

Country SA PHN Needs Assessment Report 2025–2028

November 2024

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phn
COUNTRY SA
An Australian Government Initiative

Acknowledgement of Country

Country SA PHN acknowledges the Traditional Custodians of the lands across Australia and pay respects to Elders past, present and future.

We recognise and respect the unique cultural and spiritual relationships to the land, waters, and seas that continue to be important to Aboriginal and Torres Strait Islander people living today.

About this document

This Primary Health Network's (PHN's) Needs Assessment report was submitted to the Department of Health and Aged Care on **15 November 2024** and approved on the **16 December 2024**.



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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ADAC	Aboriginal Drug and Alcohol Council (SA)
ADHA	Australian Digital Health Agency
AHCSA	Aboriginal Health Council of South Australia
AHPRA	Australian Health Practitioner Regulation Agency
AHS	Australian Health Survey
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
APHN	Adelaide PHN
APY Lands	Anangu Pitjantjara Yankunytjatjara Lands
CAC	Community Advisory Council
CALD	Culturally and Linguistically Diverse
CC	Clinical Council
CKD	Chronic Kidney Disease
CNA	Comprehensive Needs Assessment
COPD	Chronic Obstructive Pulmonary Disease
COTA	Council on the Ageing
COVID-19	Coronavirus Disease
CRM	Customer Relationship Management System
CSAPHN	Country SA Primary Health Network
CVD	Cardiovascular Disease
DoH	Department of Health
DoHAC	Department of Health and Aged Care
DST	Decision Support Tool
ED	Emergency Department
ERP	Estimated Resident Population
ESKD	End Stage Kidney Disease
FDSV	Family, Domestic and Sexual Violence
FTE	Full-time Equivalency
GCfAHPC	Greater Choice for At Home Palliative Care Measure
GP	General Practice or General Practitioner
HIV	Human Immunodeficiency Virus
HPI-O	Healthcare Provider Identifier-Organisation (HPI-O)
HPV	Human Papillomavirus
IAR	Initial Assessment and Referral
IPEPA	Indigenous Program of Experience in the Palliative Approach
IRSD	Index of Relative Socio-Economic Disadvantage

LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual+ The '+' reflects other gender identities and sexual orientations that are not already present in the lettered acronym.
LGA	Local Government Area (local councils)
LHN	Local Health Network
MBS	Medicare Benefits Schedule
NCETA	National Centre for Education and Training on Addiction
NCIS	National Coronial Information Service
NDIS	National Disability Insurance Scheme
NDSHS	National Drug Strategy Household Survey
NGO	Non-government Organisation
NHSD	National Health Service Directory
NHMRC	National Health and Medical Research Council
NMHSPF	National Mental Health Services Planning Framework
MMM	Modified Monash Model
PBS	Pharmaceutical Benefits Scheme
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
PIP	Practice Incentive Program
PMHC	Primary Mental Health Care
PPH	Potentially Preventable Hospitalisation
PSA	Pharmaceutical Society of Australia
QI	Quality Improvement
RACH	Residential Aged Care Home
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDWA	Rural Doctors Workforce Agency
RFDS	Royal Flying Doctor Service
RHD	Rheumatic Heart Disease
SA	South Australia
SA#	Statistical Area Level 1, 2, 3, 4.
SANDAS	South Australian Network of Drug and Alcohol Services
SEIFA	Socio-Economic Indexes for Areas
SES	Socio-Economic Status
STI	Sexually Transmitted Infection
TACSI	The Australian Centre for Social Innovation
TIS	Translating and Interpreting Service
UN	United Nations
WHO	World Health Organisation

Executive Summary

The Country SA PHN Comprehensive Needs Assessment report identifies the health and service needs, gaps and opportunities for improved outcomes in our region, through the synthesis of data, stakeholder and community consultations. This report will inform Country SA PHN's work over the next three years to address identified access barriers and inequities. Several factors outside our scope of work are also discussed to ensure findings are representative of our community and form a holistic foundation for evidence-based commissioning.

It is evident that the country SA region continues to experience an increasing demand for health services and workforce due to ageing populations, the prevalence of chronic disease and mental health conditions as well as increasing complexity of health needs. Findings reiterated that there are unique additional barriers to accessing and providing appropriate, timely and accessible healthcare in regional and remote South Australia. These barriers include the limited availability of healthcare professionals, long wait times, reduced access to specialist services, and culturally appropriate care. There is also limited access to public health and/or bulk billing services, as well as options available 'after hours'.

Access barriers in country SA go beyond structural disparities and instead represent the complex interaction between systems, organisations, providers, consumers, and the environment. Many people in our region live in a health landscape that continues to be impacted by environmental factors that affect health service access and utilisation, including access to transportation, living situation, and geographical location. Stoicism, confidentiality concerns, and healthcare avoidance also impacts healthcare utilisation in our region. While many of these factors are broadly experienced by our population of approximately 530,000 people, variance in aspects such as rurality, population density, health beliefs and behaviours across our region, results in differing experiences and challenges to consider.

Recognising the effects of these factors on unmet healthcare needs can help identify broader issues, opportunities for change and avoiding blame. These considerations are important when we address challenges in our region, including higher rates of chronic conditions including cancer, cardiovascular disease and chronic kidney disease in rural and remote areas. The need for a preventative approach to address the higher prevalence of behavioural risk factors and improve timely access to identification and intervention support including screening programs was identified.

Many people in country SA have a strong sense of resilience and find strength from close community bonds, which can help reduce social exclusion, isolation and loneliness. The unique challenges of rural life including economic and environmental changes, as well as stress from unfavourable conditions and natural disasters can directly impact mental health and impede healthcare utilisation. Regional and remote regions of South Australia have higher rates of mental health concerns, while workforce distribution and services decrease with rurality. As a result, mental health-related emergency department presentations are increasing in country SA, as in some regions, it is the only option for people experiencing an acute mental health crisis. There is a need for increased outreach health supports, population-specific approaches, particularly for men and young people, as well as early identification and intervention services in our region.

The following paragraph includes discussions of suicide and self-harm.

Suicide has a significant and enduring impact throughout communities in country SA. The interconnected nature of our regional communities can be protective against suicide and self-harm, providing support and a sense of belonging; however, it can also extend the impact when someone dies by suicide. In country SA, there is a need for improved access to timely, appropriate and compassionate supports as well as efforts to strengthen existing protective factors within communities. This requires planning at the local level to ensure initiatives address community needs and challenges. Country SA PHN respectfully acknowledges those impacted by suicide and self-harm, including the bereaved, people who care for loved ones through suicidal crisis and people with lived or living experience.

Alcohol and other drug use causes harm to individuals, families, and communities, with these harms disproportionately affecting specific population groups. Negative societal framing overlooks key influencing factors in usage behaviours and creates barriers to help seeking, which can exacerbate existing inequalities. In 2023, alcohol, tobacco and cannabis were the most prevalent drugs used in country SA. Alcohol was the leading principal drug of concern for clients receiving AOD treatment in our region, followed by amphetamines and cannabis. The co-occurrence of mental illness and substance misuse can amplify health impacts and complicate treatment for both conditions. The emergence of alternate nicotine delivery products including e-cigarettes presents new health risks and challenges.

Healthcare access and utilisation factors impact the health of our population in different ways over their lifespan, often resulting in cumulative challenges and barriers. The foundations of good health start during the first 2000 days of a child's life, from conception to age five years. Limited healthcare availability and choice can exacerbate existing challenges in country SA, including low rates of antenatal care attendances and higher than average rates of smoking in pregnancy in some regions, as well as immunisation rates below national targets. These factors persist into childhood, as prevalence of developmental vulnerability and potentially preventable hospitalisations increase with remoteness.

An increasing number of older people in country SA are choosing to remain in their communities as they age, enabled by the increasing availability of home support and care service packages. Older people experience a range of health conditions including dementia, heart disease and cancer as well as health concerns like falls and medication management. Increasing co-morbidity and corresponding complexity of health needs continues to be a challenge for our aged care workforce. Many older people live alone at home and enjoy the independence it offers; however, it can pose significant risks and can limit the accessibility of timely medical care. Therefore, there is a need for appropriate supports that allow older people to have an active role in their own health as well as understand and access the aged and primary health care systems.

Diagnosis of a life-limiting illness or the transition to the end-of-life phase has far reaching consequences. Community strengths, including the close-knit nature of country towns, can be a vital support for individuals and their loved ones, but may also amplify the emotional, physical, financial, and communal impacts of difficult times. In country SA, there is a need for increased multidisciplinary care delivery and the incorporation of pharmacists into palliative care teams. Community education on death literacy can support meaningful conversations about people's end-of-life wishes, facilitate proactive planning and reduce societal stigma.

Informal carers play a key role in sustaining our aged care, disability, health, mental health, and palliative care systems. In country SA, challenges including accessing respite care can exacerbate the existing personal impacts of this unpaid work on health, wellbeing, and career prospects.

Aboriginal people intimately understand that health is a complex integration and balance of physical, environmental, emotional, social, spiritual, and cultural wellbeing. This understanding, as well as the social and cultural determinants of health, must be central when addressing Aboriginal people's health needs. It has been well established that working with Aboriginal communities, on priority issues identified by Aboriginal organisations and communities achieves the best outcomes. Aboriginal people in our region and across South Australia have identified several priority needs including improved prevention and management of chronic conditions as well as enhanced access to culturally safe and responsive services. It is also important to recognise the negative impacts of deficit framing particularly on health outcomes, embed strengths-based approaches and highlight protective factors. These approaches can work to counter the intergenerational trauma and deep-seated distrust of mainstream healthcare systems among Aboriginal peoples which has resulted from colonisation, the forced removal of children, and discriminatory healthcare policies.

Specific population groups within our community experience health inequity, including Aboriginal people, the LGBTQIA+ community, people from culturally and linguistically diverse (CALD) backgrounds and people with disability. To contextualise the lived experiences of these priority populations, key facilitators, protective factors, barriers, preferred language and cultural considerations were identified. These factors vary between health areas and several additional priority populations, including young people and people at risk of or experiencing homelessness, are highlighted in this report. Country SA PHN is committed to addressing health inequity through increased workforce capability, person centred approaches and the provision of locally relevant and culturally safe services.

Long-standing challenges in attracting and retaining a suitably trained multidisciplinary primary care workforce in rural and remote South Australian communities continues to impact service availability, acceptability, and continuity. Local stakeholders identified several challenges including limited availability of transport, housing, support for families and reduced opportunities for professional development for health professionals. As demand for allied health services increases, challenges in providing culturally safe care that includes the appropriate mix of required skills to meet community needs remain. Opportunities include increased integration and coordination across the health, aged and social sectors as well as expanding the peer, lived experience and Aboriginal workforces.

Digital health and connectivity can enhance access to healthcare, improve outcomes, and facilitate the delivery of efficient and coordinated care, especially in regional and remote communities. In country SA, opportunities to increase uptake and utilisation include improving digital health literacy, building digital capability of providers, and facilitating connections and collaboration across primary care sectors.

Country SA PHN will address the identified needs of our community by working with local services and stakeholders to develop place-based solutions including education, capacity building and increased service provision.

Our Organisation

Country SA PHN is one of 31 Primary Health Networks (PHNs) nationally and is the Primary Health Network representing country South Australia.

Established by the Australian Government in 2015, PHNs are independent organisations which play a vital role in improving health services in primary care, with a particular focus on those people at risk of poor health outcomes.

The key objectives of the PHNs are to assess the health care needs of their community and commission health services to meet those needs, minimizing gaps or duplication. They support health services to connect with each other to improve people's care and strengthen the primary health care system.

PHNs are also vital in assisting in the delivery of healthcare reform and are guided by the national priorities set by the Australian Government. Fundamental in our method is to adapt and customise our services to meet the expectations and the needs of the people in country South Australia.

Our Vision

Better health and wellbeing for all country South Australians

Our Mission

Bridge the gap of health inequity

Our Objectives

- Increase health equity amongst our communities
- Increase the efficiency and effectiveness of primary health care services
- Work with communities to enable access to the right care in the right place at the right time

Our Strategy

The Country SA PHN Strategic Plan outlines our organisational objectives and priorities and is underpinned by our values. Summarised in Figure 1, it forms our foundation – guiding our activities and decision-making right across the organisation from needs assessments, program design, procurement and evaluation, through to communications. The consistent application of our values is crucial in achieving our objectives.

Figure 1. Country SA PHN Strategic Plan



Narrative

Background

The Needs Assessment is a contracted deliverable that all 31 PHNs are required to submit to the Department of Health and Aged Care (DoHAC) as part of the reporting requirements of the PHN Program. A Comprehensive Needs Assessment (CNA) must be submitted every three years. This report is the first in the 2025/26 to 2027/28 cycle. In addition to triannual submission, Country SA PHN will undertake an annual refresh of our Needs Assessment, to incorporate new data and evidence gathered in the previous year, including feedback from internal and external stakeholders, the County SA PHN Board and advisory groups, and in consideration of policy changes, funding and Commonwealth requirements.

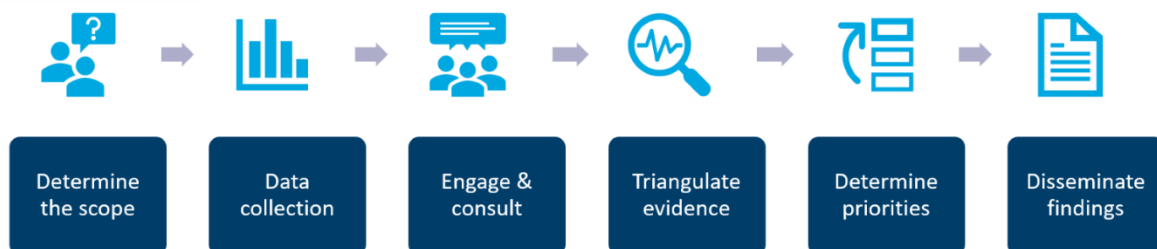
The needs assessment is a key strategic planning process and is the first stage of the commissioning cycle. As an output it provides an evidence-based foundation for a program or service design and ensures the community needs are considered and accounted for. The priorities from the needs assessment process inform the next phase of the cycle, which is annual planning.

Some factors and issues identified through the needs assessment process are outside of Country SA PHN's scope as a commissioning organisation, however it is important that we capture a holistic view of the determinants of healthcare utilisation in our region to provide a comprehensive foundation for our evidence-based commissioning.

Process

The process shown in Figure 1 outlines the broad stages of the needs assessment process, that ensures we undertake a detailed and systematic assessment of the regional population's health needs, the local health care services, and engage in stakeholder and community consultation. This overarching process has been adapted from the *PHN Program Needs Assessment Policy Guide 2021* (DoH, 2021b).

Figure 2. The Comprehensive Needs Assessment process



*A needs assessment is a systematic and transparent process
that identifies and prioritises needs in a community
in order to inform programs, policies and services aimed at addressing those needs*

Scope

As part of the planning and development of this Comprehensive Needs Assessment, an internal review was completed to determine the scope of work required, highlighting current gaps and identifying potential sources of data and evidence. Through this process, it was also decided that all PHN Program priority areas of Aboriginal Health, Aged Care, Alcohol and Other Drugs, Mental Health, Population Health, Digital Health and Health Workforce would be extensively reviewed and updated.

As a result of this process, and to support the completion of the CNA in the required timeframes, four topic-specific needs assessments were commissioned throughout 2023 and 2024:

- Family, Domestic and Sexual Violence (including Child Sexual Abuse) (in partnership with Adelaide PHN) - The Australian Centre for Social Innovation (TACSI)
- Sexual and Reproductive Health - Katina D'Onise Consulting and Shine SA
- Homelessness, After-hours and Multicultural access – Health Q Consulting, and
- Rainbow Discovery Project SA - The Equality Project

Findings from these commissioned Needs Assessments have been incorporated throughout this report.

Data collection

There was a consistent approach to data collection for this needs assessment across the broad PHN Program areas. The stages of data collection included a background analysis of the policy and strategy environment, a review of peer-reviewed and 'grey' literature, acquisition and analysis of qualitative and quantitative data sets, and stakeholder consultation.

Data was collected from a wide range of data custodians including Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), the Population Health Information Development Unit (PHIDU), Department of Health and Aged Care, SA Health and Preventative Health SA. Internal sources of data from general practices and commissioned service providers, quantitative and qualitative data, information, and reports were also included in our analysis.

Consultation

Stakeholder and community views serve to complement and contextualise information gathered from regional health and health service statistics. As such, they represent an essential element of both the needs assessment process and ongoing activity planning and implementation.

Table 1. Summary of consultation activities undertaken as part of topic-specific needs assessments, 2023-2024

Topic	Consultation	Target audience	Methodology	Respondents
Family, Domestic & Sexual violence	Adelaide PHN and Country SA PHN	Three broad groups with relevant expertise: People with: lived experience of FDSV, Professionals in the FDSV sector and primary health care professionals	1:1 conversations Focus groups Surveys	83 voices from Country SA PHN region (152 total) 6 people with lived experience (18 total) 67 FDSV professionals and organizations (105 total) 10 primary health care sector professionals (29 total)
Sexual and Reproductive Health	Katina D'Onise Consulting and Shine SA	Relevant SA government departments, Non-government organisations, Aboriginal Community Controlled Health Organisations, Peak bodies, Community advocacy groups	Aboriginal Health Council of South Australia Ltd (AHCSA) facilitated consultation with Aboriginal Community Controlled Health Organisations	11 public health system 5 public health services 9 Aboriginal health 3 Policy/advocacy 7 community representatives 4 medical 2 nursing/midwifery
Homelessness and After-Hours	Health Q Consulting Part A - key strategic stakeholders Part B: Targeted consultation in six regions 1. Ceduna 2. Coober Pedy 3. Gawler 4. Murray Mallee 5. Oodnadatta 6. Port Lincoln	Consumers, Government agencies, non-government agencies, General Practitioners and Primary Care Nurses and representative groups	Part A - virtual consultations Part B - face to face and online consultations, surveys of frontline workers and consumer(s)	104 people 18 strategic &/or statewide stakeholders 8 frontline workers surveyed 77 regional consultation participants 1 Homeless person surveyed
LGBTIQ+	The Equality Project In all six Local Health Networks in country SA	Members of LGBTIQ+ communities and local health providers within each community	Data was gathered through both informal social gatherings called "Rainbow Connection Cuppas" and scheduled interviews and workshops.	18 LGBTIQ+ community members 16 health professional who identified as LGBTIQ+ 26 health professionals

In addition to the consultations undertaken as a part of the commissioned topic-specific Needs Assessments, Country SA PHN also engaged with the Clinical Council and the Community Advisory Committees during the development of the Comprehensive Needs Assessment. Both groups were consulted through meetings, workshops, and were surveyed.

Our Clinical Council is a group of key stakeholders with expertise in a clinical practice environment, which work in partnership and contribute to ensuring that Country SA PHN decisions, investments and innovations are clinically safe, patient centred, cost effective, locally relevant, and aligned to local care expectations and experience. The Clinical Council was consulted through two workshops specifically for the CNA, which provided an opportunity to share findings and receive feedback on commissioned Needs Assessment activities. Members also provided important additional regional context for the CNA. This included guidance on processes, participant feedback on commissioned stakeholder engagements, emerging regional environmental challenges and issues facing our local workforces.

Our Community Advisory Committees (CAC) are comprised of Local Health Clusters and other stakeholders, such as regional Community Service Alliances and Advisory Groups. They provide community perspective and feedback about the experiences of health consumers and their carers who access primary health care programs and services. This information contributes to inform decisions and to ensure funding and programs within their local area are patient centred, cost effective, locally relevant and are aligned to existing local care. Through routine engagement and consultation, the CACs provide insights to Country SA PHN on the wants, experiences, barriers, challenges and opportunities within their communities. This data in both quantitative and qualitative form is then used to inform the needs assessment.

Both the Clinical Council and Community Advisory Committees were also surveyed to identify significant challenges or changes to population health needs and the health system in country SA. Outside of specific needs assessment consultations, community and stakeholders' views are captured from a range of engagement activities, program reporting and evaluations.

Triangulating evidence and determining priorities

Country SA PHN applied a systematic approach to integrating quantitative data as well as qualitative evidence obtained through stakeholder consultation. A triangulation matrix approach assisted to synthesize the issues and needs identified through our background analysis, health needs analysis, service needs analysis and stakeholder consultation.

Our final priority statements and options, opportunities for action and/or partnership in line with the requirements of the Needs Assessment deliverable were identified over a series of roundtables with internal subject matter experts. These were then considered and approved by the Country SA PHN Executive Team.

The specific triangulation and priority setting activities that occurred for each of the separate topic-specific commissioned Needs Assessment activities are provided within their individual Needs Assessment reports, which will be available on the Country SA PHN website.

Evaluation and review of needs assessment processes

As part of a continuous improvement approach, an evaluation of the Needs Assessment process will be completed following submission of the report. The result of which will inform improvements to internal processes including planning and operations, data and analysis, internal systems and resources, which will be documented and incorporated into our Needs Assessment Framework and tools.

A review and refinement of Country SA PHN's Needs Assessment Framework will also occur to ensure alignment with our revised *Integrated Commissioning Approach*. This will improve the transparency and timing of needs assessment processes and responsibilities, and support and encourage involvement of internal subject matter experts.

With guidance from our Clinical Council and Community Advisory Committees we will also review and refine our processes around consultation and engagement particularly in relation to identification of stakeholders, engaging people with lived experience and better incorporation of Indigenous knowledges.

Gaps, limitations and potential future improvements

While comprehensive, we acknowledge there are limitations and gaps in the report. We experienced difficulties getting data, organisation capacity issues, and challenges engaging external stakeholders within the time constraints of this needs assessment process.

While the availability of PHN-level data from national custodians is increasing, there are still some datasets that are only available at the State-level or a Capital City/Rest of State split. These do not align to the Country SA PHN boundary, specifically the peri-urban areas of our region, Adelaide Hills, Gawler etc, are classified as metropolitan Adelaide in these datasets. Although they still can display the disparities of rurality in the outer areas of our region, several highly populated regions in country SA are excluded. Similarly, SA4-level data can homogenize the experiences and needs of our diverse communities.

To improve the appropriateness of the needs assessment and ensure the identified needs are written by and for Aboriginal people, we will seek advice from our Executive team and the Reconciliation Action Plan Working Group, to address knowledge gaps and prioritise engagement with Aboriginal Community Controlled Health Organisations (ACCHO's), and through those organisations, with local community members. Additionally, upon public release, we will implement the AIHW-PHN guidance on Indigenous data sovereignty and governance, to ensure the needs assessment process embeds optimal collection, access and use of Indigenous data.

Additional comments

The joint Family, Sexual and Domestic Violence (including child abuse) (FSDV) Needs Assessment deliverable will be submitted separately to the Department of Health and Aged Care. The findings and outcomes of the FSDV Needs Assessment will be included in Country SA PHN's annual Needs Assessment update for 2025.

Our Region

This section provides a high-level snapshot of the Country SA PHN region including our geographies, populations and primary care services. Exploring the interaction between these elements allows unique additional barriers to accessing and providing appropriate, timely and accessible care in regional and remote areas of country SA to be identified. The maps also provide a visual reference for the locations and regions discussed within the report.

Determinants of healthcare utilisation

Factors that impact healthcare access and utilisation, known as determinants of healthcare utilisation, are necessary considerations when mapping health needs. Many people in country SA live in a health landscape that continues to be impacted by environmental factors that impact engagement, including access to transportation, living situation, and geographical location. Within this context, from the consumer's perspective, additional factors such as health literacy, ability to pay, health behaviour, beliefs and trust in providers, influence the extent to which a person can effectively engage with the healthcare system (Leach, Gunn, & Muyambi, 2022).

This issue goes beyond structural disparities and represents the complex interaction between systems, organisations, providers, consumers and the environment. When multiple structural, environmental, and consumer-related barriers to healthcare access are present, a reduction in service utilisation is likely, resulting in considerable unmet healthcare needs (Leach et al., 2022). With this understanding, the presence of stoicism, confidentiality concerns, and healthcare avoidance behaviours in regional and remote communities can be contextualised to recognise the wider system and avoid individualistic framing (Kaukiainen & Kõlves, 2020; Kavanagh et al., 2023). Recognising the presence and interaction of these factors is essential, especially when reporting on the health status and need of these communities, to generate findings that are meaningful and translatable (Leach et al., 2022).

When examining access, the availability of health services is one of many factors to consider. Approachability, acceptability, affordability and appropriateness also must be considered to understand the subsequent utilisation of services in response to consumer need. It is important to recognise that while many factors are broadly experienced, regional communities are not homogenous, and each community is likely to encounter different healthcare needs, challenges and opportunities (Leach et al., 2022).

Population

Our people and communities are diverse. People in the Country SA PHN region represent as individuals, families, all age groups, cultural diversity and values, family groupings, ability or disability, advantage or disadvantage, and sexual orientations.

Population distribution

Regional South Australia is one of the least densely populated regions in Australia (Population of Australia, 2019). The 2023 estimated resident population for the Country SA PHN region was 530,408 people, which represents almost 29% of the total South Australian population (ABS, 2021c).

Male to female proportion is relatively even, with approximately 6,300 more males than females (ABS, 2022f), and the region has a noticeably lower proportion of adults (aged 25 to 44 years) compared to the whole of South Australia and the national average (PHIDU, 2024c).

The population is widely dispersed across the region, which impacts provision of health services, workforce distribution and patient access to services. As at 30 June 2022, 51% of the region's population were found in the following areas (ABS, 2022f):

- Mount Gambier, Whyalla, Murray Bridge, Port Lincoln, Port Pirie and Port Augusta – large regional towns collectively home to over 116,000 people and each serve as a hub for health and other services for the area and surrounding regions.
- Gawler-Two Wells and Adelaide Hills – peri-urban areas located along the northern and eastern metropolitan Adelaide boundary, with a combined population of almost 122,000 people. These areas have a relatively high access to local and metropolitan health services, as well as other services.
- Victor Harbor and Goolwa-Port Elliott – coastal towns on the Fleurieu Peninsula within an hour of southern metropolitan Adelaide, home to over 29,500 people with a high proportion (43%) of persons aged over 65 years.

The remainder of the population live in small towns of up to 5,000 people, (many with less than 500 people), or are dispersed in the agricultural and outback regions of the state.

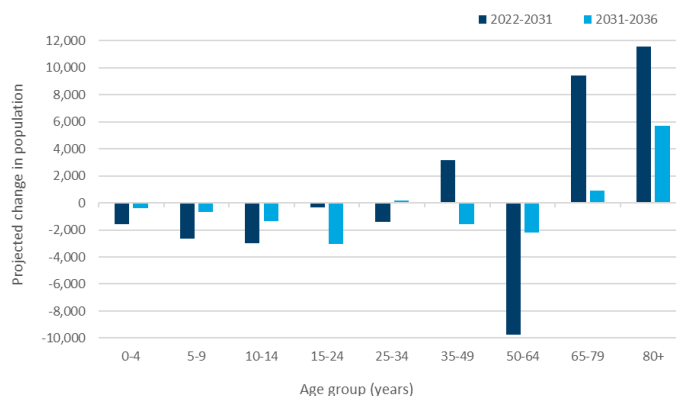
Population change

Based on moderate assumptions of future fertility, mortality and migration, in the 10 years from 2021 to 2031, the population of our region is expected to grow by 60,000 people. The largest increases in population are projected in the urban centres and localities on the outer edges the Greater Adelaide Statistical Area (as defined by the Australia Bureau of Statistics) or in the peri-urban fringe zone on the border of Greater Adelaide, specifically (Department of Trade and Investment, 2024):

- the Adelaide Hills +16,600 people, primarily in the Mount Barker area with approximately +11,400 people,
- the areas of Gawler and Lewiston-Two Wells in the Outer North on the border of metropolitan Adelaide with +10,000 people,
- across the Fleurieu Peninsula with approximately +9,000 people, +4,700 in the Victor Harbor area, and
- +5,500 across the Northern Plains and Barossa region, including +1,300 in Nuriootpa.

Population projections by age group are not available for the Country SA PHN region as a whole; however, the Australian Bureau of Statistics (ABS) has population projections for *Rest of SA*, which covers the rural and remote parts of the Country SA PHN region but excludes the larger population centres such as Adelaide Hills and Gawler within the Greater Adelaide region. They indicate a projected decline in numbers of children, young people and adults of working age in the region between 2022 to 2036, but an increase in people aged 65 years and over (ABS, 2022e).

Figure 3. Population projections for Rest of SA region by year and age group



Aboriginal population

Within the Country SA PHN region there are over 30 Aboriginal communities or nations (as preferred by different groups), which are diverse in language, culture, and history. These include:

Buandig(k); Narungga/Nharangga; Wirangu; Antakaringa; Yarluyandi; Bindjali; Nukunu; Kokatha; Arabunna; Yawarawarka; Ngargad; Ngadjuri; Mirning; Dhirari; Yandruwandha; Meru; Adnyamathanha; Ngalea; Dieri; Pirlatapa; Ngarrindjeri; Kuyani; Nakako; Ngamini; Malyangaba; Peramangk; Banggarla; Pitjantjatjara; Karangura; Wiljali; Kurna; Nawu/Nhawu; Yankunytjatjara; Wangkurgurru and Danggali. Identification of these communities or nations, was sourced through the Australian Institute of Aboriginal and Torres Strait Islander Studies Map of Indigenous Australia (Horton David R, 1996). This does not include a comprehensive list of groups within these communities/nations.

On census night in 2021, 20,128 people within Country SA PHN region identified as being of Aboriginal and/or Torres Strait Islander origin representing 3.2 % of the total population (ABS, 2021b), and almost half (48%) of South Australia's Aboriginal population (PHIDU, 2024c). The Aboriginal population in Country SA PHN is a young population, with 51% aged under 25 years old compared to 14% aged 55 years and over (PHIDU, 2024c).

Port Augusta LGA has the highest proportion of the region's Aboriginal population (16%), followed by Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands, 9%), Ceduna (7%), Whyalla (6%) and Murray Bridge (6%) (PHIDU, 2024c). Aboriginal and outback communities located in the region include Amata; Koonibba; Maralinga Tjarutja (Oak Valley); Mimili; Nepabunna (Nipapanha); Pukatja (Ernabella); Raukkan; Umuwa; and Yalata (Indigenous.gov.au, 2024).

As identified in the 2021 Census of Population and Housing, 3,430 people primarily spoke an Australian Indigenous language at home (ABS, 2021a). More than two-thirds of the people who used an Australian Indigenous Language at home (69%, 2369 people) lived in the Outback – North and East SA3 (which includes the APY Lands) and 19% lived in Eyre Peninsula and South West (662 people) (ABS, 2021a). Topics including preferred terminology, strengths-based approaches and cultural determinants of health are explored in the *Priority Populations* chapter.

Culturally and Linguistically Diverse (CALD) communities

The population of the Country SA PHN region is diverse and includes people who were born overseas, have family members who were born overseas or speak a variety of languages. In the Country SA PHN region, almost 64,000 people or 2 in 10 people living in the region in 2021 were born overseas, with around 27,000 people (5.3%) born in a non-English speaking country. The majority (80%) of people born in a non-English speaking country have been resident in Australia for more than five years (PHIDU, 2024c).

In certain regions of Country SA PHN, the proportion of people born overseas from predominantly non-English speaking countries is notably higher than the region average. Specifically, Coober Pedy (22%), Renmark Paringa (11%), Naracoorte Lucindale (10%), and Tatiara (9%) Local Government Areas (LGAs). These same areas also have the highest percentage of recent arrivals (less than five years) from non-English speaking countries and individuals born overseas with poor English proficiency (PHIDU, 2024c).

Based on estimates from the 2021 Census of Population and Housing, 12% (approximately 3,500 people) have poor proficiency in English and speak English not well or not at all (ABS, 2021a). One in every 20 people (26,900) in country SA spoke a non-English language at home (5.6%), including 3,400 people who primarily spoke an Australian Indigenous language (ABS, 2021a). For further discussion of terminology, protective factors and access barriers for people from CALD backgrounds, please refer to the *Priority Populations* chapter.

Geography

Our region is geographically large and diverse.

The Country SA PHN region covers over 980,000 square kilometres, or 99.8% of the state of South Australia (SA) geographically, excluding the Adelaide metropolitan area.

The landscape ranges from fertile hills and intensive agriculture land of the Adelaide Hills, Barossa and Fleurieu Peninsula to vast broad acre farming regions, as well as Flinders Ranges and outback.

Administrative regions

Within the Country SA PHN boundary are six regional and one state-wide Local Health Network (LHNs) (Map 1), 75 GP catchments, 53 Local Government Areas (LGAs), and 11 Statistical Area 3 regions.

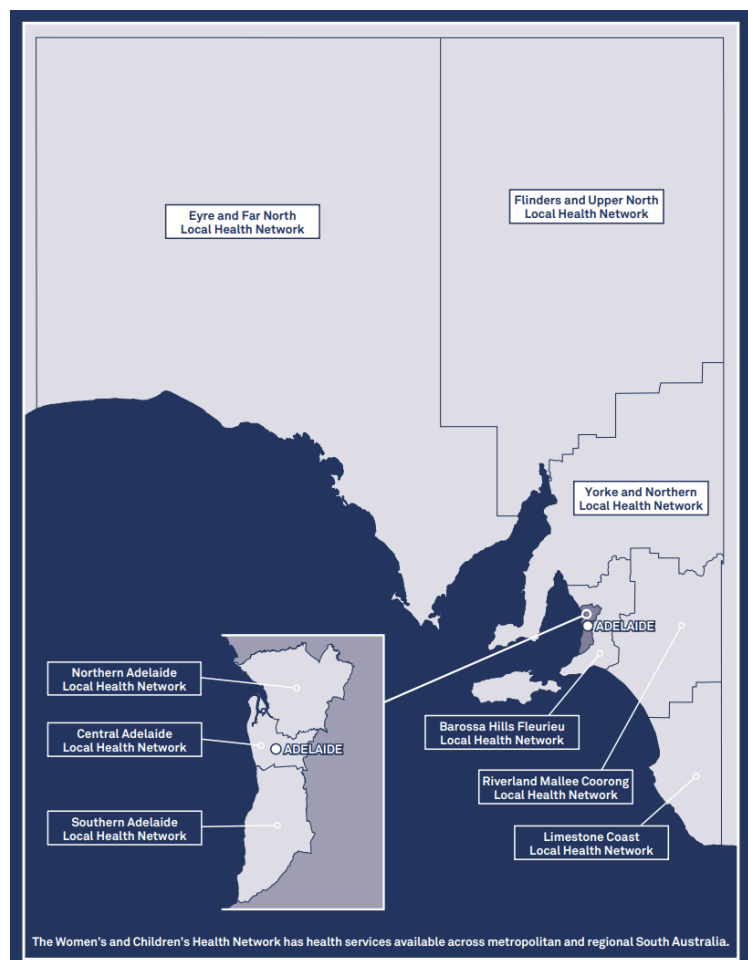
Map 1. Local Health Networks in South Australia (2023)

The geographic catchment of the Country SA PHN overlaps with the six country-based Local Health Networks incorporated under the Health Care Act 2008.

These are:

- Barossa Hills Fleurieu Local Health Network (BHFLHN)
- Eyre and Far North Local Health Network (EFNLHN)
- Flinders and Upper North Local Health Network (FUNLHN)
- Limestone Coast Local Health Network (LCLHN)
- Riverland Mallee Coorong Local Health Network (RMCLHN)
- Yorke and Northern Local Health Network (YNLHN)

In addition, Women's and Children's Health Network is a statewide network that provides public health services in the Country SA PHN region.



Source: (SA Health, 2023b)

Remoteness

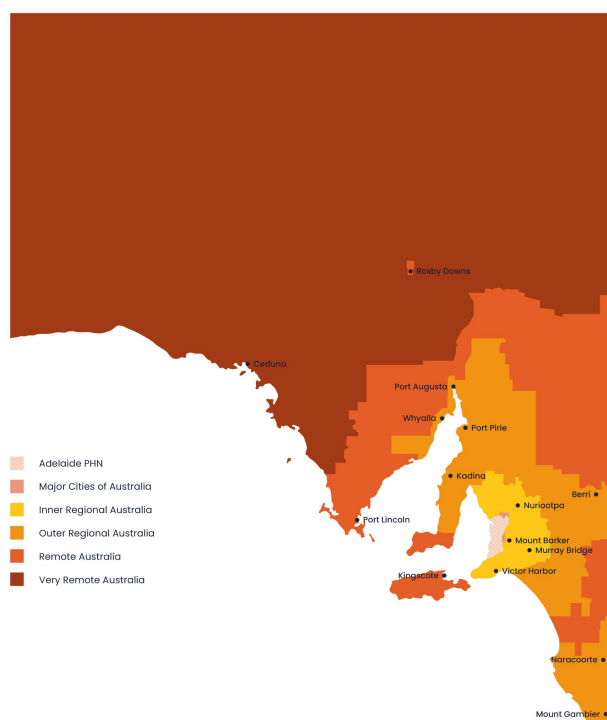
People living in remote and very remote areas can face barriers to accessing and using health care because of challenges including limited availability of services, geographic spread of services and limited infrastructure. Travel time and transportation costs to access health care services also means people in remote and very remote areas may delay access to preventive and primary health care and rely on hospital care to have their needs met (Nous Group, 2023b).

Within this report, the remoteness of our region is measured by two classifications: the ABS's Remoteness Areas (RA), or the Department of Health and Aged Care, Modified Monash Model (MMM).

Map 2. Country SA PHN by Remoteness Areas (2021)

Remoteness Areas divide Australia into five classes of remoteness on the basis of a measure of relative access to services. The five remoteness classes are (ABS, 2021d):

- Major Cities,
- Inner Regional,
- Outer Regional,
- Remote and
- Very Remote.

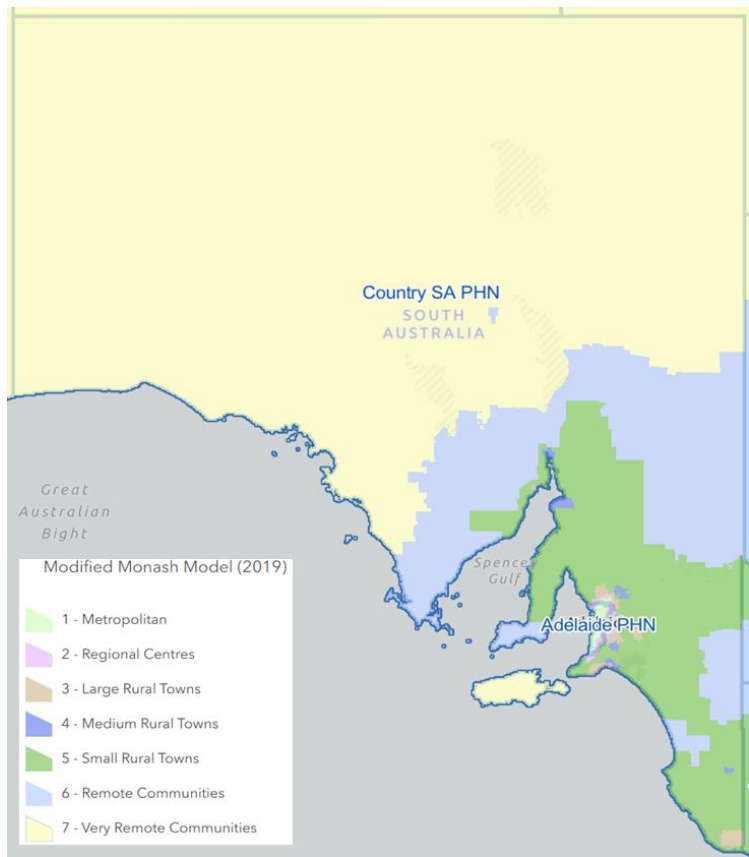


Based on the Remoteness Area classification, 73% of Country SA PHN's population lived in regional areas in 2023, 16% in areas classified as major cities, and 12% of people lived in remote and very remote areas. This was a similar pattern of distribution compared to 2013 (Figure 4) (ABS, 2021c).

Figure 4. Distribution of Country SA PHN Population by Remoteness Area, 2013 and 2023

Remoteness Area	2013		2023		Area (KM ²)	% of Country SA PHN
	Population	% of Population	Population	% of Population		
Major Cities	70,889	15%	87,129	16%	339.9	0.03%
Inner Regional	154,578	32%	175,999	33%	15197.6	1.6%
Outer Regional	201,238	41%	207,609	39%	81,381.1	8.3%
Remote	43,709	9%	45,271	9%	122,334.8	12.5%
Very Remote	15,418	3%	14,401	3%	763,414.2	77.7%
Country SA PHN	485,832	100%	530,408	100%	982,667.5	100.0%

Map 3. Country SA PHN by Modified Monash Model (2019)



The Modified Monash Model (MMM) measures remoteness and population size on a scale of seven Modified Monash (MM) categories, MM 1 to MM 7 (Map 3).

Locations are classified metropolitan (MM1), regional (MM2), rural (MM3, MM4, MM5), and remote (MM6 & MM7).

MM classifications are used to inform national workforce planning initiatives such as Distribution Priority Areas to better distribute the health workforce in rural and remote areas, and levels of general practice incentives (DoHAC, 2020).

Source: (DoHAC, 2024q)

Figure 5. Local Health Networks within Country SA PHN region by Modified Monash Model classification

MMM Category	Description	Barossa Hills Fleurieu	Eyre & Far North	Flinders & Upper North	Limestone Coast	Riverland Mallee Coorong	Yorke & Northern
1	Metropolitan areas	✓					
2	Regional centres	✓					
3	Large rural towns	✓		✓	✓	✓	
4	Medium rural towns			✓			✓
5	Small rural towns	✓	✓	✓	✓	✓	✓
6	Remote communities		✓	✓	✓		✓
7	Very remote communities	✓	✓	✓			



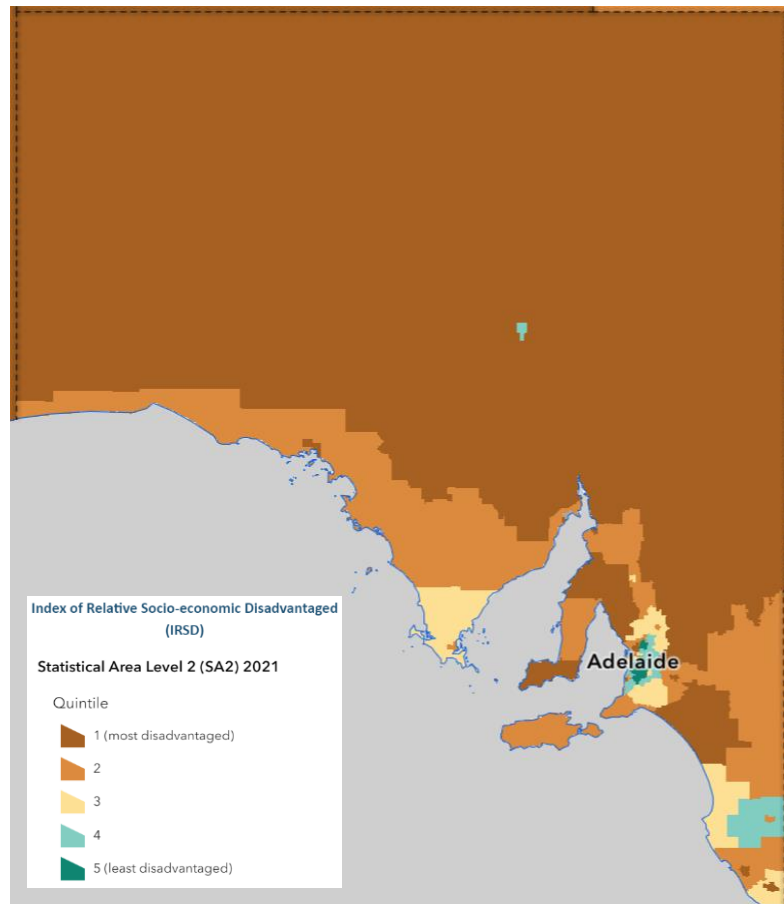
Socioeconomic disadvantage

The Index of Relative Socio-economic Disadvantage (IRSD) is a general socio-economic index that summarises a range of information from the Australian Census of Population and Housing about the economic and social conditions of people and households within an area including employment, income, levels of education, disability, homes with internet and ability to speak English.

Map 4. Index of Relative Socio-Economic Disadvantage (2021)

IRSD is a broad measure of relative disadvantage. Compared to the IRSD index score for Australia of 1000, a lower score indicates relatively greater disadvantage, and a higher score indicates a relative lack of disadvantage (ABS, 2021e).

An overall IRSD score of 967 for Country SA PHN masks the wide variation in relative disadvantage that is evident across the region at smaller geography (PHIDU, 2024c).



Source: (ABS, 2021e)

Based on the IRSD index the most disadvantage (ranked in lowest 10 per cent of areas in South Australia) were APY Lands (score of 496), Western (643), Berri (859), Renmark (862), Coober Pedy (868), Port Pirie (870) and Murray Bridge (873) (PHIDU, 2024c).

As outlined by the World Health Organisation, the interaction and impact of social determinants – the conditions in which people are born, grow, live, work, and age, and their access to power, resources and decision-making – on people’s health and wellbeing is well known (WHO, 2021b). The impact of socioeconomic status on health and illness is evident in country SA, with areas of lower socioeconomic status as identified by IRSD having substantially higher rates of premature mortality, potentially preventable hospitalisations, long-term health condition co-morbidities, and lower rates of cancer screening (PHIDU, 2024a). While the relationships between the many determinants of health and health outcomes are complex, this complexity provides many potential points of intervention to promote health and reduce the risk of ill health (AIHW, 2024bb).

Primary care landscape

People in country South Australia receive health services from a range of public and private health service providers designed to maintain and improve health care in their local communities. The scope of health services is broad, from population health and prevention, general practice and community health, through to emergency medical and hospital care, rehabilitation and palliative care, residential aged care and home care.

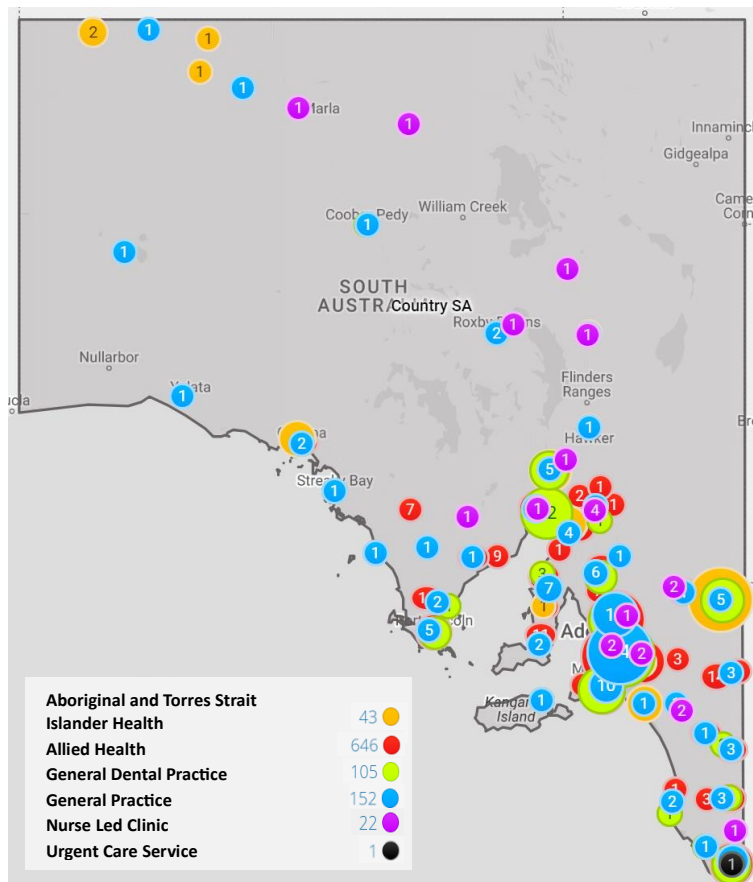
Country SA PHN's role within this health landscape is to identify gaps in service provision, increase access to primary health care, and support improvements in the effectiveness, safety and quality of services in our communities. While our focus is primary care, we also foster collaboration and partnerships with the wider health sector. Our goal is to improve health equity and health and wellbeing outcomes across country SA.

Primary health care services in South Australia are delivered across a range of settings including in the home or in community-based settings such as general practices, other private medical practices, community health centres, local government, and non-government service settings such as Aboriginal Community Controlled Health Services.

Services are provided by different primary health care professionals including but not limited to general practitioners (GPs), nurses and nurse practitioners, allied health professionals, midwives, pharmacists, dentists, Aboriginal health practitioners and paramedics.

Data and commentary about primary health care professionals and their distribution in regional SA is provided in the *Health Workforce* chapter and where relevant in other chapters including *Population Health*, *Mental Health* and *Alcohol and Other Drugs*.

Map 5. Distribution of selected primary health care services, Country SA PHN, October 2024



Map 5 sourced from the National Health Services Directory shows the distribution of a range of selected primary health care services across the Country SA PHN region.

Source: (HealthDirect Australia, 2024)

General practice

In September 2024, there were 164 general practices in Country SA PHN (CSAPHN, 2024c).

Across the Country SA PHN region, practice size in terms of GP FTE decreased with increasing remoteness. While 71% of practices across our region were small or solo practices with less than five GP FTE, this proportion increased to 100% of practices in the SA3 regions of Outback - North and East and Yorke Peninsula and 91% of practices in Eyre Peninsula and South West (CSAPHN, 2024c).

Aboriginal Community Controlled Health Organisations

An Aboriginal Community-Controlled Health Organisation (ACCHO) is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community (NACCHO, 2024).

Ten ACCHOs deliver a range of free primary health care services across the Country SA PHN region located in Yalata, Port Augusta, Port Lincoln, Mount Gambier, Murray Bridge, Coober Pedy, Ceduna, Whyalla and Alice Springs (which services Anangu Pitjantjatjara Yankunytjatjara (APY) Lands).

While most commonly addressing clinical care, ACCHOs also provide services in community and cultural engagement, health promotion, drug, alcohol and addiction services, and mental health services. They also provide a range of other client services including service navigation support (Pearson et al., 2020).

Aboriginal peoples, communities and health organisations possess substantial knowledge, skills and strengths which need to be recognised and prioritised in the planning and delivery of meaningful and impactful health services. Country SA PHN maintains a strong commitment to working collaboratively with ACCHOs to strengthen their primary health care workforce and build culturally inclusive systems and processes around data and outcomes measurement.

Hospital and emergency departments

There are 60 hospitals in country SA and 56 with emergency departments. Analysis of hospital location relative to population size (Table 2) shows wide variation in service populations per hospital.

Table 2. Hospital access by Statistical Area 3 in Country SA PHN, April 2024

SA3	Number of hospitals	Number of 24/7 emergency departments	Population per hospital
Adelaide Hills	1	1	79,723
Barossa	3	2	12,658
Eyre Peninsula and South West	11	11	5,190
Fleurieu – Kangaroo Island	3	3	18,531
Gawler – Two Wells	1	1	37,709
Limestone Coast	6	5	11,142
Lower North	7	7	3,242
Mid North	6	6	4,527
Murray and Mallee	13	11	5,481
Outback – North and East	6	6	4,260
Yorke Peninsula	3	3	8,884
Total	60	56	7,976

Market analysis

In the context of health care delivery, many locations within Country SA PHN can be considered thin markets. A thin market is a location where there is a significant gap between the needs of health care consumers and the services available in those markets. This occurs in locations where services are needed for a particular service and/or certain cohorts of health consumers and is driven by difficulties in servicing those consumers. Attributes typical of thin markets that are characterised by the locations included in this needs assessment are:

- Geographic isolation: Physical distance and travel times result in higher costs for service delivery for isolated or highly dispersed communities.
- Vulnerable clients: Some communities may have complex and higher health needs including isolation, complex support needs and challenges in self-determining these needs. These consumers require more highly qualified staff to service their needs.
- Higher operating costs: Low client numbers (or difficulty in finding/connecting with consumers in a region) and/or highly dispersed consumers result in higher per-consumer costs than in more traditional healthcare settings.
- Workforce: Challenges in recruiting and retaining qualified workforce and providing learning and development.
- Temporary supply gaps or lack of public services: There are few public services (or bulk billed) currently available. In addition, there is limited health service planning regarding provision of services.

Consequently, many of the outer regional and remote locations in country SA are locations of market failure or beyond the normal medical infrastructure available to metropolitan populations. While some thin markets can be addressed through government-led interventions, such as market facilitation, market deepening, and regulation, it is evident from stakeholder consultations that public health and Medicare-driven market responses have not been effective in increasing supply to these consumers (Health Q, 2024b).

Priority Populations

While many Australians experience poor health outcomes, concentrated inequities in health exist in some population groups. Populations experiencing inequity due to cultural, ethnic or health characteristics, and social disadvantage are at risk of disparate access to health care and outcomes.

Aboriginal people

In South Australia, the term 'Aboriginal' is widely accepted, with additional preference for the specific community where possible. Throughout this Needs Assessment, in some cases terms such as 'Aboriginal and Torres Strait Islander people' are used to maintain continuity with the source material being referenced.

In Australia, the most used definition for Aboriginal health is as follows (Bourke & Lovett, 2024):

'Aboriginal health' means "not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life...Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines, or the absence of disease and incapacity."

- Aboriginal Health Strategy Working Party, p. ix-x (1996)

Protective factors

Cultural Determinants of Health

The cultural determinants of health form a conceptual framework that is based on Indigenous knowledge, linked to social determinants of health and is rights centred (Williamson, Dent, & Bowman, 2020). Culture plays a significantly protective role in Aboriginal people's individual, and community lives, strengthening identity, bonds and resilience, particularly through its expression and continuity. The ability to know, express and nurture one's culture is also recognised as a fundamental aspect of improving Aboriginal people's health and wellbeing outcomes. Additionally, it is a way for Aboriginal people to heal from the impacts of trauma, grief, loss, and discrimination (Lowitja Institute, 2023).

Several cultural determinants that impact and shape Aboriginal people's health have been identified and grouped into the following subcategories (Lowitja Institute, 2023):

- connection to Country
- family, kinship, and community
- Indigenous beliefs and knowledge
- cultural expression and continuity
- Indigenous language
- self-determination and leadership

Research into the effectiveness of cultural health and wellbeing programs indicate they achieve better outcomes for Aboriginal people compared to mainstream services. These findings indicate the importance of investment in initiatives that support cultural determinants; however, they need to be place-based and community-led (Lowitja Institute, 2023).

For further discussion of the Cultural and Social Determinants of Health, see the *Aboriginal Health* chapter.

Approaches

The way Aboriginal people and their health are engaged, presented and discussed has a direct effect on health outcomes. Aboriginal people intimately understand that health is a complex integration and balance of physical, environmental, emotional, social, spiritual and cultural wellbeing (Fogarty, Lovell, Langenberg, & Heron, 2018).

When discussions and policies aimed at addressing disadvantage focus on people or groups as lacking something, they often place the blame on those individuals or communities, ignoring the broader social and economic systems that shape their circumstances. Recognising the harm of this "deficit" way of thinking isn't about downplaying the issue, but about highlighting how it creates a barrier to improving health outcomes (Fogarty, Lovell, et al., 2018).

A strengths-based approach is an alternate framework can be used to 'speak back' against this framing and make space for strengths-minded approaches to health issues. While further evaluation research is required, current findings suggest that acknowledging a desire to overcome deficit-based models can be a highly effective method for shifting narratives in Aboriginal and Torres Strait Islander health (Fogarty, Lovell, et al., 2018).

Cultural safety is also an important consideration when examining the approaches taken in this space. Stacey and Gollan (2020) describe the creation of a culturally safe environment as when:

"Aboriginal and/or Torres Strait Islander people's experiences are believed and validated; their cultures are centred and valued in policy development, research, evaluation and service design and delivery; they feel welcomed and respected in policy, research, evaluation and service environments; and they do not experience any form of racism in policy, research, evaluation and service contexts or processes" (p. 4).

In practice, approaches that embed cultural safety incorporate strengths-based, decolonizing research methods, which includes co-design and yarning. Co-design is an important part of ensuring that research and services are appropriate, culturally safe and needed (Butler et al., 2024). As outlined by the Office of the National Rural Health Commissioner (2022), "Transformational change can only be achieved when Indigenous knowledge and cultures are acknowledged and recognised and services are co-designed with Aboriginal and Torres Strait Islander communities and organisations"(p.1).

Yarning is a recognized culturally appropriate style of communication among First Nations peoples in Australia. It is grounded in cultural connection to one another and relationality. As a qualitative research method, Yarning is based on First Nations peoples' ways of knowing, being, and doing. It also respects traditional oral customs and builds trust between researchers and participants (Butler et al., 2024).

Truth Telling

With this context of shifting narratives, truth telling is a necessary component of efforts to move away from deficit-based approaches. The role of truth telling is defined by the Lowitja Institute (2023), "as both bringing to light historical traumas and identifies the ways that they continue to manifest in contemporary relationships, policies and institutions"(p.21). On a national level, the My Life My Lead consultations conducted by the Department of Health (2017a), identified the importance of historical trauma to understanding and addressing contemporary racism, stating:

"in order to change how governments work with Aboriginal and Torres Strait Islander people and communities to support healthy living and strong communities, there needs to be an acknowledgement of the continued impact of trauma and genuine steps taken to address trauma as an underlying cause of poor health" (p.20).

In 1788, colonisation of the Australian continent by the British began. This marked the beginning of the violent dispossession of First Nations peoples through “land theft, massacres, separation of families, forced relocation, banning of language and ceremonies, forced labour and state regulation of all aspects of sociocultural life”(p.2) (Wicks et al., 2024).

Assimilation policies continued this dispossession by enacting the systemic forcible removal of many generations of children from their countries, land, and families, known as the Stolen Generations. This disconnection from country, culture, language, and family has caused intergenerational trauma within Aboriginal communities, which is recognised as a key contributing factor in elevated chronic disease prevalence (Gatwiri, Rotumah, & Rix, 2021).

Despite the profound impacts of colonisation, healing can occur through reconnection to country, culture, and community. This connection is also linked to a wholesome cultural identity and resilience. Cultural healing is a powerful tool to counter negative impacts on the social determinants of health, as it provides connection and identity through increased social and emotional wellbeing (Gatwiri et al., 2021).

Data

The way that data pertaining to Aboriginal people is collected, held, explored and presented is of vital importance. Aboriginal people have been successfully governing Indigenous data in many formats for thousands of years and it is seen as a critical factor in ensuring the ongoing survival of their cultures (National Indigenous Australians Agency, 2024).

When discussing data in the present day, it is imperative to recognise the historical context of research, data collection and ownership. Historically, non-Indigenous people have set the agendas for research and evaluation, often driven by researcher curiosity as well as academic and political interests (Commonwealth of Australia, 2021a; Morey, Franks, Pearson, Glover, & Brown, 2023). As a result, this positions Aboriginal people as the subjects, rather than equal partners, in research. These practices are not culturally safe or to the benefit of Aboriginal people, which can become harmful when data is used to validate and perpetuate systemic and interpersonal racism. This research was not asked for and the narrative control has led to current cynicism and distrust of research in many communities (Morey et al., 2023).

The National Aboriginal and Torres Strait Islander Health Plan 2021-2031 identified the following priorities in relation to culturally informed evidence bases (Commonwealth of Australia, 2021a):

- Culturally informed and evidence-based evaluation, research and practice
- Shared access to data and information at a regional level

The role of data in self determination

Aboriginal and Torres Strait Islander people have long sought the realisation of the right to self-determination. The APS Framework for Governance of Indigenous Data acknowledged the role of data for self-determination. The framework emphasised the importance of Aboriginal and Torres Strait Islander people telling their own stories about who they are, and the role of community level decision making when planning for their future needs (National Indigenous Australians Agency, 2024). Country SA PHN recognises that partnership with Aboriginal stakeholders is essential for respecting the right to self-determination.

Data governance is recognised as an emerging area of focus in the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 (Commonwealth of Australia, 2021a). At a national level, the AIHW is exploring Indigenous Data Governance principles and the implications on the development of the National Primary Health Care Data Collection (NPHCDC). This includes research into the governance and use of primary health care data relating to Aboriginal and Torres Strait Islander people (AIHW, 2023i).

The AIHW is also working closely with several PHNs through a collaborative working group to promote and improve Indigenous Data Sovereignty and Governance understanding and practices. It is expected that once complete, this research will inform PHN operations and initiatives in relation to optimal collection, access and use of Indigenous data for Indigenous community empowerment and sovereignty (AIHW, 2023i).

Positionality

When reporting on Aboriginal people, it is important to acknowledge the positionality of those involved. This Needs Assessment report was primarily written by non-Indigenous people, in collaboration with internal subject matter experts.

As outsiders within the topic of Aboriginal health, it is important to acknowledge this position from the outset. This acknowledgement is particularly necessary considering the long history of exclusionary practices by non-Indigenous researchers, as mentioned above. It was recognised that interpreting the needs of Aboriginal people would be inappropriate, considering the positionality of the authors, due to an absence of appropriate voices within the organisation. Country SA PHN recognises that there is no substitute for the voices of Aboriginal people, which is reflected in this decision. Consequently, this limitation has restricted the scope and comprehensiveness of the *Priority Populations* and *Aboriginal Health* chapters, as well as specific sections about Aboriginal people across this report.

It is evident that greater engagement and consultation is required to ensure that the needs and priorities are identified by and for Aboriginal people.

Culturally and Linguistically Diverse (CALD) communities

The population of the Country SA PHN region is diverse and includes people who were born overseas, have family members who were born overseas or speak a variety of languages. The term Culturally and Linguistically Diverse (CALD) is a term widely used in Australia, particularly in government contexts to describe “individuals who have cultural backgrounds different from the majority or “Anglo-Celtic” Australian culture” (AIHW, 2023d). Cultural and linguistic diversity is a complex concept, often incorporating several aspects of a person’s identity including country of birth, their ancestry, where their parents were born, what language/s they speak and their religious affiliation (AIHW, 2022c).

In this Comprehensive Needs Assessment, the purpose of this classification is not to homogenise the experiences of people from culturally and linguistically diverse backgrounds, instead it aims to highlight a common experience across many distinct and unique communities.

Healthcare Access

Facilitators and Protective Factors

Nationally, strong mental health-related protective factors have been identified in CALD communities, including family and community support, connection with culture and faith, good English language acquisition, educational attainment, employment and economic opportunities (Mental Health in Multicultural Australia, 2014). However, due to the diversity of cultural backgrounds within the CALD community, further research is required to identify additional facilitators and protective factors.

Barriers

Some people from CALD backgrounds experience additional barriers when navigating the healthcare system (Health Q, 2024b). Stakeholders in the Country SA PHN commissioned Multicultural Access to Care Needs Assessment identified that one of the most significant challenges for CALD communities in country SA is language and communication barriers when accessing healthcare services. Limited English proficiency among community members often leads to misunderstandings, miscommunication, and difficulties in expressing health concerns. This barrier not only affects the quality of care received but also contributes to feelings of frustration, disempowerment, and reluctance to seek medical help (Health Q, 2024b).

The impact of English proficiency on health cannot be overlooked, as it can hinder an individual's ability to access essential health services (Health Q, 2024b). Health needs for newly arrived individuals and those from refugee backgrounds vary based on their unique experiences, regions of origin, and countries of birth. Common health concerns across these communities include trauma resulting from violence and injury, poorly managed communicable and non-communicable diseases, and limited access to preventive care and mental health support (Health Q, 2024b).

