlines the number and proportion of age pensioners within the Gold Coast region.

[116] Gold Coast City 2021, *Gold Coast City Migration by age*.

TABLE 3: AGE PENSIONERS, GOLD COAST SA3 REGIONS, 2021

Region	Number of age pensioners	Age pensioners of all persons aged 65+ (%)
Australia	2,556,017	61.8%
Gold Coast SA4	66,893	60.5%
Broadbeach - Burleigh	7,171	53.1%
Coolangatta	6,840	58.1%
Gold Coast - North	11,452	65.4%
Gold Coast Hinterland	2,351	58.1%
Mudgeeraba - Tallebudgera	3,175	60.5%
Nerang	7,359	63.4%
Ormeau - Oxenford	10,757	63.1%
Robina	5,849	63.5%
Southport	7,398	66.6%
Surfers Paradise	4,541	48.0%

Source: Social Health Atlas of Australia, compiled by Public Health Information Development Unit (PHIDU) based on data from the Department of Social Services

10.2 LIFE EXPECTANCY AND CAUSES OF DEATH

As of 2021, the median age at death for Gold Coast residents was 82.1 years (79.8 years for males and 84.2 years for females)[117]. These figures are comparable to the total Australian population.

Between 2018 and 2022, the top five leading causes of mortality for Gold Coast residents were:

1) Dementia and Alzheimer disease (n=2,072 or 10.3% of all deaths),
2) Coronary heart disease (n=2,036 or 10.2% of all deaths),
3) Cerebrovascular disease (n=1,203 or 6.0% of all deaths),
4) Lung cancer (n=1,124 or 4.1% of all deaths),
5) Chronic obstructive pulmonary disease (n=823 or 4.1% of all deaths).

10.3 PREVALENCE OF DISEASES

According to the 2021 Census, the proportion of older adults who reported having at least one long-term health condition in the Gold Coast region was lower than Queensland average (68.7% and 71.4%, respectively).

- Conditions with the highest prevalence among Gold Coast older adult population were arthritis (27.8%), heart disease (15.2%), and diabetes (11.1%).
- Most conditions (apart from dementia) had lower prevalence in the Gold Coast region when compared to Queensland averages.

[117] Australian Institute of Health and Welfare 2021, *Mortality Over Regions and Time (MORT) books: 2017-2021*.

TABLE 4: LONG TERM HEALTH CONDITIONS BY PERSONS AGED 65+, GOLD COAST AND QUEENSLAND, 2021

Condition	Gold Coast		Queensland
	N	%	%
Any long-term condition	78,578	68.7%	71.4%
Arthritis	31,800	27.8%	29.7%
Asthma	9,281	8.1%	9.1%
Cancer (including remission)	12,429	10.9%	10.9%
Dementia (including Alzheimer's)	4,852	4.2%	4.0%
Diabetes (excluding gestational diabetes)	12,695	11.1%	13.5%
Heart disease (including heart attack or angina)	17,420	15.2%	16.8%
Kidney disease	3,666	3.2%	3.4%
Lung condition (including COPD or emphysema)	8,165	7.1%	7.7%
Mental health condition (incl. depression or anxiety)	8,784	7.7%	8.6%
Stroke	4,241	3.7%	3.9%
Other long-term health condition(s)	14,825	13.0%	13.4%

Source: ABS, 2021, Census of Housing and population; Type of Long-term Health condition

10.3.1 Heart failure

Heart failure is a chronic health condition associated with impaired physical functioning, poorer quality of life, increased hospitalisation and co-morbidity. While only an estimated 1-2% of the Australian population lives with heart failure at a given time, the prevalence rises steeply with age: two-thirds of people living with heart failure in Australia are aged over 65 years.

TABLE 5: HOSPITALISATIONS FOR HEART FAILURE, GOLD COAST SA3 REGIONS, 2017-18

Region	Hospitalisations (number)	Age-sex standardised rate per 100,000
Broadbeach - Burleigh	181	172
Coolangatta	174	187
Gold Coast - North	219	173
Gold Coast Hinterland	35	123
Mudgeeraba - Tallebudgera	49	162
Nerang	147	178
Ormeau - Oxenford	174	183
Robina	190	252
Southport	168	191
Surfers Paradise	66	100

Source: Australian Commission on Safety and Quality in Healthcare (ACSQHC), the Second Australian Atlas of Healthcare Variation, 2017

10.3.2 Falls

Another significant cause of morbidity and impaired quality of life among older adults is falls, which are often related to impaired balance, immobility, and frailty, as well as feeling dizzy and having poor vision.

An AIHW report identified that between 2007-08 to 2016-17, about 125,000 people aged 65 and over were seriously injured due to a fall. Injuries to the head (26.2%), hip and thigh (22.4%) were the most common[118]. Furthermore, most hip fractures are caused by falls with 92% of surgery patients experiencing a fall-related injury event[119].

While the availability of data relating to falls among older adults is limited, hospital admissions for hip fractures in older people (most of which are associated with falls) provide an indication of incidence.

The 2023 Gold Coast HHS Local Area Needs Assessment found that 10% of annual growth in ED presentations was due to falls, and hospitalisations due to falls among older people being 16% above the Queensland average (in 2020-21, there were 4,767 hospitalisations for falls for 75+ year old living in the Gold Coast region)[120].

10.3.3 Disability

The care needs of older adults are generally higher than for the rest of the population due to disability, illness, and injury. A person with profound or severe disability needs help or supervision always or sometimes to perform core activities of self-care, mobility and/or communication.

TABLE 6: PERSONS AGED 65+ NEEDING ASSISTANCE FOR CORE ACTIVITIES, GOLD COAST SA3 REGIONS, 2021

Region	Number of people aged 65+ who need assistance	Proportion of population aged 65+ needing assistance
Queensland	156,209	17.8%
Gold Coast	19,113	16.7%
Broadbeach-Burleigh	1,917	14.7%
Coolangatta	1,866	16.0%
Gold Coast North	3,294	18.0%
Gold Coast Hinterland	510	12.3%
Mudgeeraba - Tallebudgera	851	16.2%
Nerang	1,936	16.9%
Ormeau - Oxenford	3,243	17.3%
Robina	1,870	18.9%
Southport	2,467	20.7%
Surfers Paradise	1,153	11.5%

Source: Australian Bureau of Statistics 2021, Census of population and housing

- According to the 2021 Census, over 19,000 Gold Coast older people needed assistance with core activities.
- 20.7% of total older Gold Coast population needing assistance lives in Southport.
- Gold Coast North has the largest number of people aged 65 years and over need assistance with core activities (n=3,294).

[118] Australian Institute of Health and Welfare 2019, *More older Australians hospitalized for fall related head injuries.*
[119] Australian Institute of Health and Welfare 2023, *Hip fracture care pathways in Australia*.
[120] Queensland Health 2023, Queensland Hospital Admitted Patient Data Collection (QHAPDC),.

10.3.4 Wound management

Wound care is a significant issue in Australia, with chronic wounds presenting a large health and economic burden to Australians, the healthcare system, and providers of health services.

Wounds can be broadly classified as acute or chronic based on the duration of the wound and the cause underpinning its development. Most chronic wounds in Australian hospitals and RACH consist of pressure injuries (84%), venous leg ulcers (12%), diabetic foot ulcers (3%), and arterial insufficiency ulcers (1%)[121].

The 2022 'Wounds Australia' pre- budget submission estimated that over 420,000 Australians experience a chronic wound each year, directly costing the Australian healthcare system around AUD $3 billion annually[122]. In 2010-11, the direct healthcare costs of pressure ulcer, diabetic ulcer, venous ulcer, and artery insufficiency ulcers in hospital and RACH settings in Australia were found to be approximately US$2.85 billion[122].

In 2021-22, 4,083 individuals presented to Gold Coast EDs for diseases of the skin and subcutaneous tissue, accounting for 1.8% of all ED presentations[123]. For those, the departure status was:

- emergency service episode completed and discharge: n=2,177 (53.3%),
- admitted to short stay unit: n=929 (22.8%),
- admitted to hospital: n=919 (22.5%),
- left at own risk after treatment commenced: n=35 (0.9%),
- transferred to another hospital: n=21 (0.5%),
- admitted to 'Hospital in the home' service: n<=10 (<0.2%).

The 2023, Gold Coast HHS' consultation with over 120 community stakeholders identified some acute but low urgency needs such as minor infections, which are reportedly being admitted to hospital via ambulance as RACHs and home-based carers do not know of pathways to treat within the community. In addition, QAS reported long times on stretchers to manage health needs of older adults and QPS reports increased resourcing demands managing older persons with dementia and missing persons in the community.

10.3.5 Frailty

Frailty is commonly associated with aging and includes characteristics such as low physical activity, muscle weakness, slowed performance, fatigue or poor endurance, and unintentional weight loss. Frail older adults often have many complex medical problems and a lower ability for independent living, may have impaired mental abilities, often require assistance for daily activities (dressing, eating, toileting, mobility), and have an increased risk of falls[124,125].

---

[121] Graves, N. and Zheng, H., 2014. The prevalence and incidence of chronic wounds: a literature review. Wound Practice & Research: Journal of the *Australian Wound Management Association, 22*(1).
[122] Wounds Australia 2022, *Pre-budget submission to fight Australia's chronic wound epidemic.*
[123] Gold Coast Health 2021-2022, *Emergency Department presentations.*
[124] Kojima, G., 2015. Frailty as a predictor of future falls among community-dwelling older people: a systematic review and meta-analysis. Journal of the American Medical Directors Association, 16(12), pp.1027-1033.
[125] Tom, S.E., Adachi, J.D., Anderson Jr, F.A., Boonen, S., Chapurlat, R.D., Compston, J.E., Cooper, C., Gehlbach, S.H., Greenspan, S.L., Hooven, F.H. and Nieves, J.W., 2013. Frailty and fracture, disability, and falls: a multiple country study from the global longitudinal study of osteoporosis in women. Journal of the American Geriatrics Society, 61(3), pp.327-334.

Most frail older adults are women (partly because women live longer than men), are more than 80 years old, and often receive care from an adult child[126]. Because of the rapid rate of growth in the population aged 65 years and older, the number of frail elderly persons is increasing every year.

Data on the prevalence of frailty among Gold Coast population is currently lacking. Table 7 shows the number of patients in general practice identified as being frail or at risk of frailty, obtained through Primary Sense data.

The Frailty Flag, incorporated into Primary Sense tool, was developed by Johns Hopkins University as part of their ACG System and identifies patients with diagnostic clusters that represent discrete conditions consistent with frailty, such as malnutrition, dementia, severe vision impairment, loss of weight, social support needs, difficulty walking, and falls.

TABLE 7: GENERAL PRACTICE PATIENTS AGED 65+ WITH A FRAILTY FLAG, GOLD COAST, 2023-24

	Number of patients	%
All patients aged 65+	117,815	
Patients with Frailty Flag	5,104	4.3%
Sex		
Males	2,209	43.3%
Females	2,893	56.6%
Other	<10	<0.2%
Age group		
65-74	1,310	25.7%
75-84	2,234	43.8%
85+	1,560	30.6%

Source: Primary Sense, 164 general practices, extracted 1 Nov 2024.

- In 2024, around 4.3% of general practice patients aged 65+ were identified as frail or at risk of frailty. This estimate is much lower than typically reported in the literature, which is likely a result of under recording of frailty diagnosis in primary care.
- Among patients identified through Primary Sense Frailty Flag, 56.7% were females, and almost a third were aged 85 years or older.
- Additional analysis of data on this cohort of patients showed that they also have an average of 5.5 chronic conditions (compared to 3.7 chronic conditions among patients aged 65+ without the Frailty Flag).

10.4 MENTAL HEALTH

The mental health of older adults is often affected by losing the ability to live independently, experiencing bereavement (particularly with death of a life partner), and a drop in income

[126] Torpy, J.M., Lynm, C. and Glass, R.M., 2006. *Frailty in older adults. Jama, 296*(18), pp.2280-2280.

following retirement. These factors may lead to social isolation and/or loneliness, loss of independence and increased psychological distress.

It has been estimated that around 14% of adults aged 60 and over live with a mental health disorder, with depression and anxiety accounting for over 10% of the total disability in older adults[127]. Applying these rates to the Gold Coast population aged 65 years and over, it can be estimated that over 16,000 people are suffering from a mental health disorder. Anxiety disorders among people living in RACH are believed to be higher than those residing in the community[128].

Between 2017-2022, the growth rate in Gold Coast was above the Queensland rate (1.9% and 1.6% respectively)[129], therefore it is reasonable to expect that the number of older adults in the Gold Coast region experiencing mental illness will continue to increase in the future.

10.5 DEMENTIA

10.5.1 What is dementia?

Dementia has become a significant health and aged care issue in Australia, causing a multitude of burdens on the individual, their family, and support systems. It is now the second leading cause of death of Australians and the leading cause of death for Australian women.

The likelihood of the onset of dementia increases with age, however it can also develop in those under the age of 65 (younger or early onset dementia).

Many factors have been found contribute to the development of dementia and may affect symptoms and their progression. Risk factors include age, genetics and family history, however many modifiable lifestyle factors can prevent or delay dementia, such as education, physical and social activity, smoking status, obesity, high blood pressure, hearing loss, depression, high blood plasma glucose, impaired kidney function and diabetes[130].

10.5.2 Prevalence

Based on the AIHW estimates, in 2022, there were an estimated 267,700 people (102,200 men and 165,500 women) with dementia living in the community, and additional 47,410 men and 86,173 women in cared accommodation. This equates to 66.7% of all people with dementia living in the community[131].

As of 2022, the AIHW recorded a total of 10,353 people residing in the Gold Coast area who reported having dementia, with more women (62.1%) than men (37.9%)[16].

It is estimated that in 2054, 21,587 people will be living with dementia in the Gold Coast region; a 102% increase from 2024[132].

[127] World Health Organization 2023, *Mental health of older adults*.
[128] Creighton, A.S., Davison, T.E. and Kissane, D.W., 2016. The prevalence of anxiety among older adults in nursing homes and other residential aged care facilities: a systematic review. *International Journal of Geriatric Psychiatry, 31*(6), pp.555-566.
[129] Queensland Government 2021, *Queensland Regional Profiles – generated report*.
[130] Livingston, G., Sommerlad, A., Orgeta, V., Costafreda, S.G., Huntley, J., Ames, D., Ballard, C., Banerjee, S., Burns, A., Cohen-Mansfield, J. and Cooper, C., 2017. Dementia prevention, intervention, and care. *The lancet, 390*(10113), pp.2673-2734.
[131] Australian Institute of Health and Welfare 2024, *Dementia in Australia*.
[132] Dementia Australia 2024, *Dementia prevalence data estimates 2024-2054*.

10.5.3 Hospitalisations due to dementia

In 2023-24, there were 1071 overnight hospitalisations related to dementia in the Gold Coast region, with an average length of hospital stay of 12 days. Combined, this accounted for a total of 5,232 hospital bed days.

10.5.4 ED presentations due to dementia

Dementia is highly prevalent among older patients presenting to ED. In 2023-24, there were 985 dementia related presentations to Gold Coast and Robina Hospital for older people. Of these presentations, 97 were lower urgency care (triage category 4 and 5).

There is evidence that older ED patients with cognitive impairment are at increased risk of negative events and health outcomes, including ED re-presentation and hospitalisation[133]. When caring for older persons in ED it is important to understand neurological presentations and to be able to differentiate between delirium and chronic cognitive impairment such as dementia. Older persons with dementia are also at high risk of undertreatment of pain and frequently receive fewer analgesics than others of similar age and pathology[134].

10.5.5 Deaths due to dementia

Dementia was the second leading cause of death in the Gold Coast region in 2018-22, accounting for 2,072[135] deaths.

In females, dementia was leading cause of death (1,282 deaths), and for males, it was the second leading cause (789 deaths).

10.5.6 Dementia-specific medications

Although there is no cure for dementia, there are four medicines that may alleviate symptoms: Donepezil, Galantamine and Rivastigmine are approved in Australia for the treatment of mild to moderate Alzheimer's disease, and Memantine is approved in Australia for the treatment of moderately severe to severe Alzheimer's disease. These medications are subsidised through the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme.

In 2021-22, there were over 658,000 prescriptions dispensed for dementia-specific medications to just under 67,700 Australians with dementia aged 30 and over. Since 2012-13, the number of dementia specific mediations dispensed has increased by over 50%. In addition, antipsychotic medications were dispensed to about 20% of the 68,700 people who had scripts dispensed for dementia-specific medication[136].

10.5.7 Residential Aged Care Homes

RACHs are an important resource for people with dementia and their carers. Services include those provided in the community for people living at home (home support and home care), and residential aged care services for those requiring permanent care or short-term respite stays.

[133] Meldon, S.W., Mion, L.C., Palmer, R.M., et al. 2003. A brief risk-stratification tool to predict repeat emergency department visits and hospitalizations in older patients discharged from the emergency department. *Academic Emergency Medicine, 10*(3), pp.224-232.
[134] Queensland Health 2019, *Care for The Older Person In Emergency*.
[135] Australian Institute of Health and Welfare 2023, *Mortality Over Regions and Time (MORT) books*.
[136] Australian Institute of Health and Welfare 2022, *Dementia in Australia: Prescriptions dispensed for dementia-specific medications—data tables*

In the Gold Coast region, 55.1% of people using permanent residential care in 2022 had a diagnosis of dementia[137].

People with dementia typically have longer median lengths of stay at RACH. In 2020–21, the median length of stay in permanent residential care was over eight months longer for people with dementia than for people without a record of dementia. The difference in length of stay between people with dementia and without dementia was 10 months for women and over 6 months for men.

Among people with dementia in Australia, one in three people live in cared accommodation. In 2021-22, there were over 242,000 people living in permanent residential aged care, and more than half (54% or about 131,000) of these people had dementia. In Queensland, there were 25, 377 people with dementia who were living in permanent residential aged care in 2019-20[138].

10.5.8 Carers

The level of care required for people with dementia depends upon individual circumstances but often increases as dementia progresses. Carers are often family members or friends of people with dementia who provide ongoing, informal assistance with daily activities. The negative financial, psychological and physical health consequences of looking after a loved one with dementia are well documented[139].

The AIHW estimates that in 2021, there were between 134,900 and 337,200 informal primary carers of people with dementia. Among primary carers of people with dementia, three in four were female and one in two were caring for their partner with dementia.

The 2022 ABS survey *Disability, Ageing and Carers* among carers of people with dementia found[140]:

- One in two provided an average of 60 or more hours of care per week.
- Three in four reported one or more physical or emotional impacts of the role.
- One in four reported that they needed more respite care to support them.
- One in two experienced financial impacts since taking on the role.

The projections suggest that by 2036, around 360,000 carers will be needed in the community and 170,000 carers in the paid accommodation sector. The need for carers for people with dementia is expected to double by 2056 to around 525,540 carers in the community and 250,420 paid carers in residential aged care if current levels of care are to be maintained[141].

[137] Australian Institute of Health and Welfare 2023, *Gen Aged Care Data - My aged care region*.
[138] Australian Institute of Health and Welfare 2021, *Dementia in Australia,*.
[139] Tookey, S., Greaves, C.V., Rohrer, J.D., Desai, R. and Stott, J., 2022. Exploring experiences and needs of spousal carers of people with behavioural variant frontotemporal dementia (bvFTD) including those with familial FTD (fFTD): a qualitative study. *BMC geriatrics, 22*(1), p.185.
[140] Australian Institute of Health and Welfare 2021, *Dementia in Australia: Carers*.
[141] Brown, L., Hansnata, E. and La, H.A., 2017. Economic cost of dementia in Australia 2016-2056.

10.6 CONTRIBUTING FACTORS

10.6.1 Social isolation and loneliness

Social isolation (having minimal contact with others) and loneliness (subjective state of negative feeling about having a lower level of social contact than desired[142]) can be damaging to people's mental and physical health, particularly in older persons. Loneliness and social isolation have been linked to mental illness, emotional distress, suicide, and development of dementia[143].

It is estimated that around one in five (19%) older Australians are socially isolated, with the highest rates occurring in the largest urban regions and in sparsely populated states and territories. In absence of local social isolation data, applying the national estimate to the Gold Coast region suggest that over 21,700 Gold Coast residents aged 65 years and over are socially isolated.

10.6.2 Low literacy levels

Health literacy relates to how people access, understand and use health information in ways that benefit their health[144]. Data is not regularly collected in the Gold Coast on the prevalence of people with low literacy levels, however national estimates suggest low literacy is highly prevalent among Australian communities.

The Australian Bureau of Statistics found 65% of people aged 60-74 years had low literacy levels (levels 1 and 2 out of 5)[145]. Applying this prevalence to the local Gold Coast older adult population, over 74,000 people are estimated to have low literacy skills.

People with low health literacy are more likely to have worse health outcomes, such as:

- lower engagement with health services, including for preventive services like cancer screening[146],
- higher hospital re-admission rates[147], and
- lower ability to self-manage care[148].

10.6.3 Elder abuse

Elder abuse takes a myriad of forms, including psychological abuse, financial abuse, physical abuse, and sexual abuse, and often a combination of these.

In Australia, the available evidence suggest that prevalence varies across abuse types, with neglect, psychological and financial abuse being the most common.

[142] Peplau, L.A. and Perlman, D., 1982. Loneliness: A sourcebook of current theory, research, and therapy.
[21] Beer, A., Faulkner, D., Law, J., Lewin, G., Tinker, A., Buys, L., Bentley, R., Watt, A., McKechnie, S. and Chessman, S., 2016. Regional variation in social isolation amongst older Australians. *Regional Studies, Regional Science, 3*(1), pp.170-184.
[144] Australian Institute of Health and Welfare 2024, *Health literacy*.
[145] Australian Bureau of Statistics 2013, *Older Australians have lower levels of literacy and numeracy (media release)*.
[146] Kobayashi, L.C., Wardle, J. and von Wagner, C., 2014. Limited health literacy is a barrier to colorectal cancer screening in England: evidence from the English Longitudinal Study of Ageing. *Preventive medicine, 61*, pp.100-105.
[147] Mitchell, S.E., Sadikova, E., Jack, B.W. and Paasche-Orlow, M.K., 2012. Health literacy and 30-day postdischarge hospital utilization. *Journal of health communication, 17*(sup3), pp.325-338.
[148] Geboers, B., de Winter, A.F., Spoorenberg, S.L., Wynia, K. and Reijneveld, S.A., 2016. The association between health literacy and self-management abilities in adults aged 75 and older, and its moderators. *Quality of Life Research, 25*, pp.2869-2877.

The *National Elder Abuse Prevalence survey* estimated that in 2020, 15% of older people living in the community had experienced elder abuse within the last 12 months. Furthermore, 2.9% had experienced neglect, 2.1% had experienced financial abuse, 1.8% experienced physical abuse and 1.0% had experienced sexual abuse within this period. Slightly higher rates of elder abuse were evident for women, this was also the case for psychological abuse and neglect[149].

Increasing financial stress and housing affordability are expected to place increasing pressure on older persons, which may result in mental stress and increased rates of elder abuse[150].

10.6.4 Cognitive impairment

There are limited data available on the prevalence of mild cognitive impairment, however the AIHW has estimated a national prevalence to be 13.7%[192]. In the Gold Coast region, this translates to over 15,600 people aged 65 years and over with mild cognitive impairment.

Furthermore, it is estimated that people with mild cognitive impairment are 3-5 times more likely to develop dementia, particularly Alzheimer's Disease[151].

10.7 UTILISATION OF HEALTH SERVICES

Older people who reside in aged care facilities may use hospital and primary care services more frequently than older people living within the community.

The recent findings from NSW indicates that aged care facility residents use hospitals and ambulances more frequently with 7-times the rate of ambulance episodes, 4-times the rate of ED presentations, and 6-times the rate of unplanned hospital admissions in comparison to older people living within the community. The study also found that unplanned hospitalisations due to a mental health disorder where more common for those living in residential aged care, GP visits were significantly more frequent in this population compared to those living in the community[152].

10.7.1 Hospitalisations

Reducing the number of avoidable hospital admissions is a performance priority for PHNs across the country. The analysis of potentially preventable hospitalisations (PPHs) for people aged 65 years and over shows that there were 9,278 PPHs recorded in Gold Coast public hospitals between 2019 and 2020[153].

The five leading causes of PPH in this age group are:

1. Urinary tract infections, including kidney infections
2. Chronic obstructive pulmonary disease (COPD)
3. Congestive cardiac failure
4. Iron deficiencies
5. Cellulitis

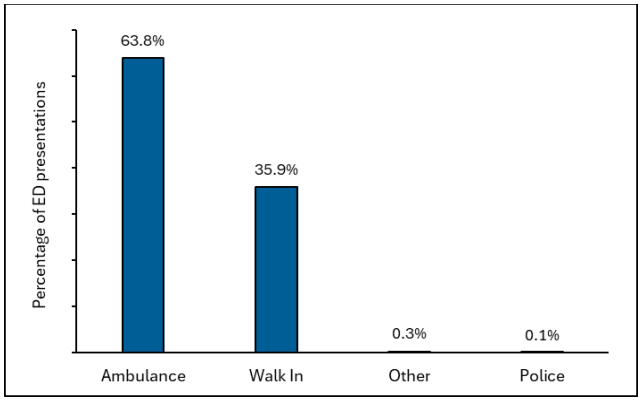
[149] Australian Institute of Health and Welfare 2024, Family, *Domestic and sexual violence*.
[150] Robinson, E. and Adams, R., 2008. Housing stress and the mental health and wellbeing of families. Melbourne: Australian Institute of Family Studies.
[151] Dementia Australia 2022, *Mild Cognitive Impairment.*
[152] NSW Health 2024, *Health care usage for older people*.
[153] Australian Institute of Health and Welfare 2022, *Potentially preventable hospitalisations in Australia by age groups and small geographic areas, 2015–16 to 2019–20*.

10.7.2 Emergency Departments

People who do not have appropriate supports or aged care services in place may utilise Queensland Ambulance Service (QAS) and hospital services more frequently.

Figure 1 demonstrates that the predominant mode of arrival for older adults to ED is via ambulance (63.8%). The ambulance service is a valuable, yet expensive service to operate compared to other primary and community services.

FIGURE 1: ED PRESENTATIONS FOR OLDER ADULTS 65+, BY ARRIVAL MODE, GOLD COAST, 2022-23



Source: GCHHS, Emergency Department presentations.

The three most common reasons for people aged 65 years and over presenting to ED continue to be tendency to fall, chest pain, and abdominal pain.

10.7.3 Primary care

The capacity of the primary healthcare system to manage health needs of older adults, particularly those living in RACHs, is critical in preventing unnecessary transfers to hospitals.

The Royal Commission into Aged Care Quality and Safety heard from many people that the level of service provision by GPs is not adequate to meet the needs of people receiving aged care. Primary healthcare practitioners are either not visiting people receiving aged care at their residences, not visiting frequently enough, or not spending enough time with them to provide the care required[154].

GPs are primarily funded via fee-for-service. The Royal Commission heard evidence about the problems with the fee-for-service funding model, particularly that it creates an incentive for care that responds to an episode of care of ill health, rather than encouraging care that proactively attempts to reduce the risk of ill health. The fee-for-service model is considered by some to be "in conflict with the proactive, coordinated and ongoing team-based approaches that are needed to support the prevention and optimal management of chronic and complex conditions"[155]. The Royal Commission into aged care identified that part of the access problem is the amount of funding available for GPs providing care to people receiving aged care.

The number of GP and specialist attendances per person for the Gold Coast region based on Medical Benefits Schedule (MBS) claims data is outlined in Table 9.

[154] Royal Commission 2024, *Aged Care Quality and Safety*.
[155] Australian Healthcare & Hospital Association 2015, *Primary Healthcare Advisory Group: Better Outcomes for People with Chronic and Complex Health Conditions*,

TABLE 9: RATE OF GP AND SPECIALIST SERVICES PER 100 PEOPLE, GOLD COAST PHN REGION, 2022-23

	GP attendances		After-hours GP attendances		Specialist attendances	
	65-79	All ages	65-79	All ages	65-79	All ages
Gold Coast	1237	709	51	46	202	91
Nationally	1102	639	31	31	224	98
	GP attendances		After-hours GP attendances		Specialist attendances	
	80+ years	All ages	80+ years	All ages	80+ years	All ages
Gold Coast	2006	709	148	46	259	91
Nationally	17827	639	89	31	272	98

Source Australian Institute of Health and Welfare (AIHW) analysis of Department of Health, Medicare Benefits Schedule claims data, 2022 -2023

- Older adults in the Gold Coast region had higher claim rates than other age groups.
- GP attendances were higher for older adults when compared to national rates, but specialist attendances were lower.

10.7.4 Medications

Polypharmacy refers to when people are using five or more medicines at the same time. This is common in older people as they are more likely to have several chronic conditions; approximately two thirds of Australians aged 75+ take five or more medicines. Polypharmacy is associated with risks of medicine-related harm particularly for older people.

Age standardised rates of polypharmacy are provided in Table 10, for people aged 75 and over who resided in the Gold Coast region.

TABLE 10: PEOPLE AGED 75+ WITH FIVE OF MORE MEDICATIONS, GOLD COAST SA3 REGIONS, 2018-19

Region	Polypharmacy (ASR per 100,000 people aged 75+)
Australia	40,226
Gold Coast	36,578
Broadbeach - Burleigh	35,219
Coolangatta	37,206
Gold Coast - North	37,201
Gold Coast Hinterland	35,927
Mudgeeraba - Tallebudgera	43,567
Nerang	34,830
Ormeau - Oxenford	39,434
Robina	32,764
Southport	40,347
Surfers Paradise	31,947

Source: Australian Commission on Safety and Quality in Healthcare (ACSQHC), the Fourth Australian Atlas of Healthcare Variation, 2021

- Rates of polypharmacy for ages 75 and over in the Gold Coast region (36,578 per 100,000) were lower than national average (40,226 per 100,000).
- Surfers Paradise SA3 region had the lowest rate at 31,947 per 100,000 people, and the highest rates were in Mudgeeraba-Tallebudgera SA3 region at 43,567 per 100,000 people.

10.8 ADVANCE CARE PLANNING

Advance care planning (ACP) is the process of planning for future health and personal care whereby a person's values, beliefs and preferences are made known so they can guide clinical decision-making at a future time when that person cannot make or communicate their decisions. ACP is a priority for quality person centered or end of life care.

An advance care directive is a type of written structured advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult[156]. An advance care directive will typically document the persons values, beliefs, and specific preferences for future care and/or include the appointment of a substitute decision maker. A substitute decision maker may be required to make medical treatment decisions on behalf of a persons whose decision-making capacity is impaired[157].

In Queensland, there are three ways individuals can record their choices for future healthcare:

- *Enduring Power of Attorney* - this process allows the individual to choose a trusted relative or friend to manage your personal matters (including healthcare) and financial matters.
- *Advance Health Directive* - this is a formal way to give instructions about the individuals future healthcare. It is sometimes called a 'living will'. It will only take effect if the individual does not have capacity to make decisions.
- *Statement of Choices* - this allows the individual to record their personal values and preferences for healthcare.

Despite the recognised benefits of formally documenting one's ACP preferences, available estimates suggest less than 30% of Australians have completed an advance care directive[158].

There are no dedicated MBS item numbers for ACP; instead, advance care planning is undertaken as part of standard GP consultations, health assessments, chronic disease management plans, or case conferencing items.

Analysing data uploaded by Gold Coast residents to Queensland Health electronic hospital record (The Viewer), a large increase was seen across all document types (statement of choice, advanced health directive and enduring power of attorney) from 2018-19 to 2022-23. In 2022-23, 1,231 Gold Coast residents completed Statement of Choices[159].

[156] Rhee, J.J., Zwar, N.A. and Kemp, L.A., 2013. Why are advance care planning decisions not implemented? Insights from interviews with Australian general practitioners. *Journal of palliative medicine, 16*(10), pp.1197-1204.

[157] Australian Government Department of Health and Ageing 2011, *A national Framework for Advance Care Directives*.

[158] Detering, K.M., Buck, K., Ruseckaite, R., Kelly, H., Sellars, M., Sinclair, C., Clayton, J.M. and Nolte, L., 2019. Prevalence and correlates of advance care directives among older Australians accessing health and residential aged care services: multicentre audit study. *BMJ open, 9*(1), p.e025255.

[159] Queensland Health 2024, *Advance Care Planning*.

TABLE 11: ADVANCE CARE PLANNING DOCUMENTS UPLOADED TO THE QUEENSLAND HOSPITAL RECORD, GOLD COAST, 2018-19 TO 2022-23

Document type	2018-19	2019-20	2020-21	2021-22	2022-23
Statement of Choices	467	1,006	918	1,055	1,231
Advance Health Directive	129	311	286	278	258
Enduring Power of Attorney	167	810	722	747	995

Source: Office of Advance care Planning – Queensland Health

10.9 AGED CARE SERVICES

Australia's changing demographic profile significantly influences the demand for and provision of aged care. Australians are living longer than ever before. It is projected that the number of Gold Coast residents aged 85 years and over will increase from 13,064 in 2021 (2% of the Gold Coast population) to 39,639 in 2041 (6% of the Gold Coast population)[160].

