May 2018

Health Needs and Priorities in South Australia

Gathering a stakeholder-informed evidence base.

Report by

THE AUSTRALIAN CENTRE FOR SOCIAL INNOVATION

SAHMRI

Joint project conducted for

FAY FULLER FOUNDATION

We pay respect to the Traditional Custodians of all lands, past, present and future. Honouring our Elders and nurturing all young people.

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Abbreviations

ABS	Australian Bureau of Statistics
AEDC	Australian Early Development Census
AHCSA	Aboriginal Health Council of South Australia
AIHW	Australian Institute of Health and Welfare
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CAMHS	Child and Adolescent Mental Health Services
CHSALHN	Country Health SA Local Health Network
CPHO	Chief Public Health Officer
CTG	Closing The Gap
DCSI	Department for Communities and Social Inclusion
HOS	South Australian Health Omnibus Survey
HPC	Health Performance Council
LGBTIQ	Lesbian Gay Bisexual Transsexual Intersex Queer
LHN	Local Health Network
NALHN	Northern Adelaide Local Health Network
NHMRC	National Health and Medical Research Council
OPAL	Obesity Prevention and Lifestyle
PHAA	Public Health Association Australia
PHIDU	Public Health Information Development Unit, Torrens University
PROS	Population Research and Outcomes Studies
SA	South Australia
SACOSS	South Australian Council of Social Service
SAHMRI	South Australian Health and Medical Research Institute
SALHN	Southern Adelaide Local Health Network
SAMSS	South Australian Monitoring and Surveillance System
SEIFA	Socio-Economic Indexes For Areas
TACSI	The Australian Centre for Social Innovation
WCHN	Women's and Children's Health Network

Introduction

The South Australian Health and Medical Research Institute (SAHMRI) and The Australian Centre for Social Innovation (TACSI) were jointly commissioned to conduct this research for the Fay Fuller Foundation.

SAHMRI and TACSI recommended that an evidence-based approach, utilising a combination of examination of secondary-source data and primary research that canvassed the expertise of both health care professionals and health consumers, would best reflect the full complexity of healthcare and health needs in South Australia.

The project therefore comprised both secondary - and primary-source research, including:

- a desktop literature review (Phase 1a).
- a state-wide quantitative survey (Phase 1b).
- systems evaluation via semi-structured interviews with service providers and other stakeholders (Phase 2).
- ethnographic research with users of the health and wellbeing systems (Phase 3).

These phases and their respective deliverables are summarised in Table 1 below.

The foundation of the work is a synthesis of the available evidence about the health and wellbeing needs and priorities of the SA population. SAHMRI has extensive knowledge of the significant health and social research, reports, plans and strategies, policies and data that have been compiled in recent years at the local, state and national level about South Australia and has used its skills and knowledge of the SA health system and research to:

- identify all relevant reports, documents and materials.
- rigorously analyse and assess the evidence.
- draw out the themes and "rate" the evidence.

	Phase 1: Compiling the Research & Evidence Base SAHMRI	**Phase 2: Mapping the existing system** TACSI	**Phase 3: Consumer Insights from priorities** TACSI	**Phase 4: Integration and conclusions** SAHMRI TACSI
Purpose	To draw on existing evidence about health priorities for South Australia and help shape the field work. To provide an evidence base for focus areas that could help shape investment decisions. To provide statewide population input on perceived health and wellbeing needs.	To map existing service providers, pathways, outcomes focus so that gaps, overlaps and opportunities can be identified. To identify providers' perceptions of areas where increased investment could add value.	To understand the challenges faced by consumers in those areas where there are specific gaps and opportunities identified. To provide an insight into the opportunities and outcomes that focused investment into specific areas could generate.	To bring together all the components of the research and integrate the findings into conclusions.
Deliverables	1a: Documented literature review providing data and evidence on health and wellbeing priorities in SA. 1b: Analysed results from questions placed on the 2017 Health Omnibus Survey.	Stakeholder and systems map and analysis of responses to health priorities in South Australia with a focus on identifying gaps and opportunities.	Health consumer insights report that helps to determine the outcomes any investment should/ could focus on.	Summarised and integrated findings, conclusions and recommendations, based on all research phases.

Table 1: Planned project components

- synthesise the data and interpret it to meet the needs of the Fay Fuller Foundation.
- identify gaps in the available evidence.
- identify potential areas of focus that can inform and help shape the field work.

TACSI draws on the strength of 'human-centred design' approaches to complement and ground evidence with insights that are drawn from people, policy and practice. Such approaches are built on research that includes:

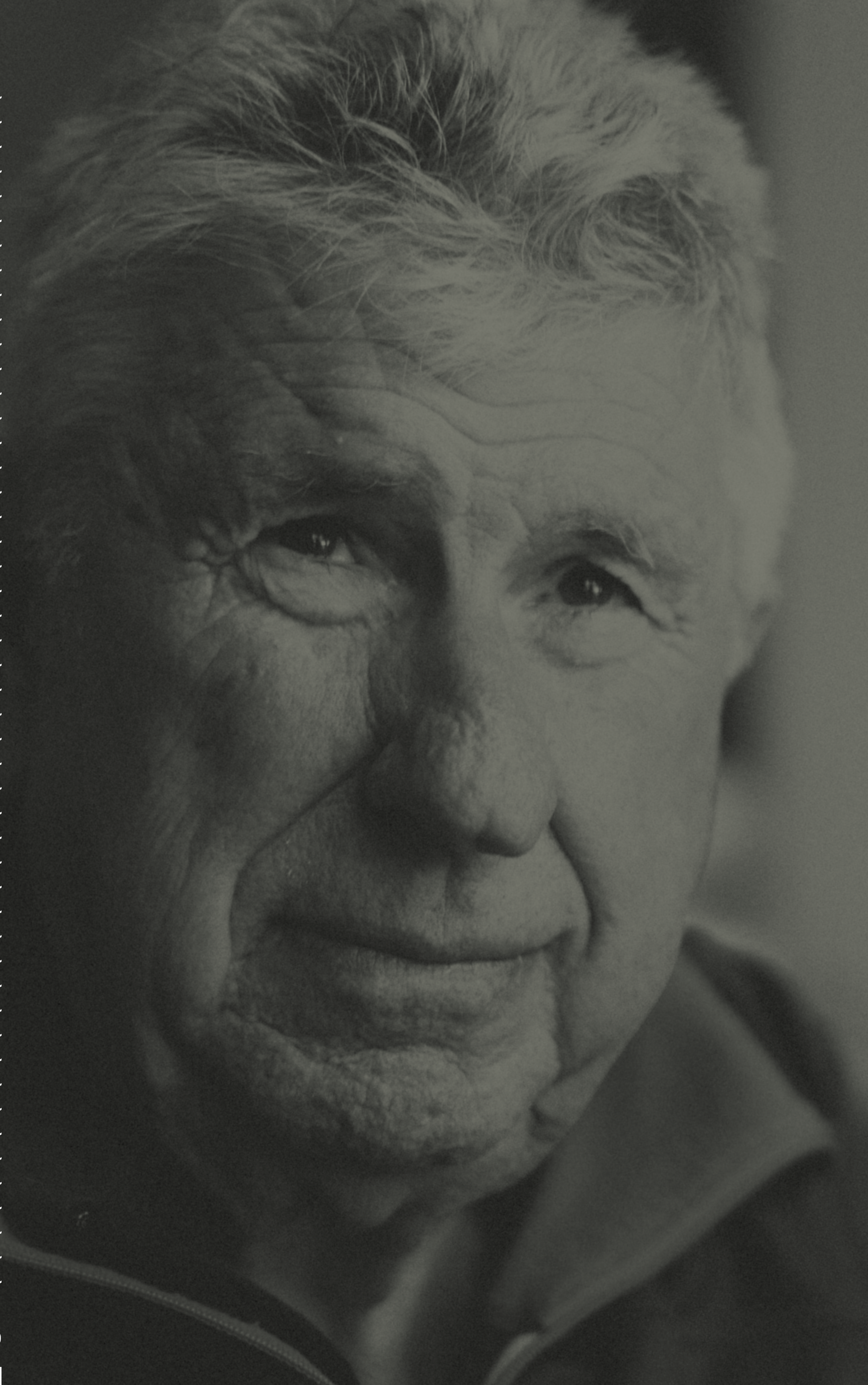
- the voices of health consumers, whose direct experience of the health system can help to ground investment decisions in people's real-life decisions, experiences, opportunities and contexts.
- the voices of key stakeholders from across the health system, who can identify practice and policy gaps and opportunities for strategic investment priorities in South Australia focused on improving outcomes for health consumers.
- clear and supported evidence of what works and what needs to change to improve outcomes for consumers.

The ultimate aim of the health system is to improve outcomes for the consumers (patients and users) of the system. This aim is, of course, constrained by resources and influenced by political factors.

The teams' approaches start and end with the end users of the health system but recognise that outcomes for consumers are predicated on the interaction of many stakeholders across the system, as illustrated in Figure 1.

Although the various components of this work may have been undertaken by two different teams, SAHMRI and TACSI worked to ensure that the deliverables were aligned and integrated. After the secondary-source and primary-source research had been completed, both teams came together to provide Fay Fuller Foundation with a high-quality synthesis drawing on the different but complementary sets of skills and inputs.

Figure 1: Health and wellbeing systems - stakeholder interactions



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Executive summary

Overview

The Fay Fuller Foundation commissioned the South Australian Health and Medical Research Institute (SAHMRI) and The Australian Centre for Social Innovation (TACSI) to jointly conduct research into health and wellbeing priorities for South Australia based on:

- identifying and examining existing, high-quality research on local health issues and priorities.
- seeking insights from key stakeholders, including health consumers and people working within the system.
- identifying opportunities to improve quality of life and health outcomes for South Australians by highlighting community priorities, gaps in knowledge, areas for greater focus or effort and points where the health and community service systems could be more efficient or effective.

Together the documents that make up this report present a picture of South Australian health needs that is supported by a wide range of evidence, expertise and experience. Effectively, the joint project team has created a unique view into the health needs of South Australia from a range of different perspectives.

The opportunities that could be identified across these perspectives include:

- Addressing growing disease burdens or gaps in the current service systems. These opportunities have been drawn from existing information, and analysis by health condition, geographic region, age group and ethnicity. As one example: while currently the leading causes of death in SA are heart disease, dementia, stroke, lung cancer and chronic respiratory disease, in the future it is likely that dementia will lead the cause of death statistics. However, there is little state-specific research data available or strategies on how to prevent, delay, or manage the expected burden of dementia in this state.
- Grow efficiency or effectiveness of the health system based on insights reflecting the experiences and perceptions of health consumers and stakeholders. During interviews with consumers and stakeholders, what constitutes ‘health’ was seen to have multiple interpretations. Stakeholders in health care spoke of the health system’s focus on illness, intervention and monitoring activity. In contrast, consumers emphasised how they keep well and talked about health in terms of how well they feel, the quality of the care they receive and how family, friends and health care professionals can affect their “wellness”. There was support for a stronger focus on wellness, health maintenance, prevention and monitoring outcomes.

The approach

This project took an evidence-based approach, both through examining secondary sources from existing research outputs and publicly available data that highlighted key issues, and then conducting primary research through ethnographic work, and questions included in the long-running Health Omnibus Survey[1]. The ethnographic primary research consisted of semi-structured interviews over a two-month period with consumers and professional stakeholders including clinicians, researchers, people in the not-for-profit sector, advocacy bodies and those working to commission, fund or develop policy.

The specific questions included in the 2017 Health Omnibus Survey were asked in close to 3000 face-to-face interviews across the state. These data were used to broaden, challenge and validate the insights from the semi-structured interviews conducted with health consumers in four regions where there is above-average prevalence of disease burdens and risk factors.

The secondary research undertaken by the project team identified all relevant reports, documents and other material on the health and wellbeing needs of South Australians available in the public domain. It assessed this evidence, drew out themes, interpreted the data and identified gaps in the available information.

The project team then drew all these data points together in a purpose-built South Australian Health Needs System Map, which captures the key components of the health system, the links between them, where funding has changed and where gaps exist.

[1] A service provided annually in South Australia since 1991 and used by government, academic and non-government organisations nationally.

Findings and opportunities

Findings from literature, research and data review

In broad terms, South Australia has some defining features that influence health needs and priorities:

- SA has an older age distribution than the country as a whole (median age 40 vs 37 years). South Australia had 306,589 people aged 65 years or over at the 2016 Census, representing 18.3% of the state's population, compared with 15.1% nationally.
- Consistent with national data, the SA Aboriginal population (about 35,000 people) has a significantly younger age profile with a median age of 23, compared with 41 for non-Aboriginal people - a gap of 18 years.
- Rural and remote populations comprise 23% of the SA population. Key differences with the metropolitan area include a lower proportion born overseas (11.2% vs 26.3%) and an older age profile (median age 44.3 vs 38.6).
- The ABS noted in its 2015 summary of the causes of death in SA that death rates for heart disease and cancer have been declining, while dementia has been increasing; it is expected that dementia will become the leading cause of death.
- From a biological health perspective, SA currently has official strategic plans that address suicide, mental health, cancer, alcohol and other drugs, and diabetes. However, the diabetes strategy is specific to the Aboriginal population and there is no such strategy for the wider SA population.

Literature identifies the following categories of **adults** as having particular health needs and priorities in South Australia (SA Health Atlas):

- adults without access to the Internet at home are more likely to have poorer health.
- adults in households with relatively large numbers of people living with a disability, or dependent on the Age Pension are more likely to have poorer health.
- adults with high or very high prevalence of psychological distress, and obesity.
- adults at high risk of premature mortality, i.e. <75 years of age.
- disadvantaged households, i.e. under financial stress from rent or mortgage payments; welfare dependent; high levels of disability; high or very high prevalence of psychological distress; no Internet access at home; inability to get support in times of crisis from outside the household, and limited participation in volunteering in the community.

The literature/data review also identified some key issues and priorities for consideration in relation to specific population groups in South Australia.

- **Adult men:** Suicide rates are three times than for women, and skin cancer, liver disease, lung cancer, and blood cancers feature more strongly for men. Older men have the highest levels of smoking, men in the lower sociodemographic group are more likely to consume alcohol at harmful levels and be obese.
- **Adult women:** There was limited material that explicitly defined gaps in needs, services or research, or particular priorities for action for the South Australian female adult population group. Relying on Australian literature then, the causes of death where the sex ratio is biased towards females (apart from breast cancer) are: dementia; hypertensive disease, cardiac arrhythmias, stroke and heart failure. Specific South Australian literature also points to a need to further raise awareness of the mental health needs of women in the perinatal period (Government of South Australia 2015) and improvement of the reach of maternal health campaigns in areas outside major cities, particularly in relation to Aboriginal women (PHIDU, 2015).
- **Children and young people:** The rate of child death in South Australia had shown a significant reduction, with the average death rate decreasing by 11% on average per year. The three leading causes of child death had remained the same: injuries, cancer and diseases of the nervous system. Children who lived in the state's more socioeconomically disadvantaged areas had higher death rates and these were not declining in the same way as for those who lived in South Australia's least disadvantaged areas (Child Death and Serious Injury Committee 2016). South Australia recorded above-average proportions of children who are "developmentally vulnerable", including close to one-quarter who were vulnerable on one or more domain (AEDC, 2009, 2012, 2015).

- **Older people:** Older people aged 65+, living in areas deemed to be socioeconomically disadvantaged and who are dependent on the aged pension, are at risk of poor health and wellbeing (PHIDU, 2016). There is a socioeconomic gradient associated with the prevalence of self-reported chronic conditions, specifically diabetes, respiratory conditions, behavioural and mental health issues and cancer rates peak at 80+ years of age (PHIDU, 2015). By 2020, SA is projected to see substantial increases in prevalence of dementia for people aged 80 years and over. These projections have significant implications for demand for health services, given that people with dementia are known to have multiple morbidities. People aged 80 years and over constitute only 5% of the population, but more than 25% of the overnight occupied bed days in South Australia. As a consequence, demand for hospital inpatient services is highly sensitive to increases in the number of people aged 80 years and older.
- **Aboriginal people:** Cardiovascular diseases represent the most frequent cause of death for Aboriginal South Australians. Aboriginal people experience heart disease and stroke at significantly younger ages than non-Aboriginal South Australians, peaking between 45 and 59 years of age, compared to 85 years of age for non-Aboriginal people (SA Health 2016). Lifetime risk of alcohol consumption is lower among Aboriginal men and women than their non-Aboriginal counterparts.
- **People from culturally and linguistically diverse backgrounds:** Mental health issues and trauma appear to be priority issues for the culturally and linguistically diverse population. Resilience in the adolescent refugee population has been demonstrated to be lower than indicated in other, non-refugee populations and lower levels of resilience have been associated with depression and emotional and behavioural problems (Ziaian, de Anstiss et al. 2012). There is no policy framework, action plan or monitoring process specific to health care services for the culturally and linguistically diverse population.
- **LGBTIQ community:** The greatest issues facing the LGBTIQ community are violence, discrimination and homelessness. Further, certain health conditions reflect patterns of health particular to the LGBTIQ community, including: specific cancers and sexually transmitted infections in gay men, cervical and ovarian cancers in lesbians and issues relating to hormone therapy and surgical intervention in transgender people.
- **People living in rural and remote South Australia:** Typically, people who live in rural and remote locations have worse health and wellbeing and are at greater risk of poor health than their metropolitan counterparts. Older adults in rural areas are a particularly vulnerable group (Health Consumers Alliance of South Australia, 2014). Rural and remote populations have been found to have poorer health outcomes in relation to chronic disease and associated risk factors than the general population. South Australians in regional and remote areas have higher incidences of behavioural risk factors such as smoking, high-risk alcohol consumption, overweight or obesity and physical inactivity than their urban counterparts. Mental health is a proportionally greater burden in rural and remote areas and help-seeking behaviours are reportedly reduced in comparison to metropolitan areas, one in five people with mental health problems who live in the metropolitan area reporting that they are seeking help, compared to less than one in ten country residents with a mental health problem.
- **People in or leaving the justice system:** Prisoners and people who have been involved in the criminal justice system, are recognised as being at risk of poor health and mental health issues in Australia, however no South Australian-specific published literature relating to the health and wellbeing status or needs of this underserved population was identified.

Health Omnibus Survey

Analysis of the Health Omnibus Survey elicited the following insights from health consumers in South Australia:

- their own physical health was the biggest health or wellbeing issue faced by 35 per cent of respondents, while 11 per cent cited mental health.
- one-quarter said their health limited their participation in work and moderate activities, such as climbing several flights of stairs.
- seventeen per cent said depression or anxiety meant they had accomplished less than they would have liked.
- issues relating to ageing were considered by one person in five to be one of the biggest health or wellbeing concerns for South Australia.

There was strong agreement between the literature and survey results in six areas:

1. **Prevention:** There is a significant emphasis on prevention in state and national plans and health priorities. The survey results show prevention and holistic approaches to health are also of importance to the general population
2. **Mental health:** Mental health issues were prominent in seven of the ten population groups covered in the literature (Aboriginal people, children and parents, older people, rural and remote communities, migrants, LGBTIQ community and people in or leaving the justice system). Mental health-related issues were rated as their biggest health or wellbeing challenge for 11% of those participating in the survey (the second highest category, after physical health) and 48% of all respondents listed mental health as one of the most important issues for South Australia.
3. **Ageing and dementia:** Issues relating to ageing were considered one of SA's biggest health or wellbeing concerns by one in every five (20%) of the survey participants. The literature covered multiple issues related to ageing and dementia.
4. **Obesity:** Weight and obesity featured highly in the survey as an issue for South Australia and was also a feature of many reports in the literature, with concerns about children's and young people's obesity and the impacts on risks for chronic disease.
5. **Health services access:** Both survey respondents and the literature raised issues about health service access, especially with regard to people living in rural and remote areas and certain sub-populations such as the LGBTIQ community, Aboriginal people and people from culturally and linguistically diverse communities. It was notable in the survey, however, that while 11% of people mentioned this as SA's biggest health or wellbeing issue, just 1% mentioned it as their own biggest issue.
6. **Physical health:** Physical health was identified most often in the survey as the biggest health and wellbeing category they faced individually and for the state as a whole. Impacts on carrying out usual daily activities, including social interaction, were identified as the most important challenges. This aligns well with the emphasis of many national- and state-level reports and priorities such as the focus on cardiovascular disease, diabetes, musculoskeletal health and injury/disability.

In terms of variances between the literature results and the survey results, three main aspects emerged:

1. The needs of **children** and the issues of **maternal health** did not emerge in the survey results, perhaps because they are not perceived as "illness" related, but also because the survey did not specifically ask about children's health or wellbeing issues.
2. **Drug and alcohol issues** were raised by only small numbers of people in the survey, although they did rate some mention as one of the issues for South Australian health and wellbeing. However, the issues of high tobacco use and excessive drinking in certain population groups was prominent in the literature, especially at national and state level planning and strategies.
3. People living in **rural and remote areas** rated their health higher than the literature suggested it really is, according to reports found in the literature review where health status is clearly at lower levels in some parts of rural and remote South Australia. This difference in perception may be driven by lower expectations of health services and by health being a lower priority in the broader set of issues affecting people in farming or remote communities.

Ethnographic and semi-structured interviews with consumers and stakeholders

The themes that emerged from the ethnographic work and semi-structured interviews with health consumers and stakeholders from across the health system elicited a number of high-level opportunities for creating more effective and efficient health outcomes. Six themes were identified from the insights gleaned from this phase of the work.

- **Wellbeing and wellness are integral to health.** While several existing policies appear to address health and wellbeing as a whole, the stakeholders spoken to who work in the health system believed that illness and wellness were considered mutually exclusive. For consumers, staying well and a focus on their own "wellness" were at the forefront of their discussions of how they interpreted their health. Interestingly, many indicated that a good relationship with a clinician plays a key role in helping them stay well, not just to treat or recover from illness. This theme suggests that opportunities for greater emphasis on integrating 'wellbeing' into health care, and approaches to strengthening the roles and relationships of core clinicians such as general practitioners, are critical to improving health and wellbeing experiences and outcomes.

"Emphasising wellbeing in discussions about health means the whole story of people and their health can be better understood and potentially reduce the amount of time people spend in the ill-health layer of the health system". (Health Professional)

- **Mental health is a growing concern in the health system.** Identified as both a national and state priority, mental health was high on the list of concerns expressed by health consumers and stakeholders, with both groups considering that the majority of focus was on treating symptoms rather than dealing with root causes. Costs, particularly for longer-term support and intervention, were cited as prohibitive and an opportunity was identified for developing more informal, peer-based and community-focused mechanisms for ongoing support of mental health.

"Wellbeing can't be maintained on, 'You have 10 appointments with me, and you're just going to be all better'." (Health Consumer)

- **Racism and low levels of cultural competency remains an issue in the health system.** The interviews uncovered a number of incidents and experiences from health consumers where interactions with health care professionals were described as stressful and upsetting because cultural identity was not recognised or acknowledged. Stakeholders also shared perspectives about health policy and practice reinforcing inequalities and affecting access to care. There are clearly opportunities to scale and deepen genuine cultural competency within the health system and also to foster workforce strategies that increase the number of Aboriginal workers in the health system.

"I think we should ask ourselves why we're not reporting routinely on racism in the health system. We know it's a determinant of health. That's a culturally incompetent system." (Healthcare Professional)

- **Evaluation of the health system remains focused on activity rather than outcomes.** Evaluation was raised in a number of stakeholder interviews, with the argument made that the dominant measures focus on activity and outputs, rather than outcomes, and that methodologies used tended to favour end-of-program evaluation rather than developmental methods that track changes across the longer term. Opportunities were identified to strengthen evaluation of health interventions across the lifecycle as an important complement to the growing use of data to track population outcomes.
- **Funding distribution needs better integration.** The flow of money around the Australian healthcare system is complex, which can make it difficult to navigate and understand. Stakeholders argued that funding is currently directed toward managing ill-health rather than prevention, to the point where the latter is increasingly considered to be under-funded. While coordination of funds was certainly identified as critical, stakeholders tended to argue that more investment was needed in prevention and early intervention. This is not a new argument, but there are increasingly opportunities to harness a more integrated commissioning of health and social services that could draw together prevention and a greater focus on investment in social determinants of health and wellbeing.

- **Community-managed health is essential but often undervalued.** The opportunity to strengthen community health and increase South Australia's capacity for managing ill-health was repeatedly championed throughout this phase of the work. The prevention and early intervention steps that happen at a community level, before people get to a hospital, are critical components in the creation of wellness. Furthermore, how well people are set-up to manage their health (chronic disease(s) in particular), at home and through the use of local services, holds some potential to decrease the burden on our hospitals and economy.

"The biggest, best, most cost-efficient health system in the country is self-management." (Health Care Professional)

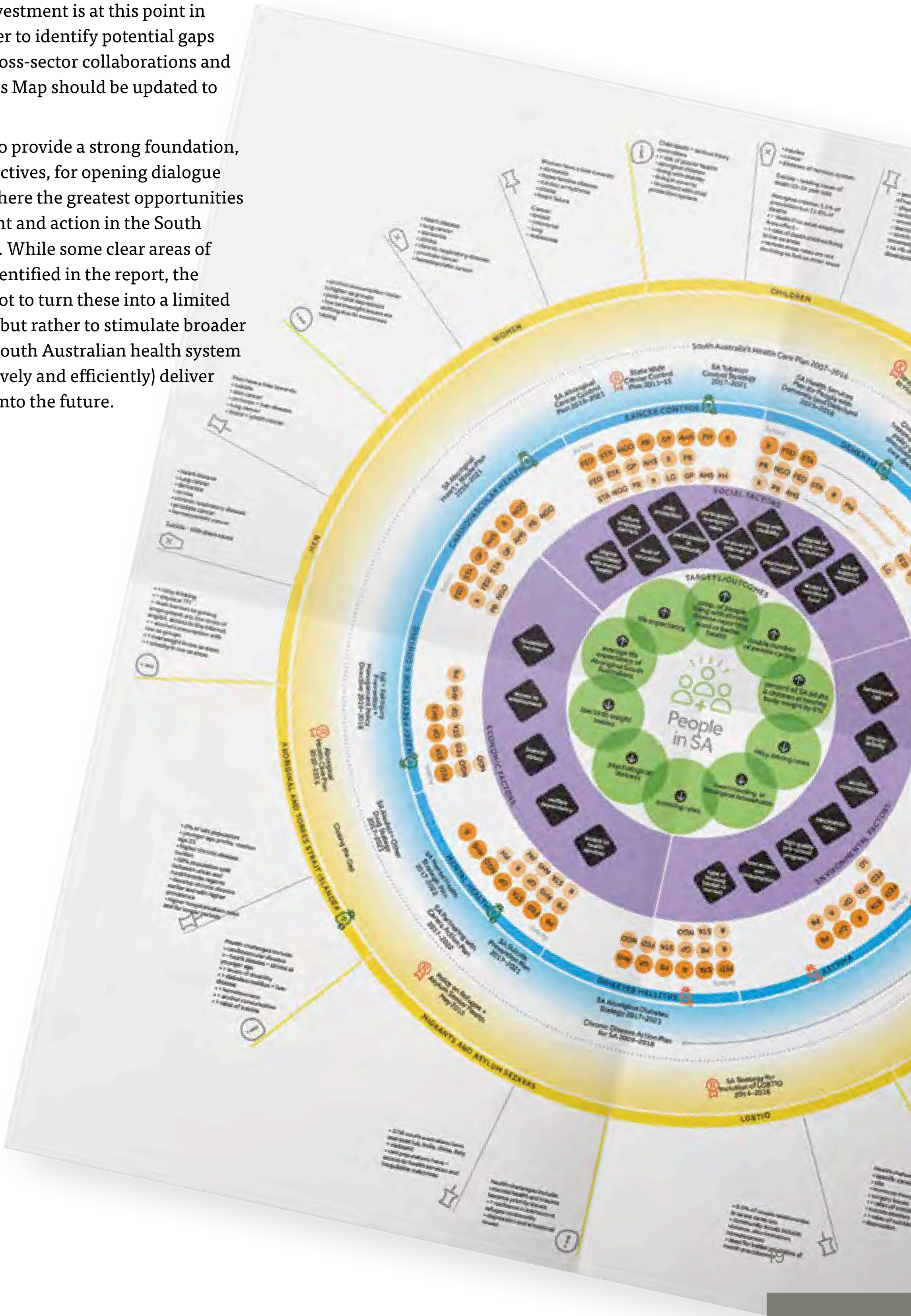
- **Finding and accessing appropriate support remains difficult.** There are opportunities not only to improve system navigation, but also in ensuring both physical access to and positive experience of health and wellness services. Finding and accessing support services that are both local and suited to an individual's needs and preferences is increasingly a game of luck for many consumers, despite the rise of greater levels of information about options. There are opportunities to strengthen not only access and choice but also to engage people in new ways to support staying well and managing ill-health within communities and at home - some of which are technological but others of which may be around growing stronger well-being support networks in local communities.

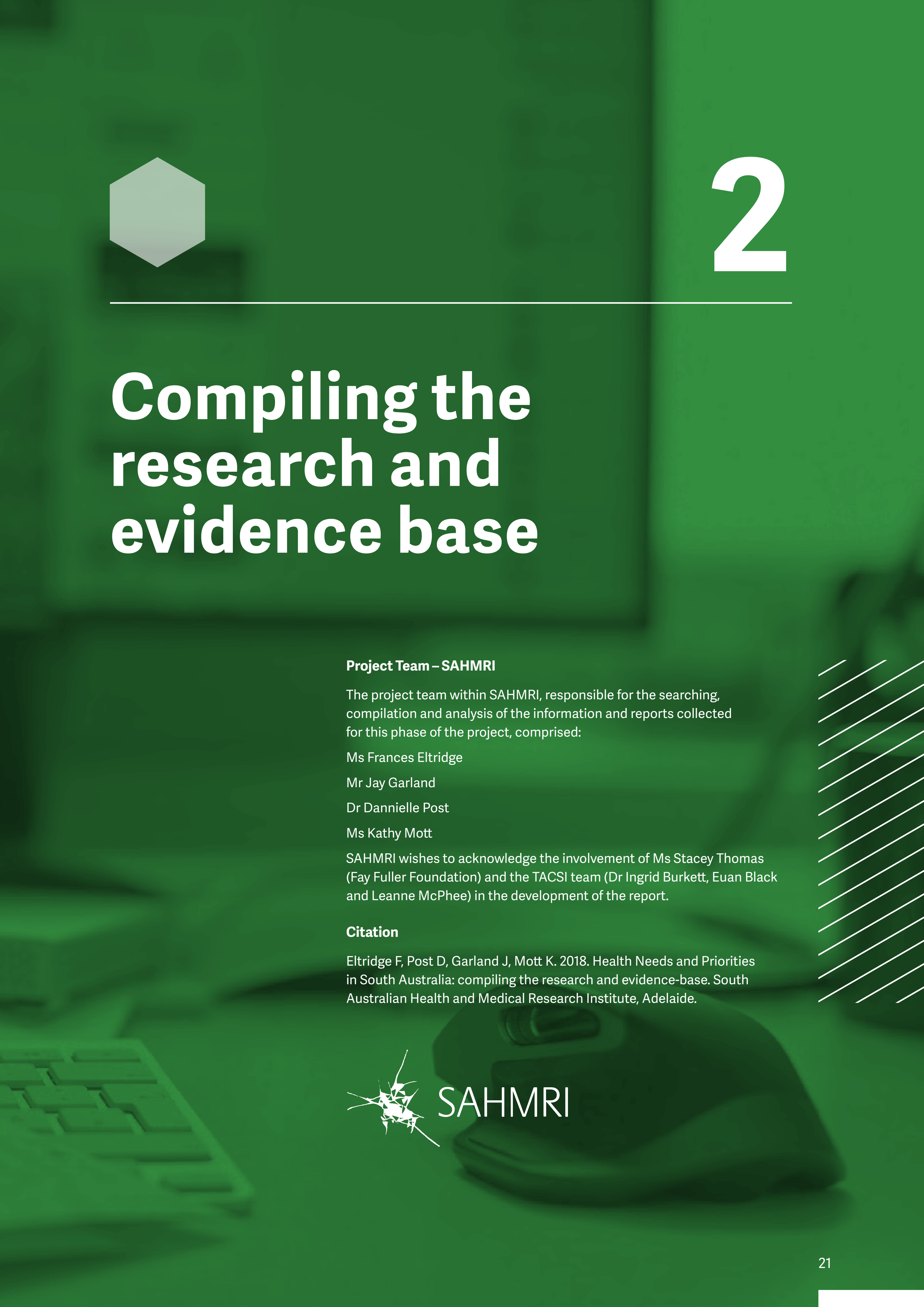
"Well, I'd say a lot of stuff doesn't come out and hit you in the face. You hear from someone whose been and tried it." (Health consumer)

Systems Map

The systems map effectively combines all the relevant data to identify current targets, risk factors, burdens of disease, related policy responses, populations and associated actors within the system. It shows where the particular focus of investment is at this point in time and allows the viewer to identify potential gaps and levers to stimulate cross-sector collaborations and create shared impact. This Map should be updated to retain currency.

The aim of this report is to provide a strong foundation, built on a range of perspectives, for opening dialogue and discussion around where the greatest opportunities lie for strategic investment and action in the South Australian health system. While some clear areas of opportunity have been identified in the report, the purpose of the report is not to turn these into a limited set of recommendations, but rather to stimulate broader engagement in how the South Australian health system could better (more effectively and efficiently) deliver outcomes both now and into the future.





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Compiling the research and evidence base

Project Team – SAHMRI

The project team within SAHMRI, responsible for the searching, compilation and analysis of the information and reports collected for this phase of the project, comprised:

Ms Frances Eltridge

Mr Jay Garland

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Ms Kathy Mott

SAHMRI wishes to acknowledge the involvement of Ms Stacey Thomas (Fay Fuller Foundation) and the TACSI team (Dr Ingrid Burkett, Euan Black and Leanne McPhee) in the development of the report.

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SAHMRI

Method

A mixed method approach was used for Phase 1 of the project, *Compiling the Research and Evidence Base*. There were two parts to Phase 1:

- Phase 1a: literature review.
- Phase 1b: questions in the 2017 Health Omnibus Survey.

Literature review

Reviewing the pre-existing literature and research is a critical element in any consideration of the health and wellbeing needs of South Australians, so that valuable resources are not spent reinventing the wheel. Synthesis of the highest quality research, reports, studies, strategies and plans available provides the Foundation with a solid evidence base on which to make decisions for investment in research, programs and organisations.

The search initially took place between Monday 14 August and Friday 08 September 2017. It was repeated on Friday 22 September to ensure that all relevant sources had been identified. Analysis and synthesis of the findings took place during the search period and continued until the end of September 2017.

The search strategy for the literature review is detailed in Appendix 1, but included searches among:

- federal and state government sources.
- university research databases.
- academic publications, including journal articles and conference presentations.
- publications from NGOs and advocacy organisations.
- other research and grey literature.

Summaries of the information found, and their sources, are discussed in the Key Findings section; full referencing is provided in Appendix 2.

The research team did not expect to identify a large number of articles that were specific to the South Australian (rather than national) population; however, we were surprised by how little published information is readily available and accessible. Apart from the 80+ documents included in this report, there appear to be no other articles or published reports that provide information that is sufficiently relevant and reliable to meet the needs of this investigation and synthesis.

All the information selected for inclusion in this review is considered to be of a standard that is acceptable to contribute to the literature in this area and is from reputable sources. The majority of the included information has been published by state or federal government agencies, such as SA Health, the Australian Institute of Health and Welfare, or the federally-funded Public Health Information Development Unit (PHIDU), situated within Torrens University. Statistics specific to lifestyle behaviours, such as diet, were generally retrieved from the Population Research and Outcomes Studies (PROS) group, formerly part of SA Health and subsequently situated within the University of Adelaide. Only a few articles published by academic researchers and specific to South Australia were included.