Furthermore, the stakeholder engagement also identified difficulties in navigating a complex and unfamiliar health system, which often requires local knowledge and English proficiency to access available services, eligibility criteria, and administrative processes (Health Q, 2024b). Additionally, this can be exacerbated for those who have temporary and dependent visas, adding further complexity to accessing healthcare and social support. To further contextualise these additional barriers, it is important to recognise that health seeking behaviours are also affected by experiences of acculturative stress and racial discrimination. Stress from adapting to a new culture and experiencing discrimination based on race or ethnicity can directly impact health, and result in reluctance towards seeking care (Health Q, 2024b).

Cultural competency and appropriate care

Limited access to culturally appropriate healthcare services emerged as a significant concern among stakeholders. CALD individuals often face challenges in finding healthcare providers who understand their cultural backgrounds, preferences, and healthcare needs. This lack of access to culturally competent care can lead to disparities in health outcomes, underutilization of preventive services, and delays in seeking treatment for acute and chronic conditions. When determining the needs of CALD communities, this context is important as it can shift narratives away from deficit discourse and reframe known health disparities, including the higher prevalence of chronic conditions among people with low English proficiency (Health Q, 2024b).

A concern consistently highlighted during consultations was the issue of accessing a doctor, especially one that wouldn't stigmatise them and was trustworthy. Therefore, stakeholders emphasized the importance of cultural competency and sensitivity in healthcare delivery for CALD communities. Many individuals within these communities may hold cultural beliefs, values, and health practices that differ from mainstream Western medicine. Healthcare providers must be equipped with the cultural knowledge and skills necessary to understand and respect these differences, fostering trust and facilitating effective communication with CALD patients (Health Q, 2024b).

Similarly, stakeholders highlighted the importance of health literacy and education initiatives tailored to CALD communities, which was also highlighted in the PHN Multicultural Health Framework (PHN Cooperative, 2024) (PHN Cooperative, 2024). Many individuals within these communities may have limited health literacy due to factors such as language barriers, low educational attainment, and unfamiliarity with the healthcare system. Providing culturally relevant health education materials, workshops, and outreach programs can empower CALD individuals to make informed decisions about their health and navigate healthcare services more effectively (Health Q, 2024b).

Data

It is broadly recognised that there is considerable variation in the indicators used to identify CALD populations. Furthermore, health is a product of many factors, including environmental, economic, genetic and socio-cultural factors, as well as migration experience, many of which are unable to be captured consistently in data (AIHW, 2022c). As previously mentioned, the use of the term 'CALD' aims to highlight a common experience across many distinct and unique communities. The AIHW has outlined several challenges associated with identifying the unique needs and experiences of several subgroups within aggregated data. From a data and reporting perspective, this diversity can be lost as the larger subgroups within the CALD population data set average out differences and disparities and hide health and welfare issues experienced by smaller sub-groups (AIHW, 2022c).

Even when presenting data by specific dimensions of cultural and linguistic diversity, there is great variation within commonly used indicators including country of birth. People migrating to Australia through the skilled visa stream undergo rigorous health screening checks, including full medical examinations and tests for infectious diseases. This stream favours younger, highly educated individuals, which positively impacts their health outcomes due to better health literacy and healthier behaviours (AIHW, 2022c).

Additionally, the immigrant self-selection process often results in healthier and wealthier individuals being more likely to be able to migrate. In contrast, people who have migrated to Australia under the humanitarian program have vastly different health needs and life experiences. Despite this diversity, these populations could all be grouped by an indicator, such as country of birth or language spoken at home. Therefore, there are gaps and inconsistencies in how and what data is used to identify the health needs of CALD communities, as seen across Australia (AIHW, 2022c). It is clear that a combination of many forms of data including stakeholder engagement is required to better capture the diversity of experiences and health needs within the CALD population.

LGBTIQ+ communities

Many LGBTIQ+ people in Australia live happy and healthy lives. Protective factors, such as community connectedness and positive relationships, create a sense of belonging and affirm LGBTIQ+ identities. However, people in LGBTIQ+ communities may experience stigma, discrimination, violence and exclusion, which may lead to poorer social, emotional and psychological wellbeing (LGBTIQ+ Health Australia, 2021).

Within this Needs Assessment report, the term LGBTIQ+ is used to refer to people who identify as lesbian, gay, bisexual, transgender, intersex, queer or asexual. The '+' reflects people who identify as same or multigender attracted or gender diverse and use a wide range of different identity terms. Throughout this report, there are several references to relevant literature which may not have used the same terminology or focussed only on specific communities. To maintain consistency, the terminology from the source material is used in these instances.

Recent stakeholder engagement in country SA identified that regional areas do have lower numbers of known LGBTIQ+ people than Greater Adelaide. This was attributed to people moving away from regional areas to "safer" better resourced metropolitan areas to be better connected to communities, improved access to medical providers and activities (The Equality Project, 2024).

Healthcare access

Protective factors

As previously mentioned, there are several protective factors that create a sense of belonging and affirm LGBTIQ+ identities (LGBTIQ+ Health Australia, 2021). The protective effect of stable and positive support networks for both the physical and emotional wellbeing of LGBTIQ+ people has been identified. Additionally, the importance of social connectedness has repeatedly been established as a key dimension of resilience, health and wellbeing among LGBTIQ+ people as it can foster both social support and companionship. A national survey of LGBTQA+ young people found that a greater proportion of participants in inner suburban areas (20.4%) attended an LGBTIQ+ youth event in the past 12 months than those in outer suburban areas (14.8%), regional cities or towns (13.0%), or rural/remote areas (14.5%) (Hill et al., 2021).

The affirmation of trans and gender diverse people's gender identities is recognised as a core determinant of health and wellbeing for this group, and buffers against the negative consequences of discrimination (Amos et al., 2023).

Barriers

In Australia, research shows that LGBTIQ people under-utilise health services and delay seeking treatment due to actual or anticipated experiences of stigma and discrimination from service providers (Carman, Rosenberg, Bourne, & Parsons, 2020).

A recent stakeholder engagement in country SA identified that various health services are not available within regional areas, as well as resigned expectations that people are on lengthy waitlists for those few services that are available. The alternative is to access Adelaide-based services, putting further demand on those limited specialised services and providers, which are already oversubscribed and requiring access to funding for travel, thereby putting up another barrier to access. Stakeholders identified the need for regionally available medical and health services for Transgender persons, specialised LGBTIQ+ mental health services and specialist trauma practitioners that are available in person and not via telehealth (The Equality Project, 2024).

There are also uncertainties surrounding privacy and confidentiality, as several participants were more comfortable identifying themselves as professionals rather than as members of community. This was attributed to not being “out” publicly for fear of workplace discrimination, or for their safety within the broader community (The Equality Project, 2024).

Inclusivity and appropriate care

A national study of LGBTQA+ people identified that there was a preference to use mainstream services that are known to be LGBTQA+-inclusive, over population-specific. However, regardless of preference, participants largely utilised mainstream services with no reputation of LGBTQA+ inclusivity (Amos et al., 2023).

There are also inconsistencies in the baseline of LGBTQA+ knowledge which limits equitable access to health providers across regions. Currently, providers and health services in country SA need to source this training or information online for themselves. This may require travel to Adelaide at the providers' expense and is at their discretion as to how and when this is done.

This ongoing gap in knowledge leads to barriers and poor experiences for LGBTQA+ people accessing health services and especially for those who are not publicly out for fear of discrimination and their own safety. This continues to cause poorer outcomes for people's physical and mental health within regional areas (The Equality Project, 2024).

Data

The lack of data on LGBTQA+ people across all jurisdictions has many implications. On an individual level, when questions and data do not account for LGBTQA+ people, it can invalidate experiences and perpetuate feelings of invisibility. On a broader systems level, this systemically erases LGBTQA+ identities from data sets, which are used to form policies, laws and when services are planned (SA Rainbow Advocacy Alliance, 2024).

LGBTQA+ inclusive data collection is vital to developing appropriate services as well as identifying barriers and gaps in service provision. In addition, these practices also encourage other positive outcomes including inclusive practices, safety and inclusion (SA Rainbow Advocacy Alliance, 2024).

The upcoming 2026 Census will include questions on sexual orientation and gender identity; however, it will not include specifications for intersex people (ABS, 2024c).

People with disability

People with disability include, but are not restricted to, those who have long-term physical, mental, cognitive, intellectual or sensory impairments. When the term ‘people with disability’ is used in this Needs Assessment, it refers to people with disability of all ages, whether their disability has been present from birth or acquired through illness, injury, accident or the ageing process, as outlined in *Australia’s Disability Strategy 2021-2031* (Department of Social Services, 2021). Other terms, including ‘people with a disability’ are occasionally used, when necessary, to maintain consistency with the source data.

Healthcare access

People with disability have specific needs, priorities and perspectives that are also shaped by their individual identities including their gender, age, sexuality, race and cultural background (Department of Social Services, 2021). An understanding of the interaction between intersectional identities of people with disability is required to identify additional barriers and inequities. Furthermore, this understanding can be used to promote positive intersectionality, where individuals’ intersectional identities allow them to access sources of resilience and support (Amos et al., 2023).

In South Australia, the new Disability Inclusion Amendment Act 2024 emphasised the need for “greater recognition of the additional barriers experienced by LGBTIQ+ people with disability, people with disability living in regional areas and those who have significant intellectual disability or vulnerability due to disability” (p.49) (Inclusive SA, 2023).

The social model of disability recognises attitudes, practices and structures can be disabling and act as barriers preventing people from fulfilling their potential and exercising their rights as equal members of the community. *Australia’s Disability Strategy 2021–2031* is based on this model and aligns with the UN Convention on the Rights of Persons with Disabilities, which states that disability results from the “interaction between persons with impairments and attitudinal and environmental barriers hindering full and effective participation in society on an equal basis with others” (Department of Social Services, 2021; United Nations, 2006). The strategy focuses on removing these barriers so people with disability can fully and effectively participate in and contribute to society (Department of Social Services, 2021).

The strategy also identifies the role of health providers in achieving better outcomes for people with disability. The importance of understanding individual’s unique situation and circumstances, the ability to communicate well and not allow disability to overshadow health issues was highlighted. It was also identified that the accessibility and appropriateness of services, premises and facilities were also important factors.

Language

Country SA PHN recognises that the way people with disability are presented through all forms of media matters. Language is a tool that can be used to empower, uplift and centre the voices of people with disability. However, it is important to recognise that ableism is often expressed and reinforced through language (People with Disability Australia, 2021).

There are two main language types used in Australia, person-first language (people with disability) and identity-first language (disabled people). Government and non-government institutions mainly use person-first language, as to avoid unnecessary focus on a person’s impairment. Many people with disability prefer this approach as it centres personhood (People with Disability Australia, 2021).

Alternatively, identity-first language is used by many people with disability as it positions disability as an identity category, which is embraced as part of who they are. This preference also signifies membership of a wider cultural group and is more common in some communities, such as Autistic and Deaf communities, who also may not define themselves as disabled at all. For example, many Deaf people identify as being part a cultural group with a different first language.

It is important to note that people with disability often have strong preferences on terminology, therefore it is best to ask and follow the lead of that person or community (People with Disability Australia, 2021).

Data

The AIHW has identified a need for improved collection of the diversity and intersectionality in this population. This included people with disability who (AIHW, 2024a):

- are Aboriginal and/or Torres Strait Islander
- live in rural and remote Australia
- live in care settings
- are LGBTIQ+ people
- are culturally and linguistically diverse
- have suffered abuse
- have suffered discrimination
- are experiencing homelessness

There is limited recent prevalence data available currently. One recent data source, the South Australian Population Health Survey 2023, identified that 22.9% of rural adult respondents and 14.7% of rural child respondents reported having a disability (Preventive Health SA, 2024a, 2024b). Updated statistics are expected to be available after the completion and release of the 2026 *Census of Population and Housing*, which will provide further insight into this population in the future.

Population Health

Population health focuses on the health of populations and communities, rather than just individuals. It considers the social, economic, environmental, and behavioural factors that influence health outcomes, and aims to improve the health of the entire population through prevention, early intervention, and chronic disease management.

Country SA PHN's Population Health activities are designed and planned with a focus on increasing access and improving quality of healthcare for priority populations, to address the disparities in health status and service access that exists between populations and/or regions of country SA. Our current areas of focus for Population Health activities include Chronic disease management, Healthy lifestyle, Sexual and reproductive health, Immunisation, Dental and oral health, Screening and prevention and Workforce development.

Key Points

- Median age at death for people living in very remote SA is eight years less than for people living in inner regional SA
- People living in outer regional and remote regions of country SA are more likely to have high blood pressure, smoke, be an unhealthy weight, and consume alcohol at levels that put them at risk of harm from alcohol-related disease or injury
- Higher rates of chronic conditions, including cancer, cardiovascular disease, diabetes and chronic kidney disease in rural and remote SA communities is the result of many compounding issues including higher prevalence of behavioural risk factors, and difficulties accessing timely support from health services including screening programs
- There are limited after-hours services available in country SA, with emergency departments relied upon as the only access to after-hours services and support
- Pockets of very high-quality sexual and reproductive health service delivery exist in South Australia but there are substantial gaps in service delivery across much of regional South Australia
- Maldistribution of oral health services in country SA contributes to adults and children living in remote or very remote South Australia having poorer oral health and substantially higher rates of dental-related potentially preventable hospitalisations
- Key barriers to preventative health and primary care services in country SA include limited service availability and long-waitlists, maldistribution, physical and financial inaccessibility due to travel, accommodation and service costs, and a lack of culturally appropriate and safe services

Identified Needs

1. Appropriate health services for culturally and linguistically diverse communities
2. Health services which prioritise equity and access for vulnerable population groups
3. Appropriate and timely sexual and reproductive health services
4. Access to after-hours primary health care services
5. Access to services that support developmental health and wellbeing of children and youth
6. Screening and early detection services which are appropriate and accessible for vulnerable population groups
7. Integrated and coordinated multidisciplinary care for people with chronic disease
8. Improvement in immunisation and vaccination rates
9. Health service integration, coordination and information sharing across the health system
10. Improved integration of Pharmacy in delivering primary health care
11. Improve awareness and access to patient centred palliative care and reduce avoidable hospital admissions

Health Needs

Health status

Self-reported health status is commonly used as a general indicator of health and wellbeing, revealing insight to a person's perception of his or her own health at a given point in time. In Country SA PHN, 50% of people aged over 15 years reported their health status as excellent or very good, 31% reported good health, and 19% reported it as fair or poor (ABS, 2022a).

Health status varied by age, socioeconomic status and remoteness. In 2022, older South Australian respondents and those living in lower socioeconomic areas were less likely to report their health status as good or better. While those living in metropolitan areas, and those with higher levels of education and household income were more likely to report their health status as good or better (Wellbeing SA, 2023a).

Mortality

A median age of death of 81.0 years in Country SA PHN is consistent with the median age of death nationally. In Country SA PHN, median age of death varied by sex and remoteness:

- a median age of 78.0 years for men is six-years less the median age for women (84.0 years) (PHIDU, 2024c).
- for people living in very remote regions of Country SA PHN the median age of death is eight years less than the median age of death for people living in inner regional areas of Country SA PHN, 74.0 years compared to 82.0 years (PHIDU, 2024d).

From 2018 to 2022, there were an average of 4,400 deaths of people living in Country SA PHN. In 2022, 32% of total deaths (1,540 deaths) were premature, meaning they occurred in people aged under 75 years, and 45% of these premature deaths (695 deaths) were considered potentially avoidable (AIHW, 2024af).

Variation in mortality rates is evident across the Country SA PHN region and the gap between areas with the highest and lowest rates has widened each year from 2018 to 2022. The SA3s of Fleurieu - Kangaroo Island and Adelaide Hills have consistently had the lowest age-standardised mortality rates in this period. There are five SA3s regions where age-standardised mortality rates were highest between 2018 to 2021: Outback - North and East, Mid North, Lower North, Eyre Peninsula and South West, and Yorke Peninsula. In 2022, the Murray and Mallee SA3 had higher age-standardise rate than Yorke Peninsula SA3 (AIHW, 2024af).

The top 10 leading causes of death for people in Country SA PHN from 2018 to 2022 are presented in Table 1. Cardiovascular-related conditions, respiratory-related conditions and cancers were the largest contributors to mortality. There was some variation in the top 10 causes by sex: Dementia including Alzheimer disease was the main cause of death for females (1,378 deaths, ASR 53.3 per 100,000), breast cancer was 6th (432 deaths, ASR 20.9 per 100,000), and accidental falls was 10th (234 deaths, ASR 9.3 per 100,000). For males, suicide was the 9th leading cause of death, with 290 deaths and an ASR of 23.5 per 100,000.

Table 3. Top 10 leading causes of death, Country SA PHN, 2018 to 2022

Cause of death	Rank	Deaths	Per cent of all causes	Age-standardised rate (per 100,000)
Coronary heart disease	1	2,538	11.4	59.5
Dementia including Alzheimer disease	2	2,078	9.3	45.8
Cerebrovascular disease	3	1,180	5.3	27.2
Lung cancer	4	1,170	5.3	27.9
Chronic obstructive pulmonary disease (COPD)	5	1,074	4.8	24.8
Diabetes	6	733	3.3	17.1
Colorectal cancer	7	708	3.2	17.0
Prostate cancer	8	526	2.4	11.8
Heart failure and complications and ill-defined heart disease	9	518	2.3	11.6
Other ill-defined causes	10	503	2.3	12.8

Source: (AIHW, 2024af)

Health risk factors

Health risk factors are attributes, characteristics or exposures that increase the likelihood of a person developing a disease or health disorder. Behavioural risk factors are those that individuals have the most ability to modify. Biomedical risk factors are bodily states that are often influenced by behavioural risk factors.

Based on results of the 2022 *National Health Survey*, in Country SA PHN (ABS, 2022a):

- One in eight (12%) people aged 15 years and over were current daily smokers in 2022, nearly three in five (59%) people aged 15 years and over have never smoked, and one in six (16%) people aged 15 years and over have used e-cigarette or vaping devices.
- Two in five (41%) adults aged 18 years and over exceeded the alcohol consumption guideline in 2022. This includes those who either consumed more than 10 drinks in the last week and/or consumed 5 or more drinks on any day at least monthly in the last 12 months (on at least 12 occasions per year). This is a higher proportion compared to both the state (29%) and national (27%) averages.
- Only six percent met both fruit and vegetable daily consumption recommendations, one in three people (33%) met the daily fruit recommendations, and 7% of people met the daily vegetable consumption recommendation.
- One in five (20%) people aged 15 years and over met the physical activity guidelines, lower than the South Australian average of 24%.
- Based on measured Body Mass Index, two-thirds (66%) of people were overweight or obese - 31% were overweight and 34% were obese. Three in five (61%) of people aged 18 years and over had a measured waist circumference that put them at an increased risk of disease.
- One in four (24%) people aged 18 years and over had high or very high measured blood pressure.

For some of the health risk factors there was a clear correlation between higher rates and increasing remoteness in South Australia. The rates in outer regional and remote regions of South Australia were substantially higher compared to metropolitan regions for rates of obesity (+37%), current smokers (males +68%; females +69%), and harmful use of alcohol (males +33%; females +76%) (PHIDU, 2024d).



Regional variation within Country SA PHN was also evident with higher rates for most risk factors compared to the PHN average rate in the SA3s of Murray and Mallee, Limestone Coast, Yorke Peninsula, Outback – North and East, and Eyre Peninsula and South West (PHIDU, 2024c).

Further details of alcohol consumption and smoking behaviours are provided in the *Alcohol and Other Drugs* chapter.

Immunisation and vaccination

The aim of immunisation is to prevent people from acquiring vaccine preventable diseases by achieving high vaccination rates in the community, through state and national immunisation programs. The National Immunisation Program (NIP) Schedule is a series of immunisations given at specific times ranging from birth through to adulthood. Immunisation coverage data are an important measure to determine the percentage of children, adolescents and adults who have received all age-appropriate vaccines recommended on the National Immunisation Program (NIP) schedule. Australia's aspirational coverage target of 95% is aimed at preventing the spread of measles and other vaccine-preventable diseases through herd immunity (NCIRS, 2022).

In South Australia reported cases of vaccine-preventable conditions such as haemophilus influenzae, invasive influenza, mumps, pertussis and pneumococcal varicella virus have remained constant or had increased in the last five years between 2019-2024 (SA Health, 2024b).

Vaccine-preventable hospitalisations

Rates of potentially preventable hospitalisations for vaccine preventable conditions (hospitalisations due to diseases that can be prevented by vaccination including pneumonia, influenza and majority of diseases covered by childhood immunisation) have increased in the Country SA PHN region, from a rate of 54 per 100,000 people in 2020-21 to 91 per 100,000 people in 2021-22. In 2021-22, the latest data available, there were 521 hospitalisations for vaccine-preventable conditions to residents of Country SA PHN (AIHW, 2024ar). Analysis of hospitalisations data from 2004 to 2018, identified Port Augusta as a continual hotspot for vaccine preventable hospitalisation (SA Health, 2019a). Data from 2021-22, highlights the SA3 region of Outback – North and East, in which Port Augusta is located, as having the highest rates of vaccine preventable PPHs, accounting for 36% of all vaccine-preventable PPHs in Country SA PHN in that year (AIHW, 2024ar).

Rates of potentially preventable hospitalisations for vaccine-preventable hospitalisations were significantly higher in very remote regions of Country SA PHN, 688.9 hospitalisations per 100,000 population compared to inner regional rate of 24.7 hospitalisations per 100,000 population (PHIDU, 2024d) (PHIDU, 2024d).

Vaccination coverage

Data for South Australia is presented where coverage data at PHN- or sub-regional SA3 level is not publicly available.

Children

In South Australia, general practice (70.1%) and local government councils (20.9%) provided the majority of vaccinations (both NIP, non-NIP vaccines including COVID-19) given to children aged less than 10 years (Hull et al., 2023).

As at 30 June 2024, the overall immunisation coverage rates for children in Country SA PHN were below the 95% target for 1-, 2- and 5-year olds (91.9%, 90.1% and 94.3% respectively). The coverage rates for Aboriginal children aged 5-years was 96.4%, but the coverage rates were lower in the 1-year olds (88.9%) and 2-year old cohort (85.1%) due to lower rates of coverage for specific vaccines (DTP, Polio, and Hib and MMR in 2-year olds) (DoHAC, 2024s). Rates of coverage varied across the Country SA PHN regions, with lowest rates across all three age groups occurring in the SA3s of Fleurieu-

Kangaroo Island, Eyre Peninsula and South West, Adelaide Hills (1- and 5- year olds) and Outback – North and East having the lowest coverage for 2 year olds (81.3%) (DoHAC, 2024s).

Influenza vaccination coverage in South Australian children aged 6 months to <5 years was 35.8% in 2022, an increase from 31.2% in 2021. In 2022, the rate was 34.1% nationally. Influenza vaccination coverage in Indigenous children aged 6 months to less than 5 years was 22% in 2022, a slight increase from 21.4% in 2021 (Hull et al., 2023).

Adolescents

In 2022, vaccinations given to adolescents aged 10–19 years in South Australia were most commonly administered by local government and council clinics which includes school-based programs (47.1%), general practice (26.5%) and pharmacies (17.2%) (Hull et al., 2023).

Coverage rates for HPV vaccine were lower for South Australian boys compared to girls, 83.3% and 85.1%, and both consistent with the national average coverage rates. Coverage rates for Aboriginal girls (74.6%) and boys (65.6%) in South Australia were substantially below national rates for Aboriginal adolescents (83% and 78.1%) in 2022 (Hull et al., 2023).

Nationally, adolescents turning 15 years in 2022 who resided in remote and very remote areas had lower coverage of at least one dose of HPV vaccine received before their 15th birthday compared to adolescents living in major cities (Hull et al., 2023).

Adults

Nationally, adult vaccinations were most commonly given in general practice settings, followed by pharmacies (Hull et al., 2023). General practice is the primary provider for flu vaccinations. Vaccinations for influenza for SA in 2024 (March to October) were reported as totalling 688,822. With 273,397 administered to people aged 65+, and 385,294 aged 5-64 years old (DoHAC, 2024c).

Most recent available data (2022) shows that vaccination coverage rates for the three adult vaccines recommended at 70 years of age (zoster, pneumococcal and influenza) have been increasing in South Australia since 2000. In 2022 the vaccination coverage for eligible South Australian adults was 46.7% for zoster, 42.6% for pneumococcal and for influenza 70.9% for 65-<75 year olds and 76.1% for people aged 75+ years (Hull et al., 2023).

As at July 2024, 58.2% of people aged 65 years and over who were active patients of a general practice in Country SA PHN had their influenza status recorded in their GP record in the previous 15 months (AIHW, 2024at).

Although also showing an increase between 2020-2022, vaccination coverage rates were lower for South Australian adults identifying as Aboriginal, 1.9 percentage points lower for pneumococcal, 3.4 percentage points lower for influenza and 12.7 percentage points lower for zoster (Hull et al., 2023).

COVID vaccination

On 20 October 2023, Australia's Chief Medical Officer declared that COVID-19 was no longer a Communicable Disease Incident of National Significance (CDINS) meaning it is no longer a public health emergency. COVID-19 remains a serious infectious disease but it can be managed with uptake of protective behaviours such as vaccination and other appropriate mitigation strategies to reduce the risk of serious illness and death. COVID-19 still poses a significant health threat to older Australians and people with multiple co-morbidities (DoHAC, 2023a).

As at June 2024, the majority of adults in Country SA PHN had received a COVID-19 vaccination, however many adults had not been recently vaccinated (within the last six months) (DoHAC, 2024f). At the state level approximately five percent of people were unvaccinated (DoHAC, 2024g).

Across South Australia and specifically Country SA PHN there is notable variation in COVID-19 vaccination rates across geography and communities. By Local Government Area (LGA), vaccination rates for people aged 18+ years ranged from 70% in the Mid Murray LGA to 94% in the LGA of Gawler. LGAs with the highest rates of recent vaccinations (within the last six months) were Victor Harbor, Clare and Gilbert Valleys, Northern Areas, Yankalilla and Alexandrina (DoHAC, 2024f). Data for COVID-19 vaccination rates uptake was not available for remote or very remote areas within the region.

As with influenza vaccination, COVID-19 vaccination coverage increased with increasing age (Hull et al., 2023). Analysis of data from the AIR-MADIP project (2024) suggest a relationship between lower vaccination rates, older age and lower English proficiency or speaking a language other than English at home.

COVID vaccination in residential aged care

People living in residential aged care are a high priority for the Government's COVID-19 vaccination program. Older age remains the biggest risk factor for severe COVID-19 disease. Vaccination offers added protection to help reduce the risk of severe illness or hospitalisation of aged care residents.

Country SA PHN funds programs that support vaccination of residents and aged care staff. The vaccination rates of aged care residents vary widely by facility. As at June 2024, a small proportion of facilities (9%) had less than 10% of permanent residents vaccinated in the last 12 months, and 28% of facilities had more than 80% of their residents vaccinated in the last 12 months (DoHAC, 2024r). The proportion of South Australian aged care residents aged 75+ years and vaccinated in the last 6 months was 43.9% as at 24 July 2024 (DoHAC, 2024e).

Emerging vaccine-preventable conditions

Japanese encephalitis

In March 2022, Japanese encephalitis was declared a Communicable Disease Incident of National Significance. In 2022, 10 cases of the virus were detected in people living in South Australia. Presence of the virus in mosquitoes and animals was confirmed in the country SA SA3 regions of Murray and Mallee, Gawler-Two Wells, the Barossa and the Lower North. Vaccinations were rolled-out to high risk and vulnerable populations. There have been no further reported cases in 2023 or 2024 (SA Health, 2024b).

Mpox (Monkeypox)

In July 2022, monkeypox was declared a Communicable Disease Incident of National Significance. In 2022, two cases of the virus have since been confirmed in people living in South Australia. Vaccines were provided to persons at high-risk of contracting mpox, including confirmed close contacts, vulnerable populations and people whose occupation may put them at increased risk. As at September 2024, 6 cases to people living in South Australia have been confirmed in 2024 to date (SA Health, 2024b).

Sexual and reproductive health

Country SA PHN commissioned SHINE SA to undertake a project to increase understanding of how to improve access to sexual and reproductive health services including contraception, sexually transmitted infections (STI) testing and early medical abortions (EMA) for people who live in country SA. The following section is an excerpt of selected content and findings of the *Improving Regional Access to Sexual and Reproductive Health project report* (2024) undertaken by Shine SA and Katina D'Onise Consulting and commissioned by Country SA PHN.

Sexual and reproductive health is critical to overall health and wellbeing and is considered a core part of primary health care service delivery. Despite this, sexual and reproductive health care can be difficult to access. In regional and remote SA there are known gaps in delivery for a range of primary

health care services, but there are particular gaps and access issues to sexual and reproductive health services.

Maintaining good sexual and reproductive health requires access to accurate, timely and comprehensive information, knowledge about risks and consequences of unprotected sexual activity and how to practice safe sex, and access to inclusive and safe sexual health care including contraception and testing, antenatal care or termination services (Phillips, Chow, & Coombe, 2023).

Priority populations

Due to reproductive health disparities as a result of social determinants of health, discrimination and limited access to sexual healthcare, the following population groups have been identified in both South Australian and national strategic plans (Phillips et al., 2023; Shine SA & Katina D'Onise Consulting, 2024):

- young people
- Aboriginal people
- gay men and men who have sex with men
- sex workers
- trans and gender diverse individuals
- Culturally and Linguistically Diverse (CALD) people
- people in custodial settings
- pregnant people.

Sexually transmitted infections

There are rising rates of *Chlamydia trachomatis* (chlamydia hereafter) and *Neisseria gonorrhoeae* (gonorrhoea hereafter), and a recent substantial rise in *Treponema pallidum* infection (hereafter syphilis) notifications has been accompanied by cases of congenital syphilis as part of a multi-jurisdictional outbreak. Infections continue to be over-represented in some communities in SA. The Eyre and Far North, and the Barossa, Hills and Fleurieu have the highest number of notifications across chlamydia and gonorrhoea, although there are high numbers of chlamydia notifications across the state (Shine SA & Katina D'Onise Consulting, 2024).

For notification to occur a test must be taken and a diagnosis made, which is a smaller number than the true infection number in the community. The difference between cases notified and the true case number is different for different diseases and depends on factors such as the proportion of people who have worrisome symptoms, and the availability and accessibility of testing services. Therefore, data on prevalence of sexually transmitted infections (STI) is likely undercounted from the true infection number as it only captures those cases where a test was taken and diagnosis made.

Chlamydia

Chlamydia is the most commonly notified STI in South Australia with an average of 6,000 infections each year since 2018.

In 2023, there were 6,414 confirmed cases of chlamydia in SA, with a notification rate of 346 per 100,000 population, an increase from 308 per 100,000 in 2022 (DoHAC, 2024m).

It is likely this is a large undercount of the true number of infections in SA as this is a commonly asymptomatic infection and screening rates are relatively low. Notifications are most common in those 15-29 years (75%). The rate of infection for Aboriginal people is higher than the non-Aboriginal population.

For residents of regional SA, the highest number of notifications were seen in the regions of: Barossa, Hills and Fleurieu, followed by Eyre and Far North.

Syphilis

A multi-jurisdictional syphilis outbreak was identified to include people in the country SA regions of Western and Eyre and Far North in November 2016, affecting predominantly Aboriginal people aged 15-34 years. In 2019, an additional 33 cases in SA met the outbreak definition and were considered to be part of the outbreak (Shine SA & Katina D'Onise Consulting, 2024).

In 2023, there were 405 confirmed cases of infectious syphilis in SA, with a notification rate of 22 per 100,000 population, an slight increase from 20 per 100,000 in 2022 (DoHAC, 2024m). Case numbers began to rise in 2015 after a previously relatively stable low but persistent case numbers. Notifications are most common in men (84%), and the most common age groups were 25-39 years old, with 55% of cases.

Gonorrhoea

There were 2,267 notifications of gonorrhoea in SA in 2023, which was a rise in infection notifications from the previous three years (average 1,600 per year), and the highest notification rate recorded, 122 per 100,000 population (DoHAC, 2024m). Notifications are most common for men and those aged 20-39 years (77%). The rate of infection in Aboriginal people is substantially higher than the non-Aboriginal population.

For residents of regional SA, the highest number of notifications were seen in the regions of Eyre and Far North followed by Barossa, Hills and Fleurieu (Shine SA & Katina D'Onise Consulting, 2024).

Rates of gonorrhoea were stable over 2017 and 2018 with a rate of 74 per 100,000 population in SA or just under 1,300 notifications (Australian Government Department of Health and Aged Care, 2021). This increased to just over 2,000 notifications in 2019 and slightly reduced from that to just under 1,700 in 2020 (Australian Government Department of Health and Aged Care, 2021).

Human immunodeficiency virus (HIV)

There were 50 cases of HIV notified in 2019. The trend over the previous 10 years is relatively stable, with the majority of infections notified in males (76%). Of the new notifications 40% were previously diagnosed overseas. The majority of male cases identified as men who have sex with men (68%).

Access to sexual and reproductive services

There are substantial gaps in service delivery for sexual and reproductive health across much of regional South Australia, however there are pockets of very high-quality services that demonstrate that service delivery is possible with some support (Shine SA & Katina D'Onise Consulting, 2024).

Early medical abortion access

Rural women are more likely to experience unintended pregnancy in Australia; that is, a pregnancy that is unexpected, mistimed or unwanted (Rowe et al., 2016). Deciding how to manage an unintended pregnancy involves considering two possible outcomes and associated reproductive healthcare pathways: continuing the pregnancy and antenatal care, or not continuing the pregnancy and abortion care. Pathways to antenatal and maternity health services in Australia are well established and supported by national policy, however there is no current equivalent for abortion care (Noonan, Black, Luscombe, & Tomnay, 2023). Rural women in Australia are entitled to the same rights to reproductive health care as their urban counterparts, yet in reality, barriers to accessing preferred health services, especially abortion, are disproportionate, complex and costly (Doran & Hornibrook, 2016).

In South Australia abortion rates have been stable since 2014 with 4,777 terminations of pregnancy occurring in 2022. Teen pregnancy rates declined from 2008-2019 and have since plateaued. Termination of pregnancy is highest amongst 20-34 year olds (72% of total) (Shine SA & Katina D'Onise Consulting, 2024).

In 2022 there were 104 terminations of pregnancy in country SA. Data from the *South Australian Abortion Report* indicated that in the last six months of 2022, only 10.9% of country SA residents were able to have an abortion within the country SA region, the majority had to engage metropolitan service providers. New legislation (*Termination of Pregnancy Act 2021*) commenced in mid-2022 allowing access to EMA services outside of a hospital, in a general practice setting or telemedicine services for gestation up to 63 days. General practitioners conducted 36% of all termination of pregnancy in South Australia in 2022, and in the last six months of 2022 four country SA residents had accessed telemedicine services, however the largest proportion of termination of pregnancy is conducted in a specialist family advisory clinic (46%) (Shine SA & Katina D'Onise Consulting, 2024).

The slow uptake of early medical abortions in primary health care in South Australia is a particular barrier to access for people living in rural and remote South Australia. In country SA the number of General Practice providers (general practitioners and nurse practitioners) is low due to a range of barriers impacting legislation, funding and prescribing in addition to general barriers identified by Haas et al (2023) including lack of clinical guidelines; the long time for consults due to the need for information provision and counselling; concern about people not presenting back for follow up, stigma of being involved in EMA care and conscientious objection. A lack of training and support, including cultural competency training, was also identified as a barrier to service provision. In country areas, the limited availability of timely ultrasound remains a significant barrier to accessing EMA. Reports through the consultation process have identified up to three weeks' delay for an ultrasound appointment, by which time the eligibility for EMA can have passed (Shine SA & Katina D'Onise Consulting, 2024).

From the available data on location of medical abortion prescribers, locations of health services conducting EMAs and the residential location of people accessing metropolitan services, service gaps for abortion exist across all areas of regional SA, however significant gaps are evident in the SA3s of Fleurieu-Kangaroo Island, Mid North, Eyre Peninsula (other than Port Lincoln) and Outback North and East (Shine SA & Katina D'Onise Consulting, 2024).

Sexual health service access

This rising burden of STIs presents significant challenges to all aspects of STI control.

A recent SA Sexual Health Services Review (RPR Consulting, 2022) identified key challenges in the control of sexually transmitted infections in SA. This included:

- that specialist care, primary health care and public health services are not operating at the scale required to provide sufficient health promotion, testing, treatment and contact tracing, and
- that there is inequitable access to sexual health services, particularly for people living in regional areas which currently have no dedicated, specialist STI services.

There is incomplete information about where testing for STIs occur for people who live in a regional area but notification data for chlamydia, gonorrhoea and syphilis from 2019 suggests a substantial proportion of the total amount of testing is occurring in metropolitan areas, with GPs in country areas diagnosing 4-6% of cases (and 8% of HIV cases), Aboriginal Health Services diagnosing 2-13% of cases and a few additional infections diagnosed from Prison Health Services regionally.

A systematic review by Gan et al of the preferences for young people for STI testing services found that there was a wide range of barriers and preferences for the different population groups in the studies (Gan et al., 2021). Stigma is a significant barrier to seeking screening, diagnosis and treatment for STIs (Hood & Friedman, 2011). Stigma can also cause psychological and interpersonal distress and discourage partner disclosure or notification. For migrant communities in Australia there are socio-cultural, religious, financial and stigma barriers to screening. Ways to overcome these barriers are thought to be education, increasing cultural competence of providers and actions to reduce stigma (Agu, Lobo, Crawford, & Chigwada, 2016).

Although the health system presently serves a large proportion of the population well, it is clear that there is limited choice of service location, modality or provider. There are still many people who are not able to access affordable, timely, appropriate, empathic/non-stigmatising sexual and reproductive health services in country SA.

Awareness and education of prevention and health promotion

There appears to be a lack of general awareness among clinicians about the best practice recommendations for STI screening, a lack of exposure to EMA prescribing, and a need for expanded long-acting reversible contraception (LARC) training for GPs, nurses and midwives. There appears to be a gap in knowledge for some GPs regarding the change in legal requirements, issues relating to being a procedural GP for insurance purposes in addition to dealing with stigma as a provider.

Community education in sexual and reproductive health and school-based programs including those tailored to Aboriginal young people to promote sexual health, wellbeing and safety is an ongoing need.

There is a significant gap in information for the community about where to seek services. Given the stigma associated with sexual health and reproductive health services, in addition to conscientious objection, people do not know where to access safe and supportive services.

Cancer

Cancer is a major cause of illness and death in Australia and has a substantial social and economic impact on individuals, families and the community (AIHW, 2023c).

Research suggests that rurality impacts people across the cancer care continuum. People in rural and remote areas experience delayed diagnosis, significant distances to travel (or relocation) to access cancer treatment and care, a lack of local support, post treatment services and pathways, and lower rates of survival (Gunn et al., 2021; van der Kruk et al., 2022).

In South Australia, cancer predominantly affects the older population; in 2020 people aged over 65 accounted for 64% of all cancers and 81% of all cancer deaths. The lifetime risk of being diagnosed with cancer in South Australia (calculated to age 75) was 1 in 3 for males and 1 in 4 for females. The lifetime risk of mortality from cancer in South Australia was 1 in 11 for males and 1 in 14 for females (Wellbeing SA, 2022b).

In the 2021 Census of Population and Housing, 18,033 people living in Country SA PHN (equivalent to a rate of 2.8 per 100 people) reported they had cancer or were in remission (PHIDU, 2024c).

Incidence

The most common cancers in South Australia in 2020 for males were prostate cancer (30.7% of all cancers), colorectal cancer (9.4%), lung cancer (9.0%), melanoma of the skin (8.5%) and Non-Hodgkin Lymphoma (4.4%). These five cancers accounted for 62.0% of all newly diagnosed cancers among males in 2020 (Wellbeing SA, 2022b). For females in South Australia, breast cancer remained the most commonly reported cancer in 2020 (28.5% of all cancers), followed by colorectal cancer (11.1%), lung cancer (9.5%), melanoma of skin (7.0%) and uterine cancers (5.0%). These five cancers accounted for 61.1% of all cancers diagnosed among females in 2020 (Wellbeing SA, 2022b).

Projections of cancer incidence in South Australia from 2020 through to 2023 expected a plateau in the incidence rates for males, and a slight increase in the incidence rates for females (Wellbeing SA, 2022b).

Mortality

In 2020, there were 3,886 cancer deaths in South Australia with lung cancer the most commonly reported cancer cause of death in both males (20.0% male cancer deaths) and females (17.4% of female cancer deaths). Second most common cause in males was prostate cancer (11.9%) and for females it was breast cancer (12.8%). Colorectal cancer (9.8% males; 11.5% females), pancreatic cancer

(6.4% males; 8.8% females), and cancer of unspecified site (5.4% males and females) were the next most common cancer causes of death (Wellbeing SA, 2022b).

Projections of cancer mortality rates for both males and females in South Australia were expected to decrease slightly from 2020 through to 2023 (Wellbeing SA, 2022b).

A South Australian study found that people living outside the major urban areas have poorer cancer survival rates than those who live in the city, and are more likely to die within five years of diagnosis the further away from the city they live. The travel and accommodation costs in the city, and the extra pressure it can place on families, can cause regional South Australians to end their cancer treatment prematurely, impacting their health and chances of survival (Wellbeing SA, 2022b).

Cancer Screening

Cancer screening programs aim to reduce illness and death from certain cancers by allowing for early detection, intervention, and treatment. High participation rates in screening programs are necessary to achieve these objectives. In Australia, there are three national population-based screening programs—BreastScreen Australia, the National Cervical Screening Program and the National Bowel Cancer Screening Program. These programs are run through partnerships between the federal and state and territory governments; the programs aim to reduce illness and death from these cancers through early detection of cancer and pre-cancerous abnormalities and through effective follow-up treatment. The programs target specific populations and age groups where evidence shows screening is most effective at reducing cancer-related morbidity and mortality (AIHW, 2024g).

In response to research that indicates that cancer screening rates amongst individuals from culturally and linguistically diverse backgrounds (CALD) are lower to the general population due to personal and cultural barriers, and lack of understanding about cancer screening (Phillipson L, Larsen-Truong K, Jones S, & L, 2012; Sax Institute, 2022), Country SA PHN has commissioned the Cancer Council SA to work with local stakeholders to address access barriers and develop local solutions through education and capacity building to increase access to evidence-based cancer screening messages to CALD communities in regional SA.

Breast screening

Breast cancer is the most common cancer in Australian women. Early detection using screening mammography among women aged 50–74 every 2 years maximises the reduction in mortality from breast cancer.

BreastScreen SA provides breast cancer screening for women living in rural and remote regions of South Australia, with one fixed breast screening clinic based in Mount Barker that operates year-round services, and three mobile screening units, that visit 36 locations around the State every two-years for periods of one week to six months depending on the location and size of the local population (BreastScreen SA, 2024).

Analysis by the Australian Institute of Health and Welfare (AIHW) indicates that potentially half of all South Australian women aged 50-74 years in Country SA PHN could experience long drive times to screening services, reducing access to and participation in screening, and ultimately delaying the diagnosis of a breast cancer. Almost 45,000 women aged 50-74 years living in Country SA PHN would need to drive more than one hour to access the single permanent breast screening service, approximately 22,000 would need to drive more than one hour to reach a screening service open at least annually, and 11,000 women would have to drive more than two hours to reach a service open annually. Women living in the Eyre Peninsula and South West SA3 (9,126), Yorke Peninsula SA3 (3,743) and Outback – North and East (3,470) are most impacted by long drive times (AIHW, 2024a).

Unlike other screening programs, people have the option to access breast screening (mammograms) through private radiology services. Anecdotal feedback from regional and rural service providers has

indicated that eligible people from rural communities may choose to access private mammography providers where local BreastScreen services are unavailable.

The following section summarises participation data for Country SA PHN from the *BreastScreen Australia monitoring report 2023* (AIHW, 2023b).

In 2019-2020, the BreastScreen Australia participation rate for people aged 50-74 years and living in Country SA PHN was 54.7%. Despite a decline in participation between 2014-2015 to 2019-2020 from 58.8% to 54.7% for 50-74 year olds, the Country SA PHN rate was higher than the national participation rate of 49.9% in 2019-2020 (AIHW, 2023b).

By age, BreastScreen Australia participation in 2019-2020 was highest among 65-69 year olds (57.0%) and lowest in people aged 50-54 years (46.0%), a pattern unchanged since 2014-2015. With the exception of the 70-74 year age group which saw participation rates increase by 10% between 2014-2015 to 2019-2020, since 2014-2015, participation rates decreased in all other age groups, with the largest decreases in the 55-59 year old group (-13%) (AIHW, 2023b).

There was evidence of variation by remoteness in Country SA PHN; in 2019-2020, there was a 17 percentage point difference between the SA3 regions with the highest and lowest rates, which is a widened gap since 2016-2017 where the difference between highest and lowest SA3 rates was 13 percentage points (AIHW, 2023b).

In 2019-2020 the SA3 of Yorke Peninsula had the highest participation rate overall at 64.1% of people aged 50-74 years, followed by Limestone Coast SA3 (59.8%) and Mid North (58.4%). Limestone Coast SA3 also had the highest (or equal highest) participation across each of the five-year age groups from 50-54 years to 70-74 years (AIHW, 2023b).

Eyre Peninsula and South West SA3 had the lowest BreastScreen Australia participation rates overall for 50-74 year olds, 46.8% in 2019-2020, and the lowest participation in across each five-year age group, with the exception of 60-64 year olds (2nd lowest) (AIHW, 2023b).

Cervical screening

Cervical screening is an important measure for the prevention and early detection of invasive cancer of the cervix. Australia commenced an organised program of routine cervical screening of the female population in 1991 (Cancer Australia, 2020). Cervical screening testing is recommended every five years for people with a cervix aged 25-74 years to look for human papillomavirus (HPV). HPV is an infection that can cause cervical cell changes and may develop into cervical cancer. Screening aims to reduce cervical cancer cases, illness, and deaths by detecting precancerous abnormalities before any potential progression to cervical cancer (AIHW, 2023h).

From 1 July 2022, the National Cervical Screening Policy changed to recommend that all participants in the National Cervical Screening Program will be given a choice in screening method - either self-collected or clinician collected, however a consultation with a cervical screening provider is still required ahead of self-collection but this may occur via telehealth where appropriate (Preventive SA, 2024). As at October 2024, there were 16 clinics in regional SA that have advised Preventive Health SA that they are offering self-collection (Preventive Health SA, 2024c).

The following section summarises participation data for Country SA PHN from the *National Cervical Screening Program monitoring report 2023* (AIHW, 2023h).

From 2018-2021, the cervical screening participation rate for people aged 25-74 years and living in Country SA PHN was 62.1%, consistent with the national participation rate of 62.4% for 25-74 year olds (AIHW, 2023h).

By five-year age group, cervical screening participation is highest among 25-29 year olds (72.2%) and lowest in people aged 70-74 years (34.7%). Although direct comparisons can't be made due to changes

to screening age cohorts, generally since 2014-2015 all age groups had increases in cervical screening participation rates, with the largest increases in the 25-29 year old group (+33%) and 11% increases for the 30-34, 45-49 and 65-69 year old age groups (AIHW, 2023h).

Nationally, cervical screening participation rates decreased with increasing remoteness, with the lowest rates nationally in Very remote areas. After adjusting for age, participation was lower for participants residing in areas with higher disadvantage (AIHW, 2023h).

Across the Country SA PHN, there was substantial geographical variation in cervical screening participation for 25-74 year olds from 2018-2021, with a 20 percentage point difference between the SA3 regions with the highest and lowest rates. This is a slightly widened gap since 2014-2015 where the difference between highest and lowest rates was 18 percentage points (AIHW, 2023h).

From 2018-2021 the SA3 of Adelaide Hills had the highest participation rate overall at 72.5% of people aged 25-74 years, followed by Barossa SA3 (63.3%) and Lower North (62.4%); the same three SA3 regions that had the highest cervical screening participation rates in 2014-2015. Adelaide Hills SA3 also had the highest participation across each of the five-year age groups from 25-29 years to 70-74 years (AIHW, 2023h).

Outback - North and East SA3 had the lowest cervical screening participation rates overall, 52.5% for 25-74 year olds, and the lowest participation across each five-year age group, with the exception of the 70-74 year olds (4th lowest) (AIHW, 2023h).

As at July 2024, 44% of eligible 25-74 year olds who were active patients of a general practice in Country SA PHN had an up-to-date cervical screening test recorded in their GP record in the previous five years (AIHW, 2024at).

Bowel screening

Colorectal cancer is the 3rd most common cancer-related cause of death in South Australia (Wellbeing SA, 2022b). The National Bowel Cancer Screening Program (NBCSP) started in 2006 with the aim of reducing morbidity and mortality from bowel cancer by screening the eligible target population for early detection or prevention of the disease. Since 2020, eligible Australians aged 50-74 years are sent a free screening kit every 2 years (Cancer Australia, 2020). From 1 July 2024, the eligibility criteria changed, facilitating access to the program for people aged 45-49 (DoHAC, 2024I).

The following section summarise participation data for Country SA PHN from the *National bowel cancer screening program monitoring report 2024* (AIHW, 2024ag).

In 2021-2022 the Bowel Screening participation rate for people living in Country SA PHN aged 50-74 years was 44.3%, higher than the national participation rate of 40.0% for this age group (AIHW, 2024ag).

Country SA PHN overall participation rates in the national bowel cancer screening program in 2021-2022 were five percent below the rate in 2014-2015 (45.8%), however before 2019-2020 (pre-COVID19) participation rates in the region were increasing (AIHW, 2024ag).

At the State-level, by five-year age group, bowel screening participation in 2020-2021 was highest among 70-74 year olds (57.2%) and lowest in people aged 50-54 years (33.6%), a pattern unchanged since 2014-2015. With the exception of the 65-69 year age group which saw participation rates increase by 7% between 2014-2015 to 2020-2021, since 2014-2015, bowel screening participation rates decreased in all other age groups, with the largest decreases in the 55-59 year old group (-9%) (AIHW, 2024ag).

Across the Country SA PHN region, there was substantial geographical variation in bowel screening participation for 50-74 year olds in 2021-2022, with a 17 percentage point difference between the SA3

regions with the highest and lowest rates. This percentage gap is unchanged since 2014-2015 (AIHW, 2024ag).

In 2021-2022 the SA3 of Fleurieu-Kangaroo Island had the highest participation rate for people aged 50-74 years old, at 50.4%, followed by Adelaide Hills SA3 (48.8%), Yorke Peninsula SA3 (47.8%) and Barossa SA3 (47.5%). Since 2014-2015 these SA3s have consistently had participation rates higher than the Country SA PHN regional average (AIHW, 2024ag).

In 2021-2022, Outback - North and East SA3 had the lowest bowel screening participation rates for 50-74 year olds, with 33.5%, substantially lower than the Country SA PHN regional average, and consistently so since 2014-2015 (AIHW, 2024ag).

Skin cancer

Skin cancer, including melanoma and keratinocyte cancers (basal cell carcinomas and squamous cell carcinomas), is the most prevalent cancer in Australia. Skin cancer is highly preventable through primary prevention activities such as avoiding ultraviolet radiation exposure during peak times and regular use of sun protection (Cancer Council Australia, 2023).

In Australia, with no population skin cancer screening program, the current system of early detection relies heavily on opportunistic, general practitioners-led screening with patients who have suspicious symptoms or are at increased risk (Singh et al., 2024). General practitioners are generally the first point of contact for patients with skin concerns (Singh et al., 2024), however most do not use, nor are trained in best-practice dermoscopic skin assessments (Fee, McGrady, Rosendahl, & Hart, 2020). The recent report, *State of the Nation - A Report into Melanoma*, recognises the significant screening gap and need for innovation to address this, especially for regional communities (Melanoma Institute Australia, 2022).

People living in regional, rural, and remote Australia have higher rates of skin cancer (15-31% higher) and experience challenges in accessing health care. Regional workers are not adequately engaging with skin cancer prevention behaviours and 35% report barriers to help-seeking (Trenerry, Fletcher, Wilson, & Gunn, 2022). Better targeting of skin protection measures and increased uptake of opportunistic screening have been identified as ways to improve care for these populations, as have the use of information technology and upskilling of primary healthcare nurses (P. Adelson & Eckert, 2020).

Nationally overall keratinocyte cancer treatment rates rose during 2012–2021, but among younger and middle-aged Australians they steadily declined. These declines were accompanied by rising biopsy rates in all age groups, including people under 55 years of age, indicating that more Australians are having skin lesions assessed, but fewer keratinocyte cancers are being detected. Between 2012–2021 in South Australia there were small average annual percentage change in MBS-subsidised squamous cell/basal cell carcinoma excisions (+1.8% women, +1.4% men) and biopsies (+3%) (Olsen, Pandeya, Neale, & Whiteman, 2024).

Melanoma of the skin was the fifth most commonly diagnosed cancer in South Australia in 2020, with 864 new cases, accounting for 8% of all cancers in that year. In 2021, melanoma of the skin was the tenth most common cause of cancer death in Australia (Cancer Australia, 2024).

In South Australia, the age-standardised rates for melanoma were highest in (AIHW, 2019):

- Mid North (0.51 per 1,000)
- Yorke Peninsula (0.48 per 1,000)
- Eyre Peninsula and South West; and
- Fleurieu – Kangaroo Island (both 0.46 per 1,000)

Similarly, the highest rate ratios for non-melanoma compared to South Australia were (P. Adelson, Sharplin, GR., Roder, DM., Eckert, M., 2018; Australian Institute of Health and Welfare, 2019b);

- Mid North (1.31 times higher than SA)
- Eyre Peninsula and South West (1.26 times higher than SA)
- Lower North (1.26 times higher than SA)
- Yorke Peninsula (1.23 times higher than SA)
- Fleurieu – Kangaroo Island (1.18 times higher than SA)

These findings correlate with MBS data showing higher rate ratios in agricultural and coastal areas of South Australia. Rates of skin cancer increase with age, with males having higher age-specific rates across all age brackets (P. Adelson, Sharplin, GR., Roder, DM., Eckert, M., 2018).

Chronic and long-term conditions

Country SA PHN recognises that there are many chronic conditions which have low prevalence at the population level but have a high burden or impact on individuals and their quality of life. This includes, but is not limited to, conditions such as multiple sclerosis, epilepsy, migraines, eating disorders and inflammatory bowel conditions. Although some of these conditions intersect with other care systems, such as the National Disability Insurance Scheme, primarily they are managed in general practice settings. It is important for the Country SA PHN to ensure that GPs and primary health care providers working in the region are confident and skilled to support patients with these conditions and where relevant and/or appropriate, consider commissioning activity which supports improved primary health care access for priority populations living with these conditions.

Chronic conditions are currently the leading cause of illness and disability in Australia; and they have significant health, social, and broader economic impacts. In 2022, approximately 270,800 people (63%) in regional and remote South Australia had one or more chronic conditions (ABS, 2022b). The prevalence of chronic conditions increases substantially with increasing age, with 87% of people aged 65 years and over in regional and remote South Australia having at least one or more chronic conditions (ABS, 2022b).

Chronic conditions are a subset of long-term health conditions that are common, pose significant health problems, and have been a focus of ongoing public health surveillance. The definition of long-term health conditions are conditions that have lasted, or were expected to last, for six months or more. Eight in ten (83% or 1.47 million) South Australians had at least one long-term health condition as estimated in the *2022 National Health Survey* (ABS, 2022b).

The *2021 Census of Population and Housing* was the first Census to collect data on long-term health conditions in Australia. In the Country SA PHN region, the age-standardised rate for people aged 15 years and over who reported having one or more long-term health conditions was 34.6 per 100 persons, almost 161,000 people. SA3 regions in 2021 with the highest rates of long-term health conditions were Gawler - Two Wells (ASR 39.0, 12,433 people), Mid North (ASR 37.4, 9,567 people), and Yorke Peninsula (ASR 36.0, 10,276 people) (PHIDU, 2024c).

Many people experience multimorbidity; that is, they have 2 or more chronic conditions at the same time. In 2022, approximately 133,600 people (31%) in regional and remote South Australia had two or more chronic conditions (ABS, 2022b). A range of factors influence the likelihood of having multiple chronic conditions; these factors are categorised as behavioural risk factors (e.g. smoking, diet), biomedical risk factors (e.g. high blood pressure, obesity), non-modifiable risk factors (e.g. age, genetics), physical environmental determinants (e.g. air pollution, geographic location), and social and economic determinants (e.g. education, employment status) (DoHAC, 2021).

Due to social inequality and disadvantage, several different population groups in Australia experience a disproportionate burden of chronic disease, leading to differences in health outcomes and life expectancy. These population groups include, but are not limited to: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; older Australians; carers

of people with chronic conditions; people experiencing socio-economic disadvantage; people living in remote, or rural and regional locations; people with disability; people with mental illness; and people who are, or who have been, incarcerated (ABS, 2022b).

Impact of selected chronic conditions

Cardiovascular Disease

Cardiovascular disease (CVD) is a broad term that describes the many different diseases and conditions that affect the heart and blood vessels. Coronary heart disease, stroke and heart failure are common forms of CVD. Other forms include atrial fibrillation, peripheral arterial disease, rheumatic heart disease and congenital heart disease. A number of risk factors can increase a person's chance of developing CVD, including behavioural (for example, smoking, insufficient physical activity and poor diet), biomedical (for example, high blood pressure or abnormal blood lipids) and other factors that can't be controlled such as age and sex (AIHW, 2024t).

Based on data from October 2024, almost 45,000 people (11.7% of active patients of a general practice that shared data with Country SA PHN) had a diagnosis related to CVD (coronary heart disease, heart failure, stroke, atrial fibrillation). Twenty percent of active patients, 76,570 people had hyperlipidaemia and 85,380 (22.3%) had hypertension (CSAPHN, 2024e).

In 2021, SA3 regions with the highest age-standardised rate of self-reported heart disease (including heart attack or angina) were Gawler - Two Wells (5.5 per 100), Outback - North and East (5.3 per 100), and Mid North (5.3 per 100) (PHIDU, 2021b). The Outback - North and East and Mid North SA3 regions also had substantially higher age-standardised rates of potentially preventable hospitalisation for congestive cardiac failure and angina compared to the country SA region as a whole (AIHW, 2024ar).

Coronary heart disease was the leading cause of death in Country SA PHN from 2018-2022, 2,538 deaths or 11.4% of all deaths. Cerebrovascular disease was the 3rd leading cause (1,180 deaths, 5.3% of all deaths) and Heart failure and complications and ill-defined heart disease was the 9th leading cause (518 deaths, 2.3% of total deaths) (AIHW, 2024af).

The higher rates of heart disease in rural and remote communities are the result of many compounding issues. Rural areas have fewer health professionals, reduced health infrastructure and higher costs of health care delivery. Rural and remote populations also have difficulty accessing affordable healthy food. This food insecurity is closely linked to obesity – a major heart disease risk factor (National Rural Health Alliance, 2017).

Respiratory Disease

Chronic respiratory conditions affect the airways, including the lungs and the passages that transfer air from the mouth and nose into the lungs. These conditions are characterised by symptoms such as wheezing, shortness of breath, chest tightness and cough. Asthma and chronic obstructive pulmonary disease (COPD) are two common respiratory conditions and are associated with poor health and wellbeing (AIHW, 2024k). Between 2018-2022, COPD was the 5th leading cause of death in country SA, contributing to 1,074 (4.8%) deaths.

Compared to national self-reported rates, in the 2021 Census, age-standardised rates for both asthma (10.1 per 100) and lung conditions (including COPD and emphysema) (2.3 per 100) were higher in country SA. Based on data from general practices in country SA, as at October 2024, almost 51,000 people (13.3% of active patients of a general practice that shared data with Country SA PHN) had a diagnosis of asthma, and almost 13,000 people (3.4%) had COPD (CSAPHN, 2024e).

The SA3 regions with the highest age-standardised rate of self-reported asthma were Gawler - Two Wells (11.7 per 100), followed by the Yorke Peninsula, Mid North, Lower North and Barossa (PHIDU, 2024c). Despite having lower prevalence rates, Eyre Peninsula and South West SA3 reported the highest age-standardised rate of potentially preventable admissions for asthma in 2021-22. Above



average rates of potentially preventable hospitalisations (PPH) for asthma also occurred in Lower North and Yorke Peninsula (AIHW, 2024ar).

Rates of PPH for COPD in Outback – North and East SA3 were more than double the average country SA rate in 2021-22, 450 per 100,000 compared to 185 per 100,000. The SA3 regions of Mid North (286 per 100,000), Eyre Peninsula and South West (257 per 100,000) and Lower North (220 per 100,000) also had PPH rates well above the regional average (AIHW, 2024ar).

Diabetes

Diabetes was the 6th leading cause of death in for people living in Country SA PHN, accounting for 733 deaths, or three percent of all deaths from 2018-2022 (AIHW, 2024af). Over 35,800 people (9.4% of active patients of a general practice that shared data with Country SA PHN) had any diagnosis of diabetes in October 2024, with the majority (79%) being for type 2 diabetes (CSAPHN, 2024e).

The Country SA PHN region has a higher age-standardised rate of self-reported diabetes (excluding gestational) (6.2 per 100 persons) than the national average (5.7 per 100 people). Self-reported rates were highest for people living in Outback - North and East primarily APY Lands and Port Augusta (8.2 per 100), Mid North including the towns of Port Pirie, Jamestown (7.8 per 100), Gawler - Two Wells (7.1 per 100), Eyre Peninsula and South West (6.9), and Yorke Peninsula (6.9) (PHIDU, 2024c).

As well as high prevalence, these regions also had rates of potentially preventable hospitalisations for diabetes complications that were substantially higher than the country SA region average of 214 per 100,000: Mid North (422 per 100,000 people), Outback – North and East (374 per 100,000), and Eyre Peninsula and South West (293 per 100,000) (AIHW, 2024ar). In 2021-22 there were 1,403 potential preventable hospitalisations for diabetes complications in Country SA PHN, consistent with the previous year. PPH rates for diabetes complications in Country SA PHN were higher than national age-standardised rate of 184 PPH per 100,000 people (AIHW, 2024ar).

As stated in *The State of Diabetes Mellitus in Australia* there are “huge barriers to appropriate management and support for people with diabetes in outer metropolitan, rural and regional areas of Australia”. Difficulties accessing support from diabetes educators, podiatrists, dietitians, general practitioners (GPs), endocrinologists, and community outreach services was a key reason. In remote areas there is a significant shortage of Indigenous health workers, and this impacts severely on diabetes management (Commonwealth of Australia, 2024b).

Musculoskeletal conditions

Musculoskeletal conditions affect the bones, muscles, joints, and connective tissues, and are large contributors to illness, pain and disability. Common types include various forms of arthritis (rheumatoid arthritis, osteoarthritis, juvenile arthritis and gout), back problems and osteoporosis (AIHW, 2024j). With age, the prevalence of musculoskeletal conditions increases markedly (Dent et al., 2017).

Over 95,000 people (24.9% of active patients of a general practice that shared data with Country SA PHN) had any diagnosis of musculoskeletal condition including Osteoporosis, Osteoarthritis, Inflammatory Arthritis or Other Musculoskeletal as at October 2024, with Osteoarthritis being the most common (11.7%) (CSAPHN, 2024e).