The Australian aged care system provides subsidised care and support to older adults. It is a large and complex system that includes a range of programs and services. The care ranges from low-level support to more intensive services, including:

- assistance with everyday living activities,
- respite,
- equipment and home modifications (e.g., handrails),
- personal care, such as help getting dressed, eating, and going to the toilet,
- health care, including nursing and allied healthcare, and
- accommodation.

Aged care can be provided in people's homes, in the community, and in residential aged care settings. People commonly think of nursing homes, or residential care, when they think about aged care. However, while most of the aged care budget is spent on residential aged care, with more than two-thirds of people using aged care services do so from home.

Government-funded aged care services include in-home care (care in your home), residential care in aged care homes, and short-term care such as respite care.

The aged care system offers care under three main types of service:

- **Care in home**: In-home aged care provides support to help older persons stay independent for as long as possible. It can help with personal care, transport, food, shopping, housework, physio, social activities, and modifications to home. The Australian Government subsidises:
    - entry-level support through the Commonwealth Home Support Program, and
    - support for more complex needs through Home Care Packages.

[160] Australian Bureau of Statistics 2018, *Regional population by age and sex*.

- **Short-term care**: Short-term care can help an older person to improve their wellbeing and independence or get back on their feet after a hospital stay. It can also give their carer a break. The Australian Government subsidises:
    - after-hospital or transition care – support for up to 12 weeks to help recover after a stay in hospital,
    - short-term restorative care – support for up to eight weeks to help improve wellbeing and independence, and
    - respite care – support for a few hours, days or longer to give the older person or their carer a break.
- **Residential care in aged care homes:** Residential care in aged care homes is for older adults who can no longer live at home or need ongoing help with everyday tasks or health care. The Australian Government subsidises aged care homes to provide care that is available 24 hours a day. Residential care can be short-term (respite care) or permanent.

TABLE 12: ALLOCATED PLACES FOR AGED CARE SERVICES BY CARE TYPE, SOUTH COAST AGED CARE PLANNING REGION, 2020 AND 2022

Care type	Number of allocated places	
	2020	2022
Residential	5,578	5,453
Home care	3,044	3,902
Transition care	99	109

Source: AIHW, GEN Aged Care data portal.

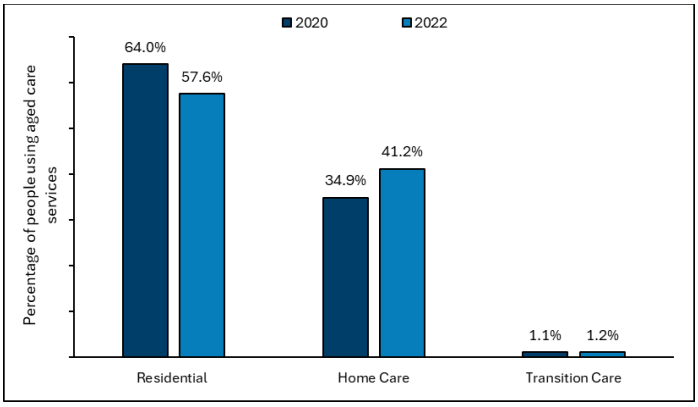
The majority of people accessing aged care services in the South Coast Aged Care Planning Region access residential aged care rather than home care. This may indicate a limited ability for some older people to access the home care services they need. If people are unable to access appropriate supports and or aged care services at home, they may require the higher level of care a residential aged care service provides sooner.

Targeted Care Finder Stakeholder Survey, distributed to Gold Coast service providers and community representatives in July 2022, found the following to be the most common challenges experienced by people navigating and accessing the aged care system:

- Fear of not being able to stay in own home if engaged with aged care services,
- Lack of insight that aged care supports are required,
- Computer literacy and access to the internet,
- Lack of family support to access the aged care system, and
- Trust issues with engaging with the aged care system.

As seen in Figure 2, residential aged care is the most utilised of the three care types in both 2020 and 2022. During this period there was a slight decline in the proportion of residential aged care users (by 6.4%), with a similar increase in the percentage of people using home care (by 6.3%).

FIGURE 2: PERCENTAGE OF PEOPLE USING AGED CARE SERVICES IN SOUTH COAST AGED CARE PLANNING REGION, BY CARE TYPE, 2020 AND 2022



Source: GEN Aged Care Data, People Using Aged Care (2022)

10.10 HOME CARE

Home care packages are one of the ways older Australians with more complex care needs can access care services to get help at home. Older person can choose a service provider while the government then pays the provider a subsidy to arrange a package of care services to meet their needs.

There are four levels of Home Care packages, spanning basic support needs through to high care needs with different funding amounts:

- Level 1: Basic care needs – $10,000/year
- Level 2: Low care needs – $18,000/year
- Level 3: Intermediate care needs – $39,000/year
- Level 4: High care needs – $60,000/year

In 2020-21, 3,044 older people in the South Coast region were using home support. Of those:

- 13.0% had a carer
- 34.7% were born outside of Australia
- 22.9% had a disability
- 0.8% identified as Aboriginal or Torres Strait Islander
- 44.8% lived alone
- 4.2% had a preferred language other than English

Current waiting lists to access home care packages are extensive within the Gold Coast region and nationally, which is likely to impact the utilisation of other aged, community and health services.

As of September 2021, there were 541 people on the National Prioritisation Queue for a home care package residing in the South Coast Aged Care Planning Region (ACPR) who were not accessing or had not been assigned a care package[161]. The majority (n=313) have been approved for Level 3 (3 people were approved for Level 1, 164 for Level 2, and 61 people for Level 4).

Estimated wait times for people entering the National Prioritisation Queue are outlined in Table 14. The first package assignment is often offered at lower level of what the applicant has applied for, as this enables the applicant to receive care and services as soon as possible whilst waiting until the requested level is made available.

TABLE 14: WAITING TIME FOR HOME CARE PACKAGE, NATIONAL PRIORITISATION QUEUE, DECEMBER 2021

Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	6-9 months
Level 3	Level 1	3-6 months	6-9 months
Level 4	Level 2	6-9 months	6-9 months

Source: Department of Health, Home Care Packages Data Report 2 October to 31 December 2021.

The Australian Government has announced an additional 80,000 home care packages nationally (40,000 in 2021-22 and 40,000 in 2022-23)[48]. The time to approve packages has decreased for levels 3 and 4 from 12+ months in March 2018 to 6-9 months in December 2021. However, the first package assignment across all four package levels is being provided at a lower level of care than what is required, potentially increasing risk of hospitalisation or early admission to RACH.

TABLE 15: WAITING TIME FOR HOME CARE PACKAGE, NATIONAL PRIORITISATION QUEUE, OCTOBER 2023

Package level	Time to approved package
Level 1	Less than 1 month
Level 2	3-6 months
Level 3	6-9 months
Level 4	1-3 months

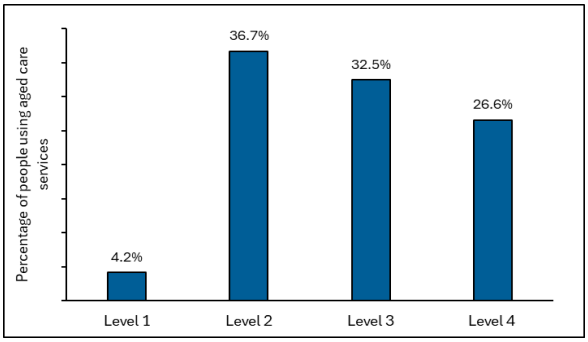
Source: Department of Health. (2023), Home care Packages Program data report: Data Report 21st Quarter 2023-24 , July -September 2023

The time to approve packages has decreased for level 4 from 6-9 months in December 2021 to 1-3 months in October 2023. Wait times for level 3 packages have remained the same since 2021 at 6-9 months.

In 2020-21, the median length of stay in home care was 18 months. Almost 60% of people leaving home care services are moving into residential care facilities. However, it is unknown what proportion of people enter residential care from home care for respite or permanent services.

[161] Department of Health 2023, *Home care Packages Program data report: Data Report 21st Quarter*.

FIGURE 3: PEOPLE USING HOME CARE SERVICES, SOUTH COAST AGED CARE PLANNING REGION, 2022



Source: GEN Aged Care Data, People Using Aged Care (2022)

10.11 RESIDENTIAL AGED CARE HOMES

A Residential Aged Care Home (RACH) is for older adults who can no longer live at home and need ongoing help with everyday task or health care.

Utilisation trends for permanent residential aged care services in the Gold Coast region is outlined in Table 16. There is a 50:50 split of admissions to residential aged care for respite and permanent services.

TABLE 16: NUMBER OF ADMISSIONS AND PEOPLE USING AGED CARE, GOLD COAST, 2022-23

		Number of admissions	Number of people using aged care
Total		3,697	4,935
Age group	Under 65	4	35
	65-74	334	469
	75-84	1317	1626
	85-94	1681	2,208
	95+	361	597
Sex	Female	2,185	3,217
	Male	1,512	1,718
Indigenous status	Yes	14	24
	No	3,667	4,445

Source: GEN Aged Care Data, People Using Aged Care (2022-2023)

Most people who exit permanent residential aged care do so due to death.

TABLE 17: LENGTH OF STAY AND EXITS FROM RESIDENTIAL CARE, BY DISCHARGE REASON, 2022-23

	Death	Return to community	To hospital	Other	To other residential care
Mean length of stay (months)	34.0	7.9	16.7	22.4	20.3
Range length of stay (months)	0.1 -291.1	0- 63.9	0.1 – 85.4	0 – 102.5	0.1– 100.4
Total exits	1,571	90	34	82	93

Source: GEN Aged Care Data, People Using Aged Care (2022-2023)

10.12 CONSULTATIONS

Below is a summary of main points received through consultations conducted in recent years through GCPHN RACH event, Care Finder Stakeholder Survey, Dementia community survey, Primary Care Partnership Council, and Community Advisory Council.

***Workforce and financial challenges*:** RACHs face staffing pressures as residents requiring escorts to external appointments must be accompanied for the duration if they need personal care, leading to additional costs for agency staff and unaffordable escort fees for some residents, ultimately preventing access to necessary care.

***Dementia care gaps*:** Increasing cases of dementia demand higher care needs and secure environments, yet there is a lack of beds in low-care facilities or those without secure units, insufficient resources for post-diagnosis support, limited oral care for residents with dementia, and a perceived lack of GP confidence in diagnosing and managing dementia.

***Access to health services*:** After-hours GP services are increasingly unavailable due to rising demand and limited availability, leading to delays, unclear timelines for RACH visits, and increased hospitalisations; miscommunication between RACHs, QAS, and Residential Aged Care Facility Acute and Social Support (RaSS) further complicates access to acute care when required.

***Barriers to aged care and system navigation*:** Common challenges include difficulty accessing consistent and timely information, low computer literacy, trust issues, fear of losing independence when engaging with aged care services, lack of confidence in navigating systems like My Aged Care, and a shortage of residential care places and funding to support in-home care.

Priority areas: A survey conducted by GCPHN identified socially isolated individuals and those at risk of homelessness as the highest-priority groups for the care finder program, with Gold Coast North and Southport regions requiring focused support; main challenges reported include computer literacy, mental health issues, and limited internet access.

***Resource availability and education**:* There is a pressing need to increase the visibility and accessibility of resources for dementia support in locations like GP practices, community centres, RACHs, and pharmacies, alongside better education.

***Impact of workforce and cost-of-living pressures**:* Staff shortages are compounded by rising living costs, housing affordability issues in the Gold Coast region, and the lack of incentives for metro-based staff, while the cost of maintaining IT systems for telehealth adds financial strain on facilities already struggling with workforce stability.

10.13 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information

General practices	212 practices, 880 GPs	Across Gold Coast region	• GP services include preparation of chronic disease management plans, team care arrangements, medication prescribing and management, health checks and plan review.
			• GPs deliver continuity of care for older adults and use their clinical judgements to make decisions about the most appropriate care for the individual. Roles carried out by GPs generally include:
			  ○ recognition and management of health conditions,
			  ○ assessment of functional capacity of the individual,
			  ○ recognition of their accommodation and care needs,
			  ○ identification of the impacts on family and carers and associated needs for respite care.
			• GPs' role in the requirement for and facilitation of ACP is critical due to their ongoing and trusted relationships with patients. In the Gold Coast region, GPs provide services for older adults in general practices, at an individual's private residence and into RACHs.
			• Activities that have come from the Australian Government investment toward Strengthening Medicare have included voluntary patient registration, GP in aged care incentive and forthcoming activities include changes to the MBS items for chronic disease management.

Residential Aged Care Homes (RACHs)	56	Spread from Ormeau to Coolangatta	• The RACHs range from capacity of up to 170 bed facilities, providing differing levels of care and services across general aged care, palliative, respite, and dementia care.

Aged care services	Residential Care: 56 Home Care: 45 Home Support: 57		Eligibility is based on individual's health, how they are managing at home, and any support they currently receive. Individuals may be eligible for aged care services if they have: • noticed a change in what they can do or remember, • been diagnosed with a medical condition or reduced mobility, • experienced a change in family care arrangements, • experienced a recent fall or hospital admission, or are • 65 years or older (50 years for Aboriginal or Torres Strait Islander people).
Medical deputising services	4	Service Gold Coast region	• The National Association for Medical Deputising includes several services that offer after-hours care in in the Gold Coast region.
Allied health services	Various	Services are spread across Gold Coast; majority in coastal and central areas	• Allied health can be provided in a community or hospital setting and include dieticians, physiotherapists, occupational therapists, pharmacists, podiatrists, psychologists, and social workers. • Allied health plays a key role in care for older adults by providing: ○ Interventions to promote healthy ageing and reduce the impact of chronic conditions and disabilities, ○ Rehabilitative care to support people to regain function and strength after serious injury or an illness such as a stroke, ○ Strategies to support people to live independently in their own home, ○ Care co-ordination to assist people navigate the aged care system.
Specialist practices	Various	Spread across Gold Coast	• Many different specialists contribute to the care of older adults in the Gold Coast region, ranging from cardiology, psychiatry, and oncology etc.

Gold Coast Hospital and Community Health Centres	9	2 public hospitals (Southport and Robina) 5 private hospitals (Benowa, Currumbin, Robina, Southport, Tugun) 2 Community Health Centres (Palm Beach and Helensvale)	• Aged Care Assessment Teams at GCUH at Southport, Robina Hospital, Helensvale Community Health Centre, and Palm Beach Community Health Centre. • Specialist palliative care in an inpatient and community setting. • Older Persons Mental Health Unit at Robina Hospital: 16 inpatient beds and community outreach. • Complex Needs Assessment Panel (CNAP) 65+ provides coordination of care and services to support older adults with complex mental health needs. • Geriatric Evaluation and Management in the Home located at GCUH. • Bereavement services at Robina Hospital and GCUH.
Residential Aged Care Homes (RACH) Acute Support Service (RaSS)		Gold Coast University Hospital and Robina Hospital	• Clinical advice is also available via phone and by virtual options. • The RaSS team provide support for residents who present to ED or are hospitalised. • The RaSS team liaise with treating hospital teams, GPs, RACH staff and support coordination around discharge with an individualised plan for continuity of care, including follow up calls post discharge. • This service does not replace existing GP cover but rather provides supplementary service as a single point of contact for RACHs and GPs on behalf of HHS.

Non-Government organisations			• A range of not-for-profit providers who deliver after hours and in-home care services, including:
			  ○ Home modification and maintenance
			  ○ Cleaning and personal care
			  ○ Shopping
			  ○ Social outings
			  ○ Transportation to respite care
			  ○ Palliative care and dementia care

			• The cost of the individual's community care can often be supported through Commonwealth Home Support Program (CHSP) and Home Care Package (HCP), depending on the eligibility.
Older Persons Advocacy Network	1	National	• OPAN offers free, independent and confidential support and information to older people seeking or already using Australian Government-funded aged care services across the nation, along with their families and carers.
End of Life Directions for Aged Services	1	National	• ELDAC is a national specialist palliative care and advance care planning advisory service. This service comprises a comprehensive website with resources to equip care providers with skills and information to help older Australians receive high-quality end of life care.
Aged and Disability Advocacy Australia	1	Brisbane	• A not-for-profit, independent, community-based advocacy and education service. • They support and improve the wellbeing of older adults and people with disability. • Services are free, confidential and client focused.
Commissioned wound clinic (GCPHN funded)	1	Bundall	• Dedicated wound clinic led by a wound specialist GP and nurse practitioner, supported by a team of highly trained nurses. • They support local GPs and their patients to improve health outcomes for people that have chronic, complex, recurrent, and debilitating wounds that impact on their quality of life.
Care Finder (GCPHN funded)	3	Gold Coast	• The care finder program aims to provide specialist and intensive assistance to help older adults to understand and access aged care support services and connect with other community supports.

Chapter 11:
CANCER AND CHRONIC DISEASE

KEY FACTS:

- 1 in 4 adults in the Gold Coast region have a self-reported long-term health condition.
- The most prevalent chronic conditions are arthritis, mental health conditions, and asthma.
- Around 25,000 people in the Gold Coast region have medium or high risk for cardiovascular disease in the next five years.
- The number of general practice patients with chronic obstructive pulmonary disease has doubled in the last five years.
- Around 15,000 people in the Gold Coast region have been diagnosed with cancer in the last five years.
- Lung cancer is the leading cause of death due to cancer in the Gold Coast region.
- Rates of participation in bowel, breast and cervical screening programs in the Gold Coast region are comparable to national rates but decreasing in recent years.
- An estimated 66,000 people aged 45+ in the Gold Coast live with persistent pain.

PRIORITISED NEEDS:

1) Effective integrated care of complex chronic disease to optimise quality of life and avoid preventable hospitalisations.
2) There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.
3) Higher rates of chronic obstructive pulmonary disease and asthma diagnoses.
4) Equitable access for integrated holistic multidisciplinary persistent pain management especially lower socio-economic groups.
5) Low rate of bowel cancer screening participation across Gold Coast, and across all national cancer screening programs in northern Gold Coast.
6) Sufficient resources required to implement National Lung Cancer Screening Program and respond in a timely way to increased demand.
7) Delayed diagnosis and limited dedicated primary care services for endometriosis and pelvic pain.
8) High melanoma incidence rate.

11.1 PREVALENCE OF CHRONIC DISEASES

According to the 2021 Census, the proportion of adults with a self-reported long-term health condition in the Gold Coast region (39.6%) was slightly below the Queensland average (41.8%).

TABLE 1: PREVALENCE OF LONG-TERM HEALTH CONDITIONS, GOLD COAST AND QUEENSLAND, 2021

	Gold Coast		Queensland
	N	%	%
Any long-term condition	254,049	39.6%	41.8%
Arthritis	53,517	8.4%	8.8%
Asthma	49,223	7.7%	8.5%
Cancer (including remission)	20,161	3.1%	3.7%
Dementia (including Alzheimer's)	5,155	0.8%	0.7%
Diabetes (excluding gestational diabetes)	22,987	3.6%	4.5%
Heart disease (including heart attack or angina)	24,123	3.8%	4.2%
Kidney disease	5,491	0.9%	0.9%
Lung condition (including COPD or emphysema)	12,151	1.9%	2.1%
Mental health condition (incl. depression or anxiety)	53,788	8.4%	9.6%
Stroke	5,927	0.9%	1.0%
Other long-term health condition(s)	50,153	7.8%	8.4%

Source: ABS, 2021, Census of Housing, and population. – Type of Long-term Health condition.

- Conditions with the highest prevalence among Gold Coast population were arthritis and mental health condition (each affecting 8.4% of population), followed by asthma (7.8%).
- Most conditions had lower prevalence in the Gold Coast region when compared to Queensland averages, apart from dementia.

11.1.1 Asthma

Around 2.8 million (11%) people in Australia were estimated to be living with asthma in 2022[162].

In 2020-21, asthma was the principal diagnosis for 508 public hospital admissions in the Gold Coast region (ASR of 88.8 per 100,000), which was lower that for total Queensland (98.2 per 100,000; n=4,933)[163].

11.1.2 Diabetes

Diabetes rates in the Gold Coast region are lower than Queensland and national averages. This is reflected in hospital admissions for diabetes, which occur less frequently in comparison to Queensland averages.

During 2020-21, in the Gold Coast region there were 888 public hospital admissions (ASR 148.9 per 100,000) where diabetes was the principal diagnosis. This was below the Queensland ASR of 219.3 per 100,000 (n=10,831)[2].

[162] Australian Institute of Health and Welfare 2023, *Asthma*.
[163] PHIDU 2024, *Social ATLAS of Australia: Primary Health Network's. Admissions principal diagnosis*.

11.1.3 Chronic kidney disease

One in three Australians have an increased risk of chronic kidney disease (CKD). Risk factors for developing CKD include:

- Diabetes, high blood pressure
- heart problems (heart failure or heart attack) or have had a stroke
- having smoked or being a current smoker
- being obese with a body mass index (BMI) 30 or higher
- being 60 years or older
- being of Aboriginal or Torres Strait Islanders origin

Hospital admissions for kidney disease in the Gold Coast region are slightly above the Queensland rate. Chronic kidney disease was the principal diagnosis for 1,216 public hospital admissions (ASR 206.2 per 100,000) in the Gold Coast region during 2020-21. Comparatively, the ASR rate for Queensland was 185.7 per 100,000[164].

No local data is available for mortality rates attributed to CKD. National rate of CKD as an underlying or associated cause of death in 2021 was 69.9 deaths per 100,000 for males and 46.1 deaths per 100,000 for females[165].

11.1.4 Cardiovascular disease

Cardiovascular disease (CVD) is a major cause of disease and death in Australia. CVD is preventable in many cases, as several of its risk factors are modifiable:

- overweight and obesity
- tobacco smoking
- high blood pressure
- high blood cholesterol
- insufficient physical activity
- poor nutrition
- diabetes

During 2020-21, there were 1,888 admissions to Gold Coast public hospital for ischaemic heart disease, 999 admissions for heart failure, and 1,100 admissions for stroke. Rate of CVD related hospital admissions in the Gold Coast region was around 25% lower than that for total Queensland despite rates of cardiac disease and stroke being comparable with national averages.

Table 2 displays risks of cardiovascular events for general practice patients in the Gold Coast region, obtained through the Primary Sense tool. The CVD risk is calculated based on the Framingham Risk Equation, which uses age, gender, ethnicity, and lipid and blood pressure measures combined with smoking habits to calculate the likelihood of a cardiovascular event in the next five years.

[164] PHIDU 2024, *Social ATLAS of Australia: Primary Health Network's. Admissions principal diagnosis*.
[165] Australian Institute of Health and Welfare 2024, *Chronic kidney disease: Australian facts*.

As of June 2024, 181,526 patients in the Gold Coast region were identified as being at risk of a cardiovascular event in the next five years.

TABLE 2: FIVE-YEAR RISK OF CARDIOVASCULAR EVENT, GENERAL PRACTICE PATIENTS, GOLD COAST, 2024

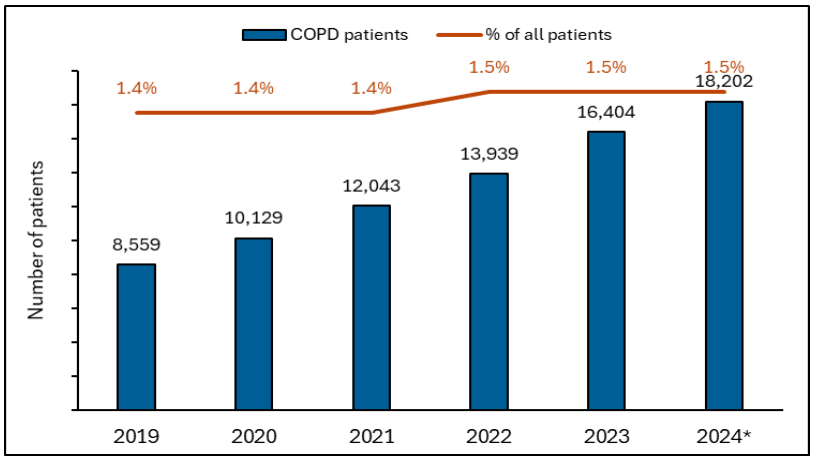
Measure	N	%
High Risk > 15%	13,670	7.5%
Medium Risk 10 - 15%	21,368	11.8%
Low Risk < 10%	129,242	71.2%
Automatic High Risk	31,923	17.6%
TOTAL	181,526	

Source: Primary Sense (data from 160 general practices).

11.1.5 Chronic obstructive pulmonary disease (COPD)

Figure 1 shows the number of patients with a diagnosis of COPD across 160 Gold Coast general practices (i.e. prevalence rather than incidence).

FIGURE 1: GENERAL PRACTICE PATIENTS WITH COPD, GOLD COAST, 2019 TO 2024



Source: Primary Sense (data from 160 general practices). *Year 2024 includes data until 10 October 2024; numbers for 2024 are likely to increase further with new patients receiving a diagnosis of COPD by the end of 2024.

- The number of unique patients with a COPD diagnosis has more than doubled from 2019 to 2024, with most recent data from October 2024 identifying over 18,000 patients.
- To account for the fast-growing population of Gold Coast, numbers of patients are also presented as a percentage of total patient population. In 2024, patients with COPD accounted for around 1.5% of total patient population (note: total patient population across Gold Coast general practices is currently around 1,1 million).
- The rate of public hospital admissions in the Gold Coast region with COPD as the principal diagnosis was lower than the Queensland rate at 189.6 per 100,000 during 2020-21 versus 230.1 per 100,00, respectively[6].

11.2 CANCER

11.2.1 Cancer incidence

In 2022, the age-standardised rate of cancer incidence in the Gold Coast region was 542.4 per 100,000 people. Although comparable to the average Queensland rate, there is significant disparity in some cancer types, increasing incidence of urological, gynaecological and endocrine cancers and a significantly higher rate of melanoma.

TABLE 3: ALL CANCER INCIDENCE RATE, QUEENSLAND AND GOLD COAST, 2012 AND 2022

	Gold Coast				Queensland
	2012		2022		2022
	N	ASR (per 100,000)	N	ASR (per 100,000)	ASR (per 100,000)
All cancer incidence	3,380	555.7	4,548	542.4	542.2
Urological	719	114.8	1,212	138.7	135.6
Melanoma	509	86.4	657	80.9	69.0
Breast	404	66.8	496	63.5	62.5
Haematological	369	60.9	467	55.3	57.9
Colorectal	391	63.9	448	53.3	50.2
Lung	321	52.8	379	42.5	47.1
Gynecological	115	36.3	151	37.5	43.5
Hepatobiliary (liver)	134	22.0	169	19.1	21.4
Head and neck	115	18.9	142	17.3	17.7
Upper GI	102	16.6	141	16.4	15.8
Endocrine	49	8.6	88	11.8	15.0
Unknown primary	64	10.4	65	7.2	8.6
CNS and brain	37	6.3	50	6.6	7.0
Other invasive cancers	24	3.8	48	5.7	7.2
Bone and soft tissue	27	4.6	35	4.3	4.7

Queensland Health. Cancer Data Explorer. Cancer Alliance Queensland, Brisbane; 2024. Accessed 26-9-2024.

- The number of cancer diagnoses in the Gold Coast region increased from 3,380 in 2012 to 4,548 in 2022; an increase of 34.6%.
- When expressed as age-standardised rate, the incidence of cancer decreased over the last 10 years (from 555.7 per 100,000 in 2012 to 542.4 per 100,000 in 2022).
- During the same time, the number of total cancer diagnoses across Queensland increased by 33.0%, however, the ASR rate decreased from 549.1 in 2012 to 542.2 in 2022[166].
- The incidence of melanoma in the Gold Coast region is higher than that for total Queensland.

11.2.2 Cancer prevalence

In 2022, the age-standardised five-year prevalence rate for all cancer types was 1,886.0 per 100,000 people, slightly higher than the Queensland rate of 1,853.4.

[166] Queensland Health 2024, *Cancer Data Explorer*.

Since 2021, the Gold Coast rate decreased from 1,902.3 per 100,000 people whilst Queensland's rate remained stable (1,854.9 per 100,000 people).

TABLE 4: 5-YEAR CANCER PREVALENCE RATE, GOLD COAST AND QUEENSLAND, 2022

	Gold Coast		Queensland
	N	ASR (per 100,000)	ASR (per 100,000)
All cancers	15,715	1,886.0	1,853.4
Urological	4,168	475.6	463.9
Melanoma	2,811	345.3	312.1
Breast	2,304	288.0	282.1
Hematological	1,747	208.7	213.3
Colorectal	1,581	188.4	187.7
Lung	871	97.5	96.2
Gynecological	672	163.0	163.5
Hepatobiliary	312	35.5	35.7
Head and neck	549	65.4	65.1
Upper gastrointestinal	419	49.2	44.2
Endocrine	433	58.0	70.2
Unknown primary	81	9.6	9.6
CNS and brain	102	14.8	14.9
Other invasive cancers	176	20.8	22.9
Bone and soft tissue	108	14.1	15.4

Source: Queensland Health. Cancer Data Explorer. Cancer Alliance Queensland, Brisbane; 2024. Accessed 26-9-2024. 5-year prevalence is the number of people who had a diagnosis within the last 5 years (i.e. between 2018 and 2022).

- Gold Coast region had higher prevalence of urological, upper gastrointestinal cancers and melanoma, compared to the Queensland average.
- In contrast, Gold Coast prevalence rates were currently lower than Queensland average for endocrine cancers, noting the 10-year growth trend already identified in Table 3 will impact this in the future.

11.2.3 Cancer mortality

The AIHW mortality data from 2018 to 2022 reveals various types of cancer were among the top 20 leading causes of death within the Gold Coast region.

Table 5 lists these types of cancer and compares their rates against the national averages.

TABLE 5: LEADING 5 CAUSES OF DEATH FOR CANCER, GOLD COAST, 2018-2022

	Number of deaths	ASR mortality rate (per 100,000 people)	
		Gold Coast	Australia
All cancer mortality*	3,769		
Lung cancer	1,124	27.0	27.1
Colorectal cancer	665	16.2	16.5
Prostate cancer	508	11.7	10.6
Breast cancer	400	10.1	10.1
Cancer of unknown or ill-defined primary site	392	9.2	9.4

Source: AIHW: Mortality Over Regions and Time (MORT) books, 2018-2022. * Only includes cancers in top 20 leading causes of death in Gold Coast.

11.2.4 Cancer screening rates

TABLE 6: PARTICIPATION IN NATIONAL CANCER SCREENING PROGRAMS, GOLD COAST SA3 REGIONS

	Bowel cancer screening % of persons aged 50–74 (2021-22)	Breast cancer screening % of women aged 50-74 (2019-20)	Cervical cancer screening % aged 25-74 (2018-21)
National	40.0%	49.4%	62.4%
Gold Coast SA4	36.2%	49.9%	63.5%
Broadbeach – Burleigh	38.6%	53.5%	71.4%
Coolangatta	38.5%	52.2%	68.7%
Gold Coast – North	37.0%	49.7%	59.8%
Gold Coast Hinterland	38.7%	50.0%	64.2%
Mudgeeraba – Tallebudgera	37.5%	51.9%	69.2%
Nerang	34.7%	49.1%	64.5%
Ormeau – Oxenford	34.7%	48.9%	59.6%
Robina	36.7%	53.7%	66.8%
Southport	33.5%	47.1%	59.9%
Surfers Paradise	35.6%	43.5%	59.4%

Source: AIHW analysis of National Bowel Cancer Screening Program Register, BreastScreen Australia data and state and territory cervical screening register data. SA3s with a numerator less than 20 or a denominator less than 100 have been suppressed.

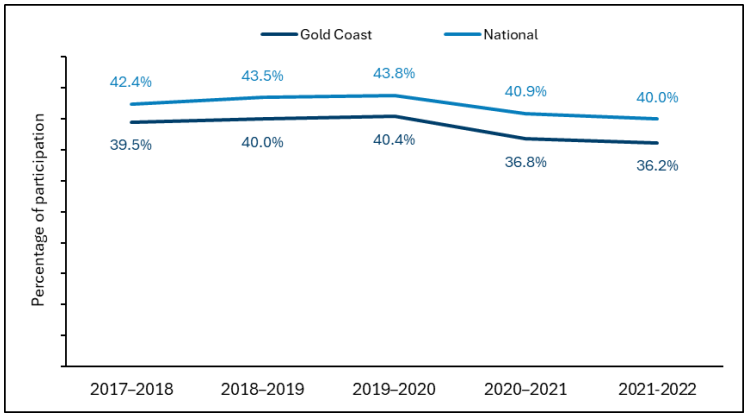
- In 2021-22, the involvement of Gold Coast residents aged 50-74 years in the National Bowel Cancer Screening Program was below the national rate (36.2% vs 40.0%).
- In 2019-20, the participation rate of patients aged 50-74 years in BreastScreen Australia services was slightly higher than the national rate (49.9% vs 49.4%).
- In 2018 to 2021, the participation rate of people with a cervix aged 25-74 years in cervical screening programs was higher than the national rate (63.5% vs 62.4%), although participation varied by suburbs (for example, lower rates in central and northern Gold Coast).

Bowel Cancer Screening

This program aims to reduce deaths from bowel cancer by detecting early signs of the disease. If found early, more than 90% of cases can be successfully treated. Eligible Australians aged 50 to 74 are mailed a free test done at home every 2 years.

As part of the 2024-25 Budget, the Government has announced that from 1 July 2024, people aged 45 to 49 are also eligible to participate in the National Bowel Cancer Screening Program. This change reflects recent updates to colorectal cancer clinical guidelines which recommend population bowel cancer screening be offered to people from the age of 45.