Information was excluded if it was considered to be of poor quality or where validity could not be assessed. For the most part, published academic research derives from a national perspective, with little information directly pertaining to the South Australian population. Information that does relate to SA is mostly very question-specific, rather than generalisable. There are indications online, through various community organisations, that there are some community-based programs that purport to cater to the needs of individual communities; however, the outcomes of these programs are rarely reported in the public domain.

Segmentation by population groups

After assessing all the information gathered during the searches, the decision was made to report the findings by population groups rather than by disease or condition states. Reporting by disease states would likely have resulted in information dominated by the most publicly-prominent conditions, i.e. cancer, cardiovascular disease and mental health. In contrast, a population-based approach allowed the concurrent review of multiple indicators and factors that contribute to health and wellbeing and provided a more comprehensive analysis of the needs of the SA population.

While most of the articles included in this review had findings that related to more than one segment of the South Australian population, their information has been included wherever relevant to a population group. Information about adults has been broken down to more detailed population segments and information related to children has been segmented to cover specific age groups. No reliable articles emerged that related specifically to the older population; instead, information about this population has been obtained from publications that addressed multiple populations.

Health Omnibus Survey

The Health Omnibus Survey (HOS) is an annual service provided, since 1991, by Harrison Health Research to a number of government and non-government organisations responsible for servicing the health needs of the South Australian community. It examines aspects of the lives of South Australians, in particular their health and wellbeing. The HOS provides organisations with an opportunity to generate population statistics of prevalence rates, program impacts and other important data at an affordable cost.

The idea of an 'omnibus' survey is that several organisations share the cost of conducting a survey, with each organisation paying only for those questions that are of direct relevance to its information requirements. The goal of the HOS is to collect, analyse and interpret data that can be used to plan, implement and monitor various programs and initiatives.

Harrison Research's Health Omnibus Survey has been designed to meet the highest standards of population survey methodology. Initially, 5300 households are randomly selected across SA, using a multi-stage, systematic, area sampling technique, with a final sample of approximately n=3000 interviews being the target. One person aged 15 years or over is randomly selected in each household, using the standard 'last to have a birthday' method, and interviewed face-to-face. No substitution of households, or of the randomly-selected respondents within households, is permitted. Consequently, the results provide good statistical rigour and representation of the SA population aged 15 and over.

Interviewing for the 2017 Health Omnibus Survey was carried out between 05 September and 17 December 2017. There were 2977 interviews completed, giving a response rate of 57%. Data have subsequently been weighted by the inverse probability of selection within each household, then by demographics to align with SA population at the 2016 Census. All sub-group sizes shown in this report are the weighted figures.

For the 2017 HOS, each client received the data from their paid questions (see Appendix 3), fourteen demographic questions and the twelve-question SF-12 Quality of Life (V1) questionnaire.

Setting the scene: Sociodemographic analysis of SA

Unless otherwise stated, the following data are sourced from the 2016 Census (Australian Bureau of Statistics (ABS) 2017b), which provides the most recent data on the Australian population. However, it should be noted that limited Census data had been released at the time of compiling this report, so some parts of the following analysis are based on the 2011 Census (Australian Bureau of Statistics (ABS) 2011), or on other sources.

The total SA population (N) at the 2016 Census was 1,676,653, including 49.3% males (N=825,997) and 50.7% females (N=850,652). The SA population increased by 5.4% between 2006 and 2011 and by a further 5.0% between 2011 and 2016; nationally, the changes were 8.3% and 8.8% respectively.

In 2015-16, South Australia gained 9163 people through net overseas migration, but lost 6398 people to net interstate migration, resulting in a net gain of 2765 people.

Figure 2 on the right shows this in context with other states and territories and reveals that SA is well behind the eastern states and the ACT, but its net growth rate is similar to Western Australia and Tasmania.

SA has an older age distribution than the country as a whole (median age 40 vs 37 years). In 2016, children and young people (0-19 year-olds) made up 23.5% of the population, compared with 24.8% nationally, while those aged 65 or older comprised 18.3% vs 15.8%.

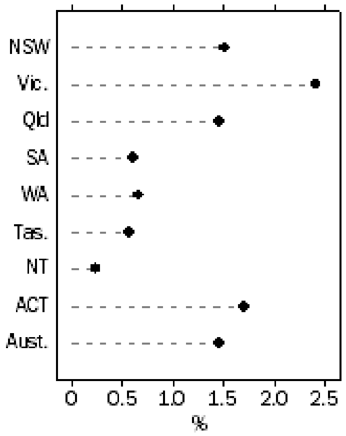


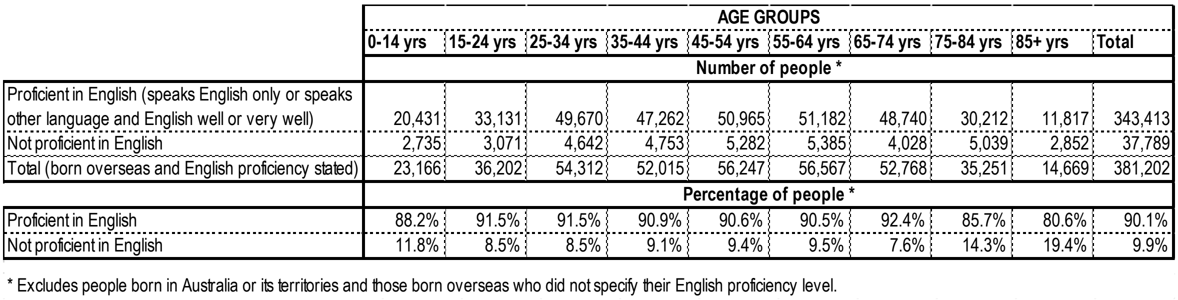
Figure 2: Population growth rate, y/e 31 December 2016 (Australian Bureau of Statistics (ABS) 2017b)

	Males	Females	Total	Males	Females	Total
0-4 years	49,910	47,163	97,072	6.0%	5.5%	5.8%
5-14 years	100,505	95,419	195,930	12.2%	11.2%	11.7%
15-19 years	51,516	49,169	100,686	6.2%	5.8%	6.0%
20-24 years	55,223	52,766	107,986	6.7%	6.2%	6.4%
25-34 years	108,274	109,837	218,107	13.1%	12.9%	13.0%
35-44 years	104,188	105,275	209,468	12.6%	12.4%	12.5%
45-54 years	112,117	114,770	226,891	13.6%	13.5%	13.5%
55-64 years	104,169	109,756	213,923	12.6%	12.9%	12.8%
65-74 years	81,316	87,533	168,852	9.8%	10.3%	10.1%
75-84 years	42,437	50,821	93,258	5.1%	6.0%	5.6%
85+ years	16,340	28,143	44,479	2.0%	3.3%	2.7%
Total	825,997	850,652	1,676,653	100.0%	100.0%	100.0%

Table 2: South Australian age distribution (Australian Bureau of Statistics (ABS) 2017b)

For SA seven in ten people were born in Australia (71.1%; 71.5% nationally) and 85.6% are Australian citizens. Overall, nine in ten of the South Australians who were born overseas were recorded as being proficient in speaking English, either as native English speakers or as speaking English well or very well as a second language.

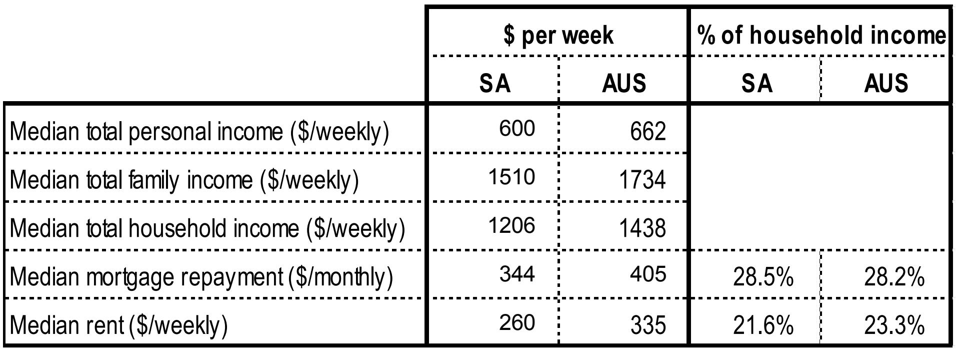
While the amounts of personal, family and household income in South Australia are notably lower than the national averages, the proportions of household income paid as mortgage or rent are generally in line (slightly lower for rent), due to proportionally lower housing costs compared to the more populous states and the two mainland territories.



	AGE GROUPS									
	0-14 yrs	15-24 yrs	25-34 yrs	35-44 yrs	45-54 yrs	55-64 yrs	65-74 yrs	75-84 yrs	85+ yrs	Total
	Number of people *									
Proficient in English (speaks English only or speaks other language and English well or very well)	20,431	33,131	49,670	47,262	50,965	51,182	48,740	30,212	11,817	343,413
Not proficient in English	2,735	3,071	4,642	4,753	5,282	5,385	4,028	5,039	2,852	37,789
Total (born overseas and English proficiency stated)	23,166	36,202	54,312	52,015	56,247	56,567	52,768	35,251	14,669	381,202
	Percentage of people *									
Proficient in English	88.2%	91.5%	91.5%	90.9%	90.6%	90.5%	92.4%	85.7%	80.6%	90.1%
Not proficient in English	11.8%	8.5%	8.5%	9.1%	9.4%	9.5%	7.6%	14.3%	19.4%	9.9%

* Excludes people born in Australia or its territories and those born overseas who did not specify their English proficiency level.

Table 3: Proficiency in English (Australian Bureau of Statistics (ABS) 2017b)

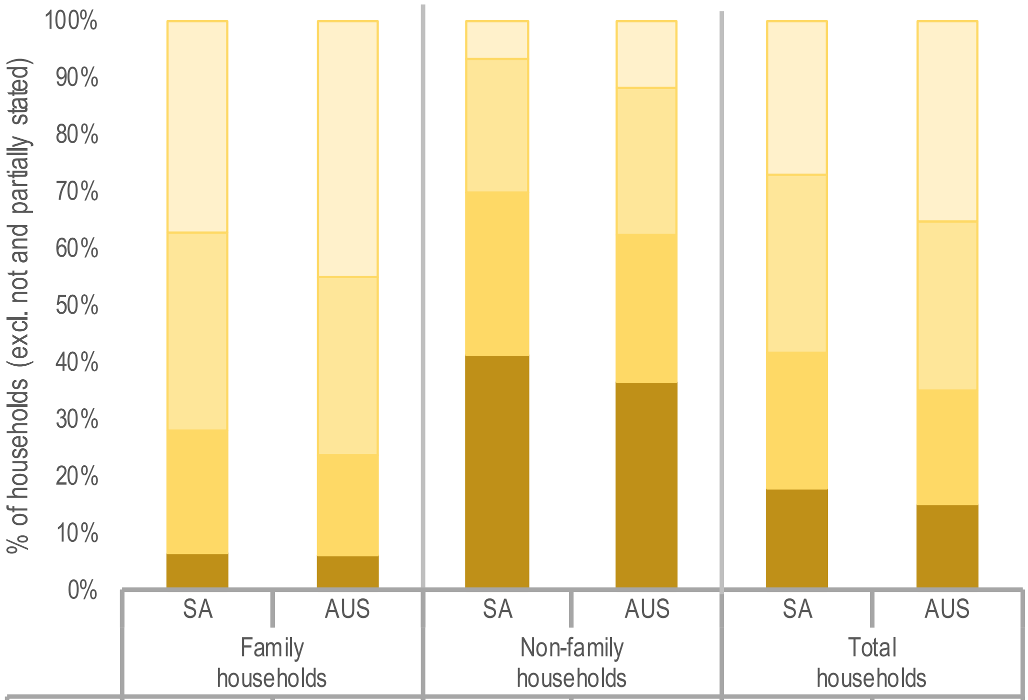


	$ per week		% of household income	
	SA	AUS	SA	AUS
Median total personal income ($/weekly)	600	662		
Median total family income ($/weekly)	1510	1734		
Median total household income ($/weekly)	1206	1438		
Median mortgage repayment ($/monthly)	344	405	28.5%	28.2%
Median rent ($/weekly)	260	335	21.6%	23.3%

Table 4: Income, mortgage and rent (Australian Bureau of Statistics (ABS) 2017b)

As can be seen in Figure 3, household incomes are significantly lower among non-family households than among family households. This is consistent nationally but, in SA, four in ten non-family households (41.4%) have weekly incomes below $500 (36.5% nationally). This equates to nearly one in five (18.0%) of all SA households (15.1% nationally).

Two-thirds of South Australian households comprise families and one-third are lone person, group or other types of households. That pattern has been statistically consistent over the last four censuses. The proportion of households comprising couple families and no children appears to have been increasing slightly each census. One-parent households were slightly higher in 2016 than previously, but it is too early to confirm this as a real change.



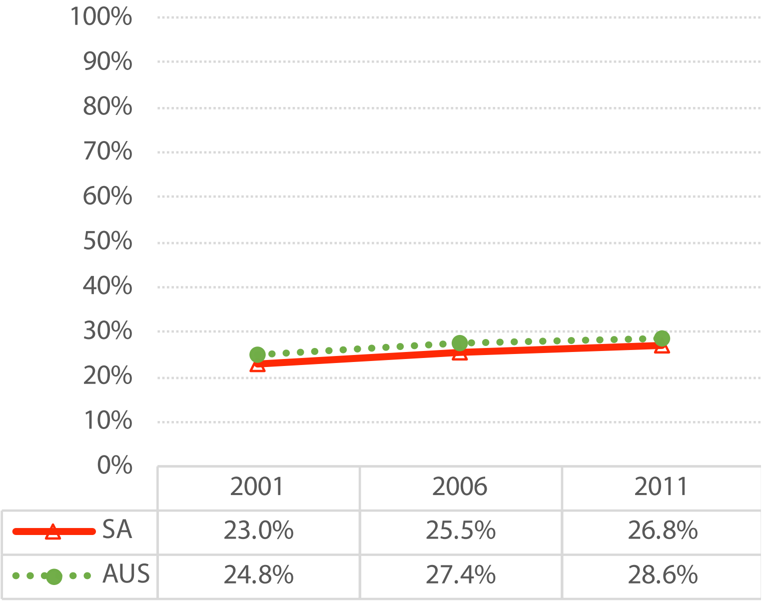
	Family households SA	Family households AUS	Non-family households SA	Non-family households AUS	Total households SA	Total households AUS
🟨 $2,000+	37.1%	45.1%	6.8%	11.9%	27.2%	35.2%
🟨 <$2,000	34.7%	31.4%	23.2%	25.7%	31.0%	29.7%
🟨 <$1,000	21.4%	17.4%	28.6%	26.0%	23.8%	19.9%
🟫 <$500	6.7%	6.2%	41.4%	36.5%	18.0%	15.1%

Figure 3: Household income ($ per week before tax), by h'hold composition, SA vs Australia (Australian Bureau of Statistics (ABS) 2017b)

HOUSEHOLD TYPES		**# OF HOUSEHOLDS**				**% OF HOUSEHOLDS**			
		2001	**2006**	**2011**	**2016**	**2001**	**2006**	**2011**	**2016**
Family households	Couple family with no children	151,821	160,368	171,617	178,588	26.0%	26.3%	26.7%	27.7%
	Couple family with children	174,783	171,701	177,552	184,733	29.9%	28.2%	27.6%	28.6%
	One parent family	61,076	64,358	68,118	73,128	10.5%	10.6%	10.6%	11.3%
	Other family	6,383	6,568	7,064	7,282	1.1%	1.1%	1.1%	1.1%
	Total family househbolds	**394,063**	**402,995**	**424,351**	**443,733**	**67.5%**	**66.1%**	**65.9%**	**68.7%**
Non-family households	Lone person	155,258	161,818	172,666	201,972	26.6%	26.5%	26.8%	31.3%
	Group	17,754	19,137	22,021		3.0%	3.1%	3.4%	
	Other	16,968	25,960	24,859		2.9%	4.3%	3.9%	
	Total non-family households	**189,980**	**206,915**	**219,546**	**201,972**	**32.5%**	**33.9%**	**34.1%**	**31.3%**
TOTAL HOUSEHOLDS		**584,043**	**609,910**	**643,897**	**645,705**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table 5: Household composition, SA, 2001-2016 (Australian Bureau of Statistics (ABS) 2017b)

Post-secondary education results from the 2016 Census are not yet available, so trend data to 2011 are used in the interim. The proportion of SA residents aged 15 years and over having any tertiary qualifications is marginally lower than nationally, but both are increasing and the gap has been consistently small (1.8%-1.9%). In both geographies, the types of tertiary qualifications are changing, with certificate level declining while higher-level qualifications have been increasing.



	2001	2006	2011
SA	23.0%	25.5%	26.8%
AUS	24.8%	27.4%	28.6%

Figure 4: Tertiary qualifications, SA vs Aus., 2001-2011 (Australian Bureau of Statistics (ABS) 2011)

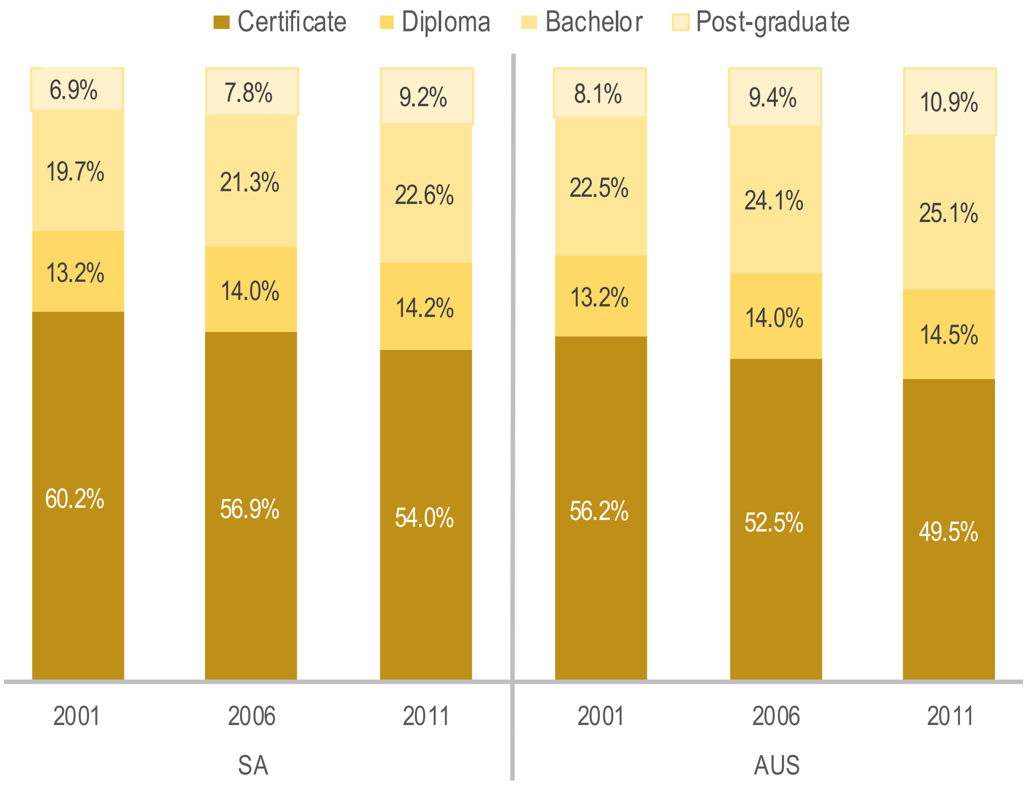
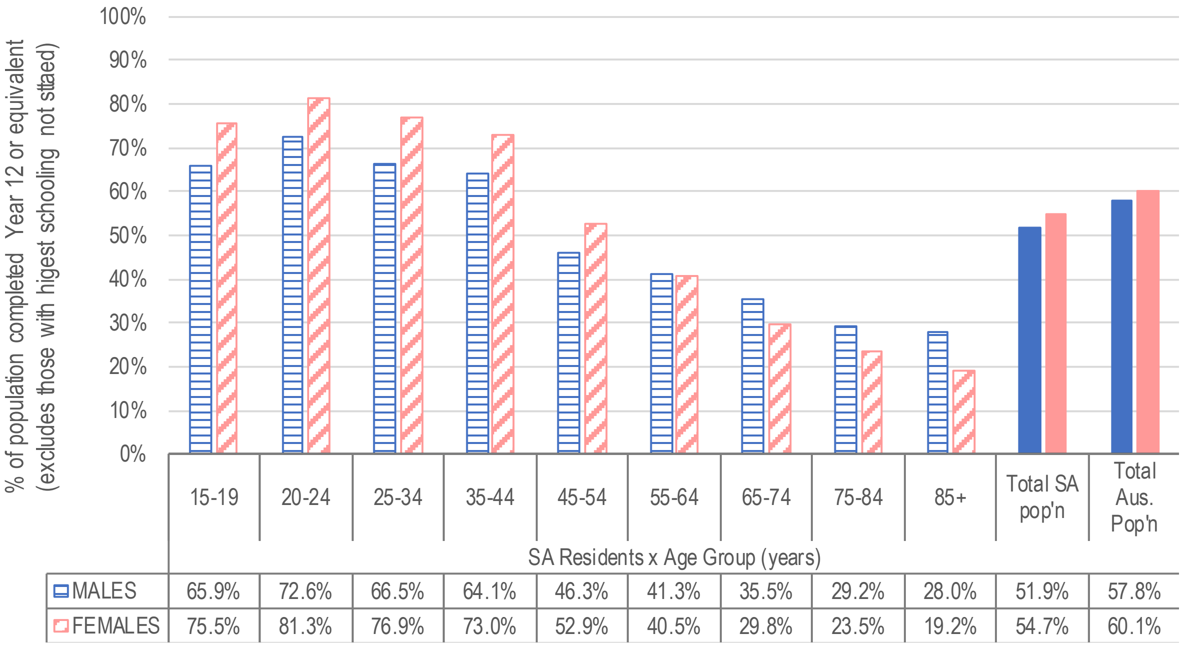


Figure 5: Types of tertiary qualific's, SA vs Aus, 2001-11 (Australian Bureau of Statistics (ABS) 2011)

School completion data for 2016 are available and summarised in Figure 6. It is notable that, for 15-54 year-olds, Year 12 completion rates are higher among females than males, while the reverse is true among those aged 55 and over, reflecting changes for women generally over the past few decades.

Further reflecting those changes, the gap in labour force participation rates among males and females in South Australia has been narrowing over time, from 33.2% in June 1978 to 9.1% in June 2017. Interestingly, while participation rates in SA have generally been a little lower than national rates among men, this has only become evident among females since the mid-1990s. Overall, the gap in male and female participation has nearly always been slightly smaller in this state than Australia-wide.



	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total SA pop'n	Total Aus. Pop'n
▤ MALES	65.9%	72.6%	66.5%	64.1%	46.3%	41.3%	35.5%	29.2%	28.0%	51.9%	57.8%
▨ FEMALES	75.5%	81.3%	76.9%	73.0%	52.9%	40.5%	29.8%	23.5%	19.2%	54.7%	60.1%

Figure 6: School completion rates by sex and age groupings (Australian Bureau of Statistics (ABS) 2017b)

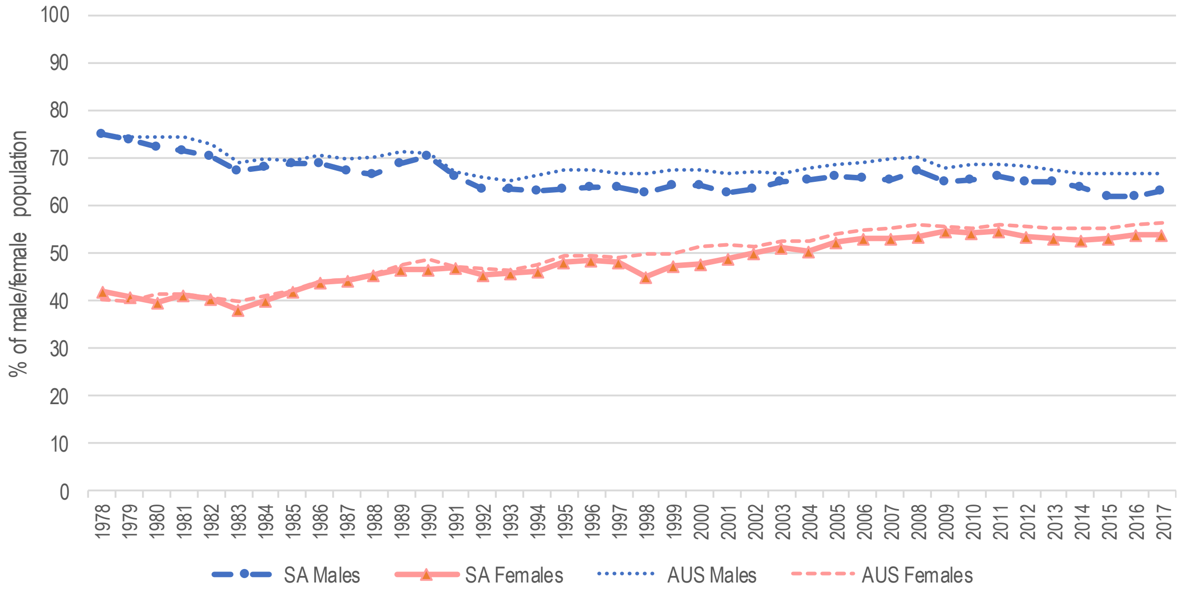


Figure 7: Labour force participation by sex, 1978-2017 (June each year), showing SA versus Australia (Australian Bureau of Statistics (ABS) 2017a)

Rural and remote populations comprise 22.7% of the South Australian population, with this being split across the South East (11.1%), the Barossa-Yorke-Mid North (6.6%) and the Outback (5.0%) regions (as defined by the ABS). These proportions are virtually unchanged compared with the 2011 Census.

Key differences between the metropolitan and rural/remote parts of the state include:

- Aboriginal people comprise 4.1% of the rural/remote population.
- 11.2% of the country population was born overseas, compared with 26.3% in Greater Adelaide.
- the rural/remote population is older (median age 44.3 vs 38.6).
- the vast majority (95.1%) speak English at home (80.3% in Greater Adelaide).

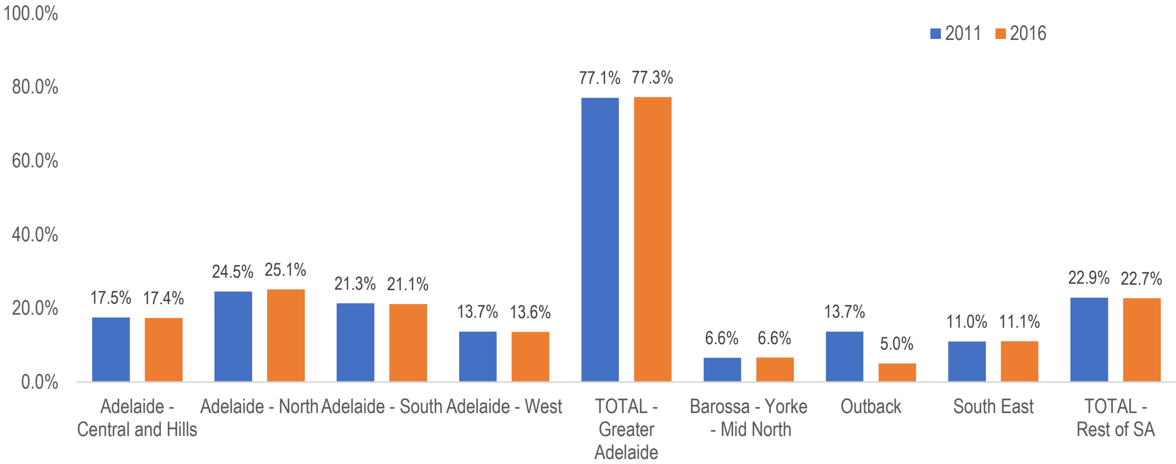
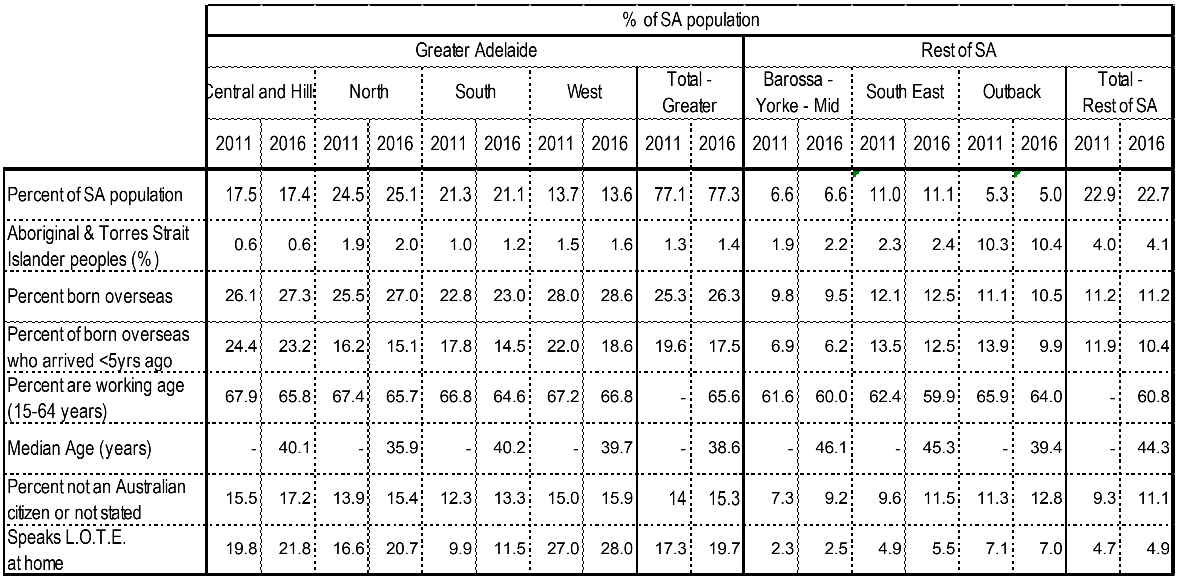


Figure 8: Distribution of SA population by region, 2011 and 2016 (Australian Bureau of Statistics (ABS) 2011, Australian Bureau of Statistics (ABS) 2017b)



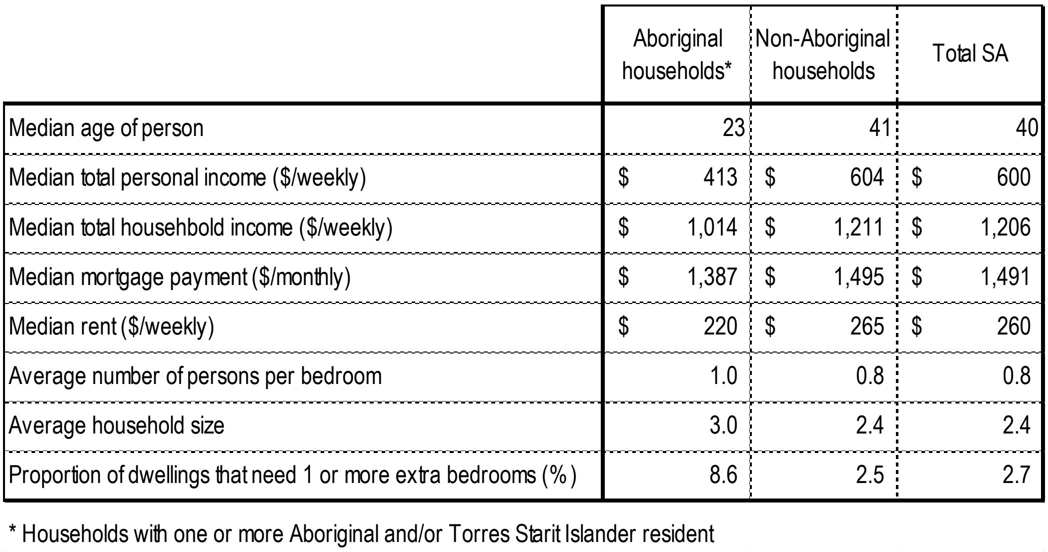
	% of SA population																	
	Greater Adelaide										Rest of SA							
	Central and Hill		North		South		West		Total - Greater		Barossa - Yorke - Mid		South East		Outback		Total - Rest of SA	
	2011	2016	2011	2016	2011	2016	2011	2016	2011	2016	2011	2016	2011	2016	2011	2016	2011	2016
Percent of SA population	17.5	17.4	24.5	25.1	21.3	21.1	13.7	13.6	77.1	77.3	6.6	6.6	11.0	11.1	5.3	5.0	22.9	22.7
Aboriginal & Torres Strait Islander peoples (%)	0.6	0.6	1.9	2.0	1.0	1.2	1.5	1.6	1.3	1.4	1.9	2.2	2.3	2.4	10.3	10.4	4.0	4.1
Percent born overseas	26.1	27.3	25.5	27.0	22.8	23.0	28.0	28.6	25.3	26.3	9.8	9.5	12.1	12.5	11.1	10.5	11.2	11.2
Percent of born overseas who arrived <5yrs ago	24.4	23.2	16.2	15.1	17.8	14.5	22.0	18.6	19.6	17.5	6.9	6.2	13.5	12.5	13.9	9.9	11.9	10.4
Percent are working age (15-64 years)	67.9	65.8	67.4	65.7	66.8	64.6	67.2	66.8	-	65.6	61.6	60.0	62.4	59.9	65.9	64.0	-	60.8
Median Age (years)	-	40.1	-	35.9	-	40.2	-	39.7	-	38.6	-	46.1	-	45.3	-	39.4	-	44.3
Percent not an Australian citizen or not stated	15.5	17.2	13.9	15.4	12.3	13.3	15.0	15.9	14	15.3	7.3	9.2	9.6	11.5	11.3	12.8	9.3	11.1
Speaks L.O.T.E. at home	19.8	21.8	16.6	20.7	9.9	11.5	27.0	28.0	17.3	19.7	2.3	2.5	4.9	5.5	7.1	7.0	4.7	4.9

Table 6: Selected data on SA regional populations, 2011 and 2016 (Australian Bureau of Statistics (ABS) 2011, Australian Bureau of Statistics (ABS) 2017b)

One of the key features of the Aboriginal population in Australia is the significantly younger age profile. This is clearly demonstrated in the graph of the 2016 Census population pyramid shown in Figure 9: the proportions of Aboriginal males and females aged under 30 are notably larger than the non-Aboriginal cohort, while the reverse is true above the age of 35. The difference is most sharply delineated among people aged 65 or over, where the proportion of non-Aboriginal people reaching that age is *four times* that of Aboriginal people. The median age for Aboriginal people in SA is 23, compared with 41 for non-Aboriginal people - a gap of 18 years.

Because of this distinct difference, when considering any population-level information for Australia (not just health and wellbeing factors) it is essential that the data have been age standardised.

Table 7 highlights key discrepancies between Aboriginal and non-Aboriginal households in South Australia, with each of these factors contributing to the lower socioeconomic, health and wellbeing characteristics evident in the Aboriginal population.