The Country SA PHN region has a higher age-standardised rate of self-reported arthritis (11.4 per 100 persons) than the national average (10.3 per 100 people). Self-reported rates were highest for people living in Gawler - Two Wells (13.2 per 100) and Mid North (13.0 per 100 people) (PHIDU, 2024c).

Chronic Kidney Disease

Chronic Kidney Disease (CKD) refers to all conditions of the kidney, lasting at least three months, affecting the filtration and removal of waste from the blood by the kidneys and/or leakage of protein or albumin in the urine. A person who has kidney failure, the most severe form of CKD, usually requires

a kidney transplant or dialysis to survive (AIHW, 2024i). People with chronic kidney disease are at greater risk of coronary artery disease, heart failure, arrhythmias, and sudden cardiac death, and people with kidney failure are at much higher risk of mortality due to cardiovascular disease (Go, Chertow, Fan, McCulloch, & Hsu, 2004; Jankowski, Floege, Fliser, Böhm, & Marx, 2021).

The most recent data available on CKD prevalence, hospitalisation and mortality indicates that CKD disproportionately impacts Aboriginal people, people living in outer regional and remote areas, and people who live in lower socio-economic areas (AIHW, 2024i; AIHW & NIAA, 2023). People with CKD living in rural and remote areas also face barriers to diagnosis and treatment, and appropriate information and education (AIHW & NIAA, 2023).

Over 9,000 people (2.4% of active patients of a general practice that shared data with Country SA PHN) had diagnosed chronic kidney disease as at October 2024 (CSAPHN, 2024e).

Based on self-report of kidney disease in the 2021 *Census of Population and Housing*, people living in the SA3s of Mid North (which includes areas of Port Pirie, Jamestown, Peterborough) and Outback - North and East (which includes areas of Port Augusta, Coober Pedy and APY Lands) had the highest rates in country SA, with an age-standardised rate of 1.3 per 100 people, higher than both the country SA age-standardised rate of 0.9 per 100 people and the national rate of 1.1 per 100 people (AIHW, 2024ar).

Long COVID

Long COVID or post-acute COVID-19 is a new chronic condition that has emerged since the start of the COVID-19 pandemic in 2019; it is estimated to affect between 5–10% of COVID-19 cases (AIHW, 2024an). It is characterised by a range of symptoms extending several weeks or months after infection with COVID-19 and has been associated with increased health-care use and costs as well as patient reports of limitations on their daily activities and a reduced quality of life (AIHW, 2024an). Knowledge of this condition, including its impact to the primary health care system, is still evolving. Current evidence estimates that incidence increases with age, number of comorbidities and severity of the acute illness (Greenhalgh, Knight, A'Court, Buxton, & Husain, 2020; Tenforde et al., 2020). Country SA PHN is monitoring the evolving evidence on post-COVID-19 syndrome and will continue to respond to emerging health and service needs in the region.

Endometriosis

Endometriosis is an inflammatory condition that can be painful, affect fertility and lead to reduced participation in school, work and social activities. Symptoms of endometriosis vary between individuals but can include severe pain, heavy menstrual bleeding, bleeding between periods, abdominal bloating, fatigue, anxiety and depression, among other symptoms (Jean Hailes for Women's Health 2023). The cause of endometriosis is unclear, and there is no known cure, but treatments are available to manage the symptoms associated with endometriosis and improve quality of life (AIHW, 2023g).

Nonspecific symptoms, lack of specific biomarkers, lack of awareness of the condition, and stigma and symptom normalisation often contributes to diagnosis delays (Zondervan, Becker, & Missmer, 2020) with an average of between 6 and 8 years between onset of symptoms and diagnosis (Armour, Lawson, Wood, Smith, & Abbott, 2019; O'Hara, Rowe, & Fisher, 2022). Nationally, diagnosis delay is decreasing, for both the time to seeking medical care and time to receiving a diagnosis (AIHW, 2023g).

Prevalence data for the number of women experiencing endometriosis and pelvic pain is limited. In 2021-22 there were 1,775 hospitalisations for endometriosis as a principal diagnosis in South Australia, and an additional 1,552 hospitalisations for any diagnosis of endometriosis. The all-age crude hospitalisation rates for South Australia, for both principal and any endometriosis diagnosis, were higher than the Australian rate.

An analysis of two years of South Australian hospital admission data (2019-20 and 2020-21) showed that one quarter (25.4%) of hospitalisations where endometriosis was a principal diagnosis were to residents of Country SA PHN. Rates of hospitalisations were substantially higher in the SA3 of Yorke Peninsula – double the PHN average rate. Admission rates were also higher than the PHN average in SA3 regions of Lower North, Adelaide Hills, Gawler-Two Wells and Murray and Mallee.

Country SA PHN funds an Endometriosis and Pelvic Pain GP Clinic to provide multi-disciplinary care to women with endometriosis and pelvic pain with a focus on improving diagnostic delay and to promote early access to intervention, care and treatment options. The clinic is based in Kadina on the Yorke Peninsula.

Chronic pain

Chronic pain is a common and complex condition characterised by persistent pain experienced on most days of the week. It can result from injury, surgery, musculoskeletal conditions such as arthritis, or other medical conditions such as cancer, endometriosis or migraines. In some cases, there may be no apparent physical cause (AIHW, 2020d).

Chronic pain can affect a person's use of health care and ability to work, exercise and socialise (Dueñas, Ojeda, Salazar, Mico, & Failde, 2016; Hadi, McHugh, & Closs, 2019). Half of (50.4%) rural and remote respondents to the 2024 *National Pain Survey* said they have had to stop work entirely due to their chronic pain, as opposed to 4 in 10 metro respondents (Chronic Pain Australia, 2024). Living with chronic pain also has a significant impact on mental health: nearly half of the respondents (49%) to the 2023 *National Pain Survey* living in rural or remote areas thought of taking their own life, and more than one in four (27%) people have experienced thoughts of self-harm (Chronic Pain Australia, 2023).

Nationally, chronic pain affects 1 in 5 people aged 45 years and over (AIHW, 2020d). Results from the 2022 *National Health Survey* found that 19% of adults in Country SA PHN, approximately 96,500 people, experience chronic and reoccurring pain, and for more than half (57%) their chronic or recurring pain restricts them in everyday activities (ABS, 2022a).

Managing chronic pain is complex – it often requires support from a range of health professionals including GPs, medical specialists, psychologists, physiotherapists and social workers, as well as a range of treatment options and medications. Some people may require treatment in hospital (AIHW, 2020d).

People living with chronic pain in rural and regional areas face additional barriers to managing their pain and accessing treatment, primarily due to cost, transport and location/geography. Half of rural/regional respondents to the National Pain Surveys (2022, 2023 and 2024) said geography/location prevents them from accessing health services, and one in four rural/regional respondents (24%) said their remote location was their most significant barrier in attending health appointments and managing their chronic pain. However, the use of telehealth by rural respondents had increased from 16% in 2022 to 42% in 2023 (Chronic Pain Australia, 2022, 2023). There are a range of primary care providers and few specialist pain clinics including hospital-based outpatient clinics in metropolitan South Australia (Adelaide), but limited service options in regional SA. Country SA PHN supports primary care providers through our IPHCS, Living Well with Chronic Pain and Healthy Habits programs to improve access to multidisciplinary allied health services for community members living with chronic conditions. Between July 2022-June 2024, chronic pain was identified as the primary condition for 11.7% of clients accessing the IPHCS program (n=5,378 clients).

Affordability was another pressing issue, with two in three (68%) people in rural and remote areas struggle with the cost of pain care. Rural and remote respondents were more likely to have had to go without all categories of essential items in order to afford medicines and healthcare for chronic pain management, and were more likely to self-medicate with non-prescription substances than metropolitan respondents (Chronic Pain Australia, 2024).

As well as access and affordability, awareness about the condition and appropriate treatments and services was another key issue. People living with chronic pain often experience stigma from their partners, families, communities and health professionals (Chronic Pain Australia, 2024). Moreover, fewer people in rural and remote areas have mental health management plans, awareness about medicine management plans, and felt that GPs were often not aware of all the treatment options (Chronic Pain Australia, 2022, 2024).

Chronic conditions and use of health services

Individuals with chronic conditions often have complex health needs and require services from all levels of the health system (AIHW, 2024an). They often require frequent use of health services and medicines (DoHAC, 2021).

Chronic condition management

Primary care is often the first contact with the health system and plays a key role in preventing, detecting, diagnosing and managing chronic conditions. Primary health care providers often refer individuals to specialist services that provide expert care for particular body systems or conditions, and to diagnostic services such as radiology and imaging (AIHW, 2024an).

Patient-centred care approaches facilitated by the GP, including regular contact, individualised care plans, multidisciplinary shared care and patients being involved in decision making about their care have been identified as effective for improving the health outcomes of patients with chronic conditions.

There are currently a range of Medicare-subsided health services available to people with chronic medical conditions, and from 2023 onwards new models and incentives payments through *MyMedicare* will be available to provide more accessible and coordinated multidisciplinary team care. Country SA PHN will support primary health care professionals in our region to implement these new models to improve health outcomes.

People with chronic conditions may be eligible for Medicare-subsidised health services to help plan and coordinate their care and access allied health services (up to 5 services per calendar year). One in five people (22%, 108,303 people) in the Country SA PHN region used GP Enhanced Primary Care services in 2022-23, a range of services aimed at preventing, diagnosing or managing chronic conditions; this increased to 65% for people aged 80+ years (AIHW, 2024u). Use of GP Enhanced Primary Care services varied across the region, with higher utilisation in the SA3s of Fleurieu – Kangaroo Island (31%, 85 services per 100 people) and Gawler-Two Wells (25%, 62 services per 100 people) and lowest utilisation in Lower North (18%, 43 service per 100 people), Eyre and South West (19%, 43 services per 100 people) and Adelaide Hills (19%, 45 service per 100 people) (AIHW, 2024u).

In 2022-23, 15% of the Country SA PHN population (78,160 people) used general practitioner Chronic Disease Management Plans (GP CDMP) services (a service within the Enhanced Primary Care service sub-group) consistent with 16% of the population nationally (AIHW, 2024u). The use of GP CDMP also increased with increasing age, with 58% of people aged 80+ years in Country SA PHN having a service in 2022-23.

The regional utilisation pattern of GP CDMP was also consistent with the Enhanced Primary Care service pattern, with the highest rates of services in 2022-23 in the SA3 of Fleurieu-Kangaroo Island (24%, 65 services per 100 people) and the lowest rates in Adelaide Hills (11%, 29 services per 100 people), Lower North (12%, 29 services per 100 people) and Eyre Peninsula and South West (12%, 32 services per 100 people).

Analysis of MBS data from 2019 showed that at this time, the Country SA PHN region had some of the lowest rates of MBS service provision for General Practice Management Plans (MBS items 721, 229) and Team Care Arrangements (MBS items 723, 230) in Australia, ranking 3rd and 4th lowest respectively. This analysis also highlighted the geographical variation and potential underutilisation of GP CDMP and

TCAs in some parts of Country SA PHN, specifically the SA3s of Eyre Peninsula and South West, Barossa, Adelaide Hills and Lower North (AIHW, 2022d).

The impact of remoteness on coordinated service provision and utilisation was also evident in this analysis – as regional remoteness increased there was a clear decrease in the proportion of TCA patients who used allied health services, 66% in major cities compared to 19% in very remote areas.

Potentially preventable hospitalisations for chronic conditions

Chronic potentially preventable conditions are a defined set of ten long-lasting conditions¹ that may be preventable through lifestyle change and be managed in the community to prevent symptoms becoming worse and requiring hospitalisation. Higher rates of potentially preventable hospitalisations may indicate less effective health care and suggest a lack of timely, accessible, and adequate primary care in a community (AIHW, 2024ar).

In 2021-22, the latest data available, there were 7,082 hospitalisations for chronic conditions to residents of Country SA PHN. Rates of potentially preventable hospitalisations for chronic conditions have decreased in the Country SA PHN region, from a rate of 1,051 per 100,000 people in 2020-21 to 964 per 100,000 people in 2021-22 (AIHW, 2024ar).

Analysis of hospitalisations data from 2004 to 2018, identified potentially preventable hospitalisation hot spots for chronic conditions where rates are continually higher than 1.5 times the state average in Port Augusta, Berri, Renmark, Port Pirie, Millicent, and The Coorong. In this 15 year period, Port Augusta and Renmark were hot for 15 years, Port Pirie was hot for 14 years, Berri for 13 years and Millicent for 11 years, highlighting the persistence of this issue across the Country SA PHN region (SA Health, 2019a).

Data from 2021-22, highlights a similar regional pattern. Numbers of chronic condition PPHs are highest in Murray and Mallee SA3 (which includes Berri, Remark and The Coorong). Rates of chronic condition PPHs are highest in the SA3 region in which Port Augusta is located, Outback – North and East (1,804 ASR per 100,000), followed by Mid North SA3 which includes Port Pirie (ASR of 1,332 per 100,000), the Eyre Peninsula and South West (ASR 1,150 per 100,000) and Limestone Coast SA3 where Millicent is located (ASR 1,001 per 100,000) (AIHW, 2024as).

Rates of potentially preventable hospitalisations for chronic conditions were significantly higher in very remote regions of Country SA PHN, 2,641.1 hospitalisations per 100,000 population compared to inner regional rate of 795.9 hospitalisations per 100,000 population (PHIDU, 2024d).

¹ Asthma, Congestive cardiac failure, Diabetes complications, Chronic Obstructive Pulmonary Disease, Bronchiectasis, Angina, Iron deficiency anaemia, Hypertension, Nutritional deficiencies and Rheumatic heart disease

The five chronic conditions with the highest number of potential preventable hospitalisations (PPH) and age-standardised rates per 100,000 in 2021-22 are shown below, along with the three SA3 regions that had the highest rates for each condition (AIHW, 2024as):

- Diabetes complications: 1,403 PPHs, ASR of 214 per 100,000 – Mid North, Outback - North and East, and Eyre Peninsula and South West
- Chronic Obstructive Pulmonary Disease: 1,516 PPHs, ASR 185 per 100,000 – Outback - North and East, Mid North, and Eyre Peninsula and South West
- Congestive cardiac failure: 1,631 PPHs, ASR 184 per 100,000 – Mid North, Outback - North and East, and Limestone Coast
- Angina: 875 PPHs, ASR 113 per 100,000 – Outback - North and East, Lower North, and Eyre Peninsula and South West
- Iron deficiency anaemia: 723 PPHs, ASR 106 per 100,000 – Adelaide Hills, Murray and Mallee and Gawler - Two Wells

Oral health

Oral health can be considered as a “state of being free from mouth and facial pain, oral diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking and psychosocial wellbeing” (World Health Organisation, 2021). Oral health is fundamental to overall health, wellbeing, and quality of life, and poor oral health has significant adverse impacts at individual, societal, and economic levels (Australian Government, 2024).

For children living in remote or very remote areas of South Australia, there is a higher prevalence and severity of untreated dental decay and total decay experience (SA Health, 2019c). For adults, decay experience is disproportionate across the social gradient and for specific populations including: rural and remote populations, Aboriginal people, frail older people, people with disabilities, those living with mental illness and culturally and linguistically diverse people (SA Health, 2019c).

A maldistribution of oral health professionals in SA has resulted in worse oral health outcomes for communities in regional, rural and remote localities. People residing outside of capital cities reported a higher percentage with complete tooth loss (1.61 times), less than 21 teeth (1.54 times) and dentures (1.35 times), and a lower percentage with dental implants (0.75 times) than capital city residents (SA Health, 2019c).

Potentially preventable hospitalisations for acute dental conditions

In the absence of timely, accessible and affordable primary health and/or dental care individuals may have to resort to hospital emergency departments to manage dental infections or exacerbations of existing oral health problems (Veginadu & Haddock, 2024).

In 2021-22, the latest data available, dental conditions were the most common PPH with 2,110 hospitalisations due to dental conditions to residents of Country SA PHN and 2,227 hospitalisations in 2020-21. This represents a small decline in rates of potentially preventable hospitalisations for dental conditions in the Country SA PHN region, from 417 per 100,000 people in 2020-21 to 388 per 100,000 people in 2021-22 (AIHW, 2024as).

Analysis of hospitalisations data from 2004 to 2018, identified nine Country SA regions where hospitalisations for acute dental conditions were persistently higher than (1.5 times) the state average rate: Renmark, Barmera, Nuriootpa, Tanunda, Berri, Ceduna, Goolwa-Port Elliot, Port Pirie and Port Augusta (SA Health, 2019a). Illustrating the persistence of this issue, Renmark and Berri had been hot spots for 15 and 14 years respectively, Port Pirie and Port Augusta were hot spots for 13 years, and Nuriootpa and Tanunda were hot for 11 years in this 15 year period (SA Health, 2019a).

Data from 2021-22, highlights the SA3 region of Barossa, in which Nuriootpa and Tanunda are located, as having the highest rates of dental conditions PPHs (ASR 517 per 100,000 people, 211 hospitalisations), followed by Fleurieu-Kangaroo Island (ASR 479 per 100,000, 313 hospitalisations) and Mid North (ASR 456 per 100,000 people, 134 hospitalisations). Adelaide Hills SA3 had the highest number of acute dental PPHs with 353 hospitalisations in 2021-22 (AIHW, 2024as).

Rates of potentially preventable hospitalisations for acute dental conditions were significantly higher in very remote regions of Country SA PHN, 265.0 hospitalisations per 100,000 population compared to inner regional rate of 94.9 hospitalisations per 100,000 population (PHIDU, 2024d).

Oral health services in regional and remote South Australia

In South Australia, oral health care services are provided by a range of oral health professionals including specialists, dentists, dental prosthetists, dental or oral therapists, hygienists and assistants. Services are provided in a range of different settings including SA Dental-run public clinics and dental hospitals, private practices, local Aboriginal Community Controlled Health Organisations (ACCHOs), the Royal Flying Doctor Service (RFDS) and other not-for profit organisations. Emergency oral health treatments can also be provided in some rural hospitals. The private sector provides the majority of oral health services through privately funded dental clinics and publicly funded dental schemes (SA Health, 2019c).

To address the gap in access to dental services including necessary emergency and after-hours dental services for rural and remote South Australian consumers, Country SA PHN has commissioned three culturally appropriate services to improve access to necessary dental services, prevent avoidable emergency presentations, and improve oral health outcomes in rural, remote and very remote communities.

The lack of culturally appropriate services in regions of remote South Australia and service cost are substantial barriers to service access. As oral health services are not covered by Medicare Benefits Schedule and with more than 85% of dental care services provided in the private sector, there are often significant patient out-of-pocket costs for dental care, either in the form of direct expenses or private health insurance premiums (Veginadu & Haddock, 2024).

The final report from the *Select Committee into the Provision of and Access to Dental Services in Australia* highlighted inequities in the current oral healthcare system including barriers to access services. Recommendations to improve oral health status for all Australians were made and summarised as (Australian Government, 2024):

- More equitable access
- Better integration
- National data and coordination
- Awareness and education
- Culturally safe, accessible care.

Workforce challenges

Nationally, access to oral health care among rural and remote Australians is poor, particularly among vulnerable groups including Aboriginal people reliant on public dental services. This is due to maldistribution of oral health services and limited dental workforce supply, recruitment and retention in these areas (Veginadu & Haddock, 2024).

A similar picture exists in South Australia. The distribution of dentists per 100,000 people decreases significantly with increasing remoteness areas (DoHAC, 2024o). Undersupply and maldistribution of oral health services can be further exacerbated by geographical and professional isolation, as well as diversity of service delivery required in regional areas. These factors contribute to challenges

attracting, developing and retaining skilled oral health workforce across rural and remote South Australia across both private and public sectors (SA Health, 2019c).

To exacerbate the challenges in regional and rural South Australia, the current oral health workforce model does not utilise the oral health workforce to their full scope of practice. There are challenging funding streams and higher costs of service delivery. In addition, senior clinicians are less accessible to support treatment plans and patient care often needs to be provided over long distances or the patient has to travel long distances to access care. The increasing workload and long waiting lists are driving fatigue within the workforce (SA Health, 2019c).

Service Needs

Patterns of health service use

Utilisation of health services can reflect on patterns of illness as well as the availability and accessibility of health services and the ways people choose to use them.

Medicare-subsidised services

Medicare-subsidised services provided in non-hospital settings enable eligible Australians to access a wide range of general practice, diagnostic, allied health, specialist, nursing and Aboriginal health worker services at no or partial cost. With the exception of Allied Health services (where rates of attendance slightly increased (+3%)), there has been a decline in overall rates of Medicare-subsidised services (per 100 people) in the Country SA PHN region from 2021-22 and 2022-23, which is consistent with the trend for Regional areas nation-wide. The largest decrease in service rates was for GP – After hours services (-21%), followed by GP attendances (-12%), Specialist attendances (-4%) and Diagnostic imaging services (-2%)(AIHW, 2021b, 2024u).

Data from 2022-23 shows that the overall rates of Medicare-subsidised services for each of these broad service groups were lower in Country SA PHN compared to the Regional and National averages (AIHW, 2024u).

Rates of service varied depending on a person's age and where a person lived within Country SA PHN; generally increasing with increasing age and decreasing with increasing remoteness. Rates for the majority of service types were highest in the 80+ years age group, with the exception of mental health-related services, where rates were higher in the 15-24 years and 25-44 years age groups. There was less of a consistent pattern with increasing remoteness, however, compared to inner and outer regional areas of country SA, rates for total attendances for GPs, Specialists, Allied Health and Diagnostic Imaging were much lower in remote areas. Rates of services for Nursing and Aboriginal health workers was comparatively higher in remote areas of our region, likely reflecting the service models in more remote areas (AIHW, 2024u).

General practice attendances

Data from the 2023 South Australian Population Health Survey suggest that 88% of adults (18+ years) living in rural SA reported using a general practice in the previous 12-months (Preventive Health SA, 2024a).

In 2022–23, 84% of people living in Country SA PHN region had at least one Medicare-subsidised GP attendance, consistent with the regional rate of 85% (AIHW, 2024u), but down from 87% in 2021-22 (AIHW, 2021b). Almost 3,042,000 GP services were provided to 442,300 people in 2022-23, at a rate of 579.4 per 100 people.

Across country SA the proportion of people who had a Medicare-subsidised GP attendance ranged from 75% in Outback – North and East to 88% in the Mid-North and Yorke Peninsula. The rate of

services for people aged 80+ years was over five times the rate of services provided to 0-14 year olds (AIHW, 2024u).

GP Enhanced Primary Care refers to a range of non-hospital Medicare-subsidised services such as health assessments, medication management reviews, the creation and review of treatment plans, and coordination for people living with complex health conditions who require multidisciplinary, team-based care from a GP and at least 2 other providers. There has been a marginal increase in the rates and the number of people receiving an Enhanced Primary Care services in the country SA PHN region from 51.5 per 100 (108,300 people) in 2021-22 to 54.5 per 100 (115,900 people) in 2022-23 (AIHW, 2024u). Regional data wasn't available in 2022-23 but in 2021-22, rates varied from 37.6 per 100 in the Lower North to 82.0 per 100 people in Gawler – Two Wells (AIHW, 2021b).

GP Chronic Disease Management Plans were the main GP Enhanced Primary service provided, with nearly 208,800 services to over 78,000 people in 2022-23, an increase in both population reached and services provided since 2021-22. In 2022-23 compared to 2021-22, there were also more GP Health Assessments (+4,500 services) and Medication Management Reviews (+500 services), but fewer GP Mental Health services (-2,700) and GP Multidisciplinary Case Conference services provided (-90 services) (AIHW, 2021b, 2024u).

Further data and commentary about the distribution of the general practice workforce are provided in the *Health Workforce* chapter.

Allied health services

Allied health services include a broad range of services delivered by health practitioners who are not doctors, nurses or dentists. This includes audiologists, chiropractors, occupational therapists, optometrists, osteopaths, physiotherapists, podiatrists, psychologists and speech pathologists (Allied Health Professions Australia, 2024). Medicare-subsidised allied health services do not cover all allied health treatments; allied health services can be accessed and funded through many arrangements including the Department of Veterans' Affairs, private health insurance subsidised, or full-fee covered by the consumer (AIHW, 2021b).

The allied health workforce in country SA is incredibly diverse. Allied health clinicians, particularly those operating in private practice settings, often work across multiple sectors, including NDIS, Aged Care and private health, in addition to the Medicare-subsidised services listed above. Country SA PHN recognises the value that allied health services bring to primary health care and is committed to greater engagement with the allied health workforce to better understand their needs and identify opportunities for further support.

In 2022-23, almost 500,000 Medicare-subsidised allied health services were provided to approximately 202,600 people in country SA PHN, at a rate of 95.2 services per 100 people, which is an increase on the rate in 2021-22, and consistent with the national Regional average rate of 96.1 per 100 people. The majority (46%) of Medicare-subsidised allied health services were for Optometry (231,300 services, at a rate of 44.1 services per 100 people), followed by Podiatry (102,400 services, 19.5 per 100), Physiotherapy (45,000 services, 8.6 per 100), and Clinical Psychologist (41,300 services, 7.9 per 100) and Other Psychologist services (31,500 services, 6.0 per 100 people) (AIHW, 2024u).

There was considerable variation in total allied health attendances across the country SA region, with rates in Remote areas of Outback - North and East (61 per 100) and Eyre Peninsula and South West (76.0 per 100) substantially lower compared to Fleurieu – Kangaroo Island (125.2 per 100) and Gawler-Two Wells (108.4 per 100) (AIHW, 2024u).

Further data and commentary about the distribution of the allied health workforce are provided in the *Health Workforce* chapter.

Lower urgency emergency department presentations

According to the 2022-23 *Patient Experience Survey*, nationally about 16% of people who visited an emergency department for any reason thought their care could have been provided by a General Practitioner (GP) for their most recent visit to the ED. The main reasons reported for going to the ED instead of a GP were because they were taken by ambulance or the condition was serious (47%), a GP was not available when required or that the waiting time for a GP appointment was too long (22%), or the GP didn't have the right equipment or facilities (16.1%). Fewer than one percent reported lower cost as the main reason (ABS, 2023b).

Nationally, people living in Primary Health Networks (PHN) in regional areas had a higher rates of lower urgency ED presentations than their metropolitan counterparts. In 2021-22, half (50%) of all presentations to public emergency departments in Country SA PHN (72,691 presentations) were lower urgency (triage 4 and 5), consistent with proportion for other the regional PHNs (AIHW, 2024az).

In Country SA PHN in 2021-22 the all-hours age standardised rate for lower urgency ED use was 153.1 per 1000 people, which is a small increase of eight percent since 2020-21, due to an increase of in-hours lower urgency presentations. Just over half (55%) of lower urgency ED presentations occurred in-hours, equivalent to a rate of 82.9 per 1,000 population in 2021-22, compared to 70.2 per 1,000 in the after-hours period. Older people (aged 65+) had a higher proportion in-hours presentations compared to younger people (0-14 years), 61% compared to 55% respectively (AIHW, 2024az).

Children (0-14 years) and young people (15-24 years) had the highest rates for lower urgency ED presentations across the three categories (all-hours, in-hours and after-hours). Despite representing 28% of total population people aged 0-24 represent 40% of all lower urgency presentations in 2021-22 (AIHW, 2024az).

Rates of lower urgency ED presentations varied substantially across the Country SA PHN region, with age-standard rates highest in Outer Regional SA3s. In 2021-22, the highest all-hours rates occurred in Mid-North, Murray and Mallee, Yorke Peninsula and Limestone Coast, and were well above the national average age-standardised rates. This pattern is consistent with 2020-21 rates. In all SA3 regions of Country SA PHN, with the exception of Muray Mallee SA3 where rates of after-hours presentations were slightly higher than in-hours rates, rates of lower urgency ED presentations were higher in-hours (AIHW, 2024az).

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) refer to hospital admissions for 22 selected acute, chronic and vaccine-preventable conditions that are considered manageable through timely and effective primary and community care interventions. Potentially preventable hospitalisations give insight into the effectiveness of health care in the community, as higher rates of PPH may suggest a lack of timely, accessible, and adequate health care provided by general practitioners, dentists, nurses, and allied health professionals. PPHs are a useful tool for identifying and investigating variation between and within communities to better understand health inequalities in a region (AIHW, 2024ar).

In 2021-22 there were 14,405 potentially preventable hospitalisations in CSAPHN, at an age-standardised rate of 2,239 PPH per 100,000 people, consistent with the national age-standardised rate of 2,293 PPH per 100,000 people. There was a small decrease in the age-standardised rates of total, chronic and acute PPH rates compared to 2020-21 but an increase in the rate of vaccine-preventable hospitalisations, an increase of 191 hospitalisations in 2021-22. Almost half (49%, 7,082 hospitalisations) were for chronic conditions, 48% were for acute conditions (6,875 hospitalisations) and four percent were for vaccine-preventable conditions (521 hospitalisations) (AIHW, 2024ar).

The top five conditions in 2021-22 were dental conditions, diabetes complications, urinary tract infections, cellulitis and chronic obstructive pulmonary disease; consistent (but not in rank order) with

the top four conditions in 2020-21, where congestive cardiac failure was in the top five and not cellulitis (AIHW, 2024ar).

There was wide variation in rates of PPH across Country SA for each of the three broad categories (acute, chronic and vaccine-preventable), by conditions and overall, but generally rates increased with increasing remoteness and were substantially higher in very remote areas of country SA (PHIDU, 2024d).

Compared to other SA3s in 2021-22, Outback – North and East, Gawler-Two Wells and Murray and Mallee had higher rates of acute conditions including dental conditions, urinary tract infections, cellulitis, convulsions and epilepsy, ear, nose and throat infections and gangrene. Outback – North and East, Mid North, Eyre Peninsula and South West, and Lower North had higher rates of chronic conditions including diabetes complication, chronic obstructive pulmonary disease, congestive cardiac failure, angina, asthma compared to other SA3s in the region (AIHW, 2024ar).

After hours services

The following section is an excerpt of selected content and finding of the Homelessness, Afters Hours and Multicultural Access Needs Assessment undertaken by Health Q Consulting and commissioned by Country SA PHN.

By definition, after-hours care refers to accessible primary health care provided outside of normal general practice opening hours and beyond hospital emergency departments. The Commonwealth Department of Health and Aged Care defines after-hours primary health care as “accessible and effective primary health care for people whose health condition cannot wait for treatment until regular primary health care services are next available”. In practice, this means services delivered to patients in the time periods specified by the after-hours MBS items of service, typically evenings, overnight and parts of the daytime at weekends. For reimbursement purposes the after-hours period is divided between sociable hours and unsociable hours (11pm and 7am) (DoHAC, 2024b).

After hours services are crucial to ensure that Australians have access to appropriate care when immediate treatment cannot wait. These services can include consultations, advice, and basic medical treatment providing an alternative to emergency departments and prevents unnecessary hospital visits, reducing that burden on health care workers also.

Various models exist for after-hours care delivery (DoHAC, 2024b):

- General Practice (GP) Clinics: Some GPs extend their hours or collaborate with other practices to provide after-hours services.
- Home Visits: GPs visit patients at home during evenings or weekends.
- Telephone Triage Services: Nurses or GPs provide advice over the phone.
- Urgent Care Centres: Dedicated centres for non-emergency care outside regular hours.
- Telehealth: Virtual consultations via video or phone.

The provision of sustainable after-hours medical services within rural and remote regions of Australia is an ongoing challenge for providers and coordinating agencies. It is reliant on not only the existence of the workforce, but also the ability of practitioners to participate in on-call, after-hours activity, especially in areas with workforce shortage where the distribution of workload disproportionately falls on very few practitioners (Health Q, 2024b).

Data accessed through the Country SA PHN data systems identified that there were 174 general practices in the country South Australia. Of particular importance, of the 174 practices, Health Direct data indicated that only 14 offered bulk billing. However, six of these were ACCHO, leaving only seven GP practices offering bulk billing, representing 4% of all practices.

After hours availability and emergency department access

In South Australia as a whole, there are limited services available after hours. After-hours services are generally accessed through hospital emergency departments (EDs) and extended hours offered by some GP clinics. Some consumers may utilise healthdirect, a 24/7 health advice line that connects consumers with the appropriate care based on their situation and location (Health Q, 2024b).

In most hospitals within this region, EDs are staffed by on-call GPs from the local area. The Country SA PHN region experiences less than half the rate of after-hours GP attendances compared to the South Australian and national averages. This discrepancy suggests potential gaps in service provision, or challenges related to access. Lower urgency presentations in emergency departments may indicate health conditions or events that could be more appropriately managed in primary care settings. A high rate of presentations during after-hours periods may signal gaps in the utilisation or availability of alternative services (Health Q, 2024b).

Previous reviews by Country SA PHN identified that the Adelaide Hills had the highest concentration of after-hours GP sites, followed by the Eyre Peninsula and South-West. However, due to the vast geographical area of the Eyre Peninsula and South-West, the availability of after-hours services is sparse outside the regional cities of Whyalla and Port Lincoln. Among the SA3 regions, the Limestone Coast, Eyre Peninsula and South-West, Yorke Peninsula, Mid North, and Fleurieu - Kangaroo Island had the lowest ratio of after-hours GP services provided per 1,000 persons.

After hours GP attendances and Medicare claims

The Australian Government provides a range of Medicare-subsidised after-hours services to support access to health care. After-hours care is categorised as urgent and non-urgent, depending on when and where care is provided. The ABS reports these Medicare-subsidised services by reporting MBS claims on different items (i.e. services).

The availability of Medicare-subsidised after-hours GP services can vary based on where a person lives, and this may impact the proportion of people who have this attendance type.

Nationally in 2022–23, after-hours GP attendance use was higher in metropolitan PHN areas (20%) than regional areas (9.3%). Across PHNs, after-hours GP visits ranged from 5.1% to 29%.

Country SA PHN reported the second lowest MBS claims for after-hours services. Of those within major cities, a higher proportion of people who live in lower socioeconomic SA3 areas had an after-hours GP attendance, than in medium and higher socioeconomic areas. In 2022–23, 23% of people in lower socioeconomic SA3 areas had an after-hours GP attendance compared with 19% in medium and 14% in higher socioeconomic SA3 areas.

GP after-hours attendances billed as 'urgent' accounted for 14% of all GP after-hours attendances in Country SA PHN in 2022–23, compared to nine percent of GP after-hours visits by people in regional areas nationally.

Medicare Urgent Care Centres and Virtual Care Services

Changes have occurred in the service landscape, state funded services, and private services in recent years with the COVID-19 pandemic, and in both provider and community preferences. The emergence and establishment of Medicare Urgent Care Centres and Virtual Care Services in South Australia have impacted on after-hour service availability for urgent care needs.

Medicare Urgent Care Clinics have been funded by the Commonwealth to provide fee free care to patients who are experiencing non-life-threatening injury or illness. The Mount Gambier Medicare Urgent Care Clinic has been open since November 2023 and providing care to patients 7 days a week. Medicare Urgent Care Clinics provide a no cost alternative for patients to general practice or hospital care. By relieving these services of urgent care presentations, hospitals are aided in meeting their demand for emergency care and general practice is aided in providing chronic disease care and

comprehensive care to patients. The Mount Gambier Medicare Urgent Care Clinic has now seen over 10,000 patients from Mount Gambier and the surrounding communities.

Virtual Clinic Care is provided by Integrated Cardiovascular Clinical Network, iCCnet. Country SA PHN funding provides opportunity for patients living in rural areas to access around the clock support for their chronic illness. Point of care testing equipment is provided to the patient to take regular observations which are monitored by clinicians in real time. Support and referral to services can then be arranged for the patient when required. This timely support prevents presentations to hospital emergency departments after hours and allows General Practice to support patients to stay at home.

After-hours utilisation

A preliminary analysis of GP visit data available to the Country SA PHN (CSAPHN, 2024e) indicated that some GP practices do have higher than average utilisation of after-hours MBS items.

While utilisation rates can vary, after-hours services play a crucial role in providing accessible healthcare beyond standard hours. Efforts to address challenges regarding accessing after-hours services include promoting awareness, improving workforce distribution, enhancing transport options, and fostering collaboration among health providers (Health Q, 2024b).

There are several factors that can influence the utilisation of after-hours services, such as (DoHAC, 2024b):

1. Perceptions of health care effectiveness: If individuals perceive after-hours services as less effective or less comprehensive, they may be less likely to seek care during those times.
2. Severity of illness or symptoms: severe symptoms or acute conditions are more likely to prompt individuals to access services outside regular hours.
3. Family requirements and commitments: patients may prioritise family needs over their own health needs.
4. Convenience and location: proximity to after-hours clinics or emergency departments matters.
5. Availability of in-care services: the availability of alternative care options (such as telehealth or home visits) during after-hours affects patient choices.
6. Health literacy and awareness: patients who understand the importance of timely care and recognise symptoms may be more likely to seek after-hours services.
7. Cultural and social factors: some cultures prioritize community-based care or traditional healing practices due to certain beliefs.
8. Fear of stigmatization or discrimination: those from marginalised groups may be anxious accessing services.
9. Financial considerations: patients may avoid after-hours care due to concerns about out-of-pocket expenses or lack of insurance coverage.
10. Previous experiences with healthcare providers: past experiences with healthcare professionals during regular hours can impact trust and willingness to seek care after-hours.

In addition, there may be people who access after-hours because it is more discreet (if late at night). For example, if someone is trying to escape domestic violence or there is a history of family violence. Also, consumers who are intoxicated or using illegal substances may present late at night and be a concern for others, especially if aggressive or violent (Economics, 2016). Recognising these factors helps healthcare providers tailor after-hours services to meet patient needs effectively. The findings from our consultations shed light on the accessibility and effectiveness of after-hours care, particularly for vulnerable populations, including homeless people, Aboriginal and Torres Strait Islander communities, and CALD populations.

Stakeholders highlighted that after-hours health services in the Country SA PHN region are often limited, particularly in rural and remote areas. While some larger towns may have access to after-hours

clinics or emergency departments, many smaller communities face challenges in accessing timely medical care outside of regular business hours (Health Q, 2024b).

Aboriginal communities often encounter cultural barriers and discrimination when accessing after-hours health services. Cultural safety and sensitivity are essential considerations in ensuring that Aboriginal people feel comfortable seeking care outside of regular hours. Additionally, limited availability of culturally appropriate after-hours services may contribute to disparities in health outcomes for Aboriginal and Torres Strait Islander peoples. CALD communities may face similar challenges in accessing after-hours health services due to language barriers and limited availability of culturally competent care. As such, it was highlighted that ensuring that after-hours clinics and services have access to interpreters and bilingual staff is a top priority, as this can improve accessibility and effectiveness (Health Q, 2024b).

Barriers to primary health care

As established in other chapters of this Comprehensive Needs Assessment, there are significant additional barriers to accessing and providing appropriate, timely and accessible care in regional and remote areas. This issue goes beyond structural disparities and represents the complex interaction between systems, organisations, providers, consumers and the environment (Leach et al., 2022). Across the general population in the Country SA PHN access to primary health care services are often affected by a number of common issues including limited service availability and choice, consumer awareness of services, environmental factors such as geographical isolations and transport, increasing costs of services, and issues with the appropriateness and cultural safety of services (Health Q, 2024b).

As highlighted in this report, people seeking preventative health services including screening or immunisation, sexual or reproductive services, dental services, or support for mental health concerns or alcohol or other drug use may face additional challenges due to circumstances and characteristics of a community or the individual consumer.

Country SA PHN's Clinical Council and Community Advisory Committees identified barriers in accessing the following services in regional and remote SA (CSAPHN, 2023):

- Aged Care
- Alcohol and other drug support
- Allied health - specifically podiatry and physiotherapy
- Diagnostic and x-ray services
- General practice
- Hospitals
- Paediatrics
- Mental health care
- Specialists

Availability and distribution

In country SA there are limited availability and service options across a range of primary health services. Residents of north east, and north and far western regions of South Australia are particularly affected by the lack of services. For these residents there are few options available 'after hours' apart from hospital emergency departments. There is also a shortage of permanently located health workforce professionals in these locations and service providers, where they do provide service, have sought to employ a fly in, fly out model to increase the pool of professionals available and support workforce retention (Health Q, 2024b). Some locations have and are somewhat reliant on (assertive) outreach health supports, like those administered by the Rural Doctors Workforce Agency and Royal Flying Doctor Service which contribute to closing local services gaps in rural and remote locations across country SA (CSAPHN, 2020; Health Q, 2024b).

A broad range of allied health services are not available to people living in rural and remote locations, and consultations suggest there would appear to be little interest in public or private health services expanding into these locations. In some areas of country SA, allied health professionals are available only once a month, and specialists once a year. There is also a distinct lack of walk-in and/or accessible

mental health services, often no 24/7 pharmacy is available in regional settings and a lack of services able to address and manage comorbidities (Health Q, 2024b).

Further while some services exist to support individual patients in the acute or later stages of chronic disease stakeholders felt there are few services providing appropriate screening, health promotion and education activities, or early intervention. Stakeholders also felt that there was insufficient service coordination and health service planning spanning the health promotion, primary health, and acute care continuum (Health Q, 2024b).

Accessibility

In the rural and remote context with small populations spread across large geographical areas, it is not realistic for everyone to have access to permanent, local services. However, all should have reasonable access to services (Gardiner et al., 2020). The Australian Institute of Health and Welfare (AIHW), proposes a patient's ability to access primary healthcare within 60 minutes of motor vehicle travel as one measure of reasonable access. This also includes the ability to access telehealth services. A 2020 study found that approximately 2,000 people or 4.5% of South Australia's population, primarily within the two regions of Outback – North and East and Eyre Peninsula and South West within Country SA PHN region, were without any primary healthcare coverage within 60 minutes' drive. Across South Australia, 5.8% of the population were without GP coverage, 8.9% without nursing coverage, 4.1% without dental coverage, 6.0% without mental health coverage and 2.6% of the Aboriginal population were without Aboriginal health coverage within 60 minutes' drive (Gardiner et al., 2020).

This was reflected in consultations with people living in country SA; they shared that they often need to travel large distances and spend time away from their community in order to participate in health care, with travel to regional service hubs or to metropolitan Adelaide to reach health services, hospitals and specialist services in particular, was often required (Health Q, 2024b). Community consultation across the region identified only half of respondents accessed a GP within their own suburb, and only 5% accessed other health professionals in this same area. Almost one in 2 (48%) respondents travelled over 450kms to access a specialist health professional (CSAPHN, 2020). The 2019 *South Australian Population Health Survey* indicated that 40% of rural South Australians were required to travel over 75kms from their homes to use a health service. For 16% of respondents it was their own choice to access a service further away, but 74% were required to do so as the required services were not located or accessible locally (Wellbeing SA, 2019).

Compounding access issues in outer regional and remote regions of SA, there is lack of public transport, community transport systems or taxi services, and where transport services are available, the frequency and times of the service do not align with the hours of specialist appointments or day surgery requirements (Combined Presiding Members Panel FUNLHN, 2024b).

Timeliness

In South Australia, one in three people (32.8%) who saw a GP in the previous 12 months waited longer than they felt acceptable to get an appointment, an increase on 2021-22 (24.6%). The proportion of people waiting 24 hours or more for urgent medical care has doubled in the five years from 2017-18 to 2022-23, from 25.3% to 55.8% (Productivity Commission, 2024).

Throughout rural and remote South Australia limited health services result in high demand for services, which in turn result in long waitlists. Stakeholder consultations reported that doctors are booked for weeks in advance and that finding a same-day appointment is difficult. Consumers faced long wait lists for initial appointments and lots of time between appointments due to limited availability, resulting in both poor attendance and issues going untreated (Health Q, 2024b).

Affordability

For the majority of South Australians there is a lack of bulk billing services and the only free access to health care for economically disadvantaged populations is through the hospital emergency

departments (Health Q, 2024b). Rising out-of-pocket costs are continuing to place more pressure on affordable patient care; data for South Australia shows that costs have increased in the last decade from 2013-14 to 2022-23 – nine percent for non-referred attendances (\$32 to \$35), 51% for specialist attendances (\$57 to \$86) and 32% for allied health attendances (\$47 to \$62) (Productivity Commission, 2024).

In line with the national trend, rates for GP non-referred attendances where patients were always bulk-billed in Country SA PHN declined by 26% from 61.1% in 2021-22 to 45.2% in 2022-23. Excluding attendances for COVID-19 vaccines (as bulk-billing for COVID-19 vaccines is mandatory), in 2022-23, the proportion of GP non-referred attendance patients who were always or usually bulk billed decreased from 84.7% to 76.5% while the proportion of patients who were never bulk billed increased from 7.1% to 11.3% (DoHAC, 2024p).

Diagnostic and treatment options are sometimes deferred by rural South Australians solely because of the cost and challenges of accessing health services. This also impacts upon the sustainability of effective health service delivery and in the long term increases the burden upon health services as consumers present with more serious health issues that could have been preventable or manageable if treatment was commenced as early as possible (Combined Presiding Members Panel FUNLHN, 2024a). While lower than the national figures the proportion of people delaying treatment due to cost in South Australia has increased over the last few years. In 2022-23, approximately five percent of respondents to the ABS *Patient Experience Survey* reported that due to costs they delayed or did not see a GP in the last 12 months or get prescription medication when needed (Productivity Commission, 2024).

Travel and accommodation costs for rural and remote consumers are in addition to the cost for the health service, which are not always (adequately) subsidised by current government allowance schemes, including the Patient Assistance Transport Scheme (PATS) (Combined Presiding Members Panel FUNLHN, 2024a). Community consultations often cited that there are multiple access barriers and issues with the current PATS which provides financial subsidies to assist with travel and accommodation costs (Combined Presiding Members Panel FUNLHN, 2024b). The recent withdrawal of a regional airline competitor in South Australia has increased in air travel costs resulting in day trips to Adelaide for appointments or treatment now being out of reach financially for many rural consumers (Combined Presiding Members Panel FUNLHN, 2024a).

Acceptability - appropriate and safe care

People may be less willing to access health services if the services do not consider community social and cultural factors, such as language, age, gender, or the ethnicity or religion of the people they serve (Evans, Hsu, & Boerma, 2013). Culturally competent health care service delivery can improve health outcomes and patient experience. A lack of access to culturally competent care can lead to disparities in health outcomes, underutilisation of preventive services, and delays in seeking treatment for acute and chronic conditions (Health Q, 2024b). Country SA PHN's Clinical Council and Community Advisory Committees acknowledged the importance of culturally appropriate care and services (CSAPHN, 2023).

From the 2022-23 *Patient Experience Survey*, the proportion of people in inner and outer regional, remote and very remote in South Australia who felt GPs always or often showed respect was 89%, lower than in other states and territories and a decrease on the rates of 93% in the two years prior (Productivity Commission, 2024). Surveyed respondents in a 2019 state-wide health survey identified the most common reasons they experienced discrimination was because of race (11.7%), age (11.2%), gender (10.3%), disability (5.4%), and religion (5.0%) (Wellbeing SA, 2019).

Aboriginal Australians encounter unique cultural and linguistic barriers when accessing healthcare services; multiple Indigenous languages are spoken in South Australia and English may not be a person's first language, and as such any one of them may not be spoken or understood by healthcare providers. This naturally leads to communication difficulties and misunderstandings (Health Q, 2024b).

Through consultations we heard that many Aboriginal people have experienced stigma and discrimination within the South Australian healthcare system, leading to reluctance to seek care. Further hindering access are a lack of culturally safe mainstream healthcare settings, where Aboriginal cultural beliefs, values, and practices are respected or understood. These are essential to overcoming these barriers and fostering trust between Aboriginal people and healthcare providers (Health Q, 2024a).

Persons identifying as LGBTIQ+ are likely to feel their sexual orientation or gender identify is not respected in mainstream services, and are more likely to access services that are accredited or identified as LGBTIQ+ inclusive (Hill A, Bourne A, McNair R, Carman M, & Lyons A, 2020). Consultations (2021 and 2024) with South Australian people of lived experience and service providers, identified key needs for provider education in LGBTIQ+ health needs, improved access to and choice of providers for LGBTIQ+ people. We heard that there are long wait lists for appropriate regional services, and people travel to Adelaide-based services at additional financial costs. People are moving away from regional areas to “safer” better resourced metropolitan areas to be better connected to communities, better access to medical providers and activities (Country SA PHN, 2021; The Equality Project, 2024).

For people from culturally and linguistically diverse communities, one of the most significant challenges identified by stakeholders in recent consultations was the language and communication barriers faced when accessing healthcare services. Limited English proficiency among community members often leads to misunderstandings, miscommunication, and difficulties in expressing health concerns. This barrier not only affects the quality of care received but also contributes to feelings of frustration, disempowerment, and reluctance to seek medical help (Health Q, 2024a). Consultations with community and stakeholders also identified a lack of translators or translation services for CALD community, including the Translating and Interpreting Service (TIS) is difficult to use in hospital by phone (Health Q, 2024a).

Awareness

Stakeholders highlighted the importance of health literacy and the influence it has on the extent to which consumers can effectively engage with and navigate the health system. Research shows that participants with higher health literacy had higher odds of being aware of and using health services (Leach et al., 2022). Stakeholders in country SA noted the importance of education initiatives tailored to CALD communities. Providing culturally relevant health education materials, workshops, and outreach programs can empower CALD individuals to make informed decisions about their health and navigate healthcare services more effectively (Health Q, 2024a).

Palliative Care

Death is a natural part of life, yet societal reluctance to discuss it can impede meaningful conversations about people's end-of-life wishes, affecting the quality of care and support for individuals and their families. By acknowledging death as inevitable, we can promote open dialogue and proactive planning, ensuring individuals receive the care they desire.

In country SA, the diagnosis of a life-limiting illness or the transition to the end-of-life phase has far-reaching consequences for the individual, their family, and the broader community. Community strengths, including the close-knit nature of country towns, can be a vital support for individuals and their families, but may also amplify the emotional, physical, financial, and communal impacts, making the role of palliative care services especially vital.

Palliative care helps people with a life-limiting illness to live comfortably at home, in hospital, hospice or a residential aged care home. It involves a range of general and specialist care services to improve overall quality-of-life for patients and their families through holistic management of disease and symptoms, as well as any associated needs including psychological, spiritual and social wellness. These needs vary across and within populations groups, as palliative and end of life decision making is deeply personal.

While originally associated with cancer care, palliative care is appropriate for anyone with life-limiting illnesses, including non-malignant degenerative diseases, and dementia.

Key Points

- Ageing population with high burden of life-limiting conditions requiring palliative care
- Several populations have unique health needs
- Major data gaps in palliative care access and service delivery across jurisdictions
- There are widespread impacts of life-limiting diseases across the community

Identified Needs

1. Improve awareness and access to patient centred palliative care and reduce avoidable hospital admissions
2. Locally relevant professional development and education for primary care clinicians

Health Needs

While dying is a natural part of life, our reluctance to think about or discuss death can hinder our ability to prepare for this inevitable event. This avoidance can prevent meaningful conversations about end-of-life wishes and planning, ultimately impacting the quality of care and support available to individuals and their families. By acknowledging death as a guaranteed occurrence, we can encourage open dialogue and proactive planning, ensuring that individuals receive the care they desire and deserve when the time comes. Embracing this reality allows us to confront our fears and foster a culture of support that values both life and the process of dying.

Although palliative care is generally recognised within the health system, there is a growing movement across Australia and globally to adopt a public health approach to serious illness, ageing, dying, grief and caregiving. This approach includes a community centric model which builds compassionate communities that integrate with health, social and community care services and civic agencies to support people approaching the end stage of life (Palliative Care South Australia, 2024b).

Demographic profile

The Country SA PHN region has an ageing population experiencing a high rate of chronic and long-term health conditions as well as behavioural risk factors. It was recently estimated that up to 72% of persons who die from a life-limiting illness in South Australia could benefit from palliative care services (SA Health, 2019b). It is also estimated that around 12,000 people who die each year could directly benefit from a palliative approach to care in South Australia (Palliative Care South Australia, 2024a). As deaths in country SA accounted for approximately 32.3% of all deaths in South Australia, it can be estimated that roughly 3,800 people in country SA could directly benefit from a palliative approach to care (AIHW, 2024ae).

Diseases requiring palliative care

Several conditions that may require palliative care have been identified, noting that the presence of these conditions does not necessitate palliative care. For adults, these conditions include Alzheimer's, cancer, cardiovascular diseases, liver cirrhosis, chronic obstructive pulmonary disease (COPD), diabetes, HIV-AIDS, kidney failure, multiple sclerosis, Parkinson's, rheumatoid arthritis, and drug-resistant tuberculosis.

For children, conditions include cancer, cardiovascular diseases, liver cirrhosis, congenital anomalies, blood and immune disorders, HIV-AIDS, meningitis, kidney diseases, neurological disorders, and neonatal conditions (SA Health, 2019b).

The holistic needs of individuals, families and communities

In country SA, the diagnosis of a life-limiting illness or the transition to the end-of-life phase has far-reaching consequences for the individual, their family, and the broader community. The close-knit nature of country towns amplifies the emotional, physical, financial, and communal impacts, making the role of palliative care services especially vital.

Living with a life-limiting illness is profoundly challenging, encompassing physical, emotional, and spiritual aspects. Individuals often face symptoms such as pain and fatigue alongside feelings of fear and uncertainty, especially in rural areas where access to specialised care may be limited.

Decisions about palliative care and death are deeply personal and it would be impossible to capture all of the unique needs and preferences of people receiving palliative care in country SA. However, it is evident that all want to die a good death. What this looks like varies, but generally a good death provides dignity, choice and comfort for the bereaved. It also often involves support to address a wide range of needs including physical, personal, social, and spiritual (SA Health, 2021). Additional population group specific health needs are discussed in the priority populations section of this chapter below.

As recognised in *South Australia's Palliative Care Strategic Framework 2022-2027* (2021), there is a growing acknowledgement that while many modern technologies can prolong life, they do not always maintain or enhance the quality of the life being lived at any age. In recognition of this, many people are now emphasising their focus on quality over quantity when considering the remainder of their lives. It is therefore important that these needs can be accommodated, as it can affect the care provided as well as how and where people die (SA Health, 2021).

Palliative care teams play a vital role in addressing these needs holistically, supporting both individuals and families through comprehensive physical, emotional, and spiritual care. Primary health care providers further strengthen this support by serving as a reliable 'place of truth', offering consistent guidance and empathy. They empower individuals to make informed decisions about their care, including the right to a dignified death, ensuring that people feel supported and informed as they navigate their journey.

This can be particularly important for people who do not have access to an informal carer, as they are likely to require more support to receive high-quality care and meet their preferences for care (AIHW, 2022b). The needs of people living alone are discussed in further depth in the priority populations section of this chapter below.

Country SA PHN recognises that, while many gaps still exist in enabling primary health care providers to deliver 'Gold Standard' care and support, we are committed to reducing these gaps. Our focus remains on empowering and supporting the primary health care workforce to better serve the country SA community. We are dedicated to facilitating access to resources and information, enabling individuals and their health providers to make informed decisions about their care, including the fundamental right to a dignified death.

Families and communities

The effects of a life-limiting illness extend to the individual's significant others, who frequently take on caregiving roles. The physical and emotional toll of caregiving can be overwhelming, with caregivers often balancing the demands of work, family, and medical appointments.

When a loved one enters the palliative stage, families face an intense emotional shift, moving from the hope of a cure to providing comfort and support. Family members often take on the role of primary caregivers, managing complex medical needs while balancing work, childcare, and other responsibilities.

The demands of caregiving, combined with the emotional toll of impending loss, can lead to exhaustion, stress, and isolation. Not knowing where to turn, they face an influx of medical details and decisions while processing their own grief. The weight of these challenges leaves many struggling to navigate the care system, all while trying to support their loved one through a profoundly difficult time.

In close-knit rural communities, a person's illness affects not only their family but also friends, neighbours, and local networks. Country SA communities have a unique spirit of solidarity, often rallying together to support those facing hardship, especially when one of their own is living with a life-limiting illness, offering meals, companionship, or help with transportation. This support can make a world of difference but can carry its own emotional weight. Limited access to healthcare resources in rural areas means families may rely heavily on local GPs and community nurses, placing further strain on individuals and services. This shared journey requires compassion, resilience, and understanding, as communities come together to support loved ones through a profoundly challenging time.

This sense of connection helps to ease the isolation that can accompany serious illness, particularly for those without family nearby. Rural communities have a profound understanding of how small gestures of care—checking in with a neighbour, organizing community fundraisers, or volunteering time—can provide comfort, dignity, and practical assistance during life's most difficult times. Palliative care services extend their reach to the community by offering grief and bereavement support, facilitating discussions around death and dying, and providing the resources needed to help communities navigate loss together.

Country SA PHN plays a vital role via the Greater Choice for At Home Palliative Care Measure (GCfAHPC) in supporting informal (often unpaid) family and friend carers, who provide essential care for loved ones in the palliative stage. To enhance this support, Country SA PHN has commissioned Palliative Care South Australia to deliver the "Nurturing Compassionate Communities in Country SA" initiative, designed to equip these carers with resources, guidance, and emotional support. This initiative recognises the unique challenges that informal carers face and seeks to strengthen their ability to provide compassionate, informed care during a difficult journey (Palliative Care South Australia, 2024b).

For further discussion of informal carers, see the *Older People* chapter.

Financial Strain of Life-Limiting Illness

Financial burden of illness can weigh heavily on families. In rural areas, where access to healthcare may require significant travel, the costs associated with transport, medications, and time off work can become a major strain. Family members may find themselves shouldering the expenses while grappling with reduced income if they need to cut back on work to provide care. Palliative care services are essential in offering practical and financial guidance, connecting families with the resources and support systems needed to alleviate some of these stresses.

The financial implications extend beyond the household. In country towns, where communities are interconnected, the economic impact of a serious illness can ripple outward. Local fundraising efforts and community support, while invaluable, can only go so far in mitigating the financial pressures faced by families. Palliative care services can support the broader community by ensuring that individuals and families have access to external financial aid and healthcare resources, reducing the load on local community networks.

Grief, Mourning and Bereavement

The terms grief, mourning, and bereavement are typically used interchangeably in everyday conversation and yet are sometimes distinguished as follows by mental health professionals (Worden, 2018).

Grief is a complex and deeply personal experience, particularly in the context of palliative care, where individuals and their families face the profound realities of serious illness and impending loss. It is a natural but often overlooked response, especially in chronic illness and bereavement, and can manifest through a spectrum of emotions, from sadness and anger to acceptance and peace. When left unaddressed, grief can significantly affect the emotional and physical wellbeing of patients and their loved ones, highlighting the need for healthcare providers to understand its multifaceted nature and its impact on the quality of care (MacArthur, Kirby, & Mowll, 2023).

People cope with grief in various ways. It has been estimated that for around 60% of people experiencing grief, the support of family and friends is sufficient to provide comfort and healing. While approximately 30% of people may need external assistance, such as counselling or therapy, to navigate their grief. The remaining 10% experience prolonged or complicated grief and often require more intensive interventions to help them manage and move forward (Aoun et al., 2015).

In collaboration with Murrumbidgee PHN, Country SA PHN has adapted the Adult Attitude to Grief (AAG) Scale into an online format, making it accessible for General Practitioners to assess how their patients are coping with grief. The surveys can be scheduled for ongoing monitoring at intervals such as three, six, or twelve months after a significant event, allowing for long-term assessment and support. This enables General Practitioners to detect complicated grief early and provide targeted interventions before it escalates. Patients can complete the survey at their convenience, ensuring they access support when they feel most comfortable or in need of assistance.

Social Prescribing

Social prescribing, which connects patients to non-medical community resources that support their wellbeing, has untapped potential in the palliative care space, especially in country areas. In rural and remote communities, social prescribing can help address some of the unique challenges faced by individuals with life-limiting illnesses by linking them with local services and social supports that improve quality of life (RACGP, 2020). For instance, connecting patients with community groups, volunteer networks, or local companionship programs can help reduce isolation and foster a sense of belonging and emotional support. Additionally, activities such as community gardening, art workshops, and spiritual or cultural gatherings can provide comfort and a positive focus during a challenging time.

In palliative care, where physical and emotional needs are interwoven, social prescribing has the power to address the person as a whole. By making social prescribing a more established element of

palliative care in country settings, health professionals can help patients and families access resources and activities that bring comfort, reduce isolation, and improve overall quality of life (Friends for Good, 2021).

While there is still much work to be done to integrate social prescribing into palliative care, several South Australian projects are already exploring the implementation and benefits of social prescribing tools, with Country SA PHN supporting the promotion of such activities.

Compassionate Communities

Compassionate Communities can foster and support the unique, quiet acts of care that are deeply ingrained in country life, opening up conversations about this informal yet essential way of supporting one another. In rural areas, people tend to simply "do what's needed," often stepping in to help neighbours and friends in ways that may go unspoken or unrecognised. By bringing awareness to these compassionate acts, we can encourage a broader understanding and appreciation for this community-based approach to care (Palliative Care South Australia, 2024b).

Promoting and sharing these everyday stories of support not only validates the natural strength and resilience of regional communities but also helps others see the value in extending a helping hand. This open dialogue encourages communities to celebrate and sustain these small, compassionate gestures, reinforcing the collective spirit that makes country life so unique. Nine Compassionate Communities Conversation workshops were held across country SA in 2023/2024 (Palliative Care South Australia, 2024b).

Key findings from the conversations indicated that residents in country SA are generally comfortable discussing death and dying, with higher comfort levels reported in the towns visited compared to statewide averages. Most participants expressed confidence in their substitute decision makers and regarded general practitioners as the most trusted source of information on serious illness, dying, grief, and caregiving. It was also suggested that many South Australians are not aware of current systems and could benefit from additional information about available services and supports. Participants ranked their trusted network, including family, friends, neighbours and colleagues as the second most popular source of information about death and dying (Palliative Care South Australia, 2024b).

There was also a strong willingness among locals to support neighbours facing life-threatening illnesses, with many open to receiving help from their community. Key initiatives that emerged include fostering community connections, offering public education, maintaining directories of local support services, co-designing new supports, and adopting the Compassionate Cities Charter to build compassionate communities across South Australia.

Consumer Education

Consumer education plays a vital role in increasing death literacy, which refers to people's knowledge, skills and capacity to engage with the process of dying, death and bereavement. Education helps normalise conversations around death, reducing the stigma or fear associated with the topic. This enables people to better understand the realities of death and dying, making them more comfortable discussing it with family members and healthcare professionals.

Death literacy fosters compassionate communities where individuals support each other through dying and bereavement. Educating the public creates a collective understanding of grief and loss, helping communities better respond to those challenges.

Country SA PHN is commissioning community education services both virtually and face-to-face through PalliLEARN short courses. Topics covered include What is palliative care?, Advance Care Planning and How to have conversations about dying and grief. Country SA PHN is also delivering Last Aid training sessions, an introductory level community education program across the country South Australia region.

Priority populations

Research into palliative care needs in South Australia identified several groups that have special needs regarding palliative and end of life care. These include “people with complex needs, disabilities, children, Aboriginal Australians and those living in rural and remote areas and of different cultural or linguistic backgrounds”(p.3) (SA Health, 2019b). It was also highlighted that there are often difficulties associated with attempts to meet the needs of these groups adequately within the current service arrangements (SA Health, 2019b).

Aboriginal people

Many Aboriginal people hold strong spiritual and cultural beliefs about the cause of serious illness, which may differ from medical explanations. The cultural belief that life is a continuum, Life-Death-Life, is common among Aboriginal people, with the underlying belief being that all living things have a spirit, which are the continuum that connects the living to the past, present and future. It is also important to note that direct statements about dying and death are not usually spoken in Aboriginal communities. The use of alternative terms such as ‘finishing up’, ‘passed on’ and ‘not going to get better’ may be more culturally appropriate (IPEPA Project team, 2020).