FIGURE 2: PARTICIPATION IN THE NATIONAL BOWEL CANCER SCREENING PROGRAM, GOLD COAST AND NATIONAL, 2017-18 TO 2021–22



Source: AIHW analysis of National Bowel Cancer Screening Program (Department of Human Services) register data and National Cancer Screening Register data

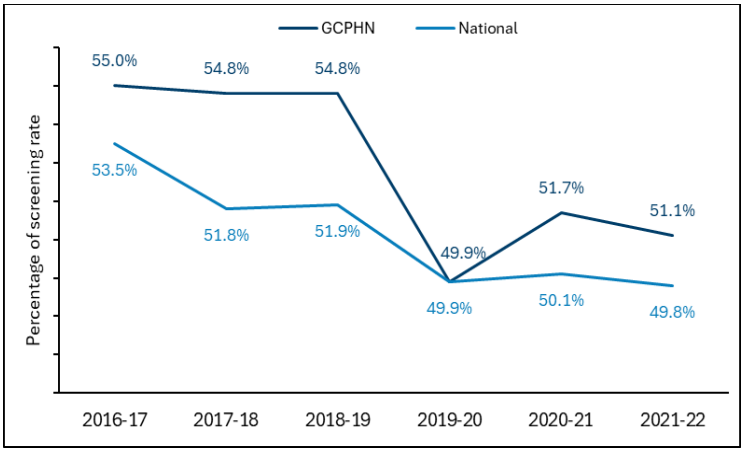
- Between 2017-18 and 2019-20, there was a consistent annual increase in participation in the National Bowel Cancer Screening Program, however, rates for the Gold Coast region remained lower than the national rates throughout this period.
- A decline is evident in 2020-21, likely influenced by the effects of COVID-19, which may have impacted individuals' opportunities to undertake screening.

Breast cancer screening

BreastScreen Australia is a joint initiative of the Australian and state and territory governments and aims to reduce illness and death from breast cancer through early identification. Women over 40 can have a free mammogram every 2 years, and women aged 50-74 are invited to screen.

- There has been a steady decrease in women participating in breast screening program since 2016-17, both at the Gold Coast and whole of Queensland level.
- In 2021-22, the participation rate for women aged 50 to 74 in the Gold Coast region in 2021-22 was 49.8%, compared to the Queensland rate of 51.1%.

FIGURE 2: PARTICIPATION IN THE NATIONAL BREAST CANCER SCREENING PROGRAM, GOLD COAST AND NATIONAL, 2016-17 TO 2021-22



Source: Data for years 2016/17 to 2019/20 were sourced from AIHW analysis of state and territory BreastScreen register data (most recent data available at the time of publication). Data for 2020/21 and 2021/22 were sourced from BreastScreen Queensland Gold Coast Service Participation Rate Summary Report, supplied by the Queensland Cancer Screening Unit.

Cervical cancer screening

The National Cervical Screening Program (NCSP) reduces illness and death from cervical cancer.

Starting in December 2017, NCSP transitioned to conducting cervical screenings every five years for individuals aged 25 to 74 (a change from the previous interval of every two years for those aged 20 to 69). Participation rates are assessed over five calendar years to match the new screening frequency, with preliminary data only currently available. During the period from 2018 to 2021, participation in the Gold Coast region was 63.5%, slightly surpassing the national average of 62.4%[167].

According to the preliminary data from 2018 to 2022, Gold Coast residents aged 25–29 had the highest participation rate (73.0%) while people aged 70–74 had the lowest estimated participation rate (29.8%). It should be noted, however, that lower participation rates are expected among people aged 70–74 as this age group was recently added to the population in scope under the renewed NCSP (previously capped at age 69).

Lung cancer screening

The new National Lung Cancer Screening Program (NLCSP) will begin from July 2025. It will use low dose computed tomography scans to look for lung cancer in high-risk people without any symptoms with the aim to find lung cancer early and reduce deaths from lung cancer.

Participants eligible for NLCSP will include:

- persons aged between 50 and 70 years, and
- who show no signs or symptoms of lung cancer, and
- have a history of at least 30 pack-years of cigarette smoking and are still smoking *or* have quit in past 10 years.

[167] Australian Institute of Health and Welfare 2024, *analysis of National Cancer Screening Register data*.

11.3 PERSISTENT PAIN

Persistent pain is any pain that lasts beyond normal healing time after injury or illness - generally three to six months, ranging from mild to severe. The defining characteristic of persistent or chronic pain is that it is ongoing and experienced on most days of the week.

Persistent pain is often linked to chronic musculoskeletal conditions which generally increase with age. An ageing population, combined with population increases and predictions that the prevalence of musculoskeletal conditions will rise in Australia over the next few decades, means that there are expected to be increasing cases of persistent pain in the Gold Coast region.

Persistent pain has a large effect on a person's life and on the Australian economy more broadly. The financial cost of persistent pain in 2018 was an estimated $73.2 billion[168]. This included:

- $48.3 billion (66%) for productivity costs, reflecting the impact on a person's ability to work, work performance and employment outcomes.
- $12.2 billion (17%) for direct health system costs (where known cause and unknown cause of chronic pain estimates are the same).

There are increasing concerns about the trend in prescribing opioid medications, dependency, addiction issues, and possible long-term adverse effects. Rates of opioid medication prescriptions in the Gold Coast region are slightly higher than the national average.

Recommended treatment for persistent pain promotes self-management and involves an integrated multidisciplinary approach. There are several specialist pain clinics and a range of primary care providers in the Gold Coast region, but consultation indicates issues exist with service access and coordination.

An initiative delivered by GCPHN found that an integrated self-management model of care can lead to improved perceptions of pain, health service access, safe and effective medication use, ability to perform everyday activities and coping, as well as a reduction in hospitalizations.

11.3.1 Prevalence

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

In 2016, it was estimated that around one in five Australians aged 45 years and over reported having persistent pain[169]. Persistent pain increased with increasing age, to almost one in four adults (24%) aged 85 and over. If this rate was to remain stable today, an estimated 66,314 residents of the Gold Coast region aged 45+ have persistent pain based on 2021 Census population.

Gold Coast region has a relatively older age profile compared to the national average, contributing to further likelihood that prevalence of persistent pain will increase in the Gold Coast region in the coming years.

[168] Pain Australia 2019, *The cost of pain in Australia*.
[169] Australian Institute of Health and Welfare 2020, *Chronic pain in Australia*.

There are many conditions that cause persistent pain, with most being chronic musculoskeletal conditions such as osteoarthritis, back and neck pain, osteoporosis, and fibromyalgia. In Australia, the burden of disease attributed to musculoskeletal conditions is ranked second amongst all chronic health conditions in terms of years of healthy life lost due to disability.

Modelling conducted in 2013 by Arthritis and Osteoporosis Victoria[170] predicted the following:

- As Australia's population ages over the next two decades, the prevalence of musculoskeletal conditions will rise significantly.
- By 2032, it is projected that the number of cases of arthritis and other musculoskeletal conditions will increase by 43% to 8.7 million, affecting 30.2% of the population.
- The number of people with osteoarthritis and osteoporosis is projected to increase by 58% and 50%, respectively, however back problems will remain the most prevalent condition.
- The age group with the most cases of arthritis and other musculoskeletal conditions is currently 55-64 years, however this will change to the 75+ age group by 2032.

11.3.2 Musculoskeletal conditions

According to the 2022 ABS National Health Survey, an estimated 29% (7.3 million) of Australians live with a chronic musculoskeletal condition. Data pertaining to the prevalence of musculoskeletal conditions in the Gold Coast region is limited, however applying this rate to the Gold Coast population results in an estimated 185,826 people living with a musculoskeletal condition in the Gold Coast region[171].

Findings from the 2020 AIHW Chronic Pain Report reveal that most Australians with chronic pain are in hospital for musculoskeletal conditions. Just under half of people with chronic pain had a principal diagnosis of a musculoskeletal system and/or connective tissue disease (such as arthritis and back pain)[172]. Based on the 2021 ABS census, 53,517 people in the Gold Coast region self-reported an arthritis diagnosis.

Persistent pain has a significant negative effect on the quality of life and contributes to economic disadvantage. In 2018, persistent pain cost an estimated $139 billion in Australia, largely due to reduced quality of life and productivity loss[172]. Over half of the cost of chronic pain is borne by individuals and their families and friends, with loss of productivity being a significant contributory factor. Over 90% of people with severe pain report some level of interference with the ability to work in both paid employment and housework.

There are several risk factors associated with the onset and management of chronic musculoskeletal conditions that cause persistent pain. These include age, obesity, physical inactivity, smoking and co-morbidities such as cardiovascular disease and mental health conditions. Persistent pain is also more common among people in low socioeconomic groups.

[170] Arthritis and Osteoporosis Victoria 2013, *A problem worth solving*.
[171] Australian Institute of Health and Welfare 2024, *Chronic musculoskeletal conditions*.
[172] Australian Institute of Health and Welfare 2020, *Chronic pain in Australia*.

11.3.3 Lower back pain

It is estimated that 70-90% of people will suffer from lower back pain in some form at some point in their life[173]. Back problems include a range of conditions linked to the bones, joints, connective tissues, muscles, and nerves of the back. Australian Bureau of Statistics 2022 National Health Survey[7] estimated that around 4 million Australians (16% of the population) had back problems.

Furthermore, Australians living in the lowest socioeconomic areas were more likely to be living with back pain than those living in the most advantaged areas (18% and 13%).

Back problems can significantly impact quality of life; in 2023, back problems were the third leading cause of disease burden in Australia, accounting for 34% of the total burden within the musculoskeletal disease group.

In 2023, there were 773 presentations to public hospital EDs in the Gold Coast region for low back pain; of those, 52.3% were by patients aged 35-64, and 19.9% by patients older than 65 years.

11.3.4 Endometriosis

Endometriosis is a chronic inflammatory condition where endometrial-like tissue exists in other parts of the body[174]. Endometrial tissue lines the uterus and responds to hormones released by the ovaries; however, tissues that exist outside of the uterus also respond to hormonal fluctuations, triggering bleeding in areas it should not occur. This process causes chronic pain in females who suffer with this condition, with severity typically increasing at times of menstruation. Inflammation and scarring can lead to separate pelvic organs joining together due to painful adhesions caused by endometriosis[175]. Characteristics involve chronic pelvic pain, heavy periods commonly accompanied by mild to severe pain, discomfort when going the bathroom and infertility in women.

Endometriosis has been referred to as the 'missed disease' due to its unclear aetiology and inconsistencies in its diagnosis and management[176]. The average time for an Australian woman to be diagnosed with endometriosis is around 7 years. Due to this, the true prevalence of endometriosis is difficult to determine.

It is currently estimated that endometriosis affects 1 in 7 girls and women, which means that there are over 830,000 individuals living with endometriosis in Australia. In 2016-17, there were around 34,200 endometriosis-related hospitalisations in Australia[176].

Endometriosis is reported to cost Australian society between $7.4 and $9.7 billion annually with two-thirds of these costs attributed to a loss in productivity with the remainder, approximately $2.5 billion, being direct healthcare costs[176].

11.4 MANAGEMENT OF PERSISTENT PAIN

Chronic pain may be treated or managed with the help of GPs, medical specialists, psychologists, physiotherapists and social workers. People with chronic pain may use medications (analgesics)

[173] Australian Institute of Health and Welfare 2023, *Back problems*.
[174] Bulun, S.E., Yilmaz, B.D., Sison, C., et al.., 2019. *Endometriosis. Endocrine reviews, 40*(4), pp.1048-1079.
[175] Australian Institute of Health and Welfare 2019, *Endometriosis in Australia: prevalence and hospitalisations*.
[176] Hudson, N., 2022. The missed disease? Endometriosis as an example of 'undone science'. *Reproductive biomedicine & society online, 14*, pp.20-27.

such as paracetamol, non-steroidal anti-inflammatory drugs and opioids to manage their symptoms. Analgesics are more commonly prescribed for those with chronic pain, according to PBS data in 2016, 57% of people aged 45 and over with chronic pain were dispensed analgesics (40% opioids, 2% migraine medication, 38% other)[177].

Pain Australia, the peak advocacy body for pain-related conditions in Australia, estimates that less than 10% of people with persistent non-cancer pain gain access to effective care, even though current knowledge would allow 80% to be treated effectively if there was adequate access to pain services[178].

Timely and coordinated multidisciplinary treatment is considered best practice for individuals experiencing persistent pain, providing cost-effective significant patient improvement and nearly halving economic impact[179]. A 2021 study investigating persistent pain service waiting times in Australia found that while pain services have expanded, wait times remain an issue and disproportionately affect those most affected by persistent pain[180].

11.4.1 Opioid prescriptions

Opioids such as codeine and oxycodone are often prescribed to relieve and treat pain symptoms. A report published by Australian Commission on Safety and Quality in Health Care[181] into the prescribing and dispensing of opioid medicines found:

- Current evidence does not support using opioid therapy for chronic pain,
- The prescribing of opioids for chronic pain is increasing,
- Evidence is growing of the adverse effects of long-term use of opioids.

In Australia, dispensing of opioids for treating chronic pain has risen 15-fold between 1992 and 2014, with around 16% of the Australian population annually prescribed an opioid in 2019[182].

Statistics from the Pharmaceutical Benefits Scheme (PBS) indicate that 57,688 prescriptions (per 100,000 population) for opioids were filled across the Gold Coast region in 2020-21, down from 65,681 in 2016-17 (a decrease of 12.1%).

11.5 LIFESTYLE-RELATED RISK FACTORS

Many chronic conditions can be prevented or managed by addressing common modifiable risk factors. These include smoking, obesity, excessive alcohol intake, physical inactivity, poor nutrition, and high blood pressure. Effective clinical management of the condition combined with health service coordination, patient health literacy, self-management and variations in healthcare can contribute to better chronic disease outcomes and preventable hospitalisations.

[177] Australian Institute of Health and Welfare 2020, *Chronic pain in Australia. Canberra*.
[178] Pain Australia 2016, *Prevalence and the Human and Social Cost of Pain, Pain Australia Fact Sheet 2*.
[179] Brecht, D.M., Stephens, J. and Gatchel, R.J., 2020. Interdisciplinary pain management programs in the treatment of pain conditions. *Pain Management for Clinicians: A Guide to Assessment and Treatment,* pp.461-489.
[180] Hogg, M.N., Kavanagh, A., Farrell, M.J. and Burke, A.L., 2021. Waiting in pain II: an updated review of the provision of persistent pain services in Australia. *Pain Medicine, 22*(6), pp.1367-1375.
[181] Australian Commission on Safety and Quality in Healthcare 2015, *The First Australian Atlas of Healthcare Variation*.
[182] Lalic, S., Ilomäki, J., Bell, J.S., Korhonen, M.J. and Gisev, N., 2019. Prevalence and incidence of prescription opioid analgesic use in Australia. *British Journal of Clinical Pharmacology, 85*(1), pp.202-215.

TABLE 7: CHRONIC DISEASE RISK FACTORS, GOLD COAST AND QUEENSLAND, 2017-2018 TO 2021-2022

Region	Overweight/ Obese	Daily smoker	Harmful alcohol intake	Physically inactive	Inadequate fruit intake	Inadequate vegetable intake
Queensland	61.5%	10.4%	36.4%	41.7%	46.5%	91.3%
Gold Coast	56.8%	8.4%	37.0%	46.2%	46.2%	90.1%

Source: Queensland Survey Analytic System. Note: Time periods for each risk factor range from 2017-18 to 2021-2022.

- Overall, prevalence of chronic disease risk factors in the Gold Coast region was comparable to Queensland rates.
- Rates of obesity and daily smoking were below that of Queensland, while rates of physical inactivity and harmful alcohol consumption were higher than the Queensland rate.

11.6 UTILISATION OF HEALTH SERVICES

There are several chronic disease management items listed on the Medicare Benefits Schedule (MBS) that enable GPs to plan and coordinate the healthcare of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. This data shows services relating to the preparation, coordination, and review of a GP Management Plan for patients with a chronic or terminal medical condition. Services also include the coordination and review of Team Care Arrangements and contribution to Multidisciplinary Care Plans.

TABLE 8: GP CHRONIC DISEASE MANAGEMENT PLAN, GOLD COAST SA3 REGIONS, 2020-21

Region	GP chronic disease management plan (rate per 100 people)
National	40.4
Gold Coast	47.7
Broadbeach - Burleigh	51.0
Coolangatta	49.1
Gold Coast - North	59.5
Gold Coast Hinterland	51.3
Mudgeeraba - Tallebudgera	42.7
Nerang	42.5
Ormeau - Oxenford	43.5
Robina	48.3
Southport	49.0
Surfers Paradise	44.5

Source: AIHW analysis of Department of Health, Medicare Benefits claims data 2020-21.

- The rate in the Gold Coast region was 47.7 services per 100 people, which was above the national rate of 40.4. In GCPHN, the rate has increased by 37.5% in the last 5 years.
- Gold Coast-North SA3 region had the highest rate, and Nerang had the lowest.

11.7 CONSULTATIONS

The information presented herein has been collated from consultations held with GCPHN Primary Health Care Improvement Committee, Primary Care Partnership Committee, general practice staff, GCPHN Community Advisory Council, and Primary Care Partnership Committee.

Community capacity and development

- Many factors impact one's capacity to self-manage their chronic condition, including cultural barriers, homelessness, alcohol and drug use, obesity, socio-economic status, health literacy and knowledge of available support.
- Stakeholders suggested that improvements in community capacity could enhance chronic disease early identification, self-management and medication management, specifically:
- More support from health professionals is required for people to manage their own health, navigate the current system and empower them to share ownership of personal health outcomes.
- Patients want support from GPs and health teams to make management decisions and goals that are realistic for their individual circumstances, moving from a medical model of care planning to a patient focused model.
- Early education is required to ensure that patients fully understand the long-term nature of chronic disease and are not waiting to access services until their condition is acute.
- Clearly communicating the benefit of prevention and engaging in your healthcare. Many GPs use health assessments (particularly 75+) as opportunity to raise issues such as advanced care planning, however, some patients may be unwilling to prioritise a health assessment over work and other family commitments, when they don't feel unwell or have concerns.

Service access

Stakeholders suggested that improved service access is required to ensure effective management of chronic disease, including:

- Enhanced access to chronic disease screening and early identification via age-appropriate health checks, particularly health checks for those at risk of developing cardiovascular disease and type 2 diabetes for those aged 40-49 years.
- Simplified criteria and referral pathways to enable access to chronic disease self-management courses and programs.
- Engagement with pharmacies to enhance the role they play in supporting chronic disease management.
- Eliminating cost barriers to enable patients to access care in general practice or the community.
- Some wound care clients are not able to afford treatment in the community setting and are returning back to the hospital for further follow up.
- Limited fully subsidised chronic pain programs exist to manage pain in the community setting and prevent hospitalisations.

- The cost of the wound management products (such as particular bandages and dressings) that are used to treat the patient is a barrier to delivery of these services by general practice.

Health professional capacity and capability development

- Chronic disease management including holistic and lifestyle approaches (as opposed to prescribing medication).
- Awareness-raising about the kinds of services already available to support people with chronic conditions.
- Chronic pain and pain management (e.g., integrated care systems in primary care, referral pathways, back pain, and role specific evidence-based treatment practices).
- Each professional needs to identify where there are gaps in their service delivery based on evidence and guidelines available and addressing the issues.
- The cost for the consumables for iron deficiency is a problem for general practice which can limit delivery of these services.

Coordination and integration

- Care coordination does not always effectively engage the person and their family. A full briefing will help to ensure information understood and actions required known.
- Dissemination about various chronic diseases is very disjointed. A single website with service and contact information across the GC would be beneficial.
- Service users need to get linked earlier to understand what is out there- If you are diagnosed with cancer there is someone/a process that is already defined for the person. This doesn't happen with other diagnosis.
- Service access and coordination is being hindered by suboptimal information sharing between hospital and primary care including lack of timeliness of discharge summaries and outpatients.
- Fragmentation between services at primary and tertiary levels of the health system creates difficulties for communication and information sharing between providers and also with patients. This is particularly evident in discharge planning and procedures.
- Further developments and enhancements for digital health, including data integration may improve care coordination.
- Wound care services lack clearly defined pathways, formalised linkages and information sharing between different providers.
- Chronic disease risk stratification processes could be better implemented to:
- target and identify patients with increasing risk of hospitalisation, particularly for diabetes complications, pyelonephritis and COPD, and
- ensure engagement and effective treatment with patients at a stage before their condition becomes acute.
- Pulmonary rehabilitation is an effective evidence-based treatment for COPD, and it is currently quite readily accessible.

System barriers

- GPs are currently not remunerated adequately for non-contact time spent planning and supporting care for patients with chronic conditions.
- Inadequate funding model for in-home GP visits, a situation likely to be exacerbated by an aging population and increasing patient complexity, necessitating more in-home GP visits.
- Difficult to identify at risk patients through current software systems.
- Case conferencing MBS items are not well utilised.
- Similarly, the current Practice Nurse Incentive Payment does not sufficiently support practice nurses to invest time in care-coordination for patients with chronic disease.
- GP management plans have limitations, such as:
- plans requested for access to team care arrangement have limited emphasis on review to ensure goals and actions are addressed by patients.
- plans are not always individualised or patient-centred meaning that goals and actions set are not achievable or meaningful to patients.
- GPs are less engaged to lead or participate in quality improvement activities than general practice nurses or practice managers. For example, feedback from general practice is that reform is challenging as non-clinical contact is not funded (for staff doing the work).

Cancer

- Many people in the community are not aware of cancer screening target groups.
- There is negative stigma with the screening process itself.
- There are low levels of health literacy in specific segments of the population which adversely influences screening awareness and uptake.
- Cultural complexities may inhibit screening for some groups.
- Inclusion of breast cancer screening reports into the National Screening Cancer Register (NCSR), a recommendation made also by the RACGP - BreastScreen Australia Program Review. Alongside bowel, cervical screening and soon to be lung cancer screening.
- Manual data entry is still necessary to import cancer screening results from the inbox or data from the NCSR into the appropriate sections of the clinical software.
- There is a need to streamline and improve the way cancer screening results are received within clinical software.

Persistent pain

- Chronic pain services face significant wait times, especially in high-demand areas like Southport and Coomera. Limited access to pain specialists compounds the issue.
- Chronic pain patients often turn to emergency departments, where some are reluctant to be discharged. Frequent ER visits also occur due to medication overdoses.
- Restricted codeine access may increase primary care demand, potentially improving long-term pain management.

- Barriers to care include transport issues, socioeconomic factors, long waitlists, and gaps in system infrastructure to track high-dose or doctor-shopping patients.
- Medication management is a focus, yet there's concern about addiction risks from a lack of holistic treatment, which ideally includes mental health support.
- Confusing terminology around pain types and inconsistent communication across providers cause patient confusion.
- Early intervention services could be more cost-effective, with a need for family-inclusive support models.
- Stronger links to mental health services and support for NDIS applications are essential, as many in this group face depression, anxiety, and isolation.
- Occupational Therapy assessments help, but implementation costs (e.g., for installing handrails) are often prohibitive.
- Short-term support for daily activities, education on meal prep, and social engagement is beneficial, especially for those without regular support.
- Demand for community-based programs has surged, but funding limits access, with only a small portion of clients able to receive service.

11.8 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information
General practices	212	Across Gold Coast region	• GPs prepare chronic disease management plans, team care arrangements, medication prescribing/management, health checks, and plan reviews.
Special interest general practices	36	Across Gold Coast region	• These practices offer a limited range of services such as skin cancer checks, cosmetic clinics and other specific health areas.
My Health for Life	State-wide programs	Currently 6 providers (may expand) and telephone option	• Evidence-based lifestyle modification program provided by trained facilitators including dietitians and exercise physiologists, who have a keen interest in preventive health.
COACH and Get Healthy services, Queensland Health	State-wide programs	Free phone services	• Both programs focus on reducing avoidable admissions through prevention and self-management. • Get Healthy service provides advice and coaching on leading a healthy lifestyle by qualified health coaches. • COACH Program involves qualified health coaches discussing treatment with patients with a diagnosed chronic condition (e.g. medication compliance, risk factor management, follow-up appointments with physicians). • Reported referrals into COACH are very low in the Gold Coast region. However, limited capacity to accept new referrals.
Quitline	Region-wide	Phone and online service	• Provides a counselling service over the phone and an online chat service. • Resources for health professionals.

Diabetes resource centre, Gold Coast HHS	Multiple	Various locations	• Focus on promoting self-management skills. • Provides care, education and support for people with diabetes and their carers, and educators (e.g. schools, community groups). • Multidisciplinary service for inpatients and outpatients. • No information online regarding eligibility or access.
Active & Healthy, City of Gold Coast	Region-wide	Varied locations (parks, sports, community centres)	• Range of free/ low-cost physical activity and healthy eating programs. • There is low referral to these programs from healthcare providers.
National Prescribing Service (NPS)	National	Phone or online	• Free clinical e-audits to help GPs review prescribing for patients with certain conditions compared with best practice guidelines. • NPS Medicinewise have produced a free application to assist consumers with managing their medications (MedicineList+). • NPS operate a help line for consumer questions about medicines.
VIP Diabetes	1	Across various locations including Southport, Benowa and Logan, online consultations available.	• Targeted allied health and coordination for people with diabetes. • Referral required from GP; self-referrals are directed to involve GP. • Home medicine review is free for people with a Medicare card and who are referred by their GP for a review. • GP case conference Medicare funded. Insulin support programs fully funded.
Diabetes Queensland	2	Helensvale and Robina	• Self-referral. Free to those with a Medicare card. • Targets newly diagnosed—new registration on national diabetes patient register will trigger an invite.
Other private and NGO services	Various	Various	• A number of services offering support for people with chronic disease.

			• Service types include medication management and review, care coordination, care planning, self- management, allied health, nursing, respite, peer support, social and community activities. • Access is varied with many fee-for-service, some claimable through Medicare or other avenues (e.g. DVA, aged care, disability services). • Limited information available on the demand and outcomes of these services.
Community Health Services GCHHS	3	Robina Health Precinct; Southport Health Precinct; Helensvale Community Centre	
CANCER			
General practice	212	Across Gold Coast region	• Screening for cervical cancer (self-collection or healthcare collected) • Skin checks for skin cancer. • Up to date results and history for bowel and cervical screening is easily found from the National Cancer Screening Register (NCSR). • Gold Coast general practices with clinical software integrated to the NCSR, is currently 47.6% as of September 2024.
BreastScreen	5	4 permanent sites (Helensvale, Robina, Southport, Burleigh Waters), plus a monthly staff clinic at Gold Coast University Hospital 1 mobile service	• Breast screening for the public. • Fewer permanent sites than comparative HHS regions (e.g. Sunshine Coast area). • Screening wait times at BreastScreen Queensland Gold Coast Service clinics are around one to two weeks. • Follow up tests occur at the Screening and Assessment clinic in Southport.

		visiting 4 locations (North Tamborine, Nerang, Elanora, Pimpama)	• Follow up of abnormal results usually incurs a two-week wait but is currently around three weeks, on average. • BreastScreen Queensland Gold Coast Service screened 34,934 clients in 2022-23 (target for 2024-25: 35,000)
Private breast screening clinics	5	Majority of providers along eastern strip of Gold Coast.	• Growing market—some private imaging clinics, some women's health-focused. • Eligible for Medicare rebate— out-of-pocket costs still generally apply.
National Bowel Cancer Screening Program (NBCSP)	1	Eligible people aged 50 – 74, identified by Medicare and Department of Veterans' Affairs, are posted a faecal occult blood test (FOBT) kit and invited to complete the test.	• NBCSP results sent electronically to GP. • Follow-up of abnormal results incurs variable wait times. • People with a positive result may choose to follow up with a private referral. • GPs can issue a bowel screening kit to a patient as part of the alternative access to kits model, bulk kits can be ordered through the NCSR, but kits handed to patients must be issued via the NCSR to ensure patients get their results. Kits also have an expiry date.
Private bowel cancer screening			• Non-program FOBTs can be sourced privately through some pharmacies, pathology companies and organisations such as Bowel Cancer Australia and Rotary. These are not integrated with the National Cancer Screening Register or factored into local bowel cancer screening participation rates. • Some people who are eligible for the NBCSP screen via private colonoscopy which provides added cost and health risk.
Skin clinics	32	Spread across Gold Coast region, mostly located at medical centres.	• A shortage of culturally appropriate and culturally safe services inhibit access for Multicultural communities and First Nations people.

Lung cancer screening			• Lung cancer screening will be available to eligible individuals from July 2025.
			• Under the plan, individuals will be eligible for the program if you:
			  ○ Are aged between 50 and 70 years,
			  ○ Show no signs or symptoms of lung cancer, and
			  ○ Have a history of at least 30 pack-years of cigarette smoking and are still smoking or have a history of at least 30 pack-years of cigarette smoking and quit in the past 10 years.

PERSISTENT PAIN			
PainWise (GCPHN funded)	1	Physical service at Varsity Lakes. Education sessions mobile across various locations including Southport, Robina and Kirra.	• No cost but limited places in each program. Must be referred by a GP. • Previous increases in funding led to an increase in patients able to access program and decreased cost per person. • Increasing demand - more GPs referring into the program each year. There is currently a wait time of around 4-5 weeks. • Past evaluations show increased ability to perform everyday activities, a significant reduction in medications, and reduced hospitalisations.
Interdisciplinary Persistent Pain Centre, Gold Coast HHS	1	Robina	• No cost to access. Eligibility criteria include impairment, no ongoing investigations or claims, no acute psychiatric condition and residing within catchment area. • GCHHS specialist wait list is approximately 8-12 months long.
Interventional Pain GC	1	Robina	• Referral required, out-of-pocket costs. • Service involves interventional pain radiology.

Persistent Pain and Rehabilitation Clinic, Griffith University	1	Southport	• Fee-for-service, rebate through private health or chronic disease management plan. • Multi-disciplinary team care approach involving physiotherapy, exercise physiology, dietetics, and psychology.
The Pain Centre of Excellence, based at Spendelove Private Hospital	1	Southport	• Multi-disciplinary teams include pain and rehabilitation specialists, occupational therapists, pharmacists, physiotherapists. • Treatment is available either as a day patient or inpatient. Program over two weeks, outpatient follow up to three months. • Cost fully covered by private insurance. • Anyone experiencing pain for more than three months can apply.
The Pain Doctors-Pindara Private Hospital	1	Benowa; services John Flynn Private Hospital (Tugun) and GC Private Hospital (Southport)	• 11-bed chronic pain inpatient service. • Pain specialists and rehabilitation consultants work with allied health services including physio, OT and exercise physiology.
Arthritis Queensland Infoline	State- wide	Phone service	• Free call Mon-Fri, 8.30am-4pm. • Can arrange free, individualised information packs for self or family.
Precision Brain, Spine and Pain Centre	1	Southport	• Treatment of spinal problems and other pain-causing conditions.
Anglicare Better Health with Self-Management	1	Delivered at Southport and Robina	• Self-referral or a GP referral. Free to HACC eligible individuals / carers. • Not specific to persistent pain; the course teaches participants skills in day-to-day management of chronic conditions. • 2,5 hr workshops run once a week, over a period of six weeks.
Pain Management Network, NSW Agency for Clinical Innovation	National	Online resource	• Focus on self-management of chronic pain. • Information available for health professionals.

Supporting Kids in Pain (SKIP) program	1	Based in Brisbane with outreach on Gold Coast	• Not-for-profit organisation, free for children under 14. • Requires GP or pediatrician referral. Self-management program, incl. assessment, education, follow-up. • Multidisciplinary approaches include pediatricians, psychologists, physiotherapists, and occupational therapists.
Endometriosis and Pelvic Pain Clinic (GCPHN funded)	1	Benowa	• Offers multidisciplinary primary care services for endometriosis and pelvic pain.
GCHHS Endometriosis and Pelvic Pain Interdisciplinary Clinical Services (EPPICS)	1	Located in Robina and Varsity Lakes	• Public health service with no cost. Requires a referral from a GP or patients already seeing a gynecologist at the GC HHS can be referred by their treating specialist. • An interdisciplinary service with a range of specialists, allied health professionals and nursing staff providing care tailored to each woman's individual symptoms, experiences and goals. • In addition to the individualised interdisciplinary care, EPPICS offers educational sessions to understand symptoms, develop self-care and self-management skills.
Managing Pain Clinic	1	John Flynn Medical Centre	• Multidisciplinary private pain medicine practice offering assessment, medication management, rehabilitation, and health psychology services.
Gold Coast Headache and Migraine Clinic	1	Bundall	• Self-referral. Private treatment for chronic migraines and headaches.
Pain Management Services	1	South Coast Radiology, across the Gold Coast region.	• Requires referral, provides treatment of chronic pain with medical imaging to guide minimally invasive pain relief treatments.