	Aboriginal households*	Non-Aboriginal households	Total SA
Median age of person	23	41	40
Median total personal income ($/weekly)	$ 413	$ 604	$ 600
Median total househbold income ($/weekly)	$ 1,014	$ 1,211	$ 1,206
Median mortgage payment ($/monthly)	$ 1,387	$ 1,495	$ 1,491
Median rent ($/weekly)	$ 220	$ 265	$ 260
Average number of persons per bedroom	1.0	0.8	0.8
Average household size	3.0	2.4	2.4
Proportion of dwellings that need 1 or more extra bedrooms (%)	8.6	2.5	2.7

* Households with one or more Aboriginal and/or Torres Starit Islander resident

Table 7: Comparison of key characteristics, Aboriginal vs non-Aboriginal households (Australian Bureau of Statistics (ABS) 2017b)

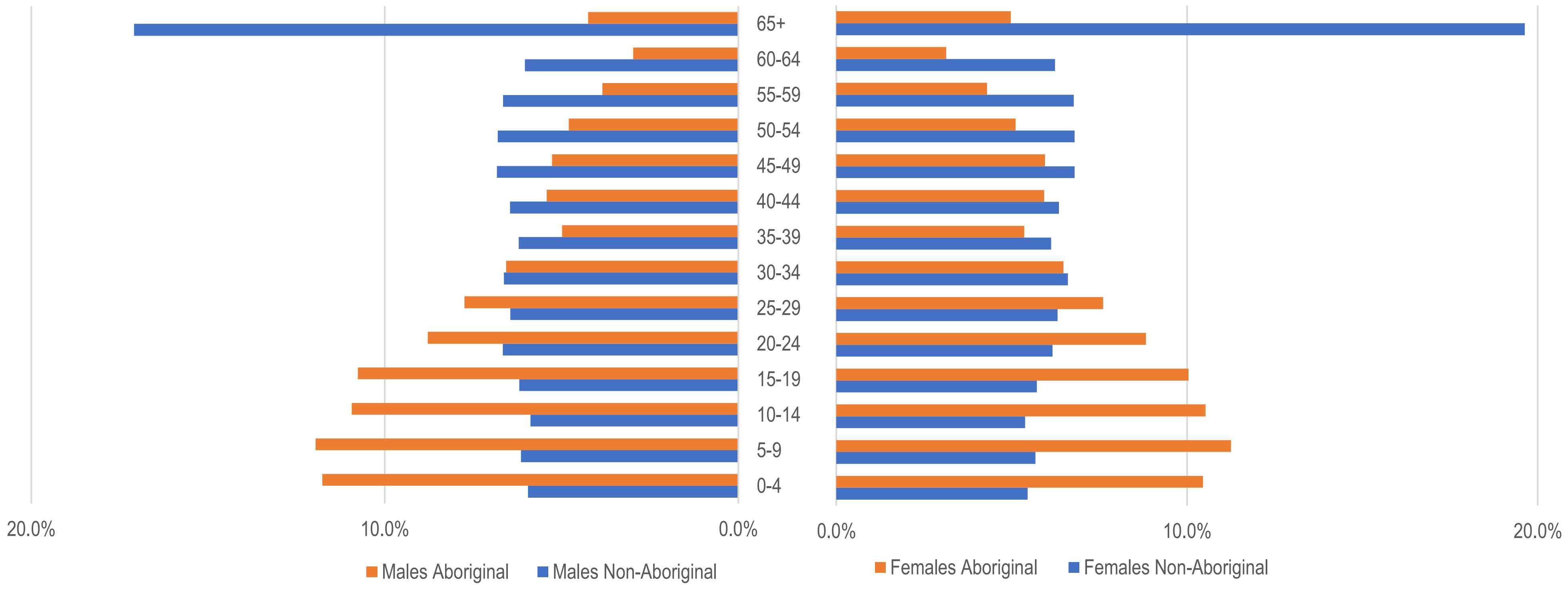


Figure 9: Age profiles, Aboriginal vs non-Aboriginal people in SA (Australian Bureau of Statistics (ABS) 2017b)

Strategies and plans in South Australia

At the time this report was compiled, there were two broad plans or strategies for South Australia relating directly to health or wellbeing:

1. State Public Health Plan (SA Health 2013).
2. South Australian Strategic Plan (Department of the Premier and Cabinet 2011).

State Public Health Plan

The State Public Health Plan published in 2013 is the first for South Australia. *"The Plan is described within the context of the changed and growing understanding of what impacts on public health in the 21st century. It canvasses the principal public health legislation and highlights the principles on which public health planning is based. In particular, it highlights the concepts of collaboration and prevention to be of central concern. The Plan also brings focus to the provision in the SA Public Health Act that ensures that the needs of vulnerable populations are addressed in public health planning, with a particular focus on the needs of Aboriginal people."* (p.6)

The Plan's vision is "South Australia: a Better Place to Live". Four strategic priorities support this:

1. Stronger and healthier communities and neighbourhoods for all generations.
2. Increasing opportunities for healthy living, healthy eating and being active.
3. Preparing for climate change.
4. Sustaining and improving public health and environmental health protection.

The Plan includes approaches to protecting, maintaining and improving health for the state's population. It acknowledges that there are multiple factors - social, economic and environmental - that influence a person's health.

The Plan references two recent reports from the University of Canberra dealing with the social determinants of health:

"A recent report into health inequalities in Australia reported that the lower a person's social and economic position, the worse his or her health is and that the health gap between the most and least disadvantaged was large and growing. The report showed that household income, level of education, access to or participation in employment, type of housing (rental vs. ownership) and degree of social connectedness all played a determining role in people's health. When it came to specific risk factors (such as smoking, physical inactivity, overweight and obesity, and risky alcohol consumption), socioeconomic status was a common element in the heightened presence of these risk factors." (p.11)

"A further recent report estimated that, if concerted action was taken to systematically address the social determinants of health in the Australian context:

- *500,000 Australians would be prevented from developing a chronic condition.*
- *170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings.*
- *annual savings would be made of $4 billion in welfare support payments.*
- *60,000 fewer people would need to be admitted to hospital annually, resulting in annual savings of $2.3 billion.*
- *5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million.*
- *5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in savings of $184.5 million."* (p.11)

The Plan includes understanding and shaping how communities are organised. There is a strong focus on prevention, addressing the underlying causes and determinants of health and that the needs of vulnerable populations are considered. The main vulnerable population it specifies is Aboriginal people. The plan also talks of the importance of the role of local government and other organisations in "joining-up" solutions, rather than working in silos.

South Australian Strategic Plan

The South Australian Strategic Plan covers seven priority areas:

1. Safe communities, healthy neighbourhoods.
2. Every chance for every child.
3. Creating a vibrant city.
4. An affordable place to live.
5. Realising the benefits of the mining boom for all South Australians.
6. Premium food and wine from our clean environment.
7. Growing advanced manufacturing.

All seven priorities have synergies and pathways with health and wellbeing outcomes; however, those priorities and their associated actions which have particular relevance with the State Public Health Plan's vision are: Safe Communities, Healthy Neighbourhoods, Creating a Vibrant City, Every Chance for Every Child and An Affordable Place to Live. The specific health Vision is "We are active in looking after our health".

Specific health-related targets are:

- Increase the life expectancy of South Australians.
- Increase the average life expectancy of Aboriginal South Australians.
- Reduce the smoking rate to 10% of the population and halve the smoking rate of Aboriginal South Australians by 2018.
- Reduce the proportion of South Australians who drink at risky levels by 30% by 2020.
- Double the number of people cycling in South Australia by 2020.
- Reduce overcrowding in Aboriginal households by 10% by 2014.
- Reduce the proportion of low birth weight babies and halve the proportion of Aboriginal low birth weight babies by 2020.
- Increase by five percentage points the proportion of South Australian adults and children at a healthy body weight by 2017.
- Increase, by five percentage points, the proportion of people living with a chronic disease whose self-assessed health status is good or better.
- Increase, by five percentage points, the proportion of people living with a chronic disease whose self-assessed health status is good or better.
- Equal or lower the Australian average for psychological distress by 2014 and maintain thereafter.

National Health Priority Areas

There are nine National Health Priority Areas (Australian Institute of Health and Welfare, 2017)

- Cancer control (first set of conditions, 1996).
- Cardiovascular health (first set of conditions, 1996).
- Injury prevention and control (first set of conditions, 1996).
- Mental health (first set of conditions, 1996).
- Diabetes mellitus (added 1997).
- Asthma (added 1999).
- Arthritis and musculoskeletal conditions (added 2002).
- Obesity (added 2008).
- Dementia (added 2012).

Table 8 (overleaf) demonstrates how South Australian plans or strategies align with these national priorities.

National Health Priority Area	South Australian Plan/Strategy
Cancer control	State Wide Cancer Control Plan 2011-2015 South Australian Aboriginal Cancer Control Plan 2016-2021 South Australian Tobacco Control Strategy 2011-2016
Cardiovascular health	South Australian Aboriginal Heart and Stroke Plan 2016-21
Injury prevention and control	Fall and Fall Injury Prevention & Management Policy Directive 2016-2018
Mental health	South Australian Suicide Prevention Strategy 2012-2016 South Australia's Mental Health & Wellbeing Policy 2010-2015 South Australian Alcohol and Other Drug Strategy 2017-2021
Diabetes mellitus	South Australian Aboriginal Diabetes Strategy 2017-2021 Chronic Disease Action Plan for South Australia 2009-2018
Asthma	Chronic Disease Action Plan for South Australia 2009-2018
Arthritis & musculoskeletal conditions	Chronic Disease Action Plan for South Australia 2009-2018
Obesity	Eat Well Be Active Strategy 2011-2016 Primary Prevention Plan 2011-2016
Dementia	SA Health Services Plan for People with Dementia (and Delirium) 2015-2018 Consent to Medical Treatment and Health Care Policy Guideline and Directive (Advanced Care Directives)

Table 8: SA plans and strategies aligned with National Health Priority Areas

From a biological health perspective, SA currently has official strategic plans that address suicide, mental health, cancer, alcohol and other drugs, and diabetes. However, the diabetes strategy is specific to the Aboriginal population and there is no such strategy for the wider SA population.

The state does not currently have a policy framework, action plan or monitoring process specific to health care services for the CALD population. While the SA Health (2015) Services Plan for People with Dementia (and Delirium) describes the services that should be available to older people with dementia, there is no plan related to prevention (the previous plan having lapsed in 2012).

Other SA plans or strategies that sit outside the National Health Priority framework are:

- Health related:
  - Aboriginal Health Care Plan 2010-2016
  - HIV Action Plan 2009-2012
  - South Australia's Oral Health Plan 2010-2017
- Social determinants related:
  - Housing Strategy for South Australia 2013-2018
  - Regional Engagement Strategy including Homeless 2 Home Data
  - Policy on Refugee and Asylum Seeker Health, May 2015
  - South Australian Strategy for the Inclusion of LGBTIQ People, 2014

NHMRC funding

These tables show the distribution of funds by the National Health and Medical Research Council (NHMRC) for the period 2012-2016. Tables 9 and 10 show that proportional funding has increased since 2012 for three priority areas (mental health, Aboriginal and Torres Strait Islander health and obesity), but has decreased for diabetes, while other funding areas to record proportional increases were child health and maternal health, whereas men's health decreased (National Health & Medical Research Council (NHMRC) 2017).

In 2017, South Australia received 9% of total grant funding and that 30% of SA grant applications were funded, which is an increase from previous years.

NATIONAL HEALTH PRIORITY AREAS	2012	2013	2014	2015	2016	Percent of expenditure 2012	Percent of expenditure 2016	Trend % of expenditure (Steady defined as within ±0.5%)
	$M	$M	$M	$M	$M			
Cancer	192.30	179.30	188.00	191.40	170.10	28.6%	28.4%	Steady
Cardiovascular Disease	121.60	112.40	122.70	120.90	106.00	18.1%	17.8%	Steady
Mental Health	70.40	73.30	83.80	86.20	71.70	10.5%	11.6%	Increased
Diabetes	74.90	65.10	69.60	69.40	64.10	11.1%	10.3%	Decreased
Aboriginal and Torres Strait Islander Health	46.60	41.50	49.10	55.80	51.80	6.9%	6.6%	Increased
Injury	51.80	46.10	58.90	61.90	46.70	7.7%	7.3%	Steady
Obesity	40.50	41.70	40.50	38.30	27.20	6.0%	6.6%	Increased
Arthritis and Osteoporosis	26.40	23.20	21.70	23.00	17.60	3.9%	3.7%	Steady
Dementia	27.60	27.10	33.50	34.60	46.40	4.1%	4.3%	Steady
Asthma	20.70	21.50	23.50	22.60	15.30	3.1%	3.4%	Steady
Totals	**672.80**	**631.20**	**691.30**	**704.10**	**616.90**	100.0%	100.0%	

Table 9: NHMRC expenditure by priority areas, 2012-2016 (National Health & Medical Research Council (NHMRC) 2017)

Burden of Disease	2012	2013	2014	2015	2016	Percent of expenditure 2012	Percent of expenditure 2016	Trend % of expenditure (Steady defined as within • 0.5%)
	$M	$M	$M	$M	$M			
Nervous System Disorders and Neuroscience	154.50	148.20	171.80	187.60	180.50	23.5%	23.2%	Steady
Infectious Disease	131.80	126.30	134.80	141.60	123.80	20.1%	19.8%	Steady
Child Health	76.80	81.40	87.50	98.70	84.30	11.7%	12.8%	Increased
Human Development	40.00	36.80	35.70	37.10	26.40	6.1%	5.8%	Steady
Respiratory Disease	41.60	42.10	47.10	49.20	36.90	6.3%	6.6%	Steady
Maternal Health	30.60	33.60	34.70	37.00	30.90	4.7%	5.3%	Increased
Nutrition	32.80	31.20	29.60	31.40	26.80	5.0%	4.9%	Steady
Congenital Abnormalities	27.00	24.50	27.40	31.20	23.10	4.1%	3.8%	Steady
Drug Addiction	23.40	24.20	22.20	21.00	20.30	3.6%	3.8%	Steady
Mens Health	25.90	19.40	17.10	18.20	15.10	3.9%	3.0%	Decreased
Eye Disease	19.70	18.60	20.80	21.60	19.80	3.0%	2.9%	Steady
Primary Health Care	19.50	19.40	24.70	31.50	25.00	3.0%	3.0%	Steady
Adolescent Health	20.10	21.00	20.00	19.20	13.70	3.1%	3.3%	Steady
Developmental Disorders	13.00	10.80	12.20	14.90	12.90	2.0%	1.7%	Steady
Total	**656.70**	**637.50**	**685.60**	**740.20**	**639.50**	100.0%	100.0%	

Table 10: NHMRC expenditure by other disease, research and health areas, 2012-2016 (National Health & Medical Research Council (NHMRC) 2017)

Key findings: Literature review

This section summarises the findings of the literature review. More than 90 publications have been located that provide relevant information, analysis and/or recommendations on the health and social welfare needs of the population in South Australia. In order to provide a useful structure for reviewing and presenting their information, the following analysis is segmented by the population groups which have developed as the primary focus of the searches; that is:

- General population (adults >18 years).
- General population - children and youth.
- Males/men's health.
- Females/women's health.
- Aboriginal and Torres Strait Islanders.
- Older people.
- Migrants/Asylum seekers.
- LGBTIQ people.
- Rural and remote residents.
- People in or leaving the justice system.

The following pages list the names and sources of the documents that have been assessed and summarised as part of this literature review. Each document is tagged against the population group(s) to which it has contributed information.

Comprehensive summaries of each of those source documents are provided as Appendix 2, which is delivered as a separate document due to its length. However, the information pertaining to the different population groups has been synthesised as key findings on the pages following the documents list.

Author	**Year**	**REFERENCE**	**Publication Type**	Adults >17 years [Ref. count = 80]	Adult Males [Ref.count=82]	Adult Females [Ref.count=83]	Children 0-4yrs [Ref.count=29]	Children 5-12yrs [Ref.count=32]	Children 13-17yrs [Ref.count=34]	Children/Youth* [Ref.count=65]	Aboriginal & Torres Strait Islanders [Ref.count=38]	Older people [Ref.count=34]	Migrants/asylum skrs [Ref.count=24]	LGBTIQ people [Ref.count=17]	Rural & Remote [Ref.count=29]	Justice System [Ref.count=12]
Australian Bureau of Statistics (ABS)	2012	3303.0 Causes of Death, Australia, 2016 (sub-page: Intentional self harm)	Report	✓	✓	✓				✓						
Australian Bureau of Statistics (ABS)	2017	2011 and 2016 Census data, trends and community profiles	Data	✓	✓	✓				✓	✓	✓	✓		✓	
Australian Centre for Child Protection (Uni SA)	2013	Maintaining connectedness: Family contact for children in statutory residential care in South Australia	Report	✓	✓	✓				✓						
Australian Early Development Census	2015	Australian Early Development Census National Report 2015	Report					✓		✓						
Australian Human Rights Commission	2017	Asylum seekers, refugees and human rights: Snapshot Report (2nd edition), 2017	Report	✓	✓	✓							✓			
Australian Institute of Health and Welfare (AIHW)	2012	A picture of Australia's Children	Report				✓	✓	✓	✓						
Australian Institute of Health and Welfare (AIHW)	2016	Skin Cancer in Australia	Report	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Australian Institute of Health and Welfare (AIHW)	2017	National health priority areas	Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Australian Journal of Social Issues, Robbins, Jane	2015	Policy approaches to addressing Aboriginal social inclusion in South	Policy discussion	✓	✓	✓				✓	✓					
Bell, Ullah et al.	2016	OPAL Project Evaluation Final Report	Report	✓			✓	✓	✓	✓						
Beyond Blue	2014	Beyond Blue Annual Report 2013-14	Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 70]	Adult Males [Ref.count=73]	Adult Females [Ref.count=74]	Children 0-4yrs [Ref.count=23]	Children 5-12yrs [Ref.count=25]	Children 13-17yrs [Ref.count=28]	Children/Youth* [Ref.count=54]	Aboriginal & Torres Strait Islanders [Ref.count=32]	Older people [Ref.count=29]	Migrants/asylum skrs [Ref.count=19]	LGBTIQ people [Ref.count=14]	Rural & Remote [Ref.count=24]	Justice System [Ref.count=10]
BMC Public Health	2017	Prevalence, perceptions and predictors of alcohol consumption and abstinence among South Australian school students: a cross-sectional analysis	Report		✓	✓				✓						
Cancer Council, SA Health	2011	State Wide Cancer Control Plan 2011-15	Plan	✓	✓	✓				✓					✓	
Centre for Social Impact	2015	The Cost of Youth Homelessness in Australia Study: Snapshot Report 1	Report							✓						
Child Death and Serious Injury Committee	2016	Child Death and Serious Injury Committee - Annual Report 2015–2016	Report				✓	✓	✓	✓						
Child Protection Systems Royal Commission	2016	The life they deserve: Child Protection Systems Royal Commission Report, Volume 1: Summary and Report.	Judicial Report							✓						
Children Australia Journal	2016	Care for Children with Migrant or Refugee Backgrounds in the School Context	Report		✓	✓				✓			✓			
Commonwealth of Australia	2017	Closing The gap Prime Minister's Report 2017	Report								✓					
Country Health SA LHN	2016	Country Health SA Local Health Network Inc Annual Report 2014-15	Plan	✓	✓	✓				✓					✓	
Department for Communities and Social Inclusion (DCSI)	2014	South Australian Strategy for the Inclusion of LGBTIQ People	Strategy	✓	✓	✓								✓		
Department for Communities and Social Inclusion (DCSI)	2017	Results of the South Australian Rainbow Survey 2015-16	Report											✓		

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 66]	Adult Males [Ref.count=67]	Adult Females [Ref.count=68]	Children 0-4yrs [Ref.count=21]	Children 5-12yrs [Ref.count=23]	Children 13-17yrs [Ref.count=26]	Children/Youth* [Ref.count=46]	Aboriginal & Torres Strait Islanders [Ref.count=30]	Older people [Ref.count=28]	Migrants/asylum skrs [Ref.count=17]	LGBTIQ people [Ref.count=11]	Rural & Remote [Ref.count=21]	Justice System [Ref.count=9]
Department of Communities and Social Inclusion	2013	Housing Strategy for South Australia 2013-18	Strategy	✓	✓	✓					✓					
Department of Communities and Social Inclusion	2016	SA: State of Wellbeing – Final Report	Report	✓	✓	✓										
Department of Environment	2013	City of Playford Profile	Report	✓	✓	✓			✓	✓		✓				
Department of Environment, Water and Natural Resources	2016	Healthy Parks, Healthy People South Australia 2016 - 2021	Report	✓	✓	✓				✓						
Department of Social Services	2012	Child Abuse And Neglect: A Socio-legal Study of Mandatory Reporting in Australia Report for South Australia Department for Education and Child Development.	Report		✓	✓				✓						
Drug and Alcohol Services South Australia	2017	South Australian Tobacco Control Strategy 2017-2020	Strategy	✓	✓	✓										
Flinders University	2012	Experiences and Needs of Families Living with Acquired Brain Injury in South Australia Stage 1 Research Report	Report	✓	✓	✓	✓	✓	✓	✓						
Flinders University	2016	OPAL Evaluation Project Final Report	Report	✓	✓	✓		✓		✓						
Gibson, Eltridge et al.	2017	The South Australian Aboriginal Diabetes Strategy 2017 – 2021	Strategy	✓	✓	✓				✓	✓					
Gibson, Peterson, et al.	2017	South Australian Aboriginal Health Needs and Gaps Northern Adelaide Local Health Network Report	Report	✓	✓	✓					✓					

Author	Year	REFERENCE	**Publication Type**	Adults >17 years [Ref. count = 56]	Adult Males [Ref.count=56]	Adult Females [Ref.count=57]	Children 0-4yrs [Ref.count=19]	Children 5-12yrs [Ref.count=20]	Children 13-17yrs [Ref.count=23]	Children/Youth* [Ref.count=39]	Aboriginal & Torres Strait Islanders [Ref.count=26]	Older people [Ref.count=26]	Migrants/asylum skrs [Ref.count=16]	LGBTIQ people [Ref.count=10]	Rural & Remote [Ref.count=20]	Justice System [Ref.count=8]
Gibson, Peterson, et al.	2017	South Australian Aboriginal Health Needs and Gaps: Central Adelaide Local Health Network Report	Report	✓	✓	✓					✓					
Gibson, Peterson, et al.	2017	South Australian Aboriginal Health Needs and Gaps: Country Health SA Local Health Network Report	Report	✓	✓	✓					✓					
Gibson, Peterson, et al.	2017	South Australian Aboriginal Health Needs and Gaps: Southern Adelaide Local Health Network Report	Report	✓	✓	✓					✓					
Gibson, Peterson, et al.	2017	South Australian Aboriginal Health Needs and Gaps: Women's & Children's Health Network Report	Report	✓		✓					✓					
Health Consumers Alliance of SA and Health Economics and Social Policy Group	2016	Final Report Health Consumers Alliance of SA and Health Economics and Social Policy Group, UniSA Youth Mental Health Consultation Project	Report					✓	✓	✓						
Health Consumers Alliance of South Australia	2014	A Framework of Engagement Practice with Vulnerable South Australian Communities HCASA	Framework	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓
Health Performance Council	2013	Improving End of Life Care for South Australians: A Report by the Health Performance Council of SA	Report	✓	✓	✓					✓	✓	✓	✓	✓	
Health Performance Council	2013	Mental Health in Rural and Remote South Australian Communities	Report	✓	✓	✓				✓					✓	

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 48]	Adult Males [Ref.count=49]	Adult Females [Ref.count=49]	Children 0-4yrs [Ref.count=18]	Children 5-12yrs [Ref.count=18]	Children 13-17yrs [Ref.count=21]	Children/Youth* [Ref.count=35]	Aboriginal & Torres Strait Islanders [Ref.count=19]	Older people [Ref.count=23]	Migrants/asylum skrs [Ref.count=13]	LGBTIQ people [Ref.count=7]	Rural & Remote [Ref.count=16]	Justice System [Ref.count=6]
Health Performance Council	2016	Productivity Commission – Reforms to Human Services: Issues Paper December 2016 https://www.hpcsa.com.au/reports#X-201704101006420	Issues Paper	✓	✓	✓				✓						
Health Performance Council	2017	Monitoring the implementation of Transforming Health Indicator Report 3rd edition – July 2017	Report	✓	✓	✓										
Health Performance Council	2017	Productivity Commission's Report on Government Services 2017: How South Australia compares with other states and territories for selected health performance indicators	Report	✓	✓	✓					✓				✓	
Heart Foundation	2015	Australian heart disease statistics 2015	Report	✓	✓	✓				✓	✓	✓			✓	
King and Brown	2015	Next Steps for Aboriginal Health Research	Report	✓	✓	✓										
Longo and Cooke	2016	Alcohol consumption and related harm in South Australia 2016	Report	✓	✓	✓			✓	✓	✓	✓			✓	
Martin K, Bowden J, et al.	2017	Key Smoking Statistics for SA – 2016 Adelaide, Australia	Report	✓	✓	✓						✓				
Multicultural Youth Advocacy Network	2014	The CALD Youth Census Report 2014	Report							✓			✓			
National LGBTI Health Alliance	2014	LGBTI Health Summary	Report	✓	✓	✓				✓				✓		

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 39]	Adult Males [Ref.count=40]	Adult Females [Ref.count=40]	Children 0-4yrs [Ref.count=17]	Children 5-12yrs [Ref.count=17]	Children 13-17yrs [Ref.count=19]	Children/Youth* [Ref.count=29]	Aboriginal & Torres Strait Islanders [Ref.count=15]	Older people [Ref.count=19]	Migrants/asylum skrs [Ref.count=11]	LGBTIQ people [Ref.count=5]	Rural & Remote [Ref.count=12]	Justice System [Ref.count=5]
Population Reseacrh & Outcome Studies (PROS)	2015	Fast Food Consumption in South Australia, 2015 Adults aged 18 years and over, January 2015 to December 2015 (SAMSS).	Report	✓	✓	✓				✓		✓				
Population Reseacrh & Outcome Studies (PROS)	2015	Fast Food Consumption in South Australian Children, 2015	Report							✓						
Population Reseacrh & Outcome Studies (PROS)	2015	Food Insecurity in South Australia, 2015 Adults aged 18 years and over, January 2015 to December 2015 (SAMSS).	Report	✓	✓	✓										
Population Reseacrh & Outcome Studies (PROS)	2015	Fruit Consumption: State, Metropolitan, and Country. Children aged 2 to 17 years January 2015 to December 2015 (SAMSS)	Report				✓	✓	✓	✓						
Population Reseacrh & Outcome Studies (PROS)	2015	Fruit Consumption: State, Metropolitan, Country and Local Health Networks. Adults aged 18 years and over January 2015 to December 2015 (SAMSS)	Report	✓	✓	✓				✓		✓				
Population Reseacrh & Outcome Studies (PROS)	2015	Soft Drinks and Sports Drinks Consumption in South Australia, 2015 Adults aged 18 years and over, January 2015 to December 2015 (SAMSS).	Report	✓	✓	✓				✓		✓				
Population Reseacrh & Outcome Studies (PROS)	2015	Soft Drinks and Sports Drinks Consumption in South Australia, 2015 Children aged 1 to 17 years, January 2015 to December 2015 (SAMSS)	Report				✓	✓	✓	✓						

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 34]	Adult Males [Ref.count=35]	Adult Females [Ref.count=35]	Children 0-4yrs [Ref.count=14]	Children 5-12yrs [Ref.count=14]	Children 13-17yrs [Ref.count=16]	Children/Youth* [Ref.count=22]	Aboriginal & Torres Strait Islanders [Ref.count=14]	Older people [Ref.count=15]	Migrants/asylum skrs [Ref.count=10]	LGBTIQ people [Ref.count=4]	Rural & Remote [Ref.count=11]	Justice System [Ref.count=4]
Population Reseacrh & Outcome Studies (PROS)	2015	Vegetable Consumption: State, Metropolitan and Country. Children aged 2 to 17 years January 2015 to December 2015 (SAMSS)	Report				✓	✓	✓	✓						
Population Reseacrh & Outcome Studies (PROS)	2015	Vegetable Consumption: State, Metropolitan, Country and Local Health Networks, Adults aged 18 years and over, January 2015 to December 2015 (SAMSS)	Report	✓	✓	✓				✓		✓				
Primary Health Networks	2016	Needs Assessment Reporting Template (2015/16) (Adelaide PHN)	Report	✓	✓	✓										
Primary Health Networks	2017	Needs Assessment Reporting Template (2016/17 Update) (Adelaide	Report	✓	✓	✓										
Primary Health Networks Country SA	2017	Needs Assessment Report 2016-2017 (Country SA PHN)	Report	✓	✓	✓									✓	
Principe	2015	Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds A Scoping Study for the Health Performance Council September 2015	Report	✓	✓	✓							✓			
Public Health Association Australia	2013	Public Health Association of Australia: Policy-at-a-glance – Injury Prevention and Safety Promotion Policy	Policy	✓	✓	✓	✓	✓	✓	✓		✓				
Public Health Information Development Unit	2015	The socioeconomic gradient and chronic conditions in Australia: Results from the 2011 13 Australian Health Survey	Report	✓	✓	✓	✓	✓	✓	✓		✓				

Author	Year	REFERENCE	**Publication Type**	Adults >17 years [Ref. count = 24]	Adult Males [Ref.count=25]	Adult Females [Ref.count=25]	Children 0-4yrs [Ref.count=9]	Children 5-12yrs [Ref.count=9]	Children 13-17yrs [Ref.count=11]	Children/Youth* [Ref.count=16]	Aboriginal & Torres Strait Islanders [Ref.count=12]	Older people [Ref.count=10]	Migrants/asylum skrs [Ref.count=8]	LGBTIQ people [Ref.count=3]	Rural & Remote [Ref.count=8]	Justice System [Ref.count=3]
Public Health Information Development Unit	2017	Regional health: trends in inequalities in health and wellbeing by remoteness, for South Australia	Report	✓	✓	✓	✓	✓	✓	✓	✓				✓	
Public Health Information Development Unit (PHIDU)	2012	An atlas of Cancer in South Australia	Report	✓	✓	✓						✓				
Public Health Information Development Unit (PHIDU)	2012	Life Opportunities, Social Inclusion and Health Outcomes: An Australian Atlas	Report	✓	✓	✓	✓	✓	✓	✓	✓		✓			
Public Health Information Development Unit (PHIDU)	2016	An atlas of six South Australian communities: Mapping the influences on community wellbeing	Report	✓	✓	✓	✓	✓	✓	✓	✓				✓	
SA Health	2009	Chronic Disease Action Plan for South Australia	Plan	✓	✓	✓										
SA Health	2010	South Australia Oral Health Plan	Plan	✓	✓	✓										
SA Health	2012	Age Friendly Living Guidelines for Residential Development	Guidelines	✓	✓	✓						✓				
SA Health	2012	Age Friendly Neighbourhoods Guidelines and Toolkit for Local Government	Guidelines	✓	✓	✓						✓				
SA Health	2012	Age Friendly South Australia Guidelines for State Government	Guidelines	✓	✓	✓						✓				
SA Health	2012	South Australian Hepatocellular Cancer Care Pathway Optimising Outcomes for South Australians diagnosed with Hepatocellular Cancer	Strategy	✓	✓	✓					✓	✓	✓		✓	

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 13]	Adult Males [Ref.count=14]	Adult Females [Ref.count=14]	Children 0-4yrs [Ref.count=5]	Children 5-12yrs [Ref.count=5]	Children 13-17yrs [Ref.count=6]	Children/Youth* [Ref.count=11]	Aboriginal & Torres Strait Islanders [Ref.count=6]	Older people [Ref.count=4]	Migrants/asylum skrs [Ref.count=5]	LGBTIQ people [Ref.count=2]	Rural & Remote [Ref.count=4]	Justice System [Ref.count=2]
SA Health	2012	South Australian Suicide Prevention Strategy	Strategy	✓	✓	✓			✓	✓	✓				✓	
SA Health	2015	Communicable Disease Control Branch, Surveillance & Investigation Section Annual Report 2015	Report	✓	✓	✓	✓	✓	✓	✓	✓	✓				
SA Health	2015	SA Health Services Plan for People with Dementia (and Delirium) 2015-2018	Plan									✓				
SA Health	2015	South Australia's Mental Health and Wellbeing Policy 2010-2015	Policy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
SA Health	2016	A report on the incidence and mortality patterns of cancer 'Cancer in South Australia 2013	Report	✓	✓	✓	✓	✓	✓	✓						
SA Health	2016	Aboriginal Health Care Plan 2010-16	Plan	✓	✓	✓										
SA Health	2016	Eat Well Be Active Strategy for South Australia	Strategy	✓	✓	✓										
SA Health	2016	Model of Care for Chronic Pain Management in South Australia	Strategy		✓	✓				✓					✓	
SA Health	2016	South Australian Alcohol & Other Drugs Strategy 2017-2021	Strategy	✓	✓	✓			✓	✓	✓					
SA Health	2016	South Australian Sexually Transmissible Infection Implementation Plan 2016-2018	Implementation Plan	✓	✓	✓					✓		✓	✓		
SA Health	2017	Protect, Prevent, Improve, Inform: Chief Public Health Officer's Report 2014-2016	Report	✓	✓	✓					✓					

Author	Year	REFERENCE	Publication Type	Adults >17 years [Ref. count = 3]	Adult Males [Ref.count=3]	Adult Females [Ref.count=3]	Children 0-4yrs [Ref.count=1]	Children 5-12yrs [Ref.count=1]	Children 13-17yrs [Ref.count=1]	Children/Youth* [Ref.count=4]	Aboriginal & Torres Strait Islanders [Ref.count=0]	Older people [Ref.count=0]	Migrants/asylum skrs [Ref.count=2]	LGBTIQ people [Ref.count=0]	Rural & Remote [Ref.count=0]	Justice System [Ref.count=0]
Shelter SA	2016	Regional Engagement Strategy including Homeless 2 Home Data	Strategy	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Shelter SA	2017	The end of the Road, Rooming Housing in South Australia	Report	✓	✓	✓				✓						
South Australian Council of Social Service	2016	Linking Services for Mental Health and Wellbeing Submission to the SA Mental Health Strategic Plan 2017-22	Submission	✓						✓						
South Australian Council of Social Service	2017	Jobs and prosperity in our digital world. SACOSS 2017-2018 State Budget Submission	Submission		✓	✓				✓						
The Royal Australasian College of Physicians	2015	Policy on Refugee and Asylum Seeker Health May 2015	Policy	✓	✓	✓							✓			
The SA Centre for Economic Studies	2013	Economic and Social Impact Study: Community and Neighbourhood Centres Sector (2013)	Report	✓	✓	✓	✓	✓	✓	✓						
Ziaian, de Anstiss et al.	2012	Resilience and Its Association with Depression, Emotional and Behavioural Problems, and Mental Health Service Utilisation among Refugee Adolescents Living in South Australia	Report							✓			✓			

* In cases where children's data are not broken down into age brackets, only the Children/Youth box is ticked.

General population overview – adults

Demographic characteristics

At the 2016 Census, there were 1,676,653 people living in South Australia (Australian Bureau of Statistics (ABS) 2017b). The population is generally older than the Australian population, with a median age of 40; the national median age is 37 years. The population is 49% male and 51% female, with 24% aged 0-19 and 18% aged 65 or older. Three-quarters (77%) of the population lives in the metropolitan area (ABS: Greater Adelaide) and 23% across the rest of the state, with approximately half of the rural population (11%) living in the "south-east" region of the state (which appears to include the area from the Riverland to the Limestone Coast).

See *Setting the Scene: Sociodemographic Analysis of SA,* for greater detail.

Relevant documents

Seventy-two of the documents sourced provided information relevant to the SA adult population. The documents were in a number of formats, including:

- 1 framework.
- 3 guidelines.
- 1 implementation paper.
- 1 issues paper.
- 5 plans.
- 3 policies.
- 1 policy discussion.
- 46 reports.
- 9 strategies.
- 1 submission.