At the time of finishing up/death, the spirit leaves the body to return to the Ancestors’ country, after which it is the responsibility of the family to ensure the safe passage of the spirit to the ancestors and return the body to country. For many Aboriginal people, it may be unacceptable to finish up/die alone.

In South Australia, the following focus areas have been identified to improve the appropriateness and accessibility of palliative care for Aboriginal people (Palliative Care South Australia, 2024a):

- Increase the provision trauma informed palliative care services that are flexible and responsive
- Prioritise systems to assist people to return to country at the end of life, if that is their wish
- Increase cultural awareness training for palliative care staff

Barriers such as mistrust of healthcare systems, limited access to culturally safe services, and communication challenges must be addressed to providing culturally appropriate, compassionate care for Aboriginal people facing a life-limiting illness through Advance Care Planning and Palliative Care.

To address these challenges, Country SA PHN, in collaboration with four respected local South Australian Aboriginal community leaders, has developed culturally tailored education bundles. These resources include video testimonials on end-of-life topics, thoughtfully crafted to encourage open, meaningful conversations with family and loved ones about subjects often considered difficult to discuss. This initiative is also supported by collaboration with Palliative Care SA and is enhanced by Indigenous Program of Experience in the Palliative Approach (IPEPA) resources.

Drawing on ancestral wisdom and a deep understanding of cultural traditions, these leaders encourage their fellow community members to reflect on what happens at the end of life and to plan for it now. This foresight eases the burden on individuals and their loved ones when the time comes. Discussing end-of-life matters is a crucial step in promoting understanding, acceptance, and preparedness. Though these conversations may seem challenging, they are essential to ensuring individuals’ wishes are respected and their loved ones receive the necessary support during difficult times.

LGBTIQ+ people

A recent South Australian research project identified a need for additional LGBTIQ+ friendly regional health service resources that support people to remain (COTA SA, 2023). A scoping review of Palliative and end-of-life care for LGBTIQ+ people identified several facilitators and barriers to inclusive care. The facilitators included LGBTIQ+ inclusive training for palliative care staff, end-of-life decision-making support and legal advice, inclusive healthcare provider policies (LGBTIQ+ Health Australia, 2022).

Past experiences of discrimination in healthcare settings can cause distrust of healthcare providers as well as reluctance and avoidance of palliative care that LGBTIQ+ people feel is inaccessible or inappropriate. It can also cause people to not disclose their LGBTIQ+ status to palliative care providers which can, in turn, reduce care outcomes. This reluctance is also attributable to concerns over potential ignorance of LGBTIQ+ specific needs within the health system, potentially leading to intrusive questioning and the need to educate staff members. Additional barriers to inclusive palliative care included social isolation, legal issues, reduced access to advance care planning and lack of recognition of families of choice by service providers (LGBTIQ+ Health Australia, 2022).

Young people

Providing palliative care for younger people in country SA presents unique complexities that affect not only the younger person but also their families and the wider community. The experience of facing a life-limiting illness at a young age is profoundly challenging in any context, but for those living far from specialised care, these difficulties are magnified, leading to emotional isolation, family separation, and significant community impact.

One of the most distressing realities for young people in rural settings with life-limiting illnesses is the necessity of traveling long distances to receive specialised treatment. In many cases, advanced medical care and palliative services are located in urban centres far from home. This separation from the familiar comforts of home and community often adds an additional layer of emotional strain for young people, who already face the overwhelming challenges of their illness. Being away from their school, friends, and normal routines can lead to feelings of isolation, loneliness, and a sense of being disconnected from the life they once knew.

For families, this situation is equally complex. The need for one or both parents to relocate temporarily to accompany their child for treatment can result in the separation of family members, leaving siblings or other dependents behind. This not only fractures the family unit during a time when unity and support are most needed but also places significant financial and emotional strain on parents. Balancing caregiving responsibilities, employment, and the emotional needs of other family members creates a heavy burden. Families in these circumstances often face difficult choices—whether it's one parent leaving a job to provide full-time care or the family taking on the additional financial costs of maintaining multiple households.

The financial toll is compounded by the emotional impact on families. Siblings, especially, may feel neglected or isolated as their parents focus on the care of the ill child. This can cause rifts in family dynamics and contribute to feelings of guilt, frustration, or helplessness for everyone involved. Palliative care services in rural areas, while invaluable, can often struggle to meet the full scope of emotional and logistical needs for families experiencing this separation.

Beyond the immediate family, the wider community also feels the impact when a young person is seriously ill. In close-knit rural and remote communities, the illness of a young person touches the lives of many. Friends, classmates, teachers, and neighbours all share in the grief and emotional weight. The challenge of supporting a young person through their illness, especially in environments where health resources may be limited, often falls on local community members who may not have the necessary expertise or support systems in place. Communities can rally to provide support, but the emotional and financial load they carry can be significant.

Perhaps one of the most difficult aspects of this situation is addressing the often-avoided topic of young people dying. In rural settings, where death may be less openly discussed, the idea of a young person nearing the end of their life is particularly hard to process. Families and communities can struggle to come to terms with the reality of a young life being cut short. The support needed to navigate this unthinkable grief is immense, yet palliative care for young people in rural and remote areas is often not fully equipped to address the emotional and spiritual complexities surrounding the

death of a young person. Bereavement support, both for the family and the wider community, is crucial in helping people cope with the loss, but access to these services can be limited.

The emotional, logistical, and communal complexities of providing palliative care for young people in rural and remote areas highlight the pressing need for greater support. Young people and their families deserve care that not only meets their medical needs but also provides comprehensive emotional, social, and spiritual support. Enhancing access to resources that ease family separation, reduce isolation, and foster open discussions about death and dying can significantly improve the quality of life for young people facing a life-limiting illness, as well as for their families and communities.

People with dementia

Receiving a dementia diagnosis can be profoundly challenging—not only for the individual but also for their loved ones and the wider community. Dementia is still widely misunderstood, and those diagnosed often find themselves viewed through a different lens, as if their identity is overshadowed by the diagnosis. This shift can lead to feelings of isolation and a sense of being undervalued, despite still having much to offer (AIHW, 2024m).

It's essential to recognise that dementia presents differently in every individual; no two experiences are alike. For this reason, each person deserves to be seen and treated uniquely, with respect and compassion. By focusing on the person rather than the diagnosis, communities can continue to value individuals with dementia as vibrant members who contribute in meaningful ways. Embracing this perspective helps dispel stigma and reinforces the idea that a person's worth and humanity are far greater than any diagnosis (Dementia Australia & Palliative Care Australia, 2017).

There is a significant lack of awareness surrounding dementia, particularly regarding its distinction from the normal ageing process. Dementia is often mistakenly viewed as an inevitable part of growing older, when in fact it is a progressive and incurable condition that brings with it a range of complexities. Unlike many other incurable diagnoses, dementia can last for several years, during which time individuals experience gradual cognitive and physical decline, significantly impacting their quality of life (AIHW, 2024m).

Given the long trajectory of the illness, it is crucial that individuals diagnosed with dementia, along with their significant others, are referred to palliative care services early. Early referral can ensure that the needs of the person with dementia are met in a holistic manner, addressing not only their medical and physical needs but also emotional and psychological support for them and their caregivers. Palliative care provides a valuable approach to managing the many challenges associated with dementia, yet the awareness of its importance in dementia care remains limited. Increasing understanding and timely integration of palliative care can greatly improve the quality of life for both individuals with dementia and their families, supporting them throughout the course of the disease (Dementia Australia & Palliative Care Australia, 2017).

While conversations about dementia and the importance of palliative care supports are becoming more frequent within the health sector, awareness within communities remains relatively low, especially when compared to conditions like life-limiting cancers. When someone is diagnosed with cancer, the community and healthcare systems are often more attuned to the need for immediate support, early intervention, and discussions around palliative care. However, dementia does not always elicit the same level of urgency or understanding (Dementia Australia & Palliative Care Australia, 2017).

People with disability

People living with disability and facing a life-limiting illness in a country setting are often presented with a unique journey marked by both heartache and strength. In rural communities, the bonds of neighbourliness can create a warm embrace, offering comfort during challenging times. When a neighbour stops by with a warm meal or a listening ear, it reinforces the idea that no one is truly alone. However, people with disability often encounter significant barriers to accessing specialised care. The

nearest hospital might be hours away, and palliative services can be scarce, deepening feelings of isolation and making the journey physically and emotionally taxing.

Despite these obstacles, many individuals find reservoirs of resilience within themselves. Growing conversations about disability in rural areas can bring hope, as awareness increases around the unique gifts individuals with disabilities offer their communities. Promising approaches to improve access and experiences of palliative care for people with disabilities include education for the community, people with disability as well as palliative care and disability service staff. Support for carers and families, advocacy support, and collaboration and inter-agency communication to boost capacity for community-based palliative care are also crucial. Additionally, the development of organisational policies and processes to support the delivery of palliative care can help address these challenges and ensure that people with disabilities receive the compassionate and comprehensive care they need (Australian Healthcare Associates, 2019a).

Yet, the need for systemic change remains. Bridging the gaps in healthcare and support services is crucial to ensuring that no one faces their challenges alone (Australian Healthcare Associates, 2019a). By acknowledging these challenges and working together, we can create an environment where every individual feels valued, understood, and empowered to thrive.

Key barriers include a lack of awareness and understanding of palliative care, communication issues between care providers and people with disabilities, and service provider assumptions about the competence of people with disabilities. Additionally, diagnostic overshadowing, physical barriers such as access and mobility, distrust of health services, inadequate support for carers and families, and a lack of integration between health, disability, and aged care sectors further complicate the provision of palliative care. In community living settings, there is often a lack of organisational support for dying in the place of choice (Australian Healthcare Associates, 2019a).

People living alone

Over 60,000 people in country SA live alone (ABS, 2021a). For individuals living alone with a life-limiting illness in Country SA, the challenges can be magnified by both physical distance and emotional isolation. Rural and remote settings, where healthcare and community resources are limited, can leave individuals without close, familiar in-home support, making an already difficult journey even harder. This isolation is especially profound during long nights when the fears and uncertainties of serious illness can feel overwhelming. Without family or friends nearby to provide companionship and reassurance, the loneliness can intensify, heightening feelings of anxiety about health and the future.

On a practical level, managing daily tasks alone with declining strength or mobility becomes daunting. Preparing meals, maintaining a clean home, or even managing personal care without assistance can impact quality of life and personal dignity. For those facing complex treatment regimens, medication adherence is another challenge as reaching pharmacies or other services can be difficult without nearby support, adding stress and risk to an already vulnerable time.

Accessing medical care also presents a significant barrier. Country residents may need to travel long distances over challenging terrain to reach a hospital or specialist, which can be especially burdensome for those without someone to help with transportation. Scarce public transportation further limits access to care, contributing to isolation and making even basic community engagement difficult.

For people without carers or a substitute decision-makers, Advance Care Planning and an Advance Care Directive can be particularly important to ensure their preferences are known ahead of time or when they lose decision-making capacity (AIHW, 2022b).

In these circumstances, person-centred support is critical. Community organisations, volunteer networks, and telehealth services can provide the social connection, practical help, and medical care that are essential for individuals living alone with a life-limiting illness. Addressing these unique

challenges with compassion and tailored resources ensures that people receive the care and companionship they need to navigate this time with dignity, even in the most isolated settings.

People from CALD backgrounds

People from CALD backgrounds may experience barriers to appropriate and accessible healthcare care, especially palliative care. As culture plays a critical role in end-of-life needs and preferences, it is important that the diverse needs within this population group are accounted for in palliative care.

The *Priorities for Palliative Care in South Australia 2024-26* (2024a) identified the following focus areas for people from CALD backgrounds:

- Provide appropriate information in multiple languages
- Increase cultural awareness training for palliative care staff
- Increase CALD community consumers engagement with palliative care

Promising strategies for improving palliative care access within culturally and linguistically diverse (CALD) communities include raising community awareness and developing culturally appropriate, translated resources. It is essential to ensure access to professional interpreting services and to provide training for interpreters on palliative care concepts and terminology (Australian Healthcare Associates, 2019b). Building community capacity for palliative care provision, along with enhancing cultural competence within services, can lead to meaningful improvements. This encompasses education and training, culturally sensitive communication, the integration of cultural practices in service delivery, and the identification and inclusion of relevant decision-makers. Additionally, recruiting staff from CALD backgrounds and appointing diversity champions can help bridge cultural gaps and enhance service delivery (Australian Healthcare Associates, 2019b).

Barriers include a lack of awareness and understanding of palliative care, combined with language and communication challenges, including reluctance to discuss death and dying, hinders effective support. Issues related to low literacy and health literacy, along with the scarcity of translated, culturally appropriate resources, further complicate access (Australian Healthcare Associates, 2019b). The inadequate availability of professional interpretation services, misalignment between the cultural, religious, and health beliefs of CALD individuals and those of service providers, and the late or absent referrals to palliative care all contribute to less than adequate care. Additionally, difficulties in accommodating cultural practices in palliative care settings, coupled with fear or distrust of services and experiences of racism and discrimination, pose significant challenges to effective care (Australian Healthcare Associates, 2019b).

Service Needs

In country SA, palliative care is not just about managing symptoms; it's about nurturing a compassionate community response to the complex emotional, spiritual, and social impacts of life-limiting illness. It reinforces the importance of ensuring that individuals, families, and communities have access to the care, support, and connections they need to navigate one of life's most challenging phases.

At the Palliative Care South Australia Summit 2023, several focus areas for people living in country SA were identified (Palliative Care South Australia, 2024a):

- Increase metropolitan multidisciplinary palliative care specialist visits
- Increase access to face-to-face clinical support out of hours for community based palliative care clients
- Inclusion of pharmacist in all country palliative care teams

Despite major national reforms of palliative care, data on service delivery and access is poor both on a national and local level (AIHW, 2024ap). Access to services to facilitate palliative care is reduced in regional SA relative to service availability in metropolitan Adelaide, including specialist end-of-life care, 24/7 clinical and nursing care, equipment and medication (SA Health, 2019b). A major challenge to equitable access for palliative care services is the uneven distribution of health professionals, particularly in rural and remote regions.

Multidisciplinary care delivery, incorporating regional palliative care, general practitioner, community nursing, home support and allied health services including pharmacy are pivotal to provision of palliative care in regional and remote areas (AIHW, 2024ap).

Workforce development

In country SA, a diverse team of healthcare professionals, including general practitioners (GPs), nursing staff, Aboriginal health practitioners and workers, personal care workers, and allied health practitioners including pharmacists, collaborate to provide compassionate and comprehensive care to individuals, particularly those facing end-of-life issues (SA Health, 2019b).

Primary healthcare providers frequently manage patients with complex conditions that require specialised knowledge, integrated care, and continuous support. Despite the need for best-practice care in local settings, many providers, particularly in rural and remote areas, face significant challenges. These challenges stem from limited access to specialist expertise, insufficient continuing education, and a lack of peer-support networks. Contributing factors include geographical isolation and the absence of structured learning models to enhance providers' confidence and capability in managing complex cases (SA Health, 2019b).

In collaboration with Wellbeing SA (in 2023) and Adelaide PHN, Country SA PHN funded the Palliative ECHO program (Extension for Community Health Outcomes) delivered by South Australian Postgraduate Medical Education Association (SAPMEA) across 2023 and 2024. The ECHO program is a virtual peer-learning model for primary health care providers, including GPs, nurses, and allied health professionals. It was developed in recognition of the benefits of the sharing of knowledge and best practices to enhance provider confidence in managing complex patient conditions and a broad need for palliative and end-of-life related professional development.

The following discussion topics were included in the program:

- Cancer and non-cancer pain management
- Emergencies in Palliative care
- Indications of and symptom management approaching last days of life
- Voluntary Assisted Dying
- Dying at home and post-death management
- Spirituality, cultural and inclusive considerations in death and dying
- Complex symptoms in Advanced malignant illness.
- Mental health at End of Life
- Emergencies in Palliative Care
- Symptom Management and establishing Goals of Care in end stage organ failure
- Agitation, delirium and terminal sedation
- Complex Bereavement

General Practitioners

GPs play a pivotal role in the care of older patients, as a trusted source of information they engage deeply with the unique challenges people encounter as they approach the end of life (Palliative Care South Australia, 2024b). Even small shifts in focus, such as anticipating and planning for predictable problems, can significantly enhance the quality of care and life experienced by both patients and their families. However, GPs have reported that a major barrier to providing advance care planning and palliative care is their uncertainty and lack of knowledge about prognosis, illness trajectory and terminal phase of advanced chronic diseases (e.g. cancer, heart failure, dementia) (RACGP, 2022).

Syringe Driver use

Ensuring patient comfort and dignity at the end of life is a core objective of compassionate healthcare. Effective symptom management, particularly for those unable to take oral medications, is critical. Syringe drivers, used for administering subcutaneous medications, allow continuous delivery, maintaining symptom control and improving quality of life for palliative care patients.

However, a notable gap exists in the proficiency and confidence of healthcare practitioners in using syringe drivers and safely prescribing palliative opioids. This gap is especially concerning for patients receiving end-of-life care at home, including those in Residential Aged Care Homes, where timely symptom management is vital.

This lack of training and confidence poses challenges in providing quality end-of-life care, often leading to inadequate symptom management and discomfort for patients in their final stages of life. Addressing these barriers is essential to equipping healthcare providers with the necessary skills to deliver competent, compassionate palliative care at home.

Opioid prescribing

Additionally, deprescribing is an often-overlooked topic, yet it is a vital component of palliative care that focuses on optimising medication management for patients with life-limiting illnesses. By reviewing and discontinuing unnecessary medications, healthcare providers can reduce side effects and simplify treatment regimens, ultimately enhancing patient comfort and quality of life. Including deprescribing in the education package highlights its significance in aligning care with patient values and promoting dignity during end-of-life care (RACGP, 2022).

In response to these identified needs, Country SA PHN, through the Commonwealth-funded Greater Choice for At Home Palliative Care initiative, has developed free online education modules. These modules specifically address the use of syringe drivers and the safe prescribing of opioids in palliative care, aiming to close the knowledge and confidence gap among healthcare professionals. However, the need for further workforce development remains, and future work should address additional knowledge and participant demographic gaps.

Country SA PHN will continue to build on existing knowledge, resources and relationships by partnering with local stakeholders, service providers, consumers and carers in a multi-phased approach focussed on improving components of the local palliative care experience including pathways, models of care, workforce capacity, engagement and data-driven quality improvement.

Child and Youth Health

The first 2000 days of a child's life, the period from conception to age five years, represents a critical window of opportunity to give children the best possible start in life for lifelong health and wellbeing (Chung A et al., 2022). The foundations for good health start during the antenatal period and early years and can have long-term impacts on a child's later life (AIHW, 2022a). The health of children and young people can influence participation in family life, schooling, social and sporting activities. Healthy young people achieve better educational outcomes, make successful transitions into full-time work, develop healthy adult lifestyles, and experience fewer challenges forming families and parenting (AIHW, 2024s).

Across rural Australian communities, including those in South Australia, disadvantage and healthcare inequalities remain a significant issue for rural children and youth, leading to poorer health and developmental outcomes. Limited availability and choice of health care including allied health and mental health services for children and young people and well-documented geographic isolation and transport issues are recognised barriers that contribute to the disproportionality that exists between the health and well-being of children and young people residing in rural Australia and their metropolitan counterparts (Modderman & Downey, 2023).

Key Points

- One quarter of young South Australians are living in areas identified as being some of the most socioeconomically disadvantaged regions in Australia
- Overall immunisation coverage rates are below the national 95% target for 1-, 2- and 5-year olds
- Regions of country SA have low rates of antenatal care attendance and higher than average rates of smoking in pregnancy
- Rates of developmental vulnerability increased with increasing distance from metropolitan centres, with one quarter of children in country SA being developmentally vulnerable on one or more domains
- Children aged 0-14 years in remote and very remote areas of country SA have more than twice the average rates of potentially preventable hospitalisations
- Mental health is an area of concern impacting the wellbeing of young people across county SA

Identified Needs

1. Access to services to support developmental health and wellbeing of children and youth
2. Improvement in immunisation and vaccination rates

Demographic profile

Children and young people in Country SA PHN

Regional distribution

Young people aged 0 to 24 years accounted for 27.8% of the total population in Country SA PHN in 2022 – 90,620 people aged 0-14 years (17.3% of total population) and 55,169 people aged 15-24 years (10.5% of total population) (PHIDU, 2024c).

As at 30 June 2022, the largest numbers of young people in Country SA PHN lived in the inner and outer regional areas - almost four in every 10 (37%, 53,347) young people aged 0-24 years resided in the outer regional areas, with a further 3 in 10 (32%, 47,267) residing in inner regional areas (ABS, 2022f).

One in every 10 young people lived in remote or very remote parts of the region, with 11,423 people aged 0-24 years living in in remote regions and 3,384 people aged 0-24 years living in very remote regions (ABS, 2022f). As a proportion of total population, people aged 0-24 years accounted for 31% of people living in the very remote areas of Country SA PHN (ABS, 2022f).

At the SA3 level within Country SA PHN the highest number of young people in 2022 lived in the Adelaide Hills (25,237, 17% of total people aged 0-24 years), Limestone Coast (19,664, 13%), Murray and Mallee (19,487, 13%) and Eyre Peninsula and South West (17,082, 12%) (PHIDU, 2024c).

Population projections

A decrease in the proportion of children (0-14 years) and a small increase in young people (15-24 years) are projected in country SA by 2030. For 0-14 year olds, a decrease of six percent (approximately -5,000 people) is projected, and a four percent increase (+2,400 people) projected in the youth (15-24 year old) population by 2030. The SA3 areas of Adelaide Hills and Gawler-Two Wells are projected to have growth in both children (0 to 14 years) and youth (15-24 years) populations, while Barossa, Eyre Peninsula and South West, Limestone Coast and Lower North are projected to have small increases in people aged 15-24 years by 2030 (PHIDU, 2024c).

Aboriginal young people

Aboriginal children and young people inherit over 60,000 years of cultural identity and form part of over 38,000 Aboriginal people living in South Australia (Lawrie, 2019). Young Aboriginal people aged 0 to 24 years accounted for 50.7% of the total Aboriginal population in Country SA PHN in 2021, with 8,428 people aged 0-14 years and 4,308 people aged 15-24 years. Areas within country SA with the highest number of young Aboriginal people in 2021 were Port Augusta and surrounds (1,770), APY Lands (1,077), Whyalla and surrounds (819), Murray Bridge (749), Ceduna and surrounding areas (733), Port Lincoln (685), Mount Gambier (573) and Port Pirie (571) (PHIDU, 2024c).

Young people with disability

People with disability include those who have a long-term physical, mental, cognitive, intellectual or sensory impairment (Department of Social Services, 2021). Children and youth with disability may experience limitations or barriers to participating in a range of activities that support developmental growth. In 2022, 15.8% of young South Australians aged 0-24 years reported having a disability, with 7.7% having a profound or severe activity limitation with at least one of the core activities of communication, mobility or self-care, and/or a schooling or employment restriction (ABS, 2024b).

Social and economic disadvantage

Social and economic disadvantage impacts on wellbeing. Analysis from the *South Australian Population Health Survey 2022* indicates that socioeconomic status, rather than rurality, had a significant influence on health status, health condition prevalence, and health-related risk and protective behaviours in South Australian children aged 0-17 years (Wellbeing SA, 2023a).

Regions with lower socio-economic status based on Socio-Economic Indexes for Areas (SEIFA) score had higher proportions of children with asthma and disability, experiencing food insecurity, soft-drink consumption, school suspension, use of screen-based activity, and not meeting sleep guidelines, and lower rates of GP use and private health insurance (Wellbeing SA, 2023a).

The national *Mission Australia Youth Survey* found that one-fifth of young people reported having experienced financial stress and these young people were more likely to face housing instability, poor mental health, and challenges in education and employment (Filia et al., 2024).

In South Australia, disadvantage increases with increasing remoteness. One out of two young South Australians are living in regions identified as having the lowest 40% of socioeconomic scores in the country; with 24% living in the most disadvantage regions and 26% in the second most disadvantaged regions (Child Development Council, 2024).

In 2021, the majority (83.0%) of people aged 15 to 24 years were learning or earning meaning they were fully engaged in school, work or further education/training, however this rate decreased substantially with increasing remoteness, to only 60.7% in very remote areas (PHIDU, 2024d). There were approximately 10,000 children in the country SA aged less than 15 years and living in jobless families, with high numbers and rates in the SA3s of Outback - North and East (1,076 and 22% of children under 15 years in the region) and Murray and Mallee (1,750, 15%) (PHIDU, 2024c).

Health profile

Infant and youth mortality

Between 2018 to 2022 there were 88 infant deaths (babies aged less than 12 months of age) in Country SA PHN. This equates to an annual average rate of 3.4 per 1,000 live births, the same average rate nationally for regional (non-greater capital city) areas (PHIDU, 2024c). Based on 2022 data, certain conditions originating in the perinatal period (P00-P96) and congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) were the main causes of death for South Australian children under 1 year of age (ABS, 2024a).

Intentional self-harm [suicide] (X60-X84, Y87.0), Land transport accidents (V01-V89, Y85) and Accidental poisoning (X40-X49) were the three main causes of death for 15-24 year old South Australian's in 2022 (ABS, 2024a). There were 93 deaths of people aged 15 to 24 years in Country SA PHN between 2018 to 2022 (PHIDU, 2024c).

Antenatal and pregnancy outcomes

In the last 10 years from 2012 to 2022, there were on average 5,000 births annually to women living in Country SA PHN (AIHW, 2024ah). In 2022, there were 5,211 births to women in Country SA PHN, equivalent to a total fertility rate of 1.92, marginally higher than the national rate of 1.62 (PHIDU, 2024c). In 2022, 130 teen mothers gave birth, equating to 9.1 births per 1,000 women (aged 15-19 years) (AIHW, 2024f).

Smoking in pregnancy

Smoking during pregnancy is an important preventable risk factor for pregnancy complications. Supporting women to stop smoking during pregnancy can reduce the risk of adverse outcomes for mothers and their babies. Smoking is associated with poorer perinatal outcomes, including low birthweight, being small for gestational age, pre-term birth and perinatal death (AIHW, 2024f).

Almost 1 in 10 women living in Country SA PHN who gave birth in 2022 (9.9%, 498/5,035) reported smoking tobacco in the first 20 weeks of pregnancy, higher than the national rate of 8.3% (AIHW, 2024ah). The rates of smoking in the first few weeks of pregnancy have more than halved in Country SA PHN in the last decade, from a rate of 20.6% in 2012, however there are still areas with our region where smoking rates are well above the region's average, including the SA3s of Outback - North and East (21.5%), Mid North (15.5%), Eyre Peninsula and South West (14.8%) and Murray and Mallee (12.9%). The rates in the Adelaide Hills (3.0%) and Fleurieu-Kangaroo Island (5.9%) were below the region average (AIHW, 2024ah).

Eight out of ten (80.9%) women who smoked before 20 weeks in 2022, continued to smoke after the first 20 weeks of pregnancy. While this is a reduction in rates from 2021 (83.8%) and 2020 (84.4%), it is a substantial increase from the rates 2012 to 2019 which fluctuated around 68% (AIHW, 2024ah).

From 2020-2022 over 1,200 women continued smoking after 20 weeks pregnancy, with highest rates in SA3s of Mid North (90.2%), Murray and Mallee (85.6%) and Outback – North and East (85.1%) (AIHW, 2024ah).

Antenatal attendance

Antenatal care is a planned visit between a pregnant woman and a midwife or doctor to assess and improve the wellbeing of the mother and baby throughout pregnancy. Antenatal care is associated with positive maternal and child health outcomes – the likelihood of receiving effective health interventions is increased through attending antenatal care (AIHW, 2024f).

In 2022, four in five women giving birth (80.8%) had an antenatal visit in their first trimester and one in five (21.2%) women who gave birth had an antenatal care visit within the first 10 weeks (as recommended by the *Australian Pregnancy Care Guidelines (2020)*). Ninety-one percent of women who gave birth attended at least five or more antenatal visits (AIHW, 2024f).

There was wide variation in the proportion of mothers who attended an antenatal care visit in the first trimester; across the Country SA PHN SA3 regions rates ranged from 72.5% in Fleurieu - Kangaroo Island SA3 to 89.6% in Gawler - Two Wells (AIHW, 2024ah).

Birth outcomes – low birthweight babies

Birthweight is an important indicator of an infant's health. Low birthweight (birthweight less than 2,500 grams) has been associated with an increased risk of death in infancy and illness into adulthood (AIHW, 2024f).

The majority of babies born to mother's living in Country SA PHN were born with a normal or healthy birthweight in 2022, however 5.9% of liveborn babies (305) had low birthweight. The rate was higher than the Country SA PHN region average in the SA3s of Outback – North East SA3 (8.0%), Mid North (7.6%) and Eyre Peninsula and South West (7.5%) (AIHW, 2024f).

Immunisation

The content on vaccination coverage in this section is also included in the *Population Health* chapter.

Children

In South Australia, general practice (70.1%) and local government councils (20.9%) provided the majority of vaccinations (both NIP, non-NIP vaccines including COVID-19) given to children aged less than 10 years (Hull et al., 2023).

As at 30 June 2024, the overall immunisation coverage rates for children in Country SA PHN were below the 95% target for 1-, 2- and 5-year olds (91.9%, 90.1% and 94.3% respectively). The coverage rates for Aboriginal children aged 5-years was 96.4%, but the coverage rates were lower in the 1-year olds (88.9%) and 2-year old cohort (85.1%) due to lower rates of coverage for specific vaccines (DTP, Polio, and Hib and MMR in 2-year olds) (DoHAC, 2024a). Rates of coverage varied across the Country SA PHN regions, with lowest rates across all three age groups occurring in the SA3s of Fleurieu-Kangaroo Island, Eyre Peninsula and South West, Adelaide Hills (1- and 5- year olds) and Outback – North and East having the lowest coverage for 2 year olds (81.3%) (DoHAC, 2024s).

Influenza vaccination coverage in South Australian children aged 6 months to <5 years was 35.8% in 2022, an increase from 31.2% in 2021. In 2022, the rate was 34.1% nationally. Influenza vaccination coverage in Indigenous children aged 6 months to less than 5 years was 22% in 2022, a slight increase from 21.4% in 2021 (Hull et al., 2023).

Adolescents

In 2022, vaccinations given to adolescents aged 10–19 years in South Australia were most commonly administered by local government and council clinics which includes school-based programs (47.1%), general practice (26.5%) and pharmacies (17.2%) (Hull et al., 2023).

Coverage rates for HPV vaccine were lower for South Australian boys compared to girls, 83.3% and 85.1% respectively, and both consistent with the national average coverage rates. Coverage rates for

Aboriginal girls (74.6%) and boys (65.6%) in South Australia were substantially below national rates for Aboriginal adolescents (83% and 78.1%) in 2022 (Hull et al., 2023).

Nationally, adolescents turning 15 years in 2022 who resided in remote and very remote areas had lower coverage of at least one dose of HPV vaccine received before their 15th birthday compared to adolescents living in major cities (Hull et al., 2023).

Health status

Health risk factors

Good nutrition, physical activity and limited screen-time are key to supporting children's health, growth, development and wellbeing. Reducing risk factors in children can reduce preventable chronic disease in adulthood (AIHW, 2022a). Based on the *2022 South Australian Population Health Survey* (Wellbeing SA, 2023b):

- 12.7% of rural South Australian children aged 2 to 17 years met the reported vegetable consumption guidelines and 64.5% met the daily fruit consumption guidelines for their age and sex,
- A quarter (24.9%) of rural South Australian children aged 5 to 17 years reported being engaged in the recommended 60 minutes of daily physical activity, and over one-third (38.4%) reported being active on 5 or more days, and
- Two in five children (43.1%) reported having screen-based activity above recommended levels (more than two-hours) during weekdays, increasing to 68.8% of children on the weekend.

Overweight and obesity (the abnormal or excessive accumulation of fat in the body), increases a child's risk of poor physical health and is a risk factor for illness and mortality in adulthood. In rural South Australia over a third (34.9%) of children were an unhealthy weight, 20.4% of children aged 5 to 17 were overweight and 14.5% were obese (Wellbeing SA, 2023b).

Long-term and chronic conditions

In the *2021 Census of Population and Housing*, one in every 10 (9.8 per 100) or approximately 8,500 children aged 0 to 14 years reported they had one or more long-term health conditions, and 81.5 per 100 reported no long-term health conditions. Asthma (7.4 per 100) and mental health (2.1 per 100) were the main conditions reported in the 2021 Census (PHIDU, 2024c).

According to self-reported data from the ABS *2022 National Health Survey*, the most common chronic conditions among children and young people aged 0 to 24 years in South Australia were (Wellbeing SA, 2023b):

- mental and behavioural conditions (22.1%) including anxiety related disorders (14.7%) and mood (affective) disorders (8.8%)
- diseases of the eye and adnexa (25.4%) including short sighted / myopia (14.9%)
- diseases of the respiratory system (24.0%) including hay fever and allergic rhinitis (20.3%) and Asthma (5.6%), and
- allergy (14.6%).

Social and emotional wellbeing and mental health

Mental health was identified as one of four main issues (along with education, online behaviours, and employment and job opportunities) affecting the wellbeing of young people across regional South Australian communities in the 2020 *Commissioner's Regional Young Voices Forum* (Connolly, 2020).

One in four (24.8%) young South Australian's who responded to *2023 Mission Australia Youth Survey*, identified mental health challenges including low mental health, stress, anxiety, depression, low self-esteem or self-harm as the biggest personal challenge experienced by young people. School was identified as the biggest personal challenge (46.2%). One in five (21%) reported feeling lonely all or

most of the time, and 39% were extremely or very concerned about coping with stress. Respondents identified that being able to ask for help and support from healthcare professionals, a better level of understanding from teachers and parents about stress levels, better access to and availability of mental healthcare services and being able to access diagnoses and treatment options would be potential solutions. Young people were also extremely or very concerned about suicide (14.4%), personal safety (11.6%), alcohol and other drugs (7.6%) and family and domestic violence (7.3%) (McHale et al., 2023).

Some young people, for example those identifying as Aboriginal or LGBTIQ+, are at higher risk of experiencing mental health issues. One third of young Aboriginal people aged 15–24 in South Australia experienced high or very high levels of psychological distress, and nationally, burden of disease analyses show that for Aboriginal people aged 10–24 the leading contributors to disease burden were suicide and self-inflicted injuries and anxiety disorders (AIHW, 2018). Results of the *Writing Themselves In 4* survey identified that four-fifths (81%) of all participants (young people aged 14–21 years identifying as LGBTIQ+) had experienced high or very high levels of psychological distress during the past four weeks, almost half had been diagnosed with an anxiety disorder and/or depression (Hill et al., 2021).

Further detail on mental health and alcohol and other drug use among young people are provided in the Alcohol and Other Drugs sections of this report.

Developmental vulnerability

The *Australian Early Development Census* (AEDC) defines developmental growth domains as: physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge. Children who experience vulnerability in key areas of developmental need are at risk of poor health outcomes over their lifespan (AEDC, 2022a).

National results from the 2021 AEDC, highlight the children growing up in regional and remote areas of Australia often have less access to services and supports with rates of developmental vulnerability increasing with increased distance from metropolitan centres. For those children living in the remotest areas, this is compounded by adversities their communities face. In 2021, there was an increase in developmental vulnerability for children living in regional and remote areas, driven primarily by fewer children on track in their language and cognitive skills (school-based) (AEDC, 2022a).

Results for the Country SA PHN region show that half (51.0%) of the region's children were identified as 'developmentally on track' for each of the five AEDC domains. The percentage of children who were 'developmentally vulnerable' has remained stable since 2018; 25.8% of children (1,352 children) were developmentally vulnerable on one or more domain(s), and 751 children (14.3%) were developmentally vulnerable on two or more domains in 2021 (AEDC, 2022b; PHIDU, 2024c).

Across Country SA PHN at the SA3 level, areas of concern based on increasing trends in developmental vulnerability between 2009 to 2021 were (AEDC, 2022b):

- Lower North: 41.7% children on track on all five domains, 32.6% developmentally vulnerable on one or more domains, and 19.7% developmentally vulnerable on two or more domains
- Mid North: 49.8% children on track on all five domains, 31.5% developmentally vulnerable on one or more domains, and 17.7% developmentally vulnerable on two or more domains
- Murray and Mallee: 48.1% children on track on all five domains, 30.6% developmentally vulnerable on one or more domains, and 18.1% developmentally vulnerable on two or more domains.

Despite decreases in developmental vulnerability between 2009 to 2021 and a 22% increase in children on-track on all five domains, Outback – North and East SA3 had comparatively high rates of developmental vulnerability, particularly for the language and cognitive skills (school-based) domain (25.3%) and physical health and wellbeing domain (18.3%) (AEDC, 2022b).

Use of health services

Primary care services

Young people across regional South Australia identified a need for more GPs with expertise in working with and providing care for youth, and wanted greater choice in primary care providers to enable seeking care from a GP that does not provide care to immediate family members or carers. Limitations in access to specialist care locally required regionally based young people to worry about issues of affordability with transport and the distance with travelling to Adelaide for care. Privacy and confidentiality were also highlighted concerns by young people in accessing care in a small community (Connolly, 2021).

General practice is the most accessed health care provider for children and youth with 80% of rural South Australian children (0-17 years) visiting a general practitioner in the 12-months prior to 2023 (Wellbeing SA, 2023b). In 2019, 24% of rural South Australian children travelled over 75km to use a health service in the 12-months prior, compared to two percent of children in metropolitan Adelaide. The majority of those who travelled (80%) did so due to lack of services in the local community (Wellbeing SA, 2019).

Data from the 2023 South Australian Population Health survey reported that 17.0% of rural South Australian children aged 5 to 15 years reported having a mental health condition, and 60% reported receiving treatment for their mental health condition in 2023, consistent with the proportions for children in metropolitan Adelaide (Wellbeing SA, 2023b).

Hospitalisations and emergency department presentations

Lower urgency emergency department presentations

Emergency department (ED) presentations that are lower urgency are sometimes used as a proxy measure of access to primary health care. Higher presentation rates may suggest a lack of access to GPs or other primary health services, which may have been better placed to manage a person's health condition, however not all conditions can be appropriately treated outside of an emergency department.

In 2021-22, children (0-14 years) and young people (15-24 years) had the highest rates for lower urgency ED presentations in Country SA PHN across the three categories (all-hours, in-hours and after-hours). Despite representing 28% of total population people aged 0-24 years represented 40% of all lower urgency presentations in 2021-22 (AIHW, 2024az).

An increase in rates of lower urgency ED use occurred for both children and young people from 2020-21 to 2021-22, primarily in the in-hours period, which rates increasing by 10% for 0-14 year olds (95.5 per 1,000 in 2020-21 to 104.9 in 2021-22) and 14% for 15-24 year olds (100.9 per 1,000 in 2020-21 to 108.4 per 1,000 in 2021-22) (AIHW, 2024az).

Potentially preventable hospitalisations

Potentially preventable hospitalisations (PPHs) refer to hospital admissions for 22 selected acute, chronic and vaccine-preventable conditions that are considered manageable through timely and effective primary and community care interventions. Potentially preventable hospitalisations give insight into the effectiveness of health care in the community; higher rates of PPH may suggest a lack of timely, accessible, and adequate health care provided by general practitioners, dentists, nurses, and allied health professionals. PPHs are a useful tool for identifying and investigating variation between and within communities to better understand health inequalities in a region (AIHW, 2024as).

In 2020-21 there were 1,283 potentially preventable hospitalisations (PPH) for children (aged 0-14 years), an age-standardised rate of 1,464.1 per 100,000 population, consistent with the national average rate in 2020-21 (PHIDU, 2024c), and a decrease from a rate of 2,014.5 per 100,000 (1,761

admissions) in 2018-19 (PHIDU, 2021a). Large variation in PPH rates existed across country SA; rates in the APY lands and Coober Pedy/Outback were more than twice the Country SA PHN average, and higher than average rates were also noted in Ceduna, Whyalla, Port Augusta, Millicent, Naracoorte, Kingston-Robe and Nuriootpa/Tanunda (PHIDU, 2024c).

Compared to 0-14 year olds, there were fewer PPH for young people aged 15-24 years in Country SA PHN in 2020-21 (514 admissions, an age-standardised rate of 920.1 per 100,000 population), and less variation in rates across the region. Rates of PPH for this age group were highest in the Coober Pedy/Outback, Murray Bridge, and Ceduna (PHIDU, 2024c). Both the number and rate of admissions for 15-24 years has decreased from 2018-19 (PHIDU, 2021a).

Acute conditions were the leading cause of PPHs in both age groups followed by chronic conditions then vaccine preventable conditions. For 0-14 years the top five causes of PPHs were Ear, nose and throat infections, Dental conditions, Asthma, Convulsions and epilepsy and Vaccine-preventable conditions. For 15-24 year olds, the top five leading causes were Convulsions and epilepsy, Urinary Tract Infections, Ear, nose and throat infections, Asthma and Dental conditions (PHIDU, 2021a).



Older People

People are living longer, and an increasing amount of older people have a strong desire to remain in their community as they grow older. This has been enabled by the increasing availability of home support and care service packages allowing people to stay in their own homes within the community while receiving care. In recognition of the diversity within this population, several priority populations were identified, and their unique needs as well as potential barriers to accessing care were explored.

Increasing comorbidity and complexity of health needs is a growing challenge across the health system. Additionally, workforce challenges, exacerbated by geographical isolation, remain significant in country SA.

Key Points

- Higher percentage of older people in country regions compared to metropolitan Adelaide
- Projected increases in population aged 65+
- Limited number of regional residential aged care homes
- Many older people in country SA live at home
- Importance of unpaid carers

Identified Needs

1. Appropriate support to older people to understand and access the aged and primary health care system
2. Aged care workforce are supported with skill and knowledge opportunities to improve workforce capacity to deliver person-centred care
3. Early intervention services which are appropriate and accessible for older people to reduce risk of frailty and deterioration
4. Appropriate support to older people to have an active role in their own health to stay independent and well in their place of residence
5. Support integrated and coordinated systems that connect providers and consumers across health, social, community and aged care services

Health Needs

Most older people living in country SA regard themselves lucky to be living there and have a strong desire to remain in their community as they grow older. Regions benefit from the wide range of contributions made by older people, as many own their own businesses and volunteer to support staffing ambulances, tourism, conservation and clubs which provide social connection and health benefits (COTA SA, 2024b).

Strong connections to community and services are crucial for supporting healthy ageing. This encompasses access to essential services such as retail, banking, transportation, healthcare, employment, volunteering opportunities, and social connections with family, friends, and community groups. For older people residing in regional communities, there are several barriers, both within and outside the scope of primary healthcare, that must be addressed to support a positive ageing experience in country SA (COTA SA, 2024b).

Demographic profile

Almost one quarter (23.4%) of Country SA PHN's population is over 65 years compared to 18.4% in Adelaide PHN (PHIDU, 2024b). Of people aged 65 and older in country SA, 23.3% live alone, 20.8% were born overseas and 3.3% use a language other than English at home (GEN, 2024b).

In some regions of country SA, over 30% of the population is over 65 years including Victor Harbor (41.9%), Yorke Peninsula (35.7%) and Yankalilla (34.3%). In country SA, 12 LGAs have over 30% of population aged 65 and older, and 16 LGAs have over 20% of their population aged 70 and older. By comparison, there are no LGAs that fit these criteria in Adelaide. At a state level, South Australia has the highest proportion of people aged 85 and over in its population, accounting for 2.6% of the state's total population (AIHW, 2024am).

Population projections

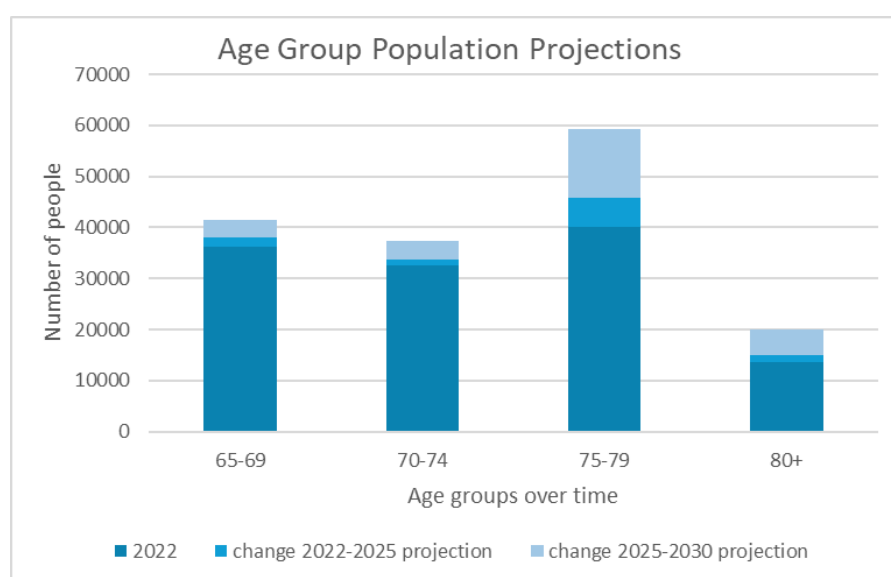
Population projections over the next decade show Country SA PHN's population over 65 increasing to 148,613 people and remaining in greater proportions to that of Adelaide PHN in 2030 (27.2%, compared to 20.6%) (PHIDU, 2024b).

The country SA Local Government Areas (LGAs) with the largest increases (between 2025 and 2030 projection) in proportion of total population over 65 years are:

- Peterborough: +5.3% increasing to 40.8%
- Orroroo Carrieton: +5.0% increasing to 38.7%
- Mount Remarkable: +4.9% increasing to 39.5%
- Flinders Ranges: +4.8% increasing to 39.1%
- Streaky Bay: +4.8% increasing to 33.2%

All of the 10 LGA areas with the highest change in proportion of people over the age of 65 between 2025 and 2030, already had a projected proportion above 32% by 2025, which is above the country SA average (27.2%) (PHIDU, 2024b).

Figure 6. Country SA population projections over time, by age group



Socioeconomic status and health outcomes

In country SA, most people aged 65 years and older are in the middle socio-economic quintiles (66.2%). The least disadvantaged (Quintile 1) and most disadvantaged (Quintile 5) groups account for a smaller percentage of the total population, at 15.1% and 19.7% respectively (PHIDU, 2024a).

It is widely recognised across Australia that the intersection of socioeconomic status (SES) and health literacy plays a pivotal role in shaping individuals' access to healthcare services as lower SES is frequently linked with reduced educational attainment, fewer economic resources, and limited access to vital health information. It is important to recognise the cumulative impact of these inequalities as

all of which contribute to poorer health outcomes and their overall quality-adjusted life years (QALYs) (AIHW, 2024ba).

This gap can be seen through the distribution of senior's health cards in country SA, as the least disadvantaged population aged 65 years and older (12.5%) was almost twice as likely to have a card compared to the most disadvantaged population (6.5%) (PHIDU, 2024a).

As individuals in the least disadvantaged groups are more likely to have higher levels of health literacy, this can allow them to be better equipped to navigate the healthcare system, understand eligibility criteria, and take the necessary steps to apply for benefits such as a Seniors Health Card. They also often have more external support systems—whether from family, community groups, or local services—that can assist them in completing the application process and managing their healthcare needs.

On the other hand, those in the most disadvantaged populations face more significant barriers (AIHW, 2024ba). Many are dealing with the immediate challenges of daily survival, such as financial insecurity, housing instability, and limited access to essential services. In this context, applying for a Seniors Health Card may be seen as a lower priority, despite the potential benefits it could provide. The ongoing economic pressures, including the rising cost of living, have placed a heavier burden on these individuals, draining their energy and resources. Even though they may greatly benefit from having access to a Seniors Health Card, they may lack the capacity, support, or time to navigate the process of applying. In country SA these challenges are magnified by geographic isolation and the scarcity of healthcare resources in rural regions, making it even more difficult for individuals to access necessary services.

This situation highlights the need for targeted interventions to improve health literacy and provide stronger outreach and support services for the most disadvantaged groups.

Long term impacts

The long-term impacts of these disparities and related factors are evident through the higher proportion of disability and lower median age at death observed among the most disadvantaged older adults in country SA. For example, the proportion of people aged 65 and older living with profound or severe disability increased by 69% between the least and most disadvantaged populations in country SA (PHIDU, 2024a).

For context, the median age at death over 2018-2022 was 81.0 years in country SA, compared to 83.0 years in Adelaide. 12 out of 52 (23.1%) country SA LGAs had a median age at death equal to or higher than the Adelaide average. Additionally, females had a higher median age at death than males by 6 years in both Adelaide and country SA.

Broadly, as level of disadvantage, measured in quintiles, increases, median age of death decreases. In Adelaide PHN, there was a 6-year median age of death gap between the most and least disadvantage quintiles (85-79 years), compared to the 3-year gap in country SA (80-77 years). Therefore, the magnitude of impact caused by SES is not equal across geographical areas (PHIDU, 2024a).

There was little variation in outcomes between the 3 least disadvantaged quintiles in country SA (PHIDU, 2024a). Additionally, the median age at death for the least disadvantaged populations in country SA was still lower than the Adelaide average (PHIDU, 2024a). While it is evident that there is a disparity in health outcomes between the most and least disadvantaged older people in country SA, the impact of rurality exacerbates the disparity between country SA and metropolitan Adelaide.

Place of residence

In country SA, there was over 28,000 people aged 65 and above living alone in their own homes (ABS, 2021a). While many older adults maintain their independence, this living situation can pose significant risks, particularly for those with dementia or other health conditions. Living alone may lead to social isolation, which can exacerbate cognitive decline and increase the risk of depression and anxiety. Additionally, individuals who live alone may face challenges in accessing timely medical care or assistance in the event of a health emergency, further heightening their vulnerability. Additional factors also to be considered include transport, labour and infrastructure challenges. Therefore, geographical isolation must be recognised as a potentially compounding factor of social isolation (Emily Stevens, Rachel Carson, & Liz Wall, 2024).

For older adults, especially those with dementia, a support system is critical to ensure safety and well-being. The increasing number of older South Australians living independently highlights the importance of community-based services, regular health check-ups, and accessible care options to mitigate these risks and support ageing in place safely.

A recent Country SA PHN commissioned Needs Assessment identified that there is a growing homelessness problem among older people in country SA. Service providers identified older people as a key group who have specific health needs, however the numbers for this population are lower in some locations (Health Q, 2024a).

Cause of death

Across South Australia, in 2023 (ABS, 2024a):

- Dementia was the leading underlying cause of death for people aged 75 and older, followed by Ischaemic heart diseases
- Malignant neoplasm of trachea, bronchus and lung was the leading underlying cause of death for people aged between 65-74, followed by Ischaemic heart diseases

Table 4. Leading cause of death by age group in South Australia, 2023

Leading cause of death	Age group				
		65-74	75-84	85-94	95+
	1st	Malignant neoplasm of trachea, bronchus and lung	Dementia, including Alzheimer's disease	Dementia, including Alzheimer's disease	Dementia, including Alzheimer's disease
	2nd	Ischaemic heart diseases	Ischaemic heart diseases	Ischaemic heart diseases	Ischaemic heart diseases
	3rd	Chronic lower respiratory diseases	Chronic lower respiratory diseases	Cerebrovascular diseases	Cerebrovascular diseases
	4th	Malignant neoplasm of colon, sigmoid, rectum and anus	Malignant neoplasm of trachea, bronchus and lung	Chronic lower respiratory diseases	Cardiac arrhythmias
	5th	Malignant neoplasms of lymphoid, haematopoietic and related tissue	Cerebrovascular diseases	COVID-19	Accidental falls
	6th	Dementia, including Alzheimer's disease	Malignant neoplasms of lymphoid, haematopoietic and related tissue	Accidental falls	Influenza and pneumonia

Impacts of risk factors and health conditions on older people

Many older people experience several different health conditions, which can impact people's health care use and wellbeing. The complexities may be compounded by the number of conditions people have, or the interactions between conditions (often referred to as comorbidities)(AIHW, 2024am). In country SA, 66.3% of people aged 65 and older had two or more conditions from different diagnosis categories including (diabetes, respiratory cardiovascular, renal impairment and/or mental health) (CSAPHN, 2024e).

Dementia

Dementia is a disease that can affect people of any age; however, it is most prevalent among people aged 65 years and older. It is also not an inevitable or normal part of the ageing process and age is one of many factors that increase the risk of developing dementia (AIHW, 2024m). A range of factors including age, gender, type of dementia, the person's comorbidities, and the severity of the illness at the time of diagnosis can impact this trajectory (Brodaty, Seeher, & Gibson, 2012).

- Dementia is the second leading cause of death of Australians
- Nationally, people who died from dementia had a high median age at death (88.7 years) (ABS, 2024a)
- On average, people with dementia survive for three to ten years after their diagnosis (Brodaty et al., 2012)

In country SA,

- 53.1% of people in permanent residential care are living with dementia
- As of 2022, 10,555 people were living with dementia, with 2085 people living at home
- There are more females living with dementia (60.5%) than males (39.5%)(GEN, 2024b)
- Between 2018-2022, it was the leading cause of death for females and second leading cause for males (ABS, 2024a)

Within country SA, the Local Government Areas (LGA's) with the highest number of people diagnosed with dementia in 2022 are as follows (AIHW, 2024m):

- Victor Harbor (648 people, 246 males and 402 females)
- Goolwa – Port Elliot (498 people, 202 males and 296 females)
- Gawler South (489 people, 174 males and 315 females)
- Murray Bridge (411 people, 159 males and 252 females)
- Whyalla (358 people, 138 males and 221 females)
- Mount Barker (355 people, 127 males and 228 females)
- Port Pirie (309 people, 118 males and 191 females)
- Port Lincoln (308 people, 119 males and 189 females).

These areas represent regions with a significant number of people living with dementia, highlighting the need for focused health initiatives and services to support affected individuals and their families.

Emerging data suggests that there is an association between loneliness, social isolation, and reduced cognitive function and increased risk of Dementia, in older adults. Additionally, the relationship between loneliness, social isolation, and mental health outcomes is also being explored as they share negative outcomes on cognitive function and are associated with an elevated risk of cognitive decline (Guarnera, Yuen, & Macpherson, 2023).

Mental health

People living in rural and remote areas of Australia are often less likely to report a decline in their mental health due to a range of factors, including limited access to mental health services, social stigma, and cultural attitudes that emphasise self-reliance. In South Australia, prevalence of a reported

mental health condition declined with age and was lowest among those aged 70 and older (13.9%). Additionally, people living in rural areas were less likely to report having a mental health condition, compared to those living in metropolitan areas (Preventive Health SA, 2024a). In many cases, mental health services are scarce or difficult to reach, leading individuals to downplay or overlook their mental health needs. Additionally, the stigma surrounding mental illness can be stronger in smaller communities, where people may fear judgment or social exclusion.

Research highlights that rural Australians are more likely to normalise stress and hardship, considering it part of everyday life, which can result in underreporting of mental health concerns. This, combined with social isolation and a healthcare system focused on physical health, creates barriers to seeking and receiving mental health support in these areas (AIHW, 2024av).

Heart disease

Heart disease is a significant health concern for older Australians, particularly those living in rural and remote areas (AIHW, 2024am). Nationally, prevalence of heart, stroke and vascular disease increased with age and people aged 65+ accounted for 42.0% total prevalence (ABS, 2022c).

In country SA (PHIDU, 2024b),

- 26,276 people aged 15 and over reported that they had heart disease (including heart attack and angina)
- 702 avoidable deaths from ischaemic heart disease between 2017-2021
- 8,408 years of life lost from ischaemic heart disease between 2017-2021

Data shows that deaths from heart disease are approximately 60% higher in these regions compared to urban settings. Additionally, hospitalisations due to heart attacks are twice as high and heart failure admissions are 90% higher compared to metropolitan areas (Beleigoli et al., 2022).

Several factors contribute to this disparity, including a higher prevalence of risk factors such as smoking and obesity in rural communities. Limited access to healthcare services, fewer health professionals, and a lack of adequate health infrastructure exacerbate the situation. Moreover, residents in these areas often face economic disadvantages, which can lead to food insecurity and a consequent increase in obesity, a major risk factor for heart disease (Beleigoli et al., 2022).

Frailty

As we age, we start to feel our bodies slow down, and for some, this becomes frailty. It's not just physical weakness, it's the struggle with daily tasks that once came easily like walking to the mailbox or meeting friends in town. Living in a rural area where space and freedom were once a key feature, changes with frailty as isolation and distance now adds to the sense of being cut off from community life. The wide-open spaces that once provided freedom now feel limiting when frailty makes it difficult to get around. Many who have lived full, active lives feel the frustration of no longer being able to do the things they love, and that can lead to feelings of loneliness or sadness.

It has been projected that over 14% of the population outside of Adelaide in the rest of South Australia are projected to be frail or pre-frail by 2027 (Taylor et al., 2019). A study of residential aged care homes in South Australia identified that 95.3% of residents were considered to be either frail or most-frail, compared to 85.2% 5 years ago (Jadczak et al., 2021).

It has been hypothesised that this may be associated with the increased effort to help older people stay at home longer through community aged care services (i.e. home care packages), therefore resulting in higher admissions into RACH for people with higher levels of frailty as they often require additional assistance (Jadczak et al., 2021).

But even with frailty, life doesn't have to lose its meaning. Staying connected to family, friends, and local services can help overcome the challenges of frailty. In country SA, where resilience is part of our



identity, there is strength in asking for support and finding new ways to stay active and engaged. With the right care and connections, older people can continue to live with dignity, independence, and purpose.

Falls

Falls are a significant health concern for older Australians aged 65 and over, representing the leading cause of accidental injury in this demographic. As the population ages, the incidence of falls and related hospitalisations is on the rise, with statistics indicating that one in four older adults experiences at least one fall each year (Healthdirect Australia, 2023).

Even when falls do not result in injury, they can trigger a loss of confidence, leading to an ongoing fear of falling. This fear often results in decreased activity levels, which further increases the risk of future falls. Addressing these concerns through prevention strategies and support is crucial for maintaining the health and independence of older individuals (Healthdirect Australia, 2023).

In South Australia (ABS, 2024a),

- the number of deaths caused by falls increased by 95.3 % in the past 10 years (211 in 2014 to 412 in 2023)
- 10th leading cause of death for all ages
- Leading external cause of death for all ages
- 5th leading cause of death for people aged 95+
- 6th leading cause of death for people aged 85–94 years
- 10th leading cause of death for people aged 75–84 years

Medication management

Polypharmacy in older adults is particularly complex, due to the increased prevalence of chronic health conditions that require multiple medications. In country SA, 40.6% of active patients (who people who had seen GP 3 times in the last 2 years at general practice that shared data with Country SA PHN) and aged 65+ had 8+ prescribed medications, and 26.4% had 3 or less. The highest prevalence medications in this population were ACE or ARB (50.7%), Lipid modifying (47.5%), Pain relief (38.7%) (CSAPHN, 2024e).

The complexity arises from several factors, including the risk of adverse drug interactions, age-related changes in drug metabolism, and the high likelihood of cognitive decline, frailty, and decreased physical function in older populations (Bell et al., 2021). Additionally, rural populations face challenges such as limited access to healthcare providers, which can complicate regular medication reviews and adjustments, further increasing the risk of inappropriate polypharmacy (Maynard, Robinson, & Simpson, 2021). Effective management strategies, including regular medication reviews, deprescribing where possible, and using simplified medication regimens, are crucial to reduce the risks associated with polypharmacy in older adults (Page, Falster, Litchfield, Pearson, & Etherton-Beer, 2019)

Wound management

Chronic wounds represent a significant and often under-recognised public health issue in Australia, impacting patients with conditions such as pressure injuries, venous leg ulcers, diabetic foot ulcers, arterial insufficiency ulcers, and atypical wounds. These wounds can have serious and long-term effects on patients' health and quality of life. Quantifying the impact of chronic wounds is challenging as there is a notable lack of reliable data on their prevalence in Australia (Nous Group, 2023a). It is estimated, based on other high-income countries, that there are approximately 400,000 cases of chronic wounds in hospital and residential care settings in Australia each year (Graves & Zheng, 2014; Nous Group, 2023a).

Wound management in Australia is provided in various settings, through providers who may have different sources of funding, including community-based care, general practice and other related

primary care settings. Despite the availability of regularly updated clinical guidelines, many Australians do not receive best practice care (Nous Group, 2023a).

A national pilot program across 3 PHNs was evaluated to determine the most appropriate evidence-based models for driving access to high quality, integrated care for the treatment and management of chronic wounds. The evaluation confirmed existing challenges, such as the significant unmet need for consistent and high-quality community-based wound care services. It was noted that where specialist wound care is available and accessed, patients experience substantial benefits, often resulting in life-changing improvements. Additionally, the potential efficiency and cost savings from providing best practice wound care and avoiding hospitalizations are considerable (Nous Group, 2023a).

The evaluation also identified workforce and capacity pressures on general practice and primary care, which, along with out-of-pocket costs, can limit timely access to wound care. Furthermore, there is a critical need for improved patient education about wound management, as many patients have limited understanding of how to care for their wounds, leading to adverse outcomes. Addressing these needs through continued efforts and ongoing programs is essential for improving health outcomes and achieving cost savings in the healthcare system (Nous Group, 2023a).

Priority populations

Aboriginal people

The health needs of Aboriginal people must be viewed within the context of colonialism and its ongoing health, social, and cultural impacts. With this understanding, the complexity of older Aboriginal people's health needs can be better understood. Existing healthcare services tend not to consider the complex care or cultural safety needs of older Aboriginal Australians, resulting in overall poorer access to services. For further information on the Cultural determinants of health, see the *Priority Populations* chapter.

Aboriginal and Torres Strait Islander people typically enter aged care at a younger age, with an average of 73 years, compared to 85 years for non-Indigenous Australians. Despite a significant presence in remote Australia, there are notably low numbers of older Aboriginal and Torres Strait Islander people accessing aged care services in these regions. This highlights a critical gap in the availability of culturally safe and appropriate aged care options on Country, which may prevent older community members from seeking the support they need (National Rural Health Alliance, 2022).

A national consultation undertaken in 2024, by the Interim First Nations Aged Care Commissioner highlighted several key points regarding what matters to older Aboriginal and Torres Strait Islander people as they age (Interim First Nations Aged Care Commissioner, 2024). These include having an accessible aged care system, ensuring the appropriateness and cultural safety of services and care, providing flexibility and choice in service delivery, and having local community members in caring roles. There was a need to steam line processes while increasing the education of the aged care sector on trauma informed care and cultural awareness, to support ongoing healing (Interim First Nations Aged Care Commissioner, 2024).

Opportunities identified include integrating culture to inform policy and practice, delivering services through Aboriginal Community Controlled Health Organisations (ACCHOs) with holistic, relationship-based models of care, forming strategic partnerships between mainstream providers and ACCHOs, and implementing navigation programs such as the Elder Care Support Program, the Care finder Program, and Aged Care Specialist Officers (Interim First Nations Aged Care Commissioner, 2024).

Barriers however do still remain such as systems that do not embed evidence on the cultural determinants of health, complex and non-inclusive language and communications, over-reliance on digital platforms, and a lack of transparent information. Additionally, there is a noted disconnection across various sectors including disability, housing, health, aged care, and veterans' affairs, as well as

workforce policies that do not adequately support the necessary personnel (Interim First Nations Aged Care Commissioner, 2024).