Chapter 12:
MENTAL HEALTH, ALCOHOL AND OTHER DRUGS AND SUICIDE PREVENTION

KEY FACTS:

- 8.4% of the Gold Coast population report (around 54,000 people) report having a mental health condition. A quarter of all Gold Coast residents with a mental health condition live in Ormeau-Oxenford SA3 region (n=13,929).
- In 2022–23, 83,394 people in the Gold Coast region (12% of the population) received 401,045 Medicare-subsidised mental health-specific services.
- In 2023-24, there were 3,447 suicide-related presentations to the Gold Coast EDs
- In 2022-23, there was a total of 21,088 hospitalisations to Gold Coast HHS for mental health and behavioural disorders.
- Almost 40% of adults Gold Coast residents exceeded guidelines for safe alcohol consumption.
- In 2022-23, 19.6% of Gold Coast residents reported using illicit drugs in the previous 12 months, a decline from 21.1% in 2016.
- ED presentations related to alcohol use have increased by 14.4% over the last 5 years, while the drug-related presentations decreased by 20.6%.
- The rate of suicide mortality for Gold Coast residents slightly decreased from 2011-2013 to 2020-2022 (13.1 per 100,000), which is the lowest rate over the 10-year period.
- Populations at risk for poor mental health outcomes include First Nations people, multicultural communities, LGBTIQAP+ community, people experiencing/at risk of homelessness, and vulnerable children.

PRIORITISED NEEDS:

1) High demand and limited availability of publicly funded AOD services, including after-hours options, acute detox and residential withdrawal services.
2) Increasing acute demand requires improvement in early intervention, prevention and community support for mental health.
3) Insufficient capacity in sub-acute community based residential mental health services.
4) Inefficient system navigation leads to delayed connection of patients with suitable mental health, AOD and suicide prevention services.
5) Poorer mental health outcomes and higher suicidality for LGBTIQAP+ people.
6) Care coordination and information sharing by mental health, AOD and suicide prevention providers and services is often inefficient, particularly for transitions between acute or inpatient care to community-based services.
7) Limited availability of suitable service options to support older population.
8) Insufficient resourcing to ensure supported, psychologically safe, meaningful engagement of people with lived experience in planning and service delivery.
9) Reported high prevalence of vaping, particularly among young people.
10) Growing demand for psychological therapies.
11) Stigma and shame associated with mental health, suicidality and AOD issues.

12.1 MENTAL HEALTH CONDITIONS

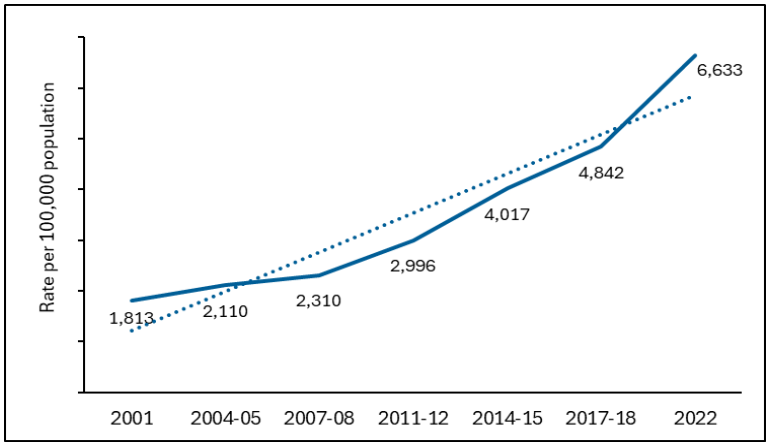
12.1.1 Prevalence

National data

The Australian Bureau of Statistics 2022 National Health Survey found that 1 in 4 (26.2%) Australians had a mental or behavioural condition. This makes mental ill-health the most prevalent chronic condition, impacting around 6,700,000 Australians.

There are currently no reliable data available on the prevalence of mental health conditions among Gold Coast population. Applying the prevalence of 26.2% recorded by the National Health Survey to the regional population in 2022, this is equivalent to around 174,000 residents.

FIGURE 1: MENTAL AND BEHAVIOURAL CONDITIONS, AUSTRALIA, 2001 TO 2022



Source: ABS (2023). National Health Survey 2022

- The rate of mental and behavioural conditions has increased 3.7-times since 2001.
- In 2022, the rate of mental and behavioural conditions increased by 37% since the previous survey in 2017-18.

Similarly, the 2023 National Study of Mental Health and Wellbeing reported that 21.5% of Australians aged 16–85 years (around 4.2 million) experienced a mental disorder within the last 12-months. Among those:

- 17.2% (3.4 million people) had an anxiety disorder
- 7.5% (1.5 million people) had an affective disorder
- 3.3% (647,900 people) had a substance use disorder

Another insight into the mental health and wellbeing of Australians is provided through measures of psychological distress in the National Health Survey, described as ‘unpleasant emotions that affect a person’s level of functioning and interfere with the activities of daily living’.

- In 2022, around one in seven (14.3%) Australians aged 18 years and over were experiencing high or very high levels of psychological distress; an increase from 13.0% in 2017-18.

Gold Coast data

According to Census 2021 data, a total of 53,788 Gold Coast residents reported having a mental health condition (including anxiety and depression), accounting for 8.4% of the total population.

TABLE 1: PEOPLE WITH MENTAL HEALTH CONDITION, GOLD COAST SA3 REGIONS, 2021

Region	Number	% of total population
Broadbeach - Burleigh	4,623	7.0%
Coolangatta	4,713	8.2%
Gold Coast - North	6,568	9.5%
Gold Coast Hinterland	1,755	8.7%
Mudgeeraba - Tallebudgera	2,675	7.4%
Nerang	6,252	9.0%
Ormeau - Oxenford	13,929	8.8%
Robina	4,400	8.2%
Southport	5,955	9.2%
Surfers Paradise	2,926	6.5%
Total	53,788	8.4%

Source: 2021 Census.

- Regions with the highest percentage of residents with a mental health condition are Gold Coast-North (9.5%), Southport (9.2%) and Nerang (9.0%).
- A quarter of all Gold Coast residents with a mental health condition live in Ormeau-Oxenford (n=13,929).

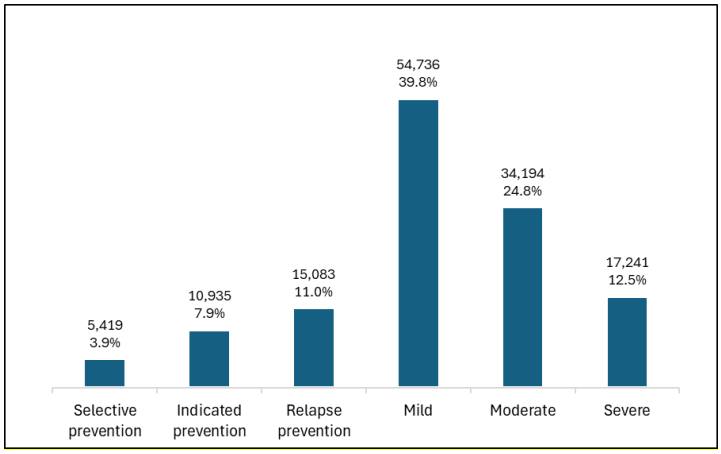
National Mental Health Service Planning Framework

National Mental Health Service Planning Framework (NMHSPF) is an evidence-based framework providing estimated need and expected demand for mental health care and the level and mix of mental health services required for a given population.

Figures 2 and 3 provide estimates of Gold Coast population with demand for mental health services in 2024-2025, obtained from the NMHSPF Planning Support Tool.

It should be noted that while the levels of need and demand for mental health care differ slightly from the 5 levels articulated in the above shown stepped care model, they nevertheless offer valuable insights into the demand for mental health services corresponding to different levels of severity.

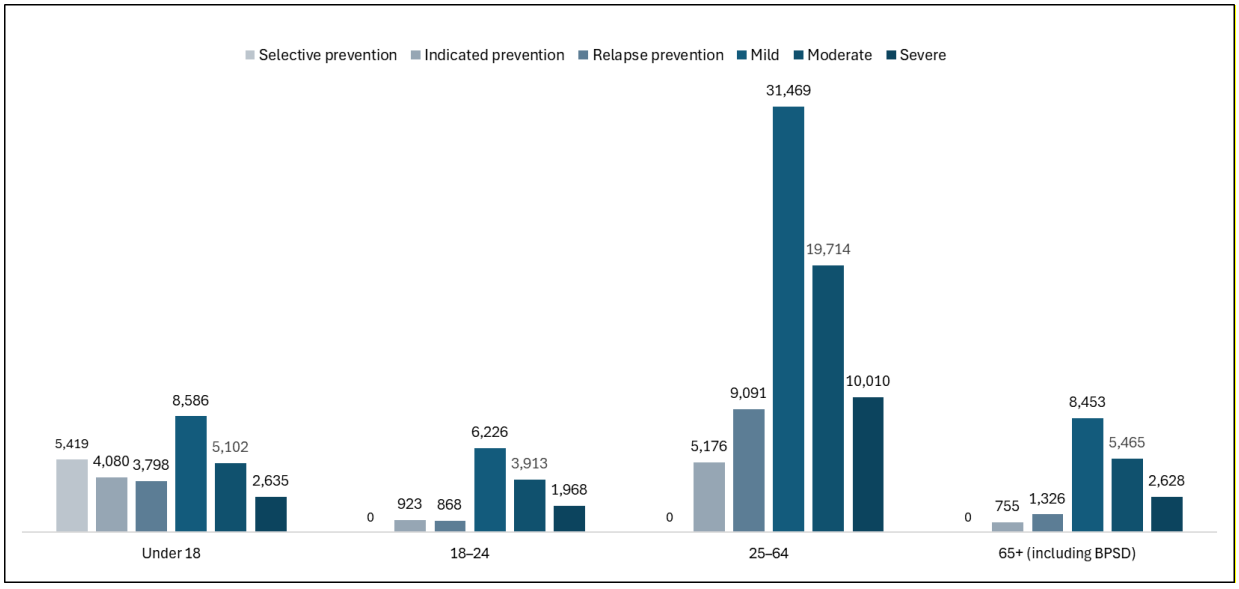
FIGURE 2: DEMAND FOR MENTAL HEALTH SERVICES, BY LEVEL OF NEED, GOLD COAST, 2024-25



Source: National Mental Health Service Planning Framework Planning Support Tool, 2024

- A total of 137,608 Gold Coast residents (around 20.0% of the total population) have been estimated to have mental health concerns in need of support.
- Of those, the highest proportion require demand for support services catering for mild mental illness (39.8%), 24.8% for moderate, 12.5% for severe mental health illness, and 22.8% for selective, indicated or relapse prevention support.

FIGURE 3: DEMAND FOR MENTAL HEALTH SERVICES, BY AGE AND LEVEL OF NEED, GOLD COAST, 2024-25



Source: National Mental Health Service Planning Framework Planning Support Tool, 2024

- Distribution of mental health demand across different age groups shows that adults aged 25-64 account for the largest segment of population in demand of mental health support services (n=75,460).
- Around 30,000 Gold Coast residents in need of mental health services are aged 18 or below.

12.1.2 Utilisation of health services

Primary care

Medicare-subsidised mental health-specific services are delivered by psychiatrists, GPs, psychologists, and other allied health professionals (e.g., occupational therapists, mental health nurses, accredited mental health social workers).

AIHW provides data on the patients and services claimed under specified mental health care Medicare Benefits Schedule (MBS) item numbers, however noting that the reported number of patients is unlikely to represent all patients who receive mental health care in primary health care as some people receive mental health-related care that is billed as a consultation against a different MBS item number. Further, not all services provided through Indigenous health services are included in the MBS counts.

In 2022–23, 83,394 people in the Gold Coast region (12% of the population) received 401,045 Medicare-subsidised mental health-specific services.

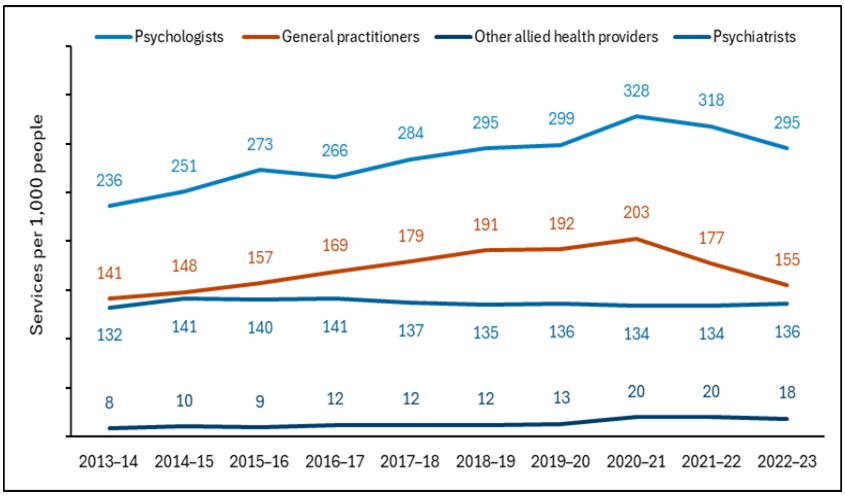
TABLE 2: MENTAL HEALTH SERVICES, BY TYPE OF PROVIDER, GOLD COAST, 2022-23

Provider	Patients	Services
General practitioners	65,370	103,092
Psychologists	41,769	195,803
Psychiatrists	18,048	90,500
Other allied health professionals	2,528	11,650

Source: AIHW (2024), Medicare Mental Health Services 2022-23

- The majority of patients who received mental health related care in primary care did so from GPs (51.2%), 32.7% from psychologists, 14.1% from psychiatrists, and 2.0% from allied health professionals.
- Almost half of mental health related services (48.8%) were provided by psychologists, 25.7% by GPs, 14.1% by psychiatrists, and 2.9% by other allied health professionals.

FIGURE 4: MENTAL HEALTH SERVICES, BY PROVIDERS, GOLD COAST, 2013-14 TO 2022-23



Source: AIHW (2024), Medicare Mental Health Services 2022-23.

- Rates of mental health services provided by psychologists and GPs in the Gold Coast region have been steadily increasing between 2013-14 to 2020-21 when they reached their peak at 328 and 203 per 1,000 people, respectively.
- In the last two years, rates of GP-provided mental health services declined by 23.6%, and those by psychologists by 10.0%.

TABLE 3: MENTAL HEALTH SERVICES, GOLD COAST SA3 REGIONS, 2021-22

Region	Rate per 100 people
National	11.2
Gold Coast	13.9
Broadbeach - Burleigh	15.0
Coolangatta	15.7
Gold Coast Hinterland	13.2
Gold Coast - North	14.9
Mudgeeraba - Tallebudgera	14.6
Nerang	13.3
Robina	12.8
Ormeau - Oxenford	14.1
Southport	13.4
Surfers Paradise	12.2

Source: AIHW analysis of Department of Health, Medicare Benefits claims data 2021-22.

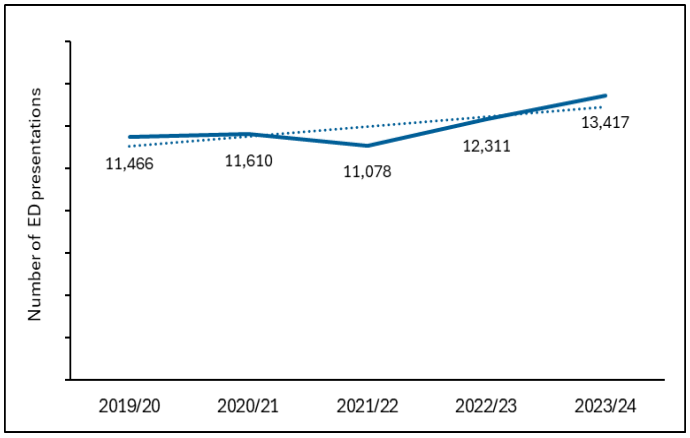
- In 2021-22, rates of mental health services provided in primary care in the Gold Coast region were 24.1% higher than the national average.
- On average, residents of Coolangatta had the highest rate of mental health services received in primary care, and residents of Surfers Paradise had the lowest.

Emergency Department

In 2023-24, there were 13,417 mental health related presentations to the Gold Coast EDs, accounting for 6.1% of all presentations.

- There has been a 17% increase in mental health ED presentations over the last 5 years.
- In 2023-24, 20.5% of mental health related presentations had a record of suicidal ideation.
- The most common types of presentations were mental and behavioural disorders due to the use of alcohol (n=985), acute stress reaction (n1=1,001) and anxiety disorders (n=559).
- 857 (or 6.2%) of ED presentations were by First Nations peoples.

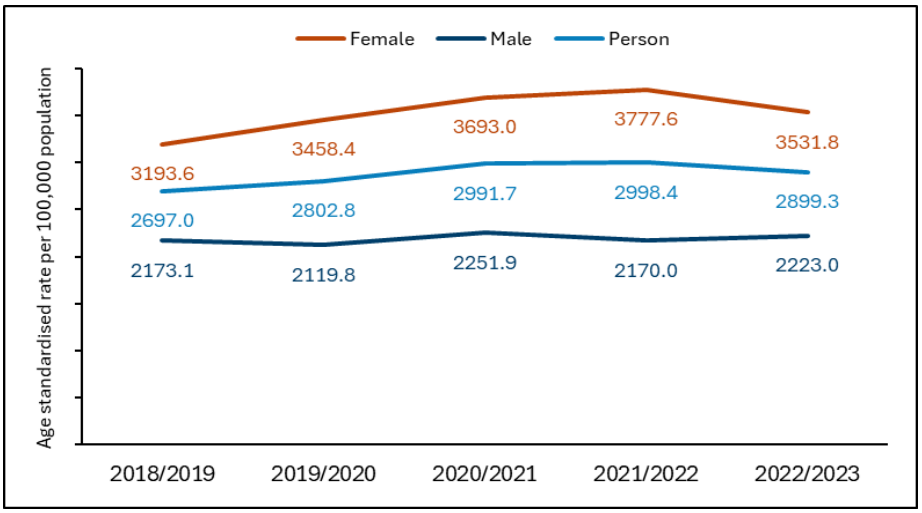
FIGURE 5: ED MENTAL HEALTH RELATED PRESENTATIONS, GOLD COAST, 2019-20 TO 2023-24



Source: Gold Coast HHS, Emergency Department Collection, Mental Health Related Flag

Hospitalisations

FIGURE 6. HOSPITALISATIONS FOR MENTAL HEALTH AND BEHAVIOURAL DISORDERS, GOLD COAST, 2018-19 TO 2022-23



Data source: Queensland Hospital Admitted Patient Data Collection (QHAPDC). ICD-10 Diagnoses included in the analyses: F00 - F99 Mental and behavioural disorders (F00-F99).

- In 2022-23, there were 21,088 hospitalisations to Gold Coast HHS for mental health and behavioural conditions. Of those, 21,088 were by females (63.4%) and 7,717 (36.6%) by males.
- This accounted for an age-standardised rate of 2899.3 per 100,000 population; the rate was 37% higher among males than females.
- A gradual increase in the rates of mental health related hospitalisations over the last 5 years can be seen in Figure 6; by 7.5% for all persons, 10.6% for females, and 2.3% for males.

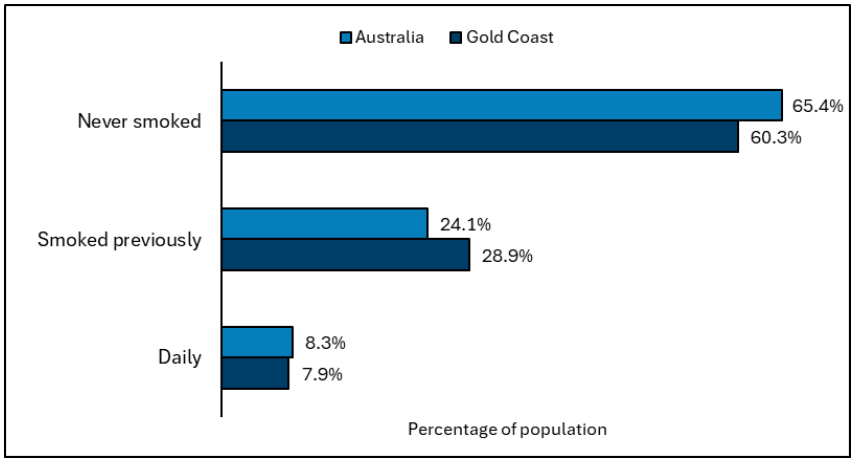
In 2022-23, the diagnostic groups of hospitalisations due to mental health and behavioural disorders with the highest number of admissions to Gold Coast HHS were:

- Depression (n=6,256 or 29.7% of admissions),
- Anxiety (n=6,241 or 29.6% of admissions),
- Mental disorders due to psychoactive substance use (n=2,432 or 11.5% of admissions),
- Schizophrenia (n=1,556 or 7.4% of admissions),
- Suicide and self-injury (n=736 or 3.5% of admissions).

12.2 ALCOHOL AND OTHER DRUGS

12.2.1 Smoking

FIGURE 7: SMOKING STATUS, GOLD COAST AND AUSTRALIA, 2022-23



Source: National Drug Strategy Household Survey 2022–2023. (a) Smoked at least 100 cigarettes or the equivalent amount of tobacco in their life and reported no longer smoking. (b) Never smoked 100 cigarettes or the equivalent amount of tobacco.

- In 2022-23, 7.9% of the Gold Coast population reported daily smoking, which was slightly lower than the national average of 8.3%.
- A notable reduction in the percentage of daily smokers among Gold Coast residents (from 13.6% to 7.9%) is comparable to that seen across Australia.

12.2.2 Alcohol

To reduce the risks of alcohol related harm, the NHMRC's first guideline recommends healthy men and women to drink no more than 10 standard drinks per week and no more than 4 standard drinks in one day.

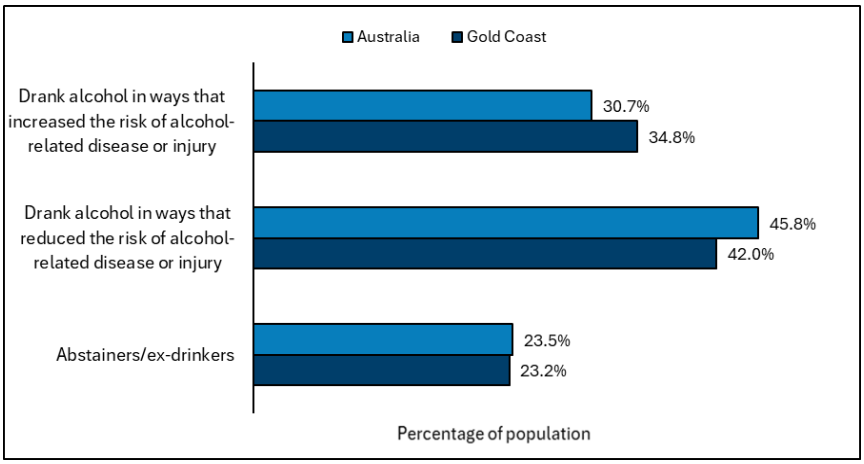
Alcohol consumption which exceeds this guideline has remained stable in recent years, however, in 2021-22, 38.3% of adults within the Gold Coast region had exceeded the guideline; this was above the Queensland rate of 36.4%.

TABLE 4. ALCOHOL CONSUMPTION EXCEEDING GUIDELINES, QUEENSLAND PHNs, 2021-22

Primary Health Network	Population exceeding guidelines for alcohol consumption
Queensland	36.4%
Brisbane North	35.5%
Brisbane South	32.8%
Gold Coast	38.3%
Darling Downs and West Moreton	32.0%
Western Queensland	42.8%
Central Queensland, Wide Bay and Sunshine Coast	38.6%
Northern Queensland	41.9%

Source: Queensland Health. 2023. Detailed Queensland and regional preventative health survey results.

FIGURE 8: ALCOHOL RISK, GOLD COAST AND AUSTRALIA, 2022-23



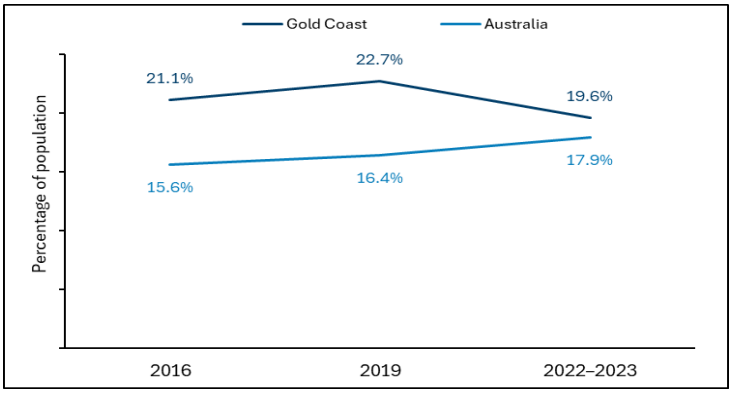
Source: National Drug Strategy Household Survey 2022–2023.

- In 2022-23, 23.2% of the Gold Coast population reported not having consumed any alcohol in the previous 12 months, a percentage comparable to the national average.
- An increase in the proportion of Gold Coast residents abstaining from alcohol increased from 15.3% in 2026.
- Just over a third of Gold Coast residents (34.8%) engaged in risky levels of alcohol consumption, down from 41.5% in 2016. However, Gold Coast figures remain higher than that for total Australia (30.7%).

12.3 ILLICIT DRUGS

AIHW's *2022–23 National Drug Strategy Household Survey* reported a decrease in the use of illicit drugs in the Gold Coast region over the last 7 years (Figure 9).

FIGURE 9: ILLICIT DRUG USE IN PAST 12 MONTHS, GOLD COAST AND AUSTRALIA, 2016, 2019, 2022-23



Source: National Drug Strategy Household Survey 2022–2023, Illicit Drugs

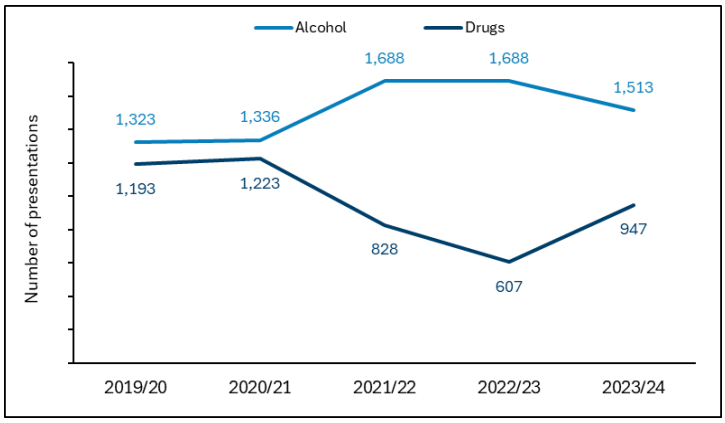
- In 2022-23, 19.6% of Gold Coast residents reported using at least 1 of 17 classes of illicit drugs in the previous 12 months, which is a decrease from 21.1% in 2016.
- In contrast, the proportion of adult population reporting using illicit drug has increased for all of Australia.

12.3.1 Utilisation of health services

Emergency Department

In 2023-24, there were 2,460 AOD-related presentations to Gold Coast Emergency Departments.

FIGURE 10: ALCOHOL AND DRUG RELATED PRESENTATIONS TO ED, GOLD COAST, 2019-20 TO 2023-24



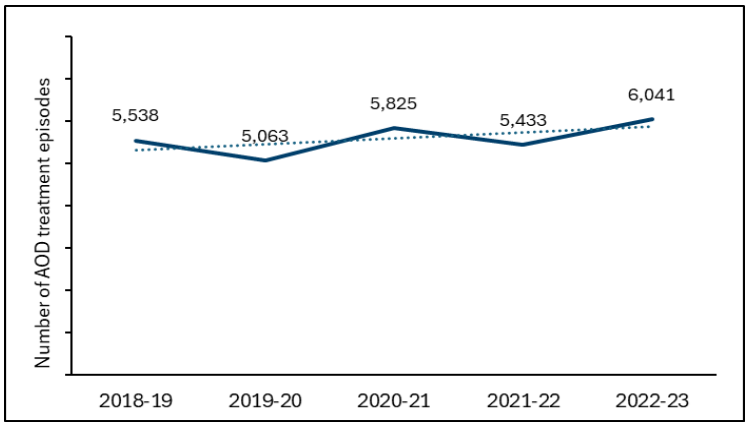
Source: Gold Coast HHS, Emergency Department Collection.

- ED presentations related to alcohol use have increased over the last 5 years (by 14.4%) while the drug-related presentations decreased by 20.6%.

Hospitalisations

In 2022-23, there was a total of 6,041 alcohol and drug related treatment episodes completed by Gold Coast residents. This represents an increase of 9.1% since 2018-19.

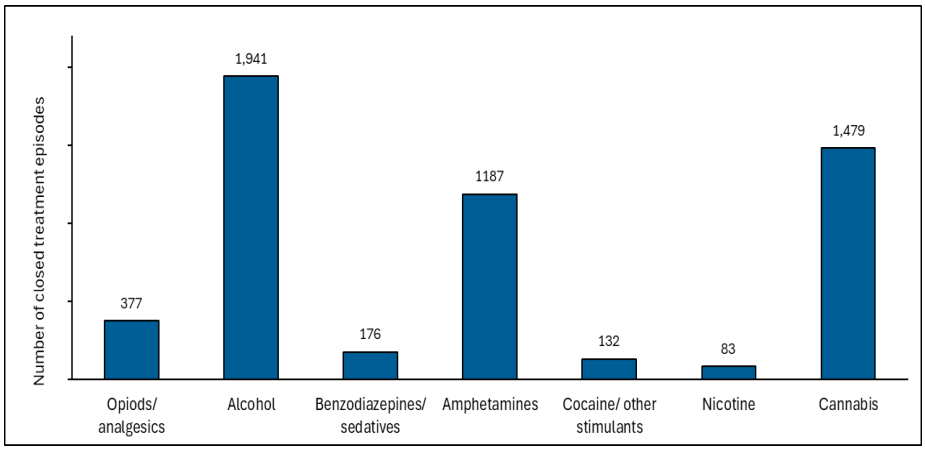
FIGURE 11: HOSPITALISATIONS FOR ALCOHOL AND OTHER DRUGS, GOLD COAST, 2018-19 TO 2022-23



Source: AIHW, Alcohol and Other Drug Treatment Services National Minimum Dataset, Alcohol and other drug treatment services in Australia 2022–23.

- Nationally, clients aged 30-39 years old (27.2%) were the most represented in episodes of care for alcohol and drug treatment services. In the Gold Coast region, 20-29-year-olds were the most represented (28.3%) closely followed by 10-19-year-olds (21.8%). This may be due to the availability of a few youth-focused AOD treatment programs.
- In the Gold Coast region, alcohol, cannabis, and amphetamines are the primary drugs of concern, accounting for just over 85% of closed treatment episodes.

FIGURE 12: HOSPITALISATIONS, BY PRINCIPAL DRUG OF CONCERN, GOLD COAST, 2022-23



Source: AIHW, Alcohol and Other Drug Treatment Services National Minimum Dataset, Alcohol and other drug treatment services in Australia 2022–23. This data set excludes closed treatment episodes for 'volatile solvents', 'other' and 'not stated'.

- In 2022-23, there were 5,374 closed treatment episodes for the clients' own drug use in the Gold Coast region, this was an increase of 10.2% from 2021-22 (=n4,876).
- Alcohol has remained the principal drug of concern for several years; in 2022-23, 36.1% of closed treatment episodes (n=1,941) were primarily concerning alcohol.
- Cannabis was the second most prevalent drug of concern, accounting for 27.5% of treatment episodes, followed by amphetamines (23.5%).

12.4 SUICIDALITY

12.4.1 Thoughts of suicide

The *2020-22 National Study of Mental Health and Wellbeing* (NSMHW)[183] surveyed around 16,000 Australian residents aged 16–85 years living in private dwellings on the prevalence of mental health disorders and suicidality and self-harm.

Suicidal thoughts and behaviours in the NSMHW refer to whether a person had ever seriously thought about taking their own life, made a plan to take their own life, or attempted to take their own life, and whether they had done so in the last 12 months.

Results in Table 5 show that in the Gold Coast region, around one in six residents (17.6%, n=1,148) aged 16–85 years had experienced any suicidal thoughts or behaviours in their life, while 3.0% (n=15,418) had experienced suicidal thoughts or behaviours in the previous 12 months.

These prevalences were similar to the Queensland and national averages.

TABLE 5: SUICIDAL THOUGHTS IN LIFETIME AND PAST 12 MONTHS, GOLD COAST, 2020-2022

	Suicidal thoughts in lifetime						Suicidal thoughts in past 12 months					
	Males		Females		Persons		Males		Females		Persons	
	N	%	N	%	N	%	N	%	N	%	N	%
16-24 years	6,903	19.2	8,960	25.0	15,863	22.1	1,738	4.8	2,625	7.3	4363	6.1
25-34 years	9,585	21.8	10,395	22.3	19,981	22.0	1,455	3.3	1,825	3.9	3280	3.6
35-44 years	7,360	16.9	8,190	17.5	15,550	17.2	884	2.0	1,444	3.1	2328	2.6
45-54 years	7,655	18.0	8,339	18.5	15,994	18.3	856	2.0	1,145	2.5	2001	2.3
55-64 years	5,042	13.9	6,687	16.8	11,729	15.4	686	1.9	794	2.0	1480	1.9
65-74 years	3,691	12.4	5,147	15.4	8,838	14.0	518	1.7	665	2.0	1183	1.9
75-85 years	1,364	7.3	1,829	9.0	3,193	8.1	334	1.8	449	2.2	783	2.0
TOTAL	41,601	16.6	49,547	18.5	91,148	17.6	6,471	2.6	8,947	3.3	15418	3.0

Source: ABS (2023). National Study of Mental Health and Wellbeing 2020-2022.