The documents identified were from various sources, including:

- state government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres and academics.

Synthesis of findings

The leading causes of death in South Australia and the social determinants that contribute to poorer health and wellbeing are covered in many of the source documents. In South Australia, the leading causes of death are the same as they are nationally: heart disease, dementia, stroke, lung cancer and chronic respiratory disease. However, the ABS noted in its 2015 summary of the causes of death that death rates for heart disease and cancer have been declining, while dementia has been increasing; it is expected that dementia will become the leading cause of death in Australia. Reflecting the older population, in 2011 "*the contribution of dementia to the burden of disease in South Australia was higher than for any other jurisdiction*" (SA Health 2017a).

The determinants of health include the social, economic and physical environments, and individuals' characteristics and behaviours. The social conditions in which people are born, live and work are the most important determinants of good or ill health.

The South Australian Chief Public Health Officer's Report 2017 (SA Health 2017a) highlights the clear relationship between socioeconomic conditions and health and wellbeing. The SEIFA set of indicators (Socio-Economic Indexes for Areas) provides measures of advantage and disadvantage across the country. "*Variations in health status generally follow a gradient, with overall health tending to improve with socio-economic position. The gradient in health can also be seen in differing rates for many health risk factors; in the prevalence of many chronic diseases and conditions. In general, people from poorer social or economic circumstances are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those who are more advantaged.*" (SA Health, 2017, p.11).

Public Health Information Development Unit, Torrens University (PHIDU) also highlights that health-related behaviours such as smoking, low levels of physical activity, alcohol consumption and conditions such as obesity and hypertension are indicators of increased risk of poor health across the life course, and that these behaviours are representative of the socioeconomic gradient (Public Health Information Development Unit (PHIDU) 2015). SA Health records that poor nutrition issues such as low consumption of fruit and vegetables and high consumption of fast food are more prevalent in the lowest SEIFA quintile areas (Population Research and Outcome Studies (PROS) 2015a, Population Research and Outcome Studies (PROS) 2015b, Population Research and Outcome Studies (PROS) 2016).

Persons most likely to die prematurely include Aboriginal and Torres Strait Islander people, those earning low incomes, those who are unemployed, and residents of rural and remote areas. The ratio of premature mortality rate in the Very Remote compared to the Major Cities areas increased, from 56% higher in 1997–2001 to 73% higher in 2010–2014, indicating a widening of the gap and worsening inequality (Public Health Information Development Unit (PHIDU) 2016).

One in six South Australians (17%) suffer from chronic pain, which has both social and economic impacts and is often associated with co-morbidities (SA Health 2016).

In support for the SA Government's Thriving Communities Initiative, PHIDU produced a report in 2016 titled *An atlas of six South Australian communities: mapping the influences on community wellbeing*, which included extensive analysis of the four communities supported under that initiative - Playford, Onkaparinga, the APY Lands and Peterborough (Public Health Information Development Unit (PHIDU) 2016). Some of the key influences on, and indicators of, wellbeing were: no access to the Internet at home; relatively large numbers of people living with a disability or dependent on the age pension; high or very high prevalence of psychological distress and obesity; and premature mortality (Public Health Information Development Unit (PHIDU) 2016).

Overall, in the 2015 Health Omnibus Survey, using the 12-item Short-Form Health Survey, South Australians rated their mental health status higher than their physical health status (SA Health, 2016, p.12).

Participation for bowel cancer screening in the Very Remote areas was 17% lower than in the Major Cities areas in 2010 and 26% lower in 2012-13; in both cases, the difference was statistically significant (Public Health Information Development Unit (PHIDU) 2017).

Identified gaps and priorities

An atlas of six South Australian communities concludes that the following categories of adults should be focused on regarding their poorer health and wellbeing:

- adults without access to the Internet at home.
- adults in households with relatively large numbers of people living with a disability, or dependent on the Age Pension.
- adults with high or very high prevalence of psychological distress, and obesity.
- adults at high risk of premature mortality, i.e. <75 years of age.
- disadvantaged households i.e. under financial stress from rent or mortgage payments; welfare dependent; high levels of disability; high or very high prevalence of psychological distress; no Internet access at home; inability to get support in times of crisis from outside the household, and limited participation in volunteering in the community.

With regard to the five leading causes of death, there appears to be limited or no material found specific to SA in the form of reports or needs analysis for dementia, which is known to be a major focus for national research (both biomedical and health services), but for which there is limited published evidence or reports on SA.

The large and increasing gap in bowel cancer screening participation between people living in the Very Remote and the other Remoteness areas presents a challenge to the delivery of this program, a challenge faced by many preventive health and service delivery programs in Australia (Public Health Information Development Unit (PHIDU) 2017).

General population overview – children and youth

Demographic characteristics

In the 2016 Census, children and young people (0-19 year-olds) made up 23.5% of the population, compared with 24.8% nationally (Australian Bureau of Statistics (ABS) 2017b).

Relevant documents

Fifty-six of the documents sourced provided information relevant to the SA Child and Adolescent population. The documents were in a number of formats, including:

- 1 framework.
- 1 issues paper.
- 2 plans.
- 2 policies.
- 1 policy discussion
- 40 reports.
- 5 strategies.
- 2 submissions.

The documents identified were from various sources, including:

- state government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.
- judicial inquiries.

Synthesis of findings

Synthesis of the relevant reports indicates that several health issues affect the young adolescent population in South Australia and that these issues vary depending on socioeconomic standing, age and background, as they do in the adult population.

The following points are taken from the *Child Death and Serious Injury Committee - Annual Report 2015–2016* (Child Death and Serious Injury Committee 2016):

- Children living with disability, in poverty, Aboriginal children, or those who have contact with the child protection system, are more likely to be at risk of poorer health.
- Although Aboriginal children make up only 3.5% of South Australian children aged 0-17 years, they accounted for 11.6% of the deaths.

- During the period 2005-2015, for all child deaths:
  - children younger than one year, and young people 15-17 years, had higher rates of death than children aged 1-14 years.
  - male children had a higher death rate than female children.
  - 322 children who died (27%), or their families, had contact with Families SA in the three years before death.
  - children who lived in areas of greatest socioeconomic disadvantage had a higher rate of death than those who lived in areas of least disadvantage.
  - living in a remote area was associated with a higher child death rate in comparison to living in a major city area.

Compared to 2006, in 2011 the proportion of South Australia children aged less than 15 years, living in families where no adult was employed, fell in the Major Cities and Inner Regional remoteness categories and increased in the Outer Regional and Very Remote areas (Public Health Information Development Unit (PHIDU) 2017).

One finding of the Child Death and Serious Injury Committee in its 2016 report is that, over the previous eleven years, the rate of child death in South Australia had shown a significant reduction, with the average death rate decreasing by 11% on average per year. However, the three leading causes of child death had remained the same: injuries, cancer and diseases of the nervous system. Children who lived in the state's more socioeconomically disadvantaged areas had higher death rates and these were not declining in the same way as for those who lived in South Australia's least disadvantaged areas (Child Death and Serious Injury Committee 2016).

The Child Protection Systems Royal Commission Report (Child Protection Systems Royal Commission 2016) reflected on some common themes regarding neglect and cumulative harm. The Commission highlighted that rural communities have higher rates of injury due to children having a higher risk of experiencing social isolation and socioeconomic disadvantage.

Suicide remains the leading cause of death among Australians between 15 and 34 years of age. Suicide rates for males in that age group have decreased over the past 10 years, with decreases of 34% for 15-24-year-olds (SA Health 2012b). According to the ABS (Australian Bureau of Statistics (ABS) 2016), in 2015 suicide was the leading cause of death among all people 15-44 years of age and the leading cause of 'Years of Potential Life Lost' across all ages (even ahead of heart disease). The median age at death for suicide was 44.5 years, compared to a median age of 81.9 years for all deaths.

From a child and youth perspective, it is important to note that, in 2015, suicide rates in the overall population remained higher than for the 5-17 years age group. The age-specific rate of suicide among 5-17 year-olds was 2.3 per 100,000, compared with a crude death rate of 12.7 deaths per 100,000 persons overall. Regardless of that, suicide was the leading cause of death among children aged 5-17 in Australia in 2016 (22.1% of male deaths and 16.8% of female deaths, in that age group). In that year also, suicide accounted for 35.7% of all male deaths in the 15-19 years age group. It is potentially useful to note that, while not specific to children or young people, SA was the only state or territory to record a reduction in the standardised death rate for suicide between 2014 and 2015 (Australian Bureau of Statistics (ABS) 2016).

Being overweight in childhood is a public health concern and leads to poor quality of life (Bell, Ullah et al. 2016). In 2009, the South Australian Government (through SA Health) established the Obesity Prevention And Lifestyle (OPAL) project, which was coordinated through local government and worked with specific communities to create opportunities to eat well and be active. OPAL was active in twenty South Australian communities and one in the Northern Territory (SA Health 2012a). Its main objective was to increase the proportion of South Australian children in the healthy weight range, through promotion of healthy eating and physical exercise (Bell, Ullah et al. 2016).

Due to a halt in funding, evaluation was not comprehensive. Instead, data from 1873 primary school children, between nine and 11 years of age, were analysed. Post-intervention, the prevalence of overweight and obesity in children in intervention communities was stable, in contrast to non-intervention communities, where a 5% (non-significant) increase in overweight and obesity prevalence was detected over the same period (Bell, Ullah et al. 2016).

On a different note, children and adolescents are susceptible to vaccine-preventable communicable diseases such as influenza and 25% of reported cases in 2015 were in children under nine years of age (SA Health 2015a).

The Australian Early Development Census (AEDC) is a nation-wide data collection of early childhood development at the time children commence their first year of full-time school (public or private) and provides evidence to support health, education and community policy and planning (Department of Education and Training 2015). Completed by teachers, the data collected relate to five key areas of early childhood development referred to as 'domains': physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge. These domains have been shown to predict later health, wellbeing and academic success.

In the three AEDC data collections conducted to date (2009, 2012 and 2015), South Australia recorded above-average proportions of children who are "developmentally vulnerable", including close to one-quarter (22.8%, 23.7% and 23.5% respectively), who were vulnerable on one or more domain. The classification of developmental vulnerability means

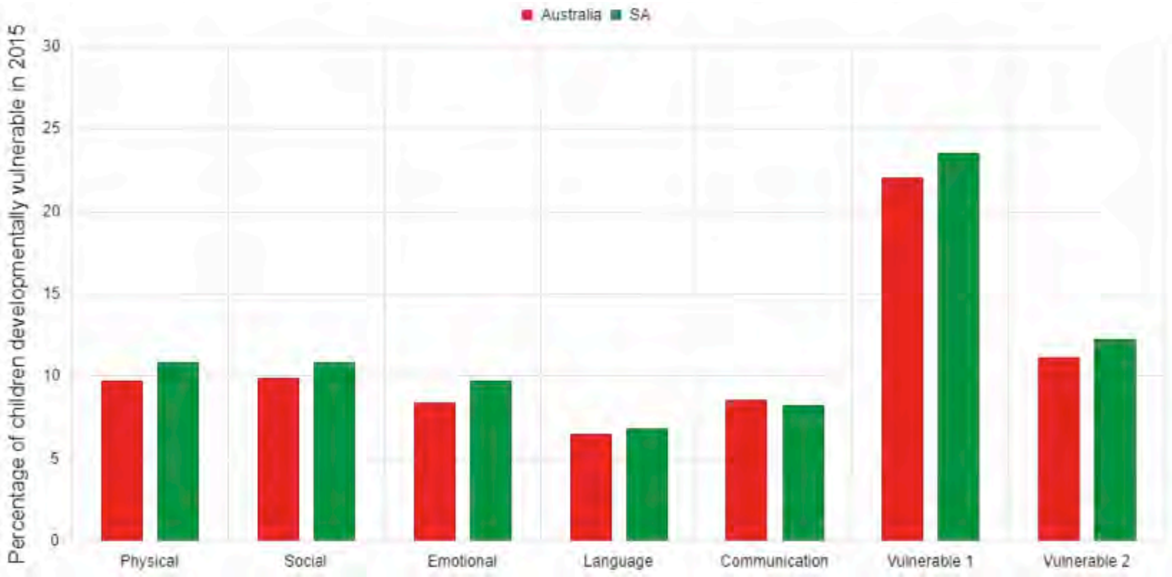


Figure 10: Results from Australian Early Development Census (2015), SA vs Australia

they fall into the lowest 10% of all children assessed and demonstrate a much lower than average ability in the developmental competencies in a domain. The overall domain results for 2015 are highlighted in Figure 10, which shows the proportions of children in their first year of school who were developmentally vulnerable on each domain, as well as the totals vulnerable on one or more domain and two or more domains, comparing South Australia versus Australia.

Identified gaps and priorities

High-quality pre-school programs are recommended as a means of improving early childhood development (Public Health Information Development Unit (PHIDU) 2016).

As a result of the decrease in the proportion of children under 15 living in jobless households in the Major Cities areas (down by 6.2%), and the large increase in the Very Remote areas, the gap between the proportion of these children in the Very Remote and the Major Cities areas increased from just 1% to 26%, indicating a widening of the gap and worsening inequality (Public Health Information Development Unit (PHIDU) 2017).

From *South Australia's Mental Health and Wellbeing Policy 2010-2015* (Government of South Australia 2015):

- Support parents, families, child care environments and schools to positively influence the social and emotional wellbeing of infants, children and young people and provide secure environments for their emotional and physical development.
- Prioritise prevention and early intervention initiatives for infants, children and young people who have, or who are at risk of developing, mental health problems or illness.
- Support strategies to minimise the social and economic consequences of mental ill-health in children and young people, including the provision of appropriate developmental opportunities such as education and vocational training, as well as opportunities for social participation.
- Implement strategies to address the specific needs of children of parents who have a mental illness.
- Develop a model of care for Child and Adolescent Mental Health Services (CAMHS) to ensure that services specific to the needs of children and young people are provided in accordance with a consistent and agreed state-wide model.

Adult males/men's health

Demographic characteristics

At the 2016 Census, there were 825,997 males in SA, forming 49.3% of South Australia's population; this proportion is in line with the overall Australian population distribution (Australian Bureau of Statistics (ABS) 2017b).

Relevant documents

Seventy-four of the documents sourced provided information relevant to the SA male population. The documents were in a number of formats, including:

- 1 framework.
- 3 guidelines.
- 1 implementation plan.
- 1 issues paper.
- 5 plans.
- 3 policies.
- 1 policy discussion.
- 47 reports.
- 10 strategies.
- 1 submission.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.

Synthesis of findings

The five leading causes of death are the same among males and females: heart disease, dementia, stroke, lung cancer and chronic respiratory disease, although not in the same order. Among males, lung/trachea cancer moves ahead of dementia.

Among males the sixth and seventh causes are prostate cancer and blood/bone marrow/lymphatic (hematopoietic) cancer, while tenth is intentional self-harm (suicide). Overall, males are more likely to develop cancer than females; the incidence of cancer in the age range 30–49 years is higher for females, but is surpassed by male cancer incidence from 60 years and onwards (Public Health Information Development Unit (PHIDU) 2012).

Causes of death with the greatest bias towards males (apart from sex-specific causes such as prostate cancer) are suicide (73.7%; 312 male deaths for every 100 female deaths), skin cancer (67.4%), cirrhosis and other liver diseases (66.5%), lung cancer (58.9%) and blood and lymph cancer (57.4%).

On a positive note, lifetime risky drinking significantly decreased for males between 2011 (29%) and 2015 (27%) and 52.8% of males reported engaging in 150 minutes of moderate intensity physical activity per week (July 2014-June 2016; SA Health, 2017 p.25).

With respect to wellbeing, males with low levels of English proficiency and reduced Internet access at home face barriers to gaining employment. There is a socioeconomic gradient associated with harmful alcohol consumption, with males in the most disadvantaged areas consuming alcohol at harmful levels. In 2016, 14% of males were daily smokers (females 12%); the highest proportion of male smokers (18.1%) was in the 45 to 59 year age group (Martin K., Bowden J. et al. 2017).

The locations with the highest rates of overweight and obesity for males in metropolitan Adelaide have quite distinct patterns, with overweight more concentrated in high socioeconomic status areas to the east and north-east, while obesity is more concentrated in low socioeconomic status areas to the west and north-west, and the outer north and south (Public Health Information Development Unit (PHIDU) 2016).

Identified gaps and priorities

The search did not find any material that explicitly defined gaps in needs, services or research, or particular priorities for action for the South Australian male adults population group.

Adult females/women's health

Demographic characteristics

At the 2016 Census, there were 850,652 females in SA, forming 50.7% of South Australia's population; this proportion is in line with the overall Australian population distribution (Australian Bureau of Statistics (ABS) 2017b).

Relevant documents

Seventy-five of the documents sourced provided information relevant to the SA female population. The documents were in a number of formats, including:

- 1 framework.
- 3 guidelines.
- 1 implementation plan.
- 1 issues paper.
- 5 plans.
- 3 policies.
- 1 policy discussion.
- 47 reports.
- 10 strategies.
- 1 submission.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.

Synthesis of findings

Among females in Australia, standardised death rates are highest for heart disease, dementia, stroke, chronic respiratory disease and lung cancer. Causes of death where the sex ratio is biased towards females (apart from breast cancer) are: dementia (65.4%; 53 male deaths per 100 female deaths); hypertensive disease (63.9%), cardiac arrhythmias (63.6%), stroke (59.9%) and heart failure (57.6%). Diseases of the urinary system are only in females' top 10 list (in 10th place), not males'.

Females between 30 and 49 years of age have the highest incidence rate of cancer. Breast cancer is the most common form, followed by colorectal cancer, lung cancer and melanoma (Public Health Information Development Unit (PHIDU) 2012).

In contrast to men's health, while there is a socioeconomic gradient associated with harmful alcohol consumption, it is females in the *least* disadvantaged areas who drink at harmful levels compared to those in the most disadvantaged areas (Public Health Information Development Unit (PHIDU) 2015).

One in eight females (11.9%) are daily smokers (Martin et al. 2017); however, rates of smoking during pregnancy have decreased over the previous ten-year period (Public Health Information Development Unit (PHIDU) 2015).

In South Australia, over the period 2003 to 2005, 16.6% of babies born to Aboriginal and Torres Strait Islander women were of low birthweight, compared to a substantially lower 6.7% of babies born to non-Indigenous women. By 2012–14, the proportions had declined to 13.1% for Aboriginal and Torres Strait Islander women and 6.4% for non-Indigenous women. Compared to the period 2003–2005, the proportion of babies who had a low birth weight in 2012–14 fell in most remoteness categories, with the largest decline in the Very Remote areas, where the rate fell by almost one-third (31.6%) (Public Health Information Development Unit (PHIDU) 2015).

Identified gaps and priorities

The search did not find any material that explicitly defined gaps in needs, services or research, or particular priorities for action for the South Australian female adult population group, apart from two references:

- In 2009, a report from SA Health recommended encouraging early intervention and treatment of conditions such as post-natal depression through raising awareness of the mental health needs of women in the perinatal period (Government of South Australia 2015).
- The low birthweight data suggest that public health campaigns and other preventive interventions to improve this aspect of maternal health are working relatively well in areas outside of the Major Cities, although the higher overall proportions for babies of Aboriginal and Torres Strait Islander women are of concern (Public Health Information Development Unit (PHIDU) 2015).

Aboriginal and Torres Strait Islanders

Demographic characteristics

In SA, at the 2016 Census, there were 34,184 Aboriginal and Torres Strait Islander people (referred to as Aboriginal people hereafter, in line with the preference of the Aboriginal Health Council of SA), forming 2% of South Australia's population; this proportion is in line with the overall Australian population distribution, as is the male:female ratio (Australian Bureau of Statistics (ABS) 2017b).

The Aboriginal population in SA has a younger age profile than non-Aboriginal people due to their higher chronic disease burden and consequent shortened life expectancy. Their median age is 23, compared to a median of 41 years for the SA population as a whole. The difference in the age profiles of Aboriginal and non-Aboriginal South Australians was clearly shown in Figure 9.

Half of the Aboriginal population lives in the metropolitan area and half in regional/remote SA. In the metropolitan area, Aboriginal people tend to reside around the Elizabeth/Blakeview/Virginia, Port Adelaide and Noarlunga areas. Although there are health and social welfare concerns for Aboriginal people throughout the state, these are more prevalent in rural and remote areas.

Relevant documents

Twenty-nine of the documents sourced provided information relevant to the SA Aboriginal population. The documents were in a number of formats, including:

- 1 framework.
- 1 implementation plan.
- 1 policy.
- 1 policy discussion.
- 18 reports.
- 6 strategies.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.
- judicial inquiries.

Synthesis of findings

The age difference between Aboriginal and non-Aboriginal people has multiple causes and strong implications for health and wellbeing - and is one of the clearest reasons behind the Australian Government's *Closing The Gap* (CTG) initiative, established in 2008 (Commonwealth of Australia Department of the Prime Minister and Cabinet 2017). While obviously not true of the whole cohort, Aboriginal people develop chronic diseases earlier and with higher prevalence; their hospitalisation rates are higher and often for longer periods; they have babies earlier in life and generally with lower birthweights; smoking rates are significantly higher and, while they have begun declining in recent years, are not declining as fast as among the non-Aboriginal population.

Cardiovascular diseases represent the most frequent cause of death for Aboriginal South Australians (26%). Aboriginal people experience heart disease and stroke at significantly younger ages than non-Aboriginal South Australians, peaking between 45 and 59 years of age, compared to 85 years of age for non-Aboriginal people (SA Health 2016, p.49).

To date, efforts under CTG have had mixed results (Commonwealth of Australia Department of the Prime Minister and Cabinet 2017), with many national targets not being on track, although there have been multiple improvements recorded, particularly at local or state levels. For example, the Prime Minister's 2017 report (Commonwealth of Australia 2017) showed that:

- nationally, the gap in mortality rates between Aboriginal and non-Aboriginal children under five has narrowed by 31% between 1998 and 2015, but the decline is not on track to meet the target of halving the gap by 2018. In SA, the mortality rates for the period 2011-2015 were 167 per 100,000 population for Aboriginal 0-4 year-olds compared with 69 for non-Aboriginal 0-4 year-olds.
- in 2015 in South Australia, there was no difference in the percentages of Aboriginal and non-Aboriginal children enrolled in early childhood education in the year before full-time school - each recorded at 100%. Only WA and the ACT had such favourable results. Full enrolment in SA was supported by strong attendance rates too - 97% and 99% respectively.
- in contrast, Aboriginal school attendance in SA (Years 1-10 combined) was slightly below the national average in 2014 and 2016 (81.1% each year, vs 83.5% and 83.4% nationally). The national rate was 93.1% for non-Aboriginal students.
- the 2016 NAPLAN results in reading, for Year 3 Aboriginal students in SA, showed 75% reaching the national minimum standards, compared with 81% nationally. However, SA and the ACT were the only states or territories on track to achieve the reading target of halving the gap between Aboriginal and non-Aboriginal students in all NAPLAN years (Years 3, 5, 7 and 9). SA results were also on track for Year 7 and 9 numeracy, but not for Years 3 or 5.
- the target to halve the gap in Year 12 attainment by 2020 is on track, both nationally and in SA; the state result is that 81.0% of 20-24 year-olds have achieved Year 12 or equivalent, up from 53.6% in 2008.
- Indigenous mortality rates did not change significantly in SA or NSW between 1998 and 2015, although rates declined by 30% in WA, 20% in Queensland and 14% in the NT. Across these jurisdictions, Aboriginal mortality remains at 1.7 times the non-Aboriginal rate and the reduction is not on track to meet national targets.

As part of its recent analysis (Gibson O, Peterson K et al. 2017a), of Aboriginal health needs and gaps in South Australia, SAHMRI reported:

- in South Australia, 35.4% of all Aboriginal participants self-reported a disability, compared to 23.6% of non-Aboriginal participants, and this difference was statistically significant.
- during the period 2006 to 2012, Aboriginal people in country South Australia had an age-standardised death rate of 9.5 per 1,000 population, compared to 6.3 per 1,000 population in non-Aboriginal people (a rate difference of 3.2 per 1,000).
- overall, external causes including suicide and transport accidents are the leading causes of death for both Aboriginal and non-Aboriginal young people, while chronic diseases were the major causes of death from mid-adulthood onwards. The leading causes of death across the life course were relatively similar in Aboriginal and non-Aboriginal people in South Australia, though there were key differences. Diabetes mellitus and liver diseases ranked highly for Aboriginal people from age 45 but were not one of the five leading causes of death for non-Aboriginal people.
- the proportion of Aboriginal people aged 15 and over in South Australia who felt that they had been badly treated in the past 12 months because they were Aboriginal or Torres Strait Islander ranged between 15% and 21% across the five LHNs. A higher proportion of Aboriginal women than men reported being treated badly.
- in 2011 in South Australia, an estimated 35.8 per 1,000 Aboriginal people and 2.9 per 1,000 non-Aboriginal people were homeless. The majority of Aboriginal people who were homeless were living in 'severely' crowded dwellings, followed by living in supported accommodation for the homeless, and staying in boarding houses. The pattern was different for non-Aboriginal people who were homeless, with the majority living in supported accommodation for the homeless, followed by people staying in boarding houses.
- in 2014-15, a higher proportion of Aboriginal participants in SA reported not exceeding national guidelines for alcohol consumption, compared to non-Aboriginal participants. Lifetime risk of alcohol consumption was lower among Aboriginal men and women than their non-Aboriginal counterparts.

- reflecting the younger age at which Aboriginal women give birth, ‘delivery’ was the most prevalent reason for hospital admission among Aboriginal females aged 15-34 and for 25-44 year old non-Aboriginal females.
- the age-standardised hospital separation rate for injury and poisoning for Aboriginal people aged 0 to 79 years was 1.5 to two times higher than for non-Aboriginal people.
- among Aboriginal people, 25-34 year-olds had the highest rate of suicides (4.5 per 10,000 population), with the second highest rate being among 15-24 year-olds (3.8 per 10,000 population).

The reduction of the smoking rate among pregnant women in all Remoteness Areas, and the narrowing of the gap between Very Remote and other areas, suggests that public health campaigns and other preventive interventions to improve maternal health are having an ongoing impact. However, the stubbornly high rates among Aboriginal and Torres Strait Islander women remains a major concern (Public Health Information Development Unit (PHIDU) 2017).

In 2015, the Aboriginal Health Council of SA and SAHMRI developed the *Next Steps In Aboriginal Heath Research report*, which provided guidelines for the ways in which health research should be undertaken within Aboriginal communities and ACCHOs (King and Brown 2015). As part of that project, the *South Australian Aboriginal Health Research Accord* was developed and signed by SAHMRI and the main universities; this should be adhered to in any research involving Aboriginal people in South Australia.

Identified gaps and priorities

Three strategies dealing with specific health conditions among Aboriginal people in South Australia had been completed in the previous two years – the SA Aboriginal Heart and Stroke Plan, the SA Aboriginal Diabetes Strategy and the SA Aboriginal Cancer Control Plan (Brown, Keech et al. 2016, Gibson O, Eltridge F et al. 2016, SA Health 2017b). Each strategy had multiple recommendations for actions that would support improvements in Aboriginal health. This year, numerous health organisations, under the auspices of the SA Academic Health Science and Translation Centre and the SA Aboriginal Health Partnership, have come together to form the SA Aboriginal Chronic Disease Consortium. *“The consortium will address priorities specific to each plan, as well as priorities which span the three plans.”* (SA Academic Health Science and Translation Centre website).

The consortium has brought together an Executive Group, an Aboriginal Community Reference Group and three, condition-specific working groups. SA Health has provided seed funding and the innovative, collaborative approach to sector-wide coordinated reform results from the commitment by the SA Aboriginal Health Partnership (which comprises SA Health, the Aboriginal Health Council of SA (AHCSA) and the federal Department of Health), the SA Academic Health Science and Translation Centre (SA Centre), and key Aboriginal health providers in South Australia.

The SA Centre itself is already a collaborative partnership between SA Health, SAHMRI, the three major SA universities, AHCSA, Health Consumers Alliance of SA, both the Adelaide and Country SA Primary Health Networks and Cancer Council SA. The SA Centre is a virtual organisation administered by SAHMRI, with seven priority areas, one of which is Aboriginal Health.

Older people

Demographic characteristics

South Australia had 306,589 people aged 65 years or over at the 2016 Census, representing 18.3% of the state’s population, compared with 15.1% nationally. In SA, 44,479 people (2.8% of SA’s population) were aged 85 years and over (Australian Bureau of Statistics (ABS) 2017b).

As Figure 3 shows, SA’s population has consistently been relatively older than Australia’s, but it is ageing more rapidly, with SA’s proportion aged 65 or older having grown by 4.3% since 2001, compared with 3.1% growth nationally.

South Australia’s population is ageing faster than other mainland states and, by 2031, there will be more than 440,000 people aged over 65, making up more than 20% (1 in 5) of South Australia’s total population (SA Health, 2012).

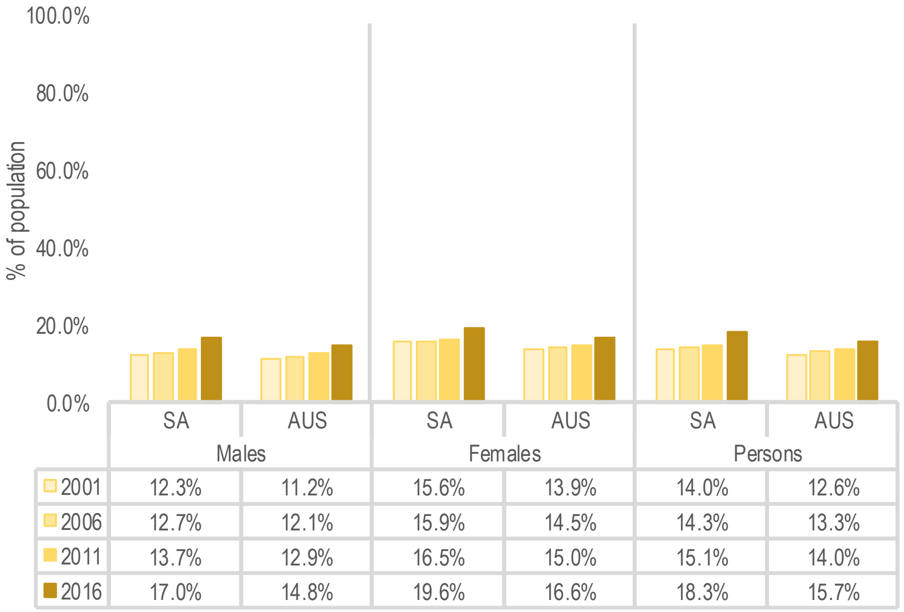
Relevant documents

Twenty-five of the documents sourced provided information relevant to the SA older population. The documents were in a number of formats, including:

- 1 framework.
- 3 guidelines.
- 1 plan.
- 2 policies.
- 15 reports.
- 2 strategies.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.



	Males SA	Males AUS	Females SA	Females AUS	Persons SA	Persons AUS
2001	12.3%	11.2%	15.6%	13.9%	14.0%	12.6%
2006	12.7%	12.1%	15.9%	14.5%	14.3%	13.3%
2011	13.7%	12.9%	16.5%	15.0%	15.1%	14.0%
2016	17.0%	14.8%	19.6%	16.6%	18.3%	15.7%

Figure 11: Percent of population aged 65 or older, 2001-2016, SA vs Australia (Australian Bureau of Statistics (ABS) 2017b)

Synthesis of findings

Not unexpectedly, older people aged 65+, living in areas deemed to be socioeconomically disadvantaged and who are dependent on the aged pension, are at risk of poor health and wellbeing (Public Health Information Development Unit (PHIDU) 2016). There is a socioeconomic gradient associated with the prevalence of self-reported chronic conditions (specifically diabetes, respiratory conditions, behavioural and mental health issues) and cancer rates peak at 80+ years of age (Public Health Information Development Unit (PHIDU) 2015).

SA Health has published three guidelines for age-friendly neighbourhoods and residential development, based on the connection between social participation and health and wellbeing. The guidelines also suggest that governments can be leaders for other employers by adopting age-friendly employment practices, adapting work places and supporting training to assist older people to transition to other career options.

Older people with a culturally and linguistically diverse (CALD) background are reported to be at increased risk of mental health issues; for example, cultural perceptions related to dementia can contribute to delays in treatment-seeking behaviour (Principe 2015).

When it comes to behavioural factors, however, figures among older people are more positive than generally, with a below average proportion (8.8%) of adults aged over 60 being daily smokers in 2016 (Martin K., Bowden J. et al. 2017). The same group was in the lowest proportion of risky alcohol consumers in 2015 (Longo and Cooke 2016).

According to the Australian Commission on Safety and Quality in Health Care, nearly one in three people over 70 years of age admitted to hospitals will have some form of cognitive impairment. Approximately 20% of these will have dementia, 10% are admitted with delirium and a further 8% will develop delirium during their hospital admission. By 2020, SA is projected to have 32,061 people with dementia. Adults of all ages can develop dementia, but it remains a low-prevalence disease among people in their 40s, 50s and 60s. The substantial increases in prevalence are projected for people aged 80 years and over.

These projections have significant implications for demand for health services, given that people with dementia are known to have multiple morbidities. People aged 80 years and over constitute only 5% of the population, but more than 25% of the overnight occupied bed days in South Australia. As a consequence, demand for hospital inpatient services is highly sensitive to increases in the number of people aged 80 years and older.

Identified gaps and priorities

The *SA Health Services Plan for People with Dementia (and Delirium) 2015-2018* (SA Health 2015b) describes what consumers and carers want, how the health system will need to change to better align service provision with what consumers and carers want, and how to maximise the use of existing levers to drive change. This plan focuses on five areas requiring reform:

- education and training.
- diagnosis.
- communication within and between services.
- hospitals.
- end of life care.

In another report, the government seeks to ensure that older people receive the relevant support, through appropriate services, with respect to the development and management of geriatric conditions, including dementia (Government of South Australia 2015).

Migrants/asylum seekers

Demographic characteristics

At the 2016 Census in South Australia three in ten residents (28.9%) were born overseas. The most common countries of birth besides Australia were England (5.8%), India (1.6%), China (1.5%), Italy (1.1%) and Vietnam (0.9%) (Australian Bureau of Statistics (ABS) 2017b).

Apart from the 'born overseas' category in the Census, information on migrant and asylum seeker numbers in South Australia is not evident, despite extensive searching.

Relevant documents:

Fifteen of the documents sourced provided information relevant to the SA migrant/asylum seeker/refugee/ CALD population. The documents were in a number of formats, including:

- 1 framework.
- 1 implementation plan.
- 2 policies.
- 9 reports.
- 1 strategy.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.

Synthesis of findings

Although information on population numbers is sparse, the Health Performance Council identified in 2014 that the CALD population (migrants and asylum seekers alike) has reduced access to health services, which contributes to inequitable health outcomes when compared to other population groups (Principe 2015). Apart from their reduced understanding of the health system and how to access services, language barriers and health or community services that are not culturally appropriate are significant barriers to both young and older people from a CALD background achieving or maintaining good health and wellbeing.

Mental health issues and trauma appear to be priority issues for the CALD population, with myriad factors contributing. Among older people, apart from cultural differences, dementia can contribute to delays in treatment-seeking behaviour (Principe 2015). For younger people (children and adolescents), trauma associated with the refugee experience, including exposure to conflict, violence and family separation, is prevalent and only a small percentage of this population has sought assistance. For asylum seekers, mandatory detention contributes to poor mental health and impacts social wellbeing (Australian Human Rights Commisson 2017). Resilience in the adolescent refugee population has been demonstrated to be lower than indicated in other, non-refugee populations and lower levels of resilience have been associated with depression and emotional and behavioural problems (Ziaian, de Anstiss et al. 2012).