LGBTIQA+ older people

It is important to contextualise older LGBTQIA+ peoples current health disparities and exacerbated age-related decline in health and wellbeing to better identify their unique needs. Many older LGBTQIA+ people came of age during an era where the pathologisation, criminalisation and repression of LGBTQIA+ identities and individuals was normalised. It has also been identified that LGBTQIA+ adults may also face discrimination and hostility from both service providers and other service users, necessitating the concealment of their identities in their later years. Additionally, LGBTQIA+ subcultures are often highly youth oriented, and older LGBTQIA+ adults may experience ostracism and rejection from their younger counterparts within the LGBTQIA+ community (Hill A et al., 2020).

Of older LGBTQIA+ Australians, high levels of psychological distress and suicidal ideation were indicated most frequently among trans and gender diverse people and those who recently experienced unfair treatment due to sexual orientation and/or gender identity. High and very high psychological distress was also indicated more frequently by people residing in outer suburban areas. It has been suggested that these LGBTQIA+ older adults may have limited access to community ties or social relationships that buffer against psychological distress as they are uniquely positioned outside of metropolitan centres of LGBTQIA+ community and close community relationships associated with regional areas (Hill A et al., 2020).

Additionally, a lack of traditional intergenerational and family support as identified in the Rainbow Rights Toolkit written by COTA SA in partnership with the Office for Ageing Well (COTA SA, 2024a). This is attributed to an increased likelihood in ageing of being single, childless, and estranged from their biological families. In response to this, 'chosen family', involving close connections with friends and peers, play a vital role in older LGBTIQ+ peoples wellbeing. The health impacts of these support systems are evidenced, as feelings of belonging to the LGBTQIA+ community has been identified as a protective factor against psychological distress (COTA SA, 2024a).

Disability

Older people can experience disability in different ways, including having a pre-existing disability, or may acquire a disability due to the ageing process and associated health conditions (COTA, 2018). Older people with disability also have varied experiences with health and health care. Some rely on informal care, often provided by family and friends, to meet or supplement their healthcare needs. They may also require coordination between different health professionals. Some people with disability experience barriers to accessing healthcare services including longer than desired waiting times, cost of services, accessibility of buildings, discrimination and insufficient communication between health professionals (AIHW, 2024aq).

The South Australian Population Health Survey identified that both rural residents and older respondents were more likely to report having a disability in 2023 (Preventive Health SA, 2024a). Nationally, the proportion of people reporting a disability doubled from the 65-69 age group (40.3%) to the 90+ age group (83.1%) (ABS, 2024b). In country SA 16.3% of people aged 65 and older reported having a severe or profound disability in 2021 (PHIDU, 2024b). Therefore, it is evident that there is a need for initiatives that address the specific needs of people with disability as they age and addresses the impact of rurality.

Findings from COTA SA's Country Listening Posts identified that older people with disability can often find themselves caught between the NDIS and aged care systems, particularly those in smaller communities. Challenges when transitioning between support systems were identified, as older people who had previously been supported through the NDIS, were not able to access these same services, including bus trips and social opportunities, through My Aged Care. It was also reported that when older people chose to stay on the NDIS for the additional services, they were ineligible for community

transport funded by My Aged Care and in some cases unable to find suitable transport alternatives through the NDIS (COTA SA, 2020).

People providing informal care

Under the Australian Government *Carer Recognition Act 2010* (*The Parliament of Australia, 2010*), a carer is defined as someone who provides care and support to a relative or friend who:

- has disability
- has a medical condition, whether terminal or chronic
- has a mental illness
- is frail due to old age (referred to as 'frail and aged')

People who are employed to look after someone, work as a volunteer for an organisation, or are doing work experience as part of a course are not considered carers.

There are 2.7 million carers in Australia. More than 856,000 carers are primary carers. South Australia's carer population is estimated at 245,000 with nearly 30,000 young carers aged 24 years or younger (Carers SA, 2024b).

Caring is a vital, yet often overlooked, form of unpaid work in our community, playing a key role in sustaining our aged care, disability, health, mental health, and palliative care systems. However, the responsibilities of caring frequently come at a personal cost to carers, affecting their health and wellbeing, and contributing to social isolation. The impact of a caring role can extend beyond personal and may impact a carers' work life, career prospects, and future aspirations. It can also have significant financial repercussions, with primary carers, on average, losing \$175,000 in superannuation and \$392,500 in lifetime earnings (Evaluate & Carers Australia, 2022).

This selfless commitment can lead to significant challenges, as many carers are unable to access the social and economic benefits necessary for a fulfilling life. This is evident in data showing that carers score significantly lower on key wellbeing indexes compared to the general population. The 2022 National Carer Wellbeing Survey revealed that carers in Australia are three times more likely to experience low wellbeing than the average adult, with 55% reporting poor wellbeing compared to just 25% of the broader population. The strain on carers intensifies with the increasing demands of their caring role, further diminishing their overall wellbeing (Carers Australia, 2022).

In a 2023 Carers SA RoundTable, carers in regional SA highlighted the challenges they face in accessing respite services. Many report that suitable providers are either unavailable or do not offer services at the times when they are most needed, leaving carers without the support they require to maintain their own wellbeing and continue in their caregiving roles (Carers SA, 2024a).

They also shared that the distances involved, combined with the demands of their caring role, often leave them feeling overwhelmed and unable to juggle the time and preparation required to take a break. When taking time off involves long travel, many carers feel it's too difficult and ultimately forgo the opportunity, feeling that it's 'just too hard' or not worth it for a 'short' break. This can lead to them missing out on much-needed respite, further impacting their wellbeing (Carers SA, 2024a).

Service Needs

The *South Australian Regional Aged Care Strategy 2021 – 2025* identified several sector pressures, including workforce gaps, financial sustainability, complex regulatory environment, quality and safety and COVID-19 impact (SA Health, 2022). Through recent listening and engagement activities in country SA, the ability to access a local GP who was trusted and reasonably available was a clear priority. There was some variation around preferences for accessing specialists in Adelaide or regional centres. Travelling to Adelaide was preferred by those who had existing relationships with specialists, family members who could also attend the appointments and the opportunity to complete other errands. The preference for a local service was motivated by a distinct preference not to have to travel to Adelaide and a desire to support local business when possible (COTA SA, 2020).

GP visits

General practitioners continued to be the most common health professionals seen in 2022-23 for older people. GP visits are vital for older Australians, especially those aged 65 and over. Regular consultations are crucial for early detection of health issues, management of chronic conditions, and support for mental health (ABS, 2023b). However, barriers such as cost and access in rural areas can hinder timely access. Despite these challenges, GPs remain a critical resource for prescribing medications and providing tailored care. Ensuring accessible healthcare services is essential for maintaining the health and quality of life of older individuals as Australia's population continues to age (ABS, 2023b).

In country SA,

- 95.85% of people aged 65-79 had attended a Medicare subsidised GP appointment in 2022-23
- 1,297,811 Medicare subsidised GP attendances were provided for people aged 65+ (AIHW, 2024q)
- 92% of the GP attendance provider fees for people aged 65+ were covered in July 2024, compared to 95% in July 2014 (AIHW, 2024v)

Hospitalisations

In South Australia, there is currently a gap in available data on hospitalisations and potentially preventable hospitalisations, as the most recent data available is from the 2020/21 financial year, which was impacted and likely skewed by the COVID –19 pandemic.

Readmissions

Avoidable hospital readmissions occur within a specific timeframe after discharge and are clinically related to the initial admission and are potentially preventable through effective discharge planning and better clinical management. It has been identified that supporting older people to transition safely to home or a residential aged care home after discharge from acute hospital care can reduce potentially preventable rehospitalisations (Rupa et al., 2022).

A recent study of service provider's perspectives about of hospital to home transitions for older South Australians identified that inconsistencies in care between different health and aged care sectors can also contribute to avoidable hospital readmissions in older people. There was also an emphasis on system-wide strategies that enhance intersectoral communication and equitable access to services (Rupa et al., 2022).

Digital connectivity

There are several factors that affect people's ability to access digital healthcare services including digital competency, reliable connectivity, affordable data plans and devices and fully accessible platforms (COTA SA, 2024b). Digital ability and access decreases with age and older people aged 65+ are the most digitally excluded. Within this context, it has been identified that the regions of South

Australia that have a higher proportion of older people are the least digitally included (Thomas et al., 2024).

A recent study by South Australian Council of Social Service highlighted the critical role that regional libraries and community centres play in providing digital devices and support to community members (South Australian Council of Social Service, 2024). For older people in regional areas, access to technology and devices and understanding of their use is fundamental to digital inclusion and must be considered as both a barrier and facilitator to healthcare services and information (COTA SA, 2024b).

Aged care services

Aged care services in country SA are tailored to meet the specific needs of older residents in regional communities. With a notable percentage of the population aged 65 and over, ensuring access to high-quality, sustainable aged care is essential. Services encompass residential care, home support, and community programs designed to enhance the quality of life for older adults.

Key offerings include personal care assistance, nursing and healthcare services, household support for cleaning and laundry, meal delivery, and transportation. These services aim to empower older people in country SA to maintain their independence and wellbeing while receiving the support they need to thrive in their communities.

The SA Health *Regional Aged Care Strategy 2021-2025* identified several trends in the sector (SA Health, 2022). A shift towards home-based care was identified, driven by consumer preferences for aging in place within their communities accelerated by the COVID-19 pandemic. The increasing number of individuals living alone and the prevalence of age-related comorbidities are contributing to a heightened demand for home care services, both in volume and complexity. It is also anticipated that the intensity and complexity of support needs will continue to grow in residential aged care. From a supply perspective, the region's service provision is predominantly skewed towards residential care and government providers, with a relative scarcity of home care options compared to other states and territories. Across the sector, workforce pressures, compounded by an ageing population, are further constraining supply. This is particularly critical as age-related conditions such as dementia become more prevalent, necessitating extra training to manage complex and challenging behaviours (SA Health, 2022).

Access to aged care

Nationally, it has been identified that culturally and linguistically diverse people, people living in outer regional and remote areas, and people with dementia may face barriers to care service access, effecting the time from service approval to receiving of that service. Additionally, it was found that in some cases people living with dementia are prematurely entered into permanent residential aged care where they do not receive the home-based care that they need (AIHW, 2023k).

Table 5. Number of aged care services in Country SA PHN 2023

Program Group	Program Type	Number of services
Residential care	Residential care	82
Home care	Home care	40
Home support	Home support	140
Flexible care	Transition care	1
	Short-term restorative care	1
	Multi-purpose service	26
	Innovative pool	1
	NATSIFAC	5

Source: (GEN, 2024b)

Residential aged care

Residential aged care is for senior Australians who can no longer live independently at home. It provides accommodation and personal care 24 hours a day as well as access to nursing and general health care services.

Across country SA, in 2022-23 (GEN, 2024b):

- People aged 85-89 were most likely to be admitted into residential aged care (470)
- More women (1062) were admitted into residential aged care, compared to men (728)

Service distribution

The number of residential care places per 1,000 people in the target population (aged 70 and older) has declined in country SA over the last 6 years from 67.4 to 55.2, following trends in Adelaide. However, country SA has continued to have around 20 less places per 1000 target population (GEN, 2024b).

Within country SA, there is significant variation in the number of residential care places per 1,000 people in the target population. Eyre Peninsula (30.1) and Flinders & Far North (34.4) have consistently had the lowest number of places per 1,000 target population. In contrast, Mid North had 71.2 places per 1,00 target population, which is more than twice (2.37) as many places as Eyre Peninsula in 2023 (GEN, 2024b).

Additionally, residential care in Country SA PHN has a lower occupancy rate (88.9%), compared to Adelaide PHN (93.1%) (GEN, 2024b).

GP attendances

A GP attendance is measured by total number of attendances and attendances per residential aged care patient. A residential aged care patient is defined as a person who received at least one Medicare subsidised GP visit in an aged care facility, which includes people living and receiving respite care in residential aged care (AIHW, 2024u).

South Australia has a lower GP attendance rate per aged care patient (15.2) than the national average (17.4). In country SA, there were fewer GP attendances per aged care patient (14.5) compared to Adelaide PHN (15.9) in 2022-23 (AIHW, 2024u).

After hours GP attendance utilisation

Residents in Residential Aged Care Homes (RACHs) may experience health deterioration outside regular hours, such as at night or on weekends. When immediate hospital transfer isn't necessary, a lack of awareness about alternative care options, including afterhours telehealth with a GP, can result in unnecessary hospital visits. A report of primary healthcare utilisation in South Australian Local Health Networks identified that while the metropolitan utilisation of after-hours and urgent after-hours GP attendances was high, regional utilisation much lower (Registry of Senior Australians, 2024).

A comprehensive survey conducted across all Residential Aged Care Homes (RACH) and Multi-Purpose Service (MPS) locations in country SA revealed a significant and resounding need for workforce education and support regarding telehealth utilisation and after-hours planning.

Respondents highlighted the importance of after-hours planning, with many facilities recognising the challenges faced in providing adequate care outside of regular hours, particularly in rural and remote locations. Challenges associated with resident preference for face-to-face consults limited access to GPs and the complexity of using multiple telehealth platforms. There is a clear need for structured support in developing after-hours protocols and strategies that ensure continuity of care, accessibility, and responsiveness to the needs of residents. It was identified that there were several barriers to adopting telehealth (CDMPlus, 2024a).

For further discussion of Digital Health in RACH, see the *Digital Health* chapter.

Home support

Home support services are entry-level support for older people in their homes, including the *Commonwealth Home Support Program* (CHSP) (GEN, 2024c). In 2022-2023, Commonwealth funded home support programs were available across the Country SA PHN region, and accessed by (GEN, 2024b):

- 219.1 people per 1000 target population (65 years and over) used this service
- This was above the state and nation average
- Domestic assistance was the most common service accessed (10,382 people)

Table 6. Table Demographics of home support users by location

Home Support users by select demographics	CSAPHN	Aged Care Planning Regions (ACPR) with the highest prevalence
Live alone	44.8%	Mid North (56.5%) Eyre Peninsula (46.9%) South East (45.3%)
Identifies as First Nations	3.6%	Flinders & Far North (33.2%) Eyre Peninsula (6.1%) Mid North (2.4%)
Has a disability	20.5%	Hills, Mallee & Southern (31.2%) Flinders & Far North (22.4%) Yorke, Lower North & Barossa (21.7%)
Preferred language other than English	2.3%	Yorke, Lower North & Barossa (13.0%) Riverland (7.5%)

Source: (GEN, 2024b)

The home support services with the highest number of users in country SA, 2022-23 (GEN, 2024b):

- Domestic assistance (10,382)
- Allied health and therapy services (8,688),
- Transport (7,067)
- Social Support Individual, (6,572)
- Home Maintenance, (6,207)

Home care

Home care services are essential for supporting older individuals with complex needs, enabling them to remain in their homes and maintain their independence. Approved aged care service providers collaborate with care recipients to plan, organise, and deliver Home Care Packages tailored to meet individual needs. These packages can include a variety of services, such as personal care, nursing, domestic assistance, and social support (GEN, 2024c).

By focusing on personalised care, home care services help older Australians manage their health conditions while enjoying the comfort and familiarity of their own homes. This approach not only improves their quality of life but also reduces the need for more intensive residential care options.

In country SA (GEN, 2024b),

- People aged 75-89 years old are most likely to be referred into home care
- Women are more likely to be admitted into home care compared to men
- There were 40 service providers
- 47.4 people per 1000 target population (65 years and over) used this service
- This was below the state and national average

Aged care navigation

The Aged Care system can be complex and difficult to navigate. The Aged Care System Navigator trial measure was introduced by the Government in 2018 and continued through to 2021-22. Early evaluation in 2021, found that a network of navigators is an effective model to support older people to access the complex aged care systems (Australian Healthcare Associates, 2022). In the Royal Commission Interim report, it was identified that these navigation challenges were compounded for vulnerable groups of older people, for example those who may have no or low IT literacy, have no other support networks to help them or the challenges of living in remote communities (Commonwealth of Australia, 2019).

The Final Report of the Royal Commission into Aged Care, Recommendation 29, stated the Government should fund a network of intensive support staff called 'care finders' (Commonwealth of Australia, 2021b). As a result, nationally in January 2023, Country SA PHN commissioned service providers to deliver the care finder program via a wide network of care finders across country SA, to provide specialist and intensive aged care navigation support. This is part of the national care finder program.

Nationally, care finder targets a specific population of older people who are eligible for aged care services and need intensive support to interact with My Aged Care or access other relevant community supports. This includes people who have no-one else to support them, communication barriers, have difficulty processing information, be resistant to engage with aged care and their safety is at risk, or have past negative experiences with institutions or government (DoHAC, 2022a).

Priority regions and sub-populations in country SA

A once-off supplementary Needs Assessment was conducted by Country SA PHN, to identify local sub-populations and priority regions with service needs for the intensive navigation service. People with significant cognitive and/or language barriers, Aboriginal and Torres Strait Islander people and people with a profound or severe disability and living in the community were identified as target populations to priorities (CSAPHN, 2022).

The Needs Assessment identified the SA3 regions with highest need based on size of potential target populations, which are Adelaide Hills, Eyre Peninsula and South West, Fleurieu – Kangaroo Island, Limestone Coast, and Murray and Mallee. Additionally, the SA3 regions with the highest complexity of need based on multiple health, social and socio-economic factors were also identified as Fleurieu – Kangaroo Island, Gawler – Two Wells, Mid North, Murray and Mallee, and the Yorke Peninsula. Findings from community consultation indicate a preference for face-to-face service delivery, with consideration of other mechanisms where available workforce capacity is limited (CSAPHN, 2022).

Barriers to service navigation

There are several barriers to integrated and coordinated health care in the Country SA PHN region, including system barriers, GP awareness of programs and inconsistent messaging. In the context of the care finder program, integration and coordination of aged care services is essential to maximizing the benefit of navigation support. In practice however, this is complex to implement. While each stakeholder has interest and acceptance of the care finder program, the silos that often exist in the

wider health system, create barriers to smoothly integrating an additional service support such as care finders.

To that end, care finder activities that enhance integration between existing regional aged care, primary health, community supports and other systems are prioritised. Consistently, care finders across country SA report the role they undertake has expanded far beyond the intended scope outlined in the care finder policy guidance. This appears to be the same across the nation. Care finders report being the identified service when other professionals or supports have reached their limit of time and understanding of how to assist an older person further.

Our role in aged care navigation

As of Jan. 2023, three care finder program service providers have been commissioned to provide intensive navigation support to target populations across the Country SA PHN region. Of these, services are provided to persons from all identified priority populations and across all Country SA PHN regions, with face-to-face support prioritised for everyone where possible.

To support the need for integrated and coordinated care, Country SA PHN engages with local aged care, health and social service providers, peak bodies, multicultural agencies, primary health practitioners and specialist services such as Dementia Australia and the Elder Care Support Program. Country SA PHN delivers with Adelaide PHN, regular statewide care finder communities of practice and networking groups.

To support workforce and service sustainability in remote and regional communities, Country SA PHN is commissioning professional development (PD) for care finders, including training in My Aged Care, older persons mental health first aid course, disability, cultural awareness in response to identified knowledge need gaps. Furthermore, it was identified that there was a knowledge gap due to an unforeseen prevalence of care finders supporting clients being at risk of homelessness or experiencing homelessness.

In response, Country SA PHN developed an online learning module for country SA care finders to become better informed on the housing and homelessness sector. Additionally, training was also provided by MindFit at Work on Compassion Fatigue and Resilience in recognition of the consistently intense role of a care finder and the impacts this has on care finder wellbeing.

Workforce

The aged care workforce is made up of a range of health professionals, including registered and enrolled nurses, personal care workers, general practitioners and allied health professionals (National Rural Health Alliance, 2022).

In South Australia, there was 48 direct care FTE positions per 1000 persons aged 65 years and older, and Aboriginal and Torres Strait Islander people aged 50-64 years.

The number of aged care employees in country SA by ACPR region is (GEN, 2024a):

- Yorke, Lower North & Barossa - 1627
- South East - 760
- Riverland - 379
- Mid North - 417
- Hills, Mallee & Southern - 1994
- Flinders & Far North - 144
- Eyre Peninsula – 558

Challenges

Challenges related to workforce and service sustainability are identified in the aged care sector, with rural and remote communities experiencing limited workforce and service capacity and capability despite an increasing demand for aged care services (GEN, 2023). Furthermore, the residential aged care sector in country SA is experiencing significant workforce challenges influenced by multiple, complex factors.

High levels of staff burnout are a primary concern, often caused by the demanding nature of aged care work. Staff shortages and the emotional toll of caring for residents with complex needs intensify these pressures, leaving workers stretched thin and more susceptible to fatigue. This, in turn, impacts the consistent, high-quality care they strive to provide (ARIIA Knowledge & Implementation Hub, 2023).

Capacity and capability

The SA Health Regional Aged Care Strategy 2021-2025, identified that existing workforce pressures in regional SA are being exacerbated by the ageing population, which is further constraining supply. The strategy emphasises the effect of increased prevalence of age-related conditions including dementia as it increases the demand for dementia services. This has flow on effects to the capability of the aged care workforce as this increasing demand requires available and accessible upskilling to manage associated challenging behaviours (SA Health, 2022).

In addition, research indicates that there is increasing prevalence of frailty in people who use aged care services. It was also identified that geriatric syndromes such as falls, polypharmacy, under-nutrition and dementia are common amongst people considered frail living in residential aged care in South Australia (Jadczak et al., 2021).

It was also highlighted that the under-recognition of these syndromes remains a significant issue, as they are often not documented in discharge summaries when patients transition into RACH from hospitals. Therefore, education and training on early recognition and management of geriatric syndromes for RACH staff, including visiting GPs, could help health outcomes and potentially reduce upstream transfers to hospitals (Jadczak et al., 2021). Broadly, further education and training is required in response to the increased prevalence of co-morbidity and corresponding complexity of patient need as the recent 2023 National Aged Care Provider Workforce census identified that only 21.9% of service providers offered training on clinical skills for high/complex care needs (GEN, 2024a). This need is not exclusive to the RACH workforce, as home care services face heightened demand and complexity of care with the increase in people living alone (SA Health, 2022).

Ensuring the cultural safety of aged care for older Aboriginal people

Cultural safety is very important to older Aboriginal people in aged care. However, there are several barriers to accessing appropriate services, particularly in rural and remote communities, with a significant barrier being the lack of culturally responsive services and suitably trained staff. It is therefore it is important to ensure that service providers and the aged care workforce is well-equipped to meet the needs of older Aboriginal people and provide respectful, supportive, and culturally safe care (SAHMRI, 2020).

A recent study, which included older Aboriginal people from three South Australian rural and remote settings, identified six principles of culturally safe aged care. The principles included co-designing facilities, respecting Aboriginal life, traditions and living culture as well as creating and maintaining Aboriginal friendly spaces. Employing Aboriginal staff, ensuring cultural competency training for all aged care staff and advocating for and with Aboriginal elders (SAHMRI, 2020).

In 2023, there were 6 aged care home support services and 4 National Aboriginal and Torres Strait Islander Flexible Care services with 50% or more First Nations clients in country SA (GEN, 2024b). Cultural safety is important across all aged care services, irrespective of resident demographics. It is also important to identify areas of heightened need.

Recruitment and retention

Rising cost-of-living pressures in rural and remote areas add another layer to these challenges. Housing, travel, and daily expenses continue to climb, yet wages in the aged care sector often lag behind, making it difficult for workers to stay in these roles long-term. Additionally, the geographic isolation of country SA limits access to professional development and training, which drives many skilled professionals to relocate to urban centres in search of career advancement.

An example of this at program level, is the recommended level of experience for care finder staff as per the Government's care finder policy guidance, is not always possible, due to a low pool of applicants for the advertised positions (DoHAC, 2022a). In addition, when a care finder vacancy arose through a resignation in remote SA, it took several months for the position to be filled due to lack of applicants and lack of suitable applicants when people did apply. This impacts continuity of service delivery and the older persons connection with the program.

Workforce supply and the challenges this brings to home care service delivery, is frequently shared as the reason why aged care providers cannot accept new clients for CHSP and or HCP.

Reform fatigue

Aged care reform fatigue in South Australia has become a growing issue, particularly as the sector continues to adapt to extensive changes following the Royal Commission into Aged Care Quality and Safety. Providers and staff are facing significant challenges due to the rapid implementation of new regulations, governance standards, and funding structures, while trying to maintain quality care. A national survey of aged care providers found that 69% felt the transition timeframes were too fast, and 74% indicated they would need six months or more to implement current Aged Care reforms (Aged & Community Care Providers Association, 2024).

Nationally, it has been highlighted that there is a need to address workforce shortages, particularly those in regional, rural and remote areas, in order to effectively implement reforms under the new Aged Care Act (Aged & Community Care Providers Association, 2024). It is clear that geographic isolation and resource limitations exacerbate the challenges associated with implementing reforms in rural areas of country SA.

As providers struggle with administrative overload and workforce pressures, there is concern that the fatigue could undermine the long-term sustainability of the sector and impact the ability to deliver high-quality, person-centred care.

Despite these challenges, the Australian government remains committed to improving aged care, aiming to streamline regulation and provide support for workers and providers. This includes initiatives such as workforce development and enhancing digital infrastructure to ease some of the burdens placed on the sector.

Aboriginal Health

For Aboriginal people, the concept of health and wellbeing is holistic throughout the entire life course and encompasses the physical, mental, cultural, environmental and spiritual wellbeing across individuals, families and communities. These elements are intrinsically interconnected, which can conflict with western understandings of health and wellbeing. This understanding of health must be centred in initiatives that seek to address Aboriginal people's health needs.

It is important to recognise that since colonisation, Aboriginal people have been subjects of research not equal partners, which has led to current cynicism and distrust of research in many Aboriginal communities. To achieve the best outcomes, there is a need to work with Aboriginal communities, on priority issues identified by Aboriginal organisations and communities.

Data from Aboriginal people identifying their own health needs have been prioritised, where possible. Additionally, comparisons between Aboriginal and non-Aboriginal people have been avoided as this can often position non-Aboriginal people as the 'norm' or 'ideal', known as 'deficit data'. Further engagement with Aboriginal people in country SA should inform practices on what data is beneficial to present.

Aboriginal people have identified that improved prevention and management of chronic conditions is a key action to drive change. The need for enhanced access to culturally safe and responsive services was also highlighted. These approaches, which centre the cultural determinants of health, can counter the intergenerational trauma and deep-seated distrust of mainstream healthcare systems among Aboriginal peoples which has resulted from colonisation, the forced removal of children, and discriminatory healthcare policies. When considering how such services are provided, a need for connection and coordination was emphasised.

The term *Aboriginal* is used throughout this document to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. This reflects South Australian Aboriginal community preferences as specified by the Council of Aboriginal Elders of SA. Country SA PHN also acknowledge and respect that many Aboriginal South Australians prefer to be known by their specific language group(s).

Key Points

- Aboriginal people have a deep understanding of their own health and priorities
- Culture is a significant protective factor in Aboriginal people's individual, and community lives, particularly through its expression and continuity
- Health services need to be culturally safe and responsive to the needs of Aboriginal people
- There are gaps in service area coverage of Aboriginal Community Controlled Health Organisations across the Country SA PHN region

Identified Needs

1. Culturally appropriate health services
2. Appropriate support to ACCHOs to improve individual and community health outcomes
3. Integrated and coordinated multidisciplinary care for Aboriginal people with chronic disease
4. Screening and early detection services which are appropriate and accessible for Aboriginal people

Further exploration of the cultural determinants of health, strengths-based approaches, truth telling, and data/research methodologies can be found in the *Priority Populations* chapter of this report.

Positionality

When reporting on Aboriginal people, it is important to acknowledge the positionality of those involved. This Needs Assessment report was primarily written by non-Aboriginal people, in collaboration with internal subject matter experts.

As outsiders within the topic of Aboriginal health, it is important to acknowledge this position from the outset. This acknowledgement is particularly necessary considering the long history of exclusionary practices by non-Indigenous researchers, who set their own agendas and positioned Aboriginal people as the subjects rather than equal partners in research. These practices are not culturally safe or to the benefit of Aboriginal people, especially when data has been used to validate and perpetuate systemic and interpersonal racism. This type of research was not asked for and the narrative control has led to current cynicism and distrust of research in many Aboriginal communities (Morey et al., 2023).

Therefore, due to an absence of appropriate voices within the organisation, it became evident that interpreting the needs of Aboriginal people would be inappropriate, considering the positionality of the authors. Consequently, this limitation has restricted the scope and comprehensiveness of the chapter. Country SA PHN recognises that there is no substitute for the voices of Aboriginal people, which is reflected in this decision.

It is evident that initiatives that seek to improve the health outcomes of Aboriginal people need to be centred on the issues that are important and of benefit to Aboriginal communities. Country SA PHN recognises that there is a need to work with Aboriginal communities, on priority issues identified by Aboriginal organisations and communities, to achieve the best outcomes for Aboriginal communities.

Population

On census night in 2021, 20,128 people within Country SA PHN region identified as being of Aboriginal and/or Torres Strait Islander origin, representing 3.2 % of the total population. Of this population, 91.4 per cent identified as Aboriginal; 4.2 % identified as Torres Strait Islander; 4.4 % identified as both Aboriginal and Torres Strait Islander (ABS, 2024d).

At the time of the 2021 census, the SA3 areas within country SA with the largest Aboriginal and Torres Strait Islander populations were Outback – North and East, Eyre Peninsula and South West, and Murray and Mallee (ABS, 2021a).

Life course approach

This approach recognises that a person's age, grouped into life stages, affects the way certain factors influence health. Aboriginal people have a whole-of-life perspective of health and wellbeing, which involves the whole community over the entire life course. This involves understanding the impact of distinct life stages, as well as the context of the person's family and community (SA Health, 2023a).

The *SA Health Aboriginal Health Care Framework 2023-2030* (2023a) centres this approach and focuses on the life course across 4 key stages:

- Healthy babies and children (Ages 0-12)
- Healthy youth and adolescents (Ages 12-24)
- Healthy adults (Ages 25-49)
- Healthy ageing (Ages 50+)

A life course approach for Aboriginal people also involves a cyclical understanding of life and death. The unique cultural practices, understandings of finishing up/death, preferred terminology and health needs of Aboriginal people in the end-of-life journey is discussed further in the *Palliative Care* chapter.

Social and cultural determinants of health

Health outcomes for Aboriginal peoples are influenced by a complex interplay of social and cultural determinants. The social determinants of health (SDH) are the non-medical factors that influence health outcomes, including the social, environmental and political contexts in which people are born, grow, work, live, and age. Taking a social determinants approach to health involves addressing these factors including education, employment, food insecurity, racism and interactions with government systems (SA Health, 2023a).

Racial discrimination is recognised as a key social determinant of health and driver of health inequities. 70% of Aboriginal people in SA have experienced racism in their lifetime, compared with around 30% of non-Aboriginal people. In March 2020, 40% of South Australian Aboriginal adults experienced racial discrimination in the past 12 months, compared with only 10% of non-Aboriginal adults (Wellbeing SA, 2022a). Studies have shown that people exposed to racism experience poorer mental health and had a poor health perception (Kairuz, Casanelia, Bennett-Brook, Coombes, & Yadav, 2021). It is imperative to recognise the role of social determinants in causing disparities in health outcomes, access and behaviours.

Housing is another key social determinant that impacts health outcomes for Aboriginal peoples. On Census night in 2021, an estimated 24,930 Aboriginal and/or Torres Strait Islander people were experiencing homelessness in Australia; 26.2% of those experiencing homelessness were youth aged 12 to 24 years (ABS, 2021b). These statistics highlight the importance of addressing housing and social support for Aboriginal and Torres Strait Islander communities. Efforts to reduce homelessness and improve wellbeing should consider the unique circumstances and cultural context of this population.

The cultural determinants of health, discussed further in the *Priority Populations* chapter, recognises the role of culture as a significant protective factor in Aboriginal people's individual, and community lives, strengthening identity, bonds and resilience, particularly through its expression and continuity. The ability to know, express and nurture one's culture is also recognised as a fundamental aspect of improving Aboriginal people's health and wellbeing outcomes and is linked to social determinants of health (Lowitja Institute, 2023).

Cultural determinants of health for Aboriginal people include (Lowitja Institute, 2023):

- connection to Country
- family, kinship, and community
- Indigenous beliefs and knowledge
- cultural expression and continuity
- Indigenous language
- self-determination and leadership

Research into the effectiveness of cultural health and wellbeing programs indicate they achieve better outcomes for Aboriginal people compared to mainstream services. These findings indicate the importance of investment in initiatives that support cultural determinants; however, they need to be place-based and community-led (Lowitja Institute, 2023).

Health Needs

Considering the positionality of the authors, it was decided that the health needs section of this chapter would follow the structure of the key health issues for Aboriginal people identified in the *South Australian Aboriginal Healthcare Framework 2023-2031*, which involved extensive consultation and was co-designed with a range of key Aboriginal stakeholders including the Aboriginal Health Council, Aboriginal Community Controlled Health Services, health sector providers including Local Health Networks (LHN) and non-government organisations, community groups and Aboriginal South

Australians. The framework highlighted the need to implement targeted strategies and strength-based approaches to address key health issues for Aboriginal people (SA Health, 2023a).

The key health issues for Aboriginal people in South Australia were (SA Health, 2023a):

- improving oral health, particularly for children
- targeting early interventions to support cessation of tobacco, alcohol and drug use
- enhancing the delivery of sexual health screening activities at the community level, particularly for adolescents and young adults
- improving cancer screening rates and care pathways for treatment
- targeting risk factors for cardiovascular disease and chronic kidney disease
- strengthening mental health and suicide prevention programs, and
- improving access to high quality end of life care

As discussed in the *Priority Populations* chapter, discussions aimed at addressing disadvantage can often focus on the disparity of outcomes for certain people or groups without acknowledging the broader societal structures at play. This can create a narrative of 'deficit', which has been shown to negatively impact health outcomes for Aboriginal people (Fogarty, Lovell, et al., 2018).

Quantitative data is not always helpful and cannot capture the full picture of Aboriginal peoples' health. It can be used to identify where more effective and appropriate service provision is needed. However, it can also be comparatively used to position non-Aboriginal people as the 'norm' and present a quantifiable measure of deviations from that norm (Fogarty, Bulloch, McDonnell, & Davis, 2018).

For this reason, comparisons between Aboriginal and non-Aboriginal populations have been avoided, recognising that further engagement with Aboriginal people in country SA should inform practices on what data is beneficial to present.

Efforts were made to prioritise the use of data from Aboriginal people identifying their own health needs and priorities, where possible, recognising that there are gaps to be addressed in future iterations of this Comprehensive Needs Assessment report. This was achieved through the use of qualitative stakeholder engagement data from a variety of sources, including Country SA PHN commissioned Needs Assessments, national and state Aboriginal health strategies/frameworks as well as published literature. This is another area that should be informed by future engagement with Aboriginal communities in country SA to address gaps and identify emerging areas of need.

Oral health

Oral health encompasses the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions with confidence in the absence of pain, discomfort and disease (HealthInfoNet, 2024). Oral health is fundamental to overall health, wellbeing, and quality of life, and poor oral health has significant adverse impacts at individual, societal, and economic levels (Australian Government, 2024). It is also associated with health problems such as stroke and cardiovascular disease (AIHW, 2024ao).

For context, SA Dental provide universal dental care for all South Australian children and priority free dental care for eligible Aboriginal adults. An average of 4,200 children and 4,500 Aboriginal adults are attended by SA Dental annually. Dental services are also provided by the Royal Flying Doctor Service in up to eight different locations across the Far North of South Australia. Private dentists and ACCHOs provide services to remote Aboriginal clients in both visiting and fixed clinics. It was reported that Umoona Health Services in Coober Pedy had provided over 1,100 treatment items to over 120 clients in the 2022/23 financial year (SA Health, 2019c).

The *SA Oral Health Plan Progress Report 2023* also detailed efforts to engage with the Aboriginal community to promote oral health awareness and service uptake (SA Health, 2019c). A Country SA PHN commissioned Needs Assessment identified that more than half (57%) of Aboriginal children aged 2–17 years had seen a dentist or dental professional in the last 12 months (Health Q, 2024b). It is evident that further stakeholder engagement is required to understand what factors are affecting the utilisation of dental services as well as Indigenous knowledge and perspectives of oral health.

Early interventions for AOD use

Alcohol consumption by Aboriginal people differs considerably between and within communities, indicating that broad population estimates may not represent individual or local community patterns. As consumption is often a group-based activity for Aboriginal people, population survey methods may have low acceptability and accuracy (Bowden & Crabb, 2021).

Alcohol and other drug use by Aboriginal people needs to be understood within the context of colonisation, and its lasting effects on the Aboriginal burden of disease gap, through factors including marginalization, discrimination and racism, cumulative trauma, poverty, and lack of adequate access to culturally appropriate services (Bowden & Crabb, 2021).

Aboriginal people are receiving AOD treatment services, as 21.6% of distinct clients identified as First Nations in country SA (AIHW, 2024c). However, key informants of Aboriginal priority needs in SA indicate that there is a need to work meaningfully and effectively on the ground with people in communities, emphasising that Aboriginal voices must be honoured. The short lifecycle of programs also limits acceptability of programs as relationships need to be developed with communities first (Bowden & Crabb, 2021).

It was broadly identified that strategies to decrease poverty, increase access to health care services, support for mental health, and reduce discrimination will result in a reduction of AOD misuse in SA. It was also noted that Aboriginal people report feeling worried about losing custody of their children if they seek treatment for AOD use (Bowden & Crabb, 2021). Unfortunately, stigma surrounding AOD use also prevents help seeking behaviours (Health Q, 2024b).

Sexual health

The following section is an excerpt of selected content and findings from the Improving Regional Access to Sexual and Reproductive Health project report undertaken by Shine SA and Katina D'Onise Consulting and commissioned by Country SA PHN.

Sexual and reproductive health is critical to overall health and wellbeing and is considered a core part of primary health care service delivery. Despite this, sexual and reproductive health care can be difficult to access. In regional and remote SA there are known gaps in delivery for a range of primary health care services, but there are particular gaps in sexual and reproductive health services. These services can be subject to stigma as well as conscientious objection which further compounds access issues (Shine SA & Katina D'Onise Consulting, 2024).

Maintaining good sexual and reproductive health requires knowledge about risks and consequences of unprotected sexual activity and how to practice safe sex as well as access to accurate, timely and comprehensive information. Access to inclusive and safe sexual health care is also required including contraception and testing, and antenatal care or termination services (Phillips et al., 2023).

Across country SA rates of notification for chlamydia, gonorrhoea and syphilis are increasing. The regions of Eyre and Far North, and the Barossa, Hills and Fleurieu have the highest number of notifications across chlamydia and gonorrhoea, although there are high numbers of chlamydia notifications across the state. Notification data for Chlamydia, Syphilis, and Gonorrhoea indicates above average rates of infection in Aboriginal people in country SA (Shine SA & Katina D'Onise Consulting, 2024).

An outbreak of infectious syphilis was declared in the country SA regions of Far North and Western & Eyre from November 2016, affecting predominantly Aboriginal people aged 15-34 years (Department for Health and Ageing, 2019). Syphilis is highly infectious during the first two years of infection and can be transmitted in pregnancy to the foetus, resulting in perinatal death, premature delivery, and congenital abnormalities. Furthermore, syphilis increases the risk of HIV transmission (Department for Health and Ageing, 2019).

Cancer screening and care pathways

The SA Aboriginal Chronic Disease Consortium produced the *SA Aboriginal Cancer Plan 2022-2027*. It involved a range of stakeholders including Aboriginal health professionals, ACCHOs and representatives from metropolitan, rural and remote SA to ensure the appropriateness of recommendations (Gilden R., Melchers A., & Morey, 2022).

To meet the needs of Aboriginal people, it was highlighted that system-level improvements must be made to improve participation in cancer screening programs, reduce delayed or incomplete treatments, and improve health system engagement (Gilden R., Melchers A., et al., 2022).

Several barriers to cancer care were identified in the Plan relating to access, the health system environment, language barriers, cultural differences and the negative impacts of separation from family and community.

It is important to note that there is no word meaning 'cancer' in most, if not all Aboriginal languages. Furthermore, the concept of cancer is not rooted in Aboriginal stories, which is unlike many other illnesses. This is an important consideration for health promotion activities to increase appropriateness and acceptability of initiatives (Gilden R., Melchers A., et al., 2022).

Screening is an important public health measure which allows for the early detection of cancer or precancerous conditions and can reduce the overall burden of cancer. It is evident that current approaches are not accessible to Aboriginal people and barriers are hindering uptake as evidenced by below average screening rates (Gilden R., Melchers A., et al., 2022).

The plan also identified that collaboration between the ACCHO sector, SA PHNs, Local Health Networks (LHNs) and Cancer Council SA could increase Aboriginal peoples' participation in cancer screening. Additionally, integrated and coordinated services were identified as an enabler of change for Aboriginal people with cancer (Gilden R., Melchers A., et al., 2022).

Cardiovascular disease

SA Aboriginal Chronic Disease Consortium produced the *SA Aboriginal Heart and Stroke Plan 2022-2027* in collaboration with Aboriginal people and communities, health service providers, clinicians, and policy makers. It covers Cardiac disease, (including Ischaemic heart disease, Rheumatic heart disease and Atrial Fibrillation), Cerebrovascular disease, (including Ischaemic and Haemorrhagic Stroke) and Vascular disease (including Atherosclerosis and Peripheral vascular disease).

The priority areas identified through this collaboration provide insight into the heart and stroke related health and service needs of Aboriginal people in South Australia. While some of the priority areas fall outside of Country SA PHN's scope, it is important that these areas are documented to obtain a more holistic scope of the health landscape.

The priority areas were grouped by theme into the following categories:

Accessibility

- culturally appropriate services, such as access to traditional healers
- addressing accommodation concerns for clients from regional and remote areas.
- Transport issues at all stages of the client journey

Health services

- Effective existing services should be supported with secure funding
- access to bulk-billing general practice services that provide Closing the Gap (CTG) services
- Standardised identification of Aboriginal clients at the first point of medical contact and sharing this information with specialist services

Systems

- Better coordination between hospitals, primary health service providers, and specialists is necessary to ensure follow-up and rehabilitation services and ensure clients are not lost in the system after discharge
- Investment is needed to increase cultural awareness and capability across the healthcare sector, and developing the cardiovascular workforce is a priority.
- Strengthening connections between Aboriginal Community Controlled Health Organisations (ACCHOs) and acute service providers

Community

- Prevention-based education and culturally appropriate health promotion activities are important, as is providing culturally respectful health services free of racism.
- Access to SA Ambulance Services should be increased by promoting ambulance insurance and reducing out-of-pocket costs

Chronic kidney disease

Chronic kidney disease (CKD) in South Australia is high, however, it is largely preventable as several of the key risk factors are modifiable. Aboriginal peoples experience the health impacts of kidney disease much earlier in life, often needing to manage the condition alongside working, studying or raising children. CKD accounted for 2.5% of total disease burden among First Nations people in 2018 (AIHW, 2021a).

When CKD progresses to kidney failure, patients require highly specialised healthcare including renal dialysis and transplantation services. Many regional centres in South Australia are equipped with renal dialysis units, and mobile dialysis trucks offer short-term treatment. However, access to dialysis services remains severely limited for people living in remote communities throughout the state (SA Health, 2024a).

Additionally, transplantation services are provided from metropolitan hospitals only. Aboriginal peoples living in remote communities are often required to relocate to Adelaide, or other regional centres to receive the care they need. Port Augusta provides dialysis services for nearly one third of Aboriginal patients receiving dialysis in SA (ANZDATA, 2021).

Aboriginal-led research conducted by the AKtion Research Group identified key themes and strategies to support improvements to provision of kidney care in South Australian Aboriginal communities. The key themes focus on the importance of family, community, and cultural connections for Aboriginal kidney patients, emphasising the need for family involvement in care and decision-making, community-based support, and culturally responsive healthcare (J. Kelly et al., 2022).

Community members involved in the research identified that prevention and early detection of kidney disease are critical, with an emphasis on accessible education, regular health checks, and community-driven programs. Access to kidney care could be improved, particularly in rural and remote areas, through more local dialysis options, transportation, and holistic support (J. Kelly et al., 2022).

In 2020, 26% of Indigenous Australians receiving Kidney Replacement Therapy were able to do so close to home. It is evident that providing care on Country is achievable and successful, as in Central Australia, survival rates for haemodialysis have gone from the lowest nationally 20 years ago to highest in the country. This can be attributed to a 42% increase in dialysis treatments delivered between 2009 and 2016 in Central Australia (AIHW, 2024i).

Key themes around workforce were also identified, with the community identifying the need for more Aboriginal health professionals working in the space. Cultural training for all health professionals was recognised as being essential to the delivery of respectful, responsive care. Peer support programs were also highlighted as a vital strategy to provide guidance and understanding for those who were newly diagnosed (AIHW, 2024i).

Mental health and suicide prevention

For many Aboriginal and Torres Strait Islander people, good mental health is indicated by feeling a sense of belonging, having strong cultural identity, maintaining positive interpersonal relationships, and feeling that life has purpose and value (P Dudgeon et al., 2015). Conversely, poor mental health can be affected by major stressors such as removal from family, incarceration, death of a close friend or family member, discrimination and unemployment, as well as stressors from everyday life (P Dudgeon, Milroy, & Walker, 2014).

Historical trauma, intergenerational trauma, cultural dislocation, and ongoing socio-economic disadvantage contribute to the mental health challenges faced by Aboriginal and Torres Strait Islander communities (Health Q, 2024b). The legacies of colonisation and the ongoing trauma experienced by Aboriginal people also affect mental health. Dispossession from land, forced removal of children from families, and institutionalised racism have enduring effects on social and emotional wellbeing (Pat Dudgeon & Walker, 2015). This trauma continues to be transmitted across generations. Exposure to stressors such as institutional and cultural racism and socioeconomic marginalisation continues and plays out in all measures of mental health and wellbeing (Martin, Lovelock, & Stevenson, 2023).

Factors such as cultural identity, family and kinship, country and caring for country, knowledge and beliefs, language and participation in cultural activities and access to traditional lands are key determinants of health and wellbeing and protective factors for maintaining high levels of social and emotional wellbeing, and good mental health (Martin et al., 2023).

The need for mental health and suicide prevention identified by Aboriginal people in the *South Australian Aboriginal Healthcare Framework 2023-2031* is supported by population health data.

In South Australia, 29.5% of Aboriginal and Torres Strait Islander people experience mental health conditions, including anxiety (21%) and depression (19%). Almost four in ten (36%) Aboriginal people living in South Australia reported having high or very high levels of psychological distress. This was a higher rate compared to the national average for all Aboriginal and Torres Strait Islander Australians (36% vs 30%) (ABS, 2019).

Data indicates that there are additional factors experienced by Aboriginal people, which may be affecting health service access and health outcomes. Compared to national rates, Aboriginal people living in South Australia were less likely to access community mental health care services (1,041.2 per 1,000 vs 1,150.6 per 1,000) and MBS-funded psychologists (137.0 vs 143.6) in 2017-18 (AIHW, 2020c).

Generally, Aboriginal people are more likely to experience racism, disempowerment, cultural dislocation, increased rates of trauma and grief, involvement in the justice system and a myriad of

physical illness and chronic disease (Lowitja Institute, 2019). These factors increase an individual's risk of suicide and self-harm. It is anticipated that appropriate prevention initiatives would be responsive to these factors, however, stakeholder engagement is required to determine the specific needs of Aboriginal communities in country SA.

Due to uncertainties around the appropriateness and benefits of quantifying the prevalence of suicide in Aboriginal communities, these statistics were not included in this chapter but are available in the *Mental Health* chapter. Potential future inclusion will be directed by stakeholder engagement with Aboriginal communities.

Palliative care

Many Aboriginal people hold strong spiritual and cultural beliefs about the cause of serious illness, which may differ from medical explanations. The cultural belief that life is a continuum, Life-Death-Life, is common among Aboriginal people, with the underlying belief being that all living things have a spirit, which are the continuum that connects the living to the past, present and future (IPEPA Project team, 2020).

It is also important to note that direct statements about dying and death are not usually spoken in Aboriginal communities. The use of alternative terms such as 'finishing up', 'passed on' and 'not going to get better' may be more culturally appropriate. Furthermore, it may be culturally unacceptable for Aboriginal people to finish up/die alone (IPEPA Project team, 2020).

At the time of finishing up/death, the spirit leaves the body to return to the Ancestors' country, after which it is the responsibility of the family to ensure the safe passage of the spirit to the ancestors and return the body to country. It is important that families and the community can practice these rituals, and a sense of acceptance, love and support is vital to the end-of-life journey for sick people (IPEPA Project team, 2020).

In South Australia, the following focus areas have been identified to improve the appropriateness and accessibility of palliative care for Aboriginal people (Palliative Care South Australia, 2024a):

- Increase the provision trauma informed palliative care services that are flexible and responsive
- Prioritise systems to assist people to return to country at the end of life, if that is their wish
- Increase cultural awareness training for palliative care staff

It is evident that Aboriginal people have specific holistic needs in preparation and at the time of finishing up/death, which vary between communities and individuals (IPEPA Project team, 2020).

Other identified chronic conditions and risk factors

Several of the aforementioned priority areas are chronic conditions, associated as modifiable risk behaviours or resulting downstream health needs. The *South Australian Aboriginal Healthcare Framework 2023-2031* also identified the role of improved prevention and management of chronic conditions as an action to drive change. The need for enhanced access to culturally safe and responsive early intervention and proactive management of chronic diseases was highlighted (SA Health, 2023a).

It was also identified that culturally responsive health services need to be delivered in a connected and coordinated way. This approach is reinforced by the *National Aboriginal Health Plan*, which also highlights the need for place-based approaches, which must be locally determined and embed multidisciplinary care (Commonwealth of Australia, 2021a).

The Health Plan also emphasised the role of community priorities in determining what these approaches look like depending on the impact of certain conditions in that region (Commonwealth of

Australia, 2021a). It was identified that some Aboriginal and Torres Strait Islander communities are impacted to greater extents by heart, ear or eye conditions. Therefore, depending on the needs of the community, there may be a focus on (Commonwealth of Australia, 2021a):

- preventing acute rheumatic fever from becoming rheumatic heart disease
- preventing hearing loss resulting from ear infections
- preventing avoidable blindness through the diagnosis and management of eye conditions

It is important to recognise that not all chronic conditions are preventable, even when prevention efforts are effectively implemented. Therefore, the *National Aboriginal Health Plan* also highlighted the need for activities to support people already affected by chronic disease, through assistance with ongoing management to prevent disease progression and complications (Commonwealth of Australia, 2021a). The delivery of culturally safe and responsive immunisation responses was also highlighted in the National Health plan. For further discussion of immunisation, please refer to the *Population Health* and *Child and Youth Health* chapters.

Diabetes

The SA Aboriginal Chronic Disease Consortium has produced the *South Australian Aboriginal Diabetes Plan 2022-2027*. It involved a range of stakeholders including Aboriginal health professionals, ACCHOs and representatives from metropolitan, rural and remote SA to ensure the appropriateness of recommendations (Gilden R., Colmer, Melchers A., & Morey, 2022).

The plan identified several population groups within the Aboriginal community in South Australia that are at higher risk of developing diabetes (Gilden R., Colmer, et al., 2022):

- Older people
- Children and adolescents
- People experiencing homelessness
- People who are incarcerated
- People living with disability
- People living with mental health conditions
- Frequent unplanned users of the hospital system
- People living in rural and remote areas.

Several priority areas were identified in collaboration with the aforementioned stakeholders, in line with the needs of Aboriginal communities in South Australia. They included an emphasis on prevention of type 2 diabetes, as well as the promotion of awareness and early intervention of both type 1 and type 2 diabetes. Efforts to reduce the impact on priority populations, as well as pre-existing and gestational diabetes in pregnancy. Additionally, statewide strengthening of research practices to inform health policy decisions was highlighted (Gilden R., Colmer, et al., 2022).

Eye health

The SA Aboriginal Chronic Disease Consortium's *Aboriginal Diabetes Plan 2022-2027* also discussed the eye health needs of Aboriginal communities in South Australia, as diabetic retinopathy (DR) is one of Australia's leading causes of blindness or vision loss (Gilden R., Colmer, et al., 2022). One in three Aboriginal people with diabetes are affected by DR, yet almost all of diabetes related blindness (98%) is preventable through early detection and timely treatment. Therefore, there is a critical need to improve the rate of annual retinal examinations and develop clear referral pathways from screening to treatment (Gilden R., Colmer, et al., 2022).

Access to retinal cameras and additional training for staff in Aboriginal health services was identified as being essential for effective screening and diagnosis.

In South Australia in 2022–23, 1,292 spectacles were provided to First Nations people under a state scheme, however, the estimated need was approximately 3,063 spectacles. People aged 45–64 received the highest number of spectacles (540) (AIHW, 2024o).

There is also a need to identify and address underserved areas in South Australia, which may also require the use of data to identify service gaps and community consultation (Gilden R., Colmer, et al., 2022).

Ear health

Nationally, it has been identified that ear and hearing problems significantly impact Aboriginal communities, affecting individuals across their lifespan (AIHW, 2023f). In young children, these issues can delay speech and language development, hinder cognitive and behavioural growth, and lead to poorer educational outcomes. Over time, they can also limit employment opportunities, increase contact with the criminal justice system, and cause social isolation and cognitive decline in older adults.

Hearing loss is experienced nationally by one in eight Aboriginal people, and by one in six in South Australia (Australian Institute of Health and Welfare, 2018). Several factors contribute to these health issues, including social determinants like education, employment, and housing conditions (AIHW, 2023f). Access to appropriate ear and hearing health services is crucial but often hindered by systemic barriers such as racism, complex referral pathways, and geographic isolation. These barriers have long term impacts, as it was identified that when children miss regular ear and hearing health checks, their likelihood of developing chronic otitis media and associated impacts increases (AIHW, 2023f).

Therefore managing repeated or chronic ear infections is a protective factor, as well as the management of other chronic conditions, limiting repeated exposure to loud noise and reducing exposure to tobacco smoke (AIHW, 2023f).

Barriers to access

Consultations as a part of a Country SA PHN commissioned Needs Assessment highlighted that there are unique challenges faced by Aboriginal communities in accessing healthcare including shortages of healthcare facilities, clinics, and medical professionals (Health Q, 2024a). This scarcity of healthcare infrastructure results in longer wait times for appointments, reduced availability of services, and the need to travel long distances to access specialized care. These often-vast distances between communities and healthcare facilities pose significant barriers to access, with limited transportation options and challenges in reaching medical services in a timely manner (Health Q, 2024b).

In addition to the limited availability and physical accessibility of services, stakeholders also identified a lack of culturally safe and responsive health services. Cultural safety and responsiveness are key determinants of Aboriginal healthcare utilisation as they work to counter the intergenerational trauma and deep-seated distrust of mainstream healthcare systems among Aboriginal peoples caused by colonisation, the forced removal of children, and discriminatory healthcare policies. Efforts to remove these barriers are essential, as many Aboriginal people have experienced culturally unsafe healthcare environments, where cultural protocols, beliefs, and practices were not adequately respected or understood (Health Q, 2024b).

Similarly, the consultations also identified the unique cultural and linguistic barriers experienced by Aboriginal people when accessing healthcare services, leading to communication difficulties and misunderstandings. As there are many Indigenous languages spoken in country SA, it can be difficult to find healthcare providers where particular languages will be spoken and understood (Health Q, 2024b).

Sexual health specific barriers

The Country SA PHN commissioned sexual and reproductive health Needs Assessment identified several barriers experienced by Aboriginal people, through a review of published literature and stakeholder consultations (Shine SA & Katina D'Onise Consulting, 2024). The social determinants of health, discrimination, limited choice and access to appropriate sexual healthcare impact reproductive health disparities for Aboriginal people in South Australia.

The literature described barriers to STI care such as Aboriginal cultural norms that require the separation of genders and traditional kinship systems that prevent some staff and patients interacting. A lack of male workers, concerns about maintaining client confidentiality, and high staff turnover were further barriers identified. A systematic review by Ubrihen et al (2022) of barriers and enablers for young Aboriginal people in accessing sexual health services found barriers in the geographic location of services, inconsistent service provision, shame and differing levels of knowledge about the effects of STIs. Enablers included incorporating STI testing into other targeted initiatives, providing self-testing kits and achieving high levels of cultural competency (Ubrihen et al., 2022).

Stakeholder consultation highlighted a range of barriers that are impacting the provision of culturally safe services to Aboriginal people in country SA (Shine SA & Katina D'Onise Consulting, 2024). These included:

- Limited ability of Aboriginal Health Services to provide IUD insertion and removal
- A shortage of trained Aboriginal Health Practitioner (AHP) in sexual health care
- AHP not working to their full scope of practice relating to STI control
- Limited access to locally-based sexual health training
- Lack of safe spaces in primary health services for Aboriginal women to conduct women's business in a private, confidential manner
- Many early medical abortion prescribing doctors will only provide the service in a regional centre, restricting access and increasing costs to women who are living remotely.

Additionally, there is currently no Aboriginal-specific sexual and reproductive health education in schools in SA. While Aboriginal students in Department of Education schools would receive education by teachers trained in the mainstream SHINE SA Relationships and Sexual Health Curriculum, it is not tailored to Aboriginal young people specifically and is not provided by Aboriginal educators (Shine SA & Katina D'Onise Consulting, 2024).

Service Needs

Access to primary health care services varies across the country SA region. Aboriginal Community Controlled Health Organisations (ACCHOs) deliver culturally safe primary health care services across many regions of country SA including:

- Pangula Mannamurna Aboriginal Corporation - Mount Gambier/Limestone Coast
- Moorundi Aboriginal Community Controlled Health Service – Murray Bridge, Raukkan, Victor Harbour
- Pika Wiya Health Service Aboriginal Corporation – Port Augusta
- Nunyara Aboriginal Health Service - Whyalla
- Yadu Health Aboriginal Corporation – Ceduna
- Tullawon Health Service - Yalata
- Port Lincoln Aboriginal Health Service – Port Lincoln
- Oak Valley (Maralinga) Aboriginal Corporation

- Nganampa Health Council – APY Lands
- Umoona Tjutagku Health Service – Coober Pedy

Aboriginal Sobriety Group is also an ACCHO which provides substance use/social emotional wellbeing services in the Riverland region (Aboriginal Health Council of South Australia, 2023).

Some regions in country SA do not have a local ACCHO; in these areas, Aboriginal services are delivered by LHNs and community service organisations. Aboriginal people may also choose to access primary health care in mainstream settings, including general practices, allied health and pharmacy.

Culturally appropriate services

Due to colonisation, along with a long history of destructive policies, Aboriginal cultures, health and wellbeing have experienced intergenerational grief, loss and trauma. Aboriginal people experience the impacts of these policies to this day (Health Q, 2024b). As identified in the *South Australian Aboriginal Health Promotion Strategy 2022-2030*, “many current systems, institutions and policies are still built on the underlying beliefs and/or intentions of those historical policies” (p.17) (Wellbeing SA, 2022a). This sentiment was reinforced by Aboriginal stakeholders in a Country SA PHN commissioned Needs Assessment which highlighted that lack of trust, respect, and cultural safety, regardless of how available the services were or were not, was a significant barrier to accessing health services (Health Q, 2024a).

Stakeholders also highlighted that culturally safe healthcare environments, where Indigenous cultural beliefs, values, and practices are respected, are lacking, and these are essential to overcoming barriers and fostering trust between Indigenous patients and healthcare providers (Health Q, 2024a).

The *South Australian Aboriginal Health Promotion Strategy 2022-2030* also identified that “change is therefore also required at the system level in order to simultaneously remove the system-imposed barriers that prevent Aboriginal people from being able to draw on cultural knowledge and practices, and empower Aboriginal people to lead the decision-making process with culture at the forefront” (p.17) (Wellbeing SA, 2022a). This sentiment echoes the views expressed by Aboriginal stakeholders in the Country SA PHN commissioned Needs Assessment, that efforts to improve Indigenous health outcomes must be grounded in partnership, respect for Indigenous knowledges, and a commitment to addressing the root causes of health inequities (Health Q, 2024a).

The *National Aboriginal and Torres Strait Islander Health Plan: 2021–2031* prioritises holistic Aboriginal and Torres Strait Islander community controlled place-based services, as they are best placed to be culturally safe and responsive to the needs of the local community. However, there is a need for all health services to be accessible, culturally safe and responsive, and free of racism (Commonwealth of Australia, 2021a).

Workforce

Given the positionality of the authors, this section was guided by the findings from the *South Australian Aboriginal Health Promotion Strategy 2022-2028*. The Strategy was developed with community and centres the Cultural Determinants of Health, equity and strengths-based approaches. The perspectives of the Aboriginal community were a key component of this strategy’s development, involving directors of Aboriginal Health, senior Aboriginal figures in government and community roles, and esteemed Aboriginal community leaders. Consultations occurred across country SA, including Mount Gambier, Murray Bridge, Ceduna, Port Augusta, and Port Lincoln (Wellbeing SA, 2022a).

Aboriginal workforce development

Promoting and expanding the Aboriginal workforce was a central focus during community consultations. It’s clear that a robust Aboriginal workforce is essential for enhancing outcomes for Aboriginal people across various determinants.

On an individual level, the benefits are direct and personal, including employment, income, a sense of purpose, and belonging, which can positively impact mental and physical health. This can also have positive flow on effects to the health of their families (Wellbeing SA, 2022a).

On a broader scale, when the Aboriginal workforce can address and support community needs, significant positive change can occur across the entire community. Aboriginal public sector employees enhance policy and program development as well as service delivery by offering insights from a unique health and healing perspective. They also contribute lived experiences of ongoing colonization, which are crucial for transformational change to the health system. Maintaining these roles and identifying new opportunities for Aboriginal positions in future workforce planning is vital for sustaining and growing a strong Aboriginal workforce (Wellbeing SA, 2022a).

Stakeholders identified several potential actions to address development, support and retention of the Aboriginal workforce, including (Wellbeing SA, 2022a):

- Enhancing human resource policies, including onboarding processes
- Expanding leadership opportunities to enable more Aboriginal people to attain senior roles, especially in the public sector, within policy, program, and service delivery positions
- Ensuring the local workforce is representative of and reflects the community it serves
- Prioritizing the creation and upkeep of culturally safe workplaces to empower the Aboriginal workforce to address and meet community needs

Non-Aboriginal workforce

It was also recognised by stakeholders that the non-Aboriginal workforce also has a role in better supporting the Cultural Determinants of Health, through (Wellbeing SA, 2022a):

- Providing regular, high-quality training in Cultural Competence, Cultural Responsiveness, and/or Cultural Safety, ensuring the training is relevant to both the community served and the specific roles within the organization.
- Utilizing Reconciliation Action Plans more effectively as a mandated tool across government agencies.
- Promoting anti-racism messages in workplaces and strictly enforcing a zero-tolerance policy towards racism.

While some of the recommendations identified fall outside the scope of Country SA PHN, all of the actions identified by Aboriginal stakeholders are important to contextualise the needs of the community and centre their voices.