- Young adults aged 16 to 24 had the highest prevalence of suicidal thoughts in their lifetime (22.1%) or past 12 months (6.1%), compared to other age groups.
- Across all age groups, females reported higher prevalence of having experienced suicidal thoughts than males.

12.4.2 Intentional self-harm

Intentional self-harm is defined as deliberately injuring or hurting oneself, with or without the intention of dying. Previous self-harm is the strongest predictor of death by suicide; therefore, monitoring of intentional self-harm is key to suicide prevention.

[183] Australian Bureau of Statistics 2023, *National Study of Mental Health and Wellbeing 2020-2022*.

NSMHW survey results showed that in the Gold Coast region, 8.7% of residents aged 16–85 years (n=44,988) have engaged in self-harming behaviours at some point in their lives, and 1.8% (n=9,544) in the past 12 months.

This prevalence was similar to national averages (8.7% and 1.7%, respectively), but lower than Queensland averages (9.1% and 2.2%, respectively).

Table 6 shows the numbers and percentages of Gold Coast residents experiencing suicidal thoughts in their lifetime or past 12 months, based on estimated modelling from the 2020-2022 NSMHW.

TABLE 6: SELF-HARM BEHAVIOURS IN LIFETIME AND PAST 12 MONTHS, GOLD COAST, 2020-2022

	Self-harm behaviours in lifetime						Self-harm behaviours in past 12 months					
	Males		Females		Persons		Males		Females		Persons	
	N	%	N	%	N	%	N	%	N	%	N	%
16-24 years	5,565	15.5	9,373	26.1	14,938	20.8	1,765	4.9	2,999	8.4	4,764	6.6
25-34 years	5,757	13.1	8,488	18.2	14,245	15.7	797	1.8	1,551	3.3	2,348	14.1
35-44 years	2,775	6.4	4,721	8.3	7,496	8.3	832	0.5	1,601	0.9	2,433	13.2
45-54 years	1,924	4.5	2,897	6.4	4,821	5.5						
55-64 years	895	2.5	1,394	3.5	2,289	3.0						
65-85 years	489	1.0	711	1.3	1,199	1.2						
TOTAL	17,404	6.9	27,584	10.3	44,988	8.7	3,394	1.4	6,151	2.3	9,544	1.8

Source: ABS (2023). National Study of Mental Health and Wellbeing 2020-2022.

- Young adults aged 16 to 24 had the highest prevalence of suicidal behaviours in their lifetime (26.1%) or past 12 months (6.6%), compared to other age groups. 1 in 4 females in this age groups have engaged with self-harming behaviours at some point in their lives.
- Across all age groups, females had a higher prevalence of self-harming behaviours than males.

12.4.3 Deaths by suicide

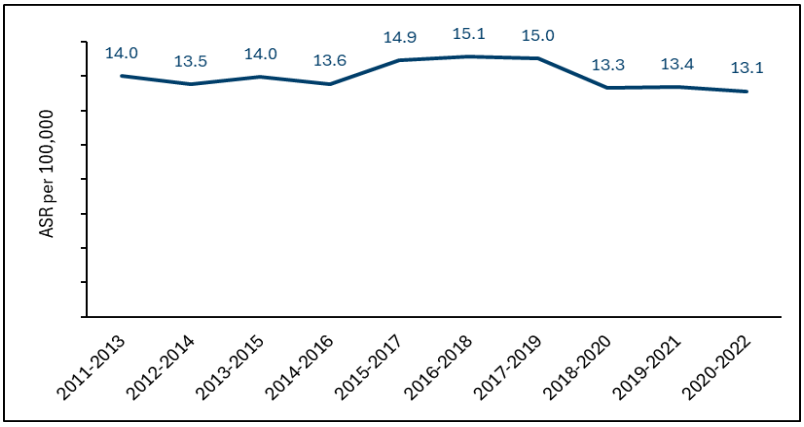
During 2018-2022, there were 448 deaths (ASR of 13.5 deaths per 100,000) due to suicide in the Gold Coast region placing suicide as the 9th leading cause of death during this period. In comparison, suicide was the 12th leading causing of death in Australia with an ASR of 12.5 deaths per 100,000[184].

The rate of suicide mortality for Gold Coast HHS residents slightly decreased (not statistically significant) between 2011-2013 and 2020-2022, from age standardised rate of 14.0 per 100,000 to 13.1 per 100,000, which is the lowest rate over the 10-year period.

Over the same period, Queensland's suicide mortality increased, from an age standardised rate of 13.8 per 100,000 to 14.5 per 100,000.

[184] Australian Institute of Health and Welfare 2024. *Mortality Over Regions and Time (MORT) books*.

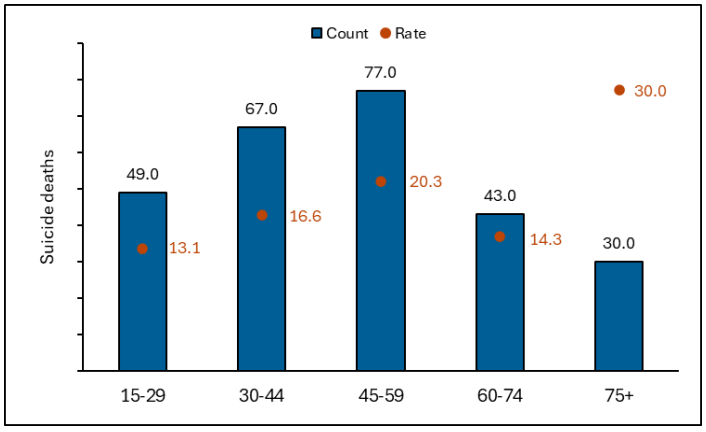
FIGURE 13: AGE-STANDARDISED RATES OF SUICIDE, GOLD COAST, 2011-2013 TO 2020-2022



Source: Cause of Death Unit Record File, Australian Coordinating Registry

- Death by suicide is one of the leading causes of death for younger people; more than half of all suicide deaths of Gold Coast residents in 2020-2022 occurred in people aged 15-44.
- The highest rate of suicide deaths was in the 45–49-year age group over the same period.

FIGURE 14: SUICIDE DEATHS BY AGE, GOLD COAST, 2020-2022



Source: Cause of Death Unit Record File, Australian Coordinating Registry

- Gold Coast men died by suicide at 2.6-times the rate of women in 2020-2022, accounting for 70.8% of suicide deaths over the period.
- Though suicide mortality is disproportionately experienced by men in the Gold Coast region, the differential is much higher for Queensland where men die by suicide at 3.4 times the rate of women.
- This was due to a higher rate of suicide mortality for Gold Coast women compared to Queensland (1.1x) and a lower rate for men (0.9x).

12.4.4 Utilisation of health services

Primary care

There are currently no national or regional data available on the contacts between persons experiencing suicidal crisis and primary healthcare. Data shown below are drawn from Primary

Sense tool, capturing all visits to the GP with suicide-related concerns across 160 general practices in the Gold Coast region.

TABLE 7: GP VISITS FOR SUICIDE RELATED REASONS, GOLD COAST, 2019 TO 2023

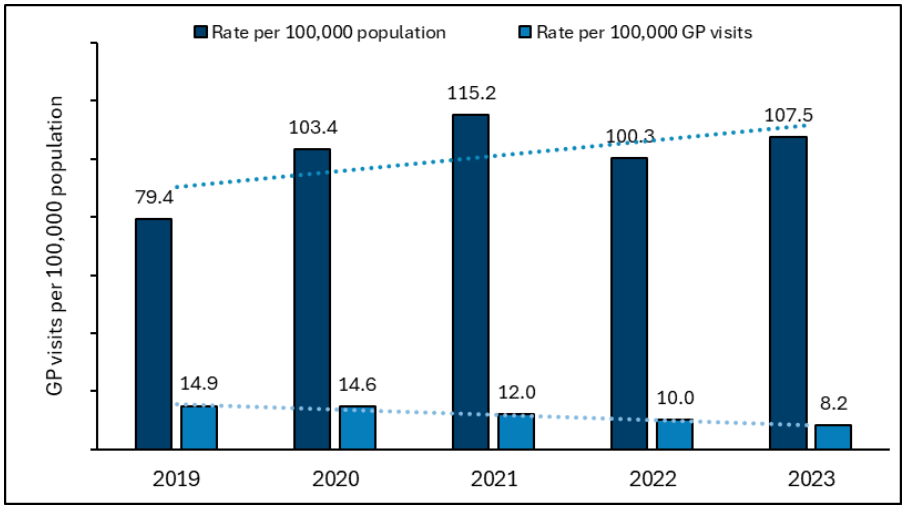
Year	Self-harm	Suicidal ideation	Suicide attempt / suicide	TOTAL
2019	202	220	78	500
2020	198	333	133	664
2021	221	394	133	748
2022	183	341	141	665
2023	210	396	119	725

Source: Primary Sense, data from 160 general practices as at January 2024.

- The number of GP visits for suicide-related presentations has been steadily increasing over the last 5 years; in 2023, they were 45% higher than in 2019 (n=725 vs. 500), though still lower than the peak reached in 2021 (n=748).
- Across all years, around half of suicide-related presentations were coded as being due to suicidal ideations, with the rest coded as self-harm, suicide or suicide attempts.

To account for the regional population growth and increases in total number of GP visits over the same period, above numbers were transformed to rates per 100,000 population (Figure 15).

FIGURE 15: GP VISITS FOR SUICIDE RELATED REASONS, GOLD COAST, 2019 TO 2023



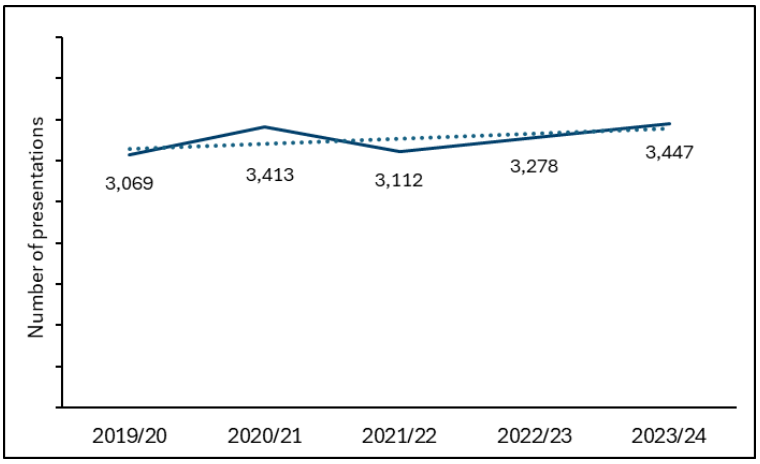
Source: Primary Sense, data from 160 general practices as at January 2024.

- Rates of suicide-related presentation per 100,000 population have been increasing over the last 5 years. However, the increase is not statistically significant.
- Figure 15 also displays rates of suicide presentation per 100,000 GP visits (blue bars). Over the years, a decrease can be seen in the proportion of all GP visits accounted for by suicide related presentations; in 2023, the rate was 45% lower than in 2019.

Emergency Departments

In 2023-24, there were 3,447 suicide-related presentations to the Gold Coast public EDs; a 12.3% increase over the last 5 years.

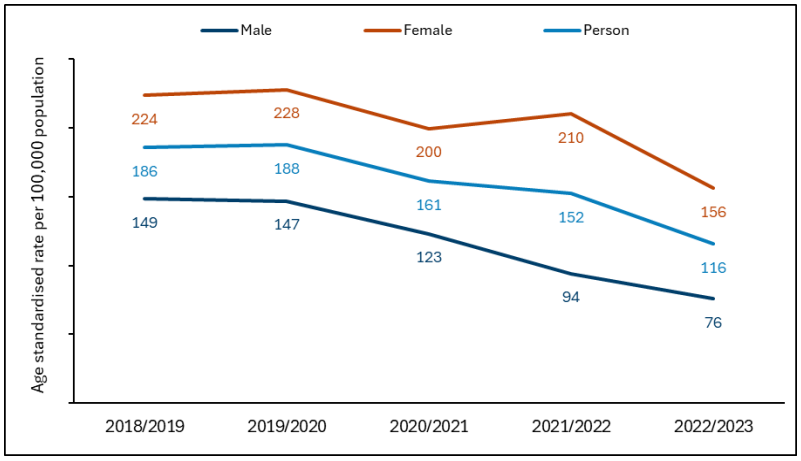
FIGURE 16: SUICIDE RELATED PRESENTATIONS TO ED, GOLD COAST, 2019-20 TO 2023-24



Source: Gold Coast HHS, Emergency Department Collection; Suicide-related Flag

Hospitalisations

FIGURE 17: HOSPITALISATIONS FOR SUICIDE AND SELF-INFLICTED INJURIES, GOLD COAST, 2018-19 TO 2022-23



Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC). ICD-10 Diagnoses included: Suicide and self-inflicted injuries (X60-X84, Y87.0)

- In 2022-23, there was a total of 116 hospitalisations to Gold Coast HHS for mental health and behavioural conditions. Of those, 493 were by females (67.0%) and 243 (33.0%) by males.
- This accounted for an age-standardised rate of 116 per 100,000 population; the rate was 2.1-times higher among males than females.
- A steady decline in the rates of suicide-related hospitalisations over the last 5 years can be seen in Figure 17: by 37.8% for all persons, 30.2% for females, and 49.1% for males.

12.5 HIGH-RISK / VULNERABLE GROUPS

12.5.1 First Nations people

Mental illness and substance abuse are one of the leading causes of the burden of disease for First Nation people across Australia. In 2023, the Institute for Urban Indigenous Health (IUIH) released a report on the mental health and substance behaviours of First Nation people in Southeast Queensland, with key findings:

- Almost half (46.5%) of participants experienced a mental disorder or harmful substance use in the past 12 months.
- Alcohol was the most used substance; 42.7% reported hazardous drinking in the past year.
- 26.4% smoked cigarettes and 11.9% vaped weekly.
- One in two (55.2%) had experienced suicidal thoughts in their lifetime.

Most recent available statistics for Queensland show that in 2022, the suicide rate in First Nations peoples was twice that of the non-Indigenous population. Of the 756 suicides reported in 2021 in Queensland, First Nations peoples accounted for 57 deaths or 7% of all suicides[185].

More information on the health of First Nations people is available in First Nations chapter.

12.5.2 Multicultural communities

Migrants often experience disadvantages on several social and cultural determinants of health, including language barriers, lower socio-economic status, lower education, and lower levels of mental health literacy, all of which can increase the risk of mental illness.

The 2021 census data showed that the prevalence of self-reported mental health conditions was lower among overseas-born population than Australian-born residents of Gold Coast (6.2% vs 10.0%).

While the reasons for lower rates of mental ill-health in multicultural communities are not clear, some of the differences could be because people who successfully migrate to Australia are required to complete rigorous health checks and testing which means they are more likely to be physically healthier than the remainder of the population. This may also be true for mental health issues. In addition, multicultural communities can have different conceptions of mental health, and varying degrees of stigma related to disclosing mental health concerns or seeking help.

Australia's multicultural communities have diverse views of suicide and suicidal thinking, and vary in the way that their community, family, and friends respond to suicide. Multicultural differences, past trauma and experiences of discrimination are acknowledged and related to effective suicide prevention strategy.

More information on health of multicultural communities is available in the chapter *Populations experiencing inequity*.

[185] Leske, S., Adam, G., Catakovic, A., Weir, B. and Kõlves, K., 2022. Suicide in Queensland: annual report 2022.

12.5.3 LGBTIQAP+ communities

Health needs related to mental health and wellbeing of LGBTIQAP+ populations remain poorly understood due to lack of inclusion of sexual orientation, gender identity and intersex status in administrative health data collections by mental health and mainstream services.

Nevertheless, there is growing evidence of the high risk of poor social, emotional and psychological wellbeing or other for LGBTIQAP+ communities. These adverse health outcomes are directly related to stigma, prejudice, discrimination and abuse experienced as part of diverse LGBTIQAP+ communities[186,187].

The 2020-2022 Australian National Study of Mental Health and Wellbeing[188] found that three in four (74.5%) people identifying as LGB+ had experienced a mental disorder at some time in their life, and 58.7% had a mental disorder in the last 12 months (almost 3-times more frequent than among heterosexual survey participants). Mental health outcomes are particularly poor for transgender young people; around 3 in 4 people have experienced anxiety or depression, 4 in 5 have engaged in self-harm and almost 1 in 2 (48%) have attempted suicide[189].

Literature reports up to 14 times more suicidal attempts amongst LGBTI people, rates of depression over five times higher amongst trans people and 3.5 times higher amongst LGB people than in the general population[190]. Of the 756 suicides reported in 2021 in Queensland, 24 (3.2% of all) suspected suicides were by persons identifying as LGBTIQ+[190].

LGBTIQAP+ people have been identified as a priority population in a range of national strategies, such as the National Mental Health and Suicide Prevention Plan, and the Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services in the Gold Coast region.

12.5.4 People experiencing / at risk of homelessness

Quantifying the prevalence of mental ill-health among homeless populations/people at risk of homelessness is difficult, and estimates vary considerably.

Nationally, 39% of adults with a history of homelessness experienced a mental health condition within the past year, which was almost twice as high as in the general Australian population[191].

In 2022-23, 31% of clients accessing specialist homelessness services reported experiencing mental health issues, and around 10% reported problematic alcohol and/or drug use.

More information on health of homeless populations is available in the chapter ‘Populations experiencing inequity’.

[186] LGBTIQ+ Health Australia 2021, *National LGBTIQ+ Mental Health and Suicide Prevention Strategy 2021-2026*.
[187] Amos, N., Lim, G., Buckingham, P., Lin, A., Liddelow-Hunt, S., Mooney-Somers, J. and Bourne, A., 2023. *Rainbow Realities: In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia.* LGBTIQ+ Health Australia.
[188] Australian Bureau of Statistics 2023, National Study of Mental Health and Wellbeing 2020-2022.
[189] Cook, A., Winter, S., Strauss, P., Lin, A., Wright Toussaint, D. and Watson, V., 2017. *Trans Pathways: The mental health experiences and care pathways of trans young people: Summary of results.* Telethon Kids Institute.
[190] Moagi, M.M., van Der Wath, A.E., Jiyane, P.M. and Rikhotso, R.S., 2021. Mental health challenges of lesbian, gay, bisexual and transgender people: An integrated literature review. *Health SA Gesondheid, 26*(1).
[191] Australian Bureau of Statistics 2023, *National Study of Mental Health and Wellbeing 2020-2022*.

12.5.5 Vulnerable children

Adverse childhood experiences (ACEs) correspond to sources of stress that people may suffer early in life usually before the age of 18, and can include verbal, physical, emotional, or sexual abuse, neglect, peer bullying, and household dysfunction.

The 2023 the Australian Child Maltreatment Study found that child maltreatment is widespread in Australia[192]. In total, 62.2% of the Australian population had experienced at least one type of child maltreatment. Exposure to domestic violence was the most common form of maltreatment, followed by physical abuse, emotional abuse, and sexual abuse.

The impacts of these forms of trauma and neglect include changes to health risk behaviour such as marked increase in suicidality, substance abuse, aggression and intimate partner violence, promiscuity, as well as health impact independent of behaviour change that include increased cancer rates, autoimmune diseases, obesity, ill mental health, and various other somatic complaints[193].

A group of particularly vulnerable children are those in out-of-home care (OOHC). Children and young people typically enter OOHC because they have experienced abuse or neglect and require a more protective and stable environment. They are more likely to have unrecognised and/or unmet complex physical or mental health needs, be socially and economically disadvantaged, or have limited access to health resources[194].

12.6 MENTAL HEALTH, AOD AND SUICIDE PREVENTION IN THE REGION

The Gold Coast region is relatively well-serviced with a wide range of service providers that support mental health, AOD and suicide prevention needs of its residents across the lifespan. Mental health concerns are often first identified through primary healthcare services, including general practice, Aboriginal and Torres Strait Islander Community Controlled Health Services, or Community Health Centres.

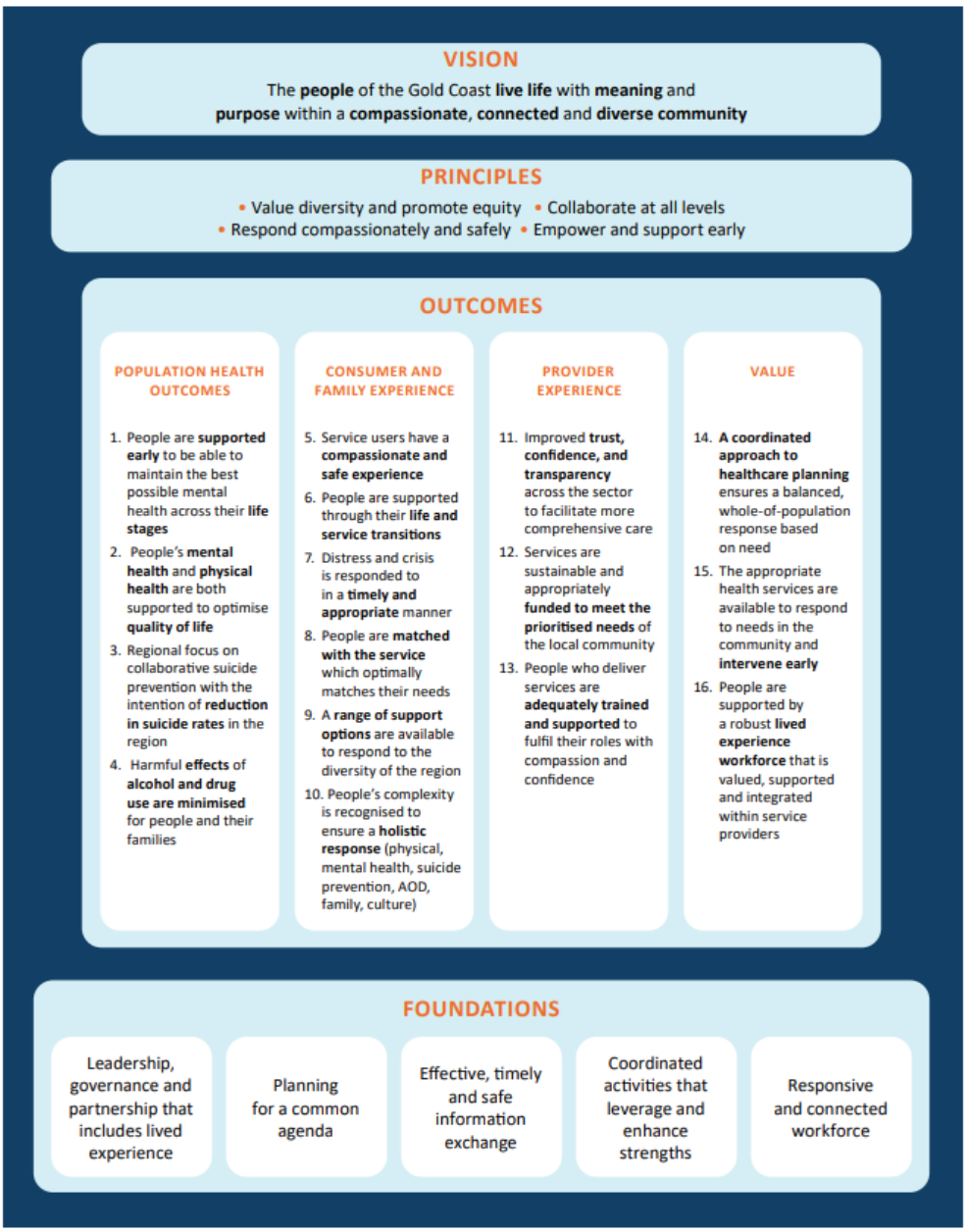
12.6.1 Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services

Mental health, suicide prevention, and alcohol and other drugs challenges faced by the Gold Coast community are complex and cannot be solved by one organization alone. In response, in 2020, GOLD COAST HHSHS and GCPHN co-developed *Planning for a Compassionate and Connected Gold Coast 2020-2025: A Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drugs Services in the Gold Coast Region (Joint Regional Plan)*.

The Joint Regional Plan lays the foundations for improved collaboration and integration between mental health, suicide prevention, alcohol and other drugs services in the Gold Coast region. A vision statement, guiding principles, long term outcomes and foundational elements of the Joint

[192] Haslam, D., Mathews, B., Pacella, R., et al., 2023. *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. The Australian Child Maltreatment Study.
[193] Felitti, V.J., Anda, R.F., Nordenberg, D., et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), pp.245-258.
[194] Engler, A.D., Sarpong, K.O., Van Horne, B.S., Greeley, C.S. and Keefe, R.J., 2022. A systematic review of mental health disorders of children in foster care. *Trauma, Violence, & Abuse, 23*(1), pp.255-264.

Regional Plan were developed through the engagement process and in consultation with a range of stakeholders and community representatives.



The following seven prioritised focus areas have been identified in Joint Regional Plan, along with specific strategies to support enhancing the service response and client outcomes:

- Children, youth, families
- Adults
- Older people
- Suicide prevention
- Crisis / distress reform
- Alcohol and other drugs

In 2022, the National Mental Health and Suicide Prevention Agreement was endorsed, along with the associated *Bilateral Schedule on Mental Health and Suicide Prevention: Queensland (Bilateral Agreement)*. In addition, the Queensland Government launched a *Better Care Together: a plan for Queensland's state-funded mental health, alcohol and other drug services to 2027*. These agreements have resulted in additional investment for the Gold Coast region and numerous initiatives to drive increased collaboration at a local level.

Some of the notable highlights achieved under the Joint Regional Plan until March 2024 include:

- Commissioning of **two Safe Space initiatives**, providing support for adults experiencing distress after hours, a time when usual supports may not be available to them.
- Delivery of **psychosocial support for people after a suicide attempt or at risk for suicide** (The Way Back Support Service; TWBSS). TWBSS now has 10 FTE providing aftercare services to consumers in the Gold Coast region. A Clinical Coordination role is embedded in the model and aims to enhance universal access to suicide aftercare services through establishment of integrated referral and escalation pathways, and care coordination.
- Establishment of a **Crisis Stabilisation Unit (CSU),** the first of its kind in Australia. The CSU is an alternative to Emergency Departments for consumers experiencing a mental health crisis, transforming their care experience and offering a more suitable environment for treatment. CSU sees around half of mental health related presentations to GCHHS.
- Regional prioritisation and collaborative implementation of DoHAC investment in **targeted regional suicide prevention initiatives.** This includes establishment of three Men's Table programs in the region, establishment of a Gold Coast Suicide Prevention Community Collaborative with support from Black Dog Institute, and delivery of suicide prevention training for frontline workers, gatekeepers and community members.
- Jointly funded **Joint Regional Plan Coordinator** role and **the Regional Suicide Prevention Coordinator** roles to support enhanced collaboration across the sector.
- Enhancement and integration of **headspace services**. Gold Coast HHS headspace in-reach program commenced from August 2023, with the primary focus on reducing fragmentation for young people engaging with more than one service through better information sharing, in particular referrals and consent. In addition, headspace is expanding service capacity for young people, especially in underserviced areas, e.g. Northern Corridor and Southport.
- **Head to Health Phone Service**, an intake, assessment, and referral phone service, was established in July 2022. It is described in more detail in chapter System navigation.

For 2024-25, key strategic priorities of Joint Regional Plan include:

- Regional referral and triage, including exploration of a singled integrated service.
- Integration with General Practice maximizing opportunities for better coordinated care.
- Better use of data, evaluation and research to inform service planning, decision making and contribute to evidence-based learning.
- Enhanced community and psychosocial services to improve efficiency and effectiveness through new ways of working together, ensuring improved consumer outcomes.
- Northern Gold Coast infrastructure project to deliver better access and integration of care closer to where priority population groups live.

12.6.2 Gold Coast Crisis Reform

The Gold Coast region has been actively working to transform mental health crisis care, driven by the *Gold Coast Crisis Reform for Responsive Effective, Compassionate, and Connected Care*. Through effective partnerships, embedding principles of crisis care and establishment of new models of care, the Gold Coast region has a coordinated continuum of care to prevent, respond to and resolve crisis.

Recognising the need for prevention, early intervention, and an alternative pathway to ED, health and community services in the Gold Coast region partnered with consumers, carers, and other key stakeholders to develop the **Gold Coast Crisis Continuum of Care**, which includes:

Pre-crisis

Outreach and engagement: Early intervention to prevent crisis, early identification and support.

Crisis

Someone to talk to: Phone, digital and in-person services, support, advice and triage for community professionals.

Someone to respond: Mobile and outreach options to support people where they are at.

Somewhere to go: Improving people's experience of crisis care including alternatives to ED.

Post crisis

Support after a crisis: Services and models to support people and communities following a crisis.

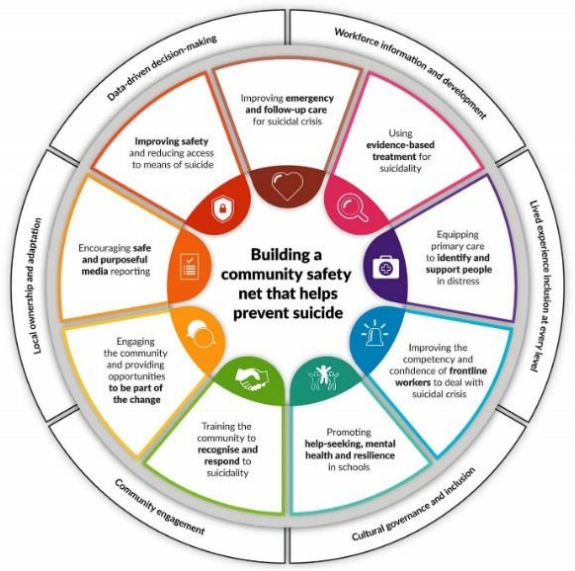
12.6.3 Community approach to suicide prevention

The health system plays a vital role in suicide prevention, particularly through the delivery of specialised mental healthcare. However, equally important roles are played by a wide range of social and human services, law enforcement agencies, industry bodies, education providers, private and non-government service providers, community services and workplaces.

Gold Coast Suicide Prevention Community Action Plan 2020-2025 was developed in parallel to the Joint Regional Plan. The Action Plan uses the LifeSpan framework developed by Black Dog Institute (Figure 18). Lifespan involves several key components:

- Nine evidence-based strategies, targeting population- to individual- level risk.
- Simultaneous implementation of all nine strategies within a localised region.
- Use of best evidence-based programs and interventions within each of the nine strategy areas, as suitable for the local region and adapted or suited to the target population.
- Governance at a local level (integration of NGOs, primary health care networks, local health districts, education, police and community groups to coordinate action).

FIGURE 18: LIFESPAN: INTEGRATED SUICIDE PREVENTION



Source: The LifeSpan lived experience framework, Australian National University.

Studies suggest it may be possible to prevent 20% of suicide deaths, and 30% of suicide attempts using the LifeSpan systems approach [195].

Incorporating the above principles, **Gold Coast Suicide Prevention Community Collaborative** (the Collaborative) was formed at the beginning of 2024. The Collaborative was founded on the common ambition of multiple government and non-government agencies to reduce the number of people who die by suicide and improving the service experience for those at risk of suicide and those who care for them.

The Collaborative aims to reduce the impact of suicide by:

- Improving the supports and support systems available to people at risk of suicide and their family, carers and friends, and people's experience of those supports.
- Encouraging systems change through collaboration.
- Ensuring that suicide prevention efforts are effective.
- Facilitating coordinated postvention support that meet the needs of those bereaved by suicide.
- Ensuring that people with lived experience are encouraged to contribute to the development, evaluation and governance of suicide prevention activities in the region.

12.6.4 Stepped care approach

Stepped care is an evidence-based approach that aims to match people to the right level of support to meet their current need. In a stepped care system, the supports around a person can 'expand' as their needs increase, or alternatively, as the person recovers, the level of care can be decreased.

[195] Hegerl, U., Althaus, D., Schmidtke, A. and Niklewski, G., 2006. The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. *Psychological medicine, 36*(9), pp.1225-1233.

It helps prevent under-servicing for people with higher levels of clinical need and over-servicing for those with lower levels of need. Stepped care supports an early intervention approach where people with mental health problems and mental illness have their needs addressed early, rather than waiting until the problems worsen and require more intensive intervention. Stepped care encourages more effective and efficient use of existing primary mental health care services, including Medicare-based psychological therapy services and prescribing of pharmaceuticals under the PBS. It also aims to improve the utilisation of evidence-based self-help and clinician-moderated digital mental health services.

A stepped care approach seeks to:

- reduce the under-servicing and over-servicing of some consumers,
- emphasise early intervention and self-care,
- match the level of service to consumers' need and change services as their needs change,
- shift focus to services that help prevent the need for acute and crisis intervention,
- offer the full continuum of services from low intensity through to high levels of care,
- ensure consumers have the choice of a broader range of services, aligned to their needs,
- increase the use of digital mental health services,
- strengthen support for GPs to ensure people are referred to the right service.

While there are multiple levels within a Stepped Care approach, they do not operate in silos or as one directional step but rather offer a continuum of service interventions matched to the spectrum of mental health needs. The spectrum and the levels of needs associated with it at a population level are illustrated below.

Figure 1 - Schematic representation of levels of care[5]

Stepped care provides guidance to GCHHS and GCPHN in planning, commissioning, and coordinating mental healthcare services undertaken by the Joint Regional Plan.