Identified gaps and priorities

It appears that South Australia does not have a policy framework, action plan or monitoring process that is specific to health care services for the CALD population.

LGBTIQ

Demographic characteristics:

The 2016 Census data on this has not yet been released but, at the 2011 Census, there were 33,715 same sex relationships reported as de facto or husband/ wife partners, which equates to 0.7% of all couple relationships counted in that year's Census. Of the total, 17,583 of those couples were reported as same sex male relationships, with 16,131 being reported as same sex female (Australian Bureau of Statistics (ABS) 2011).

In South Australia, 0.5% of all couple relationships were recorded as same-sex (n=1,930). The same-sex male/ female breakdown is not readily available.

Demographic data on other categories within the LGBTIQ population are also not readily available.

Relevant documents

Eight of the documents sourced provided information relevant to the SA LGBTIQ population. The documents were in a number of formats, including:

- 1 framework.
- 1 implementation plan.
- 5 reports.
- 1 strategy.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.

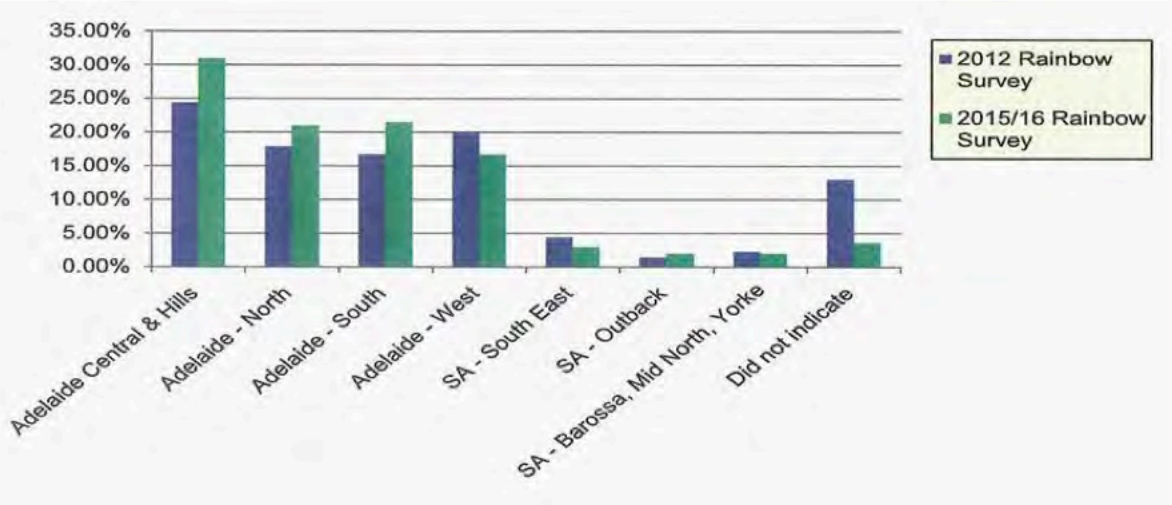


Figure 12: Rainbow Survey 2015 vs 2012: distribution of respondents, by ASGS region (Department for Communities and Social Inclusion (DCSI) 2017)

Synthesis of findings

In 2014, the SA Government released its *South Australian Strategy for the Inclusion of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer People (LGBTIQ) 2014-2016*, (Department for Communities and Social Inclusion (DCSI) 2016), which had been developed by the Department for Communities and Social Inclusion (DCSI) with the advice and assistance of a 15-member Rainbow Advisory Council.

This Strategy suggests that the greatest issues facing the LGBTIQ community are violence, discrimination and homelessness. Further, certain health conditions reflect patterns of health particular to the LGBTIQ community, including: specific cancers and sexually transmitted infections in gay men, cervical and ovarian cancers in lesbians and issues relating to hormone therapy and surgical intervention in transgender people.

Suicidal ideations and rates of depression are higher in the LGBTIQ community than in any other population in Australia (National LGBTI Health Alliance 2013), and LGBTIQ people are 14 times more likely to commit suicide than heterosexual people (Beyond Blue 2014). Rates of smoking in this population are high in comparison to other populations (National LGBTI Health Alliance 2013).

In 2015, DCSI repeated its 2012 Rainbow Survey among the LGBTIQ community, with the following outcomes noted in the report (Department for Communities and Social Inclusion (DCSI) 2017, p.10):

- 25.1% between the ages of 18 and 25; 13% between the ages 55 and over 75 (sic).
- 33.1% identify as lesbian; 29.3% as gay; 13.4% as bisexual; 4.5% as pansexual.
- 16.1% identify as transgender.
- 47.6% identify as female; 34.7% identify as male.
- 17.7% described their gender as other than the strict male/female binary.
- 0.9% identify as having an intersex variation (3 respondents).
- 87.6% live in metropolitan Adelaide.
- 3.3% identify as Aboriginal.
- 15.9% born outside Australia.
- 34.6% live in areas represented in the SEIFA index's two most disadvantaged categories.
- 25.4% indicated a long term health condition and/or disability.

The graph above from the report compares data on South Australian geographical location from the 2012 and 2015-16 Rainbow Surveys, based on South Australia's seven main statistical regions. A higher percentage of LGBTIQ people in the survey live in metropolitan Adelaide compared to the rest of the state's population, although this may reflect survey participation rather than actual population distribution.

Identified gaps and priorities

From the 2015 Rainbow Survey report (Department for Communities and Social Inclusion (DCSI) 2016, p.14):

When asked to rate their health, 75% of respondents to the question reported 'excellent', 'very good' or 'good' health. Notably, not one person who identified as transgender rated their health as 'excellent'. This indicates a greater need to identify and address health issues that are specific to the transgender community, and improve the relationship between this community and traditional health services. …

73.5% of the 54 transgender respondents reported seeking psychological or medical help in relation to their transgender status. Many reported positive experiences:

- *42.9% found their GP informative and helpful*
- *66.7% found their psychologist or psychiatrist informative and helpful*
- *54.2% found their specialist or care provider informative and helpful.*

Given that one-third to half of the respondents did not note their health service provider as informative and helpful, there would appear to be opportunities to improve these interactions. However, the report goes on to say (DCSI, 2016, p.15):

> *… none of the respondents explicitly stated that they based their negative perceptions on 'previous bad experiences'. The barriers outlined by respondents highlights a need to better educate and support healthcare professionals to understand issues that are important to transgender people. This is even more important given that many of the transgender respondents who did seek help felt that their GP wanted to assist but could not offer what they needed. The findings also correlate with other research indicating that many transgender people postpone medical care, due to fear of discrimination or lack of confidence in a service provider's ability to handle or understand transgender issues.*

Rural and remote populations

Demographic characteristics

At the 2016 Census, the population of Greater Adelaide was 1,324,279 people, which accounted for 77.3% of the state's total population. In 2011, the Greater Adelaide population was 1,264,091 (77.1%).

The 22.7% of the Rest of SA was split between the South East (11.1%), Barossa-Yorke-Mid North (6.6%) and the Outback (5.0%).

Relevant documents

Twenty of the documents sourced provided information relevant to the SA Rural and Remote population. The documents were in a number of formats, including:

- 1 framework.
- 2 plans.
- 1 policy.
- 11 reports.
- 4 strategies.

The documents identified were from various sources, including:

- State Government bodies.
- university-based data centres.
- community-based consumer and advocacy bodies.
- mental health organisations.
- community groups.
- university research centres, and academics.

Synthesis of findings

Where people live is identified as a contributor to health and wellbeing. Typically, people who live in rural and remote locations have worse health and wellbeing and are at greater risk of poor health than their metropolitan counterparts. The Barossa Valley, Mid-North and Yorke regions of South Australia are identified as being particularly vulnerable (Health Consumers Alliance of South Australia 2014). Older adults in rural areas are considered to be a particularly vulnerable group (Health Consumers Alliance of South Australia, 2014).

The prevalence of Type 2 diabetes, cancer, cardiovascular disease and mental health conditions are higher in rural and remote areas compared to metropolitan areas (Health Performance Council 2013). Country hospital admissions were most commonly associated with renal dialysis, general medicine, orthopaedics, cardiology and general surgery (Country Health SA LHN, 2016).

SA Health's 2009 *Chronic Disease Action Plan for South Australia* describes that rural and remote populations have been found to have poorer health outcomes in relation to chronic disease and associated risk factors than the general population. South Australians in regional and remote areas have higher incidences of behavioural risk factors such as smoking, high-risk alcohol consumption, overweight or obesity and physical inactivity than their urban counterparts. Smoking and high-risk alcohol consumption is increasing in regional areas while declining in urban areas. Obesity and overweight are increasing faster in regional areas than in urban areas. In South Australia in 2005, four of the seven country health regions had the highest burden of mortality and morbidity for the prioritised chronic diseases.

SA's *Oral Health Plan 2010–2017* reveals that people living in rural and remote areas experience between 25% and 30% more dental caries than metropolitan children aged 11 to 12 years, and 25% to 30% more extreme disease experience in deciduous teeth. The rate of complete tooth loss in country areas is one-third higher in the over 55 year age group when compared with metropolitan Adelaide residents of similar age, and 62% higher across all ages for rural residents.

Mental health is a proportionally greater burden in rural and remote areas and help-seeking behaviours are reportedly reduced in comparison to metropolitan areas, attributed in part to the stigma associated with mental illness. Despite this, hospitalisations related to mental health conditions are higher in rural and remote locations, compared to metropolitan locations. In 2009-10, rural and remote South Australia had an admitted mental health patient rate of 14.1 per 1,000 residents, compared to 10.4 for metropolitan Adelaide and 10.0 for Australia overall. In its 2013 report on *Mental Health in Rural and Remote South Australian Communities*, the Health Performance Council highlights that rural and remote communities have a larger percentage of people with mental health issues and are also less effective at treating these conditions.

In the development of that report, consultation participants noted a stigma and a culture of self-reliance reducing the likelihood of South Australians living in rural and regional areas seeking help before mental crises. Data seem to support this impression by indicating a regional difference for people experiencing mental health problems seeking professional help. In 2012, people living in the Adelaide area diagnosed with a current mental health problem were more than twice as likely to seek help as rural and regional South Australians, with just under one in five people with mental health problems who live in the metropolitan area reporting that they are seeking help, compared to less than one in ten country residents with a mental health problem.

Identified gaps and priorities

The search found no material that explicitly defined gaps in needs, services or research, or particular priorities for action for the South Australia's rural and remote populations.

People in or leaving the justice system

Demographic characteristics

As at 01 June 2017 there were 1167 adult prisoners on remand and 1867 sentenced adult prisoners, making a total of 3024 in custody at that time. Remand prisoners were most often being held for assaults (335) or offences against justice procedures (237). Sentenced prisoners were most often in custody for sexual assaults (375), homicide (230), offences against justice procedures (216) and assaults (191).

Between 2014 and 2017, the number of prisoners being held on remand had increased by 41%; the number being held as sentenced prisoners increased by 12% during the same period.

Among the 2017 prisoner numbers were 310 and 374 Aboriginal adults who were respectively on remand and sentenced. Those figures equate to 26.6% and 20.0% of the adult prisoner population and the numbers had increased by 30% and 9% respectively between 2014 and 2017.

Among the total, 120 of the remand prisoners and 98 of the sentenced prisoners were women. Those figures represent changes, since 2014, of +88% and -2% respectively.

In total, 3961 remand prisoners were discharged in the 12-month period prior to 1 June 2017, as were 2268 sentenced prisoners, making 6229 adults being discharged from the justice system in that period. Those were 46% and 47% increases respectively since 2014.

These data are sourced from the Attorney-General's Department website (Attorney-General's Department 2017).

Relevant documents

Apart from the website data, three of the documents sourced provided information relevant to the SA justice system population. The documents were in a number of formats, including:

- 1 framework.
- 1 policy.
- 1 report.

The documents identified were from:

- a State Government body.
- community-based consumer and advocacy body.
- university research centres, and academics.

Synthesis of findings

The findings of this review indicate that prisoners, and people who have been involved in the criminal justice system, are recognised as being at risk of poor health and mental health issues (Health Consumers Alliance of SA 2014, Government of South Australia 2015). Despite this, there is no South Australian-specific published literature relating to the health and wellbeing status or needs of this underserved population. Instead, recommendations are made to incorporate this population in health and wellbeing considerations.

Identified gaps and priorities

Recommendations include that programs should be developed to prevent people who have a mental illness from entering the prison system; and that those already in the prison system should have access to programs that support their health and wellbeing. Further, people leaving the corrections system should be referred to community-based mental health services. Better integration of government and non-government services with the Department for Correctional Services is recommended to deliver mental health services to this population while within, and as they transition from, the justice system (Government of South Australia 2015).

Key findings: Health Omnibus Survey

Short Form Health Survey (SF-12)

Self-perceived general health status

The 2017 Health Omnibus Survey (HOS) included the standardised, internationally-used, 12-question Short-Form Health Survey (SF-12), free of charge for all clients. A summary of the SF-12 results is included below, analysed first in order to provide additional context for the questions commissioned on behalf of Fay Fuller Foundation.

In the first of these questions, people were asked whether, in general, they would say their health is excellent, very good, good, fair or poor. Eight in ten people said their health was good or better, including 17% who nominated excellent and 37% who said very good.

No differences were noted by region or sex and the trend by age was entirely predictable, as can be seen in Figure 13.

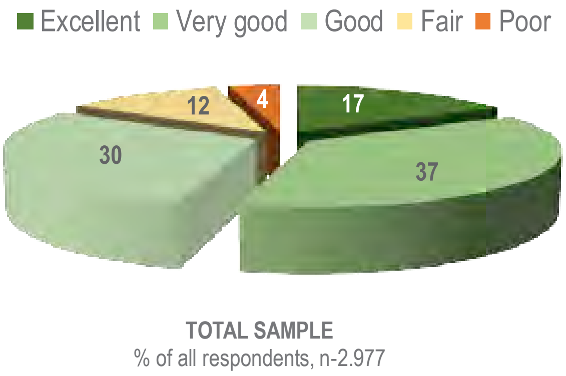


Figure 13: Self-perceptions of general health (unprompted)

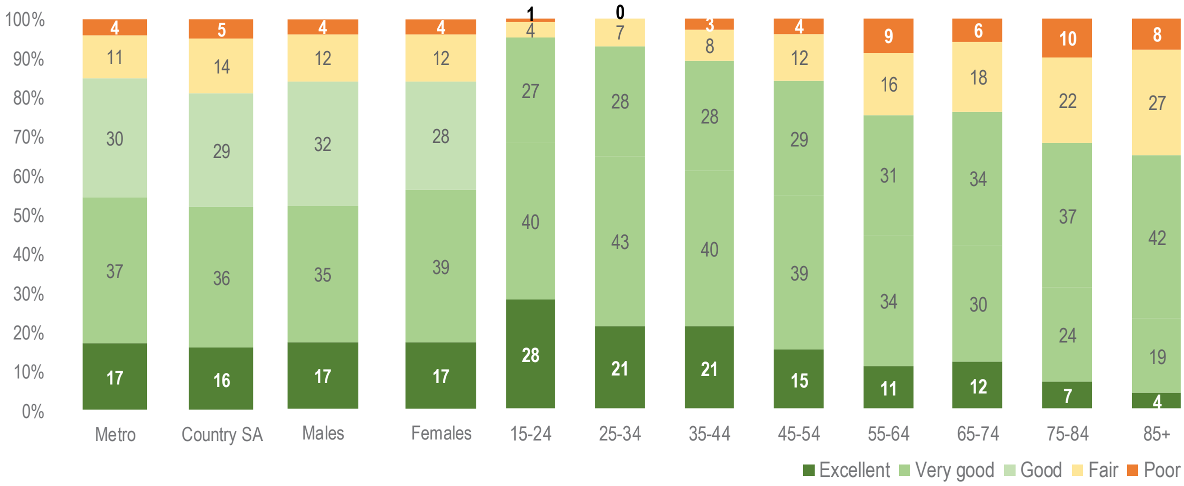


Figure 14: Self-perceptions of health x region, gender and age

The 2017 HOS results tend to agree that being married is good for your health. As Figure 14 shows, the proportions of married/de facto respondents in each major age group who said their general health was good or better was significantly higher than those who were separated/divorced, widowed or never married.

There are clear statistics nationally, as well as in South Australia, that show actual health status is significantly worse among Aboriginal people than among non-Aboriginals. In the 2017 Health Omnibus Survey, the difference by Aboriginal status was indicative, but not statistically reliable due to the small sample of Aboriginal people (n=61) who participated in the survey. While a sub-group of 61 people is large enough to validly measure statistical reliability, the confidence interval is too large in this question for the apparent differences to be statistically significant.

It should be noted, however, that the sample of Aboriginal people in the 2017 HOS was in line with the population. Aboriginal sampling in any random household survey will, inherently, include some selection bias (and the APY Lands are not included in HOS), but 3% of the 2017 sample (n=53) identified as Aboriginal (none as Torres Strait Islander or both) and those people were split 59% metropolitan and 41% country. This compares quite well with SA's 2016 Census, in which 2% of the state's population was Aboriginal, Torres Strait Islander or both, with half living in metropolitan Adelaide and half in regional SA.

As would be expected, people living with lower household incomes and those with no tertiary education tended to have poorer perceived health. A clear trend is shown in Figure 16.

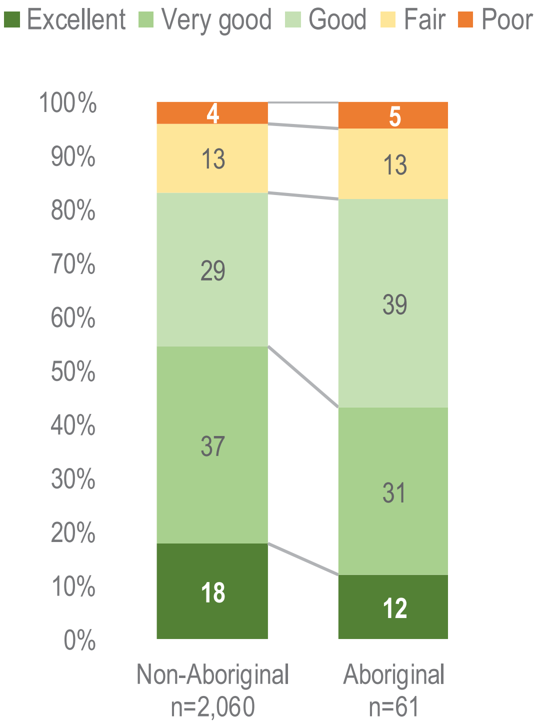
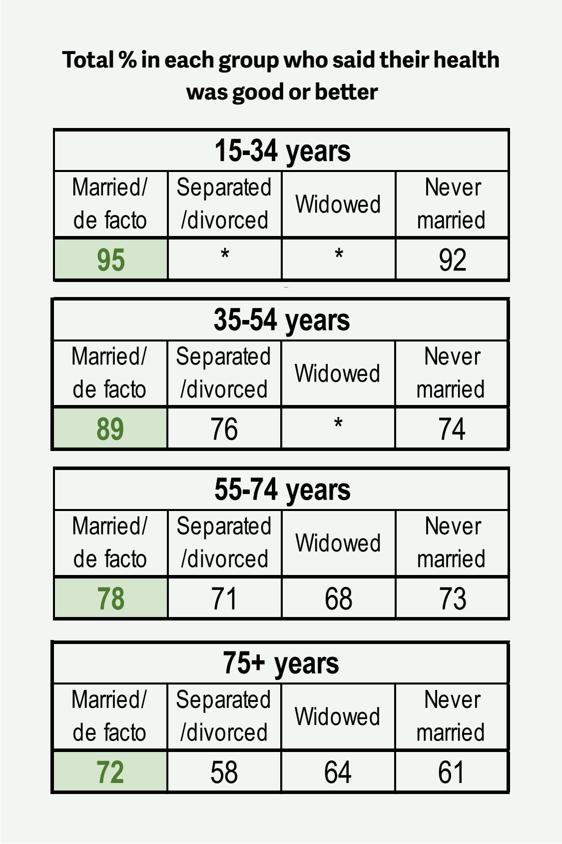


Figure 15: Self-perceptions of health x Indigenous status



Total % in each group who said their health was good or better

15-34 years			
Married/ de facto	Separated /divorced	Widowed	Never married
95	*	*	92

35-54 years			
Married/ de facto	Separated /divorced	Widowed	Never married
89	76	*	74

55-74 years			
Married/ de facto	Separated /divorced	Widowed	Never married
78	71	68	73

75+ years			
Married/ de facto	Separated /divorced	Widowed	Never married
72	58	64	61

Table 11: Self-perceptions of health x marital status

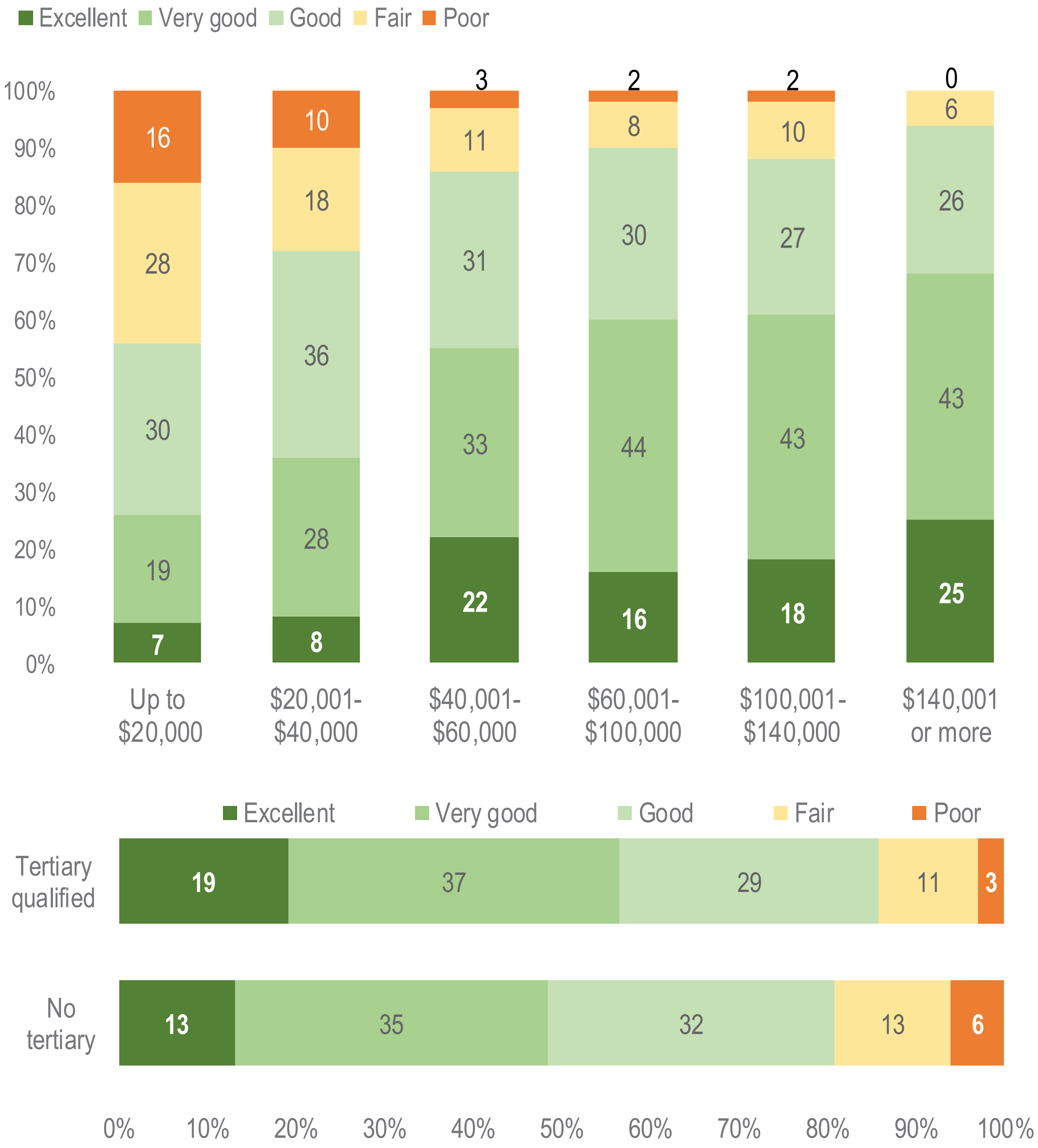


Figure 16: Self-perceptions of health by household income and tertiary qualifications, HOS 2017

Activity limitations

One-quarter of the respondents noted health limitations in undertaking moderate activities, climbing several flights of stairs, accomplishing daily activities or limited in work.

Pain interfered with normal work to some extent for half the sample, and to a moderate or greater extent among 20%.

Emotional limitations

Seventeen per cent have accomplished less than they would have liked due to emotional problems such as feeling depressed or anxious.

Twelve per cent did not do work or other activities as carefully as usual for the same reasons.

All or most of the time: 53% have felt calm and peaceful; 41% had a lot of energy; 8% have felt downhearted or blue; health or emotional problems interfered with social activities for 7%.

These data are summarised in Figure 18.

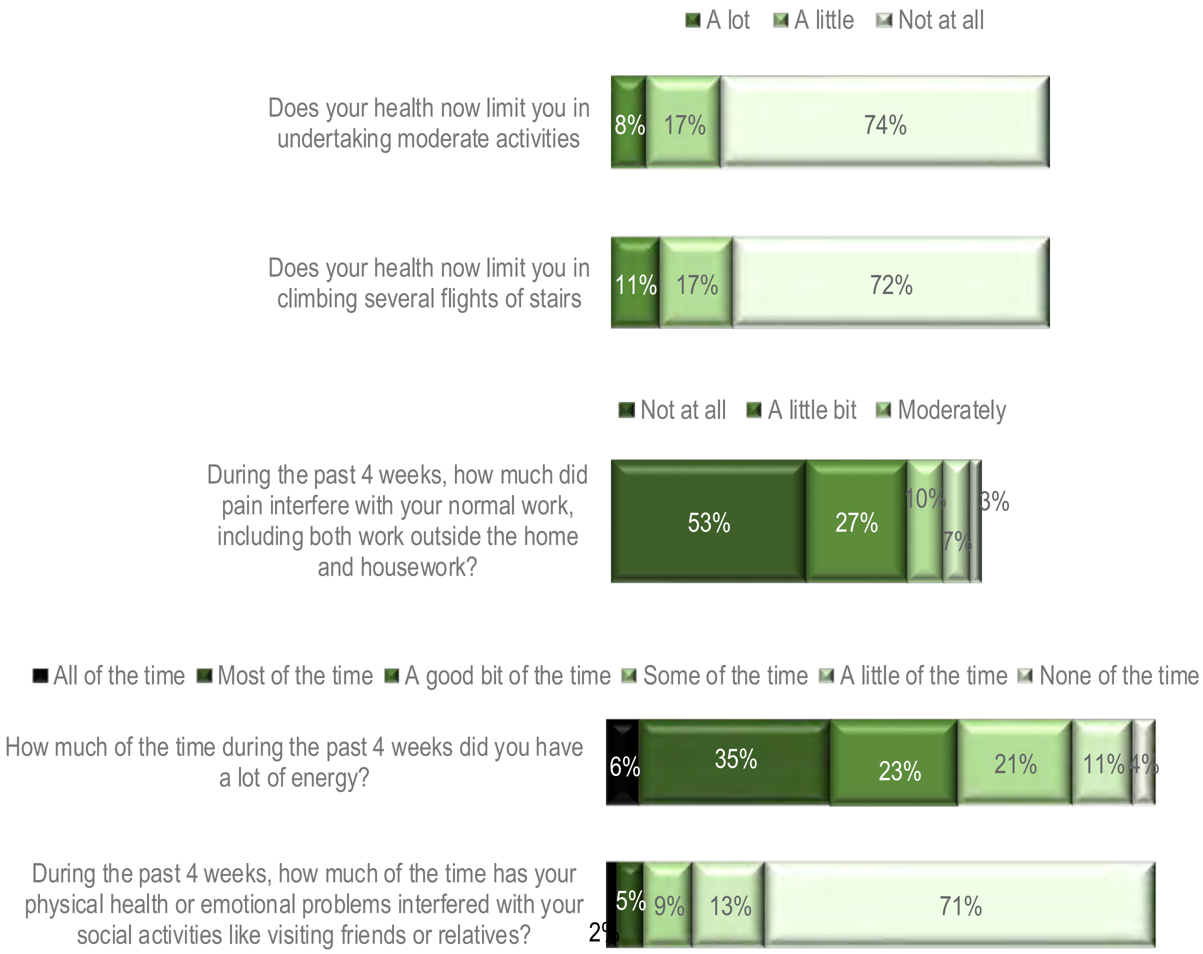


Figure 17: Limitations noted regarding physical activity, HOS 2017

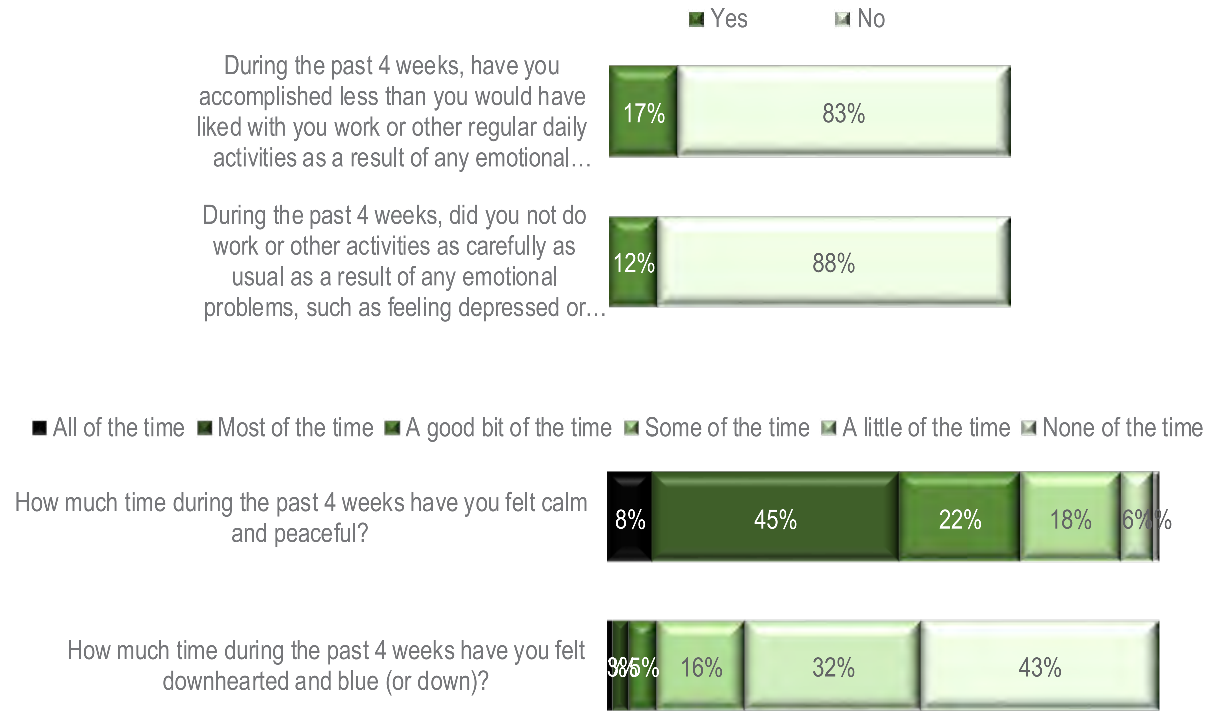


Figure 18: Limitations noted regarding emotional wellbeing, HOS 2017

Most important health or wellbeing issues personally faced

All respondents in the 2017 Health Omnibus Survey were asked: *What is the single biggest health or wellbeing-related issue that you personally face?* All responses were spontaneous and recorded verbatim. They have subsequently been coded and summarised into categories to aid analysis.

Two-thirds of the sample identified a main health or wellbeing concern, while one-third (32%) said they had none or were unable to think of any. Clearly, respondents' own physical health issues topped their health and wellbeing concerns, specified by one-third (35%). Personal mental health issues came next, listed by one in nine respondents (11%).

Financial issues were the most common 'other' response (2%).

Clearly, there were differences by age group, but none of them were unexpected:

- personal physical health and wellbeing issues were specified by significantly higher proportions in the 55+ age groups.
- personal mental health issues were significantly more common among 15-34 year-olds (18%) and significantly lower among those aged 55 and over (6%).
- interestingly, ageing was mentioned by just 12% of those aged 65 or over. While this is significantly higher than in any of the younger age groups, it remains a relatively small minority.
- half of 15-24 year-olds and four in ten 25-34 year-olds were unable to think of any personal health or wellbeing concerns. The converse of this, of course, is that half and six in ten respectively of these age groups did list issues. In contrast with the overall sample, physical and mental health issues were mentioned with statistically equal frequency among these two age groups (see Figure 20).