Mental Health

People living in regional and remote areas of South Australia face a range of unique challenges and stressors that can impact mental health. Harsh climates, higher occupational risks, geographic isolation and long-distance travel are a normal part of rural community life, however fewer economic and social resources can add to these challenges. It is evident that there are barriers to accessing mental health services in regional and remote areas, resulting in reduced utilisation and poorer health outcomes. They include a lack of services, financial and familial burden to access mental health care, stigma, and concerns about privacy and confidentiality in rural areas where mental health clinicians may be known and embedded in the community, all limit access to mental health services.

Country South Australia is rich with diversity across outer regional and remote areas. Therefore, understanding the unique diversity of our region is a critical element to providing appropriate mental health services and understanding how mental health needs change across our communities and lifespan.

For data and commentary on the prevalence and impact of suicide and suicidal behaviour, please refer to the *Suicide Prevention* chapter.

Key Points

- Early identification and intervention to provide access to mental health support early in the onset of mental illness and increase access to areas of higher disadvantage, with a focus on specific needs of young people
- Children and young people are vulnerable to mental illness and require specialised support to enable access to services as soon as possible
- Address access to psychological therapies and outreach to rural and remote areas that is financially accessible and without the need for a referral
- Work toward a connected and integrated service system that can provide coordinated holistic mental health services
- Step up and down interface with acute services to provide continuity of support as people navigate between tertiary and primary care
- Community education and training opportunities for sector staff

Identified Needs

1. Early intervention and prevention mental health services that are accessible for rural and remote populations
2. Access to psychosocial support services for people with severe and complex mental health needs
3. Mental health services that are accessible to people living in rural and remote regions
4. Mental health services are accessible to support the wellbeing of children and youth
5. Integrated mental health services and systems for coordinated care across the health and social sector
6. Access to responsive and appropriate mental health services

Health Needs

Mental health is a key component of overall health and wellbeing (WHO, 2021a). Mental health is a positive concept that is about wellness and is enhanced by a range of protective factors, such as positive relationships, sense of purpose, supportive environments, and physical activity. Mental health concerns can be the result of a complex interplay of factors including biological, environmental, cultural, physical, lifestyle and social influences. Determinants of mental health include not only the ability to manage our thoughts, emotions, behaviours and interaction with others, but also include 'social determinants' such as housing, education and employment, and fair and equitable justice. Disadvantage, inequities, and the impact of adverse events experienced in the early years of people's lives can have a significant impact on the mental health and wellbeing of people.

Prevalence of mental health concerns

The term 'mental health concerns' is used when referring to a person's experience of mental illness. A mental illness is a disorder diagnosed by a medical professional and can be defined as 'a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities', however, a person does not need to meet the criteria for a mental illness to be negatively affected by their mental health (COAG, 2017).

The terms 'mental illness', 'mental disorder', 'mental health condition' 'psychiatric illness' and other terms are used across a range of different studies and data sources to describe a range of mental health and behavioural disorders, which can vary in both severity and duration (AIHW, 2024au). In the context of this Needs Assessment, Country SA PHN aligns with terminology in the *Life in Mind Communication Charter* (Everymind, 2024). The evidence from selected sources are presented below to illustrate the prevalence and impact of mental health concerns in country SA. The term mental health concerns will be used broadly when referring to a person's experience of mental health issues. Throughout this chapter however there are several references to data and literature which may not use this preferred terminology, but to maintain consistency the terminology from the source material will be used in these instances.

Mental health concerns

As identified from results of the *2021 Census of Population and Housing*, one in every 10 people living in Country SA PHN (10%, 50,816 people) reported having been told by a doctor or nurse that they have a mental illness (including depression or anxiety). This is consistent with South Australia (10%) and Australia (9%). More females than males reported that they had a mental illness, 12% compared to eight percent respectively (AIHW, 2024au). By SA3 region, rates varied across country SA, from 7.1 per 100 in Outback – North and East to 12.1 per 100 in the Mid North (PHIDU, 2024c).

Based on results of the *National Study of Mental Health and Wellbeing 2020-2022* (NSMHW), an estimated 86,900 people aged 16-85 years (21.3%) in Country SA PHN had a mental illness in the previous 12 months to 2020-2022, consistent with the national rate of 22% (ABS, 2020-2022).

The prevalence of 12-month mental illness varied according to both age and sex. As reported in the NSMHW data, one in four females (24.7%) had a 12-month mental disorder in 2020–2022, compared with almost one in five males (17.9%). Rates of mental illness decreased with increasing age; 40% of people aged 16-24 years and 30% of people aged 25-34 years with a 12-month mental disorder (almost 36,000 people), compared to five percent of people aged 75-84 years old (1,900 people) (ABS, 2020-2022).

The rates of mental health concerns increased with increasing remoteness as shown in the South Australian results of the *National Health Survey 2022*; 35.8% of people living in the Outer Regional and Remote areas of South Australia had a mental and behavioural condition, compared to 26.2% of those living in the Major City area of South Australia (ABS, 2022d).

Severity and type of mental health concerns

As reported in the NSMHW data, of the people in Country SA PHN with a mental illness in the previous 12 months to 2020-2022, almost 27,000 people (7.0%) had a mild mental illness, over 35,000 people (8.6%) had a moderate mental illness and almost 20,000 people (4.9%) had a severe mental illness. Rates of moderate and severe mental illness were substantially higher in younger people (aged 16-24 years) (ABS, 2020-2022).

In Country SA PHN in the 12-months to 2020-2022 (ABS, 2020-2022):

- more than one in every six people aged 16-85 years (16.5%, 67,400 people) had a 12-month anxiety disorder involving feelings of tension, distress or nervousness that impacted their daily lives.
- 28,300 people aged 16-85 years (6.9%) had an affective disorder, a condition that disturbs a person's mood to the point where it becomes difficult to function in relationships or at work.

People with affective disorders and anxiety disorders were more likely to experience suicidal ideation, make a suicide plan and attempt suicide than those without these disorders (Arya et al., 2024).

Psychological distress

Psychological distress, especially when experienced for prolonged periods of time, is associated with mental health concerns (Kessler et al., 2002). Monitoring levels of psychological distress helps assess the mental health and wellbeing of people outside of being defined by a diagnosis or illness. People with or without mental illness may experience negative emotional states for any length of time, and this indicator may provide an estimate of the need for support and services across the population (Mental Health Commission, 2024).

Rates of high or very high psychological distress in people aged 18 years and over have increased in South Australia, from a rate of 13.8% in 2017-18 to 17.7% in 2022 (ABS, 2022d).

In 2022, younger South Australians (18-24 years and 25-34 years) had higher rates of psychological distress compared to other age cohorts, and rates for South Australian females were higher compared to males (ABS, 2022d).

Almost eight in 10 people (78%) with high or very high psychological distress in South Australia also have a mental illness (ABS, 2022d).

In 2017-18, people in Country SA PHN self-reported higher psychological distress in comparison with the state average. By SA3, rates of psychological distress were highest in Gawler-Two Wells (16.2 per 100), Eyre Peninsula and South West (15.9 per 100) and Outback – North and East (15.8 per 100) (PHIDU, 2024c).

Impact of mental health concerns

Consultations with health professionals

Over 73,000 people (17.7%) living in Country SA PHN had at least one consultation with a health professional for their mental health in the past 12 months, and 3.6% of these services were via a digital technology. Consistent with national rates, females were more likely than males to have had a mental health-related consultation with a health professional in the past 12-months, 22.4% compared to 13.0% (ABS, 2020-2022).

Mental health-related medications

Mental health-related medications reported in this section comprise the broad groups: Antipsychotics, Anxiolytics, Hypnotics and sedatives, Antidepressants, and Psychostimulants, agents used for Attention-deficit hyperactivity disorder (ADHD) and nootropics prescribed by all medical practitioners.

In 2022–23, 1,058,246 mental health-related prescriptions were dispensed to 109,626 people in country SA. Consistent with the national pattern, the population rate of people receiving mental health-related prescriptions in 2022–23 in country SA, was lowest for the youngest age groups (57 per 1,000 0–17 years olds) and increased by age (304 per 1,000 65+ year olds) (AIHW, 2024y).

Rates of mental health-related dispensing was higher in females (255 per 1,000 population) than males (164 per 1,000) in 2022–23 (AIHW, 2024y).

Nationally, people living in Inner regional areas were dispensed mental health-related medications at higher rates (227 per 1,000 population), than people living in other remoteness areas. Similarly in country SA, by SA4, rates were lowest in South Australia – Outback (185 per 1,000) and highest in Barossa-Yorke-Mid North (222 per 1,000) (AIHW, 2024y).

Mental health-related emergency department (ED) presentations

Three percent of all ED presentations in country SA were mental health-related in 2022–23.

In 2022–23, there were 6,411 mental health-related ED presentations in country SA, a rate of 122 per 10,000 population, which was higher than the national rate of 109 per 10,000 population.

For many rural communities, emergency departments are the only option for people experiencing an acute mental health crisis (Australasian College for Emergency Medicine, 2018). Between 2014–15 to 2022–23 there has been a substantial increase in mental health-related ED presentations in country SA, 4,135 presentations (84 per 10,000 population) in 2014–15 compared with 6,411 presentations (122 per 10,000 population) in 2022–23. This change has been driven by large increases in the SA4 regions of South Australia - South East (74% increase from 76 per 10,000 to 132 per 10,000 population) and South Australia - Outback (63% increase from 15 per 10,000 to 187 per 10,000 population) in 2022–23 (AIHW, 2024ac).

Between 2019–20 to 2022–23 rates of mental health-related emergency department presentations in country SA were highest for people aged 18–44 years and aged over 85 years (AIHW, 2024ac).

The top three principal diagnoses for mental health-related emergency department presentations in South Australia in 2022–23 were:

- Mental and behavioural disorders due to psychoactive substance use (25% of total),
- Neurotic, stress-related and somatoform disorders (19%) and
- Schizophrenia, schizotypal and delusional disorders (16%) (AIHW, 2024ac).

Mental health-related hospitalisations

In 2021–22 there were 5,697 mental health related hospitalisations in Country SA PHN, a rate of 110 per 10,000 population, the 6th highest out of 31 PHNs nationally (AIHW, 2024aa). Compared to the region average, mental health related hospitalisations were substantially higher in the SA3s of Murray and Mallee (153 per 10,000), Outback – North and East (141 per 10,000) and Mid North (137 per 10,000). These regions also had the highest patient days per 10,000 in country SA (AIHW, 2024aa).

Nationally, *Depression and other affective disorders* has consistently been the most frequently reported principal diagnosis for same day public and private hospitalisations and overnight private hospitalisations *with* specialised psychiatric care the decade to 2022–23. For overnight public hospitalisations *with* specialised psychiatric care, *Schizophrenia* was the most common principal diagnosis (AIHW, 2024aa).

Nationally, in the decade to 2022–23, *Mental and behavioural disorders due to use of alcohol* was the most frequently reported principal diagnosis for both same day public and private hospitalisations *without* specialised psychiatric care, and was the second most frequently reported diagnosis for overnight public hospitalisations *without* specialised psychiatric care (AIHW, 2024aa).

Premature deaths

An analysis by Roberts et al (2024) of the 2016 Census, death registry, Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) linked dataset revealed a significant life expectancy gap of 11 years for Australians who accessed mental health-related treatments including MBS service with a mental health-related item number and/or a PBS prescription for one or more medication types usually used to treat a mental illness (Roberts, Wong, Lawrence, Lawn, & Johnson, 2024).

The analysis also showed that people (aged 15–74) who accessed mental health-related treatments comprised 22.2% of the total population but accounted for almost half (49.3%) of all premature deaths, and that people aged 15–74 who accessed mental health-related treatments and lived in remote or very remote communities had substantially increased standardised death rates, 3.1 times higher than metropolitan regions (Roberts et al., 2024).

For further data and commentary on the prevalence and impact of suicide and suicidal behaviour please refer to the *Suicide Prevention* chapter.

Determinants of mental health in rural and remote communities

People in rural and remote areas face a range of stressors unique to living outside major cities. These include a greater prevalence of some chronic conditions and disability, and generally poorer health. Rates of smoking, risky drinking and illicit drug use are also higher. There are fewer employment opportunities leading to lower incomes and less financial security. There is also greater exposure and vulnerability to natural disasters, overcrowding, housing stress and homelessness (NRHA, 2021).

Environmental factors

Rural communities are subject to unique challenges, particularly economic and environmental changes, and stress induced by unfavourable conditions and natural disasters such as drought, bushfires, floods and cyclones – the frequency of which is projected to increase as the effects of climate change increase – can adversely affect mental health (Heanoy & Brown, 2024).

Regional incomes can be heavily reliant on farming, mining, tourism, fishing or forestry. Income from these industries directly and indirectly underpins the livelihood of many people in rural and remote areas, and can be strongly influenced by external factors such as weather conditions, commodity and fuel prices, and currency exchange rates, all of which are subject to periodic fluctuation (National Rural Health Alliance, 2024).

The mental health consequences of disasters are extensive and are often associated with trauma and the disruption of personal and socioeconomic factors in people's lives. The impact of disasters on mental health can be direct or indirect, short-term or long-term, and to some extent, depends on the recovery process of the affected community (Heanoy & Brown, 2024). Communities exposed to extreme environmental events are associated with an increased prevalence of mental distress and illness, such as anxiety and depression, and repeat exposure to disasters is associated with worsening mental health outcomes (Mitchell, Maheen, & Bowen, 2024).

Social exclusion, isolation and loneliness

Social exclusion and disadvantage are strongly associated with mental health concerns. People with mental illness are likely to be socially excluded, and people facing social exclusion for other reasons are likely to subsequently experience mental health concerns (Productivity Commission, 2020).

Social isolation and loneliness are concerning issues due to the mental and physical impact they have on peoples' lives and wellbeing. Social isolation has been linked to mental illness, psychological and emotional distress, suicide, the development of dementia, premature death and poor health behaviours (smoking, physical inactivity and poor sleep), as well as biological effects, including high blood pressure and impaired immune function and decreases in feelings of wellbeing (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015; Manera, Smith, Owen, Phongsavan, & Lim, 2022).

Conversely, more frequent social contact is associated with better overall health (AIHW, 2024aw). Loneliness has been linked to premature death, poor physical and mental health, greater psychological distress and general dissatisfaction with life (Beer et al., 2016; Manera et al., 2022).

Research revealed during 2024 Loneliness Awareness Week shows that:

- 27.7 per cent of South Australians experience persistent loneliness, which means they have felt lonely for at least 8 weeks at a time
- Nearly 20 per cent experienced persistent social isolation, meaning they had infrequent social contact for at least 8 weeks at a time
- South Australians are the second most socially isolated people in the country, after people living in the Northern Territory (Loneliness Awareness Week Australia, 2024).

Young South Australians are struggling the most to make quality social connections, with 91 per cent aged 18 to 29 reporting experiencing loneliness often or sometimes (Uniting Communities, 2023).

Populations disproportionately impacted by mental health concerns

Mental health needs vary across population groups and are influenced by factors such as: age, gender, sexuality, family situation, social, economic and cultural background. As documented in national and state mental health policies, strategies and plans, there are many experiences that heighten people's vulnerabilities and are associated with increased risk of experiencing or developing mental health concerns.

Country SA PHN recognises that the challenges associated with accessing mental health care are often further compounded by two or more intersecting risk factors and circumstances affecting an individual. The recognition of certain groups as more vulnerable or a priority population aims to continually monitor changing needs of our community. To redress inequities in mental health and suicide outcomes between population groups and to find care pathways that are safe and accessible to local community groups.

Guided by the PHN Program guidance (DOH, 2019), joint regional planning and needs assessment activities, Country SA PHN recognises the following priority population groups as they experience perceived higher risks of mental health concerns, mental illness or suicidal distress compared to other populations, and additional barriers to affordable, available, appropriate, and culturally safe mental health care:

- People living in rural and remote areas or experiencing locational disadvantage
- Children under the age of 12 years and young people
- People experiencing, or at risk of, homelessness
- Women experiencing perinatal depression
- People from culturally and linguistically diverse backgrounds
- People who identify as lesbian, gay, bisexual, transgender or intersex
- People with intellectual disability and co-occurring mental illness
- Aboriginal people
- People at risk of suicide
- People with mental illness in Residential Aged Care Homes
- People in drought impacted communities

The population groups Country SA PHN prioritises in the future will be informed by needs emerging from on-going needs assessment and joint regional planning.

Country SA PHN acknowledges that many people may identify with and form part of multiple priority populations or communities that are disproportionately impacted by poorer mental health.

Understanding the different needs for these populations and the complexity of people's lived experience, can assist in improving our approaches to promotion of mental health and wellbeing, prevention, and treatment for priority populations in our region.

Aboriginal and Torres Strait Islander people

Social and emotional wellbeing is the foundation of physical and mental health for Aboriginal people, taking a holistic view of health as it recognises that connection to land, sea, culture and spirituality all influence wellbeing. Social and emotional wellbeing varies across the life course and between different cultural groups and individuals. Social, historical and political factors can also affect wellbeing (Commonwealth of Australia, 2017; P Dudgeon et al., 2014).

As identified in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* the domains of social and emotional wellbeing include: body; mind and emotions; family and kin; community; culture; country; and spirituality and ancestors (Commonwealth of Australia, 2017).

Promoting social and emotional wellbeing is about maximising the benefits of the protective factors that connect and support wellbeing, while minimising exposure to risk factors and particularly those that are also risk factors for mental health conditions.

For many Aboriginal people, social and emotional wellbeing is indicated by feeling a sense of belonging, having strong cultural identity, maintaining positive interpersonal relationships, and feeling that life has purpose and value (P Dudgeon et al., 2015).

Conversely, poorer mental health is associated with intergenerational trauma and the legacies of colonisation and the ongoing trauma experienced by Aboriginal people also affect mental health. Dispossession from land, forced removal of children from families, and institutionalised racism have enduring effects on social and emotional wellbeing (Pat Dudgeon & Walker, 2015) and mental health, and are still experienced today.

Social and emotional wellbeing problems are distinct from mental health problems and mental illness, although they can interact and influence each other (Commonwealth of Australia, 2017). Even with good social and emotional wellbeing, people can experience mental illness. People with mental health problems or mental illness can live and function at a high level with adequate support yet continue to have social and emotional wellbeing needs (AIHW, 2020c).

The need for mental health (and suicide prevention) identified by Aboriginal people in the *South Australian Aboriginal Healthcare Framework 2023-2031* is supported by population health data.

Prevalence of mental health concerns

- Almost one in three (29.5%) of Aboriginal people in South Australia experience mental illness, including anxiety (21%) and depression (19%). Consistent with the national findings, Aboriginal South Australians living in remote regions had lower rates of mental illness (ABS, 2019).

Psychological distress

- Almost four in ten (36%) Aboriginal South Australians reported having high or very high levels of psychological distress. This was a higher rate compared to the national average for all Aboriginal Australians (36% vs 30%) (AIHW, 2020a).
- Rates of psychological distress reported by South Australian Aboriginal people have increased, from 30.2% in 2004-05 to 37.1% in 2018-19. Higher rates of psychological distress were associated with higher rates of disadvantage, unemployment, poorer health and higher rates of chronic health conditions (AIHW, 2020a).

Mental health-related hospitalisations

- The rate of hospitalisations related to mental health have increased in South Australia from 34.5 per 1,000 in 2008-09 to 41.8 per 1,000 in 2018-19, noting a peak in rates between 2010-11 (51.5 per 1,000) and 2011-12 (55.2 per 1,000). Compared to national data, Aboriginal people living in South Australia were more likely to be hospitalised for mental health-related conditions (AIHW, 2020a).
- Between July 2017 to June 2019, mental and behavioural disorders caused by psychoactive substance abuse was the leading cause of mental health-related hospitalisations (14.4 per 1,000) for Aboriginal people in South Australia, followed by Schizophrenia, schizotypal and delusional disorders (8.6 per 1,000) and mood disorders (4.7 per 1,000) (AIHW, 2020a).
- Rates of hospitalisations for injury and poisoning related to self-harm were lower in remote South Australia compared to non-remote regions, 2.7 per 1,000 compared to 5.0 per 1,000 (2017-2019) (AIHW, 2020a).

Additionally, compared to national rates, Aboriginal people living in South Australia were less likely to access community mental health care services (1,041.2 per 1,000 vs 1,150.6 per 1,000) and MBS-funded psychologists (137.0 vs 143.6) in 2017-18 (AIHW, 2020b).

People who identify as LGBTIQ+

Accessing mental health services that are inclusive and affirmative for LGBTIQ+ people living outside of urban areas is much more challenging. It is harder to establish networks, and find a sense of belonging and acceptance, with greater feelings of loneliness and the further away from metropolitan areas people live (Hill A et al., 2020).

Compared to non-LGBTIQ+ people, individuals who identify as LGBTIQ+ experience elevated rates of anxiety, depression, anxiety and psychological distress and higher rates of suicidal ideation and self-harm, and poorer long-term mental health outcomes due to the direct and enduring effects of prejudice, stigma and discrimination in everyday life because of their gender and/or sexual identity (Amos et al., 2023; Hill et al., 2021; The Equality Project, 2024).

However, as noted by Hill et al. (2020) compared to LGBT people living in inner suburban areas of Australia, LGBT people residing in rural and remote areas of Australia were more likely to have poor self-rated health and higher rates of psychological distress, and higher rates of suicidal ideation and behaviours.

LGBT people residing in rural areas have also been found to face higher levels of stigma and discrimination in accessing healthcare than those residing in urban areas (Rosenkrantz, Black, Abreu, Aleshire, & Fallin-Bennett, 2017).

As identified in consultations as part of *Rainbow Discovery Project SA: The Equality Project* there are multiple factors that create barriers and lead to poor experiences in accessing primary health care services including specialised LGBTIQ+ mental health services in country SA. They include:

- an ongoing gap in LGBTIQ+ knowledge leads to fear of discrimination and personal safety
- LGBTIQ+ services are not available within regional areas, and/or there are lengthy waitlists for the few services that are available e.g. specific LGBTIQ+ initiatives that are being run are limited to 1 or 2 services across each Local Health Network
- Lack of face to face/in person specialised LGBTIQ+ mental health services and specialist trauma practitioners in country SA
- Lack of support and services for people aged over 25 and under 65 (The Equality Project, 2024).

Efforts to prevent experiences of discrimination and abuse toward sexuality and gender diverse people is essential for protecting their mental health and wellbeing. The potential protective effects of interpersonal connection/support, engagement with the LGBTIQ+ community, or feeling a part of one's school have been shown to reduce feelings of distress and contribute to improvements in people's subjective sense of wellbeing (Amos et al., 2023).

Children and young people

Most young people in Australia are happy, feel positive about the future and are satisfied with their lives overall, however, some young people suffer poor mental health which can impact on the potential of young people to live fulfilling and productive lives (Amos et al., 2023). It is crucial that mental illness is diagnosed early and effectively treated to ensure better outcomes and prevent lifelong disability (NMHC, 2019).

Mental health concerns will often begin during childhood and can be shaped by physical, genetic, and environmental factors with strong and complex links to adverse childhood events, poor attachment or being in an unsafe environment (DoHAC, 2022c).

Mental health affects the lives of many young people. Mental health concerns were the leading cause of health burden for young Australians (aged 15–24 years) in 2023. Suicide and self-inflicted injuries were the leading specific cause of total burden among males, and anxiety disorders were the leading specific cause among females (AIHW, 2024s).

Young South Australians (aged 15-19 years) rated mental health concerns such as low mental health, stress, anxiety, depression, low self-esteem and self-harm as their second biggest personal challenge after school challenges – for which mental health was the main barrier (McHale et al., 2023). A quarter (26%) of young south Australians experienced high levels of psychological distress in 2023 (McHale et al., 2023) and while the prevalence of psychological distress among young South Australians has remained fairly steady since 2018, it had increased substantially in the last decade from 19% in 2012 (Mission Australia, 2019).

The proportion of young people aged 5 to 15 living in rural South Australia and experiencing a mental illness has also remained constant over the past few years, with approximately one in five rural young people (17%) reported experiencing a mental illness in 2023 (Preventive Health SA, 2024b). However, young people in some areas of country SA face a greater burden of mental health concerns. Self-reported data from the 2021 *Census* shows that rates of mental health concerns in people aged 0 to 14 years living in the following Local Government Areas were significantly above the national rate: Mid Murray (3.5 per 100, +64% higher), Gawler (3.4 per 100, +58% higher), Berri Barmora (3.2 per 100, +53% higher), Victor Harbor (3.1 per 100, +46% higher), and Barossa (3.0 per 100, +39% higher) (PHIDU, 2024c).

The prevalence of mental illness in young people aged 16-24 years in Country SA PHN has been estimated based on the *National Study of Mental Health and Wellbeing, 2020-2022*. For many mental illnesses, including moderate and severe disorders, anxiety disorder, and substance use disorder, younger people in Country SA PHN had higher rates compared to older people.

In the 12-months prior to the study period:

- Two in five (40%, 19,330) young people had a mental illness
 - By severity level, one in ten (10%, 4,900 people) had a mild illness, one in five (19%, 9,250 people) had a moderate illness, and one in ten (10%, 4,900 people) had a severe illness
- One in ten (10%, 4,700) young people had a substance use disorder
- One in three (33%, 15,600) young people had an anxiety disorder
- One in six (15%, 6,900) young people had an affective disorder, and

- Almost one in ten (9%, 4,200 people) young people had a mental and physical comorbidity (ABS, 2020-2022).

Compared to older people, young people living in Country SA PHN were more likely to have had at least one mental health-related consultation in the past 12-months (28%, compared to seven percent for people aged over 65 years), and to have accessed mental health services using digital technologies (9%, compared to less than one percent of people aged 65 years and over) (ABS, 2020-2022).

Young people described helpful solutions to their mental health concerns, including better access to mental healthcare services, proper diagnosis and treatment and support from their family and friends (McHale et al., 2023). Barriers to help-seeking for their mental health concerns included stigma and embarrassment, fear, lack of support and accessibility, perceived need for help, knowledge of available services, affordability and personal preference not seeking external support (wanting to manage by themselves or with help from family or friends) (Mission Australia, 2019) (Lawrence D, 2015).

Additionally, mental health literacy amongst parents and caregivers of young children has been identified as somewhat insufficient, with current deficiencies in knowledge upon how to recognise the signs of poor mental health in children, and furthermore how to address and act on these signs (Australian Government 2022). Improving the mental health literacy of parents and caregivers may lead to increased nurturing of children throughout their early years due to improved understanding, thus may benefit childhood development (Australian Government 2022).

Women in the perinatal period

Research indicates that around 12% of pregnant people become depressed during pregnancy and 15% experience postnatal depression. During pregnancy and after having a baby ten percent of parents will have significant anxiety (SA Health, 2024d). Mental health conditions in the perinatal period (pregnancy and 12 months after the birth) often go undetected and untreated, imposing a significant burden and negative impacts on parents, babies, their families, the health system and society more broadly (Highet & Expert Working Group and Expert Subcommittees, 2023).

Rural women and their infants continue to experience poorer perinatal outcomes than their urban counterparts, and face challenges in accessing perinatal care close to their homes, when compared to women living in urban environments, primarily due to increasing service closures and persistent workforce crises (Faulks, Edvardsson, & Shafiei, 2024).

For people living in remote and rural Australia, the challenges of parenthood may be compounded by social isolation, extended wait lists, lack of availability of mental health services and professionals, as well as the often-vast distances they may need to travel to access mental health services. With impacted service access, remote and rural health services are less able to intervene in response to signs of known perinatal risk factors (PIRI, 2022).

Country SA PHN has undertaken analysis of selected social and health indicators associated with an increased risk of developing perinatal depression, to identify which country South Australia regions have women who are potentially more vulnerable to developing perinatal depression and anxiety. Results of this analysis identified the following five regions: Murray Bridge, Whyalla, Port Pirie, Mount Gambier, Port Augusta (CSAPHN, 2024b).

People with mental and physical health comorbidities

Mental health is known to affect physical health and vice versa; a lack of care of one can lead to serious problems with the other (Doan, Ha, Strazdins, & Chateau, 2023). Poor mental health can inhibit physical health behaviours and increase a person's exposure to behavioural and social risk factors (RANZCP, 2015). Polypharmacy, health impacts of psychotropic medication and systemic issues including professional silos in physical and mental health care delivery also contribute to poorer outcomes for people with mental and physical comorbidity (RANZCP, 2015).

People with mental and physical co-morbidities are likely to experience more severe and chronic medical, social and emotional problems than if they had a single disease or disorder (National Mental Health Commission, 2018). People with mental-physical comorbidity have higher rates of hospitalisation (Launders et al., 2022), and particularly for people with alcohol use disorders, are at higher risk of death compared to people with only mental health disorders (and no chronic physical illness) (Tan et al., 2021). Almost 80% of premature deaths of people with mental illness are due to preventable physical health conditions (ABS, 2020-2022).

In Country SA PHN, approximately 36,000 people (8.7%) aged 16-85 years were living with a mental illness and physical condition in the previous 12 months to 2020-2022, consistent with the proportion nationally. Estimates indicate in country SA women aged 45-64 years were more likely to experience mental and physical comorbidities compared to other age and sex cohorts (ABS, 2020-2022).

People with severe mental illness requiring psychosocial support

Based on results of the *National Study of Mental Health and Wellbeing 2020-2022*, an estimated 20,000 people aged 16-85 years (4.9%) in Country SA PHN had a severe mental illness in the previous 12 months to 2020-2022 (ABS, 2020-2022). Rates of severe mental illness were highest in people aged 16-24 years, impacting over 4,900 people in this age group (10.3%). Rates of severe mental illness decreased with increasing age (1.4% of people aged 65-85 years), and were significantly higher for females than males in the 16-24 year and 25-24 year age groups (ABS, 2020-2022).

As identified by the *National Mental Health Services Planning Framework (NMHSPF)*, people with severe mental illness are more likely to have multiple mental and/or physical health problems and may experience significant impairment in psychosocial functioning which restricts their ability to participate in education and employment, and engage in meaningful relationships and social activities. Many people with severe mental conditions will also experience extensive social and environmental stressors that complicate their care needs leading to lower life expectancy and poorer physical health outcomes than the general population (Gossip et al., 2023).

In 2022-23 approximately 13,000 people in the Country SA PHN region are estimated to have a diagnosed severe mental illness that highly impacts on their day-to-day lives (Gossip et al., 2023).

The care needs and duration of support for people with severe mental illness will vary depending on individual circumstances including level of severity, risks to themselves or others, and treatment and supports required, however all individuals will likely require an intensive holistic and multidisciplinary service response, with interventions delivered by a mix of Commonwealth-funded or subsidised and state-/territory-funded clinical services as well as mental health community support services (Diminic, Gossip, Page, & Comben, 2023).

People living in regional and remote South Australia have limited inpatient and specialist mental health services in regional Local Health Networks. Rural to metropolitan transfers for mental health clients can be required for clients to receive comprehensive assessment and mental health treatment in a tertiary level service. Overall declines between 2017-2022 in rates of access to specialised clinical mental health care were evident across all South Australia, more so for consumers who resided in regional areas with an accelerated rate noted in Very Remote regions of the state (AIHW, 2024ab).

People with alcohol and other drug comorbidities

There is a complex relationship between mental health and alcohol and other drug use. People with mental illness use alcohol, tobacco and other drugs for the same reasons as other people (Department of Health, 2017b); however a mental illness may make a person more likely to use drugs to provide short-term relief from their symptoms, while other people have drug problems that may trigger the first symptoms of mental illness (AIHW, 2024ai). The use of alcohol, tobacco and other drugs can interact with mental health in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety (Department of Health, 2017b).

Substance use disorder (SUD) is a treatable mental illness that affects a person's brain and behaviour, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD (National Institute of Mental Health, 2024). In country SA, approximately 15,000 people (3.7%) aged 16-85 years had a substance use disorder in the previous 12 months to 2020-2022, consistent with the proportion nationally (3.0%). Estimates indicate the males in country SA were twice as likely as females to have had a 12-month substance use disorder (5.0% compared with 2.4%), and people aged 16–24 years had the highest rates of 12-month Substance Use Disorders (9.9%) compared with other age groups (ABS, 2020-2022).

People living with substance use disorder and another co-occurring mental illness experience greater combined disease severity and poorer outcomes than those who experience these conditions individually (AIHW, 2024ad). A recent study by Sunderland et al (2024) using data from the *Australian National Surveys of Mental Health and Wellbeing* conducted in 2020–2022 found that in Australia approximately half (49.8%) of people with an alcohol use disorder and almost three-quarters (73.4%) of people with a drug use disorder have at least one additional mental disorder (Sunderland et al., 2024).

Co-morbidity, or the co-occurrence of an alcohol, tobacco and other drug use disorder with mental illness, complicates treatment and services for both conditions (Department of Health, 2017b). Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatment and supports is being made available to the individual (Department of Health, 2017b).

People experiencing homelessness or transient housing who have a mental health condition

Regional consultations and case worker surveys conducted as part of the Country SA PHN commissioned *Homelessness Needs Assessment* (2024) frequently and consistently raised mental illness as the highest priority issue or concern needing action for people experiencing homelessness in our region, and noted the close links and association to problematic alcohol and other drugs use (Health Q, 2024a). Nationally, mental health concerns were the leading health-related reason for clients seeking support from specialist homelessness services in 2023, cited by 75% of clients seeking support for health reasons (AIHW, 2024r).

Barriers to accessing primary care and community health services, including mental health services, are widespread for people at risk of or experiencing homelessness. They involve long waiting times, inflexible scheduling, transportation issues, perceived stigma, discrimination, difficulties in appointment management, and challenges registering with a general practitioner due to lack of identification and address (AIHW, 2024r).

Rates of homelessness are increasing nationally, particularly for young people 12 to 24 years who comprise a quarter (23%) of people experiencing homelessness. Within the Country SA PHN, the following SA3s appear to be the most vulnerable in terms of homeless populations – Eyre Peninsula and South-West; Outback - North & East; Limestone Coast and Murray & Mallee. At the time of the *2021 Census of Population and Housing*, approximately 2,000 people were experiencing homelessness or living in overcrowded dwellings in country SA (Health Q, 2024b).

Service Needs

The mental health care service landscape is complex. Mental health care services are provided in the private sector via the Medicare Benefits Schedule (MBS)-subsidised system, utilising private health insurance rebates and patient contributions, among other funding streams. Non-government organisations (sometimes with state or federal government funding, for example through Primary Health Networks and other departmental programs) also deliver ambulatory and residential mental-health-specific services. State and territory health and hospital services and private hospitals deliver both community and hospital-based services. Outside of major cities, organisations such as the Royal Flying Doctor Service (RFDS) provide mental-health-related retrieval services and primary mental health care, with much of their funding derived from federal government sources (NRHA, 2021).

Timely and accessible health care is crucial for people living in country SA who are experiencing mental health concerns. This includes the provision and delivery of appropriate prevention and early intervention services, primary health care services and specialist mental health services that are joined up and integrated.

Mental health workforce

The mental health workforce plays a critical role in promoting and sustaining the mental health and wellbeing of individuals and communities across Australia (DoHAC, 2023b). The mental health workforce spans promotion, prevention, early intervention, treatment and recovery across the life course to address the needs of consumers and their families, carers and kin.

The mental health workforce includes people who work exclusively in the mental health sector (for example, First Nations mental health workers, mental health nurses, psychologists and psychiatrists) and those that work in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example, allied health, general practitioners and nurses). The workforce also extends to people with lived or living experience of mental ill-health and/or suicide and those working in other settings who are likely to have regular contact with people experiencing mental distress and/or ill-health and suicidality as part of their role (for example, aged care workers, educators, drug and alcohol workers, and housing and justice services workers) (DoHAC, 2023c). Encompassing a broad range of professions, mental health workers exist in a variety of settings including hospitals, clinics, schools, private practices and community centres (DoHAC, 2023b).

The mental health workforce has a profound impact on the quality, accessibility, effectiveness and sustainability of the mental health system. It is critical to delivering services across primary, acute, aged care, disability and veterans' care. But there are significant shortages of all professions in the mental health workforce. These shortages are getting worse, and they have the potential to curtail the amount and quality of care provided across all settings. Too many people are waiting too long or missing out on vital mental health care (Coleman, Roberts, & English, 2023).

National mental health workforce challenges

As identified in the *National Mental Health Workforce Strategy 2022-2032*, there are several challenges associated with growing and sustaining the mental health workforce in Australia to meet the needs of all Australians.

Key challenges include:

- Workforce shortages across occupations and disciplines
- Stigma and negative perceptions associated with working in mental health
- Unclear scopes of practice to establish who is able to perform what service and in which setting, particularly when working in multidisciplinary teams and in emerging workforces
- Limited connection and collaboration across mental health professions and disciplines
- Workforce maldistribution, particularly in regional, rural and remote areas
- Limited availability and use of high-quality data to inform workforce planning, and
- An overarching increasing demand for services (DoHAC, 2023c).

Mental health services in South Australia – local workforce challenges

The *Review of Rural Mental Health Services in South Australia* released in May 2023 highlighted sustained disparities in state-funded mental health service access between metropolitan and country SA (Coleman et al., 2023). The review found that the provision of mental health services in country SA faces a series of issues and challenges, particularly significant resourcing and clinical support gaps, with chronic workforce deficits. Further, the review identified an absence of lived experience, consumer and carer peer workers, and Aboriginal mental health workforce (Coleman et al., 2023). Training, attraction and retention of the workforce is limited by a lack of rural health workforce incentive schemes and training and career pathways. Additionally the reviewers noted insufficient support for rural and regional health planning from state health departments, and noted the absence of strong and clear rural advocacy voice at senior levels of government in mental health service planning (Coleman et al., 2023).

In addition to a shortage of experience and trained mental health clinicians, other issues raised by the review included limited access to integrated suicide prevention services, long waiting times, significant distances of travel required and an absolute lack of available specialist support services for at-risk groups within the community (Coleman et al., 2023).

Distribution of mental health workforce

The data presented below reiterates that the majority of mental health workforce (including Accredited mental health social workers, mental health nurses, mental health occupational therapists, Psychiatrists, and Psychologists) in South Australia is metropolitan-based. Within country SA, the mental health workforce is primarily based in outer regional areas, with low or no workforce based in remote and very remote regions of the state. Compared to the national rates, country SA as a whole has fewer mental health nurses, mental health occupational therapists, psychiatrists and psychologists per capita population (AIHW, 2024z).

Psychiatrists

Psychiatrists are medical doctors who specialise in diagnosing and treating mental health disorders. They can prescribe medication to patients and may also use talk-based therapies such as cognitive behavioural therapy and psychotherapy (DoHAC, 2023b).

Only three percent of psychiatrists in SA (10 out of 313 in 2023) were based in country SA. Compared to other PHNs nationally, Country SA PHN has the third lowest number of psychiatrists (10) and lowest rate of psychiatrists per capita, 1 psychiatrist per 100,000 people compared to a national average of 16 per 100,000 people in 2023 (AIHW, 2024z).

Five of the 10 psychiatrists in country SA worked in South Australia – South East SA4, with no psychiatrists working in SA4s of South Australia–Outback or Barossa–Yorke–Mid North (AIHW, 2024z).

Psychologists

Psychologists are mental health professionals involved in the prevention, assessment, diagnosis and treatment of psychological problems. They help people to overcome a wide spectrum of challenges including relationship problems, trauma, eating disorders, learning difficulties, substance abuse, parenting issues, grief and managing the effects of a chronic illness (DoHAC, 2023b).

In 2022, there were 162 psychologists working in country SA, 10% of the total number working in SA. Equivalent to a rate of 30 psychologists per 100,000 people, this was much lower than the national rate of 125 psychologists per 100,000 people (AIHW, 2024z).

The number of psychologists working in country SA declined with increasing regional remoteness, however the per capita rate was highest in Remote areas (37 per 100,000 population). By SA4, the number and rates of psychologists were highest in South Australia–South East, 50 psychologists, 25 per 100,000 population in 2022 (AIHW, 2024z).

Specialist mental health nurses

Mental health nurses are registered nurses who specialise in providing care for individuals with mental health disorders including depression, postnatal depression, schizophrenia, bipolar disorder or psychosis (DoHAC, 2023b).

In terms of workforce size, mental health nurses were the largest of the specialist workers providing mental health services in country SA in 2022. There were 190 mental health nurses in country SA in 2002, 11% of the total 1,773 mental health nurses working in SA. Equivalent to a rate of 36 mental health nurses per 100,000 people, this was substantially lower than the national rate of 96 mental health nurses per 100,000 people (AIHW, 2024z).

The majority of mental health nurses (107, 56%) were based in Outer regional parts of country South Australia, 41 (22%) were based in Inner Regional areas, 14 (7%) in Remote and 7 (4%) in Very Remote areas. Per capita rates of mental health nurses in country SA was highest in the SA4 of South Australia–Outback (58 per 100,000 population) in 2022 (AIHW, 2024z).

Mental health occupational therapists

Mental health occupational therapists can help people to develop strategies to cope with everyday tasks and overcome mental health issues. They might help with rehabilitation after an accident, work with children who have learning difficulties and help people have improved confidence in social situations (DoHAC, 2023b).

Fourteen percent of mental health occupational therapists in SA (29 out of 203 in 2022) were based in country SA. Equivalent to a rate of 5 per 100,000 people, this was lower than the national rate of 10 per 100,000 people (AIHW, 2024z). No mental health occupational therapists worked in the Barossa–Yorke–Mid North SA4 in 2022. Per capita provider rates were similar for South Australia–Outback (4 per 100,000) and South Australia–South East (5 per 100,000) (AIHW, 2024z).

Accredited mental health social workers

Accredited Mental Health Social Workers are mental health clinicians trained in the assessment, treatment planning, complex case formulation, and the delivery of evidence-based therapeutic interventions. They may provide Focussed Psychological Strategies (FPS) services through Commonwealth programs including the Better Access to Mental Health Care, Chronic Disease Management and Access to Allied Psychological Services (AASW, 2022).

In 2022, 87 accredited mental health social workers were working in country SA, 27% of the total (319) SA workforce. Compared to other PHN regions, Country SA PHN had the third highest rate per 100,000 in Australia, with 16 accredited mental health social workers per 100,000 compared to a rate of 11 per 100,000 nationally (AIHW, 2024z).

Although based in all SA4s, Barossa–Yorke–Mid North (11 per 100,000), South Australia–Outback (12 per 100,000) and South Australia–South East (16 per 100,000), there were no accredited mental health social workers in Remote and Very remote areas of these regions (AIHW, 2024z).

Aboriginal mental health workers

Aboriginal and Torres Strait Islander mental health workers provide specialised mental health care to Indigenous communities. They understand the mental health issues of Aboriginal people and deliver care in a culturally appropriate way (DoHAC, 2023b).

As noted by Coleman et al. (2023) there is an absence of Aboriginal employees as clinicians, peer workers and Aboriginal Mental Health Workers in regional mental health services in South Australia.

Peer workforce and lived experience participation

Lived experience (peer) workers are trained mental health professionals who have their own personal experience of mental ill-health and recovery. They are integral to mental health teams as they provide a unique form of support to people living with mental health issues (DoHAC, 2023b).

Country SA PHN is committed to working with lived experience representatives of mental ill-health and/or suicide, their families and carers, to embed lived experience knowledge as central to the design, planning, delivery and evaluation of services. Lived Experience Representatives are formally engaged to support the implementation of the Bilateral Schedule on Mental Health and Suicide Prevention: South Australia, and our broader mental health program activity.

General practitioners

General practice is central to the delivery of mental health care, especially for consumers living in regional, rural and remote areas, often acting as the first entry point to the mental health system (DoHAC, 2023c). Feedback from local GPs in the Barossa indicates that mental health issues are the most common presentation in their general practice settings, in line with recent findings by the RACGP (Higgins, 2023). GPs nationally have reported that psychological issues were the most common general practice presentation, with almost 40% of consultations in a typical week including some mental health component (Dubecki, 2017).

Primary mental health care service landscape

Access to mental health care – areas of concern

To provide an indication of access to mental health services across Australia, Mental Health Australia and the University of Canberra (UC) mapped the proportion of the population across PHNs and SA3s with psychological distress who used Medicare-subsidised mental health specific services in 2020-21.

Areas of particularly extreme concern in terms of inequalities in access to mental health care, occurred where people were experiencing higher rates of psychological distress and substantially lower access to services compared to other areas.

The results illustrated that within country SA, nine out of 11 SA3s were identified as areas of severe or high concern based on relative rates of psychological distress and Medicare-subsidised mental health service use. The Barossa, Outback–North and East, and Eyre Peninsula and South West SA3s were identified as areas of severe concern area with highest need and lowest mental health service access. Regions of very high concern with high-medium need and medium-lower service access included Limestone Coast, Murray and Mallee, Lower North, Mid North and Yorke Peninsula (Mental Health Australia & University of Canberra, 2023).

Medicare-subsidised mental health services

Medicare-subsidised mental health specific services are provided by general practitioners (GPs), psychiatrists, psychologists (clinical and other) and other allied health professionals including occupational therapists, social workers, mental health nurses for focused psychological care that are

registered with Medicare. Medicare-subsidised services are delivered in a range of settings including hospitals, consulting rooms, home visits, and telehealth (AIHW, 2024w).

For all provider types, there has been a 29% increase in per capita rates of Medicare-subsidised mental health services in country SA in the last decade, from 251 per 1,000 population in 2013-14 to 325 per 1,000 population in 2022-23 (AIHW, 2024w).

In 2022-23, 43,250 people in country SA received a Medicare-subsidised mental health service, with 171,401 services provided in total. GPs provided 53,355 (31%) of the total services, clinical psychologists 42,285 services (25% of total), and psychiatrists 31,799 services (19% of total) (AIHW, 2024w).

With the exception of services provided by Other allied health professionals, per capita service rates for the other provider types decreased with increasing remoteness, with rates lowest in the SA4 of South Australia – Outback (AIHW, 2024w).

Country SA PHN commissioned mental health services

Initial Assessment and Referral (IAR) for Mental Healthcare Guidance and Decision Support Tool (DST)

An initiative of the Australian Government Department of Health and Aged Care, the Initial Assessment and Referral (IAR) for Mental Healthcare Guidance and Decision Support Tool (DST) is a nationally consistent decision support tool to guide clinical judgement and consumer choice in recommending a level of care for a person seeking mental health support.

Each level of care is based on the least intensive and least intrusive evidence-based intervention that will likely lead to the most significant possible gain for an individual. The service also aims to improve access into mental health services to consumers by providing multiple entry pathways through their preferred platform (website, phone, face-to-face). The intake service is intended to provide service navigation to connect people to the right mental health services to meet their identified needs.

The objectives of the IAR Guidance and Decision Support Tool are:

- People seeking mental health assistance have their experiences understood in the context of holistic assessment domains (the 8 domains).
- The person's treatment needs, and recovery goals are understood and matched to a suitable service type and intensity (the 5 levels of care).
- Minimise the risks that arise through under-servicing (poor outcomes) and over-servicing (unnecessary burden of care for the person).
- To provide consumers with a choice of mental health services, compatible with their treatment needs and reduce repetition of history where possible, and referrals to incorrect levels of care.
- Improve effective use of finite (sometimes, scarce) resources.

To support the implementation of IAR into clinical practice, Country SA PHN has delivered training, built relationships with, and provided ongoing support to GPs and clinicians in Adult Mental Health Centres, general practices, Aboriginal Medical Services, and commissioned providers within the PHN region. Between March 2023 and August 2024, 219 health professionals within country SA were trained in the IAR tool (CSAPHN, 2024c).

Low intensity service delivery

Low Intensity services appropriately support individuals with or at-risk of mild mental illness at a local level, providing an initial service 'step' within the primary health stepped care framework. Through adopting a stepped care approach, services match individuals to a service adequate for their need and reduce waiting lists for more intense therapies.

In the 2023/24 financial year, 1,531 clients had received 7,004 low intensity services (CSAPHN, 2024f).

Low Intensity Services were provided to people living in the following Local Health Network regions (CSAPHN, 2024f):

- Flinders and Upper North: 19% of clients and 26% of total services
- Yorke and Northern: 22% of clients and 25% of total services
- Barossa Hills Fleurieu: 22% of clients and 17% of total services
- Eyre and Far North: 14% of clients and 15% of total services
- Riverland Mallee Coorong: 12% of clients and 10% of total services
- Limestone Coast: 9% of clients and 6% of total services

For regions without a physical service in place, Regional Access (24/7 phone and online services) and the Royal Flying Doctors Service are available.

Psychological therapies

Psychological therapies are delivered to people with mild to moderate mental illness, or in some cases severe mental illness, within the stepped care approach. Clinical outcomes for people receiving Country SA PHN commissioned Psychological Therapies showed the majority of clients had a decrease in levels of distress after receiving a service in 2023/24 (CSAPHN, 2024f).

The need for psychological therapies is growing consistently. Currently Country SA PHN commissioned psychological therapies are delivered in all LHN regions of country SA. However, service provision rates are lower than the state average across all regions in country SA, indicating an imbalance with service provision in the metropolitan area despite equal or greater need in many rural areas.

As outlined in the previous section, psychologists are in high demand and yet are limited particularly in rural and remote areas. Workforce availability in rural regions impacts consistency of delivery for psychological therapies and clinical care coordination services despite most Country SA PHN regions having some level of need. Where psychologists are available, extended waiting periods exist and/or high cost gap payments prevent consumers from attending their services.

In the 2023/24 financial year, 4,248 clients had received 22,172 psychological therapy service (CSAPHN, 2024f).

Psychological therapies were provided to people living in the following Local Health Network regions (CSAPHN, 2024f):

- Barossa Hills Fleurieu: 42% of clients and 33% of total services
- Yorke and Northern: 14% of clients and 19% of total services
- Riverland Mallee Coorong: 16% of clients and 15% of total services
- Flinders and Upper North: 9% of clients and 11% of total services
- Limestone Coast: 8% of clients and 10% of total services
- Eyre and Far North: 6% of clients and 8% of total services
- Virtual: 2% of clients and 1% of total services

Youth mental health services

Child and youth mental health services aim to increase overall community access to evidence-based early intervention to reduce the prevalence and impact of mental illness. There is evidence to demonstrate that early intervention in both management of mental illness and functional development/recovery for children and young people can have a significant impact on a wide range of outcomes (DoH, 2021a).

Country SA PHN commissioned youth mental health services are directed at children or young adults aged up to 25 years. Services range from Low Intensity, across Psychological Therapies to care coordination, and are primarily delivered via headspace centres.

Workforce shortages and retention of appropriately qualified staff impact delivery of Youth specific mental health services in the country region. These limitations affect all aspects of health in the region and are not specific to youth mental health. Commissioned service providers and tertiary partners across country SA have identified heightened and escalating demand for service resulting in extended wait times.

For youth aged 12-25 years, headspace is the predominant primary mental health service provider across the region with eight operational centres in the Country SA PHN region. headspace centres provide support for mental health, drug and alcohol, work and study and physical health needs.

Eight headspace centres are located in areas of high mental health need across the Country SA PHN region in:

- Port Augusta
- Berri
- Murray Bridge
- Mount Gambier
- Victor Harbour
- Port Lincoln
- Whyalla, and
- Mount Barker.

From 1 July 2023 to 30 June 2024, headspace centres within country SA delivered 15,150 occasions of service to 3,145 young persons. This represents an increase of almost 3,000 occasions of services compared to 2021-22 period (CSAPHN, 2024f).

Occasions of service were highest for centres located in (CSAPHN, 2024f):

- Port Lincoln (2,522)
- Mount Barker (2,390)
- Mount Gambier (1,988)
- Murray Bridge (1,723)

In the 2023/24 year, two-thirds (66.7%) of young people using headspace services were aged between 12-17 years old, and two-thirds of services were provided to females (65.9%). Potentially a reflection of the appropriateness of headspace services, 32.6% of services were provided to young people that identified as LGBTIQ+ and 9.8% of services were provided to young people that identified as Aboriginal and/or Torres Strait Islander (CSAPHN, 2024f).

To support young people aged 12 to 25 years and their families who require mental health services in very remote locations that have no or limited access to services, Country SA PHN commissions a range of outreach mental health services and supports including assessment, intervention, referral, community engagement, community awareness, to six remote South Australian communities in line with the headspace model.

Additionally, the Youth Triple C program is provided through regional headspace centres and general practice, and supports young people with severe and complex mental illness in the primary care setting through Mental Health Nursing led clinical care coordination and integration with regional LHN acute services.

The primary goals of Youth Triple C are to improve access to adequate level of primary mental health care intervention to maximise recovery and prevent escalation; and provide wrap-around coordinated care for young people with complex needs.

In 2023-24, 5,991 occasions of service were delivered to 605 people. Occasions of service were highest in the following Local Health Network regions (CSAPHN, 2024f):

- Barossa Hills Fleurieu: 40% total clients and 43% of total services
- Limestone Coast: 26% of total clients and 16% of total services
- Riverland Mallee Coorong: 16% of total clients and 28% of total services
- Flinders and Upper North: 13% of total clients and 10% of total services

Psychosocial support services

In South Australia, psychosocial support services are delivered by a range of non-government mental health organisations, with a focus on supporting people with mental illness to increase their social and economic participation, avoid preventable hospitalisations, and improve their quality of life, health and wellbeing.

Country SA PHN commissions eight service providers to deliver psychosocial support services across our region for people who are not receiving psychosocial support services funded through the National Disability Insurance Scheme (NDIS). Our commissioned services are person-centred and recovery-oriented, aimed to improve functional capacity, address individual unmet need, and complementing clinical mental health and physical health services. Our services strengthen the capacity of consumers to live independently, safely and productively in their community, form meaningful connections in a supportive environment, and reduce the need for acute care in their region.

Psychosocial services administered by commissioned service providers in country SA are delivered through a range of formats including individual support, place-based services, group activities and outreach support, and include a broad range of appropriately trained and qualified staff within their scope of practice and based on consumer needs including Mental Health Support Workers, Peer/Lived Experience Support Workers, Social Workers, and other appropriately trained Mental Health Professionals.

In 2023/24, 25,770 occasions of service for psychosocial support were delivered to 1,119 people (CSAPHN, 2024f).

Psychosocial support was provided to people living in the following Local Health Network regions (CSAPHN, 2024f):

- Yorke and Northern: 27% of clients and 23% of total services
- Riverland Mallee Coorong: 22% of clients and 21% of services
- Barossa Hills Fleurieu: 15% of clients and 18% of services
- Eyre and Far North: 12% of clients and 17% of services
- Flinders and Upper North: 11% of clients and 12% of services
- Limestone Coast: 13% of clients and 9% of services

A study by McGrath Consulting (2023) commissioned by the Office of the Chief Psychiatrist (SA Health), into unmet mental health service need in South Australia, found that despite expenditure on psychosocial support services in SA in the 2021/22 year exceeding the funding estimates predicted by the National Mental Health Services Planning Framework (NMHSPF) modelling by approximately \$34m, there is a clear current gap in service availability for those not eligible for the NDIS. The population receiving services is well below that predicted by the model with approximately 19,000 persons not receiving services that the model predicts requires them. The report also indicates there is insufficient expenditure on services for children, youth and people aged over 65, as well as insufficient expenditure on flexible respite, day respite and residential respite and crisis services in all age groups. The primary recommendation arising from this study was the requirement for cross agency, interjurisdictional service planning for psychosocial supports (David McGrath Consulting, 2023).

To support improvements in psychosocial support services delivery in South Australia and ensure clients can access appropriate services, Country SA PHN will continue to engage and consult with LHNs and other providers to better integrate our commissioned services with new service models, and will work collaboratively to address waitlists, understand organisational and sector capacity, improve workforce sustainability and identification of unmet need for people living in Country SA.

Step up and down interface

The step up and down interface provides an intermediate level of care between the inpatient and community setting, used as a bridging support between pre- and post-acute services. The step up and down services provide an alternative to hospital admission in addition to a support mechanism following hospital discharge, ensuring consumers remain supported through out.

The Mental Health Shared Care program aims to assist individuals with complex mental health needs to increase their capacity to manage their physical and mental health, avoid relapse through early intervention or the onset of acute symptoms. A key element of the service is the communication and integration between the services involved in a person's care including their GP. In country SA, the shared care locations are Port Augusta, Whyalla, Kadina, Murray Mallee, Berri, Mount Gambier, Adelaide Hills, Fleurieu and Kangaroo Island.

The Clinical Care & Coordination (Triple C) program is aimed at providing clinical care and coordination of services for an individual experiencing severe and persistent mental illness to improve access to an adequate level of primary mental health care to maximise recovery and prevent escalation, and to provide wrap-around coordinated care for people with complex needs. This may involve consultation and liaison with primary healthcare providers, acute health, emergency services, rehabilitation and support services, family, friends, other support people and carers and/or other agencies that have some level of responsibility for the client's treatment and/or well-being.

In the 2023-24 period, 6,002 Triple C services were delivered to 767 clients across the Country SA PHN region (CSAPHN, 2024f). Triple C is delivered by four regional providers in: Port Lincoln, Barossa Hills Fleurieu, Yorke and Northern, Riverland Mallee Coorong, Limestone Coast and the Riverland.

Culturally safe services

Aboriginal people face many inequalities in accessing health services, and may experience cultural, geographic, cost and availability barriers to using health and mental health services. The cultural (in)appropriateness of services, fear of discrimination, language barriers, racism and distrust are reasons for not seeking support from mainstream health and mental health care services (Nolan-Isles et al., 2021).

To support access to mental health services for Aboriginal people, all mental health services need to offer culturally safe service environments and workforces with appropriate cultural capabilities including awareness, respect and responsiveness. Culturally valid understandings must also shape the provision of services and guide assessment, care and management of First Nations health (Commonwealth of Australia, 2017; Department of Health, 2017a).

In the 2023/24, 7,765 Country SA PHN commissioned mental health services were provided to Aboriginal people in country SA, and 98.6% of these services were deemed culturally appropriate (based on PHN Program Performance and Quality Framework indicator definition of culturally safe services) (CSAPHN, 2024f).

Integrated and coordinated holistic care

Integrated care is the organisation and delivery of health services to provide seamless, coordinated, efficient care that responds to a person's health needs. An individual engaged within an integrated care model will receive a continuum of care inclusive of health promotion, disease prevention, diagnosis, treatment, disease management and rehabilitation coordinated across different levels and

sites of care, accounting for comorbidities and external factors that influence one's health (Health Performance Council, 2014; World Health Organisation, 2018). Community consultation consistently identifies the lack of cohesive and integrated services and health provider communication across the care continuum.

Joint service planning

To support integration, Country SA PHN continues to work collaboratively with six regional Local Health Networks and the Department for Health and Wellbeing to conduct service mapping of core and commissioned services across both sectors utilising the IAR levels of care. Two service mapping roundtables were held in 2023 to identify local service gaps, pressure points, points of intersection, and areas of opportunity to further collaborate.

Using the IAR levels of care approach Country SA PHN has directed all commissioned providers of psychological services to establish and formalise partnerships between organisations and services in their region to facilitate 'joined up' service provision across the following sectors: mental health, alcohol and other drugs, broader primary health care environment, acute services, community services, aged care services, child and youth services, social services, residential aged care facilities, Aboriginal health services and Local hospital networks.

Summary of community, provider and stakeholder consultations

A scoping review by Kavanagh et al. (2023) noted a number of barriers and facilitators to mental health service access and utilisation in the regional, rural, and remote Australian context identified by healthcare providers and service users.

Prominent barriers to access and utilisation included: limited resources; system complexity and navigation; attitudinal and social matters; technological limitations; distance to services; insufficient culturally-sensitive practice; and lack of awareness. Facilitators included person-centred and collaborative care; technological facilitation; environment and ease of access; community supports; mental health literacy and culturally-sensitive practice (Kavanagh et al., 2023).

Face to face consultations, paper based and online surveys in conjunction with community forums have been both participated in and facilitated by Country SA PHN to hear directly from the community, key stakeholders and service providers alike to ensure their thoughts and views are heard for the purpose of needs assessments and service planning.

The below summarises themes and issues identified from key community or stakeholder consultations conducted in the region.

1. Services that work together collaboratively

- Integrated service delivery, with holistic view on health to encompass all aspects of an individual's life
- Service providers talk to one another for a seamless referral pathway from low intensity to acute care
- A coordinated approach to the promotion of mental health and wellbeing and early-in-life intervention

2. Accessibility and meeting the needs of the population

- More mental health services based in rural and remote regions to reduce travel, distance, and time away from work
- Service access and entry issues for psychological therapy and psychiatry services: lack of regional workforce, services gaps, long wait times for services and a lack of transport options make some service inaccessible

- Youth mental health specific services and trained health professionals within this field
- Limited after-hours services available outside 9-5 and on weekends and after work hours
- Confidentiality around seeking help in small communities, where everyone knows each other
- Utilising technology and digital media to reach those in more remote and rural communities
- Services and interventions which recognise that some population groups are at higher risk of having or developing mental health issues or have diverse needs
- Need for appropriately accredited interpreters

3. *Improve community awareness and reduce stigma*

- Prejudice and discrimination surrounding mental health in some regions
- Forums and workshops for community members and health workforce, from basic to advanced knowledge bases (Mental Health First Aid, ASSIST, Question Persuade Refer)
- Improve mental health literacy to have the knowledge, understanding and skills necessary to promote mental health and enhance the ability to recognise, manage and prevent poor mental health
- Increase mental health education awareness in the community to minimise stigma
- Improve knowledge and skills of health staff in rural and remote areas – particularly around the increased stressors experienced with drought, bushfires, and floods
- Having strategies in place and training for managers from all walks of life so people feel confident to disclose knowing they will be cared for by their employer

4. *Simple and clear pathways of care*

- Inconsistent knowledge among GPs regarding mental health care and accessing specific services
- Knowing where to go and that you will be referred to the right level of care
- Communication between providers, to ensure information is passed on rather than having to start from scratch at each level of care
- Support to enable partnerships between family, carers and service providers
- Importance of strong leadership, governance, planning and funding
- South Australians and organisations are seeking greater sustainability in funding models which support innovation, opportunities for collaborative or shared approaches to developing best practice in care delivery, and excellence in service provision
- Improved governance of services to ensure person-centred, recovery-focused and outcomes-oriented approaches.

Suicide Prevention

The impact of suicide can be both traumatic and long-lasting for individuals, families, carers, colleagues and communities. Across Australia, people residing in rural and remote communities are identified as having a higher risk of suicide than those living in metropolitan areas.

It is important to remember when reviewing the statistics and data that numbers represent lives lost along with family, friends and communities who are grieving the loss of each of those people.

Country SA PHN respectfully acknowledges individuals, families, carers, colleagues and communities bereaved by suicide, those who have considered ending their life, those who have attempted to do so and those that care for loved ones through suicidal crisis.

If you or anyone you know requires immediate support, all hour's help is available:

Lifeline 131 114 or Text 0477 13 11 14

A confidential service where you remain anonymous. An online crisis chat option also exists, for those who prefer this option.

Mental Health Triage – Ph: 131 465

Immediate confidential clinical support for people with a mental health emergency providing assessment over the phone or in your home and they can arrange follow up support.

Key Points

- Suicide and suicidal thoughts and behaviours arise from a complex and personal interaction between many risk factors and triggers in a person's life at a particular point in time
- Particular population groups and outer regional and remote communities experience significantly higher rates of suicide and self-harm, compared to the national and state averages.
- Access to mental health services is limited in some rural communities, in turn reducing help-seeking and appropriate counselling or treatment options.
- There are considerable staffing gaps across the suicide prevention sector and limited capacity to meet high levels of demand. The suicide prevention workforce does not yet have a cohesive approach to workforce planning and capability building.