Grouping the complex system of mental health services available in Australia into five levels offers a convenient framework to think about stepped care rather than implying that that there is a natural division of service types into tiered categories. While some services are associated with

a single level of care, most contribute to multiple levels. For example, GP mental health care can be associated with lower levels of care when it is provided in isolation, or higher levels when delivered in combination with other services or interventions (e.g., psychiatrist or involvement of a multidisciplinary team). The levels are therefore best thought of as combinations of interventions that form potential 'packages' for people requiring that level of care, with the levels differentiated by the amount and scope of resources available.

12.6.5 System navigation

Consultations informing the development of the Joint Regional Plan identified a high demand for system navigation support for community and health professionals to assess and determine suitable options. Specifically, the stakeholders advised that:

- There are many pathways to mental health, AOD and suicide prevention and support services, however health care providers are often unclear about available services and the pathways to access these services due to frequent changes to service system.
- There is a need for timely and accurate information and easily identifiable access points for individuals seeking care to be matched with services that optimally meet their needs.
- When people are not initially matched to the right service, they have to re-take the intake process at each transition point, which can add to system inefficiency and contribute to poor outcomes.
- Limited understanding of service infrastructure can result in disengagement and lost opportunities for early intervention.

The above concerns highlight the need for provision of a seamless care pathway for consumers to receive the right level of care at the right time to meet their mental health needs. In response, various phone and web-based navigation services have been developed in recent years that support persons experiencing symptoms of mental ill-health with system navigation.

Head to Health (H2H) Phone Service

The Head to Health phone service offers a free and confidential mental health assessment and referral service for consumers, their families, carers, GPs, and health professionals. Head to Health can be accessed via self-referral, service provider warm referral, or referral by GP or psychiatrist, between Monday to Friday 8:30am – 5pm (excluding public holidays).

H2H phone service enables care pathway for consumers to receive the right level of care at the right time to meet their mental health needs by applying the concept of stepped care at the initial assessment phase, following the National PHN Guidance on Initial Assessment and Referral for Mental Healthcare[196].

Head to Health (H2H) website

The H2H website brings together a range of 500+ online and phone-based resources and services from Australia's trusted mental health service providers to support wellbeing and mental health. The website supports the consumer in finding the appropriate services required for their needs.

[196] Department of Health 2022, *National PHN Guidance: Initial Assessment and Referral for Mental Healthcare*.

1300 MH CALL

Gold Coast Mental Health and Speciality Services provides public acute and specialist services for mental health, alcohol and other drugs across inpatient and community-based settings. Advice and referrals are available 24/7 through the 1300 MH Call service.

The 1300 MH CALL service:

- is the main point of access into public mental health services,
- can provide support, information, advice and referral,
- can provide advice and information in a mental health emergency or crisis,
- is staffed by trained and experienced professional mental health clinicians, and
- provides a mental health triage and refer to acute care teams where appropriate.

12.6.6 GCPHN commissioned services

GCPHN works with clinicians, service providers, people with a lived experience and local communities to commission a range of mental health, alcohol and other drugs and suicide prevention services to meet the diverse and growing needs of the Gold Coast region. These services target populations that have been shown to be harder to engage with or with limited accessibility of other available services and are available at no cost to patients.

GCPHN commissions a range of services based on an evidence-based stepped care framework. The services comprise a range of interventions, from the least to the most intensive, across the five levels of care, which can be matched to a person's needs.

The GCPHN-funded services providing mental health, alcohol and other drugs, and suicide prevention service to the Gold Coast community in 2024 are shown on the next two pages.

GCPHN Funded Services

Mental Health, Suicide Prevention, Alcohol and Other Drug Services, and Chronic Disease Management

phn GOLD COAST
An Australian Government Initiative

	SERVICE	TARGET AUDIENCE	DESCRIPTION	PROVIDER	REFERRAL INFO
LEVEL 1: SELF-MANAGEMENT	HeadtoHealth.gov.au	**People of all ages,** at risk of developing, or with emerging mental health needs.	**HeadtoHealth.gov.au** provides a range of mental health online services, programs, websites, chat groups and apps. Online treatment programs can help individuals work through a range of mental health conditions and disorders like depression and anxiety.	**Australian Government – Department of Health and Aged Care** HeadtoHealth.gov.au 1800 595 212	Any source, including self-referrals. GPs can direct individuals to headtohealth.gov.au
LEVEL 2: LOW INTENSITY	NewAccess (Mental Health Coaching)	**People 16+** who are finding it hard to manage life stress.	**A mental health coaching program,** to provide accessible, quality structured psychological therapy services. People can access six coaching sessions delivered over the phone, via video or in person by trained mental health coaches.	**Primary and Community Care Services (PCCS)** 07 3186 4000 GCTX@pccs.org.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
LEVEL 2 AND 3 INTENSITY	Psychological Services in Residential Aged Care Homes	**Older people living in Residential Aged Care Homes** experiencing mild depression or anxiety and those having trouble adjusting to changes or coping with loss.	**Structured psychological therapies** and support for people experiencing a dual diagnosis of mental health and dementia or neurocognitive disorder (including brain injury/developmental disability) where behaviours are identified as mental health related.	**Change Futures** 07 5648 0424 racmentalhealth@changefutures.org.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
	headspace	**12-25 years** with emerging mental health needs.	**An accessible 'one-stop-shop' for young people** that supports early intervention with emerging mental health needs surrounding mental and physical health, work/study support and alcohol and other drug issues.	**Lives Lived Well headspace Southport** 07 5509 5900 **headspace Upper Coomera** 07 5600 1999	Any source including GP or self-referrals. GPs can refer by calling or emailing.
LEVEL 3: MODERATE INTENSITY	Supporting Minds (Psychological Therapies)	**16-65 years** experiencing situational distress. This can include people: at risk of homelessness, experiencing domestic violence issues, in significant financial hardship, experiencing relationship issues, and experiencing social isolation.	**Short-term clinical and non-clinical, individual and/or group based psychological support.** Situational factors include significant life transitions, trauma, experiencing harm from others, interpersonal or social difficulties, ability to or difficulty having basic physical, emotional, environmental, or material needs met, and legal issues.	**Wesley Mission Queensland** 07 3151 3828 MentalHealthIntake@wmq.org.au	Any source including GP or self-referrals. GPs can refer through Head to Health or by calling or emailing.
	Supporting Minds (LGBTIQAP+)	**12-65 years** who identify with the LGBTIQAP+ community and/or are questioning sexuality or gender.	**Short-term clinical and non-clinical individual and/or group based psychological support to** increase mental health and wellbeing, access a suite of interventions tailored to mental health needs, enhance relationships and connection to community, and provide a safe, supportive and welcoming environment.	**Wesley Mission Queensland** 07 3151 3828 MentalHealthIntake@wmq.org.au	Any source including GP or self-referrals. GPs can refer through Head to Health or by calling or emailing.
	Supporting Minds (First Nations Kids in Out of Home Care)	**Indigenous children and young people 0 – 19 years** who are in a kinship or foster care arrangement who present with mild to moderate symptoms.	**Short-term support, group programs, outreach, and case management** using an integrated, flexible, and holistic approach to promote social and emotional wellbeing. Provides tailored interventions for mental health and cultural needs, and improve relationships and community connections.	**Kalwun** 07 5578 3434 supportingminds@kalwun.com.au	GPs can refer through Head to Health or by calling or emailing.
	Virtual Psychologist: Virtual Psychological Services	**People 16+**	**Telehealth-based (text, audio, or video)** mental health services, including self-management, psychotherapeutic interventions, and low to moderate mental health support for individuals. Ensures timely and effective care for underserviced populations, including men, culturally and linguistically diverse (CALD) communities, individuals from remote areas, and those affected by natural disasters.	**Virtual Psychologist** 0481 614 647 info@virtualpsychologist.com.au	Any source including GP or self-referrals. GPs can refer by emailing and individuals can self-refer by sending a text.
LEVEL 4: HIGH INTENSITY	headspace (Early Psychosis)	**12-25 years** at risk of, or experiencing a first episode of psychosis.	A multidisciplinary service of consultant psychiatrists, peer workers and clinicians to support young people aged 12-25 at risk of or experiencing a first episode of psychosis. The Early Psychosis team is equipped to intervene early to improve the lives of young people, and their families, impacted by psychosis.	**Lives Lived Well** Early Psychosis Mobile Assessment and Treatment team 0423 614 781 earlypsychosis@headspacesouthport.org.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
	Lighthouse (Youth Clinical Care Coordination)	**12-18 years** with severe and/or complex mental health needs.	Provides trauma informed, recovery- orientated clinical care coordination and specialised treatment.	**Lives Lived Well** 07 5699 8248 lighthouse@liveslivedwell.org.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
	Plus Social® (Adult Clinical Care Coordination)	**Adults (18+)** who experience the impacts of severe mental illness, and who are not currently casemanaged or accessing Gold Coast Health mental health services.	Comprehensive, high intensity clinical care coordination support including structured, recovery and goal-oriented services to create significant improvements in quality of life, health and wellbeing.	**Primary and Community Care Services (PCCS)** 07 3186 4000 GCTX@pccs.org.au	Only GP or psychiatrist referrals are accepted. GPs or psychiatrists can refer by calling or emailing.
LEVEL 2, 3 AND 4 INTENSITY	Social and Emotional Wellbeing (First Nations Mental Health)	**Aboriginal and/or Torres Strait Islander people** struggling with their mental health or seeking a suicide support service.	Improve the social and emotional wellbeing of individuals and reduce the harm associated with social and emotional wellbeing, suicide ideation/attempts and mental ill health through the provision of an integrated, flexible, and holistic approach of care.	**Kalwun** 07 5526 1112 sewb@kalwun.com.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
SERVICE NAVIGATION	CÜRA Community Pathway Connector	**People of all ages** from culturally and linguistically diverse backgrounds.	**A culturally safe connection point and referral service,** to assist people from culturally and linguistically diverse backgrounds, with tailored information, one-on-one support to navigate the services system, working with interpreters, and linking with cultural awareness education as needed.	**Multicultural Communities Council Gold Coast** 07 5527 8011 info@curacares.com	Any source, including GP or self-referrals. GPs can refer by calling or emailing.
	Krurungal Community Pathway Connector	**People of all ages** who identify as Aboriginal and Torres Strait Islander or their family members/spouse/carer.	A culturally safe **connection point and referral service,** to assist Aboriginal and Torres Strait Islander people through tailored information and one-on-one support to navigate the services system.	**Krurungal Aboriginal and Torres Strait Islander Corporation** 07 5536 7911 reception@krurungal.com.au	Any source, including GP or self-referrals. GPs can refer by calling or emailing.

HEAD TO HEALTH

If you are unsure if one of the above services is right for your patient, you can refer to **Head to Health on 1800 595 212 between Monday to Friday, 8:30am – 5pm (except public holidays).** Alternatively, you can forward a completed referral via Medical Objects to: *Head to Health Gold Coast Referrals* or Fax: 07 3186 4099.
A mental health clinician will complete an initial assessment and referral into an appropriate service or resource that matches a person's needs.

GCPHN Funded Services

Mental Health, Suicide Prevention, Alcohol and Other Drug Services, and Chronic Disease Management

phn GOLD COAST
An Australian Government Initiative

	SERVICE	TARGET AUDIENCE	DESCRIPTION	PROVIDER	REFERRAL INFO
SUICIDE PREVENTION AND COMMUNITY SUPPORT	**Gold Coast Community Support**	**People 16+ in the Gold Coast community** at risk of suicide.	Gold Coast Community Support is **a flexible 8-week program** that provides non-clinical emotional, practical, and coaching support.	**Wesley Mission Queensland** 07 5569 1850 MentalHealthIntake@wmq.org.au	Referrals can only be made via Gold Coast Community Organisations. This service is included here for GP and health professional awareness.
	The Way Back Support Service (TWBSS) (Post-hospital Discharge Community Support)	**Adults (18+)** that have presented to or been discharged from either Robina or Gold Coast University Hospital following a suicide attempt or suicidal crisis.	Personalised **non-clinical psychosocial support** for up to three months after hospital discharge. This service supports people to stay safe, keep connected with others, and access health and community services as part of their recovery.	**Wesley Mission Queensland** 07 5569 1850 thewaybackservice@wmq.org.au	Referrals can only be made via Gold Coast Health Acute Care Team. This service is included here for GP and health professional awareness.
	The Way Back Support Service (TWBSS) Out Of Hospital pathway (OOH)	**People 16+** experiencing suicidality and have presented to either General Practice, Head to Health or an Aboriginal Medical Service (i.e. Kalwun).	Personalised **non-clinical psychosocial support for up to three months after hospital discharge.** This service supports people to stay safe, keep connected with others, and access health and community services as part of their recovery.	**Wesley Mission Queensland** 07 5569 1850 MentalHealthIntake@wmq.org.au	Referrals can be made via referral form or letter-of-referral from General Practitioner, Head-To-Health Clinician, or Aboriginal Medical Services clinician.
ALCOHOL AND OTHER DRUG SERVICES	**Lives Lived Well (Transition House, Family and Youth)**	**People 12+** impacted by alcohol or drugs, including impacts associated with mental health issues.	Short to medium term treatment and support to reduce problematic substance use via access to all Lives Lived Well programs, including family support and therapy, dual diagnosis and complex care, residential rehabilitation and transitional housing support.	**Lives Lived Well** 1300 727 957 info@liveslivedwell.org.au	Any source, including GP or self-referrals. GPs can refer by calling or emailing.
	QuIHN (AOD Adult)	**Adults (18+)** impacted by alcohol or drugs, including impacts associated with mental health issues.	Treatment and support to reduce problematic substance use and achieve recovery goals. Services include harm reduction, group programs, long term case management and counselling.	**QuIHN** 07 5520 7900 quihn@quihn.org	Any source, including GP or self-referrals. GPs can refer by calling or emailing.
	Social and Emotional Wellbeing (First Nations AOD)	**Aboriginal and/or Torres Strait Islander people** struggling with their mental health, drug and alcohol misuse or seeking a suicide support service.	Improve the social and emotional wellbeing of individuals and reduce the harm associated with social and emotional wellbeing, suicide ideation/attempts and mental ill health through the provision of an integrated, flexible, and holistic approach of care.	**Kalwun** 07 5526 1112 sewb@kalwun.com.au	Any source, including GP or self-referrals. GPs can refer by calling or emailing.
OTHER MENTAL HEALTH SERVICES	**After Hours Safe Space**	**Adults (18+)** who require a brief intervention to support de-escalation of their mental health concern and are safe and suitable to attend a community-based support service. This service can be used as a safe alternative to hospital presentations when not in crisis.	After Hours Safe Space is a confidential, low intensity, after-hours mental health service for people experiencing mental health distress. Services are delivered by clinical and lived experience staff at Mermaid Beach (2580 Gold Coast Highway) and Southport (Level 3, Southport Health Precinct building. 16-30 High Street), Mon-Fri 6pm-9pm, Sat and Sun 12pm-8pm.	**Primary and Community Care Services (PCCS)** 07 3186 4000	This is a walk-in service. GPs can contact the After Hours Safe Space provider by calling.
	Psychosocial Support	**People 16+** who experience severe and complex mental health concerns and who do not have an NDIS package.	**Moderate intensity (non-clinical) individual and group-based psychosocial support** to assist individuals achieve their recovery goals by building personal capacity and stability in one or more of the following skill areas: health and wellbeing; independence; confidence and resilience; daily living; social; relationship; finance; and vocational.	**Primary and Community Care Services (PCCS)** 07 3186 4000 GCTX@pccs.org.au	Any source including GP or self-referrals. GPs can refer by calling or emailing.
CHRONIC DISEASE SERVICES	**Turning Pain Into Gain**	**People with persistent pain for more than 3-6 months** and are not suitable for surgical or urgent pain specialist interventions.	Supports people explore a range of different strategies through education programs, individual case management, peer support, goal setting and improved use of community health services. Offers psychological support to clients experiencing anxiety due to pain who may need additional mental health support.	**PainWise** 0412 327 795 tpigpainprogram@painwise.com.au	GP referral is required. GPs can refer by calling or emailing.
SERVICE NAVIGATION	**CÜRA Community Pathway Connector**	**People of all ages** from culturally and linguistically diverse backgrounds.	**A culturally safe connection point and referral service,** to assist people from culturally and linguistically diverse backgrounds, with tailored information, one-on-one support to navigate the services system, working with interpreters, and linking with cultural awareness education as needed.	**Multicultural Communities Council Gold Coast** 07 5527 8011 info@curacares.com	Any source, including GP or self-referrals. GPs can refer by calling or emailing.
	Krurungal Community Pathway Connector	**People of all ages** who identify as Aboriginal and Torres Strait Islander or their family members/spouse/carer.	A culturally safe **connection point and referral service,** to assist Aboriginal and Torres Strait Islander people through tailored information and one-on-one support to navigate the services system.	**Krurungal Aboriginal and Torres Strait Islander Corporation** 07 5536 7911 reception@krurungal.com.au	Any source, including GP or self-referrals. GPs can refer by calling or emailing.

HEAD TO HEALTH

If you are unsure if one of the above services is right for your patient, you can refer to **Head to Health on 1800 595 212 between Monday to Friday, 8:30am – 5pm (except public holidays).** Alternatively, you can forward a completed referral via Medical Objects to: *Head to Health Gold Coast Referrals* or Fax: 07 3186 4099.
A mental health clinician will complete an initial assessment and referral into an appropriate service or resource that matches a person's needs.

Gold Coast Primary Health Network
Level 1, 14 Edgewater Court Robina, QLD 4226
07 5635 2445 | info@gcphn.com.au | www.gcphn.org.au

Scan for more information about our Funded Services

12.7 CONSULTATIONS

12.7.1 Past consultations

Various consultation activities have been undertaken to inform the identification of mental health- and suicide-related health needs and service issues for previous iterations of GCPHN's Health Needs Assessment and Gold Coast HHS's Local Area Needs Assessment, predominantly during the planning for Joint Regional Plan for Mental Health, Suicide Prevention, Alcohol and Other Drug Services in 2020. However, many of these observations remain relevant in 2024 are therefore summarised below.

Children and Youth:

- The Gold Coast region is relatively well-resourced with service providers for children, young people, and families' wellbeing, with significant investment in early psychosis services.
- The Northern Corridor is experiencing rapid population growth, with an increasing population of young people and limited early intervention and therapeutic services available locally.
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. However, their health needs are not always met due to an absence of a dedicated health care coordinator.
- There are gaps in services for children with neurodevelopment disorders who need mental health assessment or treatment.
- Transport is an access barrier for youth as public transport can be too costly or not available.
- Alcohol and drug treatment options are limited for the youth and there are no withdrawal management options for those under 18 years.

Older Adults:

- Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other.
- There is limited access to assessment and treatment by public sector geriatricians.
- Gaps in clinical resources, knowledge, and supports in the community result in people referring to tertiary service providers as a default option or last resort.
- Older people often need assistance with physical and mental health, with coordination of medical appointments and understanding their medications, and accessing broader services such as financial services, housing, and Centrelink.
- The sector seems fragmented, resulting in confusion for older people trying to access services and this leads to a decline in their overall physical and mental wellbeing.

Multicultural Communities:

- Many services for people of CALD backgrounds are concentrated in Brisbane and only limited ones in the Gold Coast region.
- Providers indicated providing psychological services to the CALD population was identified as important along with the need to ensure appropriately trained interpreters.

- There are large gaps in equity due to limited health provider support to find resources, referral pathways, communicate effectively people with a refugee/asylum seeker background.
- Concern about accessing culturally sensitive interpreters and a further concern about privacy may be compromised in smaller communities.
- Asylum seekers often have no Medicare card or have fluid access to Medicare.

Homeless populations:

- Some community-based organisations provide a soft entry point to cater for the homeless and provide an initial point of contact through which to identify and deliver healthcare.
- The homeless population do not present to mainstream services yet often have physical health issues that require regular primary care.
- Service providers identified that it takes considerable time and consistency of staff to develop trust and relationships with this group as many are suspicious of service providers due to past negative experiences.

LGBTIQAP+:

- Services and support for children who are undergoing gender transitioning or who identify early as LGBTIQAP+ are sparse.
- Long wait lists for gender affirming support.
- Issues that contribute to the health needs of LGBTIQAP+ people in the Gold Coast include lack of referral pathways, cultural competencies within health and mental health services, and limited availability of specialist medical care.

Service issues:

- There are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS.
- People with an existing health concern may be able to function independently in the community with minimal formal supports. However, when services are not well coordinated across the sectors, people may become more vulnerable resulting in exacerbation of issues and higher use of treatment services.
- There is need to increase GPs' awareness of and referral to local services, including online, self-help, and low intensity services.
- Addressing the physical wellbeing of people with severe and complex mental illness must be prioritized through strengthening collaboration between mental health and primary care services.
- Some GPs reported limited confidence in working with severe and complex mental illness, not having access to enough information about services available and referral pathways.
- Ongoing challenge to recruit suitably qualified and experienced clinicians.
- Consumer, families, and carers want opportunities to be involved in the planning, design, delivery, and evaluation mental health service.

- Consumers have limited options to access face to face support outside an emergency department or clinical setting when they are feeling distressed, particularly in the after-hours.

Alcohol and Other Drugs:

- Timely access to treatment is crucial for clients with alcohol and other drug challenges; delays or mismatches in service availability can lead to disengagement.
- Current capacity issues in withdrawal management, residential rehabilitation, and after-hours support further limit flexible and continuous care.
- Access to bulk-billing psychiatry is limited, restricting availability for those at risk.
- There is also a misconception that withdrawal must occur in bed-based facilities, though in-home and outpatient options can be effective and increase access.
- The Gold Coast region offers most of the spectrum of AOD services (except adequate residential 'detox' and withdrawal management) but struggles with transitioning clients across services as needs change, which can lead to disengagement if not managed well.
- Service providers often lack clarity on service capacity, particularly for withdrawal and rehabilitation, causing delays.
- The shortage of First Nations AOD workers limits culturally appropriate care and contributes to high disengagement rates.
- Upfront fees and financial barriers restrict access to residential rehabilitation, and there are few options for young people and parents accommodate with children.
- GPs need more information about service availability and referral pathways, especially for methamphetamines.
- Transport barriers and limited in-home outreach services, particularly in areas like Coomera/Northern Corridor, further hinder access.
- Small operational budgets and insufficient funding impact staff professional development and service quality.
- There is a need for better integration between AOD services and mental health, housing, and other support sectors.
- Service users often face barriers like lengthy wait lists, which can hinder recovery and motivation. Telehealth options could improve accessibility and address these barriers.
- Dual diagnosis specialists and mental health services need to be better equipped to handle co-occurring AOD issues.
- A bridging approach is needed for individuals transitioning from initial treatment discussions to residential detox or rehabilitation.

Suicide prevention:

- There's a need to improve skills of mainstream services, GPs, and clinicians to support populations at risk of suicide.
- Hospitalised individuals at risk of self-harm often receive insufficient follow-up if their mental health issues aren't deemed severe enough for admission.

- Early identification of at-risk LGBTIQAP+ individuals is crucial for suicide prevention.
- Insufficient support is available for individuals at risk of self-harm who are not admitted to the hospital.
- Suicide attempt survivors often lack adequate community support and need more help with non-health issues like finances and housing.
- Individuals discharged from hospitals often feel excluded from the discharge planning process.
- Consumers frequently report a lack of empathy and compassion from primary care providers.

12.7.2 2024 Gold Coast Mental Health Symposium

In May 2024, extensive consultations were undertaken at the Gold Coast Mental Health Symposium, organized by GCPHN and Gold Coast HHS. Forum was attended by health practitioners, service providers, clinicians, academics, and people with lived/living experience, who had the opportunity to provide input on the needs in the region. Main points included:

- There is a need for well-being-focused initiatives and age-appropriate mental health services for individuals over 65, including adult day programs and support for the elderly.
- Social isolation and loneliness are significant issues, particularly for older people, veterans, and those from CALD backgrounds.
- There are delays in accessing free mental health services, and the integration between mental health and non-mental health services remains inadequate.
- There is a shortage of bulk-billed psychiatric services, which many consumers cannot afford due to high out-of-pocket costs.
- Veterans and their families need improved links to mental health programs and support.
- The current focus on sickness rather than health needs to shift, and more community-based psychological therapies are required.
- There should be more support for parents, including parental and carer-specific services, and enhanced mental health support for young mothers, incl. peri-natal and post-natal care.
- Access to public detox beds in the Gold Coast region is urgently needed, as well as more social groups and opportunities for people with mental health challenges.
- There is a call for more training and support for mental health staff, including lived experience workers, and a need for improved partnerships across sectors like housing and education.
- The mental health system would benefit from better integration with primary care and an enhanced focus on early intervention, including ADHD support and prevention services.
- More free psychological support, bulk-billed psychiatrists, and community-based mental health services are needed, especially for multicultural populations.
- There is a need for innovative approaches to ADHD assessments, enhanced support for school refusal related to mental health, and integration with other services for holistic care.
- The focus should also be on addressing societal expectations, status anxiety, and the challenges faced by minority groups in accessing mainstream services.

- Enhanced community communication about available support and simplified access to long-term supports are crucial, with a specific focus on the elderly and individuals with co-morbid conditions.
- We need more accessible safe spaces that provide holistic, non-clinical support and peer assistance to help individuals get back on their feet.
- A 24/7 hotline for psychologists is needed.
- Increased community-based men's support services are essential.
- There is a need for stigma reduction and better education for staff in emergency units and mental health settings.
- Day programs, allied health delivering brief interventions, and a social worker available in Crisis Stabilisation Units (CSUs) would be beneficial.
- Increasing the skilled workforce, especially those with lived experience, and integrating support for factors like financial stress and housing crises are crucial.
- Support should also be available for individuals experiencing psychosocial distress and suicidal ideation without formal mental illness diagnoses.
- Funding and strategies to address cost-of-living pressures that contribute to suicidal distress are needed.
- Staff caring for consumers in suicidal crisis should be better supported, and there should be sustainable education for them.
- The mental health system should not overlook AOD dependence as a factor in requiring inpatient support, and there should be more rehab support.
- More research and timely data on suicide attempts, not just deaths, are needed to identify intervention points.
- Education on preventative measures for carers, especially for children at risk, and rapid outreach in home care are important.
- More bulk-billed psychological services and crisis stabilisation units are required.
- Drop-in spaces should include support for those under 18.
- Peer workers should be employed in emergency departments and mental health wards.
- There should be improved access to CSU, more hospital beds, and a reduction in waitlists for services.
- We need more information on funding for mental health services for people with disabilities and homelessness.
- Education about suicide prevention should be integrated into schools.
- Access to affordable psychologists and psychiatrists is consistently a service gap for clients
- Increasing rate of eating disorders with little community/public funded services to support early identification and treatment (without resorting to tertiary care).
- There are gaps in suicide and mental health care for youth aged 12-16.
- Housing crisis and instability leading to more acute financial and or domestic violence within households (and the associated impacts on mental health and wellbeing).

12.8 SERVICE SYSTEM IN THE GOLD COAST REGION

Mental Health

Services		Number	Distribution	Information
PRIMARY CARE	**General Practice**	212	Across Gold Coast region	• 880 GPs in the Gold Coast region, working across 212 general practices. • GPs support mental health by providing assessment, treatment, and referrals to other services, often through developing GP Mental Health Treatment Plans.
GOLD COAST HHS	**Emergency Departments**	2	Robina and Southport (public hospitals)	• The Gold Coast HHS has EDs in Robina and Southport, which provide care for mental health emergencies through Acute Care Team.
	Crisis Stabilisation Unit	1	Robina Hospital	• A 12-chair facility at Robina Hospital that provides a safe space for acute mental health assessment, treatment, and management. • CSU is accessible via contact through the 1300 MHCALL hotline and the public hospitals in Robina and Southport.
	Inpatient services	5	Robina and Southport (public hospitals)	• GCHHS Mental Health Services provide inpatient hospital admissions for people of all ages who need mental health care which cannot be provided in the community. • Referrals for admissions are through 1300 MH CALL and patients of other Queensland Health services (e.g. Crisis Stabilisation Unit, Emergency Departments, Community Services). • Some of the specialist services include: • ECT and Neurostimulation Team • Lavender Mother and Baby Unit

				• Mental Health Hospital in the Home • Secure Mental Health Rehabilitation Unit
	Community services	Numerous	Southport, Palm Beach and outreach	• GC HHS community mental health services provide support to people who are more severely impacted by mental illness as well as those experiencing mental health crisis and suicidality. Services are provided through outreach and clinics across the Gold Coast region. • Some of the specialised adult community services include: • Adult Eating Disorder Program • Homeless Health Outreach Team (HHOT) • Nurse Navigators • Mobile Intensive Rehabilitation Team • QAS/QPS Co-responders • Transitional Recovery Service • Some of the specialised child and youth community services include: • Evolve Therapeutic Service • Assertive Mobile Youth Outreach Service • Early Psychosis Team • Eating Disorder Program • headspace In-Reach • Nurse Navigation • Project Air • Yangah Adolescent Day Program

	Consumer and Carer consultants	Numerous	Across Gold Coast region	• GCHHS's Carer and Family Participation Team is a lived experience team which provides a responsive program of recovery orientated peer support, education and information for consumers, families and carers.
PRIVATE HEALTH SERVICES	**Private mental health facilities**	3	Southport, Robina, Currumbin	• These clinics offer inpatient programs inpatient therapy programs for a variety of mental health disorders for adults and young people aged 16 and up.
	Psychologists / allied health professionals	Several hundred	Across Gold Coast region	
FIRST NATIONS	**Aboriginal and Torres Strait Islander: Kalwun Social Health Clinical Care Coordination**	3	Miami, Bilinga, Coomera	• This low to high intensity service offers comprehensive support for First Nations people who are struggling with mental health or alcohol and other drug related needs. • The program offers case management and clinical care coordination and works to improve the social and emotional wellbeing of individuals and reduce the harm associated with social and emotional wellbeing, suicidality and AOD use.
DIGITAL HEALTH	**E-mental health services** **Phone Services** **Online Counselling** **Information and referral helplines and websites**	Numerous	Available for all Gold Coast residents	• Head to Health (H2) is GCPHN-funded phone service, which offers a free, confidential, and friendly mental health assessment and referral service for consumers, their families, carers, GPs, and health professionals between Monday to Friday 8:30am – 5pm. • Virtual Psychologist is GCPHN-funded telehealth-based (text, audio, or video) mental health services for adults aged 16+. • Some additional e-mental health and phone services include: headspace, Kids Helpline, beyondblue, eheadspace, ReachOut (beyondblue and headspace also provide online chat).

				• Additional information and referral helplines and websites include: MindHealthConnect, Mi networks, Commonwealth Health Website SANE Australia, beyond blue, ReachOut.com, RUOK? Black Dog Institute, Mental Health Online.
NOT-FOR-PROFIT / NGO	**headspace (12-25 years)**	2	Southport and Upper Coomera	• An accessible 'one-stop shop' for young people aged 12-25 that helps promote mental health, physical health, work/study support, and alcohol and other drug services.
	headspace Early Psychosis (funded by GCPHN)	2	Southport and Upper Coomera	• Multidisciplinary service of consultant psychiatrists, peer workers and clinicians that provide early intervention to young people impacted by psychosis and their families.
	Lighthouse Youth Enhanced (funded by GCPHN)	1	Southport	• Provides trauma informed, recovery orientated clinical care coordination and specialised treatment for young people aged 12-18.
	Psychological Services in Residential Aged Care Homes (funded by GCPHN)	1	In-person consultations in RACHs	• The Psychological Services in RACH program is GCPHN-funded program, delivered by Change Futures, that provides structured psychological therapies to people living in residential aged care.
	NewAccess: Mental Health Coaching (funded by GCPHN)	Online	Phone, online or in person	• A mental health coaching program, to provide accessible, quality structured psychological therapy services. • People can access six coaching sessions delivered over the phone, via video or in person by trained mental health coaches.
	Gold Coast Community	1	Available for all Gold Coast residents	• This is a flexible 8-week program run by Wesley Mission Qld that provides non-clinical emotional, practical and coaching support for people aged 16+ in the Gold Coast community at risk of suicide.