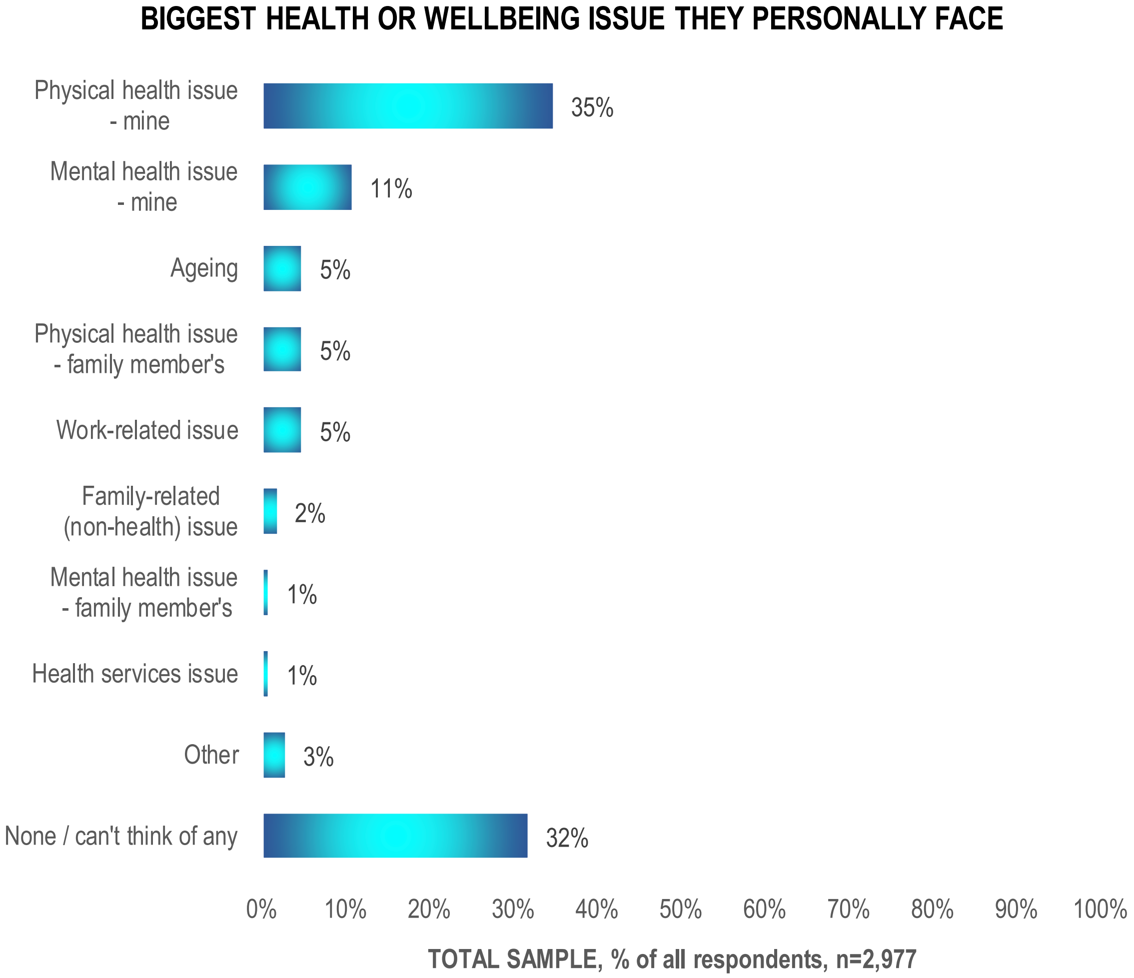
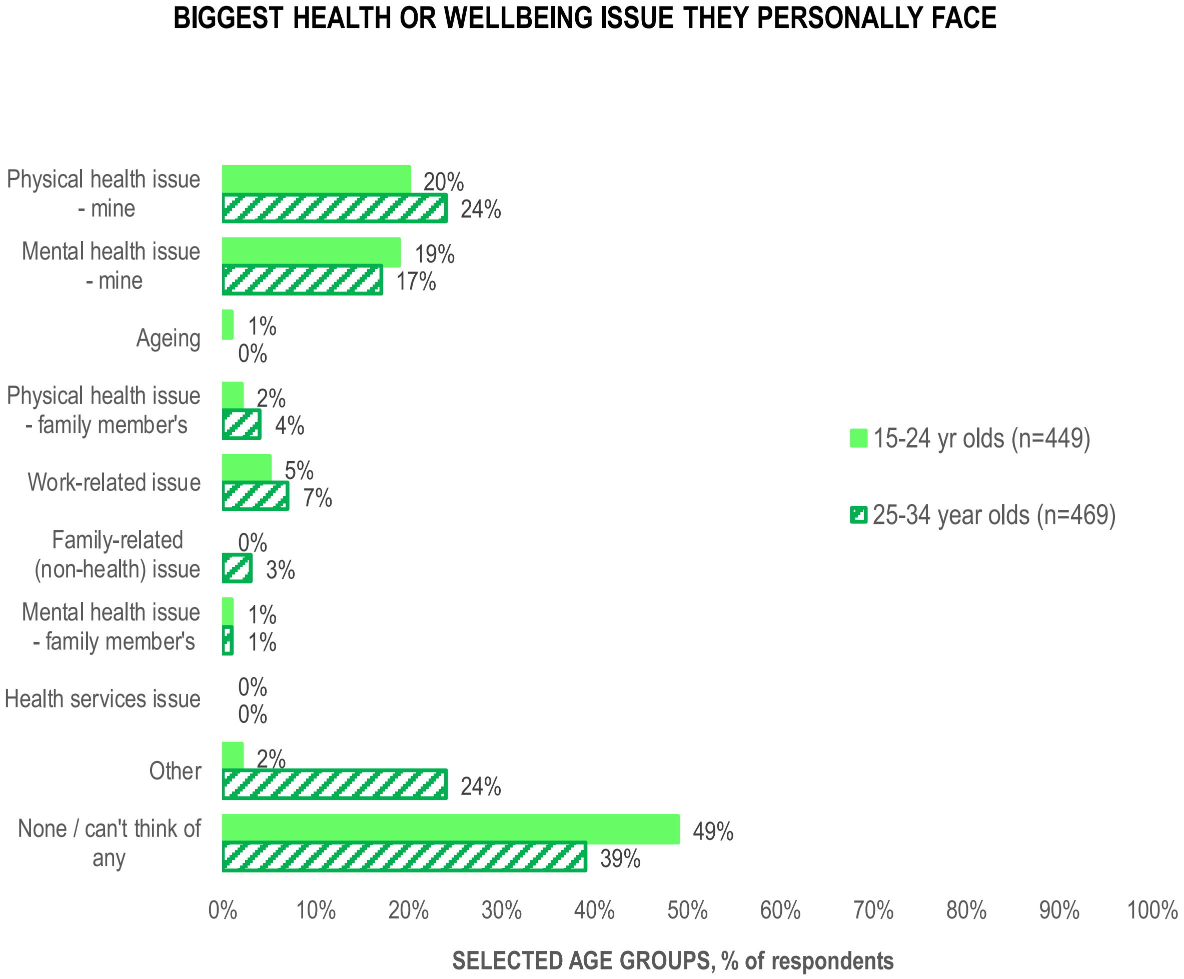


Figure 19: Most important health or wellbeing issue personally faced, HOS 2017

Other significant differences worth noting included:

- married/de facto respondents listed personal mental health issues significantly less often than others (8% vs 14% separated/divorced and 19% never married).
- forty-three per cent of respondents in households with annual incomes below $40,001 specified a physical issue as their biggest personal health or wellbeing concern – significantly more than those from higher income households (33%-39%).
- the proportion specifying at least one health or wellbeing concern (i.e. the inverse of ‘none/can’t think of any’) was significantly higher among people with tertiary qualifications (degree, diploma or trade qualification) than among those without (71% vs 63% respectively).

The health or wellbeing categories specified by 5% or more of the total sample (i.e. respondents’ own physical health, their own mental health, work-related issues, ageing and family members’ physical health) are analysed in more detail in the following sub-sections.



BIGGEST HEALTH OR WELLBEING ISSUE THEY PERSONALLY FACE

Figure 20: Most important health or wellbeing issue personally faced by selected age groups, HOS 2017

Biggest personal health or wellbeing issues – physical health (own)

Thirty-five per cent of the HOS sample (1052 people) had specified items with their own physical health as their biggest issue for health or wellbeing. Their responses were extremely varied, as would be expected among that many people. Musculoskeletal issues (17%) and weight (15%) topped their list, with arthritis coming in third at 9%. Cancer was the only other item specified by more than 5%.

While the 'other' category looks large, none of the items grouped there was mentioned by more than 1% of the personal physical health sub-sample.

There were isolated statistical variations among some of the sub-groups, but the ones that might be relevant or of interest to this study were:

- pain was the top response (11%) among those who classed their health status as 'poor', followed by respiratory (9%), musculoskeletal (9%) and other chronic disease (8%).
- weight was noted by 20% of these 1052 respondents who were employed (n=502), compared with 10% of those not then employed (n=551).
- weight was clearly the top response (31%) among the 15-34 year-olds who listed a physical health related issue as their biggest concern (n=200).

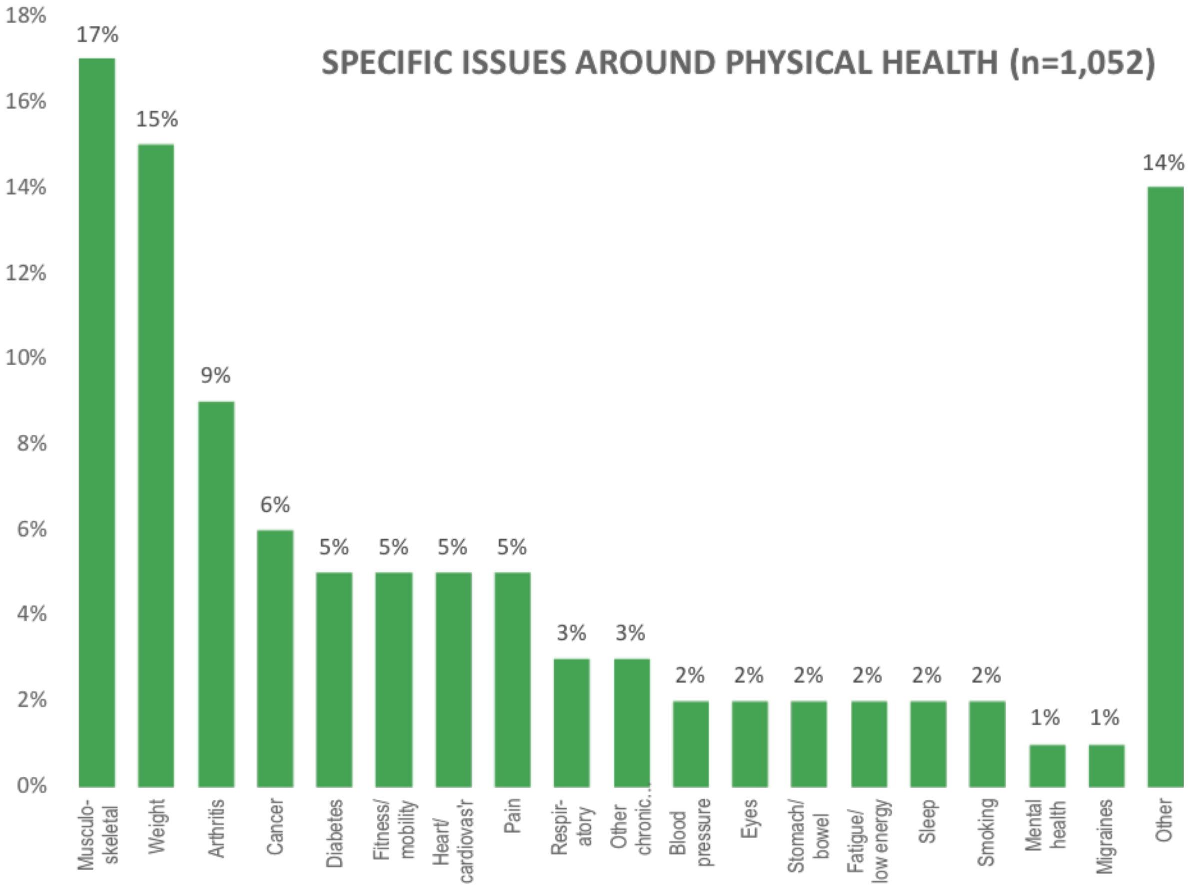


Figure 21: Biggest personal physical health issues, HOS 2017

Biggest personal health or wellbeing issues - mental health (own)

Eleven per cent (327 people) had nominated mental health subjects as their biggest personal health or wellbeing issue. These have been coded as shown in Figure 22, but briefly:

- stress and anxiety were each specified by one-quarter of these respondents.
- a further 18% nominated depression.
- 6% specified both anxiety and depression.

So, while half of these respondents (49%) listed anxiety and/or depression as their main concern, in the larger context that equates to 5% of the total HOS sample.

Other notable mentions included:

- fifteen per cent of those aged 65 and over mentioned Alzheimer's as their biggest issue – above-average but unsurprising.
- forty-seven per cent of those nominating a mental health issue and in excellent self-reported health said that stress was their biggest issue and, interestingly, this trended downwards as self-reported health status worsened.

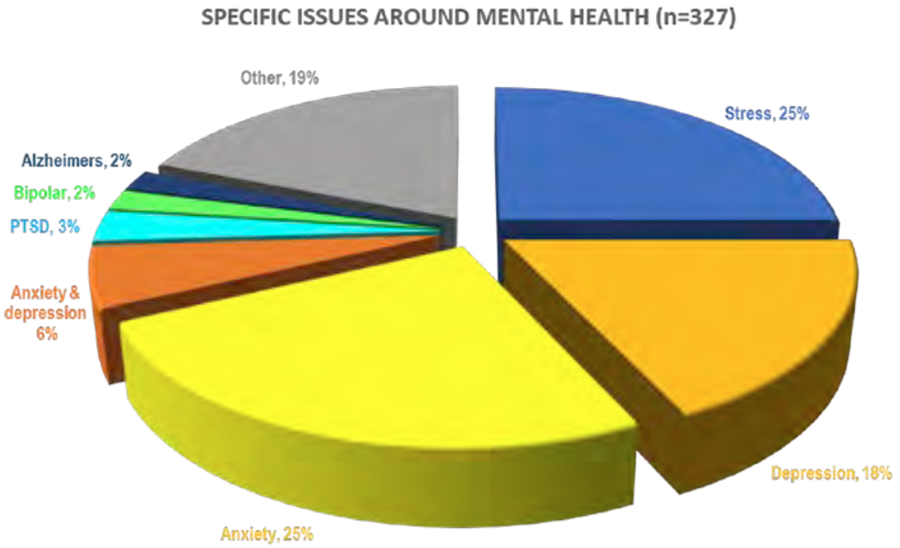


Figure 22: Biggest personal mental health issues, HOS 2017

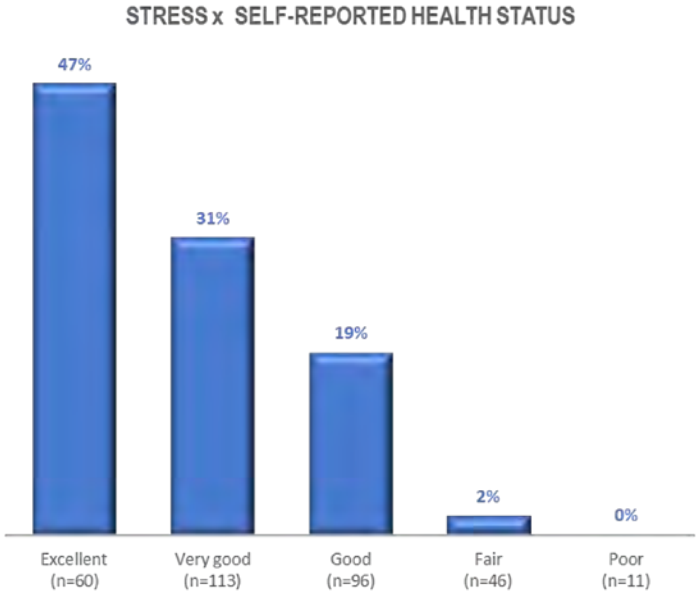


Figure 23: Stress as biggest mental health issue by self-reported health status

Biggest personal health or wellbeing issues - work-related

The biggest health or wellbeing issue for 140 people (5%) was work-related. Stress was their largest concern (29% of this group), followed by unemployment (17%). This latter issue revealed a clear difference between metropolitan and country residents, with 42% of the latter, who had specified work-related issues, listing unemployment as their biggest concern - by far their largest issue.

Within the larger HOS sample, however, that equates to 2% of all country respondents and 3% of country residents who were in the workforce (working or unemployed) at the time of interview.

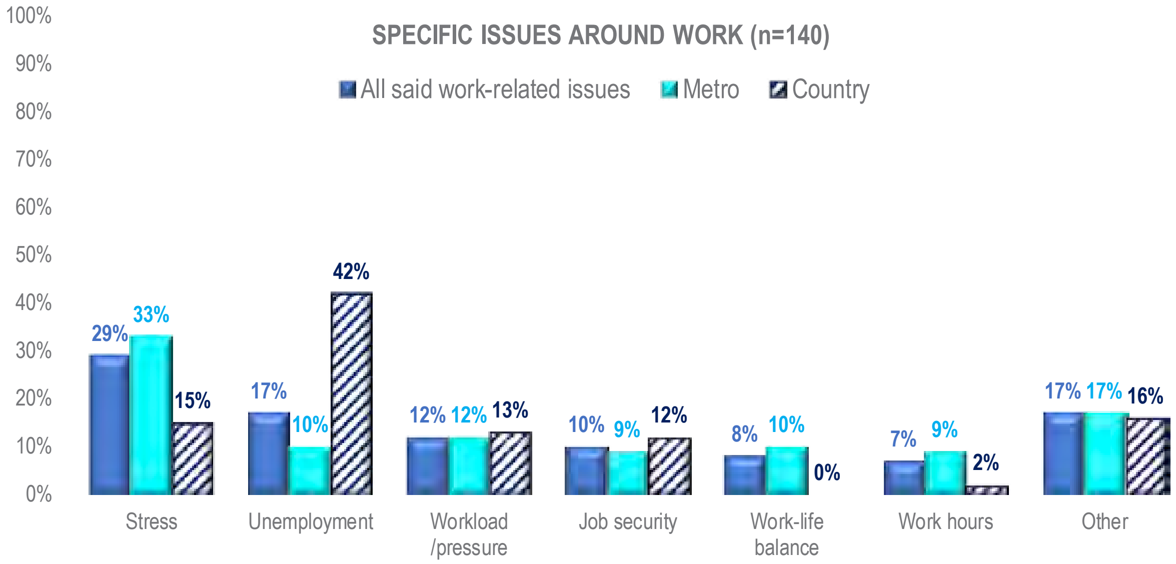


Figure 24: Biggest work-related health or wellbeing issues, HOS 2017

Biggest personal health or wellbeing issues - ageing (own)

The specific issues that 138 people (5% of the sample) mentioned with regard to ageing as their biggest health or wellbeing issue have been further coded as shown below.

Clearly, physical decline, health issues and ageing in general were the main concerns.

No significant differences were found among the demographic or geographic sub-groups.

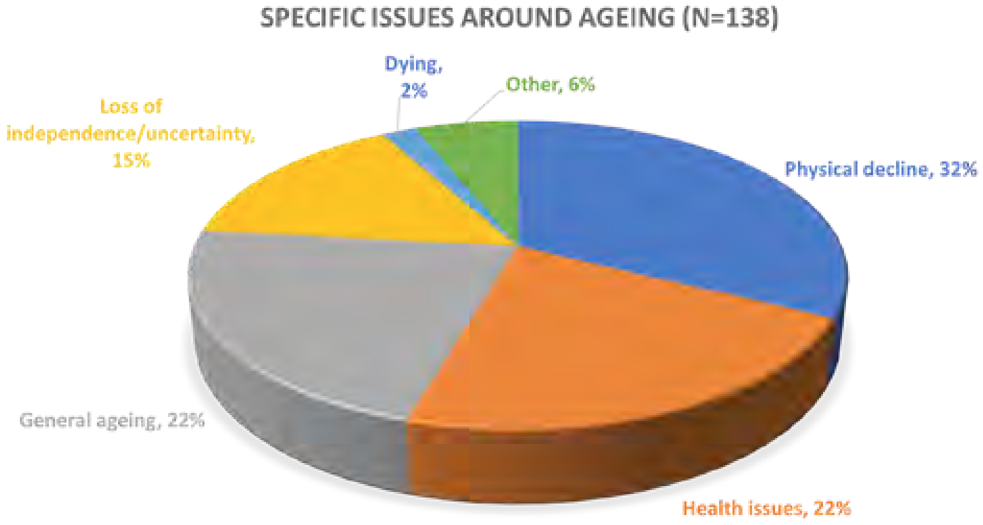


Figure 25: Biggest ageing health or wellbeing issues, HOS 2017

Biggest personal health or wellbeing issues - physical health (family)

A family member's physical health was mentioned by 141 people as their own largest health or wellbeing issue. The main aspects specified included chronic disease and cancer. A wide variety of 'other' issues was mentioned but none to any significant degree.

There were no significant differences among the demographic sub-groups.

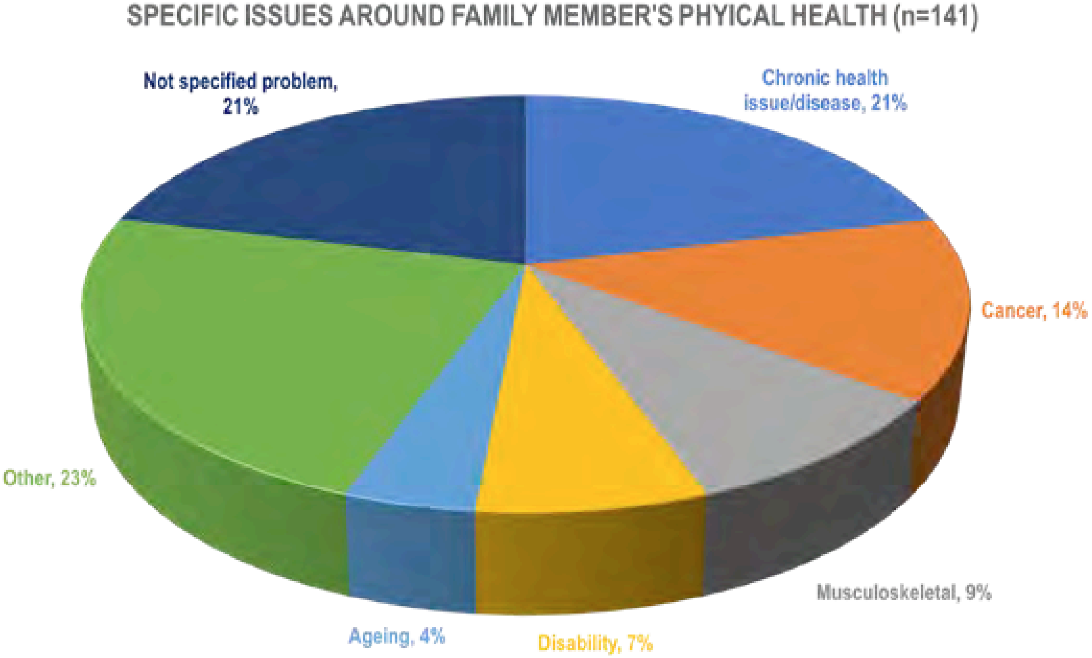


Figure 26: Biggest family member's health or wellbeing issues, HOS 2017

Main challenges in dealing with personal health or wellbeing issue

Incidence of identifying challenges

All respondents were asked: what were the main challenges they run into (up to five were allowed) in dealing with their biggest health or wellbeing issue. As in the previous question, all responses were unprompted, recorded verbatim and subsequently coded into categories for analysis.

Eight people in ten (82%) itemised a main challenge they faced in dealing with their health or wellbeing issues. That proportion was fairly consistent across those who had nominated personal physical or mental health, work-related issues or a family member's physical health issues.

A significant difference, however, was found among those who had specified ageing as their biggest personal concern. Rather than eight in ten, just two-thirds of this group specified a challenge in dealing with their ageing issues.

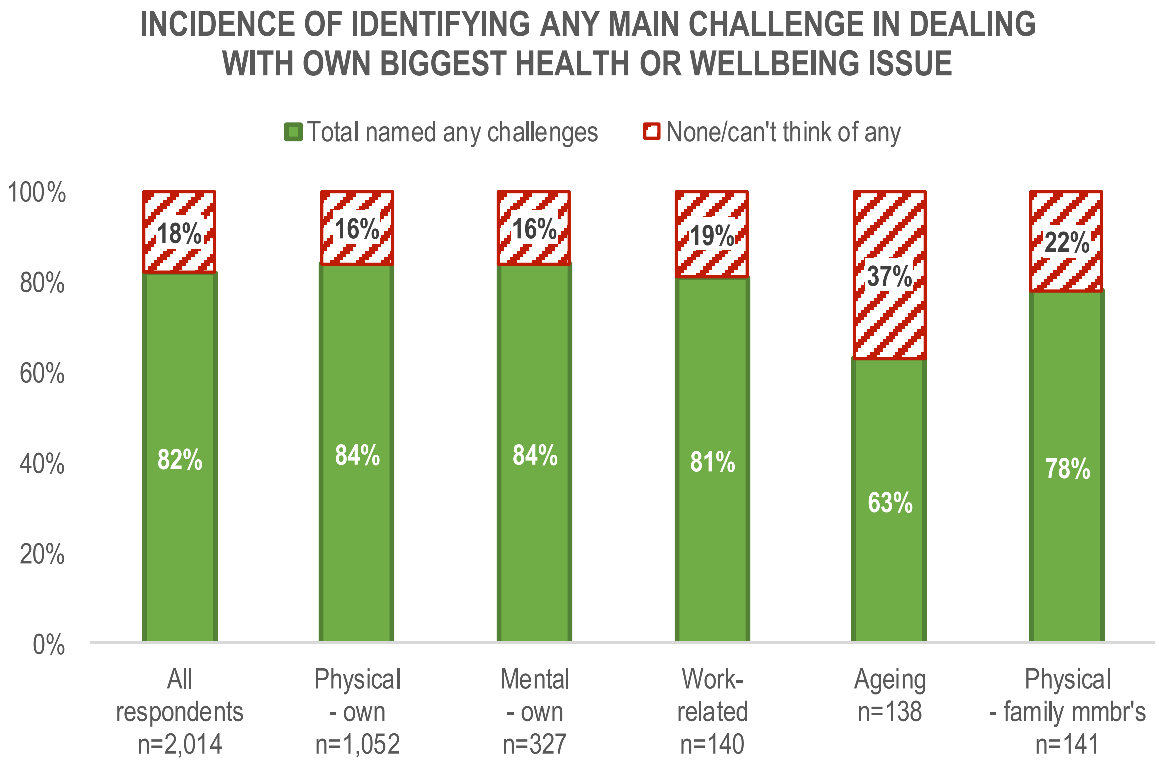


Figure 27: Incidence of identifying challenges in dealing with health or wellbeing issues, HOS 2017

Main challenges - segmented by issue

When analysed by the type of health or wellbeing issue the respondents were discussing (their own physical or mental health, a family member's physical health etc.), it can be seen in Figure 28 on the following page that the main types of challenges faced, and their prevalence, are broadly consistent between the health or wellbeing categories, with individual challenges noted more often within categories.

Note: only challenges mentioned by at least 5% of the people dealing with a particular type of health or wellbeing category have been included; other responses are too fragmentary to be useful.

Key things to note include:

- among people dealing with mental health issues, an inability to participate in social events was mentioned by almost as many respondents as an inability to undertake usual work/tasks (24% and 28% respectively). Coping with the issue was also mentioned most often by this sub-group (21%), as was low income (15%).
- dealing with a family member's physical health issues appears to raise more challenges than dealing with one's own issues; note the higher rates of mentioning most challenges among that sub-group.

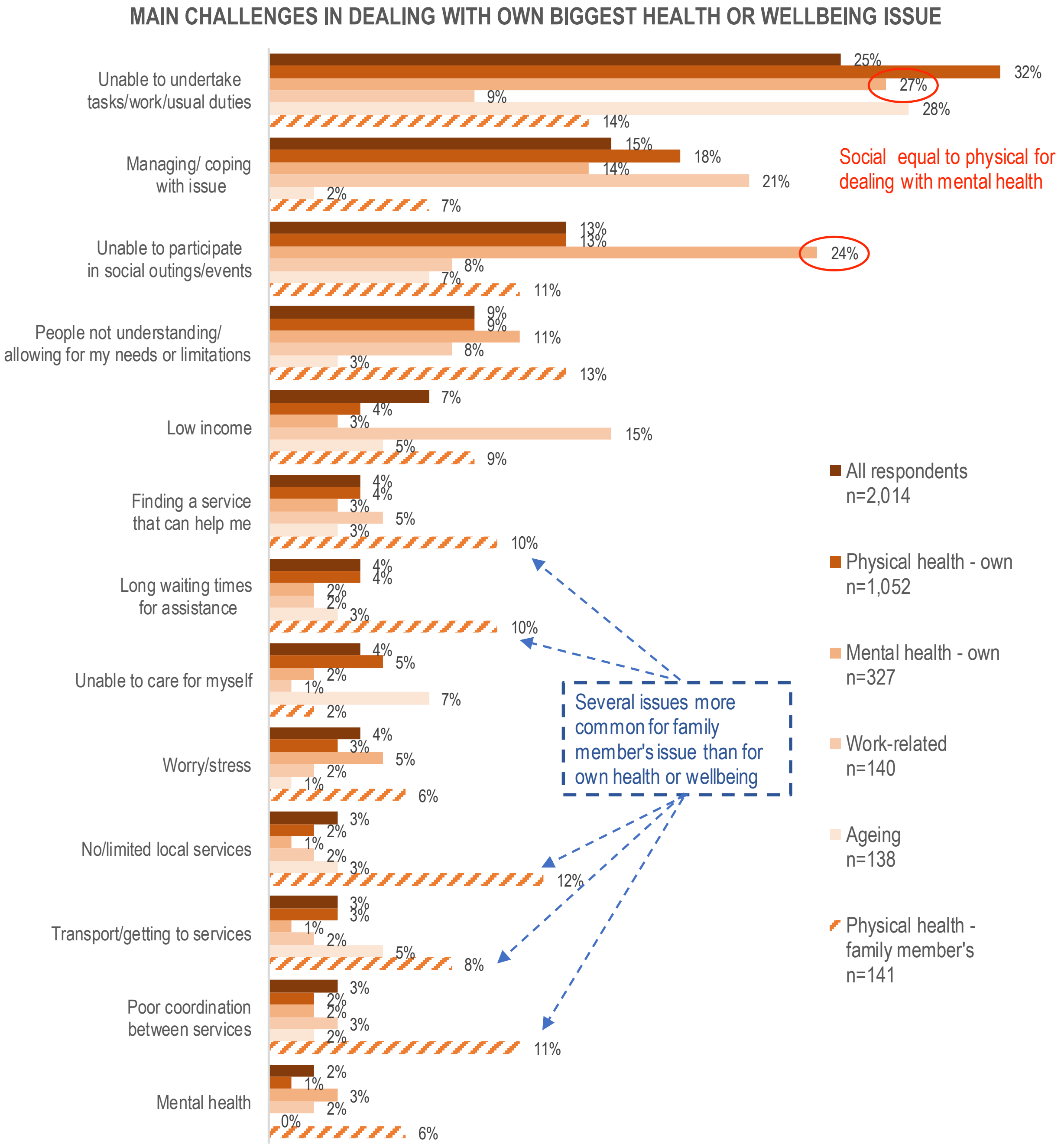

MAIN CHALLENGES IN DEALING WITH OWN BIGGEST HEALTH OR WELLBEING ISSUE

Figure 28: Main challenges noted in dealing with health or wellbeing issue, HOS 2017

Perceived biggest health or wellbeing issues for SA

All respondents were asked what they thought was the single biggest health or wellbeing-related issue faced by the South Australian community as a whole. The aim was to be able to compare what people *think* are the biggest health and wellbeing issues in South Australia, with what they said they *actually are*, in the first question.

Eight respondents in ten (83%) suggested an answer. Again, all responses were given spontaneously, recorded verbatim and post-coded for analysis. Broad categories are shown in the graphs to the right, with people's perceptions of SA's needs contrasted with perceived personal health and wellbeing issues.

The graph at the top shows all responses, including 'none/can't think of any'. It shows that far fewer people specified a health or wellbeing issue for themselves compared to perceptions for SA (68% vs 83%), making comparison of individual issue categories more complex. Consequently, the graph below shows responses only among those who specified an issue, making those figures more directly comparable. While one can understand physical health issues being less-often mentioned for SA, it is interesting to note that 11% considered health services to be the biggest issue for the state, while only 1% mentioned it as their own biggest issue.

Predictably, ageing gained greater mention as SA's foremost health and wellbeing issue in line with respondents' own increasing ages, from 5% of people aged 15-24 to 14% of those aged 65 or over. In contrast, mention of mental health issues as SA's biggest health or wellbeing challenge declined as age increased, from 36% to 14% respectively.

Health services issues were mentioned significantly more often by people whose self-reported health status was fair (17% specified service issues) or poor (23%).

No other relevant differences emerged among the sub-groups.

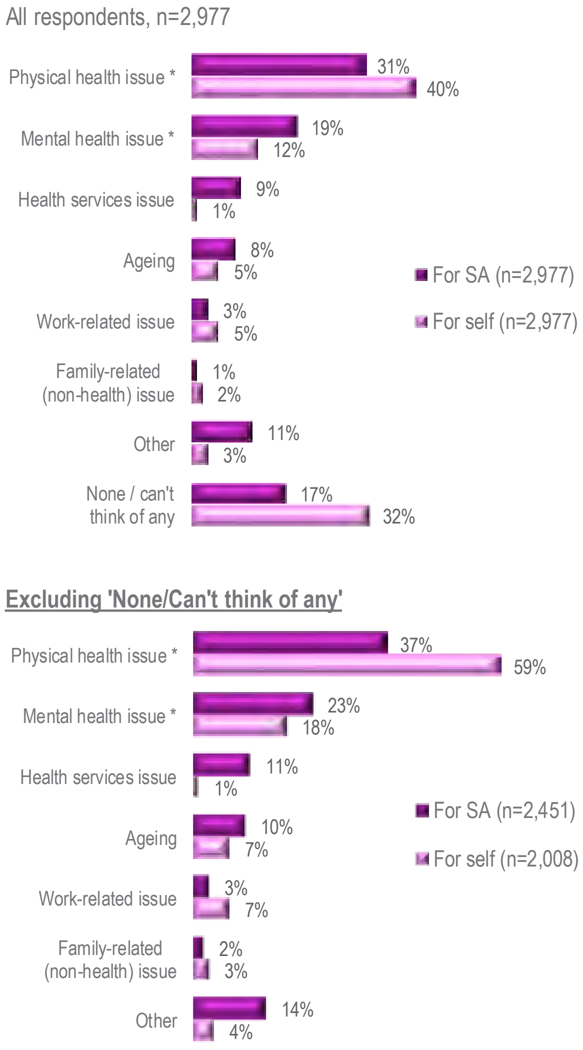


Figure 29: Perceived biggest health or wellbeing issues for SA, HOS 2017

Other health or wellbeing issues for SA

Respondents were then given the opportunity to suggest up to five other health or wellbeing issues they considered most important for SA. The graph below combines those responses with the proportions specifying each category as most important in the previous question, to give an overall perception of issue prevalence. Key things to note include:

- as in previous questions, physical health remained the largest perceived issues category overall, with detailed responses for SA including (in order): weight/obesity, cancer, chronic disease, exercise/nutrition, heart/cardio, drugs/alcohol and smoking.
- the mental health category included, in order: depression, anxiety, drugs/alcohol, lack of resourcing, stress, suicide and other, isolated responses.
- issues related to health services included (in order): lack of services/facilities, waiting times, lack of medical staff/specialists, lack of beds, ward or hospital closures and other, isolated comments.
- ageing issues were most often centred around perceptions of insufficient facilities, services and resources, followed by dementia and an ageing population.
- work-related topics were more tightly focused: on unemployment/lack of employment and stress.
- the family-related non-health issues most often mentioned were (in order) drugs, financial pressure, domestic violence, family breakdown and other related issues.
- other issues considered most important by some (but not by significant numbers) included: drugs, alcohol, smoking, cost of living, crime and other, isolated responses.

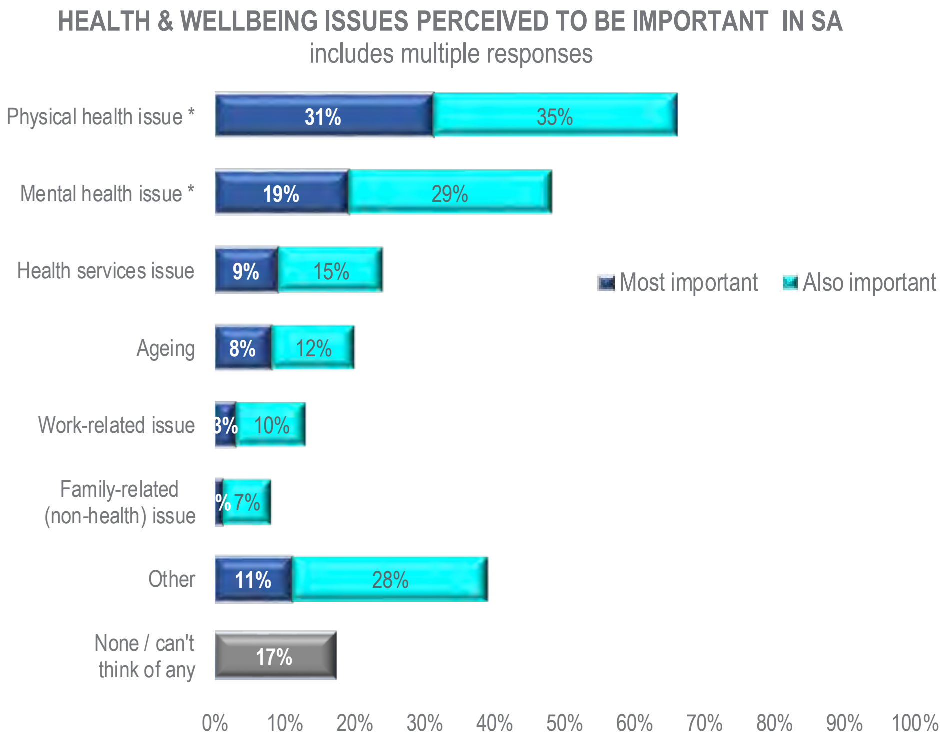


Figure 30: Combined biggest and other health and wellbeing issues for SA, HOS 2017

Preferences for relative government spending

In the final question, respondents were asked: *Imagine you were deciding how government should spend your money. If you had $100 to distribute across these six areas, how much would you give to each of them?* The six areas (presented in randomised order) were: Defence, Education, Health, Social welfare, Transport infrastructure (e.g. roads, railways, etc.) and Environment.