Identified Need

1. Access to suicide prevention services and support for people experiencing suicidal distress and or crisis.

Prevalence of suicide, self-harm and suicidal ideation

Deaths by suicide

Suicide is the act of purposely ending one's life. It is a public health issue that affects all ages and deeply impacts individuals, families, workplaces and communities across Australia. The reasons people take their own lives are complex, and often there is no single reason why a person attempts or dies by suicide (Life in Mind Australia, 2024c).

In Australia, suicide rates and suicidal behaviours are consistently higher in regional, rural, and remote areas compared to metropolitan areas (Life in Mind Australia, 2024b).

In Country SA PHN the age-standardised suicide rates have increased by 21% in the past decade from 2012 to 2022, higher than the rate of increase nationally in this period (10%) (AIHW, 2024ax).

From 2018-2022 in Country SA PHN (AIHW, 2024af):

- 364 people died by suicide. The age-standardised rate of 14.7 deaths per 100,000 people was 17% higher than the Australian rate
- Suicide was the 15th highest cause of death and accounted for 1.6% of all causes of death for people living in Country SA PHN
- Approximately 4 in every 5 people that died by suicide in 2018-2022 were male, with age-standardised rates for males being 3 times the rates for females.
- Suicide was the 9th leading cause of death for males in Country SA PHN contributing to 2.5% of all deaths in 2018-2022. It was not in the top 20 leading causes for all women, and
- Age-standardised suicide rates in the SA3 regions of Mid North, Outback–North and East and Limestone Coast were notably higher than the Country SA PHN region and Australian averages.

In South Australia in 2022, intentional self-harm [suicide] (X60-X84, Y87.0) was the leading cause of death for people aged 15-44 years and the 2nd highest cause among 45-54 year olds (ABS, 2023a).

Suicidal thoughts and behaviours

Suicidal thoughts and behaviours include suicidal ideation (thoughts about taking one's own life), making suicide plans and attempting suicide. The *National Study of Mental Health and Wellbeing 2020-2022* explored several aspects of lived experience of suicide. This included whether a person had experienced suicidal thoughts or behaviours, both in their lifetime and in the past 12 months. Only people who had experienced suicidal thoughts were asked if they had planned or attempted suicide.

Suicidal ideation

People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and those who experience all forms of suicidal thoughts and behaviours are at greater risk of dying by suicide (Demesmaeker, Chazard, Hoang, Vaiva, & Amad, 2022; Mendez-Bustos, de Leon-Martinez, Miret, Baca-Garcia, & Lopez-Castroman, 2013).

Based on modelled estimates from the *National Study of Mental Health and Wellbeing 2020-2022*, almost one in every five people aged 16-85 years in country SA (77,000 people, 18.8% of this age group) have had suicidal thoughts in their lifetime, and approximately 12,000 people aged 16-85 years (2.9% of this age group) have had suicidal thoughts in the last 12 months (ABS, 2020-2022). Rates of lifetime suicidal thoughts declined with age, with the highest rates among 16-24 year olds (26.4%) and 25-34 years olds (25.4%). In the past 12-months, young people in country SA were more likely to have suicidal thoughts compared to older people (ABS, 2020-2022).

Self-harm

Self-harm refers to a person intentionally causing pain or damage to their own body. This behaviour may be motivated as a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although some people who self-harm are at an increased risk of suicide (Mindframe, 2024).

Modelled estimates for Country SA PHN from the *National Study of Mental Health and Wellbeing 2020-2022* suggest that over 33,000 people aged 16-85 years (8.1% of this age group) have self-harmed in their lifetime, and over 6,400 people aged 16-85 years (1.6% of this age group) have self-harmed in the last 12 months (ABS, 2020-2022).

Lifetime self-harm and self-harm in the last 12 months was higher for females than males by both total rates and rates by age group. Rates of self-harm declined with age: rates of self-harm in the last 12-

months are highest among 16-24 year olds (6.6%), more than twice the rate in 25-34 years olds (2.5%) and ten times the rate of people aged 35-85 years (ABS, 2020-2022).

Hospitalisations due to intentional self-harm

The term 'intentional self-harm' in the National Hospital Morbidity Database (NHMD) provides information on patients admitted to hospital for self-poisoning or self-injury, with or without suicidal intent – and therefore includes both suicide attempts and non-suicidal self-harming behaviours (AIHW, 2024ax).

Rates of hospitalisations for intentional self-harm vary across genders, age groups and regions in Country SA PHN. Between 2018-19 to 2022-23 the overall trend for the Country SA PHN region has been a decrease in hospitalisation rates for intentional self-harm (AIHW, 2024I).

In 2022-23 there were 797 hospitalisations due to intentional self-harm in Country SA PHN, equivalent to a rate of 151.8 hospitalisations per 100,000 population (AIHW, 2024I). This is 43 fewer hospitalisations compared to 2021-22 (AIHW, 2023e).

Three in every five people hospitalised for intentional self-harm injuries in 2022-23 were female (63%, or 499 hospitalisations). The rate of intentional self-harm hospitalisations was higher for females than males, both overall and across all age cohorts, with the largest variation in rates between males and females occurring in the 0-24 year age group, 312.1 per 100,000 for females and 106.5 per 100,000 for males (AIHW, 2024I). People aged 25-44 years (245.8 per 100,000) had the highest rates of intentional self-harm hospitalisations in 2022-23 (AIHW, 2024I), this is a change from 2021-22 when the rates of intentional self-harm hospitalisations were highest for young people aged 0-24 years (239 per 100,000) (AIHW, 2023e).

Rates of hospitalisations for intentional self-harm varied widely across SA3 geographies ranging from 93.8 per 100,000 population in Adelaide Hills SA3 to 230.9 per 100,000 in Mid North SA3 in 2022-23. Data from 2018-19 to 2022-23 highlights that the SA3 regions of Mid North, Murray and Mallee, Outback-North and East, Lower North and Yorke Peninsula have consistently had higher than average rates compared to other regions of Country SA PHN (AIHW, 2024I).

Risk and protective factors

As described in the *South Australian Suicide Prevention Plan 2023-2026*, suicide is not generally caused by a single event or condition, it arises from a complex and personal interaction between many risk factors and triggers in a person's life at a particular point in time (Government of South Australia, 2023). Risk factors are characteristics, relationships, circumstances or events that can increase the likelihood of thoughts of suicide. These factors may be present at the individual or family level or at broader social, cultural or institutional levels, although not all individuals or groups may be affected in the same ways or to the same extent. Life stressors like financial hardship, relationship stress, bullying and insecure housing can contribute to suicide related distress for some people. For others, these life stressors can interact or compound with other challenges across a lifespan such as the death of a loved one, a health condition, gambling, alcohol and other drug use, and heighten suicide related distress (Government of South Australia, 2023).

The presence of one or more of these risk factors cannot predict or explain suicide or intentional self-harm as each person's experience is unique. Experiencing any of these risk factors does not necessarily mean a person has—or ever will—attempt suicide, but establishing whether a person has any of these risk factors can help determine whether they are at increased risk (AIHW, 2023j).

Similar to risk factors, a range of factors at the individual, relationship, community, and societal levels can protect people from suicide. These can include effective coping and problem-solving skills, having a strong sense of cultural identity, access to secure housing and stable employment, feeling connected

and supported, availability of timely, consistent and high quality mental and general health care, and readily accessible crisis support and postvention services (Government of South Australia, 2023).

Results of the *State of the Nation in Suicide Prevention survey* (2024) highlighted that social determinants of health and wellbeing continue to pose significant risks to suicide rates. Economic factors, such as cost of living, unaffordable housing and unstable unemployment, and social factors such as social isolation and family and relationship breakdown, continue to place pressure on individuals (Suicide Prevention Australia, 2024a). Suicide Prevention Australia's latest *Community Tracker* (2024) has revealed a stark gender disparity across a range of risk factors for suicide, with women reporting elevated distress beyond normal levels for cost-of-living and personal debt, family and relationship breakdown, and housing access and affordability when compared to men (Suicide Prevention Australia, 2024b). For young people (aged 18-24 years), cost-of-living and personal debt, housing access and affordability, social media, self-image and bullying, and unemployment and job security were the top four causes of elevated distress revealed in 2024 (Suicide Prevention Australia, 2024b).

In 2023, 83% of people who died by suicide had at least one risk factor reported, and 67% of suicide deaths in Australia had at least one psychosocial risk factor reported. Mood disorders (including depression) was the most common risk factor overall (38%) in those aged 25 to 84 years (Life in Mind Australia, 2024a).

In 2022, personal history of self-harm was the most frequently occurring psychosocial risk factor for suicide, followed by disruption of family by separation or divorce, and problems in relationship with spouse or partner. For people aged 65 years and over, limitations of activities due to disability was the most frequently occurring psychological risk factor (AIHW, 2023e).

Alcohol and other drug use was most mentioned as a risk factor for those living in remote and very remote Australia. For those who died by suicide in the five-year period 2019-2023 and lived in remote and very remote Australia, acute alcohol use and intoxication was mentioned in 36% of suicides, and acute psychoactive substance use, and intoxication mentioned in 29% of suicides (Life in Mind Australia, 2024a).

Populations disproportionately impacted by suicide

Suicide and self-harm are complex, and can affect people of all ages, cultures, sexual orientations, occupations and places they live. However, it is widely acknowledged that some groups of people have a disproportionately increased risk of suicide than that of other populations. Understanding the different needs for these populations, can assist in our approach to promotion of mental health and wellbeing, prevention and postvention initiatives which can be different in these communities. In addition, there are many people who may identify with and form part of multiple communities that are disproportionately impacted by suicide and therefore it is important to consider this diversity.

The *South Australian Suicide Prevention Plan 2023-2026*, identifies that the following population groups, people's life experiences or identities, may experience increased or disproportionate risk of suicide (Government of South Australia, 2023):

- Aboriginal people
- Men
- People living regional, rural and remote
- People who have experienced thoughts of suicide, behaviours &/or attempts
- LGBTIQA+ communities
- Veterans
- People experiencing discrimination
- Migrants
- First responders
- People who have had contact with the criminal justice system
- Children and young people along with people who have experienced early life adversity
- People bereaved by suicide
- People who have previously made an attempt on their life
- People whose identity may intersect with more than one of these groups/identities

Information about the known disproportionate impacts on some of the specific population groups within Country SA PHN region is provided below. While the specific disparities and the way they manifest differs between communities, recurring themes include experiences of discrimination, economic insecurity, stigma, poor health outcomes, and reduced access to supports capable of responding to their needs (National Suicide Prevention Office, 2024).

People living in our outer regional, remote and very remote communities

Consistent with the national pattern, age-standardised rates of suicide and self-inflicted injuries in people aged less than 75 years old in South Australia increased with increasing remoteness. Based on data from 2018 to 2022, the rates of suicide and self-inflicted injuries of people aged 0 to 44 years in very remote South Australia (13.4 per 100,000) were double the rates in the major city (6.6 per 100,000) (PHIDU, 2024d).

Rural and remote South Australian communities are diverse with each varying in size, population dispersion, culture, ethnicity, proximity to other towns and regional centres, and other demographic factors. Planning for the prevention of rural suicide at the local and regional level needs to take this diversity and variation into account. The increased risk within rural communities relates to unique challenges, particularly economic and environmental circumstances.

In the last five years, regional South Australian communities have faced floods, bushfires and droughts. Such events impact the wellbeing and economic security of rural communities often for prolonged periods causing significant immediate and long-term post-traumatic stress disorder, depression, anxiety, loss of income, social isolation, increased familial conflict and lowered resilience which in turn can increase suicide risk (Black Dog Institute, 2020; Hazell T, 2017; Health Performance Council, 2014). Additionally, access to mental health service is limited in some rural communities, in turn reducing help-seeking and appropriate counselling or treatment options.

A recent comprehensive assessment of aftercare service needs using data on deaths from suicide and self-inflicted injuries, hospital admissions for intentional self-harm, and selected socio-demographic indicators identified the following regional locations within Country SA PHN with higher needs for aftercare services: Limestone Coast, Mid North, Murray Mallee and Eyre Peninsula–South and West. Small area analysis also identified locations within the Fleurieu region (CSAPHN, 2024a).

Young people

In South Australia, intentional self-harm [suicide] (X60-X84, Y87.0) was the leading cause of death for people aged 15-24 years in 2022, accounting for 38% of total deaths in this age group (ABS, 2023a).

From 2018-2022, there were 22 deaths of children aged 5-17 years in South Australia, a rate of 2.4 per 100,000, the same as the national rate for this period (ABS, 2023a).

Results from the *Australian Youth Self-Harm Atlas study* identified that compared to the 31 other PHNs nationally, Country SA PHN had the 5th highest prevalence rates for self-harm and the 4th highest suicidality prevalence for children aged 12-17 years. Predictive modelling from the study estimates the SA3s of Mid North, Eyre Peninsula–South and West as having high rates of self-harm and suicidality (90th percentile nationally). Further analysis identified self-harm hot spots of statistically significant clusters of high youth self-harm prevalence within the following SA2 regions in country SA: Murray Bride Region, Mannum, Waikerie, Barmera, Goyder, Peterborough - Mount Remarkable, Jamestown, Gilbert Valley, Eyre Peninsula, and West Coast (Hielsher et al., 2022).

Men

In the Country SA PHN region, comparable to national trends, males are more likely to die by suicide at a greater rate than females, with males accounting for 80% of all deaths by suicide from 2018-2022 (AIHW, 2024ae). However, females were more likely to be suicidal than males, with a higher prevalence of suicidal thoughts and behaviours in their lifetime (ABS, 2020-2022).

Aboriginal people

The mental health, wellbeing and lives of Aboriginal people and communities continue to be impacted by colonisation, intergenerational trauma, loss of cultural identity and their social marginalisation in Australian society. This trauma continues to be transmitted across generations. Exposure to stressors such as institutional and cultural racism and socioeconomic marginalisation continues and plays out in all measures of mental health and wellbeing (Martin et al., 2023).

Aboriginal people have higher rates of self-harm and suicide when comparing to non-Aboriginal Australians. Generally, Aboriginal people are more likely to experience racism, disempowerment, cultural dislocation, increased rates of trauma and grief, involvement in the justice system and a myriad of physical illness and chronic disease (Lowitja Institute, 2019). These factors in addition to high proportions living in rural and remote communities, further increases an individual's risk of suicide and self-harm.

From 2018 to 2022, 51 Aboriginal people died by suicide in South Australia, a rate of 23.9 per 100,000, twice the rate of non-Aboriginal South Australians (12.4 per 100,000) (ABS, 2023a). Suicide accounted for four percent of all deaths of Aboriginal persons in South Australia, with males representing the majority of suicide deaths (71%). Intentional self-harm [suicide] (X60-X84, Y87.0) was the 5th leading cause of death among male Aboriginal South Australians and 9th for females from 2018 to 2022.

Suicide is higher among Aboriginal young people. The median age of death from suicide was younger for Aboriginal females (22 years) compared to males (34 years), with an average median age of death of 33 years (ABS, 2023a). National data on rates of death from suicide show that young Aboriginal people aged 1-14 years and 15-24 years of age were over three times as likely to die by suicide as their non-Aboriginal counterparts (ABS, 2023a). Aboriginal youth currently account for six percent of the population aged 0-24 years but 19% of suicide deaths in those under 24 years of age in Australia (PHIDU, 2024c).

People identifying as LGBTIQ+

People who identified as gay, lesbian, or bisexual or use another term to describe their sexual identity were more likely to consider suicide, make a suicide plan and make a suicide attempt than those who identified as heterosexual (Arya et al., 2024).

LGBTIQ+ young people experienced substantially higher rates – more than five times higher – of suicidal ideation (past 12 months) and suicide attempts (past 12 months: four times higher, and lifetime: five times higher) compared to the general population of young South Australians of the same age (Hill et al., 2021).

Respondants to *Writing Themselves In 4*, a national survey of health and wellbeing among LGBTIQ+ young people in Australia, highlighted the burden of suicide faced by young LGBTIQ+ people in South Australia (Hill et al., 2021):

- Three in five (59%) participants had seriously considered attempting suicide in the previous 12 months
- One in four participants (24%) had made a suicide plan in the previous 12 months
- One in ten (10.0%) had attempted suicide in the past 12 months and one in four (25%) had attempted suicide at some point in their lifetime, and

- Three in five participants (63%) reported having ever self-harmed, with two in five (38%) having self-harmed in the past 12 months.

Veterans

The *Royal Commission into Defence and Veteran Suicide* (2024a) which inquired into the systemic issues and risk factors relevant to suicide and suicide behaviours of serving and ex-serving Defence members, revealed that serving in the Australian Defence Forces (ADF) – the Royal Australian Navy (Navy), the Australian Army (Army) and the Royal Australian Air Force (Air Force) – may be associated with an increased risk of death by suicide for some cohorts.

Data demonstrates that both serving and ex-serving populations face higher rates of self-harm and suicidal behaviour and were more likely to die by suicide than comparative cohorts in the general Australian population (AIHW, 2024h; Commonwealth of Australia, 2024a). Further, the rate of suicide for males who separate from the ADF for involuntary medical reasons is three times the rate of those who separate voluntarily (62.7 compared with 22.0 per 100,000 population per year respectively) (AIHW, 2024h).

Ex-serving ADF members who served in the permanent forces also have higher rates of long-term mental health conditions, and ‘deaths of despair’, which refers to deaths caused by suicide, drug or alcohol poisoning, chronic liver disease, or cirrhosis. Males and females who served in the permanent forces are 21% and 81%, respectively, more likely to die by deaths of despair than Australian males and females (Commonwealth of Australia, 2024a).

Almost 90,000 South Australians have previously served (41,861 people) or are currently serving (47,852 people) in the Australian Defence Forces. One third of current or former members live in regional South Australia. As counted by the *2021 Census of Population and Housing*, the Local Government Areas of Adelaide Hills (1,236), Mount Barker (1,223), Gawler (1,161), Alexandrina (1,103), and Barossa (842) had the highest number of veterans.

To better manage the needs of serving and ex-serving ADF members, it is important to understand their experiences and how their characteristics and needs may differ from other Australians. The risk factors for suicide and suicidality in the military context are complex and multifaceted; they can be individual (physical, psychological and psychosocial), influenced by operational stressors, organisational culture, and structural dynamics at an institutional level (AIHW, 2024h; Commonwealth of Australia, 2024a).

Suicide prevention, crisis support, postvention support and aftercare services

As outlined in the *South Australian Suicide Prevention Plan 2023-2026* (2023): “Suicide prevention is taking action to build wellbeing, address all of life’s adversities and strengthen the protective factors already in individuals and communities.”

Suicide prevention requires a range of cohesive, connected and cross sector approaches from broad public awareness and community skill building to practical and compassionate supports for individuals. It requires action from all levels of government, health care systems, front-line health and community workers, workplaces, schools and other education settings, community groups, as well as individual, families and communities, working together to address risk and build protective factors across the lifespan which can reduce and prevent distress well before a suicide crisis occurs (Government of South Australia, 2023; Life in Mind Australia, 2024c).

It is important to ensure that anyone who makes or is impacted by a suicide attempt can access appropriate services and receive care that benefits them. As documented by Arya et al (2024) based on analysis of the *2020–2022 National Study of Mental Health and Wellbeing*, three-fifths of those who made a suicide attempt in the previous 12 months used services including counselling and support service, hospital emergency departments, psychiatrists or psychologists, and GPs. However,

two-fifths of participants who made a suicide attempt did not use any services; this could be due to a perceived lack of need to do so, barriers relating to lack of availability of services, previous poor experiences with services, or stigma.

Public consultation with people with lived experience of suicide related distress and suicide in the development of the *South Australian Suicide Prevention Plan 2023-2026* identified four key themes or enablers to improve suicide prevention outcomes in the state: respecting people as individuals, building stronger communities, building community capacity, strengthening services (Government of South Australia, 2023).

Country SA PHN is committed to providing integrated systems-based regional approaches that support people who have attempted suicide, are at risk of suicide or bereaved by suicide. Supported by Country SA PHN's Suicide Prevention Regional Response Coordinator we engage with and seek to work in partnership with Local Government, Adelaide PHN, Local Health Networks, Aboriginal Community Controlled Health Organisations, South Australian Suicide Prevention Networks, SA Department of Health and Wellbeing and Preventative Health SA, The Office of the Chief Psychiatrist, Suicide Prevention Australia, and other non-government organisations.

We currently commission a number culturally safe community-based suicide prevention interventions across the region in Port Augusta, Whyalla, Port Pirie, Clare and Adelaide Hills. In addition to clinical service provision, our programs focus on reducing stigma, building capacity and confidence of our communities and of our workforces to appropriately respond to suicide and provide best practice suicide prevention care, support and leadership across Country SA in line with the *Working Towards Zero Suicide* initiative.

Barriers to suicide prevention services

Respondents to the *State of the Nation in Suicide Prevention survey*, highlighted a range of service gaps, including (Suicide Prevention Australia, 2024a):

- Lack of services and support for people from culturally and linguistically diverse communities
- Lack of access to community services and wrap-around support
- Not enough face-to-face, peer-led crisis intervention suicide prevention services
- Significant wait times for services for people at risk of suicide
- Services not available in all areas, and
- Limited capability to address the broader, systemic drivers of suicide.

Face to face consultations, paper based and online surveys in conjunction with community forums have been both participated in and facilitated by Country SA PHN to hear directly from the community, key stakeholders and service providers alike to ensure their thoughts and views are heard:

Accessible Services

- Main barriers to accessing Suicide Prevention services:
 - Availability of services
 - Limited access to integrated suicide prevention services within the region
 - Waiting times
 - Distance of travel required to attend service
 - Stigma
- Lack of targeted services for social minority groups such as lesbian, gay, bisexual, transgender, and intersex community (LGBTIQ+) people and people from CALD backgrounds

Follow up Care

- The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient Psychiatric unit, yet in country and regional areas, discharge planning and coordinated follow up care is limited
- Aftercare services are needed across the region – particularly Aboriginal aftercare services
- Expand access for aftercare services to include people who present to hospital for suicidal crisis, self-harm or suicide attempt but are not admitted and people who do not present to hospital but may be referred from primary care settings and safe space services.
- Dedicated care coordination roles are required to support people who have been discharged from hospital after suicidal crisis or suicide attempt to provide a consistent ongoing contact point, short-term support and assistance with care coordination.

Need for community training in suicide prevention

- More community suicide prevention training for the public (e.g. ASIST)
- Training in risk assessment and safety planning is required for all of community and employers alike as identifying the at-risk person is inconsistent and often missed
- Communities and front-line workers need awareness raising and training

Workforce Collaboration

- Prevention services exist in some areas but are not well integrated or known
- Appropriate service mapping is required and needs to be transparent and show how services interconnect
- Dedicated coordination roles within suicide prevention are required to provide systemic oversight at a place-based level, reducing system siloing and duplication to maximise the sustainability of initiatives.
- A nationally consistent approach to attract, train and retain the suicide prevention peer workforce.

Workforce challenges

The suicide prevention workforce spans multiple disciplines and occupations including clinical and non-clinical professions, peer/lived experience workers, community connectors, families, friends and carers and policy makers, commissioners and advisors (National Suicide Prevention Project Reference Group, 2020). People working in service roles outside of the health and community sector are likely to have contact with people experiencing suicidality, mental distress and/or ill-health and play a role in suicide prevention and early intervention (DoHAC, 2023c). The *State of the Nation in Suicide Prevention survey* (2024) highlighted that there are considerable staffing gaps across the suicide prevention sector and limited capacity to meet high levels of demand (Suicide Prevention Australia, 2024a). Similar workforce challenges were acknowledged in the *National Mental Health Workforce Strategy – 2022-2032* regarding critical workforce shortages, maldistribution of current workforce, capacity to support and respond to community need, retention and recruitment issues (DoHAC, 2023c).

Dedicated coordination roles are required in the Suicide Prevention Sector. They are essential to providing systemic oversight at a place-based level, reducing system siloing and duplication and maximising the sustainability of initiatives. They provide the capacity to systematically coordinate and align suicide prevention efforts across the continuum of prevention, intervention and postvention, and provide a lens across Commonwealth, State and Local government-based initiatives and local community services including suicide prevention networks. They also facilitate the capacity for stakeholders across sectors to come together to collectively identify and respond to emerging distress.

A place-based approach is critical to ensuring strategies are nuanced to the needs of local contexts and supportive of flexible and agile responses.

Better support for the lived experience peer support workforce and Aboriginal workforce is also needed. People with lived experience of suicidal behaviour who are ready and properly supported can play an important role in suicide prevention. This includes reducing stigma and discrimination by sharing their experiences, providing advice to funders on priority setting, program design and delivery, research and evaluation, and delivering peer-supported or peer-led programs (National Suicide Prevention Project Reference Group, 2020). Caring and supervision for existing workforce and attracting people into the workforce needs consideration; this was highlighted during consultations on the *Advice on the National Suicide Prevention Strategy Consultation Draft*.

Also noted from the *Advice of the National Suicide Prevention Strategy Consultation Draft*, there are not enough peer workers to meet the current demand in suicide prevention services and there are challenges related to accessibility of training, a lack of consistency in training requirements and workplace supports (National Suicide Prevention Office, 2024).

Evidence from establishing a regional service in country SA indicates that there is a keen and significant untapped peer workforce many of whom could benefit from training. However, the Certificate IV in Mental Health Peer Work is currently not accessible within country SA, very few providers deliver the qualification in metropolitan Adelaide. Placement opportunities for regional students would need consideration further highlighting the need for workforce planning and capacity building.

Further, qualification and training requirements as well as definition of competencies are inconsistent across jurisdictions and disciplines – the suicide prevention workforce needs a cohesive approach to workforce planning and capability building.

Alcohol and Other Drugs

Alcohol, tobacco and illicit drug use is a major cause of preventable disease, illness and death for Australians (Australian Institute of Health and Welfare, 2019a). Tobacco, alcohol and illicit drug use accounted for 16.1% of the burden of disease in Australia. The harm associated with alcohol and other drug (AOD) use impacts individuals, their families and the community, either directly or indirectly. Impacts can include health harms (e.g. mental health conditions), social harms (e.g. domestic and family violence) and economic harms (e.g. healthcare costs).

AOD use has a significant financial impost on the Australian economy with the use or misuse of select drugs costing billions of dollars annually. For instance, alcohol alone was estimated to cost the Australian economy \$66.82 billion in 2017-18 (Steve Whetton et al., 2021).

Specific population groups experience disproportionate harms associated with AOD use. Priority populations however can change over time and differ due to local circumstances. Nationally, the following priority groups have been identified (Department of Health, 2017b):

- Aboriginal and Torres Strait Islander people
- People with co-morbid mental health conditions
- Young people
- Older people
- People in contact with the criminal justice system
- Culturally and linguistically diverse populations
- People identifying as gay, lesbian, bisexual, transgender and intersex

In South Australia, AOD use has a significant impact on service provision and the health of the community. The large geographic region of country SA denotes different region classifications, different population cohorts and therefore disproportionately affected areas.

Key Points

- Tobacco is the leading modifiable risk factor contributing to disease burden and deaths
- Alcohol, tobacco and cannabis are the most prevalent drugs used in country SA
- Alcohol, amphetamines and cannabis were the leading principal drugs of concern in 2023 for clients receiving AOD treatment within country SA
- Males are more likely to engage in alcohol and other drug use
- Lack of access to the right services at the right time is an ongoing issue across the region

Identified Needs

1. Priority populations have access to high quality, culturally appropriate alcohol and other drug treatment services
2. Integrated alcohol and other drug treatment services and systems for coordinated care across the health and social sector
3. Professionals have the appropriate skills, knowledge and capability to support people with AOD needs

Health Needs

Alcohol and other drug use

Understanding the extent of AOD use in South Australia is important as they influence health, social and economic outcomes in the community. However, negative societal framing of people who use AOD neglects key influencing factors in usage behaviour, including complex trauma and social determinants

of health (Bowden & Crabb, 2021). These perceptions can create barriers to people seeking help exacerbate existing inequalities (Bowden & Crabb, 2021).

AOD service use is often collated in terms of closed treatment episodes, these are a key means of measuring drug service use within a region. A closed treatment episode is a period of contact between a client and a treatment provider that is closed when treatment is completed or has ceased (due to non-attendance, or a change in treatment type, principal drug of concern or delivery setting)(AIHW, 2024c).

Alcohol

Alcohol is the most widely used drug in Australia with 82% of people aged 18+ years reporting alcohol use in 2022-23 (AIHW, 2024aj). The more alcohol a person consumes, the higher their risk of physical and mental illness, injury and death.

Alcohol attributed to 4.5% of the total disease burden in Australia in 2018 (AIHW, 2021a). This burden and its associated cost to the health care system, could be avoided if alcohol was not consumed.

Alcohol consumption is more frequent among the groups with higher socioeconomic status (SES), whereas the lower SES groups tend to report 'condensed' heavier-drinking occasions (Bowden & Crabb, 2021). Yet, even at the same level of consumption, more disadvantaged social groups experience greater alcohol-related harm, emphasising broader health inequalities and a need for targeted care (Bowden & Crabb, 2021).

Risk behaviours

Guidelines have been developed to inform Australians of the health risks associated with alcohol use and provide advice on how to keep risks associated with their drinking low.

The Australian Guidelines to Reduce Health Risks from Drinking Alcohol are defined as (NHMRC, 2020):

Guideline 1: To reduce the risk of harm from alcohol-related disease or injury, healthy men and women should drink no more than 10 standard drinks a week and no more than 4 standard drinks on any one day.

Guideline 2: To reduce the risk of injury and other harms to health, children and people under 18 years of age should not drink alcohol.

Guideline 3: To prevent harm from alcohol to their unborn child, women who are pregnant or planning a pregnancy should not drink alcohol. For women who are breastfeeding, not drinking alcohol is safest for their baby

Prevalence

Based on exceeding Guideline 1, the *National Drug Strategy Household Survey 2022–2023* identified that, in country SA (AIHW, 2024ak):

- 39.7% of people aged 14 and older consumed alcohol in ways that increase their risk of alcohol-related harm (age standardised)

The survey also found that in country SA, in 2022-23 (AIHW, 2024ak):

- 7.2% of people aged 14 and older were identified as 'High risk' and likely to be experiencing alcohol dependence and are likely to require specialist assessment and treatment
- Positively, 18.5% of people had not consumed alcohol in the last 12 months

Demographics

Compared to females, males in South Australia were more likely to drink more than 10 standard drinks per week and more than 4 standard drinks per drinking occasion. Consequently, men more commonly drank alcohol at levels that increase their risk of harm (41.1% vs women: 23.8%)(AIHW, 2024a).

In 2022-23, young South Australians aged 18-24 years were more likely to drink alcohol at levels that increase their risk of harm (43.3%) than the other age groups. South Australians aged 50-59 years were most likely to drink more than 10 standard drinks per week and South Australians aged 18-24 years were most likely to drink more than 4 standard drinks per drinking occasion (AIHW, 2024a).

Daily and weekly alcohol use was more common among older South Australians. One in two South Australians aged 50+ years reported at least weekly consumption (53%) and one in ten people aged 60+ years drank daily (DASSA, 2024b).

Less than one percent (0.9%) of South Australian women who gave birth in 2022 reported they consumed alcohol in the first 20 weeks of pregnancy, and fewer women (0.3%) consumed alcohol after 20 weeks of pregnancy. These rates have been consistent in South Australia since 2020. Nationally, rates of alcohol consumption increased with increasing geographical remoteness(AIHW, 2024f).

Wastewater data indicates that long-term average alcohol consumption, measured by number of standard drinks per 1,000 people per day, is slightly higher in regional Australia compared to capital cities. However, in South Australia, the regional alcohol consumption rate is below that in Adelaide (Australian Criminal Intelligence Commission, 2024).

Treatment

Alcohol was the principal drug of concern for people receiving AOD treatment for their own drug use during 2022-23 in country SA, accounting for 35.9% of distinct clients and 38.4% of closed treatment episodes (AIHW, 2024c).

Tobacco

Tobacco use has been linked to a number of chronic diseases and is the leading preventable cause of premature death (AIHW, 2024d). In 2018, tobacco attributed to 13% of all deaths and 8.6% of the total disease burden in Australia (AIHW, 2021a). Although the tobacco-related burden of disease predominately affects current or past smokers, non-smokers are also at risk of ill-health due to second-hand smoke exposure.

All forms of tobacco use are harmful and there is no safe level of exposure. Tobacco control legislation, policy and public health campaigns have been implemented across Australia to help reduce and prevent the use of tobacco. This includes actions such as banning smoking in public places, creating smoke-free workplaces, restrictions on packaging imagery, health warning displays, tobacco advertising bans, and tobacco taxes (DoHAC, 2024t). These actions have had considerable effect in preventing and reducing tobacco use as evidenced by a marked increase in people never having tried tobacco (1993: 49.1% vs 2022-23: 65.4%) and a significant reduction in daily use (1993: 25.0% vs 2022-23: 8.3%) (AIHW, 2024d).

Despite the overall prevalence of tobacco use in South Australia following a strong downwards trend, higher prevalence groups remain.

Alternate nicotine delivery products including e-cigarettes create emerging health risks and challenges.

Smoking

Prevalence

Over 2022-23 in country SA (AIHW, 2024ak):

- 14.2% of people aged 14 and over are daily smokers, compared to 6.9% in Adelaide (age standardised)
- Since 2016, there has been a steady increase in people aged over 14 who report no longer smoking (25.5%, compared to 22.7% in 2016, age standardised)
- Over half of the population (57.7%) has not smoked more than 100 cigarettes over their lifetime (age standardised)
- 18.5% of people living in outer regional, remote or very remote South Australia smoke tobacco
- 19.9% of South Australians living in SA4 region South Australia-Outback smoke tobacco daily

Over 2022-23, in South Australia (Health Policy Centre, 2024):

- Men aged 15+ are more likely to be daily (10.7%, compared to 6.8% of females) and current smokers (12.6, compared to 8.2%)
- People aged 45-59 years were most likely to be daily (13%) and current smokers (14.2%), followed by 30- 44 year olds (9.0% and 12.3%, respectively)
- 3.3% of school students aged 12-17 were current smokers (had smoked in the past week)
- Female school students were more likely to be current smokers (3.6%), compared to male students (2.8%)
- 2.5% of 12-15 year olds and 5.0% of 16-17 year olds were current smokers

Nationally, between 2019-2022/23, the proportion of people who smoke tobacco daily has decreased in major cities, inner regional, outer regional and remote areas, while remaining steady in very remote areas. This has amplified the disparity in smoking rates, as people in remote and very remote areas are 2.9 times more likely to smoke than those in major cities, compared to 2.0 times more likely in 2019 (AIHW, 2024ai).

Wastewater data shows that nicotine consumption is much higher in regional SA compared to metropolitan Adelaide (Australian Criminal Intelligence Commission, 2024).

E-cigarettes

E-cigarettes, also known as vapes, are a battery-operated device that heats a liquid that the user breathes in. Although e-cigarettes are considered a harm minimisation approach for those who use cigarettes (as it is considered a safer delivery mechanism), it is still associated with considerable harm. Vapes however have been strongly marketed towards young people through their slick design and flavouring profiles (AIHW, 2024d). Evidence suggests that vaping may lead to future smoking behaviour and thus vaping may unravel the tobacco control efforts of the past.

As a result, new laws have recently passed in Australia where the purchase of vapes and vaping products can only be sold by a pharmacy (TGA, 2024). South Australia have also enforced restrictions on the use of vaping in public outdoor areas and the requirement for pharmacy dispensing only on receipt of a prescription (SA Health, 2024c).

Prevalence

In 2023 (Health Policy Centre, 2024):

- 3.8% of people residing in country SA currently use e-cigarettes, increasing from 2.4% in 2020
- The rate of e-cigarette use is almost twice as high in Metropolitan Adelaide (7.0%), compared to Country South Australia

Across South Australia (Health Policy Centre, 2024):

- Men are more likely to be current (8.8%) and daily e-cigarette users (2.3%) than women (4.8% and 1.6% respectively)
- People aged 30- 44 are most likely to be daily users (4.3%), while current use of e-cigarettes is most common in 15-29 year olds (15.1%)
- 15.0% of school students aged 12-17 had used an e-cigarette in the past month
- Female school students were more likely to be use e-cigarettes daily (2.0%), compared to male students (1.7%)
- 7.6% of 12-15 year olds and 31.1% of 16-17 year old students had used an e-cigarette in the past month

Illicit drugs

Illicit use of drugs includes the use of illegal drugs (e.g. cannabis, cocaine, heroin), misuse of pharmaceutical drugs (oxycodone, fentanyl, buprenorphine, steroids), and inappropriate use of other substances such as inhalants (AIHW, 2024ai).

Harms from illicit drugs affects individuals, families and communities alike, either directly or indirectly. Extended use is associated with increased burden of disease, illness, injuries, trauma and mental illness. In 2018, the use of illicit drugs contributed to 3% of the total disease burden in Australia. Opioid use contributed to approximately a third of the illicit drug related burden (0.9% of the total burden) and amphetamines a quarter (0.7% of the total burden) (AIHW, 2021a).

Prevalence

During 2022-23:

- 1 in 5 people (21.2%) aged 14 and older in country SA had used an illicit drug in their lifetime
- 18.4% of people aged 14 and older had used an illicit drug in the past year
- Cannabis was the most common illicit drug used by South Australians (11.1%), followed by cocaine (4.1%)
- Recent cocaine use (i.e. past year) doubled in South Australia between 2016 (2.0%) and 2022-23 (4.1%)
- The misuse of pharmaceutical drugs (e.g. painkillers, opioids, steroids, tranquillisers, etc) was reported by 4.8% of the South Australian population, of which pain-killer misuse was most common (2.0%) (AIHW, 2024ak)
- The most common illicit drug of concern for individuals receiving AOD treatment in country SA, was amphetamines at 30.0% of closed treatment episodes, followed by cannabis (19.8%) (AIHW, 2024b)

Barriers to harm reduction

There are several factors which can affect the social and health impacts of illicit drug use. Societal perceptions and stigma around illicit drug use, as well as its association with criminality can prevent help-seeking behaviours. Factors associated with people's interaction with the health system include perceived and real costs of help-seeking, concerns about triggering social welfare consequences, resource availability, and capability of health professionals to identify issues and support treatment (Bowden & Crabb, 2021).

Cannabis

Cannabis use in Australia has been relatively stable over the last 20 years with approximately 1 in 9 people having used cannabis in the past year (AIHW, 2024ai). Cannabis was considered an illegal drug up until February 2016 when changes to the *Narcotics Drug Act 1967* allowed medicinal cannabis products to be available to specific patient groups via prescription and under strict medical supervision (AIHW, 2024ay). All other use of cannabis is still considered illicit. The non-medical use of cannabis

increases the risk of mental and physical disease and injury and accounted for 0.3% of the total disease burden in 2018 (AIHW, 2021a).

Long term cannabis use has been linked with significant psychological and physical consequences including psychosocial impacts and cognitive problems. Furthermore, the risk of developing psychotic symptoms doubles among heavy users (Department of Health and Human Services, 2019).

Wastewater data collected in December 2023 shows high levels of cannabis use in regional SA, with two of the four collection sites having the highest estimated consumption rates in Australia (Australian Criminal Intelligence Commission, 2024). However, it is important to consider that wastewater data cannot differentiate between medicinal and non-medicinal use of cannabis.

In South Australia in 2022-23:

- One in nine (11.1%) people had used cannabis in the last 12 months (AIHW, 2024ak)
- People aged 18-24 were most likely to have used cannabis in the last 12 months (28.1%)
- After peaking at 18-24 years, recent use of cannabis steadily decreased with age to its lowest prevalence in the 60+ age group (3.2%)
- Males are more likely to have used cannabis in their lifetime (45.4%) and in the last 12 months (13.9%), compared to females (37.6%, and 8.5%)
- The average age of first cannabis use is 18.7 years old in South Australia which is younger than in 2007 (19.2 years) (AIHW, 2024al)

In country SA, 604 people sought treatment where their principal drug of concern was cannabis (19.8% of all closed treatment episodes) (AIHW, 2024b).

The use pattern of cannabis is relatively stable across the week and is often used in conjunction with tobacco (Bowden & Crabb, 2021).

Amphetamines

Amphetamines are a group of drugs that are classed as stimulants as they increase the activity of certain chemicals in the brain (Alcohol and Drug Foundation, 2024). Some types of amphetamines are used for medical purposes for instance, dexamphetamine is used to treat Attention Deficit Hyperactivity Disorder (ADHD). Amphetamines are also used to treat narcolepsy and Parkinson's disease. Other types of amphetamine are produced and sold illegally. Amphetamine use increases the risk of mental and physical disease and injury and accounted for 0.7% of the total disease burden in 2018 (AIHW, 2021a).

Crystal methamphetamine is the most common form of methamphetamine used in SA (AIHW, 2024al), and is attributed with an increase in harm and violence (AIHW, 2024d).

In 2022-23,

- 1.1% of people aged 14 and over had used amphetamines over the last 12 months in South Australia (AIHW, 2024al)
- Despite amphetamine prevalence being low in South Australia, amphetamine use was the principal illicit drug of concern in approximately a third (30.0%) of all closed AOD treatment episodes in country SA (AIHW, 2024b)
- According to wastewater data, there is a higher consumption of methylamphetamine in regional SA than national average for regional areas (Australian Criminal Intelligence Commission, 2024)

Pharmaceutical drugs

Pharmaceutical drugs are substances used for diagnosis, treatment, prevention or symptom alleviation (AIHW, 2024e). Some pharmaceutical drugs are available over the counter whilst others require a doctor's prescription to dispense. The misuse of pharmaceuticals refers to the use of a prescribed or over-the-counter drug for non-medical purposes. This may include use without a prescription or by a method not described on a packaging label or by a health professional. For instance, taking the drug via a different route of administration, at a different dosage, or in combination with other drugs (AIHW, 2024e).

In country SA, opioids were the principal drug of concern in 4.8% of all AOD treatments in 2022-23 (AIHW, 2024b).

In 2022-23, of people aged 14 and over across South Australia,

- One in 20 (4.8%) had misused pharmaceutical drugs in the last 12 months
- Pain-killers/pain-relievers and opioids were the most common type of pharmaceutical drug misused in the past 12 months (2.0%) (AIHW, 2024ak)
- Males (6.2%) were more likely than females (3.4%) to have misused a pharmaceutical drug in the past 12 months
- Males were likely to misuse pain-relievers or opioids (2.6%) compared to females (1.4%)
- The proportion of females who had recently misused pain-relievers or opioids halved between 2019-2022/23 (3.1% to 1.4%)
- 1.7% of people had misused a pharmaceutical stimulant in the past year (AIHW, 2024ak)

The National Drug Strategy Household Survey updated the way amphetamines were classified, noting the non-medical use of pharmaceutical stimulants, which require a prescription from a medical professional to obtain legally, as a separate category which falls under pharmaceutical drugs (AIHW, 2024e).

Alcohol and drug related harms

The harm associated with AOD use impact on the individual, their families and the community, either directly or indirectly. Impacts can include health harms, social harms and economic harms.

The health impacts of AOD use include hospitalisation, mental health conditions, physical injury, overdose and death. Social harms include engagement in risky behaviours (e.g. drink and drug driving), criminal behaviour and engagement with the criminal justice system, victimisation, intergenerational trauma, unhealthy childhood development, domestic and family violence, and child/family wellbeing. Economic harms of AOD use include healthcare and law enforcement costs, decreased productivity and reinforcement of marginalisation and disadvantage (Bonomo et al., 2019).

AOD use has a significant financial impost on the Australian economy with the use or misuse of select drugs costing billions of dollars annually. For instance:

- Methamphetamine use: \$5.02 billion in 2013-14 (S Whetton et al., 2016)
- Tobacco use: \$136.9 billion in 2015-16 (Makate et al., 2019)
- Cannabis use: \$4.47 billion in 2015-16 (Steven Whetton et al., 2020)
- Opioid misuse: \$15.76 billion in 2015-16 (Makate et al., 2020)
- Alcohol use: \$66.82 billion in 2017-18 (Steve Whetton et al., 2021)

In Australia, alcohol is rated by experts as the drug which causes the greatest harm to users and others combined and scored highest on measures of 'family adversity', 'injury', 'economic costs', 'drug related morbidity', and 'drug specific mortality' (Bonomo et al., 2019).

Compared to Greater Adelaide (5.1%), the rest of South Australia had a higher age standardised rate of alcohol-induced deaths (7.7%) in 2022. This contrasts with 2019, when rates of alcohol induced deaths were similar for the two areas (5.9% and 5.8%, respectively). As this discrepancy follows national trends, there is a renewed need for further investigation into the disparity in alcohol-induced deaths by remoteness (ABS, 2023a).

Crystal methamphetamine has the second highest overall harm score, driven primarily by harms to the user including injury, loss of relationships, crime and drug specific morbidity (Bonomo et al., 2019). Overall harm score for heroin and fentanyl was substantially attributed to drug-specific mortality, compared to cigarettes and alcohol, which had the highest harm associated with economic cost (Bonomo et al., 2019).

Risk behaviours under the influence of AOD

The following risk behaviours were undertaken by South Australians over the past 12 months (AIHW, 2024a):

While under the influence of alcohol:

- 8.7% had driven a vehicle
- 3.0% had gone to work

While under the influence of illicit drugs:

- 15.7% had driven a vehicle
- 8.2% had gone to work

The following harms were experienced by people aged 14 and older by someone under the influence of (AIHW, 2024a):

- Alcohol:
 - Verbal abuse - 19.5%
 - Physical abuse - 6.1%
 - Put in fear - 12.8%
 - Any incident - 22.7%
- Illicit drugs:
 - Verbal abuse - 9.3%
 - Physical abuse - 2.5%
 - Put in fear - 6.2%
 - Any incident - 11.5%

Across South Australia, alcohol was detected in 38.8% of driver and motorcycle rider fatalities in 2022 (Department for Infrastructure and Transport, 2022). In over half of fatalities involving alcohol, the driver/rider had a Blood Alcohol Concentration (BAC) of 0.150 or higher (57.9%). THC, the psychoactive compound found in cannabis, was the most common illicit drug detected in fatal driver and motorcycle rider fatalities (12.2%), followed by methamphetamine (8.2%). Males accounted for 17 of the 19 driver/rider fatalities where a positive BAC was recorded and all 10 fatalities involving illicit drugs (Department for Infrastructure and Transport, 2022).

Family, domestic and sexual violence

Family, domestic and sexual violence (FDSV) can affect any individual, family or community in Australia, however, women experience a majority of these forms of violence. AOD use is both a risk factor and can be used as a coping mechanism for FDSV. It is associated with both perpetration and victimisation and may precede or follow violence (AIHW, 2024p).

After adjusting for a range of demographic and financial factors, those with maltreatment were almost three times more likely to experience generalised anxiety disorders, severe alcohol use disorders, and major depressive disorders, and nearly five times more likely to have post-traumatic stress disorder (AIHW, 2024p). Therefore, consideration for peoples lived experiences is required to contextualise AOD use, which is not captured when solely examining prevalence data.

It is evident that the relationship between AOD use and FDSV is complex and exists within a broader societal context that includes intersecting discrimination risk factors including gender inequality, racism and ableism in addition to systemic barriers to support (AIHW, 2024p).

Drug-induced deaths

The rate of drug-induced death has increased over time in country SA, following national trends, however rates have trended downwards since 2008-13 in Adelaide, highlighting remoteness as a potential exacerbating risk factor. However, while both SA PHNs have a lower unintentional and total drug-induced death rate than the national average, the drug-induced suicide rate is above national average in both jurisdictions (Penington Institute, 2024).

'Unintentional drug-induced deaths' include drug overdoses, drugs given incorrectly or taken in error, and accidental poisoning due to drugs (Penington Institute, 2024). Over 2018-2022, Murray and Mallee SA3 had the highest incidence of unintentional drug-induced deaths (24), followed by Eyre Peninsula and South West SA3 (16), and Limestone Coast SA3 (14). The highest rates of unintentional drug-induced deaths (per 100,000 people) were in the SA3s of Mid North (7.2), Lower North (6.9), and Murray and Mallee (6.6), over the 2018-22 period. However, none of the country SA SA3 areas were among five highest rates in the state (Penington Institute, 2024).

Polysubstance drug-induced deaths

Between 2018-2022, 72.7% of all unintentional drug-induced deaths in Australia involved two or more types of drugs (Penington Institute, 2024). The most common age group for unintentional polysubstance death is 40-49 years, with 30.1% of male and 31% of female deaths. The next most common age group for males was 30-39 year olds, accounting for 26.5% of deaths, while for females it was those aged 50-59 years, who account for one-quarter (25.7%) of such deaths.

Aboriginal people experienced high rates of unintentional single and polysubstance deaths between deaths, 5.8 per 100,000 people (Penington Institute, 2024).

Type of drug

Nationally, opioids were the most common drug type involved in unintentional poly-substance deaths over the five years to 2022, involved in 80.4% of such deaths (Penington Institute, 2024). The only other drug type that was involved in more than half of poly-substance deaths was benzodiazepines, which were involved in two-thirds (65.0%) of these deaths. Anti-depressants (37.9%) and stimulants (35.2%) were each involved in at least one-third of polysubstance deaths, while alcohol was involved in 24.7% of poly-substance deaths. The remaining three drug types (anti-convulsants, cannabinoids, and anti-psychotics) contributed to one-fifth or fewer of these deaths (Penington Institute, 2024).

When considering the types of opioids contributing to drug-induced deaths, pharmaceutical opioids were involved in more than two in five (42.5%) poly-substance deaths, heroin was involved in one-third (33.6%) of these deaths and methadone in almost one-fifth (18.8%) of such deaths (Penington Institute, 2024).

Priority populations

Specific population groups experience disproportionate harms associated with AOD use. Priority populations however can change over time and differ due to local circumstances.

As identified in the *National Drug Strategy 2017-2026*, the following priority groups have a higher risk of experiencing disproportionate harms (direct and indirect) associated with alcohol, tobacco and other drugs (Department of Health, 2017b):

- Aboriginal and Torres Strait Islander people
- People with co-morbid mental health conditions
- Young people
- Older people
- People in contact with the criminal justice system
- Culturally and linguistically diverse populations
- People identifying as gay, lesbian, bisexual, transgender and intersex

At the time of writing, the South Australian Drug Strategy 2024-2030 has not been publicly released. It is anticipated that the priority populations identified in this strategy will be more appropriate and relevant to country SA.

It has been well established that health follows a social gradient, where increased socio-economic position relates to better health (Bowden & Crabb, 2021). Substance dependence and use disorders are commonly associated with low socioeconomic status (SES). Further, Australian data reveal that for all drugs, except cocaine, the number of drug-induced deaths is markedly higher for the most disadvantaged than the most advantaged (Bowden & Crabb, 2021). There are many priority populations with specific experiences and needs in country SA, including emerging groups such as people who inject drugs. Further region-specific data and research is required to understand the emerging priority populations and their needs.

Aboriginal people

AOD use by Aboriginal people needs to be understood within the context of colonisation, and its lasting effects on the Aboriginal burden of disease gap, through factors including marginalization, discrimination and racism, cumulative trauma, poverty, and lack of adequate access to culturally appropriate services (Bowden & Crabb, 2021).

While most Aboriginal people live in major cities or regional areas, 19% live in remote or very remote areas compared to just 1.5% of non-Indigenous Australians (Bowden & Crabb, 2021). Aboriginal people have a much younger age structure, compared to non-Indigenous Australians. For instance, in 2021, the median age was 24 years (ABS, 2024d), compared to the South Australian median age of 41 years (ABS, 2024e).

This difference in age structure also contributes to higher rates of AOD use among Aboriginal people, as its use is more common in younger age groups (Bowden & Crabb, 2021). Aboriginal people are receiving AOD treatment services, as 21.6% of distinct clients identified as First Nations in country SA (AIHW, 2024b). However, key informants in SA indicate that there is a need to work meaningfully and effectively with people in communities, honour their voices and avoid short program lifecycles. It was also noted that Aboriginal people report feeling worried about losing custody of their children if they seek treatment for AOD use (Bowden & Crabb, 2021).

Alcohol consumption by Aboriginal people differs considerably between and within communities, indicating that broad population estimates may not represent individual or local community patterns (AIHW, 2024b). As consumption is often a group-based activity for Aboriginal people, population survey methods may have low acceptability and accuracy (Bowden & Crabb, 2021).

Impact of AOD use on Aboriginal burden of disease gap

Tobacco use is the greatest risk factor contributing to 20.3% of the gap in disease burden between Aboriginal and non-Aboriginal Australians nationally. Alcohol, illicit drug and tobacco use is responsible for a combined 39.9% of the gap in disease burden. Of those factors, alcohol use had the greatest sex-based difference in contribution percentage with 17.8% for males, compared to 7.7% in females (AIHW, 2024ai).

People experiencing homelessness

A recent consultation of key stakeholders and people with lived experience in country SA identified AOD issues are the second highest health concern for people experiencing homelessness, behind mental illness. These concerns are often exacerbated by other health concerns, including mental health issues, poor dental hygiene and chronic disease. It is imperative to recognise that health decisions made by people experiencing homelessness are influenced by many factors, and that needs for shelter, safety and food take priority (Health Q, 2024a).

Barriers to access

People experiencing homelessness face practical challenges in accessing healthcare including (Health Q, 2024a):

- **Transportation:** Affording public transport to attend appointments can be difficult for those without stable housing.
- **Lack of Mailing Address or Phone:** Having no mailing address or phone makes it challenging to receive appointment reminders.
- **Medication Security:** Homeless individuals may struggle to keep medications secure, affecting their ability to manage health conditions.

People with co-morbid mental health conditions

The co-occurrence of a mental illness and substance misuse can be bi-directional; mental illness may make a person more likely to use drugs to provide short-term relief from their symptoms, while other people have drug problems that may trigger the first symptoms of mental illness (AIHW, 2024ai).

Findings from the *National Drug Strategy Household Survey 2022–2023* indicate that compared to people without mental health conditions or psychological distress, people with mental health conditions and people experiencing high levels of psychological distress were more likely to smoke, vape, and drink alcohol at risky levels, and were twice as likely to have used any illicit drug in the previous 12 months (AIHW, 2024x).

Comorbidity of substance use disorder with another mental illness is associated with markedly higher mortality rates and larger reductions in life expectancy (Plana-Ripoll et al., 2020). In the 2023 *Australian Burden of Disease Study*, mental and substance use disorders were estimated to be responsible for 15% of the total burden of disease nationally, placing it second as a broad disease group after Cancer (17%) (AIHW, 2023a).

In Australia, co-occurring mental disorders are common among clients of alcohol and other drugs (AOD) treatment services, with estimates indicating that between 50–76% of people entering alcohol and other drug treatment programs meet the diagnostic criteria for at least one comorbid mental illness (Mills, Marel, Madden, & Teeson, 2019).

Co-morbidity, or the co-occurrence of an alcohol, tobacco and other drug use disorder with one or more mental health conditions, complicates treatment and services for both conditions. Clients experiencing co-occurring mental and substance use disorders typically present to treatment with a more complex and severe clinical profile compared to those with a substance use disorder alone, including poorer general physical and mental health, greater substance use severity, increased risk of

homelessness, poorer social and occupational functioning, greater difficulties in interpersonal and family relationships, and increased risk of suicide (T. M. Kelly & Daley, 2013; Schäfer & Najavits, 2007).

The treatment of mental health and substance use comorbidities require skilled professionals, which can be limited regional South Australia. Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve the collaboration and coordination between services to ensure that the most appropriate treatment and supports are being made available to the individual (Department of Health, 2017b).

LGBTIQA+ community

Nationally, research indicates AOD use is often highly prevalent within LGBTQA+ communities. However, it is important to recognise how this prevalence is reported, as the framing of substance use as problematic among sexual and gender minority individuals has often been used to stigmatise these communities. Therefore, it is important to contextualise these prevalence rates with the unique protective factors and barriers experienced by LGBTQA+ communities when addressing the significant impact that substance use can have on health (Amos et al., 2023).

A recent non-AOD specific stakeholder engagement of LGBTIQA+ people in country SA identified the following recurring themes:

- more specialist LGBTIQA+ services need to be provided in regional areas
- more frequent and targeted LGBTIQA+ training needed for existing services
- better support and services for those aged over 25 and under 65
- properly funded services or LGBTIQA+ supported positions within existing services

Nationally, an increased need for affirming and trauma-informed support of LGBTIQA+ individuals engaged in higher-risk concurrent AOD use behaviours has been identified. A study of AOD use by LGBTIQA+ people found that participants who were classed as 'moderate risk', indicating risk in both alcohol and other drugs measures, were significantly more likely to have experienced sexual assault, harassment, physical threats and verbal abuse in the previous 12 months (Norman et al., 2024). The disparity was most evident when compared to 'low risk' and 'moderate alcohol only risk'. It is important to note the measure of alcohol risk used (AUDIT-C) underrepresents risky alcohol consumption under the current Australian guidelines on heavy episodic drinking, as it classified six or more drinks in a day as risky, instead of four (Norman et al., 2024).

A 2021 study of South Australian LGBTQA+ young people, aged between 14 and 21 years found that (Hill et al., 2021):

- Approximately one-tenth (9.5%) of participants were current smokers, including 7.5% of participants aged 14-17 years
- One in twenty (5.8%) participants reported currently using e-cigarettes or vaping
- Half (50.3%) of participants aged 14-17 years reported ever drinking alcohol
- Among those who drank alcohol, 1 in 5 (18.2%) reported drinking six or more drinks on one occasion at least monthly
- 27.7% of participants reported using any drug for non-medicinal purposes in the past six months, (23.3% of participants aged 14-17, 33.1% of participants aged 18-21)

Further research, data collection and stakeholder engagement are required to build a more comprehensive understanding of LGBTIQA+ individuals and their needs in country SA.

Young people

Many young people experiment with alcohol and other drugs. However, the use of tobacco, alcohol, and illicit drugs is less common among young people in 2022–2023 compared to their peers in 2001.

Despite this decline, drug use among young people is still a concern because adolescents are at risk of permanent damage from substance use due to their developing brains (AIHW, 2024d).

As mentioned previously, 3.3% of school students aged 12-17 were current smokers (had smoked in the past week) (Health Policy Centre, 2024).

Guideline 2 from the *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* recommends that children and people under 18 years of age should not drink alcohol (NHMRC, 2020). However, the 2022-23 *Australian Secondary Schools' Alcohol and Drug (ASSAD) Survey* identified that 69.5% secondary school students aged 12-17 in South Australia had consumed alcohol in their lifetime (DASSA, 2024a).

One in four female high school students (25.5%) reported drinking four or more standard drinks in a single day over the last two weeks, a significant increase from 2017 (18.3%), compared to one in five males in 2022-23 (20.8%) (DASSA, 2024a).

Alcohol use and illicit drug use were the leading causes of total burden of disease for males aged 15-24 years. For females, alcohol use and illicit drug use were the second and third leading causes of disease burden, respectively (AIHW, 2021a).

Older people

The *National Drug Strategy 2017-2026* identified that “older people can be more susceptible to alcohol, tobacco and other drug problems as a result of difficulties with pain and medication management, isolation, poor health, significant life events and loss of independent living” (Department of Health, 2017b). It is evident that these factors must be considered when determining appropriate treatment types and approaches. For further information on medication management, social isolation and the health needs of older people, please see the *Older People* chapter.

Alcohol is the principal drug of concern for older people in south Australia in terms of prevalence, with 28.9% of people aged 60+ at risk of alcohol related harm in South Australia (AIHW, 2024a).

As previously mentioned, daily and weekly alcohol use was more common among older South Australians. One in two South Australians aged 50+ years reported at least weekly consumption (53%) and one in ten people aged 60+ years drank daily (DASSA, 2024b). Despite this, people aged 60+ made up just 4.8% of distinct AOD treatment clients in country SA (AIHW, 2024b).

Service Needs

Country SA PHN-commissioned AOD services

Country SA PHN commissions locally based specialist alcohol and other drug treatment services in line with community need. Services aim to improve access to, and effectiveness of, drug and alcohol treatment services in the community and achieve improved health and social outcomes for individuals, families, and communities at risk of, or currently affected by, substance misuse.

Commissioned service types

Three types of interventions make up the services commissioned by Country SA PHN:

- Interventions to reduce harm
- Interventions to screen, access and co-ordinate care, and
- Intensive interventions.

Within these three interventions the following treatment types are delivered:

- Early intervention, including brief intervention
- Counselling
- Case management and care-coordination
- Non-residential rehabilitation/day programs, and
- Culturally appropriate co-morbid treatment services.

Country SA PHN's commitment to integrated and coordinated AOD services in South Australia

In 2023, a Memorandum of Understanding (MOU) was executed between the two South Australian Primary Health Networks (PHNs) and Drug and Alcohol Services South Australia (DASSA). Under the MOU, the three organisations share a commitment to develop a high quality, coordinated and accessible AOD service system in South Australia.

Intended outcomes are to support the strategic development of an effective and responsive AOD service system in South Australia. The organisations agree to work collaboratively to achieve the below outcomes:

- developing complementary commissioning processes to provide effective and efficient service responses
- developing consistent data collection processes to develop an evidence base that will inform future decisions and directions
- building the capacity of and strengthen connections between service providers to improve service responses and streamline pathways across the sector, and
- improve the health outcomes for priority populations and strengthen connections with the community.

To increase access to targeted and culturally appropriate approaches to AOD treatment for Aboriginal people, Country SA PHN also supports commissioned and other mainstream providers to:

- Provide culturally appropriate services to meet the needs and demand of respective clients.
- Continue to build linkages across the broader drug and alcohol treatment sector, including with Indigenous AOD peak bodies, ACCHOs and primary health care providers.

Data

The main source of data about specialist drug and alcohol treatment services is the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). Commissioned providers collect data in accordance with the AODTS NMDS on specialist treatment services.

In country SA, in 2022-23 (AIHW, 2024b),

- There were 46 publicly funded AOD treatment services
- Alcohol, amphetamines and cannabis accounted for 88.2% of all closed treatment services delivered
- Counselling was the main treatment type for 45.6% of closed treatment episodes, followed by assessment only (22.8%) and support and case management (12.9%)
- 77.7% of closed treatment episodes occurred in a non-residential treatment setting

Of the 3,093 people who received AOD treatment (AIHW, 2024b):

- 63.0% were male, 36.7% were female
- 68.8% were aged between 20-49 years of age
- 21.6% of clients identified as First Nations

Workforce

The AOD workforce comprise workers from a range of occupations including drug and alcohol counsellors, social workers, Aboriginal alcohol and other drug workers, managers, medical practitioners, youth workers, psychotherapists and drug and alcohol nurses. In Australia, drug and alcohol counsellors comprise a quarter of the AOD workforce (Skinner, McEntee, & Roche, 2020).

The SA AOD workforce was estimated to comprise 778 employees working across 573 full-time equivalent (FTE) positions and were primarily employed in allied/other health (217 FTE), administrative/corporate roles (140 FTE) and nursing roles (95 FTE) (Bartram, Muminovic, & Bowden, 2023). Peer workforce accounted for almost 10% (9.1%) of total employees. The majority (58%) of AOD staff were permanently employed, 65% identified as female and 11% identified as Aboriginal or Torres Strait Islander (Bartram et al., 2023).