	Support (funded by GCPHN)			
	Supporting Minds (Psychological Therapies) (funded by GCPHN)	1	Available for all Gold Coast residents	• Mental health service run by Wesley Mission Qld that provides up to three months of structured psychological (clinical) and group-based support. • Eligible participants are adults (16-65 years) experiencing situational distress.
	Southern Gold Coast 60 & Better Program	1	Elanora to Palm Beach	• Community service that offers social connectedness, activities, support services and advance care planning support for those over the age of 65.
PARENTING / SCHOOL BASED SERVICES	**Student Wellbeing Package**	Around 28	Across Gold Coast region	• In primary, secondary, and special schools across the Gold Coast region with a wellbeing professional providing a service.
	GP Pilot in schools	5 schools participating	Across Gold Coast region	• Qld government funded program enabling a GP or nurse practitioner to provide free healthcare services to secondary students 1 day per week. • The program aims to remove barriers to timely and appropriate healthcare.
	Coaching	Reachout	National program	• ReachOut Parents One-on-One Support is a phone coaching service for parents of 12 to 18-year-olds. • This free, online program includes up to four sessions with a professional experienced in supporting families, and is used by thousands of parents and carers around Australia

Suicide Prevention

Services		Number	Distribution	Information
GOLD COAST HHS	**1300 MH CALL**	1 phone line	Supporting consumers across Gold Coast	• 1300 MH CALL (1300 642 255) is a confidential mental health telephone triage service that provides the first point of contact to public mental health services to all Queenslanders. • Available 24 hours a day, 7 days a week and links the caller to their nearest public mental health service.
	Emergency Departments	2	Southport and Robina	• Crisis services in the Gold Coast region are available through the public hospital EDs and specific crisis support (Acute Care Treatment team). • There are no specialised suicide prevention or crisis services for Aboriginal and Torres Strait Islander people in the Gold Coast region although identified Aboriginal and Torres Strait Islander positions are employed within Gold Coast HHS's mental health and crisis services.
DIGITAL HEALTH	**Crisis helplines** **Counselling helplines and websites**	Numerous	24-hour, 7-day online and telephone services	• Numerous national suicide prevention and crisis services that can be accessed by the Gold Coast community. • Crisis helplines include: Lifeline, Suicide Call Back Service, Mensline, Kids Helpline, and 13YARN. • Counselling helplines and websites include, for example: Mensline, Kids Helpline, Open Arms, QLife, Carers Australia, eheadspace, 1800 Respect, Relationships Australia, SANE Australia, ReachOut, BeyondBlue, Counselling Online, Child abuse prevention service, and others.
NOT-FOR-PROFI	**The Way Back Support Service (TWBSS) (Post-**	1	Supporting consumers across Gold Coast	• Personalised non-clinical psychosocial support for up to three months after hospital discharge for adults 18 years or older that have presented

	hospital Discharge Community Support) (funded by GCPHN)			or been discharged from either Robina or Gold Coast University Hospital following a suicide attempt or suicidal crisis. • Run by Wesley Mission Queensland (WMQ)
	The Way Back Support Service – Out of Hospital Pathway (funded by GCPHN)	1	Supporting consumers across Gold Coast	• People aged 16+ experiencing suicidality and have presented to GP, Head to Health phone line, Kalwun Medical Service, or youth mental health clinician. Service is provided by Wesley Mission Queensland. • This service supports people to stay safe, keep connected with others, and access health and community services as part of their recovery. Clients received clinical intake and assessment, followed by personalised psychosocial support for up to three months.
	Supporting Minds (Psychological Therapies and LGBTIQAP+ support) (funded by GCPHN)	1	Supporting consumers across Gold Coast	• Supporting Minds (LGBTIQAP+) is a service for people aged between 12 and 65 who identify with the LGBTIQAP+ community and/or are questioning sexuality or gender. • Run by Wesley Mission Qld, the program provides short-term clinical and non-clinical individual and/or group based psychological support to increase mental health and wellbeing and access a suite of interventions tailored to mental health needs in a safe, and welcoming environment.
	Gold Coast Community Support Program (GCCSP)	1	Supporting consumers across Gold Coast	• Self-referrals from community can be made via 01 5569 1850 or online. • Referrals accepted from GPs and community groups and organisations for individuals living in Gold Coast.
	Plus Social – Adult Clinical Care Coordination	1	Mermaid Beach	• Plus Social is a comprehensive clinical support service for people who experience the impact of severe mental illness. • The program supports individuals who struggle with maintain their regular day to day activities through clinical care coordination.

	(funded by GCPHN)			• The program includes structured, recovery and goal-oriented services focused on creating improvements in health and wellbeing.

Alcohol and Other Drugs

Service		Number	Location	Information
GOLD COAST HHS	**Inpatient service**	2	Southport and Robina (public hospitals)	• Gold Coast HHS's multidisciplinary team provides evidence-based healthcare, including substance detoxification interventions, counselling, care management, and specialised therapeutic group programs through inpatient care, community programs or outreach clinics. • AOD navigator supports consumers with frequent presentations.
	Community services	2	Southport and Palm Beach	
	Fetal Alcohol Syndrome Disorder clinic	1	Southport	• This is one of only two FASD diagnostic clinics in Australia and the only one in Queensland
NOT-FOR-PROFIT / NGO	**Community based services - focus on youth**	4	3 in Southport, 2 in Burleigh, 1 in Coomera, and some outreach	• These services provide counselling, education and referrals, and a mix of brief interventions and relapse prevention.
	Community based services – focus on pregnant women and new parents	3	3 in Southport, 1 Robina, 1 Burleigh, 3 also provide outreach to all region	
	Community based services - focus on AOD for families	5	1 in Burleigh, 3 in Southport, 1 in Southport (outreach between Coolangatta and Runaway Bay)	

	Needle exchange program	1	Southport	• Needle and Syringe Program, operating from within the Southport Health Precinct, aims to reduce the incidence of blood-borne viruses and injection-related injuries and disease by providing sterile injecting equipment, facilitating the safe disposal of used injecting equipment, and improving access and referral to drug treatment and other services.
PRIVATE HEALTH CARE	**Residential rehabilitation facility**	3	Eagle Heights, Burleigh, Southport	• Combined, these facilities offer around 110 beds for residential alcohol and drug treatment programs for Gold Coast residents.
	Inpatient rehabilitation and day program	1	Currumbin	• Currumbin Clinic offers in-hospital healthcare and day programs for patients with AOD-related concerns.
	Private home-based detox service	1	Available to all Gold Coast residents	• Addiction In-home Recovery (AIR Detox) provides home detox service to withdraw from alcohol or cannabis through daily in-home visits to manage the withdrawal, with access to 24/7 medical support. • The service also provides 12 months of aftercare support and check-in appointments to help clients achieve their long-term recovery goals.
DIGITAL HEALTH	**Online and telephone services**	Numerous	Available to all Gold Coast residents	• ADIS is Qld Health's telephone service available 24-hour, 7 days a week, offering free, anonymous and confidential support and information for anyone concerned about their own or somebody else's AOD use. • It offers telephone and online counselling and helps find local treatment. • Some of the additional online and telephone services include Cannabis Information Helpline, National Cannabis Prevention and Information Service, Hello Sunday Morning, Youth Substance Abuse Service, and National Drug and Alcohol Services Directory.

Chapter 13:
PALLIATIVE CARE (END OF LIFE CARE)

KEY FACTS:

- Rising demand for palliative care due to ageing population and chronic illness.
- Preference for home-based end-of-life care, but limited support results in 50% of deaths occurring in hospitals.
- Shortage of specialised palliative physicians and insufficient funding for community-based care.
- GPs face barriers in providing in-home care, particularly after-hours, due to funding gaps.
- Low public awareness of Advance Care Plans points to insufficient education and promotion.

PRIORITISED NEEDS:

1) Limited uptake and implementation of Advanced Care Plans, including end of life care provision in community.
2) Insufficient integration, funding mechanisms and capacity for the provision of community based palliative care.

13.1 BACKGROUND

Palliative care improves the quality of life for patients and their families, through the prevention and relief of suffering. This approach involves early identification, thorough assessment and treatment of pain and other physical, psychosocial, and spiritual challenges.

Healthcare providers deliver palliative care in almost all settings, including neonatal units, paediatric services, general practices, acute hospitals, and residential and community aged care services. Specialist palliative care teams, composed of professionals with advanced skills and training, focus on managing complex and persistent palliative needs. These teams work across diverse settings, such as specialist inpatient consulting services, inpatient units, hospices, and community-based services.

13.1.1 Definition

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) defines palliative care as care specifically tailored to assist with the effects of life-limiting illnesses[197]. It distinguishes palliative care from the broader concept of 'end-of-life care' which typically refers to the final 12 months of life, while palliative care can occur episodically over an extended period.

In October 2018, the Australian Government launched the Royal Commission into Aged Care Quality and Safety, which examined palliative care in the aged care sector. The Commission's final report, released on 26 February 2021, made several recommendations, including:

- Compulsory palliative care training for aged care workers,
- Comprehensive sector funding specifically including palliative care and end-of-life care,
- A review of the Aged Care Quality Standards to regulate high quality palliative care in RACH,
- Access to multidisciplinary outreach service, and
- A new Aged Care Act that includes the right to access palliative care and end-of-life care.

13.1.2 Service demand

Demand for palliative care services is increasing due to the ageing of the population and the increases in the prevalence of cancer and other chronic disease. Accessibility and appropriate utilisation of high-quality palliative care services can enable a person and their family to receive the care and support they need at the end-of-life, supporting them to die with dignity and in the comfort of their own home, preventing unnecessary hospitalisations. Previous estimates indicate that 70% of Australians wish to die at home[198], yet around half of all deaths occur in hospital.

Palliative care services in Australia are provided in a range of settings including:

- public and private hospital facilities,
- residential aged care facilities, and
- in patient homes through primary care providers.

[197] Australian Commission on Safety and Quality in Health Care 2023, *National Consensus Statement: essential elements for safe and high-quality end-of-life care*.
[198] Swerissen, H., Duckett, S. and Farmer, J., 2014. *Dying well (p. 12).* Melbourne: Grattan Institute.

13.2 PALLIATIVE CARE SETTINGS

There is a lack of data at the regional level to provide insight into the where palliative care is delivered in the Gold Coast region, however, national, state and qualitative input from engagement provides some indication.

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes in palliative care[199]. Participation in PCOC is voluntary and can assist palliative care service providers to improve patient outcomes. It is administered by the Australian Health Services Research Institute based at the University of Wollongong. PCOC's data collection covers more than 250,000 people who have received palliative care over the last decade.

Queensland data for July – December 2023 showed that:

- 56.8% of episodes occurred in hospitals; 43.2% in the community.
- The average patient age was 73.0 in hospitals and 75.4 in community settings.
- More males (51.7%) underwent palliative care episodes than females (48.3%).
- Over half of episodes of palliative care (64.7%) were for patients with cancer.

A lack of localised data makes planning a system of palliative care challenging. Improving data and monitoring will support better planning and care outcomes in palliative services.

13.2.1 Palliative care delivered in hospitals

Palliative care-related hospitalisations are separated into two groups:

- Palliative care hospitalisations: hospitalisations that involve specialist palliative care (coded as 'Palliative care' for the care type).
- Other palliative care hospitalisations: hospitalisations where a diagnosis of palliative care is provided but the care type is not recorded as 'palliative care'.

The 2023 AIHW report on admitted patient palliative care, other end-of-life care, and hospital-based facilities[200] found that:

- There were 94,800 palliative care-related hospitalisations in Australia, with 54% for palliative care and 46% for other palliative care. In the Gold Coast region, 1,800 presentations were recorded, with 69.9% for palliative care and 30.14% for other palliative care.
- 58% of palliative care-related hospitalisations were for individuals aged 75+.
- From 2015-16 to 2021–22, palliative care hospitalisations rose by 29%, compared to a 10% increase in all hospitalisations.
- In 2021-22, 67% of palliative care hospitalisations ended in patient death.
- 67% of primary palliative care hospitalisations during which the patient died, the patient had received palliative care in 2021-22; 43% had received other palliative care hospitalisations.

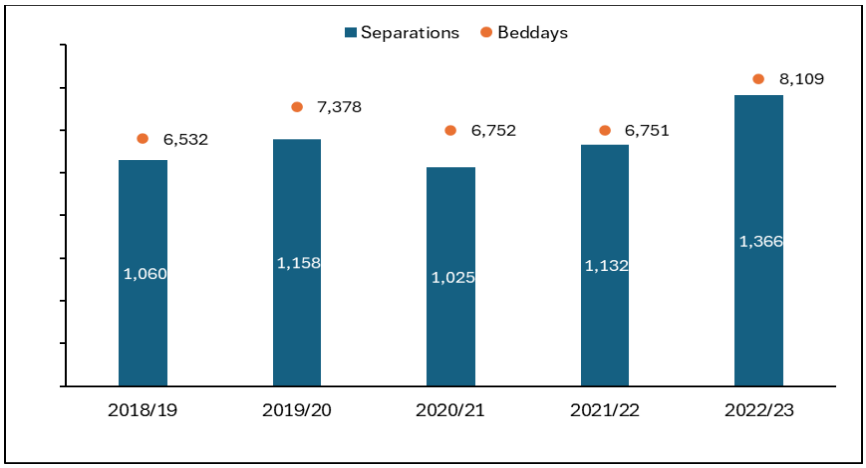
[199] University of Wollongong 2024, *Palliative Care Outcomes Collaboration* (PCOC).
[200] Australian Institute of Health and Welfare 2023, *Palliative care services in Australia.*

Diagnoses in palliative care hospitalisations

In 2021-22, cancer was the primary diagnosis in 40% of all palliative care hospitalisations, with nearly half (49%) receiving primary palliative care, and 29% other palliative care hospitalisations[4].

The other most frequently reported diagnoses for palliative care hospitalisations included cerebrovascular disease and heart failure and complications (4.7%), and for other end-of-life care, septicemia, and other ill-defined causes (4.0% and 5.2%, respectively).

FIGURE 1: PALLIATIVE CARE-RELATED HOSPITAL SEPARATIONS, GOLD COAST, 2018-19 TO 2022-23



Source: Queensland Health Admitted Patient Data Collection

- In 2022-23, there were 1,366 palliative care-related hospitalisations for Gold Coast residents.
- Hospitalisations increased over the 5 years, rising by 306 hospitalisations or 29%.
- Patients aged 80 to 84 years had the highest number of hospitalisations in 2022–23, while those aged 75 to 79 years accumulated the most bed days.

13.2.2 Palliative care delivered in primary care and community settings

The availability of data relating to palliative care services is limited, particularly data relating to palliative care services delivered in the community by GPs, non-palliative medicine specialists and allied health and ancillary practitioners.

While the Medicare Benefits Schedule (MBS) includes specific items for palliative medicine specialist services (delivered by palliative medicine specialists), for which a proportion of the MBS fee is reimbursed, there are no palliative care-specific item codes that can be used by GPs or other medical specialists for providing palliative care services. It is likely that GPs use other MBS item codes when providing palliative care, for example, chronic disease management and home visit items.

Broadly, the MBS-subsidised palliative medicine specialist services can be categorised as follows:

- palliative medicine attendances (specialist consultation with patient),
- attendances at hospital or surgery,

- home visits,
- palliative medicine case conferences (multidisciplinary team meetings),
- community case conference-organisation and coordination,
- community case conference-participation,
- discharge case conference-organisation and coordination, and
- discharge case conference-participation.

In 2021–22, there were 69,100 MBS-subsidised services provided by palliative medicine specialists nationally. Between 2012-13 and 2018-19, people receiving palliative medicine attendances/consultations increased by 35%, remaining stable for two years before declining by 13% in 2021-22. In 2021-22, 81% (n=55,900) of all MBS-subsidised palliative medicine specialist services were for palliative medicine attendances in hospital (outpatient), with a further 6.3% (n=4,300) for services in the patient's home[201.]

The AIHW is currently working with stakeholders to standardise palliative care data collection, to better understand community based palliative care, and inform decision making.

13.2.3 General practice palliative care-related attitudes and awareness

A study commissioned by the Australian Government Department of Health in 2016[202], researching the awareness, attitudes and provision of best practice advance care planning, palliative care, and end of life care within general practice, found that GP understanding of what constitutes palliative care and end of life care varies widely and that differing palliative care settings have very different requirements in terms of best practice.

The study also provided a variety of recommendations including:

- better definition of the role of GPs in palliative care,
- promoting a better understanding of the clinical triggers for commencing palliative care,
- the development of local directories to enable GPs to access palliative care resources and better communication, and
- integration with other parts of the health system, including encouraging referrals to specialist palliative care teams or GP experts[201].

13.2.4 Palliative care in residential aged care homes

The Australian Government subsidises residential aged care services for older Australians who can no longer remain living in their own home. Delivering palliative care in residential aged care is a complex task. In 2019–20, Australia's residential aged care facilities housed 244,327 residents, with 3,178 individuals (1.3%) identified as requiring palliative care[200].

[201] Australian Institute of Health and Welfare 2024, *Palliative care services in Australia*.
[202] Coulton, C. and Boekel, C., 2019. Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice. Department of Health.

13.3 WORKFORCE

The palliative care workforce comprises various health professionals, including specialist palliative medicine physicians, nurses, GPs, pharmacists, other medical specialists (such as oncologists and geriatricians), as well as support staff, other health workers, and volunteers.

In 2021, Australia employed 311 palliative medicine physicians, representing 0.8% of all medical specialists. Between 2013 and 2021, the number of palliative medicine physicians increased by 70%. Despite this growth, the workforce remains limited, with just 1.1 full-time equivalent (FTE) physicians per 100,000 people.

Currently, no data is available on the palliative care workforce specific to the Gold Coast region.

13.4 PRESCRIBED MEDICATIONS

Prescription medication is an important component of palliative care. These medications are defined as clinically relevant for patients with active, progressive and far advanced diseases for whom the prognosis is limited and the focus of care is quality of life. These medications typically involve:

- analgesics for pain relief,
- anti-epileptics to treat seizures,
- anti-inflammatory and anti-rheumatic products to treat inflammation,
- drugs for gastrointestinal disorders, and
- laxatives.

While no regional data is available, national data on palliative care-related prescribing in 2022-23 indicates[203]:

- there were 1.3 million palliative care-related prescriptions provided to 454,000 people, equating to 2.9 prescriptions per person and an increase of 47% since 2017-19,
- those aged 65+ accounted for over half (56%) palliative care-related prescriptions,
- pain relief accounted for 78% (approximately 1 million) of palliative care-related prescriptions, and
- GPs issued 90% of these prescriptions, with the majority of those (80%) focusing on pain management.

13.5 PROGRAMS IMPLEMENTED IN THE GOLD COAST REGION

Several programs focused on increasing advance care planning in RACHs have been implemented in the Gold Coast region in recent years including:

- Advance Care Planning in RACHs Project (2017–18)
- The Advance Project (2019–20)

[203] Australian Institute of Health and Welfare 2024, *Palliative care services in Australia*.

- Enhanced Primary Care (Clinical Educator- Palliative) (2019–20)
- Greater Choices for at Home Palliative Care (2017- 2025)
- Specialist Palliative Care in Aged Care (SPACE) (2020- 2024)

13.6 CONSULTATIONS

Consultations with key stakeholders, including the Gold Coast Aged and Palliative Care Steering Group, GCHHS Clinical Council, GCPHN Community Advisory Council, and the Primary Care Partnership Council revealed the palliative care faces significant challenges, such as staffing shortages in aged care, limited private options, inadequate GP engagement and training, reliance on family support, fragmented services, and underfunding, all of which hinder effective and accessible care.

Summary of palliative care consultation findings:

Staffing shortages: The palliative care sector faces challenges, particularly in RACHs, where staffing shortages hinder effective care delivery, especially after hours.

Challenges in service access and navigation: Difficulty accessing appropriate home support and after-hours care; High costs for home modifications often fall on families; and limited involvement of GPs in palliative patient care.

Limited private care options: There are few private care options, leaving most patients dependent on the public healthcare system for palliative care.

Training challenges: The SPACE Project highlighted the struggle to balance staff training needs, particularly with COVID-related training and new quality standards.

Engaging GPs for clinical governance: Local hospices find it difficult to engage GPs for clinical governance due to inadequate remuneration.

GP availability and training: Despite over 900 GPs in the Gold Coast region, most see only 10 to 20 palliative patients annually, limiting their capacity for additional training or home visits. Participation in the Program of Experience in the Palliative Approach (PEPA) has also decreased since the program stopped paying GPs.

Family support for in-home palliative care relies heavily on family support, but some elderly patients, especially those who have moved interstate, lack local support networks.

Home nursing and integration: Specialist services like home nursing are essential but need better integration with other care providers.

Volunteer support: Volunteers are key in reducing social isolation for patients. GCPHN explored supporting palliative care volunteers, but there was limited interest from NGOs.

Advance care planning (ACP): ACP helps ensure coordinated care; however, their uptake is low and there is more education around it required.

Underfunding and fragmented services create barriers to continuity and access, especially in the early stages of palliative care, leading to anxiety and confusion.

13.7 SERVICE SYSTEM IN THE GOLD COAST REGION

Services	Number	Distribution	Information
Gold Coast HHS, Inpatient Facility (Specialist Palliative Care)	1	Robina Hospital	• One public purpose-built 16 bed palliative care unit at Robina Hospital. • The Palliative care unit is not a long-term facility, and some patients may be discharged to more appropriate care including the generalist services and RACHs or the private hospice.
Hopewell Hospice	1	Arundel	• Seven beds located near GCUH; it's often used for terminal care (one non-private bed available).
Gold Coast HHS, Community Service	1	Gold Coast wide	• The Community Service team provide a consultative service in patients' homes and provide support to the GP and other teams when necessary. There are no services currently to RACH (nursing homes or hostels).
Gold Coast HHS Bereavement Services	1	Gold Coast wide	• When a palliative care patient passes away, the family and significant others receive follow up consultations by a Social Worker, Chaplain, Community Nurse or Medical Officer. • Ongoing support is arranged as needed through other community services.
Gold Coast HHS, Consultation and Liaison Service (Specialist Palliative Care)	1	Gold Coast University Hospital	• Gold Coast University Hospital has a dedicated medical and nursing team which provides consultative care five days a week. It does not admit patients under its care. • There is no service to private hospitals.
Gold Coast HHS, Outpatient/Community Facility (Specialist Palliative Care)	2	Robina and Gold Coast University Hospital	• Assessment and ongoing management via outpatient clinics and home visits. • Liaison with GPs and community nurses.

Services	Number	Distribution	Information
Gold Coast HHS, Inpatient Facility (Children's Palliative Care Service)	1	Gold Coast University Hospital	• Works closely with Children's Health Queensland. • Not a standalone service, staff are shared across multiple services.
BlueCare, Ozcare and Anglicare (funded by Gold Coast Heath)		Gold Coast wide	• Complex nursing and personal care, and support to help patient stay at home, including post-death support. • Other NGOs including Aquamarine Care, RSL Life Care at Home Kalwun Home, and Community Care provide limited services.
Aged care service providers	Numerous	Gold Coast wide	• Numerous aged care providers across the Gold Coast region provide generalist palliative services, but not specialist palliative care support. • This can include domestic and personal care, home maintenance, equipment, social support, clinical services, respite, and counselling.
General Practitioners	880	Gold Coast wide	• GPs play a critical role in coordinating care and making referrals, identifying and assessing palliative care needs pain management, medication management, bereavement support and advance care planning.

Chapter 14: ORAL HEALTH

KEY FACTS:

- Only 8.4% of eligible Gold Coast residents used public oral health services in 2019-20, which is the lowest of any Hospital and Health Service.
- More than half (51.7%) of the population were eligible for public oral health services in 2020-21. The eligible population grew by 16.7%. between 2017-18 and 2020-21, particularly in the 18–64-year age group.
- Only 6.5% of eligible children aged 0-17 accessed public oral health services in 2020-21. Access by children was particularly low in Gold Coast North.
- From 2013 to 2020, public sector dentists comprised only 10.3% of the total dental workforce in the Gold Coast region.
- There are limited dental care clinics in Gold Coast South and Gold Coast Central and no clinics at all in Gold Coast North.
- Dental vans can travel to all Gold Coast communities to support access for children however, there has been no expansion of this service for over 10 years.
- Waitlists are stable, and public patients are generally seen in time however the low utilisation means those eligible that are not seen in the public system are either paying for costly private dental care or not accessing care at all.

PRIORITISED NEEDS:

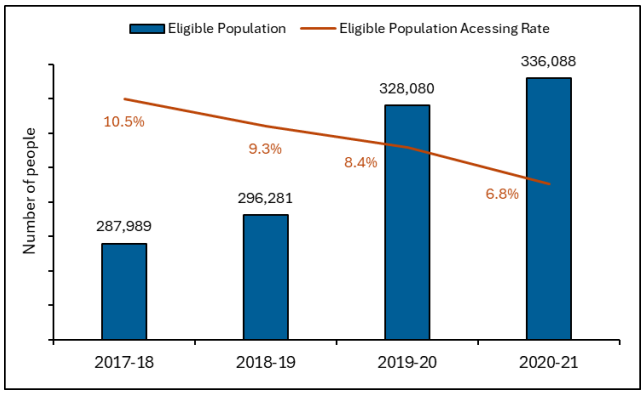
1) Access to public oral health services by eligible population is the lowest in Queensland.
2) Lack of growth in public oral health workforce, including dentists, to meet the demand of growing population.

14.1 DEMAND FOR SERVICES

14.2.1 Utilisation and eligible population

The Gold Coast has experienced rapid population growth, with an even faster growth in the population eligible for public oral health services. Despite this surge in eligible individuals, service utilisation steadily declined over the same period (noting the impact from COVID-19 measures in the latter years) (Figure 1).

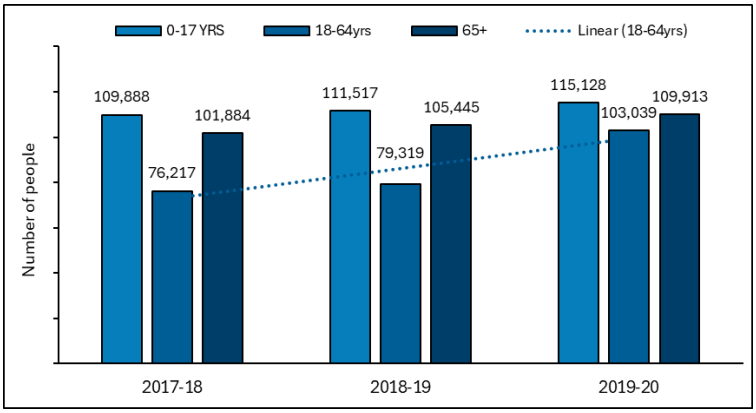
FIGURE 1: ELIGIBLE POPULATION FOR PUBLIC ORAL HEALTH SERVICES, GOLD COAST, 2017-18 TO 2020-21



Source: Queensland Health Enterprise Reporting System Oral Health Report

Approximately half of the Gold Coast population are eligible for public oral health services and the number of eligible people is growing. In 2020-21, 51.7% of the Gold Coast population (336,088 people) were eligible for public oral health services, the third highest of any HHS in Queensland. The number of eligible people grew by 16.7% between 2017-18 (287,989) and 2020-21 (336,088). However, growth isn't homogenous across age groups and is driven by an increase in the 18–64-year-old age cohort, who must hold a valid concession card to be eligible.

FIGURE 2: ELIGIBLE POPULATION FOR PUBLIC ORAL HEALTH SERVICES BY AGE, GOLD COAST, 2017-18 TO 2019-20



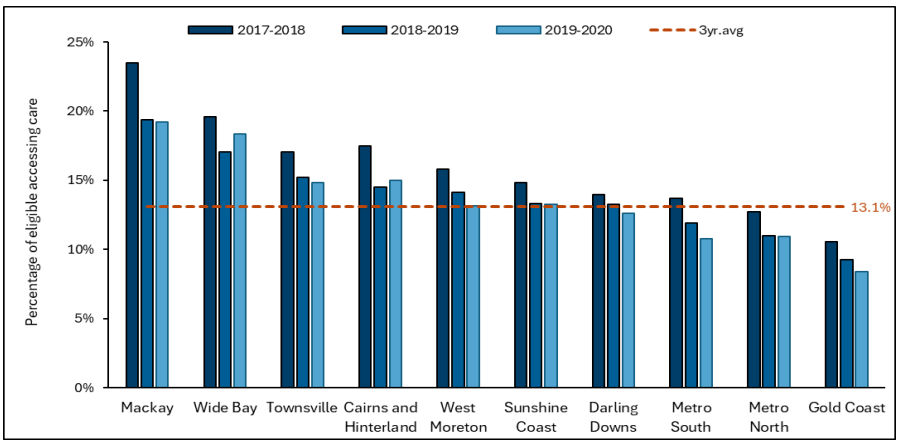
Source: Queensland Health Enterprise Reporting System Oral Health Report.

- Children's (0-17) eligibility grew by 4.8% (5,240) from 2017-18 to 2019-20.
- Eligible adults aged 18-64 grew by 35.2% (26,822) between 2017-18 and 2019-20.
- Eligible adults aged 65+ increased by 7.9% (8,029) between 2017-18 and 2019-20.

14.2.2 Comparative utilisation of public oral health services

Gold Coast residents have comparatively low utilisation of public oral health services compared to other HHSs and the rate has been declining steadily.

FIGURE 3: STATEWIDE COMPARISON OF PROPORTION OF ELIGIBLE POPULATION ACCESSING PUBLIC ORAL HEALTH SERVICES, SELECTED HHSS, 2017-18 TO 2019-20



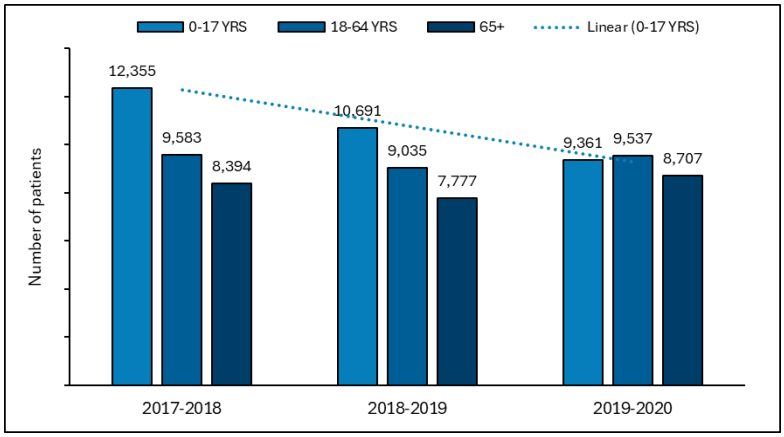
Source: Queensland Health Enterprise Reporting System Oral Health Report

- Gold Coast residents had the lowest utilisation of public oral health services in Queensland between 2017-18 and 2019-20.
- The utilisation rate declined from 10.5% to 8.4% (-2,727 episodes) over the three-year period, following a similar trend to elsewhere in the state.
- The rate continued to drop in 2021 (to 6.8%), however, as a COVID-19 affected year it is unclear if the continued trend reflects underlying demand.

14.2 AGE-SPECIFIC UTILISATION

The number of patients accessing public oral health services declined between 2017-18 and 2019-20, however the drop was inconsistent across age groups.

FIGURE 4: PATIENTS ACCESSING PUBLIC ORAL HEALTH SERVICES BY AGE, GOLD COAST, 2017-18 TO 2019-20



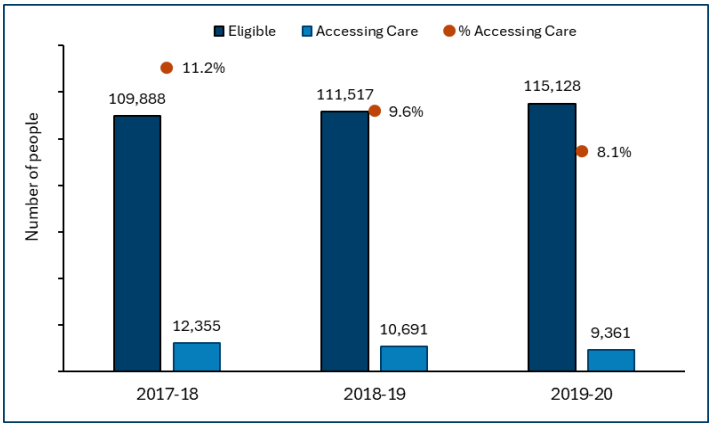
Source: Queensland Health Enterprise Reporting System Oral Health Report

- The number of 18-64 and 65+ year olds accessing public oral health services remained relatively stable between 2017-18 and 2019-20.
- Fewer children were accessing public oral health services in 2019-20 than in 2017-18, however, some of the reduced access is likely attributable to school closures due to COVID-19 public health measures.

14.2.1 Children (0-17)

Children who are not receiving regular dental check-ups are at increased risk of decay and gum disease. Public oral health service utilisation by children is declining year on year, with both the number and proportion of eligible children accessing services decreasing. With high population growth across the region, particularly among young families in Gold Coast North, and no additional infrastructure, this trend is likely to continue.

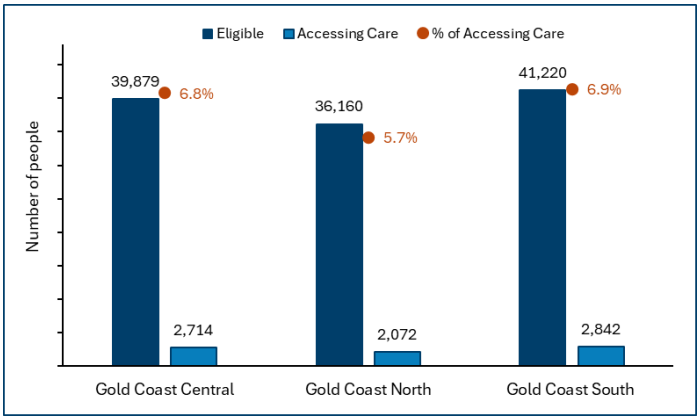
FIGURE 5: CHILDREN AGED 0-17 YEARS ACCESSING PUBLIC ORAL HEALTH SERVICES, GOLD COAST, 2017-18 TO 2019-20



Source: Queensland Health Enterprise Reporting System Oral Health Report

- Access to public oral health services by children declined by 38.3% in four years to 2020-21.