The mean (or average) spend on each area shows the in-principle, relative balance that the SA population would like to see government spend across these categories - bearing in mind that no further information was provided to respondents, just the areas' names.

Interestingly, while these six categories do not match the SA government's budget distribution areas, these are some interesting alignments, even though the question did not specify state government spending.

In particular:

- the 2017-18 SA budget allocates 31% to health and 24% to education. Respondents allocated $31.10 and $23.42 respectively.
- defence is more generally a federal responsibility, but 10% of SA's government budget this year is allocated to public order and safety. Respondents allocated $8.01.
- less well aligned are transport infrastructure (7% of the budget goes to transport and communications) and social welfare, to which the budget allocates 8%, although it should also be noted that much of Australia's social welfare system is federally-funded.
- the environment is not specified as a separate area in the budget summary, so no comparison is possible.

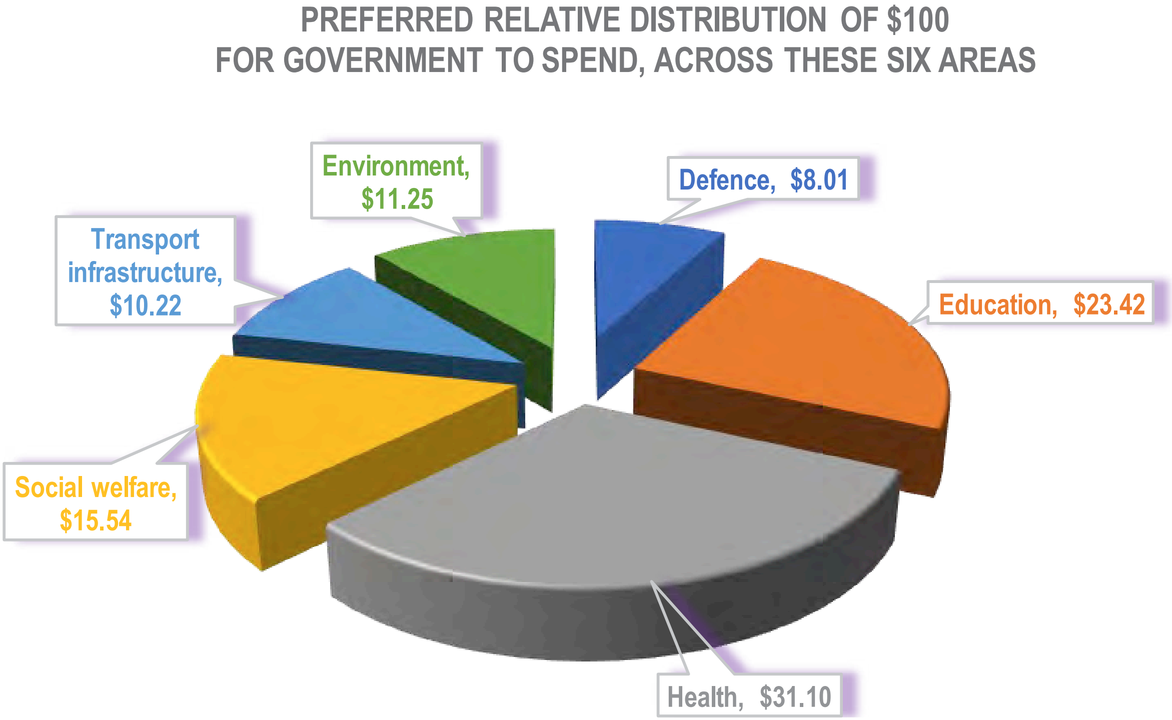


Figure 31: Preferred relative distribution of $100 for government to spend

As would be expected, there were some significant differences in how various sub-groups would divide their $100.

Mean preferred spending on **Health** was significantly different between:

- metropolitan ($30.04) and country SA ($34.24).
- employed ($29.82) vs those not employed ($32.61).
- males ($29.95) and females ($32.20).
- young people (15-34 year-olds: $28.07) and older people (65-84 years: $34.96).
- those whose self-reported health is good or better ($30.56) and those in poor health ($37.64).
- those who have never married ($27.91) vs those who are married/de facto ($31.99) or widowed ($35.81).
- people in households with up to $40,000 household income ($34.34) vs those in households earning $140,001 or more ($27.96). [Note: there was a consistent downward trend related to household income, but not all segments showed significantly differences.]
- tertiary qualified respondents ($30.16) vs those with no completed tertiary skills ($32.71).

Mean preferred spending on **Education** was more consistent across the demographic sub-groups, but significant differences were recorded between:

- students ($27.47) and those engaged in home duties ($28.02) vs people who have retired ($20.97).
- young people aged 15-34 ($25.25) vs older people ages 75+ ($18.80).
- those whose self-reported health is good or better ($23.78) and those in poor health ($21.58).
- those who have never married ($27.91) vs those who are married/de facto ($31.99) or widowed ($35.81).
- people in households with up to $40,000 household income ($21.71) vs those in households earning $40,001 or more ($24.07).
- tertiary qualified respondents ($24.14) vs those with no completed tertiary skills ($22.26).

Mean preferred spending on **Social Welfare** was significantly different between:

- people who own or are buying their homes ($14.96) and tenants of Housing SA ($21.21).
- people who work part-time ($16.92) and others in or not in employment. [Note: average preferred spending on social welfare was much higher among people who were unemployed ($18.35) and notably lower among students ($12.61), but the differences were not statistically significant.]
- males ($14.49) and females ($15.64).
- those whose self-reported health is excellent ($13.96) and those in less than excellent health ($15.86).

Mean preferred spending on **Transport Infrastructure** was significantly different between:

- people who live in community housing or retirement villages ($5.18) and those who own or rent their homes ($10.35).
- people in the workforce ($10.79) vs those giving their occupation as home duties ($6.87).
- males ($11.70) and females ($8.81).

Mean preferred spending on the **Environment** was significantly different between:

- metropolitan ($11.65) and country SA ($10.07).
- retirees ($9.09) and students ($14.85).
- males ($29.95) and females ($32.20).
- 15-24 year-olds ($14.80) and people aged 65+ ($9.26).
- those who have never married ($14.05) vs those who are or have been married/de facto ($10.39).
- people in households earning $140,001 or more ($14.85) vs those with lower household incomes, who averaged $10.49.

Mean preferred spending on **Defence** was significantly different between:

- metropolitan ($8.30) and country SA ($7.14).
- housing SA tenants ($6.05) vs other housing types ($8.09).
- males ($8.66) and females ($7.39).

Balancing the results

What does the literature tell us that is not covered in the survey results?

Given the nature of the survey, despite an excellent sample frame and high response rate, it is inevitable that some specific issues related to minority groups or sub-populations did not feature in the results.

- The interests and needs of people from the LGBTIQ community did not emerge with that focus in the survey, but there are multiple reports and a detailed strategy available in the literature to describe issues, needs and strategies for better meeting those needs. Of particular note were the issues of poor mental health and discrimination.
- The survey showed that migrants' and refugees' expressed needs were not statistically different from those of people born in Australia. However, the literature did find reports on the needs of people who had recently come to Australia and whose culture and language present challenges for integration and acceptance into Australian society. Of particular note are the issues of trauma and its consequent mental health effects, access to services and the needs of young people.
- The needs of children and the issues of maternal health did not emerge in the survey results, perhaps because they are not perceived as "illness" related, but also because the survey did not specifically ask about children's health or wellbeing issues. There was also limited literature to be found; however, what was found covered mostly issues of low birthweight in remote areas and among Aboriginal babies, although the needs of parents with mental illness and the impact on children and parenting were also a key focus.
- Drug and alcohol issues were raised by only small numbers of people in the survey, although they did rate some mention as one of the issues for South Australian health and wellbeing. However, the issues of high tobacco use and excessive drinking in certain population groups was prominent in the literature, especially at national and state level planning and strategies.
- Racism and discrimination against some people did not feature in the survey results to any degree. The literature made several references to racism and discrimination against Aboriginal people, the LGBTIQ community and people from culturally and linguistically diverse backgrounds.
- The needs of people in or leaving the justice system were not mentioned in the survey results. There is also limited literature on these matters, but the needs of Aboriginal prisoners and mental illness among the prison population generally was noted.

What do the survey results tell us that is at odds with the literature?

A small number of issues appeared to be different in the survey results than the literature:

- People living in rural and remote areas rated their health higher than is suggested it really is, according to reports found in the literature review where health status is clearly at lower levels in some parts of rural and remote South Australia. This difference in perception may be driven by lower expectations of health services and by health being a lower priority in the broader set of issues affecting people in farming or remote communities.
- Work-related issues were more prominent in the survey than the literature.
- The social impacts of poor physical health were raised by participants in the survey but did not feature strongly in the literature.

What was common across the literature and the survey results?

There was strong agreement between the literature and survey results in six areas:

1. Prevention

There is a significant emphasis on prevention in state and national plans and health priorities. The survey results show prevention and holistic approaches to health are also of importance to the general population

2. Mental health issues

Mental health issues were prominent in seven of the 10 population groups covered in the literature (Aboriginal people, children and parents, older people, rural and remote communities, migrants, LGBTIQ community and people in or leaving the justice system). Mental health-related issues were rated as their biggest health or wellbeing challenge for 11% of those participating in the survey (the second highest category, after physical health) and 48% of all respondents listed mental health as one of the most important issues for South Australia.

3. Ageing and dementia

Issues relating to ageing were considered one of SA's biggest health or wellbeing concerns by one in every five (20%) of the survey participants. The literature covered multiple issues related to ageing and dementia.

4. Obesity

Weight and obesity featured highly in the survey as an issue for South Australia and was also a feature of many reports in the literature, with concerns about children's and young people's obesity and the impacts on risks for chronic disease.

5. Health services access

Both survey respondents and the literature raised issues about health service access, especially with regard to people living in rural and remote areas and certain sub-populations such as the LGBTIQ community, Aboriginal people and people from culturally and linguistically diverse communities. It was notable in the survey, however, that while 11% of people mentioned this as SA's biggest health or wellbeing issue, just 1% mentioned it as their own biggest issue.

6. Physical health

Physical health was identified most often in the survey as the biggest health and wellbeing category they faced individually and for the state as a whole. Impacts on carrying out usual daily activities, including social interaction, were identified as the most important challenges. This aligns well with the emphasis of many national- and state-level reports and priorities such as the focus on cardiovascular disease, diabetes, musculoskeletal health and injury/disability.

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3

Lived experience and stakeholder informed findings

Project Team – TACSI

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The Australian Centre for Social Innovation acknowledges the involvement of Ms Stacey Thomas (Fay Fuller Foundation) and the SAHMRI team (Ms Frances Eltridge , Mr Jay Garland, Dr Danielle Post and Ms Kathy Mott) in the development of this work.

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Method

TACSI's approach to discovery research

Our approach to discovery and insights work involves exploring situations deeply. To do this we work with a relatively small sample size but spend considerable time with people. We adapt our methods for discovery based on the people and situation being explored and use tools that allow us to go deeper than questionnaires or standard interviews. We spend time with people in their own context: in their homes, back yards, a familiar cafe, their workplace or while interacting with services.

We also use techniques and methods that enable us to make tacit knowledge and assumptions visible. For example, many people speak of the 'health system', but what does that mean for people, what is included, excluded, what mental models and assumptions do people hold in relation to this 'system'? Asking people to 'draw' or model what something like a 'health system' looks like enables us to open conversations with them about what is happening in various parts of this 'system', what gaps and opportunities they can identify and how preconditions need to be put into place in other parts of the system that enable changes people see as critical to good outcomes. We refer to methods that enable people to 'see' or 'make' models of abstract concepts such as 'systems' as 'generative methods'. These generate deeper discussions and insights because they enable abstract concepts to be made visible and interactive.

Discovery purpose and system perspective

The purpose of this project phase was to develop a system perspective on health needs and priorities in South Australia.

The health systems map (map) presents an overview of the health system in South Australia. This was formed based on the:

- literature review conducted by SAMHRI
- key findings and opportunity areas derived from the analysis of semi-structured interviews TACSI conducted with health consumers and stakeholders working in the health system
- desktop research conducted by TACSI to provide context to the key findings and opportunity areas.

The map identifies current targets, risk factors, burdens of disease, related policy responses, populations and associated actors within the system. It also shows where the particular focus of investment is now and allows the viewer to identify potential gaps and levers to stimulate cross-sector collaborations and create shared impact. It is recommended that the map is updated biannually to retain currency.

Discovery research phases

Our discovery approach had two phases:

1. Understanding key stakeholder perspectives about health priorities and needs in South Australia and mapping the existing health system.
2. Understanding the perspectives of a range of health consumers from metropolitan and rural areas about health priorities and needs in South Australia.

Phase one – purpose, method and tools

The purpose of this phase was to gain insight into the perspectives of stakeholders working in the health system about:

- current health priorities, needs and gaps
- barriers and opportunities in addressing these
- commissioning approaches
- funding distribution
- service provision.

The stakeholders were identified purposively based on their knowledge, oversight of key health needs and priorities and their role in relation to meeting those needs and priorities. Twelve key stakeholders who work in the following areas were interviewed over a two-month period:

- health care (clinicians)
- research
- not-for-profit sector
- advocacy peak body or group
- commissioning, funding and policy within the South Australian Government.

Semi-structured interviews were conducted and included generative design activities such as card and picture sorting.

These tools were useful in exploring more deeply people's knowledge and experience, and to stimulate conversation about potential barriers, drivers and preferred solutions.

Several pilot interviews were conducted to first test and revise the questions and tools developed. Insights gathered from an initial analysis of stakeholder feedback informed the lines of enquiry and questions for the semi-structured interviews with health consumers.

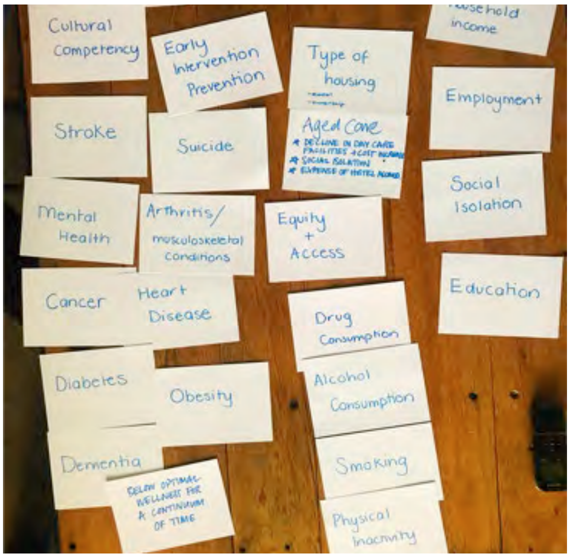

Figure 32: Card sorting

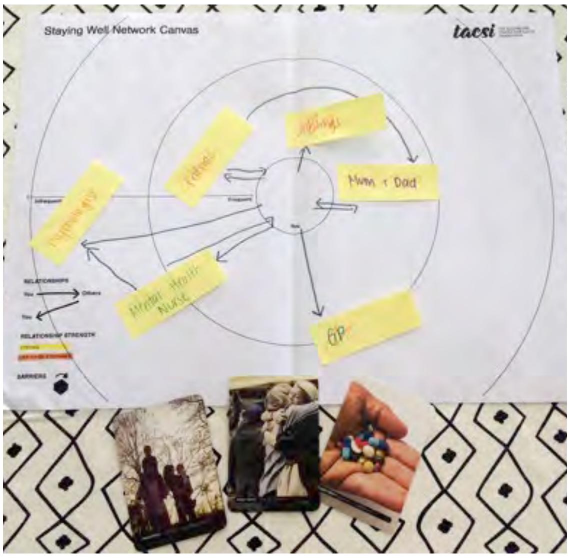

Figure 33: Picture sorting and network canvas

Phase two – approach, methods and tools

The purpose of this phase was to gain insight into health consumers' experiences of, and perspectives on, health and wellbeing. Because wellbeing was a theme continually discussed by stakeholders, we explored this as part of our conversations with health consumers.

We interviewed 18 health consumers in four different regions – three within metropolitan Adelaide and one semi-rural. These areas were based on regions with repeated high prevalence of disease burdens and risk factors, and also positive deviance, where despite experiencing health issues, people were managing to thrive. This information was derived from the *South Australian Regional Public Health Data Report* released in 2016. The four regions included Murray Bridge, the Playford-to-Gawler area, the inner-west metropolitan area and Hallett Cove to Sellicks Beach.

Semi-structured interviews were conducted in people's homes, outside shopping centres and at a swim centre. Generative tools were also used in these interviews. A picture sorting activity helped people articulate their thoughts on health and wellbeing and share their experiences about what helped or hindered their wellbeing. A 'staying well network canvas' was designed to help participants describe these supports and the strength of these in helping them to maintain their health and wellbeing.

Analysis approach

Each semi-structured interview and activity was recorded with the permission of the participant. From these, transcripts were created and analysed to identify key issues raised by participants around:

- what they found to be helpful in maintaining their health
- barriers in the way of staying well and/or getting the care and support they needed
- potential levers and opportunities for doing things differently.

These were then clustered into themes, analysed further and synthesised into key findings and opportunities.

Key findings: Wellbeing

A more holistic approach that connects health and wellbeing would reduce the amount of time people spent in the treatment layer of the health system.

The way the health system regards health and wellbeing is quite different from how it's perceived by stakeholders and health consumers. Key points that emerged from our interviews included:

- Stakeholders thought the system considers health (illness) and wellbeing (prevention) as mutually exclusive, instead of as part of a health continuum.
- Wellbeing was important for health consumers, and relationships with family, friends and clinicians were crucial to maintaining their wellness and health.

There are opportunities to emphasise wellbeing in approaches to health care that integrate these perspectives and ensure consumers get the support they need to stay well.

Stakeholder perspective on health and wellbeing

The World Health Organisation makes a connection between health and wellbeing that is widely accepted. It encourages a holistic view of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (World Health Organization,1946). It also suggests a health continuum and extends the definition of health to include positive states of wellbeing.

In South Australia this definition is interpreted in a number of ways. This includes looking at:

- the 'ill-health system' and increasing investment in hospital expenditure -*Transforming Health, 2015*
- health and wellbeing with respect to the burdens of disease, social determinants of health and wellbeing as mental and physical health, social connection and participation - *State of Public Health for SA, 2016*
- wellbeing in terms of 'mental, physical and social elements' - *South Australia: State of Wellbeing, 2017.*

This suite of policy suggests either a shift back and forth along the health continuum or a position of addressing health and wellbeing as a whole. The latter was not a view shared by stakeholders during the interviews. Most emphasised that while health and wellbeing is part of a continuum, the health sector regarded these as separate elements. This was thought to be evidenced in current service responses that focus on ill-health or disease burdens, rather than being inclusive of wellbeing.

> "People often refer to health and wellbeing as if it's a mutually exclusive category. Because when people talk about the health system they really mean the ill-health system. And when people talk about wellbeing, they actually mean the positive slant on things, about actual protective mechanisms as opposed to talking about ill-health, social, emotional, physical."

> "Issues with people's health are often categorised as either wellness or ill-health. But doing this does not recognise that wellness and managing chronic disease are part of the same continuum of human experience and therefore reflect life experience, heredity and the environment."

Several stakeholders spoke about the need to 'return to wellbeing' in the way the system looks at and treats health. As one stakeholder explained, in its current state,

> "health is about the illness system and treats the symptom rather than the person".

Focusing on the person, their experiences and wellbeing were crucial elements for some stakeholders in understanding how to support people to stay well and manage their health. The view was that doing this helped people maintain their health.

> "Understanding the whole picture and the narrative surrounding a person and what keeps them well and able to avoid or manage chronic disease is important in keeping people healthy longer."

Supporting the wellbeing of health consumers

The health consumers interviewed often spoke about the importance of being well to maintain their health. Wellbeing and health was described not as a continuum, but as layers they traverse back and forth – being well, managing health and being sick. Several elements were identified as important in helping people move back to wellness and stay healthy. These included:

- personal responsibility
- family and friends
- giving back to people
- participating in activities to connect
- the relationship with their clinician.

"What wellbeing means to me is talking to someone, like your family, and being able to unload yourself to someone who understands."

"When I forget about me, my mental health goes bad... fitting time in for myself is actually about not just my wellbeing, but about sustaining the wellbeing of my entire family. I have a strong group of friends and family members that have a strong, firm understanding of my mental wellbeing."

"I find within myself, [if] I'm out there helping the community, I feel probably better about myself than if I wasn't helping, so I like to be involved with the local community."

Community in different forms also helped people where connections with family and friends were not strong or present. In this situation, people spoke about attending health and wellbeing programs at local community centres or going to a cafe or fast food outlet. Doing this was helpful to their wellbeing.

"I come to the centre to see what's on and join in some activities that interest me. I started with the eight-week health and wellbeing course and now a few of us meet regularly to do activities."

"The other day I went over to the McDonalds. It's probably the place I most go. Sometimes you end up talking to somebody. I usually just go and have something to eat and finish my coffee and go, but I was sitting next to this woman and we started talking. So, that was a good thing."

All health consumers spoke about the relationship with their clinician – usually a general practitioner or a psychologist/psychiatrist. If their relationship with a clinician was 'strong' or 'good', they felt this relationship had a key role in helping them to stay well or recover from illness. The length of time a person had known their clinician often contributed to what they characterised as a 'good' relationship. However, it was a clinician's understanding about the circumstances surrounding a person's health and their capacity to engage in discussions about wellbeing that helped the most. This was particularly the case with GPs who were the health professional most people saw on a regular basis.

"He takes the time to ask me how I'm going, how [X] is going and what I've been up to."

"It was a different one [Dr], but he could see that I couldn't walk and he could see my situation and asked me questions, it just wasn't gonna happen."

"I've been pretty lucky. I had a really good specialist who I'd see every six to eight weeks and he was always there. He actually saved my life. I think a lot of it comes down to attitude about people, their profession."

Several people described times when they felt like their situation and the circumstances surrounding their health were overlooked or not considered by their clinician. This didn't help people feel good or well. Situations where they felt judged or where GPs, in particular, didn't have *"enough time"* exacerbated negative feelings about the quality of care received.

"I needed an operation on my hip, I could barely walk and the surgeon said he couldn't operate until I exercised and lost 30 kilos...I couldn't stand unassisted!"

"You get six minutes with GPs now and they're forever changing so you don't get the same one. They don't know who you are."

In these circumstances, many people thought not having their situation understood meant their wellbeing and health suffered and they had to rely on friends and family to gain a better understanding about their health.

"Yep, she goes straight to Google and double-checks for me."

Opportunities: Wellbeing

There are opportunities to emphasise and better translate recent policy shifts about wellbeing into service delivery that considers the whole story of a person – what can address the symptoms of ill-health and support wellness from the perspective of the health consumer. As one stakeholder suggested:

> "Emphasising wellbeing in discussions about health means the whole story of people and their health can be better understood and potentially reduce the amount of time people spend in the ill-health layer of the health system."

For health consumers, positive relationships support them to stay well longer and manage their health better. Clinicians such as GPs and psychologists are important in health consumers' circles of support. Efforts around incorporating patient-centred and bio-psycho-social models of care inevitably come up against process and attitudinal constraints as described by many health consumers (Saha et al., 2008; Margalit et al., 2004).

This therefore raises two opportunity questions:

1. **How might we develop stronger patient and practitioner relationships to improve both experiences and outcomes of health care interventions?**
2. **How might we amplify the voice of consumers to influence how the health system approaches wellbeing?**

Key findings: Mental health

Issues with mental health were experienced by all consumers; however, not all received the right type of care and support.

Identified as both a national and state priority, mental health was high on the list of concerns expressed by health consumers and stakeholders. This concern was also highlighted as part of the Health Omnibus Survey where mental health was regarded by respondents as the second-biggest health issue in South Australia (South Australian Health and Medical Research Institute, 2018).

Key points emerging from our conversations with consumers and stakeholders included:

- the current focus on treating symptoms and not dealing with the root causes of mental illness
- confusion amongst clinicians between what is sadness/grief etc. versus what is mental illness
- the cost of long-term psychotherapy treatment is prohibitive to many
- few alternatives exist for consumers and their carers to seek informal, inexpensive and ongoing support.

A national priority

Mental health is one of the nine National Health Priorities (Australian Institute of Health and Welfare, 2016). The *South Australian Mental Health Plan* sets a priority for specialist mental health services and interventions for high-risk groups. This includes Aboriginal people, culturally and linguistically diverse (CALD) communities, children and young people, older people, people living in rural and remote areas, people in the criminal justice system, women who have experienced or are experiencing violence and people with high and complex needs.

The impacts of poor mental health on individuals, carers, families and the wider community can be significant. Lost productivity due to poor health and unemployment— including the time given by carers who provide support for loved ones affected by mental illness— as well as exclusion from other opportunities for community participation and development due to illness, can also have a significant social and economic cost (SA Health, 2010).

The majority of health consumers we talked to spoke about the importance of maintaining their mental health and described either personal or close interpersonal experiences with depression, anxiety or sadness.

Confusion about diagnosis and treatment

A concern raised by several stakeholders related to the diagnosis and treatment of mental illness. It was felt that too often diagnosis led to interventions focused on the management of symptoms rather than treatment of the root cause.

> "The lack of distinction between depression on the one hand and grief and loss on the other... to me you lose your job or you lose a parent and you start feeling sad. That shouldn't be a mental health issue. That's a grief or loss issue. That's why you need a community around you, you don't need a drug."

Confusion among clinicians around what constitutes a psychological disorder versus a typical human response to life events was described and attributed to the way mental health services currently deliver care.

> "I think the model of care under-recognises that – what are symptoms of mental illness are totally understandable responses to life events rather than abnormal responses or evidence of abnormal pathology."

The level of training and competence found within services supporting the management of mental health was also questioned by both consumers and stakeholders:

“I found, with a lot of services, that there were people that weren’t qualified in the areas they were working. I find that interesting, because if you’re not qualified, then unfortunately, you’re a person that’s probably going to perpetuate stigma and it’s highly likely you’re a person that’s going to make mistakes.”
– Health consumer

“I’m not sure about the competence of a lot of people employed in mental health. I don’t think the training is evidence-based and is still too much influenced by industry [pharmaceuticals].” – Stakeholder

While the model of care and the importance of appropriate training are critical, it is also important to acknowledge the complexity that clinicians face during diagnosis. A standard GP consultation is often too short for many people with complex mental health needs to feel like they have been fully assessed. Furthermore, GPs are not mandated to complete mental health skills training which dictates whether they are able to access a higher schedule of fees to accommodate the development of a thorough *Mental Health Treatment Plan* (Department of Health, 2012).

These factors are often compounded when multiple layers of trauma, including grief, loss and a psychological disorder, co-exist, as we heard from one consumer:

“Yeah, well I’m actually on anti-depressants. Actually, I went to [my GP] feeling depressed and he was going to take me off from them. [Then] Alice [my daughter] got diagnosed with cancer and he said no. I stayed on them.”

Long-term treatment is prohibitively expensive

In light of this complexity it is unsurprising that several health consumers criticised government mental health plans which offer a Medicare rebate for up to 10 psychotherapy sessions per person/per calendar year.

“Wellbeing can’t be maintained on, ‘You have 10 appointments with me and you’re just going to be all better’.”

A scientific study of more than 10,000 therapy cases in the United States found that it takes more than 20 sessions, or about six months of weekly therapy, before 50 per cent of patients show clinically meaningful improvement. It takes more than 40 sessions before 75 per cent of patients show meaningful improvement (Lambert et al., 2001).

For many health consumers who are in most need, the out-of-pocket expense of ongoing therapy would be exclusive and unsustainable under the current mental health plan.

Conversely, those health consumers fortunate enough to have and afford ongoing therapeutic treatment regarded the relationship with their psychologist as two-way and of equal importance to their wellbeing as relationships with their loved ones and close friends. As one mentioned:

“[My psych] It’s definitely the most important relationship in my life as well [as family and friends], as I was telling Barb the other week. It’s been a life-saver for me.”

A lack of alternatives

While there appears to be a focus on formal services and supports, we heard about the need and desire for alternative options. As one consumer pointed out:

“99% of people I’ve met with mental health [issues] want somewhere to go to have a chat. No pressure, no judgement, nothing.”

Several health consumers also spoke about a desire to see different types of people delivering mental health services. The degree to which lived experience professionals are being utilised was seen to be lacking in the current South Australian mental health workforce.

“There isn’t a lot of work for them, which is really, really sad, because if you look at the stats of lived experience and peer work professionals from Narcotics Anonymous and Alcoholics Anonymous, it’s proven evidence that it works. It’s really sad that our government isn’t funding these people to be in the community because I’ve seen people’s lives seriously change from this peer support.”

Additionally, we heard from multiple consumers about the need for better engagement with their support networks, loved ones and close friends.

“I don’t have a family that wanted to come to a psychiatrist appointment with me, and they didn’t want to read flyers about my specific diagnosis or anything! But they did want to know, ‘What do we do when it’s like this [behaviour]?’… I find the more honest I am with my family, the more they notice things, the more they understand things, and the more they can support me.”

Assisting families and communities to support those affected by mental illness builds community resilience and breaks down the stigma associated with mental illness.

Other evidence

While acknowledging the need to interview a broader range of people to learn directly about their experiences of the health system, there is comprehensive South Australian and national evidence supporting the disparity in mental health outcomes experienced by the following population groups.

People living in rural areas experience poorer mental health and less frequently seek support, and services are typically less effective in responding. By contrast, people living in urban areas diagnosed with a mental health problem were more than twice as likely as rural and regional South Australians to seek help. This is attributed in part to the stigma associated with mental illness (Health Performance Council, 2013).

Social connectedness is one of the major determinants of health and wellbeing. Depression and social isolation are closely linked, with social isolation both leading to and maintaining depression (Cruwys et al., 2014). With 20% of older people in Australia socially isolated (Beer et al., 2016), it is a significant and growing problem for older people, families, communities, service providers and Australia as a whole. The recent Health Omnibus Survey also showed that 49% of respondents (n=327) listed anxiety and/or depression as the type of mental health issues they were managing. Twenty-four per cent of these respondents also indicated that the impact of dealing with their mental health issues resulted in disconnecting from social situations such as social outings and events (South Australian Health and Medical Research Institute, 2018).

We heard about the impact on social connectedness felt by older people in rural settings when care services were cut at the local hospital:

> "Because you are no longer going [axed rural hospital day care for older people] you haven't spoken to Joe who lives down the road for weeks. And you can't drive so when you went to day care and sat around for a long while and talked to Joe... now personal contact has gone out the window. It really hurts these older people."
> – Health consumer

Furthermore, older people aged 65+, living in socioeconomically disadvantaged areas and who are dependent on the aged pension, are at risk of poor health and wellbeing (Public Health Information Development Unit, 2016).

The risk of mental health issues increases still further for older people with a CALD background (Principe, 2015). This is demonstrated through delays in treatment-seeking behaviour related to certain cultural perceptions of dementia.

For younger people from CALD backgrounds (children and adolescents), trauma associated with the refugee experience, including exposure to conflict, violence, and family separation, is prevalent and only a small percentage of this population has sought assistance. For asylum seekers, mandatory detention contributes to poor mental health and impacts social wellbeing (Australian Human Rights Commission, 2017). Resilience in the adolescent refugee population has been demonstrated to be lower than indicated in other, non-refugee populations. Lower levels of resilience have been associated with depression and emotional and behavioural problems (Ziaian et al., 2012).

Prisoners and people who have been involved in the criminal justice system are recognised as being at risk of poor health and mental health issues (Health Consumers Alliance of SA, 2014). Despite this, there is no South Australian-specific published literature relating to the health and wellbeing status or needs of this underserved population. Instead, recommendations are made to incorporate this population in health and wellbeing considerations.

Recommendations include preventing people who have a mental illness from entering the prison system; and that those already in the prison system have access to support for their health and wellbeing. Better integration of government and non-government services, and corrections, is recommended to deliver mental health services to this population within, and as they transition from, the justice system (SA Health, 2010).

South Australia's Mental Health and Wellbeing Policy also prioritises Aboriginal people, acknowledging the need for further training for health care services and staff to develop understanding and cultural competency around the unique social, emotional, mental health and wellbeing perspectives of the Aboriginal community (SA Health, 2010).

Opportunities: Mental health

We heard strongly about multiple challenges clustered around the diagnosis and treatment of mental health under the current model of primary care.

We can take inspiration from Australia's strides forward in the prevention and early intervention space for young people aged 12–25 through the continued scaling of services like Headspace (the National Youth Mental Health Foundation). Headspace promotes and supports early intervention, providing an appealing soft entry point for its target cohort without labelling or prematurely medicalising the problem. In 2015 more than 65 000 young people accessed services through Headspace, of which more than 45 000 were accessing them for the first time (Headspace, 2016). We heard about the desirability of such services in some of the communities we visited.

What lessons can we learn from the success of this approach to inform alternative strategies for Australia's mental health challenges? We believe a key opportunity is articulated in the following questions:

How might we create alternative options, methods and spaces for diagnosing mental health issues?

1. **How might we assist those at risk to access sustainable, ongoing mental health support outside acute settings?**
2. **How might we create more opportunities for peer-based and informal supports in creating mental (and physical) wellbeing?**

Key findings: Racism and cultural competency

Racism continues to perpetuate poor health outcomes.

Recent studies show that Aboriginal and Torres Strait Islander people continue to report experiences of racism in the health care system (Kelaher, Ferdinand and Paradies, 2014; Ferdinand, Paradies and Kelaher, 2012). This aligns with the experiences and perspectives health consumers and stakeholders shared during our interviews that can be described as interpersonal and structural examples of racism. The perceptions shared were often expressed about, or heard from, the experience of Aboriginal and Torres Strait Islander people and, on one occasion, about a family member of Maori heritage. Key points that emerged from discussions about this included:

- Health consumers describing their experience with health care professionals as stressful and upsetting because they believed cultural identity was not recognised or acknowledged.
- Stakeholders sharing perspectives about health policy and practice reinforcing inequalities and affecting access to care.

There are opportunities to increase and deepen cultural competency training within the health system and also create workforce strategies that increase the number of Aboriginal workers in the system.

Racism in the South Australian health system

Internalised, interpersonal and systemic racism within the health system all have a significant impact on Aboriginal health across the life course (Solar and Irwin, 2010). These types of racism are described as the following:

- **Internalised racism:** acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one's own ethnic/racial group (e.g. an Indigenous person believing that Indigenous people are naturally less intelligent than non-Indigenous people).
- **Interpersonal racism:** interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. experiencing racial abuse).
- **Systemic racism:** requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. Indigenous people experiencing inequitable treatment.) (Paradies, Harris and Anderson, 2008)

We heard from a number of health consumers and stakeholders about their experience of, and perspectives on, interpersonal and structural racism. Several stakeholders spoke about the health system lacking cultural competency, empathy and understanding about Aboriginal and Torres Strait Islander people and their health needs. This was described as resulting in people leaving care prematurely and not fully understanding their treatment.