Capability

Findings from the *Australian National AOD Workforce Survey* of over 1500 AOD workers, conducted from 2019 to 2020, found that along with managing trauma (64%), workers were most concerned about receiving training on working with clients with co-occurring mental health issues (62%), and responding to multiple and complex needs (55%) (Skinner et al., 2020). Four years later these training needs remain; 50% of respondents to the *2023 South Australian AOD Workforce Census* reported training gaps regarding working with clients with co-occurring mental health disorders (50%) and responding to clients with multiple and complex needs (54%) (Bartram et al., 2023).

There should be opportunities to address this gap within the SA AOD workforce – just over half (54%) of responding organisations reporting that at least 75% of AOD staff participated in training or formal study for professional development in the previous 12 months. Additionally, most (70%) responding organisations reported that at least 75% of AOD staff participated in regular clinical supervision, mentoring, or coaching in the previous 12 months (Bartram et al., 2023).

In reference to digital capability, the SA AOD Workforce Census found that (Bartram et al., 2023):

- 88% of organizations have established referral pathways to other organizations or mechanisms to coordinate care for clients with multiple complexities, with 50% describing these pathways as “comprehensive”
- 50% of organizations reported that most or all of their AOD staff have access to telehealth resources, while 37% indicated that most or all of their AOD staff have access to other digital health technologies

In reference to cultural safety, the SA AOD Workforce Census found that (Bartram et al., 2023):

- 96% of organizations offer cultural awareness training for their AOD staff, but it is only mandatory in 71% of these organizations
- 75% of organizations have formal cultural safety policies
- 73% of organizations are committed to achieving culturally safe care
- 63% of organizations have mechanisms in place for obtaining advice on cultural matters

Recruitment and turnover

A recent SA AOD Workforce Census identified that (Bartram et al., 2023):

- 75% of responding organisations recruited AOD staff in the previous 12 months (166 total recruitments)
- 59% of respondents indicated that it was difficult to fill their most recent vacancy
- Almost two-thirds (62%) of vacancies took more than three months to fill
- There was a turnover rate of 16% across the responding organisations

The 2019-20 National AOD Workforce Survey indicated that high stress/ burnout (53%), high workload (39%), low salary (38%), poor career opportunities (28%) and job insecurity (18%) were the top five reasons contributing to turnover in the AOD sector. Additionally, 23% of respondents agreed that they would likely leave their job in the next year, with 14% agreeing they would likely leave the sector in that time frame (Skinner et al., 2020).

Aboriginal AOD workforce

In South Australia, approximately 11% of AOD staff identify as Aboriginal or Torres Strait Islander (Bartram et al., 2023). Compared to metropolitan Aboriginal AOD workers, rural and remote Aboriginal workers were more likely to identify managing risky behaviours as a training gap (68.3%, compared to 43.5%) and less likely to have access to internal clinical supervision/practice support (11.1% vs 38.1%) (McEntee & Skinner N, 2022).

Health Workforce

Workforce issues in rural and remote regions of country South Australia and Australia are well documented and highlighted in national and state health workforce strategies and plans. Rural and remote regions present unique challenges to health service delivery in already complex service landscapes. There are long-standing challenges for rural and remote Australian communities in attracting and retaining a suitably trained multidisciplinary primary care workforce with the appropriate mix of required skills to meet community needs (Argus, 2024).

Recent national government primary health care reforms such as *Strengthening Medicare* and *Australia's Primary Health Care 10 Year Plan 2022-2032* aim to improve the supply, sustainability, appropriateness and distribution of health workforces across Australia but particularly for rural and remote regions, to enable improvements in the quality, accessibility, and affordability of health care services.

Country SA PHN currently supports our rural and remote health workforces in a number of ways. We provide high intensity support for general practice and RACH staff to build digital capability and skills, undertake continuous quality improvement, build professional networks and achieve accreditation. Our workforce education and development activities support the professional development and wellbeing of the primary health workforce in country SA. Our education programs aim to build skills and capacity of general practitioners, RACH staff and allied health professionals, targeting specific topic areas and aligning with identified skills gaps and service needs across the region. We facilitate networking opportunities, and promote team-based care models and collaboration between GPs, nurses, allied health professionals, and other healthcare providers.

Key Points

- The majority of regions across country SA are nationally designated areas of workforce shortage for general practitioners and specialists
- Recruitment and retention of health professionals and the increasing demand for allied health services remains a challenge, adversely impacting primary health care service availability and continuity of care
- Funding, policy, legislative, and capability barriers restrict health professionals to work to optimal scope of practice and provide multidisciplinary care
- Ensuring all health professionals have cultural awareness and services are culturally safe is crucial to reduce access inequity for Aboriginal people and communities

Identified Needs

1. Appropriate support to allied health to improve individual and community health outcomes
2. Appropriate support to general practices to improve individual and community health outcomes
3. Locally relevant professional development and education for primary care clinicians

Primary care workforce

The primary care workforce provides care across a variety of settings including general practice, RACH, community health clinics, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, nursing and midwifery services, oral health and dental services, mental health services, maternal and child health services, urgent care clinics and allied health services such as those offered by physiotherapists, psychologists, and speech pathologists. Within the broader health system, primary care provides a range of services and intersects with several other health and social sectors to provide care (DoHAC, 2024u).

Across this diverse service landscape, there is a critical need to effectively coordinate care and maintain continuity of care, particularly at points of transition between care providers and/or health sectors (DoHAC, 2024u).

Summary of regional workforce needs and opportunities

As identified in the South Australian government's *Rural Health Workforce Strategy 2018–2022* and associated rural workforce plans, South Australia faces many challenges in recruiting, training and developing the health professionals and skilled volunteers needed to deliver health services in rural areas of South Australia. In addition to ensuring there are enough health professions in the right locations to meet the needs of our communities, our regional workforces also need to have the appropriate skills, capabilities and structural enablers to be able to work collaboratively to provide coordinated, person-centred care.

In country SA, health professions across the primary care sector are impacted by the same workforce issues, including (Health Q, 2024b):

- workforce shortages
- high workforce turnover
- skills shortages
- staff with limited experience being required to provide broad generalist services in a high-influence and high-responsibility context
- professional isolation, with limited opportunities for professional collaboration, supervision, and support
- low employment of Aboriginal people in the health workforce
- heavy caseloads, and
- high burnout.

These workforce challenges have significant flow-on effects for service availability, access, quality, continuity, and acceptability.

Workforce shortages, attraction and retention

Recruitment and retention of health professionals in rural and remote locations is an ongoing challenge that is receiving attention from all levels of government and health sector stakeholders.

Regional and rural areas of country SA face health workforce challenges related to an ageing workforce and continued difficulty in attracting, recruiting and retaining health professionals. Key challenges for recruitment and retention in country SA reported by local stakeholders include limited availability of transport and housing options, as well as limited opportunities for training and professional development for health professionals in rural and remote SA. Additionally, workforce retention is influenced by constraints related to family and lifestyle needs such as access to childcare and opportunities for social and recreational activities (CSAPHN, 2023, 2024d).

As identified in the Rural Workforce Agency SA's *Health Workforce Needs Assessment 2024*, workforce supply issues and a reduction in the available levers to attract or direct workforce into rural areas included high levels of primary health care workforce shortages in metropolitan and outer metropolitan areas, blanket Distribution Priority Area (DPA) status for all Modified Monash Model 2-7 locations rather being based on community needs, the transition to national delivery of general practice training, and the new Medical Board of Australia continuing professional development requirements for medical practitioners (Rural Workforce Agency, 2024).

Increasing demand for services and competition for health professionals

The scarcity of healthcare professionals, including doctors, dentists, pharmacists, and allied health professionals, and the expansion in the disability and social services sector is stretching the availability

of an already limited workforce and poses a significant challenge to rural areas in meeting their healthcare needs.

As well as workforce scarcity within the primary health care services, there is also competition for available local health professionals between primary and acute services in many regions of country SA. As documented in the *SA Rural Medical Workforce Plan 2019-2024*, local workforces, particularly GPs who provide primary care services to rural communities, are also contracted to provide emergency care, inpatient management, and procedural services including anaesthetics and obstetrics at local hospitals (SA Health, 2019d).

The shortfall of healthcare workers in rural areas results in increased healthcare costs for rural patients, who may need to travel to urban areas to receive health services. Moreover, the higher cost of hiring fly-in/fly-out and temporary replacements due to staff shortages adds to the already substantial employment expenses in rural healthcare (Nous Group, 2023b).

Culturally safe workforce and services

As identified in the *National Aboriginal and Torres Strait Islander Workforce Strategic Framework and Implementation Plan 2021–2031*, training for professionals across the whole health system is imperative and required to reduce access inequity and ensure Aboriginal and Torres Strait Islander peoples experience culturally safe, appropriate and responsive health care (Rural Workforce Agency, 2024). Country SA PHN encourages and supports all commissioned service providers and their staff, particularly those involved with service delivery, to have cultural awareness and deliver culturally safe services.

Culturally safe, responsive and appropriate models of care are strengthened when Aboriginal peoples are employed within these areas. An Aboriginal health workforce is central in the role of improving health outcomes for Aboriginal communities and for embedding Aboriginal cultural knowledge within clinical and professional practices. The Aboriginal health workforce plays an integral role in improving the health and wellbeing of regional South Australians. However, as identified in South Australian rural workforce plans and in the Rural Workforce Agency *SA Health Workforce Needs Assessment 2024*, Aboriginal people are underrepresented across all health professions in rural SA, and there are low levels of Aboriginal and Torres Strait Islander workforce across regional locations, particularly male Aboriginal Health Practitioners and Workers. A strong Aboriginal and Torres Strait Islander workforce is a powerful driver of change (DoHAC, 2022d; Rural Workforce Agency, 2024).

Scope of practice and provision of multidisciplinary care

As highlighted in *Unleashing the Potential of our Health Workforce Scope of Practice Review* health professionals are often not able to work to their optimal, or full scope of practice due to a range of funding, policy, legislative, and capability barriers that restrict their ability to undertake activities that they have the skill, knowledge, competency and authorisation to perform (DoHAC, 2024u). To support workforce capacity and increase access to health services in country SA there needs to be increased awareness of activities that are within the professionals' scope of practice, particularly for nurse practitioners and Aboriginal health practitioners (Rural Workforce Agency, 2024).

Rates of team care arrangements in Country SA are some of the lowest in Australia (AIHW, 2022d). There is a need to identify and build on successful models of multi-disciplinary care operating in locations that are overcoming significant workforce challenges. Building and formalising relationships between organisations, building collaborative models of care, supportive training environments and professional networks in rural SA and maximising the scope of practice of the current rural workforce will aid to support this (CSAPHN, 2023, 2024d; Rural Workforce Agency, 2024).

Stress and burnout

Health professionals are at heightened risk of experiencing stress, burnout, and the development of mental illness than the general population due to the demanding nature of their work (Productivity

Commission, 2020). Increased personal risk, trauma exposure/re-exposure, and physical demands are among the primary factors which negatively affect the mental health and wellbeing of the health workforce. Evidence suggested that existing mental health issues within the health sector were further exacerbated by the COVID-19 pandemic, with healthcare workers showing significant symptoms of moderate-severe level depression (21%), anxiety (20%) and post-traumatic stress disorder (29%) (Dobson et al., 2021). Providing mental health support reduces the risk of burnout, absenteeism, workforce attrition and ongoing mental health issues such as post-traumatic stress disorder (DoHAC, 2023c).

Workforce distribution

The rural and regional health workforce in country SA is ageing and is affected by broader demographic trends for regional and rural communities. These challenges can be exacerbated by health education, training, and continuing professional development models primarily designed to meet the needs of the metropolitan workforce.

As is the pattern across Australia, access to health practitioners in country SA becomes more difficult at greater distances from major cities (SA Health, 2018). This is reflected in lower per capita Full-Time Equivalent (FTE) rates across all health professions with increasing remoteness.

General Practitioners (GPs)

In country SA, general practitioners (GP) take on extensive roles in the delivery and coordination of both primary and tertiary care, as well as managing the overall wellbeing of clients. In addition to working in the general practice setting, GPs commonly deliver medical services in local hospitals and emergency departments and perform procedural services such as minor surgery and obstetrics. Despite this, the capacity of GPs across country SA continues to fall short of service demand.

Nationally, the *Distribution Priority Area* classification identifies locations where people do not have enough access to doctors, based on the needs of the community. Following an updated classification in December 2023, all regions in Country SA PHN are identified as *Distribution Priority Areas* for GPs, with the exception of a small portion of the Mount Barker GP catchment in the Adelaide Hills (DoHAC, 2024i).

Access to GPs in surrounding regions often becomes more challenging with increasing remoteness. Residents of communities and regions classified lower on the Modified Monash Model (MMM) scale e.g. regional centres (MM2) and larger rural towns (MM3), including communities in the Barossa, Gawler–Two Wells, and Adelaide Hills region, may have higher access to surrounding GPs and broader multi-disciplinary workforce compared to more geographically isolated communities in country SA (as shown in Map 5 in *Our Region* chapter).

In 2023, there were 568 GPs and the GP full-time equivalent (FTE) per 10,000 residents was 11.0 for the Country SA PHN region. The SA3 regions with the lowest GP FTE per 10,000 residents in this region included the Limestone Coast (8.5 GP FTE per 10,000 residents), Yorke Peninsula (9.0) and the Mid North (9.1) (DoHAC, 2024o).

Average clinical hours for GPs working in the country SA were 36.6 hours per week, four hours per week longer compared to GPs working in metropolitan SA in 2023. Average clinical hours also increased with increasing remoteness, 42.8 hours per week for GPs working in MMM 7 regions compared to 35.0 hours per week in MMM 3 regions. GPs working the Lower North SA3 had the highest average clinical hours in 2023 at 44.3 hours per week. Clinical hours were generally longer for GPs working in hospital settings, outpatient services or Aboriginal Community Controlled Health Services, although this did vary by region (DoHAC, 2024o).

The sustainability of GPs in country SA is impacted by an ageing workforce with a high proportion of practitioners who are close to retirement, particularly in rural and remote SA3 regions where

recruitment and retention is particularly challenging (CSAPHN, 2023; Rural Workforce Agency, 2024). The SA3 region with the highest proportion of GPs aged 65+ is the remote Outback–North and East (26% of all GPs aged 65+), followed by the Yorke Peninsula (25%), Mid North (21%), Murray and Mallee (20%) and Eyre Peninsula (16%) (DoHAC, 2024o).

Workforce Planning and Prioritisation Program modelling results

The Workforce Planning and Prioritisation (WPP) program was established and funded by the Department of Health and Aged Care to support the transition to college-led general practice training for the Australian General Practice Training (AGPT) program. The WPP program aims to provide advice on planning and prioritisation of GP training placements to meet current and future GP workforce needs (GPEX, 2024).

The South Australian WPP consortia, led by GPEX, has assessed the training capacity and workforce needs of our region, with the aim of identifying higher-need communities facing limited access to GP services. Areas in high need of additional GP services - that also have the capacity to deliver quality training experiences - are then recommended as priorities for registrar placement (GPEX, 2024).

The modelling incorporated data on the existing GP workforce as well as key demographic and socioeconomic indicators to construct an index of community need to develop a measure of access to services relative to need. Results of the modelling assigned the majority of country GP catchments (54%) to the highest workforce need group. All six LHNs in country SA had catchments in the highest need group: Flinders and Upper North LHN had two (out of five), while nine catchments were in the highest need group in Yorke and Northern LHN (9/17) and Barossa Hills Fleurieu LHN (9/20) (GPEX, 2024).

Nurses

Nurses across country SA play a vital role in the delivery and coordination of healthcare services and provide support, promotion and education to individuals and communities on health management and prevention, however many nurses themselves believe that the current nursing workforce is not able to address the needs of regional, rural and remote communities (DoHAC, 2024d). Nationally, nurses comprise over 40% of the health workforce, with projection analysis predicting a significant gap between supply and demand of the nursing workforce by 2025 (DoHAC, 2024n). Correspondingly, the first *National Nursing Workforce Strategy* is in development in 2024 and is expected to drive solutions to nursing challenges and gaps at a national and local level.

Despite their crucial roles and the increasing health needs of communities, local workforce capacity for nurses remains low for most healthcare settings and SA3 regions in country SA. Based on local Medicare-subsidised service claims made between July 2022 and June 2023, approximately two percent of people in the Country SA PHN region had a service with a nurse practitioner and 10% of people used a practice nurse or Aboriginal health worker service (AIHW, 2024u). Per capita rates of service per 100 people were highest for nurse practitioners in Murray Mallee (10.8 per 100) and Barossa (9.7 per 100) SA3s, and in Outback–North and East (35.9 per 100) and Fleurieu–Kangaroo Island (33.7 per 100) for practice nurse and Aboriginal health worker services.

In 2022, the majority of nurses employed in country SA worked in hospital settings (2,020.4 FTE), followed by residential health care (1,019.8 FTE), community health care services (627.3 FTE) and general practice (305.4 FTE) (DoHAC, 2024o).

The FTE per capita rate for all nurses regardless of role or setting working in country SA was 89.6 per 10,000 people; the per capita FTE for primary care nurses was 5.6 per 10,000. The per capita FTE for practice nurses varied by SA3 regions and tended to increase with increasing remoteness; the lowest rate was 3.2 FTE per 10,000 in Gawler–Two Wells increasing to 18.6 FTE per 10,000 people in Outback–North and East (DoHAC, 2024o).

Allied health professionals

There is no universally accepted definition of allied health professions however there is general agreement that allied health professionals are health professionals that are not part of the medical, dental or nursing professions. They are university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. Allied health practitioners are important to multidisciplinary health teams and provide specialised support for different patient needs (Allied Health Professions Australia, 2024).

Access to allied health services is uneven across Australia due to shortages of allied health workers particularly in rural and remote areas, and complex financing with differing arrangements across the health, aged care and disability care systems (DoHAC, 2022b). Ascertaining the supply and demand of allied health workforce is difficult due to lack of data, particularly for self-regulated and unregulated professions, however, data from the National Health Workforce Data Set (NHWDS) illustrates the distribution of AHPRA registered allied health professionals across country SA, specifically: Aboriginal Torres Strait Islander Health Practitioners, Optometrists, Chiropractors, Podiatrists, Medical Radiation Practitioners, Psychologists, Occupational Therapists, Pharmacists, Physiotherapists, and Paramedicine Practitioners.

Since 2017, the total number of allied health professionals working within the Country SA PHN region has increased by 50%, from 1,356 (1,212.5 FTE) in 2017 to 2,036 (1,970.7 FTE) in 2022. Within country SA, approximately one third (35%) of all allied health professionals in 2022 were employed within large rural towns (MMM 3 regions), one-fifth (21%) employed in small rural towns (MMM 5) and 17% employed in medium rural towns (MMM 4). Variation in access to allied health professionals is evident when comparing per capita FTE across country SA; the rates in Lower North (24.8 FTE per 10,000 population) and Yorke Peninsula (27.2 FTE per 10,000 population) SA3 regions are substantially below the Country SA PHN average of 37.6 FTE per 10,000 population in 2022 (DoHAC, 2024o).

Paramedicine practitioners (436.7 total FTE), followed by Physiotherapists (401.8 total FTE), Pharmacists (335.6 total FTE), and Occupational therapists (267.7 total FTE) were most common allied health professionals employed in country SA. There were comparatively fewer Aboriginal and Torres Strait Islander Health Practitioners (35.4 total FTE), Optometrists (74.8 total FTE) and Chiropractors (76.4 total FTE) and Podiatrists (96.9 total FTE) (DoHAC, 2024o).

With the exception of Medical radiation practitioners and Paramedicine practitioners who were based in hospitals, and Pharmacists who primarily worked in community pharmacy, the main job setting for allied health professionals working in country SA was group or solo private practice (DoHAC, 2024o).

Pharmacists

Pharmacy services are an important part of the primary health care system, providing vital access to prescription medications, professional advice and other health and wellness supplies and programs. While medications can still be obtained through pharmacy depots or online in some remote locations, the presence of a pharmacist and full-service pharmacy is an advantage to a community.

In 2022, there were 345 pharmacists in country SA. The highest ratio of pharmacists to population was in the Mid North, with 8.1 pharmacists per 10,000 population and the Lower North 7.4 per 10,000 population, and the lowest was the Adelaide Hills with 5.1 per 10,000 (DoHAC, 2024o).

Aboriginal and Torres Strait Islander health workforce

The number of Aboriginal Torres Strait Islander Health Practitioners working in the Country SA PHN almost doubled in between 2017 to 2022, increasing from 24 professionals in 2017 to 40 in 2022 (DoHAC, 2024o).

The Aboriginal and Torres Strait Islander health workforce is an enabler to improving health outcomes for Aboriginal and Torres Strait Islander peoples. Country SA PHN offers grant funds for workforce

support and capacity building to Aboriginal Health services throughout country SA. This funding supports the following:

- Staff participating/completing training, professional development, lifestyle programs or other learning activities (accredited or non-accredited; in person or online including workshops and conferences) which result in an increase of knowledge or skills, and
- Cultural activities/events or developed resource that support and improve access to a culturally safe working place.

Dentists and oral health professionals

Dentists and oral health professionals play a key role in the treatment, management, promotion, and prevention of dental and oral health concerns including but not limited to dental caries, gum disease (periodontal disease), oral infections and complications, and oral cancers.

Registered dental practitioners include dental hygienists, dental prosthetists, dental specialists, dental therapists, dentists, and oral health therapists.

The private dental sector is the largest provider of oral health care in South Australia. The number of dental practitioners working in country SA between 2017-2022 has fluctuated around 300, with the majority (82%) working in private practice. The maldistribution of dental practitioners is well documented in regional, rural and remote areas of SA; per capita rates in the SA3 regions of Barossa (2.7 per 10,000 population) and Outback–North and East (3.1 per 10,000) were lower than the regional average of 5.3 per 10,000 (DoHAC, 2024a).

As documented in the *Population Health* chapter of this report, social and economic barriers to access private services result in increased reliance on public dental services for regional and remote populations (SA Health, 2019c).

Challenges reported for the oral health workforce across country SA include recruitment and retention, challenging funding streams and high costs of service delivery compared to metropolitan areas. Further, increasing workloads and long waiting lists commonly contribute to workforce fatigue (SA Health, 2019c).

Aged care workforce

The aged care workforce is made up of a range of health professionals, including registered and enrolled nurses, personal care workers, general practitioners and allied health professionals (National Rural Health Alliance, 2022).

In South Australia, there was 48 direct care FTE positions per 1,000 persons aged 65 years and older, and Aboriginal and Torres Strait Islander people aged 50-64 years.

The number of aged care employees in country SA by ACPR region is (GEN, 2024a):

- Yorke, Lower North & Barossa: 1,627
- South East: 760
- Riverland: 379
- Mid North: 417
- Hills, Mallee & Southern: 1,994
- Flinders & Far North: 144
- Eyre Peninsula: 558

Refer to the *Older People* chapter for further data and commentary about the issues and challenges experienced by the Aged Care workforce in country SA.

Mental health workforce

The mental health workforce plays a critical role in promoting and sustaining the mental health and wellbeing of individuals and communities across Australia (DoHAC, 2023b). The mental health workforce spans promotion, prevention, early intervention, treatment and recovery across the life course to address the needs of consumers and their families, carers and kin.

The mental health workforce includes people who work exclusively in the mental health sector (for example, First Nations mental health workers, mental health nurses, psychologists and psychiatrists) and those that work in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example, allied health, general practitioners and nurses). The workforce also extends to people with lived or living experience of mental ill-health and/or suicide and those working in other settings who are likely to have regular contact with people experiencing mental distress and/or ill-health and suicidality as part of their role (for example, aged care workers, educators, drug and alcohol workers, and housing and justice services workers) (DoHAC, 2023c). Encompassing a broad range of professions, mental health workers exist in a variety of settings including hospitals, clinics, schools, private practices and community centres (DoHAC, 2023b).

Refer to the *Mental Health* chapter for further data and commentary about the distribution of, and issues and challenges experienced by the Mental Health workforce in country SA.

Digital Health

Digital health refers to systems, tools and services based on information and communications technology that can be used to treat patients and collect and share a patient's health information (AIHW, 2024n). Digital health and connectivity are important enablers of the health system in Australia, particularly in rural, remote and regional communities. When implemented effectively, digital health technologies create additional opportunities to access health care and drive benefits to consumers through increased awareness and participation in their health. Additionally, they facilitate efficient communication between multiple health care providers and consumers to drive patient-centred care and support continuity of care. Ensuring equitable access to digital health and connectivity is crucial in supporting improved health outcomes for rural Australians (National Rural Health Alliance, 2024).

Digital health transformation in Australia is guided by a series of key strategic documents including the National Digital Health Agency's *National Digital Health Strategy 2023-2028*, *Connecting Australian Healthcare – National Healthcare Interoperability Plan 2023-2028*, *National Digital Health Capability Action Plan* and the *Cyber Security Strategy 2022-2025*, and the Department of Health and Aged Care's *Digital Health Blueprint 2023–2033*.

Country SA PHN supports the implementation of the national strategic objectives for digital health transformation across our region to improve service integration, clinical decision making, patient safety and the quality of primary health care services. Our focus is to improve knowledge and digital health literacy, build digital capability of providers, facilitate connections and improve collaboration across primary care sectors, and promote the implementation, adoption and effective use of digital health infrastructure and technologies.

Key Points

- There is a high level of uptake of digital health tools and initiatives by general practice and pharmacy but use by other health providers is less mature and therefore low in country SA
- Low Healthcare Provider Identifier-Organisation (HPI-O) registration for the national Health Identifiers Service by Hospitals, Specialist Medical Services, Allied Health providers, and Dental Services in country SA
- Limited access to education, limited access to technology, and variable internet were identified barriers to using and providing telehealth services
- Continued support and education are required to increase the use of My Health Record, secure messaging, electronic referrals and electronic prescribing for all health professionals in country SA

Identified Needs

- Primary health care providers and residential aged care homes are supported to implement digital health initiatives
- Increased utilisation of digital health solutions to facilitate integrated and coordinated care across the health system

Digital health tools and initiatives

Across country SA, there is a growing need for providers to implement digital health tools including Telehealth, Secure Messaging and My Health Record to enhance access to healthcare, improve outcomes, and facilitate the delivery of efficient and coordinated care. Country SA PHN through our Primary Care and Digital Support, Ageing and Palliative Care and, HealthPathways teams educate and support providers and organisations in the uptake and use of a range of different digital health tools and technologies. Additionally, we recognise that cyber security is a growing concern and need, as is the emerging use of artificial intelligence-driven clinical and business technologies in the provision of

primary health care in our region. We will work to support providers to increase their knowledge and understand the requirements, and risks and benefits of use within primary care settings.

Clinical information systems

Country SA PHN provides PenCS licenses to practices in our region as part of our commitment to supporting continuous data driven quality improvement and the delivery of best practice care. As at September 2024, 141 accredited practices (89% of accredited practices) have been issued a PenCS license and actively share data with us.

In 2023/24, 115 practices in our region participated in the Practice Incentives Program (PIP) Quality Improvement (QI) Incentive. General practices enrolled in the PIP QI Incentive commit to implementing continuous quality improvement activities that support them in their role of managing their patients' health.

Clinical decision support tools

Country SA PHN working in partnership with SA Health and Adelaide PHN implement HealthPathways SA, an online, state-wide Clinical Referral Pathway portal, that provides GPs, other health professionals and Residential Aged Care Homes (RACH), with easy access to comprehensive, evidence-based assessment, management and localised referral resources for specific health conditions.

HealthPathways SA has been live since March 2018 with utilisation increasing as content has expanded. As at the end of September 2024, 382 localised pathways were live and 78 were in development. With approximately 1,900 registered users, the portal averages about 2,100 visits per month.

Telehealth

MBS telehealth items have existed since 2002 but were expanded during the COVID-19 pandemic to ensure people could access health care amid lockdowns and social distancing requirements. Most of the temporary MBS telehealth items introduced during the pandemic are now permanent, allowing more clinicians and patients to use telehealth (video) or by phone. According to the Department of Health and Aged Care's analysis of MBS data the proportion of services by telehealth in 2022–23 was 20% for GPs, 11% for non-GP specialists, 12% for allied health and 3% for other clinicians including nurse practitioners and midwives (DoHAC, 2024k).

People living in outer regional, remote or very remote areas of Australia were less likely to use telehealth to see GPs compared to people living in major cities. However, the use telehealth consultations with a medical specialist was higher in regional and remote areas compared to major cities (ABS, 2023b).

Across country SA, many consumers report waiting longer than they feel is acceptable to access GP services. However, the uptake of telehealth has increased since the start of the COVID-19 pandemic and has provided additional opportunities for people to access health care for select services. As of January 2022, GP telehealth and phone services as a proportion of the sum of GP telehealth services, phone services and GP attendances was 41% in South Australia (G. o. S. A. Health Performance Council, 2022). Local health service providers in country SA reported that telehealth has increased in quality and accessibility in mainstream services (CSAPHN, 2023).

In country SA, reported challenges around the uptake of telehealth include limited access to education around use and limited access to technology and internet connectivity to participate in telehealth services, especially in rural and remote settings and Aboriginal health services (CSAPHN, 2023, 2024d).

While face-to-face is the preferred standard of health care for many, telehealth can improve access to health care in some circumstances such as after-hours and in RACH (DoHAC, 2024k). Consultation with

Country SA PHN's Community Advisory Committee found that 73% of survey respondents accessed telehealth and there was overall support for continued and ongoing use of telehealth for delivery of care (CSAPHN, 2020). Specific consultation identified support for use of telehealth for (CSAPHN, 2020):

- GP consults for minor or non-clinical needs such as proof of vaccination, confirming details when there has been a change in care, or a prescription
- Specialist follow-up appointments to reduce time off work, costs associated with travel and accommodation for short consults, and
- Services that can be delivered via video or telephone but otherwise usually require travel (e.g. dietician, mental health services).

Data captured in our CRM through practice visits and/or surveys of primary care providers in country SA document the use of telehealth in the PHN region, with records at end of August 2024 showing 149 general practices, 25 pharmacies and 75 allied health services currently using telehealth (CSAPHN, 2024c).

Digital health in Residential Aged Care Homes (RACH)

Country SA PHN supports RACHs by enhancing their digital capacity, enabling better access to primary care services through virtual consultations when appropriate and safe. This initiative ensures that older individuals in RACHs and Multi-Purpose Services (MPS) have equitable access to urgent care services, regardless of their background or location.

A comprehensive survey conducted across all RACH and MPS locations in country South Australia revealed that telehealth access is still limited in many areas, with lack of availability, training and knowledge as the primary barriers. Respondents highlighted a significant and resounding need for workforce education and support regarding telehealth utilisation and after-hours planning, specifically the necessity for enhanced training and resources to effectively implement telehealth solutions, which have become increasingly vital for providing care, particularly in rural and remote settings. Many respondents expressed a desire for more robust education on how to integrate telehealth into their daily practice, enabling them to better serve their residents and clients (CDMPlus, 2024b).

Telehealth training and support initiatives

In response to the identified demand for comprehensive telehealth training, Country SA PHN commissioned CDM Plus to deliver face-to-face training sessions from October to November 2023. These sessions covered telehealth implementation, usage, policies, and the benefits of digital health records. A total of 116 RACH staff members from 46 RACHs attended, representing 40% of the region's facilities. To reach those unable to attend in person, three additional webinars were offered, attracting 112 more participants (CDMPlus, 2024b).

To ensure ongoing access to resources, RACHs can utilise an online portal until June 2025, which includes training materials on telehealth usage and procedures. Currently, 228 out of 500 available licenses are enrolled in this portal. Training has also been extended to General Practices, with the Primary Care and Digital Support and Ageing and Palliative Care teams promoting these opportunities (CDMPlus, 2024b).

Prior to these sessions, consultations with SA Health's virtual care services aligned goals and facilitated integration with state services, enhancing the virtual care landscape. Equipment purchased through the Country SA PHN telehealth grant has supported both state virtual care services and other telehealth initiatives (CDMPlus, 2024b).

Additionally, recorded online webinars are available via the education portal, along with workbooks to assist RACHs in their telehealth implementation. Country SA PHN staff will continue to provide ongoing training and support to ensure effective resource use (CDMPlus, 2024b).

Healthcare identifiers

The Healthcare Identifiers Service is a national system for individuals, healthcare providers and organisations, using a healthcare identifier. A healthcare identifier is a unique number that ensures healthcare providers can access My Health Record and other digital health tools like electronic prescribing, and accurately view records of the person they are treating. Organisations need a Healthcare Provider Identifier-Organisation (HPI-O) to use the Health Identifiers Service (DoHAC, 2024j).

A range of organisations from across health, aged care, disability care and allied health services can, and should be encouraged, to register for the Health Identifiers Service to support and allow the secure exchange of health information.

HPI-O registrations have been slowing in country SA since 2021. As at the end of the 2023/24 financial year within country SA there were 484 HPI-O registrations for the Health Identifiers Service. Reviewing registrations by organisation type highlights that there are opportunities to increase engagement with providers across country SA to increase registration, particularly for Hospitals, Specialist Medical Services, Allied Health providers, and Dental Services. HPI-O registrations by selected Organisation Type as at 30 June 2024 were (ADHA, 2024):

- General Practice: 174 organisations (100% of organisations)
- Retail Pharmacy: 171 providers
- Allied health: 81 providers
- Residential aged care homes: 20 providers
- Aboriginal Health Services: 6 providers

HPI-O registrations for Public and Private Hospitals, Specialist Medical Services, and Pathology and Diagnostic Imaging Services was low (less than 10) (ADHA, 2024).

Electronic health records

Electronic health records store health information in a secure digital system. Australia's national system is called My Health Record.

My Health Record

My Health Record is a secure digital health record where key health information such as hospital discharge, shared health and event summaries, medication, prescription and dispense records, referrals and specialist letters and pathology and diagnostic imaging reports, advance care plans and organ donation decisions can be stored and accessed by a person and their authorised healthcare providers. It is beneficial to health care providers in instances where patients are unable to converse due to illness, medical emergencies, or other communication barriers (Australian College of Rural and Remote Medicine, 2024). Statistics for South Australia show there were 1.63 million records in September 2024, which is an increase from 1.61 million in September 2023 (Australian Digital Health Agency, 2024b).

Through promotion and awareness raising, registration support and the provision of education and training, the Country SA PHN primary care and digital support and the ageing and palliative care teams have increased the uptake and use of My Health Record with General Practice, Pharmacy and Aged Care services in our region.

My Health Record allows for timely retrieval of patient medical information and offers the opportunity for providers to collaborate in a more agile and efficient manner with other healthcare providers across multiple locations. Effective use of My Health Record is measured by increases in uploads and views of records. Cross views by different HPI-Os are a measure often used to assess how providers are

utilising My Health Record to deliver coordinated care. Discharge summary uploads are also used as an indicator to reflect the coordination between hospitals and GPs.

Data for providers in country SA in 2023/24, show a total of 719,251 cross views of data in My Health Record, including 317,339 documents uploaded that were viewed by other HPI-Os, and 401,912 documents viewed that were uploaded by other HPI-Os. The majority of uploaded documents (85%) were from Retail Pharmacy HPI-Os and 95% of views were by General Practice HPI-Os.

Anecdotally, stakeholders reported that a reason for the continued low rates of discharge summary uploads by HPI-Os in My Health Record may be due to the inoperability of country SA hospital's clinical information systems.

Secure messaging

Secure messaging is a core foundational capability required to enable interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers. Secure messaging supports the delivery of messages containing clinical documents and/or other information between healthcare organisations, sent either directly or through one or more secure messaging providers (Australian Digital Health Agency, 2024c).

To enable secure sharing of information of clinical documents from hospitals in South Australia, SA Health has rolled out a secure messaging solution called HealthLink (HealthLink, 2024).

As of October 2024, a total of 156 sites (organisations) were using HealthLink including 134 general practices and 11 specialists, with 195,622 secure messages sent and received (HealthLink, 2024).

Electronic referrals

Past consultations and surveys with country SA GPs and allied health professionals noted that the use of electronic referrals was limited, and at the time, in 2016, only 46% of general practitioners and 22% of allied health professionals were employing secure messaging software to send information with faxed transfer the main method to send referrals or clinical reports (Country SA PHN, 2016).

While the use of secure messaging has increased for general practice, with the majority of practices in country SA enabled to use HealthLink for this purpose, the uptake by allied health is still maturing.

Data captured in our CRM through practice visits and/or surveys of primary care providers in country SA document the use of e-referrals in the PHN region, with records at end of August 2024 showing 95 general practices using e-referrals (CSAPHN, 2024c).

In September 2023, SA Health launched a single statewide electronic referral (eReferral) management system to enable General Practitioners (GPs) to send referral forms digitally to outpatient clinics, replacing the use of faxes and letters. The program aims to standardise how referrals are managed across the state, leading to improved access to quality healthcare for all South Australians. With the exception of the regional Riverland Mallee Coorong Local Health Network, implementation in regional hospitals will occur after metropolitan hospitals (SA Health, 2024f).

Electronic prescribing

Electronic prescriptions give people a choice of how to access their medications. Electronic prescribing is part of the broader digital health and medicines safety framework and enables the prescribing, dispensing and claiming of medicines, without the need for a paper prescription (DoHAC, 2024h).

Electronic prescribing has benefits to patients, providers and at a system level by reducing the administrative burden for healthcare providers and organisations, reducing prescription and transcription errors, supplementing the delivery of telehealth, and ensuring continuity of care (Australian Digital Health Agency, 2024a).

Throughout 2023/24 Country SA PHN engaged with general practices and pharmacies to offer support specific to fast track implementation of the national electronic prescribing program including Real Time Prescription Monitoring (RTPM), Shared Medicine List and Active Script List (ASL).

As of October 2024, 67% of General Practices (117 practices) reported that they were participating in Electronic Prescribing (CSAPHN, 2024c).

Real Time Prescription Monitoring (RTPM)

RTPM is a nationally implemented system, to monitor the prescribing and dispensing of controlled medicines. Monitored drugs include all Schedule 8 medicines (drugs of dependence) and Schedule 4 medicines that are Benzodiazepines or that contain Codeine when co-prescribed. In South Australia, the ScriptCheckSA system was introduced at the end of March 2021 to help prescribers and pharmacists assess the safety and appropriateness of high-risk prescription drugs (monitored drugs) their patients have been prescribed and supplied. The implementation of RTPM is not mandatory in South Australia (SA Health, 2024e).

Prescriptions and dispense records in My Health Record

In the 2023/24 financial year providers in country SA used My Health Record to support medicine safety. A total of 126 general practices uploaded 1,572,653 prescriptions and 151 pharmacies uploaded 4,392,238 dispense records.

The Medicines View in My Health Record provides a time-saving snapshot for providers of a persons' allergies and adverse reactions as well as medicines information collated from various parts of the My Health Record (SA Health, 2024e). In 2023/24, 36,085 Medicine Views were viewed by 128 general practices, and 1,228 Medicine Views were viewed by 86 pharmacies (ADHA, 2024).

There has been minimal uptake and consequently uploads of the Pharmacist Shared Medicine List in My Health Record.

Opportunities, Priorities and Options

This section summarises the priorities and identified needs from the health and service needs analysis, and options for how they may be addressed.

Priority Area: Aboriginal Health					
Identified Need	Sub Priority	Opportunity	Expected Outcome	Options	Potential Lead
Culturally appropriate health services	Appropriate care (including cultural safety)	Support Access to Care - Health Services	Increase access to culturally appropriate physical and mental health services for Aboriginal peoples and communities, delivered by ACCHOs and mainstream health service providers	Investigate opportunities that support provision of culturally safe care that incorporates Aboriginal and Torres Strait Islander peoples understandings of health and wellbeing	In all activities in this area and below; CSAPHN leading activity in consultation and partnership with Aboriginal Community Controlled Health Organisations, Aboriginal Health Council SA (AHCSA), Drug and Alcohol Services South Australia and SA Health AMS leads
				Support cultural competency in services delivered to Aboriginal and Torres Strait Islander peoples by mainstream health services	
Appropriate support to ACCHOs to improve individual and community health outcomes	System Integration	Improve the Health System - Health Technology	Increase health service implementation and application of technical solutions to improve integration of systems and coordination of care across health services	Support ACCHOs to build skills and capacity around performance-based commissioning. This may include co-designing outcome measures which are culturally safe and appropriate	For targeted sub activities also engaging the Adelaide PHN and Royal Flying Doctor Service
	Workforce	Support Health Services - General Practice/ ACCHOs	Aboriginal Community Controlled Health Organisations are supported to improve individual and community health outcomes and experience of health care through enhancing workforce skills and capacity	In partnership with ACCHOs provide material support according to identified needs to facilitate operational, workforce and service improvements	
Integrated and coordinated multidisciplinary care for Aboriginal people with chronic disease	Chronic Disease (Screening/ Management/Coordination)	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across health services for improved individual health outcomes and experience of health care	Investigate opportunities that support Aboriginal and Torres Strait Islander patients with chronic disease conditions in self-management, with the aims of improving individual and community health outcomes and reducing avoidable hospitalisations	
		Support Access to Care - Health Education	Increase individual and community access to resources that effectively assist use of health knowledge and understanding, increasing choices and supporting decisions on health care		
Screening and early detection services which are appropriate and accessible for Aboriginal people	Early Intervention Prevention / Social Determinants	Support Access to Care - Prevention Activities	Increase individual and community access to preventative health care services	Investigate opportunities that support prevention, early identification and treatment activities	

Priority Area: Aged Care and Older People					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Appropriate support to older people to understand and access the aged and primary healthcare system	Access	Support Access to Care - Health Education	Older people have increased knowledge to navigate the aged care system, support and services	Deliver care finder program Capacity building of service providers and health professionals to support older people	CSAPHN in partnership with Commissioned Service Providers
	Vulnerable population	Support Access to Care - Health Services	Reduced barriers to accessing aged care and primary health services	Deliver care finder program Support health and aged care service providers to adopt digital tools to enhance access to telehealth and afterhours services	CSAPHN in partnership with Commissioned Service Providers
Aged care workforce are supported with skill and knowledge opportunities to improve workforce capacity to deliver person-centred care	Workforce	Support Health Services - Workforce Training & Development	Improved access to training and development opportunities	Deliver skills and knowledge opportunities to improve health and aged care workforce capacity in providing informed health and aged care services	CSAPHN
		Improve the Health System - Workforce Sustainability	Increase in wellbeing education opportunities for aged care workforce.	Deliver skills and knowledge opportunities to improve health and aged care workforce wellbeing and job satisfaction	CSAPHN in partnership with Commissioned Service Providers
Early intervention services which are appropriate and accessible for older people to reduce risk of frailty and deterioration	Early intervention and prevention	Support Access to Care - Prevention Activities	Older people are aware of and accessing services to prevent avoidable hospitalisations	Deliver targeted early intervention activities for older people including care finder program, telehealth afterhours in RACH's, and community/RACH programs	CSAPHN in partnership with Commissioned Service Providers
Appropriate support to older people to have an active role in their own health to stay independent and well in their place of residence	Health literacy	Support Access to Care - Health Education	Older people are better equipped to maintain independence by making informed choices to manage their own health and well-being	Engage with local providers and key stakeholders to explore regional access and the uptake of health, aged care and well-being programs and services	CSAPHN
	Continuity of care	Support Access to Care - Health Services	Increased individual and community access to health, aged care and community services	Cross sector collaboration with stakeholders, to implement varied approaches for older people to maintain independence in the home of their choice	CSAPHN in partnership with Commissioned Service Providers, Aged Care and Community Services
Support integrated and coordinated systems that connect providers and consumers across health, social, community and aged care services	System integration	Improve the Health System - System Integration & Coordination	Increased awareness across community, health and key stakeholders in the aged care system key stakeholders to ensure early awareness and referral to services	Engage with key stakeholders to support and promote the implementation of Commonwealth health and aged care initiatives that support older people's health	CSAPHN in partnership with DOHAC, SA Health and Adelaide PHN and other key stakeholders
	Early intervention and prevention	Support Access to Care - Health Services	Improved system integration and coordination of care across health services to optimise the older person's health, their and aged care journey and improved outcomes	Engage with key partners in health and aged care to explore regional opportunities to enhance the older persons experiences	CSAPHN

Priority Area: Alcohol & Other Drugs					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Priority populations have access to high quality, culturally appropriate alcohol and other drug treatment services	Access	Support Access to Care - Health Services	Reduced barriers to accessing alcohol and other drug treatment services for people from culturally and linguistically diverse backgrounds	Delivery of alcohol and other drug treatment services that respond to the identified needs for population demographics experiencing vulnerability	CSAPHN SA Health Drug and Alcohol Services South Australia (DASSA) Cultural Diversity leads Peak bodies
			Increase individual and community access to health care services	Facilitate use of interpreter services and alternative technological communication support options	
				Targeted co-planning and co-design with Aboriginal organisations to realign currently funded and new activity within CSAPHN AOD scope and funding	ACCHOs Aboriginal organisations
				Facilitate establishment of interventions that screen, assess and coordinate AOD services in country regions	
				Commission and co-design brief intervention, withdrawal management and counselling services responsive to community need	CSAPHN
	Appropriate care (including cultural safety)	Engage with Stakeholders - Community	Increase knowledge and understanding of community health and wellbeing needs to support CSAPHN with effective commissioning of activity and advocacy for communities	Facilitate focused engagements to seek input, opinions, and feedback of people living in regional and remote communities in the design and delivery of AOD services	ACCHOs Aboriginal organisations Drug and Alcohol Services South Australia (DASSA) Adelaide PHN
				Engage with Aboriginal communities to implement community-specific responses and support models to address identified drug and alcohol issues	
				Engage with culturally, ethnically and linguistically diverse populations to identify concerns of significance and opportunities	

Priority Area: Alcohol & Other Drugs					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Integrated alcohol and other drug treatment services and systems for coordinated care across the health and social sector	Continuity of care	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across AOD, health and mental health services for improved individual health outcomes Increase knowledge and understanding of local, state and national health service sector to support CSAPHN with effective commissioning of activity and advocacy for primary health care	Investigate integration of drug and alcohol needs, mental health needs and physical health needs for an integrated and coordinated care approach Further engagement and consultation with the sector via ongoing community and service provider consultation forums Encourage and nurture cross sector referral and integration within mental health and AOD services	CSAPHN Drug and Alcohol Services South Australia (DASSA) ACCHOs Regional LHNs Hospitals
	System Integration	Improve the Health System - Health technology	Improved data practices, including data collection, coding, reporting and dissemination across the country regions	Work with State and Adelaide PHN to in the design and implementation of data indicators and data collection practices across NGOs	SA Government CSAPHN Adelaide PHN
Professionals have the appropriate skills, knowledge and capability to support people with AOD needs	Workforce	Improve the Health System - Workforce Sustainability	Health professionals are supported to increase skills, knowledge and capability, and improve workforce sustainability	Facilitate drug and alcohol upskilling across existing AOD and health programs and funded activity	CSAPHN
		Support Health Services - Workforce Training & Development			South Australian Network of Drug and Alcohol Services (SANDAS)

Priority Area: Mental Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Early intervention and prevention mental health services that are accessible for rural and remote populations	Early intervention and prevention	Support Access to Care - Prevention Activities	Reduce the burden of mental illness through improved access to mental health services	Support region specific, cross-sectoral approaches for people with, or at risk of, mental illness	CSAPHN SA Health Commonwealth ACCHOs
Access to psychosocial support services for people with severe and complex mental health needs	Access	Engage with Stakeholders - Health Service Sector	Psychosocial services are matched to community needs	Engage with local providers and key stakeholders to explore access and uptake of psychosocial services	CSAPHN
Mental health services that are accessible to people living in rural and remote regions	Access	Support Access to Care - Health Services	Increase individual and community access to mental health care services	Work collaboratively to develop consistent referral mechanisms, intake and assessment processes into mental health services Address service gaps and commission appropriate mental health services for local communities and other underserved or hard to reach populations	CSAPHN SA Health Commonwealth ACCHOs
		Engage with Stakeholders - Health Services Sector	Increase knowledge and understanding of community health and wellbeing needs to support CSAPHN with effective commissioning of activity and advocacy of needs for our local communities	Facilitate focused engagements to seek input, opinions, and feedback of people living in regional and remote communities in the design and delivery of mental health services	CSAPHN Lived experience representatives
Mental health services are accessible to support the wellbeing of children and youth	Access	Support Access to Care - Health Services	Increase individual and service provider access to psychiatry assessment and review for young people with complex mental health needs	Facilitate telehealth options for increased access to psychiatry services	CSAPHN headspace SA Health
			Increase individual and community access to health care services	Commission, co-design and promote youth focussed MHAOD services in communities of need including engagement with outreach service providers, lived experience representatives, First Nations and priority populations	CSAPHN Outreach service providers ACCHOs
	Early Intervention Prevention / Social Determinants	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across health services for improved individual health outcomes and experience of health care	Explore effective early intervention models and linkage into youth health services	CSAPHN SA Health

Priority Area: Mental Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Integrated mental health services and systems for coordinated care across the health and social sector	Continuity of care	Improve the Health System - System Integration & Coordination	People are supported to improve service navigation and coordination of care across health services	Implementation of a stepped care model through mental health, alcohol and other drugs reform, and suicide prevention	CSAPHN SA Health DASSA DOHAC
	System integration	Improve the Health System - System Integration & Coordination	Services are integrated and coordinated to improve individual outcomes and experience of mental health care	Work with inter-sectoral partners and use research / data analysis to identify priority activities and inform the development of primary care services Work in partnership with key stakeholders to identify gaps, opportunities and to commission mental health services that meet an identified needs for our community	CSAPHN SA Health ACCHOs
Access to responsive and appropriate mental health services	Appropriate care (including cultural safety)	Engage with stakeholders - Community	Improve individual and community outcomes and experience of mental health services	Facilitate opportunities for community input, including lived experience representatives, First Nations and priority populations, into the design and development of mental health and suicide prevention services	CSAPHN Lived experience peak bodies ACCHOs
	Safety and quality of care	Improve the Health System - System Integration & Coordination	Mental health service providers are supported to improve quality and safety processes	Work with identified service providers and sector representatives to facilitate improved clinical and operational governance practices	CSAPHN Commissioned service providers
	Workforce	Improve the Health System - Workforce sustainability	Health professionals are supported to increase skills, knowledge and capability, and improve workforce sustainability	Specialised staff upskilling across existing mental health programs and funded activity	CSAPHN Commonwealth agencies
			Strengthen the lived experience peer workforce in regional suicide prevention and mental health sector	Identify priority areas for lived experience peer role development in line with national guidance and sector reform	CSAPHN Commonwealth agencies SA Health Lived experience peak bodies

Priority Area: Mental Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Access to suicide prevention services and support for people experiencing suicidal distress and or crisis	Access	Improve the Health System - System Integration & Coordination	Advocate for community health and wellbeing needs and primary health care at a local, state and national level	Work with local communities to understand concerns and opportunities for access Utilise data and statistics to inform advocacy for service delivery Facilitate comprehensive service mapping of the sectors to ascertain service distribution and workforce gaps	CSAPHN Suicide Prevention Networks Local Government
			Improve integration of systems and coordination of care across health services for improved outcomes and experience of care	Targeted commissioning to meet areas of need Support culturally appropriate community-led suicide prevention activity in communities of need in consultation with ACCHOS Support region-specific, cross-sectoral approaches for people with, or at risk of, suicide	CSAPHN SA Health Commonwealth Suicide Prevention Networks Local Government ACCHOs
	Care Coordination	Engage with Stakeholders - Health Services Sector	Improve integration of systems and coordination of care across health services into suicide prevention and aftercare services	Engage and collaborate with Regional LHN's for referral pathways and protocols	CSAPHN SA Health Lived Experience Peak Bodies

Priority Area: Population Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Appropriate health services for culturally and linguistically diverse communities	Vulnerable population	Support Access to Care - Health Services	Reduced barriers to accessing primary health services for people from culturally and linguistically diverse backgrounds	Deliver services that respond to the identified needs for populations experiencing vulnerability Facilitate use of interpreter services and alternative technological communication support options Engage with culturally, ethically and linguistically diverse populations to identify concerns of significance	CSAPHN SA Government Cultural Diversity leads Peak bodies
Health services which prioritise equity and access for vulnerable population groups	Social determinants	Engage with Stakeholders - Health Service Sector	Increase knowledge and understanding of local, state and national health service sector to support CSAPHN with effective commissioning of activity and advocacy for primary health care	Engage with local providers to explore regional access to services and uptake of preventative care	CSAPHN State Government Commonwealth
	Access	Support Access to Care - Health Services	Increase individual and community access to health care services	Deliver regionally appropriate services for communities and population groups at risk of poorer health outcomes and service access barriers	CSAPHN Regional LHNs Community leaders CALD community Service Providers Relevant NGOs
Appropriate and timely sexual and reproductive health services	Access	Support Access to Care - Health Services	Increase individual and community access to health care services Increase availability of services/skilled workforce to deliver services	Deliver education and capacity building activities to support the establishment of sexual and reproductive health services in general practice and ACCHO settings	CSAPHN Sexual and reproductive health peak bodies/training organisations
Access to afterhours primary health care services	After Hours	Improve the Health System - System Integration & Coordination Support Access to Care - Health Services	Improve integration of systems and coordination of care across health services for improved individual health outcomes and experience of health care Increase individual and community access to health care services	Work with State and Commonwealth governments to improve public facing health professional and health service directory/database information for the after-hours period Deliver telehealth/virtual home monitoring health services for chronic disease management	Country SA PHN General Practices Regional LHNs SA Health
Access to services that support developmental health and wellbeing of children and youth	Access	Support Access to Care - Health Services	Increase individual and community access to health care services	Support organisations that provide family and community programs in the target regions	CSAPHN General practices Regional LHNs SA Health

Priority Area: Population Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
	Early intervention and prevention			Deliver targeted programs for children and young people in areas of high need.	Relevant NGOs
Screening and early detection services which are appropriate and accessible for vulnerable population groups	Early intervention and prevention	Engage with Stakeholders - Community	Increase knowledge and understanding of community health and wellbeing needs to support CSAPHN with effective commissioning of activity and advocacy for communities	Co-design screening and detection programs which meet the needs of vulnerable population groups	CSAPHN SA Government
		Support Access to Care - Health Services	Increase individual and community access to health care services	Deliver targeted screening or early detection activities for priority populations in areas of high need	Cultural Diversity leads Research groups Relevant NGOs
Integrated and coordinated multidisciplinary care for people with chronic disease	Chronic Conditions	Support Access to Care - Health Services	Increase access to coordinated, multidisciplinary health services for people with chronic conditions	Virtual/telephone support service for people with heart disease	CSAPHN Allied health providers
	Multidisciplinary care			Deliver regional and remote service models that support multidisciplinary care for chronic conditions	Peak bodies including but not limited to: Asthma Foundation Diabetes Australia Cancer Council Heart Foundation Kidney Foundation Dementia Australia Alzheimer's Australia State and Local Government
	System Integration	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across health services for improved individual health outcomes and experience of health care	Facilitate integrated approaches to chronic condition prevention and management and promotional activity across peak bodies, general practice, allied health, pharmacy and community health services Facilitate coordination of care for individuals who experience frequent or high levels of hospitalisation related to chronic conditions	CSAPHN Peak bodies including but not limited to: Asthma Foundation Diabetes Australia Cancer Council Heart Foundation Kidney Foundation Dementia Australia Alzheimer's Australia SA Health Regional LHNs State and Local Government

Priority Area: Population Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Improvement in immunisation and vaccination rates	Immunisation	Support Access to Care - Prevention Activities	Increase individual and community awareness and access to immunisation and vaccination services	Facilitate opportunities for hard-to-reach populations to access vaccinations.	CSAPHN Immunisation providers Aboriginal Health Council of South Australia ACCHOs
Health service integration, coordination and information sharing across the health system	Access	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across health services for improved individual health outcomes and the experience of health care	Work with communities, ACCHOs, general practice, the six regional LHNs, metropolitan LHNs and the Rural Doctors Workforce Agency to identify opportunities for delivering integrated health services for coordinated care	CSAPHN SA Health Regional LHNs General Practice RDWA ACCHOs
	HealthPathways	Improve the Health System - System Integration & Coordination	Improve integration of systems and coordination of care across health services for improved individual health outcomes and experience of health care	Engage GPs, medical specialists, allied health and other service providers to develop locally relevant pathways of care	CSAPHN APHN Preventative Health SA
				Engage GPs, medical specialists, allied health and other service providers in the use of HealthPathways SA	Regional LHNs
	Multi-Disciplinary Care	Improve the Health System - Health Technology	Increase health service implementation and application of technical solutions to improve integration of systems and coordination of care across health services	Enable multi-party virtual case conferencing to enable activities such as case conferencing with health professionals within across general practice and SA Health Facilitate capacity building and sharing of information between pharmacy, general practitioners and patients	CSAPHN SA Health Local Health Networks General Practice Allied health and pharmacy
Improved integration of Pharmacy in delivering primary health care	Access	Support Access to Care - Health Services	Increase individual and community access to health care services	Deliver innovative pharmacy-led programs to respond to local needs and service gaps	CSAPHN PSA
Improve awareness and access to patient centred palliative care and reduce avoidable hospital admissions	Death Literacy	Engage with Stakeholders - Community	Improved death literacy within communities. Individuals are empowered to make informed decisions about end-of-life care and fostering a supportive environment for those facing death, dying, and loss	Deliver workshops, public forums and resources to educate communities about death, dying and open conversations around these topics	CSAPHN Palliative Care Peak Bodies SA Health Commonwealth
		Engage with Stakeholders - Health Service Sector		Expand access to educational materials, training and support tools to empower non-specialist settings in palliative care delivery	

Priority Area: Population Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
	Appropriate care (including cultural safety)	A public health approach to palliative care by identifying and treating symptoms that may be physical, emotional, spiritual or social	Create compassionate communities equipped with the knowledge, skills, and support networks needed to navigate end-of-life experiences and provide holistic care to individuals and families facing death, grief, and loss	Support collaboration between healthcare providers, community organisations and local groups to enhance collaborative end-of-life care Integrate social, psychological and spiritual support services within palliative care programs to address the full spectrum of end-of-life needs Offer community workshops and preparedness programs that equip people with skills to support one another during terminal illness, death and grief Establish community groups and volunteer programs to provide emotional and practical support for people at the end of life	CSAPHN Local Government Palliative Care Peak Bodies SA Health
		Support Access to Care - Health Services	Access to health care services and preventative care Reduce potentially preventable hospitalisations Early intervention services which are appropriate and accessible for all ages to enhance quality of life and may also positively influence the course of illness Culturally relevant palliative care in rural areas, especially with indigenous communities	Improve integration of systems, telehealth options and coordination of care across health services for improved individual health outcomes and experience of health care Provide training for primary care providers to recognise and address early palliative needs, reducing hospital visits. Develop programs that offer palliative support from diagnosis onwards to improve quality of life Collaborate with Indigenous communities to include culturally appropriate palliative care into all programs Support community-based volunteer programs to offer practical and emotional support to people facing end-of-life issues. Organise community education initiatives, fostering compassionate communities	CSAPHN SA Health Palliative Care Peak Bodies Local Government Commonwealth
	Carer Health & Support		Appropriate support systems to help the family and carers cope during the person's illness and in their own bereavement	Support caregiver networks and respite care options to aid families and carers throughout the person's illness and in their own bereavement	CSAPHN SA Health Palliative Care Peak Bodies Carers SA Australia

Priority Area: Health Workforce					
Identified Need	Sub-Priority	Opportunities	Expected Outcome	Options	Potential Lead
Appropriate support to allied health to improve individual and community health outcomes	Allied Health	Support Health Services - Allied Health	Allied Health service providers are supported to enhance individual and community health outcomes and experiences, as well as to improve the quality and sustainability of health care service delivery	Provide relevant support and promotion of incentives to allied health and/or pharmacy to enable sustainable services Support allied health providers to build business and clinical capacity to deliver high-quality services Support allied health providers to ensure delivery of culturally appropriate services	CSAPHN RDWA SA Health University sector General Practice GP peak bodies ACCHOs AHCSA Allied health
Appropriate support to general practices to improve individual and community health outcomes	Practice Support	Support Health Services - General Practice/ ACCHOs	General Practices and Aboriginal Community Controlled Health Organisations are supported to enhance individual and community health outcomes and experiences, as well as to improve the quality and sustainability of health care service delivery	Provide relevant support and promotion of incentives to general practices to enable sustainable services Support general practices to build business and clinical capacity to deliver high-quality services Support general practice and service providers to ensure delivery of culturally appropriate services	CSAPHN Regional LHNs RFDS CSAPHN
Locally relevant professional development and education for primary care clinicians	Workforce	Support Health Services - Workforce Training & Development	Health service providers and organisations are supported to improve quality and sustainability in the delivery of health care services to individuals and communities Health professionals are supported to increase skills, knowledge and capability, and improve workforce retention	Provide relevant material support to general practice, community health services, ACCHOs, and allied health services in all areas of quality improvement and practice sustainability Facilitate locally relevant education and professional development opportunities for the primary health care workforce	CSAPHN
	Palliative Care	Support Health Workforce - Quality Improvement	Workforce are supported with skill and knowledge opportunities to improve workforce capacity to deliver person-centred care	Provide specialised training to improve the quality of care for end-of-life patients, while boosting staff confidence, satisfaction, and retention Provide materials to support healthcare professionals deliver person centred palliative care Offer training in empathetic communication and cultural sensitivity to help staff engage effectively with patients and families, building trust and respecting diverse needs Develop resilience and teamwork programs to help staff manage the emotional demands of palliative care and improve coordination across disciplines for comprehensive care	CSAPHN SA Health Palliative Care Peak Bodies

Priority Area: Digital Health					
Identified Need	Sub-Priority	Opportunity	Expected Outcome	Options	Potential Lead
Primary health care providers and RACH are supported to implement digital health initiatives	System Integration	Improve the Health System - Health Technology	Increase health service implementation and application of technical solutions to improve integration of systems and coordination of care across health services	Facilitate implementation, provide education and promote digital health initiatives, including but not limited to My Health Record, My Health App, electronic prescriptions, active scripts, Real Time Prescription Monitoring, Web Services, and secure telehealth and messaging services	CSAPHN ADHA Pharmaceutical Society of Australia
	Aged Care	Improve the Health System - Health Technology	Increase health service implementation and application of technical solutions in RACHs to improve integration of systems and coordination of care	Education, promotion and support to RACHs to implement digital health initiatives	CSAPHN RACHs
	Access	Support Access to Care - Health Education	Increase health service implementation and application of technical solutions to improve health outcomes	Support development of technological solutions (e.g. apps) to collect more accurate and timely feedback from consumers	SA Health
Increased utilisation of digital health solutions to facilitate integrated and coordinated care across the health system	Care Coordination	Improve the Health System - Health Technology	Increase health service implementation and application of technical solutions to improve integration of systems and coordination of care across health services	Support health service providers to actively use My Health Record (MHR)	CSAPHN
				Multi-party conferencing to enable activities such as case conferencing to support multidisciplinary team care (with health professionals in different locations including those within SA Health)	CSAPHN SA Health Regional LHNs General Practice
				Work with key stakeholders to develop and implement a secure messaging service to support electronic transfer of health information between providers	Allied Health
	System Integration			Engage with key stakeholders to identify needs for provision of specialist services via telehealth	CSAPHN GPS RDWA ACCHO Regional LHNs Colleges Private sector
				Advocate for improved system interoperability with IT providers to improve connectivity and integration of rural and remote health care providers	CSAPHN
				Work with IT providers in the investigation and implementation of technologies that will enable connections for health care in rural and remote regions whilst endeavouring not to penalise individuals and communities with prohibitive cost	

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