FIGURE 6: ELIGIBLE PEARSONS AGED 0-17 YEARS ACCESSING PUBLIC ORAL HEALTH SERVICES, GOLD COAST, 2020-21



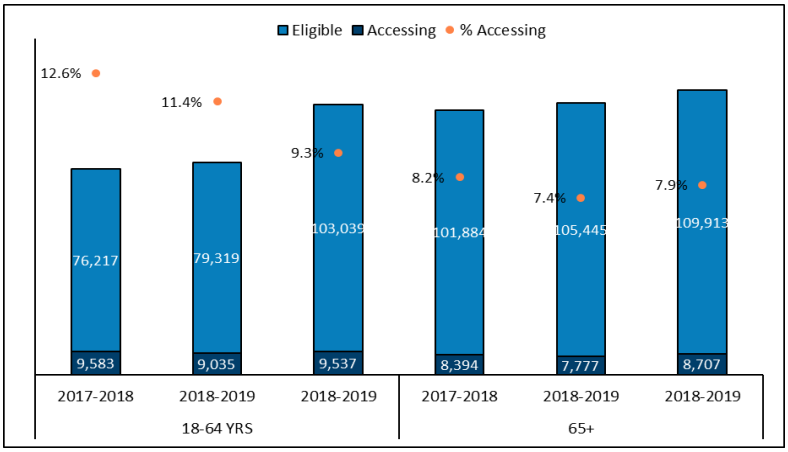
Source: Queensland Health Enterprise Reporting System Oral Health Report

- Only 5.7% of eligible children in the Gold Coast North accessed public oral health services in 2020-21 compared to 6.9% in Gold Coast South and 6.8% in Gold Coast Central.

14.2.2 Adults (18+)

There is a low utilisation of public oral health services among the Gold Coast adult population despite a significant growth in eligibility, particularly among adults aged 18-64 years. This is likely due to several factors: public oral health services may be difficult to access; awareness of the service and/or eligibility may be low; or oral health may not be a prioritised due to other pressures such as the cost of living, impacting access to health care.

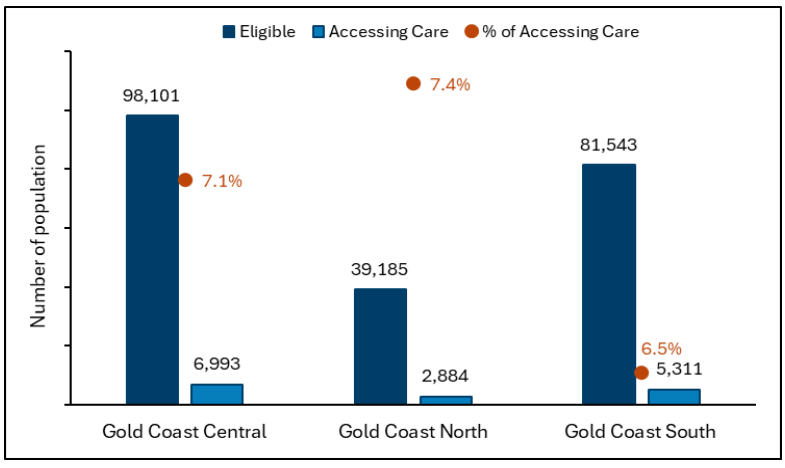
FIGURE 7. ELIGIBLE PERSONS AGED 18+ ACCESSING PUBLIC ORAL HEALTH SERVICES, GOLD COAST, 2017-18 TO 2019-20



Source: Queensland Health Enterprise Reporting System Oral Health Report

- Despite a 35.2% increase in eligibility, access for 18–64-year-olds remained relatively stable between 2017-18 (76,217) and 2019-20 (103,039).
- Eligibility for 65+ year olds increased by 7.9% between 2017-18 and 2019-20 while access remained relatively stable, with only a marginal 0.3% decrease for the same period.

FIGURE 8: ELIGIBLE ADULTS (18+) ACCESSING PUBLIC ORAL HEALTH SERVICES, GOLD COAST, 2020-21



Source: Queensland Health Enterprise Reporting System Oral Health Report

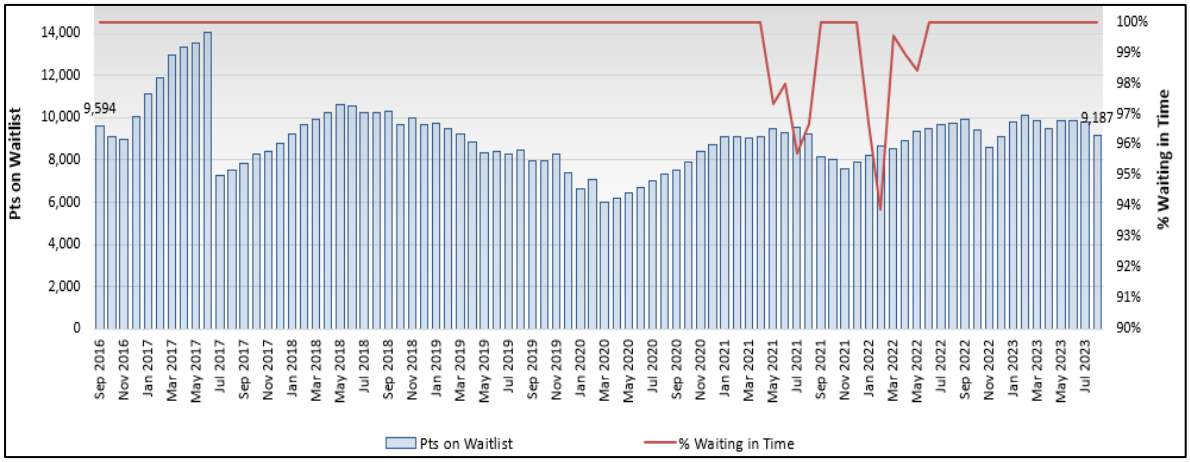
- Gold Coast South had the lowest proportion of eligible adults accessing services at 6.5% (n=5,311).
- Gold Coast North had the highest proportion of eligible adults accessing services at 7.4% (n=2,884) although still a low number overall.

14.3 SUPPLY OF PUBLIC ORAL HEALTH SERVICES

14.3.1 Dental care waitlists

Gold Coast public dental service waitlists are relatively stable, and patients are generally seen within the clinically recommended time, however, the number of patients seen each year is steadily declining.

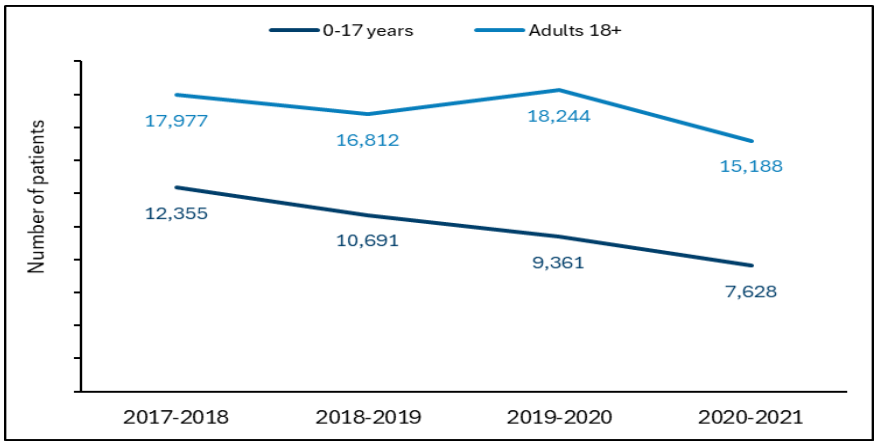
FIGURE 9: WAITLIST FOR PUBLIC DENTAL CARE, GOLD COAST, 2016 TO 2023



Source: System Performance Reporting Dashboard

- Waitlist volumes have consistently remained between 8,000-9,000, and patients are generally being treated within the clinically recommended time.

FIGURE 10: CHILDREN AND ADULTS ACCESSING PUBLIC ORAL HEALTH CARE, GOLD COAST, 2017-18 TO 2020-21



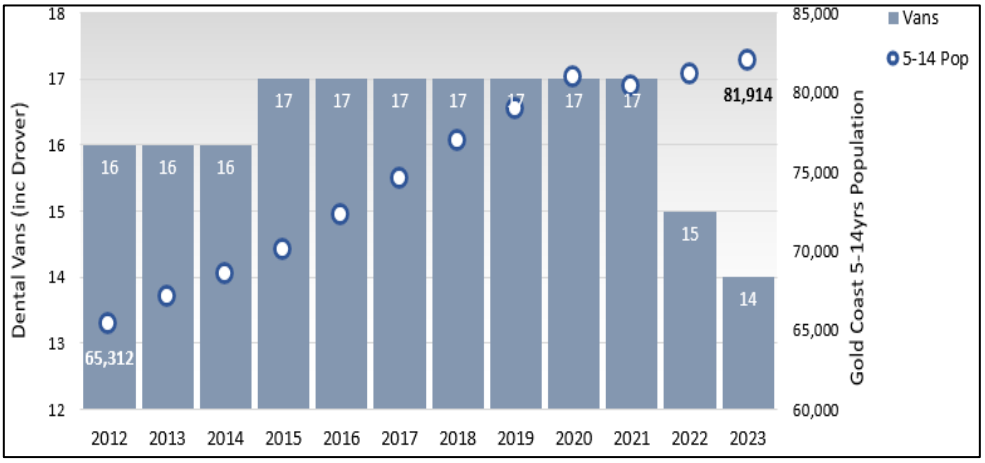
Source: Queensland Health Enterprise Reporting System Oral Health Report

- The number of patients seen is decreasing year on year with a 38.3% (4,727) reduction in access by children from 2017-18 to 2020-21 and 15.5% (2,789) less adults seen over the same period (Figure 10).
- However, it is acknowledged that as 2020-21 was a COVID-19 this may have contributed to some of the decrease during that period.

Public oral health care options for adults are limited to one of the five clinics located in Gold Coast Central or Gold Coast South. Outside of these clinic catchments, school dental vans are available, however, the vans only provide dental care to children.

Despite significant population growth across the Gold Coast, particularly in the north, the number of mobile dental vans in schools and communities has decreased from 17 in 2021 to 14 in 2023, hindering access to services (Figure 11).

FIGURE 11: NUMBER OF MOBILE DENTAL VANS, GOLD COAST, 2012 TO 2023



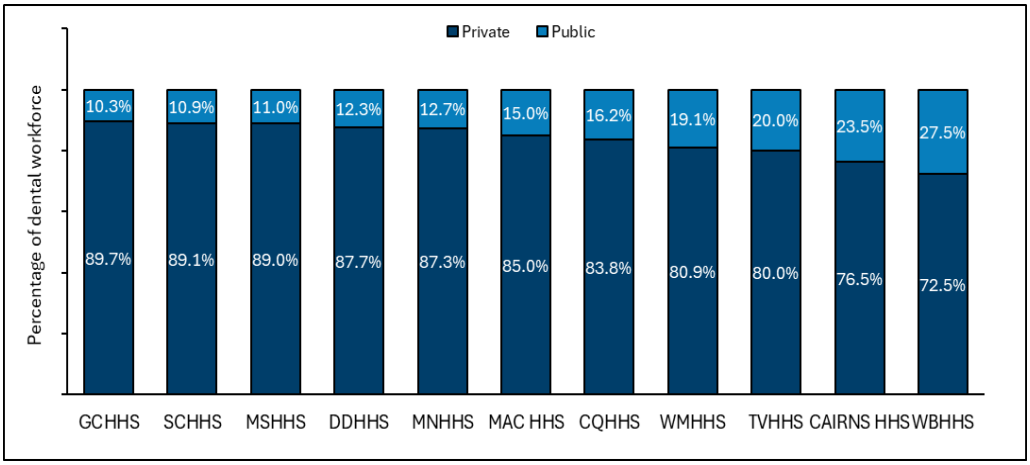
Source: Gold Coast Health, Oral Health Service data

14.4 WORKFORCE

The number of dentists working in the private sector in the Gold Coast region is growing 20 times faster than the number of dentists in the public workforce. While eligibility for public oral health services is growing, the annual growth rate of public sector dentists during 2013-2020 was only 0.3%, compared to a 6% growth rate in the private sector.

From 2013 to 2020, the Gold Coast HHS employed the lowest proportion of public dentists in Queensland, at just 10.3%, while private dentists comprised 89.7% of the workforce (Figure 12).

FIGURE 12: DENTAL WORKFORCE BY PUBLIC-PRIVATE SETTING, SELECTED HHS, 2013-2020



Source: Australian Health Practitioner Workforce Survey 2021

14.5 CONSULTATIONS

Engagement occurred with the following groups during 2023-24 to inform analyses of oral health needs, supply and demand:

- GCHHS - Oral health multidisciplinary team
- GCHHS - Executive team
- GCHHS – Public Health Unit
- Gold Coast Community – via strategic plan survey

Consultation confirmed the quantitative findings presented in this chapter, and additionally revealed:

- considerable concern from consumers and health care professionals regarding inequitable access and utilisation of oral health care services for vulnerable people and lower socioeconomic groups,
- concern regarding ongoing lack of growth,
- concern that lower service provision during COVID-19 may be inappropriately built into forward projections for service need, and
- a lack of transparent information with which to understand oral health and service utilisation due to MBS/private sector data not providing clear indications of the number of unique users.

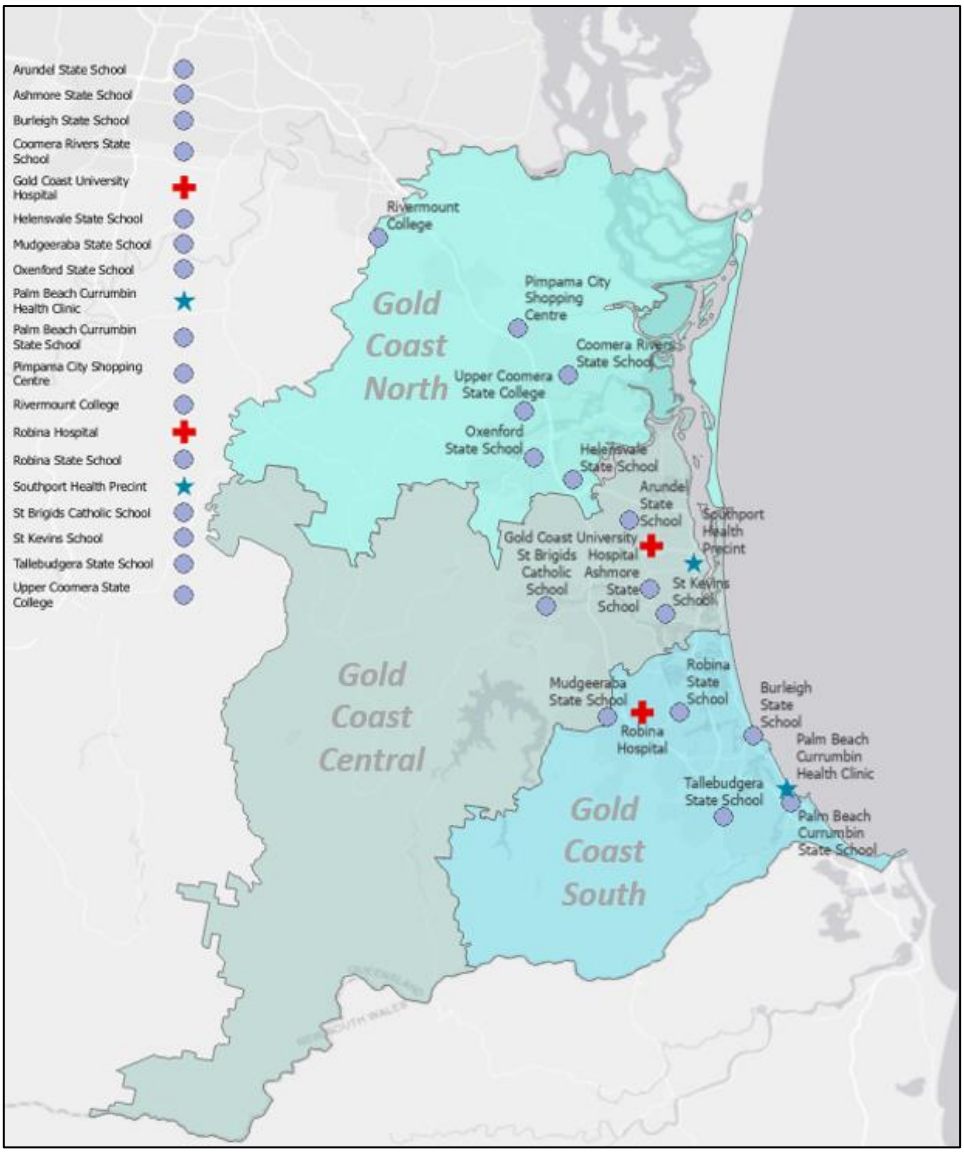
14.6 SERVICE MAPPING

Public oral health infrastructure in the Gold Coast region is limited. Public clinics are only available at five locations across the Gold Coast, with no clinics in Gold Coast North and no currently funded plans for expansion. This lack of infrastructure forces eligible individuals to seek public oral health care further away from home, turn to costly private dental options in their area, or forgo oral health care altogether.

Clinics are located as follows:

- Gold Coast North: Nil
- Gold Coast Central: Gold Coast University Hospital Dental Clinic, Southport Health Precinct
- Gold Coast South: Robina Dental Clinic, Burleigh School Dental Clinic, Palm Beach Dental Clinic

FIGURE 13: PUBLIC CLINIC AND DENTAL VAN LOCATIONS, GOLD COAST, 2021



Source: GCHHS, Oral Health Services 2021

Chapter 15:
OPPORTUNITIES AND PRIORITIES

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Effective integrated care of complex chronic disease to optimise quality of life and avoid preventable hospitalisations.	Population Health	Chronic conditions	Data linkage in key disease areas to support effective targeting of patients, promotion of best practice to general practice, use of health pathways. COPD QI activities to promote evidence-based practice, reduce gaps in care through data analysis, promotion of multi-disciplinary team care and decreasing preventable hospitalisations.	GCHHS, GCPHN, Kalwun, QAS
Higher rates of chronic obstructive pulmonary disease and asthma diagnoses.	Population Health	Chronic conditions	Continue to build on joint work in COPD to support effective targeting of at risk of patients (underpinned by use of local general practice data). Identify barriers to accessing multi-disciplinary care to support management of patients with a COPD diagnosis in solo or small number of GP practices and commission MDT service as funding allows.	GCHHS, GCPHN, Kalwun
Equitable access for integrated holistic multidisciplinary persistent pain management especially lower socio-economic groups.	Population Health	Chronic conditions	Continue to fund persistent pain program from GCPHN flexible funding.	GCHHS, GCPHN, QAS
Low rate of bowel cancer screening participation across Gold Coast, and across all national cancer screening programs in northern Gold Coast.	Population Health	Chronic conditions	Promotion, QI activity within general practice. Support integration of National Cancer Screening Register into general practice clinical information systems.	GCHHS, GCPHN,
There are high rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.	Population Health	Chronic conditions	Continue to commission persistent pain program from GCPHN flexible funding. Commissioning current healthy aging programs as funding allows.	GCHHS, GCPHN, Kalwun, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Inadequate capacity to provide timely access to several specialist outpatient; procedural; and elective surgery specialties, including ENT, ophthalmology, gastroenterology; endoscopy and cardiac investigation/intervention; and orthopaedics and general surgery respectively.	Population Health	Access		GCHHS
Insufficient service capacity to meet growing demand due to population growth, particularly in northern Gold Coast.	Population Health	Access	Establish Medicare Mental Health centre in Ormeau-Oxenford and look for opportunities for ancillary services. Identify and explore opportunities for additional funding and advocate for additional resources.	GCHHS, GCPHN, Kalwun, QAS
Need to actively eliminate racial discrimination, lateral violence and institutional racism.	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Healthy Equity plan and RAP implementation. Cultural competence of staff to be included as a requirement for funded services.	GCHHS, GCPHN, Kalwun, QAS
There are lower screening rates and increasing morbidity and mortality for cancers in the First Nations community.	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Promotion to general practices. QI activity within general practice. Support integration of National Cancer Screening Register into general practice clinical information systems. Explore local partnership to support increase screening rates (GCPHN and Kalwun).	GCHHS, GCPHN, Kalwun
Worsening clinical workforce shortage in the primary, secondary, community and aged care sectors.	Health Workforce	Workforce	Continue Clinical placements programs. Explore potential for local workforce interagency.	GCHHS, GCPHN, Kalwun, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
High demand and limited availability of publicly funded AOD services, including after-hours options, acute detox and residential withdrawal services.	Alcohol and Other Drugs	Access	Funding would be required to develop and implement suitable services.	GCHHS, GCPHN, Kalwun
Increasing acute demand requires improvement in early intervention, prevention and community support for mental health.	Mental Health	Early intervention and prevention	Establish new adult Medicare mental health service (exploring co-location in North GC). Head to Health service and website, local resources to support people to access most appropriate service for their need. Funding would be required to develop and implement additional services, particularly to assist families.	GCPHN, Kalwun, QAS
Delayed access to home care, social support and residential and community aged care services, leading to high rates of hospitalisation.	Aged Care	Access	Continue commissioning early intervention programs for elders as funding allows. Advocate for additional home care support in region. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
Limited, effective systems and models of care and support for increasing number of patients with dementia and their carers.	Aged Care	Care coordination	Support education and training for RACH and primary care staff. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun, QAS
Higher rates of mental ill health and mental health related ED presentations among people experiencing homelessness.	Mental Health	Vulnerable population (Non-First Nations specific)	Continue commissioning of after-hours safe spaces as funding allows. Explore opportunity for additional sites in north of region. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Limited resources, variable capability and unclear pathways for primary healthcare practitioners and paramedics to recognise and support patients experiencing family and domestic violence.	Health Workforce	Vulnerable population (Non-First Nations specific)	Promote health pathways. Encourage uptake of relevant education and training. Funding would be required to develop and implement additional services.	GCPHN, QAS
Sufficient resources required to implement National Lung Cancer Screening Program and respond in a timely way to increased demand.	Population Health	Early intervention and prevention	Education, training and promotion to general practice. Explore potential for general practice data analysis to support identification of eligible patients for recall. Support integration of National Cancer Screening Register into general practice clinical information systems.	GCHHS, GCPHN, Kalwun
Delayed diagnosis and limited dedicated primary care services for endometriosis and pelvic pain.	Population Health	Chronic conditions	Continue commissioning endometriosis and pelvic pain clinic as funding allows. Support Commonwealth evaluation. Education, training and promotion to general practice including referral to GCHHS service. Promote health pathways.	GCPHN
QAS capacity is unable to meet demand and scheduling pressures for non-urgent patient transfer, including renal dialysis.	Population Health	Access		GCHHS, QAS
Constrained system capacity requires investment in alternate models of care, including digital opportunities to manage and mitigate demand.	Population Health	System integration	Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Growing demand for hospital services and inadequate transition practices between paediatric and adult services requiring specialised, cohorted inpatient capacity to support safe and effective care.	Population Health	Access		GCHHS
Constrained QAS system capacity requires investment in alternate models of care, including scaling sole, co-responder and digital options.	Population Health	Emergency response		QAS
Growing numbers of people with socioeconomic disadvantage and associated higher need, especially in the northern Gold Coast.	Population Health	Social determinants	GCPHN commissioning to focus on providing services to those who cannot access private options.	Interagency
Declining vaccination rates, including in children and in RACHs.	Population Health	Immunisation	Explore use of data to better target people who would most benefit from vaccination. Promotion to public and QI activity within general practice. Education and training to better support vaccine service providers including motivational interviewing training to support better support benefits of immunisation related conversations.	GCHHS, GCPHN
Ongoing improvements are required in culturally safe service provision across the system to ensure equitable, effective access for First Nations people.	Aboriginal and Torres Strait Islander Health	Appropriate care (including cultural safety)	Cultural competence of staff to be included as a requirement for funded services.	GCHHS, GCPHN, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Low rates Indigenous specific health checks (MBS 715).	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Promotion, QI activity within general practice. Explore potential for Kalwun to share data to support patient recall.	GCPHN, Kalwun
Inadequate suicide prevention services and post event services for First Nations community.	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Progress through Joint Regional Plan. Continue to commission Social Emotional Wellbeing program as funding allows.	GCPHN, Kalwun
Systems and processes do not support consistent, effective clinical handover on discharge from the acute sector to primary and community services to support ongoing care.	Digital Health	Care coordination		GCHHS
Reduced bulk billing and reducing GP per capita rates leading to poorer access for some vulnerable people.	Population Health	Access	Support uptake of MyMedicare to optimise GP relationship and access to funding for GP.	GCPHN, Kalwun
Insufficient capacity in sub-acute community based residential mental health services.	Mental Health	Access		GCHHS
Inefficient system navigation leads to delayed connection of patients with suitable mental health, AOD and suicide prevention services.	Mental Health	Access	Head to health promotion. Resources for providers to be maintained. Resources for community to be developed.	GCHHS, GCPHN, Kalwun, QAS
Poorer mental health outcomes and higher suicidality for LGBTIQAP+ people.	Mental Health	Vulnerable population (Non-First	Continue to commission targeted services as funding allows. Promotion to optimise accessibility of existing dedicated services.	GCHHS, GCPHN, Kalwun

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
		Nations specific)		
Care coordination and information sharing by mental health, AOD and suicide prevention providers and services is often inefficient, particularly for transitions between acute or inpatient care to community-based services.	Mental Health	Care coordination	Staffing resources to build trust across providers, work towards consistent warm handovers across providers.	GCHHS, GCPHN
Limited uptake and implementation of Advanced Care Plans, including end of life care provision in community.	Aged Care	Palliative care / End of life care	Promotion to general practice and community as funding allows.	Interagency
Cost, transport and stigma limit the ability of people experiencing homelessness to access health care, including health checks, preventative and follow up care.	Population Health	Vulnerable population (Non-First Nations specific)	Explore options to provide primary care services where homeless people seek support.	GCHHS, GCPHN, Kalwun, QAS
Large and growing Māori and Pasifika community with higher reported health needs and challenges accessing healthcare.	Population Health	Vulnerable population (Non-First Nations specific)	Funding would be required to develop and implement additional services.	GCHHS, GCPHN, QAS
Out-of-pocket costs and safety concerns limit access to health services for people experiencing family and domestic violence.	Population Health	Vulnerable population (Non-First Nations specific)	Funding would be required to develop and implement additional services.	GCPHN

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Gaps in cultural capability across service providers and clinicians, particularly relating to sensitive issues such as mental health, AOD and FDV.	Population Health	Vulnerable population (Non-First Nations specific)	Education and Training. Funding would be required to develop and implement additional services.	GCPHN, QAS
Insufficient diagnostic and management service capacity for neurodevelopment exposure disorders (neonatal) neurodivergence and developmental delay.	Population Health	Access	Education and Training. Funding would be required to develop and implement additional services.	GCHHS, GCPHN
Increasing rate of eating disorders, including severe cases requiring medical stabilisation and complex multi-specialty management.	Mental Health	Multi-disciplinary care	Education and Training. Funding would be required to develop and implement additional services.	GCHHS, GCPHN
Prevalence of lifestyle and demographic maternal risk factors are increasing, including maternal smoking and high maternal age.	Population Health	Other	Education and Training. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
First Nations women have a high prevalence of smoking during pregnancy including passive smoking.	Aboriginal and Torres Strait Islander Health	Other	Promotion to community as funding allows, ensure mainstream general practices informed.	GCHHS, GCPHN, Kalwun
Growing demand for acute care, specialised rehabilitation and ongoing care for GCHHSHS catchment residents with spinal cord injuries unable to	Population Health	Multi-disciplinary care		GCHHS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
secure timely access to current statewide service.				
Limited QAS fleet capacity to manage operations including surge periods and major events.	Population Health	Emergency response		QAS
Low rates of people who identify as First Nations in health workforce, particularly for clinical roles.	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Explore potential for regional First Nations Health Workforce strategy. Additional resourcing required to develop strategy.	GCHHS, GCPHN, Kalwun, QAS
Limited culturally informed holistic approaches to wellbeing and ill health prevention.	Aboriginal and Torres Strait Islander Health	Appropriate care (incl. cultural safety)	Education and Training Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
Insufficient resources for some general practices and Residential Aged Care Homes (RACHs) to implement frequent reform and new initiatives.	Population Health	Practice support	GCPHN to provide practice and RACHs support within scope and funding to do so.	GCPHN
Increasing risks of frontline staff experiencing psychosocial/psychological hazards.	Health Workforce	Workforce	Explore options for shared development and education.	QAS
Limited availability of suitable service options to support older population	Mental Health	Access	Continue to commission Change Futures as funding allows. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, QAS
Growing demand from RACHs for non-emergency situations due to issues around staffing constraints and policy	Aged Care	Aged care	Continue to commission wound related services, support vaccination, support education and training.	GCHHS, GCPHN, Kalwun, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
requirements, even when Advance Care Plans in place.			Funding would be required to develop and implement additional services. Promotion and support to participate in General Practice Aged Care Incentive to improve access to regular GP visits and care planning to improve continuity of care and reduce presentations to hospital. Develop JRP for older people.	
Limited culturally appropriate services for culturally and linguistically diverse older people.	Aged Care	Appropriate care (incl. cultural safety)	Continue to Commission MCCGC under Care Finders and Community Connector as funding allows. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
Access to public oral health services by eligible population is the lowest in Queensland.	Population Health	Access		GCHHS, Kalwun
Lack of growth in public oral health workforce, including dentists, to meet the demand of growing population.	Health Workforce	Access		GCHHS
Insufficient integration, funding mechanisms and capacity for the provision of community based palliative care.	Population Health	Palliative care / End of life care	Funding would be required to develop and implement additional services.	GCHHS, GCPHN
People from multicultural backgrounds have higher reported prevalence of diabetes, arthritis, and heart disease.	Population Health	Vulnerable population (Non-First Nations specific)	Promotion to community and general practice (as funding allows). Funding would be required to develop and implement additional services.	GCHHS, GCPHN

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Limited effective use of translation services in primary care and ambulance response services	Population Health	Appropriate care (incl. cultural safety)	Promote use in general practice and broader primary care sector. Education and training.	GCPHN, QAS
Growing numbers of children in out of home care, who typically have high health needs, and relatively high proportion of First Nations children in out of home care.	Population Health	Other	Promotion of Health pathway to general practice. Education and training.	GCHHS, GCPHN, Kalwun
High melanoma incidence rate.	Population Health	Chronic conditions	Health promotion campaign to reduce exposure and increase awareness and skin checks that are culturally safe as funding allows.	GCPHN, Kalwun
Prevalence of select chronic disease risk factors (low vegetable intake, high BMI, alcohol) is high and/or significantly increasing for adults in the Gold Coast region.	Population Health	Early intervention and prevention	Health promotion campaign to increase as funding allows. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
Limited system partnerships addressing social determinants of health.	Aboriginal and Torres Strait Islander Health	Social determinants	Support implementation of SEQ Health Equity Strategy. Implement and update RAP.	Interagency, GCPHN, Kalwun
Some health practitioners have insufficient capability to support patients with complex needs, including mental ill health and social needs.	Health Workforce	Workforce	Education and training, health pathways. Explore social prescribing. Funding would be required to develop and implement additional services.	GCPHN
Insufficient resourcing to ensure supported, psychologically safe,	Mental Health	Other	Service Planning/ Delivery	GCHHS, GCPHN

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
meaningful engagement of people with lived experience in planning and service delivery.			Additional internal resources required. Ensure appropriately reflected in contracts.	
Reported high prevalence of vaping, particularly among young people.	Alcohol and Other Drugs	Early intervention and prevention	Information campaign from core funding. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, Kalwun
Growing demand for psychological therapies.	Mental Health	Access	Promotion of Head to Health so all appropriate options considered based on level of need.	Interagency
Stigma and shame associated with mental health, suicidality and AOD issues.	Mental Health	Early intervention and prevention		Interagency
Absence of designated First Nations Residential Aged Care Homes.	Aboriginal and Torres Strait Islander Health	Aged care	Continue funding Mungulli Clinic. Funding would be required to develop and implement additional services.	Interagency
Slow adoption of digital health solutions by RACHs and poor integration with other clinical systems limits access to clinical information between service providers, including paramedics.	Digital Health	System integration	Continue to provide practice and service support for digital adoption.	GCPHN
Migrants are often unfamiliar with the Australian health system and have lower health literacy.	Population Health	Vulnerable population (Non-First Nations specific)	Education and training and resources for providers. Funding would be required to develop and implement additional services.	GCHHS, GCPHN, QAS

Priority	Priority area	Priority sub-category	Expected Outcomes / Opportunities (GCPHN)	Potential lead agency and/or opportunities for collaboration
Limited effective support in navigating complex community, aged care system and National Disability Insurance Scheme (NDIS).	Aged Care	Other	Service Navigation Continue to Commission Care Finders as funding allows. Funding would be required to develop and implement additional services.	GCPHN
High levels of isolation and loneliness among older people.	Aged Care	Aged care	Explore opportunities for social prescribing. Funding would be required to develop and implement additional strategies.	Interagency
Challenges for general practices, primary care and RACHs in adopting digital health.	Digital Health	System integration	Practice/service support within scope and funding.	GCPHN, Kalwun

phn GOLD COAST
An Australian Government Initiative

Gold Coast Health always care

KALWUN