> "I would say that one of the biggest problems we have with equity in Australia would be racism – straight out. That's what's driving a lot of the problems that are there in hospitals, where people discharge early, where they refuse to go to hospital, why they leave hospital having no idea what actually just happened or what tablets they need to take, or any of the next steps they need to do...that's just literally not paying attention to the culture or language and other differences."

Health consumer experiences of interpersonal racism

From an interpersonal racism perspective, we heard from people about a number of experiences in the hospital context where their cultural identity was not considered and where they felt stereotypes about their heritage influenced decisions about health needs.

> "There was a lady who was Aboriginal ... this only happened last week ... for her three-month scan she was there and the nurse wrote down Caucasian. The woman said, 'You didn't ask what I was...'. The nurse said, 'You don't look Aboriginal.'"

> "My husband [he's Maori] had a stroke [and in] my husband's case notes, and it wasn't until 18 months later, two years later that we found out that he was in a hotel when he had a stroke. Because it was a violent stroke, they had to hold him down. Now, he hasn't drunk in 10, 15 years, so did they say he was drunk because he was dark, or because he was in a hotel?"

These types of experiences are not uncommon (Australian Bureau of Statistics, 2018; Kelaher, Ferdinand and Paradies, 2014; Paradies, Harris and Anderson, 2008) and are known to have a considerable impact on people's health. Longitudinal and cross-sectional studies have found a strong association between experiences of racism and ill-health and psychological distress, mental health conditions and risky behaviours such as substance use (Health Performance Council, 2017; Australian Health Ministers' Advisory Council, 2015; Ferdinand, Paradies and Kelaher, 2012). While we only heard several accounts of health consumers' experiences of racism, this research demonstrates that self-reported experiences of racism within the health system are common not only in South Australia, but also nationally.

Stakeholder perceptions about structural racism

When talking about structural inequity and racism, stakeholders referenced public policies, institutional practices and social norms that can often work to perpetuate and reinforce inequities, particularly for Aboriginal and Torres Strait Islander people. More effort was thought to be needed in highlighting circumstances where the health system, in particular, was demonstrating racism and how this negatively impacts achieving better health outcomes.

"The social structures that surround people, so that if people, for example, are admitted to hospital and if they don't get to Centrelink today to fill out some form, then they would be cut off, and even hospital trying to help out most often does not hit Centrelink or doesn't hit the right people, and so then people know that if they stay in hospital their children will not have money for food and so they leave."

"I think we should ask ourselves why we're not reporting routinely on racism in the health system. We know it's a determinant of health. That's a culturally incompetent system."

Some stakeholders argued that Aboriginal Community Controlled Health Services, despite being operated by local Aboriginal communities to deliver culturally appropriate primary health care, still experienced a layer of structural racism.

"I mean it's systemically racist when you look at what the Aboriginal Community Controlled Health Services have to go through with their multiple orders and reports to get ongoing funding. Why wouldn't Aboriginal health money go to Aboriginal health anyway [rather than through the peer chain]."

Improving cultural competency in the health system

Further work to improve the cultural competency of the non-Aboriginal workforce was discussed by both health consumers and stakeholders. Cultural competency requires that organisations have a defined set of values and principles and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally (Purdie et al., 2010). People talked about helpful changes including:

- Service provision and customer service that is culturally appropriate and culturally accessible (language, sensitive and informed).
- Care that recognises cultural identities as different and legitimate (without assumption or judgement).
- Spaces that provide cultural safety (acknowledges and respects culture and provides a safe space for dialogue).

However, as one stakeholder suggested, cultural competency to improve the delivery of health services is not enough.

"I think the role of cultural competency is clearly drawn out in the health stats around Aboriginal and Torres Strait Islander people. We have over 200 years of delivering non-culturally competent health services and we can see that impact it leaves before us every day. But that's not just cultural competency around the delivery of health services; it's cultural competency around creating structures and social determinants which support those communities to live flourishing lives."

Opportunities: Racism and cultural competency

There are opportunities to broaden the scope and depth of cultural competency training in the health system and to do this from the perspective of those experiencing barriers such as racism. Culturally competent organisation policies and procedures are also needed to support behaviour and attitudinal change (Freeman et al., 2014).

During this research we heard perspectives that related specifically to Aboriginal and Torres Strait Islander people and Maori people. However, we understand that similar experiences, although not encountered as part of our field research, are also experienced by people from culturally and linguistically diverse backgrounds.

For Aboriginal and Torres Strait Islander people, their lack of confidence in the health system will remain until action is taken against these types of racism (Health Performance Council, 2017).

Identity incorporates connection to community and country, culture and language. Culturally competent health services must encompass all of these things to even begin to improve equity of access and health outcomes for Aboriginal and Torres Strait Islander people (Health Performance Council, 2017). Such approaches also need to incorporate increasing the number of Aboriginal health employees, who currently make up one per cent of SA Health employees (Health Performance Council, 2017).

1. **How might we scale cultural awareness and competence across all levels of the health system to improve health outcomes for Aboriginal and Torres Strait Islander people?**
2. **How might we look at current workforce development strategies to increase the number of Aboriginal workers in health care?**

Key findings: Evaluation

We're measuring the wrong things in the wrong ways to know what works to create health and wellbeing outcomes.

Despite government initiatives to improve health evaluation (Program Evaluation, Government of Western Australia, 2018; Centre for Epidemiology and Evidence, NSW Ministry of Health, 2017), stakeholders described a number of issues associated with evaluation in this context. Overall, their message was clear – evaluation is not effective in helping to understand what can work to improve health outcomes. Key points discussed included:

- Short-term evaluation of long-term health issues and focusing on outputs (e.g. number of patients seen) and activity (e.g. six-minute appointments) rather than outcomes at program or population level.
- Reporting only good news stories.
- Evaluation lacking rigour.
- Evaluation happening at the end of a program, rather than developmentally, along the way.

There are opportunities to improve the design and timing of program evaluation and to integrate different perspectives into the evaluation design and reporting.

The problem with output-focused, short-term evaluation

The short-term nature of evaluation frustrated many stakeholders. It was described as measuring outputs and activities against set targets that were often influenced by political imperatives, such as election cycles. Stakeholders described this approach as continually unhelpful in understanding the impact of health interventions on reducing health disparity.

"There is no long-term tracking of data, which makes it difficult to see where things are going well and where particular interventions can be made."

Several stakeholders highlighted that the pressure for good news stories within short timeframes often had an impact on reporting evaluation results.

Pressure for success stories sometimes meant that evaluation results could not be made public.

"Quite honestly, it's very hard to do good evaluation because the government becomes very averse to anything that is less than totally good news. The culture at the moment is 'that's going to be politically threatening to us'."

"There's a lot of programs, there's a lot of evaluations commissioned by government that don't ever surface."

Waiting until the end to evaluate and outdated collection methods

Waiting until the end of a program to evaluate its success was still commonplace from the perspective of several stakeholders and representative of the traditional policy and program cycle within government. Scheduling evaluation at the start of a program and careful and deliberate evaluation design could address this issue.

"Where a lot of people fall down is tacking evaluation on the end of a program or project. Everything tends to focus more at the end, that's the impact evaluation, and not the process in the middle."

"Evaluation needs to be designed carefully with some real thinking before starting and a willingness to continue to monitor what is really going on and that's developmental evaluation."

Impact evaluation generally involves an assessment of how a particular intervention affects outcomes and whether these are intended or not. This means waiting until the end of a program to see the results of an intervention. On the other hand, developmental evaluation involves real-time data being collected and analysed in ways that lead to informed and ongoing decision-making during a program. By using both developmental and impact evaluation methods, evaluation would need to be designed in from the start of a project, which would avoid some of the issues described.

Contemporary methods of data collection, aligned with a developmental approach and more effective methods of data collection, were thought necessary by several stakeholders to improve evaluation rigour.

> “We need ways of engaging populations we are targeting. Phone surveys are only picking up those who are at home during the day, which are those over 55.”

> “What we carry around in our pockets every day [phones] can better measure our health.”

While these suggestions present opportunities to improving evaluation in the government context, the scope of evaluation was regarded by some stakeholders as equally important to consider. Addressing health disparities to improve health outcomes is a long-term game that many stakeholders agreed could not be pursued in the government context.

> “There is currently movement outside of government towards partnerships that can look at health and wellbeing, not just ill-health, and looking at longer-term evaluation that is outcomes-based. This way we can see where intervention can be made and has worked.”

Opportunity: Evaluation

Inherent in these discussion about evaluation are the different values stakeholders hold about what constitutes good evaluation. There are opportunities to integrate these perspectives to improve the design of program evaluation to not only look at evaluation points throughout a process, but to incorporate and balance these different, but not mutually exclusive, views. An opportunity for consideration could include:

How might we identify and integrate examples of good developmental and outcomes-focused evaluation design to complement clinical research across the health system?

Key findings: Funding distribution

It's not always clear to stakeholders who funds what in health. Stakeholders agreed funding is skewed towards ill-health, meaning prevention is under-funded.

The flow of money around the Australian health-care system is complex, which can make it difficult to navigate and understand. Stakeholders' lack of clarity about this system confirmed the complexity. However, stakeholders were certain about one thing – funding is currently directed toward managing ill-health rather than prevention, to the point where the latter is now under- funded. Key points discussed included:

- Funding distribution is characterised by cost-shifting and poor coordination and it is not always clear where money was being spent.
- Investment in health in South Australia is on hospitals and not prevention.

Despite these challenges, stakeholders believed there were opportunities to explore funding health interventions that responded to both prevention and treatment at the same time.

Funding distribution

The figure on the following page shows the major flows of funding between the government and non-government sectors and the providers of health goods and services (Australian Institute of Health and Welfare, 2017). The government sector includes the Australian and state and territory governments and, in some jurisdictions, local government. The non-government sector comprises individuals, private health insurers and other non-government funding sources. Other non-government sources principally include workers' compensation, compulsory third-party motor vehicle insurers, funding for research from non-government sources and miscellaneous non-patient revenue that hospitals receive.

It's not surprising, then, that many stakeholders described the distribution of health funding as confusing. While the diagram may be helpful in understanding funding distribution, the approach to funding was described as 'not entirely transparent' in terms of who funds what and how money is spent.

> "I would say there is a lack of clarity around who's funding what and what some agencies are funded to deliver. The Public Health Network [PHNs are networks implemented to improve the coordination of patient care] do have a lot of funding and I think they are supposed to fund health and wellbeing activity, but I'm not sure where the funding is flowing ... there's not a lot of transparency there, but I know they've got money."

Despite the introduction of PHNs, cost shifting between federal and state governments and poor funding coordination were described as ongoing and well-known features.

> "The integration across levels of health are famously and notoriously fucked up on any international scale of vertical or horizontal integration. There are a lot of people who have been advocating for a better health system where states don't cost-shift to the feds and the feds don't cost-shift to the states."

Most stakeholders were clear that government funding generally, and particularly in South Australia, for early intervention and prevention programs had been significantly scaled back or *"obliterated from the policy and service delivery space"*. Instead, the focus for the state government was investment in hospital infrastructure.

> "Most investment is in the crisis end when poor health arises. There's been a shift away from prevention and early intervention and looking at what keeps people well."

> "In the South Australian context, it's all been about Transforming Health and the new RAH [Royal Adelaide Hospital] that has taken priority, which has led to the demise of prevention."

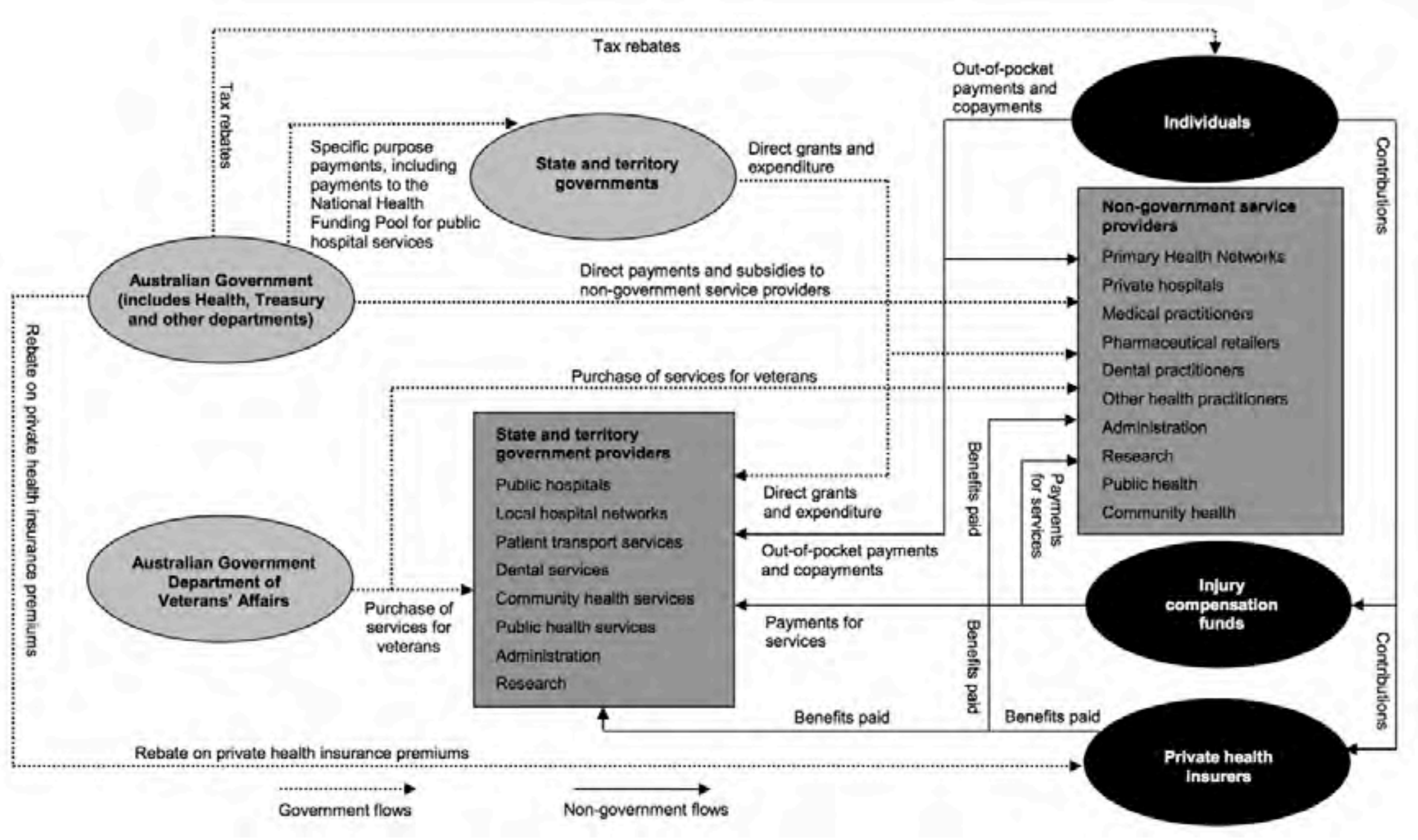

Figure 34: Distribution of health funding, Australian Institute of Health and Welfare 2017. Health expenditure Australia 2015–16. Health and welfare expenditure series no. 58. Cat. no. HWE 68. Canberra: AIHW.

A series of state health funding cuts since 2012 set this direction in motion. The *McCann Review* in 2012 significantly reduced community health and health prevention and promotion programs, while *Transforming Health,* which looked at the consolidation of hospital services in metropolitan Adelaide and the new RAH, saw an increased investment in infrastructure since 2015 (South Australian Treasury, 2018).

While some stakeholders sought action on a return to prevention and health promotion, others thought it unlikely to occur. The long-term nature of health promotion was thought to be incompatible with political cycles and would mean a double-up of expenditure not favourable to either political party.

> "The problem with prevention is the long game nature of it. It's not announceable .... for both sides of government, it's not announceable. It doesn't have immediate impact that's visible. It could be someone else's problem in five more cycles. Yeah, it's just not sexy enough. And it also doesn't create savings now, it creates savings in 20 years. So, there's double expenditure at this point. You're still paying for the hospitalisations now while you have the prevention."

This perceived difficulty was not shared by some. Their perspective was that to achieve health outcomes, policy and service delivery responses need to look at the whole rather than one aspect of the health continuum. If this is not done, then treatable burdens of disease continue to become a financial burden.

> "Well, if you take a comprehensive primary health care model then the whole basis of it is that you look at the whole. You do rehabilitation/cure, prevention and health promotion. You can take any issue you like and run it through and you should be responding at each level [of the continuum]."

This view was also conveyed in the 2017 *Productivity Commission Report*. This asserted that funding needed better structures and new incentives that promote both prevention and chronic illness management throughout the health system (Productivity Commission, 2017). In this context, it's also been argued that many preventative health interventions are cost-effective, reducing the overall cost of managing health (Jackson and Shiell, 2017).

Opportunity:
Funding distribution

While health is considered a long-term game, requiring decades to show impact and return on investment, this does not match political imperatives or the way in which the Australian health system is funded. However, there are health and financial gains to be made from approaches that look at short-term health markers that can strongly correlate with long-term outcomes. This is currently being explored at the University of Maryland's Population Research Centre in the United States. By using federal data on 40 000 households with biomarkers like blood pressure, researchers are working to determine how spending on preventative measures associated with the social determinants of health can affect long-term health — and do so in a few years, rather than decades (Freedman, 2018). Examples such as this can build the feasibility of exploring the following question:

How might we explore funding 'wellness' by focusing on commissioning for outcomes (rather than pitting prevention and treatment against one another)?

Key findings: Community-managed health

A dominant focus on the treatment of illness and disease in clinical settings diminishes individual, family and community capacity to manage health and wellbeing at home.

The opportunity to strengthen community health and increase South Australia's capacity for managing ill-health was repeatedly championed throughout our interviews. The following points emerged as key challenges:

- Reduced financial focus at the community level has seen a decline in community health promotion activities.
- The role of individuals, families and communities in maintaining and managing their own wellbeing is undervalued in the current system.
- Hospitals alone won't be able to meet the health needs of South Australians into the future.

The prevention and early intervention steps that happen at a community level before you get to a hospital are critical components in the creation of communities that build wellness. Furthermore, how well people are set up to manage their health (chronic disease(s) in particular) at home and through the use of local services holds some potential to decrease the burden on our hospitals and economy. An appropriate level of community control is also necessary to ensure the effectiveness of these services and their ability to meet the specific needs of the people they exist to benefit.

Divestment of community level health promotion activities

South Australia has witnessed the divestment of most health promotion activities at a community level since the *Review of Non-Hospital Based Services* (McCann, 2012) where an evaluation did not support the effectiveness of health promotion activities and recommended cessation of funding. The health consumers and stakeholders we spoke with criticised the reduction of health and wellbeing programs delivered at a community level.

> "For me, there's been quite a withdrawal of funding for preventative health and anything to do with the social determinants of health." – Stakeholder

> "We haven't got hardly any services down this road to help us… They're closing a lot of the stuff at the Queen Elizabeth Hospital where we need it. There's absolutely nothing down here." – Health consumer

Stakeholders said the funding cuts also impacted the ability of local governments to properly resource new initiatives and to seek qualified medical input – previously as easy as walking down the hall – when designing such initiatives. Successful health initiatives also became unsustainable for local government with the withdrawal of funding and have largely ceased operations.

> "You might have a council with a really well thought out public health plan, but if there's not the capacity, if you don't have a project officer to get programs and initiatives up and running, that's just not going to happen."

Programs and services at a community level were considered to be:

> '…an important outcome for the wellbeing of individuals because it should mean that people are managed in the community closer to home. Managing those multiple conditions, which increase as we get older, to prevent the decline and the acute hospital admission.' – Stakeholder

Impact on individuals, families and communities

> "The biggest, best, most cost-efficient health system in the country is self-management." – Stakeholder

The loss of community-based services, supports and health promotion activities impacts individual health literacy. Low individual health literacy is associated with higher rates of hospitalisation and emergency care, and with higher rates of adverse outcomes generally. Only about 40 per cent of adults have the level of individual health literacy needed to meet the complex demands of everyday life (Australian Commission on Safety and Quality in Health Care, 2014).

Multiple stakeholders reinforced the need for sustained skills-based education for individuals and their support networks to build health literacy.

> "I'd say people's immediate support network has a part to play. If they're in a supportive family, a supportive community, they have a higher chance of translating what they've learned into action. And where education is more skills-focused there's also a much better chance of bringing about [behaviour] change because you're building people's capacity and building a confidence and their self-efficacy to bring about change."

Some stakeholders described the impacts of poor health literacy on disadvantaged populations as being compounded by factors such as local amenities, educational attainment, language barriers, food insecurity, income inequity and employment opportunities.

> "It's very difficult for knowledge to translate into change without supportive environments and settings… physical settings … economic limitations … cultural limitations."

A cross-sector policy response (*Health in All Policies*) (SA Health, 2011), as witnessed with growing frequency until 2012, was commonly applauded amongst stakeholders. The need for such a response to be sustained perpetually to create and maintain the conditions for communities to build wellness was shared by many stakeholders.

> "Absolutely, connections across key stakeholders, involvement of key stakeholders that bring different expertise and connections. But I think the other point I'd like to make is 'sustained'. We see so many one-off approaches and they just don't work."

Addressing the scale of the problem

Total national health expenditure is projected to increase by 189% in the period to 2033, from $85 billion to $246 billion per year (Goss, 2008).

The desire to control health care costs has led the State Government to focus on chronic disease management and vertical integration with the hospital system (Baum et al., 2016).

This model, which does little to address the social determinants of health or community development, was characterised by one stakeholder as:

> "…one of the things which we do most poorly within our current health system. … It's basically people not understanding that we're not just individuals. We are individuals who are part of a community and society and we're heavily influenced by our environment and our social interactions."

Stakeholders widely agreed that hospitals alone would be unable to meet the scale of public health needs into the future. As one stakeholder put it:

> "I think [community managed health] it's untapped, and it's probably the only thing that actually is going to be of the breadth and depth that we're going to need to actually make it [the health system] work."

Indeed, the Australian Commission on Safety and Quality in Health Care outlined the following condition as having the potential to not only improve the safety and quality of health care, but also to reduce health disparities and increase equity: having consumers who are partners in the processes of health and health care (Australian Commission on Safety and Quality in Health Care, 2014).

Community-centred health care has been widely demonstrated to be a more cost-efficient and cost-effective alternative to hospital-centred care, particularly for prevention and care of persistent, long-term or recurrent conditions (Rosen, Gurr and Fanning, 2010). In South Australia we have witnessed community health services dismantled in favour of centralised hospitals. However, the Central Australian Aboriginal Congress's community-controlled model of comprehensive primary health care is one example of a promising alternative model for community managed health (Freeman et al., 2016). Core principles include: 'strong Aboriginal community control' as a key mechanism for delivering person and family-centred care, community development, social and preventative programs.

In a similar vein, one stakeholder cited:

> "The best example is in the Australian Capital Territory where, essentially, in the same way that we have created community-focused activity centres or sports halls or those other community-run and community-owned activities, they have done the same thing with general practice and a health clinic; so a group of communities and neighbourhoods have said 'our health is partly our responsibility and we would like to have a kind of community control'."

While PHNs do consult directly with consumers, stakeholders believed there was potential for greater consumer participation in the design and governance of community health services. One advocate said:

> 'Get the voice of consumers into the governance of services, into the way individual care occurs and the way the right services are planned, delivered and monitored'.

Benefits of this approach include increasing the agency of consumers to identify and shape services that meet the specific needs of their communities, culturally and otherwise.

Opportunities : Community-managed health

As outlined, the role of self-management and community-managed health has been undervalued. Combined they represent the latent capacity needed to meet emerging South Australian health needs into the future. To focus on keeping people well and helping them better manage their health at home – with community support – has the potential to minimise expensive acute care hospital admissions while also developing community and individual resilience. The following questions are an invitation to the health sector and adjacent sectors to consider how they might support wellness for all:

1. **How might we invest in ensuring people can manage their wellness at home to prevent hospital admission?**
2. **How might we invest in ensuring people can better manage their health at home post hospital admission?**
3. **How might we refocus more control of health and wellbeing back to communities and health consumers?**
4. **How might we better understand the opportunities for health and wellbeing coordination at the community level?**

Key findings: Finding and accessing support

Health consumers and their carers struggle to find and physically access support services and activities that effectively meet their needs and preferences.

People's needs are complex and multi-layered – especially when it comes to managing ill-health – and that is without taking personal interests and preferences into account. Health consumers shared many frustrations with both finding the health services they needed and their experience of those services. Luck is the dominant narrative when it comes to whether consumers stumble across the right supports or not.

Finding and accessing desirable services is but half the battle. The current focus on hospital-based care and managing chronic disease with individuals has led to less comprehensive service coverage and a transition away from services that sought actively to engage with the community (Baum et al., 2016). Since 2012 there has also been a decline in inter-sectoral collaboration, including relationships between education, welfare, non-government organisations and local governments (Baum et al., 2016). Today services are less coordinated, less grounded in the realities of people's lives and thus less effective and less desirable.

Physical access

Hospital-centric care and a decrease in community-based services pose a number of physical access challenges for health consumers. As chronic diseases are becoming increasingly common nationally (Australian Institute of Health and Welfare, 2016) any hospital-based focus appears to be a self-defeating strategy. Hospitals are expensive to build and run, capacity is limited and they do not attract the populations at greatest risk.

Consumers talked about access challenges from a variety of different contexts outlined below:

- Locational – where few local services are available and transportation and travel time is a barrier.
- Rural and remote – where urban service providers don't take context into account, resulting in major impositions for South Australians living in rural and remote communities: *'When you're out in the country like we are, that's where you really see how the system works. When you go somewhere and they say, "Oh no, you have to come back tomorrow. That's not like just driving down the street to do it."*
- Individual – where cultural fit, physical ability, personality and preference are not factored into the delivery of many support services.
- Informational – where program awareness and visibility are low, referral networks are absent or disjointed and luck plays a role in finding support: *'Well, I'd say a lot of stuff doesn't come out and hit you in the face. You hear from someone who's been and tried it.'*
- Eligibility – where support services require consumers to meet specific criteria: *"The mental health support groups that exist aren't maintained, or there's criteria to get in, like, 'You've got to be unwell to be a participant in this group', when how great would it be to have a couple that you could attend weekly, for no payment, no criteria, complete privacy, and just come and talk. It would be fucking awesome to have something like that for mental health."*

Services that don't fully meet consumer needs

We heard from consumers about the tendency for support services to look at health needs as separate from context. If a health consumer has issue 'X' we will offer support for 'Y'. As opposed to: health consumer with issue 'X' can't drive and also needs respite from the full-time care of a disabled child. Health consumers often spoke about needing to weigh up the hassle versus the benefits of accessing the support they need.

> "Even with groups, she [mother] can really only go to groups for Alzheimer's. She can't go to other groups, because then I'd have to be there, and that defeats the purpose [respite] of her going to a group."

Understanding context is also critical when it comes to the way in which services are delivered. For example, in mental health urban dwellers are twice as likely to seek support than their rural counterparts, which is cited as a result of stigma and a culture of self-reliance in the rural context (Health Performance Council, 2013). Aboriginal Australians are also more likely to feel comfortable seeking support from Aboriginal- specific health services. A lack of service adaption for context ultimately contributes to how successfully the needs of the specific communities and individuals are met. As one health consumer conveyed:

> "...he [locum doctor] took me aside and told me about some people in the town who I might talk to [for support with husband's dementia]. I'm a bit funny... I didn't want to talk to them. I didn't want them to know what I or my husband were dealing with and therefore the 24-hour hotline was special. It also, for me, took a bit of guts."

Another contributing factor is a lack of oversight and coordination between local government, non-government organisations and other service providers. Stakeholders spoke about service duplication, overlaps and gaps resulting from poor coordination.

> "There are lots of little groups, charities and universities working with charities, all trying to do something, but it's not in a very coordinated way."

> "What are we each going to do and [how will we] know what the other person is doing, so we are not overlapping ourselves and we are each saying that this is the bit that I can do or I have funding to do."

Choice

Individuals affected by ill-health and those who care for them often struggle to find local support services that meet their needs and align with their preferences. We heard about spectrums of need and preference (outlined below) that can be different for everyone. These spectrums expose the limitations of a blanket service approach where a level of customisation and choice are not an option.

- type of support, e.g. peer support/professional support, personal/clinical
- frequency, e.g. infrequent/frequent
- style, e.g. casual/formal, group/individual, social/therapeutic, informational/activity-based
- duration, e.g. short-term/long-term
- specificity, e.g. general/specific
- access, e.g. local/not local, free/expensive, open to all/subject to application, culturally neutral/culturally specific
- personality/attitude, e.g. closed-minded/open-minded, shy/outgoing
- respite, e.g. hours/weeks

Beyond preference, individual interests also play a role in whether someone continues with a particular support service or quits. Consumers told us about occasions where they chose to take a break or stop going to community-based services.

> "Oh, it's okay. I'm more physical and with painting and such that didn't turn me on, well it doesn't at all ... it becomes a bit of a chore because it's nothing of how I like to spend my time."

> "It seems that people are not joining. You might get the odd one here and there, but people leave if it's not what they want to do."

Compounding the lack of choice, we heard about the role that mindset, attitude and fear play for many health consumers when it comes to joining new support services.

> "I'm just talking about two people – the ones I'm a little bit more friendly with – but they're not interested, 'Why would I do that? Why would I wanna do that? You know? Without having a go'."

Currently, accessing non-referral-based services requires a level of motivation, self-confidence and vulnerability which creates a barrier for many health consumers. Once consumer shared:

> "A lot of people are scared to reach out because they're afraid to show they've got emotions and weaknesses."

The combination of improving physical access, meeting health and contextual needs and customisation for personal interest/preference offers multiple opportunities to engage people in new ways to support staying well and managing ill-health within our communities.

Opportunities: Finding and accessing support

Finding and accessing support services that are both local and suited to an individual's needs and preferences is a game of luck for many consumers. Centralised services are less attractive and accessible to the communities that need them most. The three questions below shape some of the opportunity spaces that exist to help people find and access the supports they need and want:

1. **How might we build stronger and more informed networks and channels for people to find and access the support they need – making it easier to stumble across good health and wellbeing support wherever you are?**
2. **How might we ensure health and wellbeing services better respond to individual needs and preferences, making them more personalised and person-centred rather than system-focused?**
3. **How might we create opportunities for augmenting services with 'lived experience professionals' and peer supports?**

Appendices and references

Appendix 1: Search strategy

Fay Fuller Foundation - South Australian health needs and priorities, Search Strategy for Phase 1a: Literature Review

Proposed search parameters and potential sources:

1. SA's demographic profile (incl. trends)

We propose to obtain and collect data relevant to South Australia's demographic profile (including trends) from the Australian Bureau of Statistics (ABS) and Public Health Information Development Unit (PHIDU). Data to be collected include:

- sex
- age
- cultural background
- income
- education
- employment/unemployment, hours worked
- family composition
- housing
- rent/mortgage >29% of income.

The population groups to be incorporated within this demographic profile include:

- Aboriginal and Torres Strait Islanders
- children and young people
- homeless people
- LGBTIQ
- men
- older people
- recently arrived (migrants and refugees)
- rural and remote
- sole parents
- women.

2. Physical and mental health - trends, issues and identified needs

We will investigate and collate information relevant to the physical and mental health trends, burden of disease, issues and identified needs using the following sources:

- SA Health Atlas (PHIDU)
- Health Performance Council
- Chief Public Health Officer's Report
- SA Monitoring and Surveillance System (SA Health)
- AIHW
- AHCSA Next Steps report
- ABS National Health Survey (for migrant health data)
- Refugee Council of Australia (for migrant and refugee health data)
- National LGBTI Health Alliance
- SA Health Local Health Networks
- Country Health SA Local Health Network (CHSALHN)
- Women's and Children's Health Network SA
- Headspace National Youth Mental Health Foundation
- Beyond Blue (SA and rural)
- Public Health Association of Australia (PHAA).

Additional search strategies will incorporate examination of:

- university research databases
- academic publications, including journal articles and conference presentations
- other research, grey literature.

3. Social wellbeing - trends, issues and identified needs

We will investigate and collate information relevant to social wellbeing trends, issues and identified needs. This will include information related to:

- access to and accessibility of health and wellbeing services
- access to child care/early education
- child protection
- behavioural risk factors (smoking, risky alcohol consumption, vaccination rates, etc.).

We will investigate and collate information relevant to social wellbeing trends, issues and identified needs, using the following sources:

- Index of Relative Socioeconomic Disadvantage
- South Australian Council of Social Services (SACOSS)
- Public Health Association of Australia (PHAA)
- Australian Institute of Family Studies
- Department for Communities and Social Inclusion
- Office for Youth
- Homelessness Australia
- Local council areas
- Other non-government organisations (NGOs) that arise during the investigation process.

Additional search strategies will incorporate examination of:

- university research databases
- academic publications, including journal articles and conference presentations
- other research, grey literature.

This proposed search strategy is not intended to be an exhaustive list of strategies and resources. It is expected that additional sources of information and alternative strategies will arise as the search progresses.

Appendix 2: Source document summaries

An electronic copy of this appendix, containing full summaries of all source documents, is available upon request from the Fay Fuller Foundation.

Appendix 3: Health Omnibus Survey questions

These questions were placed on the 2017 Health Omnibus Survey. Details of how the survey is conducted were provided in section 3, Methodology. N.B. Only the text in **bold** is read out to the respondents. Their responses were recorded verbatim, or as close to verbatim as possible.

Intro: **The next few questions are about health and wellbeing. Health means physical or mental health and wellbeing means feeling comfortable, happy and able to cope with the normal stresses of life.**

1. **What is the single biggest health or wellbeing-related issue that you personally face?** [unprompted; single response only]

- Ageing [specify]
- Physical health issue - mine [specify]
- Physical health issue - family member's [specify]
- Mental health issue - mine [specify]
- Mental health issue - family member's [specify]
- Family-related (non-health) issue [specify]
- Work-related issue [specify]
- Health services issue [specify]
- Other [specify]
- None/can't think of any

2. **In dealing with this health or wellbeing issue, what are the main challenges you run into?** [unprompted; multiple responses allowed; max 5]

- No/limited local services
- Finding a service that can help me
- Cultural issues
- Transport/getting to services
- Low income
- Long waiting times for assistance
- Poor coordination between services
- People not understanding/allowing for my needs or limitations
- Unable to undertake tasks/work/usual duties
- Unable to care for myself
- Unable to participate in social outings/events
- Other [specify]
- None/can't think of any

3. **What do you think is the biggest health or wellbeing-related issue that the South Australian community, as a whole, faces?** [unprompted; single response only]

- Ageing [specify]
- Physical health issues [specify]
- Mental health issues [specify]
- Family-related (non-health) issues [specify]
- Work-related issues [specify]
- Health services issues [specify]
- Other [specify]
- None/can't think of any

4. **What other health or wellbeing-related issues are most important in South Australia, in your opinion? Please list up to five.** [unprompted; multiple responses allowed; max 5]

- Ageing [specify]
- Physical health issues [specify]
- Mental health issues [specify]
- Family-related (non-health) issues [specify]
- Work-related issues [specify]
- Health services issues [specify]
- Other [specify]
- None/can't think of any

5. **Imagine you were deciding how government should spend your money. If you had $100 to distribute across these six areas (show card), how much would you give to each of them?** [read out; randomised order, total to be 100]

- **Defence**
- **Education**
- **Health**
- **Social welfare**
- **Transport infrastructure (roads, railways, etc.)**
- **Environment**